CLINICAL GUIDELINE

Ear Care, Ear Irrigation and Ear Microsuction

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	4
Does this version include changes to clinical advice:	Yes
Date Approved:	20th November 2025
Date of Next Review:	30th November 2028
Lead Author:	Linda Bias
Approval Group:	Primary Care & Community Clinical Governance Forum
Guideline ID number:	428

Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

CONTENTS

NHSGG&C has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, gender, sexual orientation, marital status, religious belief or disability.

This policy will apply equally to full and part time employees. All NHSGG&C policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals of different nationalities who require them.

This clinical guideline statement should be read in conjunction with NHSGG&C Guidelines on Infection Control and NHSGG&C Consent Policy.

1. Introduction

The number of patients presenting to GPs, Community Nurses and Treatment Rooms requesting ear irrigation and/or microsuction is increasing. Effective ear care can prevent the need for irrigation. Where ear irrigation is necessary, staff require clear guidelines to ensure-safety and efficacy of practice.

2. Scope

This guideline applies to all Nurses working within Community Nursing Services in NHS GG&C who are required to undertake ear care, microsuction and ear irrigation safely and in accordance with local and national policy to reduce the risks associated with this procedure. This document provides guidance for Community Healthcare Staff who provide ear care in the home or other care setting. It covers the removal of cerumen by the instillation of olive oil drops or by irrigation/ microsuction. It does not cover the removal of foreign bodies from the ear, routine ear irrigation on children under the age of 16, aural toilet, or instrumentation of the ears.

3. Professional Accountability

As a registered practitioner you are accountable for your actions and omissions and must always be able to justify your decision making.

It is the responsibility of each practitioner to ensure competency in ear care and ear irrigation/microsuction. Patient education and execution of the procedure must be carried out in accordance with the Nursing and Midwifery Council (NMC):

- NMC Code (2015)
- Standards for Medicines Management Policy (2010)
- Standards for Competence for Registered Nurses (2004)

This guidance has been written in conjunction with the following documents:

- NHS Greater Glasgow & Clyde Ear Care and Ear Irrigation, Primary Care Clinical Guideline (2016)
- NHS Quality Improvement Scotland (2006) Best Practice Statement. Ear Care
- Microsuction Guidelines (2017), The Rotherham NHS Foundation Trust
- BMJ Best Practice – Cerumen Impaction (2017)
- NICE Guidance – Earwax (2016)
- Nursing and Midwifery Council (2015) The Code of Conduct
- Nursing and Midwifery Council (2009) Record Keeping. Guidance for Nurses and Midwives
- Manufacturer's Guidelines for cleaning ear irrigation equipment

4. Criteria

Patients living in the community (aged 16 years or over) experiencing difficulty with excessive build-up of ear wax, should be assessed by a GP or suitably trained Health Care Professional and thereafter provided with treatment which may include education, instillation

of wax softening agents (such as olive oil) or ear irrigation/microsuction. Referral to specialist services such as Audiology may be required.

Any changes to the patient's assessment, treatment or condition should be clearly documented and communicated to all those involved in the care of that individual. Staff must ensure the correct consent is gained from the patient in line with NHSGGC consent policy.

5. Roles and Responsibilities

Responsibility for the procedure of Ear Irrigation/microsuction lies with the Registered Nurse or suitably trained Health Care Professional, either within the patient's home environment or a clinical environment such as the Treatment Room. The Health Care Professional must ensure that they are competent in the following before undertaking the procedure:

Understand and Interpret:

- Ear Assessment processes and documentation
- Ear irrigation process chart
- Ear Microsuction indications, contraindications, precautions and guidance
- Patient information
- Consent requirements

Knowledge of:

- Ear Examination and criteria for GP referral / intervention
- Indications and contraindications for ear irrigation/microsuction
- Correct use of wax softening agents e.g. olive oil (if applicable)
- Patient information about instillation of wax softening agents e.g. olive oil
- Procedure for removing wax using procured ear irrigation equipment
- Procedure for removing wax using procured ear microsuction equipment
- Equipment used to remove wax from ears
- Patient information about post irrigation/microsuction ear management
- NHSGG&C Standard Operating Procedures for Cleaning of Near Patient Equipment Disposal of clinical waste as per NHSGG&C Prevention and Control of Infection
- Decontamination of equipment and safe disposal of biological materials
- Comply with the Recording Keeping requirements (NMC Code)

6. Training & Competency Requirements of Registered Nurses or Suitably Trained Healthcare Professional undertaking Ear Care

Requirement	Methods of Meeting Requirement
Registered Nurses and Healthcare Professionals must be appropriately trained in performing ear care interventions. Competency must be sustained and evidenced	Local Protocols
	Training Opportunities
	Certificates / records of achievement following appropriate training

7. Standard Operating procedures

Ear Irrigation SOP

1. Scheduled visits / appointments to undertake ear care / ear irrigation only

All patients requiring ear care to remove impacted wax or in preparation for ear irrigation will have a visit scheduled on CNIS or (if independently mobile) will receive an appointment time to attend their local treatment room. Oil based wax softening agents, preferably olive oil, should be administered as follows:

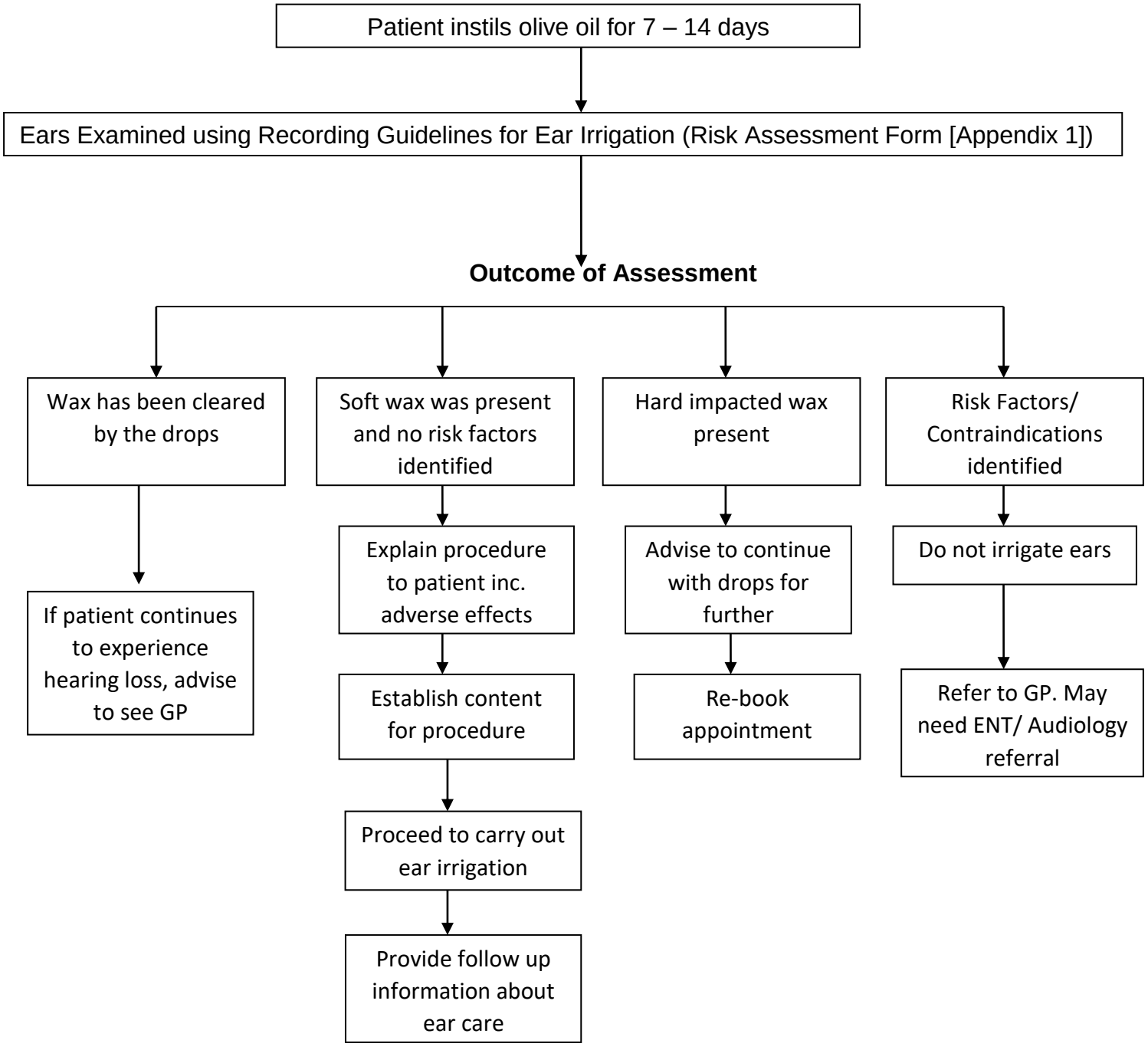
5 – 7 drops three times a day **Oil should be retained within the ear for at least 15 minutes at each Instillation of** **olive oil for 7 – 14 days**

Should a prescribed wax softening agent be a chemical oil such as Cerumol, the patient must follow prescriber's and manufacturer's instructions and not the recommendations above

2. Process for Assessment and Ear Irrigation

Based upon the Best Practice Statement issued by NHS Quality Improvement Scotland in 2006, NICE Guidelines (2012 & 2016), BNF guidelines and NHS Greater Glasgow & Clyde Ear Care and Ear Irrigation Guideline (2016), the following provides guidance on the main stages of ear assessment, treatment / management. Please refer to the flow chart below prior to considering the procedures required at each stage:

Process for Assessment and Ear Irrigation



3. Procedure: Instillation of Olive Oil

Initial management of earwax is wax softening using olive oil. Literature varies in opinion about the amount, frequency and duration of treatment with ear drops: this Clinical Guideline draws upon best evidence from the most recent literature review.
Should irrigation be the indicated choice of management, patients must be advised to oil ears up until that point.

Patients should be given clear instructions about how to instil ear drops. Patients Information Leaflets are available and could be displayed in Health Centres and Pharmacies, or given to patients by District Nursing Staff.

Patients should be advised that the amount of drops of olive oil will vary between individuals and may be less or more. The patient should stop instilling the olive oil as soon as it begins to run out of the ear. Patients should also be reminded not to place cotton wool or other products into their ear to hold the olive oil in place. Patients should be advised that this will simply absorb the olive oil and pull it away from the impacted wax.

Olive oil can be prescribed by the GP or purchased over the counter. It is available at Minor Ailments Service but only where indicated by the Pharmacist and not based upon a referral from another healthcare professional. The patient should be advised to use a dropper which will be issued by the pharmacist.

Use of ear drops can sometimes dull a patient's hearing and it is useful to inform the patient that this might occur. In either case, the instillation of olive oil is the first course of action: ear irrigation should only be considered if this treatment fails to expel the earwax.

4. Procedure: Examination of the Ear

It is essential to undertake a physical assessment of the ear and take a history.

Requirement	Example
Initial assessment is carried out before a physical examination of the ear. This includes a history of symptoms and of ear care	Suggested questions for inclusion in ear care assessment: • Have you had ear surgery? • Do you suffer from pain in or around the ear? • Have you experienced previous ear problems? • Have you ever had perforated ear drum/s? • Do you suffer from tinnitus? • Do you suffer from symptoms of dizziness, headache and nausea? • Do your ears itch? • Is there a discharge from the ear?

Requirement	Example
	• Do you use cotton buds in your ears? • Do you avoid water getting into your ears? If so, how? • Do you have any allergies? • Have you any underlying skin complaints? • Do you swim? If so, how frequently?
Physical examination of the ear takes place in accordance with local protocols and good practice	Prior to ear examination, standard infection control precautions should be used including hand hygiene (before and after the procedure), the use of gloves and protective clothing when handling instruments and equipment. The steps listed below should be followed when carrying out physical examination: • Ensure the patient is sitting comfortably • Ensure the healthcare worker is sitting at the same level as the patient • Ensure the light is good • Conduct a physical examination of both ears including pinna, ear canal and adjacent scalp (look for scars, discharge, swelling, skin lesions or defects) • Undertake the otoscope examination using the largest speculum that fits comfortably in the ear canal • The Nurse should adjust their head and the otoscope to view all of the tympanic membrane: if the view is hampered by cerumen consider the guidance included in the next section about management of cerumen.

During the process of ear irrigation, if any adverse symptoms arise, such as pain or vertigo, the procedure should be discontinued immediately, the ear should be examined and where required, referral made to the GP.

5. Procedure: Ear Irrigation

Only a suitably trained practitioner should undertake this procedure. Ear irrigation is directed at the external part of the ear but it is essential that the health of the whole organ is taken into account when assessing the indications and contraindications for irrigation. Ear irrigation should only be carried out when:

1. The history and examination reveal no current contraindications
2. The patient has used olive oil drops for the recommended period of time
3. The health practitioner is satisfied that the clinical signs would suggest that only wax is occluding an otherwise healthy ear drum
4. The wax is soft enough to be removed easily by irrigation

Ear Irrigation should **not** be carried out when:

1. The patient has had an untoward experience in the past, following ear irrigation
2. The patient has undergone any form of ear surgery (apart from grommets that have been out for an 18 month period and, the patient has been discharged from the Ear, Nose and Throat Department)
3. The patient has had a mucoid discharge in the last year
4. The patient has a mastoid cavity
5. The patient has a cleft palate (repaired or not)
6. Recent or current middle ear infections (the tympanic membrane may be under pressure from mucous or pus – irrigation would cause pain and risk perforating the membrane) 7. Grommets are in place
8. Patient with history of perforation
9. The patient is unable to sit still for the procedure

Caution should be exercised in patients who only have hearing in one ear and are presenting with earwax impaction in the functional ear.

6. Process of Ear Irrigation (including management of equipment)

The area where the procedure is being carried out should be assessed to ensure privacy and safety of patient, public and staff. Good hand hygiene and management of equipment protocols must be followed at all times.

Equipment Required
Otoscope
Head mirror and light or headlight
Ear Irrigation machine
Lotion Thermometer
Jug containing tap water to 38 degrees (no more than 40 degrees)
Noots trough / receiver
Tissues and receivers for used equipment
Non slip mat
Waterproof cape
Towel
Apron
Gloves

The stages and rationale are listed below:

Stages
Take a relevant clinical history and perform an ear examination
Obtain informed consent from the patient
Prepare equipment as per local guidelines and manufacturer's instructions. This will include a fresh speculum and jet tip for each patient. Protect the patient's clothing with a towel or waterproof covering. Ask the patient to hold the water receiver under their affected ear
Ensure the patient is sitting comfortably and that the Registered Nurse or Healthcare Professional is sitting at the same level as the patient. Use a good light source e.g. from a head lamp or a head mirror throughout the procedure

Ensure the temperature of the water is around body temperature throughout the procedure and does not exceed 40 degrees Centigrade at the beginning of the procedure
Gently pull the pinna upwards and outwards. The jet tip should be angled so the flow of water is along the posterior wall superiorly towards the superior occipital region
Inspect the ear canal periodically with the otoscope and monitor the solution running into the receiver. The procedure may be uncomfortable but should not cause pain. **If the patient reports ear pain, the procedure should be stopped**
Following irrigation examine the ear with an otoscope
Document all aspects of treatment in the patient's health records
Provide any further instructions and advice on ear care to patient

Equipment should be cleaned as per manufacturer's instructions.

7. Patient Advice and Follow up

If irrigation is unsuccessful after the first attempt, the patient should be advised to continue with the olive oil drops regime for a further 7 days and return for reassessment. Should a second attempt at irrigation fail, advice should initially be sought from the GP.

8. When Should the Nurse (or Healthcare Professional) refer to the GP or Specialist Services?

Patients presenting for ear care should be referred to the GP if the Registered Nurse or Healthcare Professional is concerned about any of the following:

1. Otitis Externa suspected
2. Otitis Media suspected
3. Anything unusual identified in or around the ear
4. Identification of any contraindications when carrying out an ear assessment

Similarly, anyone who has had earwax removed should be advised to return if they develop post irrigation problems such as otalgia, itching, discharge from the ear, or swelling of the external auditory meatus, as this may indicate infection.

Advice should be urgently sought from an Ear, Nose, and Throat Specialist (pre- and post-irrigation, when identified) if the following contraindications or side effects are identified:

- Severe pain, deafness or vertigo occur during or after irrigation, or if a perforation is seen following the procedure.
- Infection is present and the external canal needs to be cleared of wax, debris and discharge.

Appendix 1

Recording Guidelines for Ear Irrigation

(This assessment sheet is not suitable for patients under 16 years)

Name: Address: Postcode:	DOB/CHI Patient's Phone Number GP Name	
Date of Assessment	Referred by: GP / Practice Nurse / ANP/Audiology / Other / Self	
Reason for Referral: loss of hearing Other:	Allergies: None Known Other	
	Yes	**No**
Did you have any ear problems as a child?		
Have you had your ears irrigated before?		
Exclusion Criteria: Have you ever previously experienced problems with ear irrigation		
Have you suffered from a perforated ear drum? (tympanic membrane)		
Have you noticed any discharge from your ear? (Otitis externa or media)		
Have you suffered from a recent or current earache? (otolgia)		
Have you got a cleft palate?		
Have you suffered from mastoid cavities?		
Have you ever had ear surgery?		
Have you had grommets in place in the last 2 years?		
Special Precautions Required if: Tinnitus (advise patient irrigation may make it worse)		
Eczema (extra care to be taken on irrigation)		
Psoriasis (extra care to be taken on irrigation)		
Menieres Disease (increased risk of perforation)		
Diabetes (increased potential for infection)		
Any other relevant history? Yes / No Advice Sheet supplied to patient? If yes, provide details:		
Does the patient have hearing aid/s		
If hearing aids, in place record if Right Ear or Left Ear:		
Are either ears occluded with wax? Identify Right / Left		
Nurse Signature (Assessor)		
Patient Consent		

procedure of Ear Irrigation:
NB: Potential risks associated with ear irrigation:

- Damage to ear drum
- Ear canal irritation
- Dizziness, nausea, fainting and / or vertigo

If you have any concerns about this procedure lease discuss with the Nurse

Patient signature for consent: **Date:**	**Health Professional signature:** **Date:**	
Was ear prepared prior to irrigation? Yes / No Which softener? Olive oil / Almond oil / Other (specify) How often?	Irrigation Water: Temperature of water: Amount used: Return:	
	Left Ear	**Right Ear**
Pre-irrigation examination	Occluded with wax	Occluded with wax
Post –irrigation examination	Tympanic membrane visible	Tympanic membrane visible
Complications encountered e.g. failure to remove wax, pain		
Please detail what advice has been given		
Health professionals signature on completion of care		

Ear Microsuction SOP

INTRODUCTION

This guideline has been written to ensure safe aural Microsuction. The document provides the practitioner with guidance in microsuction.

Cerumen Management

Cerumen, or wax as it is commonly known, is a normal secretion of the ceruminous glands in the outer meatus. It is slightly acidic, giving bactericidal qualities in either its wet, sticky form (as secreted by Caucasians and African-Caribbeans) or dry, flaky form (as, for example, secreted by S.E. Asian people). In addition to epithelial migration, jaw movement assists the movement of wax to the entrance of the External Auditory Meatus (EAM) where it emerges onto 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 patients 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. The experienced practitioner can use his or her clinical judgement on the best method for wax management and removal. Olive oil may be advised in favour of other cerumenolytics. The practitioner may decide that extended use of olive oil is preferable to wax removal procedures. These recommendations have been developed to assist practitioners in gaining experience and knowledge in the provision of ear care. They do not replace the need for education, recognised training and supervision in order to perform these procedures.

Evidence

In order to reduce litigation in ear irrigation and provide the patient with effective and safer ear care this document was originally produced by the ‘Action On ENT’ Steering Board (2002) and endorsed by the Royal College of General Practitioners, The Royal College of Nursing, The Primary Ear Care Centre and the Medical Devices Agency. It has subsequently been revised by the Primary Ear Care Trainers (in 2017 and 2019). Purpose

- 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 discharge, keratin or debris to allow examination of the EAM and the tympanic membrane
- Remove wax in order to facilitate hearing aid mould impressions
- Facilitate the removal of wax and foreign bodies, which are not hygroscopic, from the EAM.

Hygroscopic matter (such as peas and lentils) will absorb the water and expand, making removal more difficult

Scope

This procedure is only to be carried out by an experienced healthcare worker who has received recognised training in ear care and the use of ear care equipment. This training is available UK-wide from Primary Ear Care Centre trainers. An individual assessment should be made of every patient to ensure that it is appropriate for ear irrigation/microsuction to be carried out.

PURPOSE

Use of the microscope and suction is carried out to:

- Remove cerumen and hygroscopic foreign bodies in patients who are not appropriate for ear irrigation

- Remove discharge, keratin or debris from the external auditory meatus or mastoid cavity SCOPE This procedure is only to be carried out by a doctor, nurse or audiologist who has trained in the use of the microscope/Loupes and suction. An individual assessment should be made of every patient to ensure that microsuction is appropriate.

The suction generates loud noise and patients should be advised of this.

MICROSUCTION SHOULD NOT BE CARRIED OUT IF:

- Valid consent has not been obtained

- Patients have experienced difficulties with the procedure in the past

- A history of severe dizziness

- Patients are unable to keep their head still or who are prone to unpredictable movement
- Patients who have a sensitivity to loud noise (Hyperacusis)

PRECAUTIONS

Consideration should be given to the patient's age:

There is no upper or lower age limit for microsuction, but each patient should be assessed in an individual and holistic manner.

Children may require microsuction but may be unable to keep their head still or may be fearful of the procedure. In this instance it is advisable to give serious thought to the necessity of the procedure and whether treatment may hinder any future care needed.

GUIDANCE EQUIPMENT REQUIRED

- Otoscope and spare bulbs
- Single use otoscope speculae
- Wall mounted or free standing suction bottles
- Height-adjustable couch with adjustable back rest
- Microscope and spare bulbs
- Couch roll
- Suction liner
- Suction connecting tube
- Fenestrated suction handle 30 degrees
- Single use speculae in sizes 2, 3 and 4
- 18 G fine ends • Galli pot
- Henckel
- Crocodile forceps
- Jobson Horne probe
- Gloves
- Tissues/Gauze Swabs

PROCEDURE

At the beginning of every clinic the following should be performed:

- Ensure that all hard surfaces are cleaned with disinfection wipes as per local policy
- New suction liner fitted
- New suction tubing fitted
- Couch wiped clean
- Ensure suction is set as per manufacturer's guidelines and that it is working
- Ensure microscope eye pieces are set at the neutral position
- Turn microscope on to ensure it is functioning
- Place small, clean object on couch and view through microscope to ascertain if focus is working
- Ensure couch rises and lowers effectively and back rest adjusts safely

At the end of the day the waste within the liner and the tubing should be disposed of in the clinical waste as per local policy. All hard surfaces should again be cleaned with disinfection wipes as per local guidelines.

1. 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 and assure yourself that the patient understands and gives consent.
2. Check whether the patient has had microsuction previously and explain the nature of the noise and that they can ask for a rest if they experience any vertigo (if this should occur ask the patient to focus their eyes on a fixed object until the feeling subsides).
3. Adjust the magnification, eye piece and angle of the microscope to the appropriate position. Request that the patient position themselves comfortably on the examination couch or chair.
4. First examine the pinna, outer meatus and adjacent scalp by direct light and check for incision scars and observe for skin defects.

5. Gently pull the pinna upwards and outwards (in infants downwards and backwards) to straighten out the meatus. Remember that the skin lining of the deeper meatus is very delicate and sensitive.
6. Direct the microscope down into the ear. Insert the speculum gently into the EAM/cavity - use the largest size speculum that will fit comfortably into the ear.
7. Carefully check the cavity, tympanic membrane or drum remnant. Decide the size of suction tip most appropriate for the procedure and attach it to the suction tubing.
8. Turn the suction machine on, maintaining the pressure according to the suction machine's manufacturer's guidance. Apply the suction tip to the areas requiring debris removal. Use an appropriate solution to wash through the suction tubing when it becomes blocked.
9. Avoid touching the wall of the meatus, cavity or drum/ drum remnant. By only touching the debris, most pain can be avoided.
10. The ear cannot be judged to be completely free of ear disease until the entire cavity and tympanic membrane or drum remnant has been seen. You may need to ask the patient to move his/her head e.g. lean the head towards the opposite shoulder, to be able to see more clearly into the roof of the meatus and posterior aspect of the cavity.
11. Methodically inspect all parts of the EAM/cavity, tympanic membrane or drum remnant by varying the angle of the microscope.
12. The normal appearance of the EAM/cavity varies and can only be learned by practice. Practice will lead to recognition of abnormalities.
13. Carefully check the condition of the external auditory meatus as you withdraw the speculum.
14. Advice should be given to the patient as appropriate.
15. 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 following 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.

RISK FACTORS

Dizziness Trauma

DEFINITIONS AND ABBREVIATIONS

Hyperacusis – sensitivity to loud noise
Henckel – type of forceps used in ear care

Competency Framework – Ear Instrumentation in Adults

Purpose

This document provides a record of the Participant's clinical performance indicating when competency relating to ear instrumentation in adults is attained.

Definition of Competence

Competence is a simultaneous integration of the knowledge, judgement, skills, experience and attitudes that are required for performance in a designated role and setting (Roach, 1992).

Completion

The Participant (named below) is responsible for completion of this document with their Assessor. To be deemed competent in **Ear Instrumentation** in Adults, a record of achievement in all relevant competencies must be completed and signed by both Participant and Assessor.

Assessment

During the assessment period, competency will be determined by: discussion, questioning, reflection, supervision and direct observation of practice by a designated Assessor.

	Name	Designation	Base
Participant:			
Designated Assessor:			

Competency Level Guidelines

In order to meet your learning needs and enable you to develop your clinical skills in this area, the following rating scale will be used when assessing your competence.

Rating	Level of Competence
1	Has attended theoretical session. Has only observed practice. Cannot perform this procedure unsupervised
2	Can link theory to practice. Has assisted in this area. Still requires close guidance
3	Can link theory to practice. Required direct supervision in this area and still requires prompting and guidance
4	Links theory to practice. Safely undertakes this procedure and delivers care to the patient throughout the procedure as per guidelines, with no prompting and guidance. Can perform this procedure without supervision and / or assistance. All steps are performed in order and correctly
5	Links theory to practice and is able to use initiative in response to adverse effects or technical problems during and after procedure, can demonstrate and explain this area of practice to others.

Adapted from Steinaker and Bell (1979). The Experiential Taxonomy: A new approach to teaching and learning, London Academic Press.

For Healthcare Workers the time to achieve competence will be dependent upon your opportunities to practice. If this is limited within your own clinical area you should liaise with your line manager and your designated Assessor to access further opportunities to practice.

To achieve and demonstrate your competence you will have to meet with your Assessor regularly to discuss and practice the procedure. You will be supervised a minimum of 10 interventions. On each occasion you will be assessed by questioning, discussion and direct observation.

By the end of the assessment period, Healthcare Workers are expected to have achieved competency level 5 in order to be deemed competent.

Once your competence has been confirmed by your Assessor you should retain the completed booklet in your Personal Development File. Thereafter it is your responsibility to have your practice reviewed on an annual basis in conjunction with your Line Manager and should be reflected in your Personal Development Plan.

Jobson Horne Probe, Crocodile Forceps, Wax Hook, Scoop,

Summary Table to Record Levels Achieved in Competencies by Participant at Assessment Episodes

Ear Instrumentation in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
1. Demonstrate correct cleaning and decontamination procedure prior to clinic commencement	
2. Demonstrate how to explain and prepare the patient for the procedure including carer awareness	
3. Ensure informed consent is obtained from patient or named person on Section 47	
4. List the equipment and supplies required to undertake ear Instrumentation in adults	
5. Demonstrate knowledge and correct use of a J**obson-Horne Probe**	
6. Demonstrate knowledge and correct use of **(Hartmann) Crocodile Forceps**	
7. Demonstrate knowledge and correct use of a **Wax Scoop**	
8. Demonstrate knowledge and correct use of a **Wax Hook**	
9. Demonstrate knowledge and correct use of Otoscope	

Upon Completion: Assessor Statement	**Upon Completion: Participant Statement**
Sign: Date:	Sign: Date:
Action if competency not demonstrated by Participant after agreed period of time / number of episodes: Assessor Signature: Date:	

Competency Framework – Ear Irrigation in Adults

Purpose

This document provides a record of the Participant's clinical performance indicating when competency relating to ear irrigation in adults is attained.

Definition of Competence

Competence is a simultaneous integration of the knowledge, judgement, skills, experience and attitudes that are required for performance in a designated role and setting (Roach, 1992).

Completion

The Participant (named below) is responsible for completion of this document with their Assessor. To be deemed competent in **Ear Irrigation** in Adults, a record of achievement in all relevant competencies must be completed and signed by both Participant and Assessor.

Assessment

During the assessment period, competency will be determined by: discussion, questioning, reflection, supervision and direct observation of practice by a designated Assessor.

	Name	Designation	Base
Participant:			
Designated Assessor:			

Competency Level Guidelines

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4	Links theory to practice. Safely undertakes this procedure and delivers care to the patient throughout the procedure as per guidelines, with no prompting and guidance. Can perform this procedure without supervision and / or assistance. All steps are performed in order and correctly
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Summary Table to Record Levels Achieved in Competencies by Participant at Assessment Episodes

Ear Irrigation in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
1. Demonstrate correct cleaning and decontamination procedure prior to clinic commencement	
2. Demonstrate how to explain and prepare the patient for the procedure including carer awareness	
3. Ensure informed consent is obtained from patient or named person on Section 47	
4. List the equipment and supplies required to undertake ear irrigation in adults	
5. Demonstrate knowledge and correct use of Otoscope	
6. Demonstrate how to prepare the clinical area and assemble the equipment	
7. Demonstrate the five steps of good hand hygiene	
8. Demonstrate correct use of Personal Protective Equipment (PPE)	

Ear Irrigation in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
9. Demonstrate correct position of patient for procedure	
10. Demonstrate correct procedure f or ear irrigation	
11. Demonstrate knowledge and actions to be taken in the event of adverse events	
12. Demonstrate knowledge and ability to dry External Auditory Meatus (EA M)	
13. Demonstrate post procedure actions should ear wax be successfully removed	
14. Demonstrate post procedure actions should procedure be unsuccessful in removing ear wax	
15. Demonstrate post procedure actions should issues be identified during procedure	
16. Ensure patient (or relevant other) understands and agrees to comply with advice given	

Ear Irrigation in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
17. Ensure safe disposal of single patient use equipment	
18. At end of clinic, ensure all disposable components are correctly disposed of as per Standards for COSHH regulations	
19. After each patient ensure standards infection, prevention and control guidelines are adhered to	
20. Ensure record keeping meets requirements of national and local standards	

Upon Completion: Assessor Statement	**Upon Completion: Participant Statement**
Sign: Date:	Sign: Date:
Action if competency not demonstrated by Participant after agreed period of time / number of episodes: Assessor Signature: Date:	

Competency Framework – Ear Microsuction in Adults

Purpose

This document provides a record of the Participant's clinical performance indicating when competency relating to ear microsuction in adults is attained.

Definition of Competence

Competence is a simultaneous integration of the knowledge, judgement, skills, experience and attitudes that are required for performance in a designated role and setting (Roach, 1992).

Completion

The Participant (named below) is responsible for completion of this document with their Assessor. To be deemed competent in **Ear Microsuction** in Adults, a record of achievement in all relevant competencies must be completed and signed by both Participant and Assessor.

Assessment

During the assessment period, competency will be determined by: discussion, questioning, reflection, supervision and direct observation of practice by a designated Assessor.

	Name	Designation	Base
Participant:			
Designated Assessor:			

Competency Level Guidelines

In order to meet your learning needs and enable you to develop your clinical skills in this area, the following rating scale will be used when assessing your competence.

Rating	Level of Competence
1	Has attended theoretical session. Has only observed practice. Cannot perform this procedure unsupervised
2	Can link theory to practice. Has assisted in this area. Still requires close guidance
3	Can link theory to practice. Required direct supervision in this area and still requires prompting and guidance
4	Links theory to practice. Safely undertakes this procedure and delivers care to the patient throughout the procedure as per guidelines, with no prompting and guidance. Can perform this procedure without supervision and / or assistance. All steps are performed in order and correctly
5	Links theory to practice and is able to use initiative in response to adverse effects or technical problems during and after procedure, can demonstrate and explain this area of practice to others.

Adapted from Steinaker and Bell (1979). The Experiential Taxonomy: A new approach to teaching and learning, London Academic Press.

For Healthcare Workers the time to achieve competence will be dependent upon your opportunities to practice. If this is limited within your own clinical area you should liaise with your line manager and your designated Assessor to access further opportunities to practice.

To achieve and demonstrate your competence you will have to meet with your Assessor regularly to discuss and practice the procedure. You will be supervised a minimum of 10 interventions. On each occasion you will be assessed by questioning, discussion and direct observation.

By the end of the assessment period, Healthcare Workers are expected to have achieved competency level 5 in order to be deemed competent.

Once your competence has been confirmed by your Assessor you should retain the completed booklet in your Personal Development File. Thereafter it is your responsibility to have your practice reviewed on an annual basis in conjunction with your Line Manager and should be reflected in your Personal Development Plan.

Summary Table to Record Levels Achieved in Competencies by Participant at Assessment Episodes

Ear Microsuction in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
1. Demonstrate how to explain and prepare the patient for the procedure including carer awareness	
2. Ensure informed consent is obtained from patient or named person on Section 47	
3. List the equipment and supplies required to undertake ear microsuction in adults	
4. Demonstrate knowledge and correct use of Loupes	
5. Demonstrate how to prepare the clinical area and assemble the equipment.	
6. Demonstrate the 5 steps of good hand hygiene	
7. Demonstrate correct use of Personal Protective Equipment (PPE)	
8. Demonstrate correct position of patient for procedure	

Ear Microsuction in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
9. Demonstrate correct selection of speculum size for patient	
10. Demonstrate correct procedure for ear microsuction	
11. Demonstrate knowledge and action/s to be taken in the event of adverse events	
12. Demonstrate post procedure actions should ear wax be successfully removed	
13. Demonstrate post procedure actions should procedure be unsuccessful in removing ear wax	
14. Demonstrate post procedure actions should issues be identified during procedure	
15. Ensure patient (or relevant other) understands and agrees to comply with advice given	

Ear Microsuction in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
16. Ensure safe disposal of single patient use equipment	
17. At end of clinic, ensure all disposable components are correctly disposed of as per Standards for COSHH regulations	
18. After each patient ensure standards infection, prevention and control guidelines are adhered to	
19. Ensure record keeping meets requirements of national and local standards	

Upon Completion: Assessor Statement	**Upon Completion: Participant Statement**
Sign: Date:	Sign: Date:
Action if competency not demonstrated by Participant after agreed period of time / number of episodes: Assessor Signature: Date:	

Competency Framework – Safe Use of an Loupes in Adults

Purpose

This document provides a record of the Participant's clinical performance indicating when competency relating to safe use of an Loupes in adults is attained.

Definition of Competence

Competence is a simultaneous integration of the knowledge, judgement, skills, experience and attitudes that are required for performance in a designated role and setting (Roach, 1992).

Completion

The Participant (named below) is responsible for completion of this document with their Assessor. To be deemed competent in the safe use of an Loupes in Adults, a record of achievement in all relevant competencies must be completed and signed by both Participant and Assessor.

Assessment

During the assessment period, competency will be determined by: discussion, questioning, reflection, supervision and direct observation of practice by a designated Assessor.

	Name	Designation	Base
Participant:			
Designated Assessor:			

Competency Level Guidelines

In order to meet your learning needs and enable you to develop your clinical skills in this area, the following rating scale will be used when assessing your competence.

Rating	Level of Competence
1	Has attended theoretical session. Has only observed practice. Cannot perform this procedure unsupervised
2	Can link theory to practice. Has assisted in this area. Still requires close guidance
3	Can link theory to practice. Required direct supervision in this area and still requires prompting and guidance
4	Links theory to practice. Safely undertakes this procedure and delivers care to the patient throughout the procedure as per guidelines, with no prompting and guidance. Can perform this procedure without supervision and / or assistance. All steps are performed in order and correctly
5	Links theory to practice and is able to use initiative in response to adverse effects or technical problems during and after procedure, can demonstrate and explain this area of practice to others.

Adapted from Steinaker and Bell (1979). The Experiential Taxonomy: A new approach to teaching and learning, London Academic Press.

For Healthcare Workers the time to achieve competence will be dependent upon your opportunities to practice. If this is limited within your own clinical area you should liaise with your line manager and your designated Assessor to access further opportunities to practice.

To achieve and demonstrate your competence you will have to meet with your Assessor regularly to discuss and practice the procedure. You will be supervised a minimum of 10 interventions. On each occasion you will be assessed by questioning, discussion and direct observation.

By the end of the assessment period, Healthcare Workers are expected to have achieved competency level 5 in order to be deemed competent.

Once your competence has been confirmed by your Assessor you should retain the completed booklet in your Personal Development File. Thereafter it is your responsibility to have your practice reviewed on an annual basis in conjunction with your Line Manager and should be reflected in your Personal Development Plan.

Summary Table to Record Levels Achieved in Competencies by Participant at Assessment Episodes

Safe Use of an Loupes in Adults	**Participant & Assessor will Date & Initial with 1-5 competence rating scale achieved at each episode**
Participant will:	
1. Demonstrate how to explain and prepare the patient for the use of an Loupes	
2. Demonstrate how to operate the normal functions of the Loupes	
3. Demonstrate how to the change bulb, ensuring spare bulbs are easily accessible	
4. Demonstrate how to the change batteries, ensuring spare batteries are easily accessible	
5. Demonstrate how to access, remove, clean and replace magnifier	
6. Demonstrate correct selection and connection of speculum to Loupes	

Upon Completion: Assessor Statement	**Upon Completion: Participant Statement**
Sign: Date:	Sign: Date:
Action if competency not demonstrated by Participant after agreed period of time / number of episodes:	

Assessor Signature: Date: