



# EYE OPENER

EDITOR: HEATHER MACHIN

VOLUME 7, ISSUE 1

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## THOUGHTS OF WEST AFRICA

HELEN WALKER RN,EM,RIN,OND

*How do the Benin people manage to live, with vision of often only perception of light? What makes them stand apart from Western culture? How can they, with so little, still live each day so uncomplainingly?*



These are the thoughts that occupy my mind when I think of my three month's volunteer ophthalmic work on board the Mercy Ship the Anastasis from November 2004.

By 'volunteer', I mean that each of the 350 crew on board this converted 50 year old ocean liner paid their own return air ticket, and \$16.60 a day for crew fees which covered board and lodging (less if you stayed longer than 6 months). There were 35 different nationalities on board, doing work on board and off ship, and working in trades and professions both medical and non-medical. I chose ophthalmic nursing, and updated my knowledge and skills at the Royal Brisbane Hospital beforehand, as it was many years since my diploma, and my current position is as a generalist nurse at Maleny Hospital.

At the general screening in November by Mercy Ships volunteers, over five thousand Beninese people had flocked to the stadium at Cotonou, the port at this tiny French-speaking state in West Africa. They had heard about this free health service via word of mouth, radio, and through the Ministry of Health with which this non-profit aid organisation

of Mercy Ships liaises.

We needed security police to keep the lines in some semblance of a straight line so my Jamaican nursing colleague Donna and I could assess their eyes, one by one. Even so, the queue did a colourful conga-line in the searing equatorial heat and humidity. But did they complain? Not a bit. We provided water to them, and the main focus was to bring compassion and expertise to these 7.25 million Africans who have basically one ophthalmologist for their needs for an area of 700km by 125km. This is one of the poorest countries in West Africa, and so their need was great.

The job of Donna and I was to allow into the stadium only the eye patients who would be further assessed for potential surgery. This was a heart-breaking task, as there was so much need, and so few theatre places. So many we had to turn away! Mercy Ships, based on Christian principles, had a prayer station to help to ameliorate their feeling of loss in rejection.

Outside, the only assessment tool we had was a pencil torch. Even in the bright sunlight, the dense cataracts stood out

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### LETTER FROM THE EDITOR- Heather Machin

My foot is jittering madly, I can't sit still and I haven't passed a shred of food through my mouth in hours. Yes, it's newsletter time and like a person with obsessive compulsive disorder, I just can't seem to pull myself away from the computer.

I'm rather excited as I have just completed a computer course in Adobe InDesign CS2 through a company called Odyssey training.

'What does this have to do with ophthalmic nursing?' I hear you say. Well nothing really, apart from the immense joy of learning outside of ones comfort zone.

I felt like a fish out of water, surrounded by print, media, web and production design folk. Even so, I couldn't help

but think how pivotal Eyeopener and similar health promotion material are to so many.

I felt proud to sit in a room and announce that I was an Ophthalmic Nurse and my intent was to aid my co-workers and AONA members with their print-education needs.

I guess where I am going with my garbled mumbo-jumbo, is that sometimes we have to go the extra mile, find a different niche or listen to what we really want.

My non-clinical course maybe considered unimportant to others within the profession, but at the end of the day we must all help each other in our own areas of strength.

Your speciality might be your friendly smile and compassionate approach

to patient care, or your passion may be with infection control and wriggling bugs in a petri dish.

Find your niche, passion or creative flare and use it to support and promote your profession from within.

As for me, despite some hunger pains, I am going to experiment with my new computer program until you are all tired of dropped shadows, ellipse tools or wingding fonts.

See you and your friendly smile at the clinical meet on Saturday the 11th.

*Heather Machin*  
Editor and <sup>obsessed</sup>  
COMPUTER NERD

## RENEW YOUR AONA(QLD) MEMBERSHIP TODAY

**R**enew your membership and stay up to date with the fantastic world of Ophthalmic Nursing. Advance your skills by attending clinical meetings and workshops. Receive your own quarterly issue of Eyeopener magazine, as well as remaining eligible for education grants and belonging to a network spanning the breadth of Australia.

**Annual fee only—\$40**

We also welcome new non-nurse members to the Association who are keen to learn about the world of ophthalmics. Membership renewal form available via [www.aona.org.au](http://www.aona.org.au)

## PRE-OPERATIVE NURSING ASSESSMENT OF OPHTHALMIC PATIENTS BY TELEPHONE

Walker Gwyneth  
RGN.OND

***Assessing patients by telephone requires that nurses have a high level of skill and knowledge. It is a task that is often undervalued and its importance underestimated. "Assessment of patients is a fundamental skill that all nurses need to acquire in order to deliver effective patient care". (Stollery 1997) This is generally the first point of contact with the day surgery so the nurse must convey accurate and relevant information in order to gain patient confidence.***

### BACKGROUND

Conventionally nurses assess patients within an in-patient setting. The assessment can be continually revised throughout the patient's stay. According to Stollery (1997) interaction between two people involves verbal and non-verbal components of communication. In this situation posture, body movement, facial expression and eye contact express individual attention to the patient. Information gathered from visual observation gives an overall impression of the patient's general state of health and well-being.

The components of non-verbal communication and visual observation are absent with telephone nursing assessment.

### AIMS AND OBJECTIVES

The aim of a pre-operative telephone assessment is to ensure a smooth and problem free passage through day surgery. Identifying potential problems will avoid unnecessary delays, cancellation and referral to other specialists.

It is suggested by Goldblum (1992) that day surgery patients require a vast amount of pre and postoperative information if they are to perform self-care, which achieves the desired health outcome. "Nurses who care for these

patients have to be organised, creative and knowledgeable to provide patients with appropriate information to help them through what can be a very confusing or stressful time." (Goldblum, 1992).

### FRAMEWORK FOR ASSESSMENT

The document used for recording data should form an outline of questions for the nurse to follow. "Documentation is a time-consuming but vital component of patient care. As health care providers function under increasing time constraints, well-designed forms can help simplify and improve the documentation process".

(Powers, Gillett and Goldblum, 2000)

A well-designed form reduces the risk of omitting critical facts, such as major allergies or anaesthetic risks.

Maintaining patient confidence is crucial, so a return phone call for missed details must be avoided.

A carefully constructed document reflecting the uniqueness of the day surgery is a valuable tool for the nurse who is new to assessing patients via the telephone.

### PREPARATION

Prior to contacting the patient, it is prudent that the nurse gathers important information, such as previous admission, next of kin, patient's age and occupation. The nurse should have knowledge of the planned procedure, anaesthetic type and the particular preferences of the surgeon and anaesthetist.

An assessment from the patient's general practitioner is a luxury afforded in some day surgery settings.

Adequate preparation will reduce the possibility of embarrassment by, for instance, having no awareness of a problem encountered on a previous admission or asking to speak with Jack who is a two year old.

### BUILDING A RELATIONSHIP

A warm, professional introduction is important. Revealing personal and professional identity immediately prevents an awkward response.

Generally the patient is awaiting the call and is happy to receive it.

The public, it appears, bestow a unique level of trust to nurses, allowing them to ask exceptionally personal and invasive questions. To build a relationship from this

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trust, the nurse must use tone and pitch in the voice to convey kindness and friendliness and a genuine interest in the patient. Many situations are a challenge to the nurse, such as raising the voice to a hearing impaired patient or the frustration of a language barrier. Occasionally both patient and spouse are on the line sharing information, but in turn create a confusing dialogue. Finally it may be necessary to draw in another family member to alleviate stress on the part of the patient.

As stated by (Stollery, 1997) "Verbal communication involves asking open and closed questions", however, "As time is of the essence it is tempting for nurses to use closed questions".

The use of a combination of the two is appropriate and will result in an effective assessment." (Stolley, 1997) Commonly patients are keen to know their admission time, what they should bring and how they should dress. Conveying these points foremost allow the patient to focus on other details.

The dialogue should be unhurried with adequate spaces for an exchange of questions and answers. It is acknowledged by Strong (in Rose et al, 1999) "that it is essential that patient's suitability is assessed, including factors such as limited mobility, general health, vision in the fellow eye, social circumstances and transport and distance from the hospital or day surgery".

The nurse should be mindful of the admission criteria set down by the day surgery. If for example, going home alone is inadmissible, then the nurse must explain the rationale to the patient and explore ways to resolve the problem. "Even when patients appear to be suitable for day-surgery, however, it must be remembered that the onus of early postoperative management is being transferred from hospital professionals to patients and their family". (Rose et al, 1999)

## CONCLUSION

The ophthalmic nurse is no stranger to communicating under difficult circumstances in caring for visually impaired patients. However (Stollery, 1999, states that as one can never assume what a visually impaired person can or cannot see, non-verbal communication is very important.

Voice and expression are the main tools for evaluation when using the telephone for nursing assessment. The task clearly demands that the nurse must develop new skills in practice to become proficient in this growing facet of patient care.

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AONA(QLD) would like to thank Gwyneth for her contribution to this issue of EYEOPENER. As the newsletter's previous Editor (2000-2003) Gwyneth who works at the Queensland Eye Centre, is familiar with writing and research. We welcome her back to her first issue since her editorial days, and hope the thirst sparks off many more articles.

Send your article to AONA(Q): [www.aona.org.au](http://www.aona.org.au)

## CONFERENCES and EVENTS

### 2006:

#### MAY:

24th-27th. The 12th ACORN Conference.  
Canberra, ACT. [www.acorn.org.au](http://www.acorn.org.au)

#### SEPTEMBER:

9th-13th. European Society Ophthalmic Nurses &  
Technicians. Congress. London, UK.  
[www.esont.org](http://www.esont.org)

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## EMPLOYMENT OPPORTUNITY

### CITY EYE CENTRE

Registered Nurse  
with passion for EYES  
Part-time/ 2-3 days

We are a busy sub-specialist Ophthalmology practice with two principle doctors, located in Brisbane city. We are seeking a Registered Nurse with a passion for EYES to join our team.

#### POSITION DESCRIPTION:

Duties would include medical and ocular patient assessment and computerised history screening, eye testing and assisting doctors with procedures.

#### CANDIDATE:

As the centre conducts procedures such as Fluorescein Angiograms and Photodynamic Therapy (PDT) for age-related Macular Degeneration, it would be expected that candidates have the knowledge or are willing to be trained in intravenous cannulation/phlebotomy.

Up-to date nursing skills and experience in the above areas would be an advantage.

#### EMPLOYMENT BENEFITS:

No weekend work, flexible hours and good work conditions within supportive clinical environment.

For inquires and application email current resume to-  
Kathleen Dominick Practice Manager via  
[k.dominick@cityeye.com.au](mailto:k.dominick@cityeye.com.au)  
Phone- (07) 3831 6888 Fax- (07) 3831 5883

AONA QUEENSLAND  
CLINICAL WORKSHOP

## ***INFECTION CONTROL***

for

OPHTHALMIC NURSES

***Saturday 11th*** February

8:30<sup>am</sup> to 11:30<sup>am</sup>

*morning tea provided*

QUEENSLAND EYE CENTRE  
Leichhardt Court  
55 Little Edward St  
Spring Hill  
Brisbane

RSVP

Carmen Newman (Hon. Secretary)  
via [carmen.newman@qldeye.com](mailto:carmen.newman@qldeye.com)  
or  
(07) 3236-9844

*new members welcome to attend*

## EYEOPENER NEXT ISSUE

The deadline for the May issue of Eyeopener is  
14th April 2006.

Please forward all articles, letters of interest  
or requested material by this date.  
Thankyou-*Heather Machin* Editor

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like ‘alien’ eyes. Next, the people went inside to a darkened area of the stadium where other crew members tested for pupillary reflex. If they passed this test, I tested their VA, taking particular care to get it right, and using pinhole where necessary – this reading, plus tonometry via a hand-held tonopen, was vital for the next step of the ophthalmic review by the surgeon and the decision for surgery. History and vital signs were taken. Many patients had no idea of their age.

Keep in mind that this is a French-speaking country, and my brush-up of schoolgirl French did not prepare me for conversations. Our two translators were invaluable, and we developed a close working relationship with them. Even then, the literacy rate was so low (51% for men and 25% for women) that many spoke dialects. So that was more words to learn, for it is important that I greet each patient in their own language if possible. You should have seen the surprised look on their faces when they heard their dialect language uttered by a white lady! Some thought that if they presented the worst case scenario, they would get the treasured card which secured surgery. We had to keep our wits about us, for the last thing we wanted was for unnecessary people to occupy theatre places that more needy people could have used. Quite a few slipped by the net at the first mass screening. The next one a month later, purely ophthalmic screening with Donna and I, had greater visual success with the couple of dozen candidates chosen out of 150 people seen.

Overall, we operated on 273 patients, mainly cataracts, but also strabismus and enucleation. Children and younger people had priority, and we did both eyes at a 6 week gap for them. Blind adults were the majority of cases, and only one eye each patient was done due to sheer numbers of people.

We didn’t do corneal grafting (a sister ship the Caribbean Mercy does this) as the follow-up was the problem for our outreach in Benin. But there was so many that presented with scarred corneas, often the result of shamans of the animist religion dishing out eye potions that may have been corrosive.

So many Beninese people work in the



hot equatorial sun that their skin is dry and leathery. The staff on the 44 bed ward, and anaesthetists, commented how sometimes they would have to make a nick in the skin to prepare to cannulate. Many adult patients have hypertension as the norm! But then, they don’t have running water as we do, and street vendors (‘sellers’) sell half litre plastic bags of water – you see the evidence on the street. There were so many ‘brick-like” cataracts!

The surgeon had the final say regarding suitability for surgery. They saw the patients when they presented for pre-op assessment the day before and would see the post-operative ophthalmic inpatients and any they were concerned about. Data was collated for them of VA’s pre and post op, and I included any reasons for abnormalities. This proved valuable research information, which showed the majority having vision successfully restored.

We did the pre-op bursts of drops in the nearby eye room (Cyclopentolate, Phenylephrine, Tropicamide, and Amethocaine). The anaesthetist cannulated on arrival to theatre, and the surgeon did the retrobulbar eye block. Each case took about half an hour, depending on the complexity. As the only pre-op measurements were with a Keratometer and A scan, we often could not assess the fundus through the extremely dense cataracts. Consequently there were occasions of retinal and vitreous problems only evident after removal of the cataracts, and their prognosis was poor at HM. This was evident mainly with the first screening, not our more selective one later where we ensured pupillary reflex was definitely present.

I didn’t work in theatre, but had a chance to observe. The majority of the supplies were donated, and loaded onto the ship in Germany before it arrived at Benin. It was interesting to see a porthole in the operating theatre! Sterilizing was done in a small area near the three operating theatres. The standard operating equipment was in good working order for the surgeons and theatre staff. They also used a simple device for suctioning and irrigating. Just before an ordinary IV giving set meets the cannula, a thin extension tubing extends to where a 2ml syringe is attached. The 500ml Balanced Salt solution hung from a hook on the ceiling can then be used to flush out remaining pieces of lens matter, and also the Cellugel that was protecting the corneal endothelium. Ingenious, and simple!

Our volunteer ophthalmic surgeons from USA and UK had to abandon their usual techniques of phaco, and concentrate on ECCE, in the main. These surgeons would come for two week’s stints

I think of my patient’s resilience. They have a ‘can-do’ attitude, and do not complain. Pascal was such an example. This elderly man had dense cataracts with ‘perception of light’ only, bilaterally. He and his wife could not get past the more sighted people at the first screening in November, so came again at the one a month later. This time he came alone, asking the taxi driver to drive him the 5 hour journey and drop him off at the ‘big white ship’. He was well dressed, with a quiet dignity about him. He poured sweat at the anxious emotion of being led up the gangway, along the corridors inside, up and down stairs to the eye examination room – and all by staff who were total strangers and in a strange environment. Our translator spoke his language to guide his steps. We found a bed for him on the ward for the day pre-op and also post-op. He could not be a day case, as there are no motels in Cotonou for him! This man had anticipated that, after surgery, he would be able to see to make his own way back home - and that’s exactly what happened. I watched for the African elation when he realised he could now see 6/18, but there was just a slight smile. He had had quiet confidence that it would work out.

The eye unit on dockside consisted

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of an air conditioned 'half a container'. It had a slit lamp, Keratometer, and A scan on the bench, with room for our patient's charts below it. To the side of the sink was a set of drawers which held our stock supplies. This comprised the take-home packs for our patients – a bum bag that had cotton wool balls, Tobradex eye drops, sunglasses, eye shield, micropore, and instructions in French that explained minute details of washing hands and how to use cooled boiled water in a clean container etc. The post-op instructions were similar to the West, but included time frames for when they could carry loads on their head – the most common way of transporting anything. A calico bag with soap and a towel was also given.

A medicine cupboard on the wall contained our eye drops and medications – this we stocked with supplies from our pharmacy on board ship. There were plastic seats outside this unit and covered with an awning to protect from the blazing heat. Fresh cool water was available for the patients.

To test visual acuity, it was necessary to open the door and pace 6 metres out into the heat and humidity with my Snellen's chart. The difference in temperature meant my glasses fogged up, and I had to rely on my translator Steves to call out to me what the patient was indicating! A vast majority of patients had to point to a card with letters, for the literacy rate was so low. This made it a challenge when the pin hole was used, for then I had to ask them to draw the letter in the air. The patients that we chose for surgery had VAs of '6/60' or worse.

Intraocular pressures were sometimes elevated on day one post-op, and we had a regime worked out for management. This varied from Timolol drops and reassess shortly; to oral Diamox; to occasional paracentesis by the surgeon. Review intervals were adjusted accordingly. Some lived many days' walk away, so couldn't re-present within another day or so. Even the 'one week review' proved impractical with those



Helen Walker  
and happy  
patient

from vast distances away.

Any concerns I had that required liaison with the surgeon were dealt with by either escorting the patient into the ship to await review between theatre cases, or I would have a word with him from the theatre door.

It happened on a few occasions that there were complications of iris prolapse or hyphaema on the one week review when the ophthalmologist had already flown out of the country. Then we urged the patient to go to the ophthalmologist in Cotonou. We had seen this doctor often, for he keenly took time out from his ophthalmic practice at the Ministry of Health to work along side our Western surgeons at times. Our patients were reluctant, for they have no money and the culture is 'money first', but they did go.

But the successes far outweighed any problems! I think of Marguerite, a 38 year old mother of young children, with 'hand movements' bilaterally. She had to be led about, and a simple manoeuvre such as stepping up into the dockside unit was full of hesitancy and shuffling. During the time in Benin, she had both dense cataracts removed. The day after her first surgery, she was reluctant to open her eye. When I cleaned away the ointment, and gently lifted her upper lid, she then grinned so widely, and shouted out, "bleu!" She could see that the photographer Scott had a blue shirt on, and she was amazed that she could see it, and it was so vivid. There was clapping and dancing and such happiness. When I asked her what the cataract surgery has meant for her, she said that she can now see her daughters!

While there, I learnt to use the

Keratometer and A scan, and to be more familiar with the slit lamp. I now use the slit lamp skills while on relief placements at hospitals out west with Queensland Health. I have found that the AONA clinical breakfast slit lamp skills were useful for me.

Realising that education would be required for incoming nurses once I left the ship, I compiled protocols on the pertinent areas. This was put to good use when we asked another nurse to help Donna and I in the eye room (Donna and I had been doing full-on 12 hour days, plus Saturday mornings). She was keen, but knew very little about eyes, so she found confidence in following the instructions step by step.

An Australian nurse educator, who was upgrading the standard of the Beninese nursing students, was able to refer to another protocol which outlined ophthalmic emergency patients for their hospital. A third one I did would streamline management for my replacement working in the dockside unit. The last protocol was visual acuity testing. I also enjoyed collating the data for the surgeons and Mercy Ships, and was attending to this daily up until my last day there in February 2005.

These West African people look positively on life, have close family and community connections and have dignity and resilience. I enjoyed being invited to their homes or their churches to experience first hand how they live. They were so generous in their sharing. Not one person stated 'unemployed' for occupation – most were 'sellers' or 'farmers'. Neither did I see any graffiti, or hear any tantrums.

This adventure has left a lasting impression on me, and I have gained more than I have given.

Helen Walker RN, EM, RIN, OND.  
26<sup>th</sup> October, 2005.

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## Cataract Surgery

### PART TWO

## CATARACT PATIENTS JOURNEY

JAN HAMILTON

**Patient visits an [Optometrist or General Practitioner](#) for an eye test.  
Provisional diagnosis made and given a  
[Referral to the Ophthalmologist](#)**

### [Attends an Ophthalmic Clinic](#)

General Patient details collected at reception including patients General Practitioner & Optometrist

### [Assessment & documentation by Ophthalmic Nurse or Orthoptist](#)

- Symptoms
- Ocular history
- Systemic history
- Assessment of visual functional status
- Visual acuity
- Objective refraction
- Ocular alignment and motility
- Pupil reaction and function
- Measurement of IOP
- External eye examination
- Assessment of general and medical health
- Dilation with Mydriacyl

### [Examination by the Ophthalmologist](#)

- Reviews records: Assure the evaluation accurately documents symptoms, findings and indications for treatment.
- Assessment of general and medical health
- External examination
- Slit-lamp biomicroscopy
- Evaluation of the fundus (through a dilated pupil)
- Cataract removal is indicated if there is evidence of lens-induced disease or when it is necessary to visualize the fundus in an eye that has the potential for sight.
- Treatment is indicated when visual function no longer meets the patient's needs and cataract surgery provides a reasonable likelihood of improvement.

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## Cataract diagnosis

Affecting quality of life

OR

Not affecting quality of life

**If Offered surgery**

**Refer to optician**

## The Ophthalmologist:

### **Optimize medical fitness:**

Heart disease; anticoagulation; posture  
(neck position; orthopnoea; arthritis)

### **Optimize ophthalmic fitness:**

Conjunctivitis lid disease; uveitis; diabetic retinopathy; corneal disease

- Briefly explains the operation
- Inform the patient about the risks, benefits and expected outcomes of surgery
- Formulate surgical plan, including selection of an IOL
- Review results of pre-surgical and diagnostic evaluation with the patient

## Counselling for cataract surgery by the Ophthalmic Nurse:

1. A-Scan measurement: Biometry Axial length of eye Corneal curvature (focusing power)
2. Show the Video on cataract surgery
3. Patient chooses a date for the surgery
4. Explain where the day-surgery is and with the use of pictorial illustrations explain the journey through the day surgery.
5. Day surgery health questionnaire completed
6. Using a model explain the procedure
7. Ensure the patient understands the possible risks associated with the surgery
8. Out line the surgery expenses
9. Formulate postoperative plans and inform patient of arrangements
10. Go through the patient pathway for cataract surgery
11. Answer any questions
12. Sign the consent for surgery

## Day of surgery

### **Pre-operative:**

High-risk patients should be seen within 24 hours of surgery, and also be assessed by the anesthetist.

Admission to the Day Surgery Unit:

**Clinical pathway for Cataract Extraction and Insertion of Intraocular Lens**

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## Admission Checklist

1. Documentation completed
2. Patient Pathway received
3. Identification Band
4. Escort arranged
5. Contact Lenses removed
6. Jewellery / Valuables secured
7. Post-Operative drops required

## Pre-Operative Checklist

- Procedure
- Consent signed
- Allergies recorded
- Blood Sugar level
- Identification Band
- Previous anaesthetic in past 6 months
- **Observations** Blood Pressure: Pulse: Weight:
- Operation Site Preperated
- Side of operation Right **or** Left
- (marked with **X** above the eyebrow)
- Antibiotic Preparation
- Dilate Pupil
- Topical Anaesthetic
- Sensory / motor Block
- Betadine Eye Preparation

## Intra-Operative Checklist:

- Anaesthetic Record:
- Surgical record:
- Post-operative instructions & Medications:
- Name check & Identification Band
- Identification of operation check
- Side of operation check
- Consent signed
- Allergies recorded
- Physician's notes checked
- Special implications checked
- Vital signs monitored
- Patients comfort monitored
- Replacement Lens checked

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## Recovery Checklist:

- Level of Consciousness
- Blood Pressure
- Pulse & Respirations
- Colour
- Eye pad and Shield are intact

## Discharge Checklist:

- Eye pad & shield secure
- Post-operative Instructions given
- I.V. Cannula Removed
- After hours contact given
- Level of pain adequately controlled
- Follow-up appointment given

## 1-Day Post-Operation:

### **Ophthalmic Nurse:**

- Removal of eye pad
- Interval history, including new symptoms
- Patient's assessment of visual function status
- Assessment of visual function (visual acuity, pinhole test)
- Measurement of IOP
- Instructions and demonstration of how to instill postoperative drops

**Ophthalmologist:** Slit-lamp biomicroscopy examination and evaluation.

## 1-Week Post-Operation

### **Pre-Check by the Ophthalmic Nurse**

- Interval history, including new symptoms
- Patient's assessment of visual function status
- Assessment of visual function (visual acuity, pinhole test)
- Measurement of IOP
- Assessment of compliance with postoperative medications
- Objective refraction and K readings

**Ophthalmologist:** Slit-lamp biomicroscopy examination and evaluation.

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## 4 -Weeks Post-Operation

### **Pre-Check by the Ophthalmic Nurse**

- Interval history, including new symptoms
- Patient's assessment of visual function status
- Acceptable postoperative uncorrected vision
- Assessment of visual function (visual acuity, pinhole test)
- Measurement of IOP
- Assessment of compliance with postoperative medications
- Objective refraction and K readings

### **The Orthoptist performs a subjective refraction**

- Subjective refraction for best-corrected vision for reading or both reading and distance.

**Ophthalmologist:** Slit-lamp biomicroscopy examination and evaluation.

### Refer to Optometrist:

For reading glasses, distance glasses, or both

### This is the END of the Cataract Patients Journey.

The glasses prescription should not change.

Patients are advised to return to the clinic for a 6-month check up or earlier if the notice any decrease in their vision.

*AONA-(QLD) would like to thank Jan for allowing colleagues to gain from her study. Jan completed a log distance ophthalmic nursing course with sponsorship from AONAQ. If you would like to undertake study in 2006, education grants are available from the association. Please send to the committee your course details and start date. On completion of your course, AONAQ asks that in return you share you new knowledge with other members. This can be done via a clinical meet presentation or via Eyeopener.*