**EAR CARE GUIDELINES**

All healthcare professionals must exercise their own professional judgment when using guidelines. However any decision to vary from the guideline should be documented in the patient records to include the reason for variance and the subsequent action taken.

| Lead Clinician(s): | Linda Harries  
Eleanor Williams | District Nurse  
District Nurse |
|-------------------|-----------------|
| Lead Director(s): | Sandra Rote     
Director of Clinical Development and Lead Executive Nurse |

| Ratified by: | May 2006  
July 2005 |
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Adopted by Worcestershire Primary Care Trust Board: March 2007

This Policy should not be used after end of: March 2009

Links into Healthcare Standard: Second Domain Clinical Effectiveness

Links into PCT aim: Six Clinical and cost effectiveness

Impact Analysis (Race Equality)

Impact Analysis (Mental Capacity Act)

**THIS DOCUMENT MUST NOT BE PHOTOCOPIED**

PLEASE NOTE THAT ALL CLINICAL GUIDELINES ARE AVAILABLE ON  
http://www.worcestershirehealth.nhs.uk/WorcestershirePCT
### CONTRIBUTION LIST

**Key individuals involved in developing the document**

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<thead>
<tr>
<th>Name</th>
<th>Designation</th>
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<tbody>
<tr>
<td>Linda Harries</td>
<td>District Nurse</td>
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<td>Eleanor Williams</td>
<td>District Nurse</td>
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<td>Claire Helm</td>
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<td>Cora Ferguson</td>
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<td>Dr Rumley</td>
<td>GP</td>
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<tr>
<td>Rosemary Rogers</td>
<td>Rotherham Ear Care Centre</td>
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<tr>
<td>Karen Hall</td>
<td>Infection Control Nurse</td>
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### Circulated to the following individuals for comments

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1 INTRODUCTION

Ear irrigation is a procedure carried out frequently by Community Nurses. A review by the Medical Defense Union of General Practitioners claims settled over a five year period 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.

The audit revealed the need to standardise practice by issuing guidelines for best practice and to provide training and updates for all nurses in ear care.

This policy document sets out the guidelines for ear care for the Worcestershire PCT and has been produced with reference to NHS Trust literature available and information received following attendance at the Ear Care course at Rotherham, a recognised centre of excellence in ear care.

Please note that there is no procedure contained in this document pertaining to use of the Higginson syringe as this is not advocated by the Rotherham Ear Care Centre.

2 CATEGORIES OF NURSES WHO CAN PERFORM EAR IRRIGATION

Qualified Nurses employed by Worcestershire PCT who are registered as Part 1 or 12 of the Register maintained by the NMC under section 10 of the Nurses, Midwives and Health Visitors Act (1979).

Nurses may perform the Ear irrigation Procedure if competent and skilled to do so acting in accordance with the NMC Code of Professional Conduct: Standards for conduct, performance and ethics (NMC, 2004)

2.1 Training Required for Nurses Practicing Ear Care

Nurses undertaking Ear Care should update themselves and be competent and confident in:

- Familiarisation of the anatomy and physiology of the ear.
- Patient education.
- Skills for Ear irrigation Procedure and removal of wax by instrumentation.

Update training will be provided by qualified nurses who have undertaken a period of extended training via a recognised institution and deemed competent to teach others.

2.2 Employers Responsibility

To ensure the employee has access to appropriate training and education in ear care.

To ensure equipment is available to carry out safe practice.

Employees have a responsibility for maintaining equipment by ensuring the propulse irrigator is serviced every twelve months and cleaned according to manufacturers instructions and infection control guidelines.

Employees of Worcestershire PCT will send equipment to Technical Services, Estates Department.
2.3 Record Keeping

All nurses are required to maintain contemporaneous records of patient care, which are unambiguous and legible in accordance with NMC Guidelines for Records and Record Keeping (NMC, 2005). Documentation will be provided by the Trust to assist with this process. (Recommend the use of the Ear Care Nursing Record in appendix 1)

2.4 Criteria for Referral

Nurses may irrigate patient’s ears or perform aural toilet without prior GP consent providing the nurse has current knowledge of this procedure and feels competent to do so.

In the event of uncertainty, the nurse must always seek advice from the patients GP to ascertain the most appropriate course of action.

2.5 Monitoring

Auditing of nurses’ knowledge and practice will take place periodically as per Clinical Governance agenda.

There will also be an evaluation at the end of each ear care update session, which will assist with monitoring of evidence of increased knowledge.

2.6 Outcome

There will be evidence of standardised practice in ear care across the county.

Nurses will report having increased evidence based knowledge in the clinical area of ear care.

2.7 Consent

Verbal consent should be obtained from the patient prior to the ear irrigation procedure by the nurse and documented in the patients record according to Trust policy.

3 PATIENT EDUCATION

3.1 Rationale

Patients who understand the cleaning properties of the ear canal are less likely to feel compelled to have their ears ‘wax free’ (Sharp et al, 1990).

3.2 Points to Consider

- Wax or cerumen is a normal secretion of the ceruminous glands in the outer meatus or ear canal. It acts as a filter to protect the eardrum by trapping debris and lubricates the external ear canal.

- Wax normally moves laterally along the ear canal and falls out of its own accord. It is encouraged to do so by the canal skin which itself gradually migrates laterally helped by the action of muscles used in chewing and talking. This is the self-cleaning property of the ear canal.

- Some people produce large amounts of wax, while others often impact the wax due to misinformed use of cotton buds, hair grips, matches and other objects to ‘clean’ their ears.
• In older people their wax is often drier and the possible slowing down of epithelial migration may cause the wax to build up, blocking the ear canal (Roeser & Ballachanda, 1997).

• The colour of wax is normally honey coloured, but becomes darker brown and gradually hardens as it is exposed to air (Zivic and King, 1993).

3.3 Ear Care Information for Patients
1. Explain to the patient the self-cleaning properties of the ear canal referring to an ear diagram if available. (For an example, see appendix 2).

2. Advise that wax protects and waterproofs the meatal skin and is slightly acidic which gives it antibacterial and antifungal properties, (Rogers, 1997) therefore ears need wax for protection.

3. Olive oil if used regularly can help the self-cleaning process. Advise the patient to administer two drops of olive oil once a week at night and give written leaflet if available. (See appendix 3)

4. Advise patients who have had recent ear infections to keep them dry – when showering use ear plugs or cotton wool smeared in Vaseline to keep them dry. It is not advisable to leave cotton wool in the ear.

5. Advise patients to avoid using cotton buds to clean their ears or insert any other implement into the ear canal to remove wax (Rogers, 1997).

4 REASONS FOR EAR IRRIGATION
The ear irrigation procedure should only be carried out by trained nurses in order to: (Thurgood and Thurgood, 1995, O’Reilly, 1994 and Lewis-Cullinan and Janken, 1990).

• To facilitate the removal of excessive wax (cerumen), keratin, discharge or debris from the external auditory meatus

• Improve a hearing loss, which is believed to be caused by impacted wax (Lewis-Cullinan and Janken, 1990).

• If you suspect any pathology behind the wax it is safer to use drops to dissolve the wax rather than irrigation.

• Remove a foreign body (N.B. gentle irrigation can be used to remove foreign bodies of non-vegetable matter i.e. beads, metal or insects. Referral to the GP is advised in these circumstances).

• Correctly treat otitis externa where the meatus is obscured by debris.

5 HISTORY TAKING
Obtain a holistic assessment using documentation provided by the Trust of the patient’s medical history, including medication and allergies. (Rogers, 1997; Price, 1997; Booth, 1998, Thurgood and Thurgood, 1995 and Kaufman, 1998). (See appendix 1 for recommended Ear Care Nursing Record).

Ascertain and document the following:
• What the patient says the problem is e.g. deafness, tinnitus, pain, itching.

• What is seen, e.g. wax – partial/complete occlusion; tympanic membrane inflammation.

• Previous ear surgery

• Previous perforations of the tympanic membrane

• Previous ear infections

• History of deafness and/or wearing of hearing aid

• Family history of deafness

• Previous history of ear syringing and frequency

6 EXAMINATION

The aim of the examination is exclude contra-indications (Cook, 1998) and assess the amount and position of wax.

Equipment required: Otoscope with white halogen light.

1. Explain procedure to the patient and obtain their verbal consent.

2. Ensure the patient is sitting at eye level.

3. Look for signs of discharge, skin lesions and scars behind the pinna from previous mastoid surgery.

4. Examine the pinna, outer meatus and adjacent scalp with the naked eye. Look for signs of discharge and any skin lesions.

5. Grasp the pinna and gently pull upwards and backward to straighten the ear canal in the adult and pull the pinna gently down and back in a child.

6. Hold the otoscope like a pen and rest the little finger against the side of the patient’s face to stabilise the hand.

7. Insert speculum gently into the meatus using the largest size that will fit comfortably into the ear canal.

8. Identify and note any wax evident in the ear canal and assess how much, its position and consistency. Methodically inspect all parts of the outer ear canal and tympanic membrane if visible.

9. The normal eardrum has a pearly grey appearance and you can generally see the handle of malleus in the middle ear through the drum. Often it is also possible to see the long process of the incus and the short process of the malleus. In the normal ear drum there is a reflection of light called the cone of light extending from the handle to the lower part of the eardrum which is called the pars tensa. Locating these landmarks enables the nurse to define if the eardrum has a normal appearance. Possible presenting abnormalities of the tympanic membrane are:
- Dull thickened tympanic membrane caused by previous infections.
- Yellowish appearance through tympanic membrane could denote middle ear infection.
- Previous signs of perforation – note the location.
- A red bulging tympanic membrane denotes acute otitis media with fluid in the middle ear.
- White chalky patches known as tympanosclerosis are the result of thick collagen being present. This scarring of the eardrum can follow repeated infections or trauma and the drum loses its glistening appearance.

Document what is seen, what the patient complains of, what is done and why.

ANY ABNORMALITIES THAT CAUSE CONCERN SHOULD BE REPORTED TO THE PATIENT’S GENERAL PRACTITIONER (GP) AS SOON AS POSSIBLE.

7 PREPARATION OF THE EAR

Olive oil is the softening agent with least likelihood of causing irritation (Sharp et al, 1990; BNF, 1998). Sodium bicarbonate eardrops can be used to break up hard wax but as with other cerumenolytic agents on the market the patient may react to their use and develop further meatal irritation from the astringent qualities of these agents.

Prior to ear irrigation or instrumentation, advise the patient to prepare their ears as follows: (Keane et al, 1995; Sharpe et al, 1990; Zivic and King, 1993)

1. Ask the patient to lie down with the affected ear uppermost and then instill 2 or 3 drops of oil (or sodium bicarbonate if using) at room temperature into the ear canal and massage the tragus in front of the ear.
2. Ask the patient to continue to lie down for 5 to 10 minutes to allow the drops to run into the ear canal.
3. Repeat the procedure with the other ear if there is a wax problem there, for at least seven days up to a period of fourteen days.

8 COMPLICATIONS AND CONTRA-INDICATIONS FOR EAR IRRIGATION

Most common complications (Price, 1997; Sharp et al, 1990):

- Failure to remove wax
- Otitis Externa
- Tympanic membrane perforation
- External auditory canal damage
- Pain

Potential complications:

- Vertigo
- Otitis media
- Deafness
- Tinnitus
- Infection
CONTRA-INDICATIONS:

DO NOT irrigate patient's ears if the following is present (Zivic and King, 1993; Thurgood and Thurgood, 1995):

- There is a history of a middle ear infection in the last six weeks.
- The patient has a tympanic membrane perforation or a history of mucous discharge in the last year.
- There have been any untoward experiences following irrigation in the past.
- Grommets are in place.
- There is a mastoid cavity (NEVER IRRIGATE).
- There is a cleft palate repaired or not.
- Evidence of bleeding.
- Patient has only one hearing ear.
- 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).
- In the presence of acute otitis externa with pain and tenderness of the pinna.

9 REMOVAL OF WAX BY INSTRUMENTATION

Principles

Providing the nurse has received training to perform aural toilet, the guidelines below can be followed (Wilson and Roeser, 1997; Rogers, 1997):

- Hard crusty wax can often be gently manoeuvered out of the ear canal with a ring probe, wax hook or small forceps, under direct vision using a head torch. If this procedure becomes too painful, do not continue and the patient should be advised to use olive oil for a week and return for irrigation or further instrumentation.

- Excessive soft or crumbly wax and debris can be wiped out with cotton wool onto a Jobson Horne probe under direct vision with a head torch. Dry mop using the Jobson Horne probe and a small piece of cotton wool fluffed up to the size of a postage stamp and applied to the probe.

- Clean the ear with a gentle rotary action of the probe, taking care not to touch the tympanic membrane. Replace the cotton wool as soon as it becomes soiled.

- Re-examine the ear canal with the otoscope at regular intervals during the cleaning to check for any discharge, debris or crusts, which remain in the ear canal at awkward angles.

10 EAR IRRIGATION PROCEDURE USING PROPULSE IRRIGATOR

10.1 When to irrigate:

1. If you are satisfied that there is wax occluding a healthy ear drum.

2. If the patient has had this done before with no complications and the history and examination reveal no current contraindications.

3. If the wax is soft enough to be removed easily by irrigation.

10.2 Equipment required:

- Waterproof towel and cape
- Otoscope with white halogen light
- Head torch and spare batteries
- Propulse machine with foot control
- Disposable jet tips (one per patient procedure)
- Noots trough/receiver
- Jobson Horne probe and cotton wool
- Tissues and receivers for dirty swabs and instruments
- Tap water at body temperature (40 degrees)

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

10.3 Action

<table>
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<tr>
<th>NO.</th>
<th>PROCEDURE</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>1</td>
<td>Explain and discuss the procedure with the patient. Obtain verbal consent and document</td>
<td>To ensure the patient understands the procedure and gives verbal consent.</td>
</tr>
<tr>
<td>2</td>
<td>Position the patient seated at the same level as the nurse and protect the shoulders with waterproof towel.</td>
<td>To enable the Nurse to have direct vision into the ear canal and protect patients clothing.</td>
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<tr>
<td>3</td>
<td>Examine the ear as in the previous procedure (section 4).</td>
<td>To ascertain any contra-indications for irrigation.</td>
</tr>
<tr>
<td>4</td>
<td>Inspect the ear to be irrigated with an otoscope.</td>
<td>To assess the ear canal for signs of infection and note amount and position of wax.</td>
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<td>5</td>
<td>Ask the patient to tilt the head slightly towards the affected side and to hold the receiver or noots tank beneath the same ear.</td>
<td>To aid drainage of irrigation fluid and catch irrigation fluid and debris.</td>
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<tr>
<td>6</td>
<td>Fill the reservoir tank with tap water and check the temperature is at 40 degrees using a lotion thermometer.</td>
<td>Irrigation fluid should be at body temperature to avoid triggering vestibular reflex.</td>
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<tr>
<td>7</td>
<td>Put on headlamp.</td>
<td>To illuminate the ear clearly.</td>
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<tr>
<td>8</td>
<td>Attach disposable jet tip to connector ensuring that it clicks into place.</td>
<td>To avoid jet tip from falling off and causing injury to ear canal during procedure.</td>
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<tr>
<td>9</td>
<td>Set the irrigator at minimum force. Switch on for 10-20 seconds and run water through the tubing into the</td>
<td>To expel any air or cold water remaining in the tubing.</td>
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<tr>
<td>10</td>
<td>Insert the jet tip applicator into the entrance of the ear canal and warn the patient of impending noise and jet of water.</td>
<td>To enable the patient to become used to the sound of the machine.</td>
</tr>
<tr>
<td>11</td>
<td>Gently grasp the pinna upward and backward to extend the auditory meatus in an adult and directly down and backwards in a child.</td>
<td>To stretch and straighten external auditory canal; to hold the ear steady to prevent injury.</td>
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<tr>
<td>12</td>
<td>Switch on head torch and the Propulse machine and direct the jet of water towards the posterior wall (eg. 5 minutes to the hour for right ear and 5 minutes past the hour for left ear. (Towards the back of patient’s head)</td>
<td>Water should flow behind the wax plug and back along the canal to wash it out; too forceful a stream of water may force the plug back along the canal or rupture the tympanic membrane.</td>
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<td>13</td>
<td>Examine the ear canal periodically throughout the procedure using the otoscope and also check the solution running into the receiver.</td>
<td>To evaluate effect of irrigation and monitor condition of the ear.</td>
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<td>14</td>
<td>It is advisable that irrigation lasts for no more than 2 minutes at each interval, with a maximum of two tank reservoirs used in any one procedure ie one tank per ear</td>
<td>To avoid causing trauma to the delicate lining of the skin in ear canal; to enable assessment of patient comfort during procedure.</td>
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<td>15</td>
<td>Stop immediately if the patient complains of pain, nausea or dizziness.</td>
<td>To prevent further triggering of the vestibular reflex. This procedure may cause discomfort but should not be painful. Any complaint of pain should be investigated.</td>
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<td>16</td>
<td>After removal of wax or debris, examine the ear with the otoscope and record appearance of the auditory canal and tympanic membrane.</td>
<td>To confirm removal of wax and observe for any abnormalities of external ear canal and ear drum.</td>
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<td>17</td>
<td>Dry mop excess water from the ear canal under direct vision with head torch using the Jobson Horne probe with cotton wool the size of a postage stamp applied to the probe.</td>
<td>Stagnation of water left in the ear canal could predispose to otitis externa or possible pseudomonal infection.</td>
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<td>18</td>
<td>Remove waterproof towel and ensure the patient is comfortable.</td>
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<td>19</td>
<td>Repeat the procedure with the other ear if there is a wax problem there. Record all findings and treatments in</td>
<td>To act in accordance with the NMC Guidelines for Accountability and Record Keeping; provide information for future</td>
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the patient’s documentation. | reference.
---|---
20 | Give advice regarding ear care and any relevant information/leaflets – to re-inforce the self cleaning properties of the ear and use olive oil. Report any abnormalities found to their GP as soon as possible. | To enable patients to maintain ear care and prevent future episodes of impacted excessive wax.

11 CLEANING GUIDELINES

These guidelines have been compiled using the literature supplied by the propulse II manufacturer and recent information issued by the Primary Ear Care Centre, Rotherham. Recommendations have also been sought from the Worcestershire Infection Control Nurses.

Remember, aural care and ear irrigation are ‘clean’ – not sterile procedures, however, the nurse must ensure that all items of equipment used have been thoroughly disinfected before use.

**ALWAYS USE A CLEAN SPECULUM AND DISPOSABLE JET TIP APPLICATOR AND PROBE FOR EACH PATIENT.**

**Stage 1**
- Each day before use, the Propulse should be disinfected using a solution of sodium dichloroisocyanurate (NaDCC) 0.1%
- This is available in the form of Presept tablets. I.e. 2 Presept tablets 0.5g, in 500mls of cold water or 4 Presept tablets 0.5g, in 1 litre of water if a larger volume is required).

*COSSH REGULATIONS MUST BE OBSERVED WHEN USING NaDCC*
- Fill the water tank with the NaDCC 0.1% 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 and then empty the water tank.
- Rinse and refill with clean WELL RUN tap water.
- Run the propulse to completely rinse the system before use.

**Stage 2**
- At the end of each day or ear irrigation session, disinfect the Propulse for 10 minutes using the NaDCC solution 0.1% as before, but rinse the machine by running through with well run cold tap water and dry it before leaving it overnight.
After each individual patient treatment, items of equipment should be disinfected as follows:

**Jet Tip Applicator**
- DISPOSABLE JET TIPS SHOULD BE USED ONE PER PATIENT PROCEDURE

**Speculum for Otoscope**
- Ideally this should be single use and disposable.
  OR
- If re-usable speculae are used, these should be de-contaminated between clients by washing in general purpose detergent and hot water ensuring all wax is removed, rinsed, dried and inspected. The speculum should be then stored in a manner to protect it from dust i.e. in an easily cleaned lidded box or draw. (Worcestershire Infection Control Department)

**Jobson Horne Probe, Henkles and Tilley forceps**
Should be either:
- Single use and disposable (recommended by Rotherham Primary Ear Care Centre)
  OR
- Sent to central sterilizing services
  OR
- Sterilized locally using a bench top steam sterilizer (BTSS) according to local guidelines.

**Noots tank**
- Clean the noots tank with detergent and water.
- Rinse under hot water and dry thoroughly.
- Store in a manner to protect from dust.
10. REFERENCES


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Cerumen Management: Professional Issues and Techniques *J Am Acad Audiol* 8: 421-430


Cerumen Impaction Management for Clients of all Ages *Nurse Practitioner*, March, pp. 31-37.

[www.earcarcentre.com](http://www.earcarcentre.com)  
[www.entnursing.com](http://www.entnursing.com)

11. **BIBLIOGRAPHY**

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Guidance for Nurses on Clinical Governance RCN (reprinted April 2000) publication code: 000941

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Guidelines for Administration of Medicines (August)
### APPENDIX 1: EAR CARE NURSING RECORD

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<td>Cleft Palate</td>
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<td>Recent Ear Infection</td>
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<tr>
<td>Surgery on tympanic membrane or other ear surgery</td>
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<td>Tympanic perforation</td>
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<td>Previous Ear Irrigation</td>
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<tr>
<td>Hearing Loss</td>
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**Otoscopic Examination**

- Tympanic membrane visible
- Dryness
- Scaling
- Erythema
- Discharge
- Oedema
- Pain
- Wax

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**Use of Ceruminolytic Agents**

- How much?
- How often?
- What kind?

**Physical Assessment of Pinna**

- Swellings
- Lesions
- Mastoid tenderness
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<th>DATE</th>
<th>APPEARANCE OF EAR DRUM NOTING ANY ABNORMALITIES</th>
<th>TREATMENT GIVEN (INCLUDING ADVICE)</th>
<th>SIGNATURE</th>
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13. APPENDIX 2: DIAGRAM OF EAR