Submission to CORU on

1. **Draft Profession Specific Criteria for Education and Training Programmes**
2. **Draft Standards of Proficiency for Medical Scientists**

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CORU Draft Profession Specific Criteria for Education & Training Programmes and Draft Standard of Proficiency for Medical Scientists

MLSA Submission, January 2018

In late 2017, CORU opened a consultation process on the *Draft Profession Specific Criteria for Education and Training Programmes* and the *Draft Standards of Proficiency for Medical Scientists*, via an online survey. Participants were asked to comment on the two draft documents by answering a number of questions. The MLSA completed the online survey and this separate submission consists of the answers submitted online but in a more easily readable format.

This MLSA submission should be read in conjunction with the two draft documents and the specific questions asked in the online survey (the relevant questions to which significant answers were given are reproduced in dark blue text below).

A: Comments on CORU Draft Profession Specific Criteria for Education and Training Programmes

6. 1 (1) The Medical Scientists Registration Board requires that the minimum qualification level for the entry route to the register will be the following:

NFQ level 8 Degree

The MLSA does not agree that this is the only suitable threshold for entry to the register. Many current proficient practitioners have the appropriate qualifications of Certificate and Diploma in Medical Laboratory Science that preceded the availability of degree courses, which were only introduced in the late 1980s – the first degree-level entrants graduated as recently as 1992. The pre-1992 graduates fulfilled all that was required of them educationally, have developed professional competency and have served the profession and the public well for years. They should not be made to feel like less-educated second class candidates that require "grand-parenting", with the consequent requirement after grandparenting closes to maintain their registration without a break or lose the right to practice their profession.

8.2 (2) Practice placements are integral to the programme. The variety and inclusion of practice placements will meet the requirements of the profession, as determined by the relevant registration board.
For Medical Scientists, the programme must ensure that each student completes a minimum of 1,000 hours of practice placement.
If you do not consider a standard to be threshold or you consider it only partly threshold then please explain why.

MLSA response: See comments below regarding limitations and practicalities on provision of practice placements in clinical laboratories.

1. The application of the role of student training co-ordinator, the number of co-ordinators and the dedicated time and support available to each of them to perform the role varies hugely across clinical laboratories. The number of student training co-ordinators should reflect the numbers of disciplines and specialities available and the number of students being placed (PC2.3).

2. The written agreement (PC2.4) setting out the responsibilities of all parties must detail what level of time and support is available to those undertaking the role. This may have implications for the routine workload of co-ordinators and therefore on staff resources in general. Training co-ordinators should be involved in but not left solely responsible for formulating the agreements.
3. Response to feedback on placements (PC2.5) and support of students in difficulty (PC2.16) will place extra duties on co-ordinators and will require support from management.
4. The explicit requirement of 1000 placement hours and the need to make up for any student absences (PC2.8) will place additional demands on the operation of already busy clinical laboratories and training co-ordinators.
5. Pre-placement requirements (PC2.9) should include preservation of the allowances paid to students and defining who is responsible for funding any additional placements that may be required for service needs.
6. Agreements must define who is on the "practice education team" (PC2.10, 2.13, 2.14), which may vary depending on the size of the hospital. Senior staff at laboratory management level must be responsible for governance, time allocation, absence management of the students and release of practice education team members for training.
7. Medical and nursing training is usually supported by fulltime staff and facilities so similar resources should be available for the training of other health care professionals including medical scientists and medical scientist trainers.
8. The student code of conduct (PC2.12) must correlate with the code of conduct of the workplace in which the student is placed.
9. How can students achieve Independence in practice (PC2.15) if they are not registered to practice until they are fully qualified?
10. The provision by the educator of education and support to the practice education team (PC2.17 and 2.18)) will require further time allocation by laboratory management for the team to attend such training.

B: Comments on CORU Draft Standards of Proficiency for Medical Scientists

5(5) Demonstrate a knowledge of, and be able to apply, best practice guidelines for delivery and operation of medical laboratory services and be able to advise, guide and train professional colleagues in best practices for optimal utilisation of pathology services 5 (7) Be able to identify the clinical context that a test and/or intervention will inform and be able to advise professional colleagues regarding the selection of samples, aspects of service user preparation, the timing and methodology of sample acquisition, as relevant to requirements of the medical science analyses

5(5) Advising, guiding and training professional colleagues is beyond the expertise and remit of a threshold level entrant. Candidates can be proficient to practise but not proficient to train others.

5(7) Proficiency to advise professional colleagues in these matters will develop with experience but should not be required as a threshold.

5(8) Demonstrate knowledge of blood and blood product management, stem cell, cross-matching and tissue-typing for service user therapy and be able to identify and resolve incompatibilities, anomalies and adverse responses
5(9) Demonstrate knowledge of clinical biochemistry and its role in the investigation and monitoring of disease including endocrine and metabolic disorders and have knowledge of best practice guidelines for investigation and result interpretation
5(10) Demonstrate knowledge of haematology and the role of this laboratory in the investigation and monitoring of disease including anaemias, leukemic and coagulation disorders and have knowledge of best practice guidelines for investigation and result interpretation
5(11) Demonstrate knowledge of infectious diseases, infection control and infection surveillance, and be able to identify and contain pathogenic and drug-resistant organisms; be able to respond to infection outbreaks, and be able to communicate effectively where critical interventions and urgent responses are required
5(12) Demonstrate knowledge of tumour biology and the role and importance of cytology, blood, bone marrow and tissue analysis, typing and staging of neoplasias and be able to apply to practice

5(8), 5(9), 5(10), 5(11), 5(12): Students in multi-disciplinary training will acquire basic knowledge of all of the above disciplines but will not have in-depth knowledge e.g. someone majoring in Microbiology with a minor in Biochemistry is unlikely to meet this level of knowledge of leukaemias or coagulation disorders. In clinical practice, someone working in Microbiology and covering call in Haematology will only need basic Haematology knowledge.

It is notable that in the case of Blood Transfusion, proficiency is to be required in stem cell and tissue typing, available in only a limited number of hospitals, but not in more standard and routine elements such as basic blood grouping, EU traceability or haemovigilance. Perhaps the detail of each discipline's requirements should be reviewed, and advice sought from several senior practitioners such as Chief Medical Scientists.

5(15) Be able to select, apply and interpret molecular diagnostics in disease inheritance investigation, surveillance and therapy selection

5(15) This is specialised expertise that will be developed with practice but should not be a threshold requirement.

5(26) Be able to contribute to the development of guidelines and provide advice regarding the collection, preservation, analysis, transport, storage, retention and disposal of clinical samples and related materials for service users

5 (26) Provision of advice regarding specimen collection should not be a threshold requirement because medical scientists in Ireland are not trained in or responsible for specimen collection.

Additional Comments:

2. Communication, Collaborative Practice and Teamworking

This section uses the term "service user" throughout and appears to have been lifted from documents for other professions who have direct contact with patients. For most health care professionals, this term would normally refer to the patient but in laboratory standard operating procedures it has commonly been used to refer to the clinicians who refer specimens for testing because they are the users with whom the medical scientist interacts. The terminology of "service user" and reference to managing the health and wellbeing of the service user may therefore confuse the issue. Most medical scientists have little direct contact with patients but this does not mean they lose sight of the primacy of the patient.

3. Safety and Quality

Point 9 refers to critically evaluating one's own practice against evidence based standards and implementing improvements. While evaluation and review are continuous in all laboratories operating a quality management system, such self-determined change of practice is not appropriate where all deviations from standard procedures must be documented and agreed collaboratively.

General comment on complete document:

The document appears to be developed primarily for the assessment of the proficiency of a new entrant to the profession, with the aim of preserving the multi-disciplinary placement element that is an integral part of standard education pathway for medical scientists. While this is understandable and necessary, it is important that the standard is not set so high that current practitioners of long standing would struggle to meet it, never mind new entrants to the profession. If the same standard will also be used in the future to judge the proficiency of existing practitioners where there is a doubt about fitness to practice, it is vital that the level of multi-disciplinary proficiency required is such that it can reasonably be met by a medical scientist who may only have worked in a single discipline for many years and does not practice in any other disciplines.

C: Additional Comments on CORU Consultation Process

CORU issued an email to some stakeholders (not including the MLSA) inviting submissions via survey on what were called *Criteria and Standards of Proficiency for Education and Training Programmes*. In fact, the consultation is on two separate documents:

1. Draft Profession Specific Criteria for Education and Training Programmes
2. Draft Standards of Proficiency for Medical Scientists

The existence of the two draft documents only becomes apparent when one is midway through the consultation. In addition, neither consultation is listed in the open consultation section of the CORU website and nor was any notification received by some major stakeholders.

The format of each consultation is a survey that asks for opinion on some sections of the document but not on others. At the end there is an opportunity to add general comments but the textbox provided is very limited and difficult to read so creativity is required to get one's points across in the format provided. Due to the limitations imposed by the survey format, the MLSA also submitted its responses to the survey in this separate document.