Examining the knee joint

Abstract
Appropriate history taking and examination can ensure accurate diagnosis of common knee problems, and rapid and effective interventions or referral to orthopaedic specialists. This article describes the anatomy of the knee joint and discusses relevant history taking, the examination process, special tests and radiology, as well as common knee injuries and their management.

Aims and intended learning outcomes
The aim of this article is to describe the principles of a comprehensive assessment of the knee joint and the management and treatment of common knee injuries. After reading this article you should be able to:
- Name the knee ligaments and be familiar with the related anatomy.
- Undertake a focused history of knee injury.
- Conduct a structured approach to knee examination.
- Know and perform tests specific to knee conditions.
- Be more confident when assessing knee conditions.
- Demonstrate an understanding of common knee presentations and their treatment.

Introduction
The incidence of acute knee injuries in the UK ranges between three and 13 per 1,000 of the population, and most will require a only a single visit to healthcare services followed by advice on self-management and time to heal (Hunt and Greaves 2004). People with knee injuries commonly present to emergency settings and, because mismanagement can lead to long-term problems, it is vital that emergency department (ED) practitioners have a good understanding of how to assess and manage these injuries.

Anatomy of the knee joint
The knee joint (Figure 1) consists of the distal femur, which articulates with the proximal tibia by means of a hinge joint, and the two condyles of the distal femur, which sit in hollows on the tibial plateau. The joint is stabilised by strong muscles, ligaments, tendons and meniscal structures, and its movements are primarily flexion and extension, although there is also some rotation.

Extension of the knee is performed by the extensor mechanism, which involves the quadriceps, quadriceps tendon, patella and patella tendon applying force through the tibial tuberosity. Damage to these structures can result in a deficit in extension that is likely to affect gait.

The third bone of the knee joint is the patella, a sesamoid bone that sits in the quadriceps tendon. Sesamoid bones are embedded in tendons where tendons pass over a joint. In doing so, they protect tendons and improve the consistency of power application delivered to a load, in this case to the lower leg by the quadriceps muscle (Tortora and Grabowski 2003).

The knee is a vulnerable joint because the soft tissues can be subjected to extreme forces from all sides when bearing weight, especially in contact sports and when the knee is extended (Purcell 2010).

The condyles of the femur are covered with smooth articular cartilage giving good contact over the full range of movement, and the patella-femoral groove between the condyles articulates with the patella as it moves during flexion and extension. The posterior surface of the patella is also cartilage coated, and a ridge guides the patella through the patella-femoral groove.

The intercondylar fossa is a hollow that sits between the condyles on the distal joint surface extending posteriorly to accommodate the cruciate ligaments. The femoral condyles sit in two crescent-shaped menisci on the tibial plateau that open on their medial edges to accommodate the intercondylar eminence, but are joined anteriorly (Tortora and Grabowski 2003).

These menisci, which represent the shock-absorbing system for the forces that occur in the knee joint, are...
vulnerable to tears as a result of twisting forces that grind them together when bearing weight (Purcell 2010). The fibula plays no part in joint movement but anchors some ligaments.

Ligaments The four knee ligaments provide most of the joint’s stability and oppose posterior and anterior movement, as well as lateral and medial flexion. The anterior cruciate ligament (ACL) limits anterior movement of the tibia against the femur, and inserts at the lateral femoral condyle and the medial tibial condyle, crossing anteriorly to the posterior cruciate ligament (PCL).

The PCL limits posterior movement of the tibia against the femur and inserts at the medial femoral condyle to the posterior edge of the tibia at the midline crossing posterior to the ACL. Both ligaments are vulnerable to injury when sudden anterior or posterior forces are applied, particularly when bearing weight.

The collateral ligaments limit valgus and varus movement (Figure 2), and the lateral collateral ligament (LCL) attaches at the lateral epicondyle of the femur and runs obliquely backwards to insert at the head of the fibula. The head of the fibula is extracapsular and separate from the lateral meniscus.

In contrast, the medial collateral ligament (MCL) consists of two layers; the superficial layer attaches at the medial femoral epicondyle running obliquely forwards to attach at the periosteum of the tibia, while the deeper layer thickens the joint capsule. Both are particularly vulnerable to lateral forces when the knee is extended.

Bursae are designed to alleviate friction in some joints and there are three to note in the knee:
- Infrapatella bursa, located over the tibial tuberosity.
- Prepatellar bursa, which sits over the distal edge of the patella.
- Suprapatellar bursa, which sits posterior and superior to the patella.
The last of these is important in acute knee injuries because it is the only bursa that communicates with the synovial capsule and can fill with blood as a result of soft tissue or bone injury.

Subtle swellings can be seen as a loss of definition of the medial hollow, which is found medial to the patella tendon.

Now do time out 1.

1 Anatomy review

Time out

Look at the anatomy of the knee joint in a text such as Tortora and Grabowski (2003) and identify the bony structures and ligaments, the extensor mechanism and other soft tissues.

History taking

The initial phase of history taking requires making general observations while patients are in the waiting area, or gathering information from ambulance staff. For example, an initial impression of patients’ abilities to weight bear can be formed from watching how they move from the waiting area to the consultation room.

Knee injuries can be painful and examination can worsen the pain so it is important to ensure patients have appropriate and effective analgesia before starting. This process is carried out during initial assessment in the ED, but patients’ pain should be reassessed regularly and treated accordingly.

The standard approach to history taking should be applied (Box 1, page 30) to form a clear picture of the whole episode (Purcell 2010).
Continuing professional development

Box 1  Standard approach to history taking
Assess the:
■ Presenting complaint.
■ History of presenting complaint.
■ Past medical history.
■ Medications.
■ Allergies.
■ Social history.
■ Family history (if appropriate).
■ Systems enquiry.

After explaining the process about to occur, practitioners should start history taking by listening to the patients’ answers to simple open question such as: ‘Tell me what happened?’ This approach can reveal a lot of the information required and generate differential diagnoses. For example, a young person who has sustained an injury during a sporting activity will have different potential diagnoses than an older, sedentary person with atraumatic pain (Browne and Kurtz 2009).

Further questions will confirm details of events and the specifics of the problem. Every physical factor should be considered, including, for example, direction, speed and duration of force, type of surface, height of fall, position of limbs and the direction in which they moved (Purcell 2010). Box 2 offers a structure for questioning, but this should be adapted to take patients’ responses into account.

Now do time out 2.

2  Case study: part 1

A 25-year-old man, Dave, has attended your unit after injuring his right knee during a rugby match. He complains of pain and swelling and says he has been unable to walk since sustaining the injury. What considerations should be given to pain? What important information should you obtain from Dave?

Examination
After giving effective analgesia, making initial observations and taking a full history, practitioners can start examination using the ‘look’, ‘feel’, ‘move’ approach (Douglas et al 2009, Purcell 2010). Examinations always begin with looking but the other phases can vary in order. Movement is the main assessment method for soft tissues. However, if the feel phase suggests a possibility of fracture it is sensible to delay the move phase until after X-ray (Purcell 2010).

Examinations are best performed with patients sitting on the examination table, preferably with both knees exposed to allow comparison between the injured and non-injured knee. Practitioners should remember that it may be uncomfortable for patients to straighten their knees and some support under the joint may be necessary.

It is also essential to ensure that patients’ privacy and dignity are maintained throughout the consultation (Nursing and Midwifery Council 2008). A brief examination of the joints above and below, the hip and ankle in this case, is also good practice to rule out further injuries (Douglas et al 2009).

Look In each case, help the patient undress to expose both knees from hip to ankle where possible, ensuring dignity at all times. Practitioners should then look for any swelling, bruising, redness or deformity, noting patella position and skin breaks such as abrasions, lacerations and deeper wounds. Deep penetrating wounds over the joint could indicate involvement of the joint space, which means there is a risk of infection.

Swelling is often best seen in the medial hollow and suprapatellar areas and should be compared with the non-injured knee for dissymmetry. It is also good practice to note any swelling on the posterior or popliteal areas of the knee, for palpable herniation of the joint capsule or deformities not visible from the anterior aspect. It might be necessary to adapt the examination so patients do not have to turn over from front to back, and it is good practice to perform as much of the procedure as possible with patients sitting or supine before repeating the

Box 2  Structure for history taking for knee injury
■ Establish if the injury is a result of trauma and, if so, how the trauma occurred. Offer descriptions of what patients might be experiencing, for example: ‘Does it feel like it locks or is unstable?’
■ If the injury is traumatic find out if contact was involved and, if so, from where, what kind and by what.
■ Was there twisting of the knee while the foot was on the ground?
■ Could the patient continue the activity immediately after injury? Has this changed since the incident?
■ Did the problem happen immediately or was there a delay?
■ Was the trauma accompanied by pain, or sounds such as popping or cracking?
■ Did the patient notice any swelling or deformity immediately after the incident? How quickly did it swell? Has there been any change since?
■ If there is pain, what makes it worse or better?
■ Are there any wounds? How deep are they? Are they contaminated?
■ Has the patient had previous injuries or surgery to the same knee? Was it similar or different from this injury? What was the outcome?

(Browne and Kurtz 2009, Purcell 2010)
process with them lying on their front. This should also minimize pain from excessive movement.

**Feel** This process should start with assessment of distal circulation and sensation, based on capillary refill, distal pulses and dermatome distributions comparing both knees. Joints proximal and distal to the affected knee should be examined to rule out any injury obscured by pain of the presenting injury, which can be distracting.

Practitioners should leave the most painful areas until last and palpate the bony structures with care to assess for tenderness and crepitus; these include the medial and lateral femoral condyles, patella, tibial tuberosity and fibular head (Browne and Kurtz 2009). The patella should be lightly mobilised medially and laterally to assess its alignment in the patella-femoral groove (Cox 2010) followed by examination of the soft tissues and bony landmarks of the knee (Browne and Kurtz 2009).

Starting above the knee, palpate the quadriceps muscle and tendon taking note of tenderness and spongy areas, referred to as bogginess, which can indicate the presence of fluid, or gaps in the muscle known as steps, which can indicate rupture. Lateral and posterior soft-tissue structures of the thigh should also be palpated (Figure 3).

The MCL and LCL should be palpated along with the patella tendon, and the soft tissue structures of the lower leg should be palpated in a similar fashion to the thigh. If possible, palpate the medial and lateral menisci, as well as the tibial plateau with the knee in flexion, although this procedure might be better combined with the move phase if there is a possibility of fracture.

Try to establish whether swelling is isolated or is an effusion; localised oedema indicates extra-articular injury while symmetrical swelling around the knee indicates intra-articular injury (Browne and Kurtz 2009). Effusion can be determined by a patella tap, which involves applying gentle pressure with the hand on the anterior thigh and sliding it towards the suprapatellar region to move fluid from the suprapatellar bursa to under the patella. This raises the patella, which, if then pushed in a posterior direction with the free hand, gives a tapping sensation as the posterior patella knocks against the patella-femoral groove. A patella that ‘bounces’ in this way is known as ‘ballotable’, but does not indicate the type of intra-articular fluid (Browne and Kurtz 2009).

**Move** This process is designed to assess range of movement, and ligament and joint stability. Flexion and extension are the principal movements, and these should be compared with the non-injured knee where possible to determine patients’ normal range.

The straight leg raise (SLR) is a simple, useful test that establishes the function of the extensor mechanism. Patients are asked to extend their knee and lift their leg off the examination table; some might need assistance and encouragement. Practitioners should note any deformity of the extensor structures: the quadriceps, quadriceps tendon, patella and patella tendon.

It is also useful to note ‘lag’, an inability to maintain extension while performing an SLR, which can indicate injury to, or dysfunction of, any element of the extensor mechanism. An inability to perform SLR indicates loss of connection between the quadriceps and the tibia, and possible causes include transverse patella fracture and tendon or quadriceps rupture (Purcell 2010).

Practitioners should adopt a two-phase approach to assessing range of movement: active and passive. The normal range of movement of the knee should be performed actively, by the patient, and passively, by the practitioner. These movements are also demonstrated in Figure 4, page 32.

Active movements indicate motor nerve function, while passive movements help assess range of movement and identify obstructions. A knee that will not extend fully, known as a locked knee, can indicate a loose body in the joint, commonly a meniscal fragment. Some authors also advocate medial and lateral rotation of the tibia at the knee (Purcell 2010), but it can cause pain in acutely injured knees and yield little information.

Practitioners should note the end feel of these movements (Purcell 2010), in other words how the joint feels at the end of its range of movement (Box 3, page 32). For example, passive pressure applied near the knee joint in full flexion will normally feel spongy, indicating that the musculature of the calf and hamstring are making contact.
Continuing professional development

**Figure 4** Active and passive flexion and extension demonstration

Conversely, when lifting the leg at the heel with the other hand placed under the knee, raising the knee a short distance and dropping it into the hand should result in a firm end feel which is the normal end feel when the knee is extended. A springy feel with pain indicates possible meniscal obstruction and a locked knee (Purcell 2010).

The ligaments can be checked for injury, whether complete or partial rupture, or sprain, by conducting four tests considered in pairs. The ACL and PCL are tested by pulling and pushing the knee at 90°. The MCL and LCL are tested by applying lateral and medial pressure at the joint. Essentially, if the ACL is tested, the PCL should follow, likewise with the MCL and LCL.

The cruciate ligaments, ACL and PCL, can be assessed with the knee flexed to 90° and, for the ACL, using the anterior drawer test (Figure 5). This approach involves the practitioner sitting partially on the patient’s foot to stabilise the leg and grasping the tibia with his or her fingers on the calf and thumbs on the anterior line joint. The practitioner should ensure the hamstrings are relaxed and, with his or her arms held back, lean straight. Any ligament laxity or pain when compared with the normal side is a positive test and indicates injury of the ACL. This procedure can be difficult for the practitioner to do if the patient's knee is particularly swollen or painful. An alternative approach is the Lachman test, in which anterior stress is applied to the lower leg, which is at 30° flexion with slight external rotation (Figure 5).

A similar approach to the anterior drawer test can be applied to the PCL, but in this case the tibia is pushed backwards although care should be taken that the tibia has not already fallen back as a result of a rupture.

The MCL and LCL are tested with the knee in slight flexion; the MCL is tested when pressure is applied to the lateral knee, and the LCL is tested when pressure is applied to the medial knee with the ankle braced. Again, pain or laxity is a positive result and indicates injury.

**Case study: part 2**

Dave has had effective analgesia from the assessment nurse. You establish that his injury was sustained two hours ago when he was tackled heavily while trying to score a try. The impact was above the right knee from the front and right while his foot was planted on the floor. His knee has become swollen since the time of injury and he has been unable to weight bear while in the emergency department. Dave has an unremarkable medical history, takes no medications, has no allergies and has no significant family history. He works in IT and lives with a university friend in a ground floor flat. What injury or injuries do you suspect? How would you approach the examination?

**Special tests**

Additional special tests can be carried out to help the differentiation of diagnosis by identifying specific areas of injury with some accuracy. Some patients cannot tolerate these tests well, and they can be difficult for the practitioner to perform. The tests also may yield little useful information, particularly when knees are acutely swollen and painful.

Practitioners should therefore consider whether it is necessary to perform these tests, particularly if they do not alter the patient’s management plan. The tests should be left for an orthopaedic specialist to perform when necessary. The three most common tests are discussed below and illustrated in Figure 6.

McMurray’s test can help establish meniscal injury but is difficult to perform unless practitioners

**Box 3** Normal range of movement of the knee

- **Flexion 0-140°.** End feel is spongy.
- **Extension 0-10°.** End feel is firm, and the posterior capsule is stretched.
- **Rotation of tibia.** Medial side 0-30°. Lateral side 0-40°. The end feel is firm, and the capsule and ligament is stretched.

(Adapted from Purcell 2010)
are strong. It involves grinding the joint surfaces together in all the positions of the joint from passive flexion to extension. Pain, grating or clicking all mean a positive result (Purcell 2010).

A useful test for a recently dislocated patella is the patella apprehension test, named after the obvious patient apprehension when in positive cases pressure is applied to the medial border of the patella (Douglas et al 2009).

The Apley test, meanwhile, involves asking patients to lie prone with their affected knee at 90° while the practitioner gently applies pressure to compress the joint and rotate the lower leg. A popping sensation or pain indicates damage to the medial meniscus (Hunt and Greaves 2004).

Radiography

The Ottawa Ankle Rules make up a widely recognised decision-making tool that assesses the need for ankle radiography (Stiell et al 1992). Stiell et al (1995) developed a similar framework for assessing knee injuries, called the Ottawa Knee Rules, which are also widely recommended (Raby et al 2005, MacKenzie 2011).

The Pittsburgh Decision Rules (PDR) (Seaberg and Jackson 1994) are not considered in this article because the original comparative work was performed by one of theauthors involved in the design of the PDR (Seaberg et al 1998). There is, however, debate about whether these or the Ottawa Knee Rules are more effective.

The Ottawa Knee Rules state that knee fractures are associated with five criteria, any one of which indicates X-ray (Hardy and Snaith 2005, MacKenzie 2011). The criteria are that the patient:

■ Is aged 55 years or older.
■ Has tenderness at the head of fibula.
■ Has isolated tenderness at the patella.
■ Cannot flex to 90°.
■ Cannot weight bear or take four steps at the time of injury and in the ED.

Swelling is not a criterion for X-ray given the significance of suprapatellar swelling and its relationship to haemarthrosis. This element is considered in a patient’s inability to flex to 90° or to weight bear.

Standard X-rays for the knee after trauma are anteroposterior and lateral horizontal beam views (Hardy and Snaith 2005, Raby et al 2005), and an oblique or skyline view if fracture of the patella is suspected (Raby et al 2005).

Most traumas to the knee result in soft-tissue injury, with bone injury being seen in only between
6 and 12 per cent of cases (Hunt and Greaves 2004, Hardy and Snaith 2005). Therefore, X-rays often show up significant injuries other than fracture.

For example, Figure 7 shows a lipohaemarthrosis after an intra-articular fracture. Fat and blood have escaped from the bone marrow, so that the fat can be seen floating on the blood with a sharply defined blood-fat boundary between them.

Positioning of the knee for X-ray must be appropriate and, for the horizontal beam view to demonstrate a lipohaemarthrosis, the fat and blood need time to separate. Patients requiring X-ray should be helped on to a trolley with their knee held still, and as close to extension as possible for about 30 minutes before the film is taken, so the fat-blood boundary can settle. The boundary can be seen on the horizontal view at the suprapatellar bursa and indicates fracture even when the fracture cannot be seen (Hardy and Snaith 2005, Raby et al 2005). This finding should therefore be considered a diagnosis of fracture and managed according to local policy.

Now do time out 4.

Case study: part 3

On examination, you find no obvious injury to Dave’s hip or ankle and no wounds or abrasions, but he has significant suprapatellar swelling. No abnormality is found when palpating the musculature of Dave’s knee, he has no obvious bone tenderness, and he can straight leg raise with difficulty. You find a positive patella tap. Dave is tender over the medial soft tissues and you decide not to proceed with the move phase at this time. What investigation is necessary? What considerations should be made before sending Dave for the investigation?

Common knee presentations

Ligament injuries are usually a result of violent twisting or angulation mechanisms and often occur during football and rugby matches when people have their feet planted on the ground and other players strike them laterally, medially or anteriorly. These injuries are painful and can be unstable, and often patients do not tolerate the special tests in Figure 6.

O’Donoghue’s triad suggests injury to the ACL or PCL and MCL often occur together with a meniscal tear (Cyriax and Cyriax 1993).

Meniscal tears occur as the result of rotation of the knee, which does not always have to be violent in nature, and can result in a locked knee. This is painful and can ‘unlock’ itself, although it may need surgery, and tends to heal poorly (Purcell 2010). Partial ligament tears meanwhile may recover with physiotherapy, but ruptures can require surgical intervention.

Patella fractures can be either vertical or horizontal, and occur as a result of a direct blow of significant force or a violent contraction of the quadriceps tendon. Vertical fractures tend to be more stable and are treated conservatively, while horizontal fractures often require surgical stabilisation (McRae and Esser 2008). These fractures result in an inability to weight bear or SLR, with significant localised tenderness, bruising and swelling. There may also be significant injury to other parts of the extensor mechanism.

Tibial plateau injury is commonly caused by severe valgus stress of the knee, similar to that of an MCL injury, and results in a depression fracture that can involve the neck of the fibula and require surgical intervention (McRae and Esser 2008).

Management

The injuries described above are likely to require referral to orthopaedics, according to local protocol. The largest group of injuries, however, are minor sprains and strains, and patients with these also need careful management. As a general guide, if patients have difficulty walking, they should be referred to physiotherapy for follow up and given crutches to allow safe and more stable weight bearing.

Advice for these patients and those who do not need crutches is similar: take regular analgesia, with review if this is not sufficient. Patients should be advised of the PRICE mnemonic: protection, rest, ice, compression, elevation (Hunt and Greaves 2004, Purcell 2010).

Whether or not to use compression as a form of protection for the knee depends on local protocol, and there is still debate about what should be used. Compression bandages can be used for up to 72 hours, beyond which their effectiveness is limited. These bandages should be removed at night. However, applying ice for up to 20 minutes, for example with
a bag of frozen peas wrapped in a tea towel, and elevation of the knee above hip level, with support between the ankle and knee, can help reduce swelling and pain.

A patient should be advised to rest for 48 hours, after which there should be signs of improvement. The patient can then gradually increase mobility as pain allows.

Guidance on simple exercises, designed to maintain a good range of movement, is commonly available as patient information leaflets in most departments. The leaflets are often designed with physiotherapists.

If symptoms persist or worsen after this time, advice should be sought initially from the patient’s GP.

Now do time out 5

Case study: part 4

Dave’s X-ray shows a lipohemarthrosis with no obvious fracture. You therefore continue with the examination and are satisfied that, while Dave cannot flex to 90° or attempt extension, this is due to swelling, not a motor deficit. You perform a Lachman test, which shows laxity of the anterior cruciate ligament (ACL). Testing of the medial collateral ligament (MCL) and lateral collateral ligament indicates that Dave has some medial pain without laxity. You are suspicious of an ACL rupture and partial MCL rupture and expect a possible meniscal injury. What is the appropriate management for this patient?

Practice profile

Now that you have finished the article you might like to write a practice profile. Guidelines to help you are on page 36.

References


Practice profile

What do I do now?

Using the information in section 1 to guide you, write a practice profile of between 750 and 1,000 words – ensuring that you have related it to the article that you have studied. See the examples in section 2.

Write ‘Practice Profile’ at the top of your entry followed by your name, the title of the article, which is: Examining the knee joint, and the article number, which is EN1126.

Complete all of the requirements of the cut-out form provided and attach it securely to your practice profile. Failure to do so will mean that your practice profile cannot be considered for a certificate.

You are entitled to unlimited free entries.

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You will be informed in writing of your result. A certificate is awarded for successful completion of the practice profile.

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Keep a copy of your practice profile and add this to your professional profile – copies are not returned to you.

1. Framework for reflection

Study the checklist (section 3).

What have I learnt from this article?

To what extent were the intended learning outcomes met?

What do I know, or can I do, now, that I did not/could not before reading the article?

What can I apply immediately to my practice or client/patient care?

Is there anything that I did not understand, need to explore or read about further, to clarify my understanding?

What else do I need to do/know to extend my professional development in this area?

What other needs have I identified in relation to my professional development?

How might I achieve the above needs?

(It might be helpful to convert these to short/ medium/long-term goals and draw up an action plan.)

2. Examples of practice profile entries

Example 1 After reading a CPD article on ‘Communication skills’, Jenny, a practice nurse, reflects on her own communication skills and re-arranges her clinic room so that she will sit next to her patients when talking to them. She makes a conscious decision to pay attention to her own body language, posture and eye contact, and notices that communication with patients improves. This forms the basis of her practice profile.

Example 2 After reading a CPD article on ‘Wound care’, Amajit, a senior staff nurse on a surgical ward, approached the nurse manager about her concerns about wound infections on the ward. Following an audit which Amajit undertook, a protocol for dressing wounds was established which led to a reduction in wound infections in her ward and across the directorate. Amajit used this experience for her practice profile and is now taking part in a region-wide research project.

3. Portfolio submission

Checklist for submitting your practice profile

Have you related your practice profile to the article?

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What do I know, or can I do, now, that I did not/could not before reading the article?

What can I apply immediately to my practice or client/patient care?

Is there anything that I did not understand, need to explore or read about further, to clarify my understanding?

What else do I need to do/know to extend my professional development in this area?

What other needs have I identified in relation to my professional development?

How might I achieve the above needs?

(It might be helpful to convert these to short/ medium/long-term goals and draw up an action plan.)

2. Examples of practice profile entries

Example 1 After reading a CPD article on ‘Communication skills’, Jenny, a practice nurse, reflects on her own communication skills and re-arranges her clinic room so that she will sit next to her patients when talking to them. She makes a conscious decision to pay attention to her own body language, posture and eye contact, and notices that communication with patients improves. This forms the basis of her practice profile.

Example 2 After reading a CPD article on ‘Wound care’, Amajit, a senior staff nurse on a surgical ward, approached the nurse manager about her concerns about wound infections on the ward. Following an audit which Amajit undertook, a protocol for dressing wounds was established which led to a reduction in wound infections in her ward and across the directorate. Amajit used this experience for her practice profile and is now taking part in a region-wide research project.

3. Portfolio submission

Checklist for submitting your practice profile

Have you related your practice profile to the article?

Have you headed your entry with: the title ‘Practice Profile’; your name; the title of the article, which is: Examining the knee joint, and the article number, which is EN1126.

Have you written between 750 and 1,000 words?

Have you kept a copy of the practice profile for your own portfolio?

Have you completed the cut-out form and attached it to your entry?