COMPETENT AUTHORITY PATHWAY PROGRAMME (CAPP)

GUIDE | August 2017

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Disclaimer:
The information, forms and other details in this guide and pertaining to this assessment process are accurate at the time this guide was distributed. Small changes may occur to forms and other processes from time to time as the process is reviewed. Small changes are not routinely notified to potential or actual candidates unless these are substantive in any way, or alter the process in any significant way. Any such changes will be notified to affected parties.

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The Competent Authority Pathway Programme (CAPP)

Overview

This programme will assess different aspects of your capability to practice as an Osteopath in New Zealand. To understand what you need to demonstrate to be deemed capable of being a fully independent Osteopath you need to review the publication, “Capabilities for Osteopathic Practice” available from the OCNZ website. This is important preparation for this assessment process.

Reference will be made to those capabilities throughout this CAPP guide. This guide will indicate which capabilities are being assessed at which point in the process. It will also outline each assessment component, what to expect at each point, what mark sheets will be used during your assessments and how you will be advised of any feedback and outcomes.

This assessment process has been designed to ensure you have appropriate opportunities to demonstrate your capability as an Osteopath. To this end you will have several different types of assessment/assignments to undertake where the capabilities addressed may vary between assignments or may overlap but in a different context, thereby assessing the range of your professional skills in various ways. This provides ample opportunity for you to demonstrate your clinical aptitude on numerous occasions and by various means. The CAPP, whilst being an assessment process is also a mentoring process and should assist you to develop your professional personality in the context of New Zealand practice life. It is also a learning process and one in which you will develop an understanding of the specificities of Osteopathic healthcare relevant to New Zealand.

This pathway is open to candidates who hold an award from a Competent Authority accredited programme. A competent authority is a regulatory body that the OCNZ recognises as having equivalent requirements for accreditation and standards of programme outcomes are deemed commensurate with those of accredited programmes by the OCNZ.

To begin with, applicants must apply for, and be granted registration with the Osteopathic Council of New Zealand, and can then apply for an Annual Practising Certificate (APC). This will be granted with conditions called the CAPP, or preceptorship, usually for one year. This is done whilst you are working as an Osteopath in New Zealand – hence we also refer to it as the workplace based assessment. All participants must follow the requirements of this workplace based assessment phase, whether they subsequently apply for a full practising certificate (one with no conditions) or not.

The CAPP must be successfully completed to demonstrate clinical competence to practise in New Zealand in all of the six domains outlined in the “Capabilities for Osteopathic Practice”. The CAPP is based around the concept of “reflective practice” which the OCNZ has determined represents best and safest practice, in line with many other health professions throughout the world.

The workplace based assessment (CAPP) components will include regular reviews with an Osteopath Preceptor who will speak with you by phone/skype and email, and you will need to complete various tasks such as case reviews, critical incident reports and undertake various compulsory education units.

All the required elements are outlined in this guide. Your Osteopath Preceptor for this phase will NOT be your employer or Principal Osteopath in the Osteopathic practice in which you are working. You will be assigned an Osteopath Preceptor by the OCNZ whether you are employed or working independently as a sole practitioner.

Failure to comply with the requirements of your CAPP will void your current practising certificate with the OCNZ and you will not be able to continue working as an Osteopath in New Zealand.

Outcomes

A variety of outcomes are possible, for example (including but not limited to these):

- You may be advised that your results are at or above the required standard and are recommended for independent practice, in which case you will be eligible to apply to the OCNZ for a full Annual Practising Certificate (APC), without conditions.
- You may be advised that your portfolio contents and discussions show evidence of clinical performance sufficiently below the required standard that you are not to be recommended for independent practise in New Zealand.
- If you do not comply with the requirements of this programme and your migration status (or visa class requirements) in New Zealand is dependent on your registration with the Osteopathic Council of New Zealand, you will need to take separate advice as to your continued eligibility to remain in New Zealand.

Competence Review

If outcomes are not met and you fail to achieve the standard expected for full registration in New Zealand, the OCNZ may suggest a Competence Review. This may also apply during the CAPP if compliance with, or progress on the programme falls below expected standards. A Competence Review may take the form of an Onsite Clinical Visit, the components of which are described on page 14 and in Appendices 10-12. This will also necessitate payment of an additional fee. This is charged on a cost recovery basis. Details of the fee to be charged is available on the OCNZ website.

Appeals

If you do not achieve the required standard at the completion of the CAPP, you will be advised accordingly. All information pertaining to the Appeal Process and its associated fees is available from the OCNZ website.

Overview of the Assessment Process

Figure 1: Overview of the components of the CAPP

Workplace based – Practice component — CAPP (Portfolio/Osteopath preceptoring module)
Required modules/certificates to be provided from other courses
Learning Needs Analysis including goals and provisional schedules
Self-Learning Reports covering reflection on each of the compulsory modules, including the required reading section
Critical Incident Reports
Self-Learning Reports as part of ongoing learning
Case Analysis Reflections Reports, Parts 1 and 2
Inter-Professional Learning/Education/Collaboration reports
Copies of Anonymised Patient Case Notes
Case Based Discussions
Other items your Osteopath Preceptor may require

You will be expected to use electronic forms of communication such as e mail, web-based modules and educational tools, skype and similar communications as well as telephone use. You will be submitting your work electronically. Results and formal feedback will be transmitted in a similar manner. It is extremely important that you are IT literate to participate in this process. How all this is done will be explained once you have commenced the programme.

Compulsory Modules

1. **Cultural Competency:** Completion of the online Mauriora course: "Foundation Course in Cultural Competency". This will take a minimum of 1.5 hours to complete as there are many documents included which are recommended reading, namely "Best health outcomes for Maori: Practice implications" and "Cultural competence and medical practice in New Zealand". It is advisable to look at the titles of the other documents which will indicate their relevancy as some are mainly relevant within the GP/hospital arena. The course concludes with an assessment following which you will receive a Certificate of Completion. You should send this to your Osteopath Preceptor as proof of completion.
2. **HPCAA/Ministry of Health:** Familiarise yourself with the HPCA Act 2003 and understand the purpose and procedures associated with the Health and Disability Commissioner/Ministry of Health. There is a lot of information available on their websites. This information is crucial for healthcare practitioners in New Zealand. Understanding this in the context of Osteopathic healthcare and reflecting upon this is required as part of this compulsory module. For ease of reference we have provided the following links:
    - **HDC Code of Rights**
    - **Ministry of Health About the HPCA Act 2003**
    - **HPCA Act 2003**
3. **ACC:** Understand about the Accident Compensation Corporation (ACC) and how this relates to your clinical practice. You will achieve a clinical working knowledge of some of what is required, however, the ACC website will provide for the shortfall. Be aware that your clinical records relating to ACC claims, must contain all relevant information pertaining to the accident site, mechanism of injury, accident date, etc. Refer to Appendix 1 for the required guidelines. The ACC website provides guidelines relevant to all ACC procedures/protocols including the Provider Handbook. Please also refer to "Guidelines for Clinical Record Keeping" available on the OCNZ website ("Publications" – "Policies and Guidelines").
4. **Compulsory Reading:** The following sections of the OCNZ website make up part of the compulsory modules and are therefore required reading:

    4.1 Section: "Registered Osteopaths":

    a. Scope of Practice.
    b. Code of Ethics.
    c. Professional Development.
    d. Making complaints.

    4.2 Section: "Publications" – "Policies and Guidelines":

    a. Position statement on cervical manipulation.
    b. Guidelines for clinical record keeping.
    c. "Capabilities for Osteopathic Practice".
    d. Capabilities for paediatric practice.
    e. Guidelines for informed consent.
    f. Abbreviations used in Osteopathic treatment.
    g. Practice guidelines for the examination and treatment of genitalia, sensitive areas and internal techniques in Osteopathic practice.
    h. Legislation schedule.

    4.3 Section: "About the Council":

    a. "What we do"
        - Our role.
        - The Legislation.
    b. Who we are.
    c. When we meet.

    4.4 Section: "Links":

    a. Government departments and agencies.
    b. ACC.
    c. Health and Disability Commissioner.
    d. Minister of Health.

Please note: Preceptees wishing to use Western Medical Acupuncture (WMA) in their practice must conform to the "Extended Scope of Practice" conditions outlined in the document, **"Guidelines for the use of Western Medical Acupuncture and Osteopathic Practice, August 2015".** This document is found in the above linked "Policies and Guidelines" section and is compulsory reading for individuals within this context.

Understanding and completing these compulsory modules is imperative for practice in New Zealand. You are therefore required to have completed them by the end of the first six months coinciding with the end of Stage 2. It is expected that you will complete a Self-Learning Report covering each of these modules, documenting your reflection of their relevancy and impact on your clinical practice.

Portfolio

This will contain all the other elements of your CAPP, such as:

- Learning Needs Analysis including goals and provisional schedules (LNA)
- Critical Incident Reports (CIR)
- Self-Learning Reports (SLR)
- Case Based Discussions (CBD)
- Case Analysis Reflections Reports (CARR 1 and 2)
- Copies of Anonymised Patient Case Notes
- Inter-Professional Collaboration/Education/Learning Report (ICELR)
- Other items your Osteopath Preceptor may require.

Non-compulsory items: include anything you feel will support your learning and demonstration of satisfactory standards.

Note: the above items will be explained in separate sections below, and forms will be included in various appendices.

You will be required to compile this portfolio throughout the CAPP. Assignments relating to each of the four stages will be passed to the OCNZ for archiving and you should make a copy for yourself for reference. The various components will also be shared with your Osteopath Preceptor throughout the process so they can evaluate your work and the progress you are making through the CAPP. They will provide feedback on submitted items and may give additional tasks if you need further guidance or are not making satisfactory progress. Remember, the Osteopath Preceptor programme is a two-way process. It is very important that you make every effort to communicate and dialogue with your Osteopath Preceptor to make the most of this peer review process.

Timeline for the CAPP

The 12 months usually start once you have received confirmation of registration from the Osteopathic Council of New Zealand. Remember you will have a condition on your scope of practice for the length of your preceptorship. The 12-month period is split into three-monthly segments or parts. This gives ample time for a minimum of four scheduled Osteopath Preceptor discussion meetings and time for tasks in between these meetings. You will also have time to complete the compulsory modules (these are typically to be slotted in at your convenience but to be completed by the end of the sixth month, coinciding with the end of Stage 2). The CAPP should finish with a final Osteopath Preceptor discussion/review and hopefully, sign-off (meaning you receive a recommendation for full, unconditional registration from the OCNZ).

This timeline is outlined in Figure 2: Schedule for the CAPP

Be aware that the terms “End of Stage”, “Completion date”, “Due date”, pertaining to each Stage, relates to the date that all assignments/reports for that Stage must be received by the OCNZ. It is therefore imperative that all assignments are forwarded to your Preceptor for assessment, as they are completed. Some of these assignments are very time consuming in the context of assessment and discussion, so adequate time must be allowed for this purpose, to ensure that all is received by the OCNZ before or by the actual date coinciding with the end of each stage.

These dates are based on three month intervals from the date of starting work.

Figure 2: Timeline for the CAPP

0-3 months Stage 1	Osteopath Preceptor discussion – end of Stage 1	4-6 months Stage 2	Osteopath Preceptor discussion – end of Stage 2
Read through the CAPP and familiarise yourself with the requirements of Stage 1, also understanding how to complete a Learning Needs Analysis. It is advisable to arrange a meeting with your Preceptor as soon as possible to discuss anything which may need clarification. **Tasks:** 1. LNAs (Including compulsory modules) 2. Begin the compulsory modules and document your reflection as SLRs (1) **Send your LNAs, and SLRs 1, if completed, to your Preceptor 2 weeks before the end of this stage to allow time for completion by due date.**	This will usually be scheduled in month 3. This will be done by phone/Skype, as well as by email. It is your responsibility to contact your Osteopath Preceptor and set up a time. This will review tasks submitted and discuss forthcoming tasks and timelines for completion. Your Preceptor will complete a Report for this stage to submit to Council. You will receive a copy of this for your own feedback.	Compulsory modules should be completed and documented via SLRs (1). **Tasks:** 1. CIR (1) 2. SLR (2) 3. CBD (1) 4. ICELR (1) Anonymised case notes to be submitted with the Case Based Discussion. These **will** have a Records Audit carried out on them. Your Preceptor will also complete a Report for this stage to submit to Council. You will receive a copy of both for your own feedback. **Assignments should be sent to your Preceptor as they are completed to reduce time for assessment at the end of the stage.** **Please ensure to have all assignments sent to the Preceptor 2 weeks before the end of this stage to allow for completion by due date.**	This will usually be scheduled in month 6. This will be done by phone/Skype, as well as by email. It is your responsibility to contact your Osteopath Preceptor and set up a time. This will review tasks submitted and discuss forthcoming tasks and timelines for completion. You will have a chance to ask general questions about the process and your progress., and any concerns you might have. If there are concerns about your progress at this stage, you will be notified and remedial actions discussed.

7-9 months Stage 3	Osteopath Preceptor discussion – end of Stage 3	10 – 12 months Stage 4	Final Osteopath Preceptor review and sign-off
This stage is the most time consuming, especially in terms of the CARR 1 and 2. Plan ahead to ensure you have the required patients to complete this assignment. **Tasks:** 1. CIR (2) 2. SLR (3) 3. CARR 1 and 2 4. ICELR (2) Anonymised case notes to be submitted with the Case Analysis Reflections Report. Your Osteopath Preceptor will review these notes but **will not** carry out a Records Audit on them. Your Preceptor will complete a Report for this stage to submit to Council. You will receive a copy of this for your own feedback. **Send assignments to your Preceptor as they are completed to save time closer to due date but be sure to send all a minimum of 2 weeks prior to completion date.**	This will usually be scheduled in month 9. This will be done by phone/Skype, as well as by email. It is your responsibility to contact your Osteopath Preceptor and set up a time. This will review tasks submitted and discuss forthcoming tasks. You will have a chance to ask general questions about the process and your progress, and any concerns you might have. If there are concerns about your progress at this stage, you will be notified and remedial actions discussed. Serious concerns may lead to an on-site visit from your Osteopath Preceptor to your place of work to carry out additional assessment of your performance. This meeting will also review tasks submitted and discuss potential final recommendations, and any implications this may have on your final result.	**Tasks:** 1. CIR (3) 2. SLR (4) 3. CBD (2) 4. ICELR (3) Anonymised case notes to be submitted with the Case Based Discussion. These **will** have a Records Audit carried out on them. Your Preceptor will also complete a Report for this stage to submit to Council. You will receive a copy of both for your own feedback. **Assignments should be sent to your Preceptor as they are completed to reduce time for assessment at the end of the stage.** **Please ensure to have all assignments sent to the Preceptor 2 weeks before the end of this stage to allow for completion by due date.**	This will usually be scheduled in month 12. This will be done be phone/Skype, as well as by email. It is your responsibility to contact your Osteopath Preceptor and set up a time. This will review tasks submitted and discuss final recommendations. If sign-off is recommended you will be contacted by the OCNZ so as to allow you to apply for an unconditional Annual Practising Certificate.

Preceptor – Preceptee Relationship

Your Osteopath Preceptor will not be a person who employs you or who you are directly working with. Your Osteopath Preceptor is there to support you, but is not there solely as a teacher – they are there to help facilitate *your* learning and to help find ways that you can help to help yourself. They will liaise with the OCNZ regarding your progress throughout the CAPP, and if your progress is satisfactory you should complete the CAPP with the minimum requirements outlined in this guide. If for some reason you are not maintaining satisfactory progress or are not demonstrating appropriate levels of clinical performance/analysis and reflection then the Osteopath Preceptor may ask you to undertake additional tasks, or may (where there is sufficient concern) come and see you at your place of work. Your tasks can be individually tailored to your Learning Needs Analysis – in other words whilst everyone has to do the same overall tasks the actual content can be oriented towards aspects that are most useful or necessary for you to focus on. This emphasis should be apparent from your Learning Needs Analysis and should be discussed with your Osteopath Preceptor.

Osteopath preceptorial relationships require effective communication between both parties and are a two-way learning process. It is your responsibility to ensure timely communication with your Osteopath Preceptor. Figure 2 offers a suggested timescale for submission of assignments to your Preceptor, however, the actual timescale will be negotiated with your individual Preceptor. If there are any problems or if you have concerns you should contact your Osteopath Preceptor as soon as possible. They are your first port of call, and they will liaise with the OCNZ if this is required. Your Osteopath Preceptor will have received training regarding the skills they require to guide you and support you through this phase. You will normally be expected to have the same Osteopath Preceptor throughout this phase unless illness or other unforeseen circumstances arise. In these situations, the OCNZ will identify another Osteopath Preceptor for you. If for any reason you feel communication is not satisfactory or there is some problem in your Osteopath preceptorial relationship, then please contact the OCNZ directly who will advise you of how to proceed. The OCNZ will review the situation and will ask for feedback from the Osteopath Preceptor as well as yourself. Normally it is expected that any problems should first be aired with your Osteopath Preceptor directly and resolved between you if possible.

If sickness or other problems arise for you, you will need to notify your Osteopath Preceptor immediately and discuss the impact this may have on your ongoing engagement with the requirements of the phase, relevant timelines and so on, and your Osteopath Preceptor will liaise with the OCNZ to determine if this would have significant impact on your ability to complete the required components. If any changes would be allowed to be made to the process or its current timelines, then that could only be determined at the relevant time, would be on an individual basis, and accordingly no further information about this possibility of what those changes might consist of could be given here. Any changes would also have to be compatible with your practising certificate with the OCNZ. Please contact the OCNZ directly if you have questions regarding this section. Your Osteopath Preceptor will also be able to refer to a supervisor who is also a trained Osteopath Preceptor/assessor to help mediate any concerns or problems that are not purely administrative in nature.

Continuing Professional Development (CPD) Requirements Following the CAPP

Practitioners undertaking preceptorship (CAPP) are exempt from earning CPD whilst they have that condition on their scope of practice.

If they complete their preceptorship between April 1st and September 30th, 25 hours of CPD must be earned before March 31st.

If their preceptorship is completed between October 1st and January 31st, a minimum of 12.5 hours is required for that CPD year to qualify for an APC for the following year.

Those who complete their preceptorship in February or March are exempt from earning CPD hours until the next CPD year, beginning 1st April.

Portfolio Sections in Detail

Learning Needs Analysis (LNA) Including Goals and Provisional Schedules

In the competent authority pathway, it is recognised that all practitioners require ongoing learning and capability review and so the first meeting with your Osteopath Preceptor is the ideal place to discuss the learning needs analyses that you fill in during Stage 1. They are to help focus on any professional learning goals or needs you might have and are designed to support you through the remaining stages of your assessment. The compulsory modules will form part of your Learning Needs Analyses and the mechanism for evaluation will take the form of a Self-Learning Report. In this context, you are expected to complete one Learning Needs Analysis per compulsory module and a corresponding Self-Learning Report relating to each. All the Learning Needs Analyses are to be submitted during Stage 1. However, in the context of the compulsory modules, the corresponding Self-Learning Reports can be submitted during Stage 1 or 2, as the modules are completed.

Your personal learning needs making up the other Learning Needs Analyses, and the suggested mechanism for evaluation, may take the form of Self-Learning Reports but this may vary depending on the context and what is appropriate. eg, a learning need may relate to an area which would better be reflected upon in the form of an Inter-Professional Collaboration/Education Learning Report, or take the form of a daily journal. The important thing here is to demonstrate reflection on the subject and its implications for your clinical practice.

Learning needs analyses are used to help determine the gap between your existing Osteopathic and clinical skills, knowledge and attributes (capabilities) and where you envisage yourself being. Some candidates may have a larger number of learning needs than others, and some others may have very few. Your learning needs will not necessarily be related to your number of years in practice, where you originally came from or which is your native language. Every person learns at a different rate, and has different learning needs at different stages in their professional life. You will need to look at the tasks required of you in the CAPP and, also identify any personal professional learning needs you might have in the context on continuing your professional life in a new country. A Learning Needs Analysis also helps candidates to identify where they are in terms of their knowledge, skills and competencies, versus where they themselves wish to be – to identify their personal learning goals.

There may be a gap between how you currently practice and the level at which you are expected to practice by the end of the CAPP. Once this gap is determined, decisions can be taken as to the type of learning required. This can be discussed with your Osteopath Preceptor, but you are responsible for identifying suitable learning tasks and options, and for pursuing them. The learning needs analyses are filled in at the onset of the CAPP, and used to support learning throughout it. Please refer to the "Capabilities for Osteopathic Practice" document, to understand those capabilities specifically assessed in this phase, but you should be aware that you are required to comply with all these capabilities during this assessment period.

Sample forms can be found in Appendix 2 and Appendix 13/ Assignment Exemplars, Subsection I.

Critical Incident Report (CIR)

You will fill out one of these reports in each of the 3 main stages of this phase (see Figure 2 – Timeline for CAPP). This will relate to an incident which has created an opportunity for you to become aware of a critical aspect of clinical performance.

Note: the Critical Incident Report is based on the forms and website commentary from Monash University

Sample forms can be found in Appendix 4 and Appendix 13/ Assignment Exemplars, Subsection V.

Writing a Critical Incident Report is different to writing an essay – the text should be simply written, avoiding jargon and colloquial language, but still be well organised and systematically presented. The headings will guide you to write your report logically, and should be used when you write your own reports. The other text is a sample of a typical report that might be submitted in the CAPP of the assessment process.

They are likely to arise most commonly from your patient interactions, but might emerge from other professional activities. Critical incidents are something that you have experienced directly. Critical incidents do not have to be something that has 'gone wrong'. They could be positive situations that really allow you to identify and learn a particular issue, or to recognise and learn from something that had not been previously apparent. Critical incidents are more than routine learning matters though, and a report of a patient that caused you to look up a particular pathology would not, on its own be a sufficiently critical incident to report upon. Please discuss this further with your Osteopath Preceptor as you try to identify something to report upon. One Critical Incident Report per period of your CAPP will be required.

Criteria for assessment

Reflective writing is a vehicle which you use primarily to share your thinking and learning processes with your Assessors / Osteopath Preceptors. The event or incident or experience itself is not so important – what is important is your reaction to it, and how it has informed your thinking and your learning. Assessment tends to focus on how successfully you have demonstrated a capacity to analyse and reflect on events in order to learn from them. Also, relevant to assessment is how much you are able to relate your current theoretical learning (for example, about the Osteopath-patient relationship, or about what constitutes effective communication) to a real life situation.

Self-Learning Report (SLR)

You will fill out at least one of these reports in each stage of this phase (see Figure 2 – Timeline for the CAPP). In the context of the compulsory modules, it is expected that reflection on each will take the form of a Self-Learning Report. The compulsory modules are to be completed by the end of Stage 2, however, if they are completed during Stage 1 then the Self-Learning Reports can be submitted at that stage. In the general day to day practice of seeing patients we are continuously up-skilling ourselves, critically reflecting on our performance, underlying knowledge, skills and attitudes, and must continuously evaluate our ability to engage with certain situations and certain patient problems. Whilst engaging with patients in clinic you may be able to identify a lack of appropriate capability / knowledge, skills or attitudes. Itemise what those were, and demonstrate the further self-education you have had to undertake and reflect on to remedy these issues.

Sample forms can be found in Appendix 3 and Appendix 13/ Assignment Exemplars, Subsection II.

This form therefore is to record the self-learning tasks you have undertaken, and to identify learning issues and further work required, if appropriate. **This is a type of personal CPD record, and it can be used to record all sorts of learning events in a type of diary format.** It is envisaged therefore that you will include at least 3 learning items per stage, in addition to the compulsory modules which can be documented on four separate SLRs. It is important to reflect critically on how the learning task has been of benefit to your professional practice, and it is this reflection and the implications this has for future behaviour, professional actions and/or learning that you need to make sure you record clearly. The learning tasks required might have become obvious after a critical incident, or maybe after seeing a particular patient, where you realised your pathology was a bit lacking, for example. It might be that you needed to learn a little more about the regulatory framework, or how to work through the insurance issues for patients on private health care plans. Also, your personal self-learning needs may have been identified in your Learning Needs Analysis. It could also be as part of your existing or newly emerging personal professional interests. One of the other important factors is to consider how you will monitor yourself to see if this learning is changing your practice. Remember, the Compulsory Modules will need to be completed and submitted by the end of Stage 2.

You can use learning tasks associated with peer discussion, courses you have attended, journal reading, online web searching and e-learning opportunities, general book work, peer discussions and so on. This self-learning report is designed for you to reflect on items other than direct contact inter-professional ones. You will submit your report to your Osteopath Preceptor before each of your meetings, and you can discuss it with them.

Case Based Discussion (CBD)

You will fill out one of these reports on 2 separate occasions. (See Figure 2 – Timeline for the CAPP). This will be used to assess in depth your Osteopathic analysis of a particular case during the preceding few weeks. The form will ask you to write comments about various aspects of your Osteopathic analysis and care of a patient, and you should send your responses together with an anonymised case history/treatment records for this patient. Your Preceptor will use the case notes to consider what you have written, will complete a Records Audit on your case notes, and then discuss all these things with you at your next scheduled meeting.

It is important to remember that there is no right answer in how to treat a patient. Whilst it is important to recognise and treat accordingly a variety of patho-physiological conditions and mechanical/structural factors within your patient, your Osteopathic approach is certain to be a little different to that which another Osteopath might have performed. This Case Based Discussion is for you to illustrate how YOU come to conclusions, what YOU consider are important issues, how YOU have addressed them and how YOU approach Osteopathic care, and what YOUR personal professional perspectives are.

Your Preceptor may hold different Osteopathic viewpoints, and this should not conflict with them discussing YOUR approach to patient care. The discussion is about YOUR ideas, not the Preceptor's ones. A discussion between the two of you might highlight things that you should or could have considered, and both parties are likely to learn from this type of discussion. If your Preceptor feels you have not reflected on relevant issues sufficiently though he/ she will identify these with you and work out with you a plan of action to address issues raised.

Please note: it is not the Preceptor's role to fill in all gaps in your knowledge themselves, but to help you identify how YOU will address any shortfalls identified.

Sample forms can be found in Appendix 5 and Appendix 13/ Assignment Exemplars, Subsection VII.

Case Analysis Reflections Report (CARR)

This is slightly different from the above case based discussions. There are 2 parts to this. First part: Here you are expected to identify 5 patient cases you have seen several times, who all share similarities in presentation, and compare/contrast them. Second part: Here you are expected to compare/contrast two cases you saw alongside another practitioner and two cases where you referred the patient, handing the care totally to another practitioner. You will need to supply the anonymised case history records, but these will NOT have a Records Audit done on them this time. However, if issues have been identified following on from the previous Records Audit, then your clinical case notes need to continue to reflect the improvement recommended. They will be reviewed to verify the case reflections you are undertaking in this task. For the patients with shared care or referred care, please include copies of all inter-professional correspondence also. This task looks at the decisions you make over time, and how you individualise your approaches to patient care based on the patient presentations, and how this is communicated. Where there is shared care there should be evidence of collaboration. Reading through the capabilities pertaining to this section you will see that it is you, the practitioner, who chooses the other therapist depending on the needs of the patient. The case notes should reflect this and, also reflect the ongoing collaboration in terms of communication. These cases must be different from those used in the case based discussions (item 5).

Sample forms can be found in Appendix 8 and Appendix 13/ Assignment Exemplars, Subsection VIII.

Please note: This is the most time consuming of all the assignments. It requires forethought and planning pertaining to ensuring the situations of "shared care" and "referral and handover" arise in your clinical practice. It would be wise to give due consideration to the criteria relating to each section and begin the process of choosing the relevant patients, from the beginning of the CAPP, so as to allow time for ongoing treatment, and awareness of outcomes. This will allow the whole process run smoothly and will ensure completion by end of stage 3.

Records Audit

You will submit an anonymised case record for each of the case based discussions you complete in each of stages 2 and 4 (see Figure 2 – Timeline for the CAPP). Your Osteopath Preceptor will complete a Records Audit on these case notes, and return it to you with comments. It is advisable that you read through this form to ensure your clinical case notes contain all the required information outlined therein. Appendix 13 contains a set of clinical case notes which were completed to a high standard. Take the time to read through these notes in the context of the requirements of the Records Audit.

The forms can be found in Appendix 6 and Appendix 13/ Subsection X.

Inter-Professional Collaboration/Education/ Learning Report (ICELR)

You will fill out one of these reports in each of the 3 main parts of this phase (see Figure 2 – Timeline for the CAPP). It is envisaged that you will engage with other health professionals as well as Osteopathic peers during the normal course of your clinical work. This section is where you can discuss the nature of inter-professional engagement you have undertaken, what was gained from the experience, and what further self-learning this might have prompted. Please note this is a record of **non-Osteopath** interaction/ communication.

Sample forms can be found in Appendix 7 and Appendix 13/ Assignment Exemplars, Subsection VI.

Osteopath Preceptor Reports and Feedback Review

You will receive one of these reports following each of the 4 stages of this phase after you have completed your assigned tasks as outlined above, and had your discussion with your Osteopath Preceptor. These reports will also be sent to the OCNZ administration along with your assignments.

A sample form is found in Appendix 9.

Global Rating Scale

This Scale, when applied to an individual assignment, indicates the standard attained for that assignment. When used in the context of the Osteopath Preceptor Feedback Form, it relates to the outcome based on the overall performance and standard achieved for a particular Stage:

5. Clinical skills demonstrated are above those required for practice – no supervision would be required. Capable of being a fully independent practitioner
4. Clinical skills demonstrated at minimum satisfactory level required – advisory comments only may be required to guide Candidate. Capable of being a fully independent practitioner.
3. Clinical skills demonstrated are borderline – Candidate may require some supervision or guidance to attain satisfactory performance in practice – mostly capable of independent practice.
2. Clinical skills demonstrated are below required standard for independent practice, and would require continual supervision but deficit is remediable – Not capable of independent practice but recommended for remedial supervision or Osteopath preceptoring.
1. Clinical skills demonstrated are below required standards and indicate the need for constant dependence on supervision to ensure satisfactory clinical performance – Not capable of independent practice and not recommended for remedial supervision or Osteopath preceptoring.

On-site Clinical Visit

This section is not required of everyone. It is to further evaluate candidates who are not demonstrating the required standards in the earlier parts of the CAPP. This will usually take the form of a visit to your place of work by your Osteopath Preceptor, and in some cases, possibly also by one or two other Assessors (each situation will be evaluated individually). On very rare occasions you might be required to attend a separate site to undergo the required clinical observations.

These are usually undertaken in the second 6 months of the CAPP.

For these visits the assessor will need to see you examine and treat around 6-8 patients. These patients will all be required to attend on the same day, and if you normally only work a part day, you must alter your usual arrangements so that you allow sufficient time for sufficient patients to be seen, plus to allow for additional time (one to two hours, perhaps) for discussions with your Osteopath Preceptor/assessor. This will help reduce costs and help make best use of everyone's availability. Any patient asked to attend on the day must give their general consent (in the sense that they understand the purpose of the Osteopath Preceptor being present and that they consent to attending in that situation). Clearly patients can change their mind on the day, but if a clinic visit is required then it is most important that sufficient clinical performance is available to be observed. All the specific arrangements and details relating to this event should it be required will be explained at the relevant time, but some aspects of the expected process are outlined here, for general information only. These may be adjusted depending on your individual needs and this will be discussed with you at the relevant time.

Remember: Preceptees on the CAPP are not normally required to undergo these clinical visits.

On-site Clinical visit – Mini CEX Examination

These are to observe you treating your own patients, in your familiar work environment. They will take the format of some clinical observations by the Osteopath Preceptor, and they will fill in one or more of the mini CEX forms (see below) for each patient they observe you manage.

You will also be required to fill in some self-evaluation forms, and you and your Osteopath Preceptor will discuss various issues, and your Osteopath Preceptor will fill in one or more Case Based Discussion assessments. Records reviews will also be undertaken (in addition to any previously submitted) and feedback from colleagues/patients on the day may also be sought.

Please look at the forms in Appendix 10: On-site Clinic Visit Forms

Global Rating Scale – Further Information

In addition to the above sections A – E, the assessor will give an overall rating – a sort of summary of all that they have seen when they have come in to observe you for that section. This is not the same as the 'average' of the ratings given in sections A – E. For example, although the individual parts A – E could be marked as 3 – 4 – 5 (eg borderline or satisfactory, for example) it is still possible to get a global rating or 3 – 2 – 1 (indicating borderline to unsatisfactory/fail) if there is something of concern in your performance. Don't forget that the Assessors bear in mind all Capabilities required for practice, and are not confined to those expressly listed on the form as examples for that section.

Overall mark

All the forms per patient (usually you will have one form per patient), will be collated and a summary mark will be allocated. Some forms (or some sections in some of the forms) can be 'failed' or be 'borderline' but a Candidate can still be identified as having sufficient clinical performance to be recommended for the next phase of the process. The standards a Candidate needs to achieve overall are those equivalent to independent practise in New Zealand.

On-site Clinical Observation Self-Evaluation/ Self-Reflection Case Analysis

This is where you fill in a form about one or two patients (chosen at random) detailing your thoughts, approaches and analysis / understanding of the patient and their problem, and how you aim to approach it osteopathically. Please look carefully at the form in appendix 11. This is a similar to the process you are required to do in the other parts of this workplace based programme. The actual form for the on-site visit day is slightly different, so please refer to the relevant form for this component, in appendix 11.

This section of the on-site visit is to help further understand your Osteopathic and clinical analysis of patients. At the end of the day, one or more of your patient cases will be chosen at random by the examiner, and you will need to complete a self-evaluation form on those patients. The assessor will use this as part of another discussion (see below), to further explore your clinical performance and case analysis.

On-site Clinical Observation Case Based Discussion

Your Osteopath Preceptor/assessor will take your completed case history notes for the patients chosen at random from those observed on the day, will complete a Records Audit Form for those patients, and will collect the Patient Feedback Form (if the patient elected to fill this in), and the Self-Evaluation Form you filled in regarding this patient.

The Osteopath Preceptor will review all these forms together. They will then meet with you to discuss various things including how you felt the case was handled, and discuss with you your Osteopathic ideas and approaches with that patient. This discussion should take approximately 30-45 minutes, but may vary depending on the case.

This is a further opportunity to illustrate your personal professional approach in Osteopathy, to ensure we understand the breadth and depth of your case analysis, and to gain insight into the types of management and treatment styles you might choose for the patients. We are particularly interested in your analyses, your justifications, your rationales for identified diagnoses/hypotheses and proposals for treatment and management, and how you pull all the threads of a case together into a cohesive whole. We are looking for discrimination in thought, critical reflection, self-awareness of capability, and ability to identify appropriate and patient centred Osteopathic care.

Appendix 1: ACC Guidelines for Initial and Follow up Appointments Pertaining to ACC Approved Claims

Our Recommendations for the Initial Consultation/Visit:

To help us make appropriate decisions as swiftly as possible, we ask that in the initial consultation/visit you record details of the:

- Accident, how it occurred and any mechanisms of injury
- Injury symptoms and clinical significance
- Reason for the presentation, or the main reason if the consultation/visit involves more than one condition
- History and examination findings, including important negatives
- Relevant past-history, including medications
- Initial working diagnosis
- Pain and effect on sleep, work and other activities of daily life
- Employment history – current employment, the physical, perceptual and mental demands of work as it relates to the patient's functional limitations, and the willingness of the employer to make workplace accommodations
- Initial advice you've given the patient, eg about work fitness or injury-related restrictions
- Management and follow-up plan.

Our Recommendations for the Follow-up Consultations/Visit:

Your records for any follow-up consultations/visits should demonstrate that your treatment meets the legislative requirements of being necessary and appropriate. We ask that you detail:

- The patient's progress
- Your evaluation of the effectiveness of previous treatment
- New aspects of history and examination, and the results of any new tests or investigations
- Any restated or revised diagnosis
- Any subsequent advice given to the patient
- Any treatment provided
- The reason for any change to an earlier treatment plan
- Any work capacity and return-to-work barriers.

Appendix 2: Learning Needs Analysis Form

Stage 1

Competent Authority Pathway Programme (CAPP): Learning Needs Analysis Form (LNA)

Preceptee.. Osteopath Preceptor ....

- Learning Needs Analysis Form – complete the first column on your own as best you can, using your own awareness.
- You will then discuss this form in your first meeting with your Osteopath Preceptor, who will add their comments in the column and agree action points with you.
- The Osteopath Preceptor will complete the form during the meeting and send it back to you for your records.
- This LNA will help you focus during your CAPP assessment period, and is to supplement the required portfolio elements for this phase.

Learning Needs Analysis	Give a brief summary	Comments from: Osteopath Preceptor	Agreed action points
What skills and knowledge you already have			
Identify skills/knowledge/capabilities that need developing			
Identify clearly what you wish to achieve			
Outline and define expectations and goals			
Clarify what can be achieved realistically in the current situation			
Reflect upon any obstacles or difficulties that may be relevant			
Determine suitable evaluation mechanisms to assess if the learning needs have been addressed			

Preceptee signature... Osteopath Preceptor signature...

Appendix 3: Self-Learning Report Form

Stage ....

Competent Authority Pathway Programme (CAPP): Self-Learning Report

Preceptee .... Osteopath Preceptor ....

Date	Learning item	Summary of learning content and learning objectives	Appraisal of how this learning will impact on your practice
eg 12 December 2010	Internet searching: articles found eg Johnson et al 2030, Journal of Necks Websites: pretend *www.clinicalrisks.com* Book: How to avoid patient deaths in practice, by Avoid at all Costs.	Vertebral artery tests prior to cervical manipulations, the range of tests used, which seems to be in common usage and whether they are defensible and useful in practice	This is a confusing area to research, and there is apparently no golden rule. Even the use of the test itself might be contra-indicated, and so may not be clinically acceptable. This remains an area where I will need to keep searching for information, and in the meantime perhaps I will need to use other cardiovascular and neurological screening tests and case history components to help identify patients where cervical manipulation might be inadvisable.

Osteopath Preceptor comments/feedback:

Global rating for this form:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Preceptee signature.. Osteopath Preceptor signature..

Appendix 4: Critical Incident Report Form

Stage ....

Competent Authority Pathway Programme (CAPP): Critical Incident Report Form

(Sample Critical Incident Report)

Preceptee.. Osteopath Preceptor ....

Context of the incident

This report will outline a critical incident which occurred 2 months after I had arrived in the country. I have been working as part of a group practice for a few weeks and am still finding my feet. The incident occurred in a normal working day, when I was seeing a new patient.

Details of the incident

A patient came in saying she needed her neck manipulated, and couldn't get the Osteopath who normally sees her to do it. I am anxious to please and said I was sure we could do something for her. She wasn't very clear when we were going through the history, and I couldn't get all the information out of her that I wanted, but felt a bit awkward repeating questions. During the examination, she would not do the requested active movements as instructed, even though she was not observably in pain and there was no obvious reason why she was not complying, apart than through choice. Also, it became clear very early on that she had a hypermobile neck and she was constantly self-manipulating it through the examination, and I found it very difficult to proceed. I tried to get her to do a VBA test, but she wasn't cooperating, and kept saying 'why couldn't I just get on with it she had it done so many times before?'. I didn't want to let a patient down so in the end I agreed. However, I was a bit nervous, and probably didn't do a very good job. The patient got dressed straight afterwards and said she was going straight out to reception to book another appointment as she felt sure she would need more. I had to go quickly after her and say I didn't feel that more manipulation would be a good idea, and that she might be happier seeing a different practitioner in the practice as she didn't seem comfortable with myself. Other staff were in the reception area, at this time. She became very angry, accused me of refusing to treat her, of being useless and pathetic and she threw a $50 note on the floor as payment and stormed out of the practice.

Thoughts, feelings and concerns

During the incident. I became increasing uncomfortable as I felt that the patient was quite manipulative, and although I felt initially in control things very quickly changed. I wish I had never agreed to manipulate her neck and that I had though more about why her previous Osteopath had refused to do it, and I regret that I didn't enquire more into that before I treated her. Now I feel that the patient completely embarrassed me in front of my colleagues and I am also very upset that I did not remain in control more, and that I let myself down.

I haven't been in practice all that long before migrating, and to have a patient challenge me in this way was very confronting. I am now wary of all the new patients coming in, and am not sure how to get past that. Clearly I have to keep seeing them, but don't want to be in embarrassing situation.

Reflection on why events may have occurred

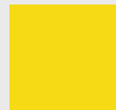
I do appreciate that I contributed to this problem in the first instance by not thinking more about the implications of why she was looking for another Osteopath to manipulate her, and why her previous practitioner was not compliant. Also, I should be more in control when conducting the examination, and more willing to take responsibility for ensuring an appropriate screening had occurred before treatment. In addition, I let the patient take over and dictate things, and that could have had serious outcomes, which although nothing adverse clinically happened on this occasion, it was more by luck than judgement.

Learning points

On talking things through with the principal Osteopath I am more reassured, but recognise that I need to become better equipped to deal with difficult patients, and to be more conscientious in going through all the stages of my case history taking and examination. But I need to accept that sometimes it is not appropriate to treat, and this should have been one of them. I think on reflection that I could now spot problems coming a little earlier as I am more alert, but I am still a bit nervous of patients and what they might bring into the consultation. Also it is clear that several Osteopaths (I talked to a few peers) that we all do our VBA tests differently, and I am now confused as to which is the correct way, or which way I should be doing them in future. I am planning to look up a few things online, and to see what comes up from that.

Osteopath Preceptor comments/feedback:

Global rating for this form:



5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Preceptee signature...

Osteopath Preceptor signature..

Appendix 5: Case Based Discussion Form

Stage ....

Competent Authority Pathway Programme (CAPP): Case Based Discussion Assessment (Preceptee to provide anonymised case notes as part of this discussion).

Preceptee.. Osteopath Preceptor ....

Rating scale for this form:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Domain	Capabilities broadly covered in this section	Your notes:
Osteopathic perspectives discussion Please review other sections before filling in this to ensure there is no overlap in your answers	1.4.5 Maintains a commitment to delivering well integrated and coordinated care for all patients, including those with multiple, ongoing and complex conditions	Please fill in an overview of your care plan for this patient, and how it fits in with any other care or self help the patient is undertaking. Comment on what makes your examination and treatment Osteopathic and which parts of this patient's general care lie outside your professional scope. Identify potential risks and benefits in your treatment of the patient and briefly describe how you feel your Osteopathic techniques will be having a physiological effect on this particular patient. Use a separate sheet for your response. Use no more than one side of an A4 when giving this response.
	2.5.1 Risks and benefits for management are identified and appropriately recorded	
	3.1.1 Understands and utilises an Osteopathic philosophy in their examination, treatment and overall care of a person	
	3.1.2 Arrives at an appropriate management plan reflecting these Osteopathic philosophies	
	3.1.3 Can identify the components of a plan of care that are in addition to (or instead of) Osteopathic manual treatment, and acts accordingly	
	3.2.1 Understands how manual Osteopathic techniques as employed by Osteopaths can interact with the body's physiological, circulatory, neuro-endocrine-immune, homeostatic and emotional environments and uses this knowledge within their Osteopathic plan of care	
	6.7.2 Understands major ongoing trends and developments in Osteopathy	
	6.7.3 Understands major ongoing trends and developments in the broad health care field	
Osteopath Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Domain	Capabilities broadly covered in this section	Your notes:
Personal profession perspectives discussion	1.6.1 Recognises and remains open to clinical challenges and uncertainty 3.6.1 Recognises any potential conflicts that their personal professional approach may have for the patients plan of care, and modifies it appropriately 3.7.1 Conditions or situations where the knowledge and management skills of the practitioner are insufficient are identified and appropriate alternative action is organised and taken 6.2.1 The need for improved skills and knowledge to maintain effective and appropriate care of the individual are identified	All Osteopaths have individual perspectives when reviewing a case. Please discuss why you made the choices you did about this patient, and what approaches you decided not to follow and why, and what procedures or treatments you feel might have been helpful osteopathically, but which you did not perform and why. Use a separate sheet for your response. Use no more than one side of A4 when giving this response.
Osteopath Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Domain	Capabilities broadly covered in this section	Your notes:
Patient centeredness discussion	1.1.4 Ensures patient-centred orientation of case analysis 1.3.2 Plan of care is within the context of the person's general health 2.4.2 Recognises the impact of patient concerns for clinical analysis and plan of care 2.6.3 Options for the person's self-care are identified and discussed, such as exercise, diet, lifestyle and workplace ergonomics 4.1.1 Identifies and acts upon those factors which are the practitioner's responsibility towards the person's welfare 4.7.2 Ensures plan of care reflects commitment to rehabilitation and amelioration of pain and suffering 4.7.4 Commitment to improving the health literacy of the patient is maintained 4.7.5 Maintains a commitment to preventative care strategies	Briefly describe what you have discussed with the patient about their own self help, how their health education has been broadened by your treatment, and what preventative strategies you have identified. Discuss how you have ensured your care is person oriented, and discuss what the major concerns of the patient were/are. Discuss how your Osteopathic care is contextualised with respect to the patients general health. Use a separate sheet for your response. Use no more than one side of an A4 when giving this response.
Osteopath Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Domain	Capabilities broadly covered in this section	Your notes:
Osteopath plan of care discussion	1.2.1 Working hypotheses are compared and contrasted, using information retrieved, to identify a suitable working diagnosis (including concepts of cause and maintaining factors and current stressors)	Please fill in on overview of your case analysis for this patient, and discuss what your Osteopathic diagnosis/hypothesis was, how you arrived at that, and how your approach was Osteopathic in nature. Discuss why you chose the techniques you did, and what aspects of the patient's overall health history are amenable to Osteopathic care or not, and whether there are any components in their health history that is making you adapt your usual Osteopathic approach – explain why if this is the case. Briefly discuss Use a separate sheet for your response. Use no more than one side of an A4 when giving this response.
	1.3.1 Plan of care is negotiated with, relevant and appropriate to person's presenting complaint	
	1.5.1 Case review is capable of identifying if information is lacking or needs investigation	
	2.1.1 Understands cultural and social factors relevant to communication and management of the individual	
	3.2.2 Selects and adapts appropriate Osteopathic techniques during their patient evaluation and treatment, relevant to the patient's condition and tissue responses, including cultural, religious, social and personal constraints	
	3.3.1 Conditions or situations that are not amenable to Osteopathic intervention are identified, and appropriate action taken	
	4.1.2 The 'gate-keeper' and 'health-screening' roles of an Osteopath as a primary healthcare practitioner are performed appropriately	
	4.2.1 Identifies situations where other healthcare professionals may be required to perform these [gatekeeper] roles, in whole or part and acts accordingly	
Osteopath Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Preceptee signature.. Date ....

Osteopath Preceptor signature.. Date ....

Appendix 6: Records Audit Form

Stage……….

Competent Authority Pathway Programme (CAPP): Osteopathic Healthcare Record Audit

Preceptee…………………………………………………………………………… Osteopath Preceptor……………………………………………………………

Stages 2 and 4: For each patient you are using for the Case Based Discussion tasks, your supervisor will fill in one of these forms for the copy of the anonymised case history you send in to accompany the completed Case Based Discussion Form, and then discuss the outcomes with you at your next meeting.

Look carefully through this form as it indicates the range of information that should be present in a typical Osteopathic healthcare record. Review Compulsory Reading Module – "Guidelines for Clinical Record Keeping", along with "Appendix 1" – "ACC Guidelines for Clinical Record Keeping".

Assessor or supervisor guide: If information should be present and is not, rate with a zero. If information is present, rate the quality of the information with 3 = Above required standard, 2 = Satisfactory, and 1 = Below required standard. Use "NA" to score items that do not apply to a given record (eg patient has no allergies).

Record components	Rating	Comments, if required
Pages have patient ID – eg for computer data base, where appropriate		
Contains spaces for biographical and/or personal data (name, address, contact details, date of birth, parental or guardian details for a minor)		
Current work and social history details are recorded (eg type of work, hobbies and sports, other interests)		
Space for Osteopath's name on records pertaining to the initial consultation, followed by initials alongside each treatment, (relevant in group practice, or where multiple practitioners see the same patient)		
Entries are dated		
Entries are legible		
Presenting problem is complete and clear. (If this patient is eligible for ACC then all required information pertaining to the injury, leading to an appropriate diagnosis, must be included. See Appendix 1: "ACC Guidelines".)		

History of presenting complaint is present and logically/ systematically presented		
Appropriate past medical history is recorded including a systems review, drug history, accident/trauma history, investigations and general procedures/surgeries noted, and record of ongoing concurrent medical care noted		
Psychosocial, lifestyle and past medical/healthcare experiences relevant to presentation are recorded		
Smoking, alcohol, or substance abuse history documented (if appropriate)		
Imaging test results recorded as appropriate		
Lab and other tests recorded as appropriate		
Pertinent examination conducted and documented		
General examination findings are recorded, with positive, negative and 'nothing abnormal detected' findings noted		
Osteopathic palpatory findings are recorded		
Working diagnoses are noted and are consistent with findings and aetiology		
Osteopathic components of the case analysis (diagnoses) are identified and recorded		
Plans of action/treatment are recorded and are consistent with diagnosis(es)		
Patient self-help, health education, and rehabilitation options are recorded		
Relative or absolute contra-indications for treatment are clearly and prominently recorded		
Details of treatments given are clearly recorded and use of personal professional jargon or shorthand that may be obscure is avoided		
Outcomes from previous visits recorded (For ACC cases refer again to Appendix 1)		

Problems from previous visits addressed		
Evidence of appropriate use of referrals		
Correspondence relevant to patient recorded and integrated into care		
Informed consent noted for all procedures		
Patients are adequately informed (ie there is documentation of patient education, follow-up instructions)		
Missed/cancelled appointments noted		
Follow-up on missed/cancelled appointments noted		
Telephone calls regarding patient care noted		
Records are organised in a consistent manner		
Paper record contents are securely fastened together, or bound in folder, or similarly secure		
No inappropriate information is in the record (eg, subjective or personal remarks about patient, family, or other caregivers)		
No inappropriate alterations or omissions (eg, erasures, missing pages)		

Preceptor comments/feedback:

Global rating for this form:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in New Zealand.
3. Borderline standards, but only minimally below required levels, some guidance in New Zealand required.
2. Borderline standards but deficiency not an over-riding bar to practice in New Zealand. significant guidance required.
1. Below standards required for independent practice in New Zealand.

Osteopath Preceptor signature ....

Credits: The Medical Record Audit form from the American Medical Association/Specialty Society Medical Liability Project was used in the development of this form Capabilities assessed using this form: 1.1.2; 1.1.5; 1.2.4; 1.3.5; 2.5.1; 2.6.1; 2.6.3; 2.7.1; 3.1.2; 3.2.2; 3.3.1; 3.5.1; 4.1.2; 4.3.2; 5.1.2; 6.5.2

Appendix 7: Inter-Professional Collaboration/ Education/Learning Report

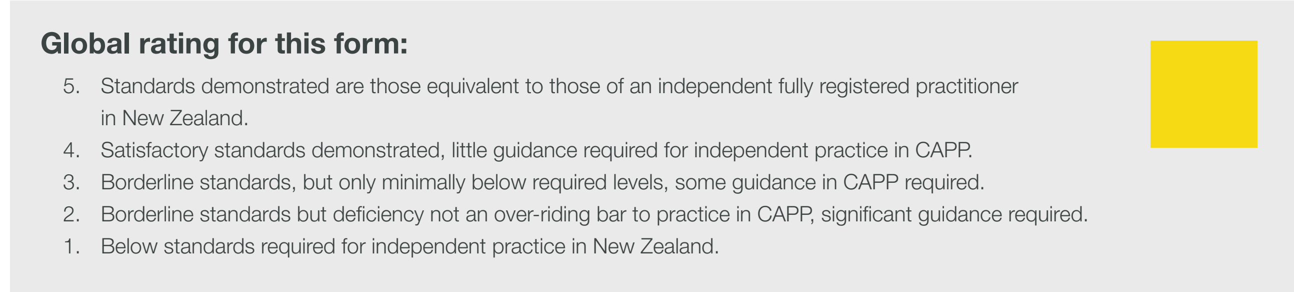
Stage ....

Competent Authority Pathway Programme (CAPP)

Preceptee .... Osteopath Preceptor ....

Date	Details and context of inter-professional learning event	Summary of learning content and learning objectives	Appraisal of how this learning will impact on your practice
eg 12 December 2010	Attended physiotherapy conference on sport injuries taping	Learned about which physios are in my area, what types of work they did and learned about some of their taping techniques that were different to those I knew already.	I was initially reluctant to communicate, as this was the first interdisciplinary conference I had attended, but I can now appreciate how Osteopaths and physios may complement each other in terms of rehabilitation and immediate first aid for injuries – which should be useful as I am going on an aussie rules football match this weekend, with some colleagues from work! I learned more about knee ligament anatomy and saw some useful images, and where they could be found online, which was useful. Also, was definitely rusty on some of the knee muscle insertions, which the physios seemed more up to date with!

Preceptor comments/feedback:



Global rating for this form:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Preceptee signature.. Osteopath Preceptor signature...

Appendix 8: Case Analysis Reflections

Stage 3

Part 1: Outcomes Comparison

Competent Authority Pathway Programme (CAPP) (Candidate to provide anonymised case notes and related inter-professional communication as part of this discussion).

Task: to compare and contrast 5 patient cases that you have seen at least 3 times each, where the presenting complaint was similar (eg All suffering from low back pain, or all from ankle ligament sprain, or all suffering cluster migraine, etc).

Preceptee.. Osteopath Preceptor ....

Global Rating Scale:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Domain	Capabilities broadly covered in this section	Your notes:
Continuing professional development	3.7.2 Seeks out opportunities to enlarge personal professional capabilities	**Compare and contrast your five patients, looking at:** What did you learn from each case that was either expected or unexpected? Are there still areas of confusion or uncertainty at this stage of your management of any of these patients, and if so what? What will you be adapting in your future management and why? Use separate sheet to write your response. Use no more than two sides of A4 when giving this response.
	3.8.3 Incorporates an understanding of the strengths and limitations of an 'evidence-based' approach to treatment	
	5.5.1 Undertakes appropriate continuing lifelong learning to ensure currency of understanding of Osteopathic philosophy and professional ethos	
	6.2.1. The need for improved skills and knowledge to maintain effective and appropriate care of the individual are identified	
	6.3.2. Practitioner recognises when performance and care is not optimal and takes appropriate action	
	6.7.2. Understands major ongoing trends and developments in Osteopathy	
	6.7.3 Understands major ongoing trends and developments in the broad health care field	
Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

<table>
<tr><th>Domain</th><th>Capabilities broadly covered in this section</th><th colspan="2">Your notes:</th></tr>
<tr><td rowspan="6">Individualising Osteopathic management discussion

Please review other sections before filling in this to ensure there is no overlap in your answers.</td><td>1.1.2 Compiles a health care record that is personal to the individual</td><td colspan="2" rowspan="6">Compare and contrast your five patients, looking at:
What your approach was for each patient – how was it adapted for each one? What aspects of your Osteopathic philosophy were used in one patient and not another for example, or if a similar approach was made, how was this justified with respect to the individual history?

Use separate sheet to write your response. Use no more than two sides of A4 when giving this response.</td></tr>
<tr><td>1.2.2 Uses a systematic Osteopathic and medical differential diagnostic process</td></tr>
<tr><td>1.3.1 Plan of care is negotiated with, relevant and appropriate to person’s presenting complaint</td></tr>
<tr><td>1.4.2 Appropriate outcome measures are utilised to monitor progress which is either a negotiated patient centered outcome, or the use of an appropriate valid and reliable outcome instrument</td></tr>
<tr><td>3.1.1. Understands and utilises an Osteopathic philosophy in their examination, treatment and overall care of a person</td></tr>
<tr><td>3.1.2. Arrives at an appropriate management plan reflecting these Osteopathic philosophies</td></tr>
<tr><td colspan="2">Preceptor comments on areas of deficiency and learning needs:</td><td>Global rating 5 – 1 for this section:</td><td></td></tr>
</table>

Domain	Capabilities broadly covered in this section	Your notes:
Treatment outcomes discussion	1.3.4 Changes to a patients physical or mental health are reviewed over time, whether related to their presenting complaint or not, and any relevant action taken accordingly	**Compare and contrast your five patients, looking at:** Your patients will all have had slightly different outcomes. Discuss how your approach to monitoring their progress differed between the patients, and discuss whether these outcomes were as you expected or not, and why you felt there was a difference. What have you learned about your original prognosis for each of these cases by doing this reflection? Use separate sheet to write your response. Use no more than two sides of A4 when giving this response.
	1.4.1 Prognoses are developed, and appropriate care is determined on that basis	
	1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis	
	1.4.4 Practitioner recognises when outcomes differ from those expected, can identify why and acts accordingly	
	1.5.2 Practitioner responds accordingly to cues emerging from case review	
	2.4.2 Recognises the impact of patient concerns for clinical analysis and plan of care	
	2.6.3 Options for the person's self care are identified and discussed, such as exercise, diet, lifestyle and workplace ergonomics	
	3.3.2 Conditions or situations that require adaptation of manual techniques and manoeuvres employed during a plan of care are identified, and appropriate action taken	
Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

(Continued – Part 2 on next page)

Part 2: Collaborative Care and Referrals Comparison

Competent Authority Pathway Programme (CAPP): Case Analysis Reflection Assessment (Candidate to provide anonymised case notes as part of this discussion).

Task: To compare and contrast two patient cases that you have seen in collaboration with another practitioner (for example a Surgeon, Physiotherapist, Naturopath, Homeopath, Acupuncturist, GP) where the care of the patient was shared between the practitioners. Compare and contrast two patients that you have referred on to another practitioner where the care was not subsequently shared.

Preceptee... Osteopath Preceptor ....

Global Rating Scale:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Domain	Capabilities broadly covered in this section	Your notes:
Collaborative/shared care discussion Please review other sections before filling in this to ensure there is no overlap in your answers.	1.2.2 Uses a systematic Osteopathic and medical differential diagnostic process	**Compare and contrast your two patients, looking at:** Why did you feel collaborative care was necessary in these cases, and what type of care was arranged? How successful was this collaboration, how did this collaboration impact on your ongoing management of these patients, and what did you learn from the experience? Use separate sheet to give your responses. Use no more than two sides of A4 when giving this response.
	1.2.3 Makes appropriate arrangements to receive additional information as required, such as referring patient for imaging, or corresponding with healthcare practitioners for test results and other relevant details	
	1.3.1 Plan of care is negotiated with, relevant and appropriate to person's presenting complaint	
	1.4.2 Appropriate outcome measures are utilised to monitor progress which is either a negotiated patient centered outcome, or the use of an appropriate valid and reliable outcome instrument	
	3.1.1. Understands and utilises an Osteopathic philosophy in their examination, treatment and overall care of a person	
	3.1.2. Arrives at an appropriate management plan reflecting these Osteopathic philosophies	

	3.1.3 Can identify the components of a plan of care that are in addition to (or instead of) Osteopathic manual treatment, and acts accordingly	
	5.3.3 Collaborative working arrangements with others are reviewed to ensure an efficient team-based approach to care of the individual	
	5.3.5 A commitment to ensuring continuity of care for the patient is maintained	
	5.5.2 Critically reflects on the relationship between Osteopathic practice and other healthcare systems, and the impact this has for overall patient care	
Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Domain	Capabilities broadly covered in this section	Your notes:
Referral and handover of patient care discussion	1.3.4 Changes to a patient's physical or mental health are reviewed over time, whether related to their presenting complaint or not, and any relevant action taken accordingly	**Compare and contrast your two patients, looking at:** In these patients that were completely referred onto someone else can you explain why, and what approaches were needed in each case that you couldn't provide. How did you manage the hand over in each case, and could this have been improved? What would you do differently next time in a similar situation, and what have you learned about your skills and underlying knowledge through these cases? Use a separate sheet to give your responses. Use no more than two sides of A4 when giving this response.
	1.4.1 Prognoses are developed, and appropriate care is determined on that basis	
	1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis	
	1.5.2 Practitioner responds accordingly to cues emerging from case review	
	1.5.3 Recognises when to withdraw or modify plan of care	
	2.4.2 Recognises the impact of patient concerns for clinical analysis and plan of care	
	3.7.1 Conditions or situations where the knowledge and management skills of the practitioner are insufficient are identified and appropriate alternative action is organised and taken	

	4.2.1 Identifies situations where other healthcare professionals may be required to perform these roles, in whole or part and acts accordingly	
	4.4.1 Practitioner identifies suitable health and community services from which the person may benefit	
	4.7.1 Identifies appropriate strategies concerning health education, public and occupational health, disease prevention for patient, or refers appropriately	
	5.3.4 Appropriate referrals are made to other practitioners, including Osteopaths, based on knowledge of presenting condition and management options and own skill levels	
	5.6.1 Undertakes appropriate continuing lifelong learning to ensure awareness of other healthcare practices and approaches to healthcare and patient management, including mental health issues	
	5.6.2 Critically reflects on the impact this awareness has to delivery of overall patient care	
Preceptor comments on areas of deficiency and learning needs:		Global rating 5 – 1 for this section:

Preceptee signature.. Date ....

Osteopath Preceptor signature... Date ....

Appendix 9: Osteopath Preceptor Feedback Form

Stage..........

Competent Authority Pathway Programme (CAPP)

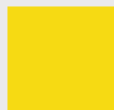
The Osteopath Preceptor will fill in this summary form, as well as the individual forms related to each part of the portfolio required at this point.

Preceptee.. Osteopath Preceptor ....

Date of discussion	All items required for review delivered or not?	Reasons for omission? Alternative satisfactorily completed or discussed, if required?	General feedback on Candidate's progress	Comments for next period if required, revision of tasks if required, or sign off if at end of CAPP
eg 12 December 2010	eg All items included, except case notes, but these emailed over at start of discussion and satisfactorily reviewed	eg Practice communication error – reception off sick	eg Candidate is progressing well, and has completed required tasks for the portfolio to date, and is providing an interesting and critically reflective series of evidences regarding their Osteopathic approach.	eg Continue learning more about trigger points, and complete compulsory module on cultural competency
Learning Needs Analysis				
Critical Incident Report				
Self-Learning Report				
Case Based Discussion				

Case Analysis Reflections Report, Parts 1 and 2				
Inter-Professional Learning Report				
Compulsory modules				
Records Audit (Stages 2 and 4) or feedback on clinical record keeping				
General communication between Candidate and Osteopath Preceptor				
General comments for learning needs, if required				

Global rating for progress at this stage of CAPP:



5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Osteopath Preceptor signature ....

Appendix 10: On-site Clinic Visit Forms

Mini CEX Assessment Form 1: Case History Interview

Competent Authority Pathway Programme (CAPP)

Candidate.. Assessor .... Patient Age.................................... Patient Gender .... Time spent observing ....

Patient Problem: .... Patient Number: .... Problem Complexity: Low ☐ Medium ☐ High ☐
(taken from patient's Health History Form)

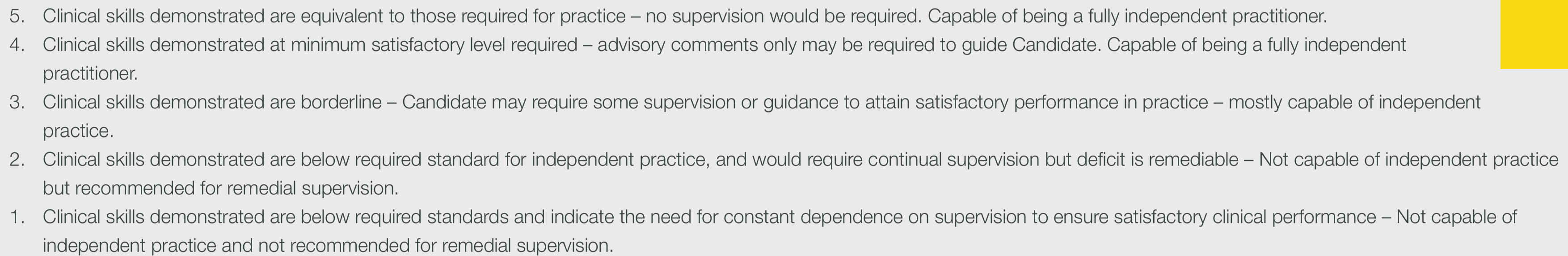
Example of Capabilities tested in each section – these are the main focus areas for this domain, and assessment is centred on these issues although all capabilities are essentially relevant to these clinical exams	Item	Domain	Descriptor – What the Assessor is focusing on in this section	Rating scale (circle according to scale below)	Tick here if this domain not observed	**Assessor notes** and/or guidance for learning, **if required**. Also, if 3-2-1 rating was given this indicates borderline or fail: please document unsatisfactory performance in detail overleaf.
2.1.1 Understands cultural and social factors relevant to communication and management of the individual 2.1.2 Communication is sensitive to and respectful of these factors (identified in 2.1.1) 2.3.2 Where communication barriers exist, efforts are made to communicate in the most effective way possible 2.3.3 Deploys a variety of communication modes as appropriate	A	Communication and counselling skills	**Case history taken with effective communication**, which is adjusted according to cues emerging during the consultation	5 4 3 2 1		

1.1.3 Incorporates bio-psychosocial components within the health record 1.1.4 Ensures patient-centred orientation of case analysis 1.5.2 Practitioner responds accordingly to cues emerging (from case review) – 1.5 as an element, basically 2.1.1 Understands cultural and social factors relevant to communication and management of the individual 2.1.2 Communication is sensitive to and respectful of these factors (identified in 2.1.1) 2.9.3 Continuously reflects on the respectful patient-centeredness of the Osteopathic management of the patient	B	Global case management and consistency of care	**Case history taken with patient centred and biopsychosocial approach**, is flexible and strategy responds to emerging cues and indicators relevant to the general health status of the patient	5 4 3 2 1		

1.1.1 Critically uses a variety of information retrieval mechanisms 1.1.2 Compiles a health care record that is personal to the individual 1.2.2 Uses a systematic Osteopathic and medical differential diagnostic process 1.5.2 Practitioner responds accordingly to cues emerging (from case)	C	Individual nature of case and Osteopathic care	All information gathered in a case specific manner, from an Osteopathic perspective and reflecting exploration of the patient that identifies factors relevant for Osteopathic examination and treatment	5 4 3 2 1		

2.9.1 Recognises if patient trust or safety is undermined and acts accordingly 2.9.2 Ensures appropriate levels of patient confidentiality throughout the Osteopathic management of the patient 2.9.4 Builds an effective patient rapport, treatment agreement and therapeutic alliance 6.1.1 Strategies to ensure ethical conduct of self and others are identified and utilised where appropriate	D	Approach to gaining informed consent	**Patient case history taken with consideration of ethical principles and informed consent** and with respect to patient trust and confidentiality	5 4 3 2 1		

1.1.2 Compiles a health care record that is personal to the individual 1.2.2 Uses a systematic Osteopathic and medical differential diagnostic process 6.3.1. Time management strategies are implemented 6.5.2 Ensures all record keeping is in accordance with current best practice 6.3.5 Maintains appropriate balance between needs of practitioner, patient, community and healthcare services	E	Organisational efficiency, general professionalism and record keeping	Time efficiency and professionalism; **All information recorded in a systematic and logical order,** reflecting Osteopathic and medical analytic approaches and principles, utilising appropriate recording standards	5 4 3 2 1		



Global Rating Scale:

5. Clinical skills demonstrated are equivalent to those required for practice – no supervision would be required. Capable of being a fully independent practitioner.
4. Clinical skills demonstrated at minimum satisfactory level required – advisory comments only may be required to guide Candidate. Capable of being a fully independent practitioner.
3. Clinical skills demonstrated are borderline – Candidate may require some supervision or guidance to attain satisfactory performance in practice – mostly capable of independent practice.
2. Clinical skills demonstrated are below required standard for independent practice, and would require continual supervision but deficit is remediable – Not capable of independent practice but recommended for remedial supervision.
1. Clinical skills demonstrated are below required standards and indicate the need for constant dependence on supervision to ensure satisfactory clinical performance – Not capable of independent practice and not recommended for remedial supervision.

Mark each domain above, or tick 'not observed' column if not seen, then, take an overall view about the whole aspect of what you have observed, and fill in this global rating box (using the same scale 5-1)

Assessor signature .... Date ....

Mini CEX Assessment Form 2: Examination

Competent Authority Pathway Programme (CAPP)

Candidate.. Assessor .... Patient Age...................................... Patient Gender .... Time spent observing ....

Patient Problem: .... Patient Number: .... Problem Complexity: Low ☐ Medium ☐ High ☐
(taken from patient's Health History Form)

Example of Capabilities tested in each section – these are the main focus areas for this domain, and assessment is centred on these issues although all capabilities are essentially relevant to these clinical exams	Item	Domain	Descriptor – What the Assessor is focusing on in this section	Rating scale (circle according to scale below)	Tick here if this domain not observed	**Assessor notes** and/or guidance for learning, **if required**. Also, if 3-2-1 rating was given this indicates borderline or fail: please document unsatisfactory performance in detail overleaf.
1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis 2.9.1 Recognises if patient trust or safety is undermined and acts accordingly 2.9.4 Builds an effective patient rapport, treatment agreement and therapeutic alliance 3.5.2 Continuously gathers evidence to monitor changes in a patient's circumstance, mental or physical condition that might require changes to their ongoing care	A	Communication and counselling skills	Recognises patient's mental state and emotional responses to examination, seeks to develop rapport and confidence, and modifies behaviour if necessary, maintaining effective communication throughout	5 4 3 2 1		

1.2.3 Makes appropriate arrangements to receive additional information as required, such as referring patient for imaging, or corresponding with healthcare practitioners for test results and other relevant details 3.1.4 Ensures Osteopathic manual skills are appropriate to meet professional requirements 4.2 Recognises and responds to professional capabilities and limitations, as a primary healthcare provider	B	Global case management and consistency of care	Examination is conducted in a way that acknowledges own limitations where applicable, is adjusted to need for externally based information from other healthcare sources, and which is cognisant of general healthcare responsibilities	5 4 3 2 1		

1.1.1 Critically uses a variety of information retrieval mechanisms 1.2.2 Uses a systematic Osteopathic and medical differential diagnostic process 1.2.5 Critically selects and adapts appropriate clinical examination techniques during their patient evaluation, relevant to the patient's condition and tissue responses, including cultural, religious, social and personal constraints 1.2.1 Working hypotheses are compared and contrasted, using information retrieved, to identify a suitable working diagnosis (including concepts of cause and maintaining factors and current stressors)	C	Individual nature of case and Osteopathic care	**Examination procedure demonstrates** critical reflection and **appropriate** broad based **clinical reasoning and reflects Osteopathic principles**, exploring tissue states and adjusting contacts and procedures according to cues emerging during examination	5 4 3 2 1		

1.2.5 Critically selects and adapts appropriate clinical examination techniques during their patient evaluation, relevant to the patient's condition and tissue responses, including cultural, religious, social and personal constraints 2.5.2 Appropriate informed consent is obtained in the light of risks and benefits being explained to and understood by patient (or their representative or carer) 2.9.1 Recognises if patient trust or safety is undermined and acts accordingly 4.2 Recognises and responds to professional capabilities and limitations, as a primary healthcare provider 6.1.1 Strategies to ensure ethical conduct of self and others are identified and utilised where appropriate	D	Approach to gaining informed consent	**Examination is performed in a safe**, sensitive **and effective manner**, with appropriately gained informed consent, is ethically informed and with respect to patient trust	5 4 3 2 1		

1.1.5 Ensures full recording of Osteopathic physical examination and palpation findings as part of a personal health record 6.3.1. Time management strategies are implemented 6.5.2 Ensures all record keeping is in accordance with current best practice 6.3.5 Maintains appropriate balance between needs of practitioner, patient, community and healthcare services	E	Organisational efficiency, general professionalism and record keeping	Time efficiency and professionalism; **recording** of **findings** is **in a logical and systematic order**, utilising appropriate recording standards	5 4 3 2 1		

Mini CEX Assessment Form 3: Negotiating Plan of Care

Competent Authority Pathway Programme (CAPP)

Candidate.. Assessor .... Patient Age...................................... Patient Gender .... Time spent observing ....

Patient Problem: .... Patient Number: .... Problem Complexity: Low ☐ Medium ☐ High ☐
(taken from patient's Health History Form)

Example of Capabilities tested in each section – these are the main focus areas for this domain, and assessment is centred on these issues although all capabilities are essentially relevant to these clinical exams	Item	Domain	Descriptor – What the Assessor is focusing on in this section	Rating scale (circle according to scale below)	Tick here if this domain not observed	**Assessor notes** and/or guidance for learning, **if required**. Also, if 3-2-1 rating was given this indicates borderline or fail: please document unsatisfactory performance in detail overleaf.
2.1.1 Understands cultural and social factors relevant to communication and management of the individual	A	Communication and counselling skills	Communicates the diagnosis and proposed Plan of Care in a culturally and socially sensitive manner, promotes understanding, and provides counselling as appropriate for Osteopathic practice	5 4 3 2 1		
2.1.2 Communication is sensitive to and respectful of these factors (identified in 2.1.1)						
2.3.2 Where communication barriers exist, efforts are made to communicate in the most effective way possible						
2.3.3 Deploys a variety of communication modes as appropriate						
2.4.3 Employs counselling skills appropriate for Osteopathic practice in the context of the Osteopathic Plan of Care						

1.2.4 Where diagnosis and patient evaluation are not able to be completed, plan of care is adapted appropriately 3.1.3 Can identify components of a plan of care that are additional to or instead of OMT, and acts accordingly 4.7.1 Identified appropriate strategies concerning health education, public and occupational health, disease prevention, or refers appropriately	B	Global case management and consistency of care	Discusses alternatives/ options where available and relevant to the Plan of Care; including issues of health promotion, disease prevention and self care, and outlines plan of action if no treatment can be given on that occasion	5 4 3 2 1		
1.3.1 Plan of care is negotiated with, relevant and appropriate to person's presenting complaint 2.6.1 The goals, nature, purpose and expected outcomes of Osteopathic intervention are discussed and agreed 3.1.2 Arrives at an appropriate management plan reflecting Osteopathic philosophies	C	Individual nature of case and Osteopathic care	The plan of care discussed is case specific, reflective of Osteopathic principles, with goals, purpose and expected outcomes explained and negotiated	5 4 3 2 1		
2.5.1 Risks and benefits for management are identified and appropriately recorded 2.5.2 Appropriate informed consent is obtained in the light of risks and benefits being explained to and understood by patient (or their representative or carer)	D	Approach to gaining informed consent	Informs the patient of the risks and benefits of the proposed plan of care, promotes understanding and gains informed consent	5 4 3 2 1		
6.3.1. Time management strategies are implemented 6.5.2 Ensures all record keeping is in accordance with current best practice 6.3.5 Maintains appropriate balance between needs of practitioner, patient, community and healthcare services	E	Organisational efficiency, general professionalism and record keeping	Time efficiency and professionalism; demonstrates complete record keeping appropriate to expected medico-legal standards	5 4 3 2 1		

Mini CEX Assessment Form 4: Management

Competent Authority Pathway Programme (CAPP)

Candidate.. Assessor .... Patient Age..................................... Patient Gender .... Time spent observing ....

Patient Problem: .... Patient Number: .... Problem Complexity: Low ☐ Medium ☐ High ☐
(taken from patient's Health History Form)

Example of Capabilities tested in each section – these are the main focus areas for this domain, and assessment is centred on these issues although all capabilities are essentially relevant to these clinical exams	Item	Domain	Descriptor – What the Assessor is focusing on in this section	Rating scale (circle according to scale below)	Tick here if this domain not observed	**Assessor notes and/or guidance for learning, if required. Also, if 3-2-1 rating was given this indicates borderline or fail: please document unsatisfactory performance in detail overleaf.**
1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis 2.9.1 Recognises if patient trust or safety is undermined and acts accordingly 2.9.4 Builds an effective patient rapport, treatment agreement and therapeutic alliance 3.5.2 Continuously gathers evidence to monitor changes in a patient's circumstance, mental or physical condition that might require changes to their ongoing care	A	Communication and counselling skills	Recognises patient's mental state and emotional responses to treatment, seeks to develop rapport and confidence, and modifies behaviour if necessary, maintaining effective communication throughout	5 4 3 2 1		
1.1.1 Critically uses a variety of information retrieval mechanisms 1.2.3 Makes appropriate arrangements to receive additional information as required, such as referring patient for imaging, or corresponding with healthcare practitioners for test results and other relevant details 1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis	B	Global case management and consistency of care	Demonstrates treatment appropriate to diagnosis and plan of care with consideration of social and cultural factors, and where care outside of the Osteopathic consultation is required	5 4 3 2 1		

3.3.1 Conditions or situations that are not amenable to Osteopathic intervention are identified, and appropriate action taken						

1.1.1 Critically uses a variety of information retrieval mechanisms 1.4.1 Prognoses are developed, and appropriate care is determined on that basis 1.4.3 Practitioner reviews progress and elicits feedback on an ongoing basis 1.5.3 Recognises when to withdraw or modify plan of care 2.6.4 Prepares the patient for ‘follow up’ where appropriate 3.1.1 Understands and utilises an Osteopathic philosophy in their examination, treatment and overall care of the person 3.1.4 Ensures Osteopathic manual skills are appropriate to meet professional requirements 3.3.2 Conditions or situations that require adaptation of manual techniques and manoeuvres employed during a plan of care are identified, and appropriate action taken 3.6.1 Recognises any potential conflicts that their personal professional approach may have had for the patients plan of care, and modifies it appropriately	C	Individual nature of case and Osteopathic care	Develops a prognosis and ongoing management plan that is Osteopathic in nature, and critically reflects on emerging cues and outcomes, adapting, modifying or withdrawing Osteopathic manual treatment and plan of care based upon response to treatment; including recognising when outcomes differ from expectations, and when personal professional skills do not match case needs, and adapts, modifies or withdraws plan of care accordingly	5 4 3 2 1		

2.9.1 Recognises if patient trust or safety is undermined and acts accordingly 2.9.2 Ensures appropriate levels of patient confidentiality throughout the Osteopathic management of the patient 2.9.3 Continuously reflects on the respectful patient-centeredness of the Osteopathic management of the patient 2.9.4 Builds an effective patient rapport, treatment agreement and therapeutic alliance	D	Approach to gaining informed consent	Consent is continuously monitored and commitment to (and achievement of) practice with continuous informed consent is maintained	5 4 3 2 1		

1.3.5 Plan of care and supporting evidence is appropriately noted in patients' record 1.4.2 Appropriate outcome measures are utilised to monitor progress which is either a negotiated patient centred outcome, or by the use of an appropriate valid and reliable outcome instrument 2.5.1 Risks and benefits for management are identified and appropriately recorded 6.3.1. Time management strategies are implemented 6.5.2 Ensures all record keeping is in accordance with current best practice 6.3.5 Maintains appropriate balance between needs of practitioner, patient, community and healthcare services	E	Organisational efficiency, general professionalism and record keeping	Time efficiency and professionalism; demonstrates complete record keeping appropriate to expected medico-legal standards, including appropriate outcome measures, where available, and documentation of informed consent, risks and benefits.	5 4 3 2 1		

Reverse of form for each of the previous four Mini CEX Assessment Forms. **Note: these comments will be available for Candidate viewing.**

Item	Domain	Comments on unsatisfactory performance (eg compromising to patient, or against Osteopathic principles; **can also include comments on general strengths and weaknesses for feedback)**
A	Communication and counselling skills	
C	Global case management and consistency of care	
E	Individual nature of case and Osteopathic care	
D	Approach to gaining informed consent	
E	Organisational efficiency, general professionalism and record keeping	
Global Rating Section	Overall clinical performance observed	

Appendix 11: On-site Clinical Assessment: Self-Evaluation Case Analysis Form

Competent Authority Pathway Programme (CAPP): **Case Based Discussion – On-site visit only**

Candidate Self-Reporting (reflective case review) Form

Candidate.. Assessor ....

Note: The Assessor of the Case Based Discussion assessment will use this form alongside your case notes to complete their assessment. They will also fill in their section of this form after your Case Based Discussion.

Scale for assessor: 1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree 0. Unable to comment

Domain	Indicative capabilities	Questions for you to consider – write your answers/responses in the next column	Your responses	Assessor agreement – use scale above	Assessor comments
Clinical Record Keeping	1.1.1, 1.5.1	Have you recorded everything appropriately? Does this record provide enough info for you or another Osteopath to work from at the next visit? Do you need to add anything or obtain any other information to complete?	Use separate sheet as required Use no more than 2 sides of A4 in total	0 1 2 3 4 5	Use reverse of form as required
Clinical Assessment – History	1.1.1, 1.1.4, 1.2.2, 1.2.3, 2.4.2	What are the most important factors in this person's case history? Was there other info you could have obtained which would be helpful?		0 1 2 3 4 5	
Clinical Assessment – examination	1.2.2, 3.1.1	What are your most important clinical findings? Were there any areas where your findings were incomplete? Were there any other examinations you did not perform which with hindsight might have been helpful?		0 1 2 3 4 5	

Clinical Reasoning – working hypothesis	1.2.1, 1.2.2, 1.4.1, 1.6.1	What is your diagnosis / working hypothesis for this patient? How did your examination support the information in the case history so you could make this diagnosis?		0 1 2 3 4 5	
Osteopathic treatment/ Non treatment	1.3.1, 1.2.3, 1.3.2, 1.5.2, 3.2.1, 3.3.2, 1.6.1	Were you able to treat this patient today? What was your objective in today's treatment? What treatment did you use to achieve that?		0 1 2 3 4 5	
Management Plan/ Handover	1.2.3, 1.4.1, 1.5.2, 1.6.1, 2.7.2	Have you noted a treatment plan for the person who sees the patient next? Is there anything incomplete you have recorded, such as X-ray/lab tests results?		0 1 2 3 4 5	
Overall clinical care	2.7.2, 3.1.1, 6.1.1	How do you feel you managed this session?		0 1 2 3 4 5	

Comments from Assessor and indicative learning needs (Assessor to complete after discussion with Candidate)

Global rating for progress on this assessment

5. Clinical skills demonstrated are equivalent to those required for practice – no supervision would be required. Capable of being a fully independent practitioner.
4. Clinical skills demonstrated at minimum satisfactory level required – advisory comments only may be required to guide Candidate. Capable of being a fully independent practitioner.
3. Clinical skills demonstrated are borderline – Candidate may require some supervision or guidance to attain satisfactory performance in practice – mostly capable of independent practice.
2. Clinical skills demonstrated are below required standard for independent practice, and would require continual supervision but deficit is remediable – Not capable of independent practice but recommended for remedial supervision.
1. Clinical skills demonstrated are below required standards and indicate the need for constant dependence on supervision to ensure satisfactory clinical performance – Not capable of independent practice and not recommended for remedial supervision.

Assessor signature .... Date ....

Appendix 12: Patient Feedback Form – On-site Clinical Assessment:

Competent Authority Pathway Programme (CAPP)

Patient Feedback Form

Patient.. I am: male / female (please indicate)

- Please think back over your experience today and answer the following questions.
- Please mark '0' 'unable to assess' if you are unable to answer any question. Otherwise please tick the relevant box for each question.
- Your replies will be in confidence.
- Replies by several patients will be compiled before feedback is given to this Osteopath.
- If you wish to give verbal feedback to one of the Assessors, then please speak to a member of staff who will organise this.
- If you do not wish to leave feedback at all this is not compulsory.

1. The instructions regarding the events of the day were helpful.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

2. This Osteopath treated me with respect.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

3. This Osteopath listened to me.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

4. I understood what this Osteopath was saying to me.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

5. I believe this Osteopath is knowledgeable and skilled in providing proper care.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

6. I would send a family member to this Osteopath.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

7. When this Osteopath does an examination I understood what was happening and why.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

8. This Osteopath discussed treatment options with me.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

9. The treatment given seemed related to my problem.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

10. The Osteopath explained how I might help myself with my problem.

Unable to assess ☐ I strongly disagree ☐ I disagree ☐ Neutral ☐ I agree ☐ I strongly agree ☐

Appendix 13: Assignment Exemplars (Subsections I–X)

The following Exemplars are actual assignments completed by a Preceptee during the CAPP. (Permission to include these has been received.) They have been added in order to provide some examples of what has been provided for each of the assignments. Each person will have different experiences and will reflect on these in their own way. Individual preferences will vary pertaining to desired layout and content, eg in the context of the Case Analysis Reflections Reports. This is all perfectly fine provided the content contains adequate information and addresses the relevant capabilities. These examples should, however, give some idea of how one could approach each of the assignments and of the kind of information to include, in keeping with the relevant capabilities.

You will notice that two Learning Needs Analyses and two Self-Learning Reports have been included: one of each relates to one of the compulsory modules, the other is addressing a personal learning need.

Note for Preceptors:

For the purposes of assessment, the comments/feedback pertaining to these Exemplars are provided in an additional resource “Preceptor Resource”, which will be provided for you, along with a copy of this CAPP Guide.

Subsection (I): Learning Needs Analysis (LNA1) – Health and Disability Commissioner (HDC)

Competent Authority Pathway Programme (CAPP): Learning Needs Analysis Form

Preceptee.. Osteopath Preceptor ....

LNA1 – Health and Disability Commissioner (HDC)

Objective: To increase my awareness and understanding of the HDC, in order to ensure that my clinical practice preserves and respects the rights of all patients, at the same time as protecting my own professional standing; and if required, that any disputes or complaints are dealt with professionally, and in accordance with HDC guidelines and protocol. This LNA reinforces a number of the OCNZ "Capabilities for Osteopathic Practice", including 'Person Oriented Care and Communication'; 'Primary Healthcare Responsibilities'; and 'Professional and Business Activities'.

Learning Needs Analysis: 1		Osteopath Preceptor comments	Agreed actions points
What skills and knowledge you already have	I have a generalised understanding of patient rights, but lack specific knowledge of complaint procedures and protocol in NZ. I feel I am a strong and adaptable communicator with patients; this has been affirmed in feedback and practical grades throughout my Osteopathic studies, and I work hard to ensure this continues in my professional practice.		
Identify skills, knowledge and capabilities that need developing	Having lived in the UK for over 9 years, I need to improve my understanding of patient rights in NZ, what this means for me as a practitioner, my obligations under the HDC, and where necessary, adapt my practice habits to better comply with these requirements. Specifically, I need to improve on my record keeping as I am currently struggling to write sufficiently detailed notes within a 30 min session; and communication of risks and benefits, in order to ensure *informed consent* for treatment techniques where appropriate. (Note: 30 min treatments are the *expected norm* within the practice where I am currently an associate).		

Identify clearly what you wish to achieve	Increase my understanding of consumer rights and the HDC in NZ. Review the formal complaints procedure at the clinic where I work. Improve my record keeping skills to ensure that all required information is recorded efficiently, *and* within expected time frames. Explore appropriate and efficient ways to communicate risks/benefits in relation to *informed* consent for treatment.		
Outline and define expectations and goals	Increased understanding of the Health and Disability Commissioner requirements as they relate to Osteopathic practice. Familiarise myself with appropriate complaints procedures and protocol. Investigate opportunities to improve my patient record keeping skills. Explore different ways to effectively and appropriately communicate treatment risks.		
Clarify what can be realistically achieved in the current situation	The above goals are chosen to be realistically achievable within my current work/life commitments, and appropriate time has already been allocated for these tasks over the coming months as part of the SLRF goals for my preceptorship timeline planner 2015/16 (Excel spreadsheet available). Improvement of my record keeping abilities will be an on-going process, with the goal of developing an efficient and compliant system which works for me in clinical practice.		
Reflect upon any obstacles or difficulties that may be relevant	As I have planned to develop a specific LNA to reinforce my abilities in record keeping, I feel sufficient time and effort has been allocated to adjust accordingly where required to achieve these tasks and I therefore don't foresee any relevant obstacles to this LNA.		
Determine suitable evaluation mechanisms to assess if the learning needs have been addressed	SLRF entries for agreed action points above, with appended procedures/support material where required.		

Preceptee signature.. Osteopath Preceptor signature..

Subsection (II): Self-Learning Report Form (SLRF1) – (Linked to LNA1 – HDC)

Stage 4

Competent Authority Pathway Programme (CAPP): Self-Learning Report

Preceptee.. Osteopath Preceptor ....

Date	Learning item	Summary of learning content and learning objectives	Appraisal of how this learning will impact on your practice
19th August 2015	Clinic complaints procedure, protocol, and patient rights.	Discuss the current complaints procedure and protocol with the clinic director/admin support. There is clear information visible to patients in the reception/waiting area, outlining the clinic complaints process, including contact details for the HDC if required. *Note: Involving HDC is preferably reserved for serious complaints, with first advice being to discuss directly with the practitioner and/or the Clinic Director, which is where most complaints appear to be resolved amicably.* There are also two separate pieces of information from the HDC – A wall poster outlining Patient Rights, and a bicultural brochure (which can be taken by patients), entitled 'Having a problem with a health or disability service?' I also discussed the complaints procedure with admin support. (See Appendix A, B, C for clinic information documents)	Knowledge of Patient Rights and appropriate procedure/protocol regarding patient complaints is crucial in running a compliant and patient-centred practice, and to abide by regulations under the HDC Act (1994). It is a requirement under the act that as a health provider (if asked) I can clearly explain an established and appropriate complaints procedure. I hope that through good patient management and communication I may avoid any complaints, but if required, I now feel comfortable about the clinic protocol and how to advise patients on their rights, with the preference being to find an amicable resolution through effective and respectful communication.
20th August 2015	Internet Research: HDC Websites: **http://www.hdc.org.nz**	Explore and research the educational tools available on the HDC website. This included a brief history of the HDC Act (1994); The Vision (Consumers at the centre of services); The Role of the Commissioner (Advocating and protecting Patient Rights); The HDC Code, including the ten rights of consumers and the duties of providers; The principle of Self-Advocacy; and the Complaint Process. (See Appendix D and E for supporting documents).	Understanding the Role and intent of the HDC, the Code, and Patient Rights is crucial to good clinical practice, because as a health provider I am obligated by law to abide by the code, and offer a compliant service with regards to Patient Rights.

21st August 2015	Video Link: HDC – “Making it easy to get the right service” **https://vimeo.com/14376807**	Watching the educational video listed (27:10), in order to further understand patient rights, in the context of daily clinical practice using various patient interaction scenarios.	Most of what I’ve researched about the HDC is an extension of what I already believe to be good communication and patient care (ie common sense professional practice), however, the video presentation helped me to understand in more detail about how specific patient rights can be acknowledged, and actualised in day to day practice. I now feel more informed about how to appropriately adapt and respond to individual patient needs, particularly if they have concerns about my service, communication, or professional conduct.
31st August 2015	30 Minute Bookings	Explore options to allow extra time for new patient consultations (this includes new patients to the clinic, and current clinic patients I am seeing for the first time). I discussed my concerns with the principal Osteopath, colleagues and also admin staff. It has been agreed that wherever possible, a double session time (1hr) will be allocated for new patients, either new to the clinic, or existing patients who I am seeing for the first time. It is however, also acknowledged that this may not always be practical, particularly with established clinic patients, and I will need to retain a degree of flexibility to take on new, or new existing patients within the current 30 minute framework if required.	This additional time will allow me to properly develop my consultation, note-taking, and examination skills during my first year in professional practice, as well as provide a more comprehensive new patient experience, inclusive of some treatment elements.
Stage 2 14th October 2015	Complaints Procedure In-Depth	Further research into the Complaints procedure, in order to understand the step by step process of what actually happens once a patient complaint is lodged with HDC – when and how OCNZ become involved, and the role of the Professional Conduct Committee (PCC), or in very serious cases, involvement of the Health Practitioners Disciplinary Tribunal (HPDT). (See Appendix F for step by step Complaints procedure from OCNZ). Weblink: **http://www.osteopathiccouncil.org.nz/making-a-complaint**	This was a helpful addition to previous study regarding patient rights and the complaints process. It’s one thing to know that patients can lodge a complaint with HDC, or OCNZ, but much more useful to have an understanding of what actually happens next, and who is involved in that process. For example, it’s good to know that the PCC contains an independent layperson, and that HPDT involvement is reserved for only very serious matters. This improved understanding allows me to better inform patients about the complaints process, and what they can expect, and also to be mindful of what that process should mean for me if a complaint was made. The formal pathway of the complaints process also serves as a reminder to ensure that my patient records accurately reflect all necessary details of the therapeutic relationship.

5th December 2015	Complaints Procedure – Practical Application: How would I handle a patient complaint, in line with clinic protocol?	The first step in handling a complaint is to respectfully acknowledge the patient, and really listen to what they have to say, and how they feel, in order to properly understand the nature of the complaint. I would firstly try to address and resolve any complaint directly with the patient if possible, through respectful and professional dialogue (including apologising if needed for any miscommunication, or actions which may have caused offence or concern). I would also inform them of their right to make a formal complaint with the HDC as per the patient information provided in the clinic, *however*, I would ask that they first put their complaint in writing to the clinic director, who would then act to investigate and follow up the complaint, and hopefully help to resolve the matter for the patient without it needing to go any further. If the matter does proceed to the HDC, or onto the OCNZ, then the clinic director and administrative staff would work with me to ensure we are able address the complaint as best we can, in compliance with any regulatory requirements, and with a goal of finding an amicable resolution for all parties concerned.	It is one thing to know what the official and regulatory procedure is, but it was useful to consider what this means in practice, and how I would go about actually addressing a patient complaint if needed. In discussing this with my clinic director, he affirmed that the most important thing is to **maintain good communication**, because ultimately it's difficult for someone to really want to follow through on a complaint if you are nice to them, and show that you understand and want to address their concerns. Whilst I hope that I won't have a need to utilise these skills, I feel that based on this research, I would be able to and effectively manage a patient complaint if required.
5th December 2015	Progress report on patient booking times	As noted previously, I have amended my diary, and instructed the admin staff to allow for double bookings (1hr) for new patients wherever possible. Whilst this has not always been possible during busy times, for the most part it is working well.	The extra time has been invaluable in terms of properly investing new patient cases, and being able to systematically undertake a full case history, examination, and allow time for treatment. I didn't realise that I was also able to charge for the extra time through ACC, so that was a bonus, and actually makes it more justifiable for the clinic. Where it hasn't been possible to book a double session, I have to comply with the clinic practice of 30 min, but where needed, I will run over by 5-10 min, or book the follow up as 45 mins to allow more time then. My list currently allows for this as I try to schedule regular breaks between every 3-4 patients, so an over-run needn't affect my whole list. I have also adapted my billing for ACC to the nearest 5 mins, and with more complex cases have allowed for scheduling a 45 min follow-up if required. This has helped to make me feel more relaxed and adaptable in practice, particularly as I know that (at least under ACC) the clinic and myself are being remunerated for any extra time needed.

Stage 4 4th April 2016	Progress Report and Conclusion of SLRF1	I have continued to allow for double booking times (1hr) for new patients, and also introduced strategic placement of complex cases into breaks or lunch as a means of allowing some additional time without further disruption of the clinic diary or patient booking numbers. I feel comfortable that I have addressed the requirements of this LNA regarding the role of the HDC, not only in terms of understanding my legal requirements under the code of practice, patient rights, and the formal process of complaints, but importantly, implementing this knowledge into my clinical practice – understanding the importance of my patient communication, informed consent, and how to practically handle a patient complaint if required, based on clinic protocol.	The increase of time for NP bookings is continuing to work well. I have found that 45 min is sufficient in *most* NP cases, and as such we try to schedule these (and other cases which I think warrant additional time) before breaks or lunch. My diary operates in 30 min blocks, and I schedule gaps every 4-5 patients anyway, to allow for overrun if needed, or to catch up on my notes (or just take a break!). This modification has been useful because if I need that extra 15 mins into a break, the 30 min blocks mean I still get the chance to reset and have a break anyway, and this approach doesn't take away from other potential bookings. During busy periods I am still seeing NP's in 30 min, but as discussed, this is a pragmatic compromise given my current clinic setting, and given the way my diary is arranged, the option is still there if I do need to overun on occasion. This approach to managing patient booking times is one which I will continue for future practice. So to clarify my time allocation, wherever available NP bookings are allocated 1hr. If a double slot is not available, we try to schedule NP's before a break. This does mean that I am compromising my break times, however they are scheduled in 30 min blocks, so if I do need to run over, I will generally still get a 15 min break, and at least 45 mins for lunch. As mentioned this is not ideal, but a pragmatic compromise on my part in order to find a happy medium between my own treatment preferences, and the practice style of this particular clinic. For future reference, in my own practice I would look to preserve both NP times as well as my own breaks.

			This has been a very useful LNA for me, not in the sense that my clinic practice has changed a great deal on the surface, but I now understand how I am meeting my obligations, and protecting patient rights under the HDC. Before this I hadn't really given it too much thought, because I have always considered patient communication to be one of my strengths, and it is my practice to try and establish a respectful rapport, and to explain all aspects of the therapeutic process in a way which is clearly understood by each patient. It would be naïve of me to think however, that I am immune from patient complaints, misunderstandings, or negative experiences. This process has helped me to realise how I can not only better protect the rights of my patients, but also protect myself, my professional reputation, as well as that of the profession in the event that a complaint is made.

Global rating for this form:

5. Standards demonstrated are those equivalent to those of an independent fully registered practitioner in New Zealand.
4. Satisfactory standards demonstrated, little guidance required for independent practice in CAPP.
3. Borderline standards, but only minimally below required levels, some guidance in CAPP required.
2. Borderline standards but deficiency not an over-riding bar to practice in CAPP, significant guidance required.
1. Below standards required for independent practice in New Zealand.

Preceptee signature.. Osteopath Preceptor signature..

Appendix of Supporting Documents:

A: Clinic Complaints Procedure – (Stage 1)
B: Clinic Patient Rights Poster (HDC) – (Stage 1)
C: HDC Advocacy Brochure (online version) – (Stage 1)
D: Complaints Management Guide for General Practice – (Stage 1)
E: Commissioner – The Code (summary) – (Stage 1)
F: OCNA Complaints Procedure – (Stage 2)

Subsection (III): Learning Needs Analysis (LNA6) – Clinical Skills Development

Competent Authority Pathway Programme (CAPP)

Preceptee.. Osteopath Preceptor ....

LNA6 – Clinical Skills Development

Objective: As a recent graduate, I am committed to further developing and refining my clinical skills. This LNA acknowledges areas where my clinical experience is limited, identified through self-reflection of my post-graduate clinical experience. A key area of clinical skills (HVTs) has been chosen for specific development within this LNA.

Learning Needs Analysis: 6		Osteopath Preceptor comments	Agreed actions points
What skills and knowledge you already have	I have a competent level of post-grad clinical skills, and understanding of common clinical presentations in order to practice safely and proficiently, however, in practice each patient is unique and doesn't necessarily present as a textbook case, requiring individual adaptation and often a more complex differential diagnosis.		
Identify skills, knowledge, capabilities that need developing	There are particular areas of the body in which my treatment experience and diagnostic skills are limited (ie Hips, Knees, Ribs); some HVT techniques require development, particularly regarding individual adaptations; my knowledge of Gait analysis and related biomechanics is limited; my knowledge of NZ specific medication/prescription drugs could be improved.		
Identify clearly what you wish to achieve	Whilst a number of areas for development have been identified, and will form part of my on-going CPD and self-learning, I have chosen to focus on development of my HVT skills for the purpose of this LNA, specifically looking at adjustment techniques for Ribs, Cervico-dorsal junction, and the Sacroiliac joint (AP Chicago).		

Outline and define expectations and goals	Develop my understanding and proficiency of Rib HVTs. Develop my understanding and proficiency of Cervico-Dorsal HVTs. Develop my understanding and proficiency of Chicago Sacroiliac HVTs.		
Clarify what can be realistically achieved in the current situation	In order to be realistic and achievable within the time frame of my preceptorship, I have chosen to focus on **one** key area of development. These goals have a practical clinical emphasis, and as such, I think they can be incorporated into my daily practice. Appropriate time has also been allocated for these tasks over the coming months as part of the SLRF goals for my preceptorship timeline planner 2015/16.		
Reflect upon any obstacles or difficulties that may be relevant	Achievement of goal #3 is partly dependent on relevant clinic presentations and patient diversity within the limited timeframe of my preceptorship. I am however, part of a busy practice team, including multiple practitioners of differing ages, gender, and body types, so I still have the opportunity to discuss, workshop, and practice clinical skills where required.		
Determine suitable evaluation mechanisms to assess if the learning needs have been addressed	SLRF entries for agreed action points above, with appended procedures/ support material where required.		

Subsection (IV): Self-Learning Report Form (SLRF6) – (Linked to LNA6 – Clinical Skills Development)

Stage 2

Competent Authority Pathway Programme (CAPP): Self-learning Report

Preceptee.. Osteopath Preceptor...

Date	Learning item	Summary of learning content and learning objectives	Appraisal of how this learning will impact on your practice
25th September 2015	Review College Revision – HVLA Techniques, with particular emphasis on Ribs, Cervico-dorsal, and Chicago Sacrolliac HVLAs, as identified in my LNA6 learning goals	Involved reviewing revision material created for my College exams, including class video demonstrations, and self-generated study notes relating to HVLAs. (See Appendix A for self-generated HVLA study notes). I had seen a particular patient for 3 sessions, with neck and shoulder pain, and struggled to successfully adjust her Csp. She has quite a long neck, and despite a palpable restriction mid Csp L/R, is quite mobile overall. In reviewing my class videos, there was a demonstration of either taking up the slack, or using traction as additional HVLA refinements. I also reviewed my overall positioning as I realised I have gradually become a bit casual in my stance, body position, and handhold.	This was very helpful as an introductory refresher to HVLA techniques. I have lots of video footage from senior clinicians and lecturers demonstrating a range of HVLA techniques in the classroom, particularly in relation to subtle adjustments and refinements which are more to do with their own clinical experience than text book theory. Reviewing the theory of more common HVLA techniques such as Lsp, Csp, Tsp, CDJ, also helped refresh my awareness of positional refinements, vectors, landmarks, etc. The impact on my practice comes from the fact that every patient is different, and has different needs. HVLA techniques are only one 'tool' in the treatment box, but if I am to use them, I would much prefer to be confident and consistent in my ability to execute them effectively, and be able to adapt them to suit the individual. A possible downside to HVLA techniques is that if an adjustment attempt is not successful, there is a risk of unnecessarily irritating the joint concerned, or the adjacent tissues. So improving my skills in this area has a direct impact on treatment efficacy, and improved patient outcomes.

15th October 2015	HVLA Technique – Individual Adaptation (identified as a clinical skills development goal for LNA6)	I spent some time during articulation refining my position and sense of barrier, and after taking up the slack in a vertical plane to further focus my fulcrum, I was able to achieve the adjustment needed, and with less stretch on the joint capsule.	This is a practical follow-on from the previous SLRF, providing a real clinic example of where this learning has enhanced my ability to adapt and tailor my treatment technique to suit an individual patient. The impact however is wider than just a successful adjustment, as there is a shared benefit for both the patient and myself, in terms of enhancing trust and belief in the efficacy of the treatment. In turn, this naturally builds confidence and self-belief when working with other patients.
Stage 4 28th April 2016	Colleague Workshops	Over the past month, an Osteopathic colleague and I have booked a weekly 45 min session as a means of working on developing our clinical skills, particularly HVLA techniques. Specifically we have been looking at Upper Csp adjustments, and refinements to Tsp and Lsp HVLAs. This is one of the specific techniques I wanted to address for this LNA, because I have never felt comfortable with them. I don't think I was taught this technique very well at all, I remember it always feeling sore and like I was being 'wound up' too much (even by the tutor who 'specialised' in HVLAs), and none of my classmates at school enjoyed them either. I did however experience a very subtle and gentle prone CT adjustment from an Osteopath in London, but of course, as the recipient I was never in a good position to properly observe and understand the refinements. I have since had some opportunities to both experience and observe my current clinic director performing this technique. He uses it often and it also has been a lot less aggressive than my past experiences. I am still not a big fan of this technique because it can be quite uncomfortable and feel a bit vulnerable for patients given the rotation and compression in a prone position, however, there are some cases where a seated or standing CT lift is not possible (eg shoulder pain), and it's good to have another option. I also find that the prone position can work very well for upper Tsp adjustments, which can be tricky to execute in a supine position.	This has been very helpful to have an opportunity to develop these techniques with a colleague who also knows what to expect, and is able to provide relevant feedback. I have found that I am making more individualised refinements to my HVLAs in practice now, adding subtle modifications to vectors etc, and the consistency of my adjustments has improved. This is due in part I think, to an increased confidence about what I am doing, and feeling more relaxed about the adjustments, which in turn translates to the patient, helping them to feel secure, relaxed, and allowing for a conducive environment for an effective result. My HVLA technique is not perfect by any means, but we are continuing to maintain this weekly get together, as there is always something for us to go over, discuss, and improve on.

<table>
<tr><td>May 2nd 2016</td><td>Prone Cervico-Thoracic Junction HVLAs</td><td>I reviewed a series of Gibbons and Tehan Instructional videos on HVLAs over the past few months, with a particular emphasis on developing my rib adjustments.</td><td rowspan="3">I don’t use prone CT adjustments regularly given the stressors imposed, but in some cases, with younger, otherwise healthy patients who can tolerate the positioning, it can be effective, and I included this as a specific goal in the LNA as I needed to overcome my fear of this technique – basically I was avoiding using it in relevant cases because I didn’t feel confident in my own ability, not because the technique itself is inappropriate. After spending time with my clinic principal, I have since tried a more subtle, gentle set up, and with some great results. I approach this technique in particular as an extension of an articulation, and with some gentle ‘priming’ mobilisation to find the barrier, and with permission and utilising patient exhalation, I follow through with a thrust. My success rate on this is still not fantastic, but where I don’t achieve an ‘audible cavitation’, I simply treat it as a strong articulation and move on. This helps me (and the patient) to stay relaxed with the technique, and I do feel comfortable with including this technique where appropriate. My preference is still to use a lift as I find it gentler, and this technique also has developed a lot for me over the past few months. I modify my lifts quite a bit now depending on the individual, including handhold, use of towel, seated vs standing, ‘rolling’ gentle springing approach vs focused thrust etc. (Note: Individual adaptation of HVLAs is also a specific goal for LNA6.</td></tr>
<tr><td>May 3rd 2016</td><td>Rib adjustments</td><td>Based on the SLRFs submitted, I feel I have sufficiently addressed the clinical skills learning goals of this LNA.
This is not of course to suggest that I feel I am now an expert in HVLAs, but I have worked to improve and develop my HVLA techniques over the past year, addressing particular identified shortcomings in my skill-set, and whilst they are still a work in progress, I am happy with the level of progress I am making.

I have also established an on-going clinical learning environment with my work colleagues for further development.</td></tr>
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			Similar to above, I had been a bit fearful of Rib adjustments due to a lack of clinical experience and confidence, hence why this was also included as a specific clinical skills development goal for LNA6. I think over the past year I have begun to feel more at home with both my sense of palpation and generally understanding the practical mechanics of working with different patients, and being comfortable with 'moving people around' with intent. This in itself has helped me to feel more relaxed about my rib adjustments, but certainly, revising these specific techniques has given me more confidence in clinic, and the ability to have different options at hand ie prone vs supine vs seated etc. I am also less reliant on the HVLA as the 'magic bullet', and am happy using METs, and articulation to achieve a positive result.
3rd May 2016	Final Entry for LNA6		This exercise has mainly been a lesson in feeling comfortable and confident in my own skin as a practitioner. It was important to address specific shortcomings but as could be expected (or realised with hindsight), the more comfortable I have become with my own practice in general, the less concerned I have become about my HVLAs. My treatments are slowly becoming more dynamic, and less compartmentalised i.e less STM + ART + HVT. There remains a separation due to permission and set up (I always discuss and/or ask before performing an HVLA, even with regular patients), however I do feel that I am more intuitively accessing a wider range of tools to achieve a therapeutic intent, and HVLAs are only one tool in the box.

Appendix of Supporting Documents: Self-generated study notes for HVLA technique (NOT REPRODUCED HERE).

Subsection (V): Critical Incident Report

Stage 3

Competent Authority Pathway Programme (CAPP)

Preceptee.. Osteopath Preceptor ....

Period: 1 Date of Incident: 25/06/15

Context of the incident:

This report outlines a critical incident which occurred approximately 1 month after I started my first professional Osteopathic role. I had been working as an associate amongst 3 other more experienced practitioners, and was still finding my feet in the clinic, particularly regarding patient management protocol and communication. The incident occurred during a normal working day, during a follow up appointment for an acute presentation of a new patient I had seen 3 days earlier.

Details of the incident:

My patient was a 31yo lady who presented with acute R LBP, with radiating pain and weakness into her R leg after slipping and falling on her back. The initial consultation was difficult as she was in a lot of pain. I did a full neurological screen, after which I was left concerned about a marked weakness into her R leg, with considerable pain on resisted hip flexion, despite no deficit in terms of reflexes or sensation. I treated very conservatively, advised ice, and gentle knee hugs (passive), with instructions to review after 3 days once the body had a chance to settle. I felt that my communication and reassurance was good at this point and she left very appreciative of my efforts and explanations, despite not feeling any better! On her return she had experienced some minor/temporary relief of the LBP, but the weakness into her R leg was still just as bad. She was clearly concerned about this and asked me if I thought she needed hospital care. I talked her through the possibility of some nerve compression from the Lsp being a possible cause of the leg weakness, and that if she was really concerned about it, that perhaps we could refer her to a specialist for some imaging. It is here that my patient management and communication was lacking. After we finished the session I asked one of my Colleagues for their opinion on the case, whilst my patient was still present. My Colleague called us both into her room, I explained the case to her, and my particular concern regarding the patient's leg 'weakness'. She then asked if I had considered a hip flexor strain, and whether the R Psoas was particularly tender to palpate. I had noted Psoas tenderness, but had been so tunnel-visioned by the presentation of unilateral LEX weakness, that I hadn't seen the wood for the trees ie a plausible hip flexor strain would also present as acute pain and therefore 'leg weakness'. My Colleague then reminded me (in front of my patient), that it's common when you're a new graduate to always think that there might be something sinister involved and it's easy to miss other musculoskeletal causes for the pain. She explained her thoughts to the patient, we agreed on a management plan for me to address the hip flexor strain, and I rebooked the patient. In discussing it afterwards with my Colleague, she suggested it probably would have been better for me to have waited until after the patient had left to discuss the case, as it's really important for the patient to feel that, as the professional, that I am in control, and that they are receiving the best possible expert care for their injury. The next day my patient cancelled their next appointment. I tried to contact her on three occasions, leaving a phone message, and on another attempt, her husband answered and said he would pass on the message that I had phoned. I have not heard from her since.

Thoughts, feelings and concerns:

I realised that I had lost the trust of this patient due to my communication choices; as someone in acute pain, she needed strong assurance, clear guidance, and expert management of her case and what she got was a 'new-grad' who was unsure of himself, and needed direction from someone with more experience! I felt annoyed and embarrassed, and wished I could replay the process from the beginning.

Reflection on why events may have occurred:

Patient communication is something that I usually consider to be one of my strengths; part of my process is to communicate in simple terms the process as I am going through it, so the patient knows what is happening, why I am doing what I am doing, and how this relates to their particular presenting complaint. On this occasion however, because I was so 'tunnel-visioned' by the prospect of something more sinister (Unilateral neurological LEX?), I found myself not being able to account for the apparent disparity of neurological findings, and because the patient needed answers I opened the door to poor communication and patient management choices.

Learning points:

A patient's trust in me as the 'expert practitioner' is crucial to their belief in the efficacy of the therapeutic relationship, and their potential for recovery. I need to remember to account for ALL potential causes of pain, and not leap to conclusions in the face of acute pain or radiating symptoms. I will no longer discuss patient cases with colleagues in front of the patient, and understand the importance of retaining my position and perceived expertise in the eyes of the patient. This experience has helped to inform and improve the way I communicate with, and manage my patients.

Appendix – Subsequent Reflection following Preceptor discussion:

It was noted by my Preceptor that the communication from my colleague was not helpful at all to my situation. This is something that I was extremely frustrated about at the time myself, but felt that it was partly my own fault as I had opened the door by asking my colleague for her opinion in front of the patient. I didn't expect her to highlight the fact that I was a new graduate, and felt that it undermined my professional integrity, and contributed to a subsequent lack of trust from my patient. I have since discussed the matter with the colleague concerned, who was very apologetic and hadn't realised the manner in which she had communicated. We have agreed that it's important to be able to discuss patient cases at times, and that in future, we will always try to communicate in a way which supports and preserves the integrity of the practitioner concerned.

Another point of discussion raised, was the amount of times I attempted to contact the patient following the incident. At the time I felt this was the right thing to do, but on reflection, as a new practitioner it was actually more about my own process and needing to regain some personal validation and professional confidence, and less about my concern for the patient. My Preceptor pointed out that other healthcare providers such as dentists, physios, and GP's do not routinely follow up patients multiple times to check if they are ok. This helped me to see my actions in a different light, and I realised that I actually overstepped professional boundaries by trying to contact the patient multiple times on this occasion. A courtesy call would have been acceptable, justified, and in this case shown good patient care, however I should have left it at that! This was a very helpful lesson going forward, in developing a better understanding of how to preserve my professional standing, maintain appropriate boundaries, and improve patient communication.

Subsection (VI): Inter-Professional Collaboration/Education/Learning Report

Stage 4

Competent Authority Pathway Programme (CAPP)

Preceptee.. Osteopath Preceptor ....

Date	Details and context of inter-professional learning event	Summary of learning content and learning objectives	Appraisal of how this learning will impact on your practice
Stage 3 29th October and 4th November 2015	Collaborative Care and Treatment discussions with Acupuncturist	An Acute Disc patient enquired about the benefits of acupuncture for his injury, and I initiated a collaborative care management approach with the resident acupuncturist who also works on-site. (Note: See also Stage 3 Case Reflections Part 2 – Patient A – Collaborative Care Discussion)	I have undertaken a basic ‘dry needling’ course in the UK, in which certain principles of traditional acupuncture were outlined, however I have not seen or discussed an acupuncture approach for acute LBP based on more traditional principles. With the patient’s permission, I was allowed to observe the initial consultation, and alongside further discussions, I found there are a lot of similarities between the Osteopathic and Acupuncture perspective. In particular is the central importance of flow throughout the body (energy or QI – Ch’i), with the objective of treatment being to encourage or re-enable energy flow, and in doing so, restore balance to homeostasis, and the natural/innate healing mechanisms of the body. I used to talk a lot about this principal in order to reinforce my patients understanding of their own body’s potential for change and health, and to encourage a ‘therapeutic partnership’; This experience has helped me to reintroduce this as part of my own patient communication again. My acupuncturist colleague noted that *“Where there is Pain, there is no free flow, and where there is no Pain, there is free flow”*. This for me resonates with Still’s own remarks that

		Dr…… and his wife are personal friends of mine, and we met recently for the first time since I have returned from the UK, and subsequently discussed my recent Osteopathic career pathway. They have developed a family health practice in a low socio-economic of, Auckland, over 35 years. Although it is primarily a GP practice, they offer on-site physiotherapy, counselling, and other community support services. I was surprised by our discussion, because both the Dr and his wife were uncertain about what Osteopathy was. We talked at length about Osteopathic philosophy, and the broader consideration of health which Osteopathy acknowledges (ie the body is a unit; of body, mind, and spirit). Also the principle of reciprocal interrelationship between structure and function, and belief in the innate capacity of the body for health.	*"The rule of the artery is supreme"*, as well as acknowledging wider principles of 'life-force' and 'universal energy' which are also held within the broad spectrum of Osteopathy. The treatment in this case, involved inserting needles into particular points of the hand, and then asking the patient to walk up and down the room, observing for a change in antalgic posture. This was repeated several times using various insertion points which traditionally connect, not only with related somatic and visceral tissues in the Lsp region, but also to the lungs, for breath and fluid dynamics (oxygen, blood, and lymph). This for me resonated with the principle of the body working as a tensegrity structure, in which changes to, or stimulation of, one part of the body, can have an influence on distal tissues, and on the body as a whole. We also discussed principles of hot and cold, and what appeared at first as some potential differences in our approaches. Within Acupuncture, Cold is always the enemy of flow, and *heat* is the pathway to restore flow and movement. This made me think about the application of ice to help calm/mediate reactionary or inflammatory responses. At first it seems that the two disciplines are opposed here, but actually, within the application of ice, I think that heat is actually still the end goal, and ultimate desired response.
		The Dr's wife had recently injured herself, and was undergoing physiotherapy, and both were interested in what I considered to be the difference between the main modalities of Osteopathy, Physiotherapy, and Chiropractic.	

Stage 4 30th April 2016	Discussion with a GP and his wife (a GP practice nurse) regarding the nature and approach of Osteopathy	MrDr…… was also very interested In cranial therapy, and an acknowledgement of more biodynamic, and energetic components of patient health. MrDr. …… is a Christian, and appreciated the premise of a universal life force (or 'higher power') which is acknowledged within cranial therapy, as this resonated with his own world view and spiritual perspective. He saw this particular aspect as being very refreshing, because even though he operates within the constraints of an allopathic system, he personally considers a universal (spiritual) dimension/energy to be at work and influencing the health potential of his patients. Mrs …… really appreciated our discussion regarding the approach of Osteopathy with some real case examples. The discussion was an eye opener for each of us in different ways. They were pleasantly surprised to find out more about Osteopathy, and I was equally surprised to realise that an experienced couple from the allopathic community, would have such a limited knowledge of Osteopathy as a viable treatment system, and a potential therapeutic referral option.	Whilst the initial 'shock' causes localised vasoconstriction and a subsequent temporary reduction of flow, the real benefit of icing I think comes after its application, once the blood and lymphatic vessels slowly re-open as the body warms. This allows for a fresh influx of blood cells (carrying oxygen, nutrients, immune cells); as well as a drainage away of cellular congestion/debri, thereby enabling *'Heat'* to be re-introduced in a measured way. Ice and Heat are therefore complimentary, and appropriate repeated application can have an influence of encouraging increased fluid dynamics, but in a way which supports the healing process, rather than congestion and stasis, which often result from an inflammatory response. This has directly impacted the way in which I now discuss the influence of cold vs heat with my patients, and I now allow more time to discuss the difference and benefits of each. Other ways in which this experience has informed and enriched my own practice, is by reminding me to consider the tensegrity nature of the body, and how focussed and considered treatment to one local area, can encourage change in distal tissues. I would also now be more open to considering collaborative therapy with acupuncture, as a potential option for my patients, and not only in cases where I feel my own techniques are limited.
			So overall the experience for me was vey positive, both to observe and appreciate another discipline in action, but also to encourage my own thinking and rationale as an Osteopathic practitioner.

			It may appear simplistic, but the learning I have taken away from this experience, is that Osteopathy as a profession has not done an effective job of branding or communicating its potential as a viable health-management system and manual therapy discipline. This is not an isolated discussion, but indicative of countless conversations I have had with people since changing my career. This was however, particularly surprising given the context of discussing Osteopathy with an experienced GP and practice nurse, and in this context I do feel it is an important Inter-professional learning experience.
			I have noted previously the dilemma that exists in effectively branding Osteopathy given its broad spectrum of practice. This experience has really affirmed the need for myself, and for Osteopathy as a profession, to better inform allied health practitioners, and the public, about the nature of what we do; and how Osteopathy can be an effective primary care system, or an effective complimentary treatment partner alongside the dominant allopathic system. As a future-learning goal, I would like to investigate extending networking opportunities between GPs and other healthcare professionals, with the Osteopathic community. The way this learning has impacted on my current practice, is that I now make a point to discuss Osteopathic principles with all my patients. I try to educate them about a wider consideration of their own health, what I am doing, how it works, and importantly, how they are an integral part of the therapeutic process. The more I am able to differentiate Osteopathy from physiotherapy, chiropractic, or any other form of manual therapy, the better, because this quickly becomes the common question once we start discussing what Osteopathy is about. Note: I discuss modality comparisons in a respectful way, and only when asked by my patients… which is often! I also contextualise the level of discussion and education to each patient, as of course, not everyone wants to talk, or necessarily to listen.

			I am passionate about this, and as I have mentioned in earlier submissions, this has been a major bug-bear for me – as a student - now as a practitioner - and also as a patient who only 'discovered' Osteopathy in recent years. Osteopathy is by nature a collaborative process, and this experience affirms the need for me to continue to share that process, and encourage my patients (as well as GPs and health nurses!) to better understand it, so that Osteopathy as a profession can develop into a more widely recognised and respected brand of health management.

Preceptee signature..

Subsection (VII): Case Based Discussion

Stage 2

Preceptee.. Osteopath Preceptor..

Osteopathic Perspectives Discussion

Overview of my care plan for this patient, and how it fits with other care or self-help undertaken?

This case was a challenge as it was my *first* acute disc patient – highly symptomatic, and who could hardly move! My therapeutic intention with *all* patients involves 3 main treatment stages: Symptomatic Relief; Tissue Repair; and Strength and Support (with patient education/reinforcement throughout). My goal is to develop a *therapeutic partnership*, so communication, language, and education, are paramount in establishing patient trust and belief, not only in me as a practitioner and the efficacy of the treatment, but also in their own capacity for health and recovery. With this patient however, my treatment plan was based on what I have learnt *in theory* about disc injuries and management, but not yet experienced in practice! After identifying the tissue causing symptom, and ruling out any red-flags, my initial treatment involved *decompressive* based STM/ART of the Lsp, in a position of ease, focussed stimulation of the affected area, and Ice. Communication was the most important aspect of my care plan in this case; given the acute presentation, my hands-on techniques offered little initial relief, but it was important to establish hope and support, and a clear pathway towards recovery. I felt I was able to manage this well for my patient, but I did 'hang my hook' on the theory in this case, and quietly had my fingers crossed! I advised my patient to see their GP for prescription strength pain-relief, and to apply ice on/off to help mediate inflammation. So from the outset there was an integrated plan of care, involving both allopathic and self-help elements.

What makes my examination and treatment Osteopathic?

I considered this patient as an individual, not as a presenting condition. By this I mean that I worked to understand and contextualise the presenting complaint within the various individual aspects unique to my patient's life, work, and general health *eg Middle aged, married (0 children), slightly overweight, underactive but with fitness goals, work responsibility, high stress at times, desk-based work, lots of driving, etc*. Osteopathy acknowledges the interconnectedness of body, mind, and spirit, and given the acute discomfort in this particular case, it was important to 'treat' all three aspects ie knowledge and education – hope and potential – therapeutic touch/support.

Which parts of this patient's general care lie outside my professional scope?

Predisposing individual factors such as excess abdominal weight, workplace ergonomics, and poor core strength were addressed and encouraged (as appropriate), as was advice for the use of ice and exercises, but ultimately, lifestyle choices and changes are dependent on the patient themselves for success and I cannot enforce patient compliance. In the short term, access to strong pain relief required a referral to the GP. Further imaging/specialist referral was not required in this case, but a collaborative care plan would have been considered if needed, and the potential of surgical intervention was discussed with the patient.

What are the potential risks/benefits in my treatment of this patient?

Initially there was a risk that I could try and do *too much*, to over-treat an area that was highly inflamed and sensitised, potentially exacerbating the problem. With a disc prolapse, there is also a risk of aggravating the bulge or potentially causing a sequestration of the disc material through forceful articulation/HVLAs, particularly in positions causing posterior-lateral disc pressure. The main benefit of my treatment in this case I believe, came from good communication and management of the patient's complaint (I realised quickly the importance of providing clear leadership in this case – despite having my fingers crossed!). Ultimately, the acute inflammatory symptoms needed time to settle and the patient really didn't experience any relief from my initial hands-on techniques, however he did feel supported, and assured that his condition was manageable, and that there was a clear pathway towards pain relief and recovery.

How will my Osteopathic techniques be having a physiological effect on this particular patient?

A side-lying position of ease with foraminal gapping allowed *decompressive* articulation of the affected area, relieving disc pressure and irritation of adjacent tissues, and allowing for dissipation of cellular congestion. Localised stimulation of the affected vertebral segment and surrounding tissues helped to interrupt the dominant pain response from local nociceptors, thereby influencing the CNS response. The application of ice allowed for localised vaso-constriction, thereby mediating inflammation and reducing nociceptive

sensitivity; this was followed by a re-introduction of fresh blood cells carrying oxygen, nutrients, immune cells, and a 'flushing' of local lymphatics as the body warmed up again.

Personal Professional Perspectives Discussion

The priority in this case for me, was directed by the state in which my patient presented. He could hardly get in (or out again!) of the clinic, and was visibly distressed by the pain he was in. A formal examination procedure was virtually impossible as it was very difficult for him to find a position of ease, let alone be subjected to a range of clinical tests. So in this case, I made a choice to determine a working diagnosis of a Lsp disc bulge based on simple questioning, the presenting antalgic posture, and basic modified tests, rather than triangulating through a series of formal active and passive examinations. Thankfully I had only recently completed a masterclass workshop weekend on managing Low Back Pain, and *acute disc presentation* was one of the conditions covered, so it was fresh in my mind. Ultimately I didn't feel I was able to initiate a thorough case history, as my patient was literally groaning with pain, and wasn't in a state to concentrate on a series of medical history questions. So I made sure to rule out any red flags (incl bowel and bladder changes, saddle anaesthesia, LEX sensory loss/weakness etc), and then concentrated on finding a position of ease for my patient.

In this case, I made a choice to not initiate a full systematic case history and examination, and instead did only what I felt was needed to establish safety, and to corroborate my working diagnosis. I felt that it was important to prioritise my patient's immediate well-being, to establish his trust in me, and to help him feel that despite the pain and discomfort, he was in the right place, and would get the care and support he needed. I subsequently added to the notes in later sessions in order to build his case history, once he was in a more stable condition.

Osteopathically, it would have been beneficial to have been able to undertake a more global postural assessment, however I chose not to attempt this as my patient was very uncomfortable standing in one position for any length of time, and a pronounced functional scoliosis/antalgia, also would not have allowed for an objective postural assessment.

In terms of hands-on treatment, osteopathically it's possible to justify a range of approaches based on the concept of tensegrity, and the principle of reciprocal interrelationship between structure and function. I had been taught at College (in relation to acute presentations), to be wary of treating the affected area directly, due to the potential of spreading inflammation to adjacent tissues, and that in such cases, it may be more beneficial to work away from the site of pain, addressing adjacent and compensatory tissues as a means of achieving a desired change. Recent discussions however have challenged this approach, including some of the material presented at the recent masterclass workshop, which suggests that *direct treatment to the symptomatic area will effect the most powerful neurophysiological change*, and that the more nerve endings stimulated, and the deeper the layers accessed, the greater chance of influencing the pain phenomenon.

I hold these two approaches not in contention, but simply as different means to an end (as is the *broad church* of Osteopathy) but in this particular case, given the limited mobility of my patient, I chose the latter approach, with direct and focussed treatment to the site of injury. I chose not to perform any HVLAs on this patient during the initial treatments. My own preference is not to directly adjust a segment with a symptomatic disc bulge given the potential risk of exacerbating the problem, but I am comfortable with, and appreciate the physiological benefits of adjusting the spine above an affected segment, both to support mobility of compensatory joints, and to achieve a neurological release of related tissues. My patient would not have tolerated any adjustments during our initial treatments, but I did progressively introduce HVLAs above the affected segment in subsequent visits, based on the above rationale.

My consultation, treatment, and management choices in this case, I felt were based on the needs of this particular patient, but as stated, my care plan on this occasion was grounded in theory, and not clinical experience! Thankfully this case was not atypical, and followed a predicted pathway of recovery, despite what was for me a challenging presentation, and a reinforcement of the importance of effective communication and patient management.

Patient Centeredness Discussion

As mentioned, my approach to treatment involves a therapeutic partnership, in which the patient themselves is an integral component of the recovery and management plan. With this case in particular, it was important to educate my patient about what was happening with his body, and to provide reassurance given his acute and painful presentation. My communication needed to be clear and simple, as my patient was understandably preoccupied with the discomfort he was experiencing and had limited capacity for absorbing information or instruction. I asked his wife to also attend the second treatment (with the patient's permission) in order to reinforce the message and reassurance for her as well, and also because at that point, she was able to take on board more information about her husband's condition, and thereby support him outside of the clinic with the self-help elements of the recovery plan.

So my first priority regarding self-help was education. Disc injuries can be scary given the wide ranging symptoms, and immobility associated with an acute presentation, and my patient was understandably fearful of what he was experiencing, and needed to know what was going on. Knowledge helps to mediate fear

and stress, and I think is the first step to initiating positive change, both in the mind and the body. It also reinforces the self-help instructions, because the patient understands *why* a particular action or exercise is helping their recovery, so can become invested in their own ability to make a difference, rather than simply adhering to a list of instructions.

The next self-help step was to introduce progressive exercises, and instruction on the use of ice to help mediate inflammation, enhance pain relief, and encourage local fluid dynamics. This is where the recent masterclass was very helpful; I advised firstly gentle side bend mobility exercises against the wall, both to ease disc pressure, to encourage the disc bulge to be 'sucked back' into the intervertebral space, and to help dissipate cellular congestion in the area.This progressed to pelvic bridge exercises once symptoms reduced and mobility allowed, and then onto extension exercises to begin strengthening and supporting the Lumbar spine.

This patient (thankfully) made a good recovery and over the course of 2 weeks and 6 treatments, was 95% improved, so we were able to initiate a full range of self-help elements through the stages of pain relief, tissue repair, and strength/support. We identified and discussed potential lifestyle changes, which could enhance my patient's general health, and reduce the risk of injury recurrence. These included stretching exercises (glutes, Lumbar spine, hip flexors, LEX, and thoracic mobility), weight-loss and fitness goals, workplace ergonomics, particularly around driving positioning, and prolonged desk-based work.

I found with this case, that the key to enhancing the self-help and education process, was to focus on developing the concept of the *therapeutic partnership*; to establish the idea that treatment was not just about him being *'fixed by the expert'*, but that he was an integral part of the recovery process. He, being an individual, meant that as that our relationship progressed, my language and communication naturally adapted to encourage rapport and resonate with aspects of his personality ie a share connection with Fiji, an interest in the property market, his relationship with his wife, etc. With increased knowledge and education about his injury, and his body's capacity for recovery and health, my patient also naturally increased his ownership and active participation in the process, to the extent that additional discussions around lifestyle adjustments and preventative strategies became self-evident.

There's nothing like a good scare to help people re-think where they are at and take a greater interest in their health, and in this case, I think the severity of the initial symptoms certainly helped to influence this particular patient's proactive investment in the recovery and management process. The important lesson for me from this case, is that communication and good management is the key. What I can offer in terms of hands-on technique, is ultimately contextualised, and may be potentially enhanced by the environment in which it is delivered and received, and helping the patient to feel valued, supported, and empowered, is an integral part for me of what constitutes *treatment*.

Osteopathic Plan of Care Discussion:

The Patient

Mr X is a 50 year old operations manager, who presented at clinic on June 6th 2015, with a four day onset of left-sided low back pain, following a long drive back from Auckland to Tauranga. He initially felt a sense of stiffness, and gradually increasing discomfort into the left low-back area, but then woke with severe symptoms, and radiating pain into the posterior lateral aspect of his left leg. Mr X was in a lot of pain (visibly distressed), and found it difficult to walk. He presented with a classic antalgic posture, with a functional protective scoliosis, side-bending away from the site of injury.

Work Life:

Mr X has worked as an operation manager for a cargo logistics company for over 10 years. His daily activities involve desk-based computer work, team management, and frequent driving for on-site client meetings. Mr X is in a position of responsibility, and admits that at times his role can be very stressful.

Home Life:

Mr X has been married for 3 years, and has no children. He appears to enjoy a strong and happy partnership with his wife, who also attended some of the earlier treatments given Mr X's initial levels of discomfort and reduced mobility. Together they enjoy travelling, and have trips planned to Australia and also Fiji this year, which is an annual pilgrimage for them to the place they were married.

General Health:

Mr X is 6"2 tall, a little overweight, and under-active in terms of fitness and activity outside of work. He admits that he has decreased his level of exercise in recent years, and expresses a desire to resume running, gym work, and swimming, which he has enjoyed in the past. His diet is balanced, with moderate alcohol intake, but he admits could be better as he has a tendency to eat out for convenience. General systemic screening questions reveal nothing of concern (ie bowel and bladder, CV/BP, Respiratory, GI, balance, vision, hearing, etc).

History:

The patient has a history of disc injury to the same area 3 years ago in 2012 (similar onset) although the previous episode was a lot less severe. X-rays taken at that time in 2012 showed no degenerative changes, bony anomalies, or reduction in intervertebral height. Previous treatment has included physiotherapy, acupuncture, strapping, and Osteopathy. Mr X complains of generalised lower back stiffness which comes and goes (approximately every 2-3

months), often exacerbated by prolonged desk-based work or driving, but it usually settles on its own within a week or so with some basic self stretches, or occasionally with the help of a sports massage.

Examination:

As mentioned, initial examination was very difficult given the acute nature of the presentation, and a working diagnosis was made on the basis of a simple case history, presenting symptoms, elimination of red flags, and basic tests, including sensory and motor testing of the distal LEX (both of which were negative). *Note: My reasons for choosing this approach have already been explained.* Over subsequent treatments I introduced a SLR as both a provocative test and a measure of improvement.

Treatment/Management:

My treatment and management plan has already been discussed in the previous response, including how my approach was Osteopathic in nature, why I chose the techniques I did, and how my care was adapted for this patient. There were no systemic or other biomechanical concerns requiring further adaptation of my Osteopathic approach, although I felt that I was having to adapt throughout, because as noted, my plan of care for this patient was not based on clinical experience, but on what I have learnt *in theory*. This was a new and challenging experience for me, and overall I feel that by keeping the needs of my patient as the central focus, I was able to adapt and learnt a great deal about the importance of effective communication and management from this case.

Appendix – Subsequent reflection following Preceptor discussion:

Some important points emerged from my Preceptor discussion regarding this case. The first is that I had not determined or recorded a justifiable aetiology/cause for this injury; I had simply described the presenting symptoms and how they had become aggravated by my patient's long drive to and from Auckland, but as my Preceptor pointed out, this in itself is not the cause, and there will have been something else in my patient's case history, some precipitating activity sufficient to cause the underlying tissue damage which then became exacerbated by the compression and vibration of the drive. As was pointed out, this is fundamentally important, both clinically as it would provide a rationale for the tissue-causing symptom, diagnosis, and therefore inform an appropriate treatment and management plan; and also for making an ACC claim in this case, as a justifiable link must to be established between a specific activity, and the resulting injury in order for ACC to approve the treatment. In this case, I was so focussed on short-term 'management' given the acute nature of the presentation that I failed to properly investigate and record a justifiable cause for the injury, as prolonged driving itself is not consistent with a spontaneous lumbar disc prolapse. Ultimately, based on my clinic notes, this case should not have resulted in an ACC claim. Whilst I can't adjust my clinic notes retrospectively, I have learnt a crucial lesson – to ensure that a justifiable cause/effect is properly investigated, and appropriately recorded, not only for ACC, but also for clinical integrity and professional compliance regarding record keeping, and the provision of appropriate patient care.

A question was also raised regarding the close spacing of the initial 5 treatments. It is not my usual practice to see patients in such quick succession, and often with acute presentations where an active inflammatory response is present, I try to allow at least 2-3 days between treatments, with advice on stretching, positional release, and icing as appropriate, in order to allow for the inflammatory response to settle first. In this case however, the patient was in such pain and distress, that I felt that it was justified, and therapeutically beneficial to see him multiple times in quick succession. Osteopathic treatment in my view, is not just about applied techniques, but about professionally managing individual health needs, and 'non-contact' communication, education, and support are crucial aspects of the therapeutic process. Whilst it could be argued that purely from a hands-on treatment perspective, there was minimal benefit in having the initial treatments so close, in terms of effectively managing the patient, his concerns, understanding of his condition, and expectations of pain-relief and recovery, I felt it was justified. Lederman (2005, p227) also suggests that, "Manual therapy is not just a peripheral event involving a patch of skin, a joint here and there, a group of muscles, but a potential catalyst for remote psychological and psycho – physiological responses". In hindsight my patient was also very appreciative of the care he received, and whilst it may not be representative of a typical approach, I felt that I provided the right treatment plan for this particular patient, on this occasion.

Another point of discussion relates to outcome measures and reporting, and utilising recognised ACC outcome measures, including the Patient Specific Functional Scale (PSFS), and the Numeric Pain Rating Scale (NPRS), or VAS.

This is something that I will take on board for future record keeping, as not only does it provide useful and consistent clinical markers for patient improvement, but it complies with ACC requirements, particularly regarding AC32 forms for validating on-going treatment, where it is a requirement to 'list measurable goals achieved as a result of treatment to date' (ACC – A guide to completing the ACC32).

Reference: LEDERMAN, E. (2005). The science and practice of manual therapy. Edinburgh: Elsevier Churchill Livingstone.

Subsection (VIII): Case Analysis Reflections Report – Part 1

Figure 1: Five Low Back Pain Patients for Case Reflection 1 Discussion

Patient	Gender	Age	Job	Presenting Complaint	Onset	Aetiology	Precipitating Factors	Differential Diagnosis	Number of Tx's	Tx Time Period	Status
1	Male	47	Tech Solutions Manager	Acute Moderate LBP L>R	1/7	Traumatic – Slipped down spiral staircase	Repeated Lsp loading, compression & vibration from prolonged seated posture in office and car.	L Disc prolapse L2-4 region	4	2/52	Ongoing
2	Female	56	Company Director	Chronic Mild Neck & Mid back pain L>R	2/12	Idiopathic/ Gradual build up	Confirmed degenerative changes C5-7, and L5-S1. Poor posture, overweight, and recent increased psychosocial stress factors.	Primary CDJ dysfunction w secondary Mid Tsp restriction	10	5/12	Ongoing
3	Male	63	Orchardist	Acute Moderate LBP pain L w prox LEX >> L	1/7	Forward bending & lifting – oven tray	Prolonged manual work stress & tissue loading over many years, combined with excess abdominal weight.	L Disc prolapse L4-S1 region	6	4/52	Ongoing
4	Female	58	Landmark Homes Franchisor	Sub-Acute Moderate LBP R w prox LEX >> R	2/52	Forward bending & lifting w rotation – lifting grandson	Confirmed Degenerative changes L5-S1; Reduced abdominal strength & stability from trans-abdominal surgery, and reduced systemic capacity (Breast Ca – 5 years).	R L3/4 dysfunction w R LEX referral	6	2.5/52	Ongoing
5	Female	38	Teacher	Sub-Acute Moderate centralised LBP	1/52	Repeated and prolonged Lsp Ext whilst painting ceiling	Structural LEX inequality L>R, giving rise to Lsp scoliosis, & asymmetrical loading of Lsp and related tissues.	R L5/S1 dysfunction (facet/ capsular)	4	4/52	Discharged

Patient 1 is a 47 year old male tech solutions manager, who spends his working days either at a desk, or driving to and from on-site client meetings. He has an unremarkable medical history, has a young family, and keeps fit and active outside of work, particularly enjoying mountain biking. He presented with a protective antalgic posture following an acute onset of moderate LBP L>R, after slipping down a spiral staircase the day before. He is a compliant patient, but whilst he understands the nature of his injury, he is keen to see results, and to get back out on his bike!

Patient 2 is a 56 year old female company director, in the final stages of selling an established care home business, a process which has been quite stressful. She presented with chronic mild L neck and upper back pain, which had gradually built over the past 2 months. She is overweight, has poor posture, and is quite mobile in her joints (possibly from a background in dance as an adolescent). Subsequent imaging reveals degenerative changes to her lower Csp. She is a spiritual person, with a positive world-view, but some of her family members struggle with drug problems, relationship, and health issues, for which she appears to carry a burden. Whilst the degenerative changes may be viewed as a differential diagnosis, her current complaint is exacerbated and maintained by a range of factors, including her increased weight – resulting in poor posture, over-loading of spinal segments, ligamentous laxity, and subsequent Muscular fatigue/Ischemia – and also, recent increased psychological stress, further exacerbating Muscle tension, and contributing to CNS fatigue as a result of an over-stimulated sympathetic response.

Patient 3 is a 63 year old successful orchardist from a hard-working farming background who presented with an acute moderate onset of L LBP, with referral into his L anterolateral thigh, after lifting an oven tray from the oven the night before. He has had a number of Lsp niggles over the years, precipitated by repeated microtrauma from the physical nature of his work, and also increased abdominal weight, contributing to weak anterior stability, and increased weight-bearing pressure and loading into the Lsp segments and related tissues. He has no remarkable systemic complaints for a man of his age, has a positive outlook on life, and is currently planning a major European holiday in the next 3 months.

Patient 4 is a 58 year old female new-build homes franchisor, who presented with R moderate LBP, after lifting her grandson, with an element of spinal rotation, two weeks earlier. This injury is precipitated by abdominal wall weakness from previous surgery, causing decreased anterior stability of the Lsp, and thereby increased loading of the Lsp segments and related tissues. She also has referred symptoms into her R proximal anterior thigh, and some weakness into her R hip flexor. She has an intuitive awareness of her body's responses and systemic health, having battled breast Cancer 5 years earlier. She is very curious about all aspects of the therapeutic process, is proactive in her self-management, and appreciates the 'holistic' Osteopathic perspective and approach.

Patient 5 is a 38 year old female Art teacher and former set designer, a mother of two, and is currently designing and planning her own wedding, to take place in the coming months. She appears positive and outgoing, but does have a history of depression for which she has been medicated for several years. She presented with sub-acute moderate centralised LBP, which occurred whilst painting a ceiling two weeks earlier. This injury is predisposed by a leg length difference, giving rise to a scoliosis, leading to asymmetrical loading of the Lsp, and subsequently, a decreased threshold of the vertebral segments and related tissues due to prolonged postural compensation and muscular adaptation.

A Brief Reflection on my Patient Notes

In reviewing my case notes, and in light of the Osteopathic capabilities identified as central to this discussion, I realise that my notes do not always provide a clear picture of my patients, or of the therapeutic process and management plan. Basic demographic, vocational, and clinical information is included, but often not to a degree which provides sufficient context for understanding the individual nature of each case. On reflection it would be difficult for a third party to gain a clear idea about *who these patients are as individuals*, and ultimately, within an Osteopathic approach, it is the *individual* we are treating, not a demographic, or a set of symptoms. In each case I have found that there is important contextual information which is either missing, or not highlighted sufficiently, usually to do with background history, potential precipitating factors, psychological/psychosocial factors, and the also the patient's own health view and perspective. There should also be clear reciprocal links between aetiology, examination findings, differential diagnosis, prognosis, and treatment/management plan. Whilst I have recently been brainstorming ideas to help with development of an online clinic notes application, I am currently required to use a pre-formatted template at the clinic, which does not lend itself to a logical flow and recording process in this regard. I do think that overall my clinical practice is largely reflective of the Osteopathic capabilities identified in this discussion, however on reflection, I need to improve on my ability to efficiently and effectively document this process. I will endeavour to reflect these improvements in my patient records report, to be delivered in Stage 4.

Individualising Osteopathic Management Discussion

I believe that 'treatment' begins from the very first interaction with each patient, establishing trust, rapport, and patient belief, not only in me as a practitioner, but in their own body's capacity for health, and the potential of their own contribution to the recovery

process. In practice, this reinforces Osteopathic principles of *body, mind, and spirit*, and each aspect ideally should be considered (where possible), in order to acknowledge the individual health journey of that patient – not in a superficial aesthetic sense, but in order to enable a treatment response which goes beyond simply the application of manual techniques to injured tissues, embracing a wider view of what constitutes 'Health and Wellbeing'. With this in mind, the 5 patients I have chosen who presented with low-back-pain, are of differing ages and genders; each has a different life-story, and a unique set of biomechanical, physiological, vocational, and psychosocial characteristics which I have tried to consider, and include in my treatment approach, communication, and management planning.

On reflection, there are some aspects of the treatment process that proved similar between these patients, particularly in relation to gender. It was not a deliberate or conscious emphasis, but with all three of the female patients in this case, there was more discussion and acknowledgement of mento-emotional factors and wider aspects of their lives, some of which may be impacting on their current health journey. For example, Patient 2, has recently gone through a major life change of selling a long-standing business, and now has significant financial freedom and life choices. On the one hand she is in an enviable position in life, however she has a lot of ongoing family dramas, she struggles with her weight (an aggravating factor for degenerative changes in her Lsp), and her husband has a volatile heart condition, so their new found freedom has its limitations. Her health and world-view is informed by her spirituality, she believes that God is intrinsically involved in all aspects of life, and that life itself is much more than just biochemistry and matter. Because of this, my sense is that her concern for her own health and well-being is very much wrapped up in her connection and ongoing relationships with those around her; investment in her own health is also an investment in her wider life mission, enabling her to continue to live out 'God's plan' for her life. In this context, acknowledgement of the complex 'design' and capacity of the body for health and positive change, encouragement of her fitness and weight-loss goals, and listening to her stories about the people in her life, are all important aspects of her treatment journey.

Patient 4 also has a wider view of her own health, and an intuitive understanding of the *reciprocal inter-relationship between structure and function*, as she has undergone both a mastectomy, and an abdominal hysterectomy in the past 5 years, the latter of which impacts directly on her lumbar stability by way of reduced strength in her abdominal wall as a result of the surgery. Similar to other patients I have treated with a history of cancer, Patient 4 has an increased awareness of physiology, systemic function, nutritional factors, and the interaction between different systems of the body. In this context, not only could we affirm her body's capacity for recovery based on her recent experiences, we could connect the biomechanical relationship between her abdominal wall weakness, to increased demand on the lumbar spine tissues, and discuss how systemic capacity influenced cellular health and the healing potential of the injured tissues in her Lsp. Through increased understanding from these wider discussions of her health and well-being, I could see that she became more invested in the treatment process, and that belief I think contributed to not only a good result and recovery, but a strong belief in an Osteopathic approach.

Patient 5 has experienced depression for which she is medicated, and was open to discussing mento-emotional factors relating to her sense of wellbeing and capacity for recovery. I should note that she was not showing signs of depression, and was in fact in a very positive frame of mind, being recently engaged, and planning and designing her own wedding. She works busy hours though as an Art teacher for which she has to commute to Matamata each day, so my emphasis was to *'accentuate the positive'* and celebrate the creative aspects of her life during the treatments, as a counter-balance for fatigue and stress factors. She also appeared to respond well to strong articulation and soft-tissue work, with lots of positional stretching and movement, which on reflection may have helped to emphasise a *'reinvigorating'* or stimulating approach to the body and her treatment experience as a whole. This contrasts with Patient 4 (above) in which the pacing and delivery of my hands-on techniques, was quite deliberate, slower, and more controlled, with more fluid/smoother transitions from one technique to the next. It should be noted that these differences are largely intuitive, but fit within an overarching ethos of creating an environment which accurately reflects and supports the nature of that particular therapeutic interaction. On reflection I do think the nature of my hands-on techniques in this case was an acknowledgment and emphasis of the *tensegrity* nature of her system – structure and function being purposefully interconnected – with an emphasis on fluidity and harmony.

In contrast, both the male patients in this discussion were much more *practical*, and the emphasis was on restoring their ability to *'do stuff'*. For Patient 1 it was about getting back on his bike, which was an interesting benchmark, as this is not how his injury occurred, and given his presenting complaint he already knew this was not going to be advisable or achievable in the first couple of weeks. There was not a lot of discussion about lifestyle factors, or wider holistic views of the body, however given his expectations it was important for me to explain clearly the nature of his symptoms, and my management approach for a disc injury. I could tell that initially he was hoping for a quick 'click back into place', but he did respond well to our discussion about the need to conservatively encourage fluid dynamics, relieve disc pressure, positional exercises, and to gradually modify the intensity of the treatment based on

his levels of improvement. Interestingly, the connection and rapport I struck with this patient was based on his interest in my musical background, and not his own story. He was initially quite formal and not very chatty, but once he discovered my background (and subsequently 'Googled' me later), his demeanour and active participation in the treatment process changed, he was much more responsive and appeared to accept his prognosis and management plan without complaint.

Patient 3, a 63 year old orchardist, is a good 'kiwi bloke' who likes a chat over the back fence, a few drinks and enjoys his life, his friends, and his family. It seemed to me that a good chat was not just a way of breaking the ice, but also a measuring tool, to see whether I was someone he could trust to do the job at hand. With this established he was very compliant and happy for me to manage his recovery. As with Patient 2 earlier, his weight is an aggravating and maintaining factor for ongoing susceptibility in the lumbar spine, and he was happy to discuss the health benefits of potentially losing some weight, but made no promises! He is both large and tall, so my hands-on techniques needed to be very firm and I also had to be quite careful of my own posture throughout, particularly when setting him up for a Lsp HVLA. This technique was modified for Patient 3 by first introducing some momentum through articulation which I then turned into a 'rolling' HVLA, an adaptation I also used with Patient 2.

Treatment Outcomes Discussion

Similar to the gender differences expressed above, feedback and outcome measures amongst the female patients in this discussion, involved more mento-emotional and holistic factors than the males. Both the males gravitated towards practical, task-oriented measures in terms of gauging their own progress ie Patient 1's chief concern was to be able to straighten his leg without pain, and Patient 3 used the amount of time he could spend on his ride-on mower, or being able to stoop under his trees as his yardstick for progress. The female patients described their progress not only in terms of mobility or pain markers, but in relation to wider lifestyle factors, including feeling less tired, clearer in their thinking, and sleeping better. With all patients I use a VAS (or NPS score), as well as a general perceived % of improvement out of 100% (this is subjective but is a pre-determined box to fill on the current patient record card used at the clinic). I have explored the physiotherapy based PSFS (Patient specific functional scale), however I am yet to include this as a quantifiable outcome measure relating to specific tasks, and instead, rely on more generalised feedback and questioning about ADT's (Active daily tasks).

On reflection I found that there is definitely a subjective element to my consideration of prognosis and management, based on my overall perception of each patient and the various factors unique to their case; and importantly, this is not always correct. For example, I made an assumption in my mind about Patient 3, primarily based on his age, weight, and lifestyle factors, that his recovery would likely be slow, with potential for ongoing 'niggly' issues into the Lsp, also with the suspicion that he would likely have some degenerative changes in the Lsp which may hinder a speedy recovery. Whilst it is highly probable that Patient 3 will have some Lsp degeneration given his working history, he has shown an excellent capacity for recovery, essentially back to feeling 100% within 5 treatments. He has been very compliant with my advice for rest, icing and stretches, and proactively took to using his pool each day for non-weight bearing mobility, all of which have contributed to an improved outcome. This exceeded my expectations based on his first visit, and affirms that each patient is unique, particularly regarding the threshold and capacity of their tissues to respond to injury and restore health. Patient 3 is continuing a maintenance program of treatment over the next 3 months, not because he is in pain, but as he has a world trip planned, for which he may have been denied travel insurance based on his initial presenting injury and age, so we have implemented a support plan to ensure that he is fit and well to travel.

Patient 2 has confirmed degenerative changes and narrowing of her Lsp, and her prognosis was poor given the gradual insidious onset of her symptoms, coupled with her being overweight, which is an exacerbating factor for increased loading and tissue stress in her Lsp. The difference in monitoring her progress was that the emphasis was on retaining rather than improving her level of mobility into the Lsp, and whilst there remains a focal tenderness over the degenerative L5/S1 segment on her left, I was more interested in monitoring pain and tension levels into the supportive soft tissues, including the glutes, and subsequent mobility above and below the Lsp, namely her hips and Tsp. Patient 2 also has degenerative changes to her Csp, which may or may not have resulted as a postural adaptation from the changes in the Lsp. Subsequently her Tsp and surrounding muscles are having to work a lot harder to compensate, and are generally quite stiff. I initially hoped to see more longer-lasting improvement with Patient 2, and this may be due in part to my lack of clinical experience over time in managing chronic patients. Once we had the imaging to confirm my suspicions however, it was a lot easier to discuss and support a rationale for ongoing management.

Patient 1, at 47 years old and being quite active, is a good Candidate for a disc injury. The markers that led to this diagnosis included a protective antalgic posture on presentation, unilateral symptoms into the leg, and increased low-back pain on straightening the leg (SLR is an ongoing outcome measure in this case). I believed his prognosis to be good, despite being in acute pain during his first visit, as there was nothing else in his history, lifestyle, or biomechanics, which might give concern about his capacity to recover. I am happy with my original diagnosis of a disc injury in

this case, and the patient appears to be responding well to the treatment plan, which is gradually intensifying as he improves.

Patient 4 was interesting, as she had been to the physio initially for 2 treatments, but did not respond well, and wasn't happy with their approach. This makes sense in hindsight (as shown in the earlier description) as she very much resonated with the wider Osteopathic philosophy of health. She was concerned about her rate of recovery as she had a long-planned trip coming up. I was actually unsure of her prognosis if I'm honest – I had a working diagnosis of an L3/4 dysfunction, consistent with a lifting injury and her presenting symptoms, however there were a number of individual factors which might hinder her body's ability to recover (these are noted earlier, but also include confirmed degenerative changes and narrowing of the intervertebral foramina at L5/S1). So I didn't make any promises but certainly tried to reinforce a positive outlook through the treatment. I do think this is an example of what can happen when the patient really buys into the treatment process. We had 6 treatments, and yes, overall her symptoms were greatly improved, but she was not yet 100%. She was however, invested in the process and felt very positive about her potential for ongoing recovery. In a case like this, with multiple underlying influences, it's difficult to know whether you've got the diagnosis right, and I would have liked to have more time to gauge this, however she has since left on her travels. Hopefully on her return I'll have an opportunity to see how she is getting on.

My working diagnosis for Patient 5 was a R L5/S1 dysfunction, however on examination I found a leg length discrepancy, which in my experience (as I have a leg-length difference myself), often hinders the recovery process, as the tissues in the region are already under strain due to the asymmetry of the pelvis/spine. My approach in this situation is to first deal with the injured tissues and get the patient back to a 'neutral-norm' for them, before looking to intervene with a heel lift. My colleagues agree that this is a good approach, so as not to introduce too much change to the body at once, but it's a grey area, and potential catch-22, because so long as an asymmetry of biomechanics exists, there will be an unequal demand and strain on the injured tissues, and recovery may therefore be impaired. My prognosis for Patient 5 was for a good recovery over time, but with a need to address the LEX discrepancy in order for an improved future outlook. Once the heel lift was introduced, I was mainly concerned with monitoring pain and tension around her hip and SIJ, due I think from adaptive tension and ischemia through the Glutes and TFL in particular, and thankfully there was a big reduction in these symptoms. I am personally familiar with the sometimes unpredictable and volatile nature of low-back pain which accompanies a leg length difference, so in this case, I think my expectations were realistic and consistent with a primary diagnosis of a Lsp injury against a backdrop of secondary aggravating/maintaining postural factors.

Continuing Professional Development

As discussed, Patient 1 has so far followed a fairly typical disc presentation (typical at least in my limited clinical experience), and from a treatment plan and management perspective, I am happy with his progress to date, and don't have any areas of confusion at this point. What I have learned from this experience however, is that rapport and connection can come from a variety of sources, and in this case as mentioned, it was my musical background which 'hit the right notes' with this particular patient. Joking aside, it's nice to remember that patients may appreciate knowing a little bit about your background and life-story; it can provide a bridge of discussion, and even reinforce trust in an odd way. In this instance, my past musical successes appeared to encourage a level of respect from Patient 1, despite the fact that my previous career in no way qualifies or reinforces my competence as an effective Osteopath! In my experience though, there is actually something about achievement within the Creative Arts, or Elite Sports arenas that can be inspirational for some people, as society often resigns these pursuits to hobbies, or amateur constraints. By contrast, Patient 5 worked at a set designer for TVNZ for many years, across a range of different shows, and I had memories of being on those same sets as a performer, so we were able to connect and share some memories. Obviously, it's not always something that comes up, and for the most part has no bearing at all on my patient interactions, and whilst it may seem trivial – having spent most of my working life doing something completely different – it's actually important and reassuring for me to realise that there is somewhat of an odd bridge between that life, and what I'm doing now, and one which can occasionally enhance the therapeutic relationship I have with my patients.

With Patient 4, there remains some uncertainty about her prognosis given that she is now overseas, but one thing I have learned from my experience with her, is the importance of maintaining my systemic knowledge of physiology, disease and dysfunction, and the interaction of the internal systems of the body. Patient 3 was very interested in asking questions about each aspect of the treatment, what I thought about this and that supplements, what a particular treatment technique was doing, etc. I do tend to talk through what I'm doing and why in simple terms anyway, as part of my intention is always to increase the patient's understanding, not only of their injury, but also how their body is going to go about healing and recovering from that injury. In this case, it was the level of communication and education that we shared, which appeared to reinforce this patient's belief in the efficacy of the treatment, and in turn her appreciation for an Osteopathic approach to managing her health. Whilst highlighted in this case, the same is true for all the patients in this discussion (even though the depth of discussion may vary) what I have learnt, is that this approach is appreciated by my patients, and should not be limited to just 'new graduate

zeal' in my first year of practice, but is a principle of patient communication which works for me and should be maintained in future practice.

With the introduction of a heel lift to address a leg length discrepancy, Patient 5 responded quite well, but I mistakenly 'kind of' discharged her after 4 treatments, with self-management stretches and advice. I was still in a phase of being quite passive in my patient management at this point, and once a reasonable level of improvement had been reached, I would often leave it up to the patient if they *'felt they needed to come back'*. In this case, she did book a follow up appointment, but didn't come, and hasn't rebooked again since. On reflection I should have implemented a support plan over the coming weeks to ensure continued progress, as she wasn't yet 100%. In discussing my passive management with the clinic director (or more to the point – him discussing it with me!), he made a good point, that if you discharge a patient too early, they can get the impression that you don't really care about them and their progress. On reflection I was still operating like a student – At the College clinic, you were never guaranteed patient continuity and because of the system of booking clinic hours, you often only got to see a patient a few times in succession, so I got used to seeing patients make some good progress over 3-4 treatments, and then I wouldn't see them again, because I couldn't always do the same clinic hours each month. The other thing with a training clinic, is that treatment costs are greatly reduced, and as a consequence often attract patients who can't afford too many treatments, so I also had cost factors in the back of my mind.

I have since adapted my management planning for future practice, and my decisions are now based primarily on what I genuinely feel would be best for that patient's care, and not perceived affordability. I was ultimately creating a false sense of effectiveness for myself by only treating people a few times and then leaving it up to them. On reflection, it is now clear that I am the health professional, not the patient, and I needed to own responsibility for making clear and sound decisions about their care, including where needed, an appropriate on-going management plan. I have applied this principle more recently with both Patient 1 and 3, and both patients have responded very well to a more confident approach, and are happy for me to make those clinical choices rather than them.

Regarding Patient 3, an important learning reflection, is to *not judge a book by its cover.* Yes, common things happen commonly, and there are certainly some suspicions and assumptions which may rightfully be made about patients during their initial presentation, however, I should always be open to positive change, and having my expectations exceeded. I do always try to emphasise the potential for health and positive change in my communication with patients, but in this case, I didn't initially expect it! And this in itself is an important lesson learned for future practice, as I think intention and belief do play a part in initiating change and helping to 'actualise' a positive result. A founding Osteopathic principle acknowledges the inherent healing capacity of the body, and I need to remember to extend that potential for *all* my patients.

My learning experiences with Patient 2, tie in with many of the reflections listed above. Although I quickly had suspicions about potential degenerative changes given her gradual onset, and minimal improvement, I was not very clear at first in my communication about appropriate management, and I guess was just *hoping* for a positive outcome. I also doubted myself as a fairly new practitioner that it may just have been my treatment that wasn't working! The imaging actually came as a relief, partly because I didn't have to beat myself up about my treatments so far, but also because it then gave me both the opportunity and the confidence to almost reset the therapeutic agenda, and discuss a sensible prognosis and management plan.

Overall, the main learning reflection from this discussion has been for me to own my responsibility as a health professional; to stay current with my knowledge and understanding so that I can appropriately respond to patient needs; and to be confident in my leadership of the management process. I have often talked about the idea of developing a *therapeutic partnership* with patients, and whilst I still believe this to be true, I need to remember that I am the qualified 'expert', and I cannot abdicate responsibility for making clear, informed, and individualised choices about the best care for my patients.

Appendix of Supporting Documents (Anonymised)

Patient 1:

- Clinical case notes copy

Patient 2:

- Clinical case notes copy
- Patient Imaging Report

Patient 3:

- Clinical case notes copy
- Patient Imaging Report

Patient 4:

- Clinical case notes copy

Patient 5:

- Clinical case notes copy

Subsection (IX): Case Analysis Reflections Report – Part 2

Figure 2: Collaborative Care Patients Comparison

Patient	Gender	Age	Job	Presenting Complaint	Onset	Aetiology	Number of TT's before Collaborative Care	Collaborative Therapy	Number of TT's with Collaborative Care	Total Number of Osteo TT's	Total TT Time Period	Status
A	Male	42	Sales Manager	Acute Severe L LBP w L LEX >>	4/7	Lifting moving boxes at work – multiple vector weight bearing Lsp	2	Acupuncture	3	5	6/52	Discharged
B	Male	43	Flooring Contractor	Sub Acute Moderate bilat Csp P; *plus* Chronic mild-moderate L LBP w L LEX >>	Csp: 2/52 Lsp: 9/12	Csp: Traumatic Lsp: Traumatic significant work-site fall, multiple Injury sites	4	Sports Physician (non-surgical)	11	15	4.5/12	On-going

Figure 3: Referral Patients Comparison

Patient	Gender	Age	Job	Presenting Complaint	Onset	Aetiology	Imaging Ordered	Number of TT's Before Referral	Referral Care	Referral Letter Sent	Referral Update(s) Received
C	Male	14	Student	Chronic Mild-Moderate L LBP	1/12	Gradual Process – Cricket Fast Bowler	Xray – LSP & Pelvis	6	Sports Physician	Yes	Yes
D	Male	47	Civil Engineer	Chronic Mild L Knee P	3/12	Traumatic – Cross-fit training	Xray – L Knee	5	Orthopaedic Surgeon	Yes	Yes

Patient Snapshots

Patient A is a successful 42 year old male sales manager, married with two kids, reasonably fit and active, with an unremarkable medical history, and no previous history of significant Lsp injury. He presented with severe L LBP w proximal posterior LEX referral, highlighted by a marked antalgic posture, which occurred whilst lifting moving boxes at his work office 4 days earlier – His symptoms had dramatically increased overnight. This injury was likely precipitated by a gradual reduction in the compensation threshold of the Lsp and related tissues, in particular, the intervertebral discs – ie Fissures > margination of Nucleus Pulposis > weakening of Annulus Fibrosis > Disc Prolapse > Inflammatory Cascade – caused by prolonged seated office posture and repeated long hours of driving and associated vibration stress. This was Patient A's first experience of Osteopathic care.

Patient B is a 43 year old male flooring contractor, who initially presented with sub-acute moderate head and neck pain after hitting his head falling out of bed. It was soon revealed however that Patient B also suffered a significant traumatic fall whilst on a building worksite over 8 months earlier, during which he suffered multiple injuries, including a broken L thumb, a torn cruciate ligament in his L knee, as well as on-going L LBP, which had not resolved with physio or chiropractic treatment. Patient B's case is ACC managed and he has been unable to work since the worksite fall. He was frustrated at a lack of clear management of his case, with priority given to his thumb and knee surgery, and subsequently the now chronic nature of his Lsp injury (disc prolapse contacting his L L4 nerve), has left him with a fatigued and over-facilitated CNS, resulting in global sensitivity and flare ups across multiple pain sites. Whilst the initial injury can be attributed to a traumatic event, the chronicity of Patient B's symptoms are further exacerbated and maintained by the psychological stress associated with being unable to return to work, earn a living, or return to full health and mobility again.

Patient C is a very active 14 year old student and developing sportsman, involved in tramping, running, soccer, surf lifesaving, and importantly – fast bowling at regional representative level cricket for his age. He presented with chronic mild-moderate L LBP, which had gradually increased over the past month in conjunction with the start of the cricket season, and was only aggravated during running or fast bowling activities. He otherwise had an unremarkable medical history, and no previous injuries of significance. This injury (as I was to find out later) was likely precipitated by repeated high-velocity asymmetrical loading of the lower Lsp segments – consistent with the particular action of fast bowling – A very specific injury, and given the patient's future sporting goals, and developing spinal joints, requiring specialist investigation and management.

Patient D is a very fit and otherwise healthy 47 year old, male civil engineer, who also trains in cross-fit, competing regularly in amateur competitions across the region. He presented with chronic mild L knee pain, after landing awkwardly during a cross-fit skipping exercise 3 months earlier. The injury was not debilitating, and hadn't slowed his enthusiasm for training, however his symptoms had not improved, despite 10 previous sessions of physiotherapy (in which no further investigation or imaging was initiated). Patient D's symptoms were characterised by an inability to fully extend his L knee, and as such, after investigating other possible causes first, specialist referral to an orthopaedic surgeon was required to differentiate a meniscus injury under MRI. The poor vascularity of meniscus tissue explains the chronicity, lack of improvement, and why this particular injury was not amenable to manual therapy, and why surgical intervention would be necessary.

Collaborative/Shared Care Discussion

Patient A presented with an acute disc injury, and was initially in a lot of pain. From the outset (before any Osteopathic treatment) he asked me if I thought acupuncture might help. He had heard of the benefits of acupuncture, and given his acutely painful condition, I think he was looking for whatever would ease his pain; as it happens we have a resident acupuncturist operating in the room next to mine. I didn't feel that this patient was outside the scope of my care, and whilst I wouldn't ordinarily look to collaborate on a case like this, I felt it was a good opportunity to explore the option at the request of the patient, and given the fact that the acupuncturist was also on site. It should be noted that I explained to the patient his options, including a clear Osteopathic management plan first, but I was also happy to facilitate a collaborative care approach at his request.

I discussed the case with the acupuncturist, who has a treatment protocol for acute back pain, and being willing to collaborate, the patient had a series of 3 acupuncture treatments, running in between his Osteopathic follow up appointments. The communication in this instance was simple and did not require any written letter of referral given that the acupuncturist is a colleague working in the room next door. So it was an informal arrangement, but there was plenty of discussion about each other's methods and management plan (as much for my own interest as for patient continuity).

Patient A expressed a good response from the acupuncture, and very much appreciated the extra attention and support given to his injury, however it would be very difficult to quantify which modality was responsible for which aspect or degree of the patient's improvement, or indeed whether it was a combination of both.

Both the patient and the acupuncturist felt that following each of his acupuncture sessions, Patient A was progressively standing

taller and straighter, and walking with more ease. Whilst I was also happy with his response from my Osteopathic treatments, I could suggest that 5 treatments over 6 weeks for an acute disc presentation is possibly a little less than I would expect to deliver in order to see the same level of improvement. Realistically, I think an additional 2-3 Osteopathic sessions over that time could have been anticipated, so it's difficult to know whether a collaborative approach in this case made a difference, but certainly from the patient's perspective, he was very happy with the care and results he achieved in 6 weeks.

For me it was an excellent chance to listen and learn about an acupuncturist approach to managing acute low back pain, but more importantly, it enhanced my practice in this case, as I was able to offer my patient a wider choice of care options and treatment experiences, something which I think is worth continuing to explore in future practice.

For a more detailed discussion regarding the collaborative approach, please see the stage 3 Inter-Professional Collaboration Report.

Patient B has been an interesting case, and I have worked in a collaborative care scenario with him for over four months now. Patient B was a flooring contractor who suffered a significant fall on a building site over 12 months ago, during which he sustained multiple site injuries to his low back, shoulder, knee, and hand, and has not been able to work since. He is case managed through ACC, and has had a number of specialist and surgical interventions, as well as different modes of manual therapy for his injuries, including physiotherapy, chiropractic, acupuncture, and now Osteopathy with myself.

Patient B initially presented to me with a new injury, following a trauma to his head after falling out of bed, but was very happy with my approach and management, and given that he had experienced minimal improvement for his concurrent injuries from the previous fall, asked me to work on his lower back, as this area had been largely neglected in favour of focussing on more acute peripheral damage to his knee and hand. The collaborative care aspect of this case was not initiated by myself, but was a natural progression given his ACC management, and the patient asked me to provide a treatment report for a scheduled sports physician consultation to further explore the on-going issues in his Lsp.

Interestingly, the sports physician was apparently not interested in my report (according to the patient at least), and initially felt on examination that there was no significant tissue-causing symptom in the lower back to explain Patient B's on-going pain. The patient described being disappointed with the initial consultation, and felt that the specialist was quite dismissive of his symptoms, and essentially told him there was nothing wrong with him. She did however agree to an MRI, which subsequently revealed an L4/5 lateral disc bulge contacting the L4 nerve root. According to the patient, the specialist's approach towards himself and the case, changed considerably for the better upon receiving confirmation of a disc injury. Her recommendation was for Patient B to continue his rehabilitation program, which included both physiotherapy and Osteopathy, and she scheduled a CT guided injection around the L4 nerve root to help settle his symptoms.

Patient B's recovery has been slow with a number of flare ups along the way, which I feel is due in part to him not receiving any real managed treatment plan for his lower back issues during the first 8 months following his injury, allowing for chronic 'facilitation' of not only the lumbar segments and related tissues, but his central nervous system as a whole, leading to increased global sensitivity.

I was initially also disappointed with the apparent disregard of my report and findings, however on reflection, this may not have actually been the case, and I can understand that the sports physician may prefer to view the situation fresh and make her own clinical decisions. According to other sources and discussions with colleagues, it seems that this specialist does have a preference for using physiotherapists over Osteopaths in her management plans; my clinic director has seen a number of referrals not sent back to the clinic, but rather referred onto her physios…

Whilst I have been CC'd on her communications regarding Patient B's case, her letters are principally addressed to the physiotherapist. As a recent graduate, it's interesting to see that there are some politics involved in inter-professional collaborative therapy, and that not everybody necessarily values Osteopathy as I do. I have tried to adapt my subsequent management of Patient B according to the sports physician's recommendations, concurrent allopathic interventions, and also taking into account the strength work he was doing with the physio. This experience of 'collaborative' treatment has felt very one-sided, however in time I hope I will become more confident in my own abilities and clinical experience to be able to respectfully make a stronger case for a more genuine collaborative partnership. I have continued to communicate with this specialist, and as you will note from the next discussion, I have since referred another patient to her.

Collaborative/Shared Care Comparison and Contrast

In one sense, Patients A and B have very similar profiles – same age range, both in a similar phase of life with young families, reasonably fit and active, unremarkable medical history prior to injury, and incidentally, they are even alike in height and physique. Both patients were ultimately diagnosed with a Lsp disc prolapse, however their presenting symptoms, severity, treatment, and management plans were very different. Patient A followed a more typical pathway for an acute single episode disc prolapse, and whilst he suffered severe pain and immobility during the first few

days following the onset, he was able to make a full recovery within 6 weeks. Patient B's disc bulge however, whilst mild in terms of pain severity, had become chronic over the past 8 months, and subsequently has had a much larger influence on his daily life, future health outlook, and capacity to return to his previous employment. This reinforces the tensegrity nature of the body, which is interconnected, not only in health, but also dysfunction and recovery – Patient A's underlying tissue and systemic health was good, and as such, his body was able to respond quickly and efficiently to restore homeostasis and initiate inherent healing mechanisms. Patient B's systemic capacity and global cellular health was impaired, not only through having multiple injury sites, but importantly, prolonged facilitation/fatigue of his CNS, leading to reduced cellular vitality and reparative capacity.

Both patients needed reassurance and clear communication about the nature, prognosis, and management plan for their injuries. Although they were on very different recovery pathways, clear communication was key to encouraging a positive patient outlook and belief in the treatment and management process. There were psychological factors present for both patients, however Patient A's concerns and anxiety diminished quickly in conjunction with increased understanding of his injury, and his symptoms settling. Patient B however, felt that despite all of the medical attention he had received over the past 8 months, there was no clear cohesive management plan towards a full recovery. He felt disempowered, and anxious about his future potential, in every sense – vocational, emotional, financial, relational etc.

The collaborative care aspect was also very different in each case. Patient A initiated a shared care approach himself by request, whilst Patient B's collaborative care was a natural progression of his ACC management, and the inter-practitioner communication was therefore very different. I had a sense of confidence about the collaborative care of Patient A, because I knew the acupuncturist, and felt comfortable with my own knowledge and experience in relation to the case. With Patient B, I was a bit intimidated, and questioned my knowledge and capabilities in relation to an experienced 'specialist consultant'. The communication and subsequent learning opportunity with the acupuncturist was excellent, because of the peer-to-peer dynamic, and obviously helped by the fact that he was a colleague who worked on-site. In comparison, I felt that in the case of Patient B, the collaborative care partnership was very one-sided, with an obvious hierarchy. It is important to recognise my own lack of confidence here, and as previously discussed, I hope that with time and experience, I will feel more confident about my role and contribution (another reinforcement of the need to network within the allopathic community).

Overall, I really enjoyed the process of working with Patient A, and I felt empowered and informed by the shared collaboration. With Patient B it was difficult to properly understand my role, and the significance of my treatments, when there was so much else going on for this patient ie chiropractic, physiotherapy, acupuncture, corticosteroid injections etc. This reinforces for me the importance of clear and centralised patient management, with inter-practitioner communication, so that everyone understands the therapeutic goal, management aims, and how they are able to contribute most effectively within a collaborative care environment.

Referral Discussion

Patient C is a 14 year old, active teen, tall for his age, and a fast-bowler, performing at regional representative level for his age. He presented with a 1/12 onset of increasing low-back pain, which was aggravated when running or bowling. On examination, I had a working diagnosis of a L Iliolumbar ligament sprain in conjunction with an anteriorised L ilium. Initial treatment response was positive, however his symptoms returned again after fast bowling, and were further aggravated by running.

Patient C's symptoms followed a pattern of temporary relief, followed by a return of symptoms after running and/or fast bowling. Adolescents should generally respond quite well to manual therapy for simple soft-tissue injuries, given the resilient nature of developing tissues; and therefore persistent and recurrent back pain in adolescence is a potential concern for underlying bony or developmental anomalies. Whilst I didn't have a specific differential in mind at the time of imaging referral, I felt that based on the persistence of localised pain over the Lsp vertebral segment, aggravated by specific weight-bearing/loading activities, that an X-ray was warranted. I requested standard Lsp and Pelvis X-ray's, and did not order any oblique imaging of the Lsp which, as will be reflected on, was a missed opportunity to aid differential diagnosis in this case. This showed a minor scoliosis, convex to the left, centred over the L3 segment. I re-examined the patient, this time pushing an SLR test up past 80°, which provoked a response into the Lsp spine. I modified my working diagnosis to a potential annular tear, and discussed a prognosis and management plan with the patient and his mother, which included necessary rest from all his sporting activities. I suggested an MRI may be advisable given Patient C's active lifestyle and sporting goals for the future, and this was the point at which I felt the referral was necessary, both for a specialist perspective on the case, and because I cannot refer directly for MRI imaging.

I discussed the case with my clinic director prior to drafting a referral letter, and he explained to me that spondylolysis is a common problem with fast bowlers, given the specific biomechanical strain of the movements, and that a large number of professional fast bowlers suffer from low back pain issues as a result of this activity. Importantly, a spondylolysis, or stress fracture, could easily

be missed on a standard X-ray! After reviewing this condition, it is now clear that oblique imaging is required to better determine the presence of a stress fracture as it highlights the area of the pars interarticularis. This was a valuable reminder, as I was able to discuss this with the patient and his mother, and also allude to it as a potential concern in my referral letter. Patient C subsequently obtained an appointment with the sports physician, who sent him for an MRI, followed by a CT scan, to confirm a diagnosis of a pars interarticularis stress fracture. The specialist also recommended a rehabilitation programme with a physiotherapist who was worked with the NZ under 19 cricket team. Based on this experience, I realised I needed to revise my own understanding of the difference between spondylolisis (stress fracture) and spondylolisthesis (subsequent vertebral slippage – degree of displacement graded 1-4), and used both internet resources, as well as my own college notes for review (See attached college study notes for a brief overview of Spondylolisthesis).

This self-study and revision has helped to clarify the importance of investigating for a potential stress fracture if suspected, *before* it potentially becomes a spondylolisthesis, and importantly, that there is a higher incidence of spondylolisis amongst active adolescent sports people (including dancers, cheerleaders, gymnast etc) given the repetitive high stress hyperextension of the Lsp. I am now clear on the fact that oblique X-ray imaging ('Scotty Dog') is required to clearly identify the pars interarticularis, and also, given the increased radiation involved, that a high degree of suspicion should be present in order to request oblique Lsp imaging. With this in mind, I have also researched some condition specific clinical tests to aid in diagnosing this issue.

On reviewing my follow up treatments for Patient C, I can see that I didn't have a clear plan for exploring other potential tissue causing symptoms (including a stress fracture), which I should have done given the transient improvement, and quick return of the patient's symptoms with strenuous weight-bearing activity. I instead focussed on my original differential diagnosis, and essentially repeated a variation of my initial treatment. If I had been more certain of my diagnosis, and had explored or 'ruled out' other potential causes, then this may have been acceptable, as it's plausible that continued provocative activity may have been a maintaining factor. However this was not the case, and in the absence of further testing, I had simply repeated a similar treatment approach, hoping for an improved result! Of crucial importance in this case, is that I utilised a bilateral HVLA to L5/S1 as part of my treatment technique during the follow up session, and in light of my revision, an HVLA is potentially contraindicated if spondylolisis is suspected, as it may actually aggravate a stress fracture!

So on reflection, in this case I was far too casual in my approach, and my condition specific knowledge was not up to speed, and I put my patient at risk through the use of a potentially provocative treatment technique. This experience has served as an important reminder for me to really hone in on the tissue-causing symptom, and crucially, to recognise and respond when my own understanding and recall of relevant conditions and important clinical tests is found lacking. For future practice, I now feel confident that I am able to recognise a potential spondylolisis in clinic, through appropriate screening and case history, clinical tests, correct Imaging, and appropriate treatment and management choices.

I have not seen Patient C in clinic since, but I appreciate that a specific lumbar stability programme to address a pars interarticularis fracture in a 14 year old fast bowler is out of my scope of practice, and am happy that this patient is receiving the tailored support he needs. I felt my referral letter in this case was suitable, and hopefully can strengthen my professional standing and connection with this specialist for future practice. I have received 4 letters informing me of the progress and management plans for Patient C, and I think the referral in this case was both necessary, and has proven to be the right clinical decision for this patient.

On reflection, I realise that my clinical experience is very limited, and there is still much for me to learn, particularly when faced with persistent spinal symptoms in younger developing patients. The discussion with my clinic director was timely, and in this instance, potentially helped me to save face somewhat, as I was able to modify my referral letter accordingly. This itself is an on-going reminder for me to ensure I am open with my colleagues regarding things I am unsure about. My current position is perfect for being able to call on more experienced clinicians, acknowledge any shortcomings, and to build on my practical clinical knowledge and experience in a supportive environment. Overall I am grateful for the lessons learned from this experience, I was happy with this referral process, and whilst I had some help in arriving at my differential diagnosis, I have gained important and practical knowledge, which I can apply for the benefit of future patients.

A footnote

Whilst I have not seen Patient C since the referral, I have since treated both his mother and his father, which does reflect well on my treatment and management in this instance.

I enjoyed the process of managing and referring **Patient D**, as I felt I communicated well with the patient in terms of his potential injury prognosis, and management options. I rewrote my referral letter to the orthopaedic knee surgeon as part of my stage 2 preceptorship work (based on feedback from my Preceptor) which proved to be a valuable exercise, providing a more appropriate professional template and format for future letters, including the case above.

Patient D presented at clinic with a 3/12 onset of anterolateral L knee pain, after landing awkwardly during a skipping exercise at cross-fit training. This patient was otherwise a very fit and healthy 47 year old, who's injury was not debilitating, but characterised by an inability to fully extend the knee, and with focal points of pain over the lateral, and anterolateral joint line. Interestingly the patient had already received 10 sessions of physiotherapy for this injury, with no improvement!

A meniscus injury was my first consideration given the lack of full knee extension however, my clinical examinations, whilst indicative, were not conclusive (ie negative McMurrays test), and the area and pattern of pain was potentially consistent with other tissue sources, including the infra-patellar bursa, and the lateral collateral ligament. The patient was continuing vigorous cross fit exercise, so it was possible that aggravation of these tissues could be maintained by continued stress, and hence the lack of improvement over time. I discussed these options with the patient, explaining the nature, prognosis, and management plan for a meniscal injury, and that this would require referral to a specialist. We agreed that we would initiate a series of focussed treatments to address the other potential causes first, as these were more amenable to Osteopathic treatment, but if the symptoms persisted, I would refer the case on. I was happy with my communication and management in this case, because the patient and I were on the same page, and he clearly understood all his options.

The process was not straight forward, as initial improvements were made to the patient's symptoms, but the reduction of knee extension remained a hallmark feature, so after 4 treatments I referred Patient D for a knee X-ray. Obviously a meniscus injury would not show directly, but there was potential to see some changes in the joint line spaces, to rule out any other bony anomalies, and I also wanted to cover this option prior to referral so that the surgeon could have some imaging to hand from the outset. The X-ray showed nothing of significance, but by the next week, the patient's symptoms had deteriorated following another cross-fit session, so the referral was initiated. I received a letter back from the surgeon following the initial consultation, who referred the patient for an MRI to delineate a meniscal tear. I have since contacted the patient to follow up, and it was indeed a meniscal tear, with surgery forthcoming.

On reflection I was very surprised that 10 sessions of physiotherapy had passed with no improvement, and yet no further investigation had been initiated? I felt that my knee examination and differential diagnosis was appropriate in this case. There was a helpful connection made with the knee surgeon a few months earlier, as he had come to speak about cruciate ligament surgery and management at a regional Osteopathic peer group gathering. This was a reminder of the need to stay connected with both the Osteopathic, and the wider health community, both in terms of increasing my knowledge but also as a networking tool. Despite this being my first formal referral, I felt reasonably comfortable with it, as I had met with and talked to the surgeon myself previously. This case also reinforced to me the importance of good patient communication, being clear about the options available, and agreeing together on a treatment and management plan. Overall I was very happy with this process; it has increased my confidence of examining and diagnosing knee injuries, offered an opportunity to improve upon my inter-professional communication, and in this instance, provided an effective solution and treatment experience for the patient concerned.

Referral Comparison and Contrast

The different ages of these patients is a point of contrast to begin with, and in the case of Patient C, his adolescence was an influence in my decision to refer at that time. As a rule, young growing teens typically have resilient, adaptive tissues, which generally respond and heal quickly when injured; and so recurrent or prolonged LBP in adolescence, is suggestive of a more serious underlying problem. If for example the conditions were reversed, and it was the 42 year old Patient D who had the low back pain, I would probably have spent more time in treatments exploring other potential postural and 'historical' contributing factors first, before considering referral. This is partly because as adults, our bones are of course fully developed and ossified, but we also have an individual history of stressors, postural strains, previous injuries, systemic issues, and subsequent protective patterns, which may be maintaining an injury, or slowing the recovery process. That being said, it was my clinic director who pointed me in the right direction with Patient C, and this has been a good reminder for me to always consider the possibility of bony anomalies and underlying structural issues.

My experience with Patient C made me realise that I didn't know how to effectively test for a potential spondylolisis/pars fracture so therefore didn't feel particularly confident of my treatments once a pattern of recurrence and minimal therapeutic effect was established (Note: I have since read up on a number of 'indicative' clinical tests, including the low midline sill sign, interspinous gap change, stork extension etc). In contrast, I felt confident of my examination, treatment, and management plan for Patient D, and was quite surprised to hear that he had already received 10 physio treatments with no real improvement, and no further investigation was initiated! Communication was again very important in both cases – with Patient C, I was honest about my lack of understanding regarding fast bowling mechanics and the potential for spondylolithesis. With Patient D I was clear about his management options, so despite only transient and minimal progress in our treatments, he was happy that we explored a non-surgical route first. For future professional development, my experience of both cases has highlighted the benefits of exploring sports injuries in more depth, in order to increase my understanding of the biomechanics, potential

stressors, and management options across a variety of sports. In addition, CPD centred around adolescent development and injuries would also be beneficial.

The importance of establishing positive networking relationships with other health professionals was again reinforced by my experience in both cases. I was a little apprehensive about referring Patient C due to my previous experience with the sports physician (as noted), but I was very comfortable having met the orthopaedic surgeon, to refer Patient D.

This experience reinforces for me two things – the learning process is on-going, and good communication is of central importance. I don't have to know everything, however, I do need to know enough to be able to recognise and differentiate important and common presenting conditions, and I need to maintain my knowledge base accordingly, in order to manage my patients appropriately, effectively, and safely. Whilst I may have felt reasonably confident with Patient D, Patient C presented a real challenge, as I was not familiar/ experienced with many aspects of this case. Despite this, I do think my communication and management ensured that each patient was able to receive the right treatment. And ultimately this is why referral is important; I can't and shouldn't be expected to be an expert in everything, however, where my knowledge and experience is limited, and referral is required, I need to understand how to appropriately direct my patients towards the best care for their needs.

Preceptee signature..

Appendix of Supporting Documents (Anonymised)

Patient A:

- Clinical case notes

Patient B:

- Clinical case notes copy
- Patient Lsp and Pelvis X-Ray Report
- Treatment report to sports physician
- Correspondence from sports physician

Patient C:

- Clinical case notes copy
- Patient Lsp and Pelvis X-Ray Report
- Referral letter to sports physician
- Correspondence from sports physician

Patient D:

- Clinical case notes copy
- Patient Lsp and Pelvis X-Ray Report
- Referral letter to Knee surgeon
- Correspondence from Knee surgeon

Also Attached:

- Spondylolisthesis College Notes

Subsection (X): Patient Case Notes

Stage 4

DATE 14.04.16 | NAME [redacted]

ADDRESS [redacted] TGA | TEL: (H)

D.O.B. 28.02.84 | G.P. [redacted] | REF ONLINE | OCCUP COMPUTER ANALYST | (W)

OSTEO = [redacted] | (M) [redacted]

P/C: Chronic Ⓛ LBP c mid Tsp Ⓟ - Mild associated w work-related postural fatigue

ACC - N/A
RC -
DOA -

ONSET: 1/12, insidious build up of mid-low Back Ⓟ; centralised Lsp → Mid Tsp; VAS = 4/10, ache w int sharp Ⓟ mid Tsp last 2/52; worse AM; ∅ referred; ∅ PNS; ∅ HA'S

AGG.
REL.

W/PLACE office / Computer
F/time ↑ driving

A - P

curves (flat)

bilat pes planus over ProN

IMAGING: ∅

PREV. T.T. & INVEST

AIM: RESOLUTION → PREVENTION

PLAN = OMT + ADVICE + SELF man. exercise

ADVICE = Seated Glutes; knee hugs; Tsp Rot

HX = No other significant back Ⓟ reported.
* Recent move from Auck to Tga

YELL. FLAGS

N.B. consider for orthotics

TREATMENT: STM / ART Lsp → Tsp L>R; Spinal Oscilation
HVLA Lsp 4/5 ✓✓; T4-6 ✓; T8-10 ✓✓

CONSENT: ICG ✓ PEA ✓ PTRE ✓

OPP.	ILL	ACC.
∅	∅	∅

DIAGNOSIS: Ⓛ L4-S1 c T8-10 dysfunction associated w workplace postural fatigue

PRECIP =

Review 1/52

TESTS: PSIS = level; ↓ Lsp + Tsp kyphosis
↓ SB c Ext Ⓛ; Facet prov +ve Ⓛ Lsp
tender over L4-S1 Ⓛ c T8-10
Palp = tight TES / med scap, c LES / QLs L>R

EXERCISE: ↓ fitness

GEN. HEALTH: NAR non-smoker

Rx: Voltaren Ibuprofen

BOWEL (CONST / DIAR / B/M): NAR

MENST. (ONSET / FINISH): ∅

DIET: Balanced. ↑ Take Out

SLEEP

BLADDER (URG. / FREQ. / CCL.): NAR

OBS (CHILD / SURG.): ∅

W/t 65" | H/t 5"9

MAT | Pillow

C.V.S. B/P: NAR

RESP.: NAR

FAMILY HIST (CA / DIAB / ARTH.): NAR

Lsp

SOCIAL CONTEXT =
- Young, single, hard worker.
- ↑ fitness / health goals
- Moved to Tga 6/12

REFLEXES	Bi	Tri	Abd.	Pat.	Ach.	Bab.
R						
L						

NEURO TESTS

S.L.R. ∅

V.A. TEST n/a

FABER PATRICK -ve

PRED = flat feet - altered biomechs
Undynamic spinal posture.

MAINT = Long driving
↓ fitness c Lsp / core stability

DATE	% IMP	ACC	TREATMENT	ADVICE
20.04.16	50		SLT - Good response, ↓ (P) Lsp + Tsp ; ↑ ROM ;	
Osteo:			Sx's Lsp agg 3/7 by prolonged standing. VAS 3-4/10	
[redacted]			EXAM = TX =	
			bilat pes planus + overProN	
			slight halux valgus bilat R>L	
			Ant prov +ve (L) Lsp HVLA L4/5 ✓✓	
			TTP L4/5 + T6-8 HVLA T6-8 ✓✓	
			tight/tender TES - LES L>R STM/ART/Oscil	
			Csp - ↑ tension suprascap/CES CD lift ✓	
			Csp psve - NAD	
		-	Discussed foot mechs ↔ LBP, need for better work shoes.	
			PLAN - Cont self-man stretches, fit formthotics next visit. Review 1/52	
27.04.16	75		SLT - Weekend trip to Sydney, very busy w lots of walking, but ∅ agg Lsp (P); slight niggle Tsp, but no sharp (P) - VAS = 2-3/10	Csp stretches: Scalenes/ Traps
Osteo=			EXAM = TX =	
[redacted]			Ant prov = mild +ve L>R Lsp HVLA low Lsp ✓✓	
			↓ tightness Tsp - TES - LES STM/ART/Oscil	
			↑ Rom Act Tsp c̄ Lsp HVLA T6-8 ✓✓	
			tight supraicap Mms → CES L>R STM/ART/CD lift ✓✓	
		-	Fitted Formthotics (Med)	
			PLAN - ↑ Self-man incl ↑ fitness/core stability; Review formthotics 2/52	

• [redacted] cont...

11.05.16. Cx due to work commitments - Rebooked 1/52

18.05.16 SLT - ↑ Driving for work, Lsp + Tsp
Osteo: present, but only minor ache - VAS 2/10
[redacted] Formthotics feel good/helping, ↓ discomfort standing long periods. Pt has ↑ ownership of
90%↑ self-man + health goals.

EXAM: Tx=
Ant prov -ve Lsp STM/ART/Oscil
↑ tonicity L>R QLs → TES → Tsp HVLA 4-6 ✓✓, 6-8✓✓
supraicap CD lift ✓
Act Lsp + Tsp ROM - NAD
PLAN= Extend review period, cont w ↑ self-man to include ↑ fitness; Review 4/52

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