‘EAR ‘TIS

ANAA Inc.
HEARING HEALTH FOR ALL

Summer 2023

www.anaa.asn.au

Newsletter for Audiometry Nurses

Welcome to the issue of the ANAA Inc. newsletter
2023 Summer Issue

Darren from Narrabri

In This Issue

President's Report

December 2023

Dear Members,

We are getting closer to ticking all the boxes for the year.

The annual conference in Parramatta went well, although extremely tiring!

If you add up all of the education hours it would be about 16-17 CPD hours. This is pretty full on & perhaps we can reduce this at the next conference allowing more time to network and see the trade displays. There is always a concern a presenter may pull out last minute so we try to fill the day. Thank you to all of you that attended.

It is always a great learning experience having our wonderful trade displays attend. The audiologists in particular have been very supportive each year & we welcome them in the future to provide ongoing education.

Good news is that Sharyn & her team from Canberra have agreed to host the next conference. Thank you girls for offering to do this massive task. It will be fun & rewarding at the same time.

Kate has sent out an email to all members asking if anyone is able to help write our new audiometry nursing course with the Australian College of Nursing. If you are interested, please let us know & also Linlin at ACN. The applicant will be paid to do this.

We have had some interest already but please let us know if you can help.

After the call out from Hear our Hearts bus in Dubbo a couple of audiometry nurses have been able to help out with their screening program. This shows great partnership with our fellow hearing health stakeholders. If anyone else is interested, please let us know or contact Rachel & Donna in Dubbo.

I hope everyone has a very happy Xmas & takes time out to reflect on the year and spend time with loved ones & friends.

Thank you all for supporting our audiometry nursing organisation for another year.

Take care & best wishes.

Tracy

Sea Change

Employment Type: Permanent Part Time

Position Classification: Clinical Nurse Specialist Gde 2

Remuneration: $55.45 - $57.27 per hour + 11% super + salary packaging

Hours Per Week: 24

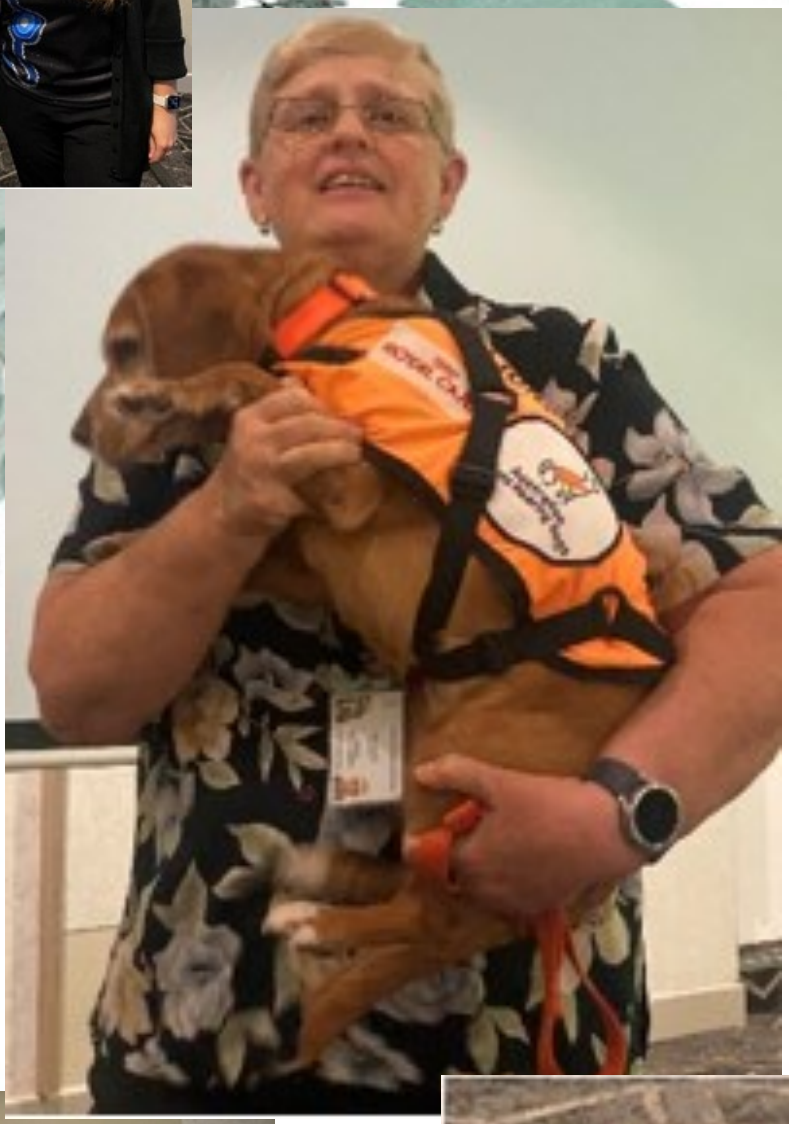
Requisition ID: REQ454013

Applications Close: Thursday, 21 December 2023

Child and Family Health Nurse - Clinical Nurse Specialist 2 Audiometry
Awabakal Country

[Child and Family Health Nurse - Clinical Nurse Specialist 2 Audiometry - NSW Health Careers]

Conference 2023 - Parramatta

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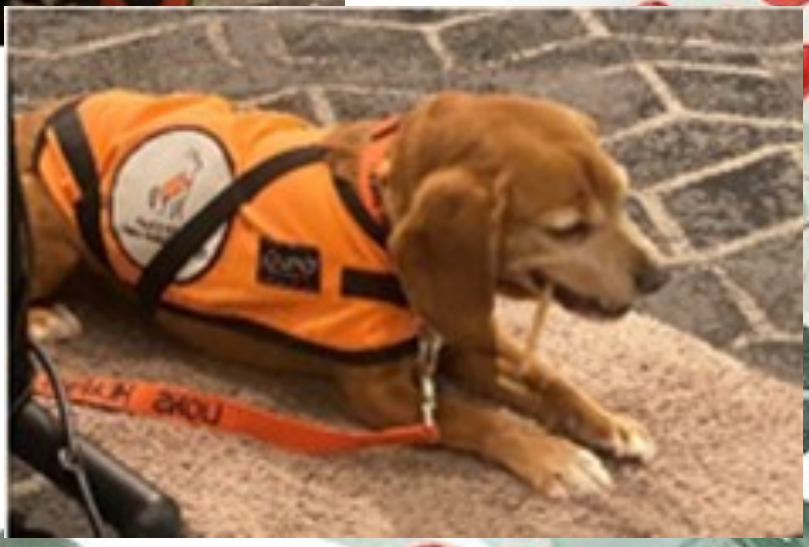

Conference 2024 for

Canberra/Queanbeyan

Requesting Contributions

Calling on all preserve makers, seed collectors this year to put some aside to contribute for the raffles please.

If you're a crafter or artisan would love to receive an artwork, piece of pottery or crotchet/ kitted piece, dyed fabric/felting, carved wooden spoon etc.

Bring them along all donations will be gratefully received and acknowledged.

Hear our Heart Ear Bus Project is 😇 feeling blessed. · **Follow**

1 Dec · 🌍

We are very thankful to our friends at Audiometry Nurses Association of Australia Inc. for helping us to organise members to come and do hearing testing for us. This week has been a Nurse Aud week.

We had Sandy Corbett from Mullaley near Gunnedah and Gisella Laughton from the Blue Mountains testing in Warren and Dubbo. We are so thankful for them coming and hope to see them back again to help our community where we take the hearing testing to the kids..... in schools where it should be!

Australian Lions Hearing Dogs

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5245)
www.lionshearingdogs.com.au

lions australia
we serve

Audiometry Nurses Association of Australia

26 October 2023

Dear Tracy

On behalf of the deaf and hard of hearing people of Australia I thank you most sincerely for your generous donation of $410.00 to Lions Hearing Dogs Inc.

It is only through the generosity of people such as you that we are able to continue to provide our services at no cost to the recipient.

Your official receipt number Don6081 is below.

Yours sincerely

David Horne
Chief Executive Officer
Lions Hearing Dogs Inc.

Receipt Number	Don6081
Received From	Audiometry Nurses Association of Australia
Amount	$410.00

Chief Executive Officer

Guidelines for Public outpatient services are currently being drafted . Below is an extract of the drafted guidelines which refer to our Audiometry Nurse children's hearing services.

It's and interesting and enlightening read for our members to be aware and have an understanding of the classification / triage categories placed on our clients referred for intervention in order for us to help us advocate when writing our hearing reports.

NSW Health

Draft Ear, Nose & Throat (ENT) State-wide Referral Criteria for Public Outpatient Services

NSW GOVERNMENT

This document is to be used for consultation purposes only

The NSW Ministry of Health, in partnership with the Agency for Clinical Innovation, are facilitating the development of State-wide Referral Criteria (SRC) for NSW public specialist outpatient services.

The aim of SRC is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services. SRC are intended to support patients and referring health professionals when issuing referrals as well as NSW public specialist outpatient services at the point of screening and triage.

An Ear, Nose & Throat (ENT) SRC Clinical Advisory Group (CAG) has been formed to develop ENT SRC for NSW public specialist outpatient services. The CAG consists of medical/surgical specialists, nursing professionals and allied health professionals who support NSW public ENT outpatient services as well as General Practitioners and other referring health professionals to NSW public ENT outpatient services.

The development of ENT SRC for identified presenting conditions is in-scope for phase 1b of the project.

This document contains working draft of the ENT SRC for the following presenting conditions:

- Allergic rhinitis, nasal congestion or obstruction (adult)
- Asymmetrical sensorineural hearing loss (adult)
- Recurrent tonsilitis (adult)
- Salivary gland disorders (adult)
- Thyroid mass (adult)
- Voice disorders (adult)
- Allergic rhinitis, nasal congestion or obstruction (paediatric)
- Asymmetrical sensorineural hearing loss (paediatric)
- Obstructive sleep apnoea or sleep disordered breathing (paediatric)
- Otitis media (with effusion and chronic or recurrent) (paediatric)
- Recurrent tonsilitis (paediatric)
- Salivary gland disorders (paediatric)
- Voice disorders (paediatric)

Glossary

The structure for SRC in NSW is divided into the following five criterion.

In some cases, component(s) may not be applicable to each presenting condition. This will be denoted by 'Nil'.

Criterion	Description
Emergency	• Clinical presentations or 'red flags' where referring health professionals should consider redirecting the patient to an Emergency Department or urgent care service, or seeking medical advice (e.g. phone on-call medical practitioner) • These criteria should not be used by referring health professionals to refer to an NSW public specialist outpatient service
Out of scope / not routinely provided	• Symptoms, conditions and/or presentations that would not routinely be provided by NSW public specialist outpatient services (i.e. could be optimally and safely managed in primary care) • These criteria acknowledge and permit exceptions, where clinically appropriate
Access / prioritisation	• Symptoms, conditions and/or presentations that advise referring health professionals, clinicians, patients and carers suitability for management by NSW public specialist outpatient services • These criteria are classified by expected clinical urgency category and clinically recommended timeframes to be seen for a new outpatient appointment (i.e. Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days) • These criteria are only applicable where NSW public specialist outpatient services exist and manage the identified presenting condition
Referral requirements	• Mandatory information that is to be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category
Other content	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria may support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

Draft Ear, Nose & Throat (ENT) State-wide Referral Criteria for NSW Public Specialist Outpatient Services

Allergic rhinitis, nasal congestion or obstruction (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.	
• Nil	
Out of scope / not routinely provided	
• Nil	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Unilateral nasal obstruction with offensive and/or bloody discharge
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nasal obstruction with failed maximal medical management or septal deviation causing symptomatic nasal obstruction • Allergic rhinitis with failed maximal medical management
Referral requirements	
• Medical management to date	
Other content	
• RAST or IgE results (allergic rhinitis) • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population	

Asymmetrical sensorineural hearing loss (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.	
• New, sudden onset hearing loss (i.e. within 72 hours) Note: these patients should ideally present to emergency within 24-48 hours of onset for assessment • Associated head trauma • Focal neurological signs or symptoms (including sudden vertigo)	
Out of scope / not routinely provided	
• Child with normal audiogram	
Note: hearing loss identified in neonates are to follow SWISH referral guidelines	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Hearing loss associated with ototoxic medicine(s) • Sudden hearing loss – if outside 7 days post onset • Asymmetric or symmetric hearing loss confirmed by diagnostic audiology assessment in children with autoimmune conditions
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Asymmetric or symmetric hearing loss confirmed by diagnostic audiology assessment in children without autoimmune conditions
Referral requirements	
• Audiogram (with bone conduction) • Description of hearing loss or change in hearing (i.e. onset, duration, timing) • Medication list	
Other content	
• Results of MRI (brain and IAM) • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population	

Obstructive sleep apnoea or sleep disordered breathing (paediatric)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acutely enlarging neck mass with any associated airway symptoms (e.g. stridor, drooling, dysphagia)
- Airway compromise with or without severe stridor, drooling or breathing difficulty
- Acute, sudden voice change
- Severe odynophagia

Out of scope / not routinely provided

- Snoring, adenoid facies or bruxism not associated with obstructions during sleep
- Significant sleep fragmentation
- Behavioural concerns

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Polysomnographic evidence of severe obstructive sleep apnoea with continuous positive airway pressure (CPAP) intolerance (despite effort) and significant, uncontrolled desaturations or cardiovascular compromise

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Severe obstructive sleep apnoea confirmed on polysomnography (PSG)
	• Obstructive sleep apnoea with faltering growth (failure to thrive)
	• All of the following after trial of nasal steroids:
	  ○ Clinical history and examination with a prolonged history (> 3 months) of an obstructive breathing pattern
	  ○ Parental report or video evidence of obstruction
	  ○ Significant daytime behavioural impacts

Category 3 (clinically recommended to be seen within 365 calendar days)	• Mild to moderate sleep disordered breathing or obstructive sleep apnoea • Obstructive sleep disordered breathing following trial of nasal steroids for ≥ 4 weeks • Sleep disordered breathing and underlying developmental or behavioural issues

Referral requirements

- Description of sleep disordered breathing or obstructive sleep apnoea
- Tonsillar hypertrophy grading scale (Brodsky scale)
- Total OSA-5 score (if available)

Other content

- Obstructive sleep apnoea with co-existing craniofacial abnormality
- Paediatric Epworth or pictorial Sleepiness Scale

Draft Ear, Nose & Throat (ENT) State-wide Referral Criteria for NSW Public Specialist Outpatient Services

- Recent paediatric polysomnography
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population

Otitis media (with effusion and chronic or recurrent) (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.	
• Any suspicions of the complications of acute suppurative otitis media (ASOM) – i.e. mastoiditis (proptosis of pinna), meningitis, associated neurological signs (e.g. facial nerve palsy, profound vertigo and/or sudden deterioration in sensorineural hearing)	
Out of scope / not routinely provided	
• Middle ear effusion in one ear for < 6 months or both ears for < 3 months	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Confirmed or suspected structural damage to the tympanic membrane (e.g. significant retraction, cholesteatoma)
	• Effusion and any of the following:
	  ○ In the setting of speech delay, educational handicap and/or Aboriginal Torres Strait Islander descent
	  ○ Structural or medical comorbidities (e.g. cleft palate, craniofacial abnormalities, diabetes, sensorineural hearing loss) and lasting > 3 months with audiometry showing significant bilateral or unilateral conductive hearing loss (≥ 30 dB in better ear)
	• Perforated tympanic membrane and any of the following:
	  ○ Ongoing pain
	  ○ Persistent drainage from the middle ear for > 6 weeks despite topical antibiotics
	  ○ Significant hearing loss ≥ 45 dB in better ear
	• ≥ 3 episodes of acute otitis media within 6 months
	• ≥ 4 episodes of acute otitis media within 12 months and hearing loss

Category 3 (clinically recommended to be seen within 365 calendar days)	• Chronic otitis media with effusion (glue ear) for 3 months with no significant hearing loss and no impact on speech and language development • Perforation not healed in 6-12 months, and a hearing loss > 25 dB, or if other significant risk factors (e.g. speech delay or other disability) are present • Dry perforation persists > 6 months in a child aged ≥ 8 years for consideration of tympanoplasty • Middle ear dysfunction (including Eustachian tube dysfunction) affecting one or both ears for > 6 months with both of the following: ○ Impact on speech and language development

Draft Ear, Nose & Throat (ENT) State-wide Referral Criteria for NSW Public Specialist Outpatient Services

	○ Pre-existing disability, or high risk of speech language or learning disability
Referral requirements	
• Medical management to date • Results of audiogram or tympanometry (preferred) • Results of otoscopic examination (appearance of tympanic membrane) (if available) • Speech pathology or audiology assessment against normal developmental milestones (if available)	
Other content	
• Diagnostic audiology assessment results • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population	

Recurrent tonsilitis (paediatric)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Swelling causing acute upper airway obstruction (e.g. stridor or respiratory distress)
- Unable to tolerate oral intake
- Severe dehydration
- Peritonsillar cellulitis or abscess
- Epiglottitis or bacterial tracheitis
- Toxic appearance (e.g. pale or mottled skin, cool extremities, weak cry, grunting, rigors, decreased responsiveness, or signs of sepsis in children)
- Haemorrhagic tonsillitis

Out of scope / not routinely provided

- Recurrent tonsilitis where episodes are fewer than described in access criteria and no modifying factors are present
- Enlarged tonsils with no recurrent tonsillitis as described in access criteria and/or no evidence of obstructive sleep disordered breathing

Access / prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Suspected malignancy
	• Abnormally appearing tonsils with:
	  ○ Drenching night sweats in the absence of infection
	  ○ Unexplained weight loss (≥ 10% of body weight over 3 months)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Ulceration and/or recurrent unilateral enlargement, with/without lymphadenopathy • Complicated tonsilitis (e.g. multiple medication allergies)
Category 3 (clinically recommended to be seen within 365 calendar days)	• > 6 episodes of acute tonsilitis in the preceding 12 months • 4-5 episodes per year in the preceding 2 years, or 3 episodes per year in the preceding 3 years • Episodes are significantly affecting schooling or employment • Associated signs of sleep disorder breathing (e.g. abnormal respiratory patterns including presence of apnoea or hyponoea, snoring, restless sleep) • Swallowing difficulties causing pathological weight loss • 2 prior episodes of quinsy in someone with no history of recurrent tonsilitis or 1 quinsy if there is history • If patient does not meet Paradise criteria above, PANDAS, PFAPA and/or Apthous stomatitis for consideration for tonsillectomy

Draft Ear, Nose & Throat (ENT) State-wide Referral Criteria for NSW Public Specialist Outpatient Services

Referral requirements

- Number and timeframe of previous episodes
- Degree of systemic upset
- Previous antibiotic prescriptions
- Medical management to date
- Severity of episodes
- Time off school or work
- If recurrent quinsy
- Symptoms of obstructive sleep apnoea

Other content

- EBV serology/monospot results
- FBC results
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population

Sandra Corbett's little men from her Gunnedah and Narrabri Clinic's

Harper at Gunnedah

Darren at Narrabri

Great to see other clinic settings.

Please send us yours.

Please see attached PDF with this email for full consensus statement.

Consensus statement

Routine ear health and hearing checks for Aboriginal and Torres Strait Islander children aged under 6 years attending primary care: a national consensus statement

Samantha Harkus[1], Vivienne Marnane[1], Isabel O'Keeffe[1], Carmen Kung[1], Meagan Ward[1], Neil Orr[2], John Skinner[2], Kelvin Kong[3,*], Lose Fonua[4,†], Michelle Kennedy[5,†], Mary Belfrage[6]

Summary

This consensus statement provides new recommendations for primary care assessment of ear health and hearing status of young Aboriginal and Torres Strait Islander children who are not known to have, or are not being actively managed for, ear health and hearing problems. Any child identified with otitis media should be actively managed. This national consensus statement extends existing treatment and management guidelines.

Main recommendations:

- Undertake checks at least 6-monthly, commencing at 6 months until 4 years of age, then at 5 years. Undertake checks more frequently in high risk settings for children under 2 years, when acceptable to families, or in response to parent/carer concerns.
- Ask parents/carers about concerns, signs, and symptoms; check children's listening and communication skills; and assess middle ear appearance and mobility.
- Otoacoustic emissions testing is suggested when equipment is available, primary health practitioners have capability and confidence to use the equipment, and there is local preference for its use.
- Video otoscopy is suggested for health promotion purposes, and/or for sharing images with other health practitioners.
- Audiometry should be done as per existing guidelines: when there are parent/carer concerns, signs of persistent/recurrent otitis media, or when listening and communication development is not yet on track.

Changes in management as a result of this statement:

- Key practice changes include routine use of tympanometry, and listening and communication skills checklists. Implementation will require access to equipment and training; clear information on immediate, practical actions for families; timely pathways to referral services; and a change management process that shifts perception and tolerance of otitis media and its impacts and raises expectations that Aboriginal and Torres Strait Islander children can have healthy ears and hearing.

The ear health and hearing check (EHHC) recommendations presented in this article are for primary health care practitioners, to guide effective assessment of ear health and hearing status of Aboriginal and Torres Strait Islander children aged under 6 years attending primary care who are not known to have, or are not being actively managed for, ear health and hearing problems. A national expert panel provided cultural, clinical and research expertise during the development process. The recommendations complement the clinical management guidance provided in the *Otitis media guidelines for Aboriginal and Torres Strait Islander children*.[1]

The prevalence of recurrent or persistent otitis media (OM) in Aboriginal and Torres Strait Islander children remains among the highest globally.[2] This prevalence is attributed to social and environmental factors that are a legacy of colonisation, racism, and disempowering government policies, including economic disadvantage, difficulty in accessing affordable and culturally appropriate health care, and lack of access to adequate housing that supports good health.[3,4] Until these determinants are addressed, the ear health and hearing status of Aboriginal and Torres Strait Islander children will remain a matter of concern for years to come.

In addition, recurrent or persistent OM can limit children's developmental potential. For Aboriginal and Torres Strait Islander children, OM often starts in early infancy [5,6] without acute or obvious symptoms,[1] and persists throughout childhood.[7] This is the sensitive period for development — a time window in which early sensory experiences lay the foundation for cognitive, social and behavioural development.[8] Persistent OM-related hearing loss significantly reduces this experience, negatively impacting developmental outcomes, quality of life, family harmony, school readiness, and transmission of cultural and linguistic knowledge.[9-13]

To avoid these negative impacts, early detection is essential. The current OM guidelines recommend ear checks at every visit to primary health care,[1] but in practice, checks are more often prompted by parent/carer concern than clinician initiated.[8,13]

These recommendations were motivated by the enormous variations in provision, components and timing of EHHCs for Aboriginal and Torres Strait Islander children in primary health care, and in identification of OM.[14-16] Despite indications that a more systematic approach may be effective,[17,18] no consensus has existed on the components or timing of EHHCs for Aboriginal and Torres Strait Islander children, or for similar populations experiencing high rates of early onset, persistent OM.[15]

Methods

The development of these recommendations was led by Aboriginal and non-Indigenous researchers experienced in health research with Aboriginal and Torres Strait Islander people. Researcher expertise included Aboriginal health,

*Worimi

†Wiradjuri

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samantha.harkus@nal.gov.au • doi: 10.5694/mja2.52100

North Coast Team

In October this year we invited Janine Leslie Audiologist from the HAPPEE program on the North Coast of NSW to attend our quarterly Audiometry Nurses meeting.

Janine was a retired Audiologist who came out of retirement to take on the role in the HAPPEE program when it commenced. She is passionate about the role and was keen to teach us her tips and tricks when testing little children. Sadly, Janine is really retiring next year. Hopefully someone as keen and energetic as Janine will take on the role.

Here are some photos from the day. Taken at Goonellabah Child and Family Health Centre. The group photo is Kate Norton, Lynne Blundell. Lyn Delaney, Janine Leslie, Shirley Howitt, Cheryl Ducat & Annette Swanson.

Masking Workshop

On Monday 17th July 2023 Audiometry Nurses from Moree, Mungindi, Gunnedah, Tamworth, Inverell, Walcha & Singleton got together for a masking workshop conducted by the amazing TAFE Ear Train team of Jean Tsembis Audiologist & Jo O'Malley at the Imperial Hotel in Bingara. Bingara was a good central meeting spot for everyone & it was a nice spot for lunch too.

It was a good refresher for the more experienced Audiometry Nurses and a good introduction to masking for the more recently trained.

We also had some practice using the new GSi Corti TEOAE that several centres in the area have been fortunate enough to receive through the ear Equipment Assistance Program from Federal Department Health & Sonic.

It was interesting as the day progressed; we discovered a few things that us Audiometry Nurses do differently from Audiologists – from how they record their results to how they condition their clients.

The Eartrain team were very happy to provide the workshops & Jean is happy to discuss your needs – their current funding continues till June 2024 & fingers crossed beyond but it you would like an education in your area please be sure to be in touch with Jo O'Malley ASAP to discuss your needs.

Joanne O'Malley

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Inaugural cCMV symposium.

Congenital Cytomegalovirus (cCMV) is a viral infection that occurs when a pregnant woman is exposed to the cytomegalovirus.

If the virus is transmitted to the fetus during pregnancy, it can lead to various health issues in newborns.

The recent inaugural cCMV Symposium in Melbourne marked a milestone in the collective efforts to combat this pervasive viral infection.

The symposium heard from maternal fetal medicine specialists, paediatricians, infectious diseases specialists, audiologists, midwives, general practitioners, public health researchers, early intervention specialists, and hearing screening professionals.

Presentations delved into ongoing initiatives across Australia, encompassing cCMV awareness and education, screening protocols for both expectant mothers and newborns, breakthroughs in treatments and vaccine development, advancements in models for prevention and treatment modalities, and the establishment of a national register.

One of the symposium's highlights was the sharing of compelling narratives by families who have directly experienced the impact of cCMV.

The event received generous support from Mercy Perinatal and the MCRI Infection Immunity Theme.

For healthcare professionals interested in enhancing their knowledge, a free online module on CMV and syphilis during pregnancy is available here.

A comprehensive set of resources, including posters, flyers, and educational videos, designed to aid healthcare practices in raising awareness about cCMV, can be accessed here.

DEAFNESS FORUM AUSTRALIA oneinsix

In Canberra we requested these boxes thinking they would be quite large but they are not they are small red boxes for the desk top. We will be just collecting them bag in plastic bag/post pack and bag.

I question the wastage around the whole scheme of single use items labelled by a company simply for the exercise of revenue generation. Is the ear canal with an intact tympanic membrane which secretes cerumen excreting membrane different from any other intact skin membrane. These tips are not required to be sterile only clean. I am fully aware of health policy and procedures around single use items. I'm just seeking more solid research and evidence around this seemingly wasteful expenditure of tax payers money .

Does anyone know about existing legislation around companies labelling these items?

Please send in your discussion.

Nursery rhymes and singing may help babies learn language.

Parents should speak to their babies using sing-song speech, like nursery rhymes, as soon as possible, say researchers. That's because babies learn languages from rhythmic information, not phonetic information, in their first months.

Phonetic information – the smallest sound elements of speech, typically represented by the alphabet – is considered by many linguists to be the foundation of language. Infants are thought to learn these small sound elements and add them together to make words. But a new study suggests that phonetic information is learnt too late and slowly for this to be the case.

Instead, rhythmic speech helps babies learn language by emphasising the boundaries of individual words and is effective even in the first months of life.

Researchers from the University of Cambridge and Trinity College Dublin investigated babies' ability to process phonetic information during their first year.

Their study, published today in the journal *Nature Communications*, found that phonetic information wasn't successfully encoded until seven months old, and was still sparse at 11 months old when babies began to say their first words.

"Our research shows that the individual sounds of speech are not processed reliably until around seven months, even though most infants can recognise familiar words like 'bottle' by this point," said Cambridge neuroscientist, Professor Usha Goswami. "From then individual speech sounds are still added in very slowly – too slowly to form the basis of language."

The researchers recorded patterns of electrical brain activity in 50 infants at four, seven and eleven months old as they watched a video of a primary school teacher singing 18 nursery rhymes to an infant. Low frequency bands of brainwaves were fed through a special algorithm, which produced a 'read out' of the phonological information that was being encoded.

The researchers found that phonetic encoding in babies emerged gradually over the first year of life, beginning with labial sounds (e.g. d for "daddy") and nasal sounds (e.g. m for "mummy"), with the 'read out' progressively looking more like that of adults.

This is the first evidence of how brain activity relates to phonetic information changes over time in response to continuous speech.

Goswami believes that it is rhythmic information – the stress or emphasis on different syllables of words and the rise and fall of tone – that is the key to spoken language learning.

ANAA Inc. Committee 2023/2024

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Wishing All
A Merry Christmas
and best wishes for
2024