Welcome to the Scheme for Registration 2018 Handbook

This handbook contains everything trainees and supervisors need to know about the Scheme for Registration. It details the range of experience a trainee requires, the standards a trainee needs to demonstrate in order to qualify and the support the supervisor is expected to provide. Therefore, we recommend both trainees and supervisors read through the handbook thoroughly to have a clear understanding of the assessment process.
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Included in each of the sections are summaries to ensure that key points are clear. We have included advice, hints and tips throughout the handbook to help you. There is also ‘New this year’, which details any significant updates from last year’s handbook.

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Section One – General information

New this year

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</tr>
</thead>
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<tr>
<td>The importance of behavioural indicators in the assessment of communication throughout the Scheme for Registration</td>
<td>Stage 1 Assessment Page 24</td>
</tr>
<tr>
<td>Removal of ‘at least one’ from record requirements for group three of Stage 2</td>
<td>Stage 2 Assessment Page 103</td>
</tr>
<tr>
<td>Adjusted wording of one record requirement in Units 1 and 2 of Stage 2 Patient episode record sheet, to bring it in line with the Stage 1 patient episodes</td>
<td>Stage 2 Assessment Page 113</td>
</tr>
<tr>
<td>Reference to electronic version of logbook available to download and complete from College website. The benefits of using this method of recording highlighted – it enables trainees to more easily find patient record evidence for assessments</td>
<td>Logbook Page 145</td>
</tr>
<tr>
<td>Refinement of the definition of contact lens fits for both the log book and assessment, to try to improve understanding</td>
<td>Logbook Page 147</td>
</tr>
<tr>
<td>Clarification that compulsory HES experience must be carried out within an NHS hospital</td>
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</tr>
<tr>
<td>Assessor processes for checking the authenticity of records provided on templates is detailed</td>
<td>Record templates Pages 169 – 177</td>
</tr>
</tbody>
</table>

GOC Standards of Practice for trainees and supervisors

1. As a professional, your fitness to practice will be determined by your professional behaviour as well as by your clinical ability.

2. All optometrists are expected to embed the GOC’s Standards of Practice in all that you do and in particular in their relationships with patients and colleagues. The main principles are set out below:

3. It is your responsibility to ensure that you are familiar with this guidance – it must underpin everything that you do. You are accountable for your actions and it is important to remember that your behaviour outside work can also affect your fitness to practice.

4. Supervisors should refer to and apply the Standards of Practice for Optometrists and Dispensing Opticians.
5. **Trainees should refer to and apply the Standards for Optical Students.** Once the training is complete and the trainee registers as a practising optical professional, they will then be expected to meet the separate Standards of Practice for Optometrists and Dispensing Opticians.


**The College’s Guidance for Professional Practice**

The College’s Guidance for Professional Practice is a much more detailed guide which builds on the principles set out in the GOC Standards of Practice. All trainees and supervisors should ensure that they are familiar with the contents of this document. It is not only essential for good practice but directly relevant to the assessments the trainee will undergo. The most up-to-date guidance is on [college-optometrists.org/guidance](http://college-optometrists.org/guidance) or available as a web app at [college-optometrists.org/app](http://college-optometrists.org/app).

Assessors will use the principles and practice outlined in these guidance documents alongside the assessment framework when assessing the professional conduct of trainees in the Scheme for Registration.

**Data protection**

When dealing with patient records you are subject to the requirements of the Data Protection Act. You must comply with it in all aspects of your work. In addition, trainees should remember to do the following in relation to the assessment process:

- At the start of every examination you should inform the patient that another practitioner might review his or her records for assessment and training purposes. Patients have a right to refuse consent for this.

- You may obtain consent orally or in written form. If you obtain consent orally you must record this by writing ‘Permission given orally on [date]’ on the patient’s record and sign the statement.

- The assessor will check that patient consent has been recorded on any patient record being reviewed as part of the assessments but it is your responsibility to ensure that this is done.

- If a trainee is gaining experience through the Hospital Eye Service, they will be subject to NHS data protection arrangements.
Equality and diversity

The College's equality and diversity policy applies to all those involved with the College including committee and working group members, assessors, supervisors, candidates, contract staff, and trainees. You must abide by the principles of equality and diversity. If you feel that these have been breached, you should write to the Director of Education at the College.

Purpose

To promote equal treatment for all participants in assessment processes in a way that ensures that the College complies with relevant legislation and codes of practice.

Scope

The College will apply the policy to all those with whom it deals in the course of assessment processes. It will seek to ensure that the policy is observed by all those over whom it has control or influence including members of the Education Committee, other relevant committees, examiners, assessors, supervisors and trainees.

Policy statement

The College is committed to eliminating discrimination, promoting diversity and providing equality of opportunity for all irrespective of sex, marital status, disability, race, colour, ethnic or national origins, age, sexual orientation, religion or belief, and politics, and that no one is disadvantaged by conditions or requirements that cannot be shown to be justified. The College also seeks to ensure that trainees are not victimised or subjected to harassment.

Assessment

The College strives to deliver assessments and examinations which are free from unfair discrimination. The College will take positive action to redress inequalities and discriminatory practice. The College is committed to ensuring that it recognises cultural differences. To this end, the College acknowledges different religious/festival requirements and aims to accommodate reasonable requests for alterations to assessment processes during such periods.

Adherence to policy

It is the responsibility of everyone covered by this policy to ensure that the minimum standards established within this policy are adhered to within their area of responsibility. Everyone must:

- co-operate with any measures introduced to eliminate discrimination and provide equality of opportunity
- report any suspected discriminatory acts or practices
- not induce or attempt to induce others to practice unlawful discrimination
- not victimise anyone as a result of them having reported or provided evidence of discrimination
- not harass, abuse or intimidate others on account of their race, gender etc.

Any breach of this policy will be dealt with accordingly.
Reporting
The College will monitor and review the operation of the policy. Anyone who has a concern regarding the application of this policy or feels that this policy has been breached should contact the Director of Education by email: jacqueline.martin@college-optometrists.org or by post: The Director of Education, College of Optometrists, 42 Craven Street, London, WC2N 5NG.

Contacting the College
You can contact us by email: education.help@college-optometrists.org or by phone on the following numbers:

Queries about the work-based assessment arrangements:
  • Trainee Services Coordinator 020 7766 4365

Queries about the technical aspects of the work-based assessment or the assessor:
  • Lead Assessor/ Deputy Lead Assessor 020 7766 4382

Queries about the Final Assessment:
  • Head of Examinations 020 7766 4367

If you have any further concerns:
  • Director of Education 020 7766 4354

Key information from this section:
You should:
  • embed the GOC’s Standards of Practice in everything you do
  • ensure you are familiar with the College’s Guidance for Professional Practice and refer to it often
  • embrace the values of equality and diversity
  • work within the Data Protection Act at all times, whether you are working or undergoing an assessment
  • ensure that you are clear on all the ‘New this year’ aspects of this handbook, where further clarification has been provided.
Assessment timeline for Scheme for Registration

**Stage 1**
- **Introduction to SfR**
  - College visit to Final year students
- **Start**
  - Start on scheme
- **4-6 weeks**
  - Visit 1
  - 10 elements of competence
- **3 months**
  - Visit 2
  - 32 elements of competence
- **6 months**
  - Visit 3
  - 33 elements of competence

**Stage 2**
- **7-8 months**
  - Visit 4
  - Outstanding elements of competence
- **8-10 months**
  - Stage 2 visit
  - Overarching elements of competence + FA of Routine and CLs by a different assessor
- **12 months**
  - OSCE

**Final Assessment**
Overview of the Scheme for Registration

The work-based assessment is a two-stage process. Stage 1 involves the assessment of 75 elements of competence by a designated assessor, over a minimum of three visits.

Stage 1
During the pre-registration period trainees are assessed in the workplace on the GOC’s eight units of competency. Every trainee is allocated a Stage 1 assessor who will ensure that they are clear about the assessment system and schedule of the assessment visits. After the first visit, the assessments take place quarterly. Trainees normally require three or four assessment visits to achieve success in Stage 1 of the work-based assessment process but, if necessary, they may have further assessments, for which there is a fee. The fee is set out in [college-optometrists.org/qualifying-fees](http://college-optometrists.org/qualifying-fees)

Trainees will enter Stage 2 of the work-based assessment process when the Stage 1 assessor has:

- judged the trainee to be competent in all 75 Stage 1 elements of competence
- confirmed that the trainee has completed the GOC’s refractions and dispensings requirement
- confirmed the trainee has completed the College’s contact lens fitting and aftercare requirements
- confirmed that the HES experience requirement has been completed if a trainee is based in community practice.

Stage 2
Stage 2 involves the assessment by a second assessor of overarching Stage 2 elements of competence, which sample a trainee’s competence across the eight units of competency. The assessment will take place once the Stage 1 assessor is satisfied that the trainee has demonstrated competence in the Stage 1 elements, has completed the HES experience requirements (if the trainee is based in community practice), has undertaken a minimum of 350 refractions and 250 dispensing episodes and has achieved the minimum contact lens fitting and aftercare experience. The Stage 2 assessment will involve a full routine eye examination and the fitting and aftercare of soft contact lenses on simulated patients provided by the College as well as discussion of patient records provided by the trainee and possibly of case scenarios that the assessor will provide.

The Stage 2 assessor will judge whether each trainee has maintained their competence in all eight units of competency by assessing:

- their ability to carry out an eye examination on a presbyopic patient
- their ability to fit soft contact lenses and provide aftercare to a soft lens wearer
- the 13 overarching Stage 2 elements of competence.

Final Assessment

Once assessed as competent by the Stage 2 assessor, the trainee may enter the Final Assessment (OSCE). This is held under examination conditions. There are four opportunities a year to sit the Final assessment examination in July, September, January and March.
The assessment framework

The various elements of GOC’s eight units of competency have been placed into an assessment framework. This framework suggests a schedule for assessing the elements by allocating them to three Stage 1 assessment visits. The relevant parts of the framework are found under each visit in the Stage 1 assessment section, ie the elements which would usually be assessed during Visit 1 are found in the Visit 1 section of this handbook. It also sets out: the evidence the trainee can use to demonstrate competence where a type of evidence is compulsory, eg which skills must be directly observed by the assessor as well as the performance criteria by which the trainee will be judged the performance indicators, ie the standards required in order for the element to be achieved.

For each set of elements of competence trainees must gain experience with patients with a number of different conditions. These are also set out in the framework and in this case patient record is a compulsory form of evidence.

Assessing evidence

The assessment of evidence by the assessor is an individualised process which is determined, in the first instance, by compulsory direct observation or patient record evidence, which the trainee is required to provide. Any follow up questions or case scenarios will always endeavour to provide the opportunity for further evidence to be provided so that the requirements of the performance indicators can be fully met. For example:

<table>
<thead>
<tr>
<th>Element of Competence</th>
<th>Compulsory evidence</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.8. Evaluates glaucoma risk factors to detect glaucoma and refer accordingly.</td>
<td>PR Patient requiring management for potential suspect glaucoma (not solely ocular hypertension)</td>
<td>Discusses the key risk factors. Identifies findings suggestive of open and <strong>closed angle glaucoma</strong> from clinical examination. Uses the above information to determine if referral is appropriate. Decides on urgency and pathway of referral.</td>
</tr>
</tbody>
</table>

The record offered as evidence is of a patient with suspect POAG with disc and field changes.

By examining the record, the assessor will be able to decide whether or not the trainee has met the standard in relation to open angle glaucoma, but will have not evidence from the record relating to whether the trainee could identify and appropriately manage a case where closed angle glaucoma was suspected. If the record covered all the salient points without the need for further clarification, then the assessor’s case scenario or questioning would simply be around ‘closed angle glaucoma’. The opposite would apply if the PR evidence provided by the trainee related to closed angle glaucoma.

In all cases the standards required are dictated by the performance indicators and should not exceed these.
Quality assurance in the Scheme

The Scheme is quality assured at all stages by strict systems and processes. In the work based assessment all assessors have to participate in compulsory annual training. Their assessments are observed, their assessment reports assessed and their trainees interviewed on a regular basis which is dictated by the experience of the assessor and the number of trainees they assess.

OSCE examiners also have to participate in compulsory annual training. Their marking decisions are peer reviewed on the day and moderated, if required, by the Final Assessment Panel.

Duration of the Scheme

The Scheme for Registration, known as the Scheme, must be completed within two years and three months of a trainee’s enrolment date on the Scheme or after a maximum of four attempts at the Final assessment, whichever occurs first.

In exceptional circumstances, we may permit a trainee additional time on the Scheme or to start again (one further time). Please refer to the Regulations on college-optometrists.org/sfr for more information.

Trainees with a disability

If a trainee has physical, mental or sensory impairments covered by the Equality Act 2010, we will not make adjustments to the standard of the assessments, but may be able to make adjustments to the arrangements. For further information please refer to the Equality and Human Rights Commission website at equalityhumanrights.com.

If a trainee would like us to consider making reasonable adjustments to an assessment or examination, they should let us know, as soon as possible, by one of the following methods:

- completing the reasonable adjustments form on college-optometrists.org/sfr
- emailing a statement to education.help@college-optometrists.org
- writing to the Director of Education at The College of Optometrists, 42 Craven Street, London WC2N 5NG.

If you think you will have difficulty completing the form or writing a statement, please contact the College.

If you delay in telling us, we may not be able to make the reasonable adjustments, in time for the date of the assessment. You can find more information on college-optometrists.org/sfr

In submitting a request for reasonable adjustments, the trainee agrees that we may store the personal information they provide in connection with the request, share it with the GOC where necessary, and use it to process their request and make reasonable adjustments to enable them to attempt the assessments and to compile statistics and undertake research.
Trainee badges and photographic identification

Trainees must wear a badge showing their name and the title ‘Pre-registration trainee’ at all times during the training. The GOC has said it would be good practice to have their GOC number on the badge as well, but this is not essential provided the number is displayed elsewhere in the practice where it can be seen by members of the public. The most important point is that the patient is clear that they are being seen by a trainee who is under supervision. For trainees in hospital placements, the GOC number should be made available if requested.

Trainees will also be required to provide photographic ID in the form of a driving licence, passport or student ID card to the Stage 1 assessor at the first Stage 1 visit and also to the Stage 2 assessor at any Stage 2 visits.

Key information from this section:

- trainees will be assessed against the GOC eight units of competency in their place of work and a sample of the knowledge and skills they need to practise will be assessed in the Final assessment
- the work-based assessment is split into two stages and the Final Assessment trainees must complete the Scheme for Registration within two years and three months of their enrolment date on the Scheme or they may attempt the Final Assessment up to four times, whichever occurs first
- the assessment process is individualised to ensure the trainee has the best opportunity to provide evidence of their competence but the standard for sign off is always dictated by the performance indicators and compulsory evidence requirements
- there are strict quality assurance processes at all stages in the Scheme
- if the trainee has a disability, we may be able to make reasonable adjustments to the work-based and Final assessments
- trainees must wear a badge to indicate that they are a trainee working under supervision and will also need to provide photographic identification to both the Stage 1 and Stage 2 assessors.
Responsibilities

The trainee
Responsible for:

- ensuring they are registered with the GOC as a student optometrist throughout the pre-registration period
- notifying us of any changes in supervision during this period
- meeting the standards set out in the GOC’s Standards of Practice and the College’s Guidance for Professional Practice
- their own learning
- taking advantage of training opportunities
- asking for clarification or assistance when they are in doubt
- preparing thoroughly for the work-based assessments
- preparing thoroughly for the Final assessment.

The supervisor
Responsible for:

- providing written conditions of employment
- giving the trainee sole access to a consulting room for testing sight for at least 20 hours a week
- giving the trainee access to the equipment they need
- giving continuous personal supervision by being on the premises, or ensuring that another suitably qualified optometrist is on the premises, when the trainee is training and ensuring that no harm can come to the patient from their actions
- giving the trainee the opportunity to attend extended tutorials and revision courses
- giving the trainee the opportunity to gain appropriate experience in the core competency areas in the practice, or elsewhere for those elements not available in the practice
- making arrangements for the trainee to undertake at least the minimum required number of refractions dispensing and contact lens experience requirements
- ensuring the trainee gains adequate clinical experience in the complete routine examination.
- making NHS hospital experience available to the trainee
- observing the trainee work and giving them constructive feedback on their performance
- discussing cases with the trainee and guiding them in prescribing
- reviewing the trainee’s progress using monthly meetings and review forms and checking their logbook
- being available to see the Stage 1 assessor during assessment visits
- ensuring adequate practical arrangements are in place for the assessment visits
- ensuring suitable patients are available for the Stage 1 work-based assessments
- helping the trainee put into practice any action plans agreed with the assessor.
The Stage 1 assessor

Responsible for:

- providing the trainee and supervisor with their contact details
- ensuring that the trainee and supervisor are clear about the assessment process
- booking all remaining Stage 1 assessment visits at the trainee’s first assessment visit and carrying out other administrative tasks to ensure the process runs smoothly and that all parties have the information they need
- maintaining the integrity of the assessment system
- assessing the trainee’s competence in accordance with the criteria and College instructions
- ensuring the evidence provided by the trainee is sufficient and valid
- providing feedback to both trainee and supervisor immediately after the assessment, including advice on strategies to achieve competency
- producing an on-line report recording the assessment results and an action plan for those areas where further development is needed, which will be copied to both the trainee and supervisor.

The Stage 2 assessor

Responsible for:

- maintaining the integrity of the assessment system
- assessing the trainee’s competence in accordance with the criteria and College instructions
- ensuring the evidence provided by the trainee is sufficient and valid
- producing and sending to the College an online report recording the assessment results.

The lead assessor, deputy lead and senior assessors

Responsible for:

- recruiting assessors
- training and developing assessors and supervisors
- providing advice to assessors
- mediating if there is conflict between the assessor and trainee or supervisor, other than about employment issues
- assuring the quality of the work-based assessment.

College staff

Responsible for:

- ensuring the Scheme for Registration is operated fairly and effectively
- ensuring the Scheme for Registration guidance and regulations are implemented
- enrolling each trainee on the Scheme for Registration and supplying the information and guidance they need
- keeping trainees’ records up to date
- ensuring each supervisor agrees to the terms and conditions when accepting to supervise a trainee
- arranging assessors for each trainee
- ensuring that the assessment results are recorded accurately
- offering trainees and supervisors advice if required
• processing each trainee’s application for the Final Assessment and ensuring they have all the information required to sit the Final Assessment
• informing trainees of their results
• confirming results to the GOC.

Key information from this section:
• trainees are responsible for their own learning and for using their time wisely
• supervisors are responsible for their trainee’s work and for supporting them throughout their training
• the Stage 1 assessor is responsible for conducting the assessment appropriately and providing each trainee with an action plan after each assessment
• the Stage 2 assessor is responsible for conducting the assessment appropriately and providing the College with a report following the Stage 2 assessment
• the lead, deputy lead and senior assessors are responsible for overseeing the assessment process in the workplace
• College staff are responsible for ensuring the Scheme for Registration is operated fairly and effectively and in accordance with the regulations.
Training and assessment

Getting to know the practice
In the first few weeks it is important to ensure that trainees become familiar with the practice and get to know the members of staff as well as the records and accounts systems. Trainees can endeavour to become part of the team by helping make adjustments and small repairs and by ordering and checking orders.

Familiarising yourself with the assessment process and framework
Both trainee and supervisor should familiarise themselves with the assessment framework. Trainees must start to log all the patients they have seen from day one. To help decide what will count towards the refraction, dispensing and contact lens experience requirements refer to the policy in the Logbook section.

The Visit 1 paperwork in the Visit 1 section shows:
- how the first assessment visit will be structured
- the evidence each trainee will have to provide to the assessor.

Look at the evidence and the patients each trainee will be required to see and consider the best way to gain the necessary experience. The Visit 2 and Visit 3 sections cover the same information for each of these subsequent visits.

Working in a trainee/supervisor partnership
The supervisor/trainee relationship is central to a success placement. Each trainee is expected to direct their own learning far more than at university – reflecting on their experience, drawing conclusions and applying what they have learnt to future activities. The supervisor helps with this process by gradually moving the responsibility for learning to their trainee.

Regular meetings
Arrange an early meeting to agree a supervisory plan setting out how that relationship will work. This provides a good opportunity to arrange an observation programme and decide how often you will have meetings throughout the pre-registration period and agree the content of those meetings and how long they will last. It is the time to draw up learning objectives based on the assessment framework.

Monthly meetings will offer an opportunity for the trainee to reflect on their performance since the previous meeting, review their learning objectives, and discuss any specific topics and plan the month ahead. The meetings will include monthly reviews of the trainee’s work by the supervisor who will complete a monthly training review sheet to provide the Stage 1 assessor with an overview of the trainee’s professional development. These can be found in the Visit section of this handbook. The trainee and supervisor sign the completed monthly training review sheet to confirm that both were present. The supervisor will check the logbook and patient records to ensure that the trainee is seeing an increasing number of patients and managing increasingly complex cases. They should discuss the trainee’s progress and give a score for each element of competence. Trainees should use the reflective learning sheet in the Reflection section to prepare for the review. There is also an example of a completed review sheet in the section.
In practice
The supervisor will provide their trainee with opportunities to gain different types of experience. If the trainee finds any gaps in their experience, they should proactively decide with their supervisor where relevant experience can be obtained.

Supervisors will begin by observing the trainee in practice and then reduce their input as the trainee gains experience. Trainees must always ask for help if they have a patient outside the limits of their competence. As well as the regular monthly observations to inform the review process, a ten minute slot at the beginning or end of each day could be an effective way of discussing issues of interest that have arisen that day or the previous day. Trainees should not let their patients leave the practice until they have, as a minimum, given the supervisor the opportunity to check the record of the consultation.

Supervisors should continue to observe their trainees in practice on at least a monthly basis to ensure that they are making good progress. It is worth spending time at your regular meetings deciding when the supervisor will observe the trainee and what aspects of their work they will observe.

Appropriate scheduling of appointments
The reception staff should be given clear instructions about which patients the trainee should see. To begin with, they should see no more than four patients a day, if they are responsible for the full eye examination and dispense.

At first, allow plenty of time for each sight test. One hour would not be excessive. As the trainee progresses they will work faster and can undertake more sight tests in a day. Remember that the supervisor must check the trainee's work at the end of each appointment, so build this into the schedule.
A typical daily clinic schedule during the first month of supervision would look like this:

<table>
<thead>
<tr>
<th>Time</th>
<th>Patient details</th>
<th>Appointment type</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00</td>
<td>Patient A</td>
<td>Routine eye examination</td>
</tr>
<tr>
<td>10.00</td>
<td></td>
<td>Supervisor check</td>
</tr>
<tr>
<td>10.30</td>
<td>Patient B</td>
<td>Routine eye examination</td>
</tr>
<tr>
<td>11.30</td>
<td></td>
<td>Supervisor check</td>
</tr>
<tr>
<td>12.00</td>
<td>Administration</td>
<td>Check records are complete</td>
</tr>
<tr>
<td>12.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.30</td>
<td></td>
<td>Routine eye examination</td>
</tr>
<tr>
<td>14.30</td>
<td></td>
<td>Supervisor check</td>
</tr>
<tr>
<td>15.00</td>
<td>Patient D</td>
<td>Soft contact lens aftercare</td>
</tr>
<tr>
<td>16.00</td>
<td></td>
<td>Supervisor check</td>
</tr>
<tr>
<td>16.30</td>
<td>Administration</td>
<td>Check records are complete</td>
</tr>
<tr>
<td>17.00</td>
<td></td>
<td>Review of today’s clinic with supervisor</td>
</tr>
</tbody>
</table>

Trainees must also be given contact lens experience from the beginning of the training, as they will be assessed on aspects of fitting and aftercare in the first assessment.

As the trainee gains experience their work schedule should be reviewed. The normal increase in workload should not exceed the following:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Numbers of patients seen by trainee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Visit 1 (4-6 weeks after enrolment)</td>
<td>No more than 4-5 patients per day</td>
</tr>
<tr>
<td>Up to Visit 2 (3 months after enrolment)</td>
<td>No more than 6-8 patients per day</td>
</tr>
<tr>
<td>Up to Visit 3 (6 months after enrolment)</td>
<td>No more than 8-10 patients per day</td>
</tr>
<tr>
<td>Visit 4 and beyond</td>
<td>No more than 12 patients per day</td>
</tr>
</tbody>
</table>

Key information from this section:
- trainees should take time to become familiar with their new environment
- trainees should ensure they become part of the team
- both trainee and supervisor should familiarise themselves with the assessment framework and the experience required
- trainees and supervisors should discuss how they will work together
- allow plenty of time for the trainee’s appointments.
Gaining experience

Checking trainees’ sight tests
As time goes on, the trainee’s sight testing will become increasingly accurate. The supervisor will continue to undertake a retinoscopy and check for abnormal conditions until they are confident that the trainee is able to spot these on their own. When the retinoscopy shows consistently reliable results, the supervisor may inspect the trainee’s records and undertake only an ophthalmoscopy. Trainees must record the results of their retinoscopy before they record the subjective results and the full details of any binocular tests. Later in the training the supervisor will use the records to assess the relationship of refractive change to acuity, the likelihood of a suggested change of power axis and its probable influence on visual comfort.

Towards the end of the pre-registration period, individual aspects of the trainee’s work will not require routine checking. However, the supervisor must always be given the opportunity to intervene before the patient leaves the practice. If a trainee has any doubts, they must refer cases to the supervisor, who should always be on hand to discuss any cases.

Remember: trainees must recognise and work within the limits of their professional competence.

What experience is needed?
Trainees must see the range of patient episodes listed in the assessment framework. Together, you should decide how this will be achieved. It may mean planning sessions in other practices that specialise in particular types of work. Assessing and dispensing patients with low vision, assessing patients with binocular vision abnormalities, fitting and aftercare of patients wearing rigid gas permeable lenses and examining young children are all of areas where experience outside the registered practice might be necessary.

Once some experience has been gained, the trainee’s workload should gradually increase from four to eight patients a day if they are responsible for the full eye examination and dispense.

Record keeping
Remember the importance of good record keeping. From the beginning, trainees must take care to write clear, accurate and legible records, reporting all relevant findings both positive and negative. The records must be contemporaneous, ie completed at the time of the consultation or as soon as possible afterwards. Never alter records at a later date. All records should show the name of the supervisor who was responsible for the trainee’s work at the time of the consultation.

Maintaining competence
Because trainees have a lot to learn and are being assessed on a three-monthly basis, it is understandable that they will want to concentrate on gaining experience in the areas that are to be assessed in next. Trainees must, however, keep up standards in those areas which have already been assessed. Skills assessed early on should be continuously practised so that they improve over time.

The assessment framework (covered in each of the assessment visits) has been designed to encourage trainees to build their skills and maintain their competence in all areas. The order in which the elements of competence are assessed reflects the usual trainee pattern of experience and the Stage 2 work-based assessment will sample widely from the whole range of Stage 1 elements.
Hospital experience
Trainees based in community practice must also gain experience in the NHS hospital eye service (HES). During this placement, the trainee will need to complete the HES logbook as evidence of their attendance and the experience gained.

Trainees will attend during normal working hours, through day or block release, for between one and three weeks during the pre-registration period. The supervisor will make the application to the NHS hospital on behalf of the trainee. At the end of the period of experience, the supervisor and assessor will check that the trainee’s attendance and participation has been satisfactory.

The application process for the HES placement will vary from trust to trust, but it is important to consider the length of time required to prepare all the necessary paperwork and for all checks to be completed in order for the trainee to be issued with an honorary contract to observe within the trust.

The trust could ask for all or any of the following:
- full name, title and address of the trainee
- the trainee’s original passport for photocopying and signature
- two original ID address documents
- occupational health clearance with occupational health check and vaccinations if these are not up-to-date
- trainee references covering the past three years (one which must be from the current employer). The name of the person providing the reference will not be sufficient. It is the trainee’s responsibility to write to the referee and obtain the references required for the trust
- a valid DBS certificate
- proof of qualifications/registration.

Realistically, you should expect that it will take at least eight weeks for an honorary contract to be completed and placement dates cannot be confirmed until this has been issued.

Refractions, dispensing and contact lens related patient episodes
Before completing the Stage 2 assessment, the trainee must complete a minimum of 350 refractions and 250 dispensings. If the trainee is a dispensing optician, they are exempt from the requirement to undertake a minimum of 250 dispensings. Clarification of what constitutes a refraction or dispensing episode is detailed in the Policy on refractions and dispensings, found in the Logbook section. It is also a requirement that each trainee needs to complete all the patient episodes listed in the assessment framework.

To ensure that the trainee has sufficient contact lens related experience to meet the requirements of the Scheme every trainee will also be required to complete by Stage 1 sign off:
  a. 20 contact lens fitting episodes to include a minimum of three complete soft fittings and three complete RGP lens fittings
  b. 40 contact lens aftercare episodes to include a minimum of three soft lens aftercares and three RGP lens aftercares. 20 of the total aftercares to be carried out on established lens wearers (i.e. who have worn their lenses regularly for a minimum of six months). The aftercare records offered for assessment will preferably be on established wearers but will always include at least one soft aftercare on an established wearer with a complication managed to resolution.
Conferences and meetings
Both trainee and supervisor should try to attend conferences and meetings wherever possible to keep up to date.

If you are in hospital practice
If a trainee’s main experience is in hospital practice, they will gain experience in several areas of specialist practice and have access to a wide range of pathology. However, if spectacles are not dispensed at their hospital, the supervisor must make arrangements for the trainee to work in community practice for at least half a day a week so that they can complete the minimum number of dispensings and cover the relevant patient episodes for assessment. There may also be other areas of clinical experience which would be useful to make arrangements for, for example soft lens fitting and management of patients requiring referral.

Key information from this section:
- the trainee’s work must be thoroughly checked until they have gained experience and trainees must always ask if they are unsure
- supervisors must be given the opportunity to check the record of the consultation before the patient leaves the practice
- the number of eye examinations and dispensings the trainee undertakes in a day should be gradually increased
- trainees should be encouraged to gain as much experience as they can and ensure they see the range of patient episodes in the assessment framework
- trainees must always keep clear, accurate and legible records and note on the record the name of the supervisor responsible for their work at the time of the consultation
- all the trainee’s work with patients must be supervised
- trainees must maintain competence in the areas in which have already been assessed
- if the trainee is based in community practice they must complete the minimum requirement of HES experience, and take advantage of the hospital experience
- sufficient time, at least eight weeks, should be allowed for the HES experience to be arranged due to the pre-checks and paperwork that is required
- trainees must complete the minimum number of refractions, dispensings and contact lens experience and all the required patient episodes before they can apply for the Final Assessment
- both trainee and supervisor should look out for other ways to broaden the trainee’s experience.
The paperwork
Logbook
Trainees should use the electronic log book, which can be found at college-optometrists.org/sfr. If this is not possible, there is a logbook available in this handbook.

The logbook should be kept up-to-date and frequently reviewed so that the trainee and supervisor can discuss progress and decide how to gain experience where it is lacking. Remember to refer to the patient episodes in the assessment framework.

The logbook should also paint an accurate picture for the assessor during assessment visits. They will use the logbook to identify other patient records to supplement the evidence the trainee provides through the patient episodes they have already identified. They will also use it to confirm the trainee’s experience to date by spot-checking records from the logbook on the practice patient database.

Reflective learning sheets
A monthly reflective learning sheet can be found in the last section of this handbook, along with a completed example. Trainees should photocopy and complete the sheet each month and use it to reflect on their experiences of the past month, consider what they have learned from them and to plan the following month. This will provide a structured learning plan for the trainee and help them to see the progress they are making.

Assessment of communication in the Scheme
Assessors in the workplace at both Stage 1 and 2 of the assessment process (and examiners in the OSCE) will consider the content of the communication and also how it is delivered in their judgements.

Addressing concerns
Occasionally, trainees may find that the training and experience is not as expected. They should talk to their supervisor in the first instance and if matters do not improve, talk to the Stage 1 assessor to see if they can offer any support to you both to address the concerns. The lead or deputy lead assessor, may also be able to help. Below are some examples of action plans which you might find useful:
### Concern 1

<table>
<thead>
<tr>
<th>Suggested action plan to address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trainee struggling to gain required experience</strong></td>
</tr>
<tr>
<td>1. Remember that a trainee has two years and three months to complete the Scheme and so there is plenty of time to gain this experience.</td>
</tr>
<tr>
<td>2. Review overall experience and then decide on the specific areas where the required experience is lacking.</td>
</tr>
<tr>
<td>3. Work together to agree an action plan to gain the required experience, e.g., highlight to the practice reception staff the types of patients required and ask them to book these patients in with the trainee.</td>
</tr>
<tr>
<td>4. If concerns continue, the supervisor should discuss with optometrist/dispensing optician/contact lens optician colleagues to see if the experience can be gained elsewhere using temporary supervision arrangements.</td>
</tr>
<tr>
<td>5. If problems persist, discuss your concerns with the Stage 1 assessor.</td>
</tr>
<tr>
<td>6. If still no progress, then contact the lead or deputy lead assessor.</td>
</tr>
</tbody>
</table>

### Concern 2

<table>
<thead>
<tr>
<th>Suggested action plan to address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trainee struggling as experience seems excessive</strong></td>
</tr>
<tr>
<td>1. Remember that the minimum requirement for sign off from Stage 1 is 350 eye examinations, 250 dispensing episodes, 20 contact lens fittings and 40 aftercares.</td>
</tr>
<tr>
<td>2. In reality, it much more likely that trainees will see around 600-800 eye examinations and 300-400 dispensing episodes during their pre-registration training and this will be required in most practices in order for them to ensure they see the full range of patient episodes.</td>
</tr>
<tr>
<td>3. Refer to the guidance in the Logbook section of the handbook for advice, namely:</td>
</tr>
<tr>
<td>• up to Visit 1-4 patients daily if trainee is carrying out full eye examination and dispense for each patient.</td>
</tr>
<tr>
<td>• from Visit 1 and up to Visit 3, 4-8 patients daily if trainee is carrying out full eye examination and dispense for each patient.</td>
</tr>
<tr>
<td>• from Visit 3 onwards 8-12 patients daily.</td>
</tr>
<tr>
<td>4. Trainees, like any optometrist professional, must always work within the confines of their professional competence. It is important that you able to carry out the required examinations for each patient. If this is not the case, then you should raise it with your supervisor as a matter of urgency (if the trainee feels under pressure to cut corners then this is not in the supervisor's interest as they are responsible for the trainee's work and, more importantly, the safety of the patient.</td>
</tr>
<tr>
<td>5. If following the discussion with the supervisor no resolution is found, then the trainee should discuss their concerns with the next line of internal management, e.g., practice manager/professional services etc.</td>
</tr>
<tr>
<td>6. In the event that this is unsuccessful or not possible (as the supervisor is also the manager), the trainee should discuss their concerns with the Stage 1 assessor.</td>
</tr>
<tr>
<td>7. If there is still no progress, contact the lead or deputy lead assessor.</td>
</tr>
<tr>
<td>Concern 3</td>
</tr>
<tr>
<td>-----------</td>
</tr>
</tbody>
</table>
| **Supervisor lack of confidence/trust in the trainee’s skills** | 1. In the first instance it is important to remind yourself about the minimal level of experience a trainee has on entering pre-registration training. They should have a very basic level of competence in the required techniques for practice but will have very limited experience of using them and will require observation and feedback regularly  
2. Do not compare them with yourself or any other trainees you have had before  
3. Don’t make assumptions about their level of competence, rather observe them and decide on which areas need most attention to ensure that your patients are safe  
4. In the first instance discuss your concerns with the trainee and agree an action plan in terms of how these weaker areas can be improved. Reinforce with the trainee the importance of keeping patients safe whilst they are gaining experience  
5. Review regularly and if the trainee fails to make progress, discuss your concerns with the Stage 1 assessor  
6. If there is still no progress, contact the lead or deputy lead assessor. |

<table>
<thead>
<tr>
<th>Concern 4</th>
<th>Suggested action plan to address</th>
</tr>
</thead>
</table>
| **Supervisor or trainee lack of confidence/trust in each other** | 1. It is important to realise that sometimes relationships break down due to various factors:  
- unrealistic expectations of each other – clear expectations from both parties are important from the start to ensure that this doesn’t happen  
- as a trainee you find, due to unforeseen circumstances, that the working location and/or your supervisor has changed. This may not be your choice, but an important factor to bear in mind is that the employer has still provided you with that all important placement – your opportunity to complete the Scheme for Registration  
2. As a supervisor you find yourself, due to unforeseen circumstances, acting as a replacement for the intended optometrist. It is key to recognise that:  
3. If you feel ill-prepared for the role, the Stage 1 assessor and the College staff are there to support both you and the trainee through the process  
4. Many supervisors who start off feeling concerned about this role often find it extremely rewarding  
5. In agreeing to supervise the trainee you are taking clinical responsibility for all the patients seen by the trainee  
6. In the first instance trainee and supervisor should speak to each other to try and resolve their differences  
7. If following the discussion no resolution is found, then the concerns should be discussed with the next line of internal management, eg practice manager/professional services etc.  
8. In the event that this is not successful or not present, discuss any concerns with the Stage 1 assessor  
9. If still no progress, contact the lead or deputy lead assessor. |
Changing supervisor or adding additional supervisors

If a trainee needs to change supervisors, then they need to refer to the Supervision section on college-optometrists.org/sfr where they will be able to request to add an additional supervisor or remove a previous supervisor from their record. Trainees should inform the College that they are changing practice and supervisor, by completing the Changing practice form in the supervision section of college-optometrists/sfr.

Cheating and misconduct

Trainees must not falsify the evidence provided to the Stage 1 assessor by altering any paperwork, entering another person’s work into their logbook or using the work of others in any other way, nor must they permit others to copy or use their work, or behave in any way unprofessionally. If they do any of these things, they will be reported to the College. If a trainee is found to have given or received help, their name may be reported to the GOC. Please refer to the Scheme for Registration regulations on the College website for further information.

Key information from this section:

- seek to gain different types of experience for the trainee and to discuss progress together on a regular basis
- make the most of the monthly review meetings
- trainees must complete their logbook diligently and use it as a tool to ensure they are gaining the experience they need
- if you feel that the training and experience is not going to plan, in the first instance, discuss this together and then if necessary, seek support from the Stage 1 assessor
- trainees must ensure the supervision and practice details on their College record are up-to-date.
- cheating or misconduct will be taken very seriously
Section Two – Stage 1 assessment

About a month after the trainee has enrolled, the Stage 1 assessor will visit you the practice. This visit will last up to two hours. A generic assessment plan for this visit can be found in the Visit 1 section of this handbook. Through assessing 10 Stage 1 elements of competence, checking how the trainee has completed their logbook and answering any questions, the Stage 1 assessor will ensure that supervisors and trainees are clear about:

- what is involved in the work-based assessment process
- what kind of evidence the trainee will need to provide to demonstrate competence
- how the logbook should be completed and its role in the provision of evidence
- dates and arrangements for the following quarterly assessment visits
- how to contact the Stage 1 assessor between visits.

The Stage 1 assessor will also explain their role in relation to the supervisor’s role, what will happen at the quarterly assessment visits and how the trainee should prepare for them. They will want to know that the trainee is familiar with the content of this handbook, including the assessment framework (covered in later in this section of the handbook).

The Stage 1 assessor will ensure that the supervisor and trainee understand that the trainee is responsible for providing the evidence for assessments and that the records provided are entirely the trainee’s own work. They will also check that you both understand the requirement for undertaking:

- a. 350 refractions
- b. 250 dispensings
- c. 20 contact lens fitting episodes to include a minimum of three complete soft lens fittings and three complete RGP lens fittings
- d. 40 contact lens aftercare episodes to include a minimum of three soft lens aftercares and three RGP aftercares. 20 of the total aftercares to be carried out on established lens wearers who have worn the contact lenses regularly for a minimum of six months.

These minimum requirements must usually be met before sign off from Stage 1 of the assessment process and certainly before the trainee undertakes Stage 2 of the work-based assessment.

If the trainee is a qualified dispensing optician, they will not be required to undertake the minimum number of dispensing again, although they will be assessed in all the dispensing elements of competence.

The Stage 1 assessor will check that the supervisor and trainee have discussed a plan for gaining experience and monitoring progress, and that how the trainee should use the logbook.

Finally, the Stage 1 assessor will check that arrangements are in place for the trainee to gain experience in the NHS Hospital Eye Service.

Each trainee will then have at least two quarterly assessment visits. The visits will normally follow the pattern set out in the timeline and assessment framework but there may be some circumstances in which this pattern may be varied. It is common not to succeed in all the competencies scheduled for each visit, particularly early on, and the trainee should discuss any
concerns they have about this with the assessor. The assessor will send the supervisor and trainee an online report after each assessment visit, including the agreed action plan for improving the trainee’s performance in weaker areas. The trainee and supervisor should then discuss how to implement the action plan.

Gathering evidence
The assessment evidence must be:

- **Sufficient** – trainees must provide enough evidence to demonstrate competence against the indicators relating to the element being assessed.

- **Current** – any evidence must be current, and never more than two years old.

- **Valid** – the evidence must clearly relate to the indicators for the element being assessed. Trainees may find that they can use one piece of evidence for more than one element.

- **Authentic** – if during the Hospital Eye Service placement, or any other placement completed outside the usual place or work, the supervisor or ophthalmologist observes the trainee undertaking a procedure and the trainee wants to include this in their assessment evidence, then they must ensure that the HES or placement supervisor completes a witness testimony in the required format for the evidence to be deemed valid. A template for this can be found in the HES placement and logbook section of this handbook.

Where a trainee is required to demonstrate an ability to undertake a skill or procedure, they must demonstrate this through working with patients. The assessor must observe every trainee undertaking the following skills:

- history taking
- communication with the patient
- interpreting and Investigating presenting symptoms
- refraction
- assessing binocular status
- assessing the external eye and adnexa
- slit lamp examination
- direct ophthalmoscopy
- indirect ophthalmoscopy
- spectacle verification
- keratometry
- soft lens fitting and aftercare
- RGP fitting and aftercare
- contact tonometry.

Direct observation of these skills is compulsory but the Stage 1 assessor will want to observe each trainee undertaking other tasks as well. As well as the evidence gained through direct observation, much of the evidence will come from the logbook. The assessor will also discuss cases from the trainee’s logbook.
Patient record evidence
Some compulsory evidence will come from patient records. It is helpful for both the supervisor and the trainee to review any such evidence being provided for an assessment. The original, contemporaneous patient records must always be presented. If the assessment is being carried out at a different practice to where the original records are kept, it is permissible to present the Stage 1 assessor with copies.

Copy records will only be accepted by the Stage 1 assessor as evidence if each copy is individually signed off by the supervising optometrist as an exact copy of the original record. If a trainee is using copy or printed records they should ensure that all the relevant detail has printed on the copy. Missing data from fields may mean that overall the record is not demonstrating competent practice.

Altering the record content in any way is unacceptable. Trainees must not
• add in additional comments
• add in revision notes (including on post-its)

If the trainee is using a printed copy of the record, then it is acceptable to use an highlighter pen to make the relevant detail more obvious to pick out. No other modification will be accepted. If a record is otherwise modified, the trainee would need to provide the assessor with a different one.

Contemporaneous records are those which were completed at the time of the patient examination or dispense. If a trainee wants to use a template as the basis for their record keeping, it must be completed at the time of the examination or dispense, ie it must be the contemporaneous record.

If you work in the Hospital Eye Service (HES), an original contemporaneous record would be the record that is kept in the trainee’s HES logbook/notebook and signed by the supervisor at the time of the consultation.

Dispensing records submitted as part of the assessment of dispensing should be the complete dispensing record and not merely the printed patient order. A complete dispensing record would outline the patient needs and requirements, the advice and the specifics relating to the device that was ordered. If a trainee needs to complete a dispensing template to accompany the order then this must be the contemporaneous record of the dispense.

Demonstrating competence
The best way for any trainee to demonstrate competence is for their Stage 1 assessor to observe them with a patient. Appointments, including sight tests, contact lens fitting and aftercare, will need to be arranged to coincide with the assessment visits.

Where a trainee is required to demonstrate an understanding of a skill rather than actually demonstrating the skill, the Stage 1 assessor may discuss cases with the trainee. Where possible these will be cases that the trainee has seen. Otherwise, the Stage 1 assessor will use hypothetical scenarios.

The assessor will require at least two, and preferably three, pieces of evidence before they will be satisfied of a trainee’s competence in any area.
Data protection
When dealing with patient records we are all subject to the requirements of the Data Protection Act, and must comply with it in all aspects of our work. Trainees should remember to do the following in relation to the assessment process:

- At the start of every examination (and dispense if they have not already examined the patient and asked their consent) they should inform the patient that another practitioner might review their records for assessment and training purposes. Patients have a right to refuse consent for this.

- Patient consent may be obtained orally or in written form. If oral consent is obtained then the trainee must record this by writing ‘Permission given orally on [date].’ on the patient’s record and sign the statement.

The assessor will check that patient consent has been indicated on any patient record being reviewed as part of the assessment process – without patient consent, the patient record cannot be used in the assessment process.

Trainees must keep all clinical information about the patient in the patient’s clinical record. This includes, but is not limited to, referral letters and visual field results. The assessor will need to be able to access the record, including referral letters and visual field results.

If a trainee is gaining experience through the Hospital Eye Service, they will be subject to NHS data protection arrangements.

Key information from this section:
- the Stage 1 assessor will visit about four weeks after the trainee has enrolled for the first assessment visit
- trainees must ensure that they gather sufficient, current, valid and authentic evidence for their assessment
- trainees must demonstrate an ability to undertake a skill or a procedure through working with patients
- trainees must provide only contemporaneous records for the assessment which are the original records or copies which have been signed by their supervisor to authenticate
- trainees may be able to demonstrate an understanding of a particular area through discussion with the assessor, but ability will always require the trainee to have gained the relevant clinical experience
- the assessor will require at least two, and preferably three, pieces of evidence
- trainees must remember to gain consent from their patients for another practitioner to review their records.
How to prepare for assessments – advice for trainees

Planning
Well before your assessment, you should remind yourself of the elements of competence which will be assessed during the next assessment visit. You should ensure that you know exactly what you can do and what you need to know to demonstrate competence in each area, and should think about the evidence you can provide for the Stage 1 assessor for each element. Remember that the Stage 1 assessor will want to see two, and preferably, three pieces of evidence for each element being assessed.

The Stage 1 assessor will agree a plan for the assessment, usually at the previous visit. Generic plans for each visit are set out in each Visit section of this handbook. If you want to change any elements of the generic assessment plan, then you should discuss this with the assessor. The plans can be changed where appropriate as they need to reflect your experience to date. The assessment plan will include the types of patients the assessors wants to be booked in for the observations and any techniques that you will have to demonstrate – for example, during assessment visit 2, the Stage 1 assessor would normally expect to observe you carrying out a routine eye examination on a real presbyopic patient and a real soft contact lens aftercare appointment, and to watch you demonstrating indirect ophthalmoscopy using a volk lens. The plan will also include timings for the observations and time for feedback and action planning with you and your supervisor. In addition to the observations, the Stage 1 assessor will discuss with you the patient records you have provided as evidence and may ask questions about photographs of abnormal eye conditions or visual field plot results which they will provide.

For all assessments, you should check in good time that you have followed the action plan the Stage 1 assessor agreed with you and your supervisor at the previous assessment visit.

Practise, practise...
You must practise the procedures as much as possible to ensure that you can perform them competently and confidently on the day of the assessment. You must practise taking histories and communicating with patients; remind yourself of the principles in the GOC Standards for Practice set out earlier in this handbook and ensure that you are familiar with any relevant College guidance.

Booking appointments
Where possible, the Stage 1 assessor will want to see you with real patients so make appointments with appropriate patients in good time. And remember to ensure your supervisor is also available to discuss your progress at the end of the visit. Allow around 20 minutes in your schedule for this discussion.

Preparing the paperwork for assessment visits
The Stage 1 assessor will ask you to complete and send the fully completed assessment framework document relevant to each assessment visit in advance to check your progress. These are found in the relevant Visit section of this handbook. You should carefully consider the patient records you want to include in the assessment. It is useful to consider the elements of competence for which you wish to use the records as evidence and to highlight this to the Stage 1 assessor by listing the patient identifier in the relevant section PR _________ in the Visit assessment framework. Refer to the indicators listed under each element in the framework, to ensure that the patient record meets the criteria required. One record could provide evidence for a number of elements, eg a patient record of a low vision patient who was
examined, advised and dispensed by the trainee could provide suitable part evidence for all of the following elements:

- 1.2.4 Explains to the patient the implications of their pathological or physiological eye condition
- Identifies and responds appropriately to patients' fears, anxieties and concerns about their visual welfare
- 3.1.5 (part) Investigates the visual fields of patients with all standards of acuity and analyses and interprets the results
- 4.2.1 Advises on the use of, and dispenses simple low vision aids including simple hand and stand magnifiers, typoscopes and handheld telescopes
- 7.1.5. Assesses patients with impaired visual function and understands the use of specialist charts for distance and near vision, and the effects of lighting, contrast and glare.

You must ensure that you have the original patient records logged and in a logical order before the assessment. You could waste much of your assessment time looking for records if they are not properly organised.

Under no circumstances should anyone attempt to change the records. Such action would be regarded as cheating. It would be taken very seriously and may be reported to the GOC.

Assessor tip – how to select appropriate patient records for the assessment

A common comment from assessors is that delays arise during the assessment process because trainees do not prepare adequately for assessments and, in particular, do not select appropriate records to evidence the elements of competence. We have devised the following series of questions you can use to help identify appropriate patient records and other forms of secondary evidence (eg witness testimonies) to use in your assessments.

Questions to help trainees in the selection of appropriate evidence

1. Do I have the consent of the patient to use this patient record for assessment purposes and if so, have I noted their consent on the record?
2. How is this patient record/witness testimony relevant to the element of competence that I'm preparing evidence for?
3. What does it show?
4. Why did I do this? (A relevant technique? fields/IOPs/dilation/refer the patient/management etc.)
5. What did I learn from this?
6. How will this shape my future practice?
7. Is there anything that I would do differently if I saw this patient again (or a patient with similar problems in the future)?
8. Consider ‘what if’ scenarios relating to this patient:
   a. What if the diplopia had been recent onset rather than longstanding?
   b. What if the IOP had been more than 5mm Hg difference between the two eyes?
   c. What if the patient was symptomatic with this degree of phoria?
9. Would this patient record be a suitable form of evidence for any other elements of competence?
Worked example

The element of competence you are preparing evidence for is:

<table>
<thead>
<tr>
<th>Stage 1 element of competence</th>
<th>Indicators</th>
<th>Patient episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.10 Uses diagnostic</td>
<td>Understands the indications and contraindications for drug use and potential side effects.</td>
<td>Patient where mydriasis or local anaesthesia was indicated and carried out.</td>
</tr>
<tr>
<td>drugs to aid ocular examination.</td>
<td>Understands and applies best practice in terms of the legal aspects of access, use and supply. Makes appropriate selection of drug/s and uses safely.</td>
<td></td>
</tr>
</tbody>
</table>

The patient record you have selected is of an elderly patient with diabetes who has lens opacities:

- you needed to dilate the patient in order to gain an adequate view of the fundus
- you have recorded some of the pre and post dilation checks (IOPs only, but you didn’t assess the anterior chamber angles pre-dilation)
- you have recorded the drug used, batch number and expiry date
- you have recorded all the salient ocular health features including the lens opacity and background diabetic eye disease
- you have recorded the advice you gave to the patient post dilation
- your record shows that you have taken the appropriate remedial action, eg notified GP of outcome/referred as appropriate etc. (relevant paperwork is included with the record)
- recall date advised is listed.

Questions

How is this patient record pertinent to the element of competence that I’m preparing evidence for? The dilated patient has diabetes.

What does it show? What did I do? It shows that you have:

- selected an appropriate drug for mydriasis
- taken one of the appropriate safeguards pre and post instillation by measuring and recording the IOPs
- omitted to check the anterior angles pre-dilation to assess angle closure risk
- recorded all the relevant information required by the College guidelines
- sent a notification letter to the GP following your examination
- advised an appropriate recall date.

Reflection

What did I learn from this?

- I learned how important it is to check the angle prior to dilation as, had I known that this patient’s angles were wide open, I wouldn’t have worried so much when the IOPs went up by 4mm Hg and I thought I’d induced an angle closure attack
- I learned what you do when you suspect angle closure in terms of keeping the patient in the practice and checking the IOPs at regular intervals until they go down again
I learned that it’s easier to see around lens opacity when a patient is dilated and I use a Volk lens to assess the fundus.

How will this shape my future practice?
I’ll consider using dilated Volk examination more often to see around lens opacities.

Is there anything you would do differently if you saw this patient again?
I’d check the patient’s anterior chamber angles at the outset to more properly assess any risk factors.

Consider ‘what if’ scenarios relating to this patient:
• what if on checking the angles pre-dilation they were Van Herrick grade 2 – would you still dilate?
• if you induced an angle closure attack, what action would you take?
• what if you’ve run out of your drug of choice, have you got an alternative drug in the practice you could use? Why wouldn’t this be your usual drug of choice? How does its action differ from your drug of choice?

Would this patient record be a suitable form of evidence for any other elements of competence?

Yes, it could also form suitable evidence for the following elements of competence:

<table>
<thead>
<tr>
<th>Stage 1 element of competence</th>
<th>Indicators</th>
<th>Patient episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.11 Makes an assessment of the fundus in the presence of media opacities.</td>
<td>Carries out dilated examination of a patient using a binocular indirect ophthalmoscopy (BIO) lens. Provides evidence of fundus seen (features recorded, eg C/D ratio, pigmentation etc.) Records the media opacity.</td>
<td>Patient with significant lens or media opacities.</td>
</tr>
</tbody>
</table>
Assessor tip – how to ensure that you have sufficient experience at the different stages in the assessment process

Assessors often comment that trainees do not have adequate experience to demonstrate competence in the range of patient episodes required for the next assessment visit. This can lead to assessments being delayed and trainees feeling pressured to achieve seemingly large ranges of experience at short notice in order to meet a deadline. The patient episodes and refraction and dispensing requirements are compulsory elements of the Scheme, which have to be achieved in Stage 1 of the assessment process. We have devised a series of targets for you to aim to achieve by the various assessments visits that will help to ensure that, as far as possible, you have a reasonable amount of experience to help you during your assessment visits.

<table>
<thead>
<tr>
<th>Eye examination, dispensing and contact lens targets to aim for before each visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visit</strong></td>
</tr>
<tr>
<td>Visit 1</td>
</tr>
<tr>
<td>Visit 2</td>
</tr>
<tr>
<td>Visit 3</td>
</tr>
<tr>
<td>Visit 4 or Stage 1 sign off</td>
</tr>
</tbody>
</table>

Trainees should aim to further increase these numbers before the Final Assessment.

Assessor tip – how to ensure that you make best use of your assessment time

There is paperwork which must be sent to the assessor in advance of the visit if the assessment is to go ahead. From, and including, Visit 2 onwards the following information must be sent to the assessor within the timescales you have agreed before the assessment visit date, if the visit is to go ahead.

This paperwork is an essential part of the assessor’s preparation for the assessment. It enables them to decide if the standard assessment plan for the next visit is appropriate or whether it would be better to delay the visit a little or to ask if you would like to cover different areas which better reflect your experience. If the assessor doesn't get this information in good time then they will be unable to support you in this way. This could delay your progress through the Scheme and mean that you incur extra costs for additional visits.

Sending information to the Stage 1 assessor

You must ensure you send the fully completed assessment framework to the Stage 1 assessor before each quarterly assessment visit and within the timescales agreed. If this information is not sent to the Stage 1 assessor by the specified deadline, the assessor may cancel the visit as they will be unable to prepare adequately for it. Cancelled visits have to be rescheduled at the assessors’ convenience, which may result in delays for you completing the assessment. You must ensure that all the following areas in the document are fully completed:

- the most recent monthly review scores from the supervisor in the final column of the assessment visit page
**Section Two – Stage 1 assessment**

- list all the patient records you want to use as evidence by completing the patient identifier against the label PR_______ in the relevant section of the document
- complete the quarterly training summary on the last page of the assessment framework document—this is summary of your logbook for the previous month (for Visit 1) or the previous quarter for Visits 2 and 3 which details how many eye examinations, dispensings and contact lens related episodes you have completed during this period
- complete and sign the relevant section on the last page to indicate that all the evidence you are submitting in the document is/or relates to your own work
- provide copies of any witness testimonies relevant to this assessment.

**Cancellation of a visit**

If the Stage 1 assessor has to cancel a visit at short notice (within one week of the agreed assessment date) because you are not prepared, you will have to pay a cancellation fee. Refer to the [college-optometrists.org/qualifying-fees](http://college-optometrists.org/qualifying-fees) for current fees.

Trainees will not have to pay if either they or their supervisor is ill, or there are exceptional mitigating circumstances, but the trainee or supervisor would be required to provide valid evidence, such as a medical certificate. See the Scheme for Registration regulations on [college-optometrists.org/sfr](http://college-optometrists.org/sfr) for further information.

**Be prepared!**

Trainees should make the most of the assessment visits. This means ensuring they are prepared, ensuring the Stage 1 assessor has the necessary paperwork in sufficient time and ensuring they do not waste any time during the visit, because they do not have the necessary patients or records available. Remember that the assessment visit is the trainee’s chance to demonstrate the knowledge and skills they have been developing over the previous few months and it is in their interest to use the time as wisely as possible.

**Key information from this section:**

- trainees should ensure they know what they need to do to demonstrate competence in the areas in which they will be assessed
- trainees must practise the procedures and other skills as often as possible
- ensure appropriate patients are booked in for the assessment and have the necessary paperwork and records to hand
- trainees must send their completed assessment framework document including the most recent quarterly training summary and monthly review assessment scores, together with any witness testimonies, to the assessor well before the visit
- ensure the supervisor will be free to discuss the trainee’s performance with both the trainee and Stage 1 assessor directly following the assessment
- if a trainee cancels a visit within a week of the agreed date because they are not prepared, they will have to pay for the visit

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During the assessment

At the start of the assessment visit, the Stage 1 assessor will ensure that everything has been arranged in line with the assessment plan. If there have been any unforeseen changes, the trainee should tell the assessor when they arrive at the practice so a revised assessment process can be drawn up to accommodate this. Whether working to the original or revised plan, the assessor will then review the trainee’s evidence to decide where it demonstrates competence.

At the end of the assessment, the Stage 1 assessor will review the trainee’s performance with the trainee and supervisor, identify which elements have been achieved, and agree an action plan for completing any outstanding elements. If a number of elements have not been assessed, the Stage 1 assessor will indicate why this is the case – for example, if the trainee was too slow and as a result the direct observations substantially over-ran the allotted time in the assessment plan, less time would be available for assessment of records.

Alternatively, if a trainee has not completed the relevant patient episodes, the Stage 1 assessor may decide to defer assessing certain elements of competence to a later date when the trainee has more experience.

The total visit, including feedback and action planning with the supervisor, should take no longer than four hours. Of this total time, assessors will normally allow 3.5 hours for assessing evidence.

Both trainee and supervisor must sign the confirmation of visit form on the day of the visit. This is the official confirmation that the visit has taken place. Supervisors sign to confirm that the visit has taken place and that both the trainee and supervisor were given feedback and involved in agreeing any action plan.

Key information from this section:
• the stage 1 assessor will begin by ensuring everything is ready for the assessment
• when the assessment is finished, the Stage 1 assessor will review the trainee’s performance with the trainee and supervisor and agree a remedial action plan if required
Section Two – Stage 1 assessment

After the assessment

The Stage 1 assessor will send a copy of the assessment report by email within a week of the assessment. It will show which elements of competence the trainee has achieved, which were not achieved and those that were not assessed. The report will include an action plan for each part of the assessment that was not achieved, the evidence the trainee will need to provide at the next assessment, and an overall summary setting out the trainee’s progress to date in terms of refractions, dispensings and the elements of competence which were assessed during the assessment visit. This will reflect the discussion with the assessor at the end of the visit and should not contain any surprises.

The trainee and supervisor should discuss the report together and decide how to implement the action plan. Remember that the supervisor’s role is to support and advise the trainee but if there are any concerns or questions, contact the assessor for clarification.

If the supervisor does not agree with the action plan, they should contact the Stage 1 assessor to discuss their concerns. If the unusual situation occurs where they are still unable to agree on the feedback or action plan, the supervisor should contact the College. The lead or deputy lead assessor will then investigate and aim to respond within 10 working days.

Maintaining competence

The trainee should have achieved many of the elements of competence that were assessed during each assessment visit. These successes should help to boost their confidence but they should not put these skills to one side. It is essential that every trainee maintains and improves their skills as they continue through the pre-registration period. If the Stage 1 assessor notices that any skill has deteriorated after it has been assessed, they will draw this to the trainee’s attention and expect to see an improvement.

To be signed off from Stage 1 of the workbased assessment process a trainee will need to have:

- achieved all 75 Stage 1 elements of competence and;
- completed the HES experience if they are based in community practice
- completed either:
  a. the GOC requirement of 350 refractions and 250 dispensings
  b. the College’s compulsory minimum contact lens experience requirements:
     1. 20 contact lens fitting episodes to include a minimum of three soft fittings and three RGP lens fittings
     2. 40 contact lens aftercare episodes to include a minimum of three soft lens aftercares and three RGP lens aftercares. 20 of the total aftercares to be carried out on established lens wearers (ie who have worn their lenses regularly for a minimum of six months).

These numbers will be verified by the Stage 1 assessor by checking the quarterly totals in their logbook.

or

b. an action plan showing that all of the above requirements will be realistically achievable prior to the Stage 2 assessment date in approximately six weeks. This will need to be agreed with the Stage 1 assessor and will allow the trainee
to fulfil the Scheme requirement before the Stage 2 visit. The Stage 1 assessor will make this decision by checking the quarterly totals in each trainee’s logbook.

The Stage 1 assessor will use the decision pathway in the Stage 2 section of this handbook to decide at the third Stage 1 assessment, or at a later assessment if appropriate, when each trainee is likely to be able to proceed to Stage 2.

**If the relationship with the assessor breaks down**

Occasionally, a trainee’s relationship with the Stage 1 assessor can break down. If this happens, the trainee should discuss it with their supervisor in the first instance, as he or she may be able to resolve the situation. If the situation cannot be resolved, a trainee can change Stage 1 assessor once by asking their supervisor to contact the Education team at the College.

<table>
<thead>
<tr>
<th>Key information from this section:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• both trainee and supervisor will receive a copy of the assessment report by email within one week of each Stage 1 assessment visit</td>
</tr>
<tr>
<td>• the trainee and supervisor should discuss how to implement the action plan together</td>
</tr>
<tr>
<td>• remember that trainees must maintain competence in the areas in which they have previously been assessed</td>
</tr>
<tr>
<td>• if a supervisor feels that a trainee has been unfairly treated by the assessor, they should discuss this with the assessor, and if unable to resolve the situation, contact the lead or deputy lead assessor.</td>
</tr>
</tbody>
</table>
Timescales for completing different stages of the assessment process

Trainees need to complete the whole Scheme for Registration within two years and three months of their enrolment date or have four attempts at the OSCE, whichever comes first. We would recognise a trainee as struggling in the Scheme if:

- they have not been signed off from Stage 1 (achieving 75 elements of competence) within a year of the enrolment date
- they have had more than five Stage 1 assessment visits
- they have had more than three Stage 2 assessment visits.

The lead or deputy lead assessor is happy to discuss a trainee’s progress with them at any point where they feel in difficulty, but particularly if they have not been signed off from Stage 1 after 12 months on the Scheme or have had more than three Stage 2 assessment visits.

Key information

- if the trainee is struggling in the scheme having not been signed off from the Stage 1 assessment process after 12 months, or having had more than five Stage 1 visits or three Stage 2 visits, then speak to the lead or deputy lead assessor.
**Scheme for Registration – Visit 1 assessment plan**

**Trainee name:**  

**Assessor name:**

<table>
<thead>
<tr>
<th><strong>Time and location for assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To be mutually agreed during initial telephone call to trainee once in practice</td>
</tr>
</tbody>
</table>

**Proposed Activity**

Check photographic ID.  
Assess the 10 Stage 1 elements of competence outlined in trainee handbook.  
Total time for visit: 1 – 2 hours

Verify a pair of multifocal spectacles provided by the assessor (10 mins to complete the task)

1. Using a simulated patient, eg member of practice staff, assessor to directly observe trainee:
   - take ‘k’ readings with a keratometer – both eyes
   - assess the tear film
   - assess pupils.

2. Assessor to review patient records for each of the following categories:
   - soft lens L and R teach
   - assessment of pupils (could be ‘normal’ outcome at this stage)
   - patient showing any risk factor for any common ocular condition.

3. Assessor to sample three other records from the logbook to check that:
   - logbook recording mechanisms are adequate
   - standard of record keeping is adequate.

4. Feedback on the assessment with both trainee and supervisor and discussion of any recommended actions.

5. Opportunity for trainee and supervisor to ask any questions they have about the framework or process.

6. Agree assessment dates for Visits 2 and 3.

**Evidence to be produced:**

- patient records as detailed above
- logbook
- completed assessment framework document.

**Target date for sign off: (this is to be agreed)**

Trainee .................................................  
Supervisor ...............................................

Assessor .................................................  
Date ......................................................
Scheme for Registration Assessment framework – Visit 1
Supervisor training review scores and monthly summary

This form is to be completed by the trainee and a copy given to the assessor at Visit 1. To ensure that the assessor has all the relevant information required to prepare for the assessment, please complete the final column on each page with your most recent supervisor review score for that element of competence. Also ensure that you have completed the final page of the report detailing all your totals for eye examinations and dispensing etc. Please consult the notes below before filling in the form.

<table>
<thead>
<tr>
<th>Unit of competence 2. Professional conduct – The ability to comply with the legal, ethical and professional aspects of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements of competence</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
</tbody>
</table>
| 2.1.2 Maintains confidentiality in all aspects of patient care | PR                        | Demonstrates knowledge of the Data Protection Act (1998) and how this impacts on security, access and confidentiality of patient records.  
**Additional guidance**  
Trainee must ask for and record verbal consent on all their records and be aware of what to do in the event that the patient refuses consent | All sampled patient records | PR ___________ |                  |
| 2.2.2 Is able to work within a multidisciplinary team |                          | Respects the roles of other members of the practice team and how working together gives the patient the highest possible level of care.  
In relation to shared care, is aware of:  
• local and national shared care schemes  
• the roles of practice staff within these  
• the local scheme protocols  
**Additional guidance**  
Able to explain how they fit into the practice team in terms of role and responsibilities  
Demonstrates respect for other members of the team | | | |

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### Section Two – Stage 1 assessment – Visit 1

**Unit of competence 2. Professional conduct** – The ability to comply with the legal, ethical and professional aspects of practice (continued)

<table>
<thead>
<tr>
<th>Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifiers</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.3 Is able to work within the law and within the codes and guidelines set by the regulator and the profession.</td>
<td></td>
<td>Demonstrates knowledge of the advice and guidance set by the respective professional body and standards set by their local CCG. Demonstrates knowledge of the Standards of Practice set down by the General Optical Council. Demonstrates a knowledge of the relevant law relating to their role, eg Opticians Act, GOS benefits, fees and charges, Medicines Act. Understands the implications for patient care in relation to the Mental Capacity Act 2005.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Unit of competence 3. Methods of ocular examination** – The ability to perform an examination of the eye and related structures

<table>
<thead>
<tr>
<th>Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Uses instruments to measure corneal curvature and assess its regularity.</td>
<td>DO</td>
<td>Uses instruments to accurately measure, assess and record the corneal curvature and regularity. Correctly interprets the information gathered. <strong>Additional guidance</strong> Choice of instrumentation could include:  - manual or automated keratometer  - topographer Accurate results to within +/-0.10mm radius.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.7 Assesses the tear film.</td>
<td>DO</td>
<td>Chooses appropriate instrumentation and uses correct and safe methods to assess tear quantity and quality. Accurately records the results and differentiates normal from abnormal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.9 Assess pupil reactions.</td>
<td>DO PR</td>
<td>Uses appropriate ambient illumination and light source to assess pupil reactions Accurately records the results and differentiates normal from abnormal. Patient showing assessment of pupils (can be normal).</td>
<td></td>
<td>PR ______</td>
<td></td>
</tr>
</tbody>
</table>
### Unit of competence 4. Optical appliances – The ability to dispense an appropriate optical appliance

<table>
<thead>
<tr>
<th>Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifiers</th>
<th>Supervisor training review score</th>
</tr>
</thead>
</table>
| 4.1.2 Measures and verifies optical appliances taking into account relevant standards where applicable. | DO | Measures and verifies that lenses have been produced to a given prescription within BS tolerances. Verifies that all aspects of the frame or mount has been correctly supplied. Measures and verifies that the lenses are correctly positioned in the spectacle frame/mount within BS tolerances. **Additional guidance** Choice of instrumentation could include:  
- manual or automated focimeter. Accurate results to within:  
  - ± 0.25DS/DC for dioptric measurements  
  - Axis appropriate to cylinder power  
    - \( \leq 0.50 \text{DC} \leq 7^\circ \)  
    - \( > 0.50 \text{DC} \leq 0.75 \text{DC} \leq 5^\circ \)  
    - \( > 0.75 \text{DC} \leq 1.50 \text{DC} \leq 3^\circ \)  
    - \( > 1.50 \text{DC} \leq 2^\circ \)  
  - Centres – 1mm tolerance. Must demonstrate a knowledge of actual tolerances. |
<table>
<thead>
<tr>
<th>Unit of competence 5. Contact lenses</th>
<th>The ability to manage the fitting and aftercare of patients with contact lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elements of competence</strong></td>
<td><strong>Compulsory evidence type</strong></td>
</tr>
</tbody>
</table>
| 5.1.2 Instructs the patient in soft lens handling and how to wear and care for them. | PR | Instructs a patient in the techniques of soft lens insertion, removal and other relevant handling instructions. Instructs a patient on the principles of soft lens wear and care including use of soft lens care products. **Additional guidance** This must include:  
• sufficient detailed knowledge of own lens banks and solutions to advise appropriately and safely  
• sufficient general knowledge of materials and care regimes to resolve problems. | Insertion and removal training to at least one soft lens patient. | PR ___________ | |

<table>
<thead>
<tr>
<th>Unit of competence 6. Ocular disease</th>
<th>The ability to identify and manage ocular abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elements of competence</strong></td>
<td><strong>Compulsory evidence type</strong></td>
</tr>
<tr>
<td>6.1.1. Understands the risk factors for common ocular conditions.</td>
<td>PR</td>
</tr>
<tr>
<td>6.1.11. Understands the treatment of a range of common ocular conditions.</td>
<td></td>
</tr>
</tbody>
</table>
Notes

**Compulsory evidence types to demonstrate competence**
- CS = Case scenario
- DO = Direct observation of clinical skills
- FP = Field plots for interpretation and management
- I = Images provided by assessor of common clinical presentations
- Log = Logbook evidence showing maintenance of competence
- PI = Prescription interpretation of a spectacle order provided by the assessor for critical discussion
- PR = Patient record
- Q = Questions from the assessor to gauge the trainee’s applied clinical knowledge
- RL = Referral letter written by the trainee for critical discussion
- RP = Role play (clinical scenario where the assessor is acting as the patient)
- WT = Witness testimony describing clinical experience and clinical competence, signed by supervising person

**Compulsory direct observation for key skills**
The key skills for which direct observation is compulsory are as follows:
- assessing binocular status
- assessing the external eye and adnexa
- communication with patient
- contact tonometry (Goldmann or Perkins)
- direct ophthalmoscopy
- history taking
- indirect ophthalmoscopy using biomicroscopy
- interpreting and investigating presenting symptoms
- keratometry
- refraction
- RGP fitting and aftercare
- slit lamp examination
- soft lens fitting and aftercare
- spectacle verification

For certain elements of competence, where patient episodes are included as part of the evidence requirements, patient record (PR) will also be a compulsory form of evidence. There are only three Stage 1 elements in the framework where a suitable witness testimony will be accepted instead of a compulsory patient record. In these three elements only the compulsory evidence type will be described as PR/WT. Where direct observation is not compulsory, or as a second form of evidence, anything relevant from the evidence types recorded above is acceptable. Where possible, evidence related to patients the trainee has seen should always be used.
## Scheme for Registration
### Visit 1 – Training summary

Three month review covering from (date) __________________________ to (date) __________________________.
Insert number of patients seen in each relevant box.

<table>
<thead>
<tr>
<th>Month</th>
<th>Refraction presbyope</th>
<th>Refraction pre-pres</th>
<th>Refraction child</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
<th>Glaucoma</th>
<th>Other</th>
<th>RGP – new</th>
<th>RGP A/C Type (N or E)</th>
<th>Soft – New</th>
<th>Soft A/C Type (N or E)</th>
<th>BV</th>
<th>Low vision patient</th>
<th>Instillation of drugs</th>
<th>Dispensing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td></td>
<td></td>
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<td>Month 2</td>
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<td>Month 3</td>
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</tbody>
</table>

I confirm that I have completed all the patient episodes used as evidence in the Visit 1 table and totalled in the quarterly training summary above.

Name of trainee __________________________ Signature of trainee __________________________ Date _______________
Scheme for Registration
Visit 1 – Training review

Key:
Level 0 – trainee has had no experience in this area
Level 1 – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor
Level 2 – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks without detailed guidance
Level 3 – trainee demonstrates safe understanding and ability in this area of practice, occasionally checking with others if uncertain.

<table>
<thead>
<tr>
<th>Unit of competence 2 – Professional conduct</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Maintains confidentiality in all aspects of patient care</td>
<td></td>
</tr>
<tr>
<td>2.2.2 Is able to work within a multidisciplinary team</td>
<td></td>
</tr>
<tr>
<td>2.2.3 Is able to work within the law and within the codes and guidelines set by the regulator and the profession</td>
<td></td>
</tr>
</tbody>
</table>
## Unit of competence 3 – Methods of ocular examination

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1</td>
<td>Uses instruments to measure corneal curvature and assess its regularity</td>
</tr>
<tr>
<td>3.1.7</td>
<td>Assesses the tear film</td>
</tr>
<tr>
<td>3.1.9</td>
<td>Assesses pupil reactions</td>
</tr>
</tbody>
</table>

## Unit of competence 4 – Optical appliances

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.2</td>
<td>Measures and verifies optical appliances taking into account relevant standards where applicable</td>
</tr>
</tbody>
</table>

## Unit of competence 5 – Contact lenses

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.2</td>
<td>Instructs the patient in soft lens handling and how to wear and care for them</td>
</tr>
</tbody>
</table>

## Unit of competence 6 – Ocular disease

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.1</td>
<td>Understands the risk factors for common ocular conditions</td>
</tr>
<tr>
<td>6.1.1</td>
<td>Understands the treatment of a range of common ocular conditions</td>
</tr>
</tbody>
</table>

Supervisor signature: ___________________________  Date: ___________________________

Trainee signature: ___________________________
Scheme for Registration Generic assessment plan: Visit 2

Trainee name: __________________________ Assessor name __________________________

<table>
<thead>
<tr>
<th>Time and location for assessment</th>
</tr>
</thead>
</table>

**Proposed activity** – competencies to be covered, methods of assessment:
We will be covering all of the visit 2 competencies listed in the SfR handbook plus _________. The actual competencies assessed will be largely dependent on the patient episodes and experience you have gained to date. Please sign and return a copy of this plan to me so indicate your agreement. University of Hertfordshire trainees need to gain prior approval from their university assessor for any changes.

**Evidence to be sent in advance:**
I must receive by ________________ at the latest please:
- _________ relating to last action plan
- completed Visit 2 assessment framework document
- copies of any witness testimonies relevant to this assessment
- this document signed to agree the assessment plan.

Via email or mail to my home address (do not send original documents).

On the day, I will need to see your completed logbook and I will need access to your patient records. Please ensure that the relevant records are easily available to view on the day.

**Agenda for assessment day.**
(Open to flexibility where needed so please contact me if you want to change anything in this plan).

- **9.00** Arrival
- **9.05** Review of logbook and training review with trainee
- **9.15** Review of visit 2 assessment framework document and patient records from this, together with other records chosen by assessor from logbook
- **9.30** Direct observation of the following patients whom you will need to organise:
  - eye examination routine on a real presbyopic patient (1 hour to complete) and using trial frame and lenses
  - soft lens aftercare on a real patient (30 mins to complete)
  - using a simulated patient to observe:
    - Volk examination (undilated or dilated, trainee to choose)
- **11.15** Continue with review of patient records, witness testimonies etc.
- **12.30** Break for assessor to consider assessment outcome and feedback content
- **12.40** Feedback of the assessment outcome with supervisor and trainee and agreement of remedial action plans

**Assessment plan review dates:** At the end of this assessment we will review the assessment dates currently booked.

**Target date for sign off _______ trainee is currently aiming for _______ OSCE**
Trainee ................................................. Supervisor .................................................
Assessor ................................................. Date .................................................
Scheme for Registration Assessment framework – Visit 2
Supervisor training review scores and monthly summary

This form is to be completed by the trainee and a copy given to assessor at Visit 1. To ensure that the assessor has all the relevant information required to prepare for the assessment, please complete the final column on each page with your most recent supervisor review score for that element of competence. Also ensure that you have completed the final page of the report detailing all your totals for eye examinations and dispensing etc. Please consult the notes below before filling in the form.

<table>
<thead>
<tr>
<th>Unit of competence 1. Communication</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifiers</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Obtains relevant history and information relating to general health, medication, family history, work, lifestyle and personal requirements.</td>
<td>DO PR</td>
<td>Asks appropriate questions to obtain a full history. Uses appropriate strategies to understand patients’ needs, eg not interrupting and then summarising and checking understanding.</td>
<td>patient with family history of glaucoma.</td>
<td>PR _______</td>
<td></td>
</tr>
<tr>
<td>1.1.2 Elicits the detail and relevance of any significant symptoms.</td>
<td>PR</td>
<td>Employs an appropriate mix of questions to elicit information from patients, for example, open and closed questions.</td>
<td>hypermetropic, myopic, astigmatic or presbyopic patient presenting with headache.</td>
<td>PR _______</td>
<td></td>
</tr>
<tr>
<td>1.1.3 Identifies and responds appropriately to patients’ fears, anxieties and concerns about their visual welfare.</td>
<td>PR</td>
<td>Establishes and maintains a good professional and clinical relationship with the patient to inspire trust and confidence. Recognises emotion in patients. Explores patient concerns and provides reassurance where appropriate, using explanations that are relevant to that patient.</td>
<td>patient with symptomatic cataract.</td>
<td>PR ______</td>
<td></td>
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</tr>
<tr>
<td>1.2.3 Discusses with the patient the importance of systemic disease and its ocular impact, its treatment and the possible ocular side effects of medication.</td>
<td>PR</td>
<td>Takes a thorough history from the patient to include: • medication, control, disease duration. Demonstrates a thorough understanding of the disease process in cases such as diabetes, inflammatory disease etc. Provides a layman’s explanation of the particular disease process.</td>
<td>patient taking medication for systemic disease, eg cardio – vascular, diabetes.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>1.2.4 Explains to the patient the implications of their pathological or physiological eye condition.</td>
<td>DO PR</td>
<td>Gives factually relevant information in a clear and understandable way, avoiding jargon and technical terms. Uses appropriate supporting material, for example, diagrams or leaflets, and uses a range of different explanations where required to avoid repetition. Understands limitations of knowledge, referring the patient for advice where necessary.</td>
<td>at least one patient with symptomatic cataract.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>1.2.5 Communicates effectively with any other appropriate person involved in the care of the patient.</td>
<td>PR</td>
<td>Records and discusses advice and management in a clear and appropriate manner.</td>
<td>Patient where communication with another appropriate person involved in their care is required.</td>
<td>PR ______</td>
<td></td>
</tr>
</tbody>
</table>
### Unit of competence 2. Professional conduct – The ability to comply with the legal, ethical and professional aspects of practice

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Adheres to health and safety policies in the practice including the ability to implement appropriate measures for infection control.</td>
<td>DO</td>
<td>Demonstrates a proactive approach to Health and Safety issues such as identifying hazards, risk assessment, first aid, etc, in order to produce a safe environment for staff and patients alike. Demonstrates appropriate personal hygiene, cleanliness of the practice, hygiene relating to instrumentation, contact lenses, disposal of clinical waste etc. <strong>Additional guidance</strong> Hygiene includes both personal hygiene and the environment. Environment – appropriate disposal, caps put back on bottles, solutions used in date, cleanliness of instruments, trial frames, lenses, clean and orderly worktops, sinks and waste bins. Personal – appropriate use of hand-washing/gels/towels and tissues.</td>
<td></td>
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</tr>
<tr>
<td>Section Two – Stage 1 assessment – Visit 2</td>
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<td>------------------------------------------</td>
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</tr>
</tbody>
</table>

### 2.1.3 Shows respect for all patients.

| DO CS | Recognises and takes into consideration patient’s specific needs and requirements, eg cultural diversity or religious belief. **Additional guidance**
|       | In all cases the trainee should:
|       | • involve patients in their decisions and advice
|       | • gain consent VCG
|       | • ensure the patient is comfortable
|       | • show interest, courtesy and respect
|       | • be aware of how the patient is reacting to them
|       | • show respect for the patient’s personal space. |

### 2.2.4 Creates and keeps full, clear, accurate and contemporaneous records.

| DO PR | Is able to produce records which are legible and contain all relevant patient details, measurements, results and advice. **Additional guidance**
|       | The PR must be an honest, accurate and contemporaneous record of the episode.
|       | The record must be tidy, logical to follow and only include accepted abbreviations.
|       | All results and advice must be recorded.
|       | Copied records must be authenticated by supervisor signature. |

### 2.2.5. Interprets and responds to existing records.

| PR | Makes a decision based on, their own and previous findings. Modifies their actions appropriately as a response to relevant history or previous records. Identifies and responds to the significance of:
|    | • refractive change/ocular status
|    | • clinical findings, for example, reduced VA
|    | • previous form of optical correction. |

| PR | Patient where a clinical management decision has been made based on previous records. |
## Unit of competence 3. Methods of ocular examination – The ability to perform an examination of the eye and related structures

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.2 Uses a slit lamp to examine the external eye and related structures.</td>
<td>DO PR</td>
<td>Demonstrates an understanding of the methods of illumination, filters and other attributes of the slit lamp and their uses. Demonstrates a full slit-lamp routine for the assessment of the external eye and related structures in a logical sequence.</td>
<td>One CL related record where slit lamp was used. One non-CL related record where slit lamp was used.</td>
<td>PR _______</td>
<td>PR _______</td>
</tr>
<tr>
<td>3.1.3 Examines the fundi using both direct and indirect techniques.</td>
<td>DO PR</td>
<td>Uses a technique which allows an appropriate view of the fundus, including thorough and systematic scanning. Demonstrates a safe technique. Detects significant lesions. Additional guidance For trainees granted reasonable adjustments because of a significant loss of visual function in one eye, a handheld Panoptic Indirect Ophthalmoscope can be used in place of a direct ophthalmoscope. Systematic scanning of each fundus in all eight positions of gaze is necessary to meet competence for all modes of ophthalmoscopy.</td>
<td>Patient where direct ophthalmoscope was used. Patient where BIO lens with slit lamp was indicated and used.</td>
<td>PR _______</td>
<td>PR _______</td>
</tr>
<tr>
<td>3.1.4 Identifies abnormal colour vision and appreciates its significance.</td>
<td>PR</td>
<td>For a minimum of 2 different test types, the ability to: - identify the test types available and who to use them on - correctly use and interpret the results - advise and manage the patient appropriately. Understands the significance of results in terms of Occupational implications and genetics.</td>
<td>Patient with a colour vision defect.</td>
<td>PR _______</td>
<td></td>
</tr>
</tbody>
</table>
### Section Two – Stage 1 assessment – Visit 2

| 3.1.5 Investigates the visual fields of patients with all standards of acuity and analyses and interprets the results. | 2 x PR | Identifies which patients require visual fields assessment<br>Chooses and carries out the appropriate method and manner of visual field assessment<br>Interprets the field plot (including reliability), describing any abnormality using recognised terminology<br>Identifies the cause of field defects from sample images, eg location of visual pathway lesion, retinal problem<br>Uses basic alternative techniques in appropriate circumstances, eg confrontation, Amsler, alternative fixation targets<br>Appropriately adapts investigation for patients with reduced acuity | Patient with visual field defect.<br>Patient with reduced acuity <6/18 requiring visual field assessment. | PR ______ | PR ______ |

| 3.1.10 Uses diagnostic drugs to aid ocular examination. | PR | Understands the indications and contraindications for drug use and potential side effects. Understands and applies best practice in terms of the legal aspects of access, use and supply. Makes appropriate selection of drug/s and uses safely. | Patient where mydriasis was indicated and carried out. Patient where local anaesthesia was indicated and carried out. | PR ______ | PR ______ |

| 3.1.11 Makes an assessment of the fundus in the presence of media opacities. | PR | Carries out dilated examination of a patient using a binocular indirect ophthalmoscopy (BIO) lens. Provides evidence of fundus seen (features recorded, eg C/D ratio, pigmentation etc.) Records the media opacity. | Patient with significant lens or media opacities with VA 6/12 or less. | PR ______ |
## Unit of competence 4. Optical appliances – The ability to dispense an appropriate optical appliance

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Identifies anomalies in a prescription and implements the appropriate course of action.</td>
<td>PR PI</td>
<td>Identifies possible errors in a prescription and follows the appropriate course of action. Identifies and explains any problems which may occur from the given prescription and offers solutions, for example aniseikonia, anisometropia. <strong>Additional guidance</strong> This will always include vertical differential prism and monocular horizontal centration.</td>
<td>Patient dispensed with spectacles to correct significant anisometropia = or &gt;2.00DS/DC.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>4.1.3 Matches the form, type and positioning of lenses to meet all the patient’s needs and requirements and provides appropriate advice.</td>
<td>PR CS</td>
<td>Provides all the necessary information for a pair of spectacles to be duplicated, to include: • prescription • lens type and form • centration and fitting positions • frame details • lens surface treatments.</td>
<td>All other dispensing records.</td>
<td>PR ______</td>
<td></td>
</tr>
</tbody>
</table>
| 4.1.4 Advises on personal eye protection regulations and relevant standards, and appropriately advises patients on their occupational visual requirements. | PR | Applies the relevant standards for:  
- VDU users, driving  
- EN standards, including markings standards BSEN 166 and legislation and sources.  
Demonstrates a knowledge of visual task analysis including lighting.  
Understands the legal responsibilities for employees, employers, dispensing opticians and optometrists.  
Understands and identifies common ocular hazards and common or sight threatening leisure activities and occupations and the ability to advise patients. | Patient where a suitable eye protector has been advised or dispensed. | PR _______ |
| 4.1.5 Dispenses a range of lens forms to include complex lenses, multifocals and high corrections, and advise on their application to specific patients needs. | 3 x PR | Demonstrates correct interpretation of prescriptions  
Understands the following lens parameters:  
- lens form, design, materials, coatings and tints, availability, blank sizes  
Demonstrates understanding of frames covering the following:  
- size, materials, relationship between frame, lenses and face.  
Demonstrates the appropriate lens and frame selection and justification (bearing in mind patient’s lifestyle requirements)  
Demonstrates appropriate frame adjustments. | Patient dispensed with multifocals.  
Patient dispensed with spectacles to correct a refractive error = or > 10 dioptres.  
At least one paediatric dispensing (four years or under). | PR _______  
PR _______  
PR _______ |
| 4.1.6 Prescribes and dispenses spectacles for vocational use. | PR | Identifies the vocational needs of the patient and carries out task analysis.  
Takes appropriate measurements.  
Prescribes and dispenses the most appropriate frames and lenses for the task. | Patient dispensed with a specific vocational or recreational correction, eg an older presbyopic VDU user. | PR _______ |
### Unit of competence 5. Contact lenses – The ability to manage the fitting and aftercare of patients with contact lenses

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5.2.1. Manages the aftercare of patients wearing soft lenses.</td>
<td>DO 3 x PR</td>
<td>Demonstrates an understanding of the content and routine of a soft CL aftercare consultation. Carries out the relevant tests and assessments which are required in a routine soft lens aftercare consultation. Demonstrates an understanding of soft lens adaptation and aftercare issues and how to manage them. <strong>Additional guidance</strong> Demonstrate assessment of: • patient assessment, eg reason for visit (presenting complaint), history and symptoms • visual and fit assessment • tissue assessment – with and without fluorescein • condition of CL.</td>
<td>Three soft lens aftercare patients covering a range of materials and modalities of wear. To include one patient with a complication requiring management.</td>
<td>PR _______</td>
<td>PR _______</td>
</tr>
<tr>
<td>5.2.1. Manages the aftercare of patients wearing soft lenses (continued).</td>
<td></td>
<td>Providing advice: • addressing presenting complaint, communicating cause and remedy of complaint including action to be taken and review date • advise need of any other examination if not up-to-date, eg next eye exam etc. • complying with appropriate lens handling, care regimes and hygiene requirements throughout • advise on the management of common CL complications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3.1. Chooses and manages the fitting of toric contact lenses.</td>
<td>PR</td>
<td>Demonstrates an understanding of the types of astigmatism which require correction. Chooses the appropriate type of CL correction to meet the relevant needs of the patient. Demonstrates an understanding of the designs and materials available in toric contact lenses and selects the appropriate toric lens for the needs of the patient. <strong>Additional guidance</strong> To include both soft toric and the fitting of RGP lenses on toric corneas.</td>
<td>Record of a complete toric CL fitting for a patient with astigmatism &gt;1.50DC.</td>
<td>PR _______</td>
<td></td>
</tr>
</tbody>
</table>
## Unit of competence 6. Ocular disease – The ability to identify and manage ocular abnormalities

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
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<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.2. Interprets and investigates the presenting symptoms of the patient.</td>
<td>PR</td>
<td>Asks appropriate and relevant questions to follow up presenting symptoms. Recognises a significant symptom (including reduced vision). Investigates the presenting symptom. Interprets the results.</td>
<td>Patient presenting with headache, symptomatic cataract or red eye.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>6.1.3. Develops a management plan for the investigation of the patient.</td>
<td>PR</td>
<td>Recognises that there is a need for action and further investigation within the primary care setting. Chooses and carries out an appropriate technique for that investigation. Interprets the results and acts in line with College of Optometrists and NHS guideline.</td>
<td>Patient presenting with headache, symptomatic cataract or red eye.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>6.1.4. Identifies external pathology and offers appropriate advice to patients not requiring referral.</td>
<td>2 x PR</td>
<td>Uses an appropriate method for looking at the external eye, grades what is seen at the initial check and at follow up covering: • external eye and ocular surfaces • lids, lashes, lumps/bumps and red eye. Gives the correct advice/treatment and review period. Aware of pharmaceutical agents available (legal status, indications, contraindications and side effects and uses appropriate sources of medicines information). Explains clearly to the patient and checks their understanding.</td>
<td>Patient with blepharitis. Patient with evaporative or aqueous deficiency dry eye.</td>
<td>PR ______</td>
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<tr>
<td>6.1.6. Manages patients presenting with cataract.</td>
<td>2x PR</td>
<td>Understands the impact of cataract on patient’s lifestyle. Provides advice on minimising impact on lifestyle – non surgical management. Shows awareness of HES management – understands the risk and benefit of surgery. Provides appropriate advice and management including when necessary referral for cataract extraction.</td>
<td>Two patients with cataract representing different management options.</td>
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</tr>
<tr>
<td>6.1.7 Manages patients presenting with red eye/s.</td>
<td>PR I</td>
<td>Obtains relevant information from the patient. Uses appropriate methods of examination to enable differential diagnosis. Appropriately manages the patient after diagnosis.</td>
<td>Patient presenting with red eye/s.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| PR | | | |</p>
<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
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<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.1. Refracts a range of patients with various optometric problems by appropriate objective and subjective means.</td>
<td>DO PR</td>
<td>Achieves accurate retinoscopy, and end point subjective results. Near add and range appropriate to needs. Uses appropriate methods of checking, eg +1.00Ds blur and use of pin-hole. Understands the relationship between vision and prescription and symptoms and prescription. <strong>Additional guidance</strong> Both accurate results and appropriate technique are required to pass the retinoscopy part of this element. Accurate results for retinoscopy within +/- 1.00 DS/DC (determined using a power cross) and axis appropriate to cylinder. Static fixation retinoscopy is the appropriate technique, but if a trainee prefers or needs to use one eye only then they would need to highlight this to the assessor and then must use a valid and appropriate technique for monocular viewing, eg Barrett method or near fixation retinoscopy. Accurate results for subjective within +/- 0.50 DS/DC (determined using a power cross) and axis appropriate to cylinder if patient VA 6/9 or better. “Understands the relationship between vision and prescription and symptoms and prescription” would also be demonstrated through making an appropriate prescribing and management decisions based on the refractive and oculomotor status.</td>
<td>Record of a refraction of a hyperopic pre-presbype. Other sampled records to reflect range of experience.</td>
<td>PR _______</td>
<td></td>
</tr>
<tr>
<td>7.1.7. Understands the special examination needs of patients with severe visual field defects.</td>
<td>CS</td>
<td>Understands the different types of severe visual field defect and how to adapt examination technique to take them into account, in particular: • consideration of patient’s mobility adaptation of the • adaptation of routine.</td>
<td></td>
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</tbody>
</table>
## Unit of competence 8. Assessment and management of binocular vision

The ability to assess and manage patients with anomalies of binocular vision

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
</table>
| 8.1.1. Assesses binocular status using objective and subjective means. | DO PR | Takes a case history that covers patient history and symptoms relevant to binocular status only. Undertakes objective tests using suitable targets, and assessing deviation accurately. Undertakes subjective tests using suitable targets, as appropriate to patient. **Additional guidance** “Assessing the deviation accurately” should include:  
- direction of latent or manifest deviation  
- speed of recovery  
- size – small/moderate or large  
- concomitant/Inconcomitant. | From other sampled records. | PR _______ | |
| 8.1.4. Manages adult patients with heterotropia. | PR | Identifies onset and type of tropia from appropriate questions during symptoms and history and appropriate clinical tests. Demonstrates appropriate management of different types and onsets of tropia. Understands treatment options including potential benefits/limitations of squint surgery. Gives advice to patient about their condition and possible effect on lifestyle, eg driving. | Adult patient with heterotropia. | PR _______ | |
Notes

**Compulsory evidence types to demonstrate competence**

CS = Case scenario  
DO = Direct observation of clinical skills  
FP = Field plots for interpretation and management  
I = Images provided by assessor of common clinical presentations  
Log = Logbook evidence showing maintenance of competence  
PI = Prescription interpretation of a spectacle order provided by the assessor for critical discussion  
PR = Patient record  
Q = Questions from the assessor to gauge the trainee’s applied clinical knowledge  
RL = Referral letter written by the trainee for critical discussion  
RP = Role play (clinical scenario where the assessor is acting as the patient)  
WT = Witness testimony describing clinical experience and clinical competence, signed by supervising person

**Compulsory direct observation for key skills**

The key skills for which direct observation is compulsory are as follows:

- assessing binocular status
- assessing the external eye and adnexa
- communication with patient
- contact tonometry (Goldmann or Perkins)
- direct ophthalmoscopy
- history taking
- indirect ophthalmoscopy using biomicroscopy
- interpreting and investigating presenting symptoms
- keratometry
- refraction
- RGP fitting and aftercare
- slit lamp examination
- soft lens fitting and aftercare
- spectacle verification

For certain elements of competence, where patient episodes are included as part of the evidence requirements, patient record (PR) will also be a compulsory form of evidence. There are only three Stage 1 elements in the framework where a suitable witness testimony will be accepted instead of a compulsory patient record. In these three elements only the compulsory evidence type will be described as PR/WT. Where direct observation is not compulsory, or as a second form of evidence, anything relevant from the evidence types recorded above is acceptable. Where possible, evidence related to patients the trainee has seen should always be used.
## Scheme for Registration  Visit 2 – Training summary

Three month review covering from (date) _____________________________ to (date) _____________________________.

Insert number of patients seen in each relevant box.

<table>
<thead>
<tr>
<th></th>
<th>Refraction prebyope</th>
<th>Refraction pre-press</th>
<th>Refraction child</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
<th>Glaucoma</th>
<th>Other</th>
<th>RGP – new</th>
<th>RGP A/C Type (N or E)</th>
<th>Soft – New</th>
<th>Soft A/C Type (N or E)</th>
<th>BV</th>
<th>Low vision patient</th>
<th>Instillation of drugs</th>
<th>Dispensing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
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</tbody>
</table>

I confirm that I have completed all the patient episodes used as evidence in the Visit 1 table and totalled in the quarterly training summary above

Name of trainee __________________________________ Signature of trainee ______________________________ Date __________________
Scheme for Registration Visit 2 – Training review

Indicate in the table a score from the key below for the GOC Elements of Competence listed. (NB: Please ensure scores are as accurate as possible as this mark will be used to inform assessors of weaker areas to be addressed.)

Key:
Level 0 – trainee has had no experience in this area
Level 1 – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor
Level 2 – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks without detailed guidance
Level 3 – trainee demonstrates safe understanding and ability in this area of practice, occasionally checking with others if uncertain
### Unit of competence 1 – Communication

<table>
<thead>
<tr>
<th>Level</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>Obtains relevant history and information relating to general health, medication, family history, work, lifestyle and personal requirements</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Elicits the detail and relevance of any significant symptoms</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Identifies and responds appropriately to patient’s fears, anxieties and concerns about their visual welfare</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Discusses with the patient the importance of systemic disease and its ocular impact, its treatment and the possible ocular side effects of medication</td>
</tr>
<tr>
<td>1.2.4</td>
<td>Explains to the patient the implications of their pathological or physiological eye condition</td>
</tr>
<tr>
<td>1.2.5</td>
<td>Communicates effectively with any other appropriate person involved in the care of the patient</td>
</tr>
</tbody>
</table>

### Unit of competence 2 – Professional conduct

<table>
<thead>
<tr>
<th>Level</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1</td>
<td>Adheres to health and safety policies in the practice including the ability to implement appropriate measures for infection control</td>
</tr>
<tr>
<td>2.1.3</td>
<td>Shows respect for all patients</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Creates and keeps full, clear, accurate and contemporaneous records</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Interprets and responds to existing records</td>
</tr>
</tbody>
</table>
## Section Two – Stage 1 assessment – Visit 2

<table>
<thead>
<tr>
<th>Unit of competence 3 – Methods of ocular examination</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.2 Uses a slit lamp to examine the external eye and related structures</td>
<td></td>
</tr>
<tr>
<td>3.1.3 Examines the fundi using both direct and indirect techniques</td>
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<tr>
<td>3.1.4 Identifies abnormal colour vision and appreciates its significance</td>
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<tr>
<td>3.1.5 Investigates the visual fields of patients with all standards of acuity and analyses and interprets the results</td>
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<tr>
<td>3.1.10 Uses diagnostic drugs to aid ocular examination</td>
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<tr>
<td>3.1.11 Makes an assessment of the fundus in the presence of media opacities</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit of competence 4 – Optical appliances</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Identifies anomalies in a prescription and implements the appropriate course of action</td>
<td></td>
</tr>
<tr>
<td>4.1.3 Matches the form, type and positioning of lenses to meet all the patient’s needs and requirements and provides appropriate advice</td>
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<tr>
<td>4.1.4 Advises on personal eye protection regulations and relevant standards, and appropriately advises patients on their occupational visual requirements</td>
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<tr>
<td>4.1.5 Dispenses a range of lens forms to include complex lenses, multifocals and high corrections, and advise on their application to a specific patient’s needs</td>
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<tr>
<td>4.1.6 Prescribes and dispenses spectacles for vocational use</td>
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</tbody>
</table>
### Unit of competence 5 – Contact lenses

| Level | 5.2.1 | Manages the aftercare of patients wearing soft lenses |
|       | 5.3.1 | Chooses and manages the fitting of toric contact lenses |

### Unit of competence 6 – Ocular disease

| Level | 6.1.2 | Interprets and investigates the presenting symptoms of the patient |
|       | 6.1.3 | Develops a management plan for the investigation of the patient |
|       | 6.1.4 | Identifies external pathology and offers appropriate advice to patients not requiring referral |
|       | 6.1.6 | Manages patients presenting with cataract |
|       | 6.1.7 | Manages patients presenting with red eye/s |

### Unit of competence 7 – Assessment of visual function

| Level | 7.1.1 | Refracts a range of patients with various optometric problems by appropriate objective and subjective means |
|       | 7.1.7 | Understands the special examination needs of patients with severe visual field defects |

### Unit of competence 8 – Binocular vision

| Level | 8.1.1 | Assess binocular status using objective and subjective means |
|       | 8.1.4 | Manages adult patients with heterotropia |

Supervisor signature:   
Date:   
Trainee signature:   
Date:
Scheme for Registration
Generic assessment plan: Visit 3

Trainee name: ________________________ Assessor name: ________________________

Time and location for assessment:

Proposed activity – competencies to be covered, methods of assessment:
We will be covering all of the visit 3 competencies listed in the SfR handbook plus
____________________ The actual competencies assessed will be largely dependent on the patient
episodes and experience you have gained to date. Please sign and return a copy of this plan to me so
indicate your agreement. University of Hertfordshire trainees need to gain prior approval from their
university assessor for any changes.

Evidence to be sent in advance:
I must receive by _______________ at the latest please:
• __________________________ relating to last action plan
• completed Visit 3 assessment framework document
• copies of any witness testimonies relevant to this assessment
• this document signed to agree the assessment plan

Via email or mail to my home address (do not send original documents).
On the day, I will need to see your completed logbook and I will need access to your patient records.
Please ensure that the relevant records are easily available to view on the day.

You will also need to provide the following lenses for the RGP and soft fit assessments.

RGP Fitting set: the lenses must be BOZR 7.60 to 8.10 in 0.1mm steps (six lenses). The power must be
between +/- 4.00DS. The material and lens form you can choose. The lenses must be demonstrably new
and unused.

Soft Fitting You may use any suitable lenses from your in-practice soft lens banks for this fitting.
The simulated patient provided for fitting must have k readings within the range 7.60 to 8.10mm

Agenda for assessment day

9.00     Arrival
9.05     Review of logbook and training review with trainee
9.15     Review of Visit 3 patient episode record, patient records from this and other records chosen by
assessor from logbook
9.30     Direct observation of the following patients whom you will need to organise:
• aftercare on an RGP patient (30 mins to complete)
• using a simulated patient/s to demonstrate:
  o soft lens fitting – one eye only, to also include soft lens insertion and removal
  o RGP lens fitting – 1 eye only, to also include RGP lens insertion and removal
  o contact tonometry using Goldmann or Perkins (one eye only).
11.15    Continue with review of patient records, witness testimonies etc.
12.30    Break for assessor to consider assessment outcome and feedback content
12.40    Feedback of the assessment outcome with supervisor and trainee and agreement of remedial
action plans

Assessment dates: We will review future Stage 1 visits.

Target date for sign off __________  Trainee is currently aiming for __________ OSCE
Trainee ...............................................  Supervisor .............................................

Assessor ...............................................  Date .............................................
### Scheme for Registration Assessment framework – Visit 3

**Supervisor training review scores and monthly summary**

This form is to be completed by the trainee and a copy given to assessor at Visit 1. To ensure that the assessor has all the relevant information required to prepare for the assessment, please complete the final column on each page with your most recent supervisor review score for that element of competence. Also ensure that you have completed the final page of the report detailing all your totals for eye examinations and dispensing etc. Please consult the notes below before filling in the form.

| Unit of competence 1. Communication – The ability to communicate effectively with the patient and any other appropriate person involved in the care of the patient, with English being the primary language of communication |
|---|---|---|---|---|
| **Stage 1 Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient episode** | **Identifier** |
| 1.2.1 Understands the patient’s expectations and aspirations and manages situations where these cannot be met. | PR | Conveys expert knowledge in an informative and understandable way, for example, not using jargon. Explores the patients’ expectations and checks the level of understanding. Employs a patient-centred approach to understand the patient’s perspective. Is able to empathise with and manage the patient’s needs, resolving any problems to mutual satisfaction. | Patient where their expectations cannot be met, eg with AMD or visual impairment. | PR _____ |
| 1.2.2 Communicates with patients who have poor or non-verbal communication skills, or those who are confused, reticent or who may mislead. | PR | Makes effective use of body language to support explanation. Demonstrates awareness of own body language. Uses appropriate supportive material. | Patient with communication difficulty or who is confused or might mislead. | PR _____ |
### Unit of competence 2. Professional conduct

The ability to comply with the legal, ethical and professional aspects of practice

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Is able to manage all patients including those who have additional clinical or social needs.</td>
<td>2 x PR</td>
<td>Respects and cares for all patients and their carers in a caring, patient, sensitive and appropriate manner. Has knowledge of the Disability and Equality Act (2010) and ensures the patient environment is safe, inviting and user-friendly in terms of access and facilities for all patients. Has an awareness of different types of disabilities and patients with additional needs. Understands the criteria and process for RVI/CVI registration, the use of the LVL and the difference between certification and registration. <strong>Additional guidance</strong> Able to explain how they have changed their routine to accommodate a particular patient's needs.</td>
<td>Patient with visual impairment Patient with physical disability.</td>
<td>PR________</td>
<td>PR_______</td>
</tr>
<tr>
<td>2.2.6 Makes an appropriate judgement regarding referral and understands referral pathways.</td>
<td>PR RL</td>
<td>Refers to the appropriate person with appropriate urgency. Recognises the difference between referral and notification. Include appropriate information in the referral letter. Gives appropriate advice to the patient including written statement. Shows understanding of local protocol / with some understanding of national variations. <strong>Additional guidance</strong> RL must be clear, show use of appropriate language and spelling and show the following consistently: • appropriate data • key symptoms, signs and findings • provisional diagnosis / action requested.</td>
<td>Patient referred (other than for cataract.</td>
<td>PR _______</td>
<td></td>
</tr>
<tr>
<td>Stage 1 Elements of competence</td>
<td>Compulsory evidence type</td>
<td>Indicators</td>
<td>Patient episode</td>
<td>Identifier</td>
<td>Supervisor training review score</td>
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</table>
| 3.1.6 Uses both a non-contact and contact tonometer to measure intraocular pressure and analyses and interprets the results. | DO (Goldman or Perkins) 2 x PR | Safely sets up and uses the appropriate tonometer For contact tonometry demonstrates appropriate choice and use of drug/s. Provides an explanation and advice to the patient covering:  
  • process, risks, after procedure advice  
  • accurately records and interprets the results. **Additional guidance**  
  Contact tonometry should be applanation using either Goldman or Perkins tonometer only. Knowledge and understanding of checking the calibration of the instrument of choice is also a requirement.  
  “Safely” in contact tonometry means that:  
  • pre and post corneal checks have been made and recorded.  
  The tonometer head must be decontaminated using a recognised method if it is to be reused on another patient.  
 | Patient where NCT has been used.  
 Patient where applanation tonometry using GAT or Perkins has been used. | PR _______  
 PR _______ | |
| 3.1.8 Uses a slit lamp to assess anterior chamber signs of ocular inflammation. | PR/WT | Uses the appropriate slit lamp technique in appropriate ambient lighting.  
 Slit lamp technique should include viewing the following:  
  • corneal endothelium  
  • aqueous humour  
  • iris and anterior lens surface.  
 Describes and grades what they would expect to see in a patient with anterior ocular inflammation. | • eg patient with anterior uveitis seen in practice or HES. | PR/WT ______ |
### Unit of competence 4. Optical appliances – The ability to dispense an appropriate optical appliance

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.7 Manages non-tolerance cases.</td>
<td>PR</td>
<td>Identifies problems. Undertakes appropriate investigation and takes appropriate action. Explains to patient what course of action will be taken and obtains patient’s agreement. Arranges follow-up if necessary.</td>
<td>Patient with intolerance where appropriate investigation and action has been taken.</td>
<td>PR _______</td>
<td></td>
</tr>
<tr>
<td>4.2.1 Advises on the use of, and dispenses simple low vision aids including simple hand and stand magnifiers, typoscopes and handheld telescopes.</td>
<td>PR</td>
<td>Identifies which patients would benefit from low vision aids and advice. Understands the principals of magnification, field of view and working distance in relation to different aids. Provides advice on the advantages and disadvantages of different types of simple low vision aids. Understands magnification including acuity reserve. Gives correct instruction to the patient in the use of various aids, to include: - which specs to use with the aid - lighting required - appropriate working distance. Provides basic advice on non-optical aids, use of contrast and lighting to enhance visual performance and daily living skills.</td>
<td>Patient where a low vision aid has been advised and dispensed.</td>
<td>PR _______</td>
<td></td>
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</tbody>
</table>
| 4.2.2 Understands the application of complex low vision aids. | Identifies appropriate patients for complex low vision aids. Selects the appropriate visual aid, eg spectacle mounted telescopes, CCTV. Considering range:
- use/magnification/limitations/lighting and environment
- demonstrates an awareness of other alternatives including other electronic aids and speech software.
Aware of access/availability of services
Makes appropriate referral and aware of potential outcome. |
<table>
<thead>
<tr>
<th>Stage 1 Competence</th>
<th>Compulsory Evidence Type</th>
<th>Indicators</th>
<th>Patient Episode</th>
<th>Identifier</th>
<th>Supervisor Training Review Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1.1. Chooses, fits and orders soft lenses</strong></td>
<td>DO 3 x PR</td>
<td>Demonstrates an understanding of the range of soft lens materials and designs available. Makes the appropriate choice of soft lens parameters. Assesses the fit of the lenses using a variety of techniques. Makes appropriate adjustment of the lens for best fit. Writes an appropriate order for a soft lens. <strong>Additional guidance</strong> This will <strong>always</strong> include the assessor directly observing the trainee insert &amp; remove the CL from the patient’s eye. PR’s should include an initial assessment of the patient’s suitability for CL wear and assessment of the eye for trauma post-fitting.</td>
<td>Three soft lens complete fittings covering a range of different materials and modalities of wear.</td>
<td>PR _______</td>
<td>PR _______</td>
</tr>
<tr>
<td><strong>5.1.3. Chooses, fits and orders rigid lenses</strong></td>
<td>DO 3 x PR</td>
<td>Demonstrates an understanding of the range of rigid lens materials and designs available. Makes the appropriate choice of rigid lens parameters. Assesses the fitting of a rigid lens. Makes appropriate adjustment of the lens for best fit. Writes an appropriate order for a rigid lens.</td>
<td>Three complete RGP lens fittings.</td>
<td>PR _______</td>
<td>PR _______</td>
</tr>
<tr>
<td><strong>5.1.3. Chooses, fits and orders rigid lenses (continued)</strong></td>
<td></td>
<td><strong>Additional guidance</strong> This will always include the assessor directly observing the trainee insert &amp; remove the CL from the patient’s eye. PR’s should include an initial assessment of the patient’s suitability for CL wear and assessment of the eye for trauma post-fitting.</td>
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</table>
| 5.1.4 Instructs the patient in rigid contact lens handling and how to wear and care for them. | PR | Instructs the patient in the techniques of RGP lens insertion, removal and other relevant handling instructions. Instructs a patient on the principles of RGP lens wear and care including the use RGP lens care products. **Additional guidance** This must include:  
- sufficient detailed knowledge of own lenses and solutions to advise appropriately and safely  
- sufficient general knowledge of materials and care regimes to resolve problems. | Insertion and removal training with one RGP lens patient. | PR _______ |
| | | | |
| 5.2.2. Manages the aftercare of patients wearing rigid gas permeable contact lenses. | DO 3 x PR | Demonstrates an understanding of the content and routine of a rigid CL aftercare consultation. Carries out the relevant tests and assessments which are required in a routine rigid lens aftercare consultation. Demonstrates an understanding of rigid lens adaptation and aftercare issues and how to manage them. **Additional guidance** Demonstrate assessment of:  
- patient assessment, eg reason for visit (presenting complaint), history and symptoms  
- visual assessment  
- fit assessment  
- tissue assessment – with and without fluorescein  
- condition of CL. Providing advice:  
- addressing presenting complaint, communicating cause and remedy of complaint including action to be taken and review date.  
- advise need of any other examination if not up-to-date, eg next eye exam.  
- complying with appropriate lens handling, care regimes and hygiene requirements throughout  
- advise on the management of common CL complications. | Three RGP contact lens aftercare patients. | PR _______ |
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<table>
<thead>
<tr>
<th>5.3.2. Chooses, fits and manages the correction of presbyopic patients.</th>
<th>PR</th>
<th>Demonstrates an understanding of the advantages/disadvantages of the various methods of managing presbyopia and chooses the most appropriate method for the needs of the patient.</th>
<th>Presbyopic patient with a <strong>suitable complete</strong> CL correction.</th>
<th></th>
</tr>
</thead>
</table>
| 5.3.3. Understands the techniques used in the fitting of complex contact lenses and advises patients requiring complex correction. | Knows the methods for the CL correction of aphakia, high ametropia, keratoconus, post-surgical and post-refractive surgery including:  
• the types of lenses available, their fitting characteristics, fitting technique and any patient advice required when fitting these lenses. |  |  |  |
### Unit of competence 6. Ocular disease – The ability to identify and manage ocular abnormalities

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.5. Recognises common ocular abnormalities and refers when appropriate.</td>
<td>PR I</td>
<td>Recognises using appropriate technique/s all of the following:</td>
<td>Other sampled records.</td>
<td>PR ______</td>
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<tr>
<td></td>
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<td>• cataract</td>
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<td></td>
<td></td>
<td>• glaucoma or glaucoma suspects</td>
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<td>• anterior eye disorders, eg blepharitis, dry eye, meibomian gland dysfunction, lid lesions</td>
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<td>• AMD and macular abnormalities.</td>
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<td>Manages appropriately.</td>
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<tr>
<td>6.1.8. Evaluates glaucoma risk factors to detect glaucoma and refer accordingly.</td>
<td>PR</td>
<td>Discusses the key risk factors.</td>
<td>Patient requiring management for potential suspect glaucoma (not solely ocular hypertension).</td>
<td>PR ______</td>
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<tr>
<td></td>
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<td>Identifies findings suggestive of open and closed angle glaucoma from clinical examination.</td>
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<td></td>
<td>Uses the above information to determine if referral is appropriate.</td>
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<td>Decides on urgency and pathway of referral.</td>
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<tr>
<td>6.1.9 Manages patients presenting with macular degeneration.</td>
<td>PR</td>
<td>Distinguishes between wet and dry AMD from symptoms and clinical findings.</td>
<td>Patient with AMD.</td>
<td>PR ______</td>
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<td>Establishes patient needs and visual function</td>
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<td>Makes appropriate recommendations for both management and referral.</td>
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<td>Understands potential treatments both medical and in practice options.</td>
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<tr>
<td>6.1.10 Recognises, evaluates and manages diabetic eye disease and refers accordingly.</td>
<td>PR I</td>
<td>Recognises and names correctly the stage of diabetic eye disease.</td>
<td>Patient with diabetic eye disease.</td>
<td>PR ______</td>
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<tr>
<td></td>
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<td>Gives local referral route and the appropriate timescales for referral following diabetic retinopathies:</td>
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<td>• background/maculopathy/pre-proliferative/proliferative.</td>
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<tr>
<td>6.1.12 Evaluates and manages patients presenting with symptoms of retinal detachment.</td>
<td>PR</td>
<td>Assesses risk factors.</td>
<td>Patient presenting with symptoms suggestive of retinal detachment.</td>
<td>PR ______</td>
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<td>Carries out an appropriate eye examination.</td>
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<td>Manages the findings according to local protocols.</td>
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<td><strong>Additional guidance</strong></td>
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<td>Appropriate eye examination would include:</td>
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<td>• dilated fundoscopy with BIO lens and slit lamp</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• findings including +/− Shafer’s sign recorded.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6.1.13 Recognises ocular manifestations of systemic disease.</td>
<td>PR</td>
<td>Provides evidence of examining patients and recognising ocular manifestations of systemic disease in hypertension and diabetes. Answers questions and recognises a range of ocular conditions from images provided by the assessor and relates these to systemic disease.</td>
<td>Patient with ocular manifestation of systemic disease other than diabetes.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>6.1.14 Assesses signs and symptoms of neurological significance.</td>
<td>PR</td>
<td>Assess the relevant symptoms and signs. Understands which signs/symptoms could relate to a neurological condition and the follow up information required to make a differential diagnosis. Understands the significance and relative importance of the findings. Manages appropriately.</td>
<td>Patient presenting with an ocular symptom or sign suggestive of a neurological condition.</td>
<td>PR______</td>
<td></td>
</tr>
<tr>
<td>6.1.15 Recognises adverse ocular reactions to medication.</td>
<td>PR</td>
<td>Shows awareness relating to sources of information of adverse reactions. Provides evidence of the recognition of an adverse reaction to medication (systemic or topical). Identifies and/or lists the ocular adverse reactions to a range of common medications (systemic or topical). Describes the reporting scheme.</td>
<td>Patient presenting with an adverse ocular reaction to topical or systemic medication.</td>
<td>PR ______</td>
<td></td>
</tr>
<tr>
<td>Unit of competence 7. Assessment of visual function – The ability to assess visual function in all patients</td>
<td></td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td><strong>Stage 1</strong> Elements of competence</td>
<td></td>
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</tr>
<tr>
<td><strong>Compulsory evidence type</strong></td>
<td><strong>Indicators</strong></td>
<td><strong>Patient episode</strong></td>
<td><strong>Identifier</strong></td>
<td><strong>Supervisor training review score</strong></td>
<td></td>
</tr>
<tr>
<td>7.1.2. Uses appropriate diagnostic drugs to aid refraction.</td>
<td>PR</td>
<td>Understands the indications/contraindications/legal aspects for use and supply of cycloplegic drugs. Carries out the procedure safely. Interprets the results. Appropriately records all aspects of the examination. <strong>Additional guidance</strong> “Safely” in cycloplegic refraction should include knowledge of possible OAR’s to the cycloplegic drug and appropriate action.</td>
<td>One appropriate cycloplegic examination of a child patient.</td>
<td>PR _______</td>
<td></td>
</tr>
</tbody>
</table>
| 7.1.3. Assesses children’s visual function using appropriate techniques. | PR | Uses a range of assessment strategies according to age and ability to include:  
  * Vision, OMB, stereopsis.  
  Knows the expected norms for different ages. | Child patient four years or under. | PR _______ |
| 7.1.4 Understands the techniques of the assessment of infants. | PR/WT | Describes the use of vision testing equipment for an infant under two, for example, preferential looking, optokinetic nystagmus. | Child patient under two years (23/12 or less) seen in practice or HES. Can be an observed episode. | PR/WT ___ |
| 7.1.5 Assesses patients with impaired visual function and understands the use of specialist charts for distance and near vision and the effects of lighting, contrast and glare. | PR | Assesses vision and adapts refraction routine depending on circumstances, for example, age, amblyopia, visual impairment.  
  Is realistic in their expectations for the patient.  
  Understands the use and scoring of specialist charts, eg Peli Robson, LogMar to assess vision/VA and contrast sensitivity.  
  Understands the benefits of lighting and the adverse affects of lighting/glare. | Patient with visual impairment (best corrected VA = or <6/18). | PR _______ |
| 7.1.6. Understands the special examination needs of patients with learning and other disabilities. | PR | Recognises what range of patients have special examination needs.  
  Treats those with learning and other disabilities without prejudice in a courteous and sensitive manner and, in addition, has an ability to empathise with the patient.  
  Demonstrates an awareness of the need to be flexible in their approach to examination, amending and adapting techniques and communication appropriately. | Patient with physical or intellectual impairment. | PR _______ |
### Unit of competence 8. Assessment and management of binocular vision

The ability to assess and manage patients with anomalies of binocular vision.

<table>
<thead>
<tr>
<th>Stage 1 Elements of competence</th>
<th>Compulsory evidence type</th>
<th>Indicators</th>
<th>Patient episode</th>
<th>Identifier</th>
<th>Supervisor training review score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.2. Understands the management of a patient with an anomaly of binocular vision.</td>
<td>PR</td>
<td>Recognises which management option is appropriate dependent on presenting symptoms and history. Demonstrates an understanding of the principles of different types of management including refractive, orthoptic, prismatic, surgery. is able to describe in detail the orthoptic exercises given.</td>
<td>From other sampled records.</td>
<td>PR</td>
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</tr>
<tr>
<td>8.1.3. Investigates and manages adult patients presenting with heterophoria.</td>
<td>PR</td>
<td>Relates OMB tests and symptoms and decides on appropriate management. Evidences correct management including complete patient advice. Is able to discuss alternatives including prism, refraction, exercises and referral.</td>
<td>Adult patient with symptomatic heterophoria.</td>
<td>PR</td>
<td></td>
</tr>
<tr>
<td>8.1.5 Manages children at risk of developing an anomaly of binocular vision.</td>
<td>PR</td>
<td>Identifies signs and symptoms in relation to personal/family history. Understands/administers and interprets appropriate examination procedures with respect to age and developmental ability. Provides appropriate management of the child.</td>
<td>Child seven years or under at risk of developing an anomaly of binocular vision.</td>
<td>PR</td>
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</tr>
<tr>
<td>8.1.6 Manages children presenting with an anomaly of binocular vision.</td>
<td>PR</td>
<td>Identifies and manages significant heterophoria or strabismus in children. Demonstrates knowledge of possible orthoptic treatment at hospital. Demonstrates knowledge of hospital waiting list times locally.</td>
<td>Child seven years or under with an anomaly of binocular vision.</td>
<td>PR</td>
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</tr>
<tr>
<td>8.1.7 Manages patients presenting with an incomitant deviation.</td>
<td>PR/WT</td>
<td>Carries out and interprets motility and cover test results. Takes and interprets history and symptoms. Recognises that additional tests are required and interprets the results. Appropriately manages the condition. Understands the musculature involved.</td>
<td>Patient with incomitancy seen in practice or HES.</td>
<td>PR/WT</td>
<td></td>
</tr>
</tbody>
</table>
Notes

**Compulsory evidence types to demonstrate competence**
CS = Case scenario
DO = Direct observation of clinical skills
FP = Field plots for interpretation and management
I = Images provided by assessor of common clinical presentations
Log = Logbook evidence showing maintenance of competence
PI = Prescription interpretation of a spectacle order provided by the assessor for critical discussion
PR = Patient record
Q = Questions from the assessor to gauge the trainee’s applied clinical knowledge
RL = Referral letter written by the trainee for critical discussion
RP = Role play (clinical scenario where the assessor is acting as the patient)
WT = Witness testimony describing clinical experience and clinical competence, signed by supervising person

**Compulsory direct observation for key skills**
The key skills for which direct observation is compulsory are as follows:
- assessing binocular status
- assessing the external eye and adnexa
- communication with patient
- contact tonometry (Goldmann or Perkins)
- direct ophthalmoscopy
- history taking
- indirect ophthalmoscopy using biomicroscopy
- interpreting and investigating presenting symptoms
- keratometry
- refraction
- RGP fitting and aftercare
- slit lamp examination
- soft lens fitting and aftercare
- spectacle verification

For certain elements of competence, where patient episodes are included as part of the evidence requirements, patient record (PR) will also be a compulsory form of evidence. There are only three Stage 1 elements in the framework where a suitable witness testimony will be accepted instead of a compulsory patient record. In these three elements only the compulsory evidence type will be described as PR/WT. Where direct observation is not compulsory, or as a second form of evidence, anything relevant from the evidence types recorded above is acceptable. Where possible, evidence related to patients the trainee has seen should always be used.
Scheme for Registration Visit 3 – Training summary

Three month review covering from (date) ______________________ to (date) ______________________
Insert number of patients seen in each relevant box.

<table>
<thead>
<tr>
<th></th>
<th>Refraction presbyope</th>
<th>Refraction pre-pres</th>
<th>Refraction child</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
<th>Glaucoma</th>
<th>Other</th>
<th>RGP – new</th>
<th>RGP A/C Type (N or E)</th>
<th>Soft – New</th>
<th>Soft A/C Type (N or E)</th>
<th>BV</th>
<th>Low vision patient</th>
<th>Instillation of drugs</th>
<th>Dispensing</th>
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</thead>
<tbody>
<tr>
<td>Month 1</td>
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<tr>
<td>Month 2</td>
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<td>Month 3</td>
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</tbody>
</table>

I confirm that I have completed all the patient episodes used as evidence in the Visit 1 table and totalled in the quarterly training summary above

Name of trainee ___________________________ Signature of trainee ___________________________ Date ___________________
**Scheme for Registration Visit 3 – Training review**

Indicate in the table a score from the key below for the GOC Elements of Competence listed. (NB: Please ensure scores are as accurate as possible as this mark will be used to inform assessors of weaker areas to be addressed).

**Key:**
- **Level 0** – trainee has had no experience in this area
- **Level 1** – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor
- **Level 2** – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks without detailed guidance
- **Level 3** – trainee demonstrates safe understanding and ability in this area of practice occasionally checking with others if uncertain

<table>
<thead>
<tr>
<th>Unit of Competence 1 – Communication</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1  Understands the patient’s expectations and aspirations and manages situations where these cannot be met.</td>
<td></td>
</tr>
<tr>
<td>1.2.2  Communicates with patients who have poor or non-verbal communication skills, or those who are confused, reticent or who might mislead</td>
<td></td>
</tr>
</tbody>
</table>
### Unit of Competence 2 – Professional Conduct

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1</td>
<td>Is able to manage all patients including those who have additional clinical or social needs</td>
</tr>
<tr>
<td>2.2.6</td>
<td>Makes an appropriate judgement regarding referral and understands referral pathways</td>
</tr>
</tbody>
</table>

### Unit of Competence 3 – Methods of Ocular Examination

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.6</td>
<td>Uses both a non-contact and contact tonometer to measure intraocular pressure and analyses and interprets the results</td>
</tr>
<tr>
<td>3.1.8</td>
<td>Uses the slit lamp to assess anterior chamber signs of ocular inflammation</td>
</tr>
</tbody>
</table>

### Unit of Competence 4 – Optical Appliances

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.7</td>
<td>Manages non-tolerance cases</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Advises on the use of, and dispenses simple low vision aids including simple hand and stand magnifiers, typoscopes and handheld telescopes</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Understands the application of complex low vision aids</td>
</tr>
</tbody>
</table>
### Unit of competence 5 – Contact lenses

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1</td>
<td>Chooses, fits and orders soft lenses</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Chooses, fits and orders rigid lenses</td>
</tr>
<tr>
<td>5.1.4</td>
<td>Instructs the patient in rigid contact lens handling, and how to wear and care for them</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Manages the aftercare of patients wearing rigid gas permeable contact lenses</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Chooses and manages the correction of presbyopic patients</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Understands the techniques used in fitting complex contact lenses and advises patients requiring complex visual correction</td>
</tr>
</tbody>
</table>

### Unit of competence 6 – Ocular disease

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.5</td>
<td>Recognises common ocular abnormalities and refers when appropriate</td>
</tr>
<tr>
<td>6.1.8</td>
<td>Evaluates glaucoma risk factors, to detect glaucoma and refer accordingly</td>
</tr>
<tr>
<td>6.1.9</td>
<td>Manages patients presenting with macular degeneration</td>
</tr>
<tr>
<td>6.1.10</td>
<td>Recognises, evaluates and manages diabetic eye disease and refers accordingly</td>
</tr>
<tr>
<td>6.1.12</td>
<td>Evaluates and manages patients presenting with symptoms of retinal detachment</td>
</tr>
<tr>
<td>6.1.13</td>
<td>Recognises ocular manifestations of systemic disease</td>
</tr>
<tr>
<td>6.1.14</td>
<td>Assesses symptoms and signs of neurological significance</td>
</tr>
<tr>
<td>6.1.15</td>
<td>Recognises adverse ocular reactions to medication</td>
</tr>
</tbody>
</table>
### Section Two – Stage 1 assessment – Visit 3

#### Unit of competence 7 – Assessment of visual function

<table>
<thead>
<tr>
<th>Level</th>
<th>7.1.2</th>
<th>Uses appropriate diagnostic drugs to aid refraction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.1.3</td>
<td>Assesses children's visual function using appropriate techniques</td>
</tr>
<tr>
<td></td>
<td>7.1.4</td>
<td>Understands the techniques for assessment of vision in infants</td>
</tr>
<tr>
<td></td>
<td>7.1.5</td>
<td>Assesses patients with impaired visual function and understands the use of specialist charts for distance and near vision, and the effects of lighting, contrast and glare</td>
</tr>
<tr>
<td></td>
<td>7.1.6</td>
<td>Understands the special examination needs of patients with learning and other disabilities</td>
</tr>
</tbody>
</table>

#### Unit of competence 8 – Binocular vision

<table>
<thead>
<tr>
<th>Level</th>
<th>8.1.2</th>
<th>Understands the management of patients with an anomaly of binocular vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.1.3</td>
<td>Investigates and manages adult patients presenting with heterophoria</td>
</tr>
<tr>
<td></td>
<td>8.1.5</td>
<td>Manages children at risk of developing an anomaly of binocular vision</td>
</tr>
<tr>
<td></td>
<td>8.1.6</td>
<td>Manages children presenting with an anomaly of binocular vision</td>
</tr>
<tr>
<td></td>
<td>8.1.7</td>
<td>Manages patients presenting with an incomitant deviation</td>
</tr>
</tbody>
</table>

Supervisor signature: ___________________________ Date: __________

Trainee signature: ___________________________ Date: __________
Scheme for Registration Visit 4 – Training review

Key:
Level 0 – trainee has had no experience in this area
Level 1 – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor
Level 2 – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks without detailed guidance
Level 3 – trainee demonstrates safe understanding and ability in this area of practice, occasionally checking with others if uncertain.

<table>
<thead>
<tr>
<th>Unit of competence 1 – Communication</th>
<th>Level</th>
</tr>
</thead>
<tbody>
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<tr>
<th>Unit of competence 2 – Professional conduct</th>
<th>Level</th>
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</table>

<table>
<thead>
<tr>
<th>Unit of competence 3 – Ocular examination</th>
<th>Level</th>
</tr>
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</table>

Trainee name
<table>
<thead>
<tr>
<th>Unit of competence</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 – Optical appliances</td>
<td></td>
</tr>
<tr>
<td>5 – Contact lenses</td>
<td></td>
</tr>
<tr>
<td>6 – Ocular disease</td>
<td></td>
</tr>
<tr>
<td>7 – Assessment of visual function</td>
<td></td>
</tr>
<tr>
<td>8 – Binocular vision</td>
<td></td>
</tr>
</tbody>
</table>

Supervisor signature:  
Date:  

Trainee signature:  
Date:
Section Three – Stage 2 assessment

In this section, you will find information about preparing for Stage 2 of the work-based assessment. It is essential that both the trainee and supervisor are familiar with this information in good time before the assessment. If you have any queries, please address these to the Stage 1 assessor in the first instance.

Sign off by the Stage 1 assessor

Trainees will be signed off from Stage 1 of the work-based assessment process once they have:

- achieved all 75 Stage 1 competencies
- completed the HES experience if they are based in community practice
- completed:
  - the
    - GOC requirement of 350 refractions and 250 dispensings.
    - The College’s compulsory minimum contact lens experience requirements for Stage 1 sign off:
      - 20 contact lens fitting episodes to include a minimum of three soft fittings and three RGP lens fittings
      - 40 contact lens aftercare episodes to include a minimum of three soft lens aftercares and three RGP lens aftercares. 20 of the total aftercares to be carried out on established lens wearers (ie who have worn their lenses regularly for a minimum of six months).

  These numbers will be verified by the Stage 1 assessor by checking the quarterly totals in their logbook.

  or

  b. an action plan showing that all of the above requirements will be realistically achievable prior to the Stage 2 assessment date in approximately six weeks. This will need to be agreed with the Stage 1 assessor and will allow the trainee to fulfil the Scheme requirement before the Stage 2 visit. The Stage 1 assessor will make this decision by checking the quarterly totals in each trainee’s logbook.

The College manages the booking of all Stage 2 assessment visits centrally. All full Stage 2 assessment visits will take a minimum of 3.5 hours and a maximum of four hours in the practice. Resits may be shorter and no visit will take more than four hours. Morning assessments will usually begin at 9.15am or 10.30am and afternoon assessments will begin at 1.30pm (for full Stage 2 assessments).

Following the third Stage 1 visit, the Stage 1 assessor will confirm with the College whether or not, in their judgement, the trainee is likely to complete the Stage 1 requirements following the next Stage 1 visit. If this is the case, then at this point, the College will confirm the Stage 2 assessor and patient bookings for around six weeks after the next Stage 1 assessment visit. The Stage 2 assessor will also be sent all the details about the Stage 2 assessment.

Alternatively, the Stage 1 assessor may decide to wait until a later visit to confirm this, if in their view, the trainee may need more time to complete the Stage 1 requirements. In either
case, the Stage 1 assessor will tell the trainee at the end of the last Stage 1 assessment visit that the first 75 elements of competence have been achieved.

Following the visit, the assessor will enter all the remaining Stage 1 information online as soon as possible and in all cases within one week of the visit. Once this information has been added to the online reporting tool, the College will, if this has not already been done, confirm the assessor and patient and send the Stage 2 assessor all the details about the assessment.

At the same time, the College will email both the trainee and supervisor with the date and time of the Stage 2 assessment. If the trainee has any concerns that they will not be available, eg holiday or other pre-planned absence, then they should inform the College of the dates they will not be available before the Stage 2 assessment visit is booked. Cancelling a pre-booked Stage 2 visit will incur a cancellation fee. Refer to college-optometrists.org/qualifying-fees for more details. A fee will not be charged if there are mitigating circumstances, such as medical reasons, for which evidence will be required.

The Stage 2 assessment will be approximately six weeks after the last Stage 1 work-based assessment. If the trainee is resitting, we will arrange the resit two-six weeks after the previous attempt. If the trainee wishes to delay this resit assessment, because they feel that they need more time to prepare, they should contact the College within 24 hours of reading their online report.

The assessment will always take place in the trainee’s main practice (place of work). This is the address listed on the enrolment form to which all College correspondence is sent. It is, therefore, critical that the trainee lets the College know before any Stage 2 visits are booked if they want to undertake their Stage 2 assessment in a practice other than the main practice. We expect the supervisor or another registered optometrist who is responsible for the trainee on the day of the assessment to be on the premises. The Stage 2 assessor will not contact the trainee, their supervisor or the practice before the assessment. You can see the shape of the Stage 2 work-based assessment by looking at the generic visit plan which follows.

Stage 2 assessments will only take place during College working hours (Monday to Friday except Bank Holidays). This is to ensure that we can help if unforeseen circumstances, such as illness, occur.
Preparing for the Stage 2 assessment

Trainees must prepare thoroughly for the Stage 2 assessment, which consists of three parts:

- a routine eye examination on a presbyopic patient provided by the College
- a soft contact lens fitting and aftercare on a patient provided by the College
- the assessment of the Stage 2 overarching elements of competence.

In making their judgements, the assessor will only use the records the trainee has listed on their Stage 2 patient episode sheets as patient record evidence. Both trainee and supervisor must, therefore, check the records to ensure that they are the most recent complete examples that the trainee has examined and/or dispensed of the required patient episodes. Check that these records are complete; if they are not, the trainee risks failing Stage 2. It is acceptable for some records to be used as evidence for more than one element of competence, but the range supplied for the Stage 2 assessor to sample should demonstrate a broad range of different patients seen by the trainee and must not number less than 35 different patient records.

Trainees must also provide their completed logbook for the assessor so that he or she can confirm that they have completed the 350 refractions, 250 dispensing episodes and the contact lens requirements of the Scheme. The assessor will ask the trainee to provide three random records (one from each quarter) to check that they saw the patient personally. No other part of the record will be checked as part of this sampling exercise.

The assessor will bring all the assessment paperwork the trainee will need to complete during the assessment:

- routine eye examination record sheet
- contact lens fitting record sheet
- contact lens aftercare record sheet.

You will find details of the individual parts of the Stage 2 assessment together with these record sheets later in this section.

For a Stage 2 visit beginning at 9.15am the usual format for this visit will be as follows:

9.15 On arrival the assessor will check the routine eye examination patient. This should take no more than 15 minutes.
9.30 The assessor will check the trainee’s photographic identification. Assessment of routine eye examination of a presbyopic patient (45 minutes allowed for the assessment). Trainees can use any appropriate method of ophthalmoscopy (either direct or indirect) and trial frame or refractor head – but they will always be expected to use retinoscopy. The use of auto-refractor results or pre-prepared notes will not be permitted.
10.15 The trainee takes a 15 minute break while the assessor takes the keratometry measurements and checks the patient provided for the contact lens assessment.
10.30 The assessment of soft contact lens fitting and aftercare (40 minutes allowed for this assessment). The trainee will need to provide a suitable range of soft lenses for this part of the assessment.
11.10 Short break.
11.15 Assessment of overarching Stage 2 elements of competence using the direct observation evidence already obtained and through reviewing a sample of the records listed on the Stage 2 visit patient episode list – using case-based discussion.
around the sampled records. For this part of the assessment the assessor will also always use field plots and images. The assessor will always need to see at least two different forms of competent evidence to sign off an overarching element of competence.

Verification of refractions and dispensing totals. The trainee will need to provide your completed logbook for this.

13.00 – 13.15 Assessment ends.

**Routine eye examination**

There are 45 minutes in total for the assessment of this section

**Process**

The assessor will examine the patient first which should take about 15 minutes. Following this they will explain to the trainee the timings for this part of the assessment, which will last 45 minutes.

The trainee will not be allowed to see the patient’s prescription or current spectacles but should assume that they are both lost.

The trainee should carry out their normal routine eye examination of the patient (excluding tonometry and fields) using appropriate instrumentation for the patient. This could include slit lamp or refractor head if they wish. The use of autorefractor results or pre-prepared sheets will not be permitted.

Trainees must use the College recording sheet provided by the assessor to record their results. This will be retained by the assessor following the assessment. A copy of this recording sheet is in the following pages.

The assessor will ensure that the trainee understands what to do and that they know how long this part of the assessment will last. If the trainee requests it, the assessor will provide time checks and give warnings about the time left at the points they have agreed.

The assessor will:

- **not** make the patient’s current spectacles, prescription or visual acuity available to the trainee
- **not** ask questions for clarification at this stage in the assessment. If clarification is required then it will, instead, be tied in with the assessment of over-arching competencies
- intervene if they think the trainee is going to harm the patient. The trainee will not be allowed to try a procedure repeatedly to the detriment of the patient.

**Making judgments**

If the assessor decides that the trainee should fail this section, then their overall judgment will be based on one or more of the following reasons:

- failed to detect, recognise or act upon significant symptoms, history or clinical signs
- compromised the safety of the patient by action, inadequate record keeping and/or management
• showed an important deficiency in technique, which could lead to significantly inappropriate management.

**Soft contact lens fitting and aftercare**

This entire section will take 40 minutes in total. The practice or hospital department will be expected to provide the contact lenses used in this part of the assessment and so it is essential that the trainee has access, in the room, to a range of suitable lenses for soft lens fitting. The assessor will also need access to a keratometer and slit-lamp to assess the patient before the assessment starts.

**Process**
The assessor will examine the patient first and complete the required patient data in the boxes at the top of the Contact Lens Fitting Record the trainee will use. The assessor will ensure that the trainee understands what to do and that they know how long this part of the assessment will last. If the trainee requests this, the assessor will provide them with time checks and give warnings about the time left at the points they have agreed. The trainee will be instructed to start with the fitting section.

**Fitting section**

This section of the assessment will take around 20 minutes. The assessor will provide the Contact Lens Fitting Record containing the patient’s keratometry readings, spectacle prescription and visual acuities for the eye to be fitted. Trainees are to assume that all other slit lamp findings are normal and the patient is suitable to be fitted with contact lenses. The assessor will also provide a fitting scenario for the patient, eg “This patient is a first time wearer who wants to wear the lenses on a social wear basis for up to six hours a day around three times weekly”.

The assessor will instruct the trainee that the patient is suitable to be fitted as all preliminary corneal checks have been completed. The trainee should proceed in their usual manner to make an appropriate first lens selection and then to fit one eye of the patient (the assessor will specify which eye) with a soft contact lens. They should then assess the fit and suggest any modifications based on their fit observations.

All fitting information, together with final lens specification, should be recorded on the Contact Lens Fitting Record provided by the assessor for their results. This will be retained by the assessor.

The trainee must then remove the soft lens following fitting and check the cornea of the patient

**Aftercare section**

This section of the assessment will take around 20 minutes. Trainees are to assume that the patient is a new patient who has booked an aftercare appointment. They should carry out an aftercare examination and record their findings on the form provided. They will be expected to examine the right OR the left eye (the assessor will specify which. This will NOT be the eye they have already fitted). The trainee must carry out a tear assessment as part of this aftercare assessment. The trainee must complete the patient record card provided by the assessor.
The assessor will:

- **not** allow the trainee to use or refer to any other record card with pre-prepared comments
- **not** ask questions for clarification at this stage in the assessment. If clarification is required then it will, instead, be tied in with the assessment of over-arching competencies
- intervene if they think the trainee is going to harm the patient. Trainees will not be allowed to try a procedure repeatedly to the detriment of the patient
- check the corneal integrity of the patient once the trainee has finished this part of the assessment.

**Making Judgments**

If the assessor decides that the trainee should fail this section, then their overall judgment will be based on one or more of the following reasons:

- failed to detect, recognise or act upon significant symptoms, history or clinical signs
- compromised the safety of the patient by action, inadequate record keeping and/or management
- showed an important deficiency in technique which could lead to significantly inappropriate management.

**Assessment of over-arching elements of competence**

The assessor will always sample at least two different forms of evidence for each element of competence. For each of the elements certain forms are evidence are compulsory and must be sampled. These are listed in the table below. In assessing over-arching competencies the assessor will:

- only sample records which are included on the Stage 2 patient episode list
- sample 14 records in total
- always ensure that the compulsory evidence is assessed in making their assessment decisions.

It is therefore essential that both the **trainee and supervisor** check that any records included in the trainee’s Stage 2 patient episode list are:

- complete records
- the most recent examples of complete records for each of the categories listed
- it is acceptable for some records to be used as evidence for more than one element of competence, but the range supplied for the Stage 2 assessor to sample should demonstrate a broad range of different patients you have seen and **not number less than 35 different patient records**.

**Feedback**

Stage 2 of the work-based assessment is different from Stage 1 and the trainee will not receive feedback on the day. Please do not ask the assessor for feedback.
Results
To progress to the Final assessment (OSCE), the trainee will need to pass all parts of the Stage 2 assessment. We will email the results to the trainee and their supervisor within one week of the visit.

If the trainee has been successful, they should complete the online application form for the Final assessment (OSCE). The link for this application form is included in the results email.

If the trainee does not pass all parts of the Stage 2 assessment, they will be told why they failed and which sections that they have to resit. The assessor comments will be included in the report they receive by email. The trainee may also request their mark sheets which we will send to them on payment of a fee, once we have received them from the Stage 2 assessor. Trainees should allow at least two weeks to receive the mark sheets. Fees information can be found on college-optometrists.org/qualifying-fees.

We will email the trainee’s resit date to them at least two weeks before their resit. We will arrange the resit within six weeks of the previous attempt. If the trainee would prefer a longer interval before the resit to allow them more preparation time, they should email lee.rolls@college-optometrists.org within 24 hours of receiving their results email.

In case of a fail – understanding your results

Fail – soft contact lens fitting and aftercare
If the trainee fails the soft contact lens fitting and aftercare, they will have to resit this section (we will provide the contact lens patient). The related overarching Stage 2 elements of competence will also not be signed off (1.1, 1.2, 2.1, 2.2, 3.1, 5.1, 5.2 and 5.3) as competent direct observation is part of the evidence required for sign off of this section of the Stage 2 assessment.

Fail – routine eye examination
If the trainee fails the routine eye examination section, they will resit routine eye examination (we will provide the routine eye examination patient). The related overarching Stage 2 elements of competence will also not be signed off (1.1, 1.2, 2.1, 2.2, 3.1, 7.1 and 8.1) as competent direct observation is part of the evidence required for sign off of this section of the Stage 2 assessment.

Fail – all sections
If the trainee fails the whole of Stage 2 they will resit soft contact lens fitting and aftercare, routine eye examination and all overarching Stage 2 elements of competence (we will provide both the contact lens and routine eye examination patients).

Fail – overarching elements but pass of all direct observation sections
If the trainee fails any overarching Stage 2 element of competence they will resit all overarching Stage 2 elements of competence (no patients required). As all the direct observation would have been deemed competent by the Stage 2 assessor, the resit will involve only assessment of secondary evidence:

- case-based discussion about a sample of records from the Stage 2 patient episode list.
- field plots and images provided by the assessor.
Key information from this section:

- Trainees will have a second assessor at Stage 2.
- Trainees will be required to undertake a routine eye examination and a soft contact lens fitting and aftercare on a simulated patient provided by the College, as well as have case-based discussions related to the overarching Stage 2 elements of competence.
- It is important that trainees maintain competence in all eight units of competency.
- The assessor will not give the trainee feedback. The results will be sent from the College by email.
Scheme for Registration – Visit 2 assessment plan

Trainee name: ________________________  Assessor name: ________________________

| Time and location for assessment: |
| Date will be advised at least 2-6 weeks before by College via email. |
| **Start time** will usually be 9.15am 10.30am or 1.30pm for a full Stage 2 assessment |
| **Location** will always be trainee’s main practice/clinic address |

**The following areas will be assessed:**

- routine eye examination
- fitting and aftercare of soft contact lenses
- all over-arching elements of competence covering the eight units (core subject areas).

Total time for Stage 2 visit will be a minimum of three and a half and a maximum of four hours.

| 9.15 | Assessor will spend 15 mins checking the patient provided by the College for the routine eye examination. |
| 9.30 | Check trainee photographic ID followed by the assessment of **routine eye examination** on a presbyopic patient (45 mins allowed).
|       | For this assessment the trainee can use any appropriate method of ophthalmoscopy, (either direct or indirect) and trial frame or refractor head – but the trainee will always be expected to perform retinoscopy. The use of autorefractor results will not be permitted. |
| 10.15 | Trainee takes a 15 mins break while assessor checks the patient provided by the College for the contact lens assessment. |
| 10.30 | The assessment of **soft contact lens fitting and aftercare** (40 mins allowed for this assessment).
|       | A suitable range of lenses must be provided by the practice for this assessment. |
| 11.10 | Short break. |
| 11.15 | **Assessment of over-arching elements of competence** through a review of Stage 2 visit patient episode records – case based discussion around a sample of these records.
|       | For this part of the assessment the assessor will always use field plots and images.
|       | The assessor will always need to see at least two different forms of competent evidence to sign off each element of competence. |
|       | **Verification of refractions and dispensing totals** using completed trainee logbook. |
| 12.45–13.15 | Assessment ends. |

Feedback will **not** be provided on the day as in Stage 1. The outcome of the assessment will be sent by email to both trainee and the supervisor once the assessor has entered the information online, at the latest within one week of the Stage 2 visit.

**Evidence to be produced by trainee:**

- **Fully completed** Stage 2 patient episode list with a minimum range of 35 different patients represented in the 41 episodes listed.
- All the records listed on this patient episode list **must** be the most recent competent examples of patients examined in each of the categories. For the assessment of the Stage 2 elements the assessor will **only** sample from the Stage 2 patient episode list of records.
  - The records must be original or if they are copies from another practice, they should signed by your supervisor to indicate that they are exact copies of the original record.
  - Patient consent must be indicated on all records used (including dispensing records).
- **Completed logbook** – to verify that the refractions and dispensing numbers, required by the GOC, have been completed.
### Scheme for Registration Assessment framework – Stage 2 visit

**Supervisor training review scores and monthly summary**

**Evidence types**
- DO = Direct observation by assessor of patient episode
- Log = Logbook signed by supervisor, ophthalmologist or hospital optometrist
- CS = Case scenarios provided by assessor
- FP = Field plots
- PI = Prescription interpretation
- RP = Role Play
- PR = Examples of patient records
- WT = Witness testimony
- Q = Questioning by assessor
- I = Images provided by assessor
- RL = Referral letter

<table>
<thead>
<tr>
<th>Overarching Stage 2 element of competence</th>
<th>Compulsory evidence</th>
<th>Other acceptable forms of evidence</th>
<th>Indicators</th>
<th>Patient episode</th>
</tr>
</thead>
</table>
| 1.1 The ability to communicate effectively with a diverse group of patients with a range of optometric conditions and needs. | DO  
PR | Log | This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply. | Any appropriate records from the Stage 2 patient episode list. |
| 1.2 The ability to impart information in a manner which is appropriate to the recipient. | DO  
PR | Log  
Q | | |
| 2.1 The ability to manage patients in a safe, appropriate and confidential environment. | DO  
PR | CS  
Q | This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply. | Any appropriate records sampled from the Stage 2 patient episode list. |
| 2.2 The ability to comply with the legal and professional issues relating to professional practice. | DO  
PR | CS  
Q | | |
| 3.1 The ability to use techniques in ocular examination and to understand the implications of the findings in terms of subsequent examination techniques. | DO  
PR  
FP | Q | This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply. | Any appropriate records in Group 3 of the Stage 2 patient episode list. |
### Section Three – Stage 2 assessment

<table>
<thead>
<tr>
<th>4.1 The ability to interpret and dispense a prescription using appropriate lenses and facial and frame measurements.</th>
<th>PR</th>
<th>CS Q PI Log</th>
<th>This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply.</th>
<th>Any appropriate records in Group 4 of the Stage 2 patient episode list.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2 The ability to advise on and to dispense low vision aids.</td>
<td>PR</td>
<td>CS Q WT Log</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 The ability to select and fit the most appropriate lens for the planned use and clinical needs of the patient.</td>
<td>DO PR</td>
<td>I Q</td>
<td>This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply.</td>
<td>Any appropriate records in Group 5 of the Stage 2 patient episode list.</td>
</tr>
<tr>
<td>5.2 The ability to assess the progress in wear of a contact lens patient and to investigate, identify and manage and aftercare issues.</td>
<td>DO PR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 The ability to select and fit the most appropriate complex lens for the planned use and clinical needs of the patient.</td>
<td>PR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 The ability to manage patients presenting with eye disease including sight-threatening eye disease.</td>
<td>PR I</td>
<td>CS Log RL Q</td>
<td>This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply.</td>
<td>Any appropriate records in Group 6 of the Stage 2 patient episode list.</td>
</tr>
<tr>
<td>7.1 The ability to make appropriate prescribing and management decisions based on the refractive and ocular motor status.</td>
<td>DO PR</td>
<td>Q Log CS</td>
<td>This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply.</td>
<td>Any appropriate records in Group 7 of the Stage 2 patient episode list.</td>
</tr>
<tr>
<td>8.1 The ability to assess and make appropriate prescribing and management decisions based on the ocular motor status of the patient.</td>
<td>CS PR</td>
<td>Q I</td>
<td>This will depend on which records the assessor samples. The Stage 1 indicators for the particular record sampled will apply.</td>
<td>Any appropriate records in Group 8 of the Stage 2 patient episode list.</td>
</tr>
</tbody>
</table>
## Scheme for Registration – Patient episode record – Stage 2 visit

<table>
<thead>
<tr>
<th>Unit of competence</th>
<th>Patient episode</th>
<th>Patient reference</th>
<th>Date seen</th>
<th>Unit of competence evidenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units 1 and 2</td>
<td>Patient presenting with headache or blurred vision</td>
<td></td>
<td></td>
<td>1.1, 1.2, 2.1, 2.2</td>
</tr>
<tr>
<td>Communication and</td>
<td>Patient whose expectations cannot be met</td>
<td></td>
<td></td>
<td>1.1, 1.2, 2.1, 2.2</td>
</tr>
<tr>
<td>professional</td>
<td>Patient with communication difficulty or who is confused or might mislead</td>
<td></td>
<td></td>
<td>1.1, 1.2, 2.1, 2.2</td>
</tr>
<tr>
<td>conduct</td>
<td>Patient where communication with carer was involved</td>
<td></td>
<td></td>
<td>1.1, 1.2, 2.1, 2.2</td>
</tr>
<tr>
<td>Unit 3</td>
<td>Patient with anterior eye disorder, e.g. blepharitis, evaporative or aqueous</td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>deficient dry eye, allergic eye problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient where mydriasis was indicated and carried out</td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Patient where BIO ophthalmoscopy with slit lamp was indicated and used</td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Patient with a visual field defect</td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Patient where a contact applanation tonometer was used</td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td>Unit 4</td>
<td>One adult vocational or lifestyle dispensing</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td>Optical appliances</td>
<td>One paediatric dispensing (four years or under)</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>Patient dispensed with multifocal spectacles</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
</tbody>
</table>
### Unit of competence: Optical appliances

<table>
<thead>
<tr>
<th>Patient episode</th>
<th>Patient reference</th>
<th>Date seen</th>
<th>Unit of competence evidenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient requiring spectacles to correct a refractive error &gt;10 dioptres</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td>Patient with visual impairment where a low vision aid was required and dispensed (A witness testimony of an observation is not acceptable)</td>
<td></td>
<td></td>
<td>4.2</td>
</tr>
<tr>
<td>Patient dispensed with spectacles to correct significant anisometropia (&gt;2.00DS/DC)</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td>Patient where a suitable eye protector has been advised or dispensed</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td>Patient with non-tolerance to spectacles where appropriate investigation and action has been taken</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
</tbody>
</table>

### Unit 5: Contact lenses

<table>
<thead>
<tr>
<th>Patient episode</th>
<th>Patient reference</th>
<th>Date seen</th>
<th>Unit of competence evidenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>One soft lens aftercare patient with a CL related complication requiring management</td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>Two soft lens fittings covering different materials and modalities of wear</td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>One RGP contact lens aftercare patient</td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>One RGP contact lens fitting patient</td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>Patient with astigmatism greater than 1.50DC fitted with toric CLs</td>
<td></td>
<td></td>
<td>5.3</td>
</tr>
<tr>
<td>Presbyopic patient fitted with a suitable CL correction</td>
<td></td>
<td></td>
<td>5.3</td>
</tr>
</tbody>
</table>

### Unit 6: Ocular disease

<table>
<thead>
<tr>
<th>Patient episode</th>
<th>Patient reference</th>
<th>Date seen</th>
<th>Unit of competence evidenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient presenting with red eye/s</td>
<td></td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td>Patient presenting with symptoms suggestive of retinal detachment</td>
<td></td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td>Unit of competence</td>
<td>Patient episode</td>
<td>Patient reference</td>
<td>Date seen</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Unit 6 continued</td>
<td>Patient with diabetic eye disease</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td>Ocular disease</td>
<td>Patient with AMD</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Patient requiring management for suspect glaucoma (not solely ocular hypertension)</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Patient with signs or symptoms of neurological origin</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Patient with adverse ocular reaction to topical or systemic medication</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td>Unit 7</td>
<td>One refraction of a hyperopic pre-presbyope</td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td>Assessment of visual function</td>
<td>One appropriate cycloplegic examination of a child</td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>One refraction of a child aged four years or under</td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>Patient with significant anisometropia</td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>Patient with best corrected acuity of less than 6/18</td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td>Unit 8</td>
<td>Patient with amblyopia</td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td>Assessment and management of binocular vision</td>
<td>Adult patient with symptomatic heterophoria</td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>A child (seven years or under) with a BV anomaly</td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>A child (seven years or under) at risk of developing a BV anomaly</td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>Patient with incomitancy seen in practice or HES</td>
<td></td>
<td>8.1</td>
</tr>
</tbody>
</table>

I confirm that I have completed all the patient episodes used as evidence in the Stage 2 episodes table above and they number no less than 35 different patients

Name of trainee ___________________________ Signature of trainee ___________________________

Date ___________________________
Section Three – Stage 2 assessment
Scheme for Registration – Stage 2 training review

Indicate in the table a score from the key below for the GOC Elements of Competence listed. (NB: Please ensure scores are as accurate as possible as this mark will be used to inform assessors of weaker areas to be addressed).

**Key:**
- **Level 0** – trainee has had no experience in this area
- **Level 1** – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor
- **Level 2** – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks without detailed guidance
- **Level 3** – trainee demonstrates safe understanding and ability in this area of practice occasionally checking with others if uncertain

<table>
<thead>
<tr>
<th>Unit of competence 1 – Communication</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The ability to communicate effectively with a diverse group of patients with a range of optometric conditions and needs</td>
<td></td>
</tr>
<tr>
<td>1.2 The ability to impart information in a manner which is appropriate to the recipient</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit of competence 2 – Professional conduct</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The ability to manage patients in a safe, appropriate and confidential environment</td>
<td></td>
</tr>
<tr>
<td>2.2 The ability to comply with legal, professional and ethical issues relating to practice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit of competence 3 – Methods of ocular examination</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The ability to use techniques in ocular examination and to understand the implications of the findings in terms of subsequent examination techniques</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit of competence 4 – Optical appliances</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The ability to interpret and dispense a prescription using appropriate lenses and facial and frame measurements</td>
<td></td>
</tr>
<tr>
<td>4.2 The ability to advise on and to dispense low vision aids</td>
<td></td>
</tr>
</tbody>
</table>
### Unit of competence 5 – Contact lenses

<table>
<thead>
<tr>
<th>5.1</th>
<th>The ability to select and fit the most appropriate lens for the planned use and clinical needs of the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2</td>
<td>The ability to assess the progress in wear of a contact lens patient and to investigate, identify and manage any aftercare issues</td>
</tr>
<tr>
<td>5.2</td>
<td>The ability to select and fit the most appropriate complex lens for the planned use and clinical needs of the patient</td>
</tr>
</tbody>
</table>

### Unit of competence 6 – Ocular disease

| 6.1 | The ability to manage patients presenting with eye disease, including sight threatening eye disease |

### Unit of competence 7 – Assessment of visual function

| 7.1 | The ability to make appropriate prescribing and management decisions based on the refractive and ocular motor status |

### Unit of competence 8 – Assessment and management of binocular vision

| 8.1 | The ability to assess and make appropriate prescribing and management decisions based on the ocular motor status of the patient |

---

Supervisor signature: 
Date: 

Trainee signature: 
Date:
<table>
<thead>
<tr>
<th>Symptoms and history</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Ocular examination</th>
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<table>
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<tr>
<th>Retinoscopy</th>
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<tr>
<td></td>
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<tr>
<td>Subjective and associated findings</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Additional tests</td>
</tr>
<tr>
<td>Action and advice to patient</td>
</tr>
<tr>
<td>Final prescription given</td>
</tr>
</tbody>
</table>
## Scheme for Registration Stage 2 assessment – Contact lens fitting record

<table>
<thead>
<tr>
<th>Keratometry</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right OR Left</td>
<td>@</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Refraction</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Right OR Left</td>
<td>/ x 6/</td>
</tr>
</tbody>
</table>

- **Patient’s initials:** ______________  
- **Age:** ____________  
- **Date of last examination:** ______________

### Pre-fitting measurements

### Soft fitting

### Specification for soft lenses

### Additional comments
Scheme for Registration Stage 2 assessment – Contact lens aftercare record

Patient’s initials: ____________  Age: ____________
Date of last examination: ____________  Occupation: ____________

Symptoms and history

Evaluation of lens fit
Slit lamp examination

Action and advice to patient
Section Four – Final Assessment

The Final assessment takes the form of an objective structured clinical examination (OSCE) as described below.

How to apply
When the Stage 2 assessor has informed us that the trainee is ready to sit the Final Assessment, the College will send the trainee an email notifying them that they have successfully completed Stage 2 of the work-based assessment with a link to the online application form. The closing date for applications is normally six weeks before the Final Assessment. Trainees will not be permitted to sit the Final Assessment if they have not submitted the appropriate application and/or they have not settled any outstanding enrolment or resit fees on their account.

Approximately two weeks after the closing date, trainees will receive an email with their Final Assessment timetable and instructions.

Photographic ID policy
Trainees will be required to provide a valid driving licence or passport number when completing the OSCE application form. They must also bring the same passport or driving licence, to the examination. No other photographic ID will be accepted and candidates without acceptable ID will not be able to sit the examination.

National Performers List or Health Board
Trainees are advised to apply to be included in the appropriate National Performers List or Health Board while applying for the OSCE. This will save them time once they have qualified as they must also apply for an enhanced report from the Disclosure and Barring Service (DBS), which can take eight to 12 weeks. For further information refer to the DBS guidelines on gov.uk. Applicants will also be required to complete on-line Level 2 Adult and Child Safeguarding Training, available free of charge on college-optometrists.org/safeguarding. On qualification, trainees should ensure they have downloaded their certificate before their access is withdrawn.

We advise trainees to apply in advance for registration to the National Performers List or Health Board of the country where they will be working after qualification. The lists in Northern Ireland, Scotland and Wales are operated locally, so trainees should apply to your local Health Board. This can be done up to three months ahead of qualifying, following the guidance above for Scotland and Wales. However, in Northern Ireland, the trainee needs to apply once qualified. If the trainee already knows where they will be working on qualification they can apply to a new area. Trainees in England should apply at performer.england.nhs.uk. The trainee will need to provide details of two colleagues who can provide a clinical reference – one of them can be the supervisor. DBS checks will also need to be arranged.
Cancelling an OSCE place

If a trainee wishes to cancel their place, they should contact the Examinations Coordinator on education.help@college-optometrists.org. We will endeavour to transfer their entry to the next sitting of the Final Assessment.

If a trainee wishes to defer their OSCE sitting, and there are no mitigating circumstances, such as medical reasons, they must cancel their OSCE place at least three working days before the examination, or they will have to pay a resit fee for their next attempt. Trainees with mitigating circumstances, will not have to pay a resit fee as long as evidence is provided.

If a trainee is unable to sit the Final Assessment so that the time allowed for completion of the Scheme for Registration is exceeded, they may, at the discretion of the College, be permitted to sit the Final Assessment at the next sitting with available places.

Fees

The trainee’s first attempt at the Final Assessment is included in their enrolment fee. Fees for subsequent resit attempts are set out on college-optometrists.org/qualifying-fees.

Key information from this section:

- trainees must apply for the Final Assessment by completing the application form – on college-optometrists.org/sfr
- trainees should think about applying as early as possible to be on the National Performers List
- if a trainee has a disability we may be able to make reasonable adjustments to the Final Assessment
- go to college-optometrists.org/qualifying-fees for current resit fees and to make a payment.
Objective structured clinical examination (OSCE)

Purpose
The purpose of the Final Assessment is to check a sample of the knowledge and skills the trainee will need to be registered to practise independently.

Instructions for candidates
The OSCE takes place four times a year in January, March, July and September. The trainee should read the information below before they come to the examination as it will help them understand the format.

Format
The OSCE consists of 16 short tasks, known as stations. Two of these stations are pilot stations that we are trialling for use in future examinations and will not be taken into account when calculating results. Trainees and examiners are not made aware which two stations are pilot stations. Every station lasts for five minutes and done in turn. Trainees will also have one minute outside each station to read the instructions. There is a five minute rest station in the exam so candidates have a chance to catch your breath.

During the OSCE trainees may be tested on any of the 75 GOC elements of competence covered at Stage 1. The examiners are looking for evidence that trainees understand the theory behind each element of competence and can apply it in a practical clinical setting.

The OSCE is very different in format from the Stage 1 and Stage 2 assessments but it covers the same elements of competence. All OSCE station content is drawn from and linked to the elements of competence from the work-based assessment so it may be useful to work through these systematically to ensure they are competent across the entire assessment framework. This can help identify weaknesses in any elements which should help focus revision. It may be a good idea to try and imagine different OSCE stations for each element of competence and think how you would approach each one.

Some candidates find the change in assessment style tricky. The examiner’s role is to observe and they will not intervene except in very limited circumstances. To prepare for the format of the examination, we recommend that trainees practise performing tasks linked to the elements of competence in five minute windows.

Content
The OSCE is designed to assess a range of skills, drawn from the GOC’s elements of competence. In the examination the trainee will be tested several times on the following skills:

- history taking, including diagnosis
- communication
- data interpretation
- clinical examination and practical skills.

Patient conditions will be drawn from the experience requirements outlined in the GOC elements of competence and have been categorised as follows:

- neurological/developmental
- neurological/acquired
- refractive
- pathological anterior segment
• pathological posterior segment
• psychological.

Details of the types of scenarios the trainee might come across are below. We know that these tasks may take longer than five minutes in real life but the stations have been designed so that the trainee can demonstrate their competence in the clinical scenario in five minutes. The list below includes examples to guide the trainee on the types of scenarios they might encounter. Trainees should remember, however, that they could be assessed on any area from the GOC units of competence – the list is not exhaustive.

Clinical examination and practical skills
Trainees will be required to demonstrate the ability to undertake a clinical examination or perform a practical procedure. This may be conducted on an anatomical model if the procedure is invasive or could harm a patient if undertaken repeatedly.

Every exam will include a station which requires the trainee to demonstrate their ability to perform indirect ophthalmoscopy. For this station, trainees will be asked to identify a set of symbols on the back of a model eye. Other stations may include, but are not limited to:

• direct ophthalmoscopy
• cover test
• focimetry
• keratometry
• visual acuity.

The OSCE will assess the trainee’s ability in a range of clinical decision-making and management situations. The patients are from across the age range and have a variety of conditions. No young children will be present – trainees will interact with the actor playing the child’s parent or guardian.

Communication
Trainees will be observed interacting with the patient or a patient’s relative (who will be played by an actor) or a fellow health professional. They may be required to:

• explain how a condition will be treated
• explain a diagnosis
• explain a prescription
• request a referral
• decide on appropriate management with a patient
• give advice on the most appropriate optical appliances
• break bad news.

Although communication skills are the main skill being tested in some stations, trainees will be marked on their communication skills in all stations involving a patient. The types of issues the examiners will be assessing are:

1. Relating to the patient:
• introduces self to patient
• is polite, considerate and respectful
• acknowledges the patient’s concerns and is empathetic, if applicable.
2. Explaining and advising:
   - gives correct information in a way the patient can understand.
   - makes the patient aware of the appropriate options available, if applicable
   - involves the patient fully in decisions about care, if applicable
   - summarises and checks the patient has understood
   - reassures appropriately.

3. Listening and questioning:
   - Uses appropriate questioning techniques (open/closed/probing)
   - Listens to and explores the patient’s response(s)
   - Checks they have understood the patient’s symptoms and concerns

4. Fluency of performance:
   - logical
   - confident
   - professional.

Communication stations are designed to test both what trainees say and how they say it. Therefore, communicating incorrect information well or communicating correct information poorly will both be penalised. On the next pages are performance indicators relating specifically to communication objectives to give trainees an idea of what examiners are looking for in these stations:
### Communication performance indicators:

<table>
<thead>
<tr>
<th></th>
<th>Communication indicators demonstrating competence</th>
<th>Communication indicators not demonstrating competence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relating to the patient/ Fluency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trainee acknowledges any patient concerns and is empathetic and but not patronising.</td>
<td>The trainee shows little or no empathy towards the patient and/or is patronising.</td>
<td></td>
</tr>
<tr>
<td>The trainee reassures the patient where appropriate.</td>
<td>The trainee does not reassure the patient or is overly reassuring when this is not appropriate.</td>
<td></td>
</tr>
<tr>
<td>The trainee is confident, fluent and logical.</td>
<td>The trainee is unconfident and/or very hesitant and/or illogical to the point where the patient loses confidence in the practitioner.</td>
<td></td>
</tr>
<tr>
<td>The trainee displays positive body language and maintains good eye contact.</td>
<td>The trainee displays negative body language.</td>
<td></td>
</tr>
<tr>
<td>The trainee is professional.</td>
<td>The trainee is unprofessional/overly casual.</td>
<td></td>
</tr>
<tr>
<td>The trainee is polite.</td>
<td>The trainee interrupts the patient.</td>
<td></td>
</tr>
<tr>
<td>The trainee introduces themselves.</td>
<td>The trainee frightens and/or confuses the patient unnecessarily.</td>
<td></td>
</tr>
<tr>
<td><strong>Explaining and advising</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trainee makes the patient aware of all options available to them, if necessary.</td>
<td>The trainee does not involve the patient in making decisions about their care.</td>
<td></td>
</tr>
<tr>
<td>The trainee speaks clearly.</td>
<td>The trainee is unclear.</td>
<td></td>
</tr>
<tr>
<td>The trainee uses language the patient can understand.</td>
<td>The trainee uses jargon so the patient cannot understand the information.</td>
<td></td>
</tr>
<tr>
<td>The trainee communicates correct information.</td>
<td>The trainee communicates incorrect/unsafe information.</td>
<td></td>
</tr>
<tr>
<td>The trainee checks the patient has understood the information provided and clarifies the next steps the patient should take. The trainee summarises information for the patient to help them understand.</td>
<td>The trainee leaves the patient confused and unsure of the next steps.</td>
<td></td>
</tr>
<tr>
<td>The trainee is able to change their language and communication style to meet the needs of the patient.</td>
<td>The trainee uses inappropriate language and communication style for the patient.</td>
<td></td>
</tr>
<tr>
<td><strong>Listening and questioning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trainee asks relevant questions.</td>
<td>The trainee asks lots of irrelevant questions.</td>
<td></td>
</tr>
<tr>
<td>The trainee questions the patient thoroughly using a range of different question types to discount other possible diagnoses.</td>
<td>The trainee asks too narrow a range of questions to effectively discount other diagnoses.</td>
<td></td>
</tr>
<tr>
<td>The trainee is adaptable in their history taking and listens to the patient’s responses.</td>
<td>The trainee does not listen to the patient or adapt their subsequent questions based on the previous answers of the patient.</td>
<td></td>
</tr>
</tbody>
</table>
Data interpretation
Trainees will be required to interpret a variety of clinical data – these may include visual field plots, charts, results of clinical examinations and clinical signs (through photographs or videos). They may have to discuss their conclusions and diagnoses with a fellow health professional or with the patient or patient’s parent, played by an actor. Trainees may also be given a set of data and asked to answer a series of questions on the data to an examiner. If this is the case, they will be given the questions before they enter the station on the candidate instructions.

History taking including diagnosis
Trainees should take an accurate and relevant history from the patient or patient’s relative, who will be played by an actor. They may be required to give a diagnosis, either to the patient or examiner, and explain their reasoning or suggest further tests that they would undertake. Presentations may include, but are not limited to:
- blurred vision
- reduced vision
- sudden visual loss
- diplopia
- red eye
- headache
- systemic disease with ocular manifestations.

Trainees should make sure they perform a thorough history and symptoms, even if they have an idea early on of what the diagnosis may be. Trainees are advised not to just reel off a memorised list of questions but tailor the questions appropriately to the responses offered by the patient. Using a one size fits all approach may disadvantage trainees and they should make the history and symptoms are thorough but bespoke to each patient based on their responses. Sometimes, it is not simply enough to just get the answer; trainees need to make sure they have explored the patient responses to get the full story behind the diagnosis to effectively exclude other differentials.

Because the criteria for referrals are different in different parts of the country, the following definitions are used for the purposes of the examination. These definitions will be placed in each station. Trainees should use these terms during the exam as the examiner may not be familiar with the referral criteria in your area.

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Same or next day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Within one week</td>
</tr>
<tr>
<td>Routine</td>
<td>In due course</td>
</tr>
</tbody>
</table>

For further guidance on referrals, please see the College’s Guidance for Professional Practice.

If asked to write a written referral in an OSCE station, trainees will be provided with a template to complete. A copy of this template is below:
Referral/Notification form

Patient name:  
Address:  
Age:  
GP:  

Significant findings

Provisional diagnosis

Refer/Notification to: (choose GP and/or ophthalmology and specify the degree of urgency for each referral)

- [ ] GP
  - Urgency:
    - [ ] Emergency (same or next day)
    - [ ] Urgent (within one week)
    - [ ] Routine (in due course)
- [ ] Ophthalmology
  - Urgency:
    - [ ] Emergency (same or next day)
    - [ ] Urgent (within one week)
    - [ ] Routine (in due course)

Requested course of action (if appropriate)
The OSCE stations

Each station has four components (or three if there is no patient present):

- examiner instructions
- candidate instructions
- actor instructions
- equipment list.

Trainees will only see the candidate instructions.

A sample OSCE station, with all components including a completed mark sheet, can be found after this section. (Please note that we do not print details of the objectives on the mark sheet.) There is a range of support available on the website, including a video of what to expect on the day, on college-optometrists.org/sfr.

Marking scheme

Each station has a construct which is the assessment objective of the station. This construct is broken down into a series of objectives, which trainees will not see, but which are the areas that each trainee would be expected to cover given the task set. Each objective carries a weighting (the percentage the objective is worth), which is unknown to the examiner to avoid bias. The weightings add up to 100%. Trainees will be graded from 'Excellent' to 'Very poor/Not attempted' for their performance against each objective. A trainee's performance in each objective is combined with the objective's weighting to calculate their final station score. Examiners also give a global score of the trainee's performance with respect to the construct. This is used for calculating the pass mark.

The passing score for each station and for the examination is set using the Borderline Regression Method - an internationally recognised method of standard setting that ensures that exams are of a consistent standard over time. Trainees must also pass a set number of stations to ensure that they are competent in a broad range of tasks.

How to prepare

The Final Assessment assesses a sample of the clinical knowledge and skills the trainee has developed during the pre-registration period. They will have already demonstrated in the workplace that they can apply their clinical knowledge and perform the skills underpinning the GOC elements of competence. In the Final assessment, they must show the examiners that they can perform a sample of tasks competently which cover a range of the elements of competence assessed in the workplace. The Final Assessment is designed to check the trainee has maintained competence across the assessment framework.

The trainee will be expected to undertake any procedures confidently and competently, so they should ensure they have practised so that their technique is correct and they can detect and know how to act upon significant signs.
Key information from this section:

- the OSCE consists of 16 clinical tasks known as ‘stations’. Each task will last five minutes and the trainee will do them one after the other. Two of the stations will be pilot stations. This means we are trying them out to see if we can use them in future examinations. Trainees will not know which stations are the pilot stations and they will not be marked on them. There will also be one rest station.

- the trainee will be tested on skills and presentations from across the GOC’s (Stage 2) elements of competence to ensure they have maintained competence across the assessment framework.
Sample OSCE station

Examiner instructions

A. Construct

The candidate demonstrates the ability to interpret the record card, reaches a reasoned provisional diagnosis of a posterior vitreous detachment (PVD), and explains the diagnosis and management to the patient.

B. Station specific instructions

N/A

C. Objectives

Content

Explanation of clinical findings

- No evidence of retinal tear or vitreous floaters
- All other results normal, ie equal VAs, equal IOPs, full visual fields condition
- Gives reasoned provisional diagnosis of a PVD

Management

- No referral necessary
- Explains all possible symptoms of retinal detachment or tear, and the need for immediate action should any reoccur

Communication

Relating to the patient

- Introduces self to patient
- Is polite, considerate and respectful
- Acknowledges the patient’s concerns and is empathetic, if applicable

Explaining and advising

- Gives correct information in a way the patient can understand
- Makes the patient aware of the appropriate options available, if applicable
- Involves the patient fully in decisions about care, if applicable
- Summarises and checks the patient has understood
- Reassures appropriately

Fluency of performance

- Logical
- Confident
- Professional
Candidate instructions

Joseph Rawlins, a 53-year-old man, is a regular patient at your practice. He is here today because three days ago he experienced a sudden onset of flashing lights in the right eye. They had ceased by the following day.

He hasn't experienced anything like this before and has no other symptoms.

His history is unremarkable. His general health is good. He does not suffer from headaches and has not suffered any trauma. There is no family history of eye problems.

You have conducted a full ocular examination. Read the record card showing your results.

Explain to the patient what you have found, what might be wrong with him and what you recommend.

You have five minutes for this station.
Simulated patient instructions

Background

You are Joseph Rawlins, a 53-year-old sales director for a large company. You visit your optometrist regularly to have your eyes examined and your contact lenses checked. You have daily progressive soft lenses and have never had any problems with them or your sight.

Presentation

Whilst driving to work three days ago you noticed flashing lights from your right eye. These continued on and off for most of the day and stopped by the following day. You have never had these types of symptoms before. You decided to make an appointment with your optometrist and have come in today. You have not had any recent accidents or any injuries. You don’t have any other symptoms such as veiling or blurred vision. You cannot recall seeing any black spots or cobweb type features floating in front of either eye.

Past history

You have had no problems with your eyes. You have never seen a doctor about your eyes, or been to an eye hospital/eye unit.

General health

You have never been seriously ill and are not on any medication. You do not suffer from migraine type headaches.

Family history

You are not aware that any member of your family has had eye problems apart from your 82-year-old mother who is developing a small cataract.

How to play the role

You feel anxious in case it this serious. You are fretting because you have a busy week at work.

Questions to ask if given the opportunity

- What are the long-term effects – will I go blind?
- What happens next?
- Can I do anything to avoid this happening again?
## Record card

**Name:** Joseph Rawlins  
**Age:** 53

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA</td>
<td>6/6</td>
<td>6/6</td>
</tr>
<tr>
<td></td>
<td>N5</td>
<td>N5</td>
</tr>
<tr>
<td>Refraction</td>
<td>-2.00DS</td>
<td>-2.00DS</td>
</tr>
<tr>
<td></td>
<td>Add +2.00 R &amp; L</td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td>No RAPD</td>
<td>No RAPD</td>
</tr>
<tr>
<td>IOP Perkins</td>
<td>15mmHg</td>
<td>15mmHg</td>
</tr>
<tr>
<td>at 2pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Fields</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Humphrey C81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior vitreous</td>
<td>Clear</td>
<td>Clear</td>
</tr>
<tr>
<td></td>
<td>No tobacco dust</td>
<td>No tobacco dust</td>
</tr>
<tr>
<td>Optic disc</td>
<td>CD 0.2</td>
<td>CD 0.2</td>
</tr>
<tr>
<td></td>
<td>Healthy neural rim, disc margins distinct</td>
<td>Healthy neural rim, disc margins distinct</td>
</tr>
<tr>
<td>Dilated fundus examination</td>
<td>Retina flat, no visible breaks/tears</td>
<td>Retina flat, no visible breaks/tears</td>
</tr>
</tbody>
</table>
Equipment

Station specific
- Record card

Standard
- Four chairs
- Three clipboards
- Three pencils
- One eraser
- One pencil sharpener
- Plain paper

Notes
What trainees should bring

Trainees must bring the following items to the OSCE:

• retinoscope
• ophthalmoscope
• their passport / driving licence that corresponds with the information submitted on the online application.

There is no guarantee that trainees will need to use them but they should have them with them just in case.

Trainees should not bring any other equipment with them as they will not be permitted to use it. We will provide any equipment necessary to complete the station.

We will provide pencils and paper in every station.

Trainees will not be permitted to use their own stationery.

On arrival...
The OSCE

We expect all examinations to start on time. Trainees must make their own arrangements for travel and accommodation and should allow plenty of time for their journey. If the trainee is late, they may not be able to take the examination.

Once the trainee has been through the building’s security procedures, they will be required to sign in at the centre. Apart from the equipment set out above they will not be permitted to take anything with them on to the test circuit. They will not be permitted to take mobile phones or other communication devices in the waiting areas, including watches.

Trainees will be given a further briefing before going into the examination.

Trainees must wear their name badge at all times so that examiners can see it clearly. The station at which they start will be on their name badge.

Trainees will be shown from the briefing room to their starting station. They will be told when they can begin to read the instructions. They should read the instructions carefully. There will be another set inside the station in case they need to refer to them.

There will be alcohol gel outside some stations for trainees to use to cleanse their hands before they enter these stations.

After one minute, trainees will be told to enter the station. They should then perform the task given to them in the instructions. Although the clinical scenario is simulated, they should act as they would in the same situation in real life. The actors who portray the patients are highly trained and experienced in playing the patient in a standardised way and, at the same time, responding to the words and actions of the trainee. So it is important that trainees watch and listen to the patient and respond appropriately.

30 seconds before the end of the station, everyone will be warned that it is almost time to move on. If the trainee finishes before the end, they should remain in the station until they are told to move on to the next. If they have not finished when the five minutes is up, they should move on promptly anyway or they will not have time to read the instructions for the next station. The cycle will continue until the trainee has completed all stations.

There may be a camera system to allow observers to watch the examination remotely. Trainees should not be put off by this. The camera does not record the examination so cannot be viewed retrospectively.

In some stations, there may be two examiners present. Trainees should not be put off by this; examiner observation is part of our quality assurance processes and the observer is watching the examiner and not the trainee.

When the examination has finished, you will be taken to retrieve your belongings. You should then leave the building quickly and quietly.
Cheating and misconduct

Trainees will be provided with all the materials they need during the examination, other than those listed in the section entitled On the day, which they must bring. They must not use or refer to any other materials or try to communicate with other trainees during the examination. All books, papers, mobile phones and other electronic equipment must be stored away when the examination begins. Trainees must not take any examination materials out of the centre. They must not write down the details of the examinations to take out and must not obtain information about the examination from any source including other trainees. They must not behave unprofessionally in any way. If a trainee does any of the above, they will be reported to the College. If they are found to have given or received help, their examination attempt will be declared invalid and their name reported to the GOC. Please refer to the Scheme for Registration regulations on college-optometrists.org/sfr for further information.

Key information for trainees in the section:
- arrive in good time
- trainees should bring their own ophthalmoscope and retinoscope, as well as the appropriate identification documentation
- remember that cheating and misconduct are taken extremely seriously.
Results
Results will be published on a secure section of the members’ only area of the College website. Trainees will be emailed with a link to results prior to results day. There will also be a link on college-optometrists.org. To access this area, trainees must know their College website login details.

Results will be posted to the trainee within two working days of appearing on the College website. This will comprise a letter confirming their results, a breakdown of their individual station marks and information on the steps they need to take next. Ensure your address is up-to-date on your record so results are sent to the correct address.

To ensure results remain confidential we will not give them out over the telephone, via email, or at the College reception.

Complaints
If a trainee wants to complain about the examination, they should submit a detailed written report to the Education Co-ordinator at the College or email: education.help@college-optometrists.org within 28 days of the date of the Final Assessment. They must include their name, address, telephone number, email address and candidate number. We will investigate and aim to respond within 10 working days.

A complaint is not the same as an appeal (see below) and cannot affect the examination result. If the service we have provided has been unacceptable, however, we would welcome the chance to investigate and put it right.

Appeals
Trainees can appeal against the result of their Final Assessment if they believe that there were irregularities in the administrative procedures and conduct of the examination. Please refer to college-optometrists.org/sfr for further details.

Next steps
Pass
If the trainee passes, they can apply for registration with the GOC, which is essential before they can begin work as a fully qualified practitioner, and obtain full membership of the College. Application forms for membership of the GOC and the College will be supplied with the letter informing them of their success. Until the trainee has received their new GOC number as a qualified optometrist, they can only perform the same supervised duties as they did while under pre-reg supervision.

Fail
If the trainee fails, they may book a place at the next set of examinations. Information on resit fees and the OSCE application form can be found at college-optometrists.org/sfr. Please remember that trainees are required to complete the Scheme for Registration within two years and three months of enrolling or have passed within their fourth attempt at the Final Assessment, whichever occurs first.
Exceptional circumstances

In exceptional circumstances, trainees may be permitted to extend their time on the Scheme or undertake it one further time. Please refer to college-optometrists.org/sfr for further details.

Key information in this section:

- results are published in the secure members’ only area of the College website
- complaints about the Final Assessment should be made within 28 days
- trainees can appeal on procedural grounds
- trainees should complete the Scheme for Registration within two years and three months of enrolling or can have up to four attempts at the Final Assessment, whichever occurs first
- if a trainee is prevented from taking the assessment they may, at the discretion of the College, be permitted to sit the Final Assessment at the next sitting with available places
- in exceptional circumstances, a trainee might be able to extend their time, or repeat, the Scheme for Registration
- successful trainees should apply for registration with the GOC and membership of the College as soon as possible
- until they have received a GOC number as a qualified optometrist, trainees can only perform the same supervised duties as they did under pre-reg supervision.
Section Five – Logbooks

Please use the Excel version of the logbook, which can be downloaded from the Scheme for Registration Handbook section on college-optometrists.org/sfr. The electronic log book has a number of advantages: it adds up the total patient numbers automatically and it allows a search to occur quickly of key words in the additional comments. If it is not possible to use the electronic log book the paper version is still available in this handbook.

The logbook allows each trainee to log the quantity and type of patients they see each day, and to identify any areas where they require more experience. It includes a section for additional comments where the trainee should note any unusual occurrences or points that they need to follow up. There is a column for them to put the name of the supervisor accountable for their work at the time of the consultation with the patient. The supervisor’s name should also be noted on the actual record card. The most up-to-date logbook summary should be provided to the assessor at each assessment visit.

Examples of a completed eye examination, contact lens fitting and aftercare and dispensing log pages can be found at the end of this section.

Minimum experience requirements

To be signed off from the work-based assessment, trainees must undertake a minimum of:

- 350 refractions
- 250 dispensings
- 20 contact lens fitting episodes to include a minimum of three complete soft lens fittings and three complete RGP lens fittings (ie to include the first aftercare where prescription is issued)
- 40 contact lens aftercare episodes to include a minimum of three soft lens aftercares and three RGP aftercares. 20 of the total aftercares to be carried out on established lens wearers who have worn the contact lenses regularly for a minimum of six months

Trainees are also expected to continue to build their experience in these areas after that point. This minimum requirement must be completed by the end of Stage 1, but at the latest by the Stage 2 assessment in time to complete the online application for the Final Assessment.

Definition of what constitutes a dispensing and refraction

There are different ways of working within the HES and community practices.

Dispensing

Community and HES practices

Within both community and HES practice, the definition of what constitutes a dispensing is consistent: dispensings are identified by the number of spectacles or low vision aids dispensed rather than the number of related patient episodes ie:

- one dispensing is equivalent to dispensing a single pair of spectacles to a single patient
• dispensing multiple pairs of spectacles, whether to many or one, is equivalent to multiple dispenses
• dispensing a low vision aid to a patient is equivalent to one dispense
• dispensing multiple low vision aids, to many patients or one patient, is equivalent to multiple dispensings.

Refraction
Community practice
A refraction in practice will normally consist of the ascertainment of a spectacle or contact lens prescription, together with some internal examination of the eye.

Community practice in Scotland
In Scotland, the system allows for two types of eye examinations – primary and supplementary. For clarity, only primary eye examinations can be included in the tally toward the statutory 350 eye examinations as stipulated in the College regulations. This does not mean, however, that the valuable experience from supplementary examinations cannot be used as evidence towards satisfying work-based assessments, ie a dilation supplementary examination could provide evidence for the patient episode required for element of competence 3.1.11 and 6.1.6 (if the patient has a cataract).

In some circumstances, the trainee may be required to undertake all of the tests as required for a full primary eye examination at a supplementary appointment. In such cases, if the record justifies that this was clinically necessary and in the best interests of the patient, then it can be counted towards the statutory 350 eye examinations requirement.

In order to avoid any confusion in this matter, clear records should be kept as to which patients underwent both a primary and supplementary examination and which only underwent one as these may be scrutinised by the College-appointed assessor.

HES practice
One refraction in HES practice will normally be when a trainee can provide evidence of carrying out the ascertainment of a spectacle or contact lens prescription, it is recognised that the remainder of the requirement will be satisfied within other procedures. Assessors will require primary evidence, ie direct observation of trainees carrying out a complete eye examination and/or contact lens episode on a patient to ensure competence in the overall procedure.

Within HES practice it is normal for a complete eye examination to be carried out as more than one procedure. Trainees in HES are booked in to carry out particular procedures in various clinics on a weekly basis, eg they may be in a refraction clinic on Monday, visual field assessment on Tuesday, contact lens clinic on Wednesday, observing pathology episodes with a consultant on Thursday, dispensing clinic on Friday. Therefore, although the trainees will not usually carry out a complete eye examination on a single patient they will receive more than sufficient practice in all the required areas throughout the week. In addition, many hospital trainees carry out refraction as part of a contact lens assessment in HES. Bearing in mind their other experiences, it is reasonable to include this experience in the figures as well.

Trainees in hospital undertake the same assessment process, ie the assessor will observe a complete eye examination or contact lens episode on a patient to ensure that they can fit all the component parts together when required.
What constitutes an appropriate CL fitting record?
In order to include the fit in the logbook, the trainee will need to show that they have:

- taken all the relevant preliminary measurements
- from these measurements decided on an appropriate lens specification
- ordered or selected the fitting lenses from stock
- checked the ordered/selected lenses on the eye
- instructed the patient to wear the lenses

If the contact lens fit is to be used for assessment purposes then it is essential that a complete fit has been undertaken by the trainee including

- a review of the fit and suitability of lenses at a follow up appointment in order to issue the contact lens prescription.

It is appropriate to count any follow up visits towards the aftercare totals.

What constitutes an appropriate CL aftercare record?

- The patient needs to have worn the lenses (a real wearer) who requires a refractive correction.
- It is appropriate to count the two week follow up visits towards your aftercare totals. These will be identified as N=New wearer aftercares in your logbook.
- Trainees need to provide a minimum of 20 aftercares records of patients who are established wearers having worn the lenses on a regular basis for a minimum of six months. These will be identified as E=Established wearer aftercares in your logbook.
- If the patients seen for aftercare are all straightforward with few or no complications, then the assessor will use images of aftercare complications to investigate the trainee’s ability in this area along with the observation and the evidence from the patient records provided.

Contact lens related logbook entries
The three RGP and three soft fits offered as evidence towards the elements of competence MUST be complete fits as described above, ie to include the post fitting aftercare where the prescription is issued (and this must be completed by the pre-registration trainee) but the 20 fits logged in the logbook can be just the initial visit to the point where the lenses are issued to be worn on a regular basis by the patient.

In addition, the trainee must complete the minimum of 40 aftercares (a minimum of 20 being on established wearers). So whether the new aftercare patients are their own follow ups or someone else’s, they will need to meet the minimum experience requirements of 40 aftercare episodes.

The complete records used as evidence of lens aftercares will preferably be on established wearers but will as a minimum always include at least one aftercare on an established wearer of soft lenses with a complication managed to resolution.
Scheme for Registration – Daily/weekly **eye examination** patient encounter record first quarter (up to Visit 1)

Trainee name ___________________________ Week commencing ___________________________

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>Refraction Presbyope</th>
<th>Refraction Pre-Pres</th>
<th>Refraction Child (&lt;8 yrs)</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
<th>Glaucoma</th>
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**Total eye examinations**
Scheme for Registration – Daily/weekly **contact lens** patient encounter record first quarter (up to Visit 1)

Trainee name ______________________________________________________  Week commencing ____________________________________________

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supervisor</th>
<th>P x ref</th>
<th>RGP fit</th>
<th>Lens type</th>
<th>RGP A/C (new)</th>
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<th>RGP A/C (estd)</th>
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<th>Soft fit</th>
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Total:  

| Contact lens fits | Contact lens aftercares (new) | Contact lens aftercares (estd) |
Scheme for Registration – Daily/weekly **eye examination** patient encounter record first quarter (Visits 1 – 3)

Trainee name ________________________________________________________  Week commencing ______________________________________

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>Refraction Presbyope</th>
<th>Refraction Pre-Pres</th>
<th>Refraction Child (&lt; 8 yrs)</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
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**Total eye examinations**
### Scheme for Registration – Daily/weekly **contact lens** patient encounter record first quarter (Visits 1 – 3)

**Trainee name ________________________________________________________  Week commencing _____________________________**

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
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<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>RGP fit</th>
<th>Lens type</th>
<th>RGP A/C (new)</th>
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<th>Contact lens fits</th>
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Scheme for Registration – Daily/weekly **eye examination** patient encounter record first quarter (Visit 4 onwards)

Trainee name __________________________________________________________ Week commencing ________________________________________

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

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<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>Refraction Presbyope</th>
<th>Refraction Pre-Pres</th>
<th>Refraction Child (&lt;8 yrs)</th>
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**Total eye examinations**
Scheme for Registration – Daily/weekly **contact lens** patient encounter record first quarter (Visit 4 onwards)

Trainee name ________________________________________________________  Week commencing ______________________________________

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>RGP fit</th>
<th>Lens type</th>
<th>RGP A/C (new)</th>
<th>Lens type</th>
<th>RGP A/C (estd)</th>
<th>Lens type</th>
<th>Soft fit</th>
<th>Lens type</th>
<th>Soft A/C (new)</th>
<th>Lens type</th>
<th>Soft A/C (estd)</th>
<th>Lens type</th>
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<tr>
<td>Contact lens fits</td>
<td>Contact lens aftercares (new)</td>
<td>Contact lens aftercares (estd)</td>
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</tbody>
</table>
Scheme for Registration – Daily/weekly **dispensing** patient encounter record

Trainee name ___________________________________________________________ Week commencing ________________________________

<table>
<thead>
<tr>
<th>Day/Date</th>
<th>Supervisor name</th>
<th>Px Ref</th>
<th>Lens type/Comments</th>
<th>Day/Date</th>
<th>Supervisor name</th>
<th>Px Ref</th>
<th>Lens type/Comments</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Total dispensing episodes**
Scheme for Registration – Daily/weekly **eye examination** patient encounter record first quarter (Visits 1 – 3)

**COMPLETED EXAMPLE**

Trainee name  P.R TRAINEE

Week commencing 31/07/2017

It is recommended that the trainee should be seeing four EE and CL related patients each day during this period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supervisor</th>
<th>Px ref</th>
<th>Refraction Pre-pres.</th>
<th>Refraction Pre-pres.</th>
<th>Refraction Child (&lt;8 yrs)</th>
<th>Cataract</th>
<th>AMD</th>
<th>Diabetes</th>
<th>Glaucoma</th>
<th>Other*</th>
<th>BV (Type)</th>
<th>Low vision patient</th>
<th>Instillation of drugs (Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/7</td>
<td>RBB</td>
<td>1307</td>
<td>X</td>
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<tr>
<td>31/7</td>
<td>RBB</td>
<td>1566</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<td></td>
<td>NIDD type 2 – background retinopathy</td>
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<tr>
<td>1/8</td>
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<td>4799</td>
<td>X</td>
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<td>1/8</td>
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<td>1799</td>
<td>X</td>
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<tr>
<td>2/8</td>
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<td>7788</td>
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<td>2/8</td>
<td>SL</td>
<td>9755</td>
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<td>4/8</td>
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<td>5/8</td>
<td>RBB</td>
<td>14099</td>
<td>X</td>
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<td>5/8</td>
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<td>RBB</td>
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**Total eye examinations** | 12
Section Six – The NHS Hospital Eye Service (HES) placement

If based in community practice, the trainee is required to spend at least 10 half-day sessions in the hospital eye service. We recommend a period of two weeks full time equivalent. This will give an insight into the workings of the HES and the various aspects of NHS eye care. They will also have the opportunity to learn about the day-to-day working of a hospital eye department and their own important role in detecting and referring eye conditions, as well as the relative urgency and possible outcomes of these referrals. Trainees will see a wider variety of ocular pathology than would normally be possible in general practice and gain some insight into how pathology is diagnosed and classified. This experience will give a trainee the opportunity to learn about the diagnostic and management methods used outside optometric practice, such as fluorescein angiography, surgical procedures, post-operative refraction and perioperative orthoptic assessment. During the NHS HES placement, each trainee will need to complete the HES Logbook as evidence of their attendance and the experience gained.

College recommendations on NHS HES experience

Apply early
Don’t assume that HES placements are easy to find. There are sufficient places for everyone but demand differs across different areas. The later the application is made, the more likely you are to be disappointed and have to search well outside your local area for a suitable placement. The more notice you have of any possible difficulties, then the longer you have to develop a contingency plan.

Be flexible
Trainees may carry out their HES experience on a regular basis each week or as block placements. The minimum experience required is one week full-time or the equivalent, and this must be completed during Stage 1 of the assessment process in order to ensure that the trainee gains sufficient experience. What may be best for your practice isn’t necessarily going to suit your local HES department who may be trying to offer experience to a large number of trainees. Be prepared to discuss block placements at a convenient time, but ideally before the third Stage 1 assessment visit is planned.

Be prepared to travel
Consider other suitable locations (for example where there are family or friends) which might prove to be possible as an alternative location for a block HES placement.
If finding a suitable placement is proving difficult, then speak with the Stage 1 assessor in the first instance and, if they are unable to to help, then contact the College.

Make sure you are covering all the required experience
Although HES departments will endeavour to provide each trainee with a wide range of experience, they cannot guarantee specific groups of patients and in many busy departments they will not be able to offer experience outside a pre-arranged plan. It is essential, therefore, that you find out in good time what can/cannot be organised during the HES placement and which experience will need to be provided elsewhere – do not make assumptions. Check beforehand what experience can realistically be expected.
Types of experience
Unlike working under supervision in community practice, the HES experience is designed to be mainly observational. However, it would be helpful if the trainee were able to gain hands-on experience in the following areas during their placement:

- slit lamp assessment of patients, eg with anterior chamber signs of inflammation
- orthoptics – assessment of patients
- low vision – assessment of patients
- low vision – dispensing of aids.

However, this hands on experience is purely at the discretion of the HES supervisor and may be influenced by a number of factors including the rules of the particular trust. It should not be an expectation of the placement for the trainee or the registered supervisor. Where hands-on experience is not possible, then allowing a trainee to observe and gain an increased awareness of the issues will help. It is not possible for all HES departments to provide contact lens and low vision services. It remains the supervisor’s responsibility to find this experience at an alternative location.

Evidence requirements
In some trusts trainees are only allowed to observe. This will not provide an acceptable level of evidence for the majority of elements because the element of competence may require a patient record as a compulsory form of evidence. You cannot assume, for example, that the evidence the trainee will gain by observing in the orthoptic clinic will be sufficient to demonstrate the “ability to assess and manage a patient with a specific type of binocular vision anomaly”. This is not true for the majority of cases and certainly for the vast majority of trainees this experience is gained in the regular practice placement. The HES experience will, in most cases, provide broader exposure to more patients with BV anomalies and how these are managed within the HES.

Patient episodes/encounters
Trainees should discuss what experience they are seeking to gain with the HES. The timetable in the trainee’s HES logbook may help the hospital to structure the experience there. If necessary, discuss with the Stage 1 assessor adjusting the assessment timetable to better reflect the trainee’s experience.

Expect to pay a fee
Many HES departments will have a set fee for providing training experience. Where this is not the case, the College recommends that the supervisor makes a token ex-gratia payment to the ophthalmic department of at least 20% of the training grant to cover the provision of this element of the pre-registration training.

Witness testimonies and patient encounter
Where the trainee has competently undertaken a procedure, eg slit-lamp assessment of a patient with anterior chamber signs of ocular inflammation under supervision during the HES placement, then it would be helpful if the HES supervisor (or any other supervisor) could complete a witness testimony stating that the trainee has competently carried out the relevant technique. It is perfectly acceptable for the trainee to complete the witness testimony, which should then be checked and signed by the supervising clinician (the witness). Witness testimonies are only used as part evidence in assessing competence and the final decision about a trainee’s competence would always lie with their assessor who would be
considering at least two or usually three different pieces of evidence to make that judgement. A generic witness template can be found in the HES logbook.

Alternatively, if a trainee observed a procedure or a patient encounter rather than carried it out themselves, then they should complete a relevant patient encounter record (also found in the HES logbook) and this will be used as an observational record of the HES experience.

If the trainee is not using one of the generic witness testimony forms from the HES logbook, they must ensure that their testimony contains all the relevant details as outlined in the example in the handbook. If any of the required detail is omitted, then the witness testimony will not be accepted by the assessor.

**Trainees as ambassadors for the profession**

It is worth noting that in a busy HES department where many different professionals are working, the trainee is an ambassador for their practice and for the profession of optometry. They should take advantage of the full range of experience offered during the placement and not just those experiences which directly link to specific competencies. It is also critical that trainees attend on all the days arranged and for the full duration. The overall purpose of the HES placement is to broaden a trainee’s experience and not just to provide witness testimony evidence for a few elements of competence.

**Completion of the HES logbook**

Every trainee is expected to complete the HES logbook during their HES experience. This provides a record of their attendance and evidence gained and shows that this HES experience has been completed.

All trainees are expected to keep a diary of their attendance in this logbook and the supervising staff in the placement will be completing a daily score of their engagement during that clinic as part of the record of the placement overall. Any witness testimony or patient encounter evidence should be recorded using the relevant proforma provided and kept in the HES logbook.

The person co-ordinating the HES placement will also have the opportunity to provide an overall statement relating to the trainee's attitude, behaviour, punctuality and anything else they think provides useful feedback to the registered supervisor and Stage 1 assessor regarding the placement.

The practice supervisor and assessor will be required to check that the HES experience has been completed before a trainee can be signed off from Stage 1 of the work-based assessment process.
Section Six – The NHS Hospital Eye Service (HES) placement
Section Seven – Record card templates

Trainees may wish to use some or all of the following templates during their training if they are working away from the usual practice under supervision and completing a patient record for:

- an eye examination or other ocular examination
- contact lens fitting
- contact lens aftercare
- dispensing.

All records completed using a template will be verified by the assessor. This verification will include some or all of the following methods:

- checking the order for the appliance dispensed, ie contact lens order or dispensing order
- cross checking the trainee’s logbook for evidence of the encounter
- cross checking the practice diary for evidence of the encounter
- cross checking the computer record of the patient encounter.

If a template has been completed as part of a dispensing record, then a copy or the actual spectacle order should be attached to the template. This will then constitute the full record of the dispense.

Records must be contemporaneous

Completed templates must be a contemporaneous record, ie completed at the time of the patient encounter. Templates completed after the encounter are not contemporaneous and therefore unsuitable as evidence in the assessment process

If an assessor suspects that a trainee is submitting records for assessment that are not contemporaneous, they will report this to the lead or deputy lead assessor who will consider whether an investigation into the authenticity of the evidence provided for assessment is required. Trainees found to be in breach of the regulations around cheating and misconduct on the Scheme will be reported to the GOC.
Scheme for Registration – Eye examination record

Patient identifier ______________________ Date of last examination ___________________
Occupation____________________________ Age ________

Symptoms and history

Ocular examination
Retinoscopy

Subjective and associated findings

Additional tests

Action and advice to patient

Final prescription given

I confirm this is the record completed at the time of the examination

Trainee name: ____________________________
Trainee signature: ____________________________ Date: ____________________________
Supervisor name: ____________________________
Supervisor signature: ____________________________ Date: ____________________________
## Scheme for Registration – Contact lens fitting record

<table>
<thead>
<tr>
<th>Patient identifier</th>
<th>Date of last examination</th>
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<tbody>
<tr>
<td>Occupation</td>
<td>Age</td>
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</table>

### Spectacle prescription

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<th>Sphere</th>
<th>Cyl</th>
<th>Axis</th>
<th>VA</th>
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### Keratometry

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<tr>
<td>LE</td>
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### Motivation for wear

### Pre-fitting measurements

### Pre-fitting slit lamp examination

### Fitting

### Lens specification

### Additional advice

### Date of collection

I confirm this is the record completed **at the time of the examination**

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Trainee signature:</th>
<th>Date:</th>
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<table>
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<tr>
<th>Supervisor name:</th>
<th>Supervisor signature:</th>
<th>Date:</th>
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<tbody>
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### Scheme for Registration – Contact lens aftercare record

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<td>________________</td>
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<tr>
<th>Occupation</th>
<th>Age</th>
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**Symptoms and history**

**Evaluation of lens fit**
<table>
<thead>
<tr>
<th>Slit lamp examination</th>
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</table>

**Action and advice to patient**

<table>
<thead>
<tr>
<th>I confirm this is the record completed at the time of the examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainee name: ________________________________ Date: ________________</td>
</tr>
<tr>
<td>Trainee signature: ______________________________ Date: ______________</td>
</tr>
<tr>
<td>Supervisor name: ______________________________ Date: ________________</td>
</tr>
<tr>
<td>Supervisor signature: __________________________ Date: _______________</td>
</tr>
</tbody>
</table>
Scheme for Registration – Dispensing record

Patient identifier ______________________ Date of last examination ___________________

Occupation ______________________ Age ______

Lifestyle requirements

<table>
<thead>
<tr>
<th>Sphere</th>
<th>Cyl</th>
<th>Axis</th>
<th>VA</th>
<th>Sphere</th>
<th>Cyl</th>
<th>Axis</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>RE</td>
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<td>LE</td>
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<tr>
<td>Add</td>
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<td>Add</td>
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<td></td>
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</tr>
</tbody>
</table>

Purpose of appliance, eg vocational /distance vision /near vision

Dispensed lens/frame/appliance with relevant measurements

I confirm this is the record completed at the time of the examination

Trainee name: ________________________________ Date: __________________

Trainee signature: ____________________________ Date: __________________

Supervisor name: ______________________________

Supervisor signature: __________________________ Date: __________________
Reflection

The Scheme for Registration provides every trainee with a structured approach to learning by ensuring that they gain an adequate range of experience to build on the core skills they have started to develop during their undergraduate training. Reflection is an important part of ongoing development as a professional. We do not learn from experience alone, but rather we learn most effectively by reflecting on experiences. Within this section of the handbook you will find reflective learning sheets which should help this process. Trainees should complete the sheets on a monthly basis in preparation for, or following, the review with the supervisor. The blank template can be photocopied and completed monthly. The example below is for guidance.

Monthly reflective learning sheet – COMPLETED EXAMPLE

Trainee name: PR Trainee

Supervisor name: Susan P Viser

Month: July 2018

Trainee completes on a monthly basis in preparation for monthly review with supervisor.

<table>
<thead>
<tr>
<th>What I’ve learnt this month…</th>
</tr>
</thead>
<tbody>
<tr>
<td>That I have to look for patients with the relevant conditions, ie ask the reception staff to book in patients for me who are children or diabetic or have a family history of/or have glaucoma.</td>
</tr>
<tr>
<td>I need to study the existing records for old patients so that I can consider their history before I hear any new information. This will help me get better at developing a plan for investigation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My action points for next month…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the manual for the field screener so I’m aware of all the programmes and revise visual pathway.</td>
</tr>
<tr>
<td>Ask reception staff to look out for children for me to test.</td>
</tr>
</tbody>
</table>
Monthly reflective learning sheet

Trainee name: ____________________________________________________________

Supervisor name: ________________________________________________________

Month: ________________________________________________

Trainee completes on a monthly basis in preparation for monthly review with supervisor.

<table>
<thead>
<tr>
<th>What I have learned this month…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>My action points for next month …</th>
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