****

**HEARING SERVICES: CLINICAL PRACTICE REVIEW**

**Name: …..…………………**…………………………………………………………………………………………

**Site: ……..**……………………………………………………………………………………………………………..

**Date of review: ..………**………………………………………………………………………………………….

**PURPOSE:**

A clinical practice review should be undertaken between a clinical senior in audiometry nursing (e.g.: CNC, CNS or Clinical Advisor in Audiometry) with the clinician to determine that a best practice approach to the provision of a high quality hearing health service is achieved. Clinical practice review should be completed at least once every 3 years or more often if required.

**GUIDELINES:**

* The environment for testing meets the ANSI/ASA S3.1 or ISO 8253 for maximum acceptable background noise levels for testing with and without headphones e.g. sound field or bone conduction

* The clinic has the essential equipment necessary for conducting hearing assessments including an otoscope, tympanometer with acoustic reflex facility, audiometer with air, bone and masking options, and a paediatric screening audiometer

* The equipment is calibrated annually and is maintained in excellent working order
* Booths are inspected at least 3 yearly by an appropriate technician.

* The length of appointment time is appropriate for a diagnostic assessment (e.g. one hour)
* Relevant State and Territory health department and local health service infection control and work, health and safety guidelines are followed

* A reporting mechanism is in place for statistical data collection
* The audiometry nurse maintains professional standards as per professional organisation guidelines

**WERE ANY POINTS RAISED AT PREVIOUS CLINICAL REVIEW? IF SO HAVE THEY BEEN ADDRESSED? IF NOT, WHY?**

……………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

**CLINICAL ASSESSMENT: To be completed by clinician**

* How often do you conduct audiometry clinics? Are you happy with this, or would you like

to discuss changes? (Recommended minimum 8 hours per month)

……………………………………………………………………………………………………………………………………..

* + What is the usual waiting time for a hearing appointment?

………………………………………………………………………………………………………………..……………………

* + Describe the process at this facility for scheduling appointments:

………………………………………………………………………………………………........................................

* + Is the time allocated to complete each appointment adequate?

………………………………………………………………………………………………………………………................

* + Describe how non attendees are followed up

……………………………………………………………………………………………………………………………………

* Does the testing environment meet the relevant A/NZ Standard?

Yes □ No □

Comment: ……………………………………………………………………………………………………………………..

* + Are there Safe Operating Procedures for each piece of equipment?

Yes □ No □

Comment: ……………………………………………………………………………………………………………………..

* Does the testing environment meet Workplace Health and Safety Standards

Yes □ No □

Comment: ………………………………………………………………………………………………………………..….

* Is there a copy of the current Audiometry Nursing Clinical Practice Standards for the hearing

 service available?

Yes □ No □

Comment: ……………………………………………………………………………………………………………………..

* Is there a copy of the current Clinical Competencies for Audiometry Nurses available?

Yes □ No □

Comment: ………………………………………………………………………………………………………………….

* Do you have adequate tools of trade available?

Yes □ No □

Comment: …………………………………………………………………………………………………………….……..

* Is the equipment checked and calibrated as per operator manual prior to each clinic

Yes □ No □

Comment: …………………………………………………………………………………………………….................

 **ASSESSMENT SKILLS to be completed by assessor**

**History taking and communication skills**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………...

**Otoscopy**

Comments: …………………………………………………………………………………………………………………………..…..

……………………………………………………………………………………………………………………………………………..….

……………………………………………………………………………………………………………………………………………..….

**Tympanometry**

Comments: ……………………………………………………………………………………………………………………………....

………………………………………………………………………………………………………………………………………………...

………………………………………………………………………………………………………………………………………..……….

**Air and bone conduction audiometry**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

**Air and bone conduction masking**

Comments: …………………………………………………………………………………………………………………………..…………………….

……………………………………………………………………………………………………………………………………………..….

……………………………………………………………………………………………………………………………………………..….

**Free field / PA5 screening**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

**Audiometry report form including appropriate report writing**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

**Interpreting and explanation of results to the client/carer**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

**Handouts for clients and other resources**

Comments: ……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………...……

…………………………………………………………………………………………………………………………………………………

**Clinical notes / data collection**

Comments: ……………………………………………………………………………………………………………………….……..

……………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….…

**CLINICIAN’S COMMENTS:**

**Quality or health promotion activities undertaken in the past 3 years**

…………………………………………………………………………………………………………………………………………….…..

…………………………………………………………………………………………………………………………………………….…

……………………………………………………………………………………………………………………………………………….

**Professional development activities related to audiometry nursing in the past 3 years**

………………...………………………………………………………………………………………………………………………..……

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

**What area of your audiometry nursing practice do you feel is your strongest area?**

………………………………………………………………………………………………………………………………………….……..

…………………………………………………………………………………………………………………………………………….…..

………………………………………………………………………………………………………………………………………….……..

**Are there any areas you feel you can improve on or benefit from further knowledge?**

……………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….…

………………………………………………………………………………………………………………………………………….…..…

**Have you considered how could this be achieved? How?**

………………………………………………………………………………………………………………………………………….……

…………………………………………………………………………………………………………………………………………….…

……………………………………………………………………………………………………………………………………….………

**Other comments?**

…………………………………………………………………………………………………………………………………….…………

…………………………………………………………………………………………………………………………………….…………

………………………………………………………………………………………………………………………………….……………

……………………………………………………………………………………………………………………………………...…………

**FUTURE NEEDS OF THE SERVICE**

List what you see as being essential for the continued quality and growth of the hearing service. For example environment, resources, educational needs, professional support.

……………………..………………………………………………………………………………………………………………….……..

**………………….**…………………………………………………………………………………………………………………….…

**………………………….**…………………………………………………………………………………………………….………

 **………………………………**………………………………………………………………………………………………..……..

Signature: ………………………………………………… Print name: ……………………………………………..

Date: ……………………………………………………….. Designation: …………………………………………..

**Assessors Comments:**

……………………………………………………………………………………………………………………………………….………

…………………………………………………………………………………………………………………………………………….…

…………………………………………………………………………………………………………………………………………….…

…………………………………………………………………………………………………………………………………………….…

Signature: ………………………………………………… Print name: ……………………………………………..

Date: ……………………………………………….. Designation: …………………………………………..