Patient Education and Counseling 98 (2015) 954–960

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Communication Study

The role of volunteer support in the community for adults with hearing loss and hearing aids

Helen Pryce [a,b], Amanda Hall [a,c,*], Rachael Gooberman-Hill [d]

[a] Centre for Hearing and Balance Studies, University of Bristol, Bristol, UK
[b] School of Life and Health Sciences, Aston University, Birmingham, UK
[c] Children's Hearing Centre, St Michael's Hospital, Bristol, UK
[d] School of Clinical Sciences, University of Bristol, Bristol, UK

ARTICLE INFO

Article history:
Received 19 August 2014
Received in revised form 14 January 2015
Accepted 4 April 2015

Keywords:
Volunteer
Hearing aid
Hearing loss
Access
Support

ABSTRACT

Objectives: To explore interactions between audiology patients and volunteers, to describe encounters and define the role of volunteers.
Methods: Qualitative ethnographic and interview study of volunteer–patient interactions. Ten volunteer participants from two volunteer schemes in South West England were observed and interviewed. Three patient participants were interviewed.
Results: Analysis of observational data showed that volunteers provided support relating to local services and hearing aids, but did not engage in discussions about hearing loss. Interviews with volunteers identified gaps in audiology provision, including accessible services and clear information and highlighted a need for more support from audiology services to enable them to fulfil their role. Volunteer interactions with patients mimicked a clinician–patient encounter and volunteers employed strategies and behaviours used by professional audiologists.
Conclusions: Audiology volunteers could provide an accessible bridge between health services and the community but their care is limited to focus on hearing aids.
Practice implications: Volunteers enable patients to use hearing aids appropriately and are a core element of current care arrangements. However, volunteers express a need for adequate support from audiology services. Volunteers have the potential to increase service capacity and to bridge the gaps between community and audiology healthcare services.

1. Introduction

Hearing aids remain the most common treatment option offered for people affected by hearing loss. However approximately 40% of people fitted with hearing aids stop using them over time [1]. This may be due to lack of support, such as emotional and psychological support for adjustment to hearing loss [2] or practical help and assistance with hearing aid use and maintenance [3]. In the UK, volunteers who often have hearing loss and wear hearing aids themselves, have supported National Health Service (NHS) patients' use of hearing aids; however the nature and impact of the support provided to date has not been investigated in detail.

Volunteering is usually understood as unpaid activity where someone gives their time freely to help an organisation or an individual who is not a relative [4]. Naylor et al. [5] estimate that around 3 million people in the UK volunteer in health and social care; those volunteering through healthcare organisations provide support across a range of settings such as acute hospital trusts, community settings and hospices.

Volunteer activities have the potential to impact positively on public health, patient experience, relationships between health services and communities, and delivery of integrated care [5]. Much of the research on volunteers in healthcare has considered their potential for public health impact and this is likely to be most relevant when considering volunteer support of hearing aid services. South et al. [6] described potential public health roles of volunteers (also termed 'lay health workers'), including peer education and support. Peer education is defined as communicating information to patients to influence behaviour change [6] and peer support is defined as provision of emotional,

* Corresponding author at: Children's Hearing Centre, St Michael's Hospital, Southwell Street, Bristol BS2 8EG, UK. Tel.: +44 1173421611.
E-mail address: Amanda.hall@bristol.ac.uk (A. Hall).

http://dx.doi.org/10.1016/j.pec.2015.04.005

physical and social support based on shared experiences of a condition [7]. However definition of 'peer' remains contested [6] and it is unclear what social characteristics connect individuals. Reviews of effectiveness of volunteer or peer based interventions on health, health behaviours and self-management of chronic conditions show some benefit but the evidence is mixed [8–11]; all reviews highlight the heterogeneity of studies in terms of intervention delivery as well as health condition or behaviour, making generalisation difficult. A key issue when considering the nature of intervention is whether volunteers complement or replace professional support [12]. Kapteyn et al. [13] conducted the only study to compare patient outcomes in an audiology service with or without volunteer support and provided an indication that volunteers reduced "ineffective" hearing aid use.

Glenton et al. [14] carried out a qualitative synthesis complementary to one of the reviews of trials [11]; they explored factors that might influence the effectiveness of peer interventions. Of those trials that included a qualitative component, a common theme was that participants valued characteristics they shared with peers, either relating to social background or health condition. Audiology volunteers may share a range of characteristics with the patients with whom they work, including experience as hearing aid users. This may enable them to provide emotional support for adjustment to hearing loss as well as practical help with hearing aid use beyond that provided by audiology professionals. Before gathering evidence about effectiveness of volunteers in audiology it is important first to identify the nature of the support provided.

1.1. Study aims

We used qualitative methods to define the role of volunteers and explore interactions between volunteers and patients. We use a broad definition for a volunteer consistent with that of Volunteering England [4]: a person who is unpaid and voluntarily provides their time to perform functions related to audiology service delivery, they have no formal training in audiology but receive training specific to their role. This approach allows us to explore whether volunteers are an intervention themselves or whether their role could equally be provided by healthcare professionals.

2. Methods

2.1. Approach

Ethnography enables a detailed examination and description of the social encounter between patient and volunteer in their natural setting. Observations were analysed and themes were linked to provide inductively-generated theory about how interactions were shaped [15]. Following broad observations we use detailed analysis of seven encounters to examine interactions [16]. The analysis of conversation provides further detail about how social roles were played out within encounters. Observational work was supplemented by interviews to explore the rationale behind their choice of behaviours and to gain greater insight into observed activities. Interviews were open-ended to allow participants to lead the direction of conversation; interviews were also tailored as data collection and analysis progressed to enable comparison of comparable experiences between cases using constant comparative analysis [17].

2.2. Ethical approval

Ethical approval was provided in May 2011 by the NHS National Research Ethics Service Committee (East Midlands – Derby 2: 11/EM/0167). We have anonymised the identities of all participants as well as locations at which the research was conducted.

2.3. Setting and participants

Volunteers at two Audiology/Hearing Therapy volunteer services in England were invited to participate in writing by volunteer service co-ordinators. These settings were chosen to provide demographic contrast and variety in the activities undertaken by volunteers. Volunteer service 1 has involved volunteers in service delivery for over 20 years and over 20 volunteers run clinics in community settings supporting hearing aid use and conducting repairs. In addition, the service offers community based information days for hearing aid users and hospital ward based repair services. Volunteer service 2 has a team of six volunteers who provide home visits to support hearing aid use. In this model patients are followed up and supported in their adjustment to hearing aid use by volunteers who visit users in their homes.

Volunteers who took part in the study provided written informed consent before data collection started (Table 1). Patients were invited to participate in the study when they visited a service; they also provided written informed consent.

2.4. Data collection

The researcher (HP) undertook observations of volunteers and patients. In total, 120 h of observations of clinical encounters were completed and interviews were conducted with 10 volunteers and three patients. Observations and interviews continued until there was no additional variation in themes, at which point saturation was achieved [17].

Interactions between Audiology/Hearing Therapy volunteers and patients were observed in clinic locations and patients' homes. Encounters between volunteers and patients were audio-recorded where acoustics would allow [18]. The researcher also made detailed field notes to record the topic, tone and content of encounters with activity noted down at least every 90 s. Data were collected from June 2011 to March 2012.

Volunteers were interviewed after clinic sessions to provide further detail on their role and their perspectives on the services they delivered. Audio-recordings were transcribed, and anonymised. All names in this article are pseudonyms.

The complete dataset comprised field notes of observations of 125 patient and volunteer encounters, 7 audio-recorded encounters, 13 audio-recorded volunteer interviews (3 volunteers participated in more than one interview) and 3 audio-recorded patient interviews.

2.5. Analysis

The approach for organising and interpreting data was informed by constant comparison and derived from Grounded Theory [17]. Field notes and in-depth interviews were analysed

Table 1
Summary of the volunteers, locations and type of service provided.

Age range (decades) of volunteers	50–80 s
Gender	Female ($n=6$)
	Male ($n=4$)
Volunteer service	Service 1 ($n=8$)
	Service 2 ($n=2$)
Volunteer service locations	Hospital ward
	Community hospital
	Church hall
	Domiciliary
	Rural, semi-rural and city locations
Patient access to volunteer	Drop in appointments
	Booked appointments
	Hospital ward visits