University Hospitals Bristol NHS
NHS Foundation Trust

Surviving the FRCPath Part 2 Viva

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Overview

- Personal view
  - How I prepared
  - Some useful tips
- Scenarios to think about
  - Groups (~10 mins to think about problem)
  - Discussion

The viva

- Module 2 of part 2
  - I did old style FRCPath (Part 2 = project + viva)

- 2 x 20 minute examinations

  1st – General clinical biochemistry issues
  No preparation time

  2nd – Clinical patient management (Medics)
  Laboratory problem solving (Clinical scientists)
  Laboratory management (All candidates)
  Given 20 minutes to prepare for this

How to prepare?

Not really in the textbooks

Speciality training curriculum

The Royal College of Pathologists

Pathology: the science behind the cure

Curriculum for specialty training in chemical pathology

January 2007 (minor amendments made August 2008)

Topics

- NHS structure (& any ongoing changes)
- Quality management/Performance Indicators
- Service provision & demand management
- IT
- Health & Safety
- Training & CPD
- Staffing issues
- Incident reporting
- Finance
- General Biochemistry
  - Key topics/cut-offs & clinical decision limits
  - Best practice guidelines

Sources of information

- RCPath website
  - Publications – best practice guidelines
- National guidelines
- Trust guidelines
- Specific websites (e.g. HSE for H&S info)
- Annals reviews/personal views
- ACB news
- Colleagues

What is topical?

- ACB mailbase
- ACB news
- Real issues
  - What's going on in your department?
    - Management meetings
    - Clinical governance meetings
    - Staff meetings
    - H&S meetings
    - Audit meetings
    - Tea-room!

Practice!

- Experience at this type of exam
  - Being given information verbally
- Weekly tutorials/scenario role-playing
  - Started badly….more confidence as weeks went by
- Asked my colleagues for some example questions
  - Staffing issues
  - Lab based problems
  - Clinical problems

- Demonstrate in your answer
  - Experience & safe practice
  - Knowing what you don’t know
    - When to refer/seek advice
  - Understanding urgency
    - Putting scenario into context
  - Preventing reoccurrence
    - Continual service improvement

Scenario Examples

Scenario 1

OOH call to on-call Biochemist from lab BMS. BMS says there is a police officer in reception wanting to retrieve a sample. What do you advise?

- Follow departmental policy for handling medico-legal samples
  - (? Why BMS not aware/training issue)
  - RCPath guidance
- Verify identity of police officer
- Verify need for sample
  - Ask for documentation
- If can verify
  - Chain of evidence forms
  - Retrieve, seal, log and sign to say it has been released
  - Copies of all documentation
- If cannot verify
  - Store sample and preserve integrity until can be
  - Discuss with Patient's Consultant
  - Discuss with Trust Legal advisor
  - Section 19 of PACE act

Scenario 2

NICU phone to say the lab are reporting higher total bilirubin results than their bilirubinometer. You were unaware they had a bilirubinometer. What do you say?

- Take details
  - Assess severity of problem
    - One patient or several etc
    - Is the lab result correct? (Rpt/Check IQC/Calibration/EQA)
    - Management of patients affected? – log as clinical incident
    - Advise stop use until reassured fit for purpose
  - What is required?
    - Go in person/build relationship etc
    - POCT guidelines/POCT committee – (Why not known about?)
    - Equipment evaluation/method validation
    - Method correlation between lab and Bilirubinometer

Scenario 3

Taxi company phone to say samples taken to neighbouring hospital have leaked in transit. What do you do?

Immediate action

- Inform taxi driver not to touch samples
- Advise to return to your hospital/or neighbouring (which ever is closer)
- Arrange for lab staff to meet taxi
  - Take details of incident
  - Identify patients affected
    - Repeats
    - Infection risks
    - If taxi driver has touched spill – wash hands etc/refer to occupational health
  - Follow lab protocol for clinical sample spill
    - PPE
    - Contain, mop-up, dispose of waste, disinfect area
- Record as non-conformity/clinical incident/H&S incident
- Conduct root-cause analysis
  - Why spillage occurred?
  - Why transporting samples by taxi? Review sample packaging & transport policy
  - Why taxi driver unsure what to do?

Scenario 4

You have been appointed as consultant clinical biochemist in a laboratory which is part of a network of 2 large city teaching hospitals and 3 smaller rural DGHs. 1. You are responsible for organising the CPD programme - how do you do this for all Biochemistry staff on all sites? 2. How would you ensure clinical scientist and chemical pathology staff on all sites provide consistent advice on biochemistry reports?

- Design CPD programme
  - Rotational topics/appropriate mix
  - Training leads to advise
  - Get staff involved at each site (? Site lead)
  - Supporting documentation
  - Central storage location for talks
  - Web seminars?
- Consistency in reporting
  - Auto-validation set-up
  - Coded comments/auto-reports
  - Duty Biochemist Guidelines
  - Audit being followed
  - Clinical meetings to discuss cases and responses
  - Cases for comments

Scenario 5

Your automation section head approaches you on Thursday afternoon to say that due to an ordering error you only have enough reagent to do 7 more Tacrolimus tests. Your hospital is a tertiary referral centre for Paediatric renal patients. What do you say?

Immediate action

- Assess situation (7 including QC & calibration)
- Assess impact on clinical service
  - Query expected workload
  - Inform key users
  - Prioritisation strategy
  - Back-up plan
    - Available at another lab?
    - Same method, if different – significance on results?
    - How to get samples there, including OOH (if required)
    - How to get results back – phone/look-up?
    - Staff to be informed/protocol in place
- Review situation over weekend

Incident review

- Log as non-conformity/clinical incident/service failure
- Root-cause analysis, discuss at clinical governance
- Put steps in place to prevent reoccurrence

Scenario 6

You become aware about one of your senior colleagues poor performance in result reporting & interpretation. What do you do?

Tricky!

How became aware? (Complaint/clinical incident)
How big is the problem? Are they unsafe?

- Gather evidence
  - Observation
  - Retrospective review
  - Discuss discreetly with other colleagues
  - Competency records?
  - Informal discussions e.g. Bring up examples at clinical meetings
  - Review against departmental protocol/DB guidelines
  - Intervene? Go to their line manager
  - Write everything down

- No improvement
  - Bring to attention of clinical lead
  - Formal reporting (non-conformity/clinical incident/NPSA/HPC/GMC)

Good luck