

# Reflective portfolio of an occupational therapist



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## Reflective Portfolio and Continuing Professional Development Portfolio

The HCPC defines a Continuing Professional Development (CPD) portfolio as:

‘ A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice’. (Allied Health Professions project) Put simply, a Continuing Professional Development Portfolio is a way for professionals to continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to work safely, legally and effectively within social services or the private sector.

Alsop (2000) recognises that there is a wide range of benefits of CPD. By keeping a Continuing Professional Development Portfolio it helps to encourage a higher standard of personal professional performance. It demonstrates a commitment from the healthcare professional to ensure the best practice is given as well as demonstrating a dedicated commitment to service users.

Continuing Professional Development Portfolio requires some specific documents. For example a CPD portfolio requires a fully up-to-date Curriculum Vitae and a personal statement with a summary of current work and how your CPD improved the quality of your work and the benefits you have provided to your service users. As well as the basic necessities there are a variety of things that could be beneficial to include in ones Continuing Professional Development Portfolio such as informative hand-outs or articles that have impacted upon your understanding of Occupational Therapy or

examples of your skills applied to your current situation. Another key aspect of keeping a Continuing Professional Development Portfolio is to have regular reflections of your objective practices and assessments. By turning ones experiences of practice into a written form of documentation it will help each individual identify and support their learning outcomes and learning needs. It also helps to have a wide range of learning activities including peer review/feedback and group projects. As well as peer feedback from group work it would also be beneficial to include feedback on assignments from professors, illustrating how your learning has developed, and your practice has improved.

The Code of Ethics and Professional Conduct (COT, 2010) specifies the requirements of an Occupational Therapist in relation to keeping a Continuing Professional Development Portfolio. It states that all Occupational Therapists must continue to keep a CPD portfolio that may be audited by the HCPC every five years. Each professional must make sure that their CPD Portfolio shows a variety of different kinds of activities and that each activity is relevant to their line of work. Each CPD portfolio should aim to improve the quality of work you produce, and ensure that each healthcare professional is able to practice safely and effectively within their scope of practice as well as being able to practise within the legal and ethical boundaries of each varying profession. For example an Occupational Therapist because they have such a holistic approach to their care would need to be aware of the impact of culture, equality and diversity on their practice (HCPC 2013) With each health care professional updating their Continuing Professional Development Portfolio they will be able to draw on up to date and appropriate knowledge

and skills to inform their practice decisions and to help them understand the need to establish and maintain a safe practice environment. However a Continuing Professional Development Portfolio is not just kept by Occupational Therapists but are required from the entire multidisciplinary team

A multidisciplinary team (MDT) is composed of members from different healthcare professions with specialised skills and expertise. This is beneficial to the patients because when professionals from a range of disciplines with different but complementary skills, knowledge and experience work together they are able to deliver comprehensive healthcare aimed at providing the best possible outcome for the physical and psychosocial needs of a patient and their carers. Multidisciplinary care occurs due to the fact that a patient's needs may change with time and treatment. Since the team has such a diverse range of professions to call upon for a patient's care the structure of the team may also change to meet these needs. There are many health care professions that make up a multidisciplinary team ranging from District Nurses, Physiotherapist, Doctors, Speech and Language Therapists and of course Occupational Therapists

The role of an Occupational Therapist can provide many benefits within the multidisciplinary team. Their specific training allows them to hold the distinctive role of understanding a patient's medical, physical and psychological state and the impact that their disability or injury might be imposing on their lives. It also helps that occupational therapists are able to address an individual's broader goals that will help a patient integrate with their local community and reduce depression and participate in the activities

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that are important to them. Essentially Occupational Therapists prove to be instrumental in combined teams as they are able to understand both the health and social care context of a client. The Occupational Therapists have a unique opportunity to link various professionals dealing with a clients care. They can act as the cohesive agent to maximise the effectiveness of a team. They have involvement in working with both health and social care and return to work schemes. Unlike the rest of the multidisciplinary team Occupational Therapists' provide a client centred approach to their practice, they look at the person as a whole so involving the clients occupation, their environment and their spirituality into their treatment. ' The occupational therapist values individual experience, cultural diversity, religious beliefs and lifestyle diversity in their clients.

The expression of these values means that occupational therapy is essentially a flexible process in which the therapist listens to the client in order to understand and respond to their individual needs, values, interests and aspirations. For intervention to be integrated into the life and context of the individual, the family and carers, it must be culturally sensitive and culturally relevant.' (Creek 2003, p29). This client centred approach is also greatly aided by the fact that occupational therapists have an extensive knowledge and understanding of the equipment and adaptations that are a major part of healthcare services (Rabiee and Glendinning 2010). This makes Occupational Therapists a valuable part of the MDT for the government as they drastically help reduce the cost of care for some clients.

A recent study which explored the relationship between provision of correct equipment from an Occupational Therapist and the reduction on care

package costs and residential care found that on average the cost of an eight week care package was dropped by over £60, 000 (Hill. S (2007)). This was because housing adaptations made by the Occupational Therapist greatly reduced the need for daily visits and reduced or even in some cases removed the costs for home care this ultimately brought savings in that ranged from £1, 200 to £29, 000 a year. (Heywood and Turner. 2007). Ultimately the setting up of supplementary moving and handling equipment by the occupational therapists reduces the need for two carers to assist the patients with their personal care. In Somerset, of the 125 services users who were assessed; 37% of them are now only assisted by one carer instead of two, with savings of £270, 000 achieved. The average initial investment in equipment was £763 per service user (Mickel 2010). This additional money saving shows that the Occupational Therapists are a cost effective and highly efficient members of the multidisciplinary team, who can provide holistic, well rounded care to each individual patient.

As well as all members of the multidisciplinary team having to keep a Continuing Professional Development Portfolio they must also keep reflection folders. Reflection can be defined as a framework through which professionals can explore all issues involved in clinical practice to them it is a means of enabling practitioners to theorise about practice and thus enable theory to emerge from practice. Schön (1983) presents the idea that there are two types of reflection: Firstly there is reflection in action this is when the professional's instinctive actions are reflected upon, whilst they are carrying it out the actions or assessment, and altered as necessary whilst in the situation. Secondly there is reflection on action this is when we as

professionals step back from the performance and reflect on that action at a later time and date.

Many different professionals have presented different models of reflection for healthcare practitioners to follow, ranging from Graham Gibbs, Christopher Johns and John Driscoll.

Graham Gibbs developed his reflective cycle (Gibbs 1988) based upon each stage of David A. Kolb's experiential cycle (Kolb 1984). He suggested how a full structured analysis of a situation could take place using prompt questions at each stage. It is probably the most cited model by health care professionals but does not contain the number or depth of prompt questions contained in some other models

**Description** – In this section, the professionals need to explain what they were reflecting on. This means that they need to include background information, such as what it is they were reflecting on and tell the reader who was involved. It's important to remember to keep the information provided relevant, to-the-point and most importantly confidential.

**Feelings** – In this section the professional needs to discuss their feelings and thoughts about the experience. They need to consider questions such as: How did you feel at the time? What did you think at the time? What did you think about the incident afterwards? Here they are able to discuss their emotions honestly.

**Evaluation**-For the evaluation, the professionals need to discuss how well the event went. Including factors such as: How they reacted to the situation at

hand, and how did other people react to the same situation? What was good and what was bad about the experience?

Analysis- In the analysis, one needs to consider what might have helped or hindered the event at the time. The professional also has the opportunity here to compare the experience with the literature they have read.

Conclusion- In the conclusion, it is important for the professional to acknowledge: whether they could have done anything else; what has been learned from the experience; consider whether they could you have responded in a different way. If the experience was positive it is important to discuss whether the same actions would be undertaken to ensure the same positive outcomes next time. At the same time considering if there is anything that could have been change a to improve things even further. If the incident was negative then you need to reflect on how this could have been avoided and what needs to be done to make sure it doesn't happen again.

I chose Gibbs' model of reflection to use in my own assignment, because I found that the structure was easy to follow, and was laid out clearly. The instructions were simple and sequential. In addition to this the model was easy to apply to my assessments and my clients.

Applying the Model to an Assessment performed on Placement.

For confidentiality reasons during this reflection the client will take the pseudonym of Mrs Jones who was a seventy five year old woman and my educator will go by the pseudonym of Mrs Smith.



Description - In this section I will be reflecting upon a washing and dressing assessment with Mrs Jones that took place on the ward before her returning home. Mrs Jones was in hospital for several months after suffering a fall at home. Mrs Jones lived at home by herself in a two storey house, with three bedrooms but with a downstairs toilet and bathroom. Involved in this assessment were myself, Mrs Jones and Mrs Smith. The assessment took place on the ward in a small wash room and toilet. After her fall Mrs Jones had been using a Zimmer frame to walk around the hospital ward.

Feelings - As this was my first assessment on my own naturally I was incredibly nervous. Throughout the entire assessment I was worried that I was going to make a wrong choice or a poor decision. Throughout the assessment I was also conscious about trying to impress my educator, so actually I could be guilty of focussing more upon impressing my educator than focussing on the patient. However after the assessment had finished I did feel that it had been a success! Mrs Jones had performed well proving that she was capable of washing and dressing herself with minimal assistance from myself or from Mrs Smith. This ultimately proved that she was ready to return home.

Evaluation- During the assessment I felt that I remained calm and collected and managed to keep my nerves under control. However looking back on the assessment and after a discussion with Mrs Smith, I feel like I could have been a bit firmer with Mrs Jones. For when she kept asking to sit down and rest during the assessment I would let her whereas Mrs Smith said that she would had encouraged Mrs Jones to keep going. Stating that since being on the ward Mrs Jones had become used to the nurses doing everything for her

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and that whilst she was with us I would need to learn to differentiate between Mr Jones genuine need for help, for example when she needed help washing the top of her back and when she was being lazy and trying to get me to do things for her. However Mrs Smith said that being firm but fair with clients would become much easier with age and experience.

Analysis- During this assessment I also learnt to give the physical environment much more thought before starting a washing and dressing assessment. The cubical wash room was quite small and I failed to take into consideration that during the assessment I would have to manoeuvre myself, Mrs Jones and Mrs Jones' Zimmer frame around the toilet, shower and wash hand basin. I should have realised that I should have entered the wash room first in order to have full access to all the facilities, however I politely followed Mrs Jones into the bathroom, but then had the difficulty of moving round Mrs Jones and her Zimmer frame in order to move on with the assessment. A greater awareness of the physical environment would have enabled me to pre-empt this inconvenience.

Conclusion- In conclusion I feel that the assessment was a positive experience for both myself and Mrs Jones. In order to replicate the same positive experience for both parties, I need to remain confident and emphatic to my clients, whilst ensuring I am realistic with their abilities. The fact that I remained in an energetic and encouraging mood help lift the spirits of Mrs Jones, and inspired her to keep going in the assessment even when she claimed she didn't want to. I found that the mood of the Occupational Therapist can quite often transfer to the patient, so remaining

positive whilst in front of the client is essential to a beneficial and successful assessment.

Reflecting on all of my assessments whilst on my placement helped me identify my future learning needs. I realised that there is still plenty of room for me to grow and develop not only as a professional but also as a person. Mrs Smith and all of the clients helped me understand that to grow as a professional I need to continue to build therapeutic and respectful relationships with my clients. Although a strong rapport with patients is essential at the same time I need to learn to distance myself emotionally from my clients and to continue to remain professional. For a few times on placement and during initial assessments I found myself becoming emotionally attached to my clients, viewing them as if they were a family member, my grandparents for example. In order to become a better professional I need to learn to differentiate sympathy and empathy for my clients. Once I have managed this it will be easier for me to learn to find the balance between firm and fair when assessing my elderly clients, and only ask them to do what was realistically achievable. The final learning need that I was able to identify from my multiple written reflections, and from my reflection discussions with Mrs Smith was that as a professional I need to learn to be more confident when in charge of an assessment, but this will be something that will continue to develop and grow with age and experience.

In assessing a client's needs and appropriate course of treatment I need to consider which methods will best help achieve the desired outcome.

Experience will help develop my ability to determine realistic targets and reflection will enable me to create a portfolio of these methods to achieve

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those targets. A record of good and effective practices such as exchanges with other Occupational Therapists can only serve to enhance my professional development.

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