THE COLLEGE OF OPTOMETRISTS

Clinical Learning in Practice (CLiP)

CLiP 1R assessment visit

December 2025

This is an extract from the Assessment Handbook. You can find a full version of the Assessment Handbook on the College website.

CLiP Part One remote visit (CLiP 1R)

Summary

When: Approximately 9-12 weeks from starting the CLiP placement

Where: Online, in practice or at another location

Duration: 2 hours

Task outline

The visit will consist of five overarching tasks:

1. Legal and ethical use and supply of ophthalmic drugs
2. Health and safety legislation
3. Patient relationships
    a. Consent
    b. Patient care (privacy, dignity, equality, inclusivity)
    c. Communication skills
    d. Information management
4. Service Evaluation Project (project orientation)
5. Quality assurance of setting and supervision (for support purposes)

Student risk profile

We expect all low and medium interaction items (except visual needs) should be amber by the time of this assessment visit. High risk items and the medium risk 'Visual needs' items can be red. If there are some red items at the time of the visit, this should be included in the 'Quality assurance of setting and supervision' discussion with the Assessor.

Task prerequisites and timing

Task/Activity	Miller's Level: GOC Outcome(s)	Prerequisites / Evidence	Duration	Redemption
Introduction				
Introductions and settling in	n/a	n/a	0:05	
1. Legal and ethical use and supply of ophthalmic drugs				
Review and discussion of logbook records, including in-practice patient records	D: 1 item of 5 from 3.5b(v) SH: 4.11	At least **one** logged drug instillation (not fluorescein) with anonymised in-practice patient record to be presented, but not uploaded to the Portal Complete and attach Drug Management Template	0:15	Resit
2. Health and safety legislation				
Student presentation	SH: 4.8	Presentation uploaded to the Portal and used to deliver presentation to Assessor: guide time 5 minutes, max. 7, then follow-up questions and discussion. Identifies and explains risks, mitigation and reporting procedures for each of **five** different categories of potential hazard in own practice: fire, hygiene, physical (trip/falling etc), chemical, electrical. One slide per category, 2 examples/images per slide	0:10	Resit
3. Patient relationships (1 hour total, to be split across the sub tasks)				
a. Consent – review and discussion of logbook records	SH: 1.6, 4.4	At least **one** logged interaction linked to outcome 1.6 and at least **one** linked to 4.4 for **each** of: • Adult • Under 12 • Vulnerable • Carer present with attached policies (safeguarding, chaperone etc) where applicable The same logbook entries may be used more than once but with no more than two learning outcomes per entry.	Indicative 0:15	CLiP 1F

b. Patient care (privacy, dignity, equality, inclusivity) – review and discussion of logbook records	SH: 1.3, 1.5, 4.9	At least **two** logged interactions for **each** outcome, linked to 1.3, 1.5 and 4.9 (six total), uploading policies where relevant. No more than two learning outcomes per entry.	Indicative 0:15	CLiP 1F
c. Communication skills – review and discussion of logbook records in relation to communication with patients and other healthcare professionals, including review of anonymised in-practice patient record involving a referral	SH: 2.1	At least **two** logged interactions linked to outcome 2.1, for **each** of: • Adult patient • Patient under 12 • Supervisor • Another colleague • External professional (at least one of these two logged interactions must include the anonymised record of a referral to be presented, but not uploaded to the Portal). The same records may be used more than once but no more than two learning outcomes per entry.	Indicative 0:20	CLiP 1F
d. Information management – review and discussion of logbook records, including patient records	SH: 4.12	**Five** logbook entries with interactions linked to outcome 4.12 with redacted patient records to be presented, but not uploaded to the Portal, and attached policies (safeguarding, chaperone etc) where applicable. NOTE: logbook entries used for other GOC Outcomes can be used here, but no more than two learning outcomes per entry.	Indicative 0:10	CLiP 1F
4. Service Evaluation Project (project orientation)				
Project orientation	D: 7.1, 7.4	Completed Service Evaluation Project planning tool	0.15	n/a
5. Quality assurance of setting and supervision (for support purposes)				
QA survey	n/a	Completed QA survey (student)	0.15	n/a

Instructions, learning outcomes and marking criteria

Ctrl+Click to go straight to task:

Task 1 – Legal and ethical use and supply of ophthalmic drugs (15 minutes)

The student will be questioned about at least one interaction in which a drug has been used (student must have patient record available to share on screen), exploring processes and protocols used by the student to ensure legal compliance and safe, appropriate use.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.5b(v) Adheres to legal requirements for the use and supply of common ophthalmic drugs. • Uses common ophthalmic drugs, safely to facilitate optometric examination and the diagnosis / treatment of ocular disease. (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Logbook and patient record (not uploaded to the CLiP Portal but ready to present)	Uses appropriate drug (could list, P, GSL and POM), explains indication(s) for use and observes guidance for use of POMs.	Uses POM when not appropriate (e.g. occ. 1% chloro) Doesn't adhere to College Guidance for Professional Practice (GfPP)
4.11 Adheres to the ethical principles for prescribing and to legislation relating to medicines management. (SHOWS HOW)	Applies the regulations regarding the use, storage, and disposal of ophthalmic drugs used in ophthalmic practice. Respects the limitations in prescribing and treating yourself and others close to you. Shows how to report incidents of adverse reactions to medical devices or medicines using the appropriate reporting schemes. Maintains appropriate knowledge regarding the drugs administered in the practice, especially contraindications and side effects, and understands how to access the relevant information relating to the medicines used.	Drug Management Template	Observes relevant sections of College GfPP Awareness of Yellow card scheme and Medical Devices reporting form. Understands the indications and contraindications for drug use and potential side effects. Understands and applies best practice in terms of the legal aspects of access, use and supply. Makes appropriate selection of drug/s and uses safely. Understands the indications/contraindications/legal aspects	Uses ophthalmic drugs without due care and attention to indications and potential side effects such as: • drug allergies • dilating without checking VH and IOPs

	Explains the requirement to register with the MHRA under specific circumstances, and identify the products regulated as class 1 medical devices. Takes appropriate measures when delegating the instillation of ophthalmic drugs		for use and supply of mydriatic/cycloplegic drugs.	

Task 2 – Health and safety legislation (10 minutes)

Over the course of a five-minute presentation, using slides, the student must identify and explain risks, mitigation and reporting procedures for each of five different categories of potential hazard in their own practice: fire, hygiene, physical (trips/falls or other), chemical, electrical. The presentation should include one slide for each category, with two examples with images on each slide. The student will have worked from the presentation assessment brief.

The student must include images in the presentation which show them in their practice and consulting room – they need to be able to demonstrate that images used are recent and their own work. The Assessor will ask checking questions at the end to cover any areas that require additional evidence.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.8 Complies with health and safety legislation. (SHOWS HOW)	Applies current health and safety legislation and professional body guidance to their practice environment. Demonstrates appropriate infection control procedures. Considers both personal and environmental hygiene when dealing with patients and colleagues.	Presentation (5 mins)	Adequate presentation and ability to respond to questions on a sample of topics. Knowledge of reporting procedures. Demonstrates a proactive approach to Health and Safety issues such as identifying hazards, risk assessment, first aid, etc., in order to produce a safe environment for staff and patients alike. Demonstrates appropriate approach to personal hygiene, cleanliness of the practice, hygiene relating to instrumentation, contact lenses, disposal of clinical waste, etc. Infection control: College Guidance	Incorrect/outdated information Missing and/or ambiguous information Evidence of basic lack of awareness or engagement with health and safety responsibilities

Task 3 – Patient relationships – total time 1 hour

3a. Consent (Indicative: 15 minutes)

The student will provide, in advance of the visit, logbook evidence of interactions in which they needed to obtain consent, including an adult, a child under 12 and a vulnerable patient or interaction with carer present. The Assessor will lead a conversation exploring the student's understanding of the relevant policies and how they apply them in practice.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate. (SHOWS HOW)	Adheres to legal requirements when gaining consent. Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management.	Logbook (1.6)	Obtain valid consent before examining a patient, providing treatment or involving patients. For consent to be valid it must be given: • Voluntarily. • By the patient or someone authorised to act on the patient's behalf. • By a person with the capacity to consent. • By an appropriately informed person. Aware of GOC Guidance and standards 3.1 and 3.3 Ensure that the patient's consent remains valid at each stage of the examination or treatment and during any research in which they are participating.	Unable to explain the need for consent, when consent is required or how to obtain it Doesn't understand capacity to consent Does not understand difference between implied and explicit consent Displays lack of knowledge of policy, or fails to follow correctly.
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot	Evaluates the appropriateness of different types of consent to clinical tests, dispensing, delegated functions, triage and release of information. Applies the principles of consent to clinical situations and evaluates situations when implied and implicit consent are required, including appropriate recording.	Logbook (4.4)	Applies principles of 1.6 to specific clinical scenarios/situations. Is aware of National Law requirements, in the student's jurisdiction, in relation to mental capacity Can explain implications of power of attorney (or equivalent in the student's jurisdiction)	Incorrect application of law and guidance

be obtained or is withdrawn. (SHOWS HOW)	Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf. Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken. Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers. Is able to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent. Reflects on different situations from the student's own practice regarding consent.		Awareness of relevant sections of College GfPP (Consent) Gillick competence Follows policy across specified range of patient characteristics	

3b. Patient care (privacy, dignity, equality, inclusivity) (Indicative: 15 minutes)

Assessor instructions

The Assessor and student will discuss the logbook entries and attached policies, focussing on each outcome as they talk through the logged interactions. One or more examples may be evaluated per outcome.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example Warning Flags
1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy. (SHOWS HOW)	Follows relevant frameworks	Logbook (1.3)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation.	Inappropriate interaction selection and/or inappropriate action.
1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs (SHOWS HOW)	Develops an awareness of differing values and belief structures and seeks to care inclusively, with attention to the potential impact of own beliefs on patient care.	Logbook (1.5)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation. Follows points listed in SPOKE indicative guidance column	Inappropriate interaction selection and/or inappropriate action.

4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity. (SHOWS HOW)	Acts in line with equality and human rights legislation in the context of patient care and the workplace. Demonstrates compassionate and professional behaviour, delivers patient centred care and an inclusive and fair approach towards patients and colleagues. Recognises the potential impact of their own attitudes, values, beliefs, perceptions and bias (conscious and unconscious) on individuals and groups and identifies personal strategies to mitigate this. Appreciates the importance of handling sensitive personal information and responding to any information divulged by the patient in a sensitive and unbiased fashion. Maintains confidentiality and respects an individual's dignity. Gives consideration to any equality, diversity and fairness issues from the outset when assessing a patient, particularly for groups of people who share protected characteristics.	Logbook (4.9)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation. Follows points listed in SPOKE indicative guidance column	Inappropriate interaction selection and/or inappropriate action.

3c. Communication skills (Indicative: 20 minutes)

Assessor instructions

The student and Assessor will discuss the examples of logged interactions demonstrating communication skills. The Assessor will suggest alternative scenarios and audiences and ask the student to demonstrate how they would manage the communication in those situations. The student will be asked to respond to at least three situations, to address effectiveness at handling different audiences, content, sensitivities and situations. They will also need to evidence methods for assuring they understand the patient, including accommodating to additional needs.

If the student fails to communicate clearly in the initial scenarios the assessor will ask for their reflections on this, and if the student can identify how to address shortfalls (further scenarios can be used for confirmation) this is acceptable to pass at the 'Shows how' level.

The uploaded written referral is discussed with reference to accuracy, completeness and appropriate use of technical language. Again, the student will be given the opportunity to offer solutions where shortcomings are identified.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public. (SHOWS HOW)	Demonstrates effective communication using verbal, non-verbal, and written skills. Seeks and communicates relevant information from and to patients in an effective and appropriate manner. Ensures the effective implementation of individual management plans, checking patient understanding by actively adapting their communication approach.	Logbook (2.1)	Deploys verbal and non-verbal skills Modifies language and communication style appropriately for different audiences – responding to cues and summarising and reiterating as necessary Acknowledges patient concerns and is empathetic and but not patronising. Reassures the patient where appropriate. Checks the patient has understood the information provided. Makes the patient aware of all options available to them, if necessary, supplementing with written materials to aid comprehension.	Lacks confidence and/or is very hesitant and/or illogical to the point where the patient would lose confidence in the practitioner. Speech difficult to comprehend. Unprofessional/overly casual. Wrong level of technical language for audience.

			Employs a patient-centred approach to understand the patient's perspective. Produces, clear, accurate and comprehensive written information using technical language correctly, when communicating with other professionals.	Inappropriate language and communication style for the patient. Incorrect or unsafe information provided Frightens unnecessarily and/or confuses the patient.

3d. Information management (Indicative: 10 minutes)

The Assessor will review at least three of the five uploaded in-practice patient records, and policies where available, and discuss these with the student. If there are any omissions, errors, or examples of lack of clarity, these will be explored to determine if the student is able to recognise what needs to be improved. In such cases, students will be encouraged to explain how they will change their future record-keeping practice to meet good practice expectations and ensure compliance with policies, to demonstrate achievement at 'Shows how' level.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality. (SHOWS HOW)	Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping. Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. Ensures that records contain the name of any staff undertaking delegated tasks/functions. Demonstrates a systematic understanding of the principles of data protection and freedom	Logbook (4.12)	Knowledge of GDPR requirements (Data Protection Act 2018). Knowledge of relevant Subject Access Request protocols. Logbook completed at least weekly (i.e. no more than 7 days from appointment to log) Case history shows full exploration of symptoms. Results from key tests recorded. Management/advice fully recorded.	Unsound knowledge of key legislation Logbook maintenance does not meet requirements Omissions from case history e.g. full exploration of symptoms, responses to key questions not recorded.

	of information legislation in relation to the use and disclosure of health data. Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.		Practice policies used effectively.	Results from key tests not recorded. Management/advice given not recorded. Practice policies poorly understood or not used correctly.

Task 4 – Service Evaluation Project (project orientation) (15 minutes)

The purpose of the task is to ensure that the student has understood the requirements of the Service Evaluation Project and has a plan for completing each of the required elements. The plan should include milestones, with deadlines, and some initial ideas about how the work will be properly connected to the student's own practice.

This is a formative task so will not be assessed with a Pass/Fail outcome. However, the Assessor will refer to the learning outcomes during the discussion, to foster development towards self-led Personal Development Planning.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Feedback Points
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.	Service Evaluation Project planning tool	All sections completed Plans well connected to setting and practice Clear understanding of requirements Reference to external frameworks/evidence base/peer-reviewed literature	Any missing sections Plans that indicate lack of understanding of task Evidence of copy/paste or AI approach Use of unevidenced source material
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis)	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements.			

and identifying and addressing their new learning needs to improve the quality and outcomes of patient care. (DOES)	Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.			

Task 5 – Quality assurance of setting and supervision (15 minutes)

The student's answers to the QA questionnaire will be discussed, with signposting to further information and support if required. The Assessor will raise a concern with the College team for action if there are concerns which cannot be addressed at the visit. If the student has not met the expected risk profile in the summary dashboard for this stage of the placement, the Assessor should ensure there is a plan in place to address this.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.