**Band 6 MSK Competency Framework**

**Introduction**

Welcome to the Neuro-musculoskeletal (NMSK) physiotherapy Band 6 competency document at Homerton University Hospital NHS Foundation Trust. This booklet is designed to take you through what is expected from you as a rotation band 6 in MSK speciality. It is also intended to be a record of your development through your rotations via common pathologies check list, clinical reasoning forms and watched assessments development form.

We hope you will enjoy your rotations and use it as an opportunity to increase your confidence in managing NMSK conditions.

**Aims**

Within the clinical setting and with reference to holistic rehabilitation of patients/ clients with dysfunction arising principally from the NMSK systems, this document aims to develop participants practical physiotherapy skills and their ability to integrate clinical reasoning, justification of intervention, analysis of outcome and reflection to enhance clinical effectiveness.

Learning Objectives

1. Be able to conduct a thorough subjective examination which is bespoke to the needs of the individual patient and will allow the clinician to formulate:
   1. Pain Mechanisms
   2. S.I.N factors
   3. Differential diagnosis to test within the objective examination.
2. Be able to perform a well justified and structured objective examination which clearly tests the differential diagnosis formulated in the subjective examination.
3. Be confident and effective in the practical handling skills required to test those differential diagnosis.
4. Able to use available evidence to formulate a treatment plan to include likely prognosis which is both effective and efficient.
5. Reflect upon and critically analyse their management of neuro-musculoskeletal patients, including your exercise prescription, manual therapy and educational information given to patients as well as decision making regarding referral onwards to ESPs and consultant services, or back to GPs for medical management.

**Role of Supervisee**

1. Be an active participant in your progression.
2. Ensure you are documenting questions and cases as you go to help build a portfolio of case studies and review progress through your rotations.
3. Be proactive at arranging joint sessions (watched assessments)
4. Be open about your concerns or weaknesses so that you can focus on these during your rotations. Keep a track of pathologies you may not be seeing and take action to ensure you are getting exposure to the widest range of patients possible.
5. Ensure feedback is taken on board from your supervisor and actioned, e.g. reading particular literature on a certain pathology or watching a webinar, listening to a podcast.
6. Equally give feedback to your supervisor if they are not giving you appropriate supervision and time to complete your competencies.

**Role of Supervisor**

1. Ensure availability for supervision and ensure supervision is covered when you are on leave.
2. Ensure good communication skills when feeding back on cases or joint sessions, giving constructive feedback to the mentee on strengths and weaknesses.
3. Ensure time is given to complete joint sessions (watched assessment) and that these are documented properly, allowing the mentee to have time to improve their skills before the next session.
4. Encourage the mentee to reflect on cases and document these as they go.
5. Stay in regular communication through face to face or email available for queries.

**Please reflect on your knowledge in the following areas – including a SWOT analysis:**

**Subjective history taking including red flags, time, impact of psychosocial factors;**

**Clinical assessment including special tests;**

**Knowledge of rehabilitation, exercise prescription and pain mechanisms;**

**Knowledge of how to communicate to patients in a way they understand and challenge common myths about their condition;**

**Knowledge of medical masqueraders and when a patient may require referral back to GP;**

**Knowledge of basic rheumatological special questions;**

**Knowledge of orthopaedic treatments, when they may be indicated and how to rehabilitate following them;**

**Common Clinical Pathologies**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region** | **Pathology** | **Direct Supervision** | **Indirect Supervision** | **Confidence 0-5 at end of rotation** |
| Cervical Spine | Cervical Radiculopathy |  |  |  |
|  | Cervical spondylosis |  |  |  |
|  | Whiplash |  |  |  |
|  | Non-specific neck and arm pain |  |  |  |
|  | Myelopathy |  |  |  |
| Lumbar Spine | Lumbar Radiculopathy |  |  |  |
|  | Lumbar Spondylosis |  |  |  |
|  | Lumbar Stenosis |  |  |  |
|  | Lumbar Spondylolythesis |  |  |  |
|  | Cauda Equina |  |  |  |
| Shoulder | SAPS |  |  |  |
|  | Instability |  |  |  |
|  | Fracture |  |  |  |
|  | ACJ |  |  |  |
|  | OA/ Frozen shoulder |  |  |  |
| Hip | OA |  |  |  |
|  | FAI |  |  |  |
|  | GTPS |  |  |  |
| Knee | OA |  |  |  |
|  | Meniscal |  |  |  |
|  | PFJ |  |  |  |
|  | Patella tendon |  |  |  |
|  | ACL |  |  |  |
|  | Posterior lateral corner (PLC) |  |  |  |
| Elbow | Tennis Elbow |  |  |  |
|  | Golfers Elbow |  |  |  |
|  | Fracture |  |  |  |
| Foot and Ankle | PTTD |  |  |  |
|  | OA |  |  |  |
|  | Plantar Fasciosis |  |  |  |
|  | Tarsal Tunnel |  |  |  |
|  | Achilles |  |  |  |
| Wrist and hand | Tenosynovitis e.g De quervains |  |  |  |
|  | Carpal Tunnel |  |  |  |
|  | OA |  |  |  |
|  | Wrist sprains |  |  |  |
|  | Trigger finger |  |  |  |
|  | Mallet fingers |  |  |  |
|  | Volar plate injuries |  |  |  |
|  | Stable phalanx and metacarpal fractures |  |  |  |
| Pelvic Health | Pelvic pain in pregnancy |  |  |  |
|  | Post partum care |  |  |  |
|  | Basic continence management |  |  |  |
| Fracture clinic | Hand and wrist fractures |  |  |  |
|  | Shoulder and elbow fractures |  |  |  |
|  | Fractures of femur proximal tibia/fibular |  |  |  |
|  | Ankle fractures and distal tib/fib |  |  |  |
| Sports | Basic physiology of loading/strength/endurance |  |  |  |
|  | Muscle tear classification |  |  |  |
|  | Adapting rehabilitation to specific sports |  |  |  |
|  | Basics of plyometrics |  |  |  |
| Rheumatology | Understand basic screening questions |  |  |  |
|  | Knowledge of common inflammatory pathologies such as RA, gout, psoriatic arthritis, PMR/GCA. |  |  |  |
| Persistent pain | Physiological mechanisms (basic) |  |  |  |
|  | Explaining pain to patients |  |  |  |
|  | Resources available to give to patients |  |  |  |
|  | Referral criteria for pain service |  |  |  |
|  | Incorporating a holistic approach around managing chronic pain including pacing, impact around psychological factors in pain, graded exposure. |  |  |  |
| Misc | Communication issues such as scan requests/barriers to rehab |  |  |  |
|  | Stress fractures |  |  |  |
|  | RETS |  |  |  |
|  | Basics of tendon loading and treatments |  |  |  |
|  |  |  |  |  |

The above is a list of common pathologies that it is important to know the signs and symptoms as well as the objective testing that is required to diagnose them, common treatments for each and what to do if patients are not improving.

There may not be direct supervision for each, but it is important that you can talk around these so that your mentor is confident you can diagnose and treat appropriately.

A useful exercise would be to rate your confidence now and then after each rotation to see how you are progressing. This can highlight areas that you need to develop in further rotations and form the basis of objectives in their next rotation’s PDR.

**Checklist of practical skills required to be observed:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of the body** | **Test** | **Watched assessment (Date)** | **Comments/areas of further development** |
| **Cervical spine** | Palpation of joints, muscles, 1st rib including PIVMS and PAIVAMs and MWMs |  |  |
| **Thoracic spine** | Palpation of joints, muscles, ribs |  |  |
| **Lumbar spine** | Palpation of joints, muscles, PIVMs and PAIVMs |  |  |
| **SIJ** | Provocation tests |  |  |
| **Hip** | Range of motion |  |  |
|  | Muscle anatomy |  |  |
|  | Special tests – impingement, labral |  |  |
| **Knee** | Ligament testing including ACL/PCL/PLC/LCL/MCL |  |  |
|  | Cartilage testing |  |  |
| **Foot and Ankle** | Ligament testing |  |  |
|  | Biomechanical assessment including tests for tib post dysfunction, navicular drop |  |  |
| **Shoulder** | Instability testing – anterior and posterior |  |  |
|  | Rotator cuff assessment – palpation and muscle testing |  |  |
| **Elbow** | Knowledge of anatomy and palpation |  |  |
|  | Cubital tunnel assessment |  |  |
| **Wrist and Hand** | TFCC testing |  |  |
|  | CMCJ assessment |  |  |
|  | Carpal tunnel assessment |  |  |
|  | De Quervains assessment |  |  |
| **Neurological** | Upper limb neurology assessment |  |  |
|  | Lower limb neurology assessment |  |  |
|  | Upper motor neurone assessment |  |  |
| **Neurodynamic testing** | Assessment of understanding the tests, what they tests and what they don’t |  |  |
|  | Demonstrate each ULTT |  |  |
|  | Demonstrate SLR/Slump/femoral slump/nerve biases |  |  |

**Core Band 6 rotational competencies:**

|  |  |  |
| --- | --- | --- |
| **Element** | **Performance indicators** | **Performance evidence** |
| **Professional Behaviour** | | |
| **Operate within scope of practice** | Act within own knowledge base and scope of practice | Via supervision/case studies. Asking appropriate questions when uncertain of diagnosis etc. |
| Work towards increasing skills in the role including clinical reasoning, knowledge of pathologies, rehabilitation etc. | Via supervision/case studies. Presenting appropriate patients and reasoning through cases to justify treatment plans |
| **Display Accountability** | Take responsibility for own actions and decision making within the role, acknowledges where the boundaries of scope lies and asks for appropriate help from supervisors. | Via reflection of situations. Discussion with supervision cases that are complex and management plans are uncertain |
| **Communication** | | |
| **Engaging patients in their care** | Seek to elicit the patient preferences on their care, what is important to them regarding their treatment or goals (i.e. values) | Watched assessments  Discussion with supervisor |
|  | Seek to elicit information regarding the impact their condition has on their quality of life, mood, interactions with others etc. | Watched assessment  Liaising with psychologists within the team |
|  | Acknowledge their expertise or the expertise of their family/carers when dealing with patients with long term conditions | Watched assessment  Supervision discussions |
|  | Modify communication as necessary to reflect the patients understanding and health literacy. | Watched assessments |
|  | Identify barriers to engagement with activity/rehab/advice | Watched assessment  Discussion  Case studies |
| **Communication with supervisor** | Demonstrate clear and concise communication the supervisor when discussing patient care | Via supervision. Laying out pertinent points of the history and examination for the supervisor to clearly gain a picture of a patient. |
| Utilise and bring relevant patients for discussion with supervisor | Via supervision/case studies. Including joint assessments as well as discussing via notes. |
| **Communication with team** | Present relevant knowledge as part of teaching within Locomotor, as part of senior teaching, and as part of GP roadshows | Via presentations |
| **General administration** | To manage administration tasks appropriately and in a time sensitive fashion including; writing discharge letters, documentation in notes, referrals for shockwave, foot health and other services | Supervisor to check letters, content and timing |
| **Provision of care: Management, Intervention, Prevention** | | |
| **Obtain patient consent** | Explain the nature of ensuing assessment and check the patient agrees before proceeding | Via watched assessments |
| Consider patient’s capacity for consent and decision making. | Discus any issues with relevant parties e.g. adult protection, GPs and ESPs |
| Ensure strategies for overcoming barriers to informed consent are employed as much as possible | Explain during supervision regarding how information has been explained to patients, what other materials have been provided. |
| **Assessment and Examination** | Perform individualised, culturally appropriate subjective examination for common and complex conditions, including acknowledgement of psychosocial factors | Via watched assessments |
| Demonstrate knowledge via differential diagnoses and hypotheses following subjective history taking. Include any action regarding biopsychosocial factors. | Via watched assessments and reflection/case studies. Discussion in supervision regarding why a patient may be suitable for pain team intervention etc |
| Modify care and treatment packages based on factors that may impact care, such as patient preference | Discuss with supervisor any barriers that arise and what attempts have been made to rectify |
| Perform an individualised, culturally appropriate clinical examination for common and complex conditions including:   * Relevant clinical tests * Measurement of health indicators * Reasoning of how the clinical examination proves or disproves hypotheses * Adapting and modifying the assessment based on findings during assessment/ feedback from patients. | Via case studies and watched assessments. Discussion with supervisor when presenting cases. |
| Identify when input from other colleagues is required such as pain team members/ESP/GP or consultants. Act to obtain their input in a timely fashion | Via case studies and watched assessments |
| Ensure all red flags are identified during assessment either subjectively or objectively, link red flags to diagnoses not to be missed, and take appropriate and timely action regarding them | Via supervision, cases and watched assessment |
| **Apply appropriate clinical decision making** | Synthesize and interpret subjective and objective findings to confirm likely diagnosis | Via supervision, cases and watched assessment |
| Demonstrate sound clinical reasoning when implementing patient care package to include all relevant factors, including biopsychosocial elements. | Via supervision, cases and watched assessment |
| Demonstrate awareness of healthcare resources whilst achieving best outcomes. | Via supervision, cases and watched assessment |
| Demonstrate knowledge of current evidence and guidelines when implementing a patient care plan. | Via supervision, cases and watched assessment |
| **Formulate a management plan** | Ensure management and intervention plans are evidence based, and in collaboration with the patient, as determined by patient assessment and diagnosis. | Discussion with supervisor to demonstrate knowledge of guidelines and research papers. |
| Ensure guidance is sought from colleagues as necessary and act on their advice | Supervision/watched assessment |
| Continue to assess the requirement for referral onwards or follow up as necessary | Notes review, case studies, discussion with supervisor |
| Identify when other colleagues may be required to be involved in case such as foot health | Discussion with supervisor |
| Provide education and advice to patients to maximise understanding and self-management of their condition (including leaflets and online sources where appropriate) | Notes review, discussion with supervisor |
| Provide education regarding smoking cessation, obesity, lifestyle choices with regards to impact on MSK conditions or refer to appropriate service e.g. smoking cessation/dietician/exercise on prescription | Documentation/referrals onwards – notes review |
| Ensure thorough hand over to other professionals as necessary | Review of notes and letters |
| **Monitoring and escalation** | Ensure monitoring of a patients progress throughout their journey, using appropriate physical examination, outcome measures etc. | Review of patient notes, discussion with supervisor |
| Respond to any atypical presentations that arise when implementing management plans or interventions | Discussion with supervisor, a studies, notes review |
| Seek colleagues’ opinions if response to management plans/interventions is not progressing as expected. | Discussion with supervisor, documentation of discussions with GPs, MDMs etc. |
| Identify when it is appropriate to refer to the MDMs or ESPs | Discussion with supervisor |
| **Document patient information** | Ensure notes/letters are an accurate legal representation of the total assessment and intervention, identifying areas of risk and consent. | Notes review using CSP/HCPC and local standards. |
| **Specific rotation competencies** | | |
| **Sports rotation** | To understand the British athletics classification of muscle injuries, including its implications for prognosis and rehabilitation programme design. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| To be able to understand theoretical concepts regarding return to sport post injury / surgery and how they inform individualised rehabilitation programmes, including testing for readiness to return to sport. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| To be aware of resistance training programme design and how variables can be manipulated to facilitate muscle growth, strength and power. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| To understand the basics of assessing and rehabilitating plyometrics and agility-based capability. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| To understand the basics regarding the assessment of running gait and implementation of return to running rehabilitation strategies. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| To understand the British athletics classification of muscle injuries, including its implications for prognosis and rehabilitation programme design. | Notes review, patient outcome, discussion with supervisor. Feedback to supervisor regarding appropriate literature. |
| **Virtual Fracture Clinic Rotation (MSKL)** | Physio will go through clinical notes and images with orthopaedic consultant and therefore should be able to navigate and interpret relevant information sources and effectively communicate this to orthopaedic consultants | Notes review, patient outcome, discussion with supervisor, case studies |
| To be able to complete a safe and effective remote consultation during the virtual fracture clinic whilst having an awareness of patient pathways if further management is required. | Notes review, patient outcome, discussion with supervisor, case studies |
| To be able to identify and appropriately assess red flags during remote consultations and seek support from supervisor and/or medical team if further management and or investigation is required beyond scope of practice. | Notes review, patient outcome, discussion with supervisor, case studies |
| To develop awareness of the data management, clinical governance and safeguarding considerations that come with remote consultations. | Notes review, patient outcome, discussion with supervisor, case studies. |
| **Spinal class rotation** | To develop increased knowledge in common spinal pathologies such as spondylolisthesis, stenosis, radiculopathy | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To improve knowledge in rehabilitation strategies for common spinal pathologies including exercise prescription, manual therapy | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To recognise serious spinal pathology including infection, fracture, myelopathy, metastatic spinal cord compression, cauda equina and to know the management of these conditions including local and national pathways | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| Understand the evidence around management of common spinal conditions including NICE, GIRFT, Cochrane reviews, and explain these to patients, improving their understanding of conditions and improving self efficacy. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To develop knowledge of when referring onwards for imaging may be appropriate for the patient. | Discussion with supervisor, case studies, ESP question time. |
| **Knee class rotation** | To understand up to date information regarding osteoarthritis pathology and be able to explain this to patients in a clear understandable way | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To understand patellofemoral dysfunction, evidence-based loading programmes and other treatments suitable to treat this condition | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To have an understanding of when injection therapy is required for treatment in osteoarthritis and the common contraindications associated with them. To provide the injection leaflets to patients as required. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To effectively communicate and encourage self efficacy in patients with osteoarthritis and how to manage the condition long term, e.g. flare up management, managing expectations. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To have an understanding of all relevant up to date guidelines around knee pathologies and trauma including NICE, GIRFT, Cochrane reviews. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| **Shoulder class rotation** | Provide appropriate rehabilitation programmes adapted to a patients particular conditioning level, occupation, or sport, being able to demonstrate progression of low-level rehabilitation to higher level rehabilitation with appropriate evidence base where possible. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To provide education at an appropriate level for patients to develop self efficacy in managing their shoulder condition, how to progress or regress rehabilitation during flare ups and mange the condition long term | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| Understand the time frames involved in rehabilitation to set expectations with patients. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To develop knowledge of when referring onwards for imaging and other treatments may be required for the patient. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To demonstrate an understanding of appropriate outcome measures used in shoulder rehabilitation and audit outcomes of the class. | Presentation at audit morning. Notes review. Discussion with supervisor. |
| **Shockwave rotation** | To understand the indications, contraindications, effects and side effects of shockwave therapy. | Notes review, patient outcome, discussion with supervisor, case studies |
| To provide education to patients around shockwave, loading and how patients can improve their condition, developing patient self efficacy. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To be able to treat a variety of conditions with shockwave, understanding how to progress treatment as required. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To be able to demonstrate a clear knowledge of anatomical tendon insertions and bony landmarks for adequate application of shockwave | Observation during class |
| To be aware of the evidence surrounding the use of shockwave in various common conditions. | Notes review, patient outcome, discussion with supervisor, case studies. Observation during class |
| To ensure all relevant outcome measures are collected and audited appropriately. | Presentation at audit morning. |
| **Hand rotation** | To provide assessment and differential diagnosis of mallet finger, volar plate injuries, phalanx and metacarpal fracture, Dupuytren’s, OA thumb and trigger fingers | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessments |
| To be able to provide adequate exercise provision, activity modification advice for the above conditions | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessments |
| To be able to provide appropriate splinting for mallet finger, volar plate injuries, phalanx and metacarpal fractures, Dupuytren’s, OA thumb and trigger finger | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessments |
| **Pain rotation** | Understand the difference between primary and secondary persistent pain. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| Have a good understanding of different pain mechanisms as well as peoples’ responses to pain. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| To confidently carry out an individual/MDT assessment of the patients with complex pain presentations and to be able to decide on the suitability for pain management based on assessment findings, including the relative weight of biopsychosocial issues. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. MDM discussions |
| Demonstrate an understanding of the complex and overlapping influences of thoughts, emotions, and body sensations and how they influence behaviour. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. MDM discussion |
| To be able to explain persistent pain in a language/other media, that are understandable for the patient and in a way that also validates the patient’s experience. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| Have a basic understanding of the principles of persistent pain management and how this differs from MSK Physiotherapy | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| Ensure a basic understanding of Acceptance Commitment Therapy and how this underpins a holistic pain management approach. | Attendance at ACT/CBT training. Notes review, MDM discussion/CPD. |
| Ensure an understanding of local psychological therapy options for patients with varying presentations such as trauma, PTSD, talk changes | MDM discussion, discussion with psychologists in the pain team. |
| Understand some common persistent pain conditions e.g., Fibromyalgia, Hypermobility Syndrome, Inflammatory arthritis, non-specific lower back pain, functional overlay, CRPS | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| Understand the importance of active listening, empathy and adapting communication to the needs of each pain patient. | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| To be able to tailor physiotherapy input to the unique needs of each patient based on their pain presentation, thoughts, fears, behaviours, culture, language, preferences and goals | Notes review, patient outcome, discussion with supervisor, case studies. Watched assessment, CPD. |
| **Pelvic Health rotation** | To develop increased knowledge in common obstetric MSK conditions | Via supervision, cases and watched assessment |
| To develop increased knowledge in common pelvic floor dysfunction conditions and how to assess/rehab | Via supervision, cases and watched assessment |
| Understand the evidence around management of pelvic floor dysfunction including NICE, Cochrane reviews, and explain these to patients, improving their understanding of conditions and improving self efficacy. | Via discussion with supervisor, case studies |
| To develop knowledge of when referring onwards may be appropriate for the patient (gynaecology, urology, colorectal and sexual health clinic) | Via discussion with supervisor, case studies |
| Service and Professional Development | | |
| **Evidence based practice** | Ensure continued knowledge of up-to-date evidence-based practice in the form of general guidance such as NICE, Cochrane reviews but also latest literature. | Review of notes and discussion with supervisor |
| **Monitor outcomes** | Be involved in collection of data (e.g. outcome measures), take part in audits, service evaluation or research to monitor effectiveness of the service an individual treatments. | Presentation of audits of service developments |
| **Service improvement** | Actively engage when deficiencies are identified in service improvement initiatives | Taking part in senior meetings, undertaking project work |
| **Documenting CPD and learning** | Document individual learning/interesting cases/CPD courses as required by CSP and HCPC and other governing bodies. | Take part in case review sessions in journal club |
| **Reflective practice** | Regularly document reflections on learning and cases seen.  Actively engage in supervision to ensure these sessions are productive and informative as possible. | CPD portfolio  Presentation at journal club  Discussion with supervisor |

**Joint Session/Watched assessment record.**

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| --- |
| **Date:**  **Mentee Name:**  **Menter Name:**  **HCPC no:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Grades | **I** – Insufficient evidence | **N** – Needs further development | **C** - Competent | **E** - Excellent |

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| --- | --- | --- |
| **Criterion** | **Grade** | **Evidence** |
| Discovers the reason for the patient's attendance | | |
| Encourages the patients contribution? |  |  |
| Responds to patient cues? |  |  |
| Places presenting problem in appropriate psychosocial context if appropriate? |  |  |
| Explores patient's health understanding? |  |  |
| Defines the clinical problem | | |
| Includes/excludes likely relevant significant condition? E.g. red flags |  |  |
| Appropriate physical examination? i.e tests were selected appropriately? |  |  |
| Appropriate handling during physical examination? |  |  |
| Uses appropriate outcome measures including PROMS and PREMS, along with objective markers as required? |  |  |
| Makes appropriate working diagnosis? Was clinical reasoning clear? |  |  |
| Deficits clearly defined to enable rehab goals to be identified? E.g. in the analysis and plan section of the notes |  |  |
| Explains the problem to the patient | | |
| Explains the problem in appropriate language for that individual patient? Was the; what you have, what they can do, what we can do and time frames of how long it may take to improve, given to the patient? Is there going to be resolution or is this a longer term condition? |  |  |
| Addresses the patient's problem | | |
| Seeks to confirm the patient's understanding and answers questions from the patient appropriately? |  |  |
| Makes an appropriate management plan? Can they justify, physio vs referral onwards appropriately? |  |  |
| Patient is given the opportunity to be involved in significant management decisions? Shared decision-making principles adhered to? |  |  |
| Makes effective use of the consultation | | |
| Diagnosis and interval for follow up are specified? |  |  |
| Makes effective use of resources? Were there signposts to appropriate reading material or exercises given – this can be written exercises not necessarily printed. |  |  |
| Documentation | | |
| Appropriate documentation including concise subjective and objective examination? |  |  |
| Documentation does not include unnecessary abbreviations and conforms to HCPC/CSP and local standards? |  |  |

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| --- |
| **Feedback & recommendations for further development** (think about communication during subjective, how questions are asked, could it be more succinct, how tests were performed, what tests selected and again was this appropriate, then how things were explained to patient, shared decision making and appropriate management. Also acknowledge the things done well!)**:** |

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| --- |
| **Agreed action** (for example, you may recommend reading material/evidence based literature, a different way of handling for a particular test, different tests to look up, communication tips and what to read or practice, different exercises, possibly different weekend courses): |

**Case based reflection form.**

|  |
| --- |
| **Date Seen:** |
| **What happened – brief description – presenting problem?** |
| **Differential diagnoses and your clinical reasoning** |
| **Reflection – what did you learn?** |
| **Impact on your practice – what will you do the same or differently next time and why?** |
| **If discussed with Supervisor: Supervisor’s comments – competencies demonstrated, learning points?** |

**Clinician name:**

**Clinician Signature:**

**Supervisors name:**

**Supervisor signature:**

**Date:**

**Appendix 1: Questions a patient wants answered! (Taken from MSK core capabilities – Skills for Health)**

**The problem and its impact**

• What is wrong? Why? What is the cause?

• What will happen to me? What is the possible impact on my health and function?

• Will I get better or worse?

• Is it curable?

• How long will it take to get better?

**The management of the problem**

• What are you (the health professional) able to do about my problem?

• What is the treatment that is most appropriate for me?

• What can I do to help myself to alleviate it?

• How can I reduce or control my pain?

• How can I maintain my function and do the things I want to and need to do?

**The practical questions**

• Where can I get more information?

• Where and how can I get support to help myself?

• What activities can I do and how should I adapt them (e.g. sports, driving, work)?

**The future**

• What’s the next step?

• Do I need to come back for a review?

• Am I going to see the same health practitioner?

• If little improvement

— Will I get back to doing what I want or need to do?

— Why am I not improving? Where have I gone wrong?

— Am I doing the right things?

— Am I doing myself damage?

— Am I receiving the best treatment

— Is there support where I can share and learn from experiences?

— Are there any other treatments available? What else can I try?

• When am I able to do various tasks important to me (e.g. work, exercise, driving)?

**Appendix 2: Learning Styles assessment**

**Learning styles questionnaire**

The following questionnaire has been adapted from Honey and Mumford (1992) *The Manual of Learning Styles,* Maidenhead, Ardingley House.

This questionnaire is designed to find out your preferred learning style(s). Over the years you have probably developed learning ‘habits’ that help you benefit more from some experiences than from others. Since you are probably unaware of this, this questionnaire will help you pinpoint your learning preferences so that you are in a better position to select learning experiences that suit your style.

There is no time limit to this questionnaire. It will probably take you 10 to 15 minutes. The accuracy of the results depends on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with the statement, put a tick (􀀳) against the appropriate number on the score sheet. If you disagree more than you agree, put a cross (x) against the appropriate number on the score sheet. Be sure to mark each item with either a tick or cross.

1 I have strong beliefs about what is right and wrong, good and bad.

2 I often act without considering the possible consequences.

3 I tend to solve problems using a step-by-step approach.

4 I believe that formal procedures and policies restrict people.

5 I have a reputation for saying what I think, simply and directly.

6 I often find that actions based on feelings are as sound as those based on careful thought and analysis.

7 I like the sort of work where I have time for thorough preparation and implementation.

8 I regularly question people about their basic assumptions.

9 What matters most is whether something works in practice.

10 I actively seek out new experiences.

11 When I hear about a new idea or approach I immediately start working out how to apply it in practice.

12 I am keen on self-discipline such as watching my diet, taking regular exercise, sticking to a fixed routine, etc.

13 I take pride in doing a thorough job.

14 I get on best with logical, analytical people and less well with spontaneous ‘irrational’ people.

15 I take care over the interpretation of data available to me and avoid jumping to conclusions

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16 I like to reach a decision carefully after weighing up many alternatives.

17 I’m attracted more to novel, unusual ideas than to practical ones.

18 I don’t like disorganised things and prefer to fit things into a coherent pattern.

19 I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.

20 I like to relate my actions to a general principle.

21 In discussions I like to get straight to the point.

22 I tend to have distant, rather formal relationships with people at work.

23 I thrive on the challenge of tackling something new and different.

24 I enjoy fun-loving, spontaneous people.

25 I pay meticulous attention to detail before coming to a conclusion.

26 I find it difficult to produce ideas on impulse.

27 I believe in coming to the point immediately.

28 I am careful not to jump to conclusions too quickly.

29 I prefer to have as many sources of information as possible – the more data to think over the better.

30 Flippant people who don’t take things seriously enough usually irritate me.

31 I listen to other people’s points of view before putting my own forward.

32 I tend to be open about how I’m feeling.

33 In discussions I enjoy watching the manoeuvrings of the other participants.

34 I prefer to respond to events on a spontaneous, flexible basis rather than plan things out in advance.

35 I tend to be attracted to techniques such as network analysis, flow charts,

branching programmes, contingency planning etc.

36 It worries me if I have to rush out a piece of work to meet a tight deadline.

37 I tend to judge people’s ideas on their practice merits.

38 Quiet, thoughtful people tend to make me feel uneasy.

39 I often get irritated by people who want to rush things.

40 It is more important to enjoy the present moment than to think about the past or future.

41 I think that decisions based on a thorough analysis of all the information are sounder than those based on intuition.

42 I tend to be a perfectionist.

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43 In discussions I usually produce lots of spontaneous ideas.

44 In meetings I put forward practical realistic ideas.

45 More often than not, rules are there to be broken.

46 I prefer to stand back from a situation and consider all the perspectives.

47 I can often see inconsistencies and weaknesses in other people’s arguments.

48 On balance I talk more than I listen.

49 I can often see better, more practical ways to get things done.

50 I think written reports should be short and to the point.

51 I believe that rational, logical thinking should win the day.

52 I tend to discuss specific things with people rather than engaging in social discussion.

53 I like people who approach things realistically rather than theoretically.

54 In discussions I get impatient with irrelevancies and digressions.

55 If I have a report to write I tend to produce lots of drafts before settling on the final version.

56 I am keen to try things out to see if they work in practice.

57 I am keen to reach answers via a logical approach.

58 I enjoy being the one that talks a lot.

59 In discussions I often find I am a realist, keeping people to the point and avoiding wild speculations.

60 I like to ponder many alternatives before making up my mind.

61 In discussions with people I often find I am the most dispassionate and objective.

62 In discussions I’m more likely to adopt a ‘low profile’ than to take the lead and do most of the talking.

63 I like to be able to relate current actions to a longer-term bigger picture.

64 When things go wrong I am happy to shrug it off and ‘put it down to experience’.

65 I tend to reject wild, spontaneous ideas as being impractical.

66 It’s best to think carefully before taking action.

67 On balance I do the listening rather than the talking.

68 I tend to be tough on people who find it difficult to adopt a logical approach.

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69 Most times I believe the end justifies the means.

70 I don’t mind hurting people’s feelings so long as the job gets done.

71 I find the formality of having specific objectives and plans stifling.

72 I’m usually one of the people who puts life into a party.

73 I do whatever is expedient to get the job done.

74 I quickly get bored with methodical, detailed work.

75 I am keen on exploring the basic assumptions, principles and theories underpinning things and events.

76 I’m always interested to find out what people think.

77 I like meetings to be run on methodical lines, sticking to a laid down agenda, etc.

78 I steer clear of subjective or ambiguous topics.

79 I enjoy the drama and excitement of a crisis situation.

80 People often find me insensitive to their feelings.

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**Learning Styles Questionnaire – Scoring**

You score one point for each item you ticked (􀀳).

There are no points for items you crossed (x).

|  |  |  |  |
| --- | --- | --- | --- |
| Simply indicate on the list below which items were ticked. 2 | 7 | 1 | 5 |
| 4 | 13 | 3 | 9 |
| 6 | 15 | 8 | 11 |
| 10 | 16 | 12 | 19 |
| 17 | 25 | 14 | 21 |
| 23 | 28 | 18 | 27 |
| 24 | 29 | 20 | 35 |
| 32 | 31 | 22 | 37 |
| 34 | 33 | 26 | 44 |
| 38 | 36 | 30 | 49 |
| 40 | 39 | 42 | 50 |
| 43 | 41 | 47 | 53 |
| 45 | 46 | 51 | 54 |
| 48 | 52 | 57 | 56 |
| 58 | 55 | 61 | 59 |
| 64 | 60 | 63 | 65 |
| 71 | 62 | 68 | 69 |
| 72 | 66 | 75 | 70 |
| 74 | 67 | 77 | 73 |
| 79 | 76 | 78 | 80 |
| TOTALS | | | |
| Activist | Reflector | Theorist | Pragmatist |

Theorist - ‘convince me’ learners who want reassurance that a project makes sense.   
These learners like to understand the theory behind the actions. They need models, concepts and facts in order to engage in the learning process. Prefer to analyse and synthesise, drawing new information into a systematic and logical 'theory'.

* models
* statistics
* stories
* quotes
* background information
* applying theories

Reflector - ‘tell me’ learners who prefer to be thoroughly briefed before proceeding.

These people learn by observing and thinking about what happened. They may avoid leaping in and prefer to watch from the sidelines.  Prefer to stand back and view experiences from a number of different perspectives, collecting data and taking the time to work towards an appropriate conclusion.

* paired discussions
* self analysis questionnaires
* personality questionnaires
* time out
* observing activities
* feedback from others
* coaching
* interviews

Pragmatist - ‘show me’ learners who prefer demonstration from an acknowledged expert.  
These people need to be able to see how to put the learning into practice in the real world. Abstract concepts and games are of limited use unless they can see a way to put the ideas into action in their lives. Experimenters, trying out new ideas, theories and techniques to see if they work.

* time to think about how to apply learning in reality
* case studies
* problem solving
* discussion

Activist - `hands on learners’ who prefer to have a go and learn through trial and error.

Activists are those people who learn by doing. Activists need to get their hands dirty, to dive in with both feet first. Have an open-minded approach to learning, involving themselves fully and without bias in new experiences.

* brainstorming
* problem solving
* group discussion
* puzzles
* competitions
* role-play

**Appendix 2: Suggestions for outline of Case Studies/Feedback**

Age and sex of patient (eg this is a 65 year old lady)

**A person in a body

Description automatically generated**

**Area of body** – body chart

Nature

? other symptoms

Related areas

Constant/intermittent

Severity  
Subjective History – 3 most important findings (asterisk signs)

1

2

3

Other important information (eg Results of investigations, consultant visits, medications, medical conditions)

Objective Examination – 3 most important findings (asterisk signs), did they reproduce pain

1

2

3

Severity: Irritability: Nature:

|  |  |  |
| --- | --- | --- |
| **Provisional Diagnosis** | **Reasons for** | **Reasons against** |
|  |  |  |
|  |  |  |
|  |  |  |

Pain Mechanisms present:

Treatment so far and response:

Reason for seeking assistance: (eg referral to consultant, reassurance that on the right track, further treatment options, etc)

Prognosis:

Suggestions (from senior or how you propose progressing management):