



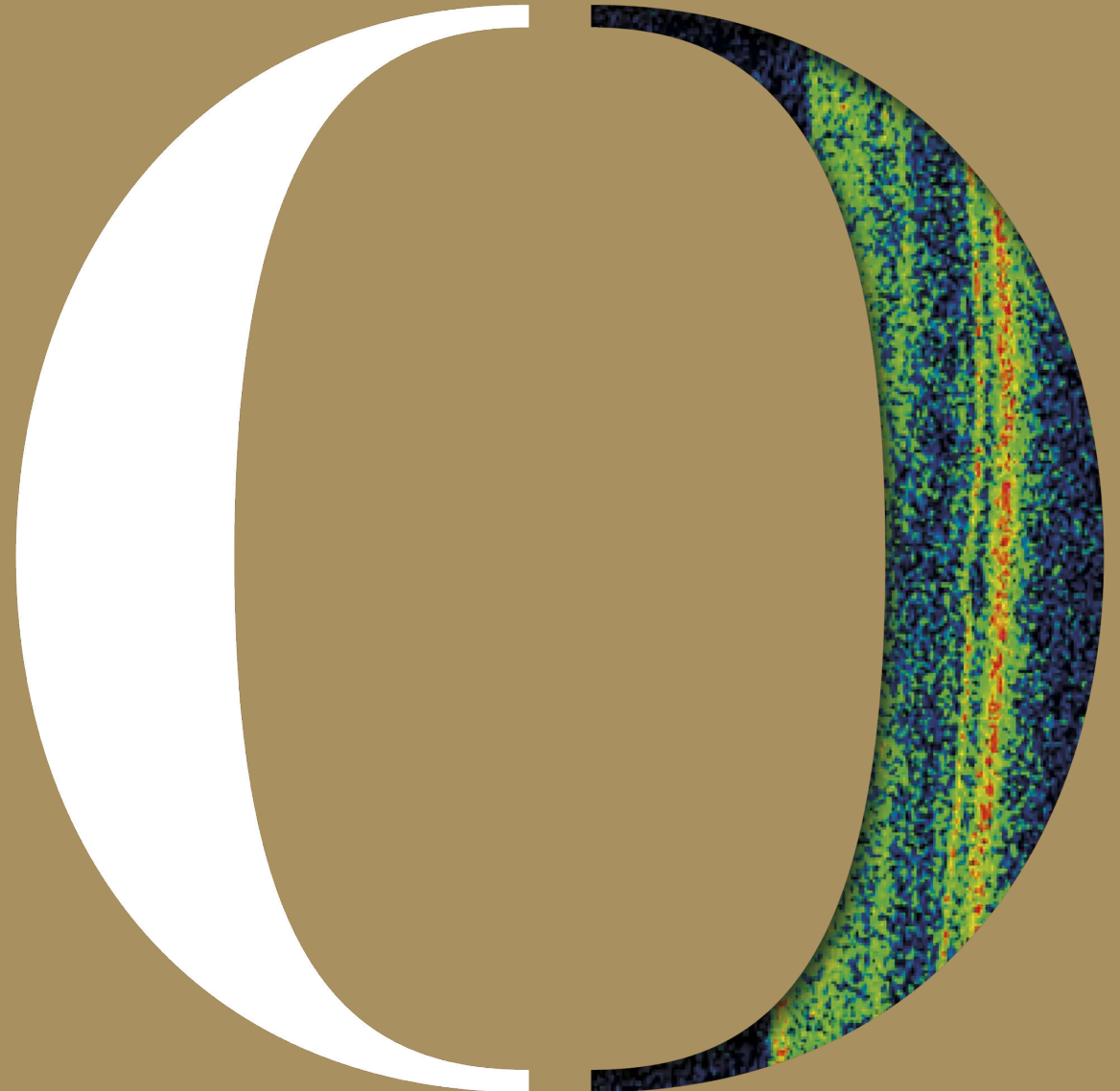
THE COLLEGE OF  
OPTOMETRISTS

# Scheme for Registration

Presenter name

Job title

12 June 2025





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## SUPERVISED PRACTICE

Intro to  
SfR

Start

6 weeks  
visit 1

4  
months  
visit 2

6  
months  
visit 3

7+  
months  
visit 4+

8+  
months  
Stage 2

12  
months  
+

College  
Information

Start on  
Scheme

12  
Competencies  
(remote)

26  
Competencies  
(face-to-face)

28  
Competencies  
(face-to-face)

9  
Competencies  
(remote/ face-  
to-face)

OA Assessment  
DO Assessment

OSCE

STAGE ONE ASSESSOR

STAGE TWO  
ASSESSORS

FINAL  
ASSESSMENT

# Demonstrating competence

The assessment of evidence by the assessor is an **individualised process** which is determined by:

- Firstly, the compulsory evidence (e.g. direct observation or patient record etc)
- Follow up questions or case scenarios to meet the performance indicators

This means that you will *not* have the same assessment as another trainee but it **will be to the same standard**



# Demonstrating competence

Where the element of competence requires that you:

- **“Do”** something - the assessor will expect to see you work with patients to perform that particular skill or procedure, either by watching you or looking at what you have done previously in your patient records.
- **“Understand”** something - the assessor will explore your knowledge and understanding using a range of evidence

**Check** that your evidence is valid and relevant to the identifier



# Demonstrating competence

## EVIDENCE TYPES

- Direct Observations (DO)
- Anonymised / Patient record (PR / APR)
- Trainee Case Discussion (TCD)
- Reflective Account (RA)
- Witness Testimony (WT)



## Patient confidentiality, anonymity and supervision requirements

For patient records to be used as evidence:

- You must seek patient consent for ALL their records to be viewed (also includes dispensing, CL related and hospital records)
- Patient consent must be noted on the records (Verbal consent from the patient is sufficient)
- You must record in your logbook and on the patient record the name of the person supervising you when you dispensed / examined the patient





## How to present your record-based evidence

Use the following format to show your assessor how the record provides appropriate evidence for an element of competence:

1. The relevant presenting symptoms and history
2. Your investigations and findings
3. Your clinical decision and management
4. Advice given to your patient





## Contact lens and Dispensing records

You must provide complete records in the assessment process.

- A complete Dispensing record outlines the patient needs and requirements, the advice and the specifics relating to the device ordered
- A complete Contact Lens fitting record should include an initial assessment of the patient's suitability of CL wear, initial measurements, trial of lens, assessment of fit and subsequent follow up, all carried out by you





## Preparation for Visits

Information from Trainee – one week before the visit:

- A completed assessment framework document with the latest supervisor review
- Patient record list
- Copy of your logbook
- Evidence requirements from the visit plan

Purpose of sending evidence:

- To help plan, identify trainee strengths and weaknesses, and allows supervisor to input into assessment decisions

*Note the number of patient encounters and patient characteristics required in your logbook*





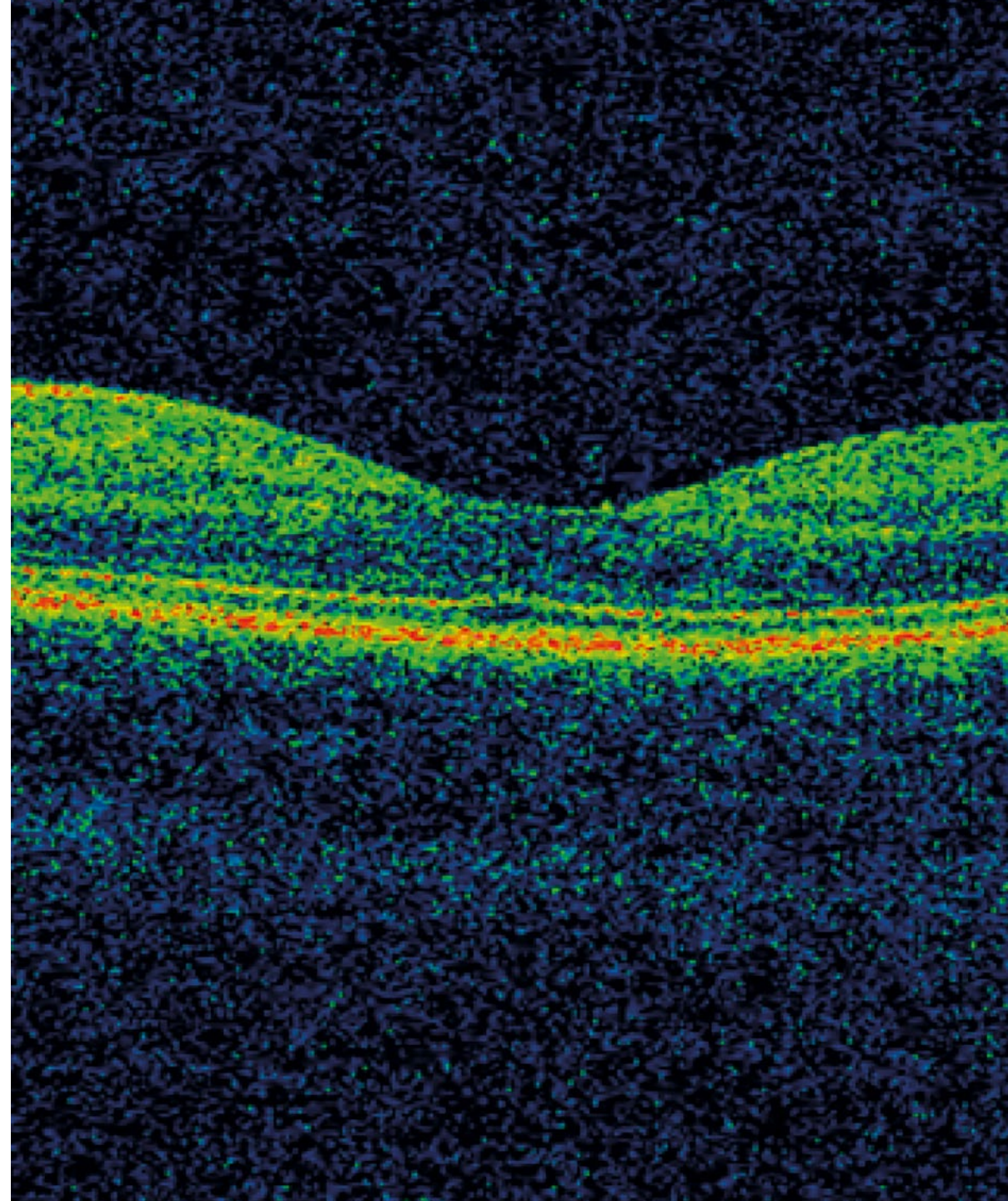
## Face-to-face visit two format

### Direct observation

- Eye examination on a presbyopic REAL patient - indirect ophthalmoscopy and using trial frame and lenses
- Direct ophthalmoscopy (one eye only), tear film assessment and soft contact lens fit (one eye only) on a simulated patient/s:

### Other Evidence

- Examination of patient records and other evidence submitted for the assessment. Evidence such as referral letters must be written by you





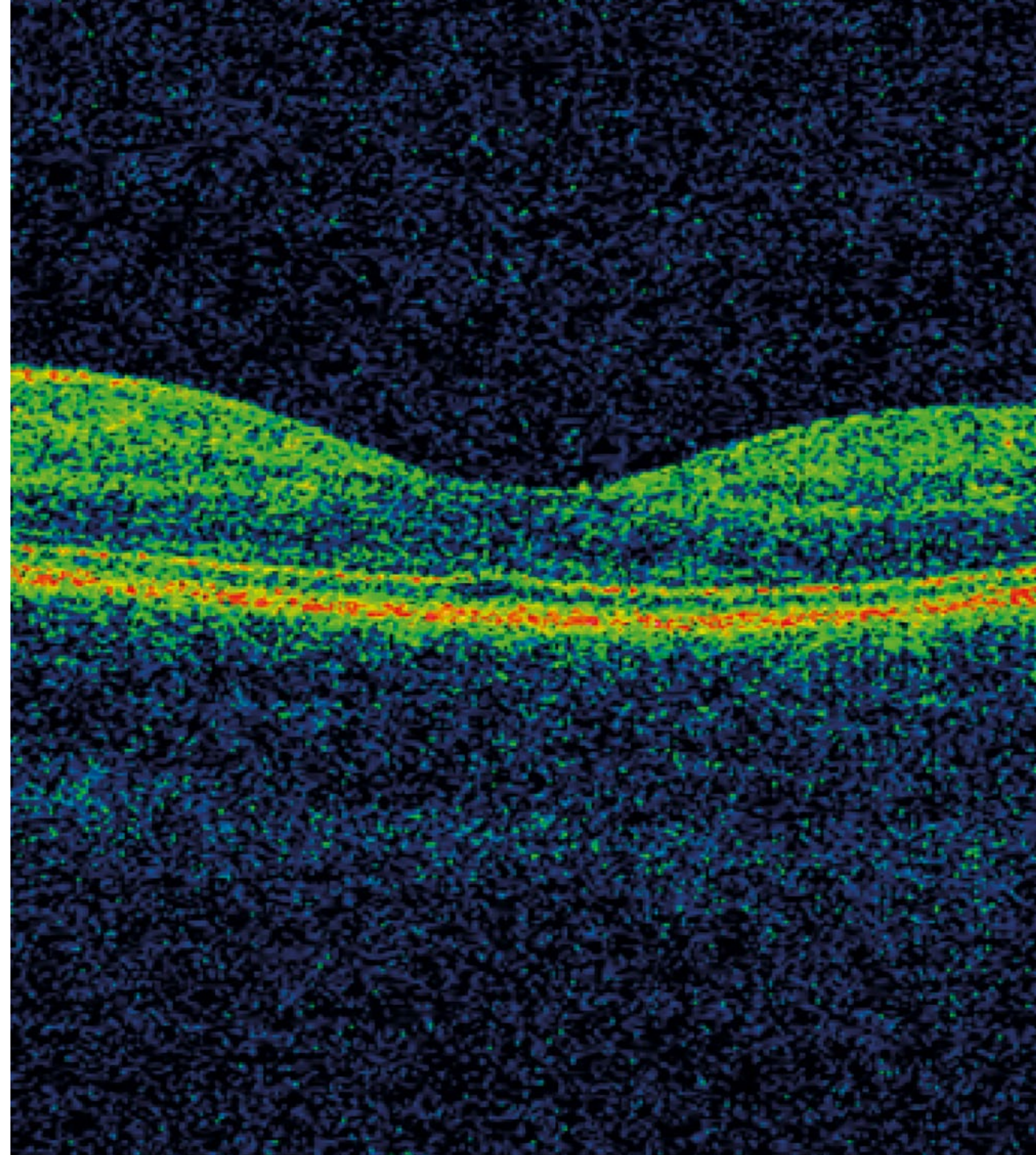
## Face-to-face visit three format

### Direct observation

- Soft lens aftercare for an established real patient wearer for whom an aftercare is due
- Contact tonometry using Goldmann or Perkins (one eye only) using a simulated patient:

### Other evidence

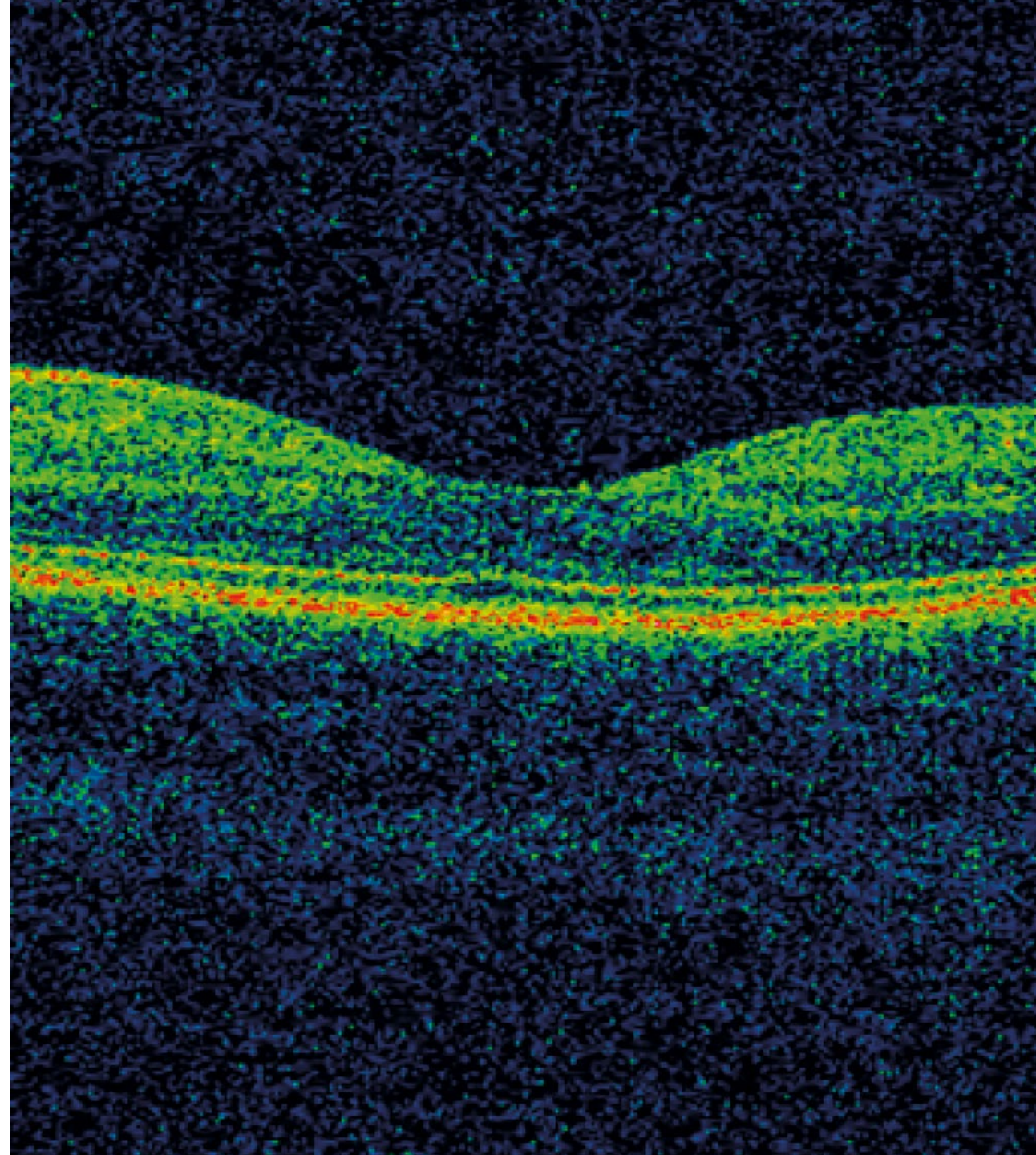
- Examination of patient records and other evidence submitted for the assessment. Evidence such as referral letters must be written by you





## Visit four format

- Remote or face-to-face based on whether there are outstanding direct observation competencies to complete
- Nine competencies to complete plus any other outstanding competencies from previous visits



## HES experience

Choice between virtual, in-person or a mix of HES experience for community practice-based trainees

If you are completing an in-person HES experience, you must use your HES logbook to provide evidence:

- This should be completed at each of your HES visits by your HES supervisor
- Your practice supervisor will need to also sign it off before it is used in the assessment

If you are completing the virtual HES experience, you will need to share your certificates with your Stage One assessor



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**Scheme for Registration**

**NHS Hospital Eye Service Logbook**

<b>Trainee name</b>	
<b>Hospital attended</b>	



## Reflective Exercise

- A reflective exercise reflecting on your entire Stage 1 journey to be submitted at your last Stage 1 assessment visit
- You cannot be signed off from Stage 1 without completing the exercise, but it is not marked
- The exercise is discussed in your final feedback section of the assessment





## Contacting your Stage One assessor

- Message through College website
- Please be aware of the cancellation policy – you will need to provide 15 days' notice to change a visit date without a charge

