Record keeping assessment matrix

Item	Requires improvement	Minimum required (for each eye)	Good	Excellent	Notes
Symptoms/reason for visit	No justification for sight test.	Approx date of last ST. Reason for visit.	Duration of any symptoms, whether L or R eye.		RED
General health		'Good', or details of any health conditions	Duration of health conditions (such as diabetes).	Whether health condition is well controlled.	AMBER
Medications		The condition for which the patient is taking medication and duration if relevant to eyes.	Names of drugs	Names and doses of drugs, and approx duration they have been taken for	GREEN
Ocular history		Whether px has been to the HES, and what for. What specs px is wearing, and how frequently.	Approximate date of HES visit, and what treatment was received		AMBER
FOH		Whether any glaucoma or other hereditary eye condition in 1st or 2nd degree relatives.	Approximate age at which the condition was diagnosed in the family member. Relevant FGH also recorded e.g. diabetes	What treatment was received by the family member.	AMBER
External examination	No separation of findings for each eye.	Evidence of examination by loupe. Note of lid position if abnormal. Pupils where relevant.	Slit lamp examination, including van Herick grade. Evidence or not of blepharitis. Note of arcus, pingueculae, pterygia (including position) if present.	Grade of blepharitis or other condition if present.	AMBER
CD ratio		10 point scale (0.1, 0.2 etc). Separate in both eyes.	20 point scale (0.05, 0.1, 0.15 etc), separate in both eyes. Note of any other features of	Diagram or photograph of disc, together with	RED

			disc, such as ISNT rule obeyed, DDLS, colour of rim.	evidence that it has been assessed by comment on record card. Comparison with previous images (if available), and their date.	
Any other specific comments from ophthalmoscopy		Note of vessel and macular appearance.	Grading of drusen if present (as per NICE guidance). Assessment with Amsler chart if any abnormality seen.	Diagram or photograph of fundus, together with evidence that it has been assessed by comment on record card. Comparison with previous images (if available), and their date.	AMBER
Unaided vision/vision in previous Rx	Unaided vision if there is no clinical relevance of this (e.g. px habitually wears specs)	Vision with previous Rx. Unaided vision only if habitual Rx not available.	Vision in previous Rx plus unaided vision at least binocularly if px drives without Rx		AMBER
Refraction result		Refraction result and BVD where relevant.	Refraction result. Approximate working distance for near where relevant.	Refraction result.	RED
Corrected VA		Distance monocularly. Near binocularly.	Distance monocularly, near monocularly.		RED
BV assessment distance		Cover test	Cover test with note of recovery or associated phoria measurement if any movement seen.	Note of the effect of any prism if associated phoria found.	AMBER

BV assessment near		Cover test	Cover test with note of recovery or associated phoria measurement if any movement seen.	Note of the effect of any prism if associated phoria found.	GREEN
Visual fields (where relevant)	No mention of having seen VF plot or interpretation of result.	Note of VF screener used, result and number of points missed (if printout not attached to record). Note of whether this is normal or not.	Printed field plot, and note of provisional management if abnormality detected.		RED
Tonometry (where relevant)		Average measurements and instrument used.	Individual measurements, and time of day.		RED
Referral letter copies		Note of whether patient has been referred and what for and how referral was sent. Referral indicates degree of urgency and is sent according to correct pathway.	Copies of referral letters. Copies of letters given to patient.		AMBER
Advice given		Whether there has been a change in prescription, and suggested recall period. When to wear specs where relevant (e.g. if required for driving). To link in with presenting symptoms.	Whether the change is for distance and/or near and type of appliance recommended. Advice on failsafe if px is referred.		Advice given should 'make sense' – i.e. if px is presenting with reading difficulty and an increased myopic prescription is found this should be reconsidered. Similarly, if the px is exophoric, will an increase in plus really help?
Sense check		Does the information on the record make sense? For example: • Stereopsis on monocular patient • Equal VA in patients with markedly different clinical pictures in each eye (cataract,			RED

		AMD etc) • Fundus view in prosthetic eye or one with dense corneal scarring/cataract • Visual fields full R and L in a patient with a non-seeing eye • Advice given is sensible in light of presenting signs/symptoms/history • History is commensurate with previous records (e.g. previous IOLs noted, but no note of cataract surgery), or cataract surgery done previously but no IOL noted. • CDRs correspond with information on fundus photographs	
GOC requirement		The GOC requires (Standard 8.2.7) that the record includes 'details of all those involved in the optical consultation, including name and signature, or other identification of the author'. It must therefore be clear whether any parts of the examination were conducted by someone other than the optometrist, and if so, who.	RED