Sample portfolio of evidence
for podiatrists who are applying for endorsement for scheduled medicines through the Podiatry Board of Australia’s pathway B
Note: This sample portfolio is an example only. The portfolio, including the example evidence matrix and log of activities, are intended to provide guidance only and are not representations of a completed portfolio, evidence matrix or log of activities.

There is no prescribed format for the portfolio but it must include:

- a completed evidence matrix
- clinical studies, and
- a reflective diary or journal, which includes a log of activities.

More information is available on the Podiatry Board of Australia's website at www.podiatryboard.gov.au/Registration-Endorsement/Endorsement-Scheduled-Medicines
Evidence matrix
Podiatry Board of Australia

Evidence Matrix: Endorsement for scheduled medicines – Pathway B

What is this document?
- During your period of supervised practice under Pathway B, you will experience different aspects of the prescribing process according to the patients you engage with and the other activities you undertake. It is important for your learning, and a requirement of the Board, that you demonstrate competence to undertake all aspects of the prescribing process (refer Guidelines: Endorsement for scheduled medicines published on the Board’s website).
- When you submit your application for endorsement for scheduled medicines under Pathway B, it must be accompanied by a portfolio of evidence. The evidence in your portfolio must be clearly presented and labelled and accompanied by an evidence matrix. The evidence matrix identifies which aspects of the prescribing competencies are addressed in each piece of submitted evidence. This matrix forms an important checklist for you to ensure that evidence of all areas of prescribing practice is included in your portfolio prior to submission.

What are the required national prescribing competencies?
- The Board’s Registration standard: Endorsement for scheduled medicines (ESM registration standard) defines the required prescribing competencies as those described in the NPS MedicineWise Competencies to Prescribe Scheduled Medicines, also known as the Prescribing Competencies Framework (PCF). This document is available here.
- The ASPRINH (Assessment of Prescribing in Health) Project, a national multi-professional project, condensed the 73 performance criteria contained in the PCF to a set of essential prescribing skills, referenced to the PCF. These essential skills are detailed in the Prescribing Assessment Toolkit which can be found here. Further details about the ASPRINH Project and how these skills were developed can be found here.
- This evidence matrix reflects the work of the ASPRINH project. Rather than listing the 73 competencies from the PCF, the table lists the condensed set of essential prescribing skills, (arranged in 22 competency areas and consisting of 45 essential prescribing skills) within each competency area
- The relevant performance criteria from the PCF (e.g. PCF: 1.1.1) that relate to each of the ASPRINH project competency areas in the table below (e.g. CA1.1 etc.) are indicated in blue text at the end of each competency area description.

How do I complete this document?
- Each piece of evidence included in your portfolio should be clearly numbered and described
- You should have at least once piece of evidence listed against each of the 45 essential prescribing skills listed in the matrix
- Some pieces of evidence may be used to demonstrate a number of the essential prescribing skills.
- The completed evidence matrix is to be submitted with your application for endorsement under Pathway B, together with your portfolio of evidence and a signed certification of completion of supervised practice.
**Evidence Matrix**

**Name:** Anna Podiatrist  
**Date completed:** 6 May 2019

<table>
<thead>
<tr>
<th>Competency area</th>
<th>Essential prescribing skills within each competency area</th>
<th>Evidence submitted</th>
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</thead>
<tbody>
<tr>
<td><strong>Competency Area 1 – Understand the patient</strong></td>
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</table>
| CA1.1 Obtain a problem-focused, comprehensive clinical history using appropriate communication, process and deductive skills  
*PCF: 1.1.1, 1.2.1, 1.2.2, 1.2.3.* | 1.1 Obtain a comprehensive clinical history, including social, cultural & demographic characteristics. Identify whether the patient is pregnant or breastfeeding | 1  
Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 1- Theoretical case using emergency medicines |
| 1.2 Establish a therapeutic relationship, build rapport and trust | 1 | Clinical study 1- 12/08/2018 |
| 1.3 Use appropriate communication strategies | 1  
4  
8 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 2- Journal review (gout) |
| 1.4 Use relevant sources of patient-specific information e.g. patient and/or family, health record, other health professionals | 1  
8 | Clinical study 1- 12/08/2018  
Reflective piece 2- Journal review (gout) |
| | | |
| CA1.2 Undertake a comprehensive treatment history including adherence to current and previously prescribed and self-initiated treatment/s. Consider risk factors for non-adherence. Reconcile the current treatment history with the clinical history and diagnoses  
*PCF: 1.2.1, 1.2.3, 1.2.4, 1.2.5* | 1.5 Obtain a comprehensive treatment history, including details of pharmacological, non-pharmacological and other relevant treatment modalities, as well as an indication of their effectiveness, ineffectiveness and/or harm. Specific details of the route, dose, indication and rationale | 1  
4  
8  
9  
10 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 2- Journal review (gout)  
NPS Module: Polypharmacy  
Reflective piece – complex case |
| 1.6 Assess the patient’s degree of adherence with prescribed (and self-initiated) therapy | 8 | Reflective piece 2- Journal review (gout) |
| 1.7 Obtain a complete allergy history | 1  
4  
7 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 1- Theoretical case using emergency medicines |
<table>
<thead>
<tr>
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<td>NPS Module: Polypharmacy</td>
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<td>9 10</td>
<td>Reflective piece – complex case</td>
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</tbody>
</table>
| CA1.3 Demonstrate appropriate profession-specific patient assessment processes including, as appropriate, those pertaining to physical examination and arranging or undertaking relevant investigations | 1.10 Undertake podiatry and scope relevant physical examination as appropriate for the patient's needs | 1 4 8 10 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 2- Journal review (gout) |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 1 10                | Clinical study 1- 12/08/2018 |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 1 11                | Clinical study 1- 12/08/2018 |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 4 8 9               | Clinical study 2- 01/09/2018  
Reflective piece 2- Journal review (gout)  
NPS Module: Polypharmacy |
| CA1.4 Appropriately demonstrate the identification of gaps in personal knowledge and skills and the willingness to seek advice or refer the patient when in doubt | 1.13 Recognise personal and professional limits within the scope of prescribing, including the process of assessing the patient's needs | 1 4 8 10 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 2- Journal review (gout)  
Reflective piece – complex case |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 1 12                | Clinical study 2- 01/09/2018 |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 1 14                | Clinical study 2- 01/09/2018 |
|                 |                                                          |                     | Reflective piece – complex case |
| Competency Area 2 - Clinical decision making | 2.1 Use appropriate information to make or review diagnosis (e.g. the clinical history, details of examinations and/or investigations, information provided by other health professionals) | 1 4 7               | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018  
Reflective piece 1- Theoretical case using emergency medicines |
|                 |                                                          |                     | Reflective piece – complex case |
|                 |                                                          | 2.2 Identify key clinical issues, including those potentially related to existing medicines | 1 4 | Clinical study 1- 12/08/2018  
Clinical study 2- 01/09/2018 |
<p>|                 |                                                          |                     | Reflective piece – complex case |</p>
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<tr>
<td>CA2.2 Consider whether existing treatment may be contributing to current health issues. Consider whether existing treatment has achieved the identified goals. Accordingly, consider the need to modify existing treatment</td>
<td>2.3 Identify whether existing treatment (where applicable) has achieved desired goals or contributed to current symptoms</td>
<td>Evidence</td>
<td>8 9</td>
<td>Reflective piece 2- Journal review (gout) NPS Module: Polypharmacy</td>
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<tr>
<td></td>
<td>2.4 Decide whether there is a need to modify existing therapy</td>
<td>Evidence</td>
<td>4 10</td>
<td>Clinical study 2- 01/09/2018 Reflective piece – complex case</td>
</tr>
<tr>
<td>CA2.3 Determine whether current symptoms are modifiable by treatment</td>
<td>2.5 Decide whether pharmacological and/or non-pharmacological treatment options are applicable, within scope of practice</td>
<td>Evidence</td>
<td>1 4 7 8</td>
<td>Clinical study 1- 12/08/2018 Clinical study 2- 01/09/2018 Reflective piece 1- Theoretical case using emergency medicines Reflective piece 2- Journal review (gout)</td>
</tr>
<tr>
<td>CA2.4 Determine the most appropriate treatment option (pharmacological and/or non-pharmacological) taking into consideration relevant patient and treatment information</td>
<td>2.6 Determine the most appropriate treatment option/s taking into consideration patient specific details (including co-morbidities and current treatment)</td>
<td>Evidence</td>
<td>1 4 8 9 10</td>
<td>Clinical study 1- 12/08/2018 Clinical study 2- 01/09/2018 Reflective piece 2- Journal review (gout) NPS Module: Polypharmacy Reflective piece – complex case</td>
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<tr>
<td>CA2.5 Negotiate with the patient the goals of treatment; respecting their beliefs, needs and attitude to the treatment options</td>
<td>2.7 Respectfully negotiate the goals of treatment with the patient</td>
<td>Evidence</td>
<td>1</td>
<td>Clinical study 1- 12/08/2018</td>
</tr>
<tr>
<td>CA2.6 Proactively seek advice where required and use</td>
<td>2.8 Demonstrate an awareness of personal and professional limits relevant to the decision to treat and the</td>
<td>Evidence</td>
<td>4 9</td>
<td>Clinical study 2- 01/09/2018 NPS Module: Polypharmacy</td>
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<td><strong>available resources effectively.</strong> Demonstrate an understanding of personal and professional limitations and refer the patient to another health professional where appropriate</td>
<td>choice of treatment. Seek advice where required</td>
<td>10</td>
<td>Reflective piece – complex case</td>
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<tr>
<td><strong>PCF:</strong> 2.2.9, 3.2.2, H1.2.2.</td>
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<td>2.9 Use appropriate resources to guide decision making e.g. protocols, guidelines, the advice of colleagues</td>
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<td>Clinical study 1- 12/08/2018</td>
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<td>Clinical study 2- 01/09/2018</td>
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<td>NPS Module: Polypharmacy</td>
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<td>2.10 Refer the patient to another health professional to determine the most appropriate treatment choice as appropriate</td>
<td>8</td>
<td>Reflective piece 2- Journal review (gout)</td>
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<td>Reflective piece – complex case</td>
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<td><strong>CA2.7</strong> In collaboration with the patient, select the most appropriate treatment according to both treatment and patient factors</td>
<td>2.11 Decide on treatment in collaboration with patient, taking patient relevant factors into consideration e.g. cost and availability of medicine, intended duration of therapy, patient preference and beliefs and the properties of the pharmacological/non-pharmacological therapy such as route, dose, frequency</td>
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<td>Clinical study 1- 12/08/2018</td>
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<td>Clinical study 2- 01/09/2018</td>
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<td>8</td>
<td>Reflective piece 2- Journal review (gout)</td>
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<td>2.12 Provide an evidence-based rationale for the prescribed therapy. Where relevant, provide details of the properties of prescribed medicine/s, potential adverse effects, interactions and contraindications and details of non-pharmacological therapies recommended to the patient. Consider relevant ethical and legal considerations.</td>
<td>1</td>
<td>Clinical study 1- 12/08/2018</td>
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<td>NPS Module: Polypharmacy</td>
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<tr>
<td><strong>CA2.8</strong> Modify the treatment according to patient specific factors</td>
<td>2.13 Consider the need to adjust the dose according to patient age, weight, renal/hepatic function, agreed goals, possible interaction with existing therapy/food</td>
<td>1</td>
<td>Clinical study 1- 12/08/2018</td>
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<td>4</td>
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<td>NPS Module: Polypharmacy</td>
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<td><strong>PCF:</strong> 2.2.3.</td>
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<td><strong>CA2.9</strong> Determine when the various components of treatment should be reviewed and agree to a plan for this with the patient</td>
<td>2.14 Discuss with the patient the need to monitor therapy and agree on a plan for this to occur</td>
<td>1</td>
<td>Clinical study 1- 12/08/2018</td>
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<td>Description of evidence</td>
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<tr>
<td>Competency Area 3 – Communicate the treatment plan</td>
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<tr>
<td>CA3.1 Discuss with the patient, carer and/or family details of the treatment plan. Provide written and verbal information as appropriate or required by law</td>
<td>3.1 Provide relevant information for the patient, carer and/or family, including: the name of the treatment/s, dose, frequency, how to administer, intended duration</td>
<td>1 4 Clinical study 1- 12/08/2018 Clinical study 2- 01/09/2018</td>
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<tr>
<td>PCF: 2.2.6, 2.2.7.</td>
<td>3.2 Provide advice regarding when to seek advice and how to know if treatment has been effective, ineffective or harmful</td>
<td>1 4 Clinical study 1-12/08/2018 Clinical study 2- 01/09/2018</td>
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<td>3.3 Provide written and verbal information as appropriate and/or required</td>
<td>1 4 10 Clinical study 1-12/08/2018 Clinical study 2- 01/09/2018 Reflective piece – complex case</td>
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</tr>
<tr>
<td>CA3.2 Ensure the patient, carer and/or family understand the details of the treatment plan</td>
<td>3.4 Use effective communication skills (e.g. active listening, awareness of cultural factors, ability to adapt communication for patients with disability such as hearing loss) to convey information and to ensure the patient has understood the information provided</td>
<td>1 8 Clinical study 1- 12/08/2018 Reflective piece 2- Journal review (gout)</td>
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<tr>
<td>PCF: 3.2.7.</td>
<td>3.5 Document the details of the agreed treatment plan (including the plan for review of therapy) using appropriate, secure methods</td>
<td>1 Clinical study 1- 12/08/2018</td>
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<tr>
<td>CA3.3 Document details of the agreed treatment plan</td>
<td>3.6 Ensure all relevant health professionals are provided with details of the agreed treatment plan (including the plan for review of therapy). Discuss any specific requirements applicable to shared care protocols.</td>
<td>1 3 Clinical study 1- 12/08/2018 Sample letter communicating with another health practitioner- 17/08/2018</td>
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<tr>
<td>PCF: H1.1.2.</td>
<td>3.7 Ensure modifications made to existing therapy are communicated to all relevant health professionals</td>
<td>4 6 Clinical study 2- 01/09/2018 Sample letter communicating with another health practitioner- 01/09/2018</td>
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<tr>
<td>CA3.4 Communicate details of the treatment plan to other health professionals including modifications to existing therapy where applicable</td>
<td>8 Reflective piece 2- Journal review (gout)</td>
<td>8 Reflective piece – complex case</td>
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<tr>
<td>PCF: 4.2.1, H2.5.4.</td>
<td>10 Reflective piece – complex case</td>
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## Competency Area 3 – Essential prescribing skills within each competency area

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<tr>
<th>Competency area</th>
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<tbody>
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<td>Description of evidence</td>
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### Evidence matrix

<table>
<thead>
<tr>
<th>Evidence number</th>
<th>Description of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8</td>
<td>Consider the need for informed consent when providing information to other health professionals. Record details.</td>
</tr>
<tr>
<td>3.9</td>
<td>Prescribe medicines according to recognised safety recommendations (appropriate abbreviations and terminology, use of standardised forms), legal and regulatory requirements.</td>
</tr>
<tr>
<td>3.10</td>
<td>Prescribe medicines accurately.</td>
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### Competency Area 4 – Monitor and review prescribed therapy

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<tr>
<th>Competency Area 4 – Monitor and review prescribed therapy</th>
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<tbody>
<tr>
<td>4.1</td>
<td>Use relevant sources of information to determine whether prescribed/recommended treatment has been effective, ineffective or harmful.</td>
</tr>
<tr>
<td>4.2</td>
<td>Seek advice if the outcome of instituted therapy is unclear, difficult to interpret or not expected.</td>
</tr>
<tr>
<td>4.3</td>
<td>Determine treatment options based on information gathered regarding the outcomes of current therapy.</td>
</tr>
<tr>
<td>4.4</td>
<td>Where required, work with other health professionals to interpret results of monitoring and to decide on possible treatment options based on monitoring.</td>
</tr>
<tr>
<td>Competency area</td>
<td>Essential prescribing skills within each competency area</td>
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<tr>
<td>CA4.3 Decide, in collaboration with the patient and/or other health professionals, whether therapy should be ceased, modified, continued or initiated depending on the results of monitoring and review</td>
<td>9</td>
</tr>
<tr>
<td>CA4.4 Communicate the findings of the review and recommendations with the patient, carer and/or family and other health professionals as appropriate, seeking advice and referring the patient when indicated</td>
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<tr>
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<td>4.6 Communicate the outcome of the review of therapy to relevant other health professionals</td>
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<tr>
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<td>4.7 Use appropriate communication methods to provide review information to other relevant health professionals, e.g. electronic, written and/or verbal methods to ensure timely provision of information</td>
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</tbody>
</table>
Clinical studies
Evidence number: 1

Clinical study number: No. 1
Date of observation: 12/8/2018
Your name: Anna Podiatrist
Attending clinician’s name: Dr V
Location/description of clinical setting (e.g. St David’s hospital, ED): Acute/Tertiary Hospital - Outpatient clinic
Session description: Initial presentation to High Risk Foot Clinic (interdisciplinary)

Patient details e.g. sex, age, medical conditions, pregnancy and breastfeeding status if relevant, social and lifestyle factors, allergies:
Mr Pxxxx Sxxxxx
Single, 52-year-old male, lives alone
Unemployed, sedentary lifestyle, BMI 26 kg/m²
Medical history:
Type 2 diabetes mellitus diagnosed 8 years ago
Current smoker - 20 cigarettes/day past 25 years
Denies any alcohol or other drug use
Sub-optimal blood glucose levels (BGLs) monitored daily at home.
Obstructive Sleep Apnoea
Hypertension
Allergies - Captopril – dry cough
Medications:
Gliclazide tablet MR; 60mg oral daily
Empagliflozin/Linagliptin tablet; 25mg/5mg oral daily
Atorvastatin tablet; 10mg oral morning
Paracetamol tablet; 100mg oral daily
Meflofin tablet (extended release); 1g oral morning
Perindopril arginine tablet; 10mg;10mg oral morning

Presenting complaint: six-month history of recurrent plantar ulceration and infection overlying left 1st metatarsophalangeal joint

Subjective:
Patient reports feeling generally unwell for the past four days, has noticed his fasting BGLs are elevated.
He has noticed increased pain and malodorous discharge from his wound in the past 48 hours. Patient reports he did see his GP when this first ulcerated and had a one-week course of antibiotics but that was over 5 months ago. Patient was unable to provide details of the antibiotic.
No previous podiatry input and patient has been self-managing with non-adherent dressings.

Objective:
HbA1c 89mmol/mol or 10.3% (30/07/18)

Isolated oedema, erythema and purulent exudate from pressure ulcer under the left 1st metatarsophalangeal joint. Wound size Length= 18mm, Width=12mm, Depth=3mm (does not probe to bone).
Infection status= Moderate, cellulitis less than 2cm surrounding peri-wound
Palpable pedal pulses (dorsalis pedis and posterior tibial) and biphasic on Doppler ultrasound bilaterally. Absolute toe pressure= 88mmHg Left and 110mmHg Right

Walking in Crocs™ today, reports rarely wearing shoes as home most of the time.

Assessment:
Diagnosis: Infected, neuropathic pressure ulcer left foot plantar to 1st metatarsophalangeal joint due to biomechanics leading to increased pressure at ulcer site.
Differential Diagnosis: Nil evidence of gout, malignancy, traumatic injury

Plan:
Discussed with patient and consent obtained
Short term:
Blood tests (C-Reactive Protein (CRP), Full blood count (FBC), Liver function tests (LFTs), vitamin D & C, estimated glomerular filtration rate (eGFR), uric acid)
Local sharp wound debridement
Oral antibiotic therapy prescribed (see below)
Implement dressing plan & referral to community nursing service.
Offloading (removable pneumatic offloading boot)- patient able to don and doff boot
Imaging (baseline X-ray)
Swab (microscopy, culture and sensitivity) / tissue culture / fungal culture
Education (verbal and written)
Correspondence/ letter to treating team

Long term:
Follow up consultation with podiatry in 5 days
Consider bone scan/MRI if X-ray is inconclusive and clinical concerns remain.
Consider total contact cast as gold standard offloading (once osteomyelitis is excluded)
Follow up consultations with diabetes educator, endocrinologist and dietitian

Medications prescribed (including scheduling):
Amoxicillin/Clavulanic acid tablet 875/125mg oral 12 hourly for 5 days
Schedule 4: Prescription Only

(1.10, 1.11, 2.1, 2.2) (1.2, 1.4, 1.5) (1.1, 1.7) (2.1, 2.2) (2.5, 2.6, 2.8, 2.9, 3.10)
This patient presents with a mild to moderate infection with no current evidence of osteomyelitis or septic arthritis and he does not report an immediate hypersensitivity to penicillin. Therefore, the following antibiotic therapy would be recommended: Amoxicillin and Clavulanic acid 875 + 125mg orally 12 hourly for 5 days. This antibiotic is contraindicated in patients with a penicillin allergy, reduced liver and kidney function, glandular fever, HIV and leukaemia. The patient does not report any of these conditions with previous history of penicillin use with no adverse symptoms.

Possible interactions reported include: Probenecid; alcohol; oral anticoagulants e.g. acenocoumarol, warfarin; ethotrexate; allopurinol. The patient does not report use of any of these drugs listed.

A podiatrist providing an empirical prescription for amoxicillin/clavulanic acid for the treatment of a mild to moderate diabetic foot infection following a thorough assessment of the individual patient would be considered suitable. This would include a swab/tissue culture taken prior to commencing any treatment for future monitoring of the infection and review of the appropriateness of the antibiotic prescribed.

Prescription provided by the Endorsed podiatrist does not attract PBS subsidy.

Take medication immediately before or with first mouthful of food to optimise absorption and minimise potential gastrointestinal intolerance.

Common side effects discussed and advised to report to his GP if they experience significant or prolonged diarrhoea and nausea especially if they experience significant or prolonged diarrhoea and nausea especially if diarrhoea.

Advice given regarding smoking cessation and the support available.

The prescription for scheduled medicines if written by an endorsed podiatrist does not attract a benefit under the PBS. Correspondence has been provided to GP with management plan and review dates.

### References:

- eTG complete [Internet]. Melbourne: Therapeutic Guidelines Limited; 2018, via https://tgldcdp-tg-org-au.sakus.idm.oclc.org/eTGAccess
Evidence number: 2

PRESCRIPTION
Anna Podiatrist
Bachelor of Podiatry
Podiatrist endorsed for scheduled medicines
Podiatry Board of Australia - Registration No: POD12345678

Practice Address:
Podiatry Department, Large Multi-disciplinary Diabetic Foot Clinic
Large Hospital, Adelaide SA
Phone: (08) 1234 5678

Patient details:
Full name: Mr Pxxxx Sxxxxx
DOB: 12/05/1966
Address: 1A Smith Street, Adelaide SA 5000
Date: 12/8/2018

Amoxicillin and Clavulanic Acid 875mg / 125mg tabs
Take one tablet every 12 hours for 5 days
Take immediately before or with first mouthful of food
Supply 10 tablets

Anna Podiatrist
Prescriber's signature

No subsidy available under the PBS for medicines prescribed by a podiatrist or podiatric surgeon with endorsement for scheduled medicines

Patient Receipt
THIS AREA DOES NOT NEED TO BE COMPLETED
Patient or agents signature
Agent address
Dear General Practitioner,

RE: Mr Pxxxx Sxxxxx
DOB 12/05/1966
Address: 1A Smith Street Adelaide SA 5000

Thank you for referring Mr Pxxxx Sxxxxx to our High-Risk Foot Clinic. At his initial presentation on 12 August 2018 he reported a six-month history of a wound and recurrent infection at the left plantar first metatarsophalangeal joint.

I observed Mr Sxxxxx to have a moderately infected neuropathic ulcer that was managed with localized sharp debridement. Based on the clinical presentation and assessment, Mr Sxxxxx was prescribed a course of Amoxicillin with Clavulanic acid 875mg + 125mg orally 12 hourly for 5 days. Baseline bloods including C-reactive protein, full blood count, liver function test, vitamin D and C were ordered as well as a microscopy culture and sensitivity swab, tissue culture and fungal scrapings. X-ray was requested to check for underlying osteomyelitis. A referral to community nursing for comprehensive wound management was arranged. Mr Sxxxxx was fitted with a Removable Cast Walker to off-load the wound with instructions to wear this boot for all weight bearing activities.

At his 5-day review appointment on 17 August 2018 the clinical signs of infection appear to be subsiding and therefore I don’t see a clinical need to continue antibiotics. You will have received Mr Sxxxxx imaging and pathology results. Mr Sxxxxx also appears to be consistently using his offloading device.

Our high-risk foot clinic will review Mr Sxxxxx again in 7 days to monitor his progress. Mr Sxxxxx appears to have a good understanding of diabetes-related foot complications and management. I have continued to encourage him to optimise his glycaemic control and consider quitting smoking.

In the short term I will closely monitor Mr Sxxxxx’s progress and I will keep you informed.

Yours sincerely,

Anna Podiatrist

Essential prescribing skills: 3.6, 4.6
Evidence 4: Clinical study 2

Clinical study

- Psoriasis
- Eczema
- Dermatitis
- Lichen planus
- Viral warts
- Onycholysis
- Onychogryphosis
- Trauma

Many nail disorders can mimic onychomycosis and microscopy and culture is important in the diagnosis. Use of topical preparation could have impaired microscopy and culture results and had the potential to produce a false negative result.

Patient had consistently adhered to topical antifungal treatment application for considerable length of time but had not produced desired results. (DermNZ, 2018) (1.5, 2.1, 2.2, 2.3, 2.4)

Plan

- Discussed with patient and consent obtained.
- Recommended oral anti-fungal treatment for 6 weeks
- Require repeat blood count including liver function tests at 4-6 weeks and results to be followed up with medical practitioner.
- Education on reducing risk of fungal infection and reinfection.

Medications prescribed

- Terbinafine 250mg orally, once daily for 6 weeks (42 tablets)
- Poisons Schedule: S4

Scheduled medicines assessment and evaluation

Rationale for prescribing oral antifungal medicine is consistent with failure of topical treatment and patient desires to improve appearance, prevent nail loss or destruction and stop spread of infection

Terbinafine is the treatment of choice for dermatophyte onychomycosis as it has a high affinity for keratinous tissues. It is given once a day and is generally well tolerated. (eTG, 2018)

For this relatively mild case a single 6-week course of treatment should be sufficient. Full nail plate growth will take 9-12 months and therefore proximal healthy nail results may not always be evident after the 6-week treatment.

Systemic treatment is more effective than topical for fungal infections. Terbinafine has a cure rate of 70 to 80% and is more effective than itraconazole and fluconazole, but its use can be limited by adverse effects.

Terbinafine is a strong inhibitor of CYP2D6, potentially increasing the concentrations and adverse effects of drugs metabolised by this enzyme. Currently this patient did not report any medications within this class of medicines that are metabolized by the CYP2D6 enzyme.

Baseline blood count for this patient does not indicate any hepatic or renal impairment that would contraindicate the use of oral terbinafine.

No known intolerance to this medication or known drug interactions with current medications. Standard adult dose to be given to patient based on weight.

Terbinafine may exacerbate or precipitate psoriasis or lupus erythematosus. This patient was not currently reporting such conditions.
Clinical study

A podiatrist providing a prescription for oral terbinafine for the treatment of onychomycosis of the toenails would be considered suitable and in context of podiatry practice when co management takes place with a medical practitioner to assist in monitoring systemic effects of this drug.

A thorough assessment of the individual patient including microscopy and culture was conducted prior to commencing treatment.

Patient counselling and education would need to occur to include the risks, monitoring and follow up.

For non-concession card holders a private prescription is comparable to the cost of a PBS subsidised prescription. The patient would also have costs involved in follow up pathology (LFTs/blood count) and a consultation with a medical practitioner to review the results.

Prior to commencement of this medicine, the patient’s general practitioner was contacted via phone initially and followed up with written correspondence. This was to inform, request and ensure agreement with the general practitioner who accepted responsibility to order and review pathology to monitor the systemic status of this patient.

Education

The patient needs to be advised of the 70-80% cure rate for terbinafine, therefore approximately 20% resistance. The nail needs to grow out before it looks completely healthy. For a young healthy patient, this would be approximately 9 months.

It is important the patient is aware to contact their health professional if they feel unusually tired, nauseous or are not eating; notice dark urine, pale faeces or yellowing of the whites of their eyes or skin; if they get fever, mouth ulcers, sore throat or unusual bruising. Advice provided to avoid pregnancy during the course of treatment and to cease treatment if may be pregnant.

Ensure the patient is aware the blood tests at 4-6 weeks are important to monitor liver and kidney function.

Advised thorough cleaning of bathroom and shower floors and treatment for any polish.

Advise on foot hygiene being important in the prevention of fungal infections. Recommended footwear in communal/public areas such as at swimming pool, drying feet and between toes meticulously, avoiding occlusive footwear and nail polish.

Clinical effectiveness is only seen some months after mycological cure and cessation of treatment due to full nail growth taking approximately 9-12 months. If treatment is not successful or the patient does not tolerate terbinafine this patient would need to be referred on to a general practitioner. Referral will be for further assessment and consideration of alternative oral antifungal therapy not available to endorsed podiatrists/podiatric surgeons.

The patient to see her GP for LFT’s and blood count to be monitored at 4-6 weeks.

(1.3, 1.14, 2.8, 2.11, 2.13, 2.14, 3.1, 3.2, 3.3, 3.6, 3.7, 3.8)

Review/monitoring

Clinical effectiveness is only seen some months after mycological cure and cessation of treatment due to full nail growth taking approximately 9-12 months.

A small scratch in the nail can be made with a scalpel blade just proximal to the dystrophy after the first course of treatment. If the dystrophy stays distal to the scratch, no further treatment is required. (eTG, 2018)

If treatment is not successful or the patient does not tolerate terbinafine this patient would need to be referred on to a general practitioner. Referral will be for further assessment and consideration of alternative oral antifungal therapy not available to endorsed podiatists/podiatric surgeons.

The patient to see her GP for LFT’s and blood count to be monitored at 4-6 weeks.

(1.3, 1.14, 2.8, 2.11, 2.13, 2.14, 3.1, 3.2, 3.3, 3.6, 3.7, 3.8)

Clinical study

Learning outcomes

(1, 3.2, 3.3, 3.6, 3.8)

Type of case

☐ High risk
☐ Polypharmacy
☐ Complex
☐ Podiatric pathology
☐ Outcome of medicines reported

Attachments

Prescription, shared care correspondence with GP.

Signature of mentor

John Smith

Date

10 October 2018

Mentor name

John Smith

Your signature

Anna Podiatrist

Date

10 October 2018

Your name

Anna Podiatrist
Evidence 5: Prescription for clinical study 2

PRESCRIPTION

Anna Podiatrist
Bachelor of Podiatry
Podiatrist endorsed for scheduled medicines
Podiatry Board of Australia - Registration No: POD12345678

Practice Address:
10 Foot Lane Webber SA 5003
Phone: (08) 8360 0000

Patient details:
Full name: Miss Jxxxx Dxxxxx
DOB: 07/07/2001
Address: 7 Bourke Street, Adelaide SA 5000
Date: 03/09/2018

Rx
Terbinafine
250mg tablets
1 daily for 6 weeks
Supply 42 tablets

Anna Podiatrist
Prescriber’s signature

No subsidy available under the PBS for medicines prescribed by a podiatrist or podiatric surgeon with endorsement for scheduled medicines

Patient Receipt
THIS AREA DOES NOT NEED TO BE COMPLETED
Patient or agents signature
Agent address
Miss Jxxxx Dxxxxxx presented today complaining of a 14-month history of onychomycosis of the toenails, non-responsive to topical preparations. Microscopy and culture results confirmed dermatophyte T. rubrum.

Based on the clinical presentation and assessment, culture results and baseline blood results a 6-week course of oral terbinafine (250mg daily) was recommended to attempt nail infection cure.

As per our phone conversation today, Miss Dxxxxxx will collect a pathology request form from your practice to complete bloods to monitor liver function and blood count in approximately 6 weeks. She has been advised to arrange a consult with you to review the results and assess the effectiveness of the treatment.

Please contact my clinic if you require any further information.

Yours sincerely,

Anna Podiatrist

3/9/2018

Dr General Practitioner
GP Clinic
Dear Dr General Practitioner,

Re: Miss Jxxxx Dxxxxxx

DOB: 07/07/2001
Address: 7 Bourke Street, Adelaide SA 5000

Miss Jxxxx Dxxxxxx presented today complaining of a 14-month history of onychomycosis of the toenails, non-responsive to topical preparations. Microscopy and culture results confirmed dermatophyte T. rubrum.

Based on the clinical presentation and assessment, culture results and baseline blood results a 6-week course of oral terbinafine (250mg daily) was recommended to attempt nail infection cure.

As per our phone conversation today, Miss Dxxxxxx will collect a pathology request form from your practice to complete bloods to monitor liver function and blood count in approximately 6 weeks. She has been advised to arrange a consult with you to review the results and assess the effectiveness of the treatment.

Please contact my clinic if you require any further information.

Yours sincerely,

Anna Podiatrist

3/9/2018

Dr General Practitioner
GP Clinic
Dear Dr General Practitioner,

Re: Miss Jxxxx Dxxxxxx

DOB: 07/07/2001
Address: 7 Bourke Street, Adelaide SA 5000

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Based on the clinical presentation and assessment, culture results and baseline blood results a 6-week course of oral terbinafine (250mg daily) was recommended to attempt nail infection cure.

As per our phone conversation today, Miss Dxxxxxx will collect a pathology request form from your practice to complete bloods to monitor liver function and blood count in approximately 6 weeks. She has been advised to arrange a consult with you to review the results and assess the effectiveness of the treatment.

Please contact my clinic if you require any further information.

Yours sincerely,

Anna Podiatrist

3/9/2018

Dr General Practitioner
GP Clinic
Dear Dr General Practitioner,

Re: Miss Jxxxx Dxxxxxx

DOB: 07/07/2001
Address: 7 Bourke Street, Adelaide SA 5000

Miss Jxxxx Dxxxxxx presented today complaining of a 14-month history of onychomycosis of the toenails, non-responsive to topical preparations. Microscopy and culture results confirmed dermatophyte T. rubrum.

Based on the clinical presentation and assessment, culture results and baseline blood results a 6-week course of oral terbinafine (250mg daily) was recommended to attempt nail infection cure.

As per our phone conversation today, Miss Dxxxxxx will collect a pathology request form from your practice to complete bloods to monitor liver function and blood count in approximately 6 weeks. She has been advised to arrange a consult with you to review the results and assess the effectiveness of the treatment.

Please contact my clinic if you require any further information.

Yours sincerely,

Anna Podiatrist

3/9/2018

Dr General Practitioner
GP Clinic
Dear Dr General Practitioner,

Re: Miss Jxxxx Dxxxxxx

DOB: 07/07/2001
Address: 7 Bourke Street, Adelaide SA 5000

Miss Jxxxx Dxxxxxx presented today complaining of a 14-month history of onychomycosis of the toenails, non-responsive to topical preparations. Microscopy and culture results confirmed dermatophyte T. rubrum.

Based on the clinical presentation and assessment, culture results and baseline blood results a 6-week course of oral terbinafine (250mg daily) was recommended to attempt nail infection cure.

As per our phone conversation today, Miss Dxxxxxx will collect a pathology request form from your practice to complete bloods to monitor liver function and blood count in approximately 6 weeks. She has been advised to arrange a consult with you to review the results and assess the effectiveness of the treatment.

Please contact my clinic if you require any further information.

Yours sincerely,
Reflective journal
Podiatry Board of Australia

Log of activities: Endorsement for scheduled medicines – Pathway B

What is this document?
As required by the Podiatry Board of Australia’s Registration standard: Endorsement for scheduled medicines (ESM registration standard) and Guidelines: Endorsement for scheduled medicines (ESM guidelines), during your period of supervised practice under Pathway B you will progressively develop a portfolio of evidence that will demonstrate to the Board that you have met the Board’s supervised practice requirements and you have the required prescribing competencies to have your registration endorsed for scheduled medicines.

Your portfolio of evidence must include a Reflective journal. The purpose of a reflective journal is to enable you to demonstrate that you have undertaken a minimum of 150 hours of supervised practice within a 12-month period and you have reflected on your prescribing practice.

Your reflective journal must include a log of the activities you have undertaken during your supervised practice.

The log of activities will be developed progressively during your period of supervised practice and should be taken to each activity and signed by the relevant practitioner involved in the activity with you on the day. For example the attending prescribing clinician for each observational clinical session must sign the entry for each session.

How do I complete this document?
The Board has developed this example of a Log of activities that you may wish to use.

Each entry in the log must include at a minimum:

- the date and time for the activity
- the duration of the activity in hours
- a brief description of the activity
- the name, profession and signature of the practitioner involved in the activity with you

When you have completed the Log of activities, sign the document and insert the period of supervised practice where indicated at the top of the template.
Log of activities undertaken during the period of supervised practice under Pathway B

**Name:** Anna Podiatrist  |  **Signature:** Anna Podiatrist  |  **Period of supervised practice:** 01/08/2018 to 06/05/2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Description of activity</th>
<th>Summary of activity</th>
<th>Duration</th>
<th>Name, profession and signature of practitioner for relevant activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/8/2018</td>
<td>14:00</td>
<td>NPS MedicineWise module-Polypharmacy</td>
<td>Completed NPS MedicineWise online learning module on polypharmacy</td>
<td>1 hour</td>
<td>Anna Podiatrist - Anna Podiatrist</td>
</tr>
<tr>
<td>3/9/2018</td>
<td>09:00</td>
<td>Observational Clinical Session</td>
<td>Dermatologist private practice -5 clinical consultations observed</td>
<td>3 hours</td>
<td>Dr Mxxx Dxxxxx, Dermatologist</td>
</tr>
<tr>
<td>10/9/2018</td>
<td>17:00</td>
<td>Teleconference with mentor</td>
<td>Discussion with mentor over the phone regarding observation at Dermatologist clinic and learnings from NPS module on polypharmacy</td>
<td>1 hour</td>
<td>John Smith, mentor</td>
</tr>
<tr>
<td>13/9/2018</td>
<td>18:00</td>
<td>Reflection on 3/9/2018 clinical session and discussion with mentor and develop clinical study</td>
<td>Clinical study write up for dermatologist session (terbinafine case) and evidence assessment</td>
<td>4 hours</td>
<td>Anna Podiatrist - Anna Podiatrist</td>
</tr>
<tr>
<td>16/9/2018</td>
<td>13:00</td>
<td>Review journal article Medication adherence among patients with gout: A systematic review and meta-analysis</td>
<td>Analyse and reflect on article. Develop reflective piece for portfolio</td>
<td>3 hours</td>
<td>Anna Podiatrist - Anna Podiatrist</td>
</tr>
<tr>
<td>24/9/2018</td>
<td>09:00</td>
<td>Face to face meeting with mentor</td>
<td>Discussion with mentor about learnings from journal article (gout). Reviewed and discussed reflective piece about journal article and clinical study (terbanifine case)</td>
<td>1 hour</td>
<td>John Smith – mentor</td>
</tr>
</tbody>
</table>
Evidence 7: Reflective piece – theoretical case study

Theoretical case scenario involving the use of emergency drugs

Location of clinical setting
Private practice - subsequent visit

Patient details
17-year-old male, living at home, currently undertaking a plumbing apprenticeship
Weight: 60kg
Allergies: no known allergies or adverse drug reactions
Smoking status: non smoker
Denies any alcohol or other drug use
Medical conditions: Nil disclosed
Current medications: Nil disclosed
Previous history of medical procedures involving local or general anesthesia: Nil disclosed
Presenting complaint: ingrown toenail

Essential prescribing skills (1.1, 1.7, 2.1)

Subjective
Patient with father. Patient reports since starting his apprenticeship he wears steel cap boots and has problems with his left 1st toenail. Reports pain especially at the end of the day and has required two courses of antibiotics in the last two months. Patient reports nail appears to be growing into the skin and it is not resolving with current management. GP recommended he see a podiatrist.
Patient’s father reports that he has the same shape toenails to his son, and he required surgery when he was a teenager.

Objective
Involuting nail resulting in spicule of nail penetrating lateral nail fold, hypergranulation tissue present. Localised erythema and oedema to proximal phalanx left 1st toe. All dermatological, neurological and vascular assessments were performed and found to be within normal limits.
Verbal and written informed consent obtained prior to the surgical procedure.

Anaesthesia: The maximum dosage of Lidocaine without adrenaline is 3 mg/kg.
Based on the use of 2% Lidocaine, a safe maximum dosage was calculated as 9ml
4ml was drawn up in a single syringe, and the toe was swabbed prior to injection.
Following the injection, patient face and neck developed a flushed appearance, appeared to be having difficulty breathing. Patient reported dizziness.

Plan
Call for assistance- advised office staff to call triple zero for an ambulance advising suspected anaphylactic reaction in 17-year-old male.
Intramuscular (IM) adrenaline (epinephrine) given into patient mid-lateral thigh (using EpiPen® auto-injector) without delay.
Used EpiPen® Auto-Injector disposed of into a secure sharps container.
Patient was placed in recovery position with treatment chair flat. Practitioner monitored patient airways and response to adrenaline.
Clinical handover (in ISBAR format) provided to paramedics including drugs administered at the clinic.
Phone call and written correspondence sent to GP documenting details from podiatry consultation.

Assessment
Diagnosis: anaphylaxis (suspected due to either latex gloves or Lidocaine)
Differential Diagnosis: asthma exacerbation (although reports no history), panic attack/ anxiety.

Medications used
EpiPen® Auto-Injector Solution for injection, Adult/ child >20kg, IM 0.3 mg. Poisons schedule: S3

Scheduled medicines assessment and evaluation
There was rapid development of life-threatening respiratory complication and patient assessment was consistent with anaphylactic reaction.
IM injection into the mid-anterolateral thigh is safe and effective. It should be used at the first suspicion of an anaphylactic reaction for prevention of serious complication and death.
Adrenaline is often life-saving and there are no absolute contraindications to adrenaline in anaphylactic reactions.
For this patient with no previous history of anaphylaxis it would be important for health professionals managing this patient to document food, medicine, sting/bite exposure in the 2–4 hours before anaphylaxis.
All auto-injectors also contain sodium chloride, sodium metabisulfite and hydrochloric acid.
Adrenaline (epinephrine) solutions are clear and colourless. Discard if the solution is pink or brown.

Education
Following specialist review, two adrenaline autoinjectors should be kept with the patient at all times. Patient, family, friends, colleagues should be taught how to recognize anaphylaxis and when and how to give adrenaline. Action plan for anaphylaxis should be provided.
Advise patient to call an ambulance as soon as possible after using adrenaline because further doses may be required.
EpiPen® should be stored between 15°C and 25°C, but not refrigerated. Store in the carrier tube provided, as adrenaline is light sensitive. Note the use by date for adrenaline and arrange a new supply in advance.

Patient to advise all health professionals of allergy/ adverse reactions history and to consider wearing a MedicAlert bracelet/product.

Review/monitoring

- Observe the patient for at least 4 hours after the last dose of adrenaline (this occurred within hospital setting).
- Ensure allergy/ adverse reactions history is taken for all patients and all clinicians are aware of EpiPen® storage location and correct procedures for use.
- Follow up with patient to determine health status and encourage referral to an allergy clinic to determine allergen source.

Learning outcomes

Adrenaline (Epinephrine) is available on the National Podiatry Scheduled Medicines List for management of anaphylaxis only. Intravenous (IV) route is restricted to podiatric surgeons only.

IM is the preferred route for anaphylaxis.

Injecting into the same IM or subcutaneous site may cause ischaemia and necrosis. If this patient required a second IM dose of adrenaline it would be important to use the opposite thigh to avoid this.

For children 10–20 kg (aged ~1–5 years) a 0.15 mg device, e.g. EpiPen Jr, should be used.

Essential Prescribing Skills relevant to this case

1.1, 1.7, 2.1, 2.5, 3.9, 3.10, 4.7

Referenced throughout the document in brackets and bold on right hand side of column e.g. (1.1).

Attachments

Australian Society of Clinical Immunology and Allergy (ASCIA) anaphylaxis e-training for health professionals - certificate of completion

References:


Mentor name

John Smith

Signature of mentor

John Smith

Date

18 November 2018

Practitioner name

Anna Podiatrist

Practitioner signature

Anna Podiatrist

Date

18 November 2018

This published systematic review was designed to assess and describe the factors relating to medication adherence in people who have gout and had been prescribed medication to lower urate levels. This review also described the gout related clinical outcomes including; poor medication adherence or early medication cessation. I chose to review this article as I want to understand how to encourage patients to continue to take their prescribed medications and to understand what factors may be involved in patient’s choosing to not take their prescribed medications.

There were 24 articles included in the review following a systematic search of the literature. The authors reported a robust method of searching and this was reviewed against the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) website. Of these studies, 16 of the studies used prescribing trend data. There were 11 studies undertaken in the USA, one in Israel, one in New Zealand and three in Europe (UK, Italy, and Ireland). All of the 16 studies reported a systematic way of diagnosing gout, and this ensured the results were relevant to the research question. There were two studies that used pill counting methods as a way to describe adherence, and six studies that used patient reported outcome measures. These outcome measures included patient described symptoms, doctor observations of symptom relief, or a standardised measure. These six studies were based in either, New Zealand, Europe and the USA. The different settings may be likened to the Australian health context when based in New Zealand, as well as some of studies based in European countries.

### Drugs of interest within the article

Allopurinol was the main drug prescribed for gout in all but two of the studies. This drug is not on the list for endorsed podiatry prescribers. Only four studies included the prescription of colchicine, which is on the podiatry list of scheduled medicines and two included the prescription of nonsteroidal anti-inflammatory drugs (NSAIDs). While the included studies did not detail which NSAIDs were prescribed, the podiatry list of medicines lists a number of scheduled NSAIDs. Recommendations for medication use in gout during an acute attack also includes NSAIDS: Commonly used NSAIDs during an acute gout attack includes ibuprofen (on the list) or indomethacin (on the list). The use of corticosteroids was not mentioned within this article.

### Findings

Seven studies reported adherence to taking the medication as prescribed, between 54% to 88%. The remaining five studies were reported in a way that it was hard to extract adherence rates. Similarly, not persisting with taking the medication was reported in six of the studies. There were 54% to 87% of participants who did not continue taking the medication in the long term. Co-morbidities appeared to play a substantial role increasing or improving adherence to taking medication, these co-morbidities included conditions such as diabetes and hypertension, but not conditions like rheumatoid arthritis or history of cancer. Different ethnicities also had a high rate of poor adherence, although the article did not discuss the reasons. There was inconclusive evidence that the following factors improved or decreased adherence: marital and smoking status, body mass index, socio-economic status, and gender. Unsurprisingly, low adherence to taking the medication resulted in more flare ups.

### What this means for podiatry prescribing

All podiatry prescribing should be in shared care arrangements with medical practitioners. This is particularly of importance with prescription of colchicine. Podiatrists should inform the medical practitioner at the time of prescription and establish the process for confirmation of diagnosis and ongoing monitoring (with appropriate blood tests).

Understanding medication adherence to prescribing is also important. Finding that people who have diabetes or high blood pressure are more likely to continue their gout medication is positive for podiatrists, it may be that these people are more likely to engage with their health care provider or simply that they are more in the habit of taking a tablet regularly, so an additional tablet is easy to add into their routine. People who have these co-morbidities often also regularly attend podiatry services. Finding different ethnicities (Maori or African American) had poor adherence has limited applicability to the Australian health setting. Instead podiatrists should consider that different cultures may have different values or understanding of disease processes. It is not appropriate to discuss or profile compliance in patients who have different ethnicities, podiatrists should be aware that these differences may exist and be complex to understand. All communication on the importance of continuing with ongoing scripts should be framed in person centred care, using language and advice that considers the person and their individual circumstances. Ongoing consultations can also be an opportunity to reinforce medication compliance, particularly in long term medication use.

### What this means for me

Following this review, I will discuss with my mentor:

1. The importance of accurate gout diagnosis and how gout diagnosis is confirmed prior to any prescribing.
2. What blood tests are undertaken by the medical practitioner and why is the podiatry correspondence important for establishing the monitoring?
3. Discuss and role play using patient-centred language to explain the importance of adherence to prescribed medication regimes and how a prescriber can influence this.
4. Shared care arrangements and effective interdisciplinary correspondence.

### Essential prescribing skills relevant to this reflective piece

This review of literature has demonstrated the following essential prescribing skills:

<table>
<thead>
<tr>
<th>Essential prescribing skills</th>
<th>Relevant to my practice</th>
<th>How can I apply this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medication adherence</td>
<td>Essential</td>
<td>Identify factors that influence adherence and tailor prescriptions accordingly.</td>
</tr>
<tr>
<td>2. Ongoing monitoring</td>
<td>Essential</td>
<td>Establish monitoring plans and follow-up schedules.</td>
</tr>
<tr>
<td>3. Patient-centred language</td>
<td>Essential</td>
<td>Use clear, simple language when discussing adherence.</td>
</tr>
</tbody>
</table>

### Evidence 8: Reflective piece on journal article

<table>
<thead>
<tr>
<th>Practitioner name</th>
<th>Anna Podiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence number</td>
<td>8</td>
</tr>
<tr>
<td>Type of evidence</td>
<td>Reflective piece for reflective journal</td>
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This review of literature has demonstrated the following essential prescribing skills:

1. Medication adherence     | Essential               | Identify factors that influence adherence and tailor prescriptions accordingly. |
2. Ongoing monitoring       | Essential               | Establish monitoring plans and follow-up schedules. |
3. Patient-centred language | Essential               | Use clear, simple language when discussing adherence. |
Certificate of Completion

This is to certify that

Anna Podiatrist

has completed

Polypharmacy 2018

8 August 2018

A module from the National Prescribing Curriculum.

This module has addressed competency areas 1, 2, 3, 4, and 5 of the National Prescribing Competencies Framework.
Evidence 10: Reflective piece complex case

**Practitioner name:** Anna Podiatrist

**Evidence number:** 10

**Type of evidence – Reflective piece for reflective journal**

A clinical narrative that highlights a situation where things did not go as well as planned and was particularly complex or demanding.

**Introduction**
This case examines the use of ultrasound-guided corticosteroid injection I observed for the management of an acutely symptomatic accessory navicular. The case highlights NPS competencies involving appropriate clinical indications for the use of scheduled medicines, the need for careful patient follow-up and management of a person with additional needs.

**Case Presentation**
A 27-year-old female presented to our private practice. Her primary complaint was pain and discomfort in the medial arch of her right foot. Following examination, a symptomatic accessory navicular was suspected, and the patient referred for imaging. This was confirmed through radiological and MRI investigation which indicated substantial bone oedema either side of a fibrocartilage attachment to the accessory navicular.

Of significance to this case was this patient has a diagnosed mild intellectual disability. She requires support from her family to manage her health care needs. This included her co-diagnoses of bipolar II disorder and autism spectrum disorder (level 1). She has been prescribed Seroquel XR (quetiapine) 200 mg tablet daily for the management of her bipolar II disorder and autism spectrum disorder (level 1). She had also been fitted with a CAM inflatable boot.

Allergies and adverse drug reactions included an adverse drug reaction to Maxolon (metoclopramide). This patient reported this medication makes her feel extremely agitated. This is a known side effect of the drug. Maxolon is also known to cause dizziness and drowsiness and it is possible that these effects may indirectly contribute to insecurity of movement, and precipitate agitation.

**Treatment**
There is some evidence supporting the use of corticosteroid injection for the management of a symptomatic accessory navicular prior to considering surgical intervention, particularly in patients where MRI findings indicate associated bone oedema. Concurrent use of NSAIDs and corticosteroids may increase the incidence and/or severity of gastro-intestinal irritation, or ulceration, so ibuprofen was ceased prior to the endorsed podiatrist administering the corticosteroid injection.

This injection was performed under ultrasound guidance and 1 mL betamethasone acetate 3 mg (in suspension) and betamethasone sodium phosphate 3.9 mg (in solution) (Celestone chondrosus) combined with 2 mL 0.5% bupivacaine plain was administered in keeping with eTG recommendations and established guidelines. Recommended patient to remain immobilised in CAM boot.

The patient was reviewed 72 hours after the corticosteroid injection as a consequence of developing insomnia and a neuroplesia. The endorsed podiatry prescriber communicated with the patient’s general medical practitioner which led to the patient commencing Lyrica (pregabalin) to effectively manage the neuropathic pain. It became evident that the neuropaxia was more associated with the wearing of the CAM inflatable boot.

**Reflection**

Upon reflection, this case demonstrated a number of important points. Firstly, the use of corticosteroids where the indications, while supported in the literature, were only marginal and another therapeutic intervention may have been more appropriate. A second important learning issue extended to potential adverse drug reactions associated with betamethasone and patients with mental health conditions. Both the TGA and MIMS online identified that in the presence of mental health conditions, administration of corticosteroid can be associated with ‘euphoria, mood swings, severe depression to frank psychotic manifestations, personality changes and insomnia.’

Complicating the prescribing matter was the development of a nonpharmacological related ‘neurapraxia’ associated with wearing a fitted CAM inflatable boot in bed, post injection. Given this scenario, it was difficult to disassociate an adverse drug reaction from a boot fitting issue, particularly in a patient who has an intellectual disability and a history of mental health conditions.

Things that were not taken into consideration included the need to use alternative databases to search for potential drug interactions between natural/complementary/alternative and prescribed medicines. Since doing so, it was found that the natural medicines, (formerly natural standards and natural medicines comprehensive database), identified no interaction between betamethasone and arnica montana, however a ‘be watchful with this combination’ interaction was recommended between betamethasone and tumeric. No further details were provided.

Importantly, this case study highlights the relevance of Competency Area 1: Understand the patient and Competency Area 4: Monitor and review prescribed therapy, and in particular Essential prescribing skills 4.4 – Where required, work with other health professionals to interpret results of monitoring and to decide on possible treatment options based on monitoring.

NPS protocols were followed, and immediately involved the patient’s general medical practitioner when signs of treatment appeared to interfere with her sleep patterns and general well-being.

**Evidence 10: Reflective piece complex case**

*Essential prescribing skills: 1.5, 1.7, 1.8, 1.11, 1.12, 1.13, 1.14, 2.3, 2.4, 2.6, 2.8, 2.10, 2.14, 3.3, 3.6, 3.7, 4.1, 4.2, 4.3, 4.4, 4.7*

**References**
3. The ASPRINH (Assessment of Prescribing in Health) Project, a national multi-professional project, which condensed the 73 performance criteria contained in the NPS MedicineWise Competencies to Prescribe Scheduled Medicines, also known as the Prescribing Competencies Framework (PCF) to a set of essential prescribing skills, arranged under four competency areas and referenced to the PCF.

**Mentor name** John Smith

**Mentor signature**

**Practitioner name** Anna Podiatrist

**Practitioner signature**

Date 8 January 2019