

## **Modernising NHS Hearing Aid Services**

### **Guidance on the use of REM to verify digital hearing aid fittings**

#### **Introduction**

The MHAS project team is committed to working towards the recommendation that all patients undergo real ear measurement, as appropriate, at their fitting appointment, along the lines suggested by Gatehouse et al, (BAAS newsletter issue 36. Spring / Summer 2001).

"...Where a fitting rationale contains an acoustical target, each hearing aid should be verified by REM using an input stimulus appropriate for the hearing aid under test. Tolerances to the prescription rationale of +/- 5dB at frequencies of 250, 500, 1k and 2k Hz, and of +/- 8dB at 3k and 4k Hz should be achieved in all cases. In addition the slope in each octave should be within +/- 5dB/octave of the target...."

We recommend the use of REM as a guideline, rather than a rule. There is agreement that audiologists should not aim to "reach target" if patient response/opinion indicates otherwise. There is also agreement that REM is useful in identifying gross differences from the acoustical target, which should be investigated at the fitting appointment as far as is possible. Reasons for gross differences include: faulty hearing aid, faulty programming, unusual shapes or sizes of ear canals and difficulties with earmoulds.

#### **Hearing Aids and Targets**

**Oticon Spirit aids.** Oticon recommend use of the NAL NL1 target for fitting of the aids, and then verification against NAL NL1. There are 3 adaptation levels in Genie, and it is recommended to use level 3. (It is important to remember that the Adaptation manager set at level 1 or level 2 will prescribe less gain than NAL NL1, which is equivalent to level 3.)

Oticon do not recommend changing the programming of the aid unless there are gross differences from target, (as defined above). If differences of this magnitude are observed, then a reason for the difference should be investigated. If necessary, adjustments to the programming should then be made to achieve a closer fit to target, as long as the patient finds the sound acceptable and comfortable. These adjustments to the programming can be made easily while the insertion gain is active on screen, using the two NOAH modules (Genie and REM) together.

## **Procedure**

### **1. Tube Calibration**

This must be done each time you use a new probe tube. That is, it must be done for each patient, and if you change the probe tube halfway through testing a patient, you must repeat the probe calibration.

Place the probe tube so that it is close to the reference microphone aperture, without blocking either of the microphones. Hold the headset 0.5m front of the speaker so the microphone and probe are facing the speaker.

Click on “task”, then “probe calibration” to calibrate.

The signal is a wide band noise.

Your hand should not be between the loudspeaker and the microphone.

### **2. Check calibration**

Holding the tube and microphone in the same position, record an open ear response using a 65dB pink noise stimulus.

Click “start” and check that there is a flat response within 3dB across all frequencies just below the 55dB line. If not, repeat the calibration. (Below 250Hz this may not be achievable - within 5 dB is acceptable). Click “stop”.

### **3. Position patient**

The patient should be seated so that the ear under test is

at 45° to the speaker,

0.5m from the speaker, and

level with the centre of the speaker (not higher or lower).

It is helpful to attach a piece of string to the speaker, to enable easy positioning of the patient, and also to have markers on the wall for the patient to look at.

The patient should be instructed to sit as still as possible during recording.

### **4. Otoscopy**

Otoscopy must always precede REM.

Proceed with caution in any of the following circumstances: perforation, grommet, mastoid cavity, discharge or glue ear, wax filling more than one-third of the cross-sectional area of the canal.

It may be advisable in these circumstances to consider fitting to real ear aided gain, rather than insertion gain, see Dillon, Hearing Aids, p248 for an explanation.

## **5. Insert probe tube**

Always use a new probe tube for each patient. We recommend using the thinner (1.1mm) probe tube (with a black-coloured marker) since this will be less uncomfortable for the patient if you touch the canal wall or TM.

Set black marker 27mm from the end of the probe tube, and insert probe tube down ear until the black marker is at the tragus. It is helpful to attach a short (15cm) ruler to the top of the Unity box so that measuring 27mm is very quick.

Accurate placement of the probe tube is important.

Use an otoscope to check that the probe-tube is lying along the bottom of the canal.

## **6. Measure Open Ear Response**

Check that you have selected NAL NL1 as the target. (Check the settings are as in notes below, under “target” and also appendix 1)

With the probe tube in place down the ear, use a 65dB pink noise stimulus.

Click on “start” and check that the response, after it has stabilised, does not look very peaky, or that the gain at 6000Hz is not below -5dB. Then click on “record”.

If it is, reposition probe or move patient slightly.

## **7. Measure Occluded Response**

### **OPTIONAL**

Insert the hearing aid into the ear, being careful not to dislodge the probe tube. With the hearing aid in place, the marker should still be at the tragus.

With the hearing aid switched OFF (muted in the software), click “start” using a 65dB pink noise stimulus.

You expect a reduction of the peak around 2-3 kHz, the natural resonance of the ear canal. Check that the gain has not reduced very much at the low frequencies. If so, reposition the hearing aid, and check the probe tube for wax/moisture.

Click “record” to save.

## **8. Measure Insertion Gain**

Switch the aid on (unmute it in the software) without moving it. It should have all its usual features left on, the correct vent size having been selected.

Select an input of 65dB modulated speech noise (aurins) stimulus and click “start” then “record”

Compare with the target insertion gains, remembering that if adaptation level 1 or 2 is programmed, this will prescribe less gain than NAL NL1.

## **9. Modify the programming in the aid.**

Ensure that you are running both the REM module and the Genie module. When re-sizing the Genie window, it is preferable to re-size the whole PN window. If necessary, make and monitor adjustments to the aid by leaving the relevant insertion gain running.

This section gives the detail on how to achieve the above, although experience so far indicates that there is some variation across sites. Staff are advised to test this out in their own departments, write a step by step protocol, and seek advice from the IHR team if in any difficulty.

1. Open Genie and program the hearing aid(s)
2. Leaving Genie open, but restored down, then also open PC Probe using the NOAH module Selection.
3. Minimise the PC Probe legacy host.
4. Maximise Genie then resize the AB/PN window containing Genie to about half the screen and resize PC Probe to the other half of the screen, so that you can see both the Genie screen, and the REIG and NAL NL1 target within PC Probe.
5. Run through steps 1-8 above.
6. Compare the REIG with the NAL NL1 target.
7. Set up the REIG to run continuously while you make changes to the Genie software.

If the Spirit high frequency gain is too low, (assuming adaptation level 3 has been selected) Oticon suggest adjustments to be made as follows:

- A. Increase HF MPO all the way to the top (assuming quiet room. The MPO defaults conservatively to the lowest ULL, so there is headroom. However, be cautious.)
- B. If target is still not closely matched, finetune it with the loud HF gain trimmer and the two HF bands in the filterbank. If the filterbank bands cannot be raised enough, decrease the reserve gain and try again.
- C. When target is matched, decrease MPO again while watching the REIR. Stop just before the IG drops below the target.

If the patient finds the sound of the hearing aid too loud, use clinical judgement and set the aid to adaptation level 2 (or 1 in extreme cases). This will maintain the frequency shaping that you have set during REM.

Further details on this are available from Oticon, who will cover this in their product training sessions at sites.

## **10. Check high level output.**

### **OPTIONAL**

A 90 dB warble tone (WT) can be used to ensure that the patient's ULL is not being exceeded and that the patient is happy at high intensity levels. This is especially important if the programming has been altered to meet the target at 65 dB. The patient should be warned that the signal is loud, and that the WT

will sweep up through the frequencies, taking longer than the pink noise or the modulated speech noise. Always use clinical judgement and caution as appropriate, particularly in patients with tinnitus or hyperacusis.

It is advisable for Audiologists to position themselves away from the speaker to avoid excessive noise exposure.

## **Notes**

### **Setting up the REM equipment**

#### **Calibration**

The REM equipment must have been subject to a full objective calibration within the last 12 months.

#### **Target**

Set up to NAL NL1. In the NAL NL1 set up box, ensure that you have selected multi-channel limiting, 2 channel compression and a compression threshold of 50dB. The reference position should be head surface, and orientation set at 45°. Select bilateral/unilateral as appropriate. Check the dob. Ensure the correct vent size is selected. In the NAL NL1 parameters box, check that the test signal is selected as “speech levels”, the coupler is selected as “REIG”, and ensure that 1 of the gain boxes read 65 dB. Tick the box “Use Bone Conduction Values” if the patient has a significant conductive loss, (use >15dB air bone gap averaged over 500, 1k and 2k Hz as a guideline).

See more detail on NAL NL1 in Appendix 1.

#### **Stimulus**

Use a modulated speech noise (aurins) stimulus for recording insertion gain, this is available from A&M on floppy disk, there are two aurins files that need to be copied onto the windows/tracks directory.

#### **Positioning the speaker**

Try to position the speaker so that it is not at the back of a table, and there are not large, flat reflecting surfaces near the patient.

## Appendix 1.

This appendix shows the appropriate settings for NAL NL1 for Oticon Spirit. They may be saved (together with other settings eg stimulus type) in a.inp file, which may then be loaded at the start of each session. (Settings menu, click save set-up or load set-up).

**NALNL1 Setup**

**Setup** Parameters

Settings

Date of Birth: 30/12/1899

Number of HI's: Unilateral

CT of Wide Band: 50

Transducer: Supra-aural headphone

Limiting: Multi-Channel

Ref. Position: Head surface

Orientation: 45 degrees

Tubing: Libby 4

Venting: Tight

Compr. Channels: 2

RECD: Predicted

REUG: Predicted

REDD: Predicted

Use Bone Conduction Values

RECD

	250Hz	500Hz	1kHz	1.5kHz	2kHz	3kHz	4kHz	6kHz	8kHz
Left									
Right									

REDD

	250Hz	500Hz	1kHz	1.5kHz	2kHz	3kHz	4kHz	6kHz	8kHz
Left									
Right									

OK Cancel Help

**NALNL1 Setup**

Setup **Parameters**

Table

Cross over freq.: 1547.16

Test Frequency: 500 3150

Comp. Threshold: 50 50

Comp. Ratio: 1.18 1.29

GAIN [ 40 ]: 7 26

GAIN [ 65 ]: 5 23

GAIN [ 80 ]: 3 16

Coupler

REIG

REAG

2cc Coupler

Ear Simulator

Test Signal

Speech Levels

Pure Tone Levels

Side

Left

Right

Recalculate

OK Cancel Help

## Useful references

BS ISO 12124: 2001. Acoustics: Procedures for the measurement of real-ear acoustical characteristics of hearing aids.

Dillon, H. 2001. Hearing Aids. Chapter 4. Electroacoustic Performance and Measurement. Boomerang Press

Mueller HG, Hawkins DB, Northern JL. 1992 Probe microphone measurements: Hearing aid selection and assessment. Singular Press.

Kuk F and Ludvigsen C. Variables affecting the Use of Prescriptive Formulae to fit modern hearing aids. J Am Acad Audiol 10: 458-465 (1999)

Mueller G. Probe mic assessment of digital hearing aids? Yes, you can! The Hearing Journal, vol 54, no 1. Jan 2001.

Gatehouse S, Stephens SDG, Davis AC and Bamford JM, 2001. Good practice guidance for Adult hearing aid fittings and services. BAAS newsletter issue 36.

PAS 9/5/03

Revised 14/8/03

25/9/03

JH 28/10/2003

3/12/2003.