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Aldous, S., Comer, C., Cox, F., Draycott, S., Flynn, K., Flynn, Jonathan, Tulwa, S., Watts, F. and Williams, L.

Musculoskeletal rotation(s): Physiotherapy Band 5 skills and objectives

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MUSCULOSKELETAL ROTATION(S)

Physiotherapy

Band 5 Skills & Objectives ...

The Leeds Teaching Hospitals 
NHS Trust

Name:

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Instructions for Use

This pack has been designed to structure your learning in the musculoskeletal (MSK) field within secondary care. This will be achieved through completing core and individual objectives and assessing your clinical skills and level of supervision required during the rotation. It is expected that all band fives will reach a minimum of level two by the end of an MSK rotation, however those who are more experienced and working towards band six positions should be aiming for level three. This pack should be taken to each MSK rotation and kept within the hospital at all times during your rotation. It is recommended you photocopy sections at the end of each rotation and add them to your Knowledge and Skills Framework (KSF) folder. This should provide evidence for sections HWB6 and HWB7.

Below is a step by step guide of how to get the most out of this pack.

1. At the beginning of each rotation complete the self assessment of your clinical skills that are relevant to the rotation, using the clinical skills rating sheet e.g the knee and ankle skills when starting the gym rotation and the shoulder and spinal sections when in outpatients. Please note specialist shoulder input is provided in SJUH outpatients, and specialist spinal input at LGL outpatients, although you will have a mixed case load on each rotation.

2. Use your self assessment to highlight weaker areas so that you can structure your background reading and focus your individual objectives towards areas that need improvement.

3. Book in your first observed assessments and notes review within the first month of your rotation. Ensure the correct paperwork is completed by your senior at the time, this may also include rating any clinical skills you have demonstrated during the assessments or knowledge and understanding you demonstrate during discussions afterwards.

4. At anytime during your rotation take the opportunity to have your clinical skills assessed, either through problem patient discussions, observed assessments, IST, or joint treatment sessions.

5. Complete the midway section of your appraisal paperwork.

6. Arrange your second observed assessment and notes review during the last month of the rotation. Ensure your senior completes the necessary paperwork.

7. Complete your self assessment of clinical skills at the end of the rotation prior to your final appraisal. You will also be rated on level of supervision required during the rotation, which assesses other skills not just clinical skills. This will give you a rating for the whole rotation. Ensure you complete the final section of your appraisal.

8. Photocopy appraisal paperwork and send onto Band 5 co-ordinator.

9. Look back and see how much you have progressed!!

Objectives



Core Objectives

Core Objectives	Key Results	How to be achieved	Timescale	Lead Roles
<p>To have at least two patient assessments observed by a senior member of staff during the rotation</p> <p>To critically evaluate at least two sets of patient notes with a senior member of staff</p> <p>To fulfil either a presentation or complete a project by the end of the rotation</p> <p>Observe at least one full patient assessment, including clinical discussion, by a senior member of staff</p> <p>To actively participate in problem patient discussions which will take place a minimum of once every two weeks</p>	<p>Ability to reflect and be able to develop skills</p> <p>To recognise the importance of clinical reasoning</p> <p>Presentation skills and self motivation</p> <p>Learn from more experienced staff and develop new skills</p> <p>Learn advanced clinical reasoning and improve patient care</p>			

Individual Objectives

Individual Objectives	Key Results	How to be achieved	Timescale	Lead Roles

Individual Objectives- Continued

Individual Objectives	Key Results	How to be achieved	Timescale	Lead Roles

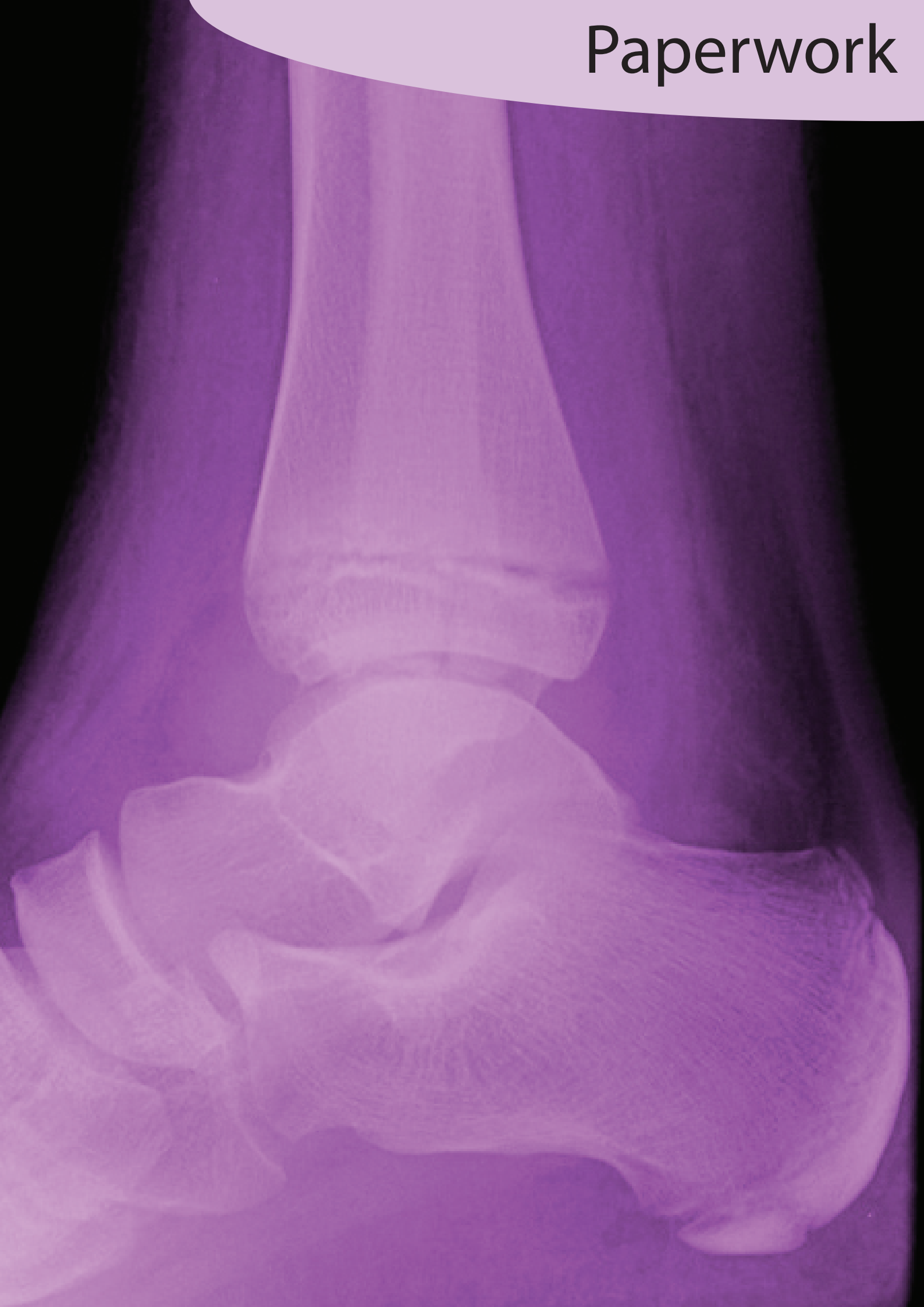
Individual Objectives- Continued

Individual Objectives	Key Results	How to be achieved	Timescale	Lead Roles

Individual Objectives- Continued

Individual Objectives	Key Results	How to be achieved	Timescale	Lead Roles

Paperwork



The Leeds Teaching Hospitals Trust
Staff Appraisal Form

Name:

Dates of Rotation

Rotation

Team Leader

Appraiser

LGI managed staff send to:

SJUH managed staff send to:

Christine Passingham
Child Therapy
A Floor
Clarendon Wing
LGI

Peter Lower
Physiotherapy Department
Chancellor Wing
SJUH

Please send within two weeks of completing the rotation

RETAIN COPY FOR CPD FILE

LEARNING OUTCOMES ALREADY MET

LEARNING OUTCOMES TO BE COMPLETED

APPRAISERS COMMENTS

APPRAISEES COMMENTS

Appraisal Conclusions

Skills and Knowledge gained

1 Communication

2 Personal and people development

3 Health, safety and security

4 Service improvement

5 Quality

6 Equality and diversity

HWB6

HWB7

What action is necessary to support further development

Final appraiser comments

Final appraisee comments

Appraiser signature and date

Appraisee signature and date

Rotation Feedback

Date.....

Rotation.....

1. INDUCTION PACK

☐

POOR

☐

AVERAGE

☐

GOOD

☐

EXCELLENT

COMMENTS

.....

2. ORIENTATION TO DEPARTMENT/WARD

☐

POOR

☐

AVERAGE

☐

GOOD

☐

EXCELLENT

COMMENTS

.....

3. INSERVICE TRAINING

TOPIC	POOR	AVERAGE	GOOD	EXCELLENT

FURTHER COMMENTS/OTHER USEFUL TOPICS

.....

.....

4. SENIOR SUPPORT

	POOR	AVERAGE	GOOD
APPROACHABLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUPPORTIVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AVAILABLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
APPROPIATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS

.....

5. WORKLOAD

☐ TOO BUSY ☐ JUST RIGHT ☐ TOO QUIET

COMMENTS

.....

6. COMMENTS

.....

.....

.....

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PLEASE RETURN WITH YOUR APPRAISAL FORM WITHIN 2 WEEKS
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Peer Review

Reviewee:

Date:

Reviewer:

1. Observed Ax / Rx / Case presentation

Subjective

Objective

Clinical reasoning

2. Knowledge of best practice and current developments within the speciality

Peer review (Cont)

3. does the documentation reflect the intervention in a logical, sequential manner? Is evidence of documented clinical reasoning

4. Reviewees objectives	Recommended action plan

5. Any other comments (reviewer or reviewee)

Signature of reviewee:

Date

Signature of reviewer:

Date

Peer Review

Reviewee:

Date:

Reviewer:

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Signature of reviewee:

Date

Signature of reviewer:

Date

Patient Record Review

Date:

Notes are legible, signed, dated and in black ink.

☐

Subjective Assessment

Presenting condition/ main problems

☐

Relevant history of presenting complaint

☐

Past medical history/allergies/contraindications

☐

Current medications

☐

Social / family / lifestyle as applicable.

☐

Relevant investigations

☐

Patient's expectations/goals

☐

Objective Assessment

Observation

☐

Use of specific assessment tools/techniques

☐

Palpation/handling

☐

Content of examination relevant to subjective information

☐

Content of examination relevant to stage of injury/operation

☐

Analysis

Identification of subjective markers

☐

Identification of objective markers

☐

Problem List

☐

Treatment Plan relating to problem list/patient goals

☐

Clinical Diagnosis/Impression

☐

Implementation

Interventions are implemented according to treatment plan

☐

Advice/information given to patient is recorded

☐

Record of any equipment given/loaned to patient

☐

Evaluation

Treatment plan is reviewed at each session

☐

Subjective markers reviewed

☐

Objective markers reviewed

☐

Evidence of clinical reasoning with progression

☐

Changes to treatment plan are documented

☐

Discharge/transfer of care.

Arrangements for transfer or discharge are recorded

☐

Discharge summary/letter to consultant

☐

Problem list signed off.

☐

Name and unit number/DOB on each page

☐

Sig Reviewer

Sig Reviewee

Patient Record Review

Date:

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☐

Subjective Assessment

Presenting condition/ main problems

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Past medical history/allergies/contraindications

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Current medications

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Social / family / lifestyle as applicable.

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Relevant investigations

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Patient's expectations/goals

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Objective Assessment

Observation

☐

Use of specific assessment tools/techniques

☐

Palpation/handling

☐

Content of examination relevant to subjective information

☐

Content of examination relevant to stage of injury/operation

☐

Analysis

Identification of subjective markers

☐

Identification of objective markers

☐

Problem List

☐

Treatment Plan relating to problem list/patient goals

☐

Clinical Diagnosis/Impression

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Implementation

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Advice/information given to patient is recorded

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Record of any equipment given/loaned to patient

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☐

Subjective markers reviewed

☐

Objective markers reviewed

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Changes to treatment plan are documented

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Arrangements for transfer or discharge are recorded

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Discharge summary/letter to consultant

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Problem list signed off.

☐

Name and unit number/DOB on each page

☐

Sig Reviewer

Sig Reviewee

Patient Record Review

Date:

Notes are legible, signed, dated and in black ink.

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Relevant investigations

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Patient's expectations/goals

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Observation

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Sig Reviewer

Sig Reviewee

Patient Record Review

Date:

Notes are legible, signed, dated and in black ink.

☐

Subjective Assessment

Presenting condition/ main problems

☐

Relevant history of presenting complaint

☐

Past medical history/allergies/contraindications

☐

Current medications

☐

Social / family / lifestyle as applicable.

☐

Relevant investigations

☐

Patient's expectations/goals

☐

Objective Assessment

Observation

☐

Use of specific assessment tools/techniques

☐

Palpation/handling

☐

Content of examination relevant to subjective information

☐

Content of examination relevant to stage of injury/operation

☐

Analysis

Identification of subjective markers

☐

Identification of objective markers

☐

Problem List

☐

Treatment Plan relating to problem list/patient goals

☐

Clinical Diagnosis/Impression

☐

Implementation

Interventions are implemented according to treatment plan

☐

Advice/information given to patient is recorded

☐

Record of any equipment given/loaned to patient

☐

Evaluation

Treatment plan is reviewed at each session

☐

Subjective markers reviewed

☐

Objective markers reviewed

☐

Evidence of clinical reasoning with progression

☐

Changes to treatment plan are documented

☐

Discharge/transfer of care.

Arrangements for transfer or discharge are recorded

☐

Discharge summary/letter to consultant

☐

Problem list signed off.

☐

Name and unit number/DOB on each page

☐

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Patient Record Review

Date:

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Subjective Assessment

Presenting condition/ main problems

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Relevant history of presenting complaint

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Past medical history/allergies/contraindications

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Current medications

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Social / family / lifestyle as applicable.

☐

Relevant investigations

☐

Patient's expectations/goals

☐

Objective Assessment

Observation

☐

Use of specific assessment tools/techniques

☐

Palpation/handling

☐

Content of examination relevant to subjective information

☐

Content of examination relevant to stage of injury/operation

☐

Analysis

Identification of subjective markers

☐

Identification of objective markers

☐

Problem List

☐

Treatment Plan relating to problem list/patient goals

☐

Clinical Diagnosis/Impression

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Implementation

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Subjective markers reviewed

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☐

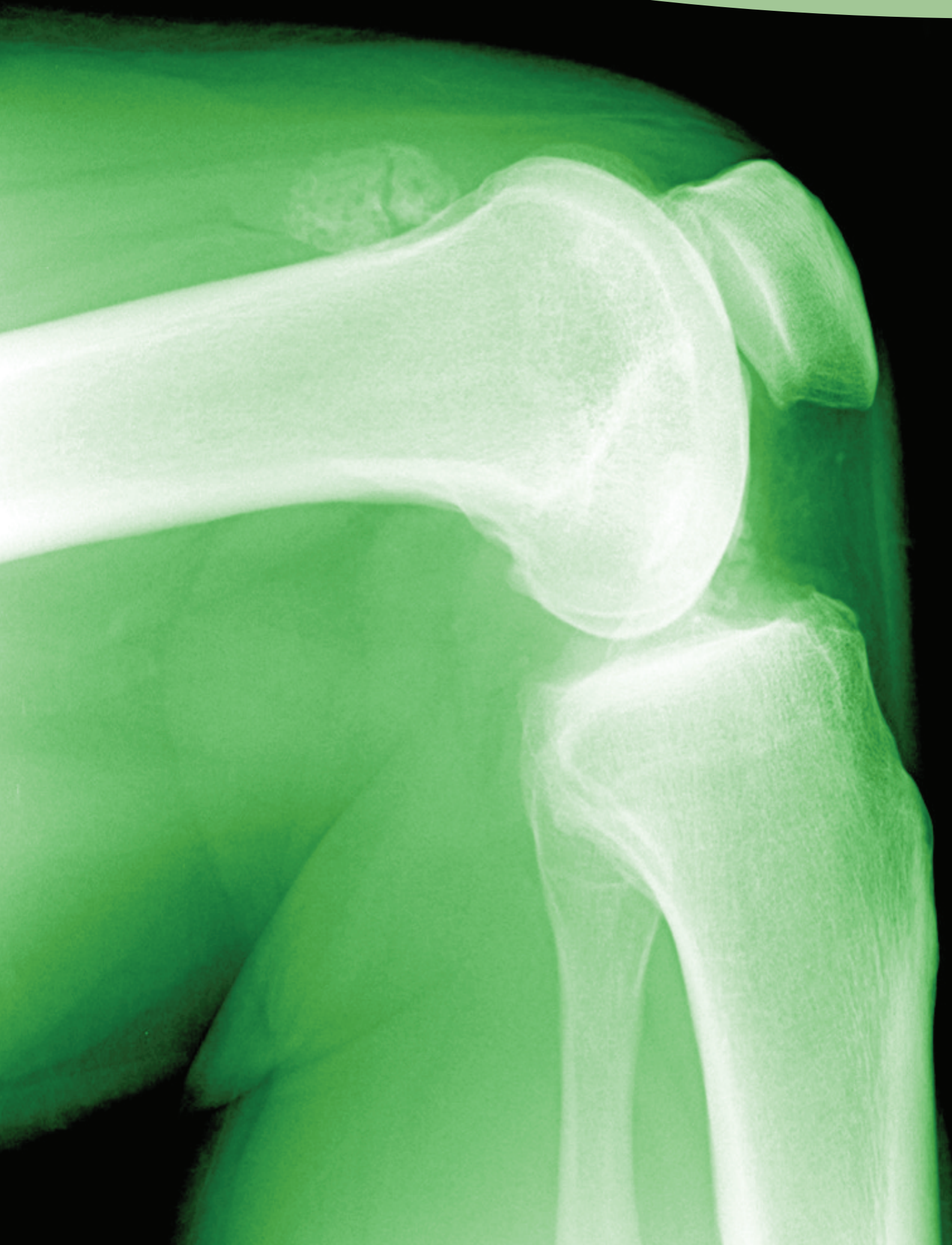
Name and unit number/DOB on each page

☐

Sig Reviewer

Sig Reviewee

Rating System



Scale of Rating Overall Supervision

This scale will be used by your senior to rate your overall performance at the end of the rotation.

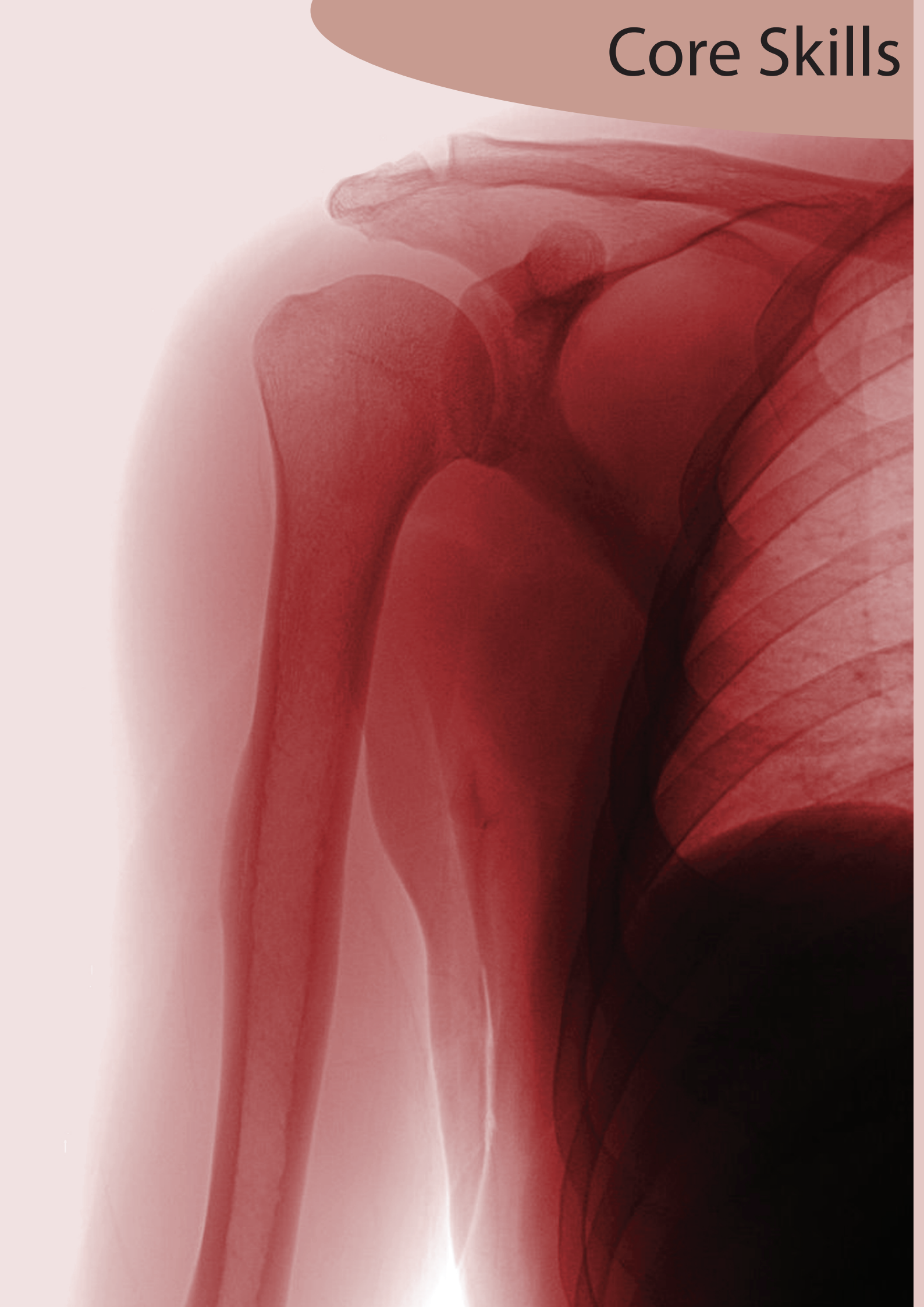
0	<p>Minimal knowledge and experience.</p> <p>No audit experience.</p> <p>Does not reflect on own practice.</p> <p>Poor communication skills.</p>
1	<p>Basic working knowledge with no / some experience.</p> <p>Adequate communication skills.</p> <p>Covert independent problem solving.</p> <p>Able to manage own practise but not others.</p> <p>Does not recognise other people's supervisory needs.</p>
2	<p>Participates with some insight into audit.</p> <p>Reasonable working knowledge with some experience.</p> <p>Problem solves explicit routine scenarios.</p> <p>Good communication skills.</p> <p>Reflects on own practise.</p> <p>Recognises when message is not getting across, needs others to offer help.</p>
3	<p>Is involved in running an audit.</p> <p>Sound working knowledge / experience.</p> <p>Problem solves complex scenarios.</p> <p>Experience in managing people but ridged in approach / does not seek others assistance.</p> <p>Recognises when message is not getting across, seeks help and learns.</p> <p>Good communication skills.</p> <p>Is flexible and adaptable to audience.</p>
4	<p>Initiate and runs audit process.</p> <p>Sound working knowledge / experience.</p> <p>Problem solved with diverse groups and meets their needs.</p> <p>Sound ability to manage people and able to offer help to other supervisors.</p> <p>Reflects on others practise and identifies a role model or mentor.</p> <p>Anticipates in supervisees their learning pattern and plans ahead.</p> <p>Excellent communication skills.</p> <p>Able to understand and convey complex ideas within own peer group.</p>
5	<p>Wide experience and in-depth knowledge of therapeutic management, able to draw on alternative strategies.</p> <p>Coordinates strategic programmes including audit.</p> <p>Develops in other skills that enable them to supervise / participate widely in a task.</p> <p>Recognise wherever the needs are met, applies different communication skills.</p> <p>Outstanding communication skills.</p> <p>Able to understand and convey complex ideas to different audiences.</p> <p>Flexible approach in developing others.</p>

Scale of Rating Clinical Skills

Use this scale to rate your skills at the beginning and end of each rotation.

0	<p>No skills and little / no knowledge of the theory.</p> <p>No working knowledge of technique.</p> <p>Little / no knowledge of research.</p> <p>No ability to teach.</p>
1	<p>Has learned skills +/- used since qualifying.</p> <p>Working knowledge of theory but minimal or no experience of the application.</p> <p>Whole situation is not understood.</p> <p>Some knowledge of research.</p> <p>Limited ability to discuss reason or teach.</p>
2	<p>Uses skills intermittently with a prescriptive approach and variable success.</p> <p>Working knowledge of theory but limited experience of application.</p> <p>Some knowledge of research.</p> <p>Beginning to develop strategies for practise.</p> <p>Can do practical demonstrations.</p>
3	<p>Regularly uses skills with good results.</p> <p>Can manage many aspects within a situation.</p> <p>Sound knowledge of theory.</p> <p>Practise informed by analysis and problem solving.</p> <p>Some knowledge of research.</p> <p>Teach less experienced junior staff theory and skills.</p>
4	<p>Regularly applies skills and flexible in application.</p> <p>Sound knowledge of theory.</p> <p>Adopts problem solving approach in all situations.</p> <p>Has holistic understanding and approach.</p> <p>Detailed knowledge of research.</p> <p>Teaches peer groups.</p>
5	<p>Consistent, sophisticated use of techniques.</p> <p>Innovative and creative.</p> <p>In-depth knowledge of theory in diverse client groups.</p> <p>Intuitive grasp of situation.</p> <p>Detailed knowledge of research +/- involvement.</p> <p>Speaks outside physio / recognised expert</p>

Core Skills



Shoulder

Section A: Knowledge and Understanding of Anatomy and Biomechanics

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Posture Types			
Acromial Morphology			
Scapulo- thoracic muscles			
Scapulo-thoracic planes of Motion			
Gleno-humeral muscles			
Gleno-humeral planes of motion			
Active control			
Passive control			
Ligaments			
Bursa			
Rotator cuff			
Capsule			
Long head of Biceps			
Normal Movement			
Thoracic Spine			

Section B: Knowledge and Understanding of Shoulder Pathologies

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Osteoarthritis			
Rheumatoid Arthritis			
Humeral #'s			
Traumatic Injuries			
Rotator Cuff Tears			
ACJ Pathology			
Tendonopathy			
Peripheral Neuropathies			
Primary Impingement			
Secondary Impingement			
Traumatic Instability			
Atraumatic Instability			
Bankart Lesions			
Hill-Sachs Lesions			
SLAP Lesions			

Section C: Competence in Shoulder Examination and Interpretation of Findings

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Observation			
Palpation			
Active ROM			
Passive ROM / overpressures			
Impingement Tests			
Instability Tests			
SLAP Tests			
Repeated Movements			
Muscle balance of GH and ST			
Stretches			
# Management			
Muscle Length Testing			
Red Flags			

Section D: Competence in Treatment Planning / Patient Management

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Treatment planning and SIN			
Patient goals and expectations			
Joint mobilisations, physiological and accesso- ry for GH and ST structures			
Stretches			
Muscle balance re-training			
Capsular techniques			
Soft tissue techniques			
Exercise therapy / rehab			
Understanding of when to refer on for further investigations			

Lumbar, Thoracic And Cervical Spine

Section A: Knowledge and Understanding of Anatomy and Biomechanics.

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Posture Types			
Cervical Spine			
Intervertebral joints and discs			
Facet joints			
Ligaments			
Muscles			
Nerve roots, cervical and brachial plexus			
Thoracic Spine			
Intervertebral joints and discs			
Facet joints			
Costotransverse / costovertebral joints			
Sympathetic nervous system			
Lumbar Spine			
Intervertebral joints and discs			
Facet joints			
SIJ and pelvic ring			
Muscles			
Ligaments			
Lumbar nerve roots and lumbosacral plexus			

Section B: Knowledge and Understanding of Spinal Pathologies

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Disc Pathologies e.g. Disc herniation, annular tears			
Facet joint locking, wry neck			
Whiplash / trauma			
Radiculitis / radiculopathy			
Rheumatological conditions			
Postural Dysfunction			
Osteoporosis			
Spondylosis and OA			
Stenosis			
Nerve root adhesion			
Scoliosis			
Spondylolisthesis			
Scheurmanns			
Cervical myelopathy			

Section C: Competence in Spinal Examination and Interpretation of Findings Lumbar Spine

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Observation			
Palpation			
Active ROM			
Repeated / sustained movements			
Passive ROM			
PAIVMs			
PPIVMs			
Muscle Balance			
Neurological Testing			
Neural Dynamics			
Differentiation Tests			
Red Flags			
Yellow Flags			
Other			

Section C: Competence in Spinal Examination and Interpretation of Findings Thoracic Spine

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Observation			
Palpation			
Active ROM			
Repeated / sustained movements			
Passive ROM			
PAIVMs			
PPIVMs			
Muscle Balance			
Neurological Testing			
Neural Dynamics			
Differentiation Tests			
Red Flags			
Yellow Flags			
Other			

Section C: Competence in Spinal Examination and Interpretation of Findings Cervical Spine

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Observation			
Palpation			
Active ROM			
Repeated / sustained movements			
Passive ROM			
PAIVMs			
PPIVMs			
Muscle Balance			
Neurological Testing			
Neural Dynamics			
Differentiation Tests			
Red Flags			
Yellow Flags			
Other			

Section D: Competence in Treatment Planning / Patient Management

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Treatment Planning			
Patients Goals and Expectations			
Joint mobs – physiological & accessory			
Soft Tissue Techniques incl. management on dysfunction			
Neural Dynamics			
Exercise Therapy			
Management of Psychological Issues			
Understanding of when to refer on			
Posture correction			
Knowledge of evidence based material and guidelines			
Other			

Knee

Section A: Knowledge and Understanding of Anatomy and Biomechanics

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Tibio-femoral Joint			
Patello-femoral Joint			
Superior Tib/fib Joint			
Bony Anatomy			
Ligaments			
Menisci			
Tendons			
Bursa			
Ligaments			
Bursa			
Fat Pad			
Muscles			
Movements			

Section B: Knowledge and Understanding of Knee Pathologies

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Trauma			
Meniscal Tears and Lesions			
Ligamentous Injury Grades			
ACLD/ACLR			
Osteochondral Lesions			
OA incl. Acute on Chronic			
Inflammatory Conditions incl. Gout			
Patello-femoral Joint Pain			
Tendinopathies			
Non-trauma			

Section C: Competence in Knee Examination and Interpretation of Findings

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Subjective Assessment			
Special Questions			
Objective Assessment			
Observation			
Palpation			
Active ROM			
Passive ROM			
Meniscal Testing			
Ligament Assessment			
MCL			
LCL			
PCL			
Post. Lat corner			
ACL- Lachmans			
Anterior Draw			
Pivot Shift			
Muscle Testing			
Muscle Length Testing			
PF Joint mobilisation Testing			
Gait and Movement Analysis			
Hip Muscle Strength			
Foot / Ankle Mechanics			
Other			

Section C: Competence in Knee Examination and Interpretation of Findings

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Treatment Planning			
Treatment planning relating to patients goals and expectations			
Joint mobilisations Physiological and Accessory			
Stretching			
Strength and muscle balance re-training			
Progression of proprioceptive control			
Manual techniques including frictions and soft tissue mobilisations			
Recognition of need for further investigations and interventions			
Open Vs closed chain exercise principles			
Gait and Movement Analysis			
Early to advanced stage rehab / plyometrics			
ACLD / ACLR			
• Principles			
• Precautions			
• Ballistic Hams.			
• Advanced Rehab			

Ankle

Section A: Knowledge and Understanding of Anatomy and Biomechanics

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Superio Tibio-femoral joint			
Inferior Tibio-femoral joint			
Talo-cural joint			
Sub-talar joint			
Mid-tarsal joint			
MTP joints			
Muscles of the lower leg and foot			
Ligaments			

Section B: Knowledge and Understanding of Ankle Pathologies

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Ankle sprains: acute and chronic			
Syndesmosis injuries			
Achilles Tendonopathies			
Tibialis Posterior Syndrome			
Osteochondral Lesions			
Fractures – operative and non-operative			
Shin splints / Tibial Torsion			
Heel pain / planterfaciatis			

Section C: Competence in Ankle Examination and Interpretation of Findings

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Subjective Assessment			
Special Questions			
Objective Assessment			
Observation			
Palpation			
Active ROM			
Passive ROM			
Ligament Testing			
• Deltoid			
• ATFL			
• PTFL			
• CFL			
• Anterior Draw			
• Talar Tilt			
Muscle Length Testing			
Static Muscle Testing			
Gait and Movement Analysis			
Biomechanical Assessment-forefoot/ rearfoot varus			
Special Tests			
• Impingement			
• Achilles tendonosis			
• Achilles rupture			
• Peroneal subluxation			
• AND			
• Sinus tarsi/ tarsal tunnel			
Calf Squeeze test			
Other			

Section C: Competence in Ankle Examination and Interpretation of Findings

	Band 5 Physiotherapist		Senior Physiotherapist
	Start	End	Completed
Date:			
Treatment planning			
Treatment planning relating to patient goals and expectations			
Joint mobs – physiological and accessory			
Stretching			
Strength and muscle balance re-training			
Eccentric Lowering programme			
Progression of proprioceptive control			
Manual techniques including frictions and soft tissue mobilisations			
Recognition of need for further investigations and interventions			
Differential Diagnosis			
• Diastasis			
• Stress Fracture			
• Avascular Necrosis of Talus			
• Heel Spurs			
• Plantafascia			
• Fat Pad			
• Bursie			
Early to advanced stage rehab			

NOTES

This document has been developed by the Leeds Teaching Hospitals NHS Trust and the University of Huddersfield.

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Aldous, S. Comer, C., Cox, F., Draycott, S., Flynn, K., Flynn, J., Tulwa, S., Watts, F., Williams, L.