Ear Care Guidelines for Adults only

<table>
<thead>
<tr>
<th>Reference No:</th>
<th>G_CS_31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>4</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>LCHS Trust Board</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>12th September 2017</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Maxine Leggett, Georgina Higgins, Maxine Cumberpatch and Darren Clawson</td>
</tr>
<tr>
<td>Name of approving committee/responsible individual:</td>
<td>Effective Practice Assurance Group</td>
</tr>
<tr>
<td>Date issued:</td>
<td>September 2017</td>
</tr>
<tr>
<td>Review date:</td>
<td>July 2019</td>
</tr>
<tr>
<td>Target audience:</td>
<td>Clinical Staff</td>
</tr>
<tr>
<td>Distributed via:</td>
<td>Website</td>
</tr>
</tbody>
</table>
### Lincolnshire Community Health Services

#### Ear Care Guidelines for Adults only

### Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Section/Para/Appendix</th>
<th>Version/Description of Amendments</th>
<th>Date</th>
<th>Author/Amended by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>New Policy</td>
<td></td>
<td>NHSL</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Revision</td>
<td></td>
<td>NHSL</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>1.0 Background / Rationale, 3.2 Guidance for the use of eardrops, 3.3.3 Guidance procedure for ear irrigation using the electronic irrigator, references, new reference number given</td>
<td>01/07/2014</td>
<td>Maxine Leggett &amp; Val Ronis</td>
</tr>
<tr>
<td>3.1</td>
<td></td>
<td>Extension</td>
<td>August 2016</td>
<td>Corporate Assurance Team</td>
</tr>
<tr>
<td>3.2</td>
<td></td>
<td>Extension</td>
<td>January 2017</td>
<td>Corporate Assurance Team</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Copyright © 2017 Lincolnshire Community Health Services NHS Trust, All Rights Reserved. Not to be reproduced in whole or in part without the permission of the copyright owner.
Lincolnshire Community Health Services

Ear Care Guidelines

Contents

i. Version control sheet
ii. Contents
iii. Policy statement

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>1.1</td>
<td>6</td>
</tr>
<tr>
<td>1.2</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>2.1</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>3.1</td>
<td>7</td>
</tr>
<tr>
<td>3.2</td>
<td>8</td>
</tr>
<tr>
<td>3.3</td>
<td>8</td>
</tr>
<tr>
<td>3.3.1</td>
<td>8</td>
</tr>
<tr>
<td>3.3.2</td>
<td>9</td>
</tr>
<tr>
<td>3.3.3</td>
<td>10</td>
</tr>
<tr>
<td>3.3.4</td>
<td>12</td>
</tr>
<tr>
<td>3.3.5</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>4.1</td>
<td>14</td>
</tr>
<tr>
<td>4.2</td>
<td>16</td>
</tr>
<tr>
<td>4.3</td>
<td>17</td>
</tr>
<tr>
<td>4.4</td>
<td>19</td>
</tr>
<tr>
<td>4.5</td>
<td>20</td>
</tr>
<tr>
<td>4.6</td>
<td>21</td>
</tr>
<tr>
<td>4.7</td>
<td>22</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
</tr>
</tbody>
</table>

Chair: Elaine Baylis QPM
Chief Executive: Andrew Morgan
Lincolnshire Community Health Services

Ear Care Guidelines

Policy Statement

Background

The purpose of the Ear Care Guidelines is to implement a co-ordinated and uniform approach to ear care in the community.

Statement

Lincolnshire Community Health Services will develop policies to fulfil all statutory and organisational requirements. These will be comprehensive, formally approved and ratified, disseminated through approved channels and implemented.

Responsibilities

Compliance with this guideline will be the responsibility of all Lincolnshire Community Health Services Staff.

Authors of policies are responsible for undertaking appropriate consultation during the development of any policy.

The guidance will be agreed at the Adult Integrated Clinical Governance and Risk Forum and ratified by the Clinical Effectiveness and Risk Committee.

Training

Heads of Service and operational managers are responsible for ensuring staff receive training relevant to their role.

Dissemination

Website
Email
Identified in Lincolnshire Community Health Service staff Newsletter

Resource implication

The policy has been developed in line with the NHS Litigation Authority guidelines to provide a framework for staff within LCHS. The guidance requires access to specific disposable clinical equipment and medical devices.
Ear Care Guidelines

The contents of this document are based on ‘Guidance for Ear Care’ published by Rotherham Primary Ear Care Centre which were developed by the ‘Action on ENT’ Steering Board (2002) and were revised by the Primary Ear Care trainers – Rotherham Primary Ear Care Centre (2014). The document ‘Guidance in Ear Care’ has been endorsed by the Royal College of General Practitioners, The Royal College of Nursing and the Medical Devices Agency. Reference: www.earcarecentre.com

1.0: BACKGROUND/ RATIONALE

Ear Wax or excess cerumen is a common problem affecting approximately one third of adults in the UK (Kraszewski, 2008). The Institute of Hearing Research (2009) estimates that over half of people aged 71 – 80 have some degree of hearing loss and that 55% of people over the age of 60 experience some deafness or are hard of hearing (Action on Hearing Loss, 2008). Nursing literature also identifies that a major cause of hearing impairment is due to impacted cerumen resulting in itchiness, discomfort and earache (Rodgers, 2009; Kraszewski, 2008).

Wax or cerumen is a normal secretion of the ceruminous glands in the outer meatus. It is slightly acidic, giving bactericidal qualities in both its wet, and sticky form, (as secreted by Caucasians and Afro-Caribbean's) or dry, flaky form (as secreted by Orientals). In addition to epithelial migration, jaw movement assists the movement of wax to the entrance of the External Auditory Meatus (EAM) where it emerges on to the skin. A small amount of wax is normally found in the EAM and its absence may be a sign that dry skin conditions, infection or excessive cleaning have interfered with the normal production of wax. It is only when there is an accumulation of wax that removal may be necessary. A build-up of wax is more likely to occur in older adults and patient with learning difficulties, hearing aid users, people who insert implements into the ear or have a narrow EAM. A build-up of wax may also occur as a result of anxiety, stress and dietary or hereditary factors. Excessive wax should be removed before it becomes impacted, which can give rise to tinnitus, hearing loss, vertigo, pain and discharge. If it is removed due to the presenting complaint of hearing loss, ascertain whether good hearing is restored after treatment or if the patient would benefit from a formal assessment by the ENT surgeon or Audiologist. Older adults with a bilateral hearing loss can be referred back to the GP for assessment and possible referral to the Audiology Department (Rotherham primary Ear Care Centre, 2014).

Although the ear has natural mechanisms for the removal of ear wax, it is recognised that contributory factors may be present; and as a result certain people do experience problems with the accumulated wax. Despite non invasive interventions being carried out first there are occasions when ear irrigation is required.

Ear irrigation is an invasive procedure with the potential to cause discomfort or injury (Cook 1998 in Kirklees) and therefore must only be considered when other conservative methods of wax removal have failed (e.g. the use of softeners).

Risk associated with irrigation include tympanic membrane perforation and otitis externa.

These guidelines only relate to ear irrigation for the purpose of cerumen (wax) removal. Metal syringes should never be used as their use is obsolete due to the dangers attached to this type of equipment. Propulse 11 or Propulse 111 is the equipment of choice. Safety precautions are essential when using electronic irrigators. Propulse irrigators should be serviced annually. (MDA 1998)

A review by the Medical Defence Union of General Practitioners looked at claims settled over a five year period and revealed that ear syringing accounted for 19% of the total claims (Price,
1997) with poor technique, faulty equipment, excess pressure and failure to examine as the four main reasons for this.

1.1: OBJECTIVES

Audit revealed the need to standardise practice by issuing guidelines for best practice and to provide training and updates for all clinical staff providing ear care. Therefore these guidelines are aimed at community staff to support their clinical practice in the provision of ear care to patients in their own home.

The experienced practitioner should use his/her clinical judgement on the best method of ear examination and wax removal and be deemed competent to undertake the procedure. He/she must be able to give advice re management options and thew administration of ear drops as required.

These guidelines have been developed to assist practitioners including band 3 and 4 staff in gaining knowledge and experience in the provision of ear care. They do not replace the need for education, training and supervision in order to perform these procedures. Practitioners undertaking ear care in the community must therefore have attended Ear Care Training and be deemed competent by a practitioner experienced in ear care and who has attended the relevant training. Competencies which must be completed after attending the Ear Care Training can be found in section 7.0. Competencies must be reassessed 2 yearly.

Professionals are individually accountable for their professional practice (NMC, 2015) and professionals using these guidelines should have their competency reviewed on annual basis via their annual appraisal.

1.2: DOCUMENTATION

Full consent, history and assessment must be documented using the Ear Care Template on System One. This can be found in the Clinical Tree under Templates and Regular Contacts.

2.0: OBJECTIVES OF EAR CARE

- To provide an opportunity to educate patients in good ear care
- Improve conduction of sound where the impacted wax is believed to be the cause of hearing deficit by recognising when ear wax needs to be removed and removing it safely and effectively when indicated
- To enable the proper functioning of a hearing aid (excessive wax causes both feedback, i.e. whistling and poor sound quality)
- Where the wax is considered to be the source of discomfort
- To prevent further wax impaction occurring by providing patient advice and education

2.1: PRINCIPLES OF ASSESSMENT

Before any intervention is initiated a through assessment and examination of the patient’s ear history should take place. The ear care checklist is a guide for staff to support them in the assessment process.

On assessment if wax is the cause of the patients hearing loss and discomfort initiate the use of a softening agent for 5-7 days to soften the wax.
DEFINITIONS AND ABBREVIATIONS

Areas of tympanic membrane - light reflex, handle of malleus, pars flaccida, pars tensa and anterior recess.

Cerumenolytics - agents that soften hardened cerumen (ear wax) and make it easier for it to be removed from the ear.

Crocodile forceps - instrument used in ear care

ENT - Ear, nose and throat - the area of medicine that deals with disorders and conditions of the ear, nose and throat

Ear irrigation - (formerly known as ear syringing) a routine procedure used to remove excess earwax or foreign materials from the ear.

External auditory meatus (EAM) - also known as the ear canal - a tunnel running from the outer ear to the middle ear.

Grommets - a tube surgically implanted in the eardrum to drain fluid from the middle ear.

Hygroscopic foreign bodies - eg peas and lentils - will absorb water and expand making them difficult to remove.

Jobson-Horne - a probe with a serrated end used in ear care.

Mastoid process - a large, bony prominence on the base of the skull behind the ear, containing air spaces that connect with the middle ear cavity.

Microsuction - a wax removal technique using a binocular operating microscope (which allows depth-perception and magnification) to look straight in to the ear canal and a very fine sterile suction device at low pressure to remove the wax.

Noots tank - a receiver to collect water during ear irrigation.

Otitis Externa - inflammation of the external auditory meatus.

Otoscopy - an examination that involves looking into the ear with an instrument called an Oscope (Auriscope/Ear torch). This is performed in order to examine the ear canal-the tunnel that leads from the outer ear (pinna) to the ear drum.

Pinna - the projecting part of the external ear.

Speculae – ends for otoscope.

Tinnitus - comes from the Latin word for ‘ringing; It is the perception of hearing sound in the absence of any corresponding external sound.

Tragus - a cartilaginous projection anterior to the external opening of the ear.

Tympanic Membrane (TM) - eardrum – a thin membrane that serves as a partition between the external ear and the middle ear, and transmits the motion of sound waves to the small bones in the middle ear.
Vertigo—a sensation of dizziness and loss of balance associated with disease affecting the inner ear or the vestibular nerves.

3. PROCEDES

3.1: GUIDELINES FOR EAR EXAMINATION (Ear Care Centre, 2014)

Adult Patient:

1. The aim of the examination is to assess the amount and position of wax, and to support the clinical decision making process regarding any procedures or interventions to be carried out. Before careful physical examination of the ear, listen to the patient, elicit symptoms and take a careful history. Explain each step of any procedure or examination possible complications of the procedure and ensure that the patient understands and gives consent. Ensure that both you and the patient are seated comfortably, at the same level, and that privacy is maintained. Past medical history should be documented, to include existing long term conditions, current medication, allergies, present and previous occupation. This should also include a comprehensive ENT history to identify contra-indications to the undertaking ear care procedures.

2. Examine the pinna, outer meatus and adjacent scalp. Check for previous surgery incision scars, infection, discharge, swelling and signs of skin lesions or defects. Identify the largest suitable disposable speculum that will fit comfortably into the ear and place it on the otoscope.

3. Palpate the tragus in order to identify if the patient has any pain. Proceed with caution.

4. Gently pull the pinna upwards and outwards to straighten the EAM (directly down and back in children). If there is localized infection or inflammation this procedure may be painful and examination may be difficult.

5. Hold the otoscope like a pen and rest the small digit on the patient’s head as a trigger for any unexpected head movement. Do not move the patient’s head when the otoscope is in the ear. Use the light to observe the direction of the EAM and the tympanic membrane. There is improved visualisation of the tympanic membrane by using the left hand for the left ear and the right hand for the right ear but clinical judgement must be used to assess your own ability. Insert the speculum gently into the meatus to pass through the hairs at the entrance to the canal.

6. Looking through the otoscope, check the EAM and tympanic membrane. Adjust your head and the otoscope to view all the tympanic membrane. The ear cannot be judged to be normal until all the areas of the membrane are viewed: the light reflex, handle of malleus, pars flaccida, pars tensa and anterior recess. If the ability to view all of the tympanic membrane is hampered by the presence of wax, then wax removal will have to be carried out.

7. If the patient has had canal wall mastoid surgery, methodically inspect all parts of the cavity, tympanic membrane, or remaining tympanic membrane, by adjusting your head the otoscope. The mastoid cavity cannot be judged to be completely free of ear disease until the entire cavity and tympanic membrane, or remaining tympanic membrane has been seen.

8. The normal appearance of the membrane or mastoid cavity varies and can only be learned by practice. Practice will lead to recognition of abnormalities.
9. Carefully check the condition of the skin in the EAM as you withdraw the otoscope. If there is doubt about the patient’s hearing, an audiological assessment should be made. Providing they meet certain criteria stated in local referral guidelines, older adults with a bilateral hearing loss can be referred to the General Practitioner (G.P) so that they may be considered for referral to the Audiology Department. Patients with a unilateral loss should be referred to ENT by the GP.

10. Document what was seen in ears, the procedure carried out, the condition of the tympanic membrane and External Auditory meatus and treatment given. Findings should be documented, with nurses following the NMC guidelines on record keeping and accountability NMC (2009, 2015). If any abnormality is found a referral should be made to the ENT Outpatient Department following local policy.

3.2: GUIDENCE FOR THE USE OF SOFTENING AGENTS

Following assessment and examination of both ears, if impacted wax is the problem advice needs to be given to the patient and/or carer regarding was softening prior to any further procedures being carried out. This is to promote patient safety by reducing risk of procedures, and increasing the likelihood of successful was removal.

It is recommended to soften the wax using olive oil. Droppers can be purchased separately at local chemists by the patient / carer and should be advised for individual use. The rationale is that olive oil is less of an irritant on sensitive skin. It also acts as a moisturiser and is cost effective when compared with other softeners some of which can be irritant. Nurse prescribers are able to prescribe olive oil if necessary from the nurse prescribers formulary. (BNF, Nurse Prescribers Formulary for Community Practitioners).

The administration is recommended as 2-3 drops, 2-3 times each day for 5-7 days is the minimum recommended. On no account should olive oil be heated.

Information to provide to patients in respect of olive oil ear drop administration; hands must be decontaminated prior to any patient contact and after the procedure is complete.

I. Lie down on your side with the affected ear uppermost
II. Insert 2 to 3 drops of oil, at room temperature into the ear massage tragus and pull pinna backwards and upwards. This enables the oil to run into the ear canal
III. Stay lying down for 5 minutes then get up, wipe away any excess oil. DO NOT leave cotton wool at the entrance of the ear

After using softening agent for a minimum of 7 days reassessment of the patients ears is required before any further intervention is planned. Some patients require the use of softening agents for longer periods prior to safe removal of wax.

3.3: GUIDELINES AND TREATMENT FOR THE REMOVAL OF WAX (Ear Care Centre, 2014)
3.3.1: GUIDELINES ON EQUIPMENT USED FOR WAX REMOVAL (NICE 2012)

The metal syringe is obsolescent for use in the External Auditory Meatus. The syringe design is inherently dangerous. Combined with the danger of the syringe itself and the pressure of water it creates with EAM, there is the difficulty of disinfecting the syringe after each use. The Medical Devices Agency (MDA, 1998) also has reservations about the use of the metal syringe for wax removal – hence they should not be used. There are issues around the poor manufacture of some syringes, allowing them to break and cause injury during use and the pressure of water that can be exerted manually on the tympanic membrane.

Electronic irrigators such as the “Propulse” and the “Otoscillo” allow irrigation of the EAM rather then wax removal under pressure. The Medical Device Agency issued Safety Notice SN 9807 in February 1998 which advised users that the original Propulse electronic irrigator required an isolation transformer for electrical safety. Subsequently, the manufacturer designed and marketed the Propulse II to replace the original Propulse. Propulse III is now available which is both mains and battery operated.

Please note: This guidance document does not recommend the use of manual syringes or the Propulse I, even with an isolation transformer, but recommends that practitioners should use the Propulse II or III irrigator and refer to the procedure as ear irrigation.

The Propulse II and III irrigator have a pressure-variable control of minimum/maximum, allowing the flow of water to be easily controlled by commencing irrigation on the minimum setting. For patient safety, Propulse has limited the maximum pressure available; this limit is stated in the user instructions. The Propulse III irrigator has specific disinfecting guidelines issued with approval from infection control committees and must be decontaminated between patients. Refer to manufacturer’s guidance.

Use disposable Jet Tips and disposable Otoscope ear pieces, disposable Jobson Horne Probes and Henkle forceps when undertaking any treatments.

3.3.2: USE OF JOBSON HORNE PROBE / OR PROPULSE 11/111

If wax is soft and at the edge of the external auditory meatus it can be removed using a Jobson Horne probe or irrigation using the Propulse 11 or the new Propulse 111.

Criteria for Patient inclusion;
- When the patient has excess wax obscuring the tympanic membrane which needs to be removed for diagnostic circumstances;
- Where the patient has wax confirmed by an examination by a GP or registered nurse;
- Where the patient has given consent to the procedure and has had the potential complications of ear wax removal explained to them. This should be documented in the patient’s records;
- Each patient should have an individual risk assessment carried out to ensure they meet the criteria for inclusion and identify risks that would exclude them from the procedure;
- The risk assessment should include an assessment of the safest environment to carry out the procedure.

Criteria for Exclusion
- The patient has previously experienced complications following this procedure in the past;
- There is a history of a middle ear infection in the last six weeks;
- The patient has undergone ANY form of ear surgery (apart from grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Department);
- The patient has a perforation or there is a history of a mucous discharge in the last year;
- The patient has a cleft palate (repaired or not);
- There is evidence of acute otitis externa with pain and tenderness of the pinna. This list is not exhaustive and the practitioner must use his or her own judgement for each individual.

**Precautions:**
- Ear irrigation should be carried out on a low setting.
- Tinnitus
- Healed Perforation
- Dizziness
- Patient taking anti-coagulants
- The patient has a cleft palate (repaired or not)

This list is not exhaustive and the practitioner must use his or her own judgement for each.

**3.3.3 GUIDANCE PROCEDURE FOR EAR IRRIGATION USING THE ELECTRONIC IRRIGATOR**

This procedure is only to be carried out by a trained doctor, nurse or audiologist. It may also be carried out by a healthcare worker who has received recognised training in ear care and the use of ear care equipment. All healthcare workers must demonstrate competency to support safe clinical practice. They must understand the normal and abnormal physiology of the ear and be aware of the complications and contraindications of ear irrigation.

An individual assessment should be made of every patient to ensure that it is appropriate for ear irrigation to be carried out. Consent should be obtained and the rationale for the procedure documented in patients records.

**PRINCIPLES** – Irrigation of the ear is carried out to:

- Facilitate the removal of cerumen and foreign bodies, which are not hygroscopic, from the external auditory meatus. Hygroscopic matter (such as peas and lentils) will absorb the water and expand, making removal more difficult;
- Remove discharge, keratin or debris from the external auditory meatus.
REASONS for using this procedure

- Correctly treat otitis externa where the meatus is obscured by debris;
- Improve conduction of sound to the tympanic membrane when it is blocked by wax;
- Remove debris to allow examination of the external auditory meatus and the tympanic membrane;
- Remove cerumen in order to facilitate hearing aid mould impressions.

Irrigation should NOT be carried out when:

- The patient has previously experienced complications following this procedure in the past;
- There is a history of a middle ear infection in the last six weeks;
- The patient has undergone ANY form of ear surgery (apart from grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Department);
- The patient has a perforation or there is a history of a mucous discharge in the last year;
- The patient has a cleft palate (repaired or not);
- There is evidence of acute otitis externa with pain and tenderness of the pinna.

Precautions:
Tinnitus
Healed Perforation
Dizziness

REQUIREMENTS

All equipment must be checked to be working, cleaned and maintained prior to the procedure to promote safety and prevent infection.

- Otoscope / disposable tips
- Head mirror and light or headlight and spare batteries
- Electronic irrigator (Propulse II or III)
- Tap water at 37°C
- Disposable Noots trough/receiver
- Disposal Jobson Horne probe and cotton wool
- Tissues and receivers for dirty swabs and instruments
- Disposable waterproof cape and paper towels
- Disposable apron and gloves

THIS PROCEDURE SHOULD BE CARRIED OUT WITH BOTH PARTICIPANTS SEATED AND UNDER DIRECT VISION, USING A HEADLIGHT OR HEAD MIRROR AND LIGHT SOURCE, THROUGHOUT THE PROCEDURE

PROCEDURE

Prior to any contact with the patient hands must be decontaminated and appropriate personal protective equipment applied. The procedure should be carried out with both participants seated and under direct supervision. A headlight and/or head mirror and light must be used to aid visibility.
1. Consent should be obtained and documented prior to proceeding;

2. Examine both ears by first inspecting the pinna and adjacent scalp using direct light. Check for previous surgery incision scars or skin defects, then inspect the EAM with the otoscope;

3. Check whether the patient has had his/her ears irrigated previously, or if there are any contra-indications why irrigation should not be performed;

4. Explain the procedure to the patient and ask the patient to sit in an examination chair (a child could sit on an adult’s knee with the child’s head held steady);

5. Check that the headlight/light source is in place and is working correctly;

6. Place the protective cape and paper towel on the patient’s shoulder and under the ear to be irrigated. Ask the patient to hold the receiver under the same ear;

7. Check that the temperature of the water is approximately 37ºC and fill the reservoir of the irrigator. Set the pressure at minimum;

8. Connect a new disposable jet tip applicator to the tubing of the machine with a firm 'push/twist' action. Push until a “click” is felt;

9. Direct the irrigator tip into the Noots receiver and switch on the machine for 10-20 seconds in order to circulate the water through the system and eliminate any trapped air or cold water. This offers the opportunity for the patient to become accustomed to the noise of the machine. The initial flow of water is discarded, thus removing any static water remaining in the tube. Check the temperature of the water again;

10. Twist the jet tip so that the water can be aimed along the posterior wall of the EAM (towards the back of the patient’s head);

11. Gently pull the pinna upwards and outwards to straighten the AM (directly backwards in children);

12. Warn the patient that you are about to start irrigating and that the procedure will be stopped if he/she feels dizzy experiences any pain. Ensure that the light is directed down the EAM. Place the tip of the nozzle into the EAM entrance and, using the foot control, direct a stream of water along the roof of the EAM and towards the posterior wall (direct towards the back of the patient’s head). If you consider the entrance to the EAM as a clock face, you would direct the water at 11 o’clock in the right ear and 1 o’clock in the left ear. Increase the pressure control gradually if there is difficulty removing the wax. It is advisable that a maximum of one reservoir of water per ear is used in any one irrigation procedure;

13. If you have not managed to remove the wax within five minutes of irrigation, it may be worthwhile moving on to the other ear, as the introduction of water via the irrigating procedure will soften the wax and you can retry irrigation after about 15 minutes;

14. Periodically inspect the EAM with the otoscope and inspect the solution running into the receiver;

15. After removal of wax or debris, dry mop excess water from the meatus under direct vision using the Jobson Horne probe and best quality cotton wool. Stagnation of water and any
abrassion of skin during the procedure predispose to infection. Removing the water with the
cotton wool tipped probe reduces the risk of infection;

16. Examine the ear, both meatus and tympanic membrane, and treat as required following
specific guidelines, or refer to a doctor if necessary;

17. Give advice regarding ear care and any relevant information;

18. Document what was observed in both ears, the procedure carried out, the condition of the
tympanic membrane and external auditory meatus and treatment given. Findings should
be documented; nurses should follow the NMC guidelines on record keeping and
accountability. If any abnormality is found a referral should be made to the ENT Outpatient
Department following local policy.

IRRIGATION SHOULD NEVER CAUSE PAIN. IF THE PATIENT COMPLAINS OF PAIN,
WATER COMING DOWN THEIR NOSE OR IF BLEEDING OCCURS – STOP
IMMEDIATELY

Always use a sterilised or single use speculum and Jobson Horne probe and a single use jet tip
applicator for each patient.

It is recommended that you follow the manufacturer’s guidelines and local policy for
cleaning, disinfecting and calibrating the irrigator and its components.

3.3.4: GUIDANCE & PRINCIPLES FOR AURAL TOILET

Aural toilet is used to clear the aural meatus of debris, discharge, soft wax or excess fluid
following irrigation.

This procedure is only to be carried out by a trained doctor, nurse, audiologist or healthcare
worker with recognised ear care training.

An individual holistic assessment should be made of each patient to ensure that it is appropriate
for aural toilet to be carried out.

1. Examine the ear using an otoscope;

2. Under direct vision, dry mop – using an ear mop or Jobson Horne probe with a small
piece of cotton wool applied to the serrated edge. Clean the EAM with a gently rotary
action. Do not touch the tympanic membrane;

3. Replace the cotton wool directly it becomes soiled. Pay particular attention to the
anterior-inferior recess, which can harbour debris;

4. Intermittently re-examine the meatus, using the otoscope, during cleaning to check for
any debris/discharge/crusts which remain in the meatus at awkward angles;

5. Patients who have mastoid cavities should be followed up in the ENT department only.
The frequency of cleaning required by the cavity will depend on the individual patient;

6. If an infection is present treatment as dictated by the result of a swab culture and
sensitivities following the failure of first line management. If the patient has repeated
problems with the ear, a referral to an ENT Surgeon is indicated to review the patient;

7. Give advice regarding ear care and any relevant information;
8. Document in electronic record what was observed in both ears, the procedure carried out, the condition of the tympanic membrane and external auditory meatus and treatment given. Findings should be documented; nurses should follow the NMC guidelines on record keeping and accountability. If any abnormality is found a referral should be made back to the referring GP so a referral to the ENT Outpatient Department may be made.

3.3.5: GUIDANCE FOR REMOVAL OF EXCESSIVE WAX

This procedure is only to be carried out by a doctor, nurse or audiologist trained in the removal of excessive wax.

These notes are to be used as a guide: when the practitioner has developed their skills they can use their own clinical judgement on the most appropriate method and instrumentation to remove wax.

1. Examine the ear to discern the type of wax to be removed. Ask yourself if it is healthy wax or may it be bacterial debris of wax-like appearance? Is it dry crumbly wax related to Seborrhoea Dermatitis? Is it soft, beige wax, in both ears, that can be associated with high cholesterol?

2. Hard, crusty wax can often be gently manoeuvred out of the meatus with a ring probe, using a head mirror and external light source or headlight for illumination. Experienced practitioners may prefer to use a wax hook or forceps. If this treatment becomes painful, do not continue as a meatal lining quickly becomes traumatised, risking infection. Instruct the patient according to your clinical judgement. A possible treatment could be to use olive oil or sodium bicarbonate inserted correctly for up to 1 week. The patient can then return for irrigation or further instrumentation. Excessive soft wax or crumbly wax and debris can be wiped out with cotton wool wound onto a Jobson Horne probe (using aural toilet guidelines) or irrigated;

3. Cerumenolytic ear drops can be used to break up hard wax but patients may develop meatal irritation from the astringent qualities of these agents. This is particularly the case with older adults or people who suffer with dermatology conditions or recurrent otitis externa;

4. If a perforation is suspected behind the wax, advise the patient to use olive oil in very small amounts, but to stop using it if they experience any pain;

5. Give advice regarding ear care and any relevant information;

6. Document what was observed in both ears, the procedure carried out, the condition of the tympanic membrane and external auditory meatus and treatment given. Findings should be documented; nurses should follow the NMC guidelines on record keeping and accountability. If any abnormality is found a referral should be made to the ENT Outpatient Department following local policy.
### 4.0: EAR CARE COMPETENCIES

To perform ear examination and treatment safely health care professionals must be deemed competent by an experienced practitioner in ear care and demonstrate their understanding of anatomy and physiology of the ear, recognise normal and abnormal features, understand the importance of history taking and recording, demonstrate correct use of equipment such as the Propulse 111, otoscope and Jobson Horne probe, understand issues of consent, infection control and provide appropriate advice to patient.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>RATIONALE</th>
<th>Competency Met (Sign &amp; Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take and document history from patient and gain consent</td>
<td>To highlight presenting problem, previous problems, any history of surgery, perforations, tinnitus, pain in ear, cleft palate repaired or not, infections of middle ear within last 6 weeks or a mucoid discharge, which could contraindicate treatment.</td>
<td></td>
</tr>
<tr>
<td>Use otoscope to examine both ears with patient's consent. Universal precautions apply (wearing of protective equipment apron and gloves)</td>
<td>To detect any abnormalities. If history of perforation, previous or present it is recommended NOT to be irrigated.</td>
<td></td>
</tr>
<tr>
<td>Document in electronic record</td>
<td>Good, expected practice, effective communication, aide memoir</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>RATIONALE</td>
<td>Competency Met (Sign &amp; Date)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>If wax occluding meatus/typanic membrane advise instillation of Olive oil 5-10 days (minimum)</td>
<td>To soften the wax and aid dispersion</td>
<td></td>
</tr>
<tr>
<td>If irrigation required use Propulse III Electronic irrigator as per guidelines using direct vision by using a headlight or head mirror and light source throughout the procedure</td>
<td>Safely remove excessive wax from external auditory canal</td>
<td></td>
</tr>
<tr>
<td>Ear to be dry-mopped following irrigation (aural toilet)</td>
<td>Prevention of infection</td>
<td></td>
</tr>
<tr>
<td>Examine ear following treatment and document outcome</td>
<td>Evidential record keeping</td>
<td></td>
</tr>
<tr>
<td>Ensure correct cleaning of instruments as per guidance and record for audit (See Appendix 1)</td>
<td>Prevention of cross infection</td>
<td></td>
</tr>
</tbody>
</table>
ALL COMPETENCIES MET AND ACHIEVED:

Name of Nurse …………………………………………………………………

Signature of Nurse ……………………………………………………… Date …………………

Name of Assessor …………………………………………………………….

Signature of Assessor …………………………………………………. Date …………………

Training record and associated competencies to be recorded within the electronic staff record.

Competencies to be viewed by line manager and copy sent to e-workforce to be entered onto ESR.
APPENDIX 1

EAR CARE GUIDELINE – MAINTENANCE AND CLEANING OF EQUIPMENT

For the purposes of infection control it is important that all equipment is cleaned in line with the manufacturers recommended guidelines as any static water present within the equipment may predispose to the development of pseudomonas.

Irrigation equipment

1 Cleaning and decontamination after individual patient use

Stage 1

- The Propulse should be disinfected using a fresh solution of Sodium dischloroisocyanurate 0.1% (NaDCC) ie. 2 Precept or HAZ tablets 0.5mg tablets, in 500ml of cold water or 4 tablets in 1 litre of water
- Fill the water tank with NaDCC solution
- Run the Propulse for a few seconds to allow the solution to fill the pump and flexible tubing
- Leave to stand for 10 minutes
- Empty the water tank
- Rinse the system through with tap water before use
- Dry the machine using paper towels

1.1 Managing Decontamination when equipment used in the patients own environment

- Drain the water from the Propulse system
- Dry the system using disposable paper towels
- Return the machine to base
- Treat equipment as above

Cleaning and disinfection of Accessories:

Stage 2 at the end of the day or ear irrigation session:

- All accessories should be disposable and stored in a dry, safe environment
- Disinfect the Propulse machine for 10 minutes as above
- Rinse the machine by running through sterile water through and dry thoroughly

2.1 Jet tip applicator
- Use disposable jet tip applicators – use one jet tip applicator per patient

2.2 Otoscope speculum
- Use disposable speculum

2.3 Jobson Horne Probe and Henkle Forceps
- Use disposable Jobson Horne probes wherever possible

2.4 Nootes tank
- Clean with general detergent and store dry or use disposable cup
- Practitioners should be aware of COSSH guidance and PCT policies related to use of hazardous substances (Health and Safety Executive, 2002)
APPENDIX 2

EAR CARE GUIDELINE – Conditions Practitioners need to be aware of:

1) The Ear Canal can be narrowed due to bony exostoses, which are said to be common in swimmers.
2) Foreign bodies can be found although more common in children.
3) Wax is more common in adults and can vary in consistency affected by genetics, dry skin, ear infections, and reduction in ceruminous wax related to the aging process. For these reasons wax can appear to be dry and flaky, of crumbly consistency, honey coloured or dark brown and hard and may attach itself quite firmly to dry skin.
4) Examination of the ear drum may reveal a perforation. This may be due to trauma, barotraumas or chronic or acute infection. Note the position and size of the perforation on a diagram, document in patients notes, and refer patient back to GP.

Sometimes a large central perforation may be seen though which the basal turn of the cochlea and ossicles can be seen.

5) Occasionally the anterior recess is filled with debris and infection. Also there may be a golden crust in the Pars Flaccida area of the tympanic membrane, where a cholesteatoma may be forming due to the prolonged retraction of the membrane. Cholesteatomas can also occur along the posterior edge of the tympanic membrane due to a perforation. This may lead to damage to the surrounding nerves and tissues and these patients need URGENT referral for possible surgery.

6) Fluid is the commonest seen abnormality in the middle ear and bubbles or a fluid level can often be clearly seen.

Chronic obstruction due to catarrh means that the air in the middle chamber cannot be replaced. This causes negative pressure or a vacuum and the drum is drawn inwards.

To check the patency of the Eustachian tube, a procedure called Valsalvas Manoeuvre may be used. Ask the patient to pinch the nostrules, and blow air into the nose, whilst you observe the drum with the otoscope. There should be a slight movement of the drum due to air pressure changes. Steam therapy should be advised here to try to re-establish the patency of the Eustachian tube, to allow air back into the middle ear space.

7) Acute Otitis media may cause a red bulging tympanic membrane or inflamed tympanic membrane with visible fluid in the middle ear.

A viral infection may result in a bilateral, non bulging pink drums or may cause pain together with a fluid swelling known as bullous myringitis.

8) Scarring of the drum from repeated infections or trauma and the drum looses its normal glistening appearance.
References:

Department of Health, Eileen House, 80-94 Newington Causeway, London SE1 6EF


Kaufman, G. (1998) *Ear Problems: Care and Prevention, Practice Nurse*


Equality Analysis

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help LCHS staff members to comply with the general duty.

Please complete the template by following the instructions in each box. Should you have any queries or suggestions on this template, please contact Qurban Hussain Equality and Human Rights Lead.
**Name of Policy/Procedure/Function***

<table>
<thead>
<tr>
<th>Equality Analysis Carried out by:</th>
<th>Maxine Leggett</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>1 July 2014</td>
</tr>
<tr>
<td>Equality &amp; Human rights Lead:</td>
<td>Rachel Higgins</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Director/General Manager:</td>
<td>Sarah McKown</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

*In this template the term policy/service is used as shorthand for what needs to be analysed. Policy/service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.*
Section 1 – to be completed for all policies

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Briefly give an outline of the key objectives of the policy; what it’s intended outcome is and who the intended beneficiaries are expected to be</td>
<td>The purpose of these Ear Care Guidelines is to work towards standardisation of the practice of ear care across the organization.</td>
</tr>
<tr>
<td>B.</td>
<td>Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? Please give details</td>
<td>Implementation and compliance with the guidelines will be the responsibility of all staff.</td>
</tr>
<tr>
<td>C.</td>
<td>Is there any evidence that the policy/service relates to an area with known inequalities? Please give details</td>
<td>No</td>
</tr>
<tr>
<td>D.</td>
<td>Will/Does the implementation of the policy/service result in different impacts for protected characteristics?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Disability</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Sexual Orientation</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Gender Reassignment</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Marriage/Civil Partnership</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Maternity/Pregnancy</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Religion or Belief</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Carers</td>
<td>X</td>
</tr>
</tbody>
</table>

If you have answered ‘Yes’ to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2

The above named policy has been considered and does not require a full equality analysis

**Equality Analysis Carried out by:** Maxine Leggett  
**Date:** 1 July 2014
Section 2

Equality analysis

<table>
<thead>
<tr>
<th>Title:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relevant line in:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What are the intended outcomes of this work?</th>
<th>Include outline of objectives and function aims</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Who will be affected?</th>
<th>e.g. staff, patients, service users etc.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Evidence</th>
<th>The Government’s commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What evidence have you considered?</th>
<th>List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender reassignment (including transgender)</th>
<th>Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bisexual people.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Religion or belief</th>
<th>Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pregnancy and maternity</th>
<th>Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.</th>
</tr>
</thead>
</table>

| Carers | Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities. |
Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.

Engagement and involvement
Was this work subject to the requirements of the Equality Act and the NHS Act 2006 (Duty to involve)? (Y/N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the policy or programme proposals?

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

What is the overall impact? Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.
**Action planning for improvement** Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment.

---

### For the record

**Name of person who carried out this assessment:**
Lynn Fitzpatrick  Diane Walker

**Date assessment completed:**
February 2017

**Name of responsible Director/ General Manager:**

**Date assessment was signed:**

---
**NHSLA Monitoring Template**

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring e.g. audit</th>
<th>Responsible individuals/group /committee</th>
<th>Frequency of monitoring /audit</th>
<th>Responsible individuals / group / committee (multidisciplinary) for review of</th>
<th>Responsible individuals / group / committee for development</th>
<th>Responsible individuals / group / committee for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and type of incidents connected with ear care</td>
<td>Review of “themes” from incident reports.</td>
<td>All Clinical Team Leaders / Community Nursing Staff</td>
<td>Annually</td>
<td>Quality &amp; Scrutiny Group</td>
<td>Quality &amp; Scrutiny Group members</td>
<td>Quality Scrutiny Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>