STYC01 Clinical Reflections

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| **Date** | **Location** | **Total Amount of Hours** | **Overview of Session**  |
| 01.04.19 – 1600 - 1700 | Sports Therapy Open Clinic – Room W233 | 1 hour | 2nd Follow-up appointment - Housemaid’s knee – right leg |
| Reflective Summary |  Areas for further Improvement plus action plan  |
| My client returned for a second follow-up appointment for treatment of Housemaid’s knee, an injury he acquired on 17.03.19.My client reported that there was no pain in the morning or throughout the day but the knee does become inflamed with exercise. The inflammation reduces with rest and a cold compress. Aggravating factors are activity e.g. walking and standing for long periods of time.On observation, when my client arrived, I could see that he was walking more freely and that the inflammation in the knee had reduced. The knee wasn’t as red as it has been on previous visits. There was inflammation in the lower leg and ankle, but this was due to my client being on his feet and the walk from home to the clinic, which was approximately 3 miles in distance.I measured the circumference of the knee and noted that the inflammation had reduced by a centimetre from the previous week – now currently at 45 cms. I also measured the lower leg 10 cms above the malleolus which was 27.5 cms. This was an improvement of 1 cm from the previous week. The circumference of the lower left leg was 25.5 cms. To establish whether there had been an improvement in flexibility I also measured the distance between the heel of the foot and the buttock, when the knee was flexed – it was 30.5 cms. I also measured the distance between the heel of the foot and the buttock of the left leg, when the knee was flexed. The result was 17.5 cms. Flexibility of the right knee was still limited due to the inflammation.On palpation with the back of my hand, the knee felt warm to touch, but not as hot as it has been on the previous visits to open clinic. The client reported the knee still gets itchy.I discussed the case with my lecturer and agreed that effleurage of the whole leg from ankle to top of the thigh and an oedema taping with K-tape was still an appropriate treatment. Effleurage would improve lymphatic drainage and reduce the inflammation. The oedema taping would also help to reduce inflammation further by increasing the interstitial space allowing the fluid to drain more effectively. At this point the client was advised that he could help reduce the inflammation further by resting the leg more and not overdoing the exercise.My client was lying in a supine position on the couch.  I placed a bolster under his head.  I raised the level of the couch at the end where his feet were.  I placed a bolster underneath his knees.  Once my client was comfortable I gently efflueraged the leg from the ankle over the knee up to the inguinal lymph node.  After effleuraging the front of the leg, I wiped off all of the excess cream and lowered the bottom end of the couch. I raised the top end of the couch so that my client could sit up comfortably.I measured the circumference of the knee and noted that the inflammation had reduced by 0.5 cms. Circumference of the knee was now 44.5 cms. The circumference of the lower leg, 10 cms above the malleolus was now 26 cms. Swelling had reduced by 1.5 cms.Whilst my client was sitting comfortably, I began to prepare the rock tape for the oedema taping. I was careful to ensure that I cut a longer strip as I did not want a repeat of the error that I made the previous week. I rounded the corners of the top of the strip. I cut the tape into five strands and rounded the corners of each strand. The corners are rounded to ensure that the tape doesn’t lift. I sprayed the knee with glue to ensure that ensure that the tape adhered to the skin. The anchor of the tape was placed at the inguinal lymph node and secured above the knee. My lecturer advised me to brake the tape at the top of the strands, so that it was easy to remove the backing paper when I had to fix each strand separately around and over the knee. The first strip was placed around the medial side of the knee and the remaining four strips placed over the knee. All strips had a 25% stretch except at each anchor point. A second, shorter strip was also cut with 5 strands from about a quarter of the way down its length. The corners of the top of the strip and each separate strand were rounded. The anchor of the tape was placed at the lateral side of the knee and placed across the knee, over the strands of the first strip of tape, in a latticed pattern.  After treatment I advised my client to continue with the programme of exercises that he had been given the previous week. He hadn’t been able to foam roller the leg because he didn’t possess a foam roller. I advised him that he would probably acquire one at a reasonable price from Amazon or any local sports shop. I advised my client to leave the K-tape on for 2-3 days.  He could wear the tape in the shower.  When removing the tape my client was advised to wet the tape for easy removal and to apply moisturising cream to the area afterwards.  He was also advised to rest and elevate the knee throughout the day, to ice if the knee was hot and if his ankle ached – to immerse it in warm water and perform mobilisation exercises. He was also advised to drink plenty of water and to rest the leg more and avoid over exercising to enable the inflammation to go down.My client has agreed to contact me after the Easter holiday should he require further treatment. | Continue to update my anatomy knowledge and practise objective and subjective assessment.Continue to practise the application of taping. |
| Returning to reflections at a later date |
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