

ABDO Certificate in Contact Lens Practice

Guidance related to the Case Records to be presented for Section 5 of the Practical Examination



For Section 5 of the ABDO Certificate in Contact Lens Practice examination, candidates are required to present 10 case records chosen from the patients fitted 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 May (for Summer practical exams) or 30 November (for Winter practical exams). The Primary Supervisor Declaration must be submitted with the case records, signed by the Primary Supervisor stating that the candidate has achieved the minimum of 224 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:

A mix and range of prescriptions, replacement modalities, lens designs and materials including silicone hydrogel, to include:

- myopes and hyperopes and a minimum of 2 patients with Rx of more than 5 dioptres
- a minimum of 2 patients demonstrating bifocal/multifocal contact lens management of their near vision requirements
- a minimum of two rigid lens patients
- a minimum of two toric lens patient
- a minimum of two aftercare problems – to show clinical problems 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 but must meet the same aftercare requirements of the other records.

The cases should be selected from those patients fitted during the personal clinical practical experience and should demonstrate a depth and breadth of experience. The patients are required to have been monitored over a minimum period of 6 months, so the first pair of lenses must be issued by the candidate to meet the following dates -

- Summer sitting (and Autumn resit session) – 30 November
- Winter sitting (and Spring resit session) – 31 May

If a case record does not meet these criteria, it will be considered invalid. The reduced number of records therefore presented, will reflect in the marks for that section.

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 re-presenting any of their original case records, it will be expected that those case records will show up-to-date aftercare. For example, if the candidate indicates that an aftercare consultation should occur in the period between the first and subsequent examination attempts, the re-submitted case records should show any notes of that and any subsequent visits.

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 2 sides of A4 and the following consultations should not generally exceed 1 side of A4 for each appointment.

The records should be presented in a flat folder, with each **case record** (not page) held within an individual punch pocket, if possible.

Supervision Guidelines

To support the progression of TCLO's since previous COVID restrictions, you may register a supporting supervisor if applicable. The supporting supervisor must not be responsible for more than 1/3rd of the total hours recorded by the TCLO.

We can also permit the registration of a secondary practice if applicable. As with a supporting supervisor, the practice must not be used for more than 1/3rd of the total hours recorded by the TCLO. Case records can be accrued with the secondary supervisor and/or the secondary practice.

Should you wish to register a secondary practice and/or a secondary supervisor, then please complete the relevant form available on the ABDO website.

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 rationale 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.