



T Level Technical Qualification in Healthcare Science (603/7083/X)

Occupational specialism assessment (OSA)

Optical Care Services

Assignment 1: observation of patient interactions

Guidance for Tutors and Supporting Documents

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Occupational specialism assessment (OSA)**

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Guidance for Tutors and Supporting Documents

Assignment 1

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Detailed assessment delivery guidance – assignment 1, task 1: patient interaction 1

This guidance is to be read in conjunction with the Provider Guide and Assignment Brief.

Setting up the assessment area

Prior to the start of the assessment, the assessment area should be set up as a simulated retail counter / office space to include:

- desktop computer / laptop
- a clock
- a telephone
- Patient Triage Form
- Appointment Book Extract
- a person enacting the role of the patient (SP)
- a person enacting the role of the optometrist (RP)
- a space for the forms provided by NCFE for the student to complete throughout the assessment
- audiovisual recording equipment to record the completion of all tasks.

Use of supporting documents

Documents for the assessment area:

- Patient Triage Form provided by NCFE in the Supporting Documents section should be printed out and placed in the assessment area for the student to complete during the assessment.
- Appointment Book Extract provided by NCFE in the Supporting Documents section should be available (electronic or hard copy) in the assessment area for the student to complete during the assessment.

Documents for standardised patient (SP) and role player (RP):

- Patient Health Form (actor script) provided by NCFE in the Supporting Documents section should be passed (electronic or hard copy) to the SP in order that they can familiarise themselves with the detail.
- Optometrist Guidance provided by NCFE in the Supporting Documents section should be passed (electronic or hard copy) to the RP optometrist in order that they can familiarise themselves with the detail.

Documents for the provider-appointed assessor:

- The Observation Record Form provided by NCFE in the Supporting Documents section should be passed to the provider-appointed assessor (electronic or hard copy) to complete throughout the assessment.

Assessment delivery

Once the student has been given sufficient time to read through the Assignment Brief and has been directed to the assessment area, the provider-appointed assessor should also read out the Assignment Brief and task information to ensure the student has understood the tasks.

The provider should ensure the audiovisual equipment is recording.

The student should then be informed the assessment will begin.

The student should then:

- ensure they can find the relevant forms in the assessment area and prepare to answer the SP's telephone call
- await the SP's indication that they are calling the student / the SP will call the telephone in the assessment area
- complete tasks 1 (a), 1 (b) and 1 (c) within **10 minutes**.

SAMPLE

Detailed assessment delivery guidance – assignment 1, task 2: patient interaction 2

This guidance is to be read in conjunction with the Provider Guide and Assignment Brief.

Setting up the assessment area

Prior to the start of the assessment the assessment area should be set up as a simulated retail counter / office space to include:

- desktop computer / laptop
- a clock
- a telephone
- a person enacting the role of the patient
- Patient Record Form
- a space for the forms provided by NCFE for the student to complete throughout the assessment
- audiovisual recording equipment to record the completion of all tasks.

Use of supporting documents

Documents for the assessment area:

- Patient Record Form provided by NCFE in the Supporting Documents section should be printed out and placed in the assessment area for the student to complete during the assessment.

Documents for standardised patient (SP) and role player (RP):

- Patient Health Form (actor script) provided by NCFE in the Supporting Documents section should be passed (electronic or hard copy) to the SP in order that they can familiarise themselves with the detail.

Documents for the provider-appointed assessor:

- The Observation Record provided by NCFE in the Supporting Documents section should be passed to the provider-appointed assessor (electronic or hard copy) to complete throughout the assessment.

Assessment delivery

Once the student has been given sufficient time to read through the Assignment Brief and has been directed to the assessment area, the provider-appointed assessor should also read out the Assignment Brief and task information to ensure the student has understood the tasks.

The provider should ensure the audiovisual equipment is recording.

The student should then be informed the assessment will begin.

The SP will enter the assessment space and the student should:

- complete tasks 2 (a), 2 (b) and 2 (c) within **10 minutes**.

Supporting documents

Refer to instructions given in the 'Use of supporting documents' section of this document on:

- page 3 for task 1
- page 5 for task 2.

SAMPLE

Task 1: Patient Triage Form

Date	Time	Staff name	Where is the patient?	
			Practice	Phone
Patient name & address		Date of birth	Contact number	GP
Patient complains of			C/L wearer	Yes / No
			Any recent trauma	Yes / No
			Any recent ocular surgery	Yes / No
			Give details:	
Main concern			Questions	
Problem with eye R L			Is it painful?	
			No	Yes
			Is it sensitive to light?	
			No	Yes
			Is the eye red?	
			No	Yes
			Is there a change in vision?	
			No	Yes
Problem with vision R L			Is there any discharge?	
			No	Yes
			Has it come on suddenly?	
			No	Yes
Flashes and / or floaters R L			Is it constant?	
			No	Yes
			When did it start?	
Are there any shadows or veils in your vision?				
Any other comments / symptoms?				

Task 1: Appointment Book Extract

	Thursday		
	Clinic 1	Clinic 2	Clinic 3
09:00			
10:00		Sarah Thompson 07782 445 119 Blurred vision in left eye, worsening over past week.	
11:00			Jonathan Myers 07932 714 886 Contact lens discomfort.
12:00			
13:00	Michael Patel 07895 661 204 Broken spectacles – needs urgent replacement.		
14:00		Emily Harding 07411 983 522 Increased floaters and occasional flashes of light.	
15:00			
16:00			
	Friday		
	Clinic 1	Clinic 2	Clinic 3
09:00	Louise Carter 07500 438 291 Sudden sensitivity to light, unsure of cause.		
10:00			
11:00			Chloe Williams 07388 512 749 Persistent headache behind eyes.
12:00			
13:00			
14:00			
15:00			
16:00		Daniel O'Rourke 07801 220 455 Difficulty reading close- up; possible presbyopia.	

Task 1: Patient Triage Form (actor script)

Name	Alex Morgan
Date of birth	14 March 1978
Home address	22 Willow Crescent, Penzale, PN12 4HT
GP	Penzale Health Centre – Dr. Lawson
Last sight test	10 months ago
Current eyecare	Daily soft contact lenses
Reason for visit (eye health concern)	Right eye became painful and red this morning; sudden onset with mild blurred vision
Symptoms (when asked)	Painful, Redness, Slight blur, No discharge
Other information	No previous ocular surgery or trauma Removed contact lenses earlier today due to discomfort Consent to GDPR data storage
Questions to ask if not prompted – task 1:	<p>General questions to ask the student</p> <ul style="list-style-type: none"> • How long until I can be seen? • Do you need to know anything else about my symptoms? <p>Following receiving advice and next steps, questions to ask if not mentioned</p> <ul style="list-style-type: none"> • Will I be able to wear my contact lenses today? • Will this cost any money?

Task 1: optometrist role player (RP) guidance

The purpose of the role of the optometrist is to support occupational authenticity, in terms of the simulated nature of this practical skills assessment. The role player (RP) **must** allow the assessor to mark and make relevant comments around student performance without the risk of distraction that would be present if they were also acting as the optometrist.

You **must** carry out the following:

- check the Patient Triage Form for completeness
- advise the student if there are any critical aspects of the form **not** completed or **not** clear
- provide the following advice to the student, to relay to the patient who is on hold awaiting a response:
 - request that the patient books an emergency appointment before the end of the day, at the practice
 - ask the patient to bring their contact lenses to the appointment but **not** wear them
- accept the Patient Triage Form and keep it secure, handing this back to the assessor upon completion of the assessment.

Task 1: Observation Record Form

This form is intended to support the capture of descriptive information as evidence of the student's skills during the practical assignment. The notes should follow the flow of the tasks and how students are expected to complete them, rather than attempting to assign evidence against the criteria at this stage. The notes should support decisions against the Mark Scheme in relation to the quality of skills demonstrated by the student.

To be completed by the provider-appointed assessor:

<p>Area / objective – the following areas / objectives can cover a broad range of skills or actions that should be considered when adding notes. The text below each area / objective is an indication of what should be observed and is not exhaustive.</p>	<p>Comments – identifying the student's areas of strengths and weaknesses in thorough and precise notes that differentiate between a range of the student's practical skills are required. This will be used to support accurate and consistent allocation of marks once all evidence has been generated.</p>
<p>Communication: patient care</p> <p>Describe how well the student interacts with the patient, with consideration to:</p> <ul style="list-style-type: none"> • how the patient may be feeling including any pain or discomfort being experienced • support, trust and confidence in service provided. 	
<p>Communication: patient</p> <p>Describe how well the student engages with the patient, including:</p> <ul style="list-style-type: none"> • questioning techniques • body language • adaption of language. 	
<p>Communication: optometrist</p> <p>Describe how well the student provides a summary of the information discussed with the patient.</p>	
<p>Patient information</p> <p>Describe how well the student adheres to their legal obligations within their own role such as:</p> <ul style="list-style-type: none"> • the GOC • GDPR • including information that must be authorised before sharing. 	

Task 2: Patient Record Form

Name	
Date of birth	
Home address	
Last sight test date	
NHS entitlements	Yes / No
GDPR	Consent / No consent

SAMPLE

Task 2: Patient Record Form (actor script)

Name	Laura Merriden
Date of birth	12 August 1984
Home address	42 Alder Crescent, West Hadwell, WH42 8TP
Last sight test	Around 2 years ago (patient unsure)
Reason for visit	Needs new lenses for existing spectacles due to scratches and glare; unsure if eye test needed first
Occupation	Secondary school English teacher
Questions to ask if not prompted – task 2:	<ul style="list-style-type: none">• Do I need an eye test before I can get new lenses?• What will the appointment involve?• Will you send me a reminder?

Task 2: Observation Record Form

This form is intended to support the capture of descriptive information as evidence of the student's skills during the practical assignment. The notes should follow the flow of the tasks and how students are expected to complete them, rather than attempting to assign evidence against the criteria at this stage. The notes should support decisions against the Mark Scheme in relation to the quality of skills demonstrated by the student.

To be completed by the provider-appointed assessor:

<p>Area / objective – the following areas / objectives can cover a broad range of skills or actions that should be considered when adding notes. The text below each area / objective is an indication of what should be observed and is not exhaustive.</p>	<p>Comments – identifying the student's areas of strengths and weaknesses in thorough and precise notes that differentiate between a range of the student's practical skills are required. This will be used to support accurate and consistent allocation of marks once all evidence has been generated.</p>
<p>Communication: patient</p> <p>Describe how well the student engages with the patient, including:</p> <ul style="list-style-type: none"> • questioning techniques • body language • adaption of language • how they explain the reasons for the actions that need to be taken • how they close the interaction. 	
<p>Patient information</p> <p>Describe how well the student adheres to their legal obligations within their own role such as:</p> <ul style="list-style-type: none"> • the GOC • GDPR • including information that must be authorised before sharing. 	
<p>Service</p> <p>Describe how well the student offers and books the appropriate appointment.</p>	

Change history record

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v1.0	First published version	20 April 2026	30 April 2026

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Document information

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