THE COLLEGE OF OPTOMETRISTS

Student guidance: CLiP 1 Face-to-face visit (CLiP 1F)

Assessment visit overview

When: Approximately 18-20 weeks from starting the CLiP placement (you'll receive notification of the exact date and time)

Where: In the student's practice

Duration: 3 and a half hours (with an additional 15 minutes for Assessor to carry out patient consultation)

Content:

The visit will consist of nine overarching tasks:

1. Clinical examination fundamentals
    a. History and symptoms
    b. Clinical examination
    c. Management plan
    d. Record keeping
    e. Health and safety including infection control
    f. Clinical decision-making
2. Dispense and verification
    a. Dispensing
    b. Verification
3. Communication and consent
4. Patient care
5. Safety and risk
6. Diagnosis and decision-making
    a. Refractive correction, investigation and decision-making
    b. Contact lens decision-making
7. Record-keeping
8. Service Evaluation Project (submission and verification)
9. Quality assurance of setting and supervision (for support purposes)

Quick reference for logbook requirements

You do not need to have logbook entries prepared for **Task 1** (Eye examination fundamentals), **Task 2** (Dispensing and verification) and **Task 7** (Record keeping).

You will need to have logbook entries for all of the following ready for the Assessor to review at least a week before your CLiP 1F visit.

Important note: Unlike the remote visit, the Assessor will be with you at your practice and will be able to see patient records on your screen in the testing room. As such, you should not need to anonymise records for this visit. However, do make sure that your visit is arranged in a practice where all your records are accessible.

Task 3

You can combine the following items in your entries. There must be a minimum of 8 logbook entries for Task 3, with no more than 2 learning outcomes linked to each entry:

- Interaction in which you obtained consent with a patient with communication or comprehension challenges.
- Interaction in which you obtained consent while needing to manage the patient's significant family history, social or cultural factors or beliefs.
- Interaction in which you obtained consent through the patient's carer.
- Interaction in which you obtained consent with a patient up to and including 7 years old.
- Interaction in which you obtained consent while needing to manage cultural barriers.
- **Three** entries with interactions showing how you achieved learning outcome 1.1 – actively listening to patients and their carers.
- **Three** entries with interactions showing how you achieved learning outcome 1.2 – taking family history, social / cultural factors or beliefs into account.
- **Three** entries with interactions showing how you achieved learning outcome 1.6 – obtaining and recording valid consent.
- **Three** entries with interactions showing how you achieved learning outcome 2.1 – communicating in a sensitive and supportive manner, adapting communication approach and style where required.
- **Three** entries with interactions showing how you achieved learning outcome 4.4 – gaining consent.

Task 4

You can combine the following items in your entries. There must be a minimum of 5 logbook entries for Task 4, with no more than 2 learning outcomes linked to each entry:

- **Three** entries with interactions showing how you achieved learning outcome 1.3 – respecting patient choice, including right to dignity and privacy.
- **Three** entries with interactions showing how you achieved learning outcome 1.5 – committing to care that is not compromised because of your values and beliefs.
- **Three** entries with interactions showing how you achieved learning outcome 4.9 – demonstrating inclusion and respecting diversity.

Task 5

You can combine the following items in your entries. There must be a minimum of 5 logbook entries for Task 5, with no more than 2 learning outcomes linked to each entry:

- **Three** entries with interactions showing how you achieved learning outcome 4.8 – complying with health and safety legislation.
- **Three** entries with interactions showing how you achieved learning outcome 5.5 – infection control.
- **Three** entries with interactions showing how you achieved learning outcome 5.7 – risk-assessing and making appropriate clinical decisions.

Task 6(a)

You need to have five entries for Task 6(a) – don't combine entries.

- **Two** entries with interactions in which you have modified the refraction to meet the patient's needs or circumstances, with notes to explain reasons for the adjustment and consider impact of the subjective refraction and patient needs on the final prescription issued.
- **Three** entries in which you selected and undertook additional investigations.

Task 6(b)

You need to have four entries for Task 6(b) – don't combine entries.

- **Three** entries with interactions in which you undertook complete contact lens fit, each with a different types of lens e.g. soft daily, soft 2-weekly/monthly, toric, multifocal or RGP.
- **One** entry with an interaction with a reusable lens in which you have carried out contact lens aftercare where an adjustment has been made to contact lens specification (not power alone).

Task 8

- Entry with Service Evaluation Project 'Planning tool and workbook' uploaded, with 'Planning tool' and 'Workbook' sections both completed as your final submission.

Task 9

- You can complete the QA 'Setting and supervision' survey in the Assessment area of the Portal – this is not a logbook entry (see details in full logbook checklist, below).

Combining logbook requirements

If you want to log separate entries for all of these items, you can. However, you are allowed to combine items into the same entry for most tasks in 1F, and you can think about whether this makes sense for any of your entries. Here are some examples of how you might do this for CLiP 1F:

- You can combine **patient types** with entries linked to **learning outcomes**. For example, in Task 3 one of your entries which demonstrates that you achieved learning outcome 1.6 can also be the one in which you show that you obtained consent with a patient's carer.
- You can add up to **two learning outcomes** to each entry, so in Tasks 4 and 5, where the learning outcomes cover similar areas, you could combine these and have two outcomes per entry.

When you combine entries and link them to more than one learning outcome, remember to explain clearly in the consultation notes how you think the entry shows you achieved **both** learning outcomes.

Relevant learning outcomes

When you link an entry to a learning outcome, you need to write a short statement (just one or two sentences) to show why you think your entry demonstrates that you achieved the outcome. You write this in the 'Consultation notes' field of the Interaction. Be as **specific** as possible – what is it about this patient, the circumstances of the consultation or how you handled it which shows you are achieving the learning outcome in your daily practice?

Here are the relevant learning outcomes for this visit, with commentary on how you might show that you achieved them.

Task 3

1.1 Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patient's care.

Examples:

- Focussing on what patients say, picking up on other visual cues and actively trying to fit the different messages together or ask follow-up questions to check.
- You asked open-ended questions which led to the patient giving you more important information than they would have provided without your intervention.
- You noticed the patient's body language, expressions or other factors which gave you information about their emotions or intentions which they had not put into words.

1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, family and social history of the patient, which may include personal beliefs or cultural factors.

Examples:

- Tailoring a patient's appliance needs to their lifestyle, work or hobbies, such as prescribing occupational spectacles.
- Or, tailoring for other factors such as medical background and disability – you established that the patient was not physically capable of administering their medication and discussed alternative methods or getting help.
- You advise a patient with a family history of early-onset cataracts on lifestyle modifications and plan for proactive screening.

1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate.

Examples:

- An entry that shows you have been able to obtain consent from someone even when there were questions or challenges. For example, a patient asked you how their information was going to be used, so you explained what type of assessment you're doing.
- Continuation of consent: for example, you needed to gain continued consent for additional steps during the appointment, such as instillation of drugs.

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.

- Times when you've changed your communication to deal with a particular person will be good entries to use here. You could show how you have tailored your delivery of information based on what a patient can understand or absorb. You could show how you have communicated something to a colleague or carer in a different way to the direct communication with the patient.

4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.

- When you describe how you met this outcome, try to focus on how you met legal requirements for obtaining consent. For example, you might describe how you established Gillick competence with a child patient or the particular steps you took to establish consent with a vulnerable patient. You don't have to include an example of withdrawn consent.

Task 4

1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy.

Examples:

- Using a particular name or form of address with a patient because they've stated a preference
- Giving a patient the time to talk if they're having problems communicating.
- You allowed a patient to make their own choice about their treatment, even if it wasn't a choice you agreed with.
- Bringing in a chaperone, or respecting the patient's right not to have anyone else in the testing room.
- Going to a quiet place for dispensing, which is away from the shop floor.

1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.

- You could provide examples of times you've been aware of your own bias or negative feelings toward a patient, but have treated them with care despite this. Examples might include patients having difficult beliefs with regard to healthcare, either refusing medication or not complying with your advice.

4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity.

Examples:

- Demonstrate ways you have adapted your approach to reflect differences in people's age, beliefs, background or other area.
- Making accommodations to allow a patient to keep garments, worn for religious or cultural reasons, on during the consultation or being sensitive about asking them to make adjustments.
- Making special arrangements to support patients with special requests, such as allowing a spouse into the testing room during the consultation.

- Arranging for a patient, with a special request, to be examined by someone of the same gender.

Task 5

4.8 Complies with health and safety legislation.

- This could include quite routine examples of how you comply with health and safety legislation around hygiene and infection control when you are with patients, such as wearing PPE when a patient has non-intact skin or disposing of clinical waste securely during patient consultations.

5.5 Applies infection prevention control measures commensurate with the risks identified.

Examples:

- Putting a suitable protocol in place for a patient with suspected or confirmed transmissible infection such as active conjunctivitis.
- You take appropriate hygiene measures when using reusable devices which touch the eye.
- You use the appropriate level of decontamination for the item which is being used.

5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.

Examples:

- You carry out extra checks for common risk factors for glaucoma based on a particular patient's age profile, family history or ethnicity.
- A patient presents with symptoms which you assess as high risk and you are able to determine an appropriate pathway.
- Connecting the patient's vision and other factors to form a picture of wider risks such as carrying out risk factors for falls in an elderly patient.

Preparing for the visit

You can also refer to our student handbook for information on how to prepare for assessment visits. Here are some key points:

4-5 weeks before the visit

- Make sure your assessment visit has been arranged in the main practice where your patient records can be accessed on screen in the testing room.
- Start checking your readiness for the assessment using the **quick-reference logbook requirements** list above.
- Go back to your University notes and learning materials to **revise the topics** covered in the visit.
- Check your visit date and time, make sure you have it recorded and that your employer knows about it.
- Arrange with your supervisors and other colleagues to **observe** you in clinical practice with patients.
- Check you are on track to have your **Service Evaluation Project** finalised and submitted for Task 8.

2-3 weeks before the visit

- Arrange a meeting with a supervisor to start sharing the logbook entries you want to use in the assessment and discuss your choices.
- As you get nearer to the visit date, you can use the more detailed **full logbook checklist**, below, for all the details of what you need to select and upload in the CLiP Portal for this visit.
- Arrange with a supervisor to **observe** you in practice for Task 1 and 2 of CLiP 1F – try to use the CLiP 1F record card and follow the stages of the visit examination.
- Complete final work and carry out final checks of your **Service Evaluation Project**.
- Make sure you and your Supervisor complete the **surveys** in the CLiP Portal (see instructions in the full logbook checklist, below).

At least 1 week before the visit

- Make sure you have all the required entries selected by the deadline, which is **one week** in advance of your visit time.
- Arrange with your supervisor to **observe** you in practice for Task 1 and 2 of CLiP 1F mock-exam style.
- Arrange for a **practice colleague** (not another student) to be available at the visit for you to do the dispensing task.

Week of the visit

- Check that everything is arranged for your assessment in the practice:
  - the practice support staff know the mystery patient is coming and are aware that they are not booked on the system like a standard patient;
  - you have a testing room available for the assessment;
  - the testing room has a computer on which the Assessor will be able to see patient records you need to show; and
  - a colleague is going to be available for your dispensing task.

On the day

- Have your own **photo ID** ready to show the Assessor.
- Have a print-out of the **1F Record card**.
- Get your testing room **ready for the visit** and make sure you are ready to show the Assessor any in-practice patient records they ask to see.

Outline of each task

Task 1 – Clinical examination fundamentals

1 hour and 40 minutes allowed for this task, incorporating: 5 minutes for introduction and settling in, 1 hour and 20 minutes for all the observed parts of the clinical examination (a – e) and 15 minutes for discussion around clinical decision making (f).

A 'mystery shopper' patient will be arranged for your assessment. This patient will either be pre-presbyopic or presbyopic and will already wear contact lenses. They will have a specific prescription and ocular health profile.

Before your assessment starts, your Assessor will review the mystery shopper's details, including their prescription and history, and carry out a basic ocular health check using the slit lamp (SLE). The Assessor will take about 15 minutes for this part of the visit but it does not come out of your assessment time.

The Assessor will then read a set of instructions asking you to carry out the following:

- A full history and symptoms relevant to both an eye examination and contact lens aftercare.
- Check the distance vision and perform an over-refraction on the right / left contact lens.
- Assess the fit and lens condition of the right / left contact lens.
- Observe the patient remove their lens.

Eye examination clinical fundamental skills:

- Perform pupil assessments and motility.
- Refract your patient (you must use a trial frame – you are not permitted to use a phoropter).
- You may perform binocular balancing if appropriate for your patient.
- You do not need to establish a near add for this patient or carry out any near acuity tests.
- Internal and external examination of both eyes including a Nafl stain check / lid eversion (you can perform this before or after the refraction).

Internal and external examination of both eyes, either before or after the refraction:

- There is a section on the record card for you to note any supplementary tests that you propose are appropriate for this patient if this was a full eye examination. You do not need to carry out those supplementary tests.
- Include the recall for the patient on the record template.

You'll complete a **record template** for this task rather than creating a record in your practice system. You will need to successfully complete and pass each sub-task of Task 1. You also need to complete this clinical examination within the 1 hour and 20 minutes time limit. If you go over this time, the Assessor will stop you and move on with the next task, even if you have not finished.

If you make minor mistakes or leave out small details during the clinical examination in Task 1b, the assessor may ask you additional scenario-based questions to check whether you meet the required standards. The Assessor will also go on to ask questions about your management plan.

At this stage, your clinical techniques should be in place and correctly performed, even if they're not fully refined yet. If you're unsure during the clinical examination, it's appropriate to say when you would need to consult your **Supervisor**. It's more important that you understand your limits than try to be completely independent.

(a) History and symptoms

The Assessor will observe you taking history and symptoms with the mystery shopper patient. The Assessor will check that you ask appropriate questions for all relevant areas set out below, and that you use effective strategies and follow-up questions to get the information you need:

- RFV, vision and symptoms
- OH and FOH
- GH, medication and FGH
- symptom check
- driving
- lifestyle/ work
- CL history and current wear habits
- smoker

(b) Clinical examination

During the clinical examination of the patient, you will perform the contact lens tasks on **one** eye only. The Assessor will check that you develop rapport with the patient, ensure and maintain consent and use the range of techniques set out below effectively:

i. CL over refraction – you need to accurately assess the patient's vision with the contact lenses and make any necessary adjustment.

ii. Evaluation of lens in situ – you need to correctly assess the fit of the lens, using a variety of techniques, and assess the lens condition.

iii. Subjective and objective refraction – you need to fit a trial frame appropriately, including pd measurement and maintain it throughout; undertake static fixation retinoscopy and use appropriate methods of checking e.g. +1.00Ds blur or use of pinhole.

Note: if you prefer or need to use one eye only for retinoscopy then you must use a valid and appropriate technique for monocular viewing e.g. Barrett Method or Near Fixation retinoscopy.

iv. Slit lamp examination (external eye and related structures) – you need to demonstrate a full slit-lamp routine for assessing the external eye and related structures in a logical sequence. Your examination must include staining. You will examine:

- the external eye and adnexa
- lids and lid evertion
- lashes
- Anterior Chamber Angle

The Assessor will check that you:

- use appropriate illumination techniques with appropriate brightness and magnification
- choose appropriate instrumentation and use correct and safe methods to assess tear quantity and quality
- demonstrate a safe technique
- detect significant lesions

v. Indirect ophthalmoscopy – you will need to use a technique which allows an appropriate view of the fundus, including thorough and systematic scanning in all nine positions of gaze.

vi. Pupil assessment – you will need to use appropriate techniques with the correct ambient illumination and light source to assess pupil reactions.

vii. Binocular vision – you will need to undertake objective tests (including cover) using suitable targets, and assessing deviation accurately to include:

- direction of latent or manifest deviation
- speed of recovery
- size
- concomitant / incomitant

The Assessor will check that you undertake subjective tests using suitable targets, as appropriate to the patient, including motility.

(c) Management plan

You will need to formulate a management plan for the patient and communicate it clearly to them. The Assessor will check that you:

- Use the clinical data you gather during the examination, along with the patient's presenting symptoms, to formulate an appropriate management plan.
- Understand the link between vision, prescription (Rx), and symptoms.
- Make prescribing and management decisions that are appropriate based on the patient's refractive and oculomotor status.
- Communicate clearly by giving factually accurate information in a way the patient can easily understand. Avoid jargon and technical terms whenever possible.

During contact lens aftercare, you will need to make appropriate adjustment of the lens to result in the best fit, if this is required.

The Assessor will check that you understand soft lens adaptation and aftercare issues and how to manage them, providing advice in the following areas (if they apply to your patient):

- You address the presenting complaint, communicate the cause and remedy of the complaint to the patient, including the action to be taken and review date.
- You advise the patient if there is the need for any other examination if they are not up to date – such as when they need to have their next eye examination.
- You comply with appropriate lens handling, care regimes and hygiene requirements at all times during the examination.
- You advise on the management of common contact lens complications.

You will need to write an appropriate specification for an appropriate soft lens following the aftercare.

When you give the patient advice, the Assessor will check that you understand the limitations of your knowledge and refer the patient if necessary, and also that you recognise and document the need for any further clinical investigations such as visual fields or IOPs, if appropriate.

At this point in the task, the observation is complete and the mystery patient is allowed to leave.

(d) Record keeping

The Assessor will take the record template you have recorded the examination on and check that you have:

- Fully and accurately recorded all the information related to the patient – your findings and your management plan.
- Produced a record which is legible and contains all the patient's details, measurements, results and advice.

(e) Health and safety including infection control

The Assessor will judge whether you handled health and safety and infection control appropriately during the examination of the patient, checking your procedure with regard to use of instruments, hand hygiene and disposal of clinical waste.

(f) Clinical decision making

The last 15 minutes of time for Task 1 is set aside for this discussion. The Assessor will check that you can explain your decision-making in the context of any relevant frameworks, the tasks you undertook and the patient's needs.

The Assessor needs to check that you can integrate risk management into your clinical decision making and that you reflect on your own performance effectively. If you are aware of any minor failings in your examination, you have a chance to raise this with the Assessor and identify how it could have been improved.

Task 2 – Dispense and verification

20 minutes allowed for this task in total

(a) For the **dispensing** part of this task *(15 minutes)*, you will advise, measure and fit a practice colleague (but not another student) for spectacles, using a prescription and scenario supplied by the Assessor.

The Assessor will check that you demonstrate knowledge of lens characteristics including lens form, design, materials, coatings and tints, availability and blank sizes. You will need to make the appropriate frame choice by considering the following: size, materials, and relationship between frame, lenses and face and be able to discuss appropriate frame adjustments.

(b) For the **verification** part of this task *(5 minutes)*, the Assessor will provide you with a pair of progressive spectacles with template and spectacle order and will observe you verifying one lens only. You will need to:

- Mark up, measure and verify that the lenses provided have been produced to the given prescription within BS tolerances.
- Demonstrate a knowledge of actual tolerances.
- Verify that all aspects of the frame or mount have been correctly supplied.
- Measure and verify that the lenses are correctly positioned in the spectacle frame/mount within BS tolerances.

You are allowed to use a manual or semi-automated focimeter. A fully automated focimeter e.g. Eye refract VX40 is not allowed.

To pass the assessment, your verification will need to produce accurate results to within:

- ± 0.25DS/DC for dioptric measurements
- Axis appropriate to cylinder power 0 ≤ 0.50DC ± 9° 0 > 0.50DC ≤ 0.75DC ± 6 ° 0> 0.75DC ≤ 1.50DC ± 4 ° 0 > 1.50DC ± 3 °
- Centres – 1mm tolerance.

Note on timing for Tasks 3 to 5

Timings for Tasks 3, 4 and 5 are indicative, and Assessors may allocate time for these tasks differently within the total 35 minutes allowed.

Task 3 – Communication and consent

15 minutes (indicative timing) allowed for this task

This is a professional discussion based on your logbook entries and the Assessor will ask to see some of your in-practice patient records. The Assessor may choose which entries to discuss for each task or may ask you to nominate. They will ask questions to check your understanding of the relevant rules and policies around consent and may suggest (or role-play) alternative scenarios to find out how you would have dealt with a different type of patient or different set of circumstances.

The Assessor will try to establish you can handle different audiences, content, sensitivities and situations. You may also need to demonstrate methods for assuring that you understand the patient, including accommodating to additional needs.

Task 4 – Patient care (privacy, dignity, equality, inclusivity)

10 minutes (indicative timing) allowed for this task

This is a professional discussion based on your logbook entries. The Assessor will ask you to show some of the in-practice patient records related to your entries for further information and for verification. Assessors will be looking to see how you adapt your routine and practices to care for a patient who has specific requirements.

Task 5 – Safety and risk

10 minutes (indicative timing) allowed for this task

This is a professional discussion, based on your logbook entries. The Assessor will ask you to show some of the in-practice patient records related to your entries for further information and for verification. The Assessor will check that in your everyday practice, as shown in your logbook and patient records, you:

- Comply with health and safety legislation.
- Apply infection control measures appropriately.
- Are able to risk-assess based on a patient's clinical condition or a situation in clinical practice and make appropriate clinical decisions.

Task 6(a) – Diagnosis and decision-making – Refractive correction, investigation and decision-making

Task 6 is 25 minutes in total – around 15 minutes allowed for this task

This is a professional discussion based on your logbook entries. The Assessor will ask you to show some of the in-practice patient records related to your entries. The Assessor will ask you about the decisions you made to modify your refraction and prescription with patients, and the decisions you made to undertake additional investigations.

Task 6(b) – Diagnosis and decision-making – Contact lens decision-making

Task 6 is 25 minutes in total – around 10 minutes allowed for this task

This is a professional discussion based on a review of your logbook entries and the Assessor will ask you to show some of the related in-practice patient records. When selecting entries for this task, you should make sure that what you select as a contact lens fit meets the definition of CL fit in the Student Handbook (see Risk framework section).

Task 7 – Record-keeping

No time is allocated for this task

The Assessor will make a judgement about the standard of your record-keeping based on records they have seen while working on Tasks 3 – 6. As such, you do not need to do anything else for this task.

The Assessor will be checking that you:

- Keep clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping.
- Produce records which are accessible, contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice.
- Ensure that records contain the name of any staff undertaking delegated tasks/functions.
- Demonstrate a systematic understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data.
- Grant, where appropriate, a patient's Right to Access their health data, and demonstrate a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.

Although no time is allocated to this task during the CLiP 1F visit, if you did not achieve a Pass result for record-keeping, we would schedule a 15 minute re-sit session for this. In this event, we will provide you with instructions about how to present your records for the resit.

Task 8 – Service Evaluation Project (project verification)

15 minutes allowed for this task

You should be prepared to guide the Assessor through everything you've done in your Project and explain or show them what it relates to. If your Project relates to physical locations or equipment in the practice, you can take the Assessor on a tour and show them what you've referred to. And/or you can show them the information systems and processes you've referred to in your project. You could demonstrate how you searched for particular records which meet the characteristics you've selected, or explain how you randomised your samples. Assessors may ask you follow-up questions about the Project and ask you to explain your work, thinking and results. They may also ask you to reflect on the experience of developing the Service Evaluation Project as part of this task.

The Assessor is not marking your Project as part of this exercise. The main aim is for them to verify that the practice you are writing about, together with the information and processes you've referred to, is actually the practice you are working in.

Task 9 – Quality assurance of setting and supervision

15 minutes allowed for this task

The Assessor will discuss your responses to the QA survey and try to establish that you are in a supportive environment, which aligns with the expectations for CLiP, and that you have good working relationships with your employers and supervisors. The Assessor will also discuss the Supervisor's questionnaire.

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

We suggest that you also look at the full marking criteria in the **CLiP Assessment Handbook**.

Full logbook checklist

For entries you want the Assessor to review, assign the correct assessment visit task in the **Task** field of the logbook entry.

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3	**One** logbook entry with Interaction (communication) In Interaction > Other characteristics, **one or more of the following is selected**: • Communications challenges - Language barriers • Communications challenges - Needs help to communicate • Communications challenges - Hard of hearing • Comprehension challenges - Neurodiversity (LV) • Comprehension challenges – Dementia • Comprehension challenges - Learning difficulties	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per logbook entry. There must be a minimum of 8 logbook entries for Task 3
3	**One** logbook entry with Interaction (family history, social / cultural factors or beliefs). In Interaction > Other characteristics field, **the following is selected**: • Significant family history	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
3	**One** logbook entry with Interaction (consent / accompanied by carer). In Interaction > Accompanied by field, **the following is selected**: • Carer	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3	**One** logbook entry with Interaction (consent / accompanied by carer). In Interaction > Patient age group, **one of the following is selected**: • Infant 0-2 (LV), or • Pre-school child 3-4, or • Child 5-7	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
3	**One** logbook entry with Interaction (communication). In Interaction > Other characteristics, **the following is selected**: • Communication challenges – Cultural barriers	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
3	**Three** logbook entries with Interaction (communication). **Explain** why each Interaction addresses learning outcome 1.1 in the Interaction field 'Consultation notes'.	1.1	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per logbook entry There must be a minimum of 8 logbook entries for Task 3
3	**Three** logbook entries with Interaction (family history, social / cultural factors or beliefs). **Explain** why each Interaction addresses learning outcome 1.2 in the Interaction field 'Consultation notes'.	1.2	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3	**Three** logbook entries with Interaction (consent / accompanied by carer). **Explain** why each Interaction addresses learning outcome 1.6 in the Interaction field 'Consultation notes'.	1.6	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
3	**Three** logbook entries with Interaction (communication). **Explain** why each Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
3	**Three** logbook entries with Interaction (consent). **Explain** why each Interaction addresses learning outcome 4.4 in the Interaction field 'Consultation notes'.	4.4	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes and multiple characteristics per entry There must be a minimum of 8 logbook entries for Task 3
4	**Three** logbook entries with Interaction (privacy, dignity, equality, inclusivity). **Explain** why each Interaction addresses learning outcome 1.3 in the Interaction field 'Consultation notes'.	1.3	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 4

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
4	**Three** logbook entries with Interaction (privacy, dignity, equality, inclusivity). **Explain** why each Interaction addresses learning outcome 1.5 in the Interaction field 'Consultation notes'.	1.5	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 4
4	**Three** logbook entries with Interaction (privacy, dignity, equality, inclusivity). **Explain** why each Interaction addresses learning outcome 4.9 in the Interaction field 'Consultation notes'.	4.9	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 4
5	**Three** logbook entries with Interaction (safety and risk). **Explain** why each Interaction addresses learning outcome 4.8 in the Interaction field 'Consultation notes'.	4.8	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 5
5	**Three** logbook entries with Interaction (safety and risk). **Explain** why each Interaction addresses learning outcome 5.5 in the Interaction field 'Consultation notes'.	5.5	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 5
5	**Three** logbook entries with Interaction (safety and risk). **Explain** why each Interaction addresses learning outcome 5.7 in the Interaction field 'Consultation notes'.	5.7	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	Yes – up to two learning outcomes per entry There must be a minimum of 5 logbook entries for Task 5

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
6a	**Two** logbook entries with Interaction (refraction modified to meet the patient's needs and circumstances). In Interaction > Tasks Undertaken, **the following are selected**: • Refraction – Objective • Refraction – Subjective • Management and advice	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	No
6a	**Three** logbook entries with Interaction (additional investigations). In Interaction > Tasks Undertaken, **one or more of the following is selected**: • Ocular motor balance – Asymptomatic • Ocular motor balance – Symptomatic • Intraocular pressures – Contact tonometry • Intraocular pressures – Non-contact tonometry • Visual fields • Additional tests – Keratometry • Additional tests – Colour vision • Additional tests – Contrast sensitivity • Additional tests – Other supplementary tests	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	No

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
6b	**Three** logbook entries with Interaction (contact lens fit with 3 different types of lens). In Interaction > Visual needs, **one of the following is selected**: • Contact lens – Rigid • Contact lens – Toric • Contact lens – Multifocal • Contact lens – Myopia management • Contact lens – Bandage • Contact lens – Cosmetic • Contact lens – Scleral • Contact lens – orthoK • Contact lens – Other soft lenses **NOTE**: Each of the three Interactions should be a different type of lens, but **Other soft lenses** can be selected more than once if there is a difference between the two – for example, one soft lens is daily and the other is 2-weekly/monthly.	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	No
6b	**One** logbook entry with Interaction (re-usable lens for which aftercare has been carried out and adjustment made to the specification – not power alone). In Interaction > Tasks Undertaken, **the following is selected**: • Contact lens – Aftercare	Not required	No, but corresponding in-practice patient record should be available and ready for the Assessor to review if required at the visit	No

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
8	**One** logbook entry. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 1 (Face-to-face Visit) 8 Service Evaluation Project (submission and verification) **Upload** attachment – Service Evaluation Project 'Planning tool and workbook', with 'Planning tool' and 'Workbook' sections both completed as your final submission.	Not required	No	No
9	**One** logbook entry: a survey for the 'Setting and supervision' discussion with the Assessor needs to be completed by your Supervisor in advance of the visit – template can be downloaded from the College website. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 1 (Face-to-Face Visit) 9 Quality assurance of setting and supervision (for support purposes) **Upload** attachment – completed Supervisor survey.	Not required	No	No

Task	Logbook record	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
9	The **student survey** for the 'Setting and supervision' discussion with the Assessor needs to be completed in advance of the visit, although this is not assessed. You can complete the student survey in the CLiP Portal, but this is a part of the **Assessment form**, not an upload to the logbook. To complete the 'Setting and supervision' survey, go to your Assessment Form in the CLiP Portal: • Main menu > Assessments • Double-click on your visit details • Use 'Go to Assessment Form' button • Click on the tab for 'Setting and Supervision Survey' in top right • Complete survey • Click 'Next' at bottom of screen • Confirm and Submit the form	Not required	No	No

More guidance and resources

You can find these templates for this visit on our website CLiP Resources page:

- CLiP 1F Record card
- Service Evaluation Project planning tool and workbook
- Supervisor survey

You can read more about logbook entries, the CLiP Portal and preparing for visits in our **CLiP Student Handbook**.

You can see the full marking criteria that your Assessor will use in the **CLiP Assessment Handbook**.

All Handbooks are available on the CLiP Resources page.

Document version	Date	Update
1.1	02/12/2025	First version
1.2	20/01/2026	Task 6 refs in logbook checklists + survey submission amended
1.3	13/03/2026	Checklist corrections + more guidance updated
1.4	08/05/2026	Changes to quick ref and change to task 3-5 indicative timing
2.1	24/06/2026	Task 3 – child patient age range changed to 5-7 Task 6 - Task split into (a) and (b) sections with indicative timing - Change to pre-requisites requirements for Assessor to search logbook removed - Requirement for Assessor to look at entries with Conditions removed from part (a) - Reduced and re-worded CL requirements in part (b)