

The profession of audiology is committed to providing auditory and vestibular care through ethical and evidence-based clinical practices that lead to optimal patient outcomes. Standard of practice documents outline basic services that audiologists are expected to include in the provision of quality healthcare. They reflect the values and priorities of the profession, providing direction for professional practice and a framework for the evaluation of practice. Standards of practice are prepared by subject matter experts, based on available evidence, peer-reviewed and subject to periodic updating.

HEARING AID FITTING STANDARD FOR PEDIATRIC PATIENTS

1. This pediatric hearing aid fitting standard is applied to patients whose objectives are supported by the processes defined in this document. The audiologist attending to the needs of patients determines when pediatric or adult standards are applicable to each patient and are provided within the patient's given family/guardian setting respecting aspects of diversity, equity, inclusion, and belonging.
2. The communication needs of pediatric patients are complex and changing over time; management of these needs is the responsibility of a multi-disciplinary professional team that includes family members and audiologists.^{1,13,46}
3. Each patient and family is unique. Audiologists make individualized recommendations based on the needs of each patient and their family. Decisions regarding hearing aid selection and use are made in collaboration with the patient when developmentally appropriate, as well as parents, guardians, other family members, etc. (herein described as "caregivers").^{8,23,25,26,27,45}
4. Communication with patients and caregivers is conducted in a clear, empathetic manner consistent with their preferred communication mode, family setting, comprehension, and health literacy level.^{7,8,9,17,27,37}
5. Applicable policies and regulations are always followed in fitting of hearing aids. Each step of the selection and fitting process and the rationale is documented, where appropriate.²²

6. The hearing aid selection and fitting process is based on a reliable and valid audiological assessment that includes ear and frequency-specific hearing thresholds. Frequency-specific thresholds are obtained at a minimum of one low frequency and one high frequency, based on auditory brainstem response (ABR) or developmentally appropriate audiometric techniques.^{18,33,38}
7. Hearing aids are indicated when persistent elevation of hearing thresholds affects access to spoken language and meaningful environmental sounds. The audiologist recognizes that hearing aids may be appropriate for pediatric patients beyond those who meet criteria outlined in this standard.^{6,14,15,20,36,39}
8. A needs assessment is used in the selection of hearing aids and may include audiological, physical, medical, communication, educational, social, and family & home needs of the patient.^{8,27}
9. Fitting of bilateral hearing aids is the recommended protocol if the patient is a candidate for hearing aids in both ears and it is supported by the needs assessment.¹¹
10. A patient with unilateral hearing loss may be a candidate for intervention as determined by the needs assessment.^{2,30,42}
11. Ear coupling and retention is adequate to support the physical and acoustic requirements of the fitting. This is re-evaluated regularly as the patient grows and develops.^{34,44}
12. Gain and output characteristics are determined and verified according to a validated pediatric prescriptive method and verified across the range of soft, moderate, and loud input levels of speech. Verification methods account for the child's ear canal acoustics to ensure safety and prescribed speech audibility.^{10,16,24,28}
13. Signal processing features that improve audibility are prescribed when supported by the needs assessment. Features are activated or adjusted as the child grows and listening needs change.^{29,31,35}
14. An assessment of initial product quality is completed, using standard electroacoustic measures to verify intended device function.^{10,12}
15. Hearing aids are fitted so that various input levels of speech result in verified ear canal output that meets the frequency-specific targets provided by an age-appropriate validated prescriptive method. The frequency-specific maximum power output is adjusted to optimize the patient's residual dynamic range and ensure safe output levels. Aided speech audibility is verified using an in situ probe microphone system or appropriate coupler-adjusted, simulated real-ear measures.^{5,19,47}
16. Assistive technology and accessories are recommended when indicated to satisfy the patient's listening and communication needs across social, vocational, and academic settings.^{2,40,41}

17. Outcomes are validated using developmentally appropriate tools. These may include aided speech recognition, caregiver and self-report questionnaires, and consultation with caregivers, healthcare providers, and other professionals supporting the needs of the patient.^{3,4,48}
 18. Device orientation is family-centered and includes use, care, maintenance and troubleshooting of the hearing aids and accessories. Expectations for the patient's involvement in these tasks are established at a level appropriate for the patient.^{21,37,43,45}
 19. Counseling is conducted to ensure appropriate adjustment to amplification and to address other concerns regarding communication, as well as unique and specific personal and family needs. Additional habilitation/rehabilitation is recommended based on patient need.^{8,32,37}
 20. Management of pediatric amplification is an on-going process. Re-evaluation of hearing status, needs assessment, verification, and validation are completed at intervals determined by the audiologist. This ensures that the child's needs are met as they grow and develop.^{5,8,13}
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CONTRIBUTORS

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