Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Continuing Professional Development

Record Templates[1]

Registrant Profile

Registrant has practised as a Physiotherapist for 3 years and currently holds a basic grade position in an acute / rehab HSE setting, treating adult service users.

Irish Society of Chartered Physiotherapists
The Voice of Physiotherapy in Ireland

This CPD Audit Record Exemplar has been produced in conjunction with the Irish Society of Chartered Physiotherapists (ISCP)

1. You must read the audit guidelines document before completing this record for audit purposes and submitting.
2. It is important that all information identifying any third party must be removed from any records submitted. Do not, under any circumstances, provide information that would enable the identification of a service user.
3. Do **not** attach any supporting documentation with this record.

[1] Version issued June 2020

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Regulating Health + Social Care Professionals

Name:	Jane Doe	CORU Registration Number:	PT123456
Audit period from:	01/06/2020	Audit period to:	30/05/2021
Registration Board	Physiotherapists		

Implement			Evaluate & Reflect	
Date and time spent When did you undertake this learning activity?	**Type of Learning Activity** What was the name of the activity?	**CPD credits** Approx. 1 CPD credit for every hour of new or enhanced learning achieved	**Learning Outcome** What have you learnt through completing this activity? How have your skills and knowledge improved or developed?	**Impact on practice** How have you integrated this learning into your practice? How has this learning made a difference to your capability and performance in your role?
16-06-2020 4 hours	PP+ Course Titled 'Introduction to the Shoulder'	2	I seem to have had a mental block on shoulder assessment and treatment since University – they always seemed so complex, I therefore decided to take this course on PP+ with an aim to improve my knowledge, skills and confidence in seeing patients with shoulder pathology. This course was one of four under the shoulder programme course. I learnt: - Epidemiology, prevalence and incidence of shoulder conditions	I am much more confident in the assessment of and clinical reasoning behind a diagnosis of shoulder pathology. I have been able to apply the knowledge gained with relation to age related changes. I now approach shoulder conditions differently in different age population, which has had a positive effect on treatment outcomes.

			- Functional anatomy and biomechanics of the shoulder - Age related differences and how anatomy and function can be affected by age – Degenerative changes within the joint may result in pain and impairment and affects >50% of individuals 70 years of age and older - Effective clinical reasoning .	
23-06-2020 4 hours	PP+ course titled 'Clinical presentation of shoulder pain'	2	This course was part 2 of the Shoulder programme on PP+. It looked at 4 main common shoulder conditions: 1- Rotator cuff/subacromial related 2- Capsular related 3- Glenohumeral instability 4- Acromioclavicular joint I learnt: - Differential diagnosis for different shoulder presentations - Predicting prognosis - Developing a hypothesis on the cause of shoulder pain	I am more confident in assessment and differential diagnosis which has had a positive impact on my assessments and treatment. I use the information gained in the subjective assessment to plan the tests I am going to include in the objective assessment. I used to just go through all the objectives tests without understanding why I was maybe doing some of them. In my head I have a hypotheses as to what the problem may be

			and how to approach and manage it based on clinical reasoning	(based on the subjective assessment) and I now use the objective assessment with much more clarity and process to confirm or deny the hypotheses. I can also explain the condition better to patients, and with them understanding the cause and the plan with treatment, they are committed to their treatment and rehabilitation which is having positive effects on treatment – their pain is reduced and QOL and ADL improved.
28-06-2020 60 min	Review of Irish Society of Chartered Physiotherapists (ISCP) committee handbook for branches, clinical interest groups and employment groups 2017, prior to attendance of AGM of an ISCP clinical interest group	0.5	When registering for the CIG AGM it asked if 'you would be interested in serving on the executive committee of the clinical interest group'. I indicated yes, then thought I wasn't quite sure what I would be expected to do, so I contacted my professional body, the ISCP and asked if they could assist. They directed me to the Committee handbook I learnt: The role of a Clinical Interest Group is to:	I have better understanding of the roles of the branches, clinical interest and education groups and their purpose. This will benefit my interaction with the ISCP and serving as a committee member. It also allows me to promote my profession and enhance public awareness.

			-Advise the Society in the area of its specific clinical expertise - Provide educational and professional development in the specific clinical area - Inform the Board of issues arising for the profession in the specific clinical area - Promote the specific clinical area - Assist the Board with submissions and responses relevant to the specific clinical area. I reviewed the roles that are available on a committee and am interested in the Education officer's role.	
30/06/2020 4 hours	PP+ course titled 'Shoulder Assessment' This was part 3 of the 4-part shoulder programme	2	This course reviewed and went into more detail on shoulder assessment and the impact assessment has on planning the management and treatment. I learnt: - The importance of combining a good subjective assessment, accurate patient history, good knowledge of	Following on from the courses already completed related to this programme, this course went into the assessment in greater detail and when to use what test, as well as the evidence behind the tests. Having a clearer knowledge of the goal of the objective assessment tests used has

			functional anatomy, observation and examination - The different orthopaedic tests for the shoulder and the evidence behind them - The difference between acute and chronic shoulder pain - The importance of addressing any possible yellow flags which could contribute to development of chronic pain - Using outcome measures (DASH and Constant-Murley shoulder outcome score) - What the clinical indications are to refer for diagnostic imaging	made it so much easier to understand when to use what. I am diagnosing shoulder conditions more competently and able to design a treatment approach accordingly. I am also more confident now when I should seek orthopaedic referral or referral for imaging or further investigations. I communicate to the patients much more about what the options are in terms of imaging and referral on to a consultant, to allay any fears and open lines of communication, for the patient to address any concerns.
Implement			**Evaluate & Reflect**	
Date and time spent When did you undertake this learning activity?	**Type of Learning Activity** What was the name of the activity?	**CPD credits** Approx. 1 CPD credit for every hour of new or enhanced	**Learning Outcome** What have you learnt through completing this activity? How have your skills and knowledge improved or developed?	**Impact on practice** How have you integrated this learning into your practice? How has this learning made a difference to your capability and performance in your role?

		learning achieved		
06-07-2020 4 hours	PP+ course titled 'Therapeutic Interventions for the shoulder'. This was the final course in four-part series under the	2.5	This course explored devising rehabilitation programmes. The aim of treatment is to reduce pain, restore function, and introduce load management to allow healing alongside rehabilitation. I found this clear explanation so valuable. I learnt: - How to apply different management / rehab skills - Specific management approaches which included: shoulder symptom modification procedure/therapeutic exercise/ prescription consideration - Clinical approaches to specific conditions which included: instability; adhesive capsulitis; RC related pain; subacromial pain syndromes - How to match the presentation of shoulder pain with the most effective	The general and then more specific rehab approaches were of great benefit to me as a practitioner. I have a greater understanding on when and how to start the rehab process with the correct load to encourage healing. Before I used to follow a very similar rehab programme with all the patients, now I devise a more individualised programme for patients based on both their subjective assessment, with an aim to return the patient to pre injury function and sports (if indicated). This has resulted in improved treatment outcomes, commitment from the patients and enjoyment in my job – seeing patients get better and knowing now I have the skills to get them better – it's been so valuable.

			treatment approach and evidence-based interventions	
Implement			**Evaluate & Reflect**	
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10-08-2020 90 min in-service (2 hours preparation on 08-08-2020)	I presented an in-service training to the MSK unit in the HSE setting where I work.	2	My manager asked if I would present an in-service training session following completing the shoulder programme course. I had not done an in-service on my own before so I was quite nervous. What I learnt: - By preparing for the in-service it was a great way to refresh the knowledge from the course	This was a personal gain for me. I was not very confident with public speaking or having to present in the department. I really enjoyed it and it wasn't as scary as I anticipated it to be. I am more confident and ready when asked to present at the next in-service session.

			- I actually enjoyed presenting - I included a practical session where we split into pairs and did surface anatomy palpation of the shoulder - Presentation skills and how to condense information into pertinent points.	
06/07 2020 3 hours	Writing up Case studies Patient 1 and patient 2.	2	Through the shoulder programme course completed earlier in the year, part of the course was presenting case studies for an assessment and for discussion forums. I chose two patients to include in case study presentation – I obtained their consent to include their case details. The clear approach to assessment, listening to the patient, choosing the objective tests based on the hypotheses, performing the objective assessment resulted in a much clearer diagnosis. What I learnt:	The impact on practice was great, however the impact on patients' pain, QOL and ADL was tremendous. By picking up the correct diagnosis, I was able to treat these patients effectively, with a completely different treatment approach for both. Prior to this course, I fear I would have gone along the same treatment rehab path with both and that would not have had favourable outcomes – particularly for the patient with the cervical problem. I am much better prepared to recognise and manage shoulder pain with a cervical origin. I am

			- The one patient has a rotator cuff pathology - The other patient had shoulder pain of cervical origin - The value of differential diagnosis - Tests to use for differential diagnosis - The subjective clues patients given that assist with the differential diagnosis e.g.: shoulder pathology is painful with overhead activities, shoulder pain referred from the cervical pain may be sore with sedentary activities such as sitting at the computer - Different presentation of shoulder pathology and shoulder pain with a cervical origin	much more informed and can explain clearer to patients. I am much more confident in my ability to treat and rehabilitate patients presenting at the clinic. I see the value and impact of continuing improving my knowledge and skills.
31-08-2020 90 min	HSELanD Children First .	1.5	The manger addressed with staff that completing Mandatory Training on Children First needed to be completed by all staff. We were given a six-week period in which to complete the course,	I have a clear understanding on the steps that need to be taken should a concern arise. I know who the mandated and designated liaison people are.

			which was available on HSELanD. I learnt: - How to recognise child abuse - Different types of child abuse - Procedure to follow in reporting child abuse - The role of the mandated person - The role of the designated liaison person	Our manager has introduced a SOP in this regard. It has also helped me to better understand my responsibilities under my Professional Code of Conduct and Ethics regarding safeguarding children.
Implement			**Evaluate & Reflect**	
Date and time spent When did you undertake this learning activity?	**Type of Learning Activity** What was the name of the activity?	**CPD credits** Approx. 1 CPD credit for every hour of new or enhanced learning achieved	**Learning Outcome** What have you learnt through completing this activity? How have your skills and knowledge improved or developed?	**Impact on practice** How have you integrated this learning into your practice? How has this learning made a difference to your capability and performance in your role?
15-09-2020 2 ½ hours	Airvo in-service	2	I had always found Airvo difficult to understand and as such, never felt very confident when a patient in my ward was on Airvo. I had linked in with my senior about such patients, but still did not feel that the information was solidified	I now feel more competent at assessing and treating patients who are on Airvo. I can now clinically reason when I should decrease/increase the flow of the Airvo or the Fio2 and know how to physically make those

			for me. I encounter many patients requiring oxygen and often patients who require increasing oxygen demands and I need to feel confident in the various oxygen delivery methods. I attended a very informative in-service about Airvo. I learnt: - Indications for Airvo use, what patient population it would help with - Explaining the physiological rationale of using it - The differences between Airvo and other oxygen delivery methods was explained - The practical elements of setting it up - Practical session where I had the opportunity to set it up and change the settings - Open discussion and case studies enhanced the learning - When to recommend starting a patient on Airvo - Setting up the Airvo - Knowing when the settings need to be changed,	changes. I think discussing this with other physiotherapists at the in-service has allowed me to feel more confident in making those decisions. It has also helped me with my oxygen delivery understanding in general, as I now better understand the physiological reasoning behind Airvo and the differences between it and nasal cannula, venturi tubes or NIV. This proved helpful as I rotated into ICU and began to see patients wean from intubated and ventilated to self-ventilating on Airvo. Recently, at the end of the rotation, I was seeing a patient who was requiring high O2 demands via nasal cannula. His work of breathing was increasing and his Sp02 levels were unstable. I suggested Airvo, and after discussing with the medical team, the patient was placed on Airvo which stabilised his condition well. I was confident to make the suggestion and recommendation to medical colleagues.

			especially changing the Fi02 or the flow rate. I am a pragmatic learner and needed it explained to me in a very literal way. The physiotherapist leading the session was very approachable and as such I felt very comfortable asking questions. Before the in service I felt daunted when a patient was on Airvo, as I was unsure about changing the settings and was scared to do harm to the patient unintentionally. Having seen some patients with my senior before the in-service, I had a basic understanding but needed to get the theoretical knowledge and also practice in a non-pressurised setting. The in-service provided me with both of these things.	
01-10-2020 4 hours	Research for presentation for in-service titled 'Post-operative complications following cervical surgery'	3	I looked at general and specific post-operative complications. I have had a fear and worry of getting patients out of bed day 1-2, so felt this would be of benefit in looking at both general and	I feel much more confident in recognising post-operative complications in the cervical spine as well as general post-operative complications.

	Reading the following journal articles and compiling research: **Post-operative** nerve injuries after cervical spine surgery. Joaquim AF, Makhni MC, Riew KD.Int Orthop. 2019 Apr;43(4):791-795. doi: 10.1007/s00264-018-4257-4. Epub 2018 Nov 29.PMID: 30498911 https://www.ausmed.com/cpd/articles/postoperative-complications Completing the following course: Physiopedia – Surgical and Post-Operative Management of Cervical Spine Stenosis		specific complications that may arise on orthopaedics. <u>General complications</u> I learnt these include: - nausea and vomiting, abdominal distention and paralytic ileus, urinary retention, constipation, pain, shock, haemorrhage, pneumonia, pulmonary embolism DVT, wound infection, wound dehiscence, post- operative delirium <u>Specific complications</u> Postoperative nerve injuries after Cx spinal procedure occur. I learnt: The most common post-operative neural disorder is C5 nerve palsy - Results in deltoid and / or biceps weakness - Risks are male, OPLL, posterior-cervical approach - Can present immediately or several days post-surgery - Rx is conservative - Need to evaluate for residual compression at C45/5	An example where I was able to implement this knowledge was with a post-operative patient who needed to mobilise, however the patient presented drowsy, fatigued and was O2 dependent. Bloods had not yet been done. I made the decision not to mobilise and spoke with the doctor to get bloods as I was concerned re haemoglobin levels. Once blood results returned the patient did have 6.3 Hb. I have gained confidence in explaining post-surgery complications to patients, and they value the input. I have gained confidence in both my assessment post operatively as well as with the knowledge now have the confidence to speak to the consultant re any concerns I have.

			Parsonage-Turner syndrome) is an idiopathic plexopathy presenting with - Severe neuropathic pain in the shoulder, neck, and arms - Followed by neurological deficits involving the upper brachial plexus. - Presents in a delayed fashion after the onset of pain - Treatment is based on pain control and physical therapy C8-T1 nerve palsies occur post operatively and present with: - Weakness of the five intrinsic muscles of the hand - Sensory symptoms in the dermatomal area of the ulnar two digits of the hand and the medial forearm. - The risk factors for C8-T1 nerve injuries after surgery are C7 pedicle subtraction osteotomies and posterior fixation of the cervico-thoracic junction	

			- A wide foraminal decompression at C7-T1 region is necessary to minimize risk of this complication. Horner's syndrome can occur post-operatively, - Risk with anterolateral approaches to the middle and lower levels of the cervical spine. - Clinical features are ipsilateral papillary miosis, facial anhydrosis, and ptosis secondary to injury of the cervical sympathetic nerves. - It can occur from iatrogenic compression or injury to the T1 nerve root, as the sympathetic chain gets some of its fibres from that level Cervical Spine Stenosis post op complications include: - Muscle weakness - Neck pain and stiffness - Deep infection - Psuedomeningocele	

			- Closure of opened laminae - Neurological deterioration - Death	
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02-10-2020 2 hrs	Developing presentation on in-service titled 'Post-operative complications following cervical surgery' Included hand out slides	1	The skills that have been improved are outside the clinical aspects of physiotherapy I have learnt: - How to put a power point presentation together - Not to fill the slides with content, but present key facts on slides which I then talk about during the in-service - Referencing articles correctly - How to search for relevant articles - How to establish the quality of research	The impact has been more on an administrative / research side as opposed to within the clinical arena. I have learnt skills with regard to evidence searches and establishing the quality of research. I have learnt skills related to putting a presentation together. This has given me more confidence in the area and I have the ability to do further research and presentations as opportunities arise.

04-10-2020 90 min	Delivering in-service presentation titled 'Post-operative complications following cervical surgery'	1	This was the second in-service I have now done. I learnt: - I have developed more skills with regards to presenting since the first in-service - Incorporating practical sessions within the in-service is of great value - Discussing patient presentations and case studies is a very beneficial way to learn	I have volunteered to do another in-service. I enjoy searching for and reading articles and being aware of evidence-based assessment and management. The benefit I feel has been to the service and my colleagues. The in-service sessions give us an opportunity to discuss with each other and ask questions, which we were maybe hesitant to ask before. Now we all take turns presenting an in-service and know how the person can feel, so we are all supportive and encouraging. I value the collective effort and teamwork.
01-11-2020 3 hours	Rotational in-service on the Cervical Spine – epidemiology, anatomy and clinical relevance Preparation / Research for in-service content included: Reading Clinical anatomy pages on Physiopedia	2	This included covering the epidemiology, prevalence and functional anatomy and biomechanics of the cervical spine. I learnt: - How the anatomical configuration of the cervical spine contributes to function	Preparing for this in-service was of great benefit. I have a much clearer understanding on the anatomy and clinical relevance for the cervical spine. In treating patients, I now picture the anatomy and what I am trying to treat – and find the treatment effect is improved.

			- The age-related differences in the cervical spine (from paediatric to older adult) <u>In paediatric spine</u> - The head is larger relative to the body, resulting in a higher centre of gravity and fulcrum of neck motion - There are multiple vertebral ossification centres - The ligamentous structures are lax - The younger the age, the more flexible the spine is - Neural damage occurs in children much earlier than musculoskeletal injury. - As age increases the likelihood of cervical cord injury decreases (with up to 75% of injuries occurring in infancy up to 8 years old) - The fulcrum of cervical mobility moves progressively downward with the child's increasing age: Younger than eight years: C1 and C3 Eight to 12 years: C3 and C5	Although at present I do not treat any paediatric patients I found studying the age differences in the anatomy and how they relate to different injuries very interesting and beneficial. When I move into a paediatric rotation this will be of benefit. I treat a large cohort of older adults with cervical symptoms. Having a clearer understanding of presentation, diagnosis and treatment of cervical spondylosis is resulting in improved treatment sessions. I can explain to patients the reason for their symptoms, I can plan treatment and plan rehabilitation. Patients have an improved treatment outcome with reduced pain and improved QOL.

			Older than 12 years: C5 and C6 <u>Cervical spondylosis</u> presents in three symptomatic forms: - Non-specific neck pain - pain localised to the spinal column. - Cervical radiculopath<u>y</u> – symptoms (may include pain, numbness, loss of function) in a dermatomal or myotomal distribution often occurring in the arms. - Cervical myelopathy – intrinsic damage to the spinal cord resulting in a cluster of complaints and findings (numbness, coordination and gait issues, grip weakness and bowel and bladder complaints)	
14-11-2020 90 min	Delivery of cervical anatomy in-service	0.5	This is the third in-service I have delivered to the department I learnt: - To be more confident in my presentation skills - To demonstrate palpation of service anatomy to my	In demonstrating and practicing the surface palpation on my colleagues – I am more confident with my palpation skills on the patients and how to modify these palpation skills as needed.

			colleagues – we split into pairs and practised these skills - Palpating different cervical spines and muscles was of great benefit and I learnt how to modify my palpation skills accordingly	
06-01-2021 4 hours	Safety in Needling Therapies Preventing Pneumothorax .	2	Review of lung anatomy, iatrogenic pneumothorax, needling principles and specific consideration for certain muscles I learnt: - Clinical implications related to lung anatomy to prevent the occurrence of needling induced pneumothorax - Stay outside the ribcage - Avoid needling close to the apex of the pleura - Iatrogenic DN induced pneumothorax do occur, the incidence rate is not known, there is a lack of research, 13 medline cited articles related to DN and pneumothorax but > 26 000 acupuncture and pneumothorax studies	The impact on my practice will ensure patient safety The importance on cautioning patients was stressed and I now make sure I caution all patients if I needle an area which contains a risk, even if the risk is very small. Previously I would be very clear going through other side effects with patients, such as drowsiness, euphoria, happiness, impulsiveness – now I include very clear description of signs to be aware of in the event of pneumthorx. As part of pre assessment I ask if patients will be flying, going on a trip, or plan to exercise that day or the next – I would not have included this previously,

			- Presentation of pneumothorax includes: SOB, chest pain, dry cough, decreased breath sounds, increased respiratory rate, altered breathing patterns - May occur hours or days following treatment Patient must always be cautioned especially if going to be exposed to exercise and marked alterations in altitude (flying/scuba diving) Review of correct dry needling technique for relevant muscles- this included - Posterior neck – trapezius, levator scapulae, rhomboids - RC - infrapsinatus, supraspinatus, teres minor and subscapularis - Scapular thoracic – ters major, latissimus dorsi, serrautus anterior - Anterior neck – scalenes, sternocleidomasteoid - Thoracic back – erector spaine, multifidus	but can see the importance of establishing this prior to using Dry Needling as a treatment technique. 'If in doubt- stay out! '

06-01-2020 1 hour	Review of ISCP Dry Needling Policy Document 2012 Review of Professional Code of Practice	0.5	I learnt: - The policy and guidelines around Dry Needling - In context with the professional code of practice - The hygiene principles that must be adhered to	To ensure that consent is always obtained – I make sure this is always in writing. I document: - Muscle needled, type of needles used, the local reaction – LTR, pain etc. length of time needles in, and how the patient felt post treatment This has a positive impact on the service and the service user and reduces the risk of an adverse event.
02-03-2020 4	Patient presenting with superficial siderosis Initial assessment and discussion with patient and family Review of evidence and journal articles Ir Med J 2016 Superficial Siderosis Mar 10;109(3):376. T Abkur , S Looby , T Counihan Epub 2017 Dec 28. Two-year observational study of deferiprone in superficial siderosis	3	Superficial siderosis is a rare disease that I have never encountered previously, I learnt: - It is a disease of the brain resulting from chronic iron deposition in neuronal tissues associated with cerebrospinal fluid, via the deposition of hemosiderin in neuronal tissue - The most common cause is chronic bleeding into the subarachnoid space, which	I have a much clearer understanding of this condition, the progression and the impact on function. Having gained this knowledge, I was able to explain to the patient clearer why he had the signs and symptoms he had. Although unlikely to see a patient with this condition again, it made me very aware of the need for further investigations on occasion if patients presenting

	Remi A Kessler , Xu Li , Kateryna Schwartz , Hwa Huang , Maureen A Mealy , Michael Levy Epub 2017 Nov 21. Superficial siderosis of central nervous system with unknown cause: report of 2 cases and review of the literature. Hao Chen , Hafiz Khuram Raza, Jia Jing , Xinchun Ye , Zuohui Zhang , Fang Hua , Guiyun Cui Neurology 2018 Jul 10;91(2):e132-e138. Cortical superficial siderosis: A prospective observational cohort study Solène Moulin, Barbara Casolla, Grégory Kuchcinski , Gregoire Boulouis , Costanza Rossi , Hilde Hénon, Didier Leys , Charlotte Cordonnier Neurol Sci, 2018 Jun;39(6):1129-1131. CT and MR myelography in superficial siderosis Nicola Morelli , Eugenia Rota , Paolo Immovilli , Giuseppe Marchesi , Emanuele Michieletti , Donata Guidetti		releases erythrocytes or blood cells into the CSF - It is very rare with less than 270 total reported cases - Affects people of a wide range of ages - Men three times more than women - Signs and symptoms include – hearing loss, ataxia, pyramidal signs, dementia, bladder disturbance, anosmia and anisocoria - Treatment with deferiprone which is an iron chelator – a study showed that treatment appears to demonstrate a measurable reduction in 50% of patients which correlated with a stabilised or improving disease course	with neurological signs and symptoms I cannot explain. This patient presented with rapid deterioration in gait, developed bilateral drop feet and ataxia over a six-week period. If I was to see this condition again, I would never miss it, and the sooner treatment on deferiprone can be started the better the chance of improvement.

15-03-2020 30 min	Discussion with consultant specialist treating patient with superficial siderosis	0.5	I learnt: - Tremendous value of communication with medical colleagues - The treatment options available - There is no cure only management - It is a progressive disease - Diagnosis is difficult, and follows a process of elimination to start with - MRI has improved the diagnosis of superficial siderosis	I have a better understanding on diagnosis and treatment options that will be tried from a consultant view point with regard to medication. I learnt there is great benefit in reaching out to the medical community especially when a patient presents with such a rare condition. Having the opportunity to discuss the prognosis and treatment with the consultant has been a tremendous benefit. I believe this instilled confidence in the patient and family, knowing there was interdisciplinary communication.

Review	Plan
What do I want or need to learn in the next 12 months?	What learning activities will I do to achieve this in the next 12 months?
I have an interest in evidence-based treatment and research and want to progress my skills and knowledge in this area. I will complete a literature review as part of the assignment requirement for PP+ shoulder programme course. Together with the 2 case studies I have already completed, I will complete further case studies and intend to write a journal article to submit to ISCP Research and Evidence Journal. I want to learn the skills required to complete a literature review and write an evidence-based journal article.	I need to complete course on Physiopedia on writing a literature review. I need to complete further case studies on shoulder presentations and I will speak to my manager about scheduling these. I need to combine this into a journal article for submission.
I need to upskill in ACL pathologies and surgery. A specialist consultant within the unit is seeing more patients for both conservative and surgical management of ACL injuries.	I will attend surgeries with the consultant seeing different surgical approaches to ACL repair and hence have a clearer understanding when it comes to the different rehab approaches with those surgeries. I will complete PP+ courses titled ACL Rehabilitation programme. This consists of four courses: ACL Rehab Introduction; ACL Rehab Acute Management after surgery; ACL Rehabilitation Planning and ACL Rehab-Return to sport and re-injury prevention

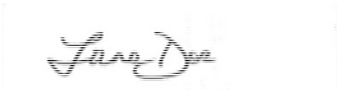
I will be on my first on call in the coming months and have identified a number of key skills that will be required to ensure my competence to undertake this role. This includes; 1. Oral and nasopharyngeal suctioning	There are in service training sessions run within the department which I will attend. I have also sourced documents from other sources which I plan to read and include: - NHS Oral and nasopharyngeal Guidance document https://www.bcpft.nhs.uk/documents/policies/s/1106-suctioning-oral-and-nasopharyngeal/file - https://www.sweethaven02.com/PDF_Health/MD542les04.pdf - https://www.bcpft.nhs.uk/documents/policies/c/1855-children-s-community-nursing-team-sop-12-suctioning-oral-nasopharyngeal/file There is an e-learning course I will complete - https://www.medexgroup.co.uk/elearning/suction-oral-and-nasopharyngeal-elearning/ -
2. Awareness of an acutely deteriorating patient	There are in service training sessions run within the department which I will attend. I have also sourced documents from other sources which I plan to read and include: - https://blogs.bmj.com/ebn/2016/11/20/1054/ - https://learning.wm.hee.nhs.uk/sites/default/files/recognising%20the%20signs.pdf
3. The use of cough assist	There are in service training sessions run within the department which I will attend. I have also sourced documents from other sources which I plan to read and include: - https://www.physio-pedia.com/Assisted_Coughing - https://www.worcsacute.nhs.uk/patient-information-and-leaflets/documents/patient-information-leaflets-a-z/2479-using-the-cough-assist/file

	- https://www.mascip.co.uk/wp-content/uploads/2015/10/Physiotherapy-use-of-Cough-Assist-Devices-or-Mechanical-Insufflation-BT-policy-general-1.pdf
Having completed the in- service training on cervical anatomy and post-operative complications, I want to upskill in assessment of red flags and upskill in the assessment of cervical arterial dysfunction.	I have downloaded but need to read International Framework for Red Flags for Potential Serious Spinal Pathologies Journal of Orthopaedic & Sports Physical Therapy Published Online: July 1, 2020Volume50Issue7Pages350-372 https://www.jospt.org/doi/10.2519/jospt.2020.9971 I am also going to complete the PP+ course Cervical Arterial Dysfunction
I want to upskill in the assessment of cervical arterial dysfunction. Having completed the previous cervical in-service, I realise I am lacking in knowledge and confidence to assess CAD.	I am also going to complete the PP+ course Cervical Arterial Dysfunction Following this I will present an in-service within the department
In the PP+ courses reference was made to using outcome measures. Although I am familiar with some outcome measures, I do not use outcome measures or self-administered questionnaires as part of my assessment. I aim to start including these more as it gives a more objective assessment value and can be used to show progress and treatment gains with regards to a reduction in pain, improved function and reduced disability.	I am going to start with the following outcome measures and become familiar with administrating and scoring them: - Visual analogue scale (VAS) - Short Form 36 (SF-36) - Neck Disability Index (NDI)

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

I want to upskill in my knowledge and assessment of chronic and acute pain and my skills in explain this to patients. I have identified this as a need as at present I cannot clearly explain his to patients and they have more questions which I do not feel I have the skills and knowledge to answer.	I will read Lorrimer Moseley and David Butlers 'Explain Pain'
I need to become more familiar with yellow flags and the assessment of yellow flags.	I will familiarise myself with and become competent in assessing fear avoidance and catastrophising. I have read some of Mick O'Sullivans work and will explore this further. The self-administered questionnaires I need to become more familiar with include: - Fear Avoidance Belief Questionnaire - Pain Catastrophising Questionnaire

I, the undersigned, certify that the information contained in this Record of CPD Activities is correct in all respects.



Signature **Date: 01/06/2021**

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CORU Registration Number **Total Number of Pages: 28**