Assessment Task 2: Written assignment
Due Date: Week 8, Friday April 29, 2022 @ 23.59pm.
Submission: Via Canvas
Weighting: 30%

Objectives:
This assessment item links the Course learning objectives: 1, 2, 3, 4 and 5 as stated in Part B of the course guide. It provides an opportunity to apply the practical and theoretical concepts explored over the semester to develop your clinical reasoning skills as a healthcare practitioner.

Overview:
Using the Case scenario provided, and with consideration of your role as a 'Primary healthcare provider' you are required to put together a LT SMART intervention strategy for Tom. The strategy will encompass and apply the use of the PHC concepts covered during the semester.

Course learning outcomes to be assessed:

1. Argue the advantages and disadvantages of potential management strategies taking into account any personal and professional limitations.
2. Describe the role of an Osteopath in Australia in a primary health care setting and define the scope of practice in the broader Australian health care system
3. Identify lifestyle and psychosocial factors that impact on health and contribute to the burden of disease.
4. Demonstrate the application of suitable advice for better health management within the scope of practice and evaluate the need for further referral
5. Apply knowledge of the underlying principles and concepts of exercise rehabilitation to a variety of patient presentations

RMIT Graduate attributes:
The following skills are being developed throughout this assessment:

- Work readiness – the ability to link presenting conditions to more LT health issues and research the healthcare sector to assist in prevention and management
- Innovative and Work-ready – to design and develop tailored management plans, showing initiative and create innovative LT benefits and solutions to patients.

Assessment brief:
Develop a LT SMART PHC intervention strategy to address Tom's early signs of a lifestyle disease. Included in your plan will be links to:

- SMART goals;
- Lifestyle medicine;
- Health education;
- Health promotion;
- Community healthcare services; and
- Evidence based clinical practise guidelines.

In order to achieve this you will need to:

- Discuss (with support from the literature) the key findings from the examination that link both the msk condition and lifestyle disease together
- Outline the combined critical factors of the 2 conditions that will need to be addressed (with supporting literature) in order to design a successful intervention;
- Discuss any Health education and promotion methods you may draw on;
- List any community health services available for Tom to access; and
- Apply your knowledge of healthy living guidelines in combination with evidence-based Clinical practise guidelines.

Summary of overall structure, presentation and referencing

- Word count: 1200 words +/- 10%;
- Use size 12 Arial font and 1.5 spacing;
- Use APA referencing (within text, and for Reference list); and
- The marking criteria is available under the Assignments menu tab in Canvas.

Case scenario

Tom is an indigenous 46-yr-old male who has presented to you with knee pain R>L.

He works in middle level management (Public servant), and is happily married with 1 child. Key findings from your Case Hx and examination are:

S	Sub-patella and along the medial joint line
Q	Ache
I	At worst 8-9/10; At best: 3/10. Tom reports thinking it doesn't ever go away
D	Deep
S	NAR
C	On and off for past 12 months. Each bout seems to be worse than the previous one
A	Sitting, too much walking
R	Heat
N	Neurofen
T	Osteo when pain is bad over past 12 months
A	Pain in L knee too
G	Obese, poor sleep – due to pain, inactive lifestyle, enjoys a social drink or three at least a few times a week

Past medical Hx:
Was a 'fit kid' and played lots of Aussie rules till early 20's – lots of ankle injuries, knee niggles, hamstring strains

Significant knee injury R – which is what stopped the football playing in early 20's – required a knee reconstruction. Never recovered well enough to feel confident playing again.
Hospitalised last year with chest pain – it was an anxiety attack

Family medical Hx:
Paternal – MI @ 52-yrs-of-age. He is still alive
Maternal – Arthritis – Hip replacement @ 60 yrs-of-age

Systems Screen:
Nervous - NAR
Cardiovascular – Anxiety attack
Respiratory – SOB – linked to anxiety attack
GI - NAR
GU - NAR
Endocrine - NAR
Mental health – Had 1 anxiety attack last year

Medication: Lipitor, Antacids as needed (at least 1x/week)

Physical/ortho examination results:
Standing:
- Observation – uneven WB with bias to non-surgical leg, large abdominal/visceral circumference (obese)
- Gait – subtle limp, not there on every cycle
- Squat – awkward – unable to execute v.well. When asked what the limitation was Tom explained it felt stiff – but also uncomfortable behind the knee-cap
- Thessaly Test –ve

Seated:
- Vital signs exam: Pulse 93, RR 19, BP 139/88, temp 37°:
- Lower limb neuro: Sensory – Tom reports it feels altered around medial knee, Myotomes +5, Reflexes +2
- Slump -ve
- Knee AROM with o/pressure: IR/ER – NAD

Supine:
- Leg length – unequal R leg shorter
- Extensor/Quad lag +ve
- Ankle AROM – full, NAD
- Knee AROM with o/pressure: Flex: 85 degrees, Ext: reduced with still 5 degrees of flexion. P reported end-ROM was uncomfortable
- Hip AROM with o/pressure – full NAD
- Patella grind test +ve
- Valgus/Varus stress tests: -ve
- McMurrays -ve
- Anterior Drawer Test -ve
- Poster Drawer Test -ve
- Palpation: localised tenderness around medial aspect of knee, pes anserine insertion joint line tenderness and patella
- Visible mm wasting of quads around R knee

S/lying:
- Obers Test -ve
- Palpation – NAD. Tom reports discomfort on medial side of knee – when knees are ‘stacked’ together

Prone:
- Palpation: NAD