

A Case Study.

Cataract Extraction

with an

Intraocular Lens Implantation.

Introduction

Mr. Ted Rollings, a healthy looking 64 year old man, was admitted into the male surgical ward of the Mildura Base Hospital on the 2nd of April, 1985. He was admitted under Doctor Snellé for a left Cataract extraction and Intraocular lens Implantation to be performed on the following day.

A Cataract is an opacity of the lens which causes considerable ^{vision} deterioration because light rays ^{are scattered and} are not able to focus properly on the retina at the back of the eye.

Mr Rollings cataract formation was caused by degenerative changes of lens fibres associated with aging. This type of cataract may be classified as a senile cataract. These cataracts are progressive, although rate varies, there are also indications of hereditary influence. The associated cause is unknown but may be due to metabolic changes occurring with the aging process.

The only method of treatment for cataracts is surgical. This involves surgical removal of the crystalline lens. With absence of the lens, known as aphakia the eye becomes hypermetropic. This is where the light rays focus behind the retina due to loss of ^{the} refractive power of the lens.

This aphakia can be corrected with glasses containing refracting lenses, or hard or soft contact lenses or as in Mr. Rollings case the implantation of an intraocular lens.

The Crystalline Lens

The Normal Anatomy and Physiology
See Appendix A

The lens is positioned between the iris and the vitreous and appears as a transparent biconvex structure. It is an avascular structure and ⁰²⁺ nutrition is obtained from the surrounding aqueous humor.

The structure of the lens consists of three parts. The elastic capsule which permits alteration of the lens in shape during accommodation and is the attachment for the suspensory fibres. The lens cortex is an outer zone of soft lens fibres in concentric layers. The lens nucleus is formed by the oldest fibres at and around the centre of the lens. The nucleus becomes larger, harder and less transparent throughout life. ✓

The functions of the lens include provision of a refractive power and variation in focus. ^{See Appendix B.} Within the eye light rays are refracted by the cornea and onto the lens, where they are again refracted and focused onto the retina. The lens also provides variation in focus which is required for accommodation in viewing near objects. Nearer objects are focused on the retina by increasing the strength of the lens. Contraction of the ciliary muscles relaxes the suspensory ligament allowing the elastic capsule to mould the lens so as it bulges centrally and therefore gives increased focus for accommodation. Another function is to maintain its own transparency, which is dependent on extreme regularity of constituent cells and the state of relative dehydration, maintained by the epithelial pump.

Admission

Mr Rallings came into hospital as a routine admission for a left Cochlear Implant and an Intraocular lens Implant.

After particulars such as full name, marital status, next of kin, birth date, address and details of medical cover were obtained in the Admissions office a nurse from the male surgical ward was sent to meet Mr Rallings and escort him to the ward.

Mr Rallings, accompanied by his wife and daughter, appeared to be a healthy although a slightly obese elderly man. On the way to his bed he was shown the toilet and bathroom facilities and was introduced to the Sister in Charge and the patients in his room.

Then the admission sheets were filled out. See App. 6. Mr Rallings' identification band was placed on his wrist after checking with him that the details were correct. The nurse also ensured a consent form had been filled out correctly for the proposed operation and signed by the doctor, patient and a witness. This had been filled out at the doctors surgery and was all correct.

Mr Rallings' admission observations were then recorded. These were:

Temperature - 36.6°C ✓
Pulse - 84 b.p.m. and regular ✓
Respirations - 18 p/minute ✓
Blood Pressure - $130/80$ mmHg. ✓

His weight of 78 kilograms was also recorded. The nurse also explained to Mr Rallings that a urine specimen was required and a bottle could be used in the bathroom once he was ready. He was also informed on the use of his buzzer, the meal times

The general information about the ward and was then left to change and unpack his belongings. ✓

Mrs Ballings and her daughter did not stay long and left as soon as Mr. Ballings had unpacked and settled in. Before leaving they were informed of the visiting hours and when they could ring to enquire about Mr Ballings condition postoperatively. ✓

Mr Ballings settled well into the ward and appeared quite comfortable with the unfamiliar surroundings. He also seemed to get along well & with his fellow patients, two of whom were also having eye surgery the following day. ✓

• Excellent introduction R.

History

Mr. Rollings first noticed a change in his sight with the development of blurred vision approximately fifteen months ago. Bright lights also began to annoy Mr. Rollings' eyes. He delayed seeing the optician putting the change down to overtiredness or aging. But the blurred vision remained and being an architect, it made work increasingly difficult and headaches became more common.

Eventually, after pressure from his wife Mr. Rollings saw the optician who diagnosed Bilateral Cataracts, the left further advanced than the right.

After further questioning Mr. Rollings recalled his father having poor vision in his later years.

Mr. Rollings' medical history consisted simply of a pneumothorax and a fractured left humerus, the result of a car accident six years previously. There was no history of further chest complications, no reportable hypertension or other diseases. And Mr. Rollings was currently on no prescribed medications.

On the whole Mr. Rollings was a fit, healthy looking man for his age.

good! ✓

Tests and Investigations

At the Doctor's surgery Dr. Snelle began with a general examination of Mr Rollings eye including the cornea, pupil, conjunctiva and eyelashes.

After considering Mr Rollings presenting symptoms he examined Mr. Rollings eyes with an ophthalmoscope. This enabled direct observation of the inner structures of the eye and therefore the degree of opacity of the lens could be assessed. If the lens is completely opaque the retina cannot be seen using the ophthalmoscope. Mr Rollings retina could be seen better in his right eye than in his left eye because the left eye's cataract was more severe. In both eyes the retina appeared healthy.

Further tests were carried out to determine the effect of the cataracts on Mr. Rollings vision.

To assess Mr. Rollings ability to distinguish detail the Snellen's Chart was used. The chart consists of a series of black letters on a white card. The average size of the letters is calculated so that the average person should be able to distinguish at the distance marked on the card. See Appendix D.

The card is held at usually a distance of six metres from the patient. The patient (with one eye covered) is then asked to read as far down as he can. The lowest line read without error is recorded.

Visual acuity is recorded as:

$$\frac{\text{Distance of card from eye in metres}}{\text{No. on lowest line that is read}}$$

The normal recording is $\frac{6}{6}$ or $\frac{6}{5}$. The results for Mr Rollings were for the left

eye $\frac{6}{18}$, for the right eye $\frac{6}{12}$. ✓
Using a tonometer the doctor measured the intraocular pressure of Mr Kallings eyes. Both eyes were within the normal range of 18-24 mmHg. ✓

To complete the eye examination a conjunctival swab was taken to eliminate the presence of any pathogenic organism. The results showed no abnormal growth.

Included in Mr Kallings general physical examination was a chest x-ray and an electrocardiogram. These procedures are routine preoperative. The chest x-ray checks that the chest is clear from infection. Mr Kallings x-ray was clear and no abnormalities were found. The electrocardiogram was done to assess Mr Kallings heart's activity. There was no sign of abnormalities here either. ✓

The investigations performed on Mr Kallings' eyes enabled diagnosis of Bilateral Cataract. The physical examination ensured Mr Kallings could withstand an anaesthetic. ✓

Nursing Care

Preoperative Preparation

For Mr. Ballings the preoperative preparation began the evening before his operation with the clipping of the eyelashes of his left eye. Before doing this it was explained to Mr. Ballings that this procedure was necessary to avoid the possibility of irritation of his eye caused by an eyelash. To clip his eyelashes the nurse used a small pair of sharp scissors, which were smeared with vaseline to catch the eyelashes. Care was taken to avoid nicking the eyelid or injuring the eye. A good light was required and it was important to stress on Mr. Ballings the necessity to keep his head very still.

The nurse also took time to explain to Mr. Ballings some important points about his postoperative condition. She explained that he would have a pad, a plastic cone and bandage over his eye when he returned to the ward. Also post-operatively he must avoid moving around too often or suddenly, he must try to refrain from coughing, sneezing or vomiting. If he feels nauseous he must tell a nurse who will give him something to help relieve this. Once he is allowed out of bed he must avoid bending or stooping and must take care when moving around, ^{as he will be surprised when ambulating} to avoid injury while he has one eye covered. The nurse ensured Mr. Ballings understood that all of these precautions were to reduce putting stress on his wound and therefore it would aid healing and prevent complications.

Mr. Ballings was also informed that he was allowed nothing to eat or drink from twelve midnight to ensure he

had an empty stomach to avoid vomiting under the anaesthetic.

Any medications and eyedrops were given as ordered by Dr Snelle on the drug therapy chart. ✓ See Appendix F. At 10pm the Chloromycetin drops were administered as ordered and to ensure Mr. Rathings had a good night's sleep preoperatively he was given 10mg of Magadan, a sedative. ✓

On the morning of the operation Mr Rathings showered, emptied his bladder and was dressed for theatre in the theatre gown, pants and cap. On his gown, the nurse taped a card with Mr Rathings' name the Doctor's name and the proposed operation on it. She then covered Mr. Rathings' wedding ring with tape and removed his false teeth placing them in a cup of water on his locker. ✓

Once Mr Rathings was dressed and resting in bed on the theatre canvas the preoperative checklist was completed. As the nurse completed the checklist she ensured all of the information required was correct, checking Mr Rathings notes to make sure his observations, analysis and weight were recorded. ✓ She also checked that the consent form was present and signed by Mr Rathings, Dr Snelle and a witness for the proposed operation. Once all the details on the checklist were completed and correct the nurse signed the sheet. ✓ See App E

It was important for the nurse to talk clearly and confidently as Mr Rathings seemed quite anxious. ✓

Mr Rathings' premedication was due one hour preoperatively at 7am. The anaesthetist had ordered two injections, Omnopon 20mg and Atropine 0.6mg. After checking the injections with a Sister

The nurse identified Mr Ballings, checking his wrist band and addressing him verbally. She then administered the injections intramuscularly in the upper outer quadrant of Mr Ballings' back. The nurse had previously warned Mr Ballings that the Omnipon would help relax his muscles and make him feel drowsy. The Atropine would dry up any secretions therefore his mouth would feel dry but he was not to drink anything.

Every fifteen minutes for the hour preoperatively Homatropine and Cocaine 2% eyedrops were ordered, one drop to be instilled into the left eye. These drops were necessary to dilate the pupil in the left eye so that the surgeon would have a clear view while extracting the lens. The theatre porter came for Mr Ballings at 7.45 am, he was transferred from his bed into the theatre trolley and the nurse went with him around to the theatre checkover, where he was transferred onto another trolley once the theatre nurse had checked she had the correct patient and that his notes were all in order and correct. From here Mr Ballings was taken to the operating theatre. The ward nurse returned to the ward and prepared Mr Ballings' bed to receive him postoperatively.

excellent work. R

Postoperative Care

Mr Ballings was collected from theatre at about 9.30am. The theatre nurse handed Mr Ballings notes over informing the ward nurse of the operation performed, the postoperative observations and Mr Ballings present condition and the postoperative orders which were:

1. Routine post operative observations
2. Oxygen 4 litres per minute for 2 hours
3. Rest in bed - may sit up.
4. As per drug chart: See Appendix F.

Stemital 12.5mg IM 4 $\frac{1}{2}$ p.r.n for nausea

Panadol 11 4 $\frac{1}{2}$ p.r.n. for pain ✓

Mr Ballings was then transferred to another hallway and the nurse escorted him back to the ward and into his bed. Mr Ballings was conscious although very drowsy but the nurse explained all procedures as they were carried out.

Mr Ballings was made comfortable with the head of the bed raised so that he was in a semi-upright position and the bed rails were raised as these patients are often confused postoperatively with one eye covered in unfamiliar surroundings the presence of a nurse was reassuring to Mr Ballings and he was recapped on where he was and his immediate surroundings. His buzzer was pinned to his pillow within his reach. He was asked not to lie on his left side, ~~not to~~ ~~to~~ to avoid touching his bandage and try to avoid coughing, sneezing or any unnecessary movement. If he felt nauseous he was to tell the nurse. As he became more alert these directions were reinforced.

When attending Mr Ballings, the nurse also took care not to bump the bed and the room was kept free from bright lights.

Stemital 12.5mg IM 4 $\frac{1}{2}$ p.r.n for nausea

Mr Rollings observations on return to the ward were:

Temperature - 36°C

Pulse - 94 beats/minute

Respirations - 16/minute

Blood Pressure - $110/50$ mmHg ✓

Mr Rollings colour was good, he was conscious, although very drowsy and had no complaints of pain. He had an eye patch cone and bandage covering his eye, this was dry and intact. He was receiving oxygen at 4 litres/minute via an intranasal cannula and this was to be maintained for two hours. ✓

These observations were carried out half hourly for four hours postoperatively the observation range at the end of the four hours was:

Temperature - $36^{\circ}\text{C} - 36.7^{\circ}\text{C}$

Pulse - 78 - 94 beats/minute

Respirations - 16-20/minute ✓

Blood Pressure - $106/50 - 130/76$ mmHg

At the end of the four hours the observations were considered stable and were therefore changed to four hourly observation.

As Mr Rollings became more alert it was important to enlist his cooperation and to reassure him of his condition. It was again explained to Mr Rollings the importance of preventing any buildup of pressure within his eye to avoid complication and eye healing. To help Mr Rollings was asked again to avoid sudden movements, not to lie on his affected side, to avoid coughing, sneezing, vomiting or bending and to remain in bed until as ordered by the Doctor.

Now that Mr Rollings was fully conscious and his observations were stable the nurse gave him a face, hands and back wash and changed him into his own pyjama ✓

Mr Kallings felt much fresher and manage to void. The nurse then left Mr Kallings to rest making sure his buzzer was within reach and that his water jug and cup and anything else he needed were on his bed side table. His bedside table was placed on his right side to prevent Mr Kallings bending unnecessarily to his left side. ✓

For dinner that evening Mr Kallings received a light meal of soup, icecream and jelly and a cup of tea. A little help was given in pouring the tea and guiding the soup spoon to his mouth. Mr Kallings seemed to enjoy his dinner but was a upset that he had to get help from a nurse in feeding. The nurse reassured Mr Kallings that once he was used to the temporary loss of sight in his left eye he would manage. ✓

Mrs Kallings wife and her daughter came to visit Mr Kallings after dinner. The nurse asked them to keep as quiet as possible and avoid bumping the bed, explaining that Mr Kallings operation went well and his condition was quite satisfactory. They did not stay long since Mr Kallings was very tired. ✓

Before settling to sleep on his first postoperative night Mr Kallings was given an injection of Stemetal 12.5mg intramuscularly for nausea and two Paracetol for a slight pain. The pain and nausea were soon relieved and Mr Kallings then settled and had a good nights sleep. ✓

The next morning Mr Kallings was sponged in bed and his bed was tidied, taking care to avoid sudden movements or straining. It was explained to Mr Kallings

that he could not shave for a couple of days to avoid any trauma to the wound. After Mr Ballings had finished his breakfast Dr Snellie came to the ward to take down his dressing, instill drops and redress the eye. The procedure is aseptic to avoid introduction of infection. The procedure was explained to Mr Ballings and he was asked to keep still and refrain from touching his eye. It was also explained to Mr Ballings that his vision will not be perfect but he was encouraged and reassured that his vision will improve and many patients are disappointed that their vision is not clear when the first dressing is done. Was the room dimmed? ^{Were the drapes cut from his face??} During the dressing change the eye is examined closely for any discharge or sign of complications. The cornea should be clear and bright. The anterior chamber is examined. The presence of a hyphaema formation is due to handling during surgery. The pupil should appear round and central. Any distortion may indicate prolapse of the iris through the wound. Mr Ballings eye had a slight serous discharge and there was a slight hyphaema formation but generally Dr Snellie was pleased.

The drops instilled were, as per the drug chart Gubhae Chloromycetin 0.5% one drop and Gubhae Homatropine 1-2% one drop, both to the left eye.

Since Mr Ballings had to remain resting in bed the first day postoperatively to improve circulation and prevent any complications such as deep vein thrombus formation a range of arm and leg exercises were encouraged. Deep breathing to promote full lung expansion was also encouraged. While resting in bed the nurse did two hourly back rubs and

position changes to avoid development of pressure areas.

On the second day postoperatively Mr Ballings was allowed to sit in a chair alongside his bed for breakfast. He managed a normal diet well and appeared to enjoy his meals. After lunch Mr Ballings was walked to the toilet. With one eye covered and slight blurring vision in the other eye it was important to have a nurse to guide and support Mr Ballings to the bathroom. Mr Ballings managed very well with no complaints of dizziness once he had begun to walk and had gained his balance. For the remainder of the day Mr Ballings remained in bed to rest and sleep.

On the third day postoperatively Mr Ballings was permitted to shower under supervision. Care had to be taken not to dampen his dressing using a hand held hose. A laxative was also ordered to be given to Mr Ballings since his bowels had not yet been opened. It was explained to Mr Ballings that two Glycerine Suppositories were to be given rectally to lubricate the internal wall and soften the faeces therefore enabling defaecation without straining. There were to be retained for fifteen to twenty minutes if possible to allow action. The end result was good and Mr Ballings was relieved.

Each day Mr Ballings' eye continued to be redressed by Dr Snellie and the eyedrops were instilled as ordered. At night a plastic cone and bandage were placed over Mr Ballings' eyepatch to prevent any injury to his eye unconsciously during the night.

Even though Mr Ballings was up walking care had to be taken not to

hand over, soap & strain.

Mr Ballings recovered well and was managing well attending to his own needs by the fifth day postoperatively.

Very caring & concerned
attitude - well done

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Discharge

On the sixth day postoperatively Dr Snelle visited and after examining Mr Ballings' eye he was allowed to be discharged home. The eyedrops to go home with Mr Ballings were obtained from pharmacy and an appointment was made at Dr Snelle's surgery for a week later. Mr Ballings was told that he must wear the eyepad at home until he saw the doctor again but he may remove the eyepad and wear dark glasses for a short time during the day when inside. Mr Ballings was also told that he must avoid lifting, stooping and strenuous activity for two weeks and should take care to move with caution. Mr Ballings was then shown how to instill his eyedrops correctly and he was told when to instill them, one drop in the left eye at night. These instructions and the appointment time were all written down and given to Mr Ballings.

Once Mr Ballings had collected his belongings and the above instructions were clear he was escorted by a nurse with his wife and daughter to the car. Care was taken to warn Mr Ballings of anything such as the front step and roof of the car which he may still have trouble noticing with one eye covered.

good points!

Psychological Aspects.

The onset of blurred vision for Mr Ballings was distressing because he was a healthy man and to him it also indicated the onset of aging. The deterioration in his sight, although gradual eventually affected his work as an architect and made reading, a favourite pastime increasingly difficult. The problem affecting his work caused a great deal of stress and the fear of losing his sight completely prompted him to see the optician. ✓

After seeing the optician and discussing the surgical treatment Mr Ballings was not so anxious and agreed to have his left cataract extracted and an intraocular lens implanted.

Admission into hospital caused some anxiety for Mr Ballings with the unfamiliar surroundings and a change in his daily routine. To relieve this anxiety the nurse's approach and Mr Ballings understanding of his hospital stay was important. The approach of a nurse as competent, warm and caring was important. ✓ It was also explained to Mr Ballings that he would have a general anaesthetic, the operation would take about one and a half hours and he would be back in the ward by 10am. Postoperatively he will feel very drowsy the first day and he will have a pad and bandage covering his eye. He appeared quite comfortable once he understood the details. ✓

Post operatively Mr Ballings had to adjust to bed rest after surgery being an active person and with other people caring for him in an unfamiliar environment.

After being so independent, to have attention coming for you and asking for help was difficult. ✓ Nursing staff were aware and encouraged as much independence as his condition permitted. Once Mr Balling was permitted to get up he quickly gained his independence and managed well attending his own needs.

When Mr Ballings received permission to go home he was relieved to be returning to his normal environment and daily routine, but he seemed pleased and appreciative of his hospital stay, the care received and the ~~promised~~ result of the operation. ✓

Possible Complications

Postoperatively the patient must be continually observed for any signs of complications.

Haemorrhage is a possible complication and signs that indicate this include sharp pain, increased feeling of pressure in eye and restlessness. An increase in intraocular pressure caused by vomiting, coughing or straining may result in shears on the suture line and rupture of blood vessels.

Infection present preoperatively or introduced during surgery or post-operatively is always a possible complication.

Other complications include prolapse of the iris due to reopening of the wound and loss of aqueous washing out the iris. This may be caused by a sudden head movement, straining, coughing or trauma to the eye. Flattening of the anterior chamber may also occur due to loss of vitreous through the wound.

Another complication is the development of a secondary glaucoma which may result from flattening of anterior chamber or blocking of vitreous flow.

Any sign of a complication must be reported immediately to ensure prompt treatment.



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Pp. 678 - 682.

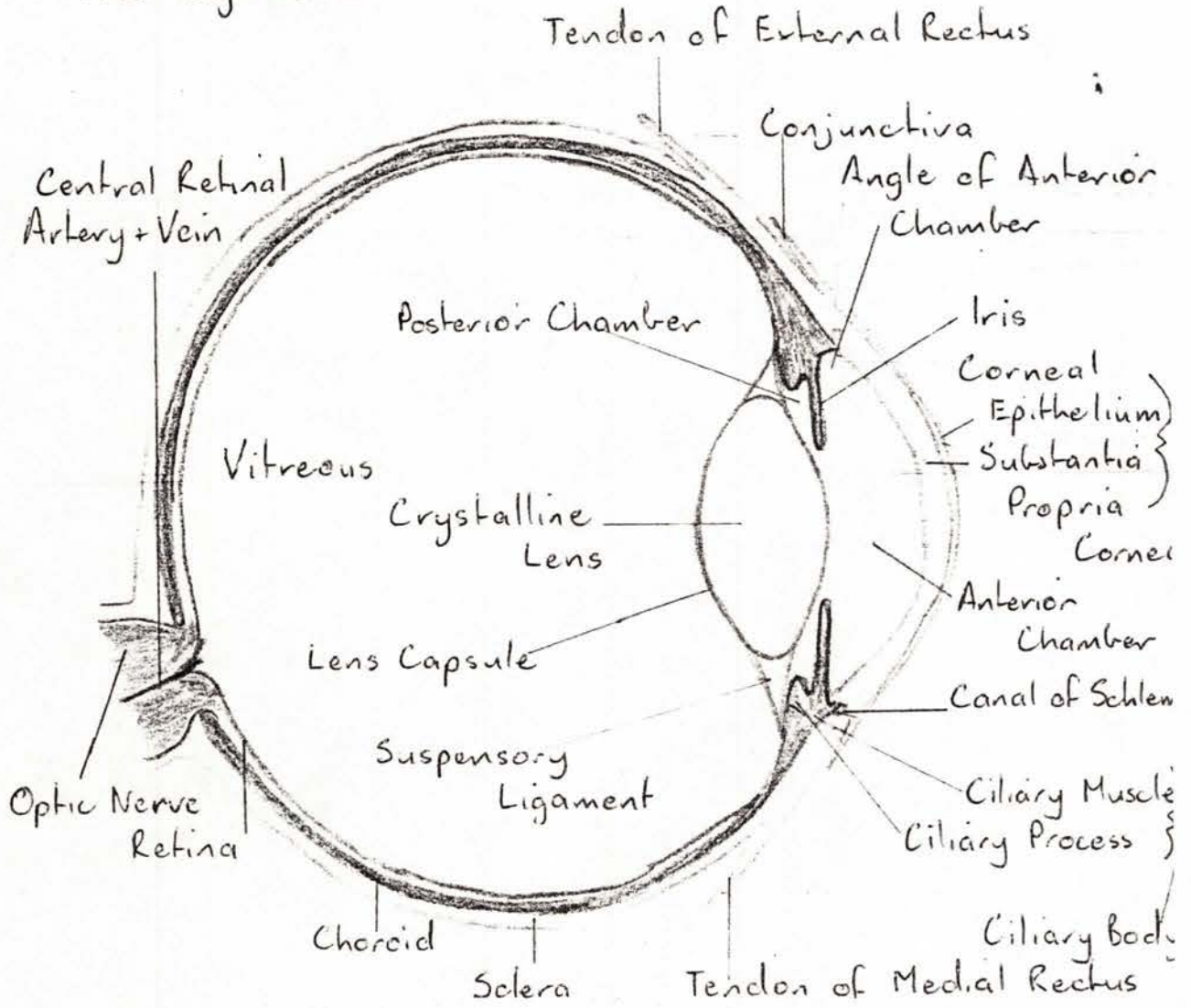
LOWE, R.F; WONG, E.S; LECTURES IN DISEASES
OF THE EYE, (3rd ED.);
The Royal Victorian Eye and Ear Hospital, 1982;
Pp. 41-44. ✓✓

Patients' History.

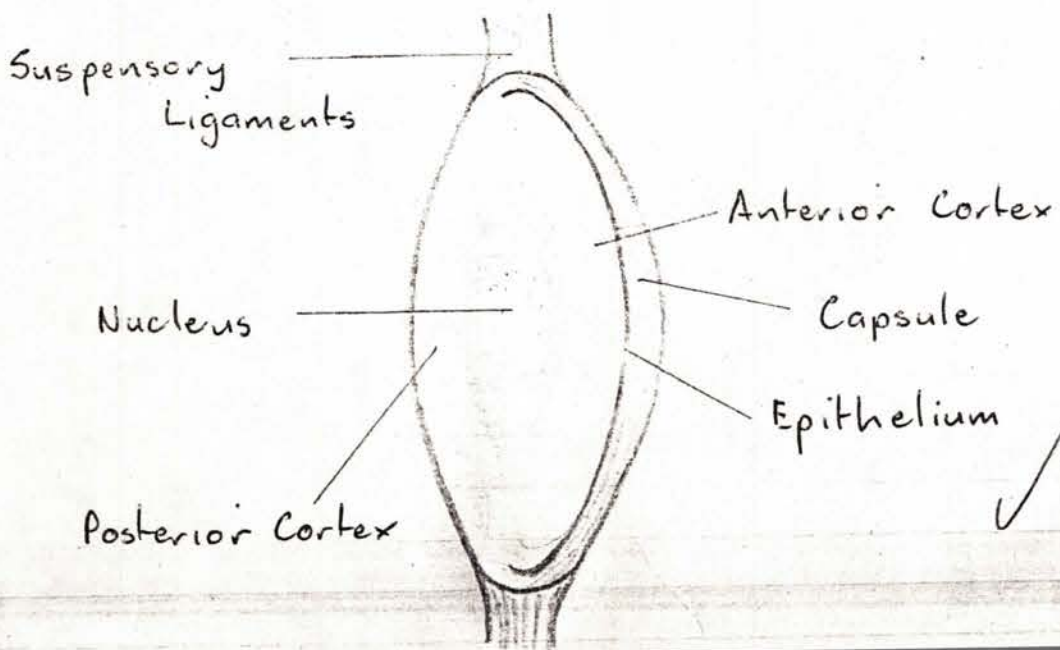
Ganemaree,
This is an excellent history, well
presented & researched. You have obviously put
a lot of work into this & as a result, this
monograph will be an excellent reference
for future nursing of pts. with a similar
condition. Notes are made, where relevant to
enhance your knowledge. Well done. Sue Reilly

The Anatomy

The Eyeball

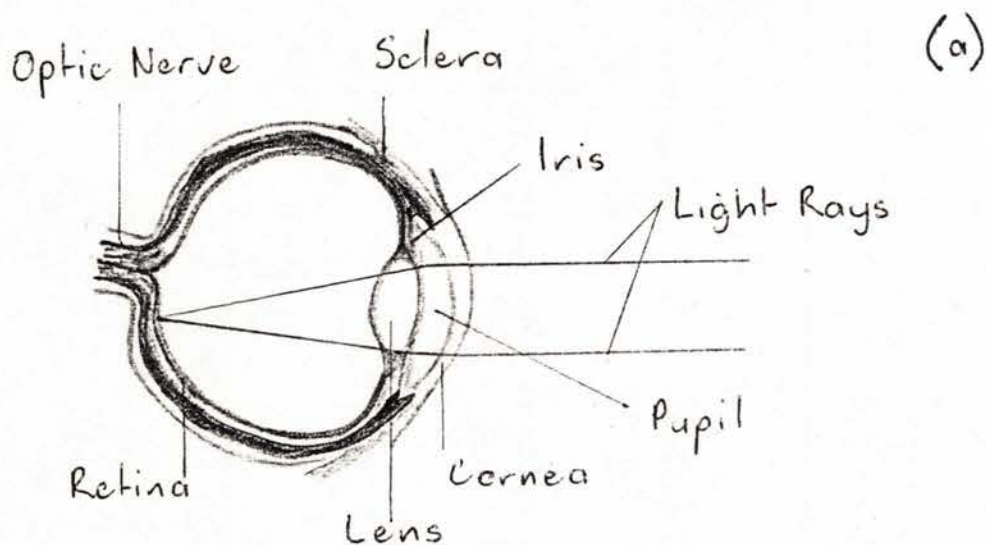


The Lens

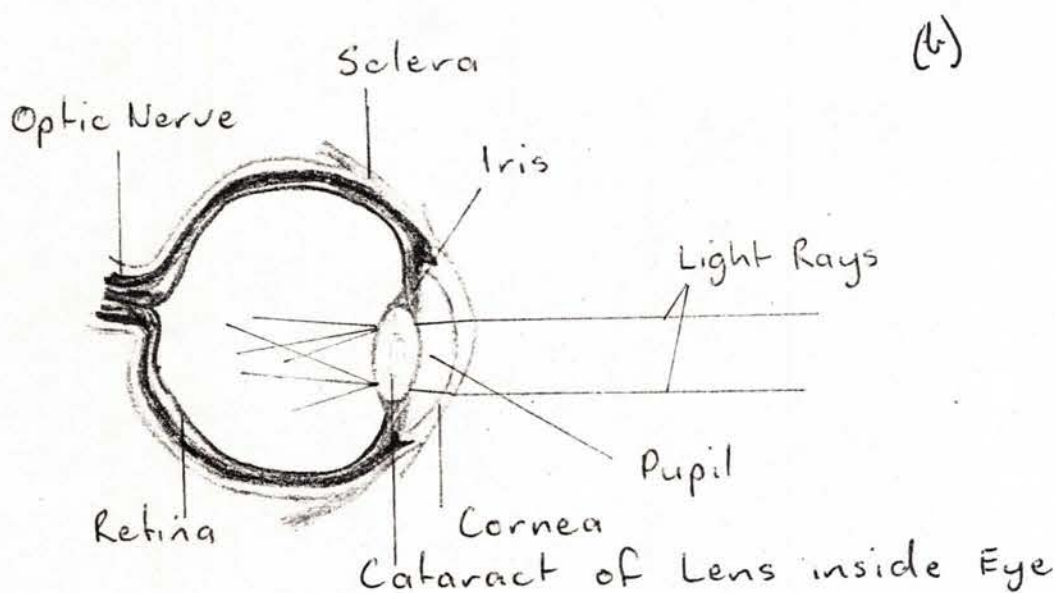


✓ good diagrams

Illustration of focusing of light rays by the normal eye (a) and the effects of the cataract (b).



In a normal eye the cornea and the lens focus light rays onto the retina, as shown above.



As illustrated above, a cataract causes light rays to be scattered so that they do not focus onto the retina.

pendix C
NURSING HISTORY

Name _____
U.R. Number 019337
D.O.B. 23-3-1921
Doctor Dr. Snelle

Date 2-4-85 Time: 2:30pm
Speaks fluently in: English

COMPLETE ABOVE IF LABEL UNAVAILABLE

Persons Aware of Admission: Mrs. Vera Rollings

Persons for Notification: 1. _____
2. _____

Preferred Name: _____

CHECK LIST: Identification Band Valuable in Office Safe
Consent Form Personal X-Rays Suit Case

Have you helped your patient feel more familiar with the environment by:

Introduction of other staff Introduction to other patients Ensure he/she has M.B.H. Information book Orientating him/her to bed unit/toilet/bathroom/day rooms

Have you provided information to your patient on:

Buzzer Light Switches Phone Television Smoking Valuables
Newspaper Laundry Menu/Meal times Visiting times Ward/Bed Transfers Personal Electrical Items

Physiological Needs. Does your patient have any Protheses/aids to daily living:

Walking Frame Dentures Spectacles Hearing Aid Other-describe: _____

Signature of Admitting Nurse N. J. ...

Allergies: NIL KNOWN

Medications (including non prescribed): _____

Medication brought in: Yes No

Medical Diagnosis/Reason for Admission: Left Cataract Extraction and Intraocular Lens Implantation

Past History: Pneumothorax, Fractured Lt Humerous 1979.

DISCUSS AND RECORD:

What your patient knows and understands about his/her condition, including expected length of stay
Pt. for elective surgery, understands stay may be up to a week.

What effect the condition/hospitalisation has on your patient, family, others at home, job, finance, etc.
No problems.

Mildura Base Hospital 436634/85

GENERAL ASSESSMENT – Comment on the following:

Physical Appearance, Skin Condition, Sensory Difficulties etc. Healthy looking, slightly obese, tall elderly man.

Do you agree to impaired hearing identification? -

How do you feel about hospitalisation? Slightly anxious

Mental State – (Orientation, consciousness, speech, etc.) orientated

How does your patient usually manage the following and what difficulties are foreseen now?

Mobility good.

Rest/Sleep no problems

Breathing no problems - good.

Personal Hygiene own.

Nutrition/Fluids (including likes, dislikes, special diets, comfort of dentures etc.)

Dislikes - tomatoe.

Elimination – Normal Bowel Habits - yes

– Normal Bladder Habits - yes

Smoking no. Alcohol occasional.

ASSESSMENT OF YOUR PATIENTS SOCIAL NEEDS – Discuss and record

Whether your patient lives alone no - with wife

Whether any family or friends will be able to visit yes all family + friends

SPIRITUAL CULTURAL NEEDS – Discuss and record

What assistance your patient requires in meeting his/her spiritual needs none.

Whether your patient has any cultural differences/beliefs that may effect attitude to conditions/hospitalisation

none

DISCHARGE PLANNING – include:

Community Services Received/Required -

Destination – where, with whom home w/ wife

Transport required, if any -

Anticipated problems, if any -

Other needs, if any -

Signature of Admitting Nurse Nse [Signature]

The Snellen's Chart



Snellen's card for visual acuity

(a) p. 28. Lowe, R.F; Wong, E.S; Lectures in Diseases of the Eye.

(b) p. 842. Phipps, I; Long, B; Wood, N Surgical - Medical Nursing.



Fig. 37-2. A, Snellen chart used in testing vision. B, Modified Snellen chart, called "E" game, for testing vision of small children and persons unfamiliar with English alphabet.

UK. No. 019351
 D.O.B. 23 / 3 / 1921

WEBER LABEL

Dr. Snelle

MILDURA BASE HOSPITAL

**PRE-OPERATIVE PATIENT
 CHECK LIST**

GUIDELINES FOR USAGE

1. This form must be completed by the Nurse who prepares the patient for theatre. (A tick must be placed in one of the three columns.)
2. All pre-operative care must be fulfilled according to the Procedure Manual.
3. Every question must be answered.
4. Any anomaly should be reported to the Sister in Charge before the patient is ready to leave the Ward.

	YES	NO	N/A		YES	NO	N/A
1. ADDRESS PATIENT BY NAME				11. PRE-MEDICATION			
Check Name Corresponds with —				(a) Given	✓		
(a) Patient's Card	✓			(b) Signed	✓		
(b) Wrist Band	✓			(c) Fasting Time 12 M.N.	✓		
(c) Operation Sheet	✓			12. PRE-OPERATIVE PREPARATION			
2. PATIENT GARB				(a) Shave Eye lashes clipped	✓		
(a) Cap	✓			(b) Special Skin Prep.			✓
(b) Jacket	✓			(c) Bowel Prep.			✓
(c) Bikini	✓			(d) Eye Pads/Drops	✓		
3. CHECK				(e) X-Rays with Patient			✓
(a) Canvas — Position	✓			(f) Toy with Patient			✓
(b) Pillow — Clean	✓			13. CONSENT FORMS			
(c) Blanket — Clean	✓			ANAESTHETIC FORMS SIGNED BY			
4. JEWELLERY				(a) Doctor	✓		
(a) Removed	✓			(b) Patient or Next of Kin	✓		
(b) Covered	✓			(c) Witness	✓		
5. DENTURES				14. CHECK			
(a) Removed	✓			(a) Artificial Limb — Intact			✓
(b) In situ — Partial			✓	— Removed			✓
— Full			✓	(b) Artificial Eye — Intact			✓
5. HAIR				— Removed			✓
(a) Pins Removed			✓	(c) Hearing Aid — Intact			✓
(b) Hair Pieces or Wigs — Intact			✓	— Removed			✓
— Removed			✓	(d) Metal Implantation			✓
7. NAILS — Free of Polish	✓			If present, state site			✓
8. ALL MAKE-UP REMOVED	✓			TERMINATION OF PREGNANCY			
9. PATIENT'S BLADDER				SIGNED BY —			
(a) Empty	✓			(a) Husband and Wife			
(b) Urine Test Charted	✓			(b) If a Minor, Next of Kin			
10. CHARTED				(c) Two letters of permission from two doctors			
(a) Drug Allergies	✓			OR Two doctor's signature on correct consent form			
(b) Special Medication	✓			STERILIZATION — Signature of			
(c) T. P. R.	✓			(a) Husband and Wife			
(d) Blood Pressure	✓			(b) If a Minor, Next of Kin			
	✓			CHECKED BY —			
	✓			Ward Staff <i>Nsejt</i>			(Signature)

Drugs

Dosage, Action, Side Effects.

Omnopon

Dose - : 20mg, I.M.I., 1 hour preoperatively

Action - : used as a premedication ;

- : a narcotic analgesic

Side Effects - : depression of respiration

- : nausea and vomiting.



Atropine

Dose - : 0.6mg, I.M.I., 1 hour preop.

Action - : anticholinergic, to reduce salivary secretion

- : used as a premedication

Side Effects - : dry mouth.



Mogadon

Dose - : 10mg, orally, nocte.

Action - : sedative

Side Effects - : drowsiness, headaches next day.

- : hypotension.



Panadol

Dose - : 0.5mg, - 1 gram, orally, $\frac{4}{24}$ prn.

Action - : analgesic

- : antipyretic

Side Effects - : (rarely)

- : nausea, dyspepsia

- : allergic reaction



Stemital

Dose - : 12.5 mg, I.M.I., $\frac{1}{24}$ prn.

Action - : antiemetic

Side Effects - : drowsiness

- : allergic reaction

Glycerine Suppositories

Dose - : $\frac{1}{4}$ - $\frac{1}{2}$, P.R.

Action - : lubricant laxative

Guttae Chloromycetin

Dose - : 0.5%, $\frac{1}{2}$ drop, t.d.s.

Action - : antibiotic (local)

Side Effects - : stinging

sometimes. ophthalmine 0.5%

is given beforehand to prevent this side effect

Guttae Homatropine + Cocaine

Dose - : 2%, $\frac{1}{2}$ drop every 15 min. for
1 hour preop.

Action - : (homatropine) - pupil dilatation

- : (cocaine) - local anaesthetic

Side Effects - : stinging - see note above.

- : drying of corneal
epithelium, can be
easily abraded.

Guttae Homatropine

Dose - : 1-2%, $\frac{1}{2}$ drop, mane.

Action - : pupil dilatation

Side Effects - : stinging - ditto

- : photophobia

NOTES FOR DOCTORS AND NURSING STAFF:

1. **TIME OF ADMINISTRATION:**
Place a cross in the appropriate square of the "time" column. The unshaded squares indicate daytime; the shaded areas indicate night time. If a drug is to be given at non-standard times, ignore the "time" columns and write straight across the sheet, e.g. "Insulin half an hour before breakfast or p.r.n." The times it is administered each day should be entered in the Drug Administration Record by Nursing Staff.
2. **DURATION OF THERAPY:**
 - (a) Drugs may be ordered for any length of time up to a maximum of twenty-four days, but the duration of therapy required must be stated in the appropriate column.
 - (b) If duration of treatment ordered is less than seven days, count the number of days required and cancel excess columns with a diagonal line.
3. **COMPLETION OF SHEET:**
To ensure that each patient has only one sheet in use at any time, when a new sheet is necessary, all current orders should be transferred to it by the doctor.
4. **CANCELLATION OF DRUG ORDERS:**
Draw a bold horizontal line straight across the sheet, write "ceased", the date and initial.
5. **AUTHORITY FOR EQUIVALENT PRODUCTS:**
Authorisation is hereby given to dispense the generic or chemical equivalent unless the product described is CIRCLED.
6. **SPECIALLY CHARTED DRUGS:**
When drugs such as anticoagulants, insulin, prednisolone, etc., are being administered, and a record is normally kept on a separate chart, this must be shown on therapy chart, e.g. "Warfarin as per chart."
7. **TELEPHONE ORDERS:**
Telephone Instructions are only acceptable in urgent situations when the Doctor cannot attend. They must be confirmed in writing within 24 hours.
8. **DISCHARGE DRUGS:**
Quantities required for each discharge drug should be specified on Discharge Therapy Prescription. N.B. The maximum quantity which can be dispensed is one weeks supply.
9. **RECORD OF ADMINISTRATION:**
 - (a) Nursing staff should record the administration of all drugs by initialling the appropriate square when a dose is administered.
 - (b) If dose is not administered for any reason e.g. patient refused dose or patient in theatre, MARK appropriate square X and initial.
10. **DRUGS OF ADDICTION:**
Drugs of Addiction Administration Book must also be filled in.

Name W. Lee Rollings
 U.R. Number 019337
 D.O.B. 23 / 3 / 1921
 Doctor Dr. Snelle

Appendix F.

NOTES FOR USE — P.T.O.

COMPLETE ABOVE IF LABEL UNAVAILABLE
 AGE 64 WEIGHT 78 Kg

ADMISSION DRUGS

No.	Current	Drug and Form (Block Letters)	Strength	Dose	Frequency	To Take Home
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

ALL ABOVE LISTED DRUGS SENT TO BY DATE T.T.H. Authority (Dr. Sign.)

DISCHARGE DATE 9th TIME 10am

DISCHARGE THERAPY

Pharmacy	No.	Drug and Form (Block Letters)	Strength	Dose	Frequency	Duration (Max. of 7 days)
<u>8/4/85</u>	<u>1</u>	<u>Chloromycetin G.</u>	<u>0.590</u>	<u>1/2 drop</u>	<u>nocte</u>	<u>7 days</u>
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	10					

Date _____ Signature (Dr. Signature) Dr. Snelle

DRUG THERAPY CHART

MR/17

