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# Aural Care Register

# BSHAA

**British Society for Hearing and Audiology**

# Contents

# Notes

Although care has been taken in preparing this information, BSHAA does not accept any responsibility for the way it may be interpreted or applied, or for any errors or omissions, and BSHAA accepts no liability whatsoever for any loss or damage from the use of this guidance, however it may arise.

The document is written for HCPC registered practitioners or those holding an officially recognised audiological qualification where aural care (wax removal) forms part of their scope of practice, those who work under their supervision and/or those who have successfully completed a BSHAA accredited aural care (wax management) training course, ensuring minimum training standards have been met.

This document is valid until superseded or withdrawn by BSHAA.

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# 1. Introduction

This document sets out what BSHAA believes to be the minimum standards needed to provide safe aural care (wax removal) for patients and to be a member of BSHAA`s aural care register. It is based on the evidence and consensus of good practice at the time of publication. It also sets out the Society`s vision of best practice and underpins the Society's requirements to join and remain on its Aural Care Register.

# 2. Scope

## 2.1. Scope of Practice

The Society adopts the HCPC definition of Scope of Practice[1] which is used to describe an activity where the practitioner holds the relevant skills, knowledge and experience to practise safely and legally.

**It is a pre-requisite of membership of the Aural Care Register that in addition to any wax removal training, practitioners have also completed training in**:

- Communication strategies for the hearing impaired;
- Aural examination (to identify routine/non-routine ears);
- Infection control;
- Onwards referral criteria and procedures.

## 2.2 Routine ears

This document is written as guidance for those working with routine ears as defined in BSA`s 2021 Aural Care (Ear Wax removal) Practice Guidance[2].

These practice guidelines therefore do not cover non-routine cases such as:

- Perforated ears;
- Post-surgery ears including provision of post-surgery care/treatment;
- Removal of foreign objects (other than hearing aid domes/wax filters);
- Treatment of medical conditions;
- Removal of discharge or debris caused by acute or chronic ear infections, or which arise from skin conditions such as eczema or psoriasis.

This list is not comprehensive and the Society accepts that some practitioners may have extended scope of practice which permits them to work with more specialist cases. Practitioners should only proceed with non-routine cases where they have the relevant skills, knowledge and experience to do so safely and an appropriate risk assessment has been carried out.

# 3. Aural Care Register Membership

## 3.1 Promotional use of Aural Care Register logo`s

On successfully joining BSHAA`s Aural Care Register and whilst remaining on that register, members will be entitled to use the BSHAA Aural Care Register Member logo for promotional purposes and details will also be displayed on our register.

For BSHAA accredited Aural Care courses, the use of the BSHAA Aural Care Register training logo is permitted for promotional purposes, so long as accreditation remains valid and details will also be promoted on our website.

## 3.2 Classes of membership

- HCPC registered Hearing Aid Dispenser or those holding an officially recognised audiological qualification (such as clinical scientist or audiologist) whose scope extends to wax management;
- Hearing Care Assistant or Practitioners whose primary duties are within audiology and whose scope of practice extends to wax management and who have appropriate supervision in place;
- Associate wax members who are not supervised but have successfully completed a BSHAA accredited wax removal course***#**.

***It is a mandatory requirement for membership of the Aural Care Register for associate wax members to have completed a 3-month reflective post-training process with their training provider. - The Society reserves the right to audit this (with their consent) and if consent to audit is not given the member will not be included in the Register.**

**#Any associates who have not completed an accredited course and commenced practice prior to the introduction of BSHAAs aural Care register must either do so; or provide reflective evidence of the previous 3-month`s practice and complete the BSHAA fitness to practice course before being inducted on to the register. BSHAA also reserves the right to carry out a supervisory clinical practice visit first.**

## 3.3 Supervision

The Society uses the term supervision to refer to a practitioner who may work autonomously but has the support of clinical and/or professional supervision of a HCPC registered HAD or a person holding an officially recognised audiological qualification.

The Society accepts that the frequency of ongoing supervision will change as experience increases. Therefore, no set requirements are laid out but as an example, the Society would expect a “glide path” typically ranging from weekly in the first month immediately following qualification through to quarterly for those with circa 12 -18 months of experience, and that those with 2+ years’ experience are able to function fully autonomously but with ad hoc supervision still available as and when needed.

The supervisee is required at all times to keep a record of dates and learning outcomes as a result of supervision and the Society may request to see these records. (Failure or refusal to provide records may result in the person being removed from the register.)

The Society has adopted a number of key points from the HCPC`s key characteristics of effective supervision in order to assist members[3]:

- Supervision should focus on sharing and enhancing knowledge and skills to support professional development and improve service delivery;
- Supervision should be regular and based on the needs of the individual, and ad hoc supervision should be available when needed or requested;
- Supervisory models should be based on the needs of the individual, such as one-to-one, group, internal, external or distance.

### 3.4 Continuing Membership requirements

- All HCA/practitioners whose primary duties are within audiology and have supervision (as defined in 3.3 above) are required to log their supervision sessions, reflectively through the CPDme app;
- All associate wax members without supervision are required to have completed a 3-month post-training, reflective period with their training course provider before eligibility to join the register is given and must continue to log monthly reflective CPD activity through CPDme;
- All associate wax members are also required to complete an annual fitness to practice course, covering clinical and professional practice - this will be delivered and administered at membership renewal point, online by BSHAA with a certificate issued on successful completion through CPDme;
- The Society reserves the right in all cases, to audit the above with consent. (If consent to audit is not given the member may be removed from the Register);

- Whilst full members may have their own regulatory body CPD requirements, BSHAA strongly advocates the use of CPDme (Premium version of which, is freely available to its members) as a way of recording/storing and being able to evidence this in line with those requirements.

# 4. Methods of ear wax removal

**Only the following wax removal methods are recognised as approved and therefore covered by this document:**

- Manual instrumentation such as curettes and forceps etc.;
- Irrigation (electronic only);
- Microsuction*****

**NB**. Whilst all the above methods are approved, the Society does not favour or recommend any one method over another but recognises that there may be times where one method may be more suitable than another. However, the **General Advice*** below should always be complied with.

Practitioners should only use the method(s) for which they hold relevant training for and should refer to another suitably qualified practitioner where the most appropriate method falls outside of their own scope of practice.

Therefore, practitioners should use their own professional judgement as to the most suitable method and must not advocate one method over another based on what they themselves can or cannot provide.

***General Advice**

**Microsuction is the preferred method for patients below the age of 18 years.**

**Whilst the anatomy of the EAM is considered to be fully developed at a young age, the ability of children to understand and co-operate with instructions, particularly the need to remain still and calm throughout any procedure can vary greatly.**

**Further training should always be undertaken before attempting to treat anyone under the age of 12 years, a further risk assessment should always be undertaken along with consideration as to the best interests of the patient, the experience of the practitioner and/or the ability of the patient to comply with instructions. In all cases, practitioners should use what they deem to be the safest method for individual cases and must have suitable insurance indemnity in place.**

**Practitioners are also reminded that the over-cleaning of ears can be counterproductive, altering the EAMs natural moisture and pH balance and as such, wax removal should only be carried out where and to a level of clinical necessity.**

**The Society does not support or recommend the use of:**

- Manual syringing;
- Self-irrigation;
- Hopi candles;
- any manual device used by the patient themselves

# 5. Professional Standards

## 5.1 Insurance

Practitioners must hold appropriate valid and current insurances needed in order to practise legally at all times.

## 5.2 Membership

A current BSHAA membership must be maintained in order to remain on the Society's Aural Care Register.

## 5.3 Fitness to Practise

- Practitioners must ensure that they are able to practise safely; sufficient visual ability and manual dexterity to undertake the procedure safely is always needed and where this changes or is impaired the Society should be notified promptly (even if the inability or lack of dexterity is regarded as temporary);

- The requirement above extends to the use of shared equipment: practitioners must be aware that they must not proceed without being able to see clearly what they are doing,; magnification/viewing equipment should have clean lenses, a good light source and should be set up to meet the practitioner's own requirements;

- Infection control prevention policies/protocol must be in place locally and always adhered to; failure to follow best practice for infection control will be considered a fitness to practise issue.

## 5.4 Equipment

**Conformity**

All equipment used must be fit for purpose and meet the relevant quality and safety specifications to allow confident examination and removal of wax (and/or foreign bodies).

Any device(s) used should comply with EU MDR must have obtained certification from a designated notified body. The CE label should be affixed to the device. Alternatively, the device should be compliant with UK MDR 2002, certified by an approved body and have the associated UKCA marked affixed to the label.

The Society does not encourage the use of non-medically certified or adapted equipment (otherwise referred to as "off label") and wherever this happens the patient must be informed in writing prior to any procedure commencing with said equipment.

**Maintenance**

All equipment must be maintained in accordance with manufacturers' recommendations, in the absence of any recommendation, practitioners should carry out their own regular, preventative maintenance checks to ensure proper functionality.

The procedure must not commence and if already underway, be abandoned immediately if it is suspected or identified that the equipment has developed a fault.

**Cleaning**

Equipment must be kept clean and in line with local infection control policy and manufacturers' recommendations.

Single use consumables must not be re-used and must be disposed of responsibly and in line with infection control policies.

All single use items must stay in any protective packaging until the point of use.

Disinfection of any re-usable equipment must be carried out carefully according to the manufacturer's recommendations.

## 5.5 Practice Environment

Aural care must be completed within a clinical setting whenever possible and in all cases must only be performed where there is sufficient lighting levels to allow the safe illumination of the equipment and the ear(s) being treated. This must be further supported by additional light sources as necessary to support the visualisation method being used.

For all wax removal methods, the environment must allow for effective infection control, including appropriate waste disposal facilities.

For irrigation there should be easy access to a sink with hot and cold water. If possible, contaminated water from the ear or water infused with decontamination agents should be disposed in a designated sluice.

The Society understands that there may sometimes be a need for the service to be provided in a domiciliary setting, where infection control and waste management may be more difficult to manage. In these circumstances an appropriate risk assessment must be completed on each occasion and treatment must not begin unless and until the practitioner is satisfied that the environment does not pose any undue risk to the patient or other persons in the setting (including the practitioner).

## 5.6 Hearing screening

Screening should not be seen and/or used as a substitute for calibrated audiometric testing, carried out by a suitably qualified professional. Consideration should always be given to temporary threshold shifts that can occur during aural care procedures and as such screening results alone should not be used to advise patients on their hearing needs or the suitability of any over the counter (OTC) hearing "aid" type/devices and/or personal amplifiers.

Where concerns over residual hearing exist, patients should always be referred to a suitably qualified professional such as a registered HAD or audiologist.

## 5.7 Consent

Practitioners must obtain informed consent for all aural care procedures that they carry out. The consent must be in writing, signed by the patient or their representative and kept on file with the patient's records. If the practitioner believes that the patient is unable to give informed consent the practitioner should decide whether the need to carry out the procedure without consent is in the patient's best interests, having regard to the urgency of the need for the treatment and the likely effects on the patient if the treatment is delayed or is given, including any discomfort or disadvantage the patient may suffer in either case.

The risks and benefits of the procedure must be clearly explained to the patient before treatment begins in order for the patient's consent to be considered "informed" and the patient must have capacity to give this. If a patient is unable to give informed consent the patient`s carer or a family member should be consulted as to whether the treatment is in the patient's best interests.

(The society has a template which can be replicated and freely used for this).

# 6 Onwards referral

**Practitioners must advise patients of the need for onward referral where:**

- The obstruction is a foreign body and the practitioner does not hold scope of practice for this;
- Foreign body is observed to be a battery and/or insect*;
- The method of removal best suited falls outside of the practitioner's scope of practice;
- The obstruction lies in an area of the EAM that the practitioner lacks confidence and experience to work within safely. (Particular care should be taken with Microsuction and close proximity to the Tympanic Membrane);

- The Society has also adopted certain "red flags" from the joint BAA/BSHAA onward referral guidance[4] used by HCPC registered hearing aid dispensers (RHADs) to provide guidance as to when all practitioners should make a referral to a suitably qualified healthcare professional in cases which have not been previously investigated by a suitable healthcare professional or have significantly changed since such investigation, including:

    a. Abnormal appearance of the eardrum and/or the outer ear such as:

        I. inflammation
        II. polyp formation
        III. perforated tympanic membrane
        IV. abnormal bony or skin growths
        V. swelling of the outer ear
        VI. blood in the ear canal

    b. Recurring or persistent pain affecting either ear which has lasted for more than seven days within the last 90 days prior to the consultation;
    c. *Patients who are immunocompromised, have a hearing loss with otalgia (earache) with otorrhoea (discharge from the ear) that has not responded to treatment within 72 hours.
    d. Discharge from the ear, other than wax, which has not resolved or is recurring.;

e. Persistent tinnitus that is either unilateral or pulsatile or has significantly changed in nature within the last 6 months or is causing distress;
f. Vertigo or dizziness that has not fully resolved or is recurrent;
g. *Facial numbness, weakness or paralysis that has not been investigated previously.;
h. Middle ear effusion not associated with an upper respiratory tract infection;
i. *Sudden onset of hearing loss or sudden deterioration in hearing. “Sudden” means occurring within the space of 3 days during the last 30 days where the hearing loss or deterioration is not attributed to wax occlusion and does not resolve immediately following removal of wax;
j. **If the sudden loss (less than 3 days) occurred more than 30 days ago;
k. **Rapid onset of hearing loss or rapid deterioration in hearing. “Rapid” means within the past 4 - 90 days and which is not attributed to wax occlusion and does not resolve immediately following removal of wax.

***Immediate referral - Should be referred immediately to be seen at emergency ENT (within 24Hrs) unless already being investigated by a medical professional.**

****Urgent referral - Should be referred to be seen by ENT (within 2 weeks) unless already being investigated by a medical professional.**

The society encourages the establishment of local referral pathways and inter-professional relationships – this is especially important where further audiometric assessment would be beneficial (RHAD for example) and where any direct referral pathway is not in place (ENT for example) this referral should go promptly via a GP, save for immediate referrals which should always be expedited through the quickest possible pathway (A&E for example).

**It is the practitioner’s own responsibility to ensure any referral made is to a suitably qualified professional, which may include but not limited to: RHAD, GP, A&E or urgent care ENT department.**

The Society provides a template for onward referral, which can be downloaded and replicated freely for use by members. BSHAA strongly advises that a copy of the referral is retained by the practitioner on file in accordance with any local GDPR requirements at the time.

If a patient declines an onward referral a written copy (ideally signed by the patient) should be kept on file stating the patient’s reason(s) for refusal together with a note by the practitioner that the consequences that may follow refusal of the referral have been explained to the patient, a note of whether the patient appeared to understand the explanation and any comments the patient made. A note should also be made if a patient refuses to sign a referral, together with any reasons the patient gives for not signing it.

# 7. Procedure Guidelines

## 7.1 Preparation

Wherever practicable, patients should be pre-examined prior to any treatment appointment, allowing the practitioner to decide on the need for any onward referral, necessity of any treatment, the appropriate method of removal and whether pre-softening of the wax is required.

It is important to note that where pre-examination is carried out by someone other than the intended practitioner the practitioner still has responsibility to assess the suitability of the ear(s) before any treatment begins and, in all cases, any person carrying out any pre-examination must be suitably trained to do so.

Where a pre-examination is not possible patients should be triaged remotely to ascertain any history of perforation, current or recent history of infection and past wax removal experience(s) before advising the use of any pre-softening treatment.

Suitable consideration must be given to the length of appointments. Whilst no procedure should ever be rushed, consideration must also be given to the patient's ability to remain still throughout the procedure and the length of time that they are exposed to noise: it is anticipated that a routine procedure should last no more than 15 minutes per ear.

**For all procedures**

Aural Care Register members must not perform wax removal on ears which are not routine as defined by this guidance document unless it is within their own extended scope of practice.

A case history should be taken and recorded, to ascertain the need for any onward referral in line with the criteria noted above (section 4.3) as well as any past history or suspected history of perforation and/or infection and surgery. If this case history is taken at any pre-examination, then the practitioner must ensure there have been no changes since.

The patient must be instructed to remain as still as possible and to keep the practitioner informed of any changes to their comfort. The practitioner must regularly ensure the comfort of the patient both visually and/or verbally.

The practitioner must be seated during the procedure; the patient may be either lying on a raised couch or sitting upright on a stable chair.

The straightening of the ear canal by gently pulling the pinna backwards and upwards can improve the line of sight and appropriate magnification and/or illumination should be used at all times.

Magnification and/or illumination may be provided in various forms such as headlights & loupes, endoscopes, video otoscopes and/or operating microscopes – whilst the society has no preference on the visualisation method used, practitioners should be particularly mindful that some forms of visualisation offer greater field of vision and depth perception and as such are more suited to more complex cases*.

A safe bracing technique must always be adopted by the practitioner, where it is safe and practicable to do so.

Practitioners are reminded that patients who take anticoagulant medicines may be at more risk of abrasion, bruising and bleeding if any wax removal instruments come into contact with the skin or if any removed wax tears the skin. **(Proceed with caution).**

Ear wax may remain adhered to the ear canal walls if the softening preparation has only penetrated the outermost layers of the ear wax obstruction.

**The procedure must be abandoned in every case if the patient reports the procedure to be painful, if the ear wax remains too solid to move, if the usual procedure time has been significantly prolonged or if a routine ear becomes non-routine and is beyond the scope of practice of the practitioner*.**

***Appropriate onward referral must be made where this occurs.**

## 7.2 Manual instrumentation

Use of hand-held fine instruments such as loops, curettes and forceps.

Any instrumentation must be directly applied to the wax itself, avoiding contact of the working end of the instrument with the canal wall.

**Close proximity and contact with the eardrum should be avoided at all times and special consideration must be given to the patient's ability to remain still whilst working with instruments**.

## 7.3 Irrigation (electronically controlled)

The water temperature should be carefully monitored to mitigate against the risk of dizziness. The water should be at body temperature (37° C) with a variation of +/- less than 1°C.
Care must be taken if the patient has an irritable cough as irrigation may trigger or exacerbate it due to the cough reflex.

Care must be taken to keep the water pressure regulated to prevent discomfort or trauma. Pressure control varies between devices and practitioners should be familiar with the device they use before any procedure commences.

**Practitioners should be especially mindful of possible calorific effects on existing troublesome vertigo.**

**Efforts must be made to minimise the time taken to complete the procedure so as to reduce the length of exposure to noise, thereby reducing the risk of triggering/exacerbating tinnitus and/or a temporary threshold shift.**

**Furthermore, practitioners must be aware of the increased risk of infection when carrying out irrigation. Where the skin of the EAM is already traumatised due to abrasions, cuts, bruising, inflammation or infection, or where skin conditions such as otitis externa are currently in their active state (e.g., causing pain, swelling, irritation or discharge) the risk may be increased, and therefore these are all contra-indications to the procedure.**

## 7.4 Microsuction

A suction device should be used to extract the ear wax from the ear canal.

The working end of the suction instrument must be applied directly to the ear wax itself.

This method should only be used to remove ear wax which is within a clear line of sight and of a consistency which is soft enough to extract without causing disruption to the ear structures or discomfort to the patient.

**Close proximity to and contact with the eardrum should be avoided at all times and efforts should be made to minimise the time taken to complete the procedure so as to reduce the length of exposure to noise, thereby reducing the risk of triggering/exacerbating tinnitus and/or a temporary threshold shift.**

## 7.5 Specialist Care

The Society acknowledges that some practitioners will hold an extended scope of practice, allowing them to work with non-routine ears and non-routine cases safely and legally. This is beyond the scope of this guidance document and therefore practitioners are reminded that in each and every one of these cases they must make their own clinical judgement on the correct course of treatment and/or onward referral.

# 8 Contra-indications

The chart below is Reproduced by kind permission of the British Society of Audiology from their "BSA (2021) Practice Guidance - Aural Care (Ear Wax Removal)"[3] to give an overview of contraindications for ear wax removal using manual instruments, water irrigation or suction. The Society recommends that these contra-indications are followed at all times.

† indicates a contraindication to irrigation according to NICE.
* indicates that irrigation can be undertaken with caution according to NICE (NICE 2018, NG98)

| **Condition:** | **Method this condition contra-indicates:** | **Condition not present or reported Proceed with aural care** | **Condition is present or reported Do not Proceed** (Refer for medical advice and/or to other services for aural care) | **Further risk assessment required** (see section below relating to this) |
|---|---|---|---|---|
| Presence of a foreign object † | All | | | |
| Ear surgery (unless isolated to the pinna and in which case must not be within last 90 days) † | All | | | |
| Middle ear infection (current or within last 6 weeks) † | All | | | |
| Outer ear infection - current | All | | | |
| Outer ear infection – recurrent history* | N/A | NB: Irrigate with caution or use other method if available | | |
| Acute otitis externa plus oedematous ear canal and painful pinna † | All | | | |
| A mucus discharge from the ear (within last 12 months) † | All | | | |
| Current active eczema or psoriasis (e.g. currently causing pain, swelling, irritation or discharge) | All | | | |
| Abrasions or inflammation of the ear canal (current or within the last 90 days) | All | | | |
| Abnormal bony or skin growths, including polyps | All | | | |
| Significant ear pain (current or within last 90 days) considered to be unrelated to the build-up of | All | | | |
| Communicable blood or skin condition/infection such as Hepatitis B, MRSA. | All | | | |
| Communicable respiratory infection such as COVID-19 or tuberculosis (TB) | All | | | |
| Cleft palate even if repaired † | Irrigation | | | |
| Perforations or recently healed perforations (current or within the last 90 days) † | Irrigation<br>Suction | | | |
| Grommet (currently in situ or within last 90 days) † | Irrigation<br>Suction | | | |
| Troublesome vertigo (current or recurrent history) * | Irrigation<br>Suction | | | |
| Troublesome tinnitus affected by noise exposure * | Irrigation<br>Suction | | | |
| Hearing in only one ear if it is the ear to be treated (remote chance that treatment could cause permanent deafness) † | Irrigation<br>Suction | | | |

| | | | | |
|---|---|---|---|---|
| Confusion, agitation, inability to cooperate † | All | | | |
| | | | | |
| **If the following conditions are present/reported, a further risk assessment is required:** | **Conditions affected** | | | **Decision after further risk assessment:** e.g., proceed or refer for medical advice and/or to other services for aural care |
| History of any previous complications from wax removal procedures (e.g. pain, perforation, severe vertigo, appearance of new tinnitus, or a permanent worsening of existing tinnitus, or other) ) † | All | | | |
| Poor head and neck control (unable to hold head in a stable position when sat or lying down) | All | | | |
| Current neck pain | All | | | |
| Dry, tickly or irritable throat | All | | | |
| Diabetes † | All | | | |
| Immunocompromised state † | | | | |
| Anticoagulant or blood thinning medication such as warfarin, heparin, clopidogrel, dabigatran, rivaroxaban and apixaban | All | | | |
| Any condition which prevents or slows down the clotting of blood such as Haemophilia | All | | | |
| Head or neck radiotherapy | All | | | |
| High or low blood pressure unless effectively regulated by medication | All | | | |

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## 9. Risks

For any conditions above where indication is given that a further risk assessment is required (section 6), it may be possible to proceed based on the clinical judgement of the practitioner.

This judgement should be self-assessed but must include consideration of the environment, equipment, training, competence and experience of the practitioner.

Any additional risk will be discussed with the individual requiring wax removal in order to obtain further consent to proceed. (If the patient is unable to give consent the notes above about acting in the patient's best interests apply.)

Practitioners must not proceed with aural care if they are in any way unsure about the procedure being safe for the individual that they are considering it for.

**There is an inherent risk attached to all procedures and therefore wax removal should only be carried out where clinically needed.**

The following list of risks is not exhaustive but should be included in any consent form signed (section 5.7), together with any risks in the individual case identified by the practitioner, prior to treatment commencing.

| Uncommon | Rare | Extremely rare |
|---|---|---|
| Discomfort/pain | Feeling sick or light-headed | Permanent hearing loss |
| Damage to skin of the ear canal | Temporary dizziness | Triggering of new tinnitus |
| Bleeding from ear canal | | Damage to the eardrum |
| Ear infection | | |
| Temporary reduction in hearing | | |
| Temporary hearing sensitivity | | |
| Temporary aggravation of existing tinnitus | | |

**Risks can be minimised by the pre-softening of wax, minimising the length of exposure to noise, minimising/restricting the depth of insertion of any instrumentation and the adherence to infection control policies.**

## 10. Aftercare

Patients must be provided a document advising them to notify the practitioner and report immediately to their GP if pain, swelling, discharge/odour, or disruption to their hearing is experienced following any procedure.

The above can form part of the consent form (section 5.7) and is part of the Society`s template for consent.

If the patient reports back to the aural care practitioner and not their GP, the practitioner must advise/examine as appropriate and provide an appropriate onward referral as soon as possible.

Good post-procedure care such as keeping ears clean and dry in the days immediately following wax removal must always be encouraged.

## 11. References

HCPC Identifying your current scope of practice | (hcpc-uk.org) [accessed 03/07/2023]

BRITISH SOCIETY OF AUDIOLOGY (2021), Aural Care (Ear Wax Removal). [accessed 03/07/2023]

HCPC Key characteristics of effective supervision | (hcpc-uk.org) [accessed 03/07/2023]

BAA/BSHAA Onward-Referral-Guidance-for-Adult-Audiology-Service-Users [accessed 09/07/2023]

NICE NG98 [accessed 09/07/2023]