Step 2. Case Log

Optometry Australia Credentialled Advanced Practitioner - Glaucoma (OACAP-G)

OACAP
Optometry Australia
Credentialled Advanced Practitioner

Instructions

Each candidate must submit:

- 5 cases that are Primary Open Angle Glaucoma (please note this includes Normal Tension Glaucoma)
- 5 cases that are Secondary Glaucoma
- 5 cases that demonstrate progression of glaucoma
- 5 cases that depict collaborative care

Beyond this, the case can be any type of glaucoma.

You must record a minimum of 20 gonioscopy's.

Each log should be no more than 800 words, with a majority of those in the Diagnosis and Management section.

Each case log is intended to document one visit for that patient.

Please ensure to use the template provided (Excel spreadsheet) to record your case log.

Visual Fields: Please describe the machine, testing used, reliability, any defects and progression analysis if applicable.

Management: Please detail collaborative care where possible and briefly outline your role.

Relevant evidence base: Please name relevant studies and the pertinent findings that guided your management. No more than 100 words.

Candidates must ensure that:

1. All patient information included in the case log is de-identified;
2. Each case log included in their application are a true and correct representation of their experience in glaucoma and not in any way falsified, misleading or deceptive;
3. Each document or record provided to Optometry Australia's Personnel or the Panel of Assessors as part of their application is true and correct and is not in any way falsified, misleading or deceptive;
4. Where necessary, they have the relevant consent of their clients to disclose their de-identified Personal Information to us in the Case Log submitted in support of their application;

5. Each document provided to Optometry Australia is their own work and they will properly acknowledge others and their work where appropriate, and that it has not been submitted by themself or others for assessment in other programs.
6. Cases will not be more than 10 years old, you can have been seeing the patient for 10 years but the point of interaction you are documenting needs to be within 10 years.

Marking Rubric

CASE LOG MARKING RUBRIC					
	Unsatisfactory		**Satisfactory**		
Category and Criteria	**Poor (1)**	**Need Improvement (2)**	**Satisfactory (3)**	**Good (4)**	**Excellent (5)**
Presenting Complaint	Incomplete or unclear documentation of the presenting complaint, lacking essential details.	Basic documentation of the presenting complaint but missing specific details like duration or severity.	Adequate documentation with most relevant details, though lacking depth in exploration of symptoms.	Thorough and precise documentation, with clear detail on onset, duration, severity, and associated symptoms.	Comprehensive and insightful documentation, showing a deep understanding of the presenting complaint, with detailed notes on progression and impact on daily life.
Patient Ocular History	Minimal or no documentation of patient ocular history.	Basic ocular history recorded, but lacking significant details or relevance.	Adequate ocular history that includes major relevant past conditions or treatments.	Detailed ocular history covering all past conditions, treatments, and outcomes with relevant contextual understanding.	Comprehensive ocular history, with an in-depth understanding of past and present conditions, treatments, and their implications for current management.
Family Ocular History	No family ocular history recorded.	Basic family history recorded, with minimal detail.	Adequate documentation of family history, including relevant conditions in immediate family members.	Thorough family history with detailed information on ocular conditions, including extended family if relevant.	Comprehensive and insightful family history, highlighting patterns or hereditary conditions with significant relevance to the patient's case.

General Health	No or insufficient documentation of general health.	Basic health information recorded, lacking in detail.	Adequate general health history, covering major conditions.	Detailed general health history, covering all relevant conditions and their management.	Comprehensive general health history, with in-depth understanding of how systemic conditions may impact ocular health.
Medications	No or incomplete documentation of medications.	Basic list of medications provided, lacking dosage or frequency.	Adequate documentation of current medications, including eye drops, with relevant details.	Thorough documentation of all medications, including past and present, with detailed notes on dosage, frequency, and potential ocular implications.	Comprehensive and precise documentation of all medications, including analysis of drug interactions and implications for ocular health.
BCVA, Refraction if clinically needed	No or incorrect documentation of BCVA or refraction.	Basic documentation of BCVA with minimal refraction data, if needed.	Adequate documentation of BCVA and refraction, providing relevant clinical information.	Detailed and accurate documentation of BCVA and refraction, with clear clinical relevance.	Comprehensive and precise BCVA and refraction documentation, demonstrating in-depth understanding of visual function and its implications for diagnosis and management.
Anterior Segment	No or incomplete documentation of the anterior segment.	Basic examination documented, lacking specific details.	Adequate documentation of anterior segment findings, covering major structures.	Detailed examination of the anterior segment, with accurate documentation of all relevant structures.	Comprehensive and meticulous documentation of the anterior segment, with an in-depth understanding of clinical findings and their implications.
Iris	No documentation of iris examination.	Basic findings recorded.	Adequate documentation of iris abnormalities.	Detailed assessment with recognition of clinical relevance.	Comprehensive documentation, linking findings to ocular pathology.
Gonioscopy	Not performed or documented.	Minimal assessment with no detail.	Adequate assessment, including angle grading.	Detailed documentation of angle structures and abnormalities.	Comprehensive gonioscopy assessment, with clinical relevance discussed.

Lens	No documentation.	Basic documentation, lacking specific findings.	Adequate assessment of lens status.	Detailed examination with identification of early pathology.	Comprehensive documentation, including grading of cataract severity.
Fundus	No or incomplete documentation of fundus examination.	Basic examination documented, with minimal detail.	Adequate documentation of fundus examination, covering major findings.	Detailed and accurate documentation of fundus findings, including all relevant structures.	Comprehensive and insightful documentation of fundus examination, demonstrating a deep understanding of the clinical significance of findings.
Optic Disc Assessment	No documentation of optic disc findings.	Basic C/D ratio recorded, but lacks detail.	Adequate assessment including C/D ratio and neuroretinal rim.	Detailed documentation including assessment of NRR, cupping, and symmetry.	Comprehensive documentation, including disc haemorrhages, RNFL defects, and ISNT rule compliance.
Retinal Nerve Fibre Layer (RNFL)	No documentation of RNFL.	Basic description lacking depth.	Adequate documentation, noting any visible RNFL loss.	Detailed description of RNFL thinning and associated changes.	Comprehensive assessment, including interpretation of red-free imaging and OCT correlation.
Applanation Tonometry / CCT	No or incomplete documentation of applanation tonometry or central corneal thickness (CCT).	Basic measurement recorded, lacking context or interpretation.	Adequate documentation of tonometry and CCT, with relevant clinical details.	Detailed and accurate documentation, with clear clinical relevance of findings.	Comprehensive and insightful documentation, demonstrating an in-depth understanding of intraocular pressure and corneal thickness implications for glaucoma management.
OCT (Optical Coherence Tomography)	No or incomplete documentation of OCT findings.	Basic OCT scan recorded, with minimal interpretation.	Adequate documentation of OCT findings, with relevant clinical interpretation.	Detailed OCT documentation, with accurate interpretation of retinal and optic nerve head structures.	Comprehensive and insightful OCT documentation, demonstrating a deep understanding of structural changes and their implications for diagnosis and management.

VF (Visual Field)	No or incomplete documentation of visual field testing.	Basic visual field test recorded, with minimal interpretation.	Adequate documentation of visual field findings, with relevant clinical interpretation.	Detailed visual field documentation, with accurate interpretation of field defects.	Comprehensive visual field documentation, demonstrating a deep understanding of field loss patterns and their implications for glaucoma management.
Glaucoma Specific Ancillary Testing	No or incomplete documentation of ancillary testing.	Basic ancillary test recorded, with minimal detail.	Adequate documentation of ancillary testing, covering relevant findings.	Detailed ancillary test documentation, with accurate clinical interpretation.	Comprehensive and insightful documentation of ancillary testing, demonstrating a deep understanding of test results and their implications for glaucoma management.
Other (Additional Relevant Information)	No additional relevant information provided.	Basic additional information recorded, lacking detail.	Adequate documentation of additional relevant information.	Detailed and accurate documentation of additional relevant information, with clear clinical relevance.	Comprehensive documentation of all additional relevant information, demonstrating a deep understanding of its significance for diagnosis and management.
Final Diagnosis / Glaucoma Type	Incorrect or incomplete diagnosis provided.	Basic diagnosis provided, lacking specificity or detail.	Adequate diagnosis, covering major relevant conditions.	Detailed and accurate diagnosis, with clear understanding of the specific glaucoma type.	Comprehensive and precise diagnosis, demonstrating a deep understanding of the glaucoma type and its implications for management.
Management (Multiple Visits if Applicable)	Incomplete or inappropriate management plan.	Basic management plan provided, lacking detail or relevance.	Adequate management plan, covering major aspects of care.	Detailed management plan, with accurate and relevant steps for multiple visits if applicable.	Comprehensive and well-structured management plan, demonstrating a deep understanding of ongoing care needs and evidence-based practices.

Relevant Evidence Base for Management Plan (Max 100 words)	No evidence base provided, or irrelevant citations.	Basic evidence base cited, lacking relevance or depth.	Adequate evidence base cited, with relevant and recent sources.	Detailed and accurate evidence base, with strong relevance to the management plan.	Comprehensive and precise evidence base, demonstrating a deep understanding of current research and its application to the management plan.
Review Period	No review period provided or inappropriate timing suggested.	Basic review period provided, lacking clinical relevance.	Adequate review period, with reasonable timing based on the patient's condition.	Detailed and accurate review period, with appropriate timing based on clinical needs.	Comprehensive and well-justified review period, demonstrating a deep understanding of the patient's condition and the need for timely follow-up.

Overall Mark /115