ABDO Diploma in Contact Lens Practice

Guidance related to the Case Records to be presented for Unit 6 of the Diploma in Contact Lens Practice

For Unit 6 of the ABDO Diploma in Contact Lens Practice, candidates are required to present 15 case records chosen from the patients fitted and managed during the personal clinical experience period. A number of the case records will be discussed in detail with the candidate, including decisions made and actions taken.

The records must reach ABDO by 31 March (for Summer practical exams) or 30 September (for Winter practical exams). The Final Declaration must be uploaded with the case records, signed by the Practice Education Lead (PEL) stating that the candidate has achieved the minimum of 225 hours of personal, clinical practical experience and that the case records are copies of records of patients who are traceable to records in the practice.

The case records should demonstrate the range and depth of experience of the candidate and are required to meet the following criteria:

Fitted Patients (10)
•2 presbyopic patients demonstrating management of both distance and near visual requirements. Please note that a minimum of 1 of these patients must have been fitted with bifocal/multifocal contact lenses for their near vision requirements
•2 rigid lens patients – Please note that we are unable to accept Ortho-K patients for this category, although corneal, mini-scleral and scleral lenses can be included
•2 astigmatic patients fitted with toric contact lenses
•2 paediatric patients (defined as aged under 16).Please note that a minimum of 1 of these must be myopic and have some discussion around myopia management as part of their fitting process(although specific myopia management lenses do not have to be fitted to the patient)
•2 patients with prescriptions of 5.00D or more

Managed Patients (5)
•2 existing patients showing clinical signs caused by contact lens wear (issues with the cornea or adnexa) which require refitting or a major change in management. These case records do not need to have been originally fitted by the candidate
•2 existing patients who have attended the practice with concerns caused by contact lens wear (this could include issues with vision or comfort) which require refitting or a major change in management. These case records do not need to have been originally fitted by the candidate
•1 patient showing clinical signs or symptoms that require referral outside of the practice (not to an optometrist). This record does not necessarily need to have been refitted or managed by the candidate, nor does this case record does not need to have been originally fitted by the candidate

The cases should be selected from those patients fitted during the personal clinical practical experience and should demonstrate a depth and breadth of experience.

For the fitted patients, the patients are required to have been fitted and monitored until the fitting is deemed to have been completed (with specifications issued) and to have a minimum of 1 routine aftercare appointment after the fitting has been completed

For the managed patients, the patients must be monitored until the existing issues have been resolved and at least one full aftercare to have taken place after the issue has been resolved

If a case record does not meet the above criteria, it will be considered invalid. Candidates will be given feedback on the reason for the invalidity and will be required to resubmit either an amended record or a replacement record. Only when all 15 records have been accepted as valid can arrangements be made for your case record discussion.

The notes should report **appropriate** aftercare so the number of appointments will depend on the type of lens, the type of lens wear and the patient's ocular status. Whilst some patients will be neophytes requiring more support, other patients who are established wearers may require less frequent aftercare consultations. Candidates should be aware that they are demonstrating appropriate aftercare for the situations they are reporting.

NB: Those re-sitting the case records section of the examination should be aware that if they are replacing any of their original case records, they will need to submit to ABDO to ensure that they are valid before arrangements can be made for a further case record discussion.

Case Record Presentation

The records are not required to be photocopies of the originals as it is appreciated that the practical experience practice record format may not demonstrate the candidate's full potential. However, the record of the initial appointment should not exceed the equivalent 2 sides of A4 and the following consultations should not generally exceed the equivalent of 1 side of A4 for each appointment.

Information regarding the Case Records to be presented for Section 5 of the Practical Examination

This information is advice regarding the layout and content of case records.

Format and layout of the records

The Association does not have any specific requirements with regard to the format and layout of the record as clinicians will have their own preferences – other than that the information is clearly recorded and in a logical order.

However, the Association states that –

- The records must be no larger than A4 size
- The initial appointment notes may cover 1 or 2 sides of A4 but should not exceed 2 sides of A4
- The layout of the routine follow-up appointments should not exceed 1 side of A4.
- The case records may be produced fully on the computer or may involve a computer produced record to which the individual patient's notes are added by hand or may be fully hand-written. As long as it is clear and legible, the structure of the pages is the candidate's choice.

The Data within the Case Records

The Association's 'Advice and Guidelines' recommends the following minimum data should be recorded -

A) For initial appointment of a new patient:

1) General Information
   - Date fitting commenced
   - Name (for the examinations, use only a reference number or initials)
   - Address/contact details (omit for the examinations)
   - Age
   - Referring optometrist/ophthalmologist
   - Spectacle prescription and VAs
   - Any initial contraindications to CL fitting
   - Patient's reason for wanting contact lenses
   - Occupation and working environment
   - Sports, hobbies and pastimes
   - Allergies/Hay Fever (Seasonal allergic conjunctivitis)
   - Personal and family ocular history
   - Personal and family general health and specific pathologies
   - Medications
   - Smoker
   - Driver
   - General practitioner (omit for the examinations)
   - Contact lens history
2) Detailed examination of the anterior eye should include space for assessments of:
   - Each layer of the cornea
   - Limbus
   - Conjunctiva
   - Lids, lid margins, and lid position (upper and lower), lid tensions
   - Tear assessments – quality and quantity
   - Other relevant data (e.g. horizontal visible iris diameter, pupil diameter in varied illuminations, vertical palpebral aperture)

   A grading scale and diagrammatic recording may be used.
3) Keratometric information
   - Type of instrument, mire quality; radii and axes/meridians, dioptric values. Topographical information if available, would be an alternative.
4) Lens options discussed with the patient should be recorded. 5) Contraindications found in the examination
6) Trial contact lenses used with full details of:
   - fit assessment over refraction
   - visual acuities
   - confirmation tests (duochrome, +1.00 blur, pin hole) where appropriate
7) Details of lenses to be ordered
8) Next scheduled appointment

B) For collection appointment

1) Assessment of lens fit and visual acuities, confirmation tests, where appropriate
2) Instruction given to the patient Lens handling and ability to
    - insert, remove, recentre
    - Personal hygiene; use of care system
3) Recommended wearing schedule.
4) Recommended care system
5) Recommended next aftercare appointment
6) Patient acknowledgement form, if used, may be completed and retained with the record (although not required for the examination).

C) For subsequent appointments:

1) General information
    - History and symptoms since last visit
    - Patient's impressions of vision and comfort
    - Wearing pattern
    - Care system, compliance and handling
2) Over refraction
    - Visual acuities with lenses
    - Subjective assessment, visual acuities, confirmation tests (duochrome, + 1.00 blur, pinhole), where appropriate
3) Examination of lenses on the eyes
    - Assessment of fit
    - Lens condition
4) Other examinations the practitioner considers appropriate
    - e.g. Pre-lens tear break-up time, keratometry, VA with current Rx.
5) Detailed examination of the anterior eye should include space for assessments of:
    - Each layer of the cornea
    - Limbus
    - Conjunctiva
    - Lids and lid margins
    - Tears

    A grading scale and diagrammatic recording may be used.
6) Conclusions/Advice/Actions
    - Space should be available for practitioners to record any recommended changes in wearing pattern, fittings, care system: the need, where appropriate, to discontinue lens wear (temporary or permanent), any adjustments to power or fit, etc. This should include the rational for any changes to meet any requests of the patient. Also included under this heading would be advice on time of next contact lens aftercare check and/or full eye examination.
7) Contact Lens Specification
    - Specifications are expected to be issued to the patient once the fitting and appropriate amount of aftercare have been completed to confirm that the lenses are suitable for the patient and their intended use: the specification expiry date should be noted and it is advisable that a copy be made and kept in the patient's records.

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