Reflexology New Zealand

Diploma of Reflexology

Module 4 Descriptor

REFLEXOLOGY CASE STUDIES

Hours:	200	
Credits:	20	
Level:	5	
Pre requisite:	First Aid	
Co requisites:	Module 1. Foundational Reflexology Knowledge Module 2. Reflexology in a Clinical Setting Module 3. Footcare	
Delivery:	Class contact hours:	15
	Self Directed Learning Hours:	185
	Total hours:	200

To maximize learning 80% classroom attendance is required.

Aim: People credited with this module are able to:

Demonstrate knowledge of case study investigation for reflexology practice; identify and use relevant reflexology treatment and **research** literature to inform treatment approach and understanding of findings for a case series; and demonstrate reflective practice in conducting **six** reflexology case studies.
A case study refers here to the collection and presentation of detailed information about a particular client, who received at least six treatment sessions. The case study draws conclusions over time, only about that client and only in that specific context.

Learning outcomes: On successful completion of this module the student will:

1. Demonstrate knowledge of case study investigation for reflexology practice.
2. Present six case studies that demonstrate a holistic approach within the Reflexology New Zealand scope of practice
3. Refer client(s) to allied health professionals if appropriate.

Content: to include but not limited to :

A full and thorough description of the client, name or alias, age, sex, date of birth, occupation, contact telephone numbers, postal address, detailed medical

history – include operations, illnesses past and present, current medication, current medical conditions, current vitamin and mineral supplementation.
NOTE: Information collected must be pertinent to the case study to conform to the Privacy Act, 1993.

Signs and symptoms of illness, symptom or condition, Reflective practice – exploration of different treatment approaches and comparison of findings with relevant literature and references. Goals and objectives of treatment formed in partnership with client. Home care advice for client - if any.
Detailed record of date of treatment, record of areas found to be tender, notes and observations of clients feet e.g. colour, texture, smell, temperature, nail diseases (if any), bio-mechanics of the feet – e.g. dropped metatarsals, bunions, corns, plantar warts, contraindications, results (if any) – what the client felt after treatment, and records of any improvement of the condition, symptom or illness.
Recorded, signed and acknowledgement by client that he/she has been informed of the treatment plan, has given consent to treatment, and has been informed that there may be a “reaction” to treatment, including explicit details of said reactions and what a client could experience e.g. tiredness, sudden onset of illness like colds/flu if client was beginning to get ill, headaches, pain in joints due to detoxification, emotional release, hormone balancing and related adjustments within the body. Consent by way of letter, giving therapist right to use them as a case study to be published and presented to relevant tutors of various establishments, and the possibility of being used as a reference for other similar cases by future students or professional practitioners.