

The Challenge of Older People Living in Aged Care Environments

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Introduction

Aged Care Facilities (ACFs) have different names in different parts of the world. They may be called nursing homes, high care homes or extended care facilities, however the feature that they all have in common is that the older adults who live in such facilities require 24-hour care. In countries such as the United States, United Kingdom and Australia only 5 to 6% of the population over 65 live in ACFs, however the proportion increases with age and approximately 30% of the population aged over 85 live in such facilities. They are, therefore, a relatively small proportion of the older population, however they are also the most frail, dependent and vulnerable and the most in need of high quality care.

What is Challenging About Audiology in Aged Care Environments?

Providing audiological services in ACFs is complex (more complex than providing services to older adults who live in the community) for three main reasons. Firstly, residents in ACFs have more complex health conditions than those living in the community and it is these health conditions that usually have necessitated entry into an ACF in the first place. There is a very high prevalence of communication impairments in older people living in ACFs, a significantly higher prevalence than is found in the wider elderly community (Stumer, Hickson & Worrall, 1996). Research studies typically show that

hearing loss occurs in 80 to 90% of ACF residents (Worrall, Hickson & Dodd, 1993; Jee et al., 1995), compared to approximately 40 to 50% of older adults living in the community. In addition, those in ACFs are more complex in terms of audiological management as they have other serious co-occurring health conditions that complicate the rehabilitation process. The major relevant health conditions are dementia and vision impairment (e.g., Worrall et al., 1993; Erber & Scherer, 1999; Jee et al., 2005).

Secondly, although older people living independently in the community require assistance from others at times, such assistance is essential for ACF residents, and staff in the facilities are the main providers of such assistance. Therefore, education of staff is essential for successful outcomes of any rehabilitation offered, whether it be hearing aid fitting, assistive device fitting, or communication strategy training. However, the education of staff in ACFs is difficult as staff have generally high workload demands and there is a high rate of staff turnover. Burnip and Erber (1996) report that it is common for staff to underestimate the extent of hearing problems in the residents and others have documented that staff have limited knowledge about hearing and focus on physical care with little time to talk to residents (e.g., Kato, Hickson & Worrall, 1996; Garahan et al., 1992). Education of staff is therefore critical for the success of hearing health care in ACFs and it needs to be ongoing to account for the high rate of staff turn-over.

Thirdly, the ACF environment itself is problematic for effective audiological management that will enhance hearing and communication function. The nature of the physical and social environment in ACFs hinders effective and satisfying communication exchanges, thus, special care needs to be taken to provide hearing services that address these issues. The physical environment is problematic because of a lack of privacy, high reverber-

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ation levels and high levels of glare (e.g., Lubinski, 1995; Looi et al., 2004). Likewise, the social environment is restricted with residents having few opportunities to talk, few communication partners and limited topics of conversation and reasons to talk (e.g., Kaakinen, 1995; Lubinski, 1995).

Different Models of Practice – What Works and What Doesn’t?

Traditional audiological care for older people involves audiological assessment and the fitting of hearing aids. Such an approach focuses on the Body Structure and Function, Activity and Participation components of the World Health Organization International Classification of Functioning, Disability and Health (WHO ICF, 2001). The evidence about such traditional audiological approaches is that they fail in the ACF environment. The take-up rates of hearing aid fitting by residents of ACFs are very low and, if aids are fitted, particularly poor outcomes are reported. For example, Ferguson and Nerbonne (2003) reported on 400 residents of four different nursing homes and found that 11% of residents ($n = 40$) had been fitted with hearing aids but only 23 had aids that were working. The most common reasons were because of dead batteries and wax occlusion. Similarly, Cohen-Mansfield and Taylor (2004) found that 28 of 175 residents (16%) identified by staff as hearing impaired successfully wore hearing aids. The American Speech Language Hearing Association stated that only 5 to 10% of hearing aids are used in an ACF at any one time (ASHA, 1997) and our Australian experience is similar to this (Looi et al., 2004; Worrall, Hickson & Dodd, 1993).

The reasons for lack of hearing aid use are complex and multifactorial. Cohen-Mansfield and Taylor (2004) and Looi et al. (2004) have suggested the following reasons:

- Complexity of residents’ health conditions
- Lack of system commitment to aid use
- Inappropriate delegation and care procedures for aid management
- Lack of staff knowledge about hearing aids
- Aid design and fit issues

For the reasons outlined thus far, audiological intervention for residents in ACFs is complex and traditional approaches are unsuccessful. It is argued here that a different model of practice is required for older people living in ACFs. In terms of the WHO ICF, the emphasis should shift from the individual (Body Structure and

Function, Activities and Participation) to the contextual factors that influence the individual’s experiences. Such a model of practice focuses on the environment in which the person lives and it is argued that “treating” the environment more will have great benefits for all residents, the vast majority of whom have a hearing impairment.

The features of an environment model of audiological management for older people in ACFs are:

- The fitting of Hearing Assistive Technology (HAT), particularly personal amplification systems, rather than hearing aids (Pichora-Fuller, 1997; Rizzolo & Snow, 1989). Telephone and television listening systems are also beneficial (Pichora-Fuller & Robertson, 1994).
- Ongoing audiological support provided by clinicians (Lewsen & Cashman, 1997; Looi et al., 2004) or volunteers (Carson, 1997).
- Staff training included as part of the intervention program (Worrall & Hickson, 2003; Looi, Hickson et al., 2004).
- Changes to the physical and social environment are part of the intervention (Looi, Hickson et al., 2004; Worrall & Hickson, 2003). Examples of helpful changes to the physical environment are: arranging face-to-face seating, decreasing the noise from televisions and radios, providing amplification for activities officer and other staff and providing private quiet places for residents to have conversations with visitors. Examples of changes to the social environment that will facilitate communication in ACFs are: matching talkers with talkers in dining area, advising family members about effective communication and developing group communication activities that motivate residents to be more interested in communication.

How Can Audiology for Residents in Aged Care be Improved?

An example of a program that included these features is called the Participation Enablement Program (PEP) and it is described by Looi et al. (2004). PEP is a holistic, communication-focused approach to the rehabilitation of older adults living in ACFs. It was developed by a multidisciplinary team of audiology, speech pathology, social work, nursing, and residential care providers and was applied in a 60 bed facility in Australia. The assessment phase of the project indicated that a small number of the 60 residents needed individual treatment in the form of hearing aid fitting and/or wax removal. The intervention phase was conducted and, in addition

to the small number who needed individual audiological management, the majority of residents benefited from the treatment of the social and physical environment. Staff and families were very satisfied with the approach as they felt they needed more support to provide effective hearing help to residents.

In conclusion, it is argued that current audiological approaches for older adults living in ACFs are not meeting their needs and that it is important for audiologists to think outside the square and provide a different type of service in the future. Key recommendations for improving the current situation are shown in Figure 1.

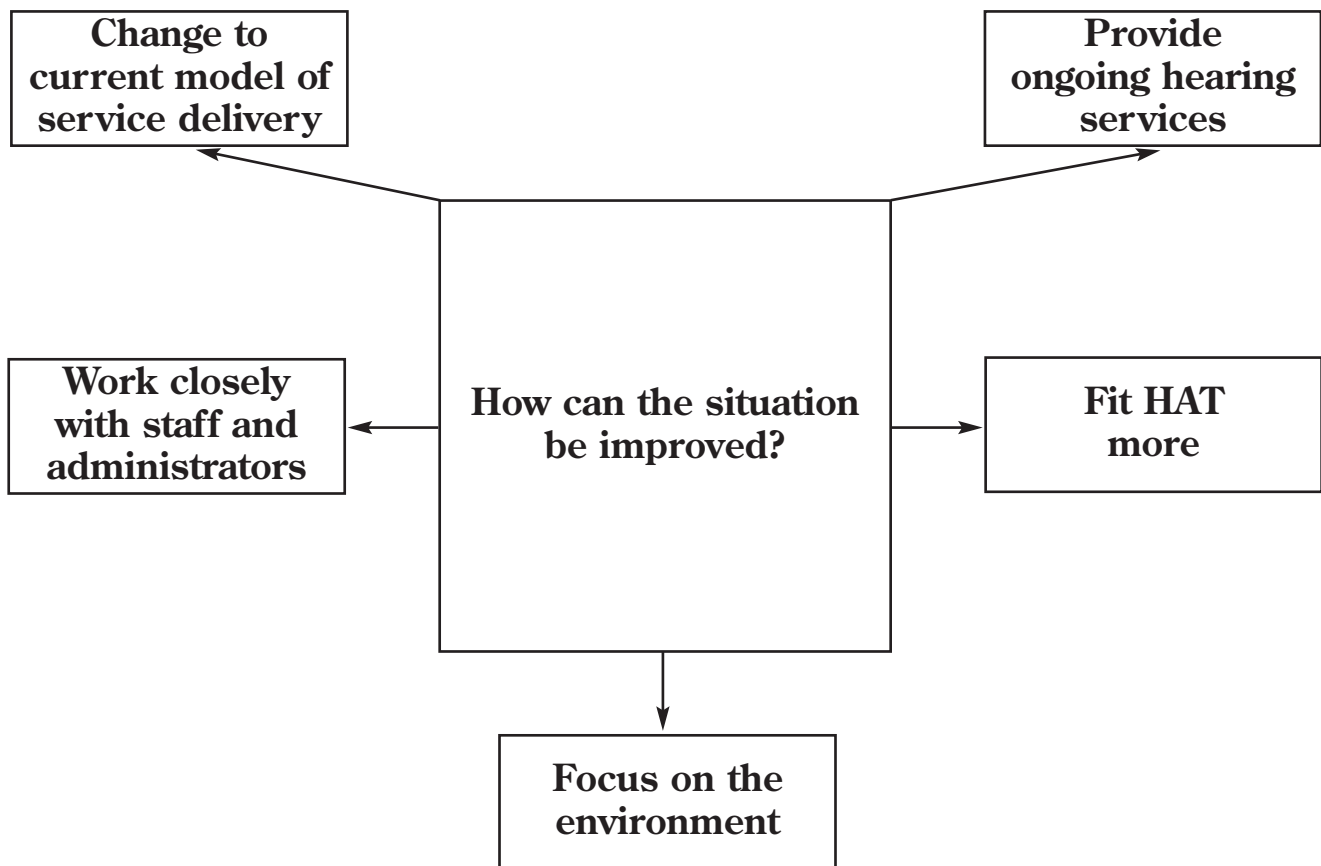


Figure 1: Suggestions for how audiological approaches for older adults in ACFs can be improved.

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