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Lived Experiences of Ophthalmic Nurses in Managing Elderly Patients with Eye Conditions

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ABSTRACT

This study explored how ophthalmic nurses interpreted and made meaning of their lived experiences in managing elderly patients with eye conditions. An interpretive phenomenological design was employed at Grace Medical Center in the City of San Jose del Monte, Bulacan. Eight registered nurses with two to ten years of ophthalmic experience were purposively selected. Data were gathered through semi-structured interviews, audio recordings, field notes, verbatim transcription, and researcher observations, and were analyzed using Colaizzi's phenomenological method within an interpretive framework. The nurses described their work as a combination of clinical assessment, education, advocacy, coordination, adaptability, and holistic care. Their principal challenges involved sensory and cognitive communication barriers, patient anxiety and difficult behaviors, unaccompanied patients, treatment-adherence difficulties, emotional fatigue, high workload, understaffing, resource limitations, and organizational constraints. They responded through simplified and repeated explanations, teach-back and demonstration, family involvement, therapeutic communication, close monitoring, multidisciplinary collaboration, time management, protocol adherence, and outcome-based evaluation. Participants attached fulfillment and professional meaning to preserving vision, improving daily functioning, and helping elderly patients feel safe. The experience also strengthened their empathy, patience, communication, autonomy, clinical competence, and adaptability. The findings indicate that quality geriatric ophthalmic care depends on both relational nursing competence and institutional support. Continuing specialty education, adequate staffing and resources, strengthened patient-family teaching, preventive safety measures, collaborative practice, and staff well-being support are recommended.

Keywords: *ophthalmic nursing, elderly patients, eye conditions, interpretive phenomenology, patient-centered care, geriatric nursing*

INTRODUCTION

Visual impairment is a major concern among older adults because cataract, glaucoma, diabetic retinopathy, age-related macular degeneration, and uncorrected refractive problems can diminish mobility, communication, self-care, and social participation. Vision loss is also associated with frailty, falls, activity limitation, and reduced quality of life, making elderly eye care a clinical, psychosocial, and public-health priority (Dinarvand et al., 2024; Jin et al., 2024; Liu et al., 2022; Takefuji, 2023).

The burden of eye disease is intensified when older adults face financial barriers, delayed consultation, limited diagnostic services, and uneven access to specialists. In the Philippines, these barriers can prolong untreated disease and increase dependence on relatives and healthcare workers (Ho et al., 2022). Elderly ophthalmic patients may also have hearing loss, cognitive changes, impaired dexterity, multimorbidity, and anxiety about blindness or surgery, requiring more time, repetition, safety monitoring, and caregiver participation.

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Ophthalmic nurses contribute to assessment, procedural preparation, medication administration, education, counseling, discharge planning, care coordination, and patient advocacy. Their responsibilities have expanded as eye-care demand increases and service models redistribute follow-up, education, and protocol-based functions to specialized nurses (Ahokas, 2023; Royal College of Nursing, 2025; Sharbini et al., 2025). Nurse-led education has also improved glaucoma knowledge, treatment motivation, health literacy, and self-management (Sng et al., 2023; Tsichla et al., 2025).

Despite this expanding role, much of the literature emphasizes prevalence, service capacity, and patient outcomes rather than the personal meanings and emotional realities of ophthalmic nursing. Outcome-focused evidence does not fully explain how nurses interpret sensory communication barriers, treatment nonadherence, family dependence, difficult behavior, workload pressure, and repeated exposure to patients' fear of vision loss. Qualitative inquiry is therefore needed to understand how technical and relational responsibilities are lived within actual clinical and organizational contexts (Burns et al., 2022; Shaban et al., 2024).

This study explored how ophthalmic nurses made meaning of their day-to-day roles, challenges, strategies, support systems, professional growth, and overall experience in caring for elderly patients with eye conditions. It aimed to generate practice-based insights for nursing education, clinical care, administration, and future research.

Literature Review

Aging, Vision Impairment, and Complex Care Needs

Older adults with vision impairment often experience a combination of physical vulnerability, reduced independence, and psychological distress. Population studies have documented a substantial prevalence of vision impairment among adults older than 70 years and among nursing-home residents, particularly in association with cataract, macular degeneration, glaucoma, and diabetic retinopathy (Killeen et al., 2023; Monaco et al., 2023). Visual impairment also increases the likelihood of falls and activity restriction (Jin et al., 2024; Thomas et al., 2025).

Clinical management becomes more complex when eye disease coexists with frailty, chronic illness, hearing impairment, cognitive change, or limited mobility. These conditions affect the patient's ability to understand instructions, instill eye drops, attend follow-up appointments, and recognize complications. Geriatric ophthalmic care consequently requires anticipatory assessment, environmental safety, caregiver coordination, and individualized teaching rather than a procedure-centered approach alone (Dinarvand et al., 2024; Howard et al., 2023).

The Philippine context adds concerns related to affordability, transportation, delayed consultation, and uneven access to eye services. These barriers can increase the educational and coordination responsibilities of nurses, especially when patients arrive late in the disease process or depend on family members for treatment adherence (Ho et al., 2022).

Expanding Roles of Ophthalmic Nurses

Contemporary ophthalmic nursing includes assessment, triage support, health education, counseling, care coordination, postoperative monitoring, and advocacy. Advanced-practice and nurse-led models have been associated with improved access, shorter waiting times, and patient satisfaction, although role expectations and educational preparation remain inconsistent across settings (Ahokas, 2023; Royal College of Nursing, 2025; Sharbini et al., 2025).

Education is a central nursing responsibility in chronic eye disease. Structured nurse-led glaucoma interventions improve knowledge, treatment motivation, health literacy, and self-management, while patient narratives show that eye-drop routines, uncertainty, and emotional distress remain difficult without sustained support (Hua et al., 2023; Sng et al., 2023; Tsichla et al., 2025).

The person-centered nursing perspective emphasizes that quality care arises from clinical competence, therapeutic relationships, supportive environments, and respect for patient values and circumstances (Kaštelan et

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al., 2024; McCance & McCormack, 2025). In elderly ophthalmic care, this requires nurses to integrate technical precision with patience, reassurance, and caregiver participation.

Communication, Emotional Labor, and Organizational Constraints

Older adults with visual, auditory, cognitive, or motor limitations often require slower pacing, repeated explanations, demonstration, and adapted materials. Nurses must also respond to fear of blindness, anxiety about procedures, loss of independence, and frustration associated with chronic treatment. These demands make communication and emotional support integral to safety and adherence rather than optional additions to clinical care (Hua et al., 2023; Shaban et al., 2024).

The nurse-patient relationship is shaped by workload, staffing, resource access, team coordination, and institutional policies. High-volume services and appointment backlogs can compress teaching time and increase coordination demands. Service redesign can improve efficiency, but it also alters nursing responsibilities and requires adequate preparation and support (Hussain et al., 2023).

Specialty nursing practice also creates emotional labor. Nurses may absorb patient anxiety, compensate for absent caregivers, and continue providing reassurance while managing their own fatigue. A person-centered institution must therefore support both patient needs and the professional well-being of nurses who provide sustained relational care (McCance & McCormack, 2025; Shaban et al., 2024).

Interpretive Phenomenology and the Research Gap

Interpretive phenomenology examines how people understand their lifeworld and assign meaning to experience within specific social and professional contexts. It assumes that reality is multiple and context-dependent and that knowledge is co-constructed through participants' narratives and the researcher's interpretation (Burns et al., 2022; Pham, 2022; Tanlaka & Aryal, 2025).

Reflexivity is essential because values, prior experience, and interaction influence qualitative interpretation. Maintaining a reflexive journal, audit trail, member checking, and transparent analytic decisions strengthens credibility and keeps interpretations grounded in participants' accounts (Adler, 2022; Ahmed, 2024; McKim, 2023; Olmos-Vega et al., 2023; Peddle, 2022).

Existing ophthalmic research explains the burden of vision loss and the effectiveness of selected nurse-led interventions, but offers limited insight into how nurses themselves experience geriatric eye care. The present study addressed this gap by interpreting their roles, challenges, strategies, professional growth, and meanings in one specialized Philippine hospital setting.

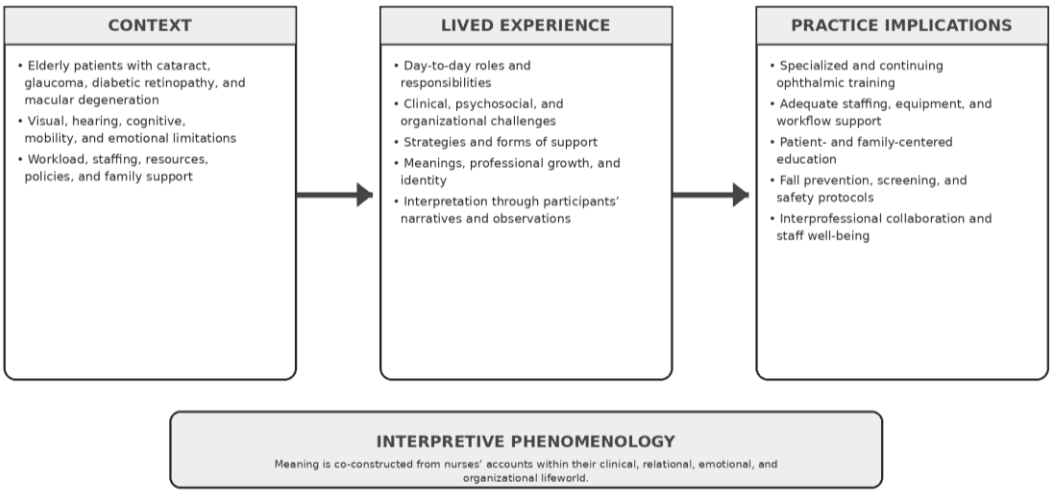

Figure 1. *Conceptual framework of the interpretive phenomenological inquiry*

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METHODS

Research Design

The study employed a qualitative interpretive phenomenological design. This approach was selected because the inquiry focused on how nurses understood and made meaning of their clinical, relational, emotional, and organizational experiences rather than on measuring variables or testing causal relationships (Burns et al., 2022; Pham, 2022).

Research Locale

The study was conducted at Grace Medical Center in the City of San Jose del Monte, Bulacan, particularly in its eye center and ophthalmology-related services. The setting provided direct and sustained exposure to elderly patients receiving care for cataract, glaucoma, diabetic retinopathy, age-related macular degeneration, and other eye conditions.

Participants and Sampling Technique

Eight registered nurses participated through purposive sampling. Eligibility required current assignment to the eye center or an ophthalmology-related service and at least two years of experience caring for elderly patients with eye conditions. The participants were 35 to 45 years old, seven were women and one was a man, and their ophthalmic nursing experience ranged from two to ten years. Daily or shift-based elderly patient exposure ranged from approximately three to forty patients. Purposive sampling was appropriate because the study required information-rich participants with direct experience of the phenomenon (Wutich et al., 2024).

Table 1. *Profile of the participants*

Participant	Age	Gender	Ophthalmic Experience	Average Elderly Patients
P1	35	Female	4 years	3–8
P2	36	Male	2 years	10
P3	39	Female	6 years	20
P4	45	Female	10 years	40
P5	41	Female	8 years	3–8
P6	42	Female	3 years	30
P7	38	Female	2 years	5–10
P8	37	Female	3 years	5–8

Research Instrument

The primary instrument was a researcher-developed semi-structured interview guide aligned with the central and corollary questions. Open-ended prompts elicited narratives about daily roles, clinical and psychosocial challenges, staffing, resources, institutional policies, coping strategies, safety practices, professional meaning, growth, and recommendations. Audio recordings, field notes, researcher observations, verbatim transcripts, and a reflexive journal supported data collection and analysis. The guide underwent expert review for clarity, relevance, sequence, and alignment with the study purpose.

Data Gathering Procedure

Eligible nurses were approached individually and informed about the study purpose, voluntary participation, confidentiality, and their right to withdraw. One-on-one interviews were conducted in a private and convenient setting. With permission, interviews were audio-recorded, and field notes documented nonverbal behavior, contextual details, and immediate reflections. Recordings were transcribed verbatim and reviewed with field notes before analysis.

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Data Analysis

Data were analyzed using Colaizzi's phenomenological method adapted to the interpretive orientation of the study (Vignato et al., 2022). The researcher repeatedly read the transcripts, extracted significant statements, formulated meanings, organized related meanings into theme clusters, developed an exhaustive description, and articulated the essential structure of the experience. The analysis moved repeatedly between participants' words, observations, emerging meanings, and the clinical context.

Trustworthiness and Reflexivity

Credibility, transferability, dependability, and confirmability guided methodological rigor (Adler, 2022; Ahmed, 2024). Probing and sustained engagement supported detailed accounts; participant confirmation or member checking was used where applicable; thick description documented the setting and participant context; and an audit trail recorded coding and theme development. Reflexive journaling helped the researcher identify assumptions and maintain interpretations grounded in the nurses' narratives (McKim, 2023; Olmos-Vega et al., 2023; Peddle, 2022).

Ethical Consideration

The manuscript identified informed consent, voluntary participation, confidentiality, anonymity through participant codes, non-maleficence, beneficence, justice, and the right to pause, skip a question, or withdraw as ethical safeguards. Data were described as securely stored and accessible only to the researcher. No institutional ethics-review approval number was reported in the source manuscript; therefore, no approval code is asserted in this article.

RESULTS AND DISCUSSION

Day-to-Day Roles: Clinician, Educator, Advocate, Coordinator, and Holistic Caregiver

Table 2. *Principal roles described by ophthalmic nurses*

Theme	Meaning in Practice	Representative Statement
Clinical assessment and vigilance	Assessing needs, monitoring visual condition, and ensuring complete and safe care	"I usually start by assessing my patients, checking what they need."
Education and critical thinking	Explaining care to patients and families and adapting teaching to patient capacity	"My role…improves how I educate different kinds of patients."
Advocacy and specialized care	Protecting rights, promoting independence, and coordinating assistive or rehabilitation support	"I advocate for them…to help them stay independent."
Coordination and teamwork	Working with ophthalmologists, relatives, and other professionals	"I work closely with doctors and other healthcare professionals."
Adaptability and holistic care	Adjusting to disability, behavior, and individual circumstances	"Every day brings a new challenge."

The nurses understood their work as broader than technical assistance. Assessment was the foundation of care, but it was inseparable from education, advocacy, coordination, and emotional support. Participants described evaluating patient needs, adapting to disability and changing behavior, involving families, and protecting patient independence. These accounts reflect contemporary descriptions of ophthalmic nursing as a specialized and expanding practice that combines clinical competence with communication and care coordination (Royal College of Nursing, 2025; Sharbini et al., 2025).

The roles were also experienced as sources of professional identity. Nurses described critical thinking, evidence-based care, holistic practice, and the responsibility to make older adults feel safe. This pattern supports

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person-centered ophthalmic care, in which clinical outcomes and human experience are treated as equally important (Kaštelan et al., 2024; McCance & McCormack, 2025).

Challenges: Communication Barriers, Emotional Labor, Behavior, and Workload

Table 3. *Major challenges encountered in elderly ophthalmic care*

Challenge Theme	Manifestation	Effect on Care
Sensory and cognitive barriers	Poor vision, hearing impairment, memory difficulty, confusion, and difficulty following instructions	Repeated explanation and extra time were required during procedures and medication teaching.
Anxiety and dependence	Fear, uncertainty, and unaccompanied elderly patients	Nurses extended assistance and reassurance beyond routine tasks.
Behavioral complexity	Irritability, short temper, or combative behavior	Nurses balanced patient safety, self-protection, and empathy.
Treatment adherence	Difficulty understanding eye-drop and home-care instructions	Family involvement, pictures, written guides, and demonstrations were needed.
Nurse strain	Physical illness, fatigue, and emotional burden	Participants acknowledged that their own condition could limit care capacity.
High workload and understaffing	Patient loads ranging from 3 to 40 and insufficient staffing	Less time was available for assessment, education, monitoring, and individualized attention.

Communication difficulties were the most consistently described clinical challenge. Poor vision, hearing loss, memory changes, and confusion made instructions difficult to understand and increased anxiety during assessment, procedures, and discharge teaching. Nurses responded by slowing the pace, repeating explanations, demonstrating medication techniques, using pictures or written instructions, and involving relatives. These findings align with evidence that chronic eye disease requires sustained self-management support and adapted communication (Hua et al., 2023; Howard et al., 2023).

The nurses also carried substantial emotional labor. Unaccompanied patients, fear of vision loss, irritability, and combative behavior required calmness and reassurance, while high patient volume and personal fatigue reduced the time and energy available for relational care. The findings show that geriatric ophthalmic nursing involves simultaneously managing patient vulnerability and the nurse's own emotional and physical limits. Broader qualitative evidence similarly positions therapeutic trust and emotional presence as central to nursing older adults (Shaban et al., 2024).

Institutional Context: Staffing, Resources, and Policies

Table 4. *Contextual factors shaping the nurses' experience*

Contextual Factor	Interpretive Summary
Staffing	Adequate staffing enabled thorough assessment, education, monitoring, and individualized care; understaffing increased waiting time, exhaustion, and risk of missed needs.
Resources and equipment	Accessible supplies and functioning equipment supported diagnostic accuracy, treatment options, efficiency, and patient safety; shortages delayed interventions.
Institutional policies	Protocols provided clarity, standardization, and error prevention but also shaped autonomy, workload, scheduling, insurance processes, budgets, and treatment availability.

All participants connected staffing levels with care quality. Adequate staffing created time for focused assessment, teaching, and monitoring; insufficient staffing increased workload and fatigue and reduced individual attention. Resource availability likewise influenced diagnostic accuracy, workflow, treatment choices, and the

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ability to manage complex cases. These contextual factors form part of the clinical lifeworld and explain why compassionate intent does not always translate into adequate time and support.

Institutional policies were generally experienced as safeguards because they standardized procedures and reduced uncertainty. At the same time, nurses recognized that policy decisions shaped role boundaries, budgets, insurance requirements, scheduling, and workload. The findings indicate that policies influence both bedside behavior and the organizational conditions under which care becomes possible. Service redesign research similarly shows that operational systems can improve efficiency only when responsibilities, resources, and professional preparation are aligned (Hussain et al., 2023).

Strategies and Forms of Support

Table 5. *Strategies used to address clinical, psychosocial, and organizational needs*

Strategy Theme	Specific Practices
Patient-centered communication	Simplified language, repetition, active listening, reassurance, and opportunities for questions
Demonstration and teach-back	Asking patients to demonstrate eye-drop instillation and explain precautions
Family and caregiver involvement	Including relatives in education, decisions, emotional support, and home medication routines
Clinical vigilance	Comprehensive assessment, close monitoring, early recognition of changes, and timely referral
Therapeutic and psychosocial support	Validation of feelings, empathy, rapport, counseling referral, and support groups
Teamwork and coordination	Collaboration with ophthalmologists, the healthcare team, and family members
Organizational coping	Prioritization, time management, standard documentation, workflow improvement, and chain of command
Safety and quality evaluation	Patient identification, dual verification, protocol adherence, outcome monitoring, satisfaction feedback, and adherence assessment

The strategies combined relational, technical, and organizational competence. Simplified explanations, repetition, active listening, demonstration, and caregiver involvement addressed comprehension and anxiety. Close monitoring and multidisciplinary coordination supported early identification of complications. These practices are consistent with evidence that nurse-led ophthalmic education can improve knowledge, motivation, and self-management (Sng et al., 2023; Tsichla et al., 2025).

Psychosocial support was delivered through empathy, validation, therapeutic communication, rapport, and referral to counseling or support groups. Organizational pressures were managed through time management, prioritization, communication, protocol use, documentation, and workflow optimization. Patient safety was reinforced through verification, teach-back, adherence monitoring, and evaluation of outcomes and satisfaction. The results show that safe care depends on both procedural precision and a relationship that enables the patient to understand and participate.

Meaning, Fulfillment, and Professional Growth

Table 6. *Meanings and growth derived from geriatric ophthalmic nursing*

Emergent Meaning	Interpretation
Preserving vision and independence	Work was meaningful when patients-maintained vision, improved daily functioning, or felt safer.
Emotional fulfillment	Participants experienced intrinsic reward through compassionate care, education, and reassurance.
Clinical growth	Experience strengthened assessment, technical skills, monitoring, decision-making, and clinical autonomy.

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Relational growth	Nurses developed patience, empathy, gentleness, communication skill, and sensitivity to vulnerability.
Adaptive professional identity	Repeated exposure to complex cases strengthened resilience, flexibility, and confidence.

The essence of the experience was a combination of responsibility, emotional connection, and professional transformation. Nurses found fulfillment in helping older adults preserve vision, remain independent, and regain confidence in daily life. The work was meaningful not only because of clinical outcomes but because patients felt understood and safe. This interpretation is compatible with person-centered nursing, where therapeutic relationships and the care environment contribute to both patient outcomes and professional fulfillment (McCance & McCormack, 2025).

Participants also described growth in communication, patience, empathy, technical skill, clinical judgment, and autonomy. Experience with sensory impairment and complex geriatric needs taught them to individualize care and become more emotionally grounded. The findings suggest that ophthalmic nursing forms professional identity through repeated encounters that integrate technical mastery with humanistic practice.

Practice Enhancement Priorities

Table 7. *Practice priorities derived from participant recommendations*

Priority Area	Recommended Actions	Expected Contribution
Specialty education	Provide regular ophthalmic and geriatric training, seminars, simulation, and opportunities for postgraduate specialization.	Improved competence, confidence, and evidence-based practice
Staffing and resources	Review nurse-patient allocation; maintain equipment, supplies, and accessible teaching materials.	More time for assessment, teaching, monitoring, and safe care
Patient-family education	Use simplified instructions, large-print or pictorial materials, demonstration, teach-back, and caregiver coaching.	Better comprehension, medication adherence, and continuity at home
Prevention and access	Strengthen eye screening, fall-prevention practices, and early referral.	Earlier detection and reduced injury risk
Collaborative learning	Create case conferences, peer mentoring, and shared learning with ophthalmologists and other professionals.	Improved coordination and clinical decision-making
Relational and staff support	Promote rapport, patience, debriefing, and attention to nurses' physical and emotional well-being.	Sustained compassionate care and reduced strain

Participants consistently recommended continuous training, adequate staffing and resources, stronger patient-family education, preventive measures, and collaboration. These priorities recognize that improvement requires both individual competence and organizational support. The proposed actions should be implemented within institutional policy, available resources, and formal quality-improvement procedures rather than treated as isolated personal initiatives.

CONCLUSION

Ophthalmic nurses experienced geriatric eye care as a complex, relational, and professionally meaningful practice. Their daily work combined assessment, education, advocacy, coordination, safety monitoring, and holistic support. Communication barriers caused by poor vision, hearing impairment, confusion, and memory difficulty were central challenges, while anxiety, difficult behavior, lack of companions, treatment nonadherence, heavy workload, and nurse fatigue increased the emotional and practical demands of care.

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The nurses responded through patient-centered communication, repeated and simplified instruction, demonstration, caregiver involvement, therapeutic support, clinical vigilance, teamwork, prioritization, adherence to protocols, and outcome monitoring. Their experience showed that technical accuracy and compassionate relationships cannot be separated in elderly ophthalmic care. Staffing, resources, and institutional policies shaped the time, options, confidence, and autonomy available to nurses.

The essential meaning of the experience was found in preserving vision, supporting independence, reducing fear, and witnessing improvements in patients' quality of life. Caring for elderly ophthalmic patients also transformed the nurses by strengthening empathy, patience, communication, clinical competence, adaptability, and professional autonomy. Quality geriatric ophthalmic nursing therefore depends on both the human capacities of nurses and an institutional environment that enables those capacities to be practiced safely and consistently.

Recommendation

Grace Medical Center and similar eye-care facilities should institutionalize continuing ophthalmic and geriatric nursing education, including communication with sensory-impaired older adults, eye-drop teaching, fall prevention, behavioral management, emergency response, and family-centered care. Mentoring, case conferences, simulation, and interdisciplinary learning should be integrated into staff development.

Administrators should review staffing patterns, patient allocation, equipment availability, supply continuity, and workflow processes. Large-print and pictorial teaching materials, medication demonstration aids, and caregiver-assisted discharge protocols should be standardized. Policies should preserve patient safety while supporting clear role definitions, timely decisions, and practical nursing autonomy.

Nurses should continue using teach-back, repeated explanation, therapeutic communication, family involvement, and systematic follow-up to strengthen adherence and safety. Formal mechanisms for staff debriefing, emotional support, and health protection should also be provided because nurse well-being directly affects the capacity to deliver patient-centered care. Future research should include multiple institutions and the perspectives of elderly patients, caregivers, ophthalmologists, and administrators, and may use longitudinal or mixed-method designs to evaluate the recommended practice improvements.

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