

# **Universal Newborn Hearing Screening and Early Intervention Programme**

National Policy and  
Quality Standards

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July 2016



Citation: Ministry of Health. 2016. *Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP): National policy and quality standards* (2nd edn).  
Wellington: Ministry of Health.

First published in June 2013, 2nd edition July 2016  
by the National Screening Unit  
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-0-947515-35-5 (online)  
HP 6447

This document is available on the National Screening Unit website: [nsu.govt.nz](http://nsu.govt.nz)



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# Abbreviations

aABR	automated auditory brainstem response
AoDC	adviser on deaf children
BOA	behavioural observation audiometry
CPA	conditioned play audiometry
dBHL	decibels Hearing Level
DHB	district health board
DNA	did not attend
LMC	lead maternity carer
MOE	Ministry of Education
MOH	Ministry of Health
NHI	National Health Index number
NICU	neonatal intensive care unit
NSU	National Screening Unit
RECD	real-ear aided response
SCBU	special care baby unit
UNHSEIP	Universal Newborn Hearing Screening and Early Intervention Programme
VRA	visual reinforcement audiometry

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# Key definitions

**Offer:** Refers to a verbal offer of newborn hearing screening with information about the UNHSEIP.

A letter sent to parents/guardians that includes the offer of a screening appointment is not in itself an acceptable offer as there is no assurance of it having been received. Where it is followed up with a phone call that confirms the address, or a visiting midwife confirms it has been received, this may constitute an offer of screening.

For the purpose of programme monitoring, the outcome to the offer of screening can be one of the following (see also Figure 1):

**Completed screen:** A final screening outcome has been achieved for the baby with either a 'pass' or 'refer diagnostic' outcome.

**Pass:** Where the baby has a 'pass' screen result for both ears. There is either no follow-up required or hearing surveillance due to the identification of risk factor/s.

**Refer diagnostic:** Where a referral to audiology is indicated because the screening outcome on aABR2 is either 'refer' for one or both ears as indicated on the screening device or is an 'incomplete screen' due to too many attempts or not being able to achieve a successful screen.

**Hearing surveillance:** The programme of hearing checks for babies who pass screening but are identified with one or more of a defined set of risk factors for late onset or progressive hearing loss.

**Incomplete screen:** Where a screen has not been able to be completed due to either:

- three unsuccessful attempts
- an ear not successfully screened.

**No clear response:** The terminology used for communicating results of a screen to parents when either the test result is 'refer' or the screen is unable to be finished due to too many unsuccessful attempts.

**Decline:**

- Active declines – when a parent/guardian explicitly indicates, after an explanation of rationale and process that they do not wish to proceed following an offer of newborn hearing screening for their newborn.
- Also includes where parents/guardians have neither consented nor explicitly declined but indicate they do not wish to be engaged in the programme (Disengaged).

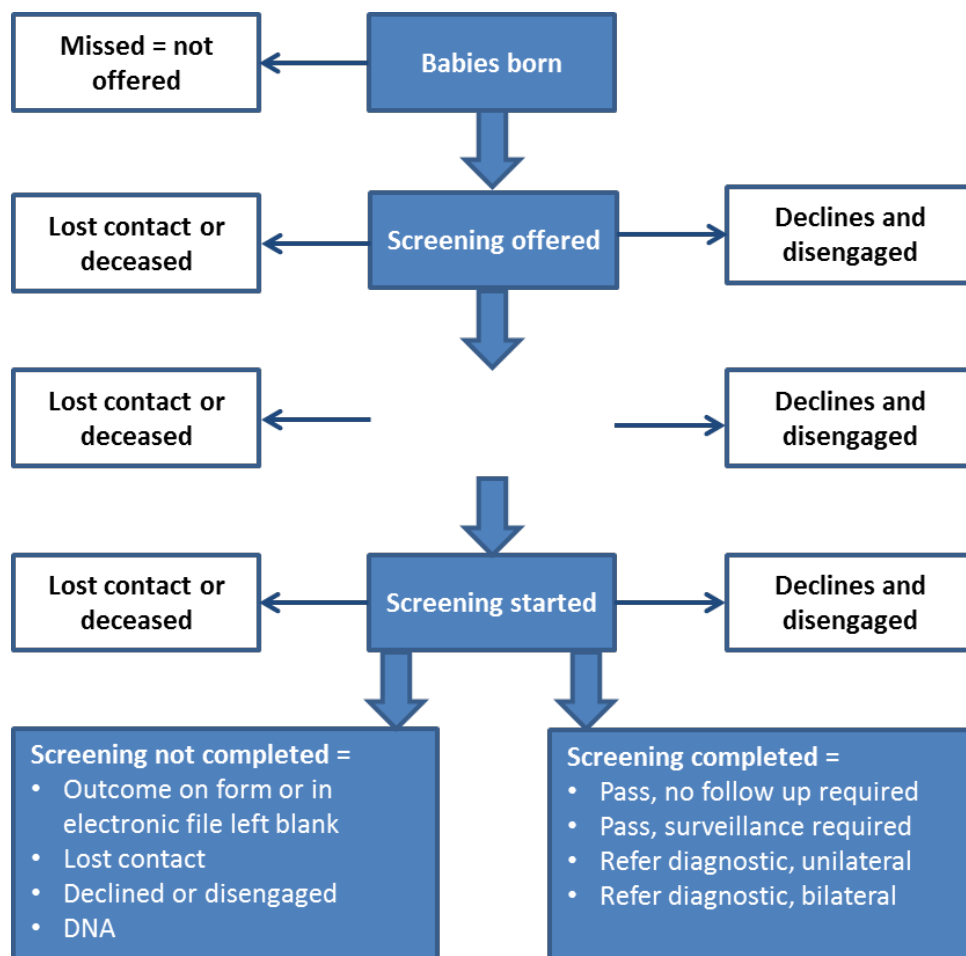
**Did not** Where verbal confirmation (in person or via phone or text) of a

**attend (DNA):** screening appointment is received but the appointment is not kept.  
 For NSU purposes, a baby is classified as a DNA after three attempts have been made for the family to attend a screening appointment by a range of means (attempts may be by letter, phone or text).

**Lost contact:** Where there may have been an initial offer of or commencement of screening, but subsequently no response to letters or telephone calls and/or attempts to establish correct details have been unsuccessful (and documented).

**Missed baby:** Where a baby for whom no offer of screening has been made and no contact has been made with the parents/guardians and the baby is now more than 3 months old.  
 Refers to permanently missed babies, that is, who never had the opportunity to be offered, rather than those who can still be contacted and may attend screening as an outpatient. These could be home births or late referrals from midwives or other health professionals from small community birthing units, or babies picked up via cohort auditing i.e. births in DHB versus offers of screenings in DHB.

**Figure 1: UNHSEIP screening pathway definitions for monitoring**



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# Other Relevant Documents

These policy and quality standards should be read in conjunction with the documents and information resources listed below. All NSU and UNHSEIP documents are available through the National Screening Unit website (<https://www.nsu.govt.nz/>) or by emailing a request to [screening@moh.govt.nz](mailto:screening@moh.govt.nz)

## NSU

- Informed consent in screening  
<https://www.nsu.govt.nz/about-us-national-screening-unit/informed-consent>
- Quality improvement  
<https://www.nsu.govt.nz/about-us-national-screening-unit/quality-improvement>
- Records management  
<https://www.nsu.govt.nz/health-professionals/tools-and-resources/records-management>

## UNHSEIP

The most current version of the following programme documentation:

- UNHSEIP Screener Manual
- UNHSEIP Screening Form HP5065
- UNHSEIP Risk Factors form for hearing loss requiring surveillance
- UNHSEIP Coordinators Manual
- UNHSEIP Monitoring Framework
- UNHSEIP Diagnostic and Amplification Protocol
- UNHSEIP Diagnostic Assessment Data Form



## Other Health Sector Documents

- Eligibility for publicly funded health services:  
[www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services](http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services)
- He Korowai Oranga: Māori Health Strategy (MoH 2002):  
[www.maorihealth.govt.nz/moh.nsf/menuma/About+Maori+Health](http://www.maorihealth.govt.nz/moh.nsf/menuma/About+Maori+Health)
- Whānau Ora:  
[www.tpk.govt.nz/en/in-focus/whanau-ora/](http://www.tpk.govt.nz/en/in-focus/whanau-ora/)
- ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2010–2014:  
[www.moh.govt.nz/pacific](http://www.moh.govt.nz/pacific) [www.asianhealthservices.co.nz/](http://www.asianhealthservices.co.nz/)
- Asian Health Support Services:  
<http://www.asianhealthservices.co.nz/>
- Code of Disability Services Consumers’ Rights Regulation 1996,
- Health Information Privacy Code 1994 (revised 2008)  
[www.privacy.org.nz/health-information-privacy-code/](http://www.privacy.org.nz/health-information-privacy-code/)
- Health Information Security Framework 2015  
<http://healthitboard.health.govt.nz/standards/approved-standards/hiso-100292015-health-information-security-framework>



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# Introduction

These National Policy and Quality Standards form part of the contract between the Ministry of Health (MOH) and District Health Boards (DHBs) for the provision of services for the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP). They are intended to increase knowledge and understanding about the programme, outline requirements of services, and assist DHBs achieve high standards of practice that support the programme's aim. The policy and quality standards cover the following four topic areas:

Section 1: Programme Management

Section 2: Screening Services

Section 3: Audiology Services

Section 4: Quality Assurance

The UNHSEIP National Policy and Quality Standards together with service agreements and the UNHSEIP Diagnostic and Amplification Protocols (January 2016) form the basis of DHB audits.

It is expected that all those involved in programme provision meet their professional and ethical standards as well as their legal obligations in relation to health legislation and any legislation concerning the privacy of health information. All local DHB policies and procedures must also be adhered to.

## About the UNHSEIP

The first six months of a baby's life is a critical period for language development. Lack of exposure to language during this period, such as caused by a hearing loss, can affect a child's development, communication skills, and educational and career achievement. The early detection of hearing loss and the initiation of early medical and educational interventions has been demonstrated to significantly improve long-term outcomes for children with hearing loss and their parents/guardians/whānau.

The UNHSEIP was implemented over a three-year period from 2007–2010. The aim of the programme is:

*early identification of newborns with hearing loss so that they can access timely and appropriate interventions, inequalities are reduced and the outcomes*

*for these children, their families and whānau, communities and society are improved.*<sup>1</sup>

The UNHSEIP is jointly overseen by the Ministries of Health and Education. The MOH has responsibility for screening, diagnosis of hearing loss and medical interventions, and the Ministry of Education (MOE) has responsibility for early intervention services.

The UNHSEIP is an organised screening programme, characterised by planning, coordination, monitoring and evaluation of all activities along the screening pathway. The nationally organised approach to the UNHSEIP facilitates:

- clear lines of accountability
- high quality service provision of all parts of the programme
- defined policy and quality standards
- timely availability and appropriate integration of screening services with diagnostic, support and intervention services
- monitoring and evaluation of the entire screening pathway.

The UNHSEIP is not designed to identify babies with mild hearing losses. Babies with milder hearing losses may not require assistive hearing technologies or intensive intervention. Parents/guardians who have a baby with mild hearing loss may choose to access support services such as parent support networks, the Special Education Information Line and resource materials.

Regular interaction and review with Well Child providers and family doctors will be important to detect progressive hearing losses if these occur.

## **Eligibility**

All babies are eligible for newborn hearing screening under the Health and Disability Services Eligibility Direction 2011.

## **Programme goals**

The core goals of the UNHSEIP are described as '1-3-6' goals, which are based on international best practice proposed by the Early Hearing Detection and (EHDI) programme and endorsed by the Joint Committee on Infant Hearing (2007) and the World Health Organization (2010):

- 1 = Babies to be screened by 1 month of age
- 3 = Audiology assessment completed by 3 months of age
- 6 = Initiation of appropriate medical and audiological services, and early intervention education services, by 6 months of age<sup>2</sup>.

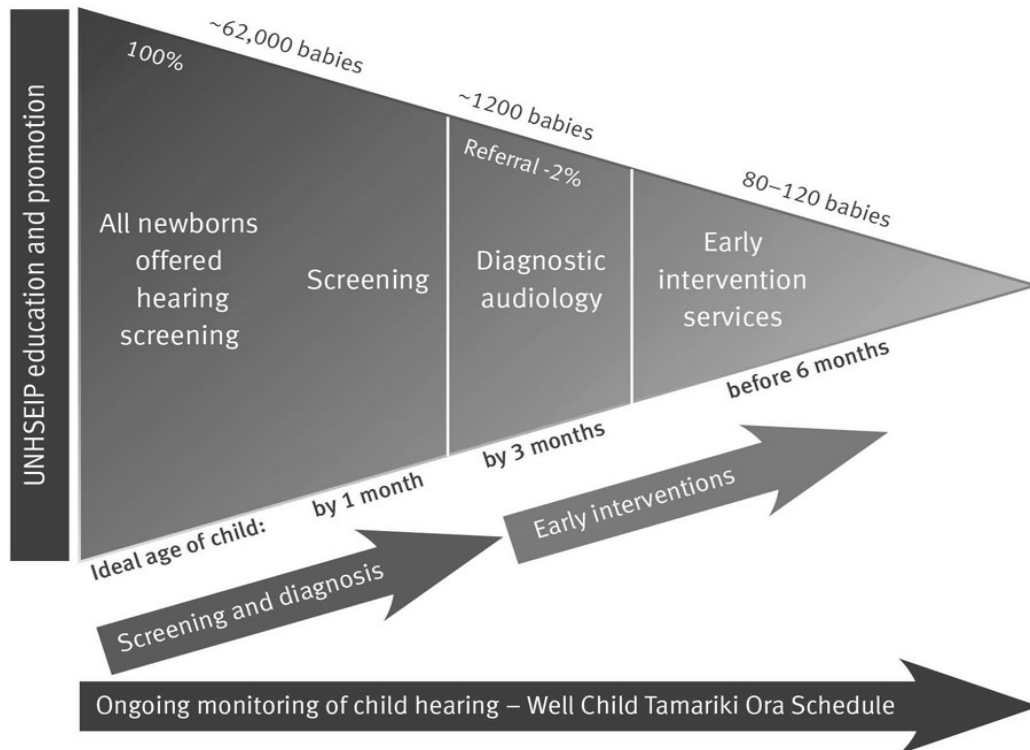
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<sup>1</sup> UNHSEIP Implementation Advisory Group, 2007.

## UNHSEIP screening pathway

Newborn hearing screening and any subsequent diagnostic testing or early intervention services must be offered within a framework of nationally consistent policies, standards and guidelines to ensure quality in the services being delivered.

**Figure 2: Overview of the UNHSEIP screening pathway**



### Screening offer

Newborn hearing screening must be offered to the parents/guardians of all babies born in a DHB region, whether they are born in hospital, a birthing centre or at home.

Participation in the UNHSEIP is strongly recommended by the MOH.

The screening pathway should start with the initial discussion with parents/guardians/whānau and the provision of information in the antenatal period. This provides parents/guardians/whānau with sufficient time to allow them to consider the information provided and ask questions, thus enabling them to make informed choices about participation in newborn hearing screening.

Screening is undertaken according to prescribed protocols by one month of age. The screening threshold for the UNHSEIP is 35dBHL, designed to identify permanent

<sup>2</sup> Note that ages are based on 'corrected age' that is, age adjusted for premature birth.

congenital hearing loss that is likely to impact on the development of speech and language.

Most babies will pass the newborn hearing screen, which means that at the time of screening they are unlikely to have a hearing loss. For babies who pass the newborn hearing screen and who do not have a risk factor for hearing loss, their involvement in the UNHSEIP ends here.

For babies that pass newborn hearing screening but do have one or more of the risk factors listed in the document '*Risk Factors for Congenital and Delayed Onset/Progressive Hearing Loss Sept 2015*', it is expected that they will have at least one audiology assessment as per the hearing surveillance criteria pathway. A clinical person (a doctor, nurse or a midwife) will be responsible for identifying babies with conditions requiring hearing surveillance and completing the appropriate documents required for referral to audiology. The relevant documents must be forwarded to the screener by the person who completed it to enable the screener to make a referral to audiology.

### **Diagnostic audiology**

Babies who do not pass screening have a higher risk of having a hearing loss, and are referred for audiological investigations. The audiologist will carry out the diagnostic assessment of the baby's hearing, which will provide definite answers about the hearing status of the baby. It is expected that diagnostic audiology is completed by age three months.

### **Early intervention**

If a baby is diagnosed with a hearing loss, a multidisciplinary team will develop an action plan for the baby and their parents/guardians/ whānau. The team will include an audiologist, Adviser on Deaf Children (AoDC), ear, nose and throat specialist (ENT) and, depending on the degree of hearing loss and the needs of the family, other care providers such as a paediatrician and speech and language therapist. Parents/guardians/whānau may choose to work with other clinical, education and social support professionals and community groups.

## **Essential elements of the UNHSEIP**

Fundamental to the delivery of the UNHSEIP are:

- coordination of all components of the programme
- an organised invitation for screening to parents/guardians of all newborns
- a multidisciplinary approach to screening, diagnosis and follow-up
- close links with treatment and early intervention services
- operational policies and quality standards and on-going monitoring
- a focus on continuous quality improvement.

## **Equitable screening**

New Zealand Deafness Notification data indicate that Māori are over-represented among children identified with hearing loss.<sup>3</sup> Some evidence also points to later identification of hearing loss among Māori and Pacific children compared to non-Māori, non-Pacific children.

Efforts to reduce these inequalities are mandated by a number of documents including the New Zealand Health Strategy and He Korowai Oranga: Māori Health Strategy. The New Zealand Health and Disability Act 2000 established statutory obligations for DHBs to reduce inequalities by improving the health status of Māori and increasing Māori participation in the health and disability sector.

The UNHSEIP is monitored by ethnicity and socioeconomic status. This helps to inform areas within the programme that may need to be addressed to support equity in access and outcomes.

## **Informed consent**

A newborn hearing screening test is part of a pathway which may result in other interventions and treatment. Parents/guardians/whānau must be informed about the purpose of newborn hearing screening, the process and use of the equipment, how and when the results will be provided, and who the information about the screen may be shared with. Where appropriate, screeners may discuss the difference between screening and diagnostic services. Parents/guardians/whānau have a legal right to receive such information pursuant to the Code of Health and Disability Services Consumers' Rights Regulation 1996.

## **A family focus**

The UNHSEIP is committed to working collaboratively with parents/guardians/whānau to ensure that the programme is focused on their needs. The entire screening pathway, and all other activities provided within the UNHSEIP, must be centred around babies and their parents/guardians/whānau and providing a service which is sensitive and responsive to their individual needs. A high level of community acceptance and confidence in the programme must be maintained.

## **Collaboration**

The success of the UNHSEIP depends on professionals working together throughout the programme. Professionals need to work collaboratively, sometimes across traditional professional boundaries, as a well-coordinated multi-disciplinary team.

Because the UNHSEIP is a pathway of care, sharing of information on outcomes helps enhance ownership for all professionals involved in delivering services along the pathway. Effective communication of any service issues that may impact on other

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<sup>3</sup> Digby JE, Kelly AS, Purdy SC. 2011. *Hearing Loss in New Zealand Children: 2010*. Auckland: New Zealand Audiological Society. Available at [www.audiology.org.nz](http://www.audiology.org.nz)

services on the pathway is also important to ensure continuity of care and quality service provision consistent with the programme expectations and standards.

## **Continuous quality improvement**

Quality improvement activities are concerned with maximising the likelihood that the day-to-day operations of a screening programme deliver the expected outcomes. Monitoring, quality assurance and audit activity can identify issues in a screening programme which can be addressed through improvement activity. This will help maintain quality in service provision, providing parents/guardians/whānau with a positive experience of the programme, enhancing public confidence in the programme and minimising false positive and false negative results.

## **Audit and monitoring of the UNHSEIP**

### **Audit**

Regular auditing of the programme is undertaken to assess whether DHBs are delivering newborn hearing screening and diagnostic audiology services consistent with these policy and quality standards. Approaches to what standards are assessed through an audit, how information is collected and who completes the audit will vary.

A full provider compliance audit is usually initiated by the NSU and uses an external agency to audit service delivery against most or all of the standards. Information is usually collected from multiple sources to assess delivery.

A desk-top audit is more limited in scope and tends to focus more on a review of documentation and records and rarely uses informant interviews or participant observation. A few critical standards are identified for assessment across all DHBs, and some DHBs may also be assessed against key standards where there is concern about delivery. Standards identified for assessment at an individual DHB level is usually informed by findings from a previous audit, concern raised from quarterly reporting or annual monitoring, or a specific incident or concern. A desk-top audit is usually completed internally by the NSU.

### **Monitoring**

Programme monitoring is concerned with the routine, systematic collection and recording of information about aspects of a programme over time, to assess whether programme goals are being met.

High-quality and reliable data must be collected to enable robust monitoring and evaluation at both DHB and national levels.

DHBs are monitored against a number of key national targets on a regular basis. It is expected that each DHB will have systems in place, including internal audit processes that ensure their ongoing adherence to the NPQS. There is an expectation that where shortcomings are identified as a result of internal auditing, steps will be taken to meet the required standard and relevant elements.



A range of performance indicators reflecting different aspects of the UNHSEIP screening pathway are regularly reported on at a national level as well as by DHB, ethnicity and deprivation status. The indicators are subject to review as appropriate.

UNHSEIP internal monitoring reports are provided to DHBs three -monthly. An external report is published annually. The draft annual report is reviewed by a multidisciplinary advisory group who make recommendations to the National Screening Unit (NSU) on quality improvement. The NSU follows up any issues arising from the reports.

Routine monitoring based on newborn hearing screening and audiology data is reported to the Ministry by DHBs on a quarterly basis as part of their own internal quality control.

**MINISTRY OF HEALTH**

<b>Stage</b>	<b>Component</b>	<b>Indicator name</b>
<b>1. Screening</b>	Participation	1.1 Newborn hearing screening offered
		1.2 Newborn hearing screening consents and declines
		1.3 Newborn hearing screening coverage a) Screening completed by 1 month ( <i>1 month goal</i> ) b) Screening completed c) Screening completed of those consented.
		1.4 Newborn hearing screening DNAs and lost contacts
	Outcomes of screening	1.5 Referral rate to audiology assessment
		1.6 Hearing surveillance rate: a) Referral for surveillance rate b) Distribution of risk factors
	Screening performance	1.7 Second positive screening rates
		1.8 Positive predictive value of the screening test
<b>2. Audiology</b>	Timeliness and completion	2.1 Audiology assessment timeliness a) Audiology appointment within 4 weeks of referral b) Audiology assessment started
		2.2 Audiology assessment completion a) Audiology assessment completion rate ( <i>3 month goal</i> ) b) PCHL diagnosed by 3 months
		2.3 Audiology not attended
	Outcomes of audiology	2.4 Hearing loss detected
		2.5 Outcome of hearing surveillance a) Hearing loss detected b) Referred for surveillance but not assessed
		2.6 Cases not identified from screening
	Audiology early intervention	2.7 Age at first assistive hearing device ( <i>6 month goal</i> )

**MINISTRY OF EDUCATION**

<b>3. Early intervention</b>	Participation in early intervention	3.1 Contact with families following referral to early intervention education services
		3.2 Commencement of early intervention education services ( <i>6 month goal</i> )
		3.3 Continuation of early intervention education services
	Outcomes of early intervention	3.4 Outcomes of early intervention

## **UNHSEIP services**

National coordination and leadership of newborn hearing screening services is the responsibility of the NSU. This responsibility includes:

- setting the strategic direction of the screening programme
- developing and maintaining policy and standards across the screening pathway
- national monitoring, audit, evaluation and quality improvement
- funding and contract management
- providing educational resources.

### **DHBs**

DHBs are the providers of newborn hearing screening and follow-up audiology and medical services for UNHSEIP. DHBs are responsible for ensuring the provision of high quality screening and audiology services. This includes leadership and oversight of the multi-disciplinary team, internal quality assurance and quality improvement, clinical leadership and executive support.

An essential aspect of coordination of UNHSEIP services in DHBs is ensuring that babies are not lost to follow-up as they move through the screening pathway and in particular if they move between regions at any stage during their involvement with the programmes. DHBs must have procedures in place to manage this.

### **Newborn hearing screeners**

Newborn hearing screeners have an important role in the UNHSEIP and they are often the first point of contact for parents/guardians/whānau entering the screening pathway. As most babies do not require follow up diagnostic audiology, newborn hearing screeners will be the only contact parents/guardians/whānau will have with the UNHSEIP. Their role spans:

- identifying babies to be screened;
- obtaining informed consent
- screening babies according to UNHSEIP protocols;
- communicating results to parents/guardians;
- referring babies to audiology if required; and
- collecting and managing screening data.

## **Audiology**

Audiology services for babies requiring follow-up from screening may be locally or regionally provided. The role of audiology includes:

- assessing hearing status of all referred babies
- providing diagnostic and habilitation services for babies identified with hearing loss
- working with parents/guardians/whānau to achieve best outcomes for children with hearing loss.

## **Surveillance and early intervention**

Babies with conditions requiring hearing surveillance are identified and assessed by a clinical person (a doctor, nurse or midwife), with referrals made to audiology via the screener.

Depending on the needs of the baby and the choices made on their behalf by their parents/guardians/whānau, the following medical professional groups may be involved in delivering the early medical intervention plan:

- Ear nose and throat specialists
- Cochlear implant specialists
- Paediatricians
- Ophthalmologists
- Radiologists
- Genetic services.

## **Ministry of Education Early Intervention Services**

Early intervention education services for babies identified with a hearing loss are coordinated by the Ministry of Education. Services are regionally based and service providers travel to parents/guardians/whānau as necessary. Parents/guardians/whānau may choose to work with an Adviser on Deaf Children (AoDC), other clinical, education and social support professionals and community groups. Depending on the needs of the baby and the choices made on their behalf by their parents/guardians/whānau, the following educational professional groups and other support services may be involved in delivering the early education intervention plan:

- New Zealand Federation for Deaf Children and local parents groups
- Advisers on Deaf Children, Speech Language Therapists, Early Intervention Teachers (Ministry of Education)
- Northern and Southern Cochlear Implant Programmes, clinic based and outreach services
- First Signs Facilitators (Deaf Aotearoa).

## **Advisory and special expertise groups**

The UNHSEIP Advisory Group is multidisciplinary with representation from professional bodies, Māori, Pacific and consumer groups. The group provides advice to the NSU on matters pertaining to the monitoring and strategic direction of the programme.

From time to time the NSU convenes working groups to provide advice on specific clinical and technical aspects of UNHSEIP development.



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# UNHSEIP Policy and Quality Standards

It is a requirement of the NZ Health and Disability Act (2000) that all health care services are delivered in accordance with any approved quality standards.

The following policy and quality standards have been approved by the UNHSEIP Advisory Group, with the audiology standards also being endorsed by the New Zealand Audiological Society (NZAS). All providers of UNHSEIP newborn hearing screening and audiology services must comply with these standards. As well as meeting these standards, all services must meet their obligations in relation to the following legislation and standards:

- Care of Children Act 2004
- Health Act 1956
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health and Safety in Employment Act 1992
- Health Information Privacy Code 1994
- Health Information Security Framework 2015
- Health Practitioners Competency Assurance Act 2003
- Health (Retention of Health Information) Regulations 1996
- Human Rights Act 1993
- New Zealand Bill of Rights 1990
- New Zealand Public Health and Disability Act 2000
- Public Records Act 2005
- Vulnerable Children Act 2014 (updated 2015).

Compliance with the UNHSEIP policy and quality standards will be assessed through one or more of the following approaches:

- Monitoring of delivery against the contract service specification
- Programme audit
- Quarterly monitoring against priority programme performance indicators
- Annual monitoring against programme performance indicators.



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# Section 1: Programme management

## Programme management and official requirements

### Standard 1

The day-to-day operation of the UNHSEIP will be managed by each DHB in a manner that ensures clear accountabilities and consistent with the service contract and current programme policy and standards.

### Rationale

The UNHSEIP must be managed in a consistently efficient, effective and safe manner.

High quality screening and audiology services must be provided to maintain public confidence in the UNHSEIP.

### Criteria

- i. Each DHB must have a clearly documented multidisciplinary management and governance structure for UNHSEIP services, with clearly defined Terms of Reference. It must include:
  - a. identification of the person/persons who has designated responsibility for the management of all aspects of the UNHSEIP service, and clarification of roles if accountability is shared across more than one person or department
  - b. responsibilities and accountabilities of specific individuals, groups and/or committees and the relationship between them
  - c. clear delineation of the relationships and responsibilities of clinical and non-clinical staff
  - d. representation from relevant consumer and professional groups on any advisory and/or management groups.
- ii. Agendas and meeting minutes for any meeting relating to the delivery of UNHSEIP services must be kept in accordance with local record keeping requirements.

- iii. Persons responsible for co-ordination of DHB UNHSEIP services must be familiar with the Screener Manual, the Coordinators Manual and all relevant service policies, procedures, guidelines and standards, including the UNHSEIP National Policy and Quality Standards.
- iv. During a temporary absence (including, but not limited to, illness, leave and position vacancy) of the programme manager/coordinator, DHBs must have in place a clear process which ensures:
  - a. the availability of appropriately trained and designated replacements
  - b. that the level of resources and expertise provided by the service is appropriate to meet normal volumes/activities.
- v. DHBs must have a current Service Delivery Plan for provision of UNHSEIP services in accordance with a template provided by the NSU. This plan must be approved by the NSU and should be reviewed annually by the DHB.
- vi. Strong working relationships must be established and maintained between:
  - a. all departments involved in the provision of UNHSEIP services
  - b. UNHSEIP programmes in other DHBs, in order to facilitate national consistency of services, sharing of best practice and transfer of babies between regions.
- vii. DHBs must:
  - a. have in place policies, procedures, guidelines, systems of plans to ensure that all services delivered for the UNHSEIP are consistent with these Policy and Quality Standards
  - b. review these documents as appropriate to ensure they are consistent with the requirements of the UNHSEIP
  - c. have in place effective document control processes.
- viii. DHBs must ensure that all providers of UNHSEIP newborn hearing screening and audiology services have access to and are conversant with the UNHSEIP National Policy and Quality Standards and all relevant UNHSEIP documentation that supports programme delivery.
- ix. All documentation relating to the delivery of UNHSEIP must be up-to-date.
- x. Where a DHB subcontracts to another provider to deliver UNHSEIP services this must be consistent with the requirements outlined in the UNHSEIP Service Agreement.



# Reducing hearing loss inequalities

## Standard 2

In delivering the UNHSEIP, DHBs will lead initiatives to reduce inequalities in detection of hearing loss and ensure appropriate levels of coverage are achieved.

### Rationale

A core goal of the UNHSEIP is to screen >95% of babies by 1 month of age.

Reducing inequalities between population groups is a health and disability sector goal and integral to the aim of the programme.

Culturally appropriate practices and procedures are integral requirements of the provision of health services.

### Criteria

- i. In delivering the UNHSEIP, DHBs must engage with Māori health providers for their input into service design, planning and delivery of UNHSEIP.
  - a. Where appropriate, the specific ways in which the DHB will contribute to improving hearing outcomes for Māori, will be included in Māori health plans or other relevant policy or plan.
- ii. DHBs must monitor the involvement of Maori and Pacific, and other population groups as appropriate, in newborn hearing screening for their service. Where rates are below 95% of live births who complete screening by 1 month, DHBs must implement a plan of action to address the issue.
- iii. DHBs must target delivery of UNHSEIP services to Māori and Pacific newborns, and other population groups where the need has been identified, by:
  - a. developing relationships with ethnicity-based organisations, particularly maternity and child health services, to assist with raising awareness of the UNHSEIP in communities
  - b. implement initiatives aimed at reducing access barriers to screening and audiology, such as financial, transport and geographical barriers
  - c. developing staff competencies to meet the specific needs of Māori and Pacific and other population groups where required including completion of cultural competency training provided by their organisation.



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# Section 2: Screening services

## Screener competency

### Standard 3

Newborn hearing screening will be carried out by screeners who meet UNHSEIP training and competency requirements.

### Rationale

Well trained, competent screeners are fundamental to achieving the aims of the UNHSEIP.

### Criteria

- i. All new UNHSEIP screeners employed since October 2010 must complete the NZQA qualification 1623: National Certificate in Health, Disability, and Aged Support (Newborn Hearing Screening) (and its revision and updates).
- ii. All newborn hearing screeners must be employed by DHBs. DHBs must ensure that screeners complete local orientation requirements prior to commencing formal newborn hearing screening training.
- iii. When employing new screeners, DHBs must make it clear in their contracts that a condition of their employment is that they pass the DHB-based course and achieve the NZQA qualification within one year.
- iv. DHBs must ensure that screeners have an annual performance appraisal and regular continuing education relevant to their role.
- v. To ensure the necessary skill level and competence is maintained, screeners must have their individual competence assessed in accordance with the UNHSEIP Screener Competency Framework (and its revisions and updates):
  - a. Annual Competency Exercise (ACE)
  - b. after a break of six months or more in screening for the UNHSEIP.

## Screener performance

### Standard 4

DHBs will monitor the quality of screening provided by newborn hearing screeners.

### Rationale

High quality screening services minimise harms and maximise the benefits of newborn hearing screening and facilitate a positive screening experience for parents/guardians/whānau.

Internal quality control systems such as monitoring help to ensure high quality screening. They include activities that:

- identify potential sources of error in newborn hearing screening activities
- detect and minimise errors
- monitor the quality of screening
- identify ways of improving the quality of newborn hearing screening service to babies, parents/guardians/whānau.

### Criteria

- i. Internal quality assurance activities for newborn hearing screening must include routine monitoring of completed screening forms and individual screener data downloaded from screening equipment consistent with the guidelines '*Monitoring and Reporting for the UNHSEIP*'.
- ii. A register of screener competency assessments (ACE) must be maintained by the DHB service manager/programme coordinator.

## Offering newborn hearing screening

### Standard 5

Newborn hearing screening will be offered to parents / guardians of all eligible babies.

### Rationale

UNHSEIP has a principle of universality, whereby all eligible babies are offered a hearing screen. Participation in the UNHSEIP is voluntary but strongly recommended by the Ministry of Health.

It is important that parents are made aware of newborn hearing screening in the antenatal period, including providing information to women at antenatal classes. Establishing and maintaining good working relationships with key health and disability providers in each region, particularly lead maternity carers (LMCs), general practitioners (GPs), Well Child providers and other key stakeholders are necessary to help ensure this is achieved.

The requirements of the Health and Disability Code of Consumers Rights must be fully met. Each baby's parents/guardians will be provided with full, accurate and appropriately conveyed information about newborn hearing screening and the UNHSEIP to enable them to make an informed choice regarding participation in all aspects of the screening pathway.

### Criteria

- i. DHBs must ensure that all parents/guardians of newborn babies are offered screening<sup>4</sup>.
- ii. A written procedure must be in place outlining the process for screening services to be notified of births by DHB maternity services, local birthing units and independent LMCs (for babies who are born at home).
- iii. DHBs must ensure that the baby's parents/guardians:
  - a. receive information about the UNHSEIP conveyed in an appropriate language and manner
  - b. are provided with sufficient and relevant information, as per criterion iv below, in a manner that is understood
  - c. are able to have questions answered by an appropriately qualified and authorised person.

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<sup>4</sup> There will be a very small number of babies ineligible for screening for medical reasons.

- iv. To ensure sufficient information has been provided, screeners must discuss all of the following:
  - a. the purpose of hearing screening
  - b. the procedure, equipment and the anatomy involved, in addition to other details that may be required by the parent
  - c. how and when the screening results will be provided
  - d. the UNHSEIP, the objectives of the programme and the benefits and limitations of participating
  - e. information about how to check for hearing loss.
- v. Where appropriate, screeners may discuss the difference between screening and diagnostic services.
- vi. Screeners must ensure that the pamphlet *Your Baby's Hearing Screen: About Newborn Hearing Screening* (HE2429), which provides the information described above, is given to all parents / guardians.
- vii. DHBs must provide translation services where necessary to facilitate communication of screening information to parents/guardians/whānau.
- viii. The discussion and outcome regarding consent for the newborn hearing screen must be documented.
- ix. Where babies over three months are identified as having not been offered newborn hearing screening ('missed baby') parents/guardians/whānau should, where possible, be given information about monitoring their baby's hearing (*UNHSEIP Hearing Checklist* HE1922) and be advised that, if they have concerns about their baby's hearing, they should talk to their GP or Well Child provider.

## Decline of newborn hearing screening

### Standard 6

DHBs will have effective systems for managing and recording declines of the offer of newborn hearing screening.

### Rationale

It is important that parents/guardians who decline newborn hearing screening are made aware of how to monitor their baby's hearing and of opportunities for their baby's hearing to be assessed. The decline rate is an important measure of the reach and success of the UNHSEIP, reflecting public awareness and acceptability of the programme as well as screener engagement.

### Criteria

- i. DHBs must have a written policy with clearly defined procedures to support delivery against this standard and which meet the criteria described below.
- ii. DHBs must accurately record and monitor screening declines.
- iii. DHBs must ensure that parents/guardians who decline newborn hearing screening are aware that if they have any concerns about their child's hearing at any time they should talk to their Well Child provider or their GP and discuss an assessment at audiology.
- iv. When screening is declined:
  - a. the decline must be noted on the *UNHSEIP Screening Form* and the form initialled by the screener
  - b. it is noted in the baby's clinical records and Well Child Tamariki Ora Health book
  - c. parents must be provided with a copy of the *UNHSEIP Hearing Checklist HE1922*.

# Notification of the collection, storage and access to health information

## Standard 7

All parents/guardians will be informed about how information that is collected as part of the UNHSEIP will be stored and used and who will be able to access it.

UNHSEIP related health information will be appropriately stored and protected from unauthorised use or disclosure.

## Rationale

Health information created and stored as part of the UNHSEIP must be done so in accordance with legal obligations outlined in the Privacy Act (1993). Individual clinical records are unique to each baby and that baby's parents/guardians. The records are protected from unauthorised access and disclosure. Specific legal requirements in relation to the collection, storage and use of health information are set out in the *Health Information Privacy Code 1994*.

Parents/guardians must be advised of what information is collected as part of their involvement in the UNHSEIP, how it will be stored and who will be able to access it. Parents/guardians provide their consent to the collection of information about their child.

## Criteria

- i. DHBs must ensure that the individual (in this case the baby's parent/guardian) is given the pamphlet *Your Baby's Hearing Screen: About Newborn Hearing Screening* (HE2429), which fully informs of the purpose, use and recipients of information that is collected about them, and the code of Health and Disability Services Consumers' Rights.
- ii. DHBs must ensure that:
  - a. the UNHSEIP service meets its legal obligations for the collection, storage and access of health information in accordance with the *Health Information Privacy Code 1994*, and the *Public Records Act, 2005*
- iii. DHBs must ensure that staff involved in newborn hearing screening:
  - a. sign a DHB confidentiality declaration in relation to use of information at the commencement of their employment
  - b. know, understand and adhere to all legal and ethical professional obligations in relation to privacy and confidentiality of patient information



- c. **know and understand that access to an individual baby's and parent's or guardian's personal health information is restricted under the law to the minimum number of persons and on a 'need to know' basis.**
- iv. **In the case of hearing surveillance or referral to audiology, the parent/guardian must be informed that the screening results will be sent to other parties, namely the baby's GP, Well Child provider or education providers in the event of hearing loss.**

# Infection control

## Standard 8

Screeners will maintain high standards of infection control when performing screening.

### Rationale

The safety of babies when participating in the UNHSEIP must be ensured by maintaining proper hygiene.

### Criteria

- i. Screeners must ensure that:
  - a. proper hand washing techniques between handling babies and after handling equipment
  - b. gloves are used when appropriate
  - c. equipment is cleaned between screening babies consistent with the requirements specified in the *UNHSEIP Screener Manual*
  - d. DHB-specific infection control policies are adhered to.

## Screening equipment and maintenance

### Standard 9

All newborn hearing screening equipment will meet UNHSEIP and manufacturer safety, quality and technical criteria.

### Rationale

Equipment used within the programme must be reliable, safe and appropriate for the UNHSEIP.

### Criteria

- i. It is the responsibility of DHBs to ensure that all newborn hearing screening equipment used within the UNHSEIP:
  - a. meets criteria for universal newborn hearing screening equipment in New Zealand<sup>5</sup>
  - b. is correctly calibrated for the UNHSEIP:
    - the stimulus level for aABR screening is 35 dBHL
  - c. calibration is maintained as per the manufacturer's instructions.
- ii. DHBs must ensure that the most current version of the MAICO MB11 Beraphone software is installed on all computers that are used for UNHSEIP screening.
- iii. Daily checks must be carried out on all screening equipment in use and documented on the programme's daily equipment checklists.
- iv. Equipment must be maintained according to the requirements outlined in the *UNHSEIP Screener Manual*
- v. Must be handled and stored when not in use according to the manufacturer's recommendations.

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<sup>5</sup> BERAphone MB11.

## Adherence to UNHSEIP screening protocols

### Standard 10

Screening will be carried out in accordance with the UNHSEIP screening protocols.

### Rationale

The protocols are based on an extensive review of international best practice and on expert advice of clinicians. Strict adherence to protocols is fundamental to a high quality screening programme and ensuring public confidence in the UNHSEIP is maintained. This regime applies to **all babies** regardless of whether they are being screened on the ward, in a neonatal special care unit, or as outpatients.

### Criteria

- i. Screening must be carried out in accordance with the current *Newborn Hearing Screening Protocol*.
- ii. All babies that pass newborn hearing screening but have one or more risk factors for congenital and delayed onset/progressive hearing loss must be offered an assessment at audiology at a clinically appropriate time. The risk factors for hearing surveillance at audiology are set out in '*Risk Factors for Congenital and Delayed Onset/Progressive Hearing Loss Sept 2015*'.
- iii. In order to meet programme goals, >95% of live births must have completed screening by the time the baby is one month old (corrected age). Screening can however be undertaken up to three months of age.

# Communicating results of newborn hearing screening

## Standard 11

The results of newborn hearing screening, including information about next steps, will be communicated to all participating parents/guardians immediately, in a sensitive and culturally appropriate manner.

## Rationale

The UNHSEIP is family centred and provides results to parents/guardians in a timely manner. Sensitivity is important in communicating results — screeners should be guided by close attention to the recommended scripts and supported by coordinators and maternity staff.

## Criteria

- i. *For a 'pass' result:* Where the screening equipment records a 'pass' or clear response for both ears:
  - a. the newborn hearing screener must follow the script on communicating results, as detailed in the UNHSEIP Screening Manual
  - b. the parents/guardians must be provided with the leaflet *Newborn Hearing Screening Results* (HE 1922)
  - c. if the baby has been identified as having one or more hearing surveillance criteria for delayed onset/progressive hearing loss, the newborn hearing screener must ensure that the parents/guardians are aware of this.
  - d. Parents/guardians must be informed of the procedure for surveillance and their consent to refer the baby to audiology for further follow-up must be obtained.
- ii. *For a 'refer' (no clear response) result:* Where the screening equipment records no clear response for one or both ears, the baby should be screened again in accordance with the *Newborn Hearing Screening Protocol*:
  - a. the newborn hearing screener must follow the script on communicating results, as detailed in the *UNHSEIP Screener Manual*
  - b. the screener must discuss with parents/guardians what the next steps will be, including the likely timing and location of the repeat screen
  - c. the parents/guardians must be provided with the leaflet *Repeat Newborn Hearing Screen* (HE1923)

- iii. *For referral to diagnostic audiology:* Where the screening equipment records a 'refer' or no clear response for one or both ears and the screening protocol indicates that the baby should be referred to diagnostic audiology:
- a. the newborn hearing screener must follow the script on communicating results as detailed in the *UNHSEIP Screener Manual*
  - b. the screener must discuss with parents/guardians what the next steps will be, including the likely timing and location of the audiology appointment
  - c. the parents/guardians must be provided with the pamphlet *Your Baby's Newborn Hearing Screen: Referral to Audiologist* (HE 1924)
  - d. DHBs must ensure that referrals to audiology are made promptly
  - e. the referral to audiology must be noted in the Well Child Tamariki Ora Health book (if available) and clinical records
  - f. health providers involved in the care of the baby must be informed of the referral as appropriate.

# Ensuring high screening completion rates and managing DNAs and lost contacts

## Standard 12

Providers will have a policy and procedures in place to ensure screening is completed and to work with parents/guardians who do not attend screening appointments.

### Rationale

A core goal of the programme is for all babies to be screened by one month of age<sup>6</sup>. Where possible, babies are screened in the hospital/birthing unit before discharge otherwise screening should take place in outpatients and/or outreach clinics.

Monitoring the proportion of screens incomplete due to non-attendance at screening appointments or other loss to follow-up is an important measure of the success of the programme.

To facilitate engagement in the UNHSEIP, where appropriate, Māori, Pacific and other support services, where they are available, should be used to assist with locating and supporting babies and parents/guardians/whānau to attend screening appointments.

### Criteria

- i. DHBs must have a written policy with clearly defined procedures in place to support delivery against this standard and which meet the criteria described below.
- ii. Outpatient clinics and/or community-based newborn hearing screening must be offered as well as screening in hospitals/birthing facilities. Screening clinics must be provided with a view to accessibility for parents/guardians/whānau.
- iii. Processes are in place for making appointments for:
  - a. babies who are not screened before discharge
  - b. babies who are born at home
  - c. babies who require further follow-up.
- iv. Screening appointments must be confirmed verbally or via text, email or voice message. Every effort must be made to ensure screening appointments are accessible to parents/guardians/whānau.

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<sup>6</sup> Based on age corrected for premature birth.

- v. DHBs must ensure that:
  - a. processes for identifying and following parents/guardians who do not attend (DNA) for screening appointments are clearly documented
  - b. there are a minimum of three attempts to contact the parents/guardians – this may include letter, text and phone contact, with at least one verbal attempt
  - c. alternative appointment times are offered that, where practicable, are responsive to the needs of the parents/guardians
  - d. each offer and outcome is clearly documented in the baby's clinical records.



## Managing transfers between DHBs

### Standard 13

DHBs will have systems in place to ensure continuity of service for babies and their parents/guardians who move between regions.

### Rationale

Some families may relocate to another DHB before the offer or completion of the screening pathway. Procedures must be in place to ensure screening is offered/completed by the receiving DHB for these babies.

### Criteria

- i. DHBs must have a written policy with clearly defined procedures in place to support delivery against this standard.
- ii. If a baby transfers to another DHB before being screened, the transferring DHB (where the baby was born) must notify the receiving DHB that the baby has not been screened and forward their *UNHSEIP Screening Form* with contact details.
- iii. If screening has commenced but is not complete, including diagnostic audiology where appropriate, the transferring DHB must ensure that a copy of the baby's *UNHSEIP Screening Form* is sent to the new provider.
- iv. Where screening has been completed but hearing surveillance is indicated, the transferring DHB must ensure that a copy of the baby's *UNHSEIP Screening Form* and all appropriate hearing surveillance documents completed for referral to audiology are sent to the new provider.

# Screening data collection and management

## Standard 14

Newborn hearing screening data will be consistently complete, accurate and supplied to the NSU in the specified form in a timely manner.

### Rationale

Accurate and complete newborn hearing screening data is essential to ensure robust monitoring and evaluation against national standards, indicators and targets, and identification of areas of risk.

It is acceptable for DHBs to send one form of identifiable personal health information<sup>7</sup> to the NSU, most usually the NHI, through ordinary email as long as no clinical information is included. Where more than one form of identifiable personal health information (i.e. NHI, full name, street address and/or date-of-birth) and/or screening data is to be sent to the NSU it must be transmitted via protected electronic channels<sup>8</sup> or hard copy (courier only). Sending of data electronically is strongly encouraged by the NSU.

### Criteria

- i. The *UNHSEIP Screening Form* (either electronic or hard copy) must be used to document required information fields and to record the results of screening.
- ii. UNHSEIP Screening Forms must be filled in accurately and completely. Forms must be checked for completeness and accuracy before being sent to the NSU.
- iii. Incomplete data returned by the NSU to the DHB must be corrected and returned to the NSU within one month.
- iv. Ethnicity data must be collected according to Ministry of Health protocols, ie, parent/guardian identification of baby's ethnicity.
- v. Screening data must be sent to the NSU monthly for:
  - a. all babies screened for whom data collection has been consented
  - b. all babies whose parents/guardians decline newborn hearing screening but consent to data collection.
- vi. The DHB UNHSEIP service must meet the security and backup requirements specified by each DHBs policy for all IT hardware.

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<sup>7</sup> Identifiable health information is anything that could be used to identify an individual. This may comprise one or more of: NHI, full name, street address and/or date of birth.

<sup>8</sup> Protected electronic channels include the Connected Health network, or secure file transfer (sFTP).





# Section 3:

## Audiology services

### Audiologist qualifications and competency

#### Standard 15

Audiologic assessment and amplification services within the UNHSEIP will be carried out by appropriately trained and competent audiologists that meet UNHSEIP requirements.

#### Rationale

Expertise in providing quality diagnostic and intervention services to babies referred from their newborn hearing screen is fundamental to achieving the aims of the programme. Delayed diagnosis and/or missed cases of hearing loss attributed to poor quality audiology services may subsequently lead to compromised short and/or long-term outcomes for children.

The NSU supports continuous improvement in the quality of the UNHSEIP. This includes working with the sector to develop and monitor a competency framework for audiologists working with babies referred through the UNHSEIP.

Internal quality control systems for audiology include quality control activities that:

- identify and minimise errors and potential sources of error in audiology activities
- monitor the quality of audiology assessment and diagnostic services
- identify ways of improving the quality of audiology service
- provide a framework for remedial action to improve operational processes when a problem is identified.

#### Criteria

- i. Paediatric audiologists working in the UNHSEIP must have either:
  - a. a New Zealand Master's degree in audiology or its equivalent, as assessed by the New Zealand Qualifications Authority (or other approved external organisation) or
  - b. an audiology postgraduate qualification and have passed an equivalency exam approved by the New Zealand Audiological Society

- ii. Audiologists working in the UNHSEIP must:
  - a. comply with the New Zealand Audiological Society Paediatric Certification requirements
  - b. have either completed or be in the process of completing a recognised New Zealand clinical competency programme that includes the diagnosis and habilitation of babies and children
  - c. be aware of the UNHSEIP National Policy and Quality Standards
  - d. meet a professional code of ethics.
- iii. For audiologists new to working with babies, supervision by a senior audiologist (e.g. regular service in paediatrics for the last two years) must be in place.
- iv. Audiologists working with babies referred from the UNHSEIP must ensure their practice is current and undertake continuing professional development. This includes:
  - a. remaining up to date with advances in newborn hearing screening
  - b. regularly attending newborn hearing screening update courses or seminars.
- v. DHBs must establish and demonstrate that processes are in place that enable effective review of audiologist performance to ensure quality in audiology service provision including:
  - a. regular peer review of all audiologists working with babies referred from UNHSEIP
  - b. forums or clinical networks for regular discussions of cases between audiology colleagues and other team members
  - c. evaluation, audit and/or benchmarking of individual audiologist service provision.
- vi. Audiology technicians, audiometrists or other staff providing support services – such as assisting with BOA, VRA, CPA, distracting during RECD measurements, taking ear impressions and fitting ear moulds – must be appropriately qualified and supervised.

## Audiology equipment and environment

### Standard 16

Audiology facilities and equipment used for babies referred from newborn hearing screening will meet UNHSEIP specifications.

### Rationale

Appropriate facilities and resources must be available to carry out audiology assessments for babies referred from newborn hearing screening. Equipment must be appropriately calibrated.

### Criteria

- i. Providers must ensure that the audiology room:
  - a. has an appropriate chair, such as upholstered recliner, so that the parent can hold the baby in comfort, and an alternate arrangement for the baby to sleep (such as a cot)
  - b. has access to a sink, either in the room or in close proximity
  - c. meets the maximum sound levels set out in the *UNHSEIP Diagnostic and Amplification Protocol*
- ii. Audiology equipment must meet the requirements set out in the current *UNHSEIP Diagnostic and Amplification Protocol*, as well as other NSU approved lists of equipment meeting UNHSEIP specifications.
- iii. Instruments must be calibrated as per UNHSEIP and manufacturer specifications.
- iv. Safe sleeping protocols must be adhered to.

## Audiology timeliness and completion

### Standard 17

All babies will have their first audiology appointment either within four weeks of screen completion or by 44 weeks gestational age.

Audiology providers will have written protocols and procedures in place to encourage attendance at audiology appointments and to work with parents/guardians who do not attend.

### Rationale

To achieve the core programme goal of audiology assessment completed by three months of age (corrected age), audiology services must be managed so that assessments occur promptly on receipt of a referral from screening.

### Criteria

- i. DHBs must have a written policy with clearly defined procedures in place to support delivery against this standard and which meet the criteria described below.
- ii. The maximum waiting time for the first audiology appointment following a referral result from screening is four weeks after the completion of screening or by 44 weeks gestational age.
  - a. DHBs must have processes in place to monitor wait times from screening to audiology.
  - b. DHBs must put in place actions to reduce wait times to achieve this target where necessary.
- iii. Audiology assessment appointments must be offered in a timely manner to parents/guardians of:
  - a. babies who are referred from UNHSEIP screening
  - b. babies and children who are referred for hearing surveillance through the UNHSEIP
  - c. babies and children up to five years who acquire high-risk status incidentally or through post-natal risk indicator discovery.
- iv. Information about the audiology service, including HE1924 – *Referral to Audiologist*, must be provided to parents/ guardians when the audiology appointment is arranged.

- v. Every effort should be made to ensure parents/guardians referred from UNHSEIP are aware of the benefits of attending audiology appointments. DHBs must ensure that:
- a. processes for identifying and following up babies who do not attend (DNA) audiology appointments are clearly documented
  - b. there are a minimum of three attempts to contact the parents/guardians by a range of means, at least one of these verbal for audiology appointments
  - c. alternative appointment times are offered which are, where practicable, responsive to the needs of the parents/guardians
  - d. each offer of an audiology appointment and outcome is clearly documented in the baby's clinical records or electronically in the referral management system
  - e. the GP is advised that the baby has not attended audiology and may be of risk of a delayed confirmation of hearing loss. Where a Well Child Health provider has been identified they will also be notified
  - f. there are effective processes in place when babies referred to audiology transfer to another DHB before assessment is completed
  - g. there is effective liaison with Well Child services and Māori, Pacific and other support services to assist with locating and supporting babies and parents/guardians to attend audiology.
- vi. All audiology assessments must be completed by the time the baby is three months old<sup>9</sup>. This takes into account that full diagnosis may take more than one appointment.
- vii. All hearing surveillance referrals are to be assessed at audiology at a clinically appropriate time.

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<sup>9</sup> Corrected age



## Adherence to UNHSEIP audiology protocols

### Standard 18

Audiologists, except in special circumstances, will follow the *UNHSEIP Diagnostic and Amplification Protocols* when assessing and managing babies referred through the UNHSEIP.

### Rationale

The *UNHSEIP Diagnostic and Amplification Protocols*, which include specification of key procedural elements and technical appendices, were developed by a technical working group established to provide audiological advice and support to the UNHSEIP and are reviewed from time to time. Departures from the protocols may be appropriate for individual babies under special circumstances.

### Criteria

- i. Audiology providers must comply with *UNHSEIP Diagnostic and Amplification Protocols* except in special circumstances.
- ii. If an audiology provider is unable to meet any protocol requirements for babies referred to them through the UNHSEIP:
  - a. this must be raised with the NSU as soon as possible
  - b. the nature and rationale for deviation from the protocol must be documented in clinical case records
  - c. it must be confirmed that alternative protocols will not be to the detriment of the baby and their parents/guardians/whānau.

The NSU reserves the right to review documentation and clinical records involving any such departures from the protocol.

- iii. Services must comply with facility standards and generally accepted standards relating to infection control.
- iv. All hearing surveillance referrals are to be managed according to the test protocol as detailed in the *UNHSEIP Diagnostic and Amplification Protocols*.

# Results of audiology assessment

## Standard 19

The results of audiology assessment, and information about recommended next steps, will be communicated to the parents/guardians immediately, in a sensitive and culturally appropriate manner.

### Rationale

The UNHSEIP is family centred and provides results to parents/guardians in a sensitive and timely manner.

### Criteria

- i. *Giving results when no hearing loss is identified:* The audiologist must:
  - a. explain to the parents/guardians what the results of the audiology assessment mean, taking time to make sure they understand that the audiology assessment does not indicate a hearing loss at the time
  - b. provide the parents/guardians with a hearing checklist and confirm that, if they have concerns about their child's hearing at any time, they should talk to their primary health care provider, Well Child provider or early childhood or school teacher.
- ii. *Giving results when a hearing loss is identified:* The audiologist must:
  - a. explain to the parents/guardians what the results of the audiology assessment mean, taking time to make sure they understand that their baby has been identified with a hearing loss
  - b. provide the parents/guardians with an opportunity to ask questions and to discuss recommended next steps (this may be at another time if more appropriate for parents/guardians/whānau)
  - c. provide the parents/guardians with appropriate written resources, including *Getting Started* and *When your baby has a hearing loss*
  - d. ensure that members of the multidisciplinary team are available if required
  - e. explain the role of Advisers on Deaf Children (AoDC) and ask the parents/guardians if they would like to talk to an adviser – agreeing to or declining this offer must be recorded
  - f. explain the reasons for other referrals (including referral to parent support groups)

- g. send a written report of the audiologist assessment and subsequent referrals to the parents/guardians and GP (and AoDC, ENT, paediatrician and Well Child provider as required) within two weeks of the assessment.**

# Initiation of early intervention services

## Standard 20

Initiation of early intervention services for babies identified with a hearing loss will meet programme goals.

### Rationale

A core goal of the UNHSEIP is initiation of appropriate medical, audiological and early intervention education services by six months of age<sup>10</sup> for babies referred from UNHSEIP and diagnosed with a permanent congenital hearing loss.

Timely and relevant information from the audiologist together with support for parents/guardians/whānau from the AoDC is the desired minimum.

### Criteria

- i. DHBs must have a written policy with clearly defined procedures in place to support delivery against this standard and which address the criteria described below.
- ii. Babies identified with a permanent congenital hearing loss must be referred immediately to an otolaryngologist (or paediatrician, depending on local referral pathways) and offered the services of an Adviser on Deaf Children (AoDC).
- iii. UNHSEIP policy is that the AoDC makes contact with the parents/guardians ideally within ten working days of referral.
- iv. If required, amplification must normally be provided within four weeks of diagnosis.
- v. DHBs must have systems and processes in place for minimising loss to follow-up.

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<sup>10</sup> Corrected age

## Audiology follow-up

### Standard 21

Audiologist support, including regular follow-up appointments as appropriate will be provided to ensure progress is monitored.

### Rationale

Support of the parents/guardians/whānau during the process of acceptance and adaptation to hearing loss is essential to maintain engagement with the programme. This will include the provision of supportive information and instructions for the parents/guardians/whānau at the time of the first fitting of a hearing instrument, including explanations of use, care and maintenance. Demonstrations of what they need to do to ensure a child can hear speech in an understandable way, with this being supplemented with appropriate printed material will help ensure good outcomes are achieved.

The provision of regular audiologist follow-up appointments is essential to achieving the aim of the programme.

### Criteria

- i. The provision of audiology follow-up must be consistent with the *Diagnostic and Amplification Protocol* particularly in relation to:
  - a. information to parents/guardians/whanua on the use of hearing instruments
  - b. follow-up to the initial hearing instrument fitting
  - c. consideration of alternate approaches where progress is unsatisfactory.
- ii. Outcome measures and reports from other members of the early intervention team must be maintained to ascertain satisfactory progress with amplification.

# Audiology data and record management

## Standard 22

All data on audiology assessments relating to babies referred through the UNHSEIP will be collected and stored as per legislative requirements.

All audiology data must be sent promptly to the NSU.

## Rationale

Accurate and timely information on audiology appointments and outcomes is essential for programme monitoring.

## Criteria

- i. For all audiology assessments undertaken for babies referred through the UNHSEIP, DHBs must ensure that:
  - a. UNHSEIP Diagnostic Assessment Data Forms, or electronic equivalent are fully and accurately completed
  - b. a copy of the UNHSEIP Diagnostic Assessment Data Form, or equivalent is sent to the NSU on completion of the assessment at the end of each month
  - c. in order to provide timely data for monitoring reports, the NSU is also notified monthly of babies:
    - who have started but not completed audiology assessment
    - not assessed due to DNA/decline/transfer/deceased
  - d. audiologic records maintained consistent with the *UNHSEIP Diagnostic and Amplification Protocols*. Records must be sufficient to facilitate consultative, clinical review and case conferencing and must be available to the NSU on request.
- ii. The assessment and amplification records must be maintained in electronic and/or hard copy.
- iii. When a baby is referred from another DHB for audiology, it is the responsibility of the DHB who undertakes the assessment to send a copy of the UNHSEIP Diagnostic Assessment Data Form to the NSU on completion of the assessment at the end of each month (with a copy of the DHB of referral for their records).

iv. DHBs must ensure that:

- a. systems are developed and maintained to ensure collection, storage and reporting of audiology data is accurate and reliable
- b. audiology data is collected and stored in a manner consistent with privacy legislation and the guiding principles of data collection and management
- c. an effective system of retrieval of records is maintained
- d. appropriate and timely information is provided to GPs, paediatricians and Well Child providers.





## **Section 4:**

# **Quality assurance**

### **UNHSEIP quality assurance, quality improvement and risk management**

#### **Standard 23**

DHBs will have quality and risk management systems in place that reflect continuous quality improvement principles.

#### **Rationale**

Effective and well documented policy, procedures and quality management systems relating to UNHSEIP services are critical to programme quality.

#### **Criteria**

- i. DHBs must have a written quality plan that outlines its intentions to support quality improvement in the delivery of UNHSEIP and which:
  - a. includes a regular assessment of all practices relating to UNHSEIP, including management systems, policies, procedures and guidelines
  - b. details the systems and processes that will be used to assess quality, implement change and evaluate effectiveness of quality activities
  - c. is reviewed regularly to ensure the plan remains relevant to service delivery and the UNHSEIP policy and quality standards
  - d. assigns responsibilities and accountabilities for meeting quality standards
  - e. enables consumer participation wherever appropriate
  - f. has the commitment and participation of management and staff.
- ii. To ensure quality standards are met, DHBs must clearly identify the personnel responsible for:
  - a. monitoring programme data locally for quality assurance and improvement purposes



- b. providing strategic oversight and accountability for UNHSEIP service quality assurance and improvement activity
  - c. ensuring that quality management/improvement processes are documented, implemented, evaluated and reported.
- iii. DHBs will undertake their own monitoring against UNHSEIP indicators especially those indicators where they are not achieving the target. Where targets are not being met or where issues with any other aspect of service delivery are identified, the DHB will:
  - a. undertake quality assurance or audit activities to identify causes of the issue/s
  - b. implement any remedial actions or quality improvement activities to ensure the issue/s are addressed
  - c. ensure that all staff involved in delivering UNHSEIP services are informed of the issues and changes implemented
  - d. evaluate and report as to whether the changes implemented have been successful in addressing the issue/s
  - e. prepare a written report which documents the issue/s, changes in practice that are adopted and an evaluation of the effectiveness of the intervention.
- iv. DHBs must have policies and procedures in place for incident reporting, which includes risk management plans.
- v. All adverse events or near misses<sup>11</sup> must be systematically recorded as per local DHB policy.
- vi. DHBs must inform the UNHSEIP Programme Leader, National Screening Unit, Ministry of Health:
  - a. at the earliest opportunity of any adverse event in writing using an *Incident Notification Form* available from the NSU
  - b. of any near misses in the DHB quarterly report.
- vii. Where an adverse event or near miss occurs, if programme quality is deemed to have been compromised, the NSU and provider will work together to agree on a process that may include review by a designated party.

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<sup>11</sup>. An adverse event is an incident which results in harm or death to a patient. A near miss is an incident which under different circumstances could have caused harm to a consumer but did not, and which is indistinguishable from an adverse event in all but the outcome.

# Complaint management

## Standard 24

DHBs will have an accessible and constructive process in place for consumer complaints/feedback about UNHSEIP.

### Rationale

In accordance with the HDC Code of Health and Disability Services Consumers' Rights 1996, parents/guardians/whānau has the right to complain if dissatisfied with the UNHSEIP service.

### Criteria

- i. DHBs must ensure that all parents/guardians/whānau are aware of their right to complain and the process by which to make a formal complaint.
- ii. DHBs must maintain clearly defined processes for identifying, managing and resolving complaints that:
  - a. are understood and implemented by all staff
  - b. have the underlying principle of being resolved at the lowest possible level
  - c. are compliant with legislative and contractual requirements
  - d. assure anonymity and confidentiality for each person who accesses the complaints process.
- iii. DHBs must:
  - a. record all complaints, comments and suggestions in a specific service logbook/file/database
  - b. inform DHB personnel as required (eg. Quality Manager)
  - c. identify specific personnel with responsibility for ensuring that the complaints management process is effective and efficient
  - d. immediately inform the Programme Leader, National Screening Unit, Ministry of Health of any serious complaint that may have adverse effects on the programme.
- iv. DHBs must establish formal mechanisms for collecting feedback from parents/guardians/ whānau to evaluate their experience of participation in the programme.

## Communication regarding the UNHSEIP

### Standard 25

All UNHSEIP-related media and other communications will be accurate and consistent with the philosophy of the UNHSEIP.

### Rationale

It is important that the public are aware of and have confidence in the UNHSEIP. This includes providing consistent messages about the programme that are robust and evidence-based.

UNHSEIP branding – graphics, descriptors and colour sets – enhance the programme's recognition and profile and allow practitioners and parents/guardians/whānau to easily identify official programme communications.

### Criteria

- i. DHBs must:
  - a. inform the Programme Leader, National Screening Unit, Ministry of Health of any media enquiries relating to the programme
  - b. seek prior written approval from the Programme Leader, National Screening Unit, Ministry of Health, to communicate with the media about the programme
  - c. forward media promotional material relating to the programme to the Programme Leader, National Screening Unit, Ministry of Health for review before any public release.
- ii. Where appropriate and approved by the NSU, DHBs must use UNHSEIP branding in programme communications and publications including graphics, descriptors and colour sets in accordance with the NSU UNHSEIP visual standards guides.

# Research relating to the UNHSEIP

## Standard 26

Research projects related to UNHSEIP will be in keeping with the aim of the programme and managed in consultation with the NSU.

### Rationale

Research completed that is related to the UNHSEIP must be of a high standard and compliant with local, national and international requirements for research, including obtaining ethical approval through the New Zealand Health and Disability Ethics Committee or other Health Research Council approved ethics committee as required as well as comply with any local DHB or other provider research governance requirements.

### Criteria

- i. DHBs must notify the Programme Leader, National Screening Unit, Ministry of Health of any proposed research activity that uses UNHSEIP data or information prior to its commencement. The NSU may seek feedback on the proposed research activity prior to commencement from the UNHSEIP Advisory Group.
- ii. For requests to use UNHSEIP data held by the NSU, the Antenatal and Newborn Screening Programmes Application Form must be completed. Enquiries regarding applications should go to the Executive Assistant, Antenatal and Newborn Screening, National Screening Unit, as per the application form.
- iii. Any report or publication using UNHSEIP data information must acknowledge the Ministry of Health and the UNHSEIP as the source of the data.
- iv. A copy of any report prepared using UNHSEIP data must be provided to the Programme Leader, National Screening Unit, Ministry of Health for comment before publication.