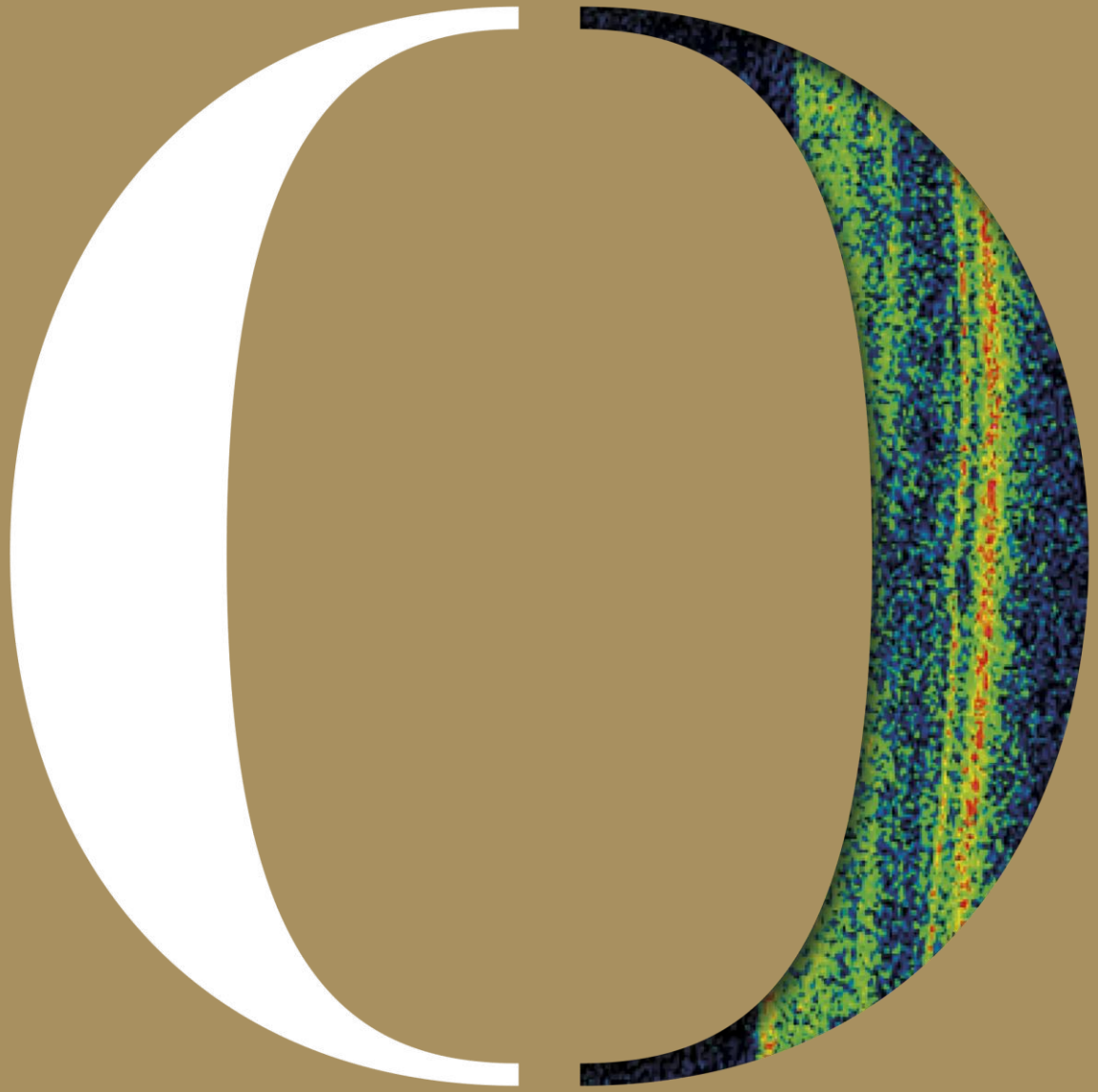
THE COLLEGE OF OPTOMETRISTS

Scheme for Registration:

Structure of the Scheme and tips for Stage One



Presenter name
Job title

01 July 2024

THE COLLEGE OF OPTOMETRISTS

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 (eg 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

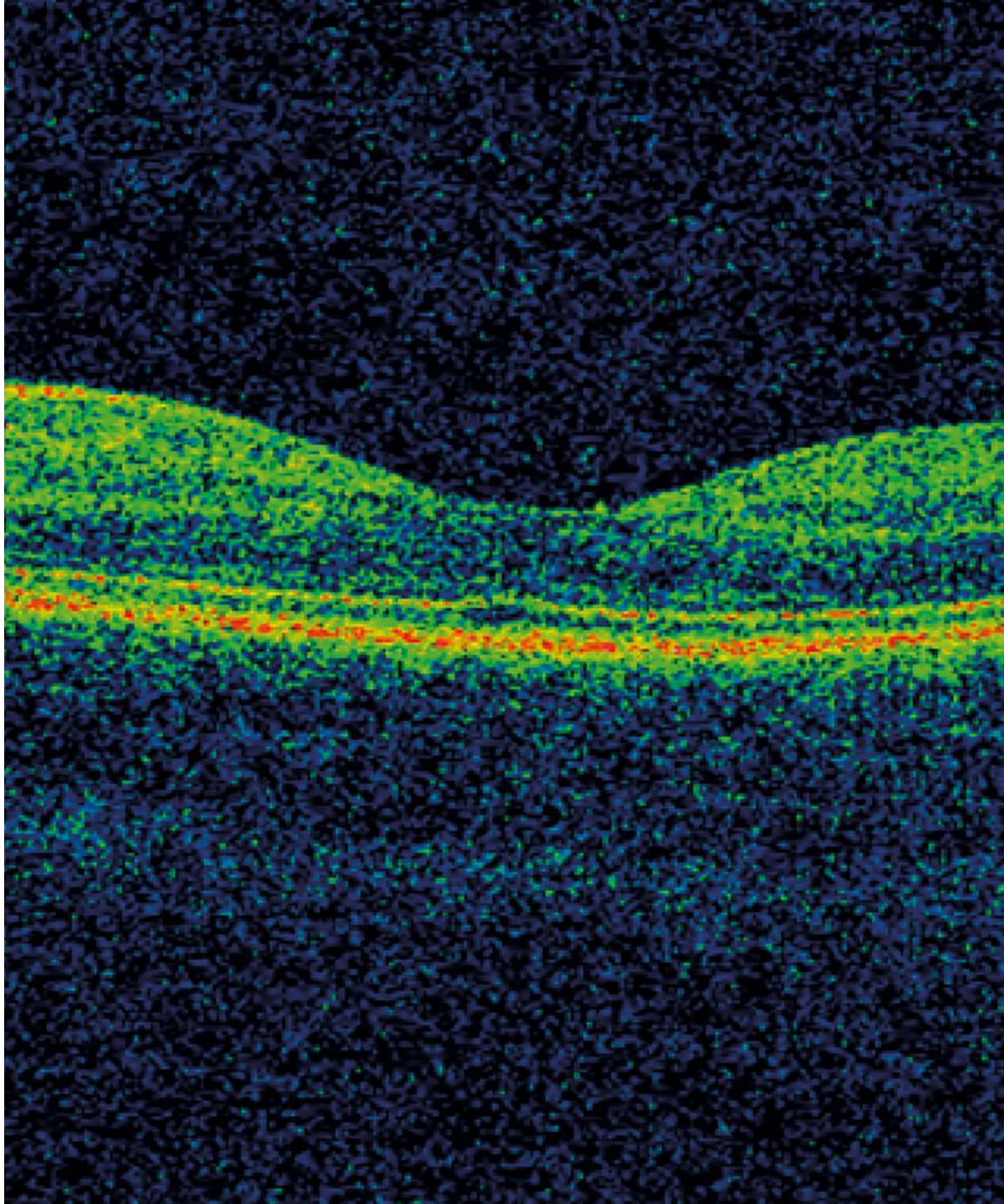
Face-to-face Visit two format

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



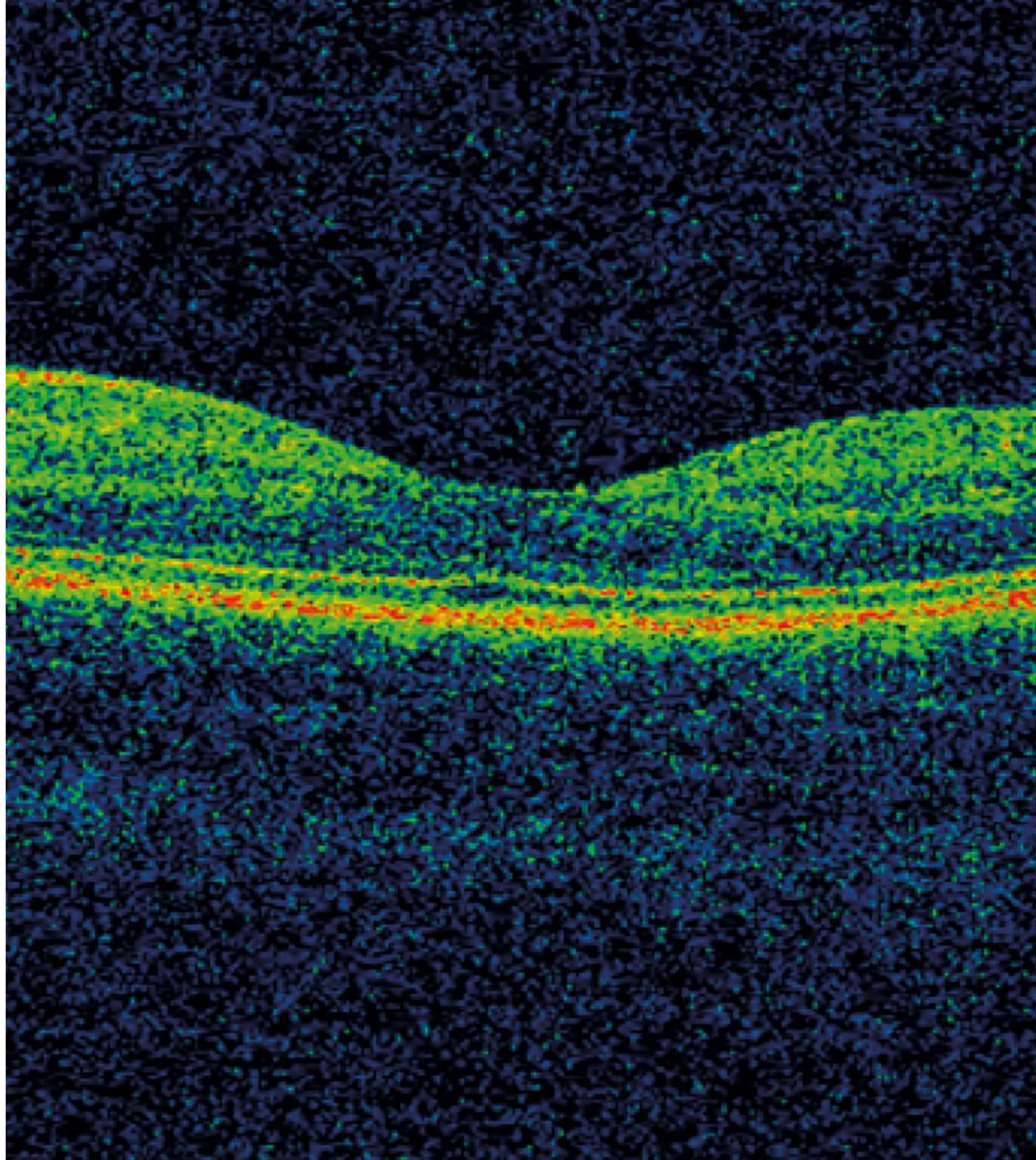
Face -to-face visit three format

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

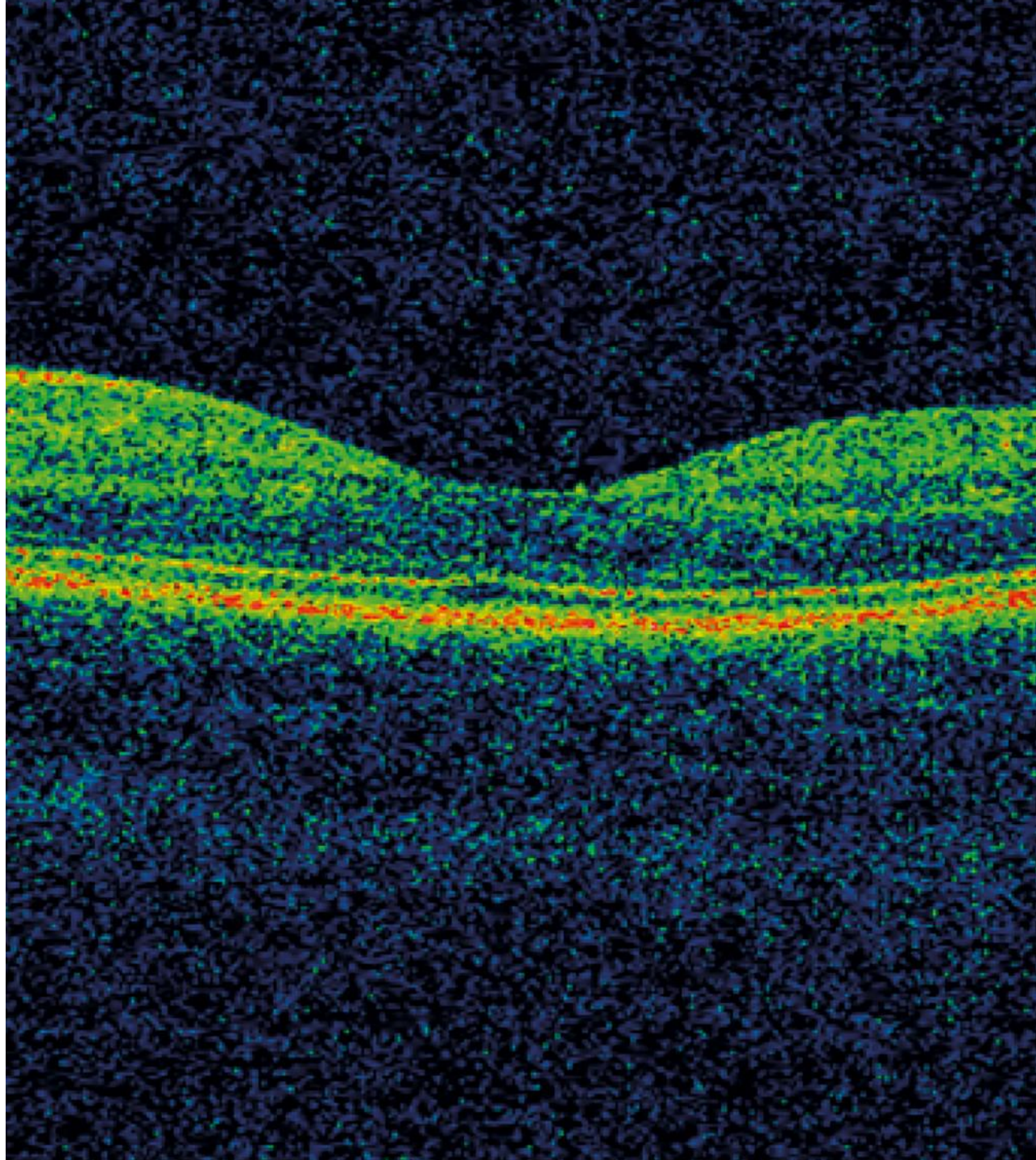
- Examination of patient records and other evidence submitted for the assessment. Evidence such as referral letters must be written by you



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

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