Ear Irrigation
Guidelines for Community Nursing

Reference Number:
NHSCT/12/504

Target audience:
All community nursing staff who perform ear irrigation either in a clinic or domiciliary setting

Sources of advice in relation to this document:
Roy Hamill, Assistant Director
Wendy Magowan, Community General Manager
Dr R Bill, ENT

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N/A

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Policy, Standards and Guidelines Committee

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NHSCT Mission Statement
To provide for all the quality of services we would expect for our families and ourselves
Ear Irrigation – Guidelines for Community Nursing

November 2011
Ear Irrigation – Guidelines for Community Nursing

Introduction
Ear wax is also known as cerumen. It is made up of oil and sweat secreted from glands in the outer ear canal, scales from skin and dust particles. Ear wax helps to keep ears healthy. It is anti fungal and anti-bacterial. Some people feel that they should have their ears cleared regularly, but there is usually no need for ear wax to be cleared.

The external ear canal keeps itself clean using a natural process involving ear wax. It takes about two weeks for skin to move outwards from the eardrum to the external ear. This process goes on all the time and means that the ear canal is continually developing a new lining.

Occasionally wax can build up in your canal and cause a blockage.

Aim of guidelines
These guidelines are intended for registered nurses who are competent in carrying out safe and effective ear irrigation. It provides the nurse with guidance in assessment, examination for ear prior to irrigation and details the ear irrigation procedure.

Ear irrigation should only be considered when other conservative methods of wax removal have failed e.g. use of softeners. Patient’s requiring ear irrigation should always receive education and advice which may reduce contributory factors and therefore the need for ear irrigation.

Ear irrigation is undertaken for the purpose of removing wax from the external auditory meatus where this is thought to be causing a hearing deficit and or discomfort or restricts vision of the tympanic membrane preventing examination in the patient.

Target Audience
All community nursing staff who perform ear irrigation either in a clinic or domiciliary setting.

Policy Statement
Contraindications to ear irrigation
Irrigation should NOT be carried out when;
• The patient has experienced complications following this procedure in the past.
• There is a history of 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 mucus discharge in the last year.
• The patient has a cleft palate (repaired or not)
• In the presence of acute otitis externa with pain and tenderness of the pinna.
Equipment
Staff need to ensure that equipment is used safely and appropriately according to the medical devices management policy. Equipment must be stored cleaned and checked as specified as per manufactures instructions. Any faulty equipment should be reported to the Practice and equipment taken out of use until repaired.

Use of softeners
Prior to ear irrigation a softener should be used for a minimum of 7 days. Firstly it is necessary to determine if the ear is occluded by wax or any other matter i.e. infected debris or a foreign body. Secondly the nurse must identify the type of wax present as if normal soft wax is present this can be irrigated without the need for softeners. However if hard wax is present and is located deep in the ear canal then a softener should be used prior to irrigation. Current studies recommend olive oil as the safest most suitable pre-irrigation treatment. Nut based oils should NOT be used where allergies are known or suspected.

Procedure for the examination of the ear
- The nurse should refer to the Consent/Check list form Appendix 1 as part of the examination process.
- Ensure that both the practitioner and the patient are seated comfortably at the same level if possible
- Examine the pinna outer meatus and adjacent scalp, check for precious surgery incision scars, infection, discharge, swelling and signs of skin lesions or defects. Decide the most appropriate size of speculum that will fit comfortable in the ear and place it on the auroscope.
- Gently pull the pinna upwards and backwards to straighten the ear canal. Localised infection or inflammation will cause this procedure to be painful, if this is present DO NOT continue.
- Hold the auroscope like a pen and rest the small digit on the patient’s head as a trigger for any unsuspected head movement.
- Use the light to observe the direction of the ear canal and the tympanic membrane. There is improved visualisation of the eardrum 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, and using gentle movement of the auroscope and the patients head examine the walls of the canal which are sensitive and fragile.
Identify any of the following

- Wax in the canal – this can range from black or dark brown and solid to yellow and sticky to white and flaky. However white and flaky debris may be due to excess keratin signifying an external ear infection.
- Foreign bodies
- Inflammation in the canal – the canal could be red, swollen and tender, or pale and moist. The nurse should also identify if an odour is present, or if there is a discharge which may be creamy or have the appearance of mucous.
- The normal eardrum – the colour is normally pearly light grey, shiny and translucent.
- Other visible abnormalities
- Document what is seen in both ears, this should be in accordance with the NMC guidelines on record keeping and Trust policy.

Sometimes tinnitus is triggered by this change in hearing or even by the removal of the wax in particular by syringing. Most people whose ears are blocked by wax however benefit from having it removed.

Consent
Informed consent should be obtained prior to proceeding. The patient should be informed of the risks of the procedure i.e. trauma, minor infection chronic infection, acute and chronic tinnitus perforation of the eardrum and deafness to enable them to give consent. (Appendix 1)

Ear irrigation procedure

- Examine both ears by following the ear examination procedure above.
- Check to see if the ears still require irrigation, the olive oil may have removed the wax.
- Wash hands prior to the procedure, wear appropriate personal protective equipment.
- Explain the procedure to the patient and ask the patient to sit in chair with their head tilted towards the affected ear so that the nurse is still able to see into the ear canal.
- Place a disposable waterproof covering and an absorbent covering around the patient’s shoulders and under the ear to be irrigated.
- Ask the patient to hold the Noots receiver on the neck approximately 2cm below the ear.
- Fill the reservoir of the irrigator with water that is approximately 37 degrees C by finger touch and testing on the patient’s earlobe.
- Set the pressure at minimum.
- Securely connect a clean disposable jet tip applicator to the tubing of the machine.
- 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 allows the patient to become accustomed to the noise of the machine.
- Gently pull the pinna upwards and backwards to straighten the ear canal.
• Warn the patient that you are about to start irrigating and ask the patient to alert you if they become dizzy or experience any pain so that the procedure can be discontinued immediately.
• Place the tip of the nozzle into the ear canal entrance and using the foot control direct the stream of water towards the posterior canal wall (towards the back of the patient's head).
• Nothing should be inserted into the ear further than can be seen.
• If you consider the entrance to the ear canal as a clock face the practitioner would direct the water at 11 o'clock in the right ear and 1 o'clock in the left ear.
• Always start with two short applications of water to determine if the patient is sensing water in the nose or throat, which signifies a perforated tympanic membrane. The procedure should then be terminated and medical advice sought.
• However if the patient does not experience such problems the procedure may be continued.
• Increase the pressure control gradually if there is difficulty removing wax.
• It is advisable that a maximum of one reservoir of water is used in any one procedure per ear.
• Periodically inspect the ear canal with the auroscope and inspect the solution running into the receiver.
• After removal of ear wax or debris dry mop any excess water from the meatus under direct vision as stagnation of water and any abrasion of the skin during the procedure can predispose to infection.
• Examine ear including tympanic membrane and meatus following irrigation and refer to doctor if there is severe inflammation or trauma.
• Give advice regarding ear care and patient information leaflet.

Appendix 2.

Irrigation should never cause pain.

Stop immediately if the patient complains of pain.

Always use a clean speculum and jet tip applicator for each patient.

Propulse Ear Irrigation cleaning guidelines
Manufactures guidelines on cleaning and maintenance of the Propulse should be followed.

Cleaning of the Noots ear tank
• Clean with detergent solution.
• Rinse under hot water.
• Dry thoroughly.
Specific responsibilities and accountability
The Trust will ensure that;

- Staff have access to guidelines on ear care.
- Appropriate training is available to staff in order to carry out these procedures.
- A system is in place that ensures the availability of safe appropriate equipment to staff for this procedure in partnership with GP Practices.

Legislative Compliance
NHS Quality Improvement Scotland (2006) Best Practice Statement Ear Care
NMC Guidance on Record Keeping (2007)

Equality, Human Rights and DDA
This guideline is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

Alternative formats
This guideline can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

Sources of Advice in relation to this document
Dr R Bill – General Practitioner with special interest in ENT, ICATS, NHSCT.
Wendy Magowan – Community General Manager - NHSCT
Appendix 1

Consent / checklist

Important information for the patient to read and inform the nurse about prior to having their ears irrigated.

NB irrigation may cause slight discomfort but should never cause pain. If the patient complains of pain stop immediately.

Name……………………………………………………………………DOB……………………

<table>
<thead>
<tr>
<th>Past history</th>
<th>Right ear Y/N</th>
<th>Details</th>
<th>Left ear Y/N</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Previous problem following ear syringing/Irrigation</td>
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<tr>
<td>Previous ear perforation</td>
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<td>Previous ear surgery e.g. mastoidectomy?</td>
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<td>Discharge from the ear</td>
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<td>Current or recent ear infection</td>
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<td>Catarrh or cold</td>
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<td>Pain in the ear</td>
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<td>Grommets</td>
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<td>Permanent deafness in one ear</td>
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<td>Radiation therapy</td>
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<td>Presence of unsoftened wax</td>
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<td>Cleft Palate repaired or not</td>
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<td>Foreign body insitu</td>
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<td>Hearing aid</td>
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<td>Auditometry clinic appointment on same day</td>
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<td>12 years or under</td>
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<td>Use of olive oil appropriately for a minimum of 7 days</td>
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<tr>
<td>Right ear Y/N</td>
<td>Details</td>
<td>Left ear Y/N</td>
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<td>After Irrigation</td>
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<tr>
<td>Tympanic membrane visible</td>
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<tr>
<td>Tympanic membrane perforated</td>
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<tr>
<td>Any other complications</td>
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**NB Flying**
Reference is not available but best practice suggests that patients should **not** fly with in 48 hours of having this procedure undertaken.

**Consent**
Tinnitus is not a reason to **not** irrigate the ears as it does not worsen tinnitus.

The nurse has asked questions related to the above conditions. She/He has explained the proposed treatment and given the information on ear care. I understand that ear irrigation carries a rare risk of perforation to the eardrum. I understand and consent to the proposed treatment.

**Service User**
Signature………………………………………………………………Date…………

**Nurse**
Signature………………………………………………………………Date…………
Patient advice following ear irrigation
The ear canal may be vulnerable to an ear infection after irrigation. This is caused by removal of all the wax, which has inherent properties to protect the ear canal.

- Until the ear produces more wax to protect the canal keep the ear(s) that have been irrigated from entry of water for 4 – 5 days after the procedure.
- To keep the ears dry when you are washing your hair, showering, bathing or swimming, insert ear plugs or cotton wool coated in petroleum jelly into the outside of the ear canal(s) to act as a protective seal.
- In the unlikely event that you develop pain, dizziness, reduced hearing or discharge from the ear after the procedure consult with your nurse/doctor.
- If wax is removed due to the presenting complaint of hearing loss ascertain whether good hearing is restored if not please consult GP who may consider referral to an audiologist.

Advice on routine ear care

- The normal ear has self cleaning properties and wax is normal and has protective qualities.
- Do not use cotton buds or cotton wool – poking will only push wax deeper into the canal and cause problems.
- Frequent wax blockage may be caused by a narrow ear canal that easily becomes obstructed. It may be helpful to instil ear drops 1 – 2 times a week and wear ear plugs when in water for people who have a recurrent build up of wax.
- Wax contains a high concentration of fatty acids and a change of diet may reduce the incidence of blocked ears especially if your blood cholesterol is high.
- If your ears become itchy it may be because of too little wax, see their GP or Nurse for advice.

Ear irrigation does not cause a build up of wax.
References

Birmingham East and North Primary Care Trust (2007) Ear Irrigation Policy.


NMC Guidance on Record Keeping (2007)


NHSCT Management of Medical Devices, NHSCT/09/171, July 2009