AURAL INSTRUMENTATION GUIDELINE

PROCEDURAL

Document Category	Clinical		
Document Type	Guideline		
Keywords	Ear care procedure, wax removal, removal of foreign bodies		
Version:	**Issue Date:**	**Review Date:**	
4	1st December 2025	1st December 2028	
Supersedes	Guideline for Aural Instrumentation November 2022 –November 2025		
Approved by (Committee / group)	Rotherham NHS Foundation Trust Ear Care and Audiology clinical governance Heads of Service Clinical governance	**Date Approved:**	1st December 2025
Scope of target audience	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 Rotherham Ear Care Centre trainers. The healthcare worker should also access a two yearly update.		
Evidence base/ References	NICE Clinical Knowledge Summaries for management of ear wax (2025)		
Lead Care Group	Care Group 4		
Lead Specialty/ Department: (Or Care Group if 'care group' owned)	Ear Care and Audiology Specialist Nursing team.		

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Sponsor (position/ role):	N/A
Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Policy	N/A
Associated Procedure(s)	N/A
Associated Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Consultation Undertaken:	Consultation undertaken with Ear Care Specialist Nursing Team and Clinical Lead for Ear Care and Audiology.
Template control:	

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/page)	Amendment (author to summarise)
3	November 2022	Section 7. Related documents and guidance	Guidance outdated therefore removed and replaced with information obtained from current NICE Clinical Knowledge Summary.

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1.0 INTRODUCTION/BACKGROUND

This is a guideline for aural instrumentation to be carried out by a trained healthcare worker. Aural instrumentation can be performed to remove wax, foreign bodies or infection debris from an external auditory meatus or mastoid cavity.

If aural instrumentation is the practitioners preferred method of wax removal, the use of cerumenolytics may be required before the procedure takes place.

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 favor of other cerumenolytics. The practitioner should advise patients to instil olive oil 3-5 days prior to their wax removal appointment. The practitioner may decide that extended use of olive oil is required.

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.

2.0 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

This procedure is only to be carried out by a suitably trained healthcare worker, with recognised ear care training. 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 instrument to remove wax**.**

Related Trust Documents

- To consent to examination or treatment (trust policy available on HUB)
- Heath records policy (trust policy available on HUB)
- Standard infection prevention and control precautions (trust policy available on HUB)

3.0 ABBREVIATIONS AND DEFINITIONS

3.1 **Abbreviations**

None

3.2 **Definitions**

Carbon curette - plastic probe with serrated end used in ear care

Jobson Horne – probe with a serrated end used in ear care

Speculae – otoscope ends

Henckel, crocodile and alligator forceps – single use metal instruments used in ear care

4.0 ROLES AND RESPONSIBILITIES

All staff involved in the aural care of patients must follow the guidance within this document or record any justifications for not doing so.

5.0 GUIDELINE DETAILS

EQUIPMENT REQUIRED

- Otoscope
- Otoscope Speculae
- Head light
- Jobson Horne probe or carbon curette
- Henckel crocodile or alligator forceps
- Wax hook
- Tissues
- Sharps bin
- Disposable gloves

PROCEDURE

This procedure should be carried out with both participants seated and under direct vision, using a headlight or other suitable light source.

1. Examine the ear using an otoscope.

2. Pull the pinna up and back in order to straighten the external auditory meatus, withhold this position throughout the procedure.

3. Hard, crusty wax can often be gently maneuvered out of the external auditory meatus with a probe, using a headlight or external light source for illumination. Experienced practitioners may prefer to use a wax hook or Henckel/crocodile forceps. If this treatment becomes painful, do not continue as the meatal lining quickly becomes traumatised, risking infection. Instruct the patient according to your clinical judgement to use olive oil inserted correctly for 3-5 days prior to their next appointment. The patient can then return for irrigation, microsuction 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 removed by microsuction or irrigation.

4. If a perforation is suspected behind the wax, advise the patient to use olive oil in very small amounts, Earol can be useful for patients with perforations as only a fine mist is delivered. Advise patients 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 according to the NMC guidelines for documentation.

7. All contaminated equipment and PPE should be disposed of in clinical waste, with sharp instruments to be disposed of in appropriate sharps disposal

RISK FACTORS

- Trauma
- Dizziness
- Infection
- Patient cough

6.0 EDUCATION AND TRAINING

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 the Ear Care Centre trainers. The healthcare worker should also access a two yearly update.
An individual assessment should be made of every patient to ensure that it is appropriate for ear irrigation to be carried out.

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7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Compliance with this procedural guideline will be monitored by undertaking yearly peer led clinical supervisions.