Student guidance: CLiP 1 Remote visit (CLiP 1R)

Assessment visit overview

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

Where: Online: in practice or at another location

Duration: 2 hours

Content:

The visit will consist of five overarching tasks, which mainly involve a professional discussion with the Assessor based on your logbook entries and other evidence you supply:

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)

Quick reference for logbook requirements

You will need to have logbook entries for all of the following, and have these entries confirmed and approved by your Supervisor at least a week before your CLiP 1R visit:

Task 1

- An entry with the completed drug management template for CLiP 1R uploaded (complete our template, links below)

- An entry which logs a drug instillation to a patient (not stain). You will need to have the corresponding in-practice patient record anonymised and ready to show the Assessor on-screen

Task 2

- An entry with your completed health and safety presentation uploaded (see our presentation brief, links below)

Task 3(a)

- An entry with an interaction with an adult patient which shows you achieved learning outcome 1.6 – obtaining and recording valid consent.

- An entry with an interaction with an adult patient which shows you achieved learning outcome 4.4 – following relevant law and taking appropriate action to gain consent.

- An entry with an interaction with a patient under 12 which shows you achieved learning outcome 1.6 – obtaining and recording valid consent.

- An entry with an interaction with a patient under 12 which shows you achieved learning outcome 4.4 – following relevant law and taking appropriate action to gain consent.

- An entry with an interaction with a vulnerable patient which shows you achieved learning outcome 1.6 – obtaining and recording valid consent.

- An entry with an interaction with a vulnerable patient which shows you achieved learning outcome 4.4 – following relevant law and taking appropriate action to gain consent.

- An entry with an interaction where the patient had a carer present, which shows you achieved learning outcome 1.6 – obtaining and recording valid consent.

- An entry with an interaction where the patient had a carer present, which shows you achieved learning outcome 4.4 – following relevant law and taking appropriate action to gain consent.

Task 3(b)

- Two entries with interactions showing how you achieved learning outcome 1.3 – respecting patient choice, including right to dignity and privacy.

- Two entries with interactions showing how you achieved learning outcome 1.5 – committing to care that is not compromised because of your values and beliefs.

- Two entries with interactions showing how you achieved learning outcome 4.9 – demonstrating inclusion and respecting diversity.

Task 3(c)

- Two entries with interactions with adult patients which show how you achieved learning outcome 2.1 – communicating in a sensitive and supportive manner, adapting communication approach and style where required.

- Two entries with interactions with patients under 12 which show how you achieved learning outcome 2.1 – communicating in a sensitive and supportive manner, adapting communication approach and style where required.

- Two entries with interactions in which you consulted with a supervisor, which show how you achieved learning outcome 2.1 – communicating in a sensitive and supportive manner, adapting communication approach and style where required.

- Two entries with interactions in which you consulted with a colleague, which show how you achieved learning outcome 2.1 – communicating in a sensitive and supportive manner, adapting communication approach and style where required.

- Two entries with interactions in which you referred the patient to an external professional (for one of these you will need to have the corresponding referral letter anonymised and ready to show the Assessor on-screen).

Task 3(d)

- Five entries with interactions which show how you achieved learning outcome 4.12 – correct management of patient information and records (for each of these five entries, you will need to have the corresponding in-practice patient record anonymised and ready to show the Assessor on-screen).

- If possible, upload your practice policies for record-keeping and information management to a logbook entry.

Task 4

- One entry with Service Evaluation Project template 'Planner' section completed and uploaded (see our template, links below).

Task 5

- 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, 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 1R:

- You can add up to **two learning outcomes** to each entry, so for example in Task 3(a) you could have one entry for an adult patient and link it to both learning outcomes, 1.6 and 4.4, instead of logging two adult entries.

- You can combine the **patient types**. For example, you could have one entry in which a 'Vulnerable patient' was also 'Accompanied by carer', and this would cover both of those requirements.

- Your five entries for **task 3(d)** can all relate to in-practice patient records which you have already prepared for other tasks, for example the records you're using for task 3(a).

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(a)

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.

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 3(b)

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 3(c)

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.

Task 3(d)

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.

Examples:

- Demonstrate how you understand the requirements for clear, contemporaneous and accurate records and point out good examples of what you have recorded.

- How have you recorded information such as sensitive personal data in your in-practice patient records?

- If you have had to add in additional information to a patient record, how did you go about this?

- If you spotted a mistake in a patient record you wrote, what did you do to follow up and correct it?

Preparing for the visit

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

4-5 weeks before the visit

- During your daily practice, if you think one of the entries you are creating would be good for the next assessment visit, you can switch '**Include in assessment**' to 'Yes' to flag it (this can still be turned back to 'No' if you change your mind).

- 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.

- Check your progress with ideas and planning for **Service Evaluation Project** and discuss ideas with your supervisors.

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 **logbook checklist**, below, for all the details of what you need to select and upload in the CLiP Portal for this visit.

- Make sure a supervisor **approves** your selected entries after you have agreed them.

- **Anonymise** in-practice patient records, and have them **checked** by your supervisor.

- To make the records easy to match with your logbook entries, make the file names for each record the relevant **Patient ID** from the in-practice patient record, and this ID must also be in the 'Reference' field for the related logbook entry (see below).

- Complete planner section of **Service Evaluation Project** if you haven't already.

- Complete the **student survey** in the CLiP Portal (see instructions in full logbook checklist, below).

1 week before the visit

- The deadline for having all your logbook entries ready and approved on the CLiP Portal is **one week** in advance of your visit time.

Week of the visit

- **Do not upload** the anonymised records to the CLiP Portal, but copy them to your own device, ready to share on the visit.

On the day

- Your anonymised in-practice patient records need to be **open and ready** on your device, on the assessment day, before your visit starts.

- Have your own **photo ID** ready to show the Assessor.

- Get your workspace and computer **ready for the visit**, make sure you are plugged in or have enough charge, and that you are in a quiet room where you won't be disturbed.

Outline of each task

Task 1 – Legal and ethical use and supply of ophthalmic drugs

15 minutes allowed for this task.

The Assessor will ask you to share your completed drug template and will ask you to comment on things you have shown in the photographs – for example you may be asked to explain why drugs have been stored in a particular way or why a particular labelling has been used. You will also be asked to share your patient record and explain why you instilled the drug, how you made sure this was done safely and carried out checks with the patients. You could be asked what the side effects and contraindications of the drugs are, and what advice was given to the patient pre- and post-instillation.

Task 2 – Health and safety legislation

10 minutes allowed for this task

You will be asked to share your slides and give a five-minute presentation, identify and explaining the risks, mitigation and reporting procedures as set out in the instructions for this task. The Assessor will ask you some questions to verify that the images used are recent and from your own place of work. They may ask checking questions for any areas that need additional evidence.

Task 3(a) – Patient relationships – Consent

Task 3 is an hour in total – around 15 minutes allowed for this task

You will be asked to share your logbook entries and 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 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.

Task 3(b) – Patient relationships – Patient care (privacy, dignity, equality, inclusivity)

Task 3 is an hour in total – around 15 minutes allowed for this task

This is a professional discussion based on your logbook entries, similar to 3(a). Assessors will be looking to see how you adapt your routine and practices to care for a patient who has specific requirements.

Task 3(c) – Patient relationships – Communication skills

Task 3 is an hour in total – around 20 minutes allowed for this task

You will discuss the examples of logged interactions demonstrating communication skills. The Assessor may suggest other scenarios and audiences and ask the student to demonstrate how they would manage the communication in those alternative situations. The Assessor will try to establish how 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 3(d) – Patient relationships – Information management

Task 3 is an hour in total – around 20 minutes allowed for this task

The Assessor will ask you to show some of your anonymised in-practice patient records, and policies where available, and discuss these with you. They might ask you about areas where they see information could be missing or where they can see there is a lack of clarity. If they do find examples like this, it is important that you can demonstrate that you understand the problem and can suggest ways your record-keeping can be improved.

Task 4 – Service Evaluation Project (project orientation)

15 minutes allowed for this task

The Assessor wants to check that you understand the requirements of the Service Evaluation Project and have 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 your practice.

This is a formative task so will not be assessed with a Pass/Fail outcome. However, it is the only opportunity you will get to discuss your plans for the project with an Assessor before you submit, so make sure you have done proper planning and are prepared to discuss how your project will develop.

Task 5 – 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.

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 at an assessment visit, the field **Include in assessment?** on the logbook entry must be changed to **Yes**. Then the Supervisor will need to check any associated patient records and **approve** that entry.

For all other logbook entries, it is not necessary to change **Include in assessment?** and the Supervisor just needs to **confirm** the entries.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
1	**One** logbook entry with Interaction. In Interaction > Tasks Undertaken, **one of the following is selected**: • Drugs – Mydriatics • Drugs – Cycloplegia • Drugs – Anaesthetic	Not required	Yes, prepare anonymised in-practice patient record and have this ready to share on your device	No
1	**One** logbook entry. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 1 (Remote Visit) 1 Legal and ethical use and supply of ophthalmic drugs **Upload attachment**: completed CLiP 1R Drug management template	Not required	No	No
2	**One** logbook entry. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 1 (Remote Visit) 2 Health and safety legislation **Upload attachment** – Health and safety presentation	Not required	No	No

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3a	**One** logbook entry with Interaction (adult patient, involving consent). In Interaction > Patient age group, **one of the following is selected**: • Young adult 17-45, or • Middle-aged 46-60, or • Older adult 61-74, or • Senior 75+ **Explain** why this Interaction addresses learning outcome 1.6 in the Interaction field 'Consultation notes'.	1.6	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3a	**One** logbook entry with Interaction (adult patient, involving consent). In Interaction > Patient age group, **one of the following is selected**: • Young adult 17-45, or • Middle-aged 46-60, or • Older adult 61-74, or • Senior 75+ **Explain** why this Interaction addresses learning outcome 4.4 in the Interaction field 'Consultation notes'.	4.4	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3a	**One** logbook entry with Interaction (patient under 12, involving consent). In Interaction > Patient age group, **one of the following is selected**: • Infant 0-2 (LV), or • Pre-school child 3-4, or • Child 5-6, or • Child 7-11 **Explain** why this Interaction addresses learning outcome 1.6 in the Interaction field 'Consultation notes'.	1.6	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3a	**One** logbook entry with Interaction (patient under 12, involving consent). In Interaction > Patient age group, **one of the following is selected**: • Infant 0-2 (LV), or • Pre-school child 3-4, or • Child 5-6, or • Child 7-11 **Explain** why this Interaction addresses learning outcome 4.4 in the Interaction field 'Consultation notes'.	4.4	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3a	**One** logbook entry with Interaction (vulnerable patient). In Interaction > Vulnerable? **the following is selected**: • 'Vulnerable?' box is ticked. **Explain** why this Interaction addresses learning outcome 1.6 in the Interaction field 'Consultation notes'.	1.6	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3a	**One** logbook entry with Interaction (vulnerable patient). In Interaction > Vulnerable? **the following is selected**: • 'Vulnerable?' box is ticked. **Explain** why this Interaction addresses learning outcome 4.4 in the Interaction field 'Consultation notes'.	4.4	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3a	**One** logbook entry with Interaction. In Interaction > Accompanied by, **the following is selected**: • Carer **Explain** why this Interaction addresses learning outcome 1.6 in the Interaction field 'Consultation notes'.	1.6	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3a	**One** logbook entry with Interaction. In Interaction > Accompanied by, **the following is selected**: • Carer **Explain** why this Interaction addresses learning outcome 4.4 in the Interaction field 'Consultation notes'.	4.4	No	Yes. There must be a minimum of 3 logbook entries for Task 3a. No more than 2 learning outcomes to be linked to each entry.
3b	**Two** logbook entries with Interaction (patient care). **Explain** why each Interaction addresses learning outcome 1.3 in the Interaction field 'Consultation notes'.	1.3	No	No
3b	**Two** logbook entries with Interaction (patient care). **Explain** why each Interaction addresses learning outcome 1.5 in the Interaction field 'Consultation notes'.	1.5	No	No

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3b	**Two** logbook entries with Interaction (patient care). **Explain** why each Interaction addresses learning outcome 4.9 in the Interaction field 'Consultation notes'.	4.9	No	No
3c	**Two** logbook entries with Interaction (patient communication) for adult patient. In Interaction > Patient age group, **one of the following is selected**: • Young adult 17-45, or • Middle-aged 46-60, or • Older adult 61-74, or • Senior 75+ **Explain** why each Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.
3c	**Two** logbook entries with Interaction (patient communication) for patient under 12. In Interaction > Patient age group, **one of the following is selected**: • Infant 0-2 (LV), or • Pre-school child 3-4, or • Child 5-6, or • Child 7-11 **Explain** why each Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3c	**Two** logbook entries with Interaction (consulting with a supervisor). In Interaction > Tasks undertaken **the following is selected**: • Referral - Consult with supervisor **Explain** why each Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.
3c	**Two** logbook entries with Interaction (consulting with another colleague). In Interaction > Tasks undertaken **the following is selected**: • Referral - Consult with colleague **Explain** why each Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.
3c	**One** logbook entry with Interaction (referring to an external professional). In Interaction > Tasks undertaken **one of the following is selected**: • Referral – Non-emergency • Referral – Emergency **Explain** why the Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	No	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3c	**One** logbook entry with Interaction (referring to an external professional). In Interaction > Tasks undertaken **one of the following is selected**: • Referral – Non-emergency • Referral – Emergency **Explain** why the Interaction addresses learning outcome 2.1 in the Interaction field 'Consultation notes'.	2.1	Yes, prepare anonymised referral letter and have this ready to share on your device	Yes. There must be a minimum of 6 logbook entries for Task 3c. No more than 2 learning outcomes to be linked to each entry.
3d	**Five** logbook entries with Interaction (information management). **Upload** attachments to logbook entry: • Anonymised in-practice patient record and • In-practice policy or procedure, where available, to increase impact of evidence **Explain** why each Interaction addresses learning outcome 4.12 in the Interaction field 'Consultation notes'.	4.12	Yes, prepare anonymised in-practice patient records and have these ready to share on your device	Yes. There must be a total of 5 entries linked to this outcome but you can use other entries you've already included for review. No more than 2 learning outcomes to be linked to each entry.
4	**One** logbook entry. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 1 (Remote Visit) 4 Service Evaluation Project (project orientation) **Upload** attachment – completed Service Evaluation Project (SEP) planning template.	Not required	No	No

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
5	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 survey in the CLiP Portal, although this is not done in your logbook: To complete the Task 5 '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 1R Drug template

- CLiP 1R Health and safety presentation brief

- Service Evaluation Project workbook

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

Document version	Date	Update
1.1	02/12/2025	First version
1.2	20/01/2026	Survey update