Podiatrists Board of New Zealand
Te Poari Tiaki Waewae O Aotearoa

Continuing Professional Development (CPD) Recertification Policy – additional requirements for Podiatric Surgeons (Draft)

1. Introduction

The Health Practitioners Competence Assurance Act 2003 (**the Act**) provides a framework for the regulation of health care providers. Among other responsibilities set out in section 118 of the Act, it is the Podiatrists Board's (**the Board**) role to recognise, accredit and set programmes to ensure the ongoing competence of health practitioners.

In order to meet this obligation, the Board has set a recertification programme under section 41(3)(f) of the Act, requiring all podiatrists who hold a practising certificate to actively engage in CPD in accordance with the requirements set out in the Board's Continuing Professional Development (CPD) Recertification Policy.

In addition to the requirements set out in the Board's Continuing Professional Development (CPD) Recertification Policy for podiatrists, all podiatric surgeons who hold a practising certificate will be required to complete **additional Core Requirements and CPD relating to their advanced scope of practice**, which is outlined in sections A-E of this policy. These additional activities related to podiatric surgical practice are considered by the Board to be fundamental to support ongoing competency and to ensure the health and safety of all people/patients.

2. Core Requirements

In line with the requirements for podiatrists in the Board's Continuing Professional Development (CPD) Recertification Policy, podiatric surgeons will submit their **Annual Practice Plan** and include in it:

a. a description of their area of practice and continuing professional development to support this.
b. peer support and engagement activities specific to their podiatric surgical practice.

Additional core requirements for podiatric surgeons are as follows:

Compulsory Activities
Advanced Life Support (ALS)

Ongoing Activities
Surgical Practice Logbook
Self-Audit

Additional CPD Activities (specific to podiatric surgical practice)
20 hours in each 2-year CPD cycle

3. Pro-rating of Requirements

Where a podiatric surgeon obtains a practising certificate part way through a cycle, their **additional CPD activities only** will be reduced on a pro-rata basis, as follows:

Practising Certificate Issued	**Additional CPD Activities (specific to podiatric surgical practice)**	**Compulsory Activities - Advanced Life Support (ALS)**	**Ongoing Activities – Surgical Practice Logbook and Self-Audit**
Year 1: Jan - Mar	20 hours	Required	Required
Year 1: Apr - Jun	18 hours	Required	Required
Year 1: Jul - Sep	16 hours	Required	Required

Year 1: Oct - Dec	14 hours	Required	Required
Year 2: Jan - Mar	12 hours	Required	Required
Year 2: Apr - Jun	10 hours	Required	Required
Year 2: Jul - Sep	8 hours	Required	Required
Year 2: Oct - Dec	6 hours	Required	Required

A. Advanced Life Support (ALS) Course

Podiatric surgeons must be able to use immediate life support and deal with clinical emergencies safely.

- Complete an Advanced Life Support (ALS) course and hold a **current** certificate of attainment from a recognised New Zealand Resuscitation Council (NZRC) provider or equivalent from Australia, United Kingdom or United States of America, or equivalent course as determined by the Board.

- Note: The New Zealand Resuscitation Council (NZRC) recognises two primary course types for health professionals: CORE Immediate and CORE Advanced. CORE Immediate is designed for early responders, while CORE Advanced is for those who may manage and supervise resuscitation events. According to the NZRC, both courses cover essential skills such as managing collapsed patients, airway management, and AED use, whilst emphasising communication and teamwork.

The certification issued should contain the following:

- The length of the course in hours.
- A statement that acknowledges successful participation and/or assessment at the advanced level.
- Date of issue.

Please refer to **Annex A** for further course providers.

B. Self-Audit

Podiatric surgeons have to be able to monitor and evaluate the quality of their podiatric surgery practice and use that evaluation to improve practice.

- Podiatric surgeons must conduct ongoing self-audit processes to regularly review and evaluate their own podiatric surgical practice which includes monitoring throughput (caseload), procedures performed and clinical outcomes. These ongoing self-audit processes assist the practitioner to review complication rates, patient satisfaction and health related quality of life indicators.

This evidence should include:

- Continuous Quality Improvement (CQI) – **(Annex B)**

- Patient Reported Measures – Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) – **(Annex B)**

  Please also refer to Te Tāhū Hauora | Health Quality & Safety Commission guidance on patient-reported measures. https://www.hqsc.govt.nz/our-data/patient-reported-measures

C. Surgical Practice Logbook

Podiatric Surgeons must be able to keep accurate, comprehensive and comprehensible records of a surgical intervention in accordance with applicable legislation, protocols and guidelines.

- Podiatric surgeons must maintain a surgical practice logbook which provides evidence of recency of surgical practice and outcomes. This must be in the form of a detailed case logbook of surgical procedures in which the practitioner was the primary surgeon.

- The logbook must reflect a minimum of 30 hours surgical practice annually.

The logbook should include but is not restricted to:

- **Patient demographics**
- **Date of surgery**
- **Procedure name/type**
- **Surgical technique**
- **Anaesthetic type**
- **Complications (including post-operative infection)**
- **Surgeon(s) involved and roles**
- **Pre-operative and post-operative diagnosis**
- **Post-operative notes**
- **Follow-up notes**
- **Learning outcomes**

The Podiatrist's Board does not approve of any Podiatric Surgeon performing any procedure beyond their competence, training and qualifications.

D. Additional CPD Activities (specific to podiatric surgical practice)

Podiatric surgeons must understand the importance of participation in ongoing training and professional development. For the safety of their patients, podiatric surgeons are obliged to remain current on advances and trends in their area of expertise, and this is achieved through participation in a variety of activities that constitute CPD.

CPD is a career-long obligation which must be responsive to the changing needs of individuals, groups and society. In this regard, the Board recognises that individuals learn in different ways. To address individual learning needs, the CPD recertification programme provides some freedom for each participant to self-direct their learning, however this is balanced against a need for evidence that meaningful and relevant learning is taking place.

- Podiatric surgeons must complete an **additional 20 hours CPD in each 2-year CPD cycle, specific to podiatric surgical practice.**

Examples of CPD activities include:

- Attending educational conferences, courses, and workshops (e.g., advanced wound care management, surgical site infections)
- Self-directed learning programs
- Presenting, teaching, or preparing educational materials
- Participating in assessments to identify learning needs
- Observing surgical procedures
- Writing and publishing articles or reports
- Participation in audit of medical practice and peer review
- Participation in supervision and mentoring
- Participation in peer group activities

E. Board Audit Process

In line with the Continuing Professional Development Audit Policy in place for podiatrists, the Board will also oversee the random audit of up to 20% of podiatric surgeon APC holders in each 2-yearly CPD cycle.

Due to the low numbers of registered podiatric surgeons holding a practising certificate, in instances where only one practitioner is available for audit selection, the audit may also be conducted as part of a routine quality assurance process.

In addition to the random selection, the Board may conduct follow-up audits where low-level issues have been identified in a previous audit. The Board will notify these participants of the need for a follow-up audit at the time it completes the audit in which the concerns were identified.

The Board may also include in the CPD audit, any practitioner who has been the subject of a competence review, complaint, competence concern or for any other reason.

Annex A: Advance Life Support (ALS) Course Providers

New Zealand Resuscitation Council https://www.resus.org.nz/healthcare-resources/resuscitation-training
Resuscitation Skills https://www.resuscitationskills.com
Meditrain https://www.meditrain.co.nz
Emcare https://www.emcare.co.nz
Triple One Care https://book.tripleonecare.nz/event?id=840
Hato Hone St John https://buy.stjohn.org.nz/
First Aid Training Company https://firstaidcompany.nz/advanced-resuscitation-acls-cpr/
Resuscitation Council UK (RCUK) https://www.resus.org.uk/training-courses/adult-life-support/als-2-day-course-advanced-life-support
Australian Resuscitation Council (ARC) https://resus.org.au/als-courses

Annex B:

1. Continuous Quality Improvement (CQI) for Podiatric Surgery

Example:

a. Objective - 80% of patients will have achieved stated goals and objectives, e.g., to straighten toes.

b. Method of Collection - 100% of discharged patient files are reviewed at time of discharge to determine if initial goals and objectives were achieved/not achieved/exceeded. Information is tracked by patient, surgical procedure, complications (e.g., infection, wound complications, poorly managed pain control, fixation issues), patient outcomes and surgeon.

c. Possible reasons for non-attainment:
   - Patient related: motivation, attendance record, illness, severity, complications, psycho-social/economic/cultural/ethnic factors.
   - Financial related: limitation of comprehensive options of surgery, follow-up limitations.
   - Treatment related: poor surgical technique, poor choice of procedure, lack of post operative education and therefore patient compliance.

d. After initial outcome data is collected the data is analysed and the practitioner ascertains the reason for non-attainment/attainment of outcome goals and objectives.

e. Action to be taken/not taken as appropriate:
   - If goals met - identify the measures that contributed to the successful outcome.
   - If goals not met - identify the measures that contributed to this outcome and identify the actions that need to be taken.

f. To complete the CQI cycle, use this system to determine if there is a greater/lesser incidence of patients meeting discharge goals/objectives.

   If greater, then quality has improved.
   If less, then quality of care has not improved.

2. Patient Reported Measures (PROMs and PREMs)

Patient-reported measures can be used for any healthcare activity and can be the assessment of the benefits of an intervention, or the goals and objectives that are established after an initial diagnostic workup. Measuring patient outcomes obligates podiatric surgeons to address the efficacy and quality of interventions. For example, a podiatric surgeon may focus on post-surgical healing rates, numbers of patient presenting with digital operations, as opposed to forefoot etc.

Patient experience is also a good indicator of the quality of health services. Strong evidence shows that patients who have better experiences, who report being listened to and treated with respect by their health providers are more likely to follow advice and get recommended follow-up care.

Patient-reported outcomes are a measure of healthcare quality that reflect the patient's perception of their own health status. Patients are asked to participate in validated questionnaires pre and post operatively. Some examples of these used in foot and ankle surgery are:

a. Manchester Oxford Foot Questionnaire (MOXFQ) – This is a 16-item questionnaire which is completed by the patient, which is divided into 3 domains:
   - walking/standing (7 items)
   - pain (5 items)
   - social interaction (4 items)

   It is scored from 0-100 in which 100 is most severe.
   Preoperative Assessment - Administered 1-2 weeks preoperatively
   Early post operative assessment - Administered 6 weeks post operatively
   Midterm post operative assessment - Administered 3-6 months post operatively
   Long term post operative assessment - Administered 12 months post operatively

b. American Orthopaedic Foot and Ankle Score (AOFAS)

AOFAS is widely used in journal publications as an outcome measure for foot and ankle surgery although arguably has some limitations. It was produced mainly for reporting outcomes for surgery of the hindfoot and ankle. Patients report on pain and function and there are 3 subscales with scores:

- Pain 40 points - indicating no pain
- Function 50 points, indicating full function
- Alignment 10 points, indicating good alignment

Scoring is 0-100 with 100 indicating no symptoms

3. Audit Tools

Useful online audit tools used in podiatric surgery in Australia and the United Kingdom include:

Australasian College of Podiatric Surgeons (ACPS) https://stride.podiatry.org.au/articles/auditing-foot-ankle-surgery-to-improve-outcomes-the-acps-experience/
Podiatric Audit of Surgery and Clinical Outcome Measurement (PASCOM) https://www.pascom-10.com/

Annex C:

Surgical Procedures

Category A (Complex Reconstructive): These procedures include, but are not limited to:

- Complex rearfoot and ankle reconstruction
- Complicated revision surgery
- Multi-planar deformity correction

Examples of but not exclusive to:

- Rearfoot fusion including subtalar joint fusion/triple arthrodesis.
- Gastrocnemius resection/ Achilles tendon lengthening (adjunct procedure for pes planus correction/ increased forefoot pressure
- Diabetic foot debridement
- Limb salvage procedures – including amputations
- Charcot foot surgery – exosecetomy, beaming

Category B (Intermediate): These procedures include:

- Primary joint fusion procedures
- Tendon transfers
- Osteotomies

Examples of but not exclusive to:

- Hallux abducto-valgus correction via osteotomy or arthrodesis

- Hallux Limitus/Rigidus – osteotomy, arthroplasty, implants, arthrodesis
- Corrective joint implants (metatarsophalangeal joints)
- Lesser metatarsal joint resections
- Mid-tarsus exostectomies
- Mid-foot joint arthrodesis

Category C (Minor): These include:

- Digital procedures
- Incisional nail surgery
- Soft tissue procedures
- Simple excisions
- Minor tendon procedures

Examples of but not exclusive to:

- Incisional nail surgery -Sharp partial nail bed and matrix tissue wedge resection/Sharp total nail bed and matrix tissue resection
- Subungual exostectomy/Osteochondrectomy
- Forefoot Superficial biopsy
- Sub-cutaneous lesions/masses excisions Peri-neural fibroma (neuroma) resection
- Simple tenotomies for flexible digital deformities
- Simple Lesser Digital arthroplasty on interphalangeal joints
- Sequential reduction of digital deformities (extensor/flexor tendon lengthening, extensor tendon/hood release, digital arthroplasty/arthrodesis metatarsal osteotomies, plantar plate repair)
- Interphalangeal joint implant (smart toe or similar)