STRIDE

FOR PODIATRY

SUMMER 2021-2022

The Summer Issue

Taking action: podiatry enrolments in crisis

Podiatry assistants and insurance cover explained

How to increase a runner's performance and reduce injury

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IN THIS ISSUE

WANT TO SHAPE THE CONVERSATION IN STRIDE?

Contact STRIDE's editor to contribute, tell us what you would like to read about, or to share your knowledge on these topics: **siobhan.doran@podiatry.org.au**

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All editorial submissions will be considered for publication and should be sent by email to siobhan.doran@podiatry.org.au. The above dates are deadlines for Intention to Contribute and Advertising. Editorial deadlines for final content will be provided. The Australian Podiatry Association reserves the right to edit material for space and clarity and to withhold material from publication. Individual views expressed in this publication are not necessarily those of the Association and inclusion of product or service information does not imply Association endorsement unless specifically stated.

The Australian Podiatry Association would like to acknowledge the traditional owners of all the many Aboriginal and Torres Strait Islander Nations that make up the great continent of Australia. We would like to pay our respects to the Aboriginal and Torres Strait Islander elders past and present, also the young community members, as the next generation of representatives.

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LEADERSHIP UPDATE

From the CEO

No doubt we are all looking forward to a summer break ahead, given the challenges of this year and let's be frank – last year too, when COVID's impact first emerged.

Whilst 2021 is another year I would rather forget, on reflection I can't help but feel it has helped shape us and continued to sharpen our focus on the things that are important, most notably supporting our members. We continue to look forward to projects continuing to unfold at a rapid pace, internal developments being ushered through more efficiently and continuing collaboration in forthcoming years.

Speaking of looking ahead, I am excited by the developments taking place within the APodA as we look to the year 2030 via our project, 'Stepping Up: Podiatry 2030'. As you will have seen in updates throughout the year, this project is designed to predict changing trends in and around the profession and leverage these as opportunities for our members. The consultation process has been deliberately detailed so far, marked by conversations involving over 60 key stakeholders and extensive member feedback. We will present the full report to members in 2022.

In fact, member feedback has been a prominent topic of conversation at the APodA lately, given the wealth of useful member feedback received in this year's member survey. We will be sure to update you on this feedback and share how we will weave your feedback into every single touchpoint next year onwards.

Until then, I hope you find some time to rest and recuperate, and let's all hope for a better 2022. Regardless, we are here to guide you with resources and advice every step of the way.

Have a great break and enjoy your time with friends and loved ones.

Nello Marino

From the President

The impact of COVID has been far reaching for so many of us. Whether you work in the public or private health sector, unspeakable hardship has presented itself time and again; much of which is still reverberating.

While reflecting on what has been a difficult time, I want to also acknowledge the role the APodA has played in representing the profession this year. This support translates to greater access for your patients, which goes a long way to protect vulnerable populations. Your health and safety has been of paramount importance through every piece of advice shared, and as a national body, the APodA is placed stronger than ever.

Looking forward, there is a lot of positive action happening at the APodA, with the Board addressing strategic planning and oversight to further streamline our goals and objectives. At the heart of these changes lies the recent member survey feedback. As Nello touched on, 'Stepping Up: Podiatry 2030' is taking shape with exciting insights already emerging, thanks to your feedback and stakeholder engagement with entities such as AHPRA, ACPS, APERF, and SEPA.

Soon however, it's time to 'down tools' and reflect on our work/life balance, given the festive season is officially here. It will be so heartening to finally share conversations with family and friends that have been so difficult to have without face-to-face contact. So let's try to carve out some precious time this summer to reflect on the values that drive us, and to spend our time and energy on what's really important for our collective and personal future.

Have a great summer.

Ainslie Davies

INFECTION CONTROL GUIDELINES: COMING SOON

The APodA is updating its infection control guidelines to help members understand the latest insights in this often complex space.

#1 THE BACKGROUND

It's a Podiatry Board of Australia (PBA) registration requirement that podiatrists, podiatric surgeons (and the individuals they work with in practice) comply with the National Health & Medical Research Council's (NHMRC) Australian Guidelines for the Prevention & Control of Infection in Healthcare.

To make the process of compliance so much easier for podiatrists, in 2022 APodA will launch version two of the Infection, Prevention and Control Guidelines and Policy set, in consultation with Steam Consulting.

#2 WHY THIS MATTERS

Most of the material will simply be amended to reflect current recommendations, but major additions to the NHMRC 2019 will also be addressed. These include the use of assistance animals in healthcare and awareness of increased sensitivity/ anaphylaxis to Chlorhexidine.

Not only that, but along with the NHMRC Guidelines, state-based regulations and national standards must also be factored into podiatric clinical practice infection control compliance.

In short, there is a lot of information to process and review which can, not only be time consuming, but potentially overwhelming.

#3 THE GOOD NEWS

Since you are a member, you are entitled to a complementary set of the APodA's Infection, Prevention and Control Guidelines and customised policies valued at $1000. The APodA is also monitoring the progress of revised instrument reprocessing standards and the impact this may have on its guidelines and policies. These issues will be addressed in 2022 when the new standard is adopted.

#4 THE EVEN BETTER NEWS...

There will be plenty of benefits here for members. They will include:

- Providing you with a valuable 'go-to' reference tool, specific to the podiatric profession
- Customised infection control policies, templates and forms for your practice or facility
- Ensuring you are compliant with PBA expectations
- Enabling peace of mind by knowing that you are protecting yourself, your staff and your clients
- Positioning you strongly to handle an Infection Control Audit if it were to occur in your practice
- Equipping you to meet the criteria for 'Preventing & Controlling Infection' in the Commission's Primary and Community Healthcare Standards. This is on the basis you voluntarily choose to be accredited against the National Safety & Quality Primary & Community Healthcare Standards.

#5 THE BEST NEWS!

Once the guidelines are released in early 2022, claim your copy by logging in as a member at the APodA website and go to the Member Resource Section and you'll find it under 'Clinical Support'.

Last but by no means least, we want to share a huge thanks to member and past president of the APodA Brenda Tonkin. Brenda has spent a lot of time and energy developing these new and improved guidelines and policies.

Questions or feedback?

We would love to know your feedback or answer your questions. Please email

info@podiatry.org.au ■

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HIERARCHY OF MANAGING THE RUNNER: PART 2

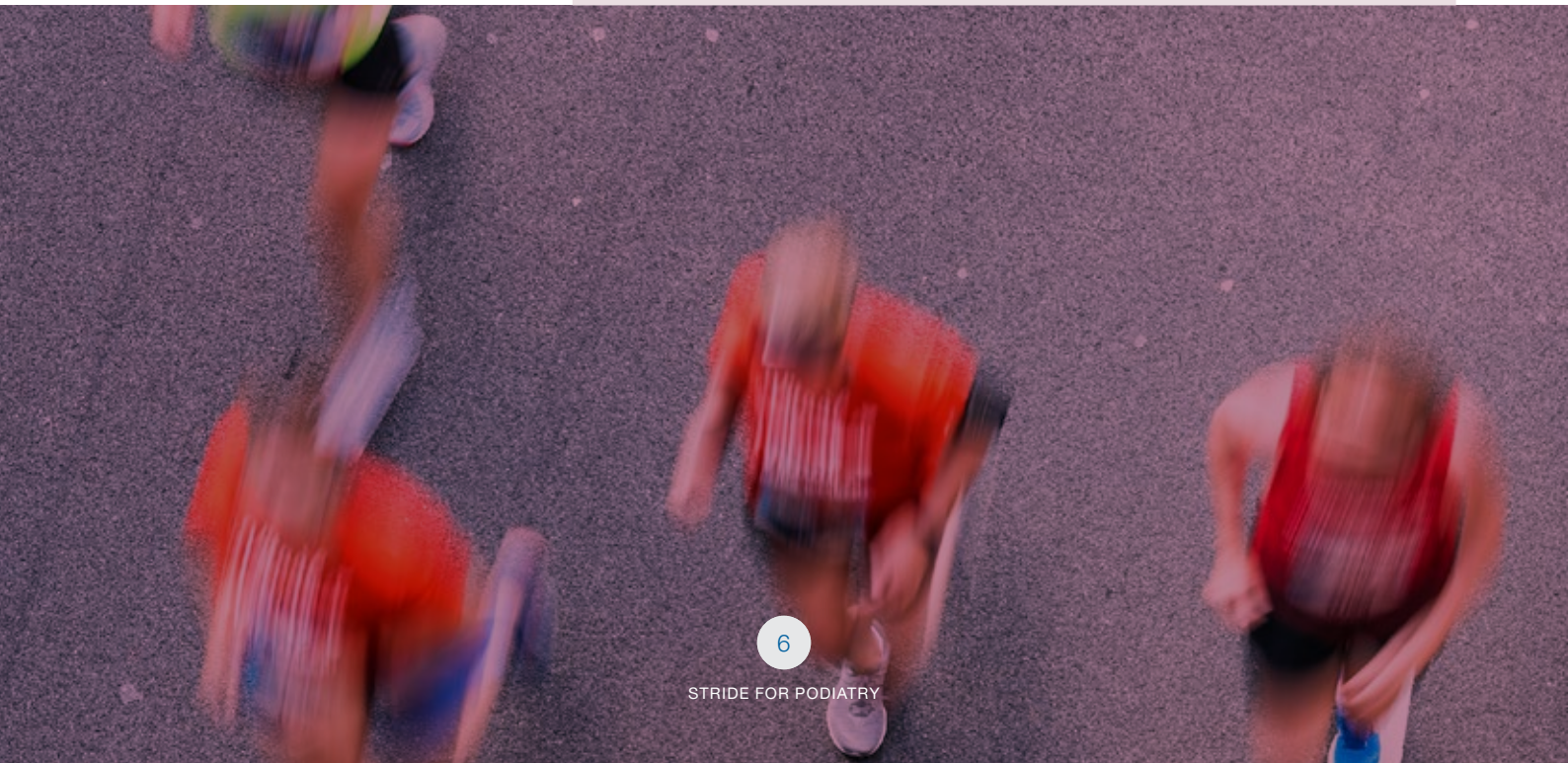
Edited by John Osborne, Certified Sports Podiatrist & Section Editor
Written by Michael Nitschke

John Osborne was the first podiatrist to fulfil the criteria for the title of Certified Sports Podiatrist in Australia. He currently works privately and consults with the Victorian Women's cricket team, Southside Flyers (WNBL) and Olympic and international gymnasts helping them manage lower limb pathology. John is currently completing a PhD at La Trobe University investigating the role of muscle strengthening with plantar heel pain.

With over a decade of clinical experience in private practice and exceptional anatomy and biomechanics knowledge, Michael Nitschke is a Partner at Adelaide's Sports & Arthritis clinic where he focuses on the diagnosis and treatment of running injuries.

As a former accomplished track athlete, Michael is well versed in working with amateur, junior and elite athletes. However, his passion for the sport has grown beyond just the competitive side. Michael is now committed to growing the entire running community in South Australia by providing an innovative running service which is accessible to all runners, both recreational and elite, in his role as assisting coach at the Adelaide Harriers Athletic Club.

Michael is also currently in his master's candidacy at the University of Adelaide. His research project is focused around the training characteristics of recreational runners and the relationship between performance and injury.



Did you know that prioritising the organisation of one's training characteristics may be the most important consideration for consistent running? Michael Nitschke explores this issue and he shares the characteristics that cause injury as well as what sustainable training looks like up close.

It's well accepted that sustainable running training begins with selecting a training regime that is suited to the runner's relative training state at that point in time. With training errors arguably the most important factor in Running Related Injuries (RRI), it makes sense to avoid those errors. However, we need to know what these errors are in an attempt to avoid them! Running coaches have spent many years intuitively or subjectively manipulating runners' training characteristics to improve a runner's performance while attempting to reduce the risk of a training error that may lead to injury or overtraining.

Which characteristic(s) cause injury?

Running training characteristics are best described via running; frequency (sessions/weeks), running volume (can be described as distance (km) or duration (hours: minutes) and intensity (effort).

So, which one of these training characteristics is responsible for RRI?

Imagine if it was that easy, with only a single variable as the major risk factor to RRI? Unfortunately, it's far from that simple. A systematic review of 30 studies found it was not possible to determine which specific training characteristic was associated with RRI, as these variables have complex interactions with each other which most studies have been unable to dissociate (Nielsen et al., 2012).

Evidence from clinical and experimental studies show training characteristics such as rapid increases in volume may be linked to the development of common knee RRI, while rapid increases in pace may be associated with lower-leg RRI (calf, foot or Achilles injury). This suggests that rapid increases in particular training characteristics may increase risk at different anatomical sites (Nielsen, 2013). Indeed, it could be argued that the interaction of multiple training characteristics are required to increase the risk of RRI. For example, a weekly 30 minute running session that has a focus on speed/intensity may not exceed tissue capacity that leads to RRI, however two speed sessions within 48 hours (increased frequency), or one 60 minute speed session (increased duration) may increase the risk for that runner.

Manipulation of training habits to keep loading

The manipulation of training characteristics is not only important to improve running ability, but they are also important to reduce or manage injury and pain. A clever running coach/practitioner may be able to keep a runner running, even if they are struggling with a pain related to a spike in a particular training characteristic. The coach can do this through a temporary manipulation of their running habits. For example, a runner may have quickly increased their running volume, and the large accumulative load leads to experiencing knee pain (iliotibial band syndrome or patella-femoral pain syndrome). Whereas a training tweak could include replacing volume with more intense, but shorter training sessions. This may reduce cumulative loads, but increase (in the short term) peak loading that may shift loading to more distal structures.

This approach could also work in reverse. For example, if a runner is suffering from ongoing calf issues, the relative intensity (running pace) could be reduced and/or replaced with lower paced running, but temporarily collecting more duration. Even those niggling Achilles' tendon injuries (that many runners take time off for) could benefit

> A clever running coach/ practitioner may be able to keep a runner running, even if they are struggling with a pain related to a spike in a particular training characteristic.

from an attempt to maintain running loads while reducing the frequency of sessions per week to allow for tendon adaptation. Those who continue to train with lower-leg tendon issues and who incorporate high speed sessions (such as increasing tendon energy storage activities) could reduce the frequency of those sessions temporarily. Alternatively, they can replace them with easier runs while building their tissue tolerance (weight training) away from running.

These habits may promote strength yet still allow positive adaptations, while also reducing risks associated with de-conditioning.

Sustainable training organisation

While the literature has not yet cleared up the 'best way' to train to improve and stay injury-free, retrospective studies over the past two decades have investigated how the best endurance athletes organise their training. We know that top endurance runners train a lot (resulting in lots of volume for many years on end), which usually means they've selected a model that is consistent and sustainable.

In an attempt to chase improvements, endurance running requires organisation of duration, frequency and intensity of training sessions. A recent interest has evolved in the literature, discussing how the best endurance runners distribute their intensity throughout a training cycle (training intensity distribution [TID]).

For simplicity, intensity in running can be measured with multiple methods (heart rate, pace or rate of perceived exertion) and described as three intensity zones:

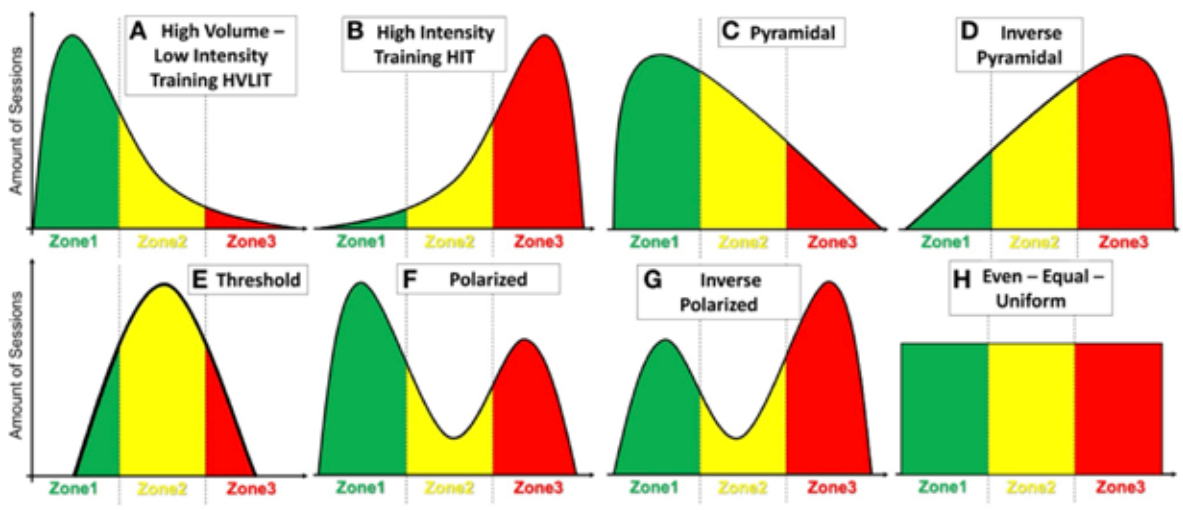
- Low intensity (LIT – jogging, aerobic running)
- High intensity (HIT – repetitions, intervals or sprinting)
- Threshold intensity (ThT – between low and high intensity).

It was the work from Dr Stephen Seiler that began to spark interest in this area when his data showed that the best endurance runners tended to select a Polarised (POL) TID (80% low intensity and 15-20% high intensity and the rest ThT intensity) (Seiler 2006). Further research has confirmed this, and suggested other top endurance athletes select a similar TID known as a pyramidal model (LIT > ThT > HIT) (Stoggl & Sperlich 2015).

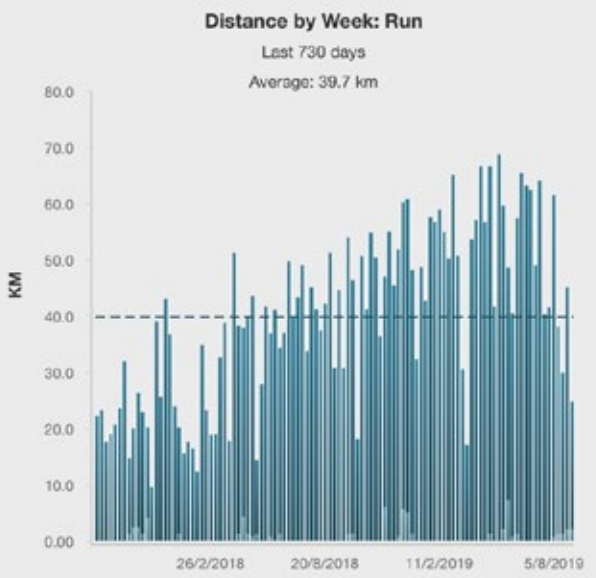
Specifically for top class runners, Keneally et al (2017) performed a systematic review that showed Pyramidal and Polarised TID were more effective in relation to increasing performance than a Threshold TID. Both these models have a large amount of LIT, suggesting perhaps it's a requirement to be a higher performer?

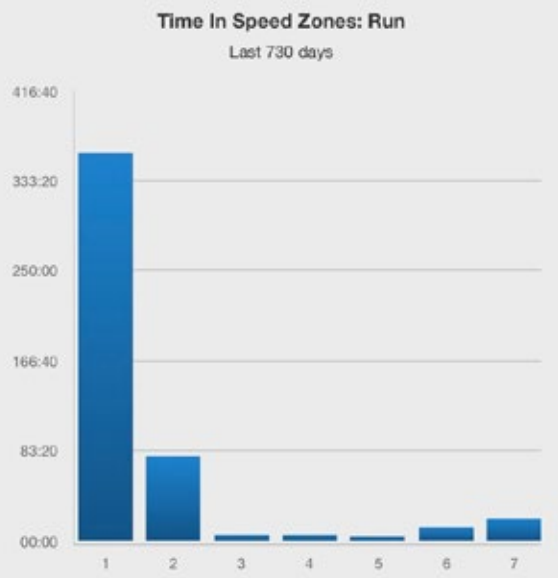
Training Intensity Distribution variations (Stoggle 2018)

Top class runners still complete many ThT or HIT sessions in order to improve, yet due to the large duration of training time required to be at the top, it is really no surprise that plenty of low intensity training is required. It may add to their sustainability. However, someone who runs less frequently could surely benefit from a higher ratio of HIT or ThT sessions though? Munoz et al (2013) found recreational runners actually improve more following a POL TID than ThT TID, and this was also noted amongst recreational trail runners (Perez et al 2018). While there is limited research in this area when it comes to the training characteristics of recreational runners, anecdotally we tend to see many runners run 'not too easy, not too hard', suggesting a threshold TID. Whether this is a risk factor for injury, this is yet to be established, but it is very interesting and should be considered clinically.



Training Intensity Distribution variations (Stoggle 2018).





Measuring Load: Top left – Training distance progression, Top Right – TID (pace), Bottom (Training Stress Graph) – all over two years.

Training progressions

So how much training increase is too much increase? While it is common sense that too much too soon is associated with injury risk, we do not have a clear answer. The 10% rule has been quoted often, yet literature hasn't shown this to be more protective than other increases (Buist et al 2008). Other research has shown that over 30% increases of weekly volume may have higher associations to RRI risk than say 20% (Nielsen et al,). Obviously, common sense would suggest that continual increases of volume of 10% or 20% are not sustainable forever, and they are not necessarily required to continually improve.

There is NO ABSOLUTE value of weekly increase that has been shown to be a silver bullet in answer to this question. The amount of dose you can increase from week to week varies between populations, due to so many complex variables. Your training frequency, duration, distance and intensity all have complex interactions that lead to external and internal stimuli that require varied adaptation time.

So how much training increase is too much increase? While it is common sense that too much too soon is associated with injury risk, we do not have a clear answer.

Spending time assessing and organising the training characteristics of a runner remains arguably the most important piece of the performance increase and injury reduction puzzle.

Monitoring a person's training load needs to take into account non-modifiable risk factors (experience, age and previous injury) and modifiable risk factors (BMI, biomechanics, tissue tolerance) in order to allow a runner to find their balance between attracting performance adaptations and perhaps keep their injury risk lower (Hume et al, 2015)! Sometimes we react to the same mileage differently due to not accounting for the other training characteristics that may alter (intensity) or because of higher internal stresses (not to do with running) that may delay adaptation.

So, how much increase is too much too soon that can be relied on sustainably? Is it 10%, 20%, 30%...? Well, it's much more complicated. Solving the puzzle is currently as much intuitive as it is science, as a recent systematic review revealed our evidence for 'too much too soon' is clearly not there yet (Damsted et al 2018).

Spending time assessing and organising the training characteristics of a runner remains arguably the most important piece of the performance increase and injury reduction puzzle. A good understanding of the sport and the individual's goals; along with experience and recognition of the evidence is required to optimise this process. As practitioners working with runners, the value of focusing on training characteristics should be as high (probably higher) than other aspects of the hierarchy.

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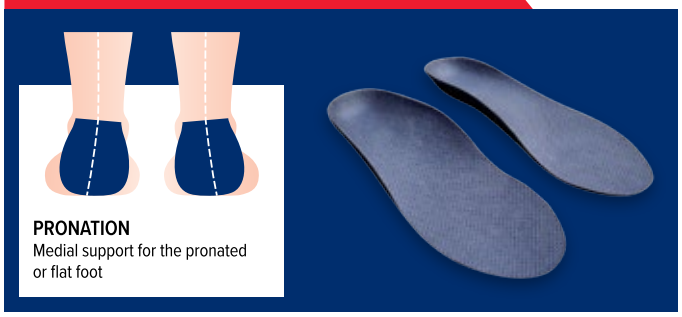
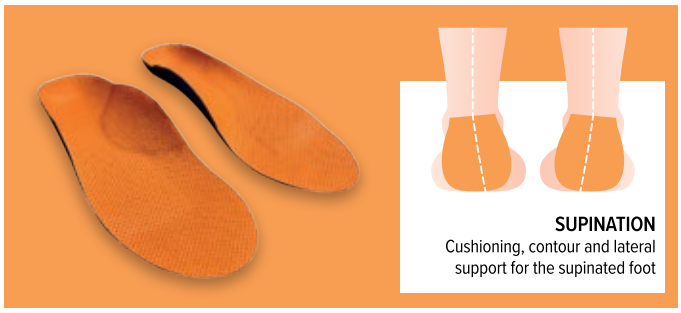
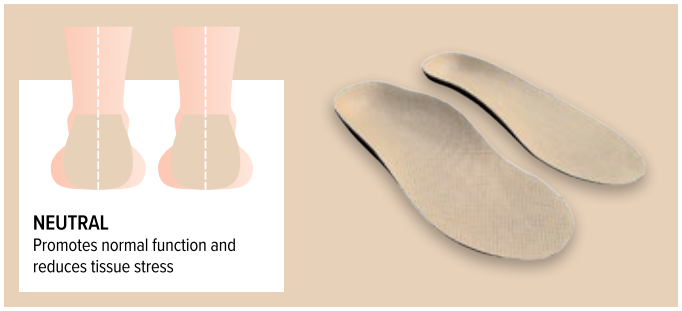


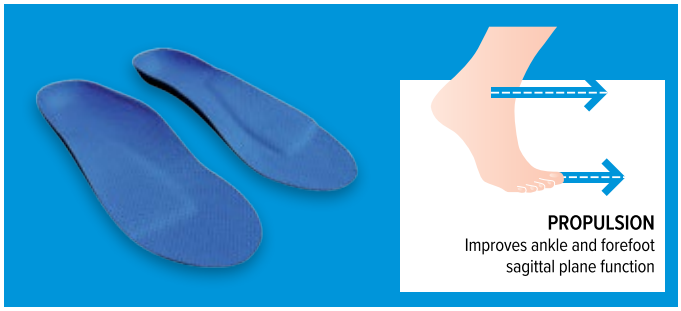
PRONATION
Medial support for the pronated or flat foot



SUPINATION
Cushioning, contour and lateral support for the supinated foot



NEUTRAL
Promotes normal function and reduces tissue stress

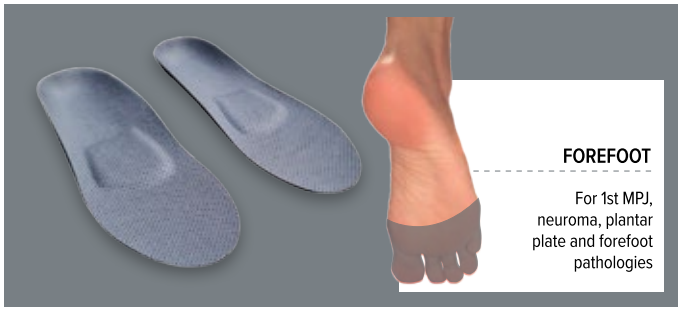


PROPULSION
Improves ankle and forefoot sagittal plane function

SELECT BY PATHOLOGY

5 MODELS

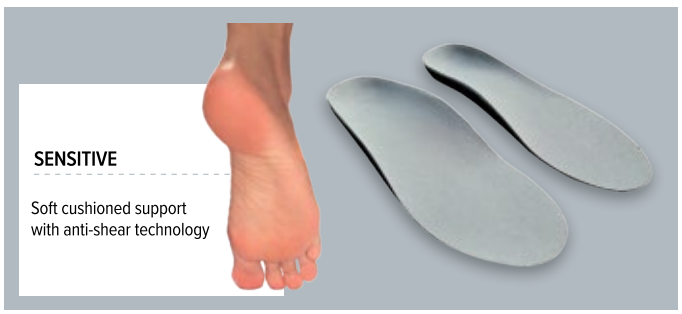
REARFOOT
For posterior pathologies including Achilles, Severs, Gastroc and Soleus



FOREFOOT
For 1st MPJ, neuroma, plantar plate and forefoot pathologies

MEDIAL
For the medial foot and leg including plantar fasciitis, tibialis posterior and plantar heel pain

LATERAL
For lateral foot, ankle and peroneal pathologies



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WHAT ARE SIMULTANEOUS DUAL-TASK INTERVENTIONS?

By Associate Professor Caroline Robinson in collaboration with Natasha Versi and Dr Kylie Murphy

Associate Professor Caroline Robinson is the Associate Head of School of Community Health (SCH) and Discipline Lead Podiatry at Charles Sturt University (CSU).

I'm delighted to share some of Natasha's work with you as the final contribution to this year's series on Aged Care.

This piece provides an insight into simultaneous dual-task interventions and their benefit to maintaining cognitive function in older people.

In this article I will focus on:

- The impact of decreased cognitive function in older adults
- Neuroplasticity
- Simultaneous dual-task interventions
- Benefits of simultaneous dual-task interventions in maintaining cognitive functioning in older age
- Implementation of simultaneous dual-task interventions in healthcare practice.

Natasha Versi is an occupational therapist who graduated recently from Charles Sturt University. She completed honours in 2020 and submitted a paper titled 'Simultaneous dual-task interventions that improve cognition in older adults: A scoping review of implementation-relevant details'. Her honours supervisors were Dr Kylie Murphy and Associate Professor Caroline Robinson.

Dr Kylie Murphy coordinates the Honours program at Charles Sturt University's School of Allied Health, Exercise Science and Society. She enjoys teaching and supervising students and encouraging an evidence-based client-centred approach to healthcare practice. Kylie's background also includes choreographing and teaching dance in community settings with all age groups.

Cognitive decline is not an inevitable outcome of ageing. When it does occur in one or more cognitive domains, a neurocognitive disorder is said to be present.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) identifies six cognitive domains that may be impacted:

- Complex attention
- Executive function
- Learning and memory
- Language
- Perceptual and motor function
- Social cognition.

Neurocognitive disorders involve a disturbance in functionality in one or more of these cognitive domains, due to cerebral pathology (such as Alzheimer's disease, fronto-temporal lobar degeneration, Lewy body disease, and vascular disease).

As the prevalence of cognitive decline increases with age, by 2050 it is predicted that the number of people living with a neurocognitive disorder could be around 100 million globally. The total cost of dementia is predicted to increase by 81% to $25.8 billion by 2036. The costs are predicted to further increase to $36.8 billion by 2056 which is a 2.6-fold increase in costs from 2016.

Impact of decreased cognitive function in older adults

In addition to the cost of neurological disorders on the healthcare system, there are significant impacts on a person's ability to participate in daily activities. People living with major neurocognitive disorders experience reduced autonomy and have generally been found to have a lower health-related quality of life as compared to older people without known impairment. People living with Alzheimer's disease have also been found to have substantially lower resilient coping mechanisms.

Implementing early interventions to delay the onset of neurological impairment, and to maintain/improve functional capacity and independence for people living with a neurocognitive disorder, is important for individuals, their families and communities, and health services.

Neuroplasticity and cognitive reserve

Neuroplasticity is a concept that describes how the brain responds to environmental changes; new neuronal synapses are created during exposure to new stimuli. When experiences that promote new connections are repeated, the cerebral cortex becomes denser with more complex connections forming in the brain. Cognitive reserve relates to cerebral functional capacity. Greater cognitive reserve, or

> “Cognitive decline is not an inevitable outcome of ageing.

stronger and more complex brain connectivity, means cognitive functioning can be better sustained when disruptions in the brain occur, because alternate neural pathways are available. Interventions to delay or slow cognitive decline aim to stimulate neuroplasticity and increase cognitive reserve.

Simultaneous dual-task interventions

Simultaneous dual-task (SDT) interventions are activities that require a person to engage physically and cognitively at the same time. Examples of activities which result in cognitive improvements include dance, Tai Chi, exergames[1], karate, musical instrument playing, and activities such as memory training performed simultaneously with physical activities. Performing a physical task and a cognitive task *simultaneously* has been shown to be more effective for improving cognitive function in healthy and clinical populations, as compared to performing tasks *sequentially*.

Benefits of simultaneous dual-task interventions

There is a strong evidence base which demonstrates the effectiveness of SDT interventions for improving cognition in older adults. As these interventions combine cognitive engagement/stimulation and physical movements, the cognitive challenge produces beneficial neurological changes in the brain. Positive brain changes including enhanced neuroplasticity, increased prefrontal cortex activity during walking, and increased whole brain volume, have been documented following SDT interventions. Overall, the impact for a person will be a variable combination of improved: complex attention; executive function; learning and memory; language; perceptual and motor function; and social cognition.

Simultaneous dual-task interventions in healthcare practice

Whilst the beneficial effect of SDT interventions is well-established, it is relevant to consider how they might be implemented in practice. Unfortunately, this is a notable gap in the literature as most studies fail to report on key implementation details which are required to facilitate the translation of research to practice. Whilst effective interventions such as Tai Chi and dance require few resources to implement with a group of clients in the community, other interventions require props and equipment which might not be so readily available, for example; exercise balls, stationary recumbent bikes, step mania software, and video game consoles.

> “There is a strong evidence base which demonstrates the effectiveness of SDT intervaentions for improving cognition in older adults.

A vital implementation detail to consider is how long the cognitive benefits persist before a person needs to re-engage in the activity to maintain or enhance cognitive performance. Only a few of the studies included in this scoping review reported on follow-up effects but these findings suggest that cognitive benefits may be evident for up to five months after completion of the SDT intervention.

So what does this mean for podiatrists?

As one of Natasha's honours supervisors, my involvement in this scoping review increased my understanding of the value of combining physical activity with simultaneous cognitive challenge. As podiatrists, we have the perfect opportunity to build on our core purpose of enabling mobility and physical activity by educating clients about SDT interventions to maintain cognitive function into older age. It's essential to encourage dual-task activities with clients who are younger, prior to any evidence of cognitive decline, so they can develop good lifestyle behaviours which enhance neuroplasticity and build cognitive reserve. For six months I had the joy of participating in Dr Kylie Murphy's line dancing classes which was an excellent lived experience of this topic. The cognitive challenge of learning a sequence of dance steps, and executing a routine in time with the music, is a perfect example of a simple and low-cost SDT intervention.

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(1) Exergames have been extensively used in a broad range of therapeutic interventions, including: Burn recovery, cerebral palsy, stroke rehabilitation, adapting to limb amputation and spinal injury, and Parkinson's disease www.sciencedirect.com/topics/psychology/exergames

More information

If you are interested to explore this topic further, I encourage you to take a look at:

- Dual Task Training Exercises to Improve Balance and Walking video **www.youtube.com/watch?v=qFr_-1yBsGk**
- Youth Fitness, Adult Wellness, and Family Fun with Exergaming video **www.youtube.com/watch?v=K-Oy3IGTj9Q**
- Dual-Task Exercise to Improve Cognition and Functional Capacity of Healthy Older Adults paper **www.frontiersin.org/articles/10.3389/fnagi.2021.589299/full** ■

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Foot logics

Given a key principle of cultural safety is self-reflection, section editor James Gerrard reflects on the purpose and progression of the Indigenous section in STRIDE magazine across 2021.

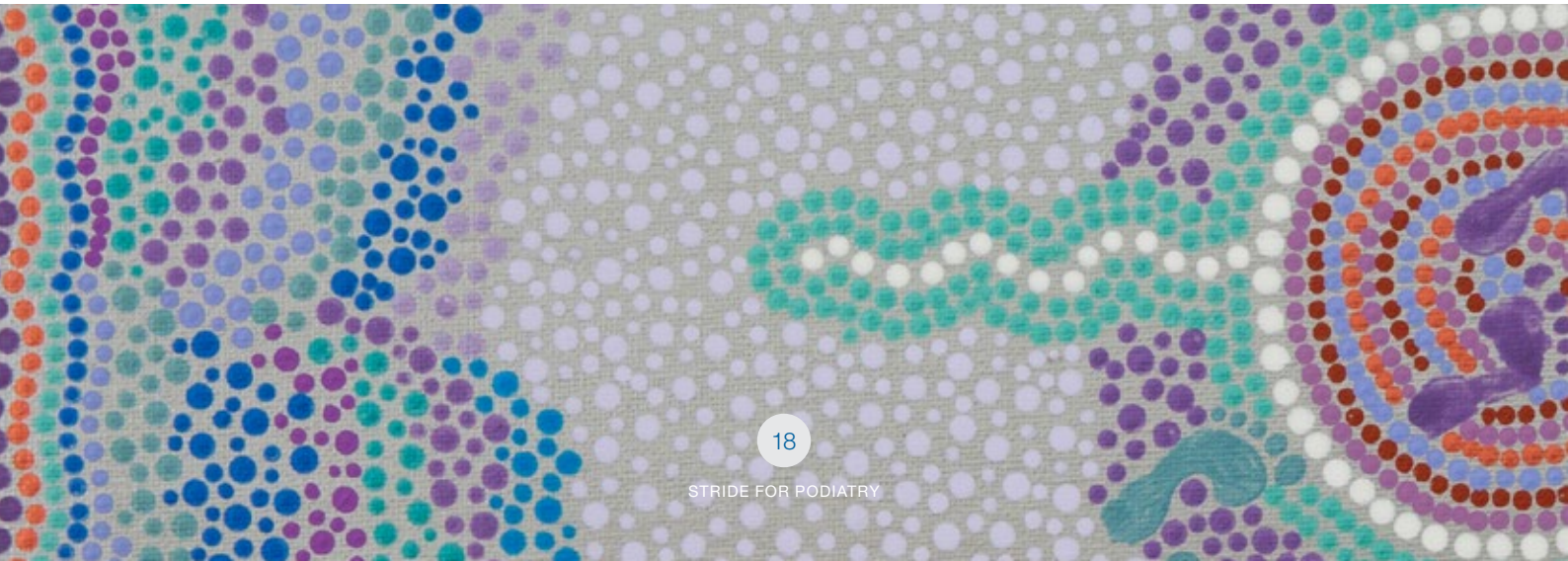
James is a podiatry graduate who has worked in public and private settings in Victoria, New South Wales and Tasmania, and he now lectures at La Trobe University within the discipline of podiatry. James is also a current University of Newcastle PhD candidate, involved in research giving First Nations voice to foot health education, and the developing, delivering, and evaluating of cultural safety education for undergraduate podiatry students.

At the beginning of the year the Australian Podiatry Association incorporated an 'Indigenous section' within STRIDE magazine, this created space for combined knowledge and worldviews to be shared.

#1 Clarifying the National Scheme

This year the Indigenous section has promoted the Australian Health Practitioner Regulation Authority (Ahpra) who released the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. This is critically important to the podiatry profession in Australia because it is the first national guideline for:

- Shaping podiatry and other professions' cultural practice
- Recognising that cultural safety is a critical component of patient safety – the ultimate goal being to empower all registered health practitioners within



Australia to provide health care to Aboriginal and Torres Strait Islander Peoples that is inclusive, respectful, and safe, as judged by the recipient of care.

The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 defines cultural safety today as 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism'. It is judged by the recipient of care, Aboriginal and Torres Strait Islander Peoples.

Providing access to culturally safe care is essential to improving health outcomes for Aboriginal and Torres Strait Islander people.

#2 Introducing industry experts

We also had industry experts such as Professor Vivienne Chuter add her thoughts and comments to the introductory discussion. The Head of Discipline (Podiatry) and Higher Degree Research Coordinator within the College of Health, Medicine and Wellbeing at University of Newcastle contributed the following:

"Providing access to culturally safe care is essential to improving health outcomes for Aboriginal and Torres Strait Islander people. As podiatrists we have a central role in the health care delivery deficit and with that comes both the opportunity and responsibility to help address the cultural safety in our healthcare system. Although we have a big task ahead, developing our understanding of, and skills in culturally safe care provision should be embraced as a continual and evolving process that is consistent with our commitment to life-long learning as evidence-based health practitioners."

#3 Changing the name

During the year, this section's name became *Gugurr yan.guwan dhadhadya* (pronounced gu-gurr yan-gwa da-da-ja), which translates to 'Keep on walking strong'; demonstrating inclusive and respectful language, and importantly promoting and privileging First Languages.

The name for this section of STRIDE comes from Badimaya Country. We acknowledge the dedication of Badimaya Elders and Community in their work to revitalise a language almost lost through violent colonising processes. See if you can locate Badimaya Country on the Australian Institute of Aboriginal and Torres Strait Islander Studies First Nations map at: **www.aiatsis.gov.au/explore/map-indigenous-australia**

#4 Creating bespoke art

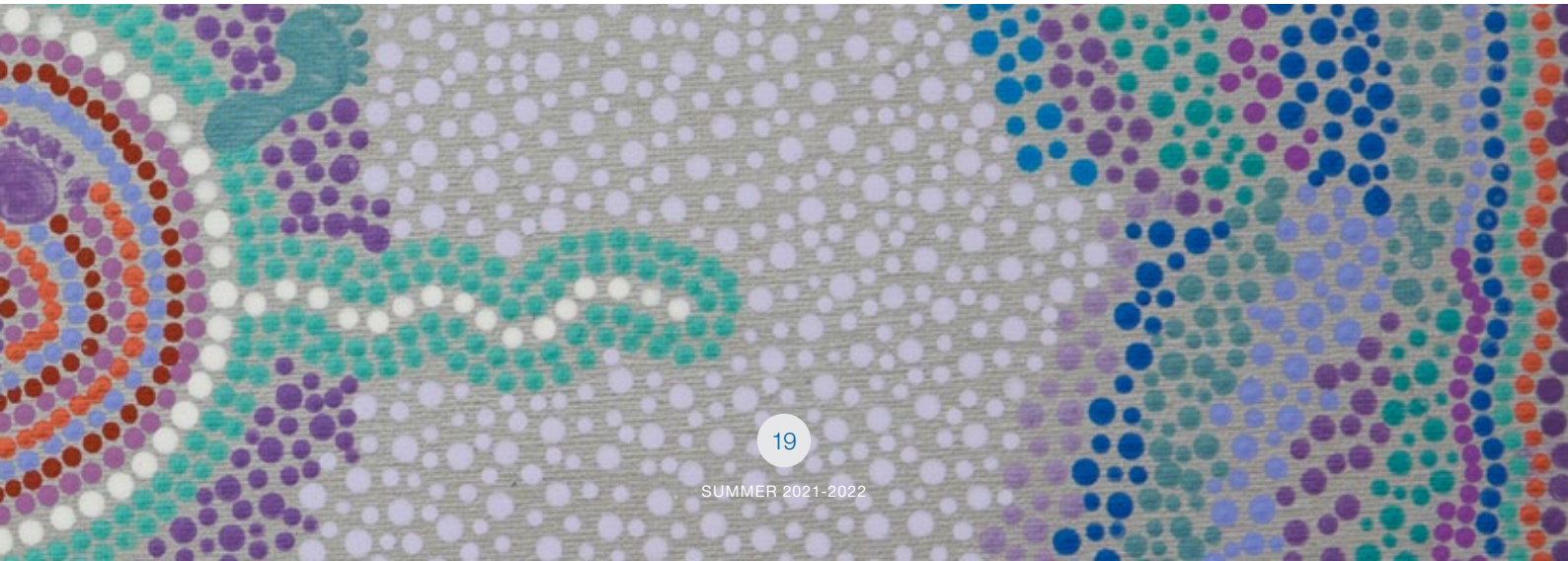
Created specifically for this section of STRIDE, First Nations artist Nellie Green (Badimaya) now speaks to this space through her art which shares the same namesake of this section of STRIDE, *Gugurr yan.guwan dhadhadya: Keep on walking strong*. Dedicated to creating a progressively decolonised space, Nellie's art educates us of First Nations perspectives of foot health.

Nellie described her work (detail shown below) telling of, "The importance of foot health to First Nations Peoples, with footprints in the work depicting the footsteps that take us through a lifetime... (Footsteps) that carry us on continuous journeys along different paths, that carry the energy, that carry the burdens, that carry the accomplishments, and that carry the stories of our own lives."

Nellie described the colours she has used in the art, "As a means to present a serious message in good humour; while the loss of foot health is traumatic, a lot of people need to get over the stigma about feet and hiding them, and need to be proud of their feet, considering what they put up with and what we put them through" As Nellie aptly sums up: "We trust our feet to bring us home."

#5 Sharing conference insights

This year also saw STRIDE magazine cross promote and report on the



inaugural Indigenous conference stream at the Australian Podiatry Association 2021. The stream displayed our profession's position in this space: late to take action, but certainly more than capable of becoming a leader in culturally safe healthcare delivery in this country. Check out what Associate Professor Cylie Williams, Chair of the Podiatry Board of Australia thought of the session at: **twitter.com/cyliepaedspod/**

This year, conference attendees were privileged to hear keynote presentations from Kaurna man Associate Professor James Charles, Murrawarri man Dr Brett Biles, and Māori woman Belinda Ihaka. We were then lucky enough to have keynote speakers take a live Q&A session, and then contribute to a live panel discussion with Associate Professor Caroline Robinson.

#6 Highlighting recommended resources

One of the main themes arising from delegate questions for panellists across these sessions was what and where are professional and personal development tools and resources in the area of cultural safety? During the sessions Brett discussed some really good references for everyone to consult in a professional space, he listed Australian Indigenous HealthInfoNet, The LIME network, and Indigenous Allied Health Australia (IAHA). These are driven by First Nations' leadership, governance and voices.

Brett also spoke of the importance of getting the basics right in this space. For example, something as simple as improving our use of correct terminology. Brett suggested the NSW Department of Health (2004) resource as one such tool: Communicating positively: A guide to appropriate Aboriginal terminology. Another great resource in both professional and personal contexts is the Aboriginal and Torres Strait Islander Guide to Terminology, produced for Public Health Association (Australia). The contributors to this work are Yorta Yorta woman Dr Summer May Finlay. These are of course but only two of the fantastic resources existing in this space.

#7 Explaining the Podiatry Board of Australia's role in the National Scheme

More recently, Gugurr yan.guwan dhadhadya has been discussing the importance of the Podiatry Board of Australia's role in the National Scheme's process of embedding cultural safety expectations nationally across all its 15 health professions. The release of our profession's new professional capabilities were published on the Board's website in September 2021 and will come into effect on 1 January 2022. The 'Podiatry professional capabilities' for both podiatrists and podiatric surgeons is available at: **www.podiatryboard.gov.au/Registration-Endorsement/Podiatry-professional-capabilities.aspx**

The professional capabilities regulate registered participants of our profession to meet and maintain a 'threshold or minimum level of professional capability required for registration as a podiatrist.' The key cultural safety aspects of the documents relate to being a professional and ethical practitioner, as well as a communicator and collaborator.

The new professional capabilities foreground developing cultural safety as a fundamental skill of a podiatrist. This is a great example of anti-racist action by the authors and a means to working towards ending systemic racism within our profession. These professional capabilities provide courses for our individual and collective development of cultural safety and for the ongoing development of cultural safety as a fundamental skill of a podiatrist.

As we continue our pursuit of the Ahpra strategy to embed cultural safety into the health system, our new professional capabilities will add to our profession's key achievements, including recommending and advocating for changes to the Health Practitioner Regulation National Law to ensure consistency in cultural safety for Aboriginal and Torres Strait Islander people.

We are signatories to the National Scheme's strategy developed with the leadership of Aboriginal and Torres Strait Islander health organisations and individuals, and through the Podiatry Board of Australia.

The Australian Podiatry Association is responsible for the development of national policies, representation of podiatry in Australia to government and industry bodies, and assistance for Continuing Professional Development. The Association also supports research within the discipline of podiatry.

In summary...

Gugurr yan.guwan dhadhadya signals the intent of the Association to greatly increase Aboriginal and Torres Strait Islander leadership in these pursuits. We will advocate for words on a page to become actions in future.

Anyone can contact me at any time regarding wanting to contribute within this space, or regarding topics they would like to learn more about – so we can all keep on walking strong, as individuals and as a profession, in 2022 and beyond. ■

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PODIATRY ENROLMENTS: AN EMERGING CRISIS

Associate Professor Shannon Munteanu

At a time when demand for healthcare services is forecast to increase, there is a concerning decline in the overall number of enrolments in podiatry programs across Australia and New Zealand, explains Associate Professor Shannon Munteanu.

Associate Professor Shannon Munteanu is currently Discipline Lead for the Discipline of Podiatry at La Trobe University, Victoria, and member of the Australasian Council of Podiatry Deans.

There are approximately 400 job openings for podiatrists per annum[1] in Australia, driven by workforce need and workers leaving the industry. However, modelling by the Australasian Council of Podiatry Deans (ACPD) has estimated that the number of students entering podiatry programs across Australia has reduced approximately 10% year-on-year since 2015.

This reduction in demand is reflected in estimates of student completions, with overall completions in podiatry courses across Australia and New Zealand, reducing from approximately 350 students in 2016 to a forecast of approximately 270 completions in 2024.

The consequences

The chasm between increasing demand for podiatry services and reduced supply from graduating podiatry students is predicted to have significant consequences. First, the reduction in the supply of podiatry graduates will create challenges for employers filling vacant or newly created positions. Second, podiatry services are essential for preventing and treating lower limb disease, so any unmet demand for podiatry services will be likely to result in reduced overall health and well-being of our communities and place increased burden on the healthcare system. Third, there is the threat to the identity of podiatry as a profession, as the number of professionals in other health disciplines grows and begins to compete for market share. Finally, universities are facing significant threats to their viability because of reduced revenue created by the COVID-19 pandemic. Any programs of study with low enrolments may be considered unviable. Therefore, specific podiatry programs that are experiencing a notable decline in enrolments could be at risk at closure. Any suspension or closure to podiatry programs will lead to a widening in the chasm between demand and supply for podiatry graduates.

Action is needed

We urgently need a unified approach to rectify this crisis. We need collective action from universities, our professional bodies, and employers and employees. Recognising this need, the ACPD has recently partnered with the Australian Podiatry Association to develop a strategic plan to address this issue. The success of this strategic plan will be contingent on buy-in and efforts of all stakeholders, so we urge you to support the future of the profession and contribute to the actions of this plan.

1. www.joboutlook.gov.au/Occupation?search=Career&code=2526

Launch of a strategy

In May 2021, the ACPD engaged with the APodA to collaborate on a strategy to address the issue of declining enrolments and ensure the profession is promoted as an enticing career choice. Short and long term goals are now in place and in development across a range of platforms and networks. These outlets include high schools, universities, social media channels and interactive web-based tools and quizzes designed to engage would-be podiatrists. More information will be shared across all our social, emails and on **www.foothealthaustralia.org.au** and **www.podiatry.org.au** ■

A YEAR IN REVIEW

By Professor Keith Rome, Editor-in-chief of JFAR (Australia)

The editor in chief of the Journal of Foot and Ankle Research (JFAR), Professor Keith Rome, reflects on the year that was.

> 2021 has again illustrated the wealth and depth of research being published by APodA members that have significant ramifications to clinical practice. I encourage members to review the articles published in the journal, which is an open access journal free of charge.

A warm welcome to everyone from the Journal of Foot and Ankle Research editorial team. The editorial team includes Dr Andrew Buldt, Dr Daniel Bonanno and Associate Professor Cylie Williams who have been working tirelessly and in their own time to ensure we produce a high-quality journal for clinicians as well as researchers based in Australia.

I have highlighted key performance statistics:

- The journal received 232 submissions in 2020, an increase of 8% from 214 submissions in 2019.
- Submissions from China contributed significantly to this increase, and resulted in China being the largest source of submissions to the journal at the country level (18%).
- The journal accepted 74 articles in 2020, an increase of 45% from 51 acceptances in 2019.
- This means that the acceptance rate during 2020 was 36%, an increase from 2019 (27%)
- Articles in the journal were accessed 675,439 times during 2020, compared to 557,773 times during 2019, most likely as a result of the increase in publications.
- The 2020 Impact Factor (released in 2021) was 2.303, compared to a 2019 Impact Factor of 1.598.
- Manuscript turnaround times remained fairly constant in 2020. The average time from submission to first decision was 30 days, and the mean time from submission to acceptance was 98 days.

The journal has historically received significantly more submissions from Australia and the UK than from other nations, and increasing submissions from outside these two countries was a particular focus for the journal. Although submissions and accepted articles from outside these countries increased in 2020, the majority of accepted articles still originate from Australia. At the time of writing this review, 21 articles have been published with a further 12 under review from Australian podiatrists. This is a significant increase and demonstrates the high level of research being published from centres of excellence in podiatric research based across Australian universities.

I have highlighted four articles from this year that illustrate the diversity of research being conducted in Australia.

1. Williams, C., Couch, A., Haines, T. et al. *Experiences of Australian podiatrists working through the 2020 coronavirus (COVID-19) pandemic: an online survey.* J Foot Ankle Res 14, 11 (2021)

On 19 January 2020, the Chief Medical Officer of Australia issued a statement about a novel coronavirus, or SARS-CoV-2. Since this date, there have been variable jurisdictional responses, including lockdowns, and restrictions on podiatry practice. This study aimed to describe impacts of the SARS-CoV-2 pandemic on the podiatry profession in Australia. Podiatrists in Australia reported variable impact of the pandemic on their business decisions, limited impact on their Personal Protective Equipment (PPE) stores, and their valued sources of information. Podiatrists also described their "marathon" journey through the pandemic with quotes describing their challenges and highlights. Describing these experiences should provide key learnings for future workforce challenges, should further restrictions come into place. While the SARS-CoV-2 pandemic is still prevalent throughout the world, this study highlights the resilience of the profession and its adaptability during unprecedented times.

2. Modi, S., Turner, D. & Hennessy, K. *Non-pharmacological interventions and corticosteroid injections for the management of the Achilles tendon in inflammatory arthritis: a systematic review.* J Foot Ankle Res 14, 48 (2021).

The article aimed to identify and critically appraise the evidence for non-pharmacological interventions and corticosteroid injections in the management of Achilles tendon pathology in those with inflammatory arthritis. The authors reported that weak evidence is available regarding the efficacy of corticosteroid injections in reducing pain and inconclusive evidence for the improvement of abnormal ultrasound detectable features. No studies were identified for non-pharmacological interventions. Future research should consider how study outcomes may be interpreted in the context of co-interventions, such as pharmacological management, and variable disease course and progression, and consider analysis for specific subtypes of inflammatory arthritis to allow applicability of results in wider clinical practice.

3. Evans A. *Sustainable healthcare – Time for 'Green Podiatry'.* J Foot Ankle Res 14: 45.

The commentary reports podiatrists, as allied health professionals, have wide community engagement, and hence, can model positive environmental practices, which may be effective in changing wider community behaviours, as occurred last century when doctors stopped smoking. As foot health consumers, our patients are increasingly likely to expect more sustainable practices and products, including 'green footwear' options. Green Podiatry, as a part of sustainable healthcare, directs us to be responsible energy and product consumers, and reduce our workplace emissions.

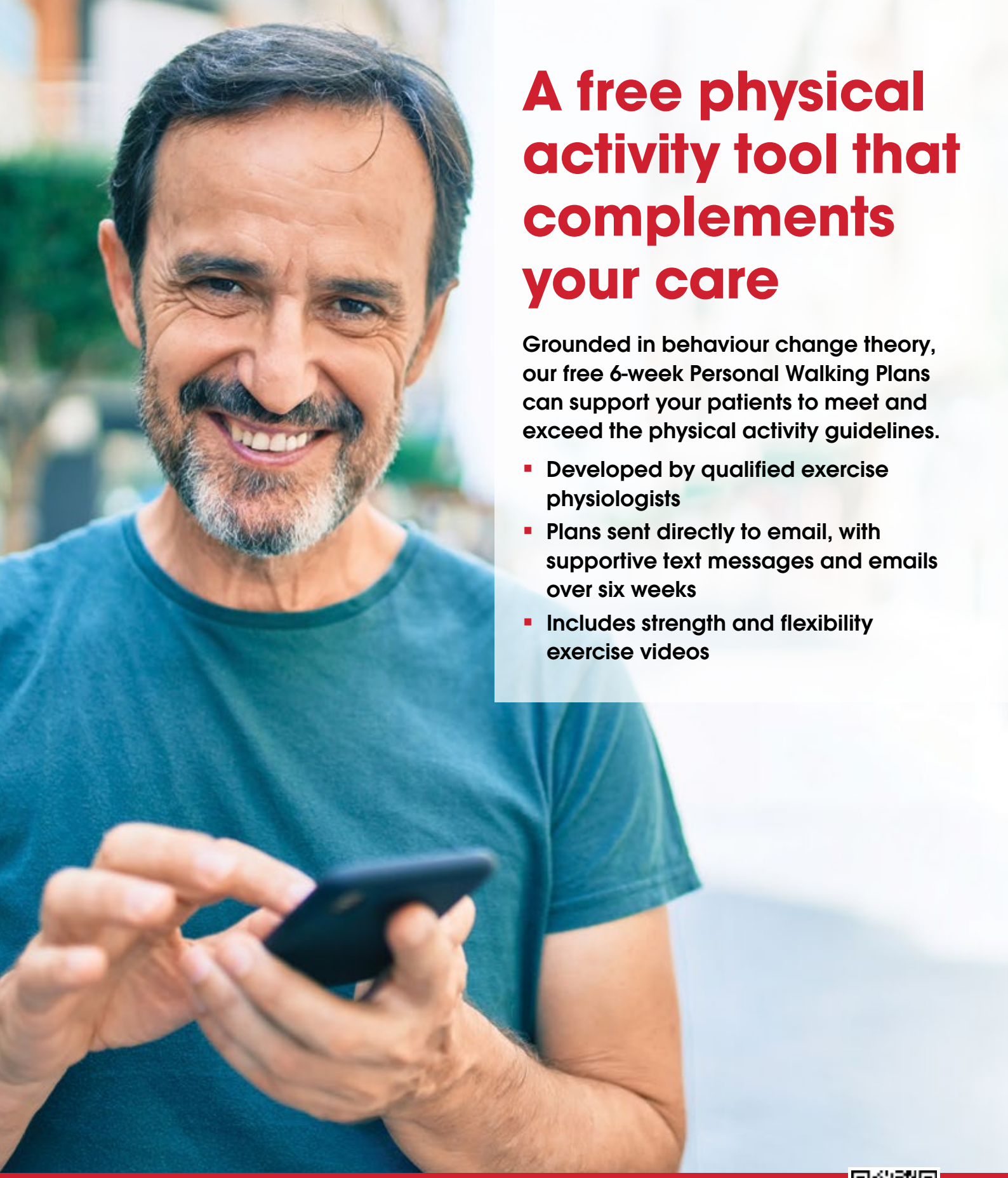
4. Graham, K., Banwell, H.A., Causby, R.S. et al. *Barriers to and facilitators of endorsement for scheduled medicines in podiatry: a qualitative descriptive study.* J Foot Ankle Res 14, 16 (2021)

The qualitative study aimed to explore barriers to, and facilitators of, engagement with endorsement for scheduled medicines by podiatrists. The authors concluded that the negative impact of a lack of access to mentors and supervised training opportunities may be diminished by a more formal structure for the endorsement pathway. The findings highlight the advantage that hospital-based podiatrists have in opportunities to undertake supervised training. The authors suggest that investment in upskilling established podiatrists and financial incentives for endorsed prescribers may be the most rapid method of building a larger pool of endorsed podiatrists. Further research could explore the level of interest in undertaking training in this group, the most influential incentives to become an endorsed prescriber, and the unique circumstances of rural podiatrists.

In summary

In summary, 2021 has again illustrated the wealth and depth of research being published by APodA members that have significant ramifications to clinical practice. I encourage members to review the articles published in the journal, which is an open access journal free of charge. Finally, I would like to thank APodA for their full support of the journal.

Best regards, Professor Keith Rome (editor-in-chief Australia) ■



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COVID's impact on charities

By Anthony Lewis, CEO Footscape

Anthony Lewis, the CEO of Footscape discusses the impact of COVID on charities such as Footscape, and where the future may be headed.

Since completing his Bachelor of Podiatry at La Trobe University in 2000 Anthony Lewis has worked in a range of Australian healthcare settings serving marginalised population groups predisposed to foot pathology. Observing the startling implications of debilitating foot pathology upon the most vulnerable has motivated Anthony to establish Footscape. Anthony has completed further post graduate studies extending to a Master of Public Health at Flinders University and Graduate Certificate in Wound Care at Monash University.

Deep into a second year of the COVID pandemic our communities are clearly fatigued by the resultant health and economic consequences. The Australian Charities and Not-for-Profits Commission recognise that charities are not immune from such implications. At a time where charities, including Footscape, are being relied upon more than ever, Australians have needed to tighten their purse strings in response to the economic downturn and this has created unprecedented financial stress on the sector.

COVID's impact on charities

Social Ventures Australia and the Centre for Social Impact (SVACSI) (2020) modelled that 88% of charities would immediately be making an operating loss and that 17% would be at high risk of closing their doors within six months. Equally, Chartered Accountants Australia and New Zealand (CAANZ) (2020) identified that in the initial months of the pandemic almost two thirds of Australian volunteers stepped down from volunteering and other unpaid work as a precaution against spreading COVID.

As a small charity at increased operational risk Footscape is likewise concerned by CAANZ's conclusion that a reduction in capacity has concurrently placed vulnerable people, who rely on the services and support of charities, in a very high-risk position.

In addition to this, SVACSI (2020) puts forward that for Australia to thrive, charities will need to grow, not shrink, in the recovery phase. Stronger charities will be well positioned to provide the services needed to support the community, accelerating our collective recovery. Weakened charities will be forced to cut jobs and services, which will compound the collective challenges we face.

Focus on Footscape

Footscape is fortunate to have received financial and material assistance throughout our twelve-year history from wonderful supporters including My Foot Doctor, Orthotech, Hanes and Active Feet. In recent times clinics including Fairfield Podiatry, Stance Podiatry and Active Health Podiatry have equally initiated valuable fundraising activities on our behalf.

Footscape continues to appeal for assistance from the podiatry sector to help maintain our project work. As a registered charity with the Australian Charities and Not-for-Profits Commission financial donations made by podiatrists are deemed tax deductible.

In keeping with this theme of partnership, SVACSI (2020) concludes that governments, philanthropists and charities need to work in partnership to ensure that our charities emerge stronger.

An announcement to share

In consideration of this collaborative need I'm thrilled to announce that Footscape has received new and significant support from the Banyule City Council for the 2021/22 Financial Year. A funded Footscape Support Officer position has been created through Banyule's Inclusive Employment Program for a twelve-month period. The employment program is intended to assist local people experiencing barriers to employment in a paid role tailored to an individual's areas of interest, goals, strengths and ability.

The successful candidate, Marjan, started her new role during September this year and her presence has already proved beneficial for all parties. Outcomes achieved to date include a monthly distribution record of over 2,000 pairs of footwear, pairs of socks and foot care kits.

These items have been provided to identified disadvantaged people who are encountering foot pathology issues including people who are experiencing homelessness, financial disadvantage, and/or seeking asylum, Aboriginal persons and victims of domestic violence. We acknowledge and thank Banyule City Council for their support. As such, the Footscape team is again feeling hopeful and optimistic about the coming period.

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Dr Steven Edwards is a registrar with the Australasian College of Podiatric Surgeons. He holds master's degrees in podiatric medicine from Queen Margaret University, Edinburgh and in Evidence-Based Health Care from the University of Oxford. He is endorsed to prescribe scheduled medicines. He has published over 20 papers in peer-review journals and mentors several post-graduate podiatrists undertaking scheduled medicines training.

POSTOPERATIVE PAIN MANAGEMENT INSIGHTS

By Dr Steven Edwards, Surgical Registrar

Registrar with the Australasian College of Podiatric Surgeons Dr Steven Edwards discusses the importance of multimodal therapy to improve post-surgical outcomes, and what the future for podiatrists and podiatric surgeons should look like in this respect.

Acute postoperative pain is a common event encountered by podiatrists and podiatric surgeons. Historically, foot and ankle surgery has been considered painful surgery, resulting in fear and avoidance amongst patients.[1,2] Whilst acute pain usually resolves with healing, failure to adequately control postoperative pain can significantly affect outcomes. These include prolonged recuperation, readmission to hospital, progression to chronic pain and delayed return to normal activities[3]. A key strategy for managing pain is the development and implementation of multimodal therapy, which has been demonstrated to have a good effect on short-term and long-term pain control.[4] General podiatrists, endorsed podiatrists, and podiatric surgeons all play a significant role in implementing and managing multimodal analgesia to improve post-surgical outcomes.

What is multimodal analgesia?

Each patient's pain management plan should be approached in a systematic and multimodal manner. Multimodal analgesia involves using various analgesic agents that have different mechanisms of action. This approach improves pain relief due to synergistic effects of other medications that can be achieved with reduced individual doses. Most importantly, this technique enhances patient satisfaction and minimises reliance and adverse events related to opioid use.[1,5] Depending on the podiatrist's endorsement, a stepwise approach can be considered in the early and ongoing acute postoperative pain management. Numerous pain medications can be included in multimodal therapy, including paracetamol, nonsteroidal anti-inflammatory drugs (NSAIDs), neuromodulatory medications (gabapentin and pregabalin), opioid agonists and glucocorticoids. Local anaesthesia techniques also provide excellent pain relief with very few adverse events.[2,3]

Medication options

Paracetamol is the mainstay of all pain management plans and is favoured due to its safety profile and ability to be easily augmented with other medications[2,6] During surgery, controlled tissue damage occurs, in

turn releasing prostaglandins which play an important role in inflammation, pain and fever.[7] Paracetamol exerts its analgesic effect by inhibition of central prostaglandin synthesis and modulation of inhibitory descending serotonergic pathways.[8] In the first instance it is recommended that paracetamol 1g orally, four to six hourly be prescribed. It should be kept in mind that a maximum of 4g in 24 hours is recommended. Alternatively, paracetamol modified-release can be taken. This is 1.33g orally every eight hours adhering to the same maximum safe dosage of 4g.[6] Careful monitoring of adjunctive products containing paracetamol is essential to avoid accidental overdosing.

If the pain is inadequately managed by paracetamol alone it is advised to add a nonsteroidal anti-inflammatory (NSAID) due to its synergistic effect where there is an inflammatory component. Depending on endorsement, podiatrists have access to a number of NSAIDs. Following the controlled trauma of the surgical episode, arachidonic acid is metabolised by cyclooxygenase (COX) to produce inflammatory mediators such as prostaglandins, prostacyclin and thromboxane.[7] NSAIDs inhibit synthesis of prostaglandins by inhibiting cyclo-oxygenase (COX) present as COX-1 and COX-2 enzymes. Whilst most NSAIDs are non-selective due to their inhibition of both pathways, there are selective COX-2 inhibitors also available.[2,8] Patient selection and factors are essential when looking to add NSAIDs to a drug regime. Those patients with cardiovascular disease are likely to experience adverse events such as increased blood pressure, fluid retention and increased risk of myocardial infarction or stroke. In these patients, short term use of up to five days is recommended. Patients with a history of gastrointestinal disease are also likely to experience adverse events with NSAIDs. In this instance, up to five days of use with a selective COX 2 inhibitor is advised. It's also imperative to ensure that patients are not concurrently taking aspirin. It is also advised to avoid NSAID use in patients with acute or chronic kidney disease due to the risk of haemodynamic instability.[2,8,9] NSAIDs are thought to increase the likelihood of osseous non unions. Studies have shown that short-term use of appropriate NSAIDs in the postoperative period (up to two weeks) was not associated with bony non-union in foot and ankle surgery.[9]

When the postoperative pain is moderate to severe it is warranted to consider an opioid analgesic as a means of breakthrough pain management.[6] Opioids act mainly at mu-opioid receptors in the CNS, reducing transmission of the pain impulse, and by modulating the descending inhibitory pathways from the brain.[2] Currently endorsed podiatrists and podiatric surgeons have limited options with respect to opioids. For acute pain management the combination of a weak opioid in the form of codeine is available. Options include combination products with paracetamol ranging from 8mg to 30mg and ibuprofen which has 12.8mg of codeine.[8] In both instances it is important to cease the baseline paracetamol or NSAID use if they are introduced. Following more extensive podiatric surgery immediate release of oxycodone is often utilised.

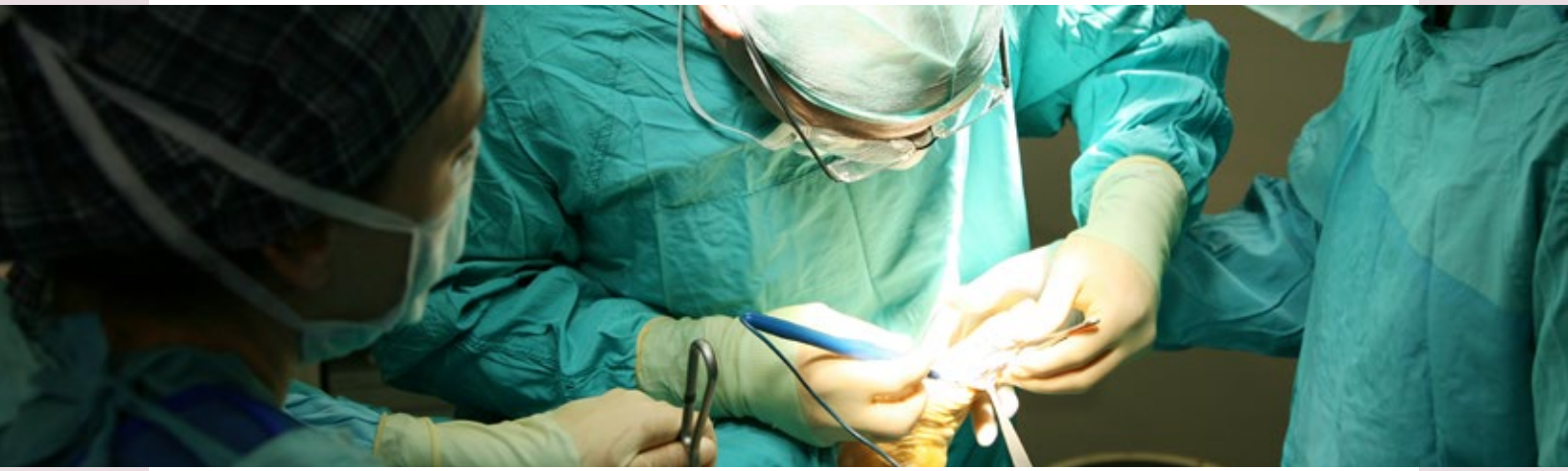
Currently Tapentadol is also used by many anaesthetists for post-surgical management. It has a dual mechanism of action which also involves noradrenergic pathways and opioid receptors. It has a relatively weak opioid effect and this is reflected in its lower incidence of morphine-like adverse effects.[8]

Multimodal pain management plans reduce the reliance on opioids and the associated adverse effects. These occur frequently amongst patients with increasing age, obesity, chronic obstructive pulmonary disease, obstructive sleep apnea and hepatic and renal impairment.[1] Common side effects of opioids include respiratory depression, itching, urinary retention, constipation, nausea, vomiting, euphoria, dysphoria and addiction and abuse.[8]

If there is suspicion of acute neuropathic pain, gabapentinoids such as pregabalin and gabapentin are an option. This however, requires concurrent management with the patient's GP or pain management specialist. Gabapentin and pregabalin act by blocking calcium channels, thereby inhibiting the transmission of pain in the central and peripheral nervous system. Gabapentinoids have been shown to both decrease postoperative pain and, secondarily, decrease opiate dependence.[2,6,8] Whilst they have been shown to be effective, no current consensus has been reached regarding the dosage and length of use postoperatively.[10]

Long acting regional blocks

Another important component of multimodal pain management is the use of long acting anaesthetic regional blocks at the time of surgery and during the postoperative period. The use of any regional anaesthesia lower limb techniques prior to major foot and ankle surgery has been proven to not only reduce postoperative pain but reduce opioid use and readmission due to pain.[4,12] The addition of dexamethasone administered preoperatively has been



shown to decrease narcotic consumption and improve pain control, without affecting wound healing.[5]

Who can supply and administer analgesics?

Currently in Australia a podiatrist's ability to manage pain is dictated by their registration and relevant endorsements.[11] General podiatrists can recommend the use of S3 medicines such as paracetamol and some non-selective NSAIDs. Endorsed podiatrists have a larger scope of medicines that includes further NSAIDs, corticosteroids, longer active local anaesthetics and weak opioid combination products such as Panadeine Forte. Depending on their state's poisons regulation, podiatric surgeons have access to further opioids however this is somewhat limited in comparison to their surgical scope. Currently in Australia, no endorsed podiatrist or podiatric surgeon has access to specific medications to manage acute neuropathic pain. The current system also makes direct referral to pain management specialists difficult as a GP referral is required.

Conclusion

All podiatrists and podiatric surgeons have a role in the management of acute postoperative pain. Adherence to multimodal pain management strategies have been shown to be effective and safe. The future for endorsed podiatrists and podiatric surgeons needs to entail a larger scope of medicines to ensure effective patient management along with the ability to work in direct conjunction with other specialities.

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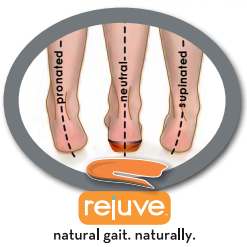

Are podiatry assistants covered under my insurance

Have an insurance question? Ask it here!

Q I have noticed more recruitment stress within the podiatry profession which seems to reflect similar patterns across other professions. This appears to be a combination of graduate shortages, border closures, no overseas recruitment and vaccination status (with staff refusing to be double vaccinated are being stood down). If I want to employ a podiatry assistant to help with my clinical load, what should I be aware of in terms of what they are insured to do? Are they covered under my Personal Indemnity cover for example, or do they need specific documented training to meet these kinds of insurance requirements?

A In response to your enquiry we can confirm that Allied Health Assistants (AHA) / NDIS Assistants are covered under your APodA policy if the supervising podiatrist is an APodA member with our insurance.

The AHA needs to act under direct supervision, direction or control of the APodA member. A home visit is also okay, as long as the AHA is working within the direction or plan set by the APodA podiatrist.

It's important to bear in mind that the supervising podiatrist can only delegate services within their individual scope of podiatry practice, based on their judgement of the assistant's knowledge and skill-set. Such coverage would all be subject to the Policy terms and conditions, which are in no way different for a podiatry assistant.

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DO YOU KNOW WHAT YOUR CASUAL EMPLOYEES ARE ENTITLED TO?

By Kain Hourn, APodA HR Advisory Service

Kain Hourn explores the nuances within a casual employee working engagement and advises podiatrists on how to best navigate this sometimes complex topic to ensure compliance with the Fair Work Act.

So, what exactly is a casual employee? Casual employees are a vital element of Australia's workforce but up until recently, there has been no clear definition of what a casual employee really is.

However, after recent changes to the Fair Work Act 2009 ('the Act'), casual employment is now clearly defined and there are also clear circumstances where a "regular" casual employee can be eligible to "convert" to permanent employment. While most modern awards already contained casual conversion provisions, a harmonised approach to casual conversion now exists under the Act. This article will explain casual employment and specifically – casual conversion – in more detail.

The true definition of a casual employee

The definition of a casual employee is now provided in the Fair Work Act 2009. Specifically, an individual is a casual employee if: an offer of employment is made on the basis that the employer makes no firm advance commitment to continuing and indefinite work according to an agreed pattern of work, and employment is accepted on that basis.

As such, an employer will offer work on an as-needs basis, but the employee can also accept or decline any work that is offered.

Casual employees lack the assurance of regular and ongoing work that permanent employees enjoy. However, they are entitled to receive a 25% casual loading which is intended to compensate them for this, as well as the paid annual and sick leave entitlements they do not receive.

All about 'casual conversion'

Recently, the most significant change to casual employment laws involves the addition of offers and requests for casual conversion within the Act, through which a casual employee may convert to permanent employment if they satisfy certain criteria.

An employee eligible for casual conversion has:

- Been engaged for at least 12 months continuous service
- For the most recent six months, worked a regular pattern of hours on an ongoing basis; and
- Could, without significant changes to their work pattern, continue to perform these hours on a permanent part-time or full-time basis.

What employers should consider

Let's look at how this change impacts employers.

For all business owners (other than small business owners), there is an obligation to offer casual conversion to your employees after they have performed 12 months' service, or you must outline the reasons why you are declining to offer casual conversion. This must be done formally in writing, and take place within 21 days of their 12-month anniversary of work.

If you decide not to make an offer, this needs to be justified by either outlining

that the employee/s:

- Have not worked a regular pattern of hours on an ongoing basis for the last 6 months which they could continue working as a permanent employee without significant changes; or
- The business has reasonable business grounds to decline to make an offer.

These reasonable business grounds include:

- In the next 12 months:
  - o the employee's position will not exist
  - o the employee's hours of work will significantly reduce
  - o the employee's days or time of work will significantly change, and this cannot be accommodated within their available days and hours to perform work
- The employer would have to make significant changes to the employee's hours of work for them to be engaged on a permanent part-time/full-time basis (i.e. they are not performing a regular pattern of hours)

A note for small business employers

Under the recent changes, there is no obligation to offer casual conversion to your casual employees when operating a small business with less than 15 employees. However, all casual employees will still retain the right to request casual conversion to permanent employment if they believe they meet the eligibility requirements for doing so.

What happens if an employee wants to request casual conversion?

In some situations, an employee can request casual conversion if they believe they meet the requirements, and they can make this request every six months.

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If they were told by their employer in the previous six months that no casual conversion offer will be made since they had not worked a regular pattern of work for six months, they can still request casual conversion if they have now reached the six month threshold of performing regular work.

How these changes fit real world scenarios

To give an example, a casual employee regularly performs work on Monday, Tuesday, and Thursday, performing four to six hours each day. While the hours they work each day or the shift commencement and finish times are not exactly the same, there is certainly an argument that they are engaged to perform a regular pattern of hours on an ongoing basis. As such, they would likely be eligible for casual conversion once they have completed 12 months' service.

Final thoughts

In summary, it is important for members to be aware of how a genuine casual employee should be engaged. Periodically reviewing employment contracts, payroll systems, and patterns of work will enable both employees and employers to keep on top of their casual conversion obligations.

Need more information?

For more assistance, please contact the APodA HR Advisory Service on **1300 620 641** or **hrhotline@podiatry.org.au**. As always, our online resources (including resources related to casual conversion) are available 24/7 at www.podiatry.org.au/member-resources/human-resources-portal.

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