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ROYAL COLLEGE of PODIATRY

Accreditation of Individual Support Workers

Clinical Portfolio - Application Handbook 2023

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Contents

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Glossary

AP	Assistant Practitioner
AQA	Academic Quality Assurance committee
FCA	Foot Care Assistant
FHP	Foot Health Practitioner
GDPR	General Data Protection Regulation
HEE	Health Education England
MSK	Musculoskeletal
NHS	National Health Service
SNOB	Strengths, Needs, Opportunities, Barriers

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1.0 Introduction

The HEE **Standards for the Foot Health Workforce (also referred to as the Foot Health Standards)** have been created to expand the role of the foot health support workforce. The key objective of the standards is to ensure that the NHS recognises the knowledge and skills of the wider foot health support workforce. The standards provide thresholds at each level of practice for safe and effective patient care. By standardising foot health practice, the public and employers can build assurances regarding the level of care provided. Currently, not all of the foot health support workforce is able to work in the NHS due to variation in training and practice levels. Provision of accredited pathways that align training to the Standards for the Foot Health Workforce will provide a recognised threshold of practice.

An accreditation pathway for education providers offering training for the foot health support workforce Foot / Podiatry Care Assistants (FCAs), Foot Health Practitioners (FHPs) and Assistant Practitioners in Podiatry (APs) has been established. Newly qualified practitioners completing an accredited programme will now be able to directly apply for roles in the NHS, however, practitioners working in the foot health support workforce in independent practice who wish to apply for a role in the NHS will need to demonstrate by accreditation at which level of practice they work. This will be done by a clinical portfolio mapping their skills to the Standards for the Foot Health Workforce. Similarly, those who are already working in the NHS may wish, as part of their career development, to become accredited by completing the process.

This portfolio handbook is a personal guide for those individuals already working in the foot health support workforce wishing to have their individual practice accredited to the Standards for the Foot Health Workforce. Following successful accreditation, individuals will be able to apply for a support worker role within a NHS setting (Health Education England, 2021 **NHS England, AHP support worker framework).**

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2.0 Purpose

The individual accreditation process will provide the existing foot health support workforce the opportunity to demonstrate that they work at, or above, the threshold of the Standards for the Foot Health Workforce and are therefore eligible to apply for a role in the NHS. The portfolio process enables you as a practitioner to be recognised for the skills obtained in the key themes set out in the standards. The portfolio process allows you to map your current experiences and skills to the set standards based on the themes of practice.

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3.0 Aims

The key aim for developing a portfolio route for accreditation is to recognise those support workers who have already completed educational programmes relevant to the foot health workforce and who are already working at or above the Standards for the Foot Health Workforce threshold.

By completing the portfolio accreditation process, you will be demonstrating that you have developed a threshold skill set that underpins your daily work. You will be expected to meet the following three sections which are defined in the standards:

- Common Themes,
- Educational Standards and
- Clinical Domains.

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4.0 Eligibility Criteria

To be eligible to apply for individual accreditation you must have completed your foot health support workforce training and be actively working, or employed, as an FCA, FHP or AP.

4.1 Levels of Practice

As part of the foot health support workforce, there are recognised educational levels of practice based on initial training and continued professional development (Levels 3, 4 and 5). There are themes of practice that are general across all levels of practice. Then for each level of education and clinical practice there are specific criteria that are associated with the skills and standards at that level of practice. The Standards for the Foot Health Workforce define the professional levels of practice within the foot health care map (Figure 1). You should define, with mentor or peer support, which level of practice accreditation you are applying for. Reflect on what current practice you provide and align this to the defined level of practice in the Standards for the Foot Health Workforce.

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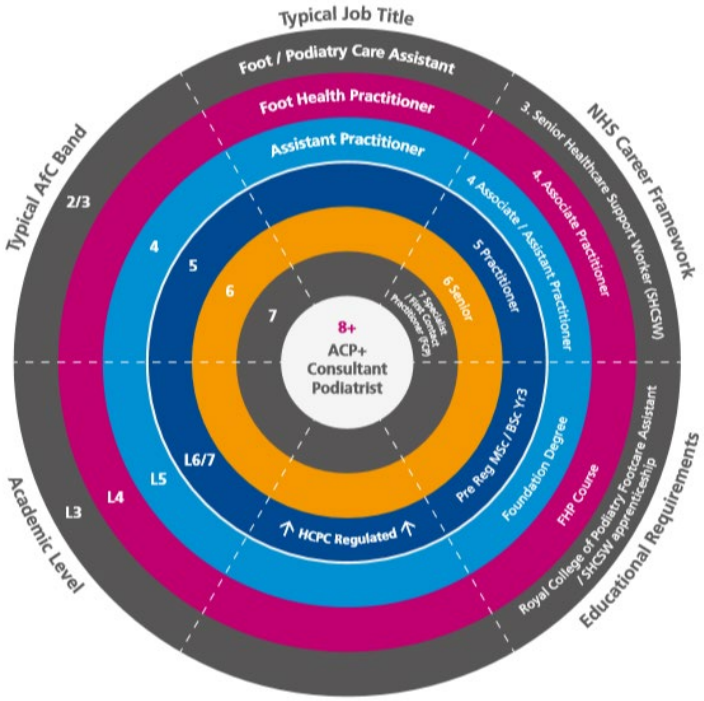

Figure 1 – Foot Health Care Map, from the Standards for the Foot Health Workforce, indicating the levels of education/ NHS banding and job role.

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5.0 Guidance and Mapping

This portfolio handbook is designed to provide guidance for any individual wishing to gain accreditation as a foot health support worker by the Royal College of Podiatry (RCPod). The process of gathering evidence is the responsibility of the individual and should be relevant to individual level of practice. At all times the evidence that you provide, to support the work, should remain compliant to all aspects of data protection laws and no information identifying a person should be made without relevant consent. The evidence you provide to support each of the standards should be supplied as part of your portfolio as an appendix with cross referencing to the relevant reflection section. (Appendix 4, Portfolio Proforma).

The Standards for the Foot Health Workforce are segmented into two areas “You will be able to” and “You will know and understand,” both which are relevant to the portfolio. The actions of “you will be able to” are consolidated in the Portfolio Mapping Matrix document for ease of reference. When constructing your portfolio, it is essential to refer to the completed Standards for the Foot Health Workforce document and address all the standards for both areas.

The standards cover 3 sections, with each section focusing on a different area (Appendix 1). Each section addresses different practices, which will require you to consider and reflect on the area and describe how you meet that standard of practice. From this exercise, a reflective piece of writing for each standard, supported by evidence of your work, will provide the content for you to build your portfolio. This handbook provides some examples to show you how you could support your work in the most relevant way but is not an exhaustive list. Individual applicants can provide other relevant evidence that would demonstrate that the standard has been met.

All elements of the portfolio should be completed before the document can be uploaded into the RCPod e-platform, TALUS, in a pdf format. It is acknowledged that one piece of supportive evidence

may be relevant to more than one of the themes and therefore a cross referencing model using codes, related to the standards, is recommended (see Case Study Exemplar Appendix 6) For example: a patient case history could demonstrate skill levels for several of the defined standards, you can cite these by a numerical referencing system highlighting which standard the work relates to.

The accreditation process is based on you demonstrating, in a portfolio format, which level of practice you work at, with evidence to support this practice mapped against the defined standards set out in the Standards for the Foot Health Workforce document. The outcome of your accreditation application will be based on the evidence that you submit in your portfolio. The assessor can only assess what you submit, and it is, therefore, vital that you include as much evidence as possible and mapped accordingly to all relevant areas.

Detailed description of the standards for the general and specific themes for each level of practice can be found here:
[**https://www.hee.nhs.uk/sites/default/files/HEE_Foot_Health_Standards_2021.pdf**], with the overview document and portfolio mapping matrix (Appendices 1 and 6), providing a concise summary of each standard with suggested modes of evidence.

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6.0 Application Process

Initially, details will be available on how to apply for accreditation via RCPod web page. This will include an application form with an expression of interest task (Appendix 3). The task will be assessed by the accreditation team and feedback will be given as to your success of applying for accreditation. Once this has been approved you will be able to proceed to apply for the portfolio.

The cohort of applications will be accepted by RCPod for portfolio accreditation via its e-platform, TALUS. Within the platform you will find relevant support and guidance documents to assist your portfolio construction. It is advisable to seek support and feedback from peers and line managers as to the relevance and suitability of your evidence included into the portfolio. It is also advisable to seek the support of a clinical mentors, or a peer, who would support you with defining areas of strength and development when creating the portfolio. (Appendix 2 Learning needs analysis - Strengths, Needs, Opportunities, Barriers SNOB). A mentor could be a colleague, supervisor or peer who would be able to direct you in your development and reflection.
The structure of the portfolio should adhere to the proforma in Appendices 3 and 4 of this guide, where the following sections will be required.

- Personal details – This standard form identifies the applicant with clear indication of what level of practice they are applying for.
- Common clinical standards – These eight themes are common across all levels of practice and provide a generic level of skills. Supportive evidence is required to demonstrate the applicant has met these standards.
- Educational standards – These standards vary between each level of care with additional skills present as the level of practice increases. Reflective statements as well as academic documents can support this section of the portfolio.

- Clinical standards - These standards vary between each level of care with additional skills present as the level of practice increases. Supportive evidence is required to demonstrate the applicant has met these standards.

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7.0 Timeframe

There will initially be a defined **open access** period of 18 months after the launch date to apply for accreditation with the RCPod. This initial open access period will allow those individuals currently in a foot health support work role to apply free of charge to be accredited in the first cohort. In the first instance there will be an **expression of interest** form (Appendix 3), that will allow the RCPod to complete an assessment of the levels of interest, this will be followed by an invitation to apply for accreditation.

On your initial application being accepted, you will then gain access to the e-platform, TALUS, where all the necessary resources will be available to you. From your accepted application, you will have a period of 12 months to upload your completed portfolio. This timeframe will give you the necessary time to gather the evidence and construct your portfolio.

After the open access period ends, any further applications will be accepted on an annual call from the RCPod and there will be an application fee which must be paid at the point of application. Similarly, on applying for accreditation in the future you will have a period of 12 months to upload your completed portfolio.

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NHS
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8.0 Feedback and Approval

Applications will be individually assessed against the portfolio mapping matrix. Assessors will be familiar with the standards, working with support workers or as one and will be appropriately qualified to assess if the portfolio has met the Standards of the Foot Health Workforce. Once assessed individually, the portfolios will be reviewed be a lead assessor who will then report the outcomes of the portfolios to the Royal College of Podiatry Academic Quality Assurance Committee (AQA), who will then decide if accreditation is granted. Feedback and approval status will occur within eight weeks of the application deadline and the portfolio will be classified as one of the following:

1. Approved – applicant accredited.
2. Approved with conditions – applicant to provide further evidence based on the feedback. The revised portfolio will be resubmitted at the next date for applications and must be accompanied by a detailed response to feedback, demonstrating where they have improved and altered their work. There will be no additional cost for re-submission
3. Not approved – applicants portfolio fails to meet the standards and needs considerable work. Feedback will be given to the applicant on where they have failed to meet the standards and the applicant will have a period of two years to address the feedback before reapplying. On resubmission, a further document should be submitted to indicate where they have improved and altered their work to meet the feedback. There will be no fee for resubmission.

8.1 Appeals

In the event of an applicant being unsatisfied with the outcome from AQA, they have the right to appeal this decision with a supported letter from a senior colleague, mentor, peer or manager, indicating where they feel that there has been an oversight of the examiners. An individual can appeal on the following grounds:

- The approval procedure has been incorrectly followed or
- There have been circumstances that affected performance of the individual that had not been divulged at submission of the portfolio.

All appeals will be considered by the RCPod and internally reviewed by the AQA. All decisions from this group are final and if unsuccessful, individuals will have to reapply.

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NHS
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9.0 Constructing the Portfolio

The clinical portfolio is a collection of supporting evidence that demonstrates how you meet the defined Standards for the Foot Health Workforce, the key sections to be completed can be viewed in the overview of Standards for the Foot Health Workforce (Appendix 1). When building your portfolio, you must work with the Standards for the Foot Health Workforce documents from HEE as well as the portfolio mapping matrix to ensure that you have met all criteria. Your portfolio should use the proforma starting with the personal information front sheet (Appendix 3) and then follow with a critical narrative of 4000-4500 words maximum that demonstrates you meet the standards (proforma Appendix 4). The personal construction of a portfolio allows you to showcase your skills and knowledge with relevant examples of the level of practice you work to. The document is a narrative of your experiences and will heavily rely on reflective practice and case study examples.

9.1 Reflective practice

The main body of your portfolio will include a reflection on the current practices you undertake in your role that meet the Standards for the Foot Health Workforce. Reflective practice includes a narrative on learning from the experiences you have had. Most reflective practice follows a cyclic notion of continued learning, where we learn from experiences and make decisions based on that learning. It includes a description of what has happened (in this case a standard to meet) and how you feel you meet that standard with evaluation of evidence and material that supports the standard. As you go through the cycle, you will become more analytical of how you meet the standard with a concluding plan to complete the cycle. This then provides a new experience to reflect upon and so the cycle starts again (Figure 2). Reflective clinical practice mapped to the Standards for the Foot Health Workforce will allow you to express and demonstrate a level of skill at your defined level of practice.

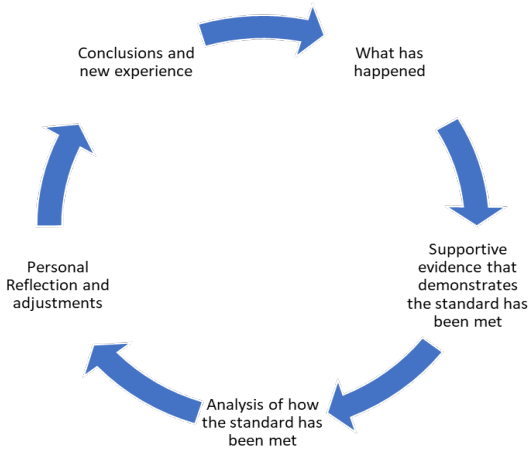

Figure 2: Reflective Cycle, applying the Standards for the Foot Health Workforce to clinical practices and practitioners.

You can describe an event or standard in detail and highlight with evidence of what happened, how you addressed the situation, what the impact was, and how that influenced your plan and progression. When looking at clinical reflection, the application of this practice can be easily applied to a patient history or case study with descriptions of the presenting problem, how the patient felt and interpreted the problem, what actions were taken and what was the impact of that, then reviewing and planning based on outcomes and experiences.

Examples of reflective clinical practice can be seen in Appendix 5 and additional information can be found from the following article Koshy *et al*., (2017)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5673148/

9.2 Case Study

Presenting a case study is another way to demonstrate how a standard has been met and at what level of practice you work to. Case studies are not specific guides for treatment but a factual record of clinical interactions. When writing a case study, all identifiable information should be removed

and a **third person tense** used (Atwood,2021), giving a broader non-personalised presentation of the case. Consent from the patient should be taken with knowledge that all data about them will be anonymised. Prior to writing your case study, all information about the case should be gathered including medical history and medication, diagnostic testing, social care plans, etc.

A normal format for writing a case study includes the following:

- History of the case – including information of the presenting problem and medical background
- Observations made – any details on assessment or initial perceptions
- Diagnosis and aims – an indication of a diagnosis with differential diagnosis thoughts
- Action to the problem
- Review or plan with suggestion for prognosis
- Conclusion.

An example of a case study can be seen in Appendix 6.

9.3 Other forms of evidence

Other forms of clinical and professional evidence can be used to support the descriptions in the portfolio. Although not exhaustive, Table 1 highlights other suitable forms of evidence that will help you map the standards to your clinical practice. The Portfolio Mapping Matrix document will help you see all the standards that need to be met with a suggestion on the type of evidence that could be used to demonstrate how the standards has been met. Where you work in independent practice without a supervisor or mentor, evidence of your work or how you meet the Standards for the Foot Health Workforce can be provided by a professional within your community healthcare network, e.g., GP, practice nurse, peer review, carer or other member of the multidisciplinary team.

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Evidence	Example	Evidence	Example
Advice Sheets	Patient information from the clinic or charity organisations	Working practice procedures	Clinical set up and practices
Assessment Sheets	Patient consent and other assessment proformas	Team working	Arrangements and set up of team working
Testimonials	Patient and peer testimonials on your work	Diary Systems	Mechanisms for time management and patient appointments
Referral mechanism	Pathways of referral	Photographs	Demonstration of practice and clinical set up
Guidelines and policies	Department policies, national and regional guidelines	Flow diagrams	Demonstration of pathways, policies and procedures
Professional Development	Courses and seminars attended for CPD	Care Plans	Agreed care plans for patient management
Membership	Groups and professional memberships	Support groups	Patient and professional support groups

Table 1: Examples of evidence that can support each standard of practice.

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10.0 Submission

On agreement with peers and mentors, your final portfolio can be submitted through the e-platform, TALUS. A PDF version of your portfolio is required, allowing for a collection of multimedia to be combined. On submission of your work, you will receive feedback after marking and accreditation status within eight weeks of your deadline.

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11.0 Accreditation

On your portfolio being successfully accredited by the RCPod, you will be able to apply for roles in the NHS that match the level of practice that you have been approved for. The accreditation given is aligned to your level of practice and should only be used to demonstrate this.

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12.0 Further reading

To help you build your portfolio you may find the additional information of use:

Atwood, M., 2021. *What is third person point of view in writing?: how to write in third person narrative voice with examples* [online]. Masterclass: San Francisco. Available at: **https://www.masterclass.com/articles/what-is-third-person-point-of-view-in-writing-how-to-write-in-third-person-narrative-voice-with-examples** [Accessed: 26.07.2023].

Health Education England., 2021. *Allied Health Professions' Support Worker Competency, Education, and Career Development Framework: realising potential to deliver confident, capable care for the future* [online]. Health Education England: Birmingham. Available at: **https://www.hee.nhs.uk/sites/default/files/documents/AHP_Framework%20Final_0.pdf** [Accessed: 26.07.2023].

Koshy, K., Limb, C., Gundogan, B., Whitehurst, K. and Jafree, D.J., 2017. Reflective practice in health care and how to reflect effectively. *International Journal of Surgery. Oncology* [online]. July, vol. 2, no. 6, pp. 1-3. Available at: **http://doi.org/10.1097/IJ9.0000000000000020** [Accessed: 26.07.2023].

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Appendix 1

Portfolio construction should be developed in conjunction with the Portfolio Mapping Matrix Document and the HEE Standards for the Foot Health Workforce. The standards are split into three sections as stated below and all sections need to be addressed in your portfolio reflecting the level of practice you work at. For each of the standards, a short description should be provided on how you address and maintain the level of practice defined in the Standards for the Foot Health Workforce and, where relevant, support this with evidence.

Section 1

Common Themes

The following themes are common across all levels of practice and all individuals completing the portfolio should map evidence against each of the themes.

- Health and wellbeing
- Person centred care, treatment and support
- Communication
- Team working
- Personal, people and quality improvement
- Health, safety and security
- Duty of care and candour, safeguarding, equality and diversity
- Basic life support.

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Section 2

Educational Standards

The following educational standards vary across all levels of practice and all individuals completing the portfolio should map evidence against each of the themes relevant to the level of practice they are applying for.

Academic Level 3

Key and transferable skills (1-9)

Practical skills (10-17)

Knowledge and understanding (19-23)

Academic Level 4

Key and transferable skills (1-9)

Practical skills (10-17)

Knowledge and understanding (19-28)

Academic Level 5

Key and transferable skills (1-9)

Practical skills (10-18)

Knowledge and understanding (19-33).

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Section 3

Clinical Domains

The following clinical standards vary across all levels of practice and all individuals completing the portfolio should map evidence against each of the domains relevant to the level of practice they are applying for.

- Health check
- Nail care
- Dermatology
- Musculoskeletal (MSK)
- Wound management
- Assisting in theatre.

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Appendix 2

SNOB Analysis

What is it?

It is a method of self-assessment, which allows you to identify your strengths, needs (areas of improvement), opportunities and barriers.

In order to get the most from this exercise, you need to be honest with yourself. Honesty will allow you to identify your goals, which will then enable you to formulate a personal development plan.

Strengths/Skills:

- What do you do well?
- What are you confident about?
- What are your good qualities?

Needs:

- What would you like to do better?
- Do you perceive any problems in yourself?
- Is there anything holding you back?

Opportunities:

- How can you improve?
- Are there any learning opportunities available?
- What is happening in your part of the profession?

Barriers:

- What might stop you developing?
- Does anything worry you about the profession and your part in it?
- Does anything worry you about your workplace and your part in it?

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SNOB Analysis activity

Use this SNOB tool to assist you in identifying your learning and development needs.

You should discuss this with peers and any supervisors or mentors.

Don't forget, you need only share what you feel happy about someone else seeing.

Initial Needs	
Strengths/Skills	**Needs**
Opportunities	**Barriers**

Review 1 (if required)	
Strengths/Skills	**Needs**
Opportunities	**Barriers**

Review 2 (if required)	
Strengths/Skills	**Needs**
Opportunities	**Barriers**

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Appendix 3

Portfolio Front Sheet/Expression of interest

Portfolio Application	ROYAL COLLEGE of PODIATRY
Name:	
Address:	**Phone:**
	Email:
	Work Email:
Place(s) of Work:	
Level of Practice: Level 3 ☐ **Level 4** ☐ **Level 5** ☐	
Training Course Completed:	
Summary of Current Role (300-400 words – including hours and place of work, key roles and a brief summary of the work you complete).	
By attaching this cover sheet to your work, you declare that you have read the Portfolio handbook and understand the Royal College of Podiatry accreditation process for individual approval of the foot health workforce. Additionally, you declare that all evidence provided associated with this work is related to your own work and that there is no evidence of professional misconduct or plagiarism.	
Signed:	**Name:** **Date:**

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Appendix 4

Portfolio Proforma

Section 1 Common Themes
Introduction a short introduction to current role and how overall you meet the common themes in your practice. For each theme you should demonstrate with a short narrative how you meet each of the standards defined: **Health and wellbeing** **Person centred care, treatment and support** **Communication** **Team working** **Personal, people and quality improvement** **Health, safety and security** **Duty of care and candour, safeguarding, equality and diversity** **Basic life support** **Conclusion** a summary of your work

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Section 2 Educations Standards

Introduction *a short introduction to current role and how overall you meet the educational standards in your practice.*

For each educational area you should demonstrate with a short narrative how you meet each of the standards defined:

Key and transferable skills

Practical skills

Knowledge and understanding

Conclusion *summary of your work*

Section 3 Clinical Domains

Introduction *a short introduction to current role and how overall you meet the clinical domains in your practice.*

For each clinical domain you should demonstrate with a short narrative how you meet each of the standards defined:

Health check

Nail care

Dermatology

MSK

Wound management

ROYAL COLLEGE of PODIATRY

NHS
Health Education England

Assisting in theatre

Conclusion *summary of your work*

Appendix

All supporting evidence can be placed in an appendix and cross referenced in the statements for each section.

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Appendix 5 Reflective clinical practice examples

Reflective Practice – an exemplar

A review of your clinical practice whilst applying the Standards of the Foot Health Workforce will enable you to demonstrate how you are practising at the chosen level. The examples below are based on these standards and follow the sections and themes created (See Appendix 1).

The reflective cycle (as per the example of Figure 2, page 7) of continued learning will aid you define areas for career development and growth as well as assist you in evaluation of your current skills. Below are examples of reflective writing aligned to the defined sections and themes of the Standards of the Foot Health Workforce. Including appendices in your portfolio should be used to support the evidence provided, enhancing the reflective part of the portfolio.

Example for Section 1

Common Themes

Health and Wellbeing

When considering the health and wellbeing of patients, I pride myself in providing a safe and effective treatment for them. When looking at implementing a treatment plan, I endeavour to review information changes that may have occurred since the last treatment. Communication with the patient is essential to ensure that practice is current and relevant. [Evidence 1, Patient testimonial]. This was evident on a recent occasion when the patient I was treating spoke throughout the treatment about her brother and how he supported her. She indicated that he applied cream to her feet as she couldn't do it anymore, as previously defined on treatment plan. On leaving the appointment, in conversation with the patient's daughter, it became apparent that the brother had recently passed away and that the patient was distressed about the situation. This

broader communication with family members made me mindful of the impact this had had on the patient [Evidence 2, Support statement] and her care. At the next appointment, the patient did indicate that her brother had recently died and she was struggling to apply the cream, that we had previously discussed, to her feet. By having wider discussions with patients and their family I can signpost and provide effective measures to assist their wellbeing.

Example for Section 2

Educational Standards

Practical Skills

The patient is at the centre of all decisions made for their care. It is vital to provide them with a safe effective treatment that will keep them informed of their foot health status [Evidence 3, Referral pathways]. On reviewing a regular domiciliary patient, it was evident that there were some hygiene changes in their foot health. After a short discussion, the patient indicated that she had experienced a different carer who was less attentive to her. This led onto wider discussions with the care provider, who altered the care package provided, resolving the issue. Creating a wider holistic approach to patient care encompasses all elements of the patient's foot health needs. The changes were recorded in the patients notes with a short correspondence to the new care team about hygiene changes [Evidence 4, patient records]. Continued domiciliary care for the patient included assessment of foot health as well as social wellbeing. I was able to escalate a concern for the patient, change a service for them as well as review the needs of the patient showing how I am able to identify, respond and refer patients who have altered needs.

Example for Section 3

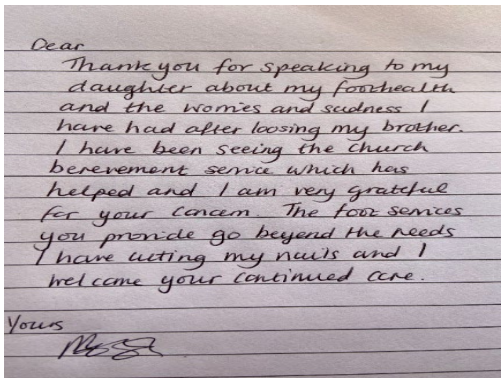
Clinical Domains

Nail Care

On reviewing a routine patient for care of thickened nails, it was evident that there had been trauma to the right first nail with dried blood on the apex of the toe. The patient recalled that the toe was sore since stubbing it on the bed. On examination, the toenail had fractured in the medial

sulcus and was avulsed from the nail bed. There were no signs of infection, only trauma. This was confirmed on escalating to the supervisor who directed a new treatment pathway to manage the nail [Evidence 5, Care plan]. The nail was clipped back filed and the nail bed wound was cleansed and dressed with an appropriate dressing. The patient returned four days later for a dressing check where the wound had healed, and routine care continued. Being able to provide responsive care to patients allows me to implement the relevant training that I have received and is rewarding to see patients recover from trauma due to the care I have given. I can identify nail disorders and implement the relevant care defined. Reviewing the outcomes after a few days completes the cycle of care ensuring a safe and effective treatment is utilised [Evidence 6, Example of working practice]. By attending to these conditions, I can build skills and confidence in the care I provide enabling me to become a more effective practitioner.

Evidence 1: Patient Testimonial



Dear
Thank you for speaking to my daughter about my foot health and the worries and sadness I have had after loosing my brother. I have been seeing the church bereavement servic which has helped and I am very grateful for your concern. The foot services you provide go beyond the needs I have cutting my nails and I welcome your continued care.

Yours

Evidence 2: Support Statement

From: [redacted]

To: [redacted] Cc & Bcc

support statement

Dear XX

I am happy to provide a support statement for you accreditation portfolio that corresponds to the rest care you showed my mother. We were aware that she had not taken the news well about her brother passing away but did not know that it had such an impact on her. By you raising the concerns we were able to talk more openly to my mother about her loss and got her some support offered for bereavement from the local church. We appreciate the support and care that you have shown to her and feel that you provide a high level of care.

We support your continued service

Mrs xxxx

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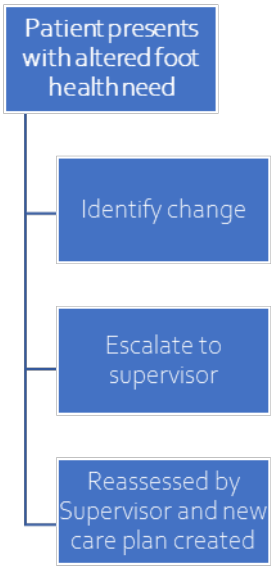
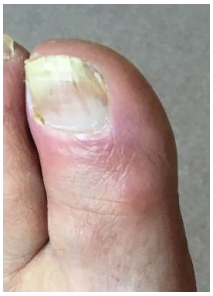
Evidence 3: Referral pathways

Referral Pathway Foot Health Changes



Evidence 4: Patient Records

Evidence 5: Care Plan



PLAN: Continue with care of regular nail cutting until there are any changes observed which should be highlighted to the relevant supervisor. (Where work is

not supervised and changes beyond scope are observed, then referral to the relevant member of the community healthcare network are followed).

Evidence 6 Example of working practice

Patients nail after treatment, evidence of nail thickening but the wound has healed, and nail cut back, consent received from patient.

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Appendix 6 Case study examples

Case Study Writing – An Exemplar

When looking at a case study to describe a patient's story there are certain factors to consider. The following will help you describe your chosen 'story,' with a proforma to creating a written case study. By including the details advised here you will be able to map the Standards for the Foot Health Workforce directly to the skills you have.

1. History of the case – including information of the presenting problem and medical background
2. Observations made – any details on assessment or initial perceptions.
3. Diagnosis and aims – an indication of a diagnosis with differential diagnosis thoughts
4. Action to the problem
5. Review or plan with suggestion for prognosis
6. Conclusion.

Writing in the third person improves the quality of the presentation. Cross referencing your work to the Standards for the Foot Health Workforce will demonstrate where and how you have met the criteria. In the examples below, the standards have been cited by CT = Common Themes, ES = Educational Standard and CD = Clinical Domain and then the number of which standards the content refers to. There are other methods to indicate where the case study fits into the portfolio including a small introduction and mapping paragraph highlighting which standards the work maps to.

The following case history/studies are examples written at each level education, which may be of use for you to build your own work.

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Level 3

History

A 75-year-old male presented to the service with long-standing challenges in self-management of nail care. Care had previously been given by a family member but that was now difficult and a detailed conversation with the patient's daughter highlighted the challenges she had with attending to his nails [CT 3.2 & 5.1, ES 1, CD 1.1.1]. Work history revealed the patient had sustained a chronic back injury whilst working as a manual labourer and was unable to bend comfortably. Now retired, activity was a low level with restrictions in walking but able to take part in activities of daily living [CT 2.1, ES 12]. There were no other underlying medical complaints, the patient did smoke and depended on support for shopping. These were checked with the patient as being current and relevant and consent was gained for observations to be made [CD1.1.2 and 1.1.3].

Observations

On examination the nails on both feet were long in length with some damage observed to the lesser digit nails. The patient commented on how the nails were long and pulling on bedding as well as some soreness in the first nail on the left foot [CD 1.1.5]. Both first nails were thickened and discoloured with a brittle presentation in keeping with onychomycosis, this had been previously diagnosed and persisted [CD 2.1.3]. There was anhydrosis of the skin, which the patient was aware of and had been using an emollient. This was harder to use more recently due to mobility issues [CD 3.1.3, 3.1.4]. As the skin condition had deteriorated, a report was made to the lead supervisor indicating a risk of cracking from the skin and difficulty in self-management [CT 5.3, ES 20, CD 1.1.6].

Diagnosis

Long nail length with both first nail previously diagnosed onychomycosis. Advancing anhydrosis which is not being self-managed.

Action

After careful preparation of the foot, the treatment plan was followed of nail care with reduction of first nail with a nail file only. Nail care was required to prevent cutaneous injury and possible infection [CD 2.1.6 – 2.1.10]. Emollient was applied to the skin as previously indicated in the care plan. However, as this had deteriorated and there were defined issues with self-management further supervisory input was requested [CT 2.3, 2.6, ES 14, CD3.1.9, 3.1.10]. A discussion about the patient's smoking habit and the potential issues that can be associated including peripheral arterial disease [1.4]. All treatment and advice were recorded, and a discussion was had with the patient's daughter to advise about the changes in the skin condition. This was communicated with the patients consent [CD 1.1.12, 1.1.13, 2.1.13].

Review

After supervisory input and communication with the patient's daughter, a long handled emollient applicator was purchased to enable the patient to apply emollient to the feet after bathing [CT 1.2,3.2]. This assisted the patient in maintaining a healthy skin condition and helped prevention of deterioration and fissures forming. On visiting for a third treatment 3 months later [CD 1.1.14], there was marked improvement of the skin quality and brittle appearance of the nails. The patient was encouraged to continue with the emollient and the improvement was noted in the records [CT 3.5, CD 2.1.15].

Conclusion

After consulting with the supervisory team, patient and family members, the needs were reviewed and assessed a continuous care plan agreed and adhered set to improve the foot health of the patient.

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Level 4

History

A 78-year-old female retired maths teacher presented to the service with a recurrent callus on the plantar aspect of the right 4th and 5th metatarsal heads. At initial contact, after confirming details in care pathway, consent was taken from the patient for assessment and treatment to be completed [CT 1.1]. The patient had recently bought new shoes as there was a hole in her trainers, the new shoes were not as comfortable [CT 2.1, ES 12,]. The patient associated the painful lesion with this change in footwear and had attempted to self-manage the issue by filing the area. The patient remained on her current medication of omeprazole and naproxen, for management of her lower back complaint, of which she was awaiting a further opinion from the orthopaedic surgeons.

Observations

On examination, there was callus on the right 4th and 5th plantar metatarsal heads [ES 19,20 & 25]. The surrounding tissue on the lateral aspect of the 5th metatarsal was more inflamed than usual, in keeping with footwear irritation [CD1.2.1, 2.1.3]. This change in presentation was escalated to the supervising team [CT 5.6]. Assessment of the footwear worn to clinic showed a thin sole to the shoe with a narrow toe width [CD 1.1.7].

Diagnosis

Plantar callus from fat pad atrophy due to the change in footwear, additionally irritation from the shoe to the lateral border of the foot [ES3].

Action

The lesions and surrounding areas were prepared with antiseptic solution and precautions were taken to maintain a clean environment around the lesion [ES 26]. The lesion was debrided removing all callus as per the treatment plan [CD 2.3.3]. There was evidence of superficial localised infection which was flagged to the supervising clinician who directed the correct use of topical dressing to be

applied. It was checked with the patient that they had no allergies to components in the dressing and then the lesion was bathed with cleansing solution and the dressing applied [CD 5.1.7]. Additionally, an offloading pad with cushioning was used for pain relief around the area [CD 4.2.4]. A template was taken of the shoe for a simple insole to be made as a longer-term intervention [CD 4.2.5].

Review

The patient was given instructions from the supervisor on how to monitor the lesion for progression of the superficial infection. The dressing was reviewed one week later as per the treatment plan, where on removal of the dressing the area had healed with no swelling present and the skin returning to normal appearance [5.1.10]. Footwear advice was provided for the patient to help prevent a further recurrence of the lesion [5.1.8]. Advice was given about self-management with a file and the cushioned insole was fitted to help prevent further problems [CD 4.7.2]. On review six weeks later, the patient reported that the callus no longer bothered her and that the insole was comfortable to wear with suitable shoes being worn [CD 4.7.3].

Conclusion

Self-management of the callus with a file and inappropriate footwear had led to superficial infection of the surrounding tissue. This was rectified by debriding the callus, application of the appropriate medicated dressing and advice for the patient. Footwear styling was discussed and a simple insole with cushioning solved the problem from reoccurring.

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Level 5

History

A 64-year-old female, who works as a full-time carer, presented with pain posterior to the right medial malleolus radiating along the medial border of the foot, onto the navicular. Pain was worse when raising on to the toes and walking over 3 km. Pain was described as a dull throbbing pain and there was no pain at night. A clinical history revealed an injury some 4 months ago when taking on a long walk challenge. There have been peaks and troughs in the presenting symptoms, which were not improving [CT 2.1, CD 1.1.5]. Medical history highlighted that the patient has been treated for rheumatoid arthritis for the last 15 years with methotrexate and steroid management [CT 1.3.1].

Observations

Anatomically, the region of pain corresponded to the route of the tibialis posterior tendon as it wraps around the medial malleolus. There was swelling around the medial malleolus and pain at the insertion of tibialis posterior on the navicular [CD 1.4.1]. When asked about the level of pain at present, a visual analogue scale produced a pain level of 4. Other significant history included an increase in BMI to 30, which accompanied with flat foot posture which has been highlighted as a contributing factor in developing tibialis posterior dysfunction (Arai *et al.,* 2007) [ES 32]. From the supervisory assessment, it was noted that in weight bearing examination the right foot was markedly more pronated than the left and the patient was unable to elevate weight on to the forefoot in a heel raise test [CD 4.3.1].

Diagnosis

Grade II tibialis posterior tendon dysfunction (Johnson and Strom, 1989).

Action

Working with the advanced musculoskeletal (MSK) podiatrist through a full biomechanical assessment, bespoke orthoses had been made to support the foot and reduce the load on the

tendon. The patient was given advice on how to use the orthoses at the fitting appointment with specific instructions on footwear choices [CD 4.3.3 & 4.7.2,]. Advice was also given about the potential issues that could occur from wearing the orthoses, including arch irritation and other lower limb pain.

Review

After 8 weeks, the patient was reviewed to assess the effectiveness of the device. Although the pain had significantly reduced, there had been some problems with the shape of the device with arch irritation present over the navicular [CD 4.7.4]. This was referred to the supervisor for modification and adaptation of the prescription which resolved this issue.

Conclusion

Increased walking in a medically compromised patient caused injury to the posterior tibial tendon. This was effectively treated with bespoke orthoses and footwear advice which resolved the presenting complaint when modifications had been made.

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References

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- Johnson, K.A. and Strom, D.E., 1989. Tibialis posterior tendon dysfunction. *Clinical Orthopaedics and Related Research,* February, vol. 239, pp. 196-206.