# The European Diploma Portfolio

# Guidance for Candidates and Examiners

**February 2014**

# Introduction

Congratulations on your decision to enter for the European Diploma in Optometry. This is the highest non-therapeutic qualification in Europe and is equivalent to World Council of Optometry Category 3. To demonstrate you have achieved this standard you need to keep a record of all the primary healthcare eye examinations that you undertake on real patients, either as a student in supervised university clinics, during externships or in your professional practice following graduation.

To complete **Section 2 (Page 4 of the Portfolio document)** you should select 150 cases seen over the last two years that demonstrate your optometric knowledge and skills. For 130 of these cases full clinical details are not required but you must include in the Portfolio a list of these cases, in the format shown on page 8 of the Portfolio, so that these patient records can, when necessary, be retrieved from the practice and examined by representatives of the European Diploma..

The remaining 20 cases are to be submitted with the portfolio in sufficient detail to demonstrate that you have been offering optometric care at the European Diploma scope of practice. These should be challenging cases that demonstrate the range of your optometric skills and knowledge. Five detailed records are required under each of the four headings given in **Section 3 (Page 5 of the Portfolio)**.

# The Purpose of the Portfolio

The Portfolio provides ECOO with the evidence to that you have the patient experience and clinical skills to offer optometric care at the level of the European Diploma. This Guidance is for Candidates and Examiners and its purpose is to suggest what level of detail might be expected in the case records and in particular how to present these data in the twenty detailed case studies.

Guidance is given below on each of the three sections of the Portfolio to help the Candidate when writing up the portfolio and the Examiner when assessing it. It is hoped that this guidance will ensure consistency in the evaluation of the patient experience data by examiners from ECOO and by the departmental staff of fully accredited institutions.

**N.B. A satisfactorily completed Portfolio or a training institution "accredited as equivalent" record of patient experience is required for all European Diploma candidates.**

# Part One: Guidance for Candidates

## Guidance for Completion of each Section of the Portfolio

**Section 1. Candidate details (Page 3 of the Portfolio)**

In this section the Candidate provides his/her name and address and contact details.
A copy of the Candidate's passport or identity card is to be enclosed with the Portfolio.

The remainder of this section then defines which of the possible educational routes the Candidate has followed to reach the stage of submitting the Portfolio and lists what supporting evidence is required.

**Routes to the Portfolio**

**a) By Examination** – by passing all of the written and practical examinations of the European Diploma.
***Information required:*** *The European Diploma candidate number, the date of successful completion of the examinations.*

**b) By Partial Accreditation and Examination** - by graduating from a partially accredited training institution and subsequently passing the non-accredited sections in the European Diploma examinations.
***Information required:*** *The name of the training programme, the name and address of the training institution, the starting and finishing dates of study at the institution, the European Diploma candidate number, the date of successful completion of the non-accredited sections in the European Diploma examinations. A certified copy of the national (professional) diploma and/or university diploma.*

**c) By Accreditation of all the European Diploma Examinations but NOT the patient experience requirements –** by graduating from a training institution accredited for all of the written and practical examinations of the European Diploma but where students are unable to gain sufficient patient experience within the period of training for them to fulfil the Portfolio requirements. The Candidate completes a Portfolio after graduation containing any suitable patient experience gained within the training programme and further patient experience gained as a qualified optometrist.
***Information required:*** *The name of the training programme, the name and address of the training institution, the starting and finishing dates of study at the institution. A certified copy of the national (professional) diploma and/or university diploma.*

**Section 2: Evidence of Clinical Experience. (Page 4 of the Portfolio)**

The objective of this section is to broadly define the nature and extent of the Candidate's optometric experience on the basis of the approximate numbers of patients seen over the last two years.

***Information required:*** *Date of qualification as an optician, years of practice as an optician, date of qualification as an optometrist, years of practice as an optometrist, copies of certificates, the names and addresses of practices, hospitals (see Section 4, page 6 of the Portfolio).*

*Approximate patient numbers over the last two years divided into:*

*Eye examinations,*
*Ophthalmic dispensings,*
*Contact lenses RGP and Soft,*
*Referrals of ocular disease and abnormalities.*
*Patients seen under ophthalmological supervision in a hospital or eye clinic.*

***Supporting evidence.***

*A list of 130 Patients presented in the format indicated on page 7 of the Portfolio, with each patient classified into the appropriate group(s).*
*The 130 patients should not be identified by name but by a unique reference number that will permit the original record card to be retrieved from the practice if it is requested by the examiner.*

**Section 3: Evidence of scope-of-practice**. (Page 5 of the Portfolio)

The requirement of this section is that the candidate presents twenty detailed case records that demonstrate experience of the whole range of optometric practice at the level of the European Diploma (WCO Category 3).

**Primary Care Eye Examinations** (5) – All the records should cover a complete eye examination, starting with a summary of the history, any previous treatment up to the time of the examination and follow the guidance given below. The five patients selected should include two with binocular vision anomalies, one patient with low vision and one patient who is 12 years of age or younger.

**Abnormal Ocular Condition Cases** (5) – All the records should cover a complete eye examination, starting with a summary of the history, any previous treatment up to the time of the examination and follow the guidance given below. The discussion should include a description of the abnormal ocular condition and how the presentation in this case differs from the text book description. Three of the cases should include letters referring the patient to an ophthalmologist.

**Contact lenses** (5) including 1 RGP fitting – All the records should cover a complete eye examination, starting with a summary of the history, any previous treatment up to the time of the examination and follow the guidance given below. The contact lens fittings should be illustrated with appropriate diagrams or photographs.

**Dispensing** (5) - All the records should cover a complete eye examination, starting with a summary of the history, any previous treatment up to the time of the examination and follow the guidance given below. These records should be of patients whose ophthalmic dispensings presented particular challenges. Outline the nature of the dispensing difficulty and justify the solution chosen.

**Record Format for the 20 detailed case records.**

There is no standard record card for the twenty detailed cases. Candidates should present these cases as they think most appropriate and the records may be all to the same format or different for each patient.
The 20 patients should not be identified by name but by a unique reference number that will permit the original record card to be retrieved from the practice if it is requested by the Examiner.

There are many ways of presenting these records and it is for the candidate to decide what format and content is most effective for each case. The diagnosis and management must be evidence-based and as far as is possible the evidence should be included in the record
The important thing is that in each of these twenty case records the candidates should demonstrate:

- their understanding of the patient's problems,
- how they decide which clinical tests are appropriate,
- how they interpret their clinical findings,
- how they come to a diagnosis,
- the logic of their management plan,
- the prognosis.

**Further Guidance for Candidates who are not familiar with presenting Detailed Case Studies.**

The following list of headings and content might be useful when deciding on how to present a particular case. These are just suggestions for you to consider and obviously not all are relevant to all patients.

**History and Symptoms (Anamnesis):**
Age, gender, ethnical background (pertinent for differential diagnosis)

| | |
|---|---|
| Chief complaint: | Why does the patient want an eye examination?<br>Signs and symptoms as described by patient<br>What additional information do you obtain about the patient's complaints?<br>For contact lens or spectacle follow-up, what additional information is needed for you to evaluate compliance? |
| Refractive history: | Does the patient wear glasses, contact lenses (solutions used), etc. |
| Ocular history: | Did the patient have problems in the past? Did or does he/she have medical or surgical treatments in the past or currently? If so, when and where? |
| Systemic history: | Pertinent information about systemic disease such as diabetes, hypertension, thyroid disease, etc. |
| Medication use: | Does the patient use medication (think of side effects )? If so, what type and how often? Compliance? Including rewetting-drops for ocular problems. |
| Family history: | Are similar problems in the family? |

**Differential diagnosis:**
Based on the obtained information provided by the patient during history taking, you should be able to provide at least two (2) diagnoses which could be the cause of the patient's complaints. Which condition do you need to rule in or out during your examination? Based on the differential diagnoses, you then build your examination strategy.

**Clinical information collection:**
List the tests and the test results you performed to evaluate the patient. These should include examination of the anterior and posterior segments of the eye, cover test, ocular

motility, objective and subjective refraction and any other tests as required, supporting photographs, printouts, visual fields, details of diagnostic drugs used etc. Indicate whether test results are outside normal limits and whether findings are different from what you would expect considering age, gender, appearance etc.

**Pictorial evidence:** Including drawings, diagrams, visual field plots and photographs in the record is recommended. If a photo slit-lamp is not available it is possible to take reasonable quality photographs of the external eye with a normal digital camera or a smartphone. Sometimes photographing through the slit lamp eye piece can give adequate results.

**Tentative Diagnoses:**
Provide a list of possible diagnoses. Think of refractive problems, ocular disease primary or secondary to systemic disease, systemic diseases that potentially could cause the current or future ocular problems.

**Management Plan:**
Each diagnosis should go along with a plan that you make on how to approach or solve the patient's problems. The plan should contain pertinent information on

- Your clinical judgment (i.e. situation stable, better, worse)
- Are there other tests you need to perform to come up with a definite diagnosis?
- Your advice and explanation to the patient
- Whether or not you need to refer the patient, to whom and the timeframe
- Do you need to see the patient again for follow-up? If so, when?
- What is the appropriate refractive correction?
- How should the refractive correction be dispensed? Spectacles or contact lenses
- Specification of spectacles lenses and frame/Contact lenses.
- Instructions for wear.

**Discussion:**
Provide a brief discussion of your case. What problems did you encounter? Describe the thinking process of how you came up with the differential diagnosis after history. Describe how you came to the final diagnosis and why you did or did not refer the patient. Justify your refractive correction. Why and when you want to see the patient again for a follow-up.

**Additional guidance for Contact lens fitting.**

***Example of information needed on Portfolio contact lens case.***
A contact lens case should not only contain the contact lens specific information but also a baseline full eye examination including posterior segment assessment prior to lens fitting. Below is an example of the information needed for a contact lens case.

1. Full eye examination (see above)

2. Contact lens specific testing
    Refraction
    Cornea topographical data:
        Central and peripheral keratometry readings OR
        Corneal topography pictures with readable K-readings
    Data of the selected preliminary lens
    Evaluation of the preliminary lens including supporting evidence

Drawings, photos (or movie on a CD) showing the movement and positioning of the lens

Fluorescein evaluation (drawing or photo) for RGP lenses

Refraction with preliminary lens

Tentative Diagnoses (see information above)

Management Plan (see information above plus)

Include changes you need to make to improve the lens fitting

Provide an explanation why you need to make the changes

Include a follow-up visit with the evaluation of the adjusted lens

Include the data of the lens prescribed

Discussion (see information on discussion above)

It would be sensible to choose contact lens cases to show your skills e.g.

| | |
|---|---|
| 2 cases | Soft-toric contact lenses (astigmatism > 2 dioptres) |
| 2 cases | RGP-toric contact lenses (astigmatism > 2 dioptres) |
| 1 case | Specialty contact lens (i.e. keratoconus, keratoplasty after refractive surgery, bifocal RGP lens, multifocalt RGP or soft contact lens, scleral lens, etc.) |

*The above example is based on a contact lens fit. Please think of a similar testing and reporting scheme for other cases, i.e. binocular vision or ocular health problems.*

**Section 4: Certificates.**

Certificate to be completed by the candidate.

Certificates of support from lecturers, colleagues etc. (Page 7 of the Portfolio)

**Page 8 of the Portfolio.**

Format for presentation of the details of the 130 patients required in Section 2.

# Part Two: Guidance for Examiners

## This advice is additional to and should be read together with the Part One: Guidance for Candidates.

**Fully Accredited Programmes** – Graduates of training programmes that are accredited for all sections of the European Diploma Examinations and where the programme contains patient experience "accredited as equivalent" to the Portfolio, do not submit a Portfolio. They are awarded the European Diploma by the accredited institution on Graduation from the accredited programme.

## However, to ensure equivalence between the different routes, the Examiners in Fully Accredited Institutions should consult these guidelines when assessing their students' patient experience to ensure that it is at an equivalent standard to that described below.

## Notes for Examiners

### Section 2: The list of 130 cases.

The patients presented should cover all the classifications on page 7 of the Portfolio.
If there is doubt about the validity of these data a request for a specified 10% sample of practice records can be made.

### Section 3: The 20 detailed cases

The assessment is based on the completeness and coherence of the record.

**Points to consider:**

Has the candidate gained sufficient information from the patient?
Have all likely possibilities been explored?
Have inconsistencies in the findings been noted and discussed?
Is there an adequate description of the ocular and general health of the patient?
Is the relationship between unaided vision, refractive error and corrected acuity plausible?
Is the relationship between the objective refraction, the subjective refraction and the final prescription plausible? Are any differences noted and discussed?
In the different cases is there a reasonable range of numerical descriptors e.g. C/D ratio, A/V ratio, phoria, anterior chamber angle, IOP etc.

**Criteria:**

Overall are you convinced that the Candidate understood the problems of the patient, performed an adequate investigation and provided a safe and satisfactory service to the patient?
Is the record convincing as an eye examination performed by a reasonably experienced, 1-2 years, and competent optometrist working independently with patients at the level of the European Diploma?

**NOTE: The Candidate's investigation and management does not have to be the same as how the Examiner would have managed the patient!**

**- END -**