HAND THERAPY NEW ZEALAND
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HAND THERAPY NZ CASE PRESENTATION CRITERIA AND INFORMATION

The case study is designed to outline a course of hand therapy treatment and to show your clinicial reasoning for the modalities used and the timing of implantation.

The aim of the case presentation is to demonstrate that the therapist is able to implement a timely and appropriate assessment and treatment regimen for patients with injury to the hand and/or upper limb. This regimen should be based on sound clinical reasoning and an in depth knowledge of clinical problems specific to the treatment of such patients.

Please use the information below to write your case study.

Academic Standard and Word Count:

An academic standard at a post-graduate level is expected, with a minimum word count of 1,500. (This does not include appendices or direct transcriptions of treatment notes).

- All submissions must be typed
- The case study can be essay style and/or point form.
- Lists, graphs, photos and tables can be included.
- Language and grammar are expected to be professional and you should ensure you have edited your case study for typing errors.
- Do not use names, initials, hospital identification numbers or any wording that may contravene the Privacy Act (1993). If photographs of patients are used, either the subject should not be identifiable, or include a separate signed statement from the patient indicating permission to use the photograph.

The Patient

- The case should have at least three involved structures such as bone, tendon, skin, soft tissues etc. (these do not necessarily have to have been directly "injured" but if not you need to show how a minimum of three structures are involved as sequelae).
- You need to have treated the patient within the last 12 months (at the time of case study submission) i.e. if you discharged the patient on 1st July, HTNZ needs to receive the case study by 1st July the following year.
- You need to have directly treated the patient for a minimum 8 week period. This does not include follow up phone calls or seeing them later for a separate/new/co-existing injury. (e.g. if they have a hand and a back injury and you are seeing them for both, treating the hand injury for 6 weeks and the back injury for 10 weeks, this would not meet the criteria). A starting date should be stated, and the date of discharge from treatment (if treatment has ceased at the time of writing).

Content

The content of your case study should include the following. The precise sequence, format and presentation style are up to you.

1.) Outline of the condition or injury.

- The injury/condition should be described and anatomical structures involved clearly outlined.
- State if it is the dominant or non-dominant hand.
- Describe any surgical/medical intervention (information from operation notes can be included).
- Sequalea should be outlined. (e.g. if there have been soft tissue changes/effects secondary to surgery, immobilization, oedema).
- Discuss the biomechanical and functional implications of the injury/condition

2.) Social and Vocational Situation

- Include some detail of the patient's social situation and discuss any implications this may have for treatment.
- Discuss current employment situation and implications on treatment. Discuss implications of their injury/condition for their employment.
- Discuss functional implications for the patient in relation to social and vocational roles.

3.) Initial Assessment

- Should include appropriate objective and subjective data.
- Include time framed goals (short and long term) that reflect patient involvement in their development.

4.) Treatment/Intervention

- The treatment should be based on the principles of hand therapy treatment and demonstrate specialist hand therapy skills.
- Should be presented chronologically.

- Your treatment description may be essay, chart, table or timeline style (remembering to include adequate information that the reader can readily understand what your treatment involved).
- Do not include your actual treatment notes or anything that resembles "SOAP" notes. Please do not describe each individual treatment session – for example if you undertake the same
- ROM exercises for a four week period they can be described along with the timeframe for when they were used and when and why changes were made.
- You may choose to bracket descriptions/outlines of your treatment. For example according to
- phases of healing or "stages" for protocols.
- All treatment modalities you have undertaken should be described to a degree that the reader is able to understand what you did with the patient (assume a familiarity with hand therapy terminology). For example, if stating you undertook active range of motion, describe each exercises using common hand therapy terminology (e.g tendon gliding exercises, blocked
- PIPj). If the reader is uncertain re a treatment at the time of marking they will email for clarification (or if your case study is sent back for amendments they would request clarification then.
- Include treatment frequency and duration for modalities (i.e. if you undertook range of movement exercises explain how often they were undertaken and how may repetitions each time and then in your rationale you would give your reasoning for this)
- Appropriate objective data showing progress through the course of treatment and final outcome should be included. Outcome should include physical/objective data and functional outcomes.

- If this information is not available you should seriously consider if this is an appropriate patient to present as a case study. If objective data is incomplete and you decide to proceed with presenting the patient you need to outline why the data is incomplete.

5.) Tissue Healing

- Your case study should include discussion of the healing process for each involved tissue type
- (referenced). This should be directly related to your individual patient (i.e. if your patient had a fracture that was ORIF'd make sure your discussion focuses on healing of ORIF'd bones rather than describing the healing process for non ORIF'd bones).
- This can be covered in other sections or you may choose to include a dedicated section to cover each tissue type.

6.) Rationales

- A rationale is required for each modality you have used as a part of intervention. This can be included in the section where you describe the treatment or included in a separate section.
- Include discussion and rationale re the timing of use of each modality in relation to tissue healing time frames. Reference this. (n.b. it is not adequate to state a modality was commenced at a certain time because an author you reference has stated this, you actually need to explain the rationale)
- The rationale needs to include some discussion of how the modality is thought to produce a result (i.e. what is actually happening at a tissue level to result in a change). This can be brief and to the point, but is a strictly applied criteria.
- References must be included for your rationales. These must be original authors (e.g. the manuals from the hand therapy course are not accepted as references, you need to go back to the original references)
- Ensure your references are specific for the treatment you have given:
  - e.g. if you have followed a specific protocol ensure your references relate to this protocol,
  - if they don't, you need to outline why the reference is relevant to what you have done e.g. if you have used static progressive splinting ensure your discussion and references relate to this rather than to dynamic splinting
- Identify any controversies in relation to treatment recommended in the literature and outline your rationale your treatment in this case
- Avoid stringing quotes together without any of your own discussion as to how these relate to your treatment
- Rationales are not needed for medical or surgical treatment, only for treatment you have given or continued with (if referred on from another service).
- Rationales are not necessary for assessment techniques (e.g. goniometry, Semmes Weinstein, Grip testing).

7.) Reflective Practice

Include a section demonstrating reflective practice e.g.:

- What could you have done differently and why
- How you may alter your clinical practice in the future
- If the "perfect" outcome was not achieved what factors influenced this (e.g. psychosocial or patient compliance issues) and how did you, or could you, have tackled these
- Identify any controversies in relation to the injury and treatment described in the case study and reflect on how else you may have approached treatment in light of this
- If you did not follow the treatment you would have chosen because otherwise directed by a
- surgeon, or due to patient's wishes, outline and reflect on this

8.) References

- Only references cited in the text need to be presented in the reference list
- Detailed texts, hand therapy and surgery journals are recommended
- A minimum of 10 references including “recent” journal articles is required, although generally more than this will be necessary to cover all your rationales etc.
- APA referencing system preferred
- An even or high ratio of current articles to books is preferable, as compared to a heavy reliance on books.
- The case study marker or the executive can request a copy of any reference cited and the applicant must supply it within 2 working days (if so requested).

ONCE FINISHED

When you have completed your case study your supervisor should read this and sign the cover sheet. The purpose of this is to check that you have included details as outlined above. Give your supervisor a copy of these criteria and have them check off the requirements. Remind your supervisor of the timeframe for submission so that they undertake to read it in a timely manner!

Complete a cover sheet (available off the website) and send two copies of the completed case study to the admin assistant (see cover sheet for address). These do not need to be bound, stapling is sufficient.

Send payment to the Admin Assistant (see cover sheet for details and current fee).