The Identification and Assessment of the Needs of Older People with Combined Hearing and Sight Loss in Residential Homes

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Executive Summary for Bupa Charitable Giving on Phase I and II of the project
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Note on terminology
The term resident is used here for those older people who lived in residential homes.
The word carer is used in most cases for staff who work in those residential homes, although more specific terms related to job roles are used where these are relevant.
EXECUTIVE SUMMARY

Aim and overview
This report presents the results and discussion from two phases of a project based on the needs of older people who have combined hearing and sight loss and who live in residential homes, and the training needs of the care staff who work with them. It was carried out by Sense and the University of Birmingham and funded by Bupa Charitable Giving.

Phase I of the project developed the use of a screening tool in care homes to identify those residents with combined hearing and sight loss. The key aims of Phase II were to explore the needs and circumstances of a sample of older residents identified as potentially having both sight and hearing loss, and to assess the training needs of the residential care home staff who work with them. In Phase III the information gathered will be used to develop training and development materials for staff and care workers in residential homes.

Phase I
Phase I (completed by Sense researchers) developed a screening tool based on one originally used in Scandinavia that aimed to identify awareness of hearing and sight loss in older people.

The screening tool contains three sections (A, B and C). Part A includes questions related to a carer’s assessment of the resident’s hearing and visual functioning. Part B and C are aimed at the resident and ask (B) two summative questions about their sight and hearing, and (C) questions related to everyday functioning that is possibly affected by hearing and sight loss.

Care homes within the Birmingham area were contacted to be part of the screening phase of the project. From 121 homes in this area, 13 homes agreed to take part (only eight were included in the end), and the total number of residents within these homes (according to the Care Quality Commission website) was 651. Visits were arranged to meet with the care home managers and care staff to explain the project in detail. All residents who wished to take part and whom staff considered competent, were included, with each resident also giving individual consent. 89 of the
screening tools were returned, with 69 of these giving sufficient data in relation to sight and hearing loss. Of these 69 respondents, 25 were identified as having both hearing and sight difficulties. Discussions with care staff in the homes suggested that the tool was easy to use. Analysis of the use of the tool however suggested several potential areas for further development. These included

- finding out why residents and carers do not identify difficulties consistently with one another (staff and residents frequently did not match in their perceptions of sensory loss)
- rewording sections to make answers potentially less ambiguous
- removing questions which did not discriminate between hearing and sight loss
- changing the instructions and scoring mechanism to be more straightforward

**Phase II**
Phase II involved face to face interviews with both residents and staff, in the residential homes in which the residents lived. This was to explore the needs and circumstances of the residents and the training needs of the care staff. Ethical approval was given by both the University of Birmingham’s Research Ethics Committee and Birmingham City Council’s Research Governance process.

The method chosen for collecting information was the life story interview. This was to enable residents to predominantly talk in the interview, rather than have to listen to and answer multiple, survey-like questions, and to gather deep and rich information that was not shaped too much by the point of view of the researcher.

14 people identified by the screening phase and who were still willing and able to take part were recruited, and each also gave their individual consent. In addition, nine members of staff were interviewed either face to face or by telephone. Interviews were carefully arranged to take account of sensory loss, and wherever possible were carried out in a quiet room away from background noise. Nevertheless a number of participants required a significantly raised voice from the researcher in order to understand the questions.
Residents' self-perception of their hearing and sight loss

None of the residents said that they were registered as sight impaired. Half said that their lives were not really much affected by sight loss, and some thought that their sight was relatively good, although they had difficulty reading. Just over half reported that a hearing loss was affecting their lives, most often in relation to hearing conversation in crowded environments. Five of them had hearing aids which they used, two had hearing aids but did not use them and seven did not have them at all.

None of the participants talked about having a dual sensory loss or deafblindness – rather, they talked about their sight and hearing loss separately, and none of the participants talked about the compounding difficulties from having both sight and hearing loss.

Most residents were fairly pragmatic about their deteriorating hearing and sight, they considered that sensory loss is simply an unavoidable consequence of getting older and that they just had to adjust. However, some were very clear that their remaining vision was very important to them. Having difficulty hearing people when in group situations also appeared to affect many of the residents. This sometimes had particularly bad consequences since many of the activities provided in the homes were group activities, such as talks, quizzes, and social gatherings. Residents who wore hearing aids had sometimes had difficulty in getting them appropriately prescribed, or in using them at all.

Accessing information, mental wellbeing and inclusion in the ‘community’ within the home

Most residents could still read to some degree, though many said that they could not read for long periods. Three had a low vision aid, though one described it as ‘useless’. Good lighting was mentioned as essential to be able to read. In general residents kept up to date by watching television, or in some cases, listening to the radio.

About half of the residents described themselves as ‘content’ although this was sometimes tempered by saying they would rather live at home. Others felt that they had enjoyed busy lives and were not longer able to be active. Family and friends were mentioned by several as key to their enjoyment of present life. Deterioration of sight was a particular worry expressed.

Most residents felt that they had some choices and control over decisions made about their life whilst living in the home, though in some cases they were happy to let trusted staff make decisions for them. Others felt however
that they had no control, including over when they went in or out of the home. Half of the participants said that they regularly socialised with other residents, and many had visits from friends and family. Two residents never went out of the home except for medical appointments. Most took part in some activities within the home, although several mentioned the difficulties of hearing in an environment with background noise. Others were not able to take part in activities which required good vision, in particular many missed being able to read.

**Mobility, independent living skills, and support from staff within the home and external organisations**
Most residents could still walk around although several of them had mobility difficulties related to physical issues and balance as well as possibly to poor sight. Living in a residential home most were not required to do their own washing or make their own meals, but some did need help with eating and it was not clear whether this related to their sight loss. Only two residents had seen any outside agencies (apart from clinicians) in relation to sensory loss, and in both cases this was someone from a voluntary organisation for people with sight loss. Neither of these residents had regular contact with the organisation concerned. Most of the residents could not recall their last involvement with clinicians about their hearing or sight difficulties.

**Key issues identified from interviews with staff**
Nine staff from seven homes were interviewed.

**Facilities offered**
All residents interviewed lived in single occupancy rooms and all homes where staff were interviewed had at least one communal area. Only one of the homes reported that they had a hearing loop system fitted. Otherwise, none of the homes had any adaptations specifically for people with sight and/or hearing loss (as far as those interviewed were aware). Some used large print notices and one ordered a large print newspaper.

**Awareness and understanding of combined hearing and sight loss**
Most staff thought they had not met many people with a combination of hearing and sight loss. While noting that hearing and sight loss would be part of an initial assessment process, this was not explored in detail. Some homes had sections in care plans that covered this, others did not. Most
said that an optician visited regularly, and that the home referred residents with hearing difficulties to GPs. None of those interviewed were aware that the local authority has a duty to provide an assessment for people with combined hearing and sight loss under the Deafblind Guidance. Staff from only two homes were aware of local services for people with hearing and sight loss.

**Communication with residents with combined hearing and sight loss**

All of the residents could still communicate by speech. When asked staff mentioned a range of other communication methods, but they also said that they used clear speech, and four of them mentioned helping residents to care for hearing aids.

**Supporting residents in accessing information, their mental wellbeing and inclusion in the ‘community’ within the home**

Most staff said their overall aims were to support residents in being as independent as they could, to include and involve them. This might include reading letters out loud, or adapting activities to include residents with sight and hearing loss. At one home one to one support would be offered for a trip outside the home for a person with sight loss.

**Training for staff in hearing and sight loss**

Five staff said they had had some training in sensory loss, though sometimes this was generic training. In three cases this was specific training using simulation to mimic eye conditions. Training in the maintenance of hearing aids was much rarer. All but one participant said they would welcome further training in the needs of people with hearing and sight loss and the specific areas they mentioned included; making care plans person centred; information about hearing aids; demonstration of aids to vision.

**Issues arising from the study**

The large number of people who were not included because they were considered unfit to consent is of concern because of the possible interaction between perceived dementia and difficulty in communicating due to combined hearing and sight loss. In addition, this group is very under-researched and more information from their perspective, sought in an ethical way, is badly needed.
Secondly, the number identified as having sensory loss by the screening tool was perhaps lower than expected. Some improvements to the tool have been suggested. The concept of combined hearing and sight loss was broadly unfamiliar to both staff and residents. Thirdly, many residents with hearing loss had difficulty in communicating against background noise. Staff working with audiology departments to try to improve the use of hearing aids could help. Fourthly, simple strategies to help people with combined hearing and sight loss to manage, such as a loop system, large print newspapers, and different coloured plates could help. The importance of one to one contact was recognised by residents (and by the Deafblind Guidance DOH 2009). Fifthly, medical and clinical appointments related to hearing and vision are very important in monitoring deterioration in sight or hearing. Many residents were unaware of when they had last seen, or would next see, a clinician. Staff also need to follow up medical appointments to ensure residents understand what has been said. Sixthly, few homes, and therefore residents, had any contact with voluntary organisations related to hearing or sight loss, or the services and support they could provide. Seventhly, it was difficult to include residents with combined hearing and sight loss in the community life of the home, although this was not always attributed by the individuals to their combined sensory loss. Finally, while residents were appreciative of the efforts of staff for their care, staff had little training in sensory loss (particularly combined sensory loss) and were often too busy to spend much time with residents.