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Consultation on draft

Standards of Practice

June 2017

Consultation paper

22 June 2017

The Podiatrists Board of New Zealand is consulting on its new Standards of Practice document, intended to replace its current Code of Practice. The consultation paper (following) proposes:

- To replace the Board's current Code of Practice with its new Standards of Practice document.

Please provide feedback by email to registrar@podiatristsboard.org.nz by close of business on 2 August 2017.

How your submission will be treated

Submissions may be published unless you request otherwise. The Board may publish submissions on its website to encourage discussion and inform the profession and stakeholders. However, the Board retains the right not to publish submissions at its discretion, and will not place on the website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the consultation.

Before publication, the Board may remove personally-identifying information from submissions, including contact details. The views expressed in the submissions are those of the individuals or organisations who submit them and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board also accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Please let the Board know if you do not want your submission published, or want all or part of it treated as confidential.

Overview

June 2017

Consultation on Standards of Practice

This consultation paper seeks feedback on this proposed draft document.

The Board will consider the consultation feedback on the draft Standards of Practice before finalising and introducing the document.

Please provide feedback by email to registrar@podiatristsboard.org.nz by close of business on 2 August 2017.

Background

The Board operates under the mandate of the Health Practitioners Competence Assurance Act 2003 (HPCA Act). The principal purpose of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practice their professions.

Requirements for registration, defining scopes of practice, accreditation of education providers, practising certificates, fitness to practice, continuing competence and dealing with complaints and discipline matters are some of the many ways that the Board undertakes its role under the Act's ambit.

The HPCA Act is available at http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Estimated impact of the revised document

The impact on practicing podiatrists and other stakeholders arising from the changes proposed in the revised document, are expected to be small.

The Standards of Practice provides guidance to practitioners about professional, clinical and ethical conduct, and further clarifies and modernizes the guiding principles already set out in the Board's Code of Practice.

Standards of Practice

The Standards of Practice seeks to help and support registered practising podiatrists to deliver effective health services within a competent professional clinical framework. Practitioners have a duty to make the care of patients their first concern and to practise safely and effectively. Maintaining a high level of professional competence and conduct is essential for good care.

The **Standards of Practice** contains important standards for practitioner behaviour in relation to:

- professional practice
- patient partnership
- effective communication
- patient assessment and treatment plan
- documentation
- working environment
- continuing professional development

including;

- providing good care, including shared decision-making
- working with patients
- working with other practitioners
- working within the health care system
- minimising risk
- maintaining competent professional performance
- professional behaviour and clinically safe conduct
- ensuring practitioner health, and
- teaching, supervising and assessing.

You are invited to provide feedback

The Board is seeking feedback on the proposed draft Standards of Practice as well as on the following questions;

- Is the content of the Standards of Conduct helpful, clear and relevant?
- Is there any content that needs to be changed, added or deleted?
- Do you have any other comments on the proposed Standards of Conduct?

Next steps

The Board will consider the valuable feedback from consultation and decide whether to revise the document to take the feedback into account. The Board will then release the final version of the Standards of Practice with information about the timeframe for implementation

Podiatrists Board of New Zealand

STANDARDS OF PRACTICE

2017

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INTRODUCTION

The Standards of Practice play an important role in the delivery of best practice podiatry to patients and it is important to understand the place of these standards in everyday clinical practice.

Firstly, podiatrists must practice within New Zealand law, acknowledging the partnership with tangata whenua established by the Treaty of Waitangi. The Health Practitioners Competence Assurance (HPCA) Act 2003 is the primary piece of legislation that requires podiatrists to meet the Podiatrists Board's (the Board) competencies for registration and recertification.

Podiatrists must work within the podiatry scope of practice as gazetted by the Board and abide by the Board's Ethical Codes and Standards of Conduct.

Podiatrists must work within the legal framework that impact upon the practice of health care in New Zealand. In the case of a complaint or legal action against a podiatrist, the Health and Disability Commissioner or the Health Practitioners Disciplinary Tribunal may refer to these Standards of Practice to establish whether the podiatrist concerned was practicing to the level expected by the profession.

The purpose of these Standards is to cover the profession's expectations of all practicing podiatrists. Effort has been made to ensure the criteria chosen and the guidance given remains in keeping with current best practice podiatry.

These Standards of Practice support the Board's Ethical Codes and Standards of Conduct and provide the basis for podiatry practice in all settings.

Podiatry is a constantly evolving profession and there is ongoing change in the health and social sector with a continual drive towards excellence and consistency in clinical practice.

The term 'patient' has been used throughout this document but is synonymous with 'client/consumer' which may be the preferred term in some podiatry settings.

The Podiatrists Board of New Zealand would like to acknowledge Physiotherapy New Zealand and their Standards of Practice which has been the basis for the Standards of Practice for the Podiatry profession.

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SECTION 1

PROFESSIONAL PRACTICE

Standards for professional practice include criteria for the podiatrist and evidence based practice.

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PROFESSIONAL PRACTICE

A. Podiatrist

	Criteria	Guidance	References
1	The podiatrist understands and complies with the Codes of Ethics and Professional Conduct of the Podiatrists Board New Zealand.	The podiatrist maintains the highest standards of professional practice and acts with integrity in all dealings with the patient and the public including funders of podiatry services.	Podiatrists Board New Zealand Code of Ethics and Professional Conduct 2016
2	A practicing podiatrist holds an Annual Practicing Certificate issued by the Podiatrists Board of New Zealand.	APC' s are due for renewal by the 31st March each year.	Health Practitioners Competence Assurance (HPCA) Act 2003
3	The podiatrist meets the competencies required by the Podiatrists Board of New Zealand for registration in New Zealand.	The title Podiatrist is protected under the HPCA Act 2003. Any person calling themselves a podiatrist must be registered with the Podiatrists Board of New Zealand.	Podiatrists Board of New Zealand: Podiatry Competencies for podiatry practice in New Zealand 2016
4	The podiatrist continues to meet the ongoing competency requirements of the Podiatrists Board of New Zealand	Ongoing competency also includes taking responsibility for one's own mental and physical health and seeking assistance if required.	Podiatrists Board of New Zealand Recertification Guidelines Booklet 2016
5	The podiatrist will claim only the qualifications, and affiliations to which they are entitled.	Additional qualifications can be added to the register.	HPCA Act 2003 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
6	The podiatrist is aware of the scope of practice for podiatry and only practises in those areas where he/she is competent.	If a patient presents with a condition outside the scope of practice of the podiatrist the patient will be informed and referred on to another provider and/or seek the advice of a senior colleague to assist with patient management. In an emergency situation it is the individual who is best able to determine whether his or her competence is sufficient to provide first aid.	HPCA Act 2003 General Scope of Practice: Podiatry Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Medical Council of New Zealand: A doctor's duty to help in a medical emergency

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B. Evidence Based Practice

	Criteria	Guidance	References
1	The podiatrist uses evidence based research to inform their clinical practice.	Practice integrates evidence based research, clinical experience and the individual requirements of the patient.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	Where guidelines and protocols are available the podiatrist uses these as framework for assessment and intervention.	Guidelines and protocols support practice and do not replace clinical judgement.	Code of Health and Disability Services Consumers' Rights 1994, (4.2)
3	Podiatrists are aware of the need to appraise critically new technologies and techniques, papers and/or journal articles before implementing their findings into their clinical practice.		

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SECTION 2

PATIENT PARTNERSHIP

Standards for patient partnership include cultural competence, the podiatry and patient relationship, consent and confidentiality.

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PATIENT PARTNERSHIP

A. Cultural Competence

	Criteria	Guidance	References
1	The podiatrist acknowledges Te Tiriti o Waitangi/Treaty of Waitangi as the founding document of Aotearoa New Zealand, and acknowledges the particular values and beliefs of Māori as the indigenous people of Aotearoa New Zealand.	The partnership between the Crown and tangata whenua, established in Te Tiriti o Waitangi, must be respected at all times.	Te Tiriti o Waitangi 1840 (Treaty of Waitangi) United Nations Declaration on the Rights of Indigenous People Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	The podiatrist recognizes individual's lifestyles, cultural beliefs and practices.	Podiatrists need to respect and respond actively to every patient as an individual. The podiatrist takes into consideration the patient's culture, language, spirituality, race, gender, sexual orientation, disability and age, as well as their beliefs, values, abilities, mental well-being, social, occupational, recreational and economic commitments and the impact these may have on the patient's perception of health and illness. The podiatrist considers the impact of podiatry on a patient's physical, psychological and spiritual well-being.	Code of Health and Disability Services Consumers' Rights Regulation 1996 Health and Disability Commissioner Act 1994 Human Rights Act 1993 Cross-cultural resource kit: CALD resources. Podiatrists Board of New Zealand: Cultural Competence Position Statement Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
3	The podiatrist will create a culturally safe environment.	The podiatrist is aware of their own beliefs and culture and is respectful of the values, beliefs and cultural needs of others.	Podiatrists Board of New Zealand Guidelines for Cultural Competence in Aotearoa/New Zealand 2016 Podiatrists Board of New Zealand: Cultural Competence Position Statement Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016

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B. Podiatrist – Patient Relationship

	Criteria	Guidance	References
1	The patient is addressed by the name of their choice.	Podiatrists should be aware of the cultural differences in naming systems. Patients should be asked how they wish to be addressed.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	The podiatrist introduces him or herself by name and profession to the patient and family/support person present.	At the first appointment ensure there is adequate time to develop a therapeutic relationship.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
3	Podiatrists are courteous and considerate.	All interactions with patients and whanau are appropriate, sensitive and responsive to difference in need and approach.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
4	The patient is aware of and understands the role of all members of the podiatry/health team involved in their care including where students or podiatry assistants are involved in care.		Code of Health and Disability Services Consumers' Rights Regulation 1996 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
5	The patient's dignity and privacy are respected at all times.	Assessment, examination and treatment require a private environment. Appropriate draping practices are utilised. Care should be taken where discussions may be overheard.	Privacy Act 1993 Health Information Privacy Code 1994 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Code of Health and Disability Consumers' Rights 1996(1)
6	Chaperones are provided where appropriate (for the safety of the podiatrist or patient).	Chaperoning depends on the type of examination being performed and the personal wishes and culture of the patient, and the needs of the podiatrist.	

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7	The podiatrist establishes appropriate professional boundaries with patients and their whanau and families.	Podiatrists need to be aware of the inherent risks in therapeutic relationships, and the potential for misunderstanding.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Podiatrists Board of New Zealand Position Statement: Treatment of Whanau/Family members and Self-Treatment 2016
8	Patients are informed that a support person can attend their appointments with them.	Podiatrists need to be aware of the role of whānau in decision making. It is the cultural norm in some cultures to be accompanied on a regular basis. However it must not be assumed the patient wants an accompanying person, and time/space should be provided to enable the patient to indicate their wishes.	Code of Health and Disability Services Consumers' Rights Regulation 1996
9	The podiatrist may refuse to treat a patient if they have good reason for doing so, and should inform the patient of alternative options of care, and where appropriate refer to another practitioner.	Good reasons for refusing treatment might include: • where the podiatrist believes the treatment requested will provide no clinical benefit; • where the podiatrist has a conflict of interest; • where the patient is abusive and/or poses a serious risk of harm to the podiatrist, their family, or their employees.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Code of Health and Disability Services Consumers' Rights Regulation 1996

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C. Consent

There are times when a patient is unable to give consent due to compromised decision making capacity. Examples include children, those with advanced dementia or other form of mental disability, and those who have lost their decision making capacity due to physical illness, injury or sedation.

In emergency situations where treatment is necessary to save the patient's life or to prevent harm to the patient and the patient's wishes are not known, the professional is expected to act in the patient's best interests (which may include for example providing resuscitation).

Relevant law: Doctrine of necessity in the common law.

If there is no emergency, but the patient is unable to consent, the podiatrist should seek consent from a person who is legally entitled to consent on behalf of the patient, if there is such a person.

In the case of a child, the child's parent or legal guardian is normally entitled to consent on behalf of the child. However, s 36 Care of Children Act 2004 states that children aged 16 and over are deemed to have the same decision making capacity as adults to consent or refuse consent to treatment for their benefit. A child below the age of 16 who has sufficient knowledge and understanding of the nature, risks and benefits of the particular treatment is also competent to consent or refuse consent to the treatment. This test, known as the Gillick Decision Making Capacity (or competency) test, requires an individual assessment of the capacity of the child in relation to the particular decision for which the consent is required. Even if the child is not competent to consent, his or her assent should be sought and documented. Not only does this show respect to the child patient, but it is also more likely to ensure the child's participation in the treatment.

An adult patient who does not have decision-making capacity (and is therefore incompetent) may have executed an Enduring Power of Attorney prior to becoming incompetent, authorising someone else to make decisions on behalf of the patient. Alternatively the court may have appointed a welfare guardian to provide consent. The patient may also have an Advance Directive which may be relevant to care.

If an incompetent adult patient has no welfare guardian or Enduring Power of Attorney authorising someone to consent on behalf of the patient, the podiatrist must act in the patient's best interest having taken reasonable steps to ascertain the views of the patient, for example by consulting with the whanau and family. The purpose of this consultation is not to seek consent from the family but to determine what choice the patient would make if he or she were competent. If the patient's views cannot be ascertained, the podiatrist must act in the best interests of the patient, taking into account the views of suitable persons who are available and interested in the welfare of the patient.

Relevant law includes: s 36 Care of Children Act 2004; *Gillick v West Norfolk and Wisbech AHB* (1986); Protection of Personal and Property Rights Act 1988; Right 5-7; Code of Health and Disability Services Consumers' Rights 1996.

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	Criteria	Guidance	References
1	The patient's informed consent is obtained prior to commencing assessment and again prior to commencing treatment and both are documented in the patient record.	The criteria for informed consent include disclosure of relevant information to the patient, checking that the patient understands the information, ensuring that the patient is competent to give informed consent and that consent is given voluntarily. Informed consent is an ongoing process. Consent must be revisited if there are changes to the treatment plan or changes in the patient's condition that are likely to alter the risks or treatment outcomes.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Code of Health and Disability Services Consumers' Rights Regulation 1996 Health and Disability Commissioner Act 1994 Human Rights Act 1993
2	Treatment options, including significant benefits, risks and side effects, are discussed with the patient.	Where possible patients should have access to information in a format that facilitates understanding. Written material, diagrams and models may be useful in explaining treatment options.	Code of Health and Disability Services Consumers' Rights Regulation 1996
3	The patient is given an opportunity to ask questions and discuss treatment options.	Patients may need time to assimilate information given. They should have the option of deferring treatment until their next appointment if they are in any doubt as to the risk and benefits of treatment. The patient should be given opportunities to ask questions on a number of occasions.	Code of Health and Disability Services Consumers' Rights Regulation 1996
4	The podiatrist checks with the patient to ensure that the decision to accept or refuse treatment is given freely. The patient may refuse treatment at any point without it prejudicing the provision of care in the future.	If the patient declines podiatry treatment this is documented in the patient's records, together with the reasons if these are known	Code of Health and Disability Services Consumers' Rights Regulation 1996

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5	The podiatrist checks that the patient has understood the information provided and documents this in the clinical records.	Information must be provided in a manner that can be understood by the patient. The use of jargon or other technical language can impede understanding. Deafness, visual impairment or language difficulties can also hinder comprehension. Other means of disclosure may be required. Podiatrists should access interpreting services where necessary and practicable. Family members may not always be suitable, and the use of children as interpreters is to be avoided. It also must not be assumed the patient wants a family member to act as an interpreter, and time/space should be provided to enable the patient to indicate their wishes	Code of Health and Disability Services Consumers' Rights Regulation 1996
6	Informed consent is gained if a student is to be involved in their care, or is observing a treatment session.	The education of students is an important role for all podiatrists; however the patient must always be informed if a student is involved in their care and has the right to refuse at any time without prejudice.	AUT University and other educational institutions provide handbooks for providers working with their undergraduate students Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
7	Informed consent is gained if a podiatry/foot care assistant is to be involved in their care, or is observing a treatment session.	Podiatry/foot care assistants have an important role in the treatment of patients; however the patient must always be informed if an assistant is involved in their care and has the right to refuse at any time without prejudice.	

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8	Informed consent in writing should be obtained for any research, for invasive, high risk podiatry, or for innovative podiatry interventions.	For most podiatry procedures verbal consent is usually sufficient (however this should be documented). For invasive procedures (e.g. surgery); or when the patient is to be involved in research, written consent is required. Written consent is not necessarily a safeguard for the podiatrist if the process of informed consent has not been fulfilled. Getting patients to sign a non-specific consent to any future proposed treatment is not acceptable. Consent must be obtained for every new treatment, or when the patient's circumstances change.	Code of Health and Disability Services Consumers' Rights, 1996 (11) New Zealand Bill of Rights Act 1990

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D. Confidentiality

	Criteria	Guidance	References
1	The podiatrist treats all clinical information relating to the patient as confidential and divulges information only with the patient's permission, except when permitted or required by law.	Trust is important in the podiatry-patient relationship, and maintaining confidentiality is central to that trust. It is expected that podiatrists respect the confidentiality, privacy and security of patient information. However, the duty of confidentiality is subject to some exceptions.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016 Privacy Act 1993 Health Information Privacy Code 1994
2	A podiatrist may share patient information with other members of the health team providing care for the patient.	Podiatrists frequently work as part of a team of health professionals, and the sharing of information between team members is important for co-ordinated, patient centred treatment.	Privacy Act 1993 Health Information Privacy Code 1994
3	Patient records are stored securely to prevent unauthorised access to information.	This also applies to any records that are stored or transmitted electronically including photos, images, videos/DVD.	NZ Standards Health Records 8153:2002 Privacy Act 1993 Health Information Privacy Code 1994 (10) Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
4	Steps are taken to ensure the confidentiality of patient-identifiable data held, or transmitted, in electronic format.	Electronic notes should be stored on a password protected device. Podiatrists should endeavour to use a secure network when sharing patient information. If not available it is important to ensure the information is sent to an individual recipient.	
5	Where confidentiality cannot be guaranteed, the patient should be informed of this fact and given the option to decline giving information.		
6	Relevant patient information may be disclosed without the patient's permission.	In some circumstances information may be disclosed without patient consent and even against the patient's wishes (e.g. when the patient poses a serious and imminent threat to themselves or someone else).	Health Information Privacy Code 1994 (11)

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7	Permission is obtained from the patient prior to using identifiable clinical information for teaching; written permission is compulsory if using the information for publication.		
8	The patient has the right to access their own medical records.	Podiatrists should have a process in place for patients to access their notes and be mindful that treatment records may be accessed by the patient. Therefore all entries should comply with documentation requirements and must be respectful.	Health Information Privacy Code 1994
9	Patient records must be stored in a secure place for a minimum of 10 years from the time the patient last accessed podiatry services and disposed of in accordance with the law.	Examples of secure storage of patient records include a locked filing cabinet or in a locked office that is not accessible to others, or on a password protected electronic device/computer in a locked office, or on a password protected storage device. Where children may require services over their lifetime, but may not access podiatry for more than 10 years, it is recommended these records should be retained until the patient reaches 21. Patient records must be disposed of in accordance with the law.	Health (Retention of Records) Regulations 1996 NZ Standards Health Records 8153:2002 Health Information Privacy Code 1994

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SECTION 3

EFFECTIVE COMMUNICATION

Standards for effective communication include criteria on communicating with your patients, with other service providers and the use of social media.

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EFFECTIVE COMMUNICATION

A. Communication with Patients

	Criteria	Guidance	References
1	The podiatrist communicates openly and honestly with patients.	In some circumstances, for example a treatment plan or terminal care, an approach to communication may need to be agreed within the team.	Code of Health and Disability Services Consumers' Rights 1996 Health and Disability Commissioner Act 1994 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	The podiatrist uses active listening skills, providing opportunities for the patient to communicate effectively.	Particular care should be taken with non-verbal communication that can affect the interaction.	
3	The podiatrist adapts their method of communication to meet the requirements of the patient providing patient information in written, verbal or diagrammatic form.	Abbreviations and jargon are to be kept to a minimum and not to be used in patient information leaflets. Interpreters should be available for those who require them.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
4	The podiatrist assesses the patient's understanding of the information given.	Feedback is sought from the patient to ensure their level of understanding is appropriate.	
5	Communication of a sensitive nature is undertaken in a private environment.	This applies during face to face contact with patients, carers or other health professionals, and includes telephone conversations and other methods of communication.	Code of Health and Disability Consumers' Rights 1996, Right 5

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6	The podiatrist responds appropriately to situations of conflict with a patient or the patient's family.	In the event of a conflict the podiatrist should acknowledge the patient's concerns and seek ways of resolution. The patient has the right to get a second opinion, and the podiatrist should facilitate this if asked. The podiatrist should seek advice and support from colleagues and senior staff where available. The patient has the right to make a complaint and the podiatrist should facilitate this if asked.	Code of Health and Disability Services Consumers' Rights 1996 Health and Disability Commissioner Act 1994

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B. Communication with Other Service Providers

	Criteria	Guidance	References
1	Podiatrists communicate professionally and effectively (verbally and in writing) with and about: • podiatry colleagues • referrers and keeping them informed of the patient's progress, including a discharge summary • other members of the health care team • funders of podiatry services.	Feedback is sought from the patient to ensure their level of understanding is appropriate.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	Podiatrists are aware of and recognise the role and contribution of other members of the health care team.		
3	Podiatrists inform other members of the health care team of their own specific role.	Communication and discussion with other members of the health care team including agreed roles and responsibilities enhance health outcomes.	
4	Podiatrists communicate using language understood by the recipient.	Jargon and abbreviations should not be used when communicating with patients and others. When communicating with other podiatrists, technical language or language that has meaning only to other podiatrists may be used.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016

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C. Social Media

	Criteria	Guidance	References
1	Podiatrists uphold the values of the profession when using text messaging, electronic and social networking sites.	Social networking sites pose a number of risks for podiatrists: There is a risk that the patient may be identifiable, and patient confidentiality may be breached inadvertently. Podiatrists must therefore be particularly careful when discussing any aspect of clinical practice online. If a podiatrists posts identifiable patient information to an online site to get assistance with patient care or for some other purpose, the podiatrists should inform the patient and get consent to do so. Podiatrists should avoid making comments about other professionals or institutions that could be interpreted as defamatory or inappropriate. Podiatrists need to be careful to maintain professional boundaries while using social networking sites. Some social networking sites allow public access to information. Podiatrists should be mindful about the public persona they want to display and should not compromise the dignity of the profession.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016

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SECTION 4

ASSESSMENT OF THE PATIENT

Standards for the assessment of the patient include gathering the relevant information, assessment and gaining consent.

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ASSESSMENT OF THE PATIENT

	Criteria	Guidance	References
1	The podiatrist gathers and records information relevant to the patient's presenting condition as consented by them and for all relevant information impacting on the purpose of the assessment.	Assessment is an ongoing process. When working in a health care team some back-ground information may have already been collected, and can be referred to by the podiatrist only when confirmed and consented by the patient.. The patient's expectations may be expressed as anticipated gain from podiatry, and should be discussed with the patient. In some instances (e.g. case review for insurance companies) assessment is done from the patient's file and physical assessment of the patient is not required.	NZ Standards Health Records 8153:2002 Medical Council of New Zealand: Non-treating doctors performing medical assessments of patients for third parties. 2010
2	The podiatrist conducts safe, systematic and efficient assessments in accordance with accepted procedures. Where available, validated assessment tools and outcome measures are used.	The inclusion of a template, diagrams or pain charts is useful.	World Health Organisation: International Classification of Functioning Disability and Health (ICF)
3	Any physical examination that is carried out to obtain measurable data used to determine the patient's podiatric needs and should be documented.		
4	The podiatrist gains consent from the patient before undertaking a clinical assessment.		Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
5	The findings of the clinical assessment are explained to the patient.		Code of Health and Disability Consumers' Rights 1996 (6.1)

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SECTION 5

TREATMENT PLAN

Standards for Treatment plans include assessing, developing, applying and evaluating your treatment plans. They also cover discharging a patient from your podiatry service.

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TREATMENT PLAN

A. Develop Treatment Plan

	Criteria	Guidance	References
1	The podiatrist analyses and interprets the assessment findings and identifies any potential risks associated with treatment.	The use of relevant research findings and reflective practice will support the clinical reasoning process and the mitigation of any risk factors.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	Relevant clinical investigations/results used to assist the diagnosis and management process are documented and evaluated.	These may have been requested by the podiatrist, or by other health professionals. The results of the tests inform the management of the patient e.g. x-rays.	
3	A diagnosis with relevant signs and symptoms is recorded.		
4	The podiatrist ensures that the patient is fully involved in the decision-making process during treatment planning.	The podiatrist should take account of the goals and aspirations of the patient and ensure that they have sufficient information in order to participate in the decision-making process.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
5	Short and long term goals are set in collaboration with the patient, and where appropriate in consultation with other health professionals involved in the patient's care.	The S.M.A.R.T. format is the preferred format for writing treatment goals: **S** - specific **M -** measurable **A** - attainable **R -** realistic **T –** time-based In some clinical environments other formats for goal setting may be the preferred option.	Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
6	A treatment plan is developed based on best practice and the patient's treatment preferences and the podiatrist's skills and experience.	This plan will be based on the information gathered during the assessment process relating to social and family history (e.g. work, sport, and lifestyle) and reflect cultural and religious beliefs.	Code of Health and Disability Consumers' Rights 1996 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016

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7	The plan clearly documents planned interventions which make best use of existing resources where appropriate.	The plan should include time frames and when review of the effectiveness of treatment will be reviewed.	
8	Suitable (reliable and valid) outcome measures for evaluating the treatment are identified and recorded.	Outcome measures are used at the beginning and end of treatment. It is recommended the outcome measure is repeated at least every two treatments to evaluate progress. However, re-measurement may be required more or less frequently depending on the patient's condition, and anticipated rate of change. In some instances re-measurement should occur at each treatment session.	

B. Apply Treatment Plan

	Criteria	Guidance	References
1	The podiatrist gains informed consent for the intervention.		Code of Health and Disability Consumers' Rights 1996 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
2	Interventions are implemented safely and effectively according to the treatment plan.	Assessment is an ongoing part of podiatry. Interventions are modified as required in response to reassessment following treatment	
3	Any deviation from the intended treatment plan is discussed with and agreed to by the patient and re-corded in the patient's notes with the reasons given.	It must be clear in the notes why any changes to the intended plan have occurred.	Code of Health and Disability Consumers' Rights 1996 Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016
4	Adverse and unexpected effects during treatment are managed, reported and evaluated using the relevant mechanisms.	The podiatrist has an obligation to mitigate, as far as possible, the effects of any adverse reaction. There must be honest disclosure of any adverse reaction to the patient.	ACC treatment injury claim (ACC2152) New Zealand Health and Disability Services National Reportable Events Policy 2012
5	Information is available on condition-specific support groups and networks.	Where applicable and available, including online references.	

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C. Evaluate Treatment Plan

	Criteria	Guidance	References
1	During the treatment sessions the podiatrist continually evaluates and records the treatment plan.	Objective findings including information derived from the use of the outcome measure is shared with the patient.	
2	If progress towards agreed goals and outcomes is not occurring the podiatrist re-evaluates the intervention and/or treatment plan. The podiatrist can also seek assistance from a colleague; transfer the patient's care back to the referrer, or on to another provider.	If the patient is transferred to another podiatrist a written record of the transfer of care with any notes on the patient's ongoing care and treatment should be provided to the new podiatrist.	

D. Discharge from Podiatry Services

	Criteria	Guidance	References
1	The patient is discharged or care is transferred from the podiatry service when agreed goals and relevant outcomes are achieved or the patient has the tools to be able to self-manage.	It is acknowledged that some patients may self-discharge early. Failure to meet the treatment goals may also result in transfer or discharge.	
2	The patient is involved with the arrangements for their transfer of care/discharge from podiatry.	Health promotion and injury prevention education are core components of any podiatry discharge plan.	
3	A treatment summary is sent to the referrer on completion of care and a copy offered to the patient.	A discharge or transfer letter should always be sent if the referral was from another health professional. Referrers should also receive summaries for those who self-discharge or fail to attend.	
4	Appropriate treatment information is supplied to the patient's GP for those patients who self-refer to podiatry.	If the patient has self-referred, the podiatrist should discuss with the patient in advance which other health professionals e.g. GP, will receive information. The patient has the right to refuse to allow such sharing of information, but the implications of such refusal should be discussed and clearly documented.	

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SECTION 6

DOCUMENTATION

Standards for documentation include the accuracy of patient records, demographic details of the patient and other set criteria.

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DOCUMENTATION

	Criteria	Guidance	References
1	Patient records must be a contemporaneous, accurate, legible and concise record of patient diagnosis, treatment and progress.	Patient records may be electronic or paper based Patient records are a vital source of communication between health professionals providing care to a patient. The records must therefore provide clear details on investigations and diagnosis, information provided by and given to the patient, consent given by the patient, and treatment carried out. Patient records are started at the time of initial contact. Patient records must contain sufficient detail that they can be understood by others.	Standards New Zealand Allied Health Sector Standards NZS 8171;2005 Standards New Zealand Health Records NZS 8153:2002
2	All patients receiving treatment must have a record that clearly identifies the patient and their health problems.		Standards New Zealand Allied Health Sector Standards NZS 8171;2005 Standards New Zealand Health Records NZS 8153:2002
3	Demographic details of the patient including name in full, National Health Index (NHI) number (if known), date of birth, gender, ethnicity, contact details, residency status and General Practitioner/Primary Care Provider are recorded.	The NHI number is the common language for patient identification between health providers. The Health Practitioner Index (HPI) is the personal identification number for health providers.	Standards New Zealand Health Records 8153:2002 National Health IT Board
4	Continuation pages must include name in full, date of birth and NHI number (if known) and date of treatment.	With electronic records this process should occur automatically.	
5	The records must be dated with the time of entry recorded.	Entering the time of patient contact may be necessary in certain acute situations.	

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6	Patient records are written as soon as possible after the contact with the podiatrist. Records must be completed before the end of the day.		
7	The records must be signed by the treating podiatrist with their name printed after each entry. Signing may be done electronically.	It is necessary for the name to be printed after each entry so the podiatrist can be traced when the signature is not legible. Where patients are treated by the same podiatrist throughout, it is sufficient for a printed name to appear once on each page of the record. For electronic records each provider must have their own password which clearly identifies them as the author of the records. If the patient is treated by a student, the supervising podiatrist should counter-sign the notes.	The AUT University provide handbooks for providers working with their undergraduate students
8	Pages are numbered.		
9	Notes are written in permanent ink that remains legible with photocopying.		
10	Correction fluid or tape is not used.		
11	Errors are crossed out with a single line and initialed.	Within electronic records, the 'strike through' function is used to indicate corrections once the notes have been completed.	
12	Any changes to the treatment plan are documented and the patient's consent to the changes documented.		
13	All activities and contact regarding a patient whether the patient is present or not (e.g. phone calls, text messages, emails) need to be recorded in the notes.		

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14	Patient non-attendance at a treatment session should be recorded.		
15	Acronyms used need to be commonly understood within the profession and be included within the service provider’s list of agreed terminology.	Use of non-standard abbreviations may lead to misinterpretation during retrospective inspection of records. A provider should have a list of abbreviations acceptable in their practice.	

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SECTION 7

WORKING ENVIRONMENT

Standards for the working environment relate to your patients safety, infection control procedures, equipment, emergency procedures, staffing and working alone.

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WORKING ENVIRONMENT

A. Patient Safety

	Criteria	Guidance	References
1	The podiatrist identifies and mitigates any risks to patient safety.	A risk assessment should be carried out prior to each interaction/intervention for every patient.	Allied Health Sector standards 2005
2	Adverse or unexpected events during or following podiatry interventions are reported using appropriate local, national and professional systems.	Where possible if an adverse event occurs a systems analysis should be undertaken to prevent recurrence.	ACC treatment injury claim (ACC2152) New Zealand Health and Disability Services National Reportable Events Policy 2012
3	Patients receiving treatment are made aware of how to summon assistance.		

B. Surgical Facility

	Criteria	Guidance	References
1	**The Facility** Standards outlined in this section apply to a dedicated room designated for use as a surgical facility only. The surgical facility, or clinical office based facility may be used for some surgical procedures (eg: certain nail and wart procedures). A dedicated surgical facility should be used for invasive surgery, that is surgery that involves bone (eg: exostoses), or extensive soft tissue (eg: neuroma.)	The podiatrist is responsible for properly maintaining the surgical facility according to acceptable minimum standards. The surgical facility, including its usage, structural design, size, location relative to other rooms, sterilising and scrub facilities, should be comparable to the minimum required in a hospital setting for the type of surgery being performed.	

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2	**Personnel** Only personnel properly attired and required for the procedure should be allowed in the operating area.	Personnel numbers and their activity should be restricted to minimize the risk of contamination. Unnecessary activity should be kept to a minimum. Unscrubbed observers should wear a scrub suit, hat and shoe coverings and mask.	
3	**Cleaning/ Infection Control** The operating room should be cleaned every morning, between cases and at the end of the day. The adoption of Standard (Universal) Precautions will reduce the risk of cross infection in the surgical environment. High Risk Situation recommendation:	Compliance with current guidelines for cleaning of such a facility is needed. This will include maintaining records of such cleaning. Initially the room should be damp dusted with suitable disinfectant to reduce the concentration of airborne microorganisms Weekly cleaning should include cabinet shelving, autoclave and air conditioning filters. With a high risk patient it is advisable to combine Universal Precautions with modifications to usual work practice, to reduce.	

C. Infection Control Procedures

	Criteria	Guidance	References
1	There is an infection control policy to which the podiatrist is formally orientated.	The policy complies with current guidelines and standards and is reviewed and updated as part of a cycle of policy review.	
2	Infection control procedures are followed e.g. hand hygiene washing, correct disposal of sharps, clinical waste and sterilisation.	Single use items and sterile packs are used as per requirements. The manufacturer's instructions on single use equipment e.g. needles, will be adhered to.	Health and Safety in Employment Act 1992 OSH: How to Manage Hazards OSH: Improving Workplace Safety and Health Standards New Zealand Infection Control NZS 8142:2000

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3	Universal precautions are followed to prevent the spread of infectious diseases.	Podiatrists and other staff are familiar with and follow current hand hygiene and infection prevention and control guidelines and policies. The importance of hand washing cannot be over stated.	
4	Prevention of Cross Infection	Patient exposure to risks of infection/ contamination reduced to lowest possible levels with the practice of disinfection, instrument sterilsation and correct disposal of clinical waste.	

D. Infection Control Protocol

	Criteria	Guidance	References
1	Podiatrists have a responsibility to know their Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Immunodeficiency Virus (HIV) status. Podiatrists who have been exposed to HBV, HCV or HIV through personal risk behavior, exposure to blood products or occupational accidents are encouraged to seek testing in order to determine their serological status.	Infected podiatrists should seek appropriate advice regarding their continued practice of podiatry and act on that advice to protect patients from exposure to infection. Routine testing can be seen as an admission of risk taking and has not been recommended. Screening prior to starting practice is seen as acceptable Podiatrists should be tested to determine whether they have the HBV infection, or are susceptible of infection or are already immune.	
2	It is recommended that all podiatrists be vaccinated against HBV when appropriate and retested to confirm immunity following infection.	Practitioners who are carriers of infectious diseases must seek medical advice regarding the risks to themselves and others and take all reasonable measures to mitigate these. If found to be infected podiatrists should be tested to determine if they are highly infectious (ie: HBeAG or HBV DNA positive.)	

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3	Podiatrists who have HBV infection and are HBeAG or HBV DNA positive should not perform exposure-prone procedures.		
4	The contaminated hands of personnel are potentially the most significant transmitter of cross-infection in the health care setting.	Hand hygiene washing decreases contamination of the hands and helps to prevent nosocomial infections.	
5	Podiatrists should accept responsibility for their skin integrity prior to commencing work.	All cuts, abrasions and open skin areas must be occluded with a waterproof dressing.	
6	Podiatrists who have dermatitis, eczema, paronychia or any other skin lesions may put the patient and other health care workers at risk as:	It is recommended to refrain from treating patients until severe conditions have resolved. Rinse and dry hands thoroughly after washing and use alternate hand wash solutions. Use of hand moisturisers should be considered and must be compatible with gloves. Wear gloves (however this may exacerbate dermatitis due to a change in the residual flora and number of bacteria present.) Jewellery and watches should not be worn during level 1 procedures and must not be worn during level 2 and 3 procedures as these are a potential source of cross-infection.	

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7	**Hand hygiene washing** is recommended: • before, between and after all direct patient contacts • before and after handling clinical and surgical equipment and handling specimens • before wearing gloves, after removing them and before going home • after handling patient's footwear. Basic hand hygiene washing requires vigorous mechanical action, 15 seconds is recommended It is recommended that antibacterial soap is used for level 2 and 3 procedures. When liquid antibacterial soap is used, containers should be disposable not refillable, and should not be "topped up". Itinerant podiatrists should carry a liquid soap dispenser and disposable hand towels to each destination.	Ideally hand hygiene washing facilities should consist of a basin with mixer taps and foot, knee or elbow controls, an elbow operated antibacterial soap dispenser and a wall mounted paper towel dispenser. Use alcohol rub, gel or rinse for routine hand decontamination when hands are not visibly soiled- i.e. accessing items outside treatment zone or when hand washing facilities are not available. Non sterile nail brushes are not recommended as they harbour bacteria and may cause damage around the mail bed and increasing the risk of paronychia.	

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8	**Personal Protection Equipment, Gloves and Protective Clothing** For the protection of both patient and podiatrist it is recommended that gloves be worn when there is an anticipated or evidenced contact with blood or body fluids. Sterile gloves must be used to protect the patient and wearer during invasive procedures (in which there is deliberate intent to sharply or bluntly penetrate intact skin), or when open wounds are touched. Sterile gloves must be worn for some level 2 procedures and all level 3 procedures. Non-sterile gloves are recommended for level 1 and some level 2 procedures Nail dust is an occupational hazard to podiatrists who use nail drills. To avoid inhaling infective material, masks should be worn during nail grinding. This will avoid inhaling infective material (such as keratin, keratin hydrolysates, microbial debris and viable fungal elements including saprophytes and dermatophytes.)	Gloves must be always be changed between patients and hands must always be washed immediately after wearing gloves. Non-sterile gloves should be used to protect the wearer when hands are likely to become contaminated with potentially infective material, i.e. blood body fluids etc. Hazards of nail dust include damage to eyes, ears or face by flying debris. Glasses, face shields or goggles help prevent such damage. Masks, protective glasses and impermeable clothing must be worn when blood or body fluids are likely to splash. Current guidelines for the use of PPE should be followed at all times.	

9	**Sharps** Special care must be taken to prevent injuries caused by scalpels, needles and other sharp objects before, during and after procedures, and during handling, cleaning or disposal of sharps after procedures. If there is a sharps incident with exposure to blood or body fluids it is recommended to: • Encourage bleeding • Cleanse wound vigorously with copious soap and water to disinfect • For eyes, nose and mouth, rinse thoroughly with clear running water or saline • Cover the wound with an adhesive waterproof dressing • Ascertain status of source where possible • Follow established institutional protocol if the situation is applicable • Following incidents involving blood or body fluids which are considered to be high risk podiatrists should consult their doctor or microbiology laboratory for blood tests.	Needles must not be recapped by hand, or bent or broken prior to disposal. All sharps must be disposed of immediately after use into an appropriate puncture resistant, waterproof and leak proof container designed specifically for the purpose, with a clearly visible Biohazard symbol. The sharps container must be located as close as practicable to the use area. It is recommended that a policy of recording and following up cases of exposure to the blood/ serum body fluids of patients from sharps injury be adopted. **Potential risk incidents are :** • Contact with used needles or other sharp objects • Splashing of blood or body fluids from sharps on to a mucous membrane (eyes or mouth) or on to a fresh unhealed wound (less than 24 hours old) • Sustaining an injury which breaks the skin.	
10	**Disposal of Clinical Waste** The Resource Management Act 1991 (amended 2015) states how waste is disposed of. The owner of the practice which generates the waste is ultimately responsible for correct disposal even if it is sub-contracted. NZ Standard 4304 1990 defines "special waste" as soiled dressings, swabs and other contaminated waste from treatment areas- this includes nail clippings and tissue, disposables i.e. syringes, hypothermic needles, scalpels, razors, gloves and masks. Podiatrists are advised to contact their local body authorities for specific area regulations.		

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E. Equipment

	Criteria	Guidance	References
1	Sterilisation is the complete destruction of all microorganisms. An item is either sterile or not, there are no probabilities. Patients have the right to expect the podiatrist to have access to appropriate instruments for the service they are providing.	All re-useable instruments (including burrs) must be steam sterilized cleaned between patients. All instruments that may penetrate body tissues must be sterile at the time of use. A practice must have enough instruments to allow sufficient time to decontaminate and all instruments before use.	Standards New Zealand Infection Control NZS 8142:2000 Health and Safety at Work Act 2015
2	Steam sterilisation is the only safe, reliable and effective means of sterilising instruments. A sterilizer without a drying cycle is only suitable when unwrapped items are intended for immediate use.	Where possible a separate sterilising room should be used for cleaning, ultrasound, sterilising and storing sterile supplies.	
3	Sterilisation process efficiency should be regularly monitored, with processes validated before use, routinely calibrated and monitored, and equipment maintained to ensure complete sterilization.	The sterilizer should be calibrated at least annually by a qualified tradesperson with written proof of the testing compliance. A daily monitoring procedure must be carried out, recording the results for legal reference.	
4	Monitoring the sterilization process can be done in 3 ways: chemical, biological and physical.	**Chemical**: It is recommended that a chemical indicator be used with every article for packaged loads and every load of unwrapped items **Biological**: These indicators are recommended for use on a weekly basis, using either an on-site self-contained biological test kit or sending samples to the local medical laboratory for testing, records to be maintained regardless **Physical**: testing is available on steam sterilizers with built in chart recorders, gauges and printed/ digital readouts which provide verifiable evidence of sterilization.	

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5	Instruments sterilized after use, where sterility does not need to be maintained, must be stored in a dry covered container. All articles must be thoroughly cleaned prior to being processed for sterilisation.		
6	Documentation: every load sterilized must be allocated a batch control number which is recorded in the sterilizer logbook or digitally:to include the date of processing, number of the load for the day, and number of the sterilizer used (if more than 1).	The batch control number must be labeled in every pack in the load and recorded on the patient's case record. Non-permanent markers should be used for labeling (as pens may make minute perforations in the packs).	
7	Equipment is safe and clean.	The practice has a policy on the cleaning of equipment, frequency required and materials used. Equipment is used and cleaned according to the manufacturer's instructions and your infection control policies.	Standards New Zealand Infection Control NZS 8142:2000 Health and Safety at Work Act 2015
8	All electrical equipment must be checked annually (or more frequently if stipulated by the suppliers) and there is written evidence of such checks.	Electrical equipment should be tagged with test and expiry date.	
9	Warning notices on specific risks associated with equipment are prominently displayed.	The warning notices are to remind podiatrists and alert the patient to potential risks.	

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F. Emergency Procedures

	Criteria	Guidance	References
1	Each premises where the podiatrist works has specific emergency procedures for that location which the podiatrist is formally orientated to the emergency procedures policy. Earthquake, fire, and the evacuation plans of the building are clearly displayed and known by all staff.	The information must also be clearly displayed in the practice so patients are aware of emergency exits.	
2	All emergency numbers and alarms are clearly listed and accessible to all staff.		
3	The podiatrist is able to summon urgent assistance when required; this will range from systems for summoning colleagues, carers or hospital emergency teams, to dialing 111 in community or private settings.	A whistle is an example of this.	
4	Staff are competent in first aid including cardiopulmonary resuscitation, use of an automated external defibrillator and management of anaphylaxis equal to the level of assessed risk for the practice and work environment. This competence is reviewed at least every two years.	The New Zealand Resuscitation Council recommends Level 4 as the first appropriate level for health professionals. It is recommended at least one person in the work environment has this level of competency.	New Zealand Resuscitation Council

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G.Staffing

	Criteria	Guidance	References
1	All employed or contracted podiatry staff have a current job description and employment contract, or appropriate contractor agreement.	Job descriptions may need to be revised periodically as the person's role changes.	Department of Labour Employment Relations
2	The podiatrist aims to identify and control all possible relevant risks in the workplace.	A risk assessment should be carried out.	Health and Safety at Work Act 2015
3	All staff are formally orientated to the work environment and practice procedures.		
4	There is an agreed and protected working time for professional learning activities.	There is an obligation on employers to help their staff meet the competency requirements for continued registration, by providing a planned continuing education and staff training programme.	Podiatrists Board of New Zealand: Podiatry Competencies for podiatry practice in New Zealand 2009
5	Regular supervision is an integral part of podiatry practice and is consistent with the CPD framework.	Supervision is important throughout a podiatrist's career. It is recommended recent graduates receive supervision at least every 2 weeks for at least the first year post-graduation.	Podiatrists Board of New Zealand Position Statement: Supervision
6	Supervision occurs within a structured contractual relationship as defined in the CPD framework.		
7	A system of regular staff review is in place.	A formal review of staff performance, including peer review, occurs at an agreed timeframe, eg annually.	
8	All podiatrists have the appropriate insurance cover relevant to their status.	The level of insurance cover required may be different for employees and business/practice owners. Note staff employed by the DHBs are covered by the DHB insurance only for DHB related work.	

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H. Working Alone

	Criteria	Guidance	References
1	Podiatrists take measures to ensure that the risks of working alone are minimised.	Consider the physical safety of all staff (particularly students and junior staff) when working after hours or in isolated areas. Before commencing weekend and/or on-call work the employer needs to ensure staff are orientated to the area and are competent to cover the case load they are reasonably likely to encounter. Podiatrists working in isolation are responsible for organising regular peer review and supervision.	Health and Safety Guide to Working in Isolation in the Health and Disability Sector.
2	Communication mechanisms are established between podiatrists working alone in the community and their base.	A log of staff movements and communication process will facilitate this.	
3	Where a risk assessment has identified high levels of risk to the podiatrist, the podiatrist attends with support people.	Eg outreach workers or district nurses.	

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SECTION 8

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Standards for continuing professional development detail the need for reflective practice, formal planning and evaluation.

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CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

	Criteria	Guidance	References
1	The podiatrist assesses his/her own learning needs.	Learning needs are assessed in line with the current CPD framework.	Podiatrists Board of New Zealand -Recertification Guidelines Podiatrists Board of New Zealand - Code of Ethics and Professional Conduct 2016
2	The podiatrist plans his or her own CPD, however areas for CPD may be identified during supervision or performance reviews.	CPD needs to cover clinical, ethical, cultural and professional requirements outlined in the boards current CPD framework.	Podiatrists Board of New Zealand -Recertification Guidelines
3	Professional development (CPD) should relate to the enhancement of an individual's scope of practice and/or desire to move into a new clinical area or an area not practised for some time.	As above.	
4	The podiatrist undertakes reflective practice on a regular basis.	As well as personal reflection on the outcomes of treatment it is important to discuss with your colleagues any patient you are concerned about and ask for advice if required.	
5	A formal plan is developed based on the assessment of learning needs and the identification of learning outcomes and data from performance appraisals.	There is a written plan based on the assessment of learning needs and the identification of learning outcomes. The plan is subject to review and linked to the appraisal cycle of the individual podiatrist.	
6	The podiatrist evaluates the benefit of their CPD.	There is evidence that the learning outcomes have been achieved and reflective practice has occurred. The individual can demonstrate that their learning has enhanced and developed their practice.	Podiatrists Board of New Zealand - Recertification Guidelines

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APPENDIX

REFERENCES

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APPENDIX

References including relevant legislation referred to in the Standards of Practice

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ACC treatment injury claim (ACC2152)	http://www.acc.co.nz/for-providers/lodge-and-manage-claims/PRV00028
Allied Health Sector Standards (NZS 8171:2005)	
Code of Health and Disability Services Consumers' Rights 1996	http://www.hdc.org.nz/the-act--code/the-code-of-rights
Cross-cultural resource kit:	http://www.caldresources.org.nz/info/Cross_Cultural_Resource_Kit- Printable.pdf
Department of Labour: Employment Relations	http://www.dol.govt.nz/er/index.asp
Health and Disability Commissioner Act 1994	http://www.legislation.govt.nz/pdflink.aspx?id=DLM333583
Health and Safety at Work Act 2015	http://www.legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.htm
Health and Safety Guide to Working in Isolation in the Health and Disability Sector:	http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/publications_promotion/prd_ctrb136069.pdf
Health Information Privacy Code 1994	http://www.privacy.org.nz/health-information-privacy-code/
Health Practitioners Competence Assurance (HPCA) Act 2003	http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html
Health (Retention of Records) Regulations 1996	http://www.legislation.govt.nz/regulation/public/1996/0343/latest/whole.html
Human Rights Act 1993	http://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html
Medical Council of New Zealand: A doctors duty to help in a medical emergency	http://www.mcnz.org.nz/assets/News-and-Publications/Statements/A- doctors-duty-to-help-in-a-medical-emergency.pdf
Medical Council of New Zealand: Non-treating doctors performing medical assessments of patients for third parties 2010	http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Non- treating-doctors.pdf
National Health IT Board	http://www.ithealthboard.health.nz/
New Zealand Bill of Rights Act 1990	http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html
New Zealand College of Physiotherapy Peer Review Guidelines	http://www.physiotherapy.org.nz
New Zealand Health and Disability Services National Reportable Events Policy 2012	http://www.hqsc.govt.nz/our-programmes/reportable-events/publications- and-resources/publication/320/
New Zealand Resuscitation Council	http://www.nzrc.org.nz/training/
Occupational Safety and Health and ACC: Improving Workplace Safety and Health	http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/reference_tools/pi00211.pdf
Occupational Safety and Health : How to Manage Hazards	http://www.osh.govt.nz/order/catalogue/pdf/acc1104hazards.pdf
Office of the Ombudsmen: A guide to the Protected Disclosures Act	http://www.ombudsmen.parliament.nz/index.php?CID=100018

Physiotherapy NZ Standards of Practice 2012	http://physiotherapy.org.nz/assets/About-Physiotherapy/7.-PNZ-Standards-of-Practice-2012.pdf
Privacy Act 1993	http://www.legislation.govt.nz/act/public/1993/0028/latest/contents.html
Podiatrists Board of New Zealand Code of Ethics and Professional Conduct 2016	http://www.podiatristsboard.org.nz/Site/practitioners/Code_of_Practice.aspx
Standards New Zealand Allied Health Sector Standards NZS 8171;2005	
Standards New Zealand Health Records NZS 8153:2002	
Standards New Zealand Infection Control NZS 8134.3:2008	https://www.health.govt.nz/system/files/documents/pages/81343-2008-nzs-health-and-disability-services-infection-prevention-and-control.pdf
Te Tiriti o Waitangi 1840 (Treaty of Waitangi)	http://archives.govt.nz/exhibitions/treaty
United Nations Declaration on the Rights of Indigenous People 2008	http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
WCPT Critical Appraisal Skills	http://www.wcpt.org/node/27527
WCPT Evidence Based Practice and Critical appraisal of papers	http://www.wcpt.org/node/27527 - ebp
World Health Organisation: International Classification of Functioning Disability and Health (ICF)	http://www.who.int/classifications/icf/en/

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