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 Podiatrist for 20 years and is currently working part-time in private practice and holds a 0.5 WTE post in a HSE community setting.

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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| Name: | Jane Murphy | CORU Registration Number: | POD 01824 |
| Audit period from: | 1 April 2020 | Audit period to: | 31 March 2021 |
| Registration Board | Podiatrists Registration Board | | |

| Implement | | | Evaluate & Reflect | |
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| **Date and time spent**<br>When did you undertake this learning activity? | **Type of Learning Activity**<br>What was the name of the activity? | **CPD credits**<br>Approx. 1 CPD credit for every hour of new or enhanced learning achieved | **Learning Outcome**<br>What have you learnt through completing this activity? How have your skills and knowledge improved or developed? | **Impact on practice**<br>How have you integrated this learning into your practice? How has this learning made a difference to your capability and performance in your role? |
| 4/12/2020<br>2 hours | Online, Essentials of Wound care - Biofilms | 1.5 | Although I had a broad knowledge of biofilms, I had heard some conflicting views from other Health Care Professionals and felt I needed to go back to basics. My knowledge was from a working clinical environment rather than academic. I was wary as the course was provided by a pharma company so my concern was it would be commercially led. These concerns were unfounded.<br>I learnt that although my clinical appreciation of biofilms was good, I needed to be reminded of old learning and some newer concepts, such as: | I have felt that there has been misunderstanding of biofilms by other Health Care Professionals so now I have easy-to-access information that I can direct people to.<br><br>Interesting to note that biofilms are present (of course they are!) in chronic sinusitis as this affects many podiatrists and particularly now when there is greater use of face masks that may exacerbate the condition.<br><br>The course acknowledged the knowledge gaps and the lack of any one |

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| | | | There is likely self-perpetuating damage by some treatments and that although biofilms are seen in chronic wounds, their formation is rapid and it is based in the reduced metabolic activity of the bacteria that leads therefore to anti-microbial resistance. | test to determine presence of biofilms. So underlining the knowledge that we mainly rely on clinical judgement. |
| 14/04/2020<br>3 hours | Case review with diabetes team regarding a patient diagnosed with diabetic amyotrophy and followed by self-directed research and reading (Barohn, Sahenk, Warmolts & Mendell (1991). The Bruns-Garland syndrome (diabetic amyotrophy): revisited 100 years later. *Archives of neurology*, *48*(11), 1130-1135.: Dyck & Windebank (2002). Diabetic and nondiabetic lumbosacral radiculoplexus neuropathies: new insights into | 3 | Diabetic amyotrophy (DA) is fairly rare and I've only seen 2 cases in the last 15 years prior to this. It was an interesting learning experience as I always assume that other Healthcare Professionals HCPs will know more than me and their knowledge will be more current. From our case review it showed that my clinical base knowledge was good from the diagnosis point of view, but I then needed to learn more about the pathophysiology to be able to discuss my diagnosis.<br>There are a number of anomalies with Diabetic amyotrphy compared with other neuropathies, usually early in the course of the disease, with good blood glucose control and typically unilateral and proximal. | Diabetic amyotopghy is rare and it is possible I may never see another case, but with my recent learning I was able to inform other team members of differential diagnoses. |

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| | pathophysiology and treatment. *Muscle & nerve*, *25*(4), 477-491.) and follow up discussion with the team, neurology and physiotherapy | | | |
| April 2020 4hrs | Devising Protocol for Covid as per HSE Guidelines | 1.0 | The plan for 2020 was to upskill on dermatological conditions and improve my diagnostic skills in PAD assessment but with the COVID 19 outbreak conferences and workshops were cancelled and the initial priority became achieving excellence in infection control, protocols and decontamination.<br>I read the HSE Guidelines for COVID-19 learned how to implement effective infection prevention<br>Stay 2 metres apart<br>Cover the mouth and nose. Avoid touching eyes, nose, mouth.<br>Wash hands often with soap and water for at least 20 secs, use alcohol based (>60%) sanitiser.<br>Sneeze, cough into the elbow<br>Disinfect all touched surfaces.<br>Check for raised temperature, fever, cough, shortness of breath (and later; loss of sense of taste & smell). | To create a safe environment for patients and staff I implemented a clinical protocol for the private practice:<br>Less than 24 hours before appointment – I contact the patient to ask about status, contacts and symptoms & tell them that they will be temperature checked.<br>When patients arrive, they are triaged and sign symptom & contact questionnaire; this was added to their notes.<br>Complete step-by-step clinic cleaning and patient spacing protocol drawn up.<br>All staff required to read and discuss the steps. |

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| 1 April 2020<br>&<br>8th Dec 2020<br>1 hr | HSEland Online courses: 1. How to don & doff PPE<br>2. AMRIC Personal Protective Equipment | 1.0 | These courses were very useful in the clinic setting and my learning included:<br>Identify why and where I need to wear PPE.<br>Recognise the appropriate PPE in different situations.<br>How to safely put on and remove, and then dispose of PPE in different setting.<br>Putting on the extra PPE: visors, masks and aprons takes more time, so I had to practice putting them on in the clinic and then had to find a safe place to take off PPE so that I would not contaminate any other surfaces.<br>Doing this safely helps to protect me, patients and other staff from possible spread of infections and particularly COVID 19. | I have had to change the way I work: Before, I would have hurried to get ready but I now have a set of actions which are performed unhurriedly before and after treating any patient.<br>While I would always wear a mask anyway while drilling nails, I will now continue to wear a visor to protect my eyes from dust from the nail drill.<br>I now look around my area and assess the risks and dangers to reduce any chance of accidental contamination.<br>This change in practice will continue to enhance patient safety. |
| 18th April 2020<br>2 hrs | Reading about Clinisept:<br>**Bristow, I (2020)** Hypochlorous Acid, A new solution in Podiatry? Podiatry Now. 13-16.<br>And papers by:<br>**Selkon et al. (1999).**<br>**Ragab et al. (2017).** | 1.0 | I needed to have a good surface cleaner for my clinic and I kept seeing Clinisept coming up. I was not familiar with this product so I read some information about it and learned that Clinisept is Hypochlorous acid (HOCL) - pH 5.8<br>HOCL breaks down into salt and water so does not irritate skin<br>It is highly recommended in the literature as a decontaminant, a | I started to use Clinisept in the clinic as a disinfectant both on solid surfaces and skin. There have been no side effects or reactions and I will use it on broken skin as an antiseptic and anti-inflammatory agent. Analysing and evaluating research around the product, it allowed me to have confidence to use this product in practice in an evidence informed manner. |

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| | **Martínez-De Jesús et al. (2007)**<br>**Landsman et al. (2011)**<br>**Eryilmaz et al. (2013)** | | disinfectant, and has anti-inflammatory properties. | |
| 2h April 2020<br>1 hr workshop<br><br>5 hours follow up actions. | Mike James lecture "Online consultations" (podchatlive.com) | 3.0 | This lecture was very useful in preparing to deliver assessment/care online and I learnt or was reminded of the following points, :<br>• To make sure that my insurance covers online consultations & that I am working within my scope of practice.To be very aware of confidentiality and need to ensure that I and the patient are in private places when conducting online consultations<br>• That the normal consents apply; a reminder of the importance of compliance with GDPR.<br>• Raised awareness of the many online platforms available; zoom is not as 'glitchy' as some of the others. Whatsapp good for photo consultation.<br>• To prepare in advance; send prep email to patient. To | This was a very steep learning curve; I had to download apps and learn how to send zoom links out to patients. I can unmute and set up the video camera. I had to learn the utility of Whatsapp for photo sharing.<br>I listen really carefully to the patient because a lot of online consultation seems to be differential diagnosis.<br>I am confident that I am working legally and within my scope of practice, as outlined in my Code of Professional Conduct and Ethics.<br>I now have an increased awareness of the ethics involved in online consultation – the need to delete images and to have laptop encrypted.<br>Whatsapp photos worked really well and I will use this going forward to assess the need for a face-to-face consultation.<br>Patients were happy that they could be facilitated without having to leave their cocoon. |

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| | | | prepare the consultation-notes and white board for drawing, etc.<br>• The importance of keeping to a timetable – personally to allow time for admin & record keeping and not to keep patients waiting.<br>• The new importance of subjective assessment – let the patient tell their story; past med history, surgery, meds. Current problem, occupation, values.<br>• To let patient know that notes are being taken.<br>• Post-consultation care – follow up email with summary of consultation (so patient can verify) & advice.<br>• I was reminded of the importance to look and act professional online | |
| April 2020<br>5 Hours | Follow-up actions to enable on-line consultations:<br>**Read;** Zoom website instructions<br>**Watched**: Youtube instructional videos | 3.0 | I initially found this online working very difficult as it was something I was not familiar with but as I learned more and then put that into practice, I realised that this had enormous potential to provide a service to patients who were not in the 'urgent' | I had to be very aware of GDPR and patient confidentiality when contacting patients to set up their online consultations because many of the older adults do not have email accounts.<br><br>Using Zoom consultations facilitated patients who were cocooning, to have a |

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| | on how to conduct zoom consultations **Asked** other people who have more technology knowledge than I, about how to send links and use the waiting room facility | | category but still needed support, advice and encouragement.<br>• I learned how to download the Zoom app and how to send out zoom links to patients.<br>• I learned the Zoom utilities, such as 'unmute', breakout rooms and how to include participants.<br>• I learned how to give patients an appointment time and then how to finish a consultation and admit the next patient from the waiting room. I also learned to lock the meeting to prevent waiting patients from entering too soon.<br>• I learned how to create close captions to meet patient accessibility requirements (some patients are hearing impaired and I didn't want to shout, so they could read the text version of my questions). I quickly learned that I need to speak more clearly online. | patient centred online consultation in a confidential environment. Patients seemed to be very happy that they could be facilitated without having to leave their cocoon (when they got used to the technology).<br><br>Going forward online consultations may be a very useful service for patients who are unable or unwilling to attend the clinic and who do not need "hands on" treatment but require advice and help to self-manage.<br><br>Whatsapp photos worked really well and I will use this going forward to assess the need for a face-to-face consultation. This will free up time for both me and patients, and will enable patients to decide if they actually need a face-to-face appointment. |
| 28th April 2020<br>7-8pm | Back to basics - Communicating with patients (Online webinar) Emma McConnachie | 1.0 | I learned<br>• the importance of using leaflets to introduce patients to the practice, fees, consents. | I have started to create a bank of downloadable leaflets.<br>During the COVID 19 era I will offer to email leaflets rather than have too much paper to be handled. |

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| | Glasgow Branch - The College of Podiatry | | • Usefulness of pre-printed leaflets to remind patients of what happened during the appointment and recommendations for at-home treatment; application of moisturising cream, exercise, how to break-in, wear and care for orthotic insoles, etc.<br>• To provide step by step details of different treatment plans so that patient knows what is expected of them, what will happen and prevents arguments in case of litigation.<br>• It is important to date all leaflets to ensure these are regularly reviewed with the most up to date information.<br>• Importance of updating medical history at each visit. | Using leaflets improves patient autonomy by having the option to review all the suggestions and recommendations in their own time, (especially when there is a lot of information which is new and easily forgotten). They are encouraged to make their own suggestions based on this information and are enabled to have the ability to decide on their own treatment plan. |
| 25th June 2020<br>3 hrs | Online CPR update by Alex Chadwick, Blue Fox First Aid Training.<br><br>**Watched:** What To Do When Someone Is Choking - First Aid Training - St | 1.0 | Due to Covid 19 restrictions the annual CPR update had to be conducted remotely. While this update would not have been suitable for someone who is learning CPR, it was a very useful format for Podiatrists who have already attended several practical hands-on courses. We learned other valuable aspects of CPR. | I have downloaded the “what3words” app and have written down the eircodes of the clinics that I work in, to facilitate the emergency services if a patient collapses.<br><br>I am now continuously updating patients’ file at every visit to have the most up-to-date information about medical history and medications, so that |

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| | John Ambulance video<br><br>**Read:** Resuscitation UK website advice (resus.org.uk) | | While most of the basics were a review of basic CPR there was new learning in the form of updated CPR for the Covid 19 environment:<br>I learned; that when checking for breathing, do not put my cheek to the person's mouth to feel or listen for breaths, instead look across the chest to observe chest movement.<br>Put on a mask before approaching a casualty for the safety of both. Place a towel over the mouth and nose of an unconscious casualty.<br>Did not give mouth-to-mouth resuscitation, instead clear the airway and do 100/120 compressions/minute, press down hard and firm about 5cm.<br>To find the closest AED ring the emergency services and they will give the location and a code to open the box.<br>I learned that it is useful to download the "what3words" app to let emergency services know exactly where you are. | I do not give out-of-date medical information should a patient need emergency services. |
| 9th Sept 2020<br><br>1 hr | Katie Collins webinar; Back to basics - Infection control | 1.0 | Through this webinar I learnt, To ensure that the instrument washing bowls are labelled dirty and clean.<br><br>It is advisable to wear a visor for scrubbing dirty instruments. | I am more aware of decontamination and the need to maintain the logbook to document sterilisation.<br><br>This not only ensures a safe environment for both patient and staff but protects the practice in case of |

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| | | | Do not use wire scrubbers for instruments – causes microscopic abrasions which can trap microbes – use soft bristles.<br><br>Do not use ordinary nail scrubbers as these can cause micro-scratches on skins.<br><br>Protocol for environment decontamination<br><br>To remember about alcohol resistant organisms, eg. C Diff.and the importance of good hand washing – I now implement a long hand washing protocol between patients – at least 40 secs.<br><br>To check for the CE mark on facemasks and that FFP3 are vital for drilling fungal nails.<br><br>Throw out the Paragon domiciliary sharps container-it is not safe for use.<br><br>Covid specific –to space appointments to enable thorough cleaning between patients, remove magazines & leaflets, and no more than 1 person in the waiting room. | complaints. I have made up a checklist for decontamination, infection control and cleaning which makes life easier than trying to remember all the steps. |
| 2nd June 2020<br>5 hrs | Patient consultation: Feedback from patients how to | 3.0 | While discussing the private practice clinic protocol with a colleague I realised that it is important to have the | Now I read out the triage questions and consents and note that the patient was triaged/asked for consent in the notes. |

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| | improve the clinic hygiene | | patients' perspective. So, I took a random sample of the patients who had attended the clinic during May (urgent cases, high priority patients; many vulnerable) and I rang them asking open ended questions – Did you feel safe when you attended for Podiatry treatment? What could I do to make the clinic safer?<br>The answers included "No paper triage or consent; too much handling"; "The receptionist should be behind a screen"; "I was worried about wet bleach on the patient chair"; "Let us know what you are doing because when we come in, you have all cleaned but we don't know what we can or can't touch". I realise that while I was running around trying to find PPE and scrubbing and cleaning, it was really important to listen the patients' opinion. | A Perspex screen was erected on the desk in front of the receptionist.<br>I make sure that any surface that the patient touches is perfectly dry before the patient enters the treatment room.<br>I have printed the protocol and it is visible for all to see in the reception area – this highlights areas which are cleaned after each patient (door handles, chair arms and seats, units) and put up hangers for patients belongings.<br><br>Patients are now encouraged to make suggestions about improvements in both service and the clinic environment. |

| Implement | | | Evaluate & Reflect | |
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| 13th -15th April 2020<br>3 hrs<br>4th Nov 2020<br><br>4th Nov 2020<br>1 hr<br><br><br>April/May 2020<br><br>1 h | Ivan Bristow's online Dermatology course<br><br>Ivan Bristow online lecture: Skin Cancers<br><br>**Looked up** the recommended websites: dermnetnz.org (the clinical resource website about dermatology and skin conditions) and pcsd.org.uk (**Primary Care Dermatology Society**) | 3.0 | Conferences and workshops which had been cancelled now became available online as we all adapted to a new way of working:<br><br>Ivan Bristow presented an online dermatology course over 3 evenings: Skin, nails & skin cancers.<br>Lecture 1 focused on Skin: I learned about:<br>• Checking for underlying conditions; Tinea Pedis, Vit A, B, C, E, iron deficiency, diabetes (autonomic neuropathy) underactive thyroid, medications such as statins. Review the history; is there new medication, a new medical condition (DM, thyroid..), new bathing/washing products eg. Epsom salts? Older | I'm sure I have seen retronchyia before but never knew why it happened or the correct treatment. 1 week later I had this condition present to my clinic and I was able to refer for nail surgery with instructions.<br>I can now give evidenced based advice on treatment for skin and nail conditions.<br>I am much more aware of the possibility of skin cancers and will take a careful history even if it on the leg, make notes on size and local and refer if I am suspicious. Early detection saves lives. |

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| | **Read**; Scher & Daniels Nails – Diagnosis, Surgery, Therapy (ebook) by Rubin, Jellinek, Daniels &Scher (2018). | | medical history; Atopic, psoriasis, medications?<br>• Eczema & psoriasis rarely go between toes, mostly on flexor surfaces. Asteatotic eczema looks like “a dry river bed” & affects older people mostly in winter & may be caused by the drying effects of central heating or soap products.<br>• Discoid (nummular) eczema is thin & easily excoriated – affects younger women & older men.<br>• Treatment: Moisturiser, (not aqueous cream - contains sodium lauryl sulphate). Pump dispenser is most hygienic. 4 pumps for dry skin, 8 for very dry.<br>• Ointment or emulsifying best on foot which has no sebaceous glands – explain this to patients as rationale for application of greasy moisturiser; waterproofs and restores skin barrier function. More use of emollient reduces dose of topical steroid.<br>• Urea based cream holds moisture and upregulates skin to produce its own moisture. Eczema; urea | |

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| | | | cream on damp foot, damp sock and leave on at night.<br>• Steroid to control inflammation flares. 1% not much use on soles of feet.<br>• Tacrolimus cream (Protopic) or pimecrolimus cream (immunomodulating agents) can be used as steroid substitutes.<br><br>Lecture 2 focused on Nails.<br>I learned:<br>• To recognise fungi & pseudomonas, & to differentiate between pigmented streaks and subungal melanoma.<br>• The comparison of treatments for onychomycosis.<br><br>• I had never heard of retronychia; where the damage to the nail halts growth and then the “new” nail pushes the “old” nail up into the flesh instead of growing out & off. Treatment = removal of old nail and possibly the new nail if it becomes troublesome.<br>• To look out for verrucous lesions around the nails which may be squamous cell carcinoma. | |

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| | | | Lecture 3 focused on Skin Cancers. I learned:<br>• How to identify risk factors; To accurately record any lesions; Monitor for changes; If suspicious or diagnosis in doubt, refer to the GP / Consultant.<br>• The characteristics of Non-Malignant lesions - Seborrhoeic keratosis (BCP), Dermatofibroma, Pyogenic Granuloma, naevi.<br>• About the characteristics of malignancy of sweat glands (Eccrine Poroma), Pre-malignant Lesions (treatment is photo dynamic therapy (PDT)) and Malignant skin lesions: squamous cell carcinoma, Malignant melanoma: Verrucous Carcinoma, superficial spreading, nodular or Acral Lentiginous melanoma, Basal Cell Carcinoma (treatment is Curettage and electro-desiccation, Surgical excision, cryosurgery, PDT or occasionally x-ray therapy),<br>• The use of acronyms; ABCDE and CUBED | |

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| | | | • Coloured marks, Uncertain diagnosis, Bleeding, oozing or hypergranulation, Enlargement, Delay in healing more than 2 month should all be regarded as suspicious. | |
| 19th June 2020<br>1 hr | Nadia Dembskey online lecture on ”Chilblains & COVID toes” | 1.0 | Chilblains after COVID-19 (particularly in young people) were seen months after the chilblain season had finished & there were papers published every week about possible cause of this phenomenon. It is postulated that COVID-19 causes a condition which deprives red blood cells of $O_2$ as a result of a ‘cytokine storm’ which causes an inflammatory condition in small blood vessels. Skin manifestation is under reported. The chilblains in COVID-19 are different in histology from the ‘normal chilblain’. | I need to be aware of the possibility that skin lesions presenting outside chilblain season may be as a result of COVID-19. This may be important to a patient who was asymptomatic and may now have some immunity. |
| 16th June 2020<br>1 hr | Belinda Longhurst webinar: HPV & other viral lesion of the foot. [Glasgow Branch (College of Podiatry) Facebook Live] | 1.0 | From this webinar and from asking questions in the Q&A I learned:<br>• How to differentiate verrucae from corns and how HPV can emit anti-inflammatory cytokines and alter the function of Langerhans cells to promote immune ignorance to this HPV. | I am more confident about my ability to diagnose verrucae but very aware now to examine it more closely and to always suspect malignancy. While I will spend more time reassuring patients that verrucae do no harm & there is no magic bullet for treatment, I look at the verrucae under magnification to differentiate from squamous cell carcinoma. |

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| | | | • HPV types which affect feet and hands = 1, 2, 4, 27, 57<br>• Treatment requires a heightened immune response and there is no treatment which works 100%.<br>• "Hand foot and mouth disease"; itchy macules which resolve by peeling after about a week.<br>• Herpes Simplex can cause a herpetic whitlow when immune system is compromised and that Erythema Multiform macules are triggered by hypersensitivity to Herpes Simplex but these are just a hypersensitivity to the virus. | I enable patients to access websites such as PCDS (Primary Care Dermatology Society) which gives descriptions of lesions on their website and DermNet NZ and BDNG (British dermatological nurse group) so they can understand the pathology and treatment options. |
| 14th March 2021 | **Attended**: Online lecture on foot & ankle dermoscopy - malignant skin lesions as seen through the lens of the dermatoscope. Ivan Bristow<br><br>**Read**; Marghoob, A.A., Usatine, R., & Jaimes, N. (2013). Dermoscopy for the family physician. *American* | 1.0 | In this lecture I learned about using a dermatoscope and its importance in the diagnosis of basal cell carcinomas (BCC) which are common on the lower limb. I didn't know how a dermatoscope worked so before the lecture I read about its mechanism so that I could understand why it is used to investigate suspicious lesions.<br>I learned that looking at a superficial BCC through the dermatoscope you can see how it is well demarcated with sharply focussed deformed blood vessels which can be treated by curettage. Superficial pigmented BCC which although not | After this lecture I invested in a dermatoscope for private practice but it has become invaluable to all aspects of practice.<br><br>I will review this knowledge every time I see a patient with a lesion and will use the dermatoscope to investigate and become familiar with all the different lesions malignant and benign.<br>I will also use reflective practice after each patient on whom I use the dermatoscope and assess my need for further practice and training. |

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| | *Family Physician*, *88*(7), 441-450. | | urgent may be treated with Imiquimod cream.<br>Fibroepithelioma of Pinkus – a variant of BCC with a pink plaque with little obvious defined linear blood vessels requires urgent referral.<br>The individual discrete coiled blood vessels of Bowens Disease may be obscured by a keratolytic plaque which does not flake. Pigmented Bowens Disease is a result of very high UV exposure. (Treat with Imiquimod first).<br>Under the dermatoscope Squamous Cell Carcinoma which has metastatic tendency is seen as 2-3mm wide and thick, characterised by white circles with irregular blood vessels going toward the centre + erosion. Urgent referral.<br>The brown-grey smudges of Acral malignancy which differentiates it from naevi is easily seen on dermoscopy. | |

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| Wed 22nd April 2020 8pm – 9pm | Michaela Nuttall (Learn with Nurses) webinar; Blood Pressure - The Basics | 1.0 | During this lecture I learned that high blood pressure (BP) is the second biggest risk factor for premature death and disability (stroke or MI) & may be prevented or controlled through lifestyle changes. Determinants matter - people from the most deprived areas are 30% more likely to develop high blood pressure. High BP = risk factor in PAD Normal < 120/80, <80: BP < 140/90, >80: BP < 150/90<br>I learned about role of baroreceptors in carotid sinus & aortic arch– these maintain control of systemic blood pressure by 'negative feedback' – they respond to tension in the arterial wall; acetylcholine slows SA node & heart rate reduces in response to increasing BP. When BP is low, baroreceptor firing | As I now understand the mechanism of high blood pressure, it is easier to explain this in simple terms to patients and to reinforce lifestyle messages already given by GPs and nurses, - making every contact count.<br>I understand the importance of checking BP pressure before any invasive treatment as high BP can cause osteoporosis, leg & foot selling & damage to small arterioles & pressure on lymph vessels. |

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| | | | reduces parasympathetic control & permits central sympathetic control. Renin (hormone produced by kidneys) controls production of angiotensin (causes vasoconstriction & increase in BP) & aldosterone (promotes sodium retention and $H_2O$ reabsorption – increases BP)<br>I was reminded how Podiatrists can help by reinforcing the advice – a diet of whole grains, fruit, veg & low-fat dairy, reduce weight, reduce dietary Na and alcohol intake, increase physical activity. | |
| 2nd June 2020<br>8pm - 9pm<br><br>Jan 2021 | Michaela Nuttall webinar (healthsolutions.co.uk) Atrial Fibrillation – the basics: what is AF, why does it matter and how to treat<br><br>Prof Caroline Mackintosh OSGO Foot and Ankle virtual Conference (Atrial Fibrillation – what role can Podiatrists play in early detection?) | 1.0 | I often note irregular heartbeat on doppler assessment but wasn't confident in my ability to describe AF or explain to consequences to patients.<br><br>I learned that atrial fibrillation might come and go (paroxysmal atrial fibrillation – does not need treatment if heart rate goes back to normal). Medication is needed for persistent AF. It's not life-threatening, but could create blood clots that may lead to heart failure or stroke: The upper chambers (the atria) of the heart do not produce an effective, regular contraction, but contract irregularly. Blood can pool in the | I feel more confident to conduct opportunist vascular assessment and detecting persistent AF and referring to GP. This can control the symptoms and reduce incidence of stroke.<br>I can reinforce the advice on lifestyle changes similar to high BP. |

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| | | | atria and may clot which may be pumped to the brain, causing an embolic stroke. Atrial flutter is too fast heart rate. Many older people don't experience symptoms with AF being detected at check up. The cause of AF associated with damage to the heart as result of High BP, heart disease, pericarditis, cardiomyopathy, diabetes. Treatments to control heart rate & rhythm include beta blockers, anti-arrhythmic & anticoagulants, cardioversion, ablation, pacemaker. | |
| Monday 21st Sept, 28th Sept, 5th Oct 3 hrs | Martin Fox online lectures on "PAD, CLI or CLTI" **Watched**: Youtube videos; Peripheral vascular disease made easy **Read:** NICE (2018) guidelines | 3.0 | I knew that Podiatrists are important in diagnosing peripheral arterial disease PAD but did not appreciate our role in protection against amputation, heart attacks, stroke & early death. I should be carrying out vascular assessment (barrier was lack of confidence). Minimum PAD assessment: I can use the "Clinic template" questionnaire to document the history, symptoms & the 3 Ps: 1. Pulse palpation -> 2. Doppler -> 3. ABPI -> 4. TBPI before treatment. I have practised angling the doppler on many patients & trying to recognise the different signals. (Pad-database.co.uk) Not all PAD needs to be referred to vascular consultant; may need exercise | I carry out ankle brachial pressure index assessment (ABPI) as often as possible. I can now perform ABPI safely and competently, giving the rationale for my actions. I now check every patient (using 3 Ps) where I suspect a vascular deficit and have already referred several patients back to GP with the full details of all findings. |

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| | | | plan, dietetics, and medication (NICE guidelines).<br>I learnt how to differentiate between critical limb ischaemia (CLI) and critical life-threatening ischaemia (CLTI). | |
| 18th Jan 2021<br>2 hrs | Motivational Interviewing webinar Jen & David Unwin "A simple model to find patient hope for positive lifestyle change: GRIN | 2.0 | I was often disheartened when I have referred patients to their GP with conditions such as PAD and suspicious lesions, and the patient did not make or attend the appointment. I have used some motivational interviewing techniques to enable patients to take control of their health but I frequently felt that the patient did not fully appreciate the risks associated with the condition. I wanted to develop my skills to motivate and also to include advice.I watched this webinar by J & D Unwin and while this model was originally designed to achieve medication reduction in diabetes, it seemed very adaptable to other situations:<br><br>I learned about how to use the concepts of this model:<br>• Goals – agree on shared goals; ask the patient what they are hoping for, what difference that would make to their life. When they start to imagine a better | This model is working very well for all types of situations; applying cream to dry skin, keeping an eye on moles, and attending for Podiatry treatment more regularly.<br>This feels like a gentle model which is unforced and stops me from feeling desperate and feeling like a failure because they didn't do what I thought they should do.<br>I can confidently use this model in most situations in clinic and I feel that patients are now more receptive to my suggestions but this may be because my suggestions are open-plan. |

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| | | | future, they start to move toward it.<br>• Resources – the patient is the expert in their own lives, ask could they make changes to exercise, do they have a dog to be walked? a friend to buddy? A favourite walk?<br>• Increments – encourage patient to set small goals/aims/increments, eg. “when I see you again what steps might you have taken toward your goal?”<br>• Noticing – At review; reflect on what is working, give sincere compliments on successes, then ask; “What will you do next?”<br>This is a very doable model which fits into the treatment time, does not come across as artificial, and allows the patient space but with a structure in mind.<br>As a Podiatrist I am an expert in feet and using this model I can explain to the patient what they ‘should do’ from my viewpoint but then I can step back and allow them to choose where or when to start or even to choose to tackle a different aspect that I had not thought about. | |

| Review | Plan |
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| 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? |
| Assisted decision making: I want to learn more about ADM, the legislation, skills to improve communication with patients who have learning disability/ stroke or neurodegenerative conditions and to incorporate them into my practice to enable all patients to give fully informed and enabled consent. | Read legislation by end of May 2021.<br>Source lectures and information. Liaise with other HCPs who regularly have contact with people who have communication challenges by end of June 2021.<br>Post-grad modules in communication strategies by the Health Promotion Unit in NUIG in Oct 2021. |
| I need to keep up to date with skin manifestations of COVID-19. | I will read the abstracts of medical journals and buy the full-text articles if there is new evidence of skin manifestations. |
| I want to learn more about dermatological conditions. I need to learn more about the dermoscopy to enable me to be more confident in the diagnosis of naevus or melanomas. | I will subscribe to a dermatology journal by May 2021 and join the Primary Care Dermatology Society which has lots of educational events, diagnostic tools and an A-Z.<br>To undertake a practical hands-on course in dermatoscopy by Dec 2021.<br>Research other methods of treatment for verrucae by March 2022 |
| To become more proficient in vascular assessment. | Mentoring by Podiatrist who specialises in vascular assessment in NUIG in Oct 2021.<br>Enroll in a Post-grad vascular module in NUIG in Jan 2022. |

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

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

Jane Murphy
**Signature**

**16 April 2021**
**Date**

**POD 01824**
**CORU Registration Number**

**26**
**Total Number of Pages**