

RETINOPATHY OF PREMATURITY CHART

DATE:

HOSP. NO:

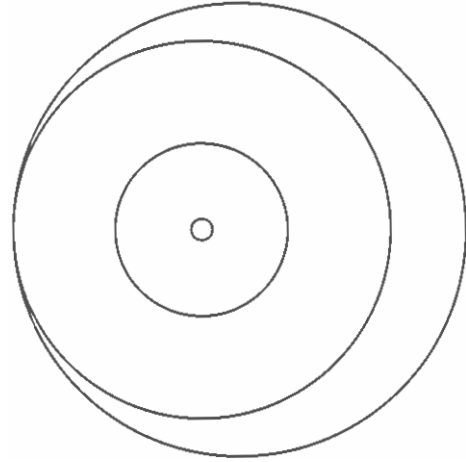
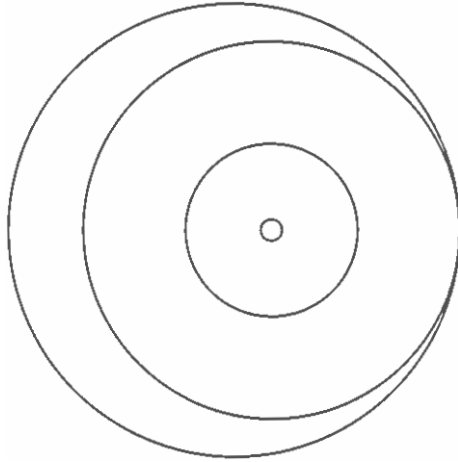
NAME:

DATE OF BIRTH:

GESTATIONAL AGE:

BIRTH WEIGHT:

CORRECT AGE:



	IMMATURE	MATURE	ZONE	STAGE
OD:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLUS DISEASE:	OD		OS
	<input type="checkbox"/>	Retinal vascular dilation	<input type="checkbox"/>
	<input type="checkbox"/>	Iris vessel dilation	<input type="checkbox"/>
	<input type="checkbox"/>	Vitreous haze	<input type="checkbox"/>
	<input type="checkbox"/>	Retinal haemorrhage	<input type="checkbox"/>
	<input type="checkbox"/>	Pupil rigidity	<input type="checkbox"/>

COMMENTS:

NEXT EXAMINATION:

SIGNATURE:

Our Lady's Children's Hospital, Crumlin
Nursing Careplan 33: Retinopathy of Prematurity (ROP) Eye Assessment and Management in the
Ophthalmology Suite

Care plan ROP 33	Issue date: April 2015 Review date: April 2018											
Problem Is attending the ophthalmology OPD and will require an eye examination for investigations and/or monitoring for ROP												
Goals <ul style="list-style-type: none"> The infant and parent or guardian will be safely prepared for the examination Parent/ guardian will be reassured prior to the procedure Interpreter is arranged as required 												
Nursing Intervention												
1. Before the procedure												
<ul style="list-style-type: none"> Administer dilating eye drops as prescribed as per OLCHC Policy (2001) Allow 30 minutes to take effect and ensure pupils dilated. Record and report side effects to the medical team if any noted Equipment check--- Emergency trolley available for use <table style="width:100%; margin-top: 5px;"> <tr> <td style="width:30%;">Oxygen</td> <td style="width:20%;">Yes/No</td> <td style="width:30%;"></td> <td style="width:20%;"></td> </tr> <tr> <td>Suction</td> <td>Yes/no</td> <td></td> <td></td> </tr> </table> Record baseline observations and report any deviation to the medical team T P R O₂ Sats Wrap infant in a blanket Administer Sucrose (Sweetease)® as prescribed prior to the procedure to alleviate pain 					Oxygen	Yes/No			Suction	Yes/no		
Oxygen	Yes/No											
Suction	Yes/no											
Time	Heart rate	Oxygen saturations <i>(Detail if in room air or oxygen)</i>	Other comment	Signature								
During procedure												
Post procedure 1												
Post procedure 2												
*****Please note if the infant becomes bradycardiac during the procedure this is an indication to stop procedure*****												
2 Parental information												
<ul style="list-style-type: none"> Ensure the parent/guardian has the opportunity to discuss the procedure with the consultant Give parents/guardians an opportunity to ask questions Ensure follow up appointment is given as per consultant 												
Traceability record		Nursing care evaluation										

		Signature: _____ NMBI: _____										