RN Protocol: Eye Injury/Irritation

I. POLICY

A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients presenting with common eye injuries/irritation.

B. Circumstances under which the RN may perform the function:
   1. Setting: Outpatient clinic.
   2. Supervision: No direct supervision required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients presenting with common eye injuries/irritation including (1) blunt injury or contusion to the eye; (2) chemical burns to the eye i.e., bleach, ammonia, etc.; (3) penetrating eye injuries; (4) foreign bodies on the conjunctiva; (5) eyelid lacerations; (6) hordeolum; and (7) red, irritated eyes. A hordeolum (also known as a stye) is a localized infection of a sebaceous gland along the margin of the eyelid. Symptoms include a painful erythematous swelling at the margin of the eyelid, with no visual disturbances. Purulent drainage may be observed along the eyelid margin. *Staphylococcus aureus* is the infectious agent in 90-95% of the cases. Hordeola may spontaneously resolve or progress to chronic granulation with formation of a painless mass.

B. Subjective:
   1. Chief complaint (document in the patient's own words).
   2. Which eye is affected (left, right, both)?
   3. Date and time of onset.
   4. Assess for foreign body sensation and photophobia.
   5. Assess for pain and rate on a scale of 0-10 (0=no pain 10=worst pain).
   6. What makes the pain better? What makes the pain worse?
   7. Assess for sinus pain
   8. Assess for accompanying symptoms such as nausea and vomiting.
   8. History of seasonal allergies, sinusitis, conjunctivitis, corneal foreign body, chemical exposure (for chemical exposure be sure to identify the name of the chemical).
   9. Past medical history (e.g., glaucoma, diabetes, previous eye problems).
   10. Allergies
   11. Current medications

C. Objective
   1. Vital signs.
   2. Test visual acuity (with corrective lens if normally used) using Snellen's eye chart. Test each eye separately. If vision is extremely blurred assess visual acuity in terms of ability to count fingers, perceive hand movements, or detect light. (Notify

physician of any changes in sensory/perception, or visual acuity). **NOTE: For chemical burns irrigate eye IMMEDIATELY. Then test visual acuity.**

3. Assess eyelash line and surface of eyelid for nodules, erythema, and edema. Assess conjunctiva for erythema, bleeding, discharge (describe), bruising, profuse tearing, and foreign body.
4. Assess cornea for clarity, injury, and foreign body. Note any photophobia on examination.
5. Assess anterior chamber for blood or other fluid.
6. Assess pupil for roundness, reactivity to light, and symmetry with contralateral pupil.
7. Assess for sinus pain

D. Assessment:
- Impaired tissue integrity evidenced by/related to:
- Alteration in sensory/perception, visual, evidenced by/related to:

E. Plan:

FOR PHOTOPHOBIA, CHANGE IN VISUAL ACUITY, DIPLOPIA, DYSCONJUGATE GAZE, IRREGULARITY OR ASYMMETRY OF THE PUPIL, LIMITATION OF EYE MOVEMENT, BLOOD OR CLOUDY FLUID IN THE ANTERIOR CHAMBER, EVIDENCE OF CORNEAL INJURY OR FOREIGN BODY REFER PATIENT TO A PHYSICIAN STAT FOR IMMEDIATE EVALUATION.

1. **Blunt injury or contusion**
   a. Notify physician **STAT**.
   b. Keep the patient in an upright position.
   c. Protect the affected eye with a shield until physician examines the patient. **DO NOT APPLY COMPRESSES OR PATCH.**

2. **Chemical burns (bleach, ammonia, etc.)**
   a. Immediately irrigate the affected eye with two liters of sterile normal saline or water for at least 15 minutes. May instill 2 drops of topical anesthetic (such as Proparicaine 0.5% Opth. Soln.) if necessary to relieve pain and facilitate irrigation. Avoid self-contamination with the chemical.
   b. Assess visual acuity.
   c. If symptoms persist following irrigation, **or** there is a change in visual acuity, **or** a topical anesthetic was used, refer patient to a physician for evaluation before discharging from treatment.

3. **Foreign bodies**

   IF FOREIGN BODY APPEARS ON THE CORNEA OR PENETRATES THE GLOBE DO NOT ATTEMPT TO REMOVE. INSTEAD NOTIFY PHYSICIAN STAT.

   a. If foreign body is not seen on the conjunctiva invert upper eyelid using a sterile cotton-tipped applicator to check for foreign body. Gently irrigate eye with Sodium Chloride Irrigation Solution (0.9%) to dislodge foreign body.

b. If sensation of foreign body persists attempt to remove with a sterile moistened cotton-tipped applicator.
c. If no foreign body can be seen, but patient complains that sensation of foreign body persists refer patient a physician **STAT.**

4. **Perforating or penetrating injuries to the eyeball**
   a. Notify physician **STAT**.
   b. **DO NOT** attempt to remove the object or irrigate the eye. Protect affected eye with a firm shield until physician examines the patient.

5. **Eyelid laceration**
   a. Notify the physician **STAT**.
   b. Gently cleanse laceration with sterile saline-soaked gauze.
   c. Cover laceration with saline-soaked sterile gauze to prevent wound from drying out.
   d. Administer tetanus prophylaxis per Tetanus Immunization Guidelines if indicated.

6. **Hordeolum**
   a. Instruct patient to apply warm compresses to affected eye for 15 minutes QID.
   b. Instruct the patient to return to clinic in 3 days if there is no improvement.

7. **Red, irritated eyes**
   a. If red, irritated eye is the result of a superficial conjunctival foreign body that has been removed, no further intervention is indicated.
   b. If the red, irritated eye is related to seasonal allergies, or if the patient has had similar symptoms in the past that were relieved with allergy drops, administer Naphcon A (pheniramine/naphazoline) Ophthalmic Solution 0.025% 1-2 gtts to affected eye Q3-4hrs PRN pain while symptoms persist
   c. All other complaints concerning red, irritated eyes shall be referred to a physician on a **STAT, Urgent**, or **Routine** basis as indicated.

F. Patient Education:
   1. Assess patient's potential for understanding the health information to be provided.
   2. Provide patient education consistent with the assessment of the condition.
   3. Evaluate the patient's level of understanding and document all patient education on the encounter form or progress note.
   4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.

G. Documentation:
   All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with common eye injuries/irritation and achieve a minimum score of 80% on the written post-test examination.
B. Experience: None.
C. Certification: None.
D. Initial Evaluation: Initial competency will be validated onsite through simulated exercises, mock scenarios, and return demonstrations. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform this protocol independently.

   A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

E. Ongoing Evaluation: Ongoing competency will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE _____ REVISION DATE _____
_____ _____
_____ _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

_____ DATE: _____
Chief Nurse Executive/Director of Nursing

_____ DATE: _____
Chief Medical Executive