



**Paediatric Audiology care pathway
redesign to meet NICE guideline
CG 60- management of children
with Otitis media.**

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NHS Foundation Trust

Background

- Otitis media with effusion (OME) is a common condition in children with a peak incidence from about 2 to 6 years of age.
- Most cases resolve spontaneously.
- Bilateral hearing loss ($\geq 25\text{dB}$) is the major concern in children with persistent (≥ 3 months) OME.
- OME is an accumulation of fluid within the middle ear space that sometimes causes hearing impairment.
- **The hearing loss is usually transient and self-limiting over several weeks, but may be more persistent and lead to educational, language and behavioural problems.**

Objective

To ensure children receive best practice care in line with the-

- NICE CG 60, guideline for otitis media with effusion in children
- The Trust's key implementation standards
- NHS NW London commissioning criteria (Aug. 2011) for funding for grommets- OME persisted, following a period of watchful waiting, for 3 months from diagnosis And Evidence of delay in speech development educational or behavioural problems attributable to persistent hearing impairment

Sample

- The sample for this audit-
100 children diagnosed with OME in the Direct Access Paediatric Audiology clinic referred by General Practitioners/ School Nurses/ Health Visitors/ Paediatricians in year 2010-11

Methodology

A local Clinical audit undertaken at Paediatric Audiology department, Hillingdon Hospital.

Clinical audit was undertaken in the following way-

- Data obtained through patient audiology clinical notes and Auditbase computer database system
- Data analysis- the package used is MS Excel
- Report written by Harpreet Nijar, Head of Paediatric Audiology Service
- Data collection tool- paper based then input onto a MS Excel spreadsheet.
- Information collected only related to the criteria/ standards

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 1: Percentage of parents/ carers offered evidence-based written information about: <ul style="list-style-type: none"> •The nature and effects of OME, including its usual natural resolution •Various options for treatment of OME including their benefits and risks 	100	100%

All parents/ carers of children should be given evidence- based written information about: the nature and effects of OME (N = 100) - Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
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<p>Standard 2: At the point of formal assessment, the percentage of children for whom the clinical history taking focussed upon:</p> <ul style="list-style-type: none"> •Poor listening skills •Indistinct speech or delayed language development •Inattention and behavioural problems •Hearing fluctuation •Recurrent ear infection or upper respiratory tract infections •Balance problems and clumsiness •Poor educational progress 	100	100%
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All children should have clinical history taken as part of the formal audiological assessment. (N = 100) - Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 3: At the point of formal assessment, the percentage of children with suspected OME for whom the clinical examination focused upon: <ul style="list-style-type: none">Otoscopy	100	100%

All children suspected of OME should have Otoscopic examination as part of the formal audiological assessment. (N = 100) - Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 4: Percentage of children assessed for OME using: <ul style="list-style-type: none">•Audiometry•Tympanometry	100	100%

All children assessed for OME should have age appropriate Audiometry and Tympanometry as part of the formal diagnosis. (N = 100)
Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 5: Percentage of children with persistent bilateral OME documented/ confirmed over a period of 3 months with a hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available), before intervention is considered. The child's hearing re tested at the end of this time	100	100%

All children with OME should have repeat Audiometry over a period of 3 months before any form of intervention is considered. (N = 100)
Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 6: During the active observation period, percentage of children received advice on educational and behavioural strategies to minimise the effects of the hearing loss	100	100%

All children with OME should be advised on educational and behavioural strategies to minimise the effects of hearing loss during the active observation/watchful monitoring period. (N = 100)
Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
Standard 7: Percentage of children with persistent OME and hearing loss offered hearing aids as an alternative where surgery is contraindicated or not acceptable	100	100%

All children with persistent OME and hearing loss should be offered hearing aids as an alternative where surgery is contraindicated or not acceptable.

(N = 100)

Compliance 100/100 (100%)

Findings

Key:	Adherence >90%	Adherence 60% – 89%	Adherence < 59%
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Clinical Standard/ key priorities for implementation	N	Compliance
<p>Standard 8: Percentage of children with Downs syndrome who are suspected of having OME-</p> <ul style="list-style-type: none"> •Hearing aids offered to these children with hearing loss •Before ventilation tubes suggested as an alternative to hearing aids the following factors considered <ul style="list-style-type: none"> –The severity of hearing loss –The age of the child 	100	100%

All Downs syndrome children with persistent OME and hearing loss should be offered hearing aids as the preferred option and ventilation tubes only considered based on the severity of hearing loss and age of the child. (N = 100). Compliance 100/100 (100%)

Observations/Conclusion

The Paediatric Audiology care pathway at Hillingdon Hospital for management of children diagnosed with OME-

- Is 100% compliant with NICE guideline CG 60 within the criteria measured.
- Is an example of Best Practice for children diagnosed with OME.

References

- NICE guideline CG 60, Surgical Management of OME in Children, by the Collaborating Centre for Women's and Children's Health.
- SIGN Guideline 66, Diagnosis and Management of Childhood Otitis Media in Primary Care.
- http://www.northwestlondon.nhs.uk/_uploads/documents/all-documents/ppwt/policies/33-grommets-in-children.pdf

Paediatric Audiology Service

- Direct access service.
- Also supports ENT and Paediatrics.
- A cost effective combined 2nd and 3rd Tier service model.
- The aim is to provide a high quality patient centred hearing care at the first point of contact in a child friendly setting.