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**CLiP Supervisor Bulletin – Assessments on CLiP**

**April 2025**

The College has prepared this bulletin for supervisors to provide some broad information about assessments in the Clinical Learning in Practice placement.

**How CLiP students will be assessed**

CLiP students will have four scheduled assessment visits (two remote and two face-to-face), and one written assessment project. Remote visits are online and can be conducted in the practice or at another location. Assessors will visit the practice for the face-to-face visits, which will involve direct observation tasks. The visits will happen within a time-window at set points in their placement, so they will need to be ready for each visit. The visit is organised into separate assessment tasks.

To prepare for a visit, a student will need to have gathered appropriate evidence in the form of patient interactions, which will have been recorded and categorised in their CLiP Portal logbook. The categorisation is based on patient characteristics, needs and conditions, and enables assessment of the relevant GOC Learning Outcomes (the Learning Outcomes can be found on the GOC website here: *Requirements for Approved Qualifications in Optometry or Dispensing Optics*). Some tasks also require other documentation, such as an uploaded presentation.

A set number of assessment tasks will be covered at each visit and the student will be given a pass or fail grade for each. They will have one further opportunity to take any failed assessment task again (if elements within a task are failed, the entire task will need to be taken again). Depending on the task, this could be arranged on a different day or covered at the next visit.

The assessment strategy for CLiP is one of verification and observation. Accordingly, it relies on the use of logged experiences, signed off by approved supervisors and, where required, backed up by patient records (anonymised and uploaded, or viewed during a practice visit).

Assessors will examine the evidence available for each task and outcome, with assessment criteria set out in detail. This will be supplemented with an enquiry approach to determine the student’s understanding of, and reflections on, their experiences. Assessors will also judge their ability to make and rationalise appropriate clinical decisions on the basis of objective data, in line with GOC standards and other relevant clinical frameworks.

Many assessment tasks for CLiP will be familiar to those who have supervised Scheme trainees, as face-to-face visits will include everyday clinical skills. More detailed information is set out below.

**CLiP Part One remote visit (‘CLiP 1R’)**

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

Where: Online, in practice or at another location

Duration: 2 hours

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
4. Consent
5. Patient care (privacy, dignity, equality, inclusivity)
6. Communication skills
7. Information management

4. Service Evaluation Project (project orientation)

5. Quality assurance of setting and supervision (for support purposes)

Evidence required prior to assessment visit:

|  |  |  |
| --- | --- | --- |
| **Task/Activity** | | **Prerequisites / Evidence** |
| 1. Legal and ethical use and supply of ophthalmic drugs | | |
| Review and discussion of logbook records, including patient records | At least one drug instillation (not fluorescein) with patient record  Complete and attach Drug Management Template |
| 1. Health and safety legislation | |
| Student presentation | Presentation uploaded to the Portal and used to deliver five-minute discussion during visit.  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, ideally 2 examples/images per slide. |
| 1. Patient relationships\* | |
| 1. Consent – review and discussion of logbook records | At least **one** logged interaction citing outcome 1.6 or 4.4 for **each** of:   * Adult * Under 12 * Vulnerable OR Carer present (separate to Under 12)   Include attached policies (safeguarding, chaperone etc) where applicable |
| 1. Patient care (privacy, dignity, equality, inclusivity) – review and discussion of logbook records | At least **one** logged interaction for **each** outcome (three total), uploading policies where relevant |
| 1. Communication skills – review and discussion of logbook records, including patient records | At least **two** logged interactions, including reflections, citing outcome 2.1, for **each** of:   * Adult patient * Patient under 12 * Supervisor * Another colleague * External professional (including upload at least one anonymised record of a referral) |
| 1. Information management – review and discussion of logbook records, including patient records | **Ten** examples citing outcome 4.12 with redacted patient records and attached policies (safeguarding, chaperone etc) where applicable.  NOTE: records used for other Learning Outcomes can be used here. |
| 1. Service Evaluation Project (for support purposes) | |
| Project orientation | | Service Evaluation Project planning tool |
| 1. Quality assurance of setting and supervision (for support purposes) | |
| Discussion of student experience | Completed QA survey |

\*If this is failed, it will be re-assessed at CLiP 1F

**CLiP Part One face-to-face visit (‘CLiP 1F’)**

When: Approximately 18-20 weeks from starting the CLiP placement

Where: In the student’s practice

Duration: 3 and a half hours

The visit will consist of nine overarching tasks:

1. Eye examination fundamentals
2. History and symptoms
3. Clinical examination
4. Management plan
5. Record keeping
6. Health and safety including infection control
7. Clinical decision-making
8. Dispense and verification
   1. Dispensing
   2. Verification
9. Communication and consent
10. Patient care
11. Safety and risk
12. Diagnosis and decision-making
13. Record-keeping
14. Service Evaluation Project (submission and verification)
15. Quality assurance of setting and supervision (for support purposes)

Evidence required prior to assessment visit:

|  |  |
| --- | --- |
| **Task/Activity** | **Prerequisites / Evidence** |
| 1. Eye examination fundamentals | |
| 1. History and symptoms – observation | No task-specific documentary evidence  Pre-presbyope or presbyope contact lens wearing patient will be provided by the College  Direct observation will be used as evidence |
| 1. Clinical examination – observation 2. CL over refraction 3. Evaluation of lens in situ 4. Subjective and objective refraction 5. Slit lamp examination (external eye and related structures) (must include staining) 6. Indirect ophthalmoscopy 7. Pupil assessment 8. Binocular vision |
| 1. Management plan, inc. CL aftercare, and any additional tests – observation |
| 1. Record-keeping – observation |
| 1. Health and safety including infection control – observation |
| 1. Clinical decision-making – observation and discussion |
| 1. Dispense and verification | |
| * 1. Dispensing – observation: dispensing advice, measurements and fitting on a simulated patient provided by the practice | No task-specific documentary evidence |
| * 1. Verification – observation |
| 1. Communication and consent | |
| Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation | A range of interactions citing outcomes 1.1, 1.2, 1.6, 2.1 and 4.4.  Must include examples of the following, with history, examination and management, including consent:   * patient with carer * patient with difficulty communicating * children under 7 years old * significant family history * significant social/cultural factor * consideration of when capacity not established or consent is withdrawn * management of sensitive information |
| 1. Patient care | |
| Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation | A range of interactions citing outcomes 1.3, 1.5 and 4.9 |
| 1. Safety and risk | |
| Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation | A range of interactions citing outcomes 4.8, 5.5 and 5.7 |
| 1. Diagnosis and decision-making | |
| Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation | A range of interactions citing outcomes:  3.1: clinical decision making, with examples of diagnosing and managing ocular pathology – assessor to review at least 3  3.4: refractive management, including routine and where dispense has been adapted – assessor to review at least 5  3.5b(ii): contact lens prescription and dispense, including:   * student undertakes application and removal * a replaceable lens with CL aftercare * a toric or multifocal fitting * CL teach including care regime   – assessor to review at least 5, including 3 where student has undertaken application and removal |
| 1. Record-keeping | |
| Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation | No specific examples – assessors will observe the approach to record management displayed during the visit. |
| 1. Service Evaluation Project | |
| Project verification | Service Evaluation Project submitted with all sections completed |
| 1. Quality assurance of setting and supervision (for support purposes) | |
| Discussion of student experience | QA survey |

**CLiP Part One Service Evaluation Project (‘SEP’) assessment**

The Service Evaluation Project, submitted for CLiP 1F, will be evaluated and marked separately as a stand-alone assessment.

# CLiP Part Two remote visit (‘CLiP 2R’)

When: Approximately 27-30 weeks from starting the CLiP placement

Where: Online, in practice or at another location

Duration: 2 hours and 20 minutes

The visit will consist of seven overarching tasks:

1. Low vision
2. Paediatrics and vulnerable patients
3. Non-tolerance and contact lens complications
4. Use of drugs to aid refraction and assessment of fundus
5. Multidisciplinary collaboration, communication and leadership
6. 360° review
7. Coaching exercise
8. Personal Development Plan discussion (for support purposes)
9. Quality assurance of setting and supervision (for support purposes)

Evidence required prior to assessment visit:

|  |  |
| --- | --- |
| **Task/Activity** | **Prerequisites / Evidence** |
| 1. Low vision | |
| Review and discussion of logbook records, with patient records | At least **two** interactions (which include advice and at least **one** dispense of an LV aid) with patients with vision that meets the specified LV definition, with anonymised patient records attached. |
| 1. Paediatrics and vulnerable patients | |
| Review and discussion of logbook records, with patient records | 1. At least **four** logged interactions with attached anonymised records for children aged 7 or under, including  * **One** aged 4 and under * **One** Dispense for a child aged 4 or under * **One** with a BV anomaly that has been managed (which may include referral) by the student  1. Uploaded certificate for Paediatric clinic online HES course with reflection (with logged interaction and anonymised record for patient under 2, if achieved) 2. At least **two** anonymised records of patients with disabilities, including  * At least one with a disability that impacts communication * At least one with a disability that impacts mobility |
| 1. Non-tolerance & CL complications | |
| Review and discussion of logbook records, including patient records | Interactions with anonymised patient records, including at least **one** example of each of the following circumstances:   1. Non-tolerance to new Rx due to dispensing issues 2. Non-tolerance to new Rx due (i) incorrect Rx issued to suit px needs or (ii) Other reasons 3. Symptomatic CL complications that require management |
| 1. Use of drugs to aid refraction and assessment of fundus | |
| Review and discussion of logbook records, including patient records | Anonymised patient records, with rationale for use, of at least **one** example of use of **each** of the following drug types:  1. Mydriatic  2. Cycloplegic  3. Local Anaesthetic |
| 1. Multidisciplinary collaboration, communication and leadership | |
| 1. 360° Review – discussing reflections on feedback | Completed 360° Reviews: completed by one patient, one supervisor, one other colleague |  |
| 1. Coaching exercise – role play | No task-specific documentary evidence. Direct observation will be used as evidence |  |
| 1. PDP discussion (for support purposes) | |
| Discussion and feedback on draft PDP | Draft copy of Personal Development Plan |
| 1. Quality assurance of setting and supervision (for support purposes) | |
| Discussion of student experience | QA survey |  |

# CLiP Part Two face-to-face visit (‘CLiP 2F’)

When: Approximately 36-40 weeks from starting the CLiP placement

Where: In the student’s practice

Duration: 3 hours

The visit will consist of five overarching tasks:

1. Complete eye examination
2. History and symptoms
3. Refraction
4. Eye health assessment
5. Binocular vision assessment
6. Management plan
7. Record-keeping
8. Specialist dispense
9. Diagnosis: management and referral
10. Learning and development
11. Quality assurance of setting and supervision (for support purposes)

Evidence required prior to assessment visit:

|  |  |
| --- | --- |
| **Task/Activity** | **Prerequisites / Evidence** |
| * 1. Complete eye examination | |
| 1. History – observation | No task-specific documentary evidence  Presbyope patient will be provided by the College  Direct observation will be used as evidence |
| 1. Refraction – observation |
| 1. Full eye health assessment – observation 2. Anterior segment 3. Posterior segment 4. Neurological |
| 1. Binocular vision – observation |
| 1. Management plan (inc. supplementary tests) – observation |
| 1. Record-keeping – observation |
| * 1. Specialist dispense | |
| Student to provide advice on different dispensing scenarios | No task-specific documentary evidence |
| * 1. Diagnosis: management and referral | |
| Discussion based on logbook and practice records | Practice records must be available for all logged interactions – student will need to log examples of anterior and posterior eye conditions as well as neurology and fields. |
| * 1. Learning and development | |
| Discussion of PDP (including response to feedback on draft) | Finalised PDP document |
| * 1. Quality assurance of setting and supervision (for support purposes) | |
| Discussion of student experience | QA survey |

More detailed information about CLiP assessments will be published on our website in the coming months. We will keep you informed as we update on aspects such as:

* Assessment criteria
* Service Evaluation Project
* How the CLiP Portal logbook works
* How Supervisors will be able to use the logbook

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