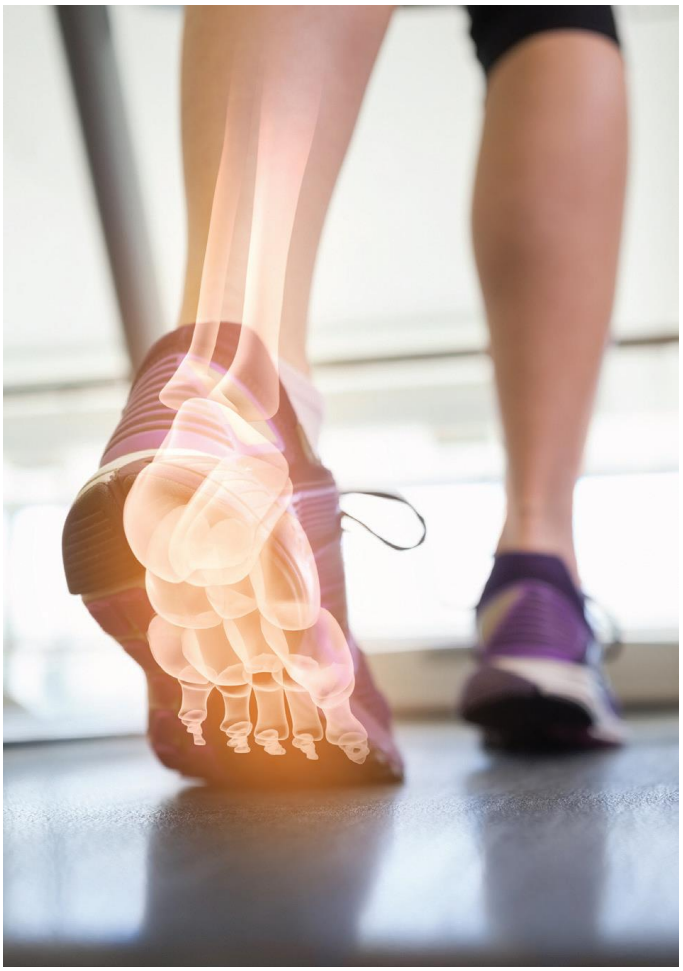
The Institute of Chiropodists and Podiatrists

Supporting Podiatry Professionals



Minimum Standards of Clinical Practice

for Members of the Institute of Chiropodists and Podiatrists

Contents

Minimum Standards of Clinical Practice

Introduction

This document applies to all members of the Institute of Chiropodists and Podiatrists (hereafter referred to as the Institute) and has been prepared whilst acknowledging that a wide spectrum of standards currently exists in Chiropody/ Podiatry. These guidelines are based on the minimum acceptable levels applied by other Allied Health Care Professions; they are not the gold standard. This standard is what is expected of all membership grades of this Institute.

Our profession has to have a commitment to review our professional standards and guidelines on a regular basis.

It is beholden on all members to uphold these Minimum Standards of Clinical Practice of the Institute. Failure to do so may affect the outcome of any legal action against the Chiropodist/ Podiatrist (hereafter referred to as practitioner), and may invalidate their Indemnity Insurance.

It is of paramount importance the practitioner, carry out a risk assessment based on their clinical practice and the healthcare legislation within their local area (County, Country, etc.).

Practitioners must also be aware of, and comply with, all Health and Safety Regulations, Department of Health and Local Guidelines, Fire Regulations, and First Aid procedures, which may apply to premises outside their normal clinical area, in which they may also practice.

1. Clinical Skills

As members of the Institute, we have a professional and ethical obligation to provide a service to patients commensurate with our level of training and scope of practice. Members must undertake a commitment to continuing professional and clinical development in order to maintain their membership.

1.1 General Practice Principles

- The patient is acknowledged and respected as an individual.
- The patient is provided with relevant written and verbal information.
- Communication with carers, when involvement in the patient's management is considered appropriate, should respect the wishes of both patient and carer.
- Communication with other practitioners and health professionals should ensure continuity of effective patient care and facilitate the use of all available clinical expertise.
- Communication links should exist between the practitioner and other healthcare and multidisciplinary teams involved in the care of the individual patient.
- Clear, accurate and up to date patient records must be maintained.
- Records must describe all elements of the consultation. (Please refer to Appendix 1)
- The assessment process must provide sufficient information to formulate a treatment plan using a clinical reasoning process.
- The practitioner must maintain written evidence of treatment plans and objectives and outcomes.
- Patients should be given information about the treatment proposed.
- The practitioner's practice/clinic shall have sufficient space, facilities, and equipment to meet its professional and managerial needs and to ensure that staff and patients are provided with a comfortable and safe environment.
- Treatment areas should offer privacy and comfort.

2. Clinical Premises

2.1 Minimum Acceptable Equipment List

The following is the minimum equipment considered by the Institute to be required for safe practice:

- Sufficient lighting.
- Extra directional lighting/lamp. Preferably colour corrected (daylight bulbs).
- Hand washing facilities.
- Sufficient ventilation.
- Autoclave, within easy access, and ultrasonic cleaner.
- Cleaning equipment.
- Provision of suitable instruments.
- Operator's chair.
- Drill.
- Non-carpeted floors, preferably with splash back, skirting's and seams.
- Operator's unit or trolley with suitable surface for decontamination.
- Patient's chair with adjustable height/ leg rests, with a collapsible back.
- Appropriate storage facilities are required by legislation
- First Aid kit.
- Waste collection and disposal facilities to include sharps disposal.
- Telephone or emergency call system.
- Fire evacuation plan, including extinguishers.

2.2 Storage of Drugs, Medicaments and Medical Devices

Ensure that all drugs, (medicaments) and medical devices are kept in the approved manner. These precautions should also be followed for the storage of needles and syringes.

- All flammable products must be stored in metal containers or in accordance with COSHH guidelines or equivalent (this is dependent on your country of practice), separate from other drugs and dressings.
- All drugs, needles and syringes must be stored in a locked cupboard.
- All medical gases are stored in accordance with Health and Safety regulations.
- All substances must be stored in accordance with the manufacturers' guidelines and all Government and State legislation.

2.3 First Aid

There are no mandatory items which must be included in a First Aid box. A risk assessment should be carried out on the premises and the work place to identify potential risks. Where no special risks have been identified, a British standard industrial First Aid kit must be in place.

2.4 Patient Privacy

The privacy and dignity of the patient must be at all times respected.

1. Practitioners must acknowledge social, cultural, religious, and gender issues, relevant to their patient. It may be necessary, in certain circumstances, to ensure that a chaperone is present during any examination and/or treatment.
2. All patients must be afforded the maximum privacy possible within the clinical environment, whilst preparing for a treatment and again after the treatment is complete. Auditory and visual privacy is also important and should be implemented where possible.

2.5 Safety Responsibilities

It is the responsibility of individual practitioners to ensure the health, safety and welfare of their patient is assured, at all times. This includes the entrance and exits to the premises, including fire exits if these are different to the main exits. The Health and Safety Authority can provide support and Information to all practitioners on this issue.

1. It is mandatory for all members of the Institute to regularly update and maintain resuscitative techniques. An annual update on resuscitative procedures is required, unless the course taken has an approved two or three year certification.
2. A telephone must be available to call assistance in the event of a clinical emergency.
3. All infectious human tissue, and all related infectious swabs and dressings should be placed in yellow waste sacks for safe disposal. All non-infectious waste maybe placed in normal household refuse.
4. Portable Appliance testing (PAT) (Electricity at Work Regulation, 1989) (http://www.hse.gov.uk/pubns/priced/hsr25.pdf).
5. Ergonomics is the study of relationships between people and the furniture, tools and machinery used in the workplace. This includes practitioner's chair, work station design, the patient's chair and working unit (http://www.hse.gov.uk/pharmaceuticals/issues/workingposture.htm).
6. Manual Handling (http://www.hse.gov.uk/healthservices/moving-handling.htm).
7. Fire safety control measures in the workplace (https://www.gov.uk/workplace-fire-safety-your-responsibilities).

2.6 Confidentiality

It is incumbent on the practitioner to ensure they and all staff maintain the confidentiality of all information relating to the patient at all times.

1. All patient records, to include paper and electronic format are subject to the regulation of Data Protection Legislation pertinent to the region or country in which practice is carried out.
2. Paper records must be stored in a locked area, which does not allow access to unauthorised persons. It is recommended that metal storage facilities be used to minimise fire hazards and ensure safe storage of records in the event of a fire.
3. Electronic patient records stored in computers, laptops, tablets, etc., should be password protected**.** You are required to register with the Information Commissioner's Office (ICO) for a small annual fee to keep electronic patient records on file.
4. Practitioners must be aware of patients' rights of access to their treatment records in accordance with freedom of information legislation, and should maintain records in an appropriate way. Judgemental statements of a personal nature should not be made.
5. Changes in patient medical and personal information should be recorded at regular intervals. These changes should be signed and dated.
6. Consent for treatments should be signed and dated by the patient.
7. The General Data Protection Regulation (GDPR) will come into effect in the UK from 25 May 2018. Please refer to the Information Commissioner's website, ico.org.uk for more information on preparing for the GDPR.
8. The GDPR are suggesting that practitioners start to consider how they process personal data at each stage of the patient's journey and the information gained from each patient, before, during and after a treatment. This will include everything from the initial enquiry from a prospective patient, or an un-planned patient coming for a treatment; the process of making an appointment and confirming the booking; the communication i.e. what is seen and heard, in the waiting room or reception, and during any treatment.
9. Practitioners must be aware of the privacy aspects of having a treatment and also the communication between the scheduled appointments, and referrals with another health professional or member of the multidisciplinary team, or with other third parties such as insurers, etc.
10. Practitioners must also consider how they store and dispose of personal data.

3. Records

It is the duty of the practitioner to ensure that clear, accurate and up-to-date records are maintained.

1. In the case of written records writing must be legible and preferably in black ink (this facilitates duplicating in the event that records are required for legal and other reasons). A record must be made at the time of treatment, and any subsequent corrections to the entry must be signed and dated.
2. With paper records a clear and logical format must be used. Where blank spaces appear, they should be scored through. All attendances and entries must be dated and signed. It is not acceptable to write in a record 'treatment as above' or 'treatment unchanged'. All events and treatments MUST be recorded in full. It is a legal requirement that all patient records are retained for a period of 8 years after the patient's last appointment. Records relating to children and to young people must be kept until the patient's twenty-fifth birthday, or for eight years after the last entry, if that is longer
3. Paper records that are scanned and stored on electronic devises i.e. computers for access to current practice, the original records must be retained in the time period indicated in 3.2.
4. In the case of electronic records, the programme used will dictate the format of records.

3.1 Abbreviations

Practitioners being members of the Institute are advised **NOT** to use clinical abbreviations, which is no-longer considered good practice within clinical records by many professional bodies, and more importantly in a Court of Law. The Institute recommends its members to use the full medical descriptions, whether they are of a simple or complex nature, and should be written in longhand (or typed in full) on Patient Record Cards. This will remove any questions of doubt in a legal context.

However, practitioners working in practice where standard abbreviations (as in Appendix 2) or other abbreviations are currently acceptable (i.e. NHS or other professional body practice), must be listed in 'Practice Policies or Protocols, or Minimum Standards of Clinical Practice', for use within their clinical records. Whereby, practitioners, are recommended to keep any abbreviations to a minimum and more specifically are required to hold a record of these abbreviations on file in order to maintain consistence and to allow where necessary for these records to be translated for legal purposes.

3.2 Informed Consent

The practitioner should explain the nature and purpose of any procedure, to include potential risks, alternative treatment regimes, and expected outcomes. Prior to commencing any treatment, assessment or examination informed consent should be obtained from the patient, care giver or guardian (see section 3.3.). It is acceptable for the patient to fill out a health questionnaire which includes informed consent. However, should a treatment further to the standard treatment be required involving acupuncture, or complementary and alternative medicines therapies (CAM), or other therapies, (injections or surgery performed by suitably qualified practitioners only), then a specific consent should be obtained for that treatment exclusively.

It is recommended as good practice that written consent is obtained for those procedures where the treatment or the procedures are complex and may involve significant risks, (the term "risk" including any potential adverse outcome that may be described as a "side effect or complication"), or the procedure involving local anaesthesia or surgery as eluded to above.

It is recommended that written consent be obtained, where local anaesthesia is to be administered to carry out any clinical procedure, and where any other injectable substance may be an element of, or included in a treatment regime by the qualified practitioner.

It is recommended that all verbal advice and information provided to patients to inform them of any decision, to agree or refuse to proceed with a treatment intervention, should be supported by written information recorded on the Patient Record. It is crucially important that verbal consent from the patient is recorded for every treatment provided; as implied consent no longer exists in law. In addition it is advisable that the patient signs and dates this notation on the patient record. The recommendations in this section are particularly important where treatment interventions may involve a negative outcome, adverse reaction, or may involve the individual in potential high cost treatment interventions.

It is recommended that a signed general consent is required for every new patient, which can be part of the health questionnaire or a separate consent form. In addition it is recommended that a patient review is undertaken with each treatment to update and review medications and any other changes to their conditions or circumstances.

3.3 Consent for Treatment of Children (under the age of 18)

Children and their parents require informed and detailed information, relating to any clinical procedure required for care, before any decision to proceed with treatment can be made.

Where children, over 16 years old (Gillick competency, 1984, and Fraser Guidelines, 1985), are competent to give consent for themselves, practitioners should seek consent directly from them. Although, it is a legal requirement to seek the parent's or legal guardian's consent in all cases where the child is less than 18 years of age. It is recommended that no child under the age of 18 years old, be assessed for clinical treatments in the absence of a parent or legal guardian being present.

When a child reaches the age of 18 years old, they are presumed in law to be competent to give consent for their own medical interventions. In all instances, the parent or guardian of the child must sign the consent form and the signature on the consent form should reflect this.

3.4 Consent for Treatment with Learning Difficulties, Mental Health Issues or Other Disabilities.

Patients over the age of 18 years old that are known to have Learning Difficulties, Mental Health issues and any other disabilities must be able to give their consent freely and not be coerced. The Mental Capacity Act (2007) and NICE Guidelines regard all adults as having capacity, unless and until they are shown not to. Capacity refers to the ability to make a particular decision at a particular time. If a patient with capacity is forced to have a treatment, in law this is considered to be an assault.

N.B. Adults expect to be asked whether they want a treatment, and equally have the right to refuse a treatment, it is their right to have their decisions respected. They also expect that the treatment will be given, even if they are not in a position to consent, for example being unconscious. This also includes adults with complicated cognitive and social disabilities who may have literacy and/ or communication problems, or as with some patients who are just not competent to make some decisions, or by unsubstantiated assumptions made by professionals. If a treatment is denied to a patient who lacks capacity this may be considered to be neglect. It is important to remember that a practitioner (as other health professionals), has a duty of care to their patients.

4. Assessment

All patients attending their initial appointment, with a practitioner, should undergo a primary assessment to establish their need. By the establishment of these needs a care plan can be implemented.

1. At the first visit the practitioner should complete or confirm all clerical details on the Patient Record.
2. A clinical assessment must be made of the patient.
3. An initial assessment record should include pertinent information gathered from the patient's medical history and relevant clinical findings, along with medications the patient is taking, either prescribed or otherwise (including complementary and alternative medicines (CAM), herbal and homoeopathic medicines).
4. On completion of the assessment, a diagnosis should be made of the presenting conditions, wherever possible, a treatment plan suggested, and possible outcomes agreed with the patient.
5. Required tests, referrals and/or consultations should be recorded.
6. It is recommended that regular re-assessment of the patient takes place in order to update records and to redirect the treatment plan if needed. The patient's current medical status should at all times be up to date. Any changes noted must be signed and dated. (Please refer to Appendix 1)

5. Patient Management

Treatment areas should provide privacy, security and comfort. The diagnosis, treatment plan, and prognosis must be discussed with, and explained to the patient, carer or guardian.

A member of the Institute should not:

1. Treat or attempt to treat a problem or condition which is beyond their experience, scope of practice or competence.
2. Provide a treatment, which they know, or should have known, would be harmful, or which is inappropriate to meet the needs of the patient.

Consultation with, and/or referral to another practitioner, health professional or multidisciplinary team, should be made when the patient's condition is beyond the practitioner's scope of practice. Referrals must be given when necessary in the best interest of the patient. Members of the Institute shall take into account the personal and social circumstances of the patient before advising on treatment planning.

The treatment plan must be reviewed periodically.

6. Medicines, Therapeutic Substances and Chemicals

Medicines fall into one of the following categories:

- General Sales List (GSL) medicines which can be purchased freely online or from supermarket shelves for example, these are regarded as (relatively) 'low risk' substances that people can utilise to self-medicate, without the input of a health or pharmacy professional.
- Pharmacy only (P) medicines which should only be sold by, or under the direction of, a registered Pharmacist.
- Prescription Only Medicines (POMs) which can only be supplied to a patient by a pharmacist against a written prescription from a licensed prescriber (i.e. Doctor, Podiatrist Prescriber, Nurse Prescriber etc.), or by a regulated Health Professional stipulated in law to have 'statutory exemptions' to this requirement which may cover their sale/supply and administration such as an HCPC registered Podiatrist with POM-A and POM-S noted against their registration entry.
- Controlled Drugs (CD) are noted in a schedule (1, 2, 3 or 4) of substances that have the potential for abuse, misuse or addiction. They are regulated by the UK Home Office and misuse carries substantial legal penalties in criminal law. Example are Morphine, Methadone, Benzodiazepines etc. There are special requirements for their prescription and supply, which are over and above the rules applying to POMs.

Some substances are not regarded as 'medicines' and therefore fall outside the remit of the various medicines acts and rules on purchase and administration. Chemicals used for disinfection, wound cleansing etc., may fall into this category. Practitioners should only use such of these agents as they have been trained in the use of and comply in full with any safety regulations pertaining to their use. Where legislation (Control of Substances Hazardous to Health - COSHH) applies to any substances, any stipulations pertaining to the storage of such substances must be followed in entirety.

7. Administration of Injectable Substances

Only a practitioner, appropriately qualified, insured and approved by the relevant authority, may undertake a procedure involving injectable substances. They must have the necessary clinical expertise to carry out the procedure being undertaken. They must be insured for the procedure and the Institute, being the Professional Body must have copies of all paperwork pertaining to the qualification.

A qualified practitioner will always administer an injectable substance for which they are trained, using a safe technique. To achieve this, the practitioner should:

1. Administer the injectable substance, only if they have gained a qualification to do so, this qualification being recognised by the relevant local/national authority and the Institute as stated above.
2. Students from a board or Health Care Professions Council (HCPC) approved school will be eligible to administer injectable substances under the direct and constant supervision of a practitioner or health professional qualified and trained to administer the substance, if that student or practitioner has prior approval from the school in question.
3. Convey suitable and sufficient information to the patient, and obtain written consent before administering any injectable substance.
4. Be proficient in the procedures relating to clinical emergencies. Practitioners must attend an update in CPR at intervals designated by the Institute.
5. Ensure needles, syringes and substances to be injected are sterile, and not contaminated.
6. Always follow criteria for safe infection control.
7. Not discharge the patient from the clinic following administration of an injectable substance, until they (the practitioner) are happy that the patient is stable.
8. Contact numbers should be given to the patient, carer or guardian in case of emergency.
9. In all cases where an injectable substance is administered, the dosage, quantity, site, effectiveness, and the presence or absence of adverse reactions, must be recorded in detail.
10. The disposal of sharps, including needles, syringes and vials, must be in accordance with these Guidelines on Minimum Standards of Clinical Practice.
11. Any emergency kit and oxygen supply, where available, must be maintained in good order in the clinic.
12. If the emergency kit and/ or the oxygen supply are used, the practitioner must be trained in its use, this training being certified and updated on a regular basis.

Where individual practitioners have access to oxygen for clinical emergencies, they must have undertaken appropriate training in the use of oxygen and its administration in clinical emergencies. They should also be able to demonstrate their participation in such training and regular refresher training.

8. Control of Cross Infection

It is the responsibility of all practitioners to maintain standards published by the Institute and Local and Statutory Bodies in relation to Infection Controls and Antiseptic procedures.

As a profession, we must ensure that the risk of infection to a patient is reduced to a minimum.

1. Appropriate antiseptic procedures must be followed pre, and postoperatively when preparing the patient for treatment.
2. Practitioners and staff must be thoroughly instructed in the handling and disposal of instruments and clinical waste, to avoid cross infection and injury from instruments as well as injury from sterilising instruments and devices.
3. Instruments and other equipment that is sent for repair should be decontaminated where possible and instruments should be aseptically clean. If this is not possible, these items should be suitably labelled so that any potential risk is clearly identifiable at the point of repair. If in any doubt of the correct procedure, it is recommended that practitioners contact the relevant supplier or agent, or their Infection Control Department for advice.
4. It is recognised that not all podiatric procedures need to be carried out under aseptic conditions. However, it is a requirement that all instruments are subjected to a decontamination process by approved methods described below, prior to, and immediately following treatments.
5. The wearing of disposable gloves during treatment should be related to a risk assessment; however, the Institute recommends the use of gloves and other personal protection devices. Please be aware that some patients (as well as practitioners) can have allergies to latex.
6. Where appropriate, practitioners should wear a plastic apron and disposable gloves. In cases where there is a risk or likelihood of splashing, blood or other exudates, the wearing of a suitable facemask and eye protection is advisable.
7. All surfaces and equipment, which may come into contact with body fluids, should be protected by water repellent laminate surfaces or equivalent.
8. Cuts or abrasions on hands or other exposed parts of the body must be covered with waterproof dressings.

These guidelines should be used as minimum standards for the control of cross infection. It is essential that practitioners familiarise themselves with local guidelines, available from an Infection Control Department of a local NHS hospital.

9. Decontamination of Surgical Instruments

All re-usable surgical equipment must be decontaminated to a high standard to minimise the risk of cross infection between patients. Practitioners should have equipment and procedures that ensure all reusable medical devices are properly decontaminated before use and that the risks associated with decontamination facilities and processes are adequately managed.

Practitioners perform a wide variety of procedures. This guidance is intended for individual practitioners, practicing in the public, private and commercial sectors. It is important for practitioners working in private practice or providing treatments on behalf of, or under contract to the health authority to consult with that authority regarding their infection control policies.

Decontamination is the combination of cleaning and or disinfection or both. Sterilisation renders a re-usable medical device safe to handle or to re-use on another patient. Thorough cleaning is a prerequisite for disinfection and sterilisation, as residual tissue and other deposits can protect infective organisms from destruction by the disinfectant or sterilisation process. Generally, manual cleaning is less consistent and effective than mechanical processes, which therefore, are preferred and recommended. Sterilisation must be carried out in a suitable steam or vacuum autoclave suited to the task at hand and these units must be maintained and validated to ensure effectiveness. (Disinfection may not reduce the level of microbial contamination to the same extent as sterilisation).

It is required by the Institute, for practitioners to undertake at the very least steam sterilisation as the method of sterilisation within the decontamination process.

9.1 Guidance on Decontamination

Decontamination is defined as the combination of processes that removes and or destroys contamination. This process in turn prevents micro-organisms or other contaminants reaching a susceptible site in sufficient quantities to cause infection or other undesirable response. It comprises cleaning, disinfection and sterilisation.

It is an essential process to make re-usable instruments and other surgical devices safe to handle or to re-use on another patient. Therefore, all surgical instruments that are used in the clinical environment must be decontaminated without exception. It is unacceptable to decontaminate only instruments that come into direct patient contact.

All instruments and instrument trays that are taken to a treatment area must be decontaminated before being re-used. All stages of the decontamination process should be documented and controlled, in accordance with best practice. The process should be reviewed and documented periodically to ensure that it continues to be effective. The person who has overall managerial responsibility for the practice is responsible for all matters concerning decontamination of reusable medical devices and their traceability.

Devices designated for single-use must not be re-used under any circumstances.

Used devices should be decontaminated immediately after use, or as soon as is reasonably practicable, to minimise the growth of microorganisms on them, and minimise the risk of cross infection.

Instruments that cannot be cleaned immediately should be immersed in cold water to prevent coagulation when contaminants dry on the instrument. Use of hot water or disinfectant can also cause protein coagulation. Coagulated protein is difficult to remove and may reduce effective decontamination of the device.

9.2 Acquisition of Surgical Instruments

Individual clinics should aim to have a written policy for the acquisition of instruments and devices. This should help to ensure the instruments and devices are fit for the intended purpose. It is recommended that all new instruments and devices are compatible with existing equipment and can be decontaminated using processes that are already in operation. Practitioners should review their instruments and replace any that are faulty or would have difficulty decontaminating adequately.

9.3 Storage and Transportation of used Instruments and Devices

If used instruments have to be stored prior to decontamination, after domiciliary visits and before returning to base, they should be stored wet to prevent coagulation of proteinaceous deposits, in an area that is accessible only to authorised people (i.e. the practitioner or where applicable, staff). The instruments should be packed securely so as to minimise the possibility of contact with anyone in the event of a road traffic accident. The instruments should be stored for as little time as possible after use to minimise the growth of micro-organisms on them, and minimise the risk of cross infection.

9.4 Cleaning

Cleaning is a process that physically removes contamination but does not necessarily destroy microorganisms. Thorough cleaning is essential to ensure effective disinfection for sterilisation, the presence of organic matter and other deposits can protect infective organisms from destruction and inactivation, therefore mechanical cleaning processes are preferred.

The Institute recommends as the minimum standards of clinical practice the use of such mechanical methods and where practicable their introduction generally. They are more effective and consistent than manual cleaning. They also reduce handling by staff carrying out the reprocessing, thus reducing the potential for injury and risk of infection from contaminated instruments and devices.

Devices must be inspected to ensure they are clean, before they are put in the steriliser.

9.5 Mechanical Cleaning

Bench top washer-disinfectors provide automated, pre-programmed cycles that can be validated.

Ultrasonic Cleaning Baths are available in a wide range of sizes and can provide a convenient and effective method for cleaning small numbers of instruments. Before instruments are processed in an ultrasonic cleaning bath, gross soiling should first be removed in cool water (below 35°C). The liquid in the bath should be changed frequently but after filling, or replenishing the bath, it should be operated for a few minutes to de-aerate the solution. If this is not done, air bubbles may form on the devices being processed, and impair the effectiveness of the process. Detergents and other chemicals should be those recommended and specified by the manufacturer of the mechanical cleaner. The effectiveness of mechanical cleaning equipment requires it to be maintained, validated and tested periodically.

That work should be carried out by competent, qualified personnel that the manufacturer recommends or the supplier provides.

9.6 Manual Cleaning

Manual cleaning of items should only be undertaken when other mechanical methods are inappropriate or unavailable. To minimise the risk of injury during manual cleaning cause by sharp edges, points, splashing and the creation of aerosols protective equipment should be worn at all stages of the manual cleaning process.

9.7 Facilities

Practitioners should, where possible, have a segregated area or room for decontaminating equipment, and have a documented flow system as described below.

This should minimise the risk of contamination to other staff and patients and minimise the risk of re-contaminating equipment that has been decontaminated. The area to be used for manual cleaning should be dedicated for the sole purpose and not shared with other activities.

It should be equipped with:

1. A dedicated sink (not a hand wash basin), or other suitably sized receptacle, which is used solely for manually cleaning instruments and devices.
2. A second sink (not a hand wash basin), or other suitably sized receptacle for rinsing instruments and devices.
3. A drainage surface.

9.8 Equipment

1. Personal Protective Equipment for manual cleaning e.g. gloves, eye protection, face masks, waterproof aprons. A first aid kit and eye wash bottle should also be available nearby in case of sharps injuries or splashing in the eyes.
2. Detergents specified by the device manufacturers (enzymic detergent can be advantageous).
3. Cleaning materials recommended by the device manufacturers e.g. brushes, cloths, etc., which are single use or are routinely decontaminated.
4. A clean, disposable, absorbent, non-shedding cloth for hand drying items, or a mechanical drying facility (e.g. a drying cabinet).

9.9 Immersion Method

Check that it is safe to immerse the instrument or device.

Fill the clean sink or receptacle with water below 35°C. Wear protective clothing. Where appropriate dismantle or open the instrument to be cleaned and remove gross soiling by brushing, wiping, agitating and irrigating the item while it is submerged, taking care to ensure it remains under the surface of the water at all times to prevent the creation of aerosols. Remove the item, drain it and then rinse it by submerging, and agitating it in clean water in the second sink. Dry instruments and devices and prep them for sterilisation.

Non-emersion manual cleaning should be used on electrical and electronic equipment as these instruments may be compromised by submersion in aqueous solutions. All items should be cleaned strictly in accordance with the manufacturers' instructions.

9.10 Sterilisation

All podiatric instruments must be steam or vacuum sterilised after cleaning and the temperature must be verified by test indicator paper in the unit or by a printout where available. The recommended cycle is 134-137°C for a minimum holding time of 3 minutes, but cycles with other time and temperatures are possible.

Gravity displacement (i.e. non-vacuum, or traditional), bench top sterilisers, from which air is passively displaced by steam, are suitable, but only for processing devices that are not wrapped and not hollow (e.g. cannulated items).

Instruments or devices which are wrapped (including pouches), cannot be sterilised reliably in a gravity displacement steriliser. Wrapped devices must be sterilised in a steriliser with an effective vacuum system, which has been validated for its intended load.

Instruments for podiatric surgery should be sterilised at the point of use and always used immediately. A printout of the cycle must be attached to the surgical record for reasons of accountability.

The effectiveness of sterilisation depends on sterilising conditions being achieved consistently. It is dependent on the application of quality assurance principles, which require the steriliser to be maintained, validated and tested periodically. Test cycles should be run daily and all cycle printouts should be logged.

Instruments once sterilised, should be used immediately or within a maximum time period of 3 hours after sterilisation or as advised by the manufacturer of the sterilisation equipment being used.

9.11 Inspection of Instruments

Inspection of instruments is important to ensure they remain within specification and will operate safely and effectively.

This inspection should be carried out during the decontamination process, preferably after sterilisation, to minimise the risk of infection from sharps injuries, and also to check if damage or deterioration has occurred during sterilisation. It is the responsibility of the practitioner to carry out the inspection and confirm the instruments are fit for use.

9.12 Prevention of re-contamination

It is important to segregate used devices from those that have been reprocessed, to prevent cross infection. This is most easily achieved by having a flow system. This gives the maximum easily achievable physical separation between the contaminated and sterilised items. Great care should be taken to prevent recontamination of the sterilised items, by transfer via contaminated gloves during manual handling. Sterilised items should only be moved with sterilised forceps that are used solely for that purpose.

9.13 Storage, Packing and Transport

All sterilised items that need to be stored after decontamination should have a designated storage area, with adequate protection and environmental conditions that prevent deterioration and contamination of the product i.e. it should be clean dry, well ventilated and secure.

Instruments processed in a bench top non-vacuum autoclave, must not be wrapped and should be used within 3 hours of sterilisation. They may be stored in a dry, clean, disinfected, airtight container (see also 8.10 above).

Where instruments and devices are to be transported outside of the clinical area for domiciliary visits, it is essential to pack them to prevent damage to delicate surgical instruments and to prevent contamination during transit.

Practitioners must ensure they have sufficient sets of sterilised instruments to treat the impending caseload.

9.14 Traceability

When possible, there should be a system in place that enables sets of instruments to be traced after use on a patient, through the decontamination process, storage and distribution, to their use on the next patient. Practitioners should not mark instruments as this could make them more difficult to clean and might lead to mechanical failure (See Appendix 3).

10. Gloved Technique

The Institute recommends that gloves are worn at all time, however some practitioners may wish to adopt a different approach based on risk assessment and glove use. The following will help in the discussion.

1. It is recommended if, after a suitable and sufficient risk assessment has been demonstrated that disposable gloves are not required for non-sterile podiatric interventions.
2. It is recommended if, after a suitable and sufficient risk assessment has been demonstrated, that non-sterile treatments that pose an assessed risk to either patient or practitioner should be carried out wearing disposable gloves. The risk assessment must include the assessment of risk, to the practitioner, from the material of which the glove is made. In the event of a glove being punctured, it must be replaced. Non-sterile disposable gloves are single use items, and should only be worn for one patient and then disposed of appropriately.
3. All aseptic and sterile procedures should be carried out using sterile single use disposable gloves. These must only be used for single procedures.

11. Scalpel Blades

1. A sterile scalpel blade is a single use device.
2. Each treatment requiring the use of a scalpel will require the use of a new sterile blade.
3. All used contaminated blades should be removed from the scalpel handle by means of an appropriate blade remover, to avoid injury to the operator and patient and should be placed in a suitable container for disposal in the approved manner.
4. It is recommended that a sterile blade is not fixed to a scalpel handle until it is required, as part of the treatment regime.

12. Disposal of Clinical Waste

Waste identified as clinical waste, must be disposed of in a safe and appropriate manner by a registered disposal contractor.

All human tissue, including blood (infected or not), and all related swabs and dressings, soiled surgery dressings, swabs and other soiled waste from the treatment areas, are defined as Group A Clinical Waste and must be disposed of appropriately.

1. It is the responsibility of the practitioner to ensure that all clinical waste is collected separately from domestic waste, for safe and suitable disposal by an approved contractor.

2. The clinical waste must be placed in an appropriate container, as specified by the approved contractor providing the service.
3. All receptacles for clinical waste, must be disposed of when no more than ¾ full.
4. A new receptacle (yellow sack/bag) for none sharp waste must be used for each working day.
5. Practitioners are advised, where appropriate (yellow sack/bag, to select a suitably sized receptacle for their daily clinical practice.

13. Disposal of Sharps

All used sharps (needles, blades, etc.,) must be disposed of in the appropriate manner.

1. It is the responsibility of the practitioner, to ensure that all employees adhere to safe systems of work, for handling sharps/blades.
2. It is the responsibility of the practitioner to ensure that all blades are removed from instruments, by use of a suitable blade box remover device.
3. The removed sharps must be placed in an appropriate, marked sharps container. This container must be stored in a safe place and disposed of, when the container is ¾ full, using an approved contractor.
4. Needles and disposable syringes are single use devices and should be used accordingly.
5. It is recommended that contaminated needles are not removed from disposable syringes. They should be disposed of together in an appropriate container. Where dental style syringes are in use, an appropriate needle guard system, should also be used.
6. Practitioners should be able to demonstrate evidence of approved disposal methods (waste disposal certificate) (NICE Guidance CG139).

14. Nail and Cutaneous Soft Tissue Surgery

Each practitioner should make every effort to ensure a satisfactory post-surgery result, and reduce the risk of complications.

1. The operating environment must be prepared in accordance with best practice infection control standards.
2. Clean equipment and sterile instruments must be used.
3. An appropriate pre-operative assessment must be performed and recorded prior to surgery.

4. Patients must be informed of the purpose and the nature of the treatment, and the risks involved, in a clear and precise way, in order for the patient to make an informed decision to undergo surgery. Signed consent must be sought.
5. All surgical fees should be discussed, recorded and fully explained to the patient, prior to the surgery. Any related services requiring an additional fee, should be listed, and any time limit on inclusive post-operative visits should be stated.
6. The patient should be given a post-operative advice sheet (as necessary), which must be reviewed verbally to avoid any misinterpretation.
7. The information sheet should provide 24-hour emergency contact numbers for help and assistance.
8. The practitioner must have the education and experience relative to the procedure being performed.

15. Prescription of Orthotic Devices

Comprehensive, detailed prescription must be written to ensure that the appropriate orthotic devices are manufactured for the patient, and to the qualified practitioner's or orthotists' requirements.

Some devices are off the shelf so this is not necessary. Many device manufactures supply the formatted form for use in their labs. Should this not be the case the following information is advisable.
All prescriptions must include detailed and clear information required by the manufacturer, to ensure suitability and accuracy of the completed orthotic device. The date of casting (if used), measurement, manufacture and issue of any orthotic device must be recorded in the patient treatment record. A copy of the completed prescription form must be attached to the patient treatment record.

The prescription must include clear and detailed information, to include:

- Assessment and diagnosis
- Prognosis
- Description of required device
- Specification of materials and method of manufacture
- Evaluation of outcome and a review period

Manufacture of Orthotic Devices

The purpose of this statement is to ensure compliance with current legislation and directives, and to ensure safe working practice and correct use of equipment and appropriate materials, for the manufacture of all orthotic devices if this manufacture is undertaken by the practitioners and orthotists.

Individual practitioners and orthotists who may manufacture, or make up orthotic devices must be aware of, and comply with, current legislation and EC directives including legislation on C E Marking and tracking of devices.

It is not the remit of these guidelines to furnish this information. It is incumbent on the individual practitioners and orthotists.

Practitioners and orthotists, who use external manufacturing agencies and suppliers, must ensure that these agencies are working in accordance with current legislation and EC directives. This is essential in the event of a claim.

15.1 Premises used in the Manufacture of Orthotic Devices

All practitioners and orthotists involved in the manufacture and production of orthotic devices must receive appropriate and adequate training in the safe use of each piece of equipment and materials used in the manufacturing process.

Appendix 1

Patient Assessment Protocol

The following data should be entered on the patient's record card during the initial consultation or be included on the electronic storage system used.

1. Patient's personal details:
   - Name and Title
   - Address
   - Post Code (where applicable)
   - Date of Birth
   - Telephone Numbers
   - Type of Work/ retired

2. History of chief complaint

3. Medical history

4. Drug history

5. Surgical history

6. Patient assessment:
   - Vascular; arterial, venous and lymphatic
   - Neurological; motor, sensory and automatic
   - Functional
   - Skin condition

7. Podiatric diagnosis

8. Treatment plan

9. Prognosis
   - Vascular; arterial, venous and lymphatic
   - Neurological; motor, sensory and automatic
   - Functional
   - Skin condition

Patient Health Record

The patient record must include the following:

- The patient's name and address
- The date of each of the patient's visits to the clinic
- The name and address of the primary care physician and any referring health professionals
- A history of the patient
- Reasonable information about every examination performed by the practitioner and reasonable information about every clinical finding, diagnosis and assessment made by the practitioner. Reasonable information about every order made by the practitioner for examinations, tests, consultations or treatments performed by any other person
- Every written report received by the practitioner with respect to examinations, tests, consultations or treatments performed by other health professionals
- Reasonable information about all significant advice given by the member and every pre, and post-operative visit
- Reasonable information about every post-operative visit
- Reasonable information about every referral of the patient by the practitioner, to another health care professional, service or agency
- Reasonable information about every procedure that was commenced, but not completed, including reasons for the non-completion
- A copy of every written consent
- Any radiographs taken by or on behalf of the practitioner

In addition, the patient record should;

- Include complete and up to date information
- Be legible
- Be written in permanent black ink
- Have all corrections initialed, signed and dated
- Use a clear and logical format
- Have a glossary available if abbreviations are used
- Be secure and kept together
- Be recorded at the time
- Identify the author
- Conform to institutional/ HSE policies, where applicable

Appendix 2

List of Clinical Abbreviations

General Terminology

Pt	Patient
Rx	Treatment
O/E	On Examination
GHG	General Health Good
B/F	Both Feet
H	Haemorrhage
>>>	Condition improving
<<<	Condition worsening
H/O	History Of
C/O	Complains Of
TBS	To Be Seen
TCI	To Come In
3/7	Three days
1/52	One week
1/12	One month
Rt	Right
Lt	Left
Bilat.	Bilateral/both sides
CSP	Cardinal sagittal plane

Anatomical Terminology

1st	Hallux
2nd – 5th	Digits 2 to 5
Inf.	Inferior
Med.	Medial
Met.	Metatarsal
J	Joint
I/D	Inter-digital
Ant	Anterior/to the front
Post	Posterior/to the rear
Sup	Superior/above/over
Inf	Inferior/below/beneath

Med	Medial/towards midline
Lat	Lateral/to the side
Plant	Plantar/sole surface
Dors	Dorsal/top/back of foot
Apical	On the apex/tip/end of toe
1st web	First interdigital space
Dist	Distal/further out
Prox	Proximal/closer in
MPJ	Metatarsophalangeal joint
IPJ	Interphalangeal joint
3rd.Met.Hd.	Third metatarsal head

Nail Conditions

O/MY	Onychomycosis
S/U	Sub-ungal
IGTN	Ingrown toe nail
HG	Hypergranulation tissue
Onycho~	Specific nail dystrophy e.g. onychomycosis (fungal toe nail)
~nychia	Specific nail dystrophy e.g. paronychia (infection of nail fold)
O/HD	Subungual heloma durum
O/C	Onychocryptosis
O/G	Onychogryphosis
O/X	Onychauxis
O/P	Onychophosis
PNA	Partial nail avulsion
TNA	Total nail avulsion
NT&F	Nails trimmed and filed

Skin Conditions

HD	Heloma Dura (hard corn)
HNV	Heloma Neurovasculare (neurovascular corn)
H Fib	Heloma Fibrous (fibrous corn)
VP	Verruca Pedis
PP	Pressure point
CPMA	Callus plantar metatarsal area
Pl 1st	IPJ Callus plantar digital area of first toe

HD	Heloma durum hard corn
H.Molle	Heloma molle soft corn
Hmille	Heloma milliaire seed corn
enuc	enucleated
pr	pared
call.rcd.	callus reduced
call.rdn	callus reduction

Medical / Biomechanical Conditions and Terms

OA	Osteoarthritis
RhA	Rheumatoid arthritis
MODY	Maturity onset diabetes in the young
IDDM	Insulin dependent diabetes mellitus
NIDDM	Non-Insulin dependent diabetes mellitus
CVI	Cerebro-vascular incident
MI	Myocardial infarction
UMNL	Upper motor neurone lesion
LMNL	Lower motor neurone lesion
PAD	Peripheral Arterial Disease
PVD	Peripheral Vascular Disease
LLD	Limb length discrepancy
HAV	Hallux abducto valgus
HL	Hallux limitus
FHL	Functional Hallux Limitus
HR	Hallux rigidus
NCSP	Normal Calc. Stance Position
RCSP	Resting Calc. Stance Position
OA	Osteoarthritis
RhA	Rheumatoid Arthritis
IDDM	Insulin Dependent Diabetes Mellitus
NIDDM	Non-Insulin Dependent Diabetes Mellitus
PVD	Peripheral Vascular Disease
DVT	Deep Vein Thrombosis
PreOp	Before operating
PostOp	After operating
Dx	Diagnosis

Tx	Treatment
Rx	Prescription/recommendation
x3, x5	Multiple lesions (e.g. HDs x3 - three HDs)
TBW	To Be Worn (duration of dressing wear)

Padding

SCF	Semi-compressed felt
SR	Sponge rubber
FW	Fleecy web
TG	Tubular gauze
TF	Tubular foam
PMP	Plantar metatarsal pad
Pl Cush	Plantar Cushion
OCP	Oval cavity pad
ACP	Apex cavity pad

Miscellaneous

DNA	Did not attend
CNA	Could not attend
CANC	Cancelled an appointment

Notes

Write in passive past tense: (e.g. HD enuc 2nd met hd - pressure-relief dressing applied)

Write notes in this order:

1. What was done to the nails
2. What was done to the soft tissues
3. Dressings or medicaments applied
4. Instruction to patient - (to be kept dry 48hrs)
5. Intention: (TBS 3/52 - to be seen in three weeks)

Be specific about sites:

1. HD enuc prox IPJ 4th digit Rt
2. Call rdn plant Lt 5th MPJ
3. O/P med groove Rt Hallux
4. When note-writing, relate to body midline (CSP): i.e. lateral groove of hallux abuts 2nd toe

Appendix 3

Decontamination Quality Assurance Checklist

Checkpoint	'Yes'	'No'	N/A
Was mechanical cleaning used for this set of instruments?			
If you answered no, to the above statement, was method of cleaning was used for this set of instruments?			
Were all instruments in the set immersed?			
Were grossly soiled and contaminated instruments placed in water below 35°C, with no detergent?			
Was this set of instruments cleaned adequately?			
Were all instruments checked for quality of manual/mechanical cleaning?			
Were all instruments in this set rinsed after cleaning?			
Were all instruments dried prior to sterilisation?			
Did the steriliser reach sterilising temperature?			
Did the steriliser stay at the correct sterilising temperature for the required time?			
Did the steriliser reach the optimum pressure?			
Were the instruments removed from the steriliser and used immediately?			
Were the instruments checked for integrity and maintained before use?			
Were the instruments from the steriliser clearly segregated from contaminated instruments?			

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References

Data Protection Act 1998 – GDPR reforms May 2018
Electricity at Work Regulation, 1989
Gillick and Fraser Competency (West Norfolk and Wisbech Area Health Authority, 1984, and Fraser Guidelines, 1985)
The Control of Substances Hazardous to Health Regulations (COSHH) 2002
The Health and Safety at Work Act 1974
NICE Guidelines CG139 - Healthcare-associated infections: prevention and control in primary and community care
The Management of Health and Safety Regulations 1999
The Mental Capacity Act (2007)
The Mental Health Act (2007)
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Websites

https://www.gov.uk/topic/environmental-management/waste

https://www.gov.uk/workplace-fire-safety-your-responsibilities

http://www.hse.gov.uk/pubns/priced/hsr25.pdf

http://www.hse.gov.uk/pubns/indg163.pdf

http://www.hse.gov.uk/pubns/indg231.pdf

http://www.hse.gov.uk/pubns/indg453.pdf

http://www.hse.gov.uk/coshh/

http://www.hse.gov.uk/healthservices/dermatitis.htm

http://www.hse.gov.uk/healthservices/moving-handling.htm

http://www.hse.gov.uk/healthservices/needlesticks/index.htm

http://www.hse.gov.uk/pharmaceuticals/issues/workingposture.htm

http://www.hse.gov.uk/pubns/hsis7.htm

https://www.nice.org.uk/Guidance/CG139