

College of Audiologists and
Speech-Language Pathologists of Ontario
Ordre des Audiologistes et
des Orthophonistes de l'Ontario

PRACTICE STANDARDS FOR CERUMEN MANAGEMENT MARCH, 2018

5060-3080 Yonge Street, Box 71 | March, 2018
Toronto, Ontario M4N 3N1
416-975-5347 1-800-993-9459
www.caslpo.com

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23 EXECUTIVE SUMMARY

24 This document identifies the standards of practice for audiologists in Ontario when
25 providing cerumen management. Cerumen management involves the removal of
26 cerumen, also called earwax, from the ear. Cerumen management includes the
27 education, counseling and recommendations provided to the patient by the
28 audiologist to prevent an accumulation of cerumen that could affect hearing, delay
29 audiological assessment, or cause discomfort. The standards in this document may
30 also be applied to removal of other materials from the ear that are applicable to an
31 audiologist’s clinical practice, such as hearing aid domes, ear impression materials,
32 and cotton swabs.

33 Practice standards define the level of practice required to ensure safe and
34 competent care and are identified through consensus within the profession. The
35 standards in this document reflect the generally accepted practices adopted by
36 Ontario audiologists when removing cerumen from the ear canal and when
37 providing cerumen management. This includes conducting a detailed case history,
38 thorough examination of the ear canal and ear drum, selecting appropriate
39 intervention options, evaluating post-procedure status of the ear, and educating the
40 patient¹ regarding follow-up and prevention.

41 Throughout the process, the audiologist must provide the patient and/or [Substitute](#)
42 [Decision Maker \(SDM\)](#) with information, act as a resource, and provide the
43 opportunity to make informed decisions regarding the [intervention](#). Audiologists
44 must also provide services that are respectful and responsive to the cultural needs
45 of patients and families. All the required components in the provision of cerumen
46 management must be documented.

47

¹ The term “patient” is used to represent an individual who receives health care intervention from an audiologist and is synonymous with “client” or “student”. The use of the term “Patient” mirrors the language used in the *Regulated Health Professions Act, 1991* and by the Ministry of Health and Long-Term Care.

48 A. PREAMBLE

49 Standards of practice articulate expectations with regard to the knowledge, skill and
50 judgement that the member must possess, as well as specific practices to which
51 they must adhere. Generally, standards are developed through a process of
52 consensus within the profession. As members of CASLPO, audiologists are required
53 to ensure their knowledge, skill and judgement are current. This is monitored
54 through the Quality Assurance Program. Therefore, it is reasonable to assume that
55 the members are best able to identify the standards of practice. However, this does
56 not preclude the College from setting a standard that is not currently practiced by
57 the profession if there is compelling evidence to suggest that a standard should be
58 set to mitigate significant risk. In such cases, it is the College's duty to gather
59 appropriate evidence, set the standard and allow the members to respond.

60 The standards of practice contained in this document have been identified through
61 consultation with the members of the profession, as well as a review of other
62 resources, such as legislation and interjurisdictional standards.

63 CASLPO's Practice Standards ensure quality care to the people of Ontario. This
64 document outlines the necessary standards and competencies but is not intended to
65 be a tutorial or to provide audiologists with all the information required for the
66 provision of [cerumen management](#) services.

67 The "must" statements in this document establish standards that members are
68 required to follow. In some cases, "must" statements have been established in
69 legislation and/or other CASLPO documents. In other cases, the "must" statements
70 describe practices that are established by virtue of what the profession agrees are
71 to be "standard" practices. To the greatest extent possible, members are expected
72 to follow these practice standards.

73 However, audiologists must also exercise professional judgment, taking into
74 account the environment(s) and the individual patient's needs, when considering
75 deviating from these standards and must document and be prepared to justify any
76 departures from the standards.

77 B. DEFINITION OF SERVICE

78 [Cerumen](#), or “earwax”, is a naturally occurring substance that cleans, protects, and
79 lubricates the [external ear canal](#). Accumulation of cerumen in the ear canal is a
80 common reason for patients to seek care for ear-related problems. While usually
81 harmless, an accumulation of cerumen or blockage of the ear canal by cerumen can
82 lead to hearing loss, ringing in the ear ([tinnitus](#)), itching, and ear pain (otalgia).

83 In addition, excessive cerumen may:

- 84 • Prevent complete visual examination of the external ear canal and ear drum
85 (tympanic membrane)
- 86 • Cause discomfort to the patient
- 87 • Be cosmetically unappealing for the patient
- 88 • Interfere with the provision of audiological services (hearing and balance
89 assessments, hearing aid fittings)
- 90 • Prevent the development and implementation of an audiological treatment
91 plan

92 Audiologists typically provide [cerumen management](#) services to patients who are
93 receiving audiological services. However, cerumen management may also occur as
94 an isolated [intervention](#). At times, audiologists may be requested to remove other
95 materials, such as hearing aid domes or foreign objects, from the ear.

96 This document is intended to provide standards of practice for all instances of
97 removal of material from the ear canal.

98 C. SCOPE OF PRACTICE

99 The *Audiology and Speech-language Pathology Act, 1991* states: “The practice of
100 audiology is the assessment of auditory function and the treatment and prevention
101 of auditory dysfunction to develop, maintain, rehabilitate or augment auditory and
102 communicative functions.”

103 Audiologists are concerned with the prevention, identification, assessment,
104 treatment and (re)habilitation of auditory and balance difficulties in children and
105 adults. Audiologists also provide education and counseling services for people
106 experiencing problems in these areas.

107 Audiologists’ scope of clinical practice includes the provision of assessment,
108 treatment, (re)habilitation and consultation services for:

- 109 • Auditory Function
- 110 • Vestibular (balance) Function
- 111 • [Tinnitus](#) (ringing in the ears)
- 112 • Auditory Processing Disorders
- 113 • [Cerumen Management](#)
- 114 • Prescription and dispensing of hearing aids, cochlear and middle ear
115 implants, as well as assistive listening and alerting devices

116 Removing cerumen from the ear canal is within the scope of practice for
117 audiologists in Ontario.

118 Audiologists should note that these procedures do not and should not involve:

- 119 “Putting an instrument, hand or finger,
120 1. beyond the [external ear canal](#)”

121 As specified in paragraph 27 (2) 6 of the *Regulated Health Professions Act, 1991*,
122 which is a controlled act that audiologists do not have the authority to perform.

123

D. RESOURCE REQUIREMENTS



Standard
D.1

Audiologists must ensure availability of resources and equipment for the safe and effective removal of cerumen from the ear.

125 Audiologists must ensure that they have the appropriate equipment and technology
126 in order to:

- 127 • Adequately visualize the ear canal during all stages of the [intervention](#) with
128 appropriate illumination and magnification (e.g., through the use of a
129 headlight, [otoscope](#), video [otoscope](#) etc.)
- 130 • Assess the status of the [outer ear](#), ear canal, and [tympanic membrane](#)
131 before, during, and after cerumen management (e.g., conducting [otoscopy](#)
132 and [tympanometry](#))
- 133 • Extract the cerumen by the appropriate technique, which may include:
 - 134 i) Manual removal using instruments (e.g. stainless steel and disposable
135 ear cures, hooks, forceps)
 - 136 ii) Suctioning (e.g. medical grade apparatus)
 - 137 iii) Irrigation (e.g. aural irrigation equipment, syringes, etc.)
- 138 • Determine the effectiveness of the [intervention](#)
- 139



Standard
D.2

Audiologists must ensure that all materials and equipment utilized in service provision are in proper working order.

140 All equipment must be maintained according to manufacturers' specifications and
141 recommendations, as outlined in the Self-Assessment Tool (Management
142 Standards). Audiologists must also ensure equipment is calibrated according to
143 manufacturers' specifications as required in [CASLPO's Code of Ethics](#) 4.2.9 (2011):

144 " Audiologists and Speech-Language Pathologists:

145 shall ensure that all equipment used is calibrated and in proper working
146 order"

147

E. COLLABORATION REQUIREMENTS



Standard
E.1

Audiologists must communicate effectively and collaboratively with the patient and/or the [SDM](#) and others who are involved with the patient, with appropriate consent.

149 Other healthcare providers may be required both for prevention and [intervention](#).
150 Due to the potential for complications when removing cerumen, or any other
151 materials from the [ear canal](#), Audiologists must be able to quickly refer patients if
152 further medical intervention is warranted.

153 Consent is required when communicating with others involved with the patient or
154 the SDM, as indicated in CASLPO's [Professional Misconduct Regulation](#) and the
155 [Personal Health Information Protection Act \(PHIPA\), 2004](#).

156 F. HEALTH AND SAFETY PRECAUTIONS

157



Standard
F.1

Audiologists must employ current practices for infection prevention and control.

158 All intervention procedures must ensure the safety of the patient and audiologist,
159 and must adhere to current infection control practices, as indicated in the [Infection](#)
160 [Prevention and Control Guidelines for Audiology](#), as well as additional precautions
161 where specified by the practice setting and/or the manufacturer’s instructions.

162 Audiologists must ensure that all equipment used is disinfected/sanitized in
163 accordance with the [Infection Prevention and Control Guidelines for Audiology](#). This
164 includes sterilization of usable materials and disposal of single use items as
165 indicated.

166

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170 G. PRINCIPLES GUIDING SERVICE DELIVERY

171 1. PRINCIPLES OF CULTURALLY RESPONSIVE
172 INTERVENTION



Standard
G.1

Audiologists must make reasonable efforts to be responsive to socio-cultural factors in all phases of intervention.

173 Audiologists must be aware that socio-cultural factors such as age, ancestry, colour,
174 race, citizenship, ethnic origin, place of origin, creed, disability, family status,
175 marital/single status, gender expression, socio economic factors, gender identity,
176 sex, sexual orientation may affect screening, assessment, [management](#),
177 communication and therapy relationships and must incorporate this knowledge into
178 the patient's [intervention](#). Equally, the audiologist must not make assumptions
179 about a patient based on their socio-cultural background. Each patient is unique
180 and should be treated accordingly. Service provision and collaboration must allow
181 the patient or their [SDM](#) a choice that is fully informed and based on unbiased
182 culturally relevant information as discussed in CASLPO's [Guide to Service Delivery](#)
183 [Across Diverse Cultures](#).

184

185 2. PRINCIPLES OF EVIDENCE-BASED PRACTICE



Standard
G.2

Audiologists must use evidence-based practice principles in their intervention.

186 CASLPO defines evidence-based practice as intervention based on the integration of
187 current research evidence with clinical knowledge, skill and judgement and patient
188 needs and values.



189

190 Audiologists' primary ethical obligation is to practice their skills for the benefit of
 191 their patients ([Code of Ethics 3.1 2011](#)). Evidence-based practice must be patient
 192 centered. The member should interpret best current evidence from research
 193 combined with the member's clinical knowledge and relate it to the patient,
 194 including their preferences, environment, culture, and values.

195 3. CONSENT

196 CONSENT TO COLLECT, USE, DISCLOSE AND RETAIN PERSONAL HEALTH 197 INFORMATION



Standard
G.3

Audiologists must obtain knowledgeable consent from the patient or [SDM](#) for the collection, use, disclosure and retention of personal health information.

198 The *Personal Health Information and Protection Act (PHIPA), 2004*, requires
 199 members to obtain knowledgeable consent for the collection, use and disclosure of
 200 any personal health information obtained during screening, assessment and
 201 [management](#). All consent must be documented. It can be obtained in written format
 202 or verbally.

203 Agencies may have various procedures for obtaining consent for the collection, use
 204 and disclosure of information. These may be used if they comply with the *PHIPA,*
 205 *2004*, and CASLPO requirements.

206 The Information and Privacy Commission of Ontario has outlined the criteria
 207 whereby members can rely on assumed implied consent to collect, use and disclose
 208 personal health information. This is known as the '[Circle of Care](#)'.

209 All of the following six criteria must apply:

- 210 1. The Health Information Custodian (HIC) is entitled to rely on assumed
211 implied consent. Audiologists are considered HICs.
- 212 2. The personal health information must have been received from the individual,
213 [SDM](#) or another HIC
- 214 3. The personal health information was collected, used and disclosed for the
215 purposes of providing health care
- 216 4. The HIC must use the personal health information for the purposes of
217 providing health care, not research or fundraising
- 218 5. Disclosure of personal health information from one HIC must be to another
219 HIC
- 220 6. The receiving HIC must not be aware that the individual has expressly
221 withheld or withdrawn consent
- 222 Consent to collect, use and disclose personal health information can be withdrawn
223 in full or in part at any time by the patient or by his /her SDM.

224 [CONSENT TO TREATMENT](#)



Standard
G.4

Audiologists must obtain valid and informed consent for all interventions.

225 Audiologists must obtain valid and informed consent from the patient or SDM, as
226 indicated in the [CASLPO Position Statement on Consent to Provide Screening and](#)
227 [Assessment Services](#) for all interventions. Interventions include screening,
228 assessment, and [management](#). Further information on consent, capacity to consent
229 and withdrawal of consent is found in the Consent and Capacity E-Learning Module
230 ([Member's Portal](#), select Education) and in the document, [Obtaining Consent For](#)
231 [Services: A Guide For Audiologists And Speech-Language Pathologists](#).

232 To obtain informed consent, as defined in the [Health Care Consent Act, 1996](#), it is
233 necessary to provide to the patient or their SDM the following information:

- 234 • the nature of the service
- 235 • the expected benefits
- 236 • any probable or serious risks and side effects
- 237 • alternative courses of action
- 238 • likely consequences of not receiving service

239 Audiologists are reminded that the critical element in obtaining consent is the
240 discussion of the information as described above and not the act of signing a
241 consent form. All consent to perform a screening, assessment or [management](#) must
242 be documented.

243 Consent for screening, assessment and management can be withdrawn at any time
244 by the patient or by their [SDM](#).

245 CAPACITY TO CONSENT TO TREATMENT



Standard
G.5

Audiologists must evaluate capacity if the ability of the patient to consent to the audiologist's services is in doubt.

246 If the patient's ability to provide informed consent for the proposed intervention is
247 in doubt, the audiologist must evaluate the individual's capacity to consent.
248 Capacity evaluation examines the patient's ability to understand relevant
249 information and his or her ability to appreciate the reasonably foreseeable
250 consequences of a decision or lack of decision. If the patient is found lacking in
251 capacity to consent, the audiologist must approach the SDM for informed consent.
252 The audiologist must also inform the patient on the process to appeal the finding of
253 incapacity to consent to [intervention](#) with the Consent and Capacity Board. Further
254 information regarding consent and capacity is found in Obtaining Consent for
255 Services: A Guide for Audiologists and Speech-Language Pathologists.

256



Standard
G.6

Audiologists must document every consent received regarding [intervention](#).

257 CASLPO requires members to document verbal consent and to maintain any written
258 consents as evidence that the process of obtaining consent was undertaken. The
259 Records Regulation (2015) requires members to document:

260 32. (2) 14. A record of every consent provided by the patient or by the patient's
261 authorized representative.

262

263

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266

4. PRINCIPLES OF RISK MANAGEMENT DETERMINATION



Standard
G.7

Audiologists must identify and manage risk factors, including those related to physical and emotional risk, as well as risk to communication outcomes.

267 Audiologists must take steps to minimize the risks associated with removing
268 cerumen from the ear canal. The risk of harm is increased in certain populations,
269 such as infants, children, and the medically fragile.

270 These risks may be considered with respect to risk of:

- 271 • Physical harm (e.g. injury to the ear canal, perforation of the [tympanic](#)
272 [membrane](#), exacerbation of chronic [middle ear](#) disease, damage to the [ossicular](#)
273 [chain](#))
- 274 • Causing discomfort to the patient
- 275 • Worsening a condition
- 276 • Causing undue stress for the patient related to participation in the procedures

277 Once risks have been identified the audiologist must implement an appropriate risk
278 management plan. The plan should mitigate risk where possible and/or be able to
279 address any complications that may arise, including a plan to refer to a physician, if
280 necessary. In certain instances, immediate medical intervention may be required
281 (e.g. significant abrasion, perforation of the tympanic membrane, and/or profuse
282 bleeding of the ear canal).

283

5. PRINCIPLES OF DOCUMENTATION



Standard
J.1

Audiologists must document all aspects of the provision of services.

285 All documentation by audiologists must conform to the [Records Regulation \(2015\)](#).

286 For cerumen management services this would include but is not limited to:

- 287 • The status of the ear canal before and after the cerumen management
288 procedure has been performed

- 289 • The type of management procedure used
- 290 • The status of the [tympanic membrane](#)
- 291 • Modifications made to the intervention plan based on any condition of the ear
- 292 canal or an inability to visualize the tympanic membrane
- 293 • The outcome of the management procedure
- 294



Standard
J.2

Audiologists must document communication and collaboration with other professionals in the planning or delivery of services

295 Communication and collaboration with other educational, psychosocial or health
296 care professionals in the planning or delivery of services must be documented. This
297 would include referrals to other providers.
298



Standard
J.4

Audiologists must ensure that records are securely stored.

299 Records must be stored securely in accordance with CASLPO's [Records Regulation](#)
300 [\(2015\)](#) and any other relevant legislation, such as the [Personal Health Information](#)
301 [Protection Act, 2004](#). Reasonable steps must be taken to ensure that personal
302 health information in the member's custody of control is, " ...protected against theft,
303 loss and unauthorized use or disclosure and to ensure that the records containing
304 the information are protected against unauthorized copying, modification or
305 disposal." PHIPA 2004, c. 3, Sched. A, s. 12 (1).
306

H. INTERVENTION: COMPETENCIES



Standard
H.1

Audiologists must have the required competencies to provide cerumen management services.

308 When providing [cerumen management](#) services, audiologists must ensure that they
309 possess the necessary competencies, as determined by their education, training and
310 professional experience. The [intervention](#) must be carried out in the patient's best
311 interest and ensuring patient safety (Code of Ethics 4.2.2 2011).

312 Audiologists must possess the knowledge, skill and judgement in order to carry out
313 the intervention, which may include some or all of the following components of
314 care:

- 315 1. Obtaining a case history
- 316 2. Examination of the ear pre and post-intervention
- 317 3. Cerumen removal procedures
- 318 4. Follow-up and prevention
- 319

320 When audiologists determine that they do not have the required knowledge, skill
321 and judgment to provide intervention, they are advised to consult with and/or refer
322 to other health care providers with the required competencies.

323

324 1. CASE HISTORY



Standard
H.2

Audiologists must work in collaboration with the patient and/or [SDM](#) to obtain a thorough case history, which includes relevant medical information

325 A thorough case history will inform the audiologist as to the nature and cause of the
326 problem. Furthermore, the case history will identify any complicating factors and/or
327 contra indicators for cerumen management.

328 COMPETENCIES FOR OBTAINING A CASE HISTORY

329 Audiologists must demonstrate the knowledge, skill and judgement in order to:

- 330 • Obtain and interpret valid and reliable case history and assessment data (e.g.,
331 tympanogram, audiogram data)

- 332 • Determine the degree and type of symptoms associated with cerumen
333 accumulation
- 334 • Identify exacerbating behaviours related to cerumen accumulation
- 335 • Obtain and interpret information provided by the patient and/or [SDM](#) related to
336 ear canal structure and function
- 337 • Identify and determine the impact of any conditions of the ear that may increase
338 the risks associated with cerumen removal (e.g. [tympanic membrane](#)
339 perforations, ear surgery, pathological conditions of the [pinna](#), ear canal, and
340 tympanic membrane, [myringotomy tubes](#))
- 341 • Determine the impact of any general health conditions and medications on the
342 risks associated with the [intervention](#) (e.g., immunocompromised patient,
343 patient using blood thinners)

344
345

346 2. EXAMINATION OF THE EAR



Standard
H.3

Audiologists must conduct a thorough examination of the ear prior to, during, and following any cerumen removal.

347 An ear examination must occur in order to determine the need for treatment, the
348 scope of the intervention, and the ability to carry out the intervention safely.

349 The audiologist will examine the [pinnae](#), ear canal, and if possible the tympanic
350 membrane. When possible, the audiologist will conduct testing to assess the
351 function of the outer ear, tympanic membrane and [middle ear](#).

352 Examination of the ear prior to the intervention allows the audiologist to establish:
353 the presence and consistency of cerumen, the shape and size of the ear canal, the
354 status of the tympanic membrane, and the safest removal technique. Examination
355 of the ear during and post intervention allows the audiologist to closely monitor the
356 intervention and determine the effectiveness of the procedure.

357 COMPETENCIES FOR EXAMINING THE EAR

358 Audiologists must demonstrate knowledge, skill and judgement in order to:

- 359 • Determine the consistency of the cerumen and whether cerumen removal is
360 appropriate or necessary
- 361 • Determine any conditions of the outer ear, middle ear and/or tympanic
362 membrane that may affect or prohibit treatment (e.g., active ear infection)

- 363 • Identify pre-existing conditions of the ear that inform the treatment plan and
364 post-evaluation (e.g., abrasions in the ear, bleeding, redness, scarring of the
365 eardrum)
- 366 • Recognize variations and/or abnormalities in anatomy that affect treatment and
367 post evaluation (e.g., exostoses)
- 368 • Monitor the status of the [tympanic membrane](#), [middle ear](#), and [outer ear canal](#)
369 throughout the procedure (before, during, and after the [intervention](#))
- 370 • Identify when it is appropriate to proceed with or discontinue any removal
371 technique
- 372 • Identify when a medical referral is required
- 373

374 3. REMOVAL OF CERUMEN



Standard
H.4

Audiologists must have the competencies to perform the required techniques or procedures to remove cerumen.

375 A variety of approaches may be used to remove cerumen from the ear canal
376 including softening agents, mechanical removal, suctioning, irrigation or a
377 combination of these methods. Any procedure for removal of cerumen from the ear
378 canal should be considered an invasive procedure with a risk of complication or pain
379 and discomfort to the patient. Audiologists should proceed with caution and never
380 work beyond their level of professional competence.

381

382 GENERAL COMPETENCIES FOR REMOVAL OF CERUMEN

383 Audiologists must possess knowledge, skill and judgement in order to:

- 384 • Determine the preferred procedure or technique for removal based on the
385 case history and examination of the ear
- 386 • Continually assess the effectiveness of the selected technique, the need for
387 an alternative approach or to combine approaches, and/or the need to
388 discontinue the intervention
- 389 • Continually assess and confirm the comfort of the patient and their ongoing
390 consent to continue throughout the intervention

- 391 • Recognize the conditions and/or circumstances arising from the [intervention](#)
392 that require a medical referral (e.g., profuse bleeding in the ear canal,
393 perforation of the ear drum)

394

395 In addition to these general competencies, audiologists must possess specific
396 competencies associated with specific procedures.

397

398 [COMPETENCIES FOR CERUMEN SOFTENING](#)

399 [Cerumenolytic agents](#) are designed to soften or dissolve cerumen. Audiologists
400 must demonstrate the knowledge, skill and judgement in order to:

- 401 • Determine when the use of cerumenolytic agents is appropriate
- 402 • Select the appropriate cerumenolytic agents
- 403 • Provide counseling and explain appropriate methods for their use, including
404 the manufacturer recommended methods
- 405 • Recognize possible side effects (e.g. allergic reaction)
- 406 • Identify contraindications for the use of specific cerumenolytic agents

407

408

409 [COMPETENCIES FOR REMOVAL OF CERUMEN BY MECHANICAL EXTRACTION,](#) 410 [AURAL SUCTIONING, AND AURAL IRRIGATION](#)

411 When proceeding to remove cerumen from the ear canal using mechanical
412 extraction, aural suctioning, and/or aural irrigation audiologists must demonstrate
413 the knowledge, skill and judgement in order to:

- 414 • Select the appropriate equipment and instruments, such as cures and
415 suction tips, based on the patient's ear canal size and shape
- 416 • Determine contraindications (e.g., [tinnitus](#) or [hyperacusis](#) for aural
417 suctioning, [myringotomy tubes](#) for aural irrigation)
- 418 • In the case of aural irrigation, determine the appropriate water temperature,
419 apply the appropriate water pressure and angle that will effectively dislodge
420 the cerumen, and determine if drying agents should be employed
- 421 • Prevent and/or minimize any instrument contact with the ear canal and
422 [tympanic membrane](#)

423

424

425 4. FOLLOW-UP AND PREVENTION



Standard
H.5

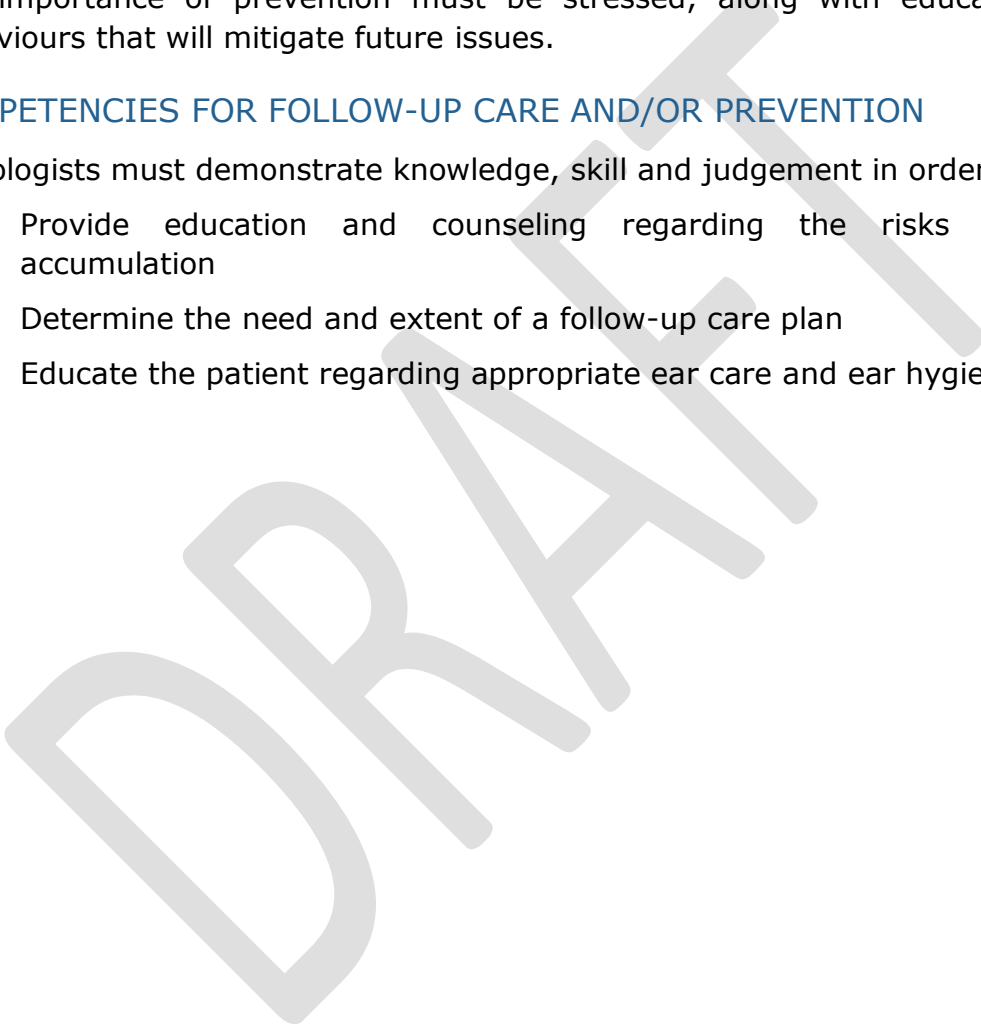
Audiologists must provide education, counseling, and follow-up care to mitigate future cerumen accumulation and to educate the patient or [SDM](#) on ear hygiene

426 The importance of prevention must be stressed, along with education on any
427 behaviours that will mitigate future issues.

428 **COMPETENCIES FOR FOLLOW-UP CARE AND/OR PREVENTION**

429 Audiologists must demonstrate knowledge, skill and judgement in order to:

- 430 • Provide education and counseling regarding the risks of cerumen
431 accumulation
- 432 • Determine the need and extent of a follow-up care plan
- 433 • Educate the patient regarding appropriate ear care and ear hygiene



I. GLOSSARY

434
435

436 ACOUSTIC IMMITTANCE

437 A measurement of energy or air pressure flow, involving the ear canal, eardrum,
438 [ossicular chain](#), and certain muscles and nerves of the ear. Also known as
439 impedance audiometry a primary purpose of this group of measurements is to
440 determine the status of the tympanic membrane and middle ear via
441 [tympanometry](#).
442

443 CERUMEN/EAR WAX

444 A substance found in the external ear canal, which is composed of a mixture of
445 secretions from sweat glands in the ear with epithelial cells, hair, and other
446 particulate matter. Also known as "ear wax" cerumen is a naturally occurring
447 substance that cleans, protects, and lubricates the ear canal.
448

449 CERUMEN MANAGEMENT

450 Removal of cerumen from the external ear canal using any [intervention](#) or
451 procedure. Cerumen management also involves recommendations and counseling
452 provided to the patient regarding ear hygiene and the prevention of cerumen
453 accumulation.
454

455 CERUMENOLYTIC AGENT

456 A chemical agent that is instilled into the ear canal in order to soften or dissolve
457 cerumen to facilitate its removal.
458

459 EXOSTOSES

460 Benign bony overgrowth of the bony portion of the external auditory canal brought
461 about by exposure to cold wind and water combined.
462

463 EXTERNAL AUDITORY CANAL/EAR CANAL/OUTER EAR

464 The tube or passage made of skin and bone that runs from the opening at the pinna
465 to the middle ear and directs sound to the tympanic membrane.
466

467 HYPERACUSIS

468 Heightened auditory perception, often accompanied by painful sensitivity to
469 ordinary environmental sounds, to the extent that normal sound levels are
470 intolerable.
471

472 **INTERVENTION**

473 Intervention includes screening, assessment, treatment, [management](#), consultation,
474 education and counselling.
475

476 **MANAGEMENT**

477 Refers to treatment, monitoring, follow up, education, counselling, and discharge
478 planning.
479

480 **MIDDLE EAR**

481 A part of the ear that consists of the tympanic membrane and the space behind it
482 that houses the [ossicular chain](#), which transmits sound vibrations from the tympanic
483 membrane to the inner ear.
484

485 **MYRINGOTOMY TUBE**

486 Small tubes made of plastic or metal open at both ends and placed in an incision
487 made in the tympanic membrane by a physician for the removal of middle ear fluid
488 (myringotomy procedure). Myringotomy tubes allow the [middle ear](#) space to be
489 aerated. Also known as a tympanostomy tube or "ear tube".
490

491 **OSSICULAR CHAIN**

492 The small bones of the [middle ear](#) that are articulated to form a chain for the
493 transmissions of sound from the tympanic membrane to the oval window
494

495 **OTOSCOPE**

496 A hand-held tool with a speculum and light source used to magnify and examine the
497 external ear canal.
498

499 **OTOSCOPIC EXAMINATION/OTOSCOPY**

500 The examination of the ear canal and tympanic membrane through the use of
501 an otoscope.
502

503 **PINNA/PINNAE/AURICLE**

504 The visible cartilaginous structures of the ear that lie outside the head. Also known
505 as auricle(s), which are the outer projecting portions of the ear.
506
507

508 **SUBSTITUTE DECISION MAKER (SDM)**

509 An individual such as a relative, trustee, guardian or person with power of
510 attorney who is permitted to make a decision on behalf of another individual

511 who is deemed incapable of making his/her own decisions regarding personal
512 health information or treatment.
513

514 TINNITUS

515 The sensation of ringing, buzzing, chirping, or hissing in the ear.
516

517 TYMPANIC MEMBRANE

518 Also known as the eardrum, a thin membrane that serves as a partition between
519 the external ear and the middle ear and transmits the motion of sound waves to the
520 ossicular chain in the [middle ear](#)
521

522 TYMPANOMETRY

523 An objective test of [middle ear](#) function that provides information on the condition
524 and mobility of the tympanic membrane and ossicular chain by creating variations
525 of air pressure in the ear canal.
526

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