

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 and Triage and Treatment Area.
 - 2. Supervision: None 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 (e.g., bleach, ammonia); (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 accompanying symptoms such as nausea, vomiting, and sinus pain.
 - 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 a Snellen 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 the physician of any changes in sensory/perception or visual acuity).

NOTE: For chemical burns irrigate the 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:

1. Impaired tissue integrity evidenced by/related to: (specify on associated encounter form).
2. Alteration in sensory/perception, visual, evidenced by/related to: (specify on associated encounter form).

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 the patient to a physician STAT for immediate evaluation.

1. **Blunt injury or contusion**

- a. Notify the physician **STAT**.
- b. Keep the patient in an upright position.
- c. Protect the affected eye with a shield until the physician examines the patient.

DO NOT APPLY COMPRESSES OR PATCHES.

2. **Chemical burns (bleach, ammonia, etc.)**

- a. Immediately irrigate the affected eye with 2 liters of sterile normal saline or water for at least 15 minutes. May instill 2 drops of topical anesthetic (such as Proparacaine 0.5% Ophthalmic Solution) 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 the patient to a physician for evaluation before discharging from treatment.

3. **Foreign bodies**

If a foreign body appears on the cornea or penetrates the globe do not attempt to remove. Instead notify the physician STAT.

- a. If the foreign body is not seen on the conjunctiva invert upper eyelid using a sterile cotton-tipped applicator to check for the foreign body, gently irrigate the eye with Sodium Chloride Irrigation Solution (0.9%) to dislodge.
- b. If sensation of the foreign body persists, attempt to remove with a sterile moistened cotton-tipped applicator.
- c. If no foreign body can be seen, but the patient complains that the sensation of the foreign body persists, refer the patient to a physician **STAT**.

4. **Perforating or penetrating injuries to the eyeball**

- a. Notify the physician **STAT**.

- b. **DO NOT** attempt to remove the object or irrigate the eye. Protect the affected eye with a firm shield until the 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 the patient to apply warm compresses to the affected eye for 15 minutes QID.
- b. Instruct the patient to return to the clinic in 3 days if there is no improvement.

7. **Red, irritated eyes**

- a. If the 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 0.3%/0.025% 1-2 drops to the affected eye up to QID PRN pain for a **MAXIMUM** of 3 days.
- c. All other complaints concerning red, irritated eyes shall be referred to a physician on a **STAT, Urgent, or Routine** basis as indicated.

8. **Itchy, irritated eyes**

- a. If the itchy, 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 Ketotifen 0.025% Ophthalmic Solution 1 drop to the affected eye BID.
- b. All other complaints concerning itchy, irritated eyes shall be referred to a physician on a **STAT, Urgent, or Routine** basis as indicated.

F. Patient Education:

1. Assess the 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 in the health record.
4. Refer the patient to other resources as needed. Document all referrals in the health record.
5. Advise the patient to resubmit a CDC 7362, Health Care Services Request Form, if symptoms persist; deteriorates, or there is a change in visual acuity or pain; increased redness; swelling; or other symptoms consistent with the assessment.

G. Documentation:

All information related to the patient's complaint shall be documented on the emergency care flow sheet, nursing protocol encounter form, or progress note and filed in the patient's health record.

III. REQUIREMENTS FOR THE REGISTERED NURSE

- A. Education/Training: The RN 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 RN 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 RN 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

The Chief Nurse Executive shall ensure a current list of all RNs authorized to perform this procedure is on file within Nursing Services as required by Inmate Medical Services Policies and Procedures, Volume 5, Chapter 4.2, Nursing Competency Program Procedure.

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:

Chief Nurse Executive

DATE: _____

Chief Medical Executive

DATE: _____