Flying Start Portfolio

AHP

Record of reflective account

Reflective Account (Adapted from Gibbs, 1998, Model)

Title

Assessment of patient

Date

April 2019

Description

What happened?

I was referred a patient who, prior to his hospital admission, had been independently mobile and independent with personal care and kitchen tasks at home. He had presented with delirium pre- and post-admission due to a UTI and his functionality had reduced to the extent that he was requiring assistance in washing and dressing himself at his bedside. I therefore conducted a full assessment inclusive of a physical assessment, self-care assessment, and kitchen assessment.

Physical assessment: Though the patient had been observed by nursing staff to be "independent", mobilising to and from the ward toilet with his walking stick, I determined that his balance was poor and that he "furniture-walked". I therefore sought to correct this by, firstly, attempting to undertake re-education to improve his walking pattern. However, due to the patient's delirium and inability to correctly follow instructions, I ultimately telephoned his wife to request that she bring his 3-wheeled delta frame to the ward. The patient managed much better with the use of the frame and I ultimately updated his whiteboard to reflect the fact that he was independently mobile with his delta frame. I also assessed his functional transfers, and deemed it appropriate to provide him with a free-standing toilet frame for home use, as he would otherwise have had to hold onto his radiator or wash-hand basin to transfer on and off his toilet.

Self-care assessment: I initially offered a level of prompting in the hope that the patient would manage to initiate the tasks and follow through to completion, but I ultimately had to assist him in donning his underwear and securing his trousers at the waist. When factoring in the time that the patient spent engaged in the activity, and the level of prompting required to initiate, I did not think it was fair to expect him to be able to complete these tasks without some support at home. I therefore recommended to the nursing staff that he receive a package of care on discharge.

Kitchen assessment: Though the patient indicated that his wife did "most of the cooking" it was agreed that he would benefit from receiving some practice engaging in basic kitchen activities. However, as with the self-care assessment, the patient appeared quite confused and struggled with the task, even with prompting. I therefore clarified with the patient's wife that she was able to support meal preparation tasks at home post-discharge.

Feelings

What were you thinking and feeling?

With regards to the physical assessment I felt that the patient's furniture-walking was unsafe, though I considered that this was likely a long-term behaviour and I would struggle to change this. I did feel that it would be a lot safer if the patient had access to his delta frame on the ward, as he was disinclined to mobilise with a wheeled walking frame. To this end I felt vindicated when the patient's balance improved to the extent that I was able to reliably mark on his whiteboard that he was independently mobile. I did however feel that the patient struggled with both the self-care and kitchen assessments and thus I could reasonably recommend a package of care be arranged and that the patient's wife support kitchen tasks going forward.

Evaluation

What was good and bad about the experience?

Good – The intervention was effective insofar as it offered an accurate indication of the patient's new functional baseline. The separate kitchen and self-care assessments carried out in controlled environments, with supervision and prompting, served to underscore the patient's cognitive deficits, which may otherwise have not been fully recognised.

Bad – There were nil negative consequences of the intervention, as, although the patient was unable to execute certain tasks without support and/or prompting, solutions were proffered which supported the patient's discharge back to his home environment. Fundamentally, the patient is less likely to struggle with self-care and kitchen tasks at home now that appropriate support is in place.

Analysis

What sense can you make of the situation?

I believe I improved my assessment skills through my ability to identify issues with the patient's mobility, as well as the requirement for a free-standing toilet frame to be provided to support toilet transfers at home. By facilitating further mobility practice, with a more appropriate walking aid, I was able to support the patient to regain his baseline mobility. My clinical reasoning skills were also improved as I utilised two distinct assessments to amass compelling evidence as to the patient's reduced functionality. This supported the subsequent intervention strategy: namely, the recommendation of a care package. The patient has been assessed safely mobilising with a walking aid which he normally uses – and to which he has access – at home. The patient has also been assessed safely executing functional transfers with no equipment, or with equipment provided to him prior to discharge.

Conclusion

What else could you have done?

My assessment was comprehensive in that it tackled both the patient's physical capacities and also his ability to meet needs by using his problem-solving skills and responding appropriately to prompts, where applicable. Due to other priority patients and additional demands there was little to no scope in which for a follow-up self-care assessment to be carried out. Furthermore, it is unlikely that this would have been appropriate given that the patient continued to require assistance from nursing staff and likely would have struggled in the absence of this help. I therefore do not believe that any more could have been done to accurately measure or counterbalance the patient's deficits.

Action Plan

If it arose again, what would you do? Are there any development needs that could be included in your Personal Development Plan (PDP)?

In repeat instances, in which a thorough assessment of a patient is required, I will attempt to gather as much reliable information at the outset, so as to better understand the level of support to which the patient is accustomed when executing ADLs at home, where applicable. This will help to better inform decision-making and enable me to tailor the assessments, so that I am setting achievable goals.

Record of reflective account

Reflective Account (Adapted from Gibbs, 1998, Model)

Title

Initial assessment of patient

Date

April 2019

Description

What happened?

I was asked to review 3 patients, each of whom had been boarded to the overflow ward prior to the Easter weekend. Subject to satisfactory physical assessment and robust family support, where applicable, I was able to assess and safely discharge 2 of the 3 patients; however, the third patient presented with reduced mobility and increased anxiety. Specifically, the patient was unable to mobilise 30 metres independently with his original walking aid without reaching out for furniture/walls and I was therefore obliged to set goals appropriately and feed back to the nursing staff.

Feelings

What were you thinking and feeling?

I felt that the patient was not fit enough to be discharged from the OT/PT caseload, in light of his poor mobility and the risk of him sustaining a fall, either on the ward or at home.

Evaluation

What was good and bad about the experience?

Good – I correctly identified that the patient in question was not fit for discharge and ensured that he was not placed in a position whereby he may have sustained an unwitnessed fall.

Bad – The patient required to remain on the OT/PT caseload, which necessitated more work for my colleagues.

Analysis

What sense can you make of the situation?

Ultimately, this experience has served to reaffirm the importance of safeguarding patients over and above all other responsibilities. Though I had approached the referral with the mindset that I could complete a clean sweep of discharges – and reduce the OT/PT caseload accordingly – I quickly became aware of the patient's unsafe walking pattern and concluded that he required further rehab in order to be safe and independent.

Conclusion

What else could you have done?

There was little else I could have done in the first instance, as it had been relayed to me that the patient had mobilised independently to the toilet and back with his walking stick earlier in the day. I therefore opted for him to use this same walking aid when I carried out the physical assessment. When it became apparent that he was unsafe using this method I firstly ensured that the patient was assisted in safely transferring back into his armchair, after which I thoroughly documented his ongoing goals and the likely requirement for a wheeled walking aid to be employed going forward. All other goals, including a bathing assessment and stairs practice, were not deemed to be appropriate until after the patient had had sufficient opportunity in which to improve his mobility.

Action Plan

If it arose again, what would you do? Are there any development needs that could be included in your Personal Development Plan (PDP)?

In subsequent assessments I will undertake the same practice, of asking the nursing staff for clarity regarding any outstanding issues prior to commencing treatment, as this will assist me in foreseeing the level of support, if any, that a newly-referred patient will require. Though the nurse's comments did not always correlate with the patient's presentation on assessment, as was evidenced here, it is best practice to apprise oneself of the most up-to-date information before commencing input.

Record of reflective account

Reflective Account (Adapted from Gibbs, 1998, Model)

Title

Mobility / transfer practice with patient

Date

December 2018

Description

What happened?

I attended with a patient who had been referred to OT and PT, and had been seen on three previous occasions by my PT colleague. The patient had a previous history of two myocardial infarctions and three strokes, and had been admitted to hospital with increased breathlessness. By consulting my colleague's notes I understood that the patient had previously mobilised approximately 10 metres with her zimmer frame and the assistance of one.

I initiated contact with the patient, advising that I wished to review her mobility and transfers. The patient consented to this, but, due to the restrictions imposed by her ongoing oxygen therapy, I had to source extra tubing in order for her to be able to mobilise beyond her bed space. As the patient's baseline mobility was zimmer frame and assistance of one I maintained close contact to safeguard against any falls. I was also compelled to offer consistent verbal prompts as the patient kept externally rotating her left lower limb and seemed unable to actively correct this. I also encouraged standing rest and provided regular reassurance as the patient frequently became breathless. By maintaining dialogue with her throughout I was able to accurately gauge the extent to which she was able to continue mobilising until requiring seated rest.

Safeguarding the patient was of chief importance, so I assisted her in lowering herself into a chair on two occasions to enable her to collect her breath. Ultimately, I determined that the patient was too fatigued and breathless in which to mobilise back to her bed space, so I sourced a wheelchair and assisted her back to her armchair.

Feelings

What were you thinking and feeling?

I very much felt in control of the situation throughout, partly because the patient was largely reticent and thus offered no objections. I maintained a calm demeanour but was inwardly concerned that the patient might sustain a fall if she panicked or felt too breathless to continue. Therefore, I felt it was appropriate to take measures to reassure her as best I could that she would be alright and maintain close contact throu[illegible]he session.

Evaluation

What was good and bad about the experience?

Good – Ultimately, the patient was supported to get back on her feet and mobilise a short distance, which likely increased her exercise tolerance going forward, thereby having a positive impact on subsequent treatment sessions.
Bad – The patient had been deemed to be medically fit for input by the nursing staff; nevertheless, with the benefit of hindsight, I felt that she may have benefited from a period of rest prior to further mobility practice. I was only able to make this judgement post-input.

Analysis

What sense can you make of the situation?

The patient in question was limited due to breathlessness and I therefore adapted the treatment offered to accommodate her limitations. In safeguarding the patient, by maintaining close contact and offering regular reassurance, I was able to minimise clinical risk and build the patient's trust, thereby assisting subsequent treatment sessions.

Conclusion

What else could you have done?

I might have been more proactive, and less reactive, had I anticipated the patient's reduced exercise tolerance and arranged to see her with a support worker, to enable a chair to be positioned behind her at all times. As it happened, I was reliant on another patient on the ward to provide a chair in the absence of any staff members. Fortunately, the patient in question had nil mobility issues and was thus easily able to provide a chair which had been stacked next to her bed space.

That said, there was no indication, from my colleague's notes, that the patient was unable to mobilise a short distance without taking seated rest, which is indicative of the variability of patients with acute breathlessness.

Action Plan

If it arose again, what would you do? Are there any development needs that could be included in your Personal Development Plan (PDP)?

Prior to commencing input with a patient I will adequently prepare by reading casenotes and speaking to the appropriate nursing staff members who have had sameday input with the patient. Additionally, I will maintain a regular dialogue with the patient before and during any input, as I did in the above example. This will enable me to better foresee and respond to any issues arising as a result of the treatment offered.

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Record of learning activity

Title of your learning activity

Dementia Awareness

Date

May 2019

Number of CPD hours (optional)

3 hours

Number of Participatory CPD hours (optional)

Description of Learning / Professional Development Activity

Please provide a brief summary of the learning activity

I was fortunate enough to attend the Virtual Dementia Tour, which called at my working site a few weeks into my rotation. I was briefed by my team lead beforehand and made aware that the purpose of the experience was to improve one's awareness of the primary symptoms experienced by people with dementia.

I was received by the facilitator, who dispensed with the usual introductions and prompted myself and another attendee to enter the back of the bus. I was given a pair of gloves whose digits were stitched together, a pair of eyeglasses with black dots obscuring the lenses, and a pair of headphones which delivered an unnerving static sound, akin to an out of tune radio. Additionally, I was told to place a pair of spiky insoles in my shoes, the purpose of which was later explained to me.

I was led into the main section whereupon the door was closed over and the lights were switched off. The facilitator gave instructions for me to fold some clothes which were scattered around. This proved difficult, owing to the restrictive gloves, and was made further difficult by the fact that the facilitator kept swiping the clothes away from my grasp. To compound the sense of unpleasantness a siren began blaring over the speakers and blue, red and green lights began to blink intermittently overhead. The session soon ended.

Afterwards, the facilitator explained that he had purposefully not introduced himself by name, so as to contribute to the sense of unfamiliarity. The spiky insoles were worn to stimulate the symptoms of peripheral neuropathy. Likewise, the glasses and headphones were donned to recreate macular degeneration and hearing loss/impairment respectively. The gloves, meanwhile, were designed to restrict manual dexterity skills.

Key Learning Points

What did you learn as a result of undertaking this activity?

I gained an invaluable insight as to the physical and mental barriers to emotional health and wellbeing experienced by people with dementia. This was manifested in the physical discomfort and sensory impairment which I experienced during my brief time on the bus. Though I had some degree of awareness of the different auditory and visual impairments experienced by dementia patients it was beneficial for me to experience them myself, albeit fleetingly, and thus better understand how these can impact upon an individual's ability to engage with their immediate environment.

Also, I believe I developed an improved awareness of the level of communication difficulties which exist between therapists and people with dementia, owing to environmental factors (e.g. distracting sounds, the presence of other patients/visitors, etc).

Impact on your practice

What areas of your practice have you changed or improved?

Subsequent to the experience indicated above I have undertaken to draw bedside curtains and use therapeutic touch as appropriate when engaging with patients with a form of dementia. By drawing the curtains I am trying to actively counteract the presence of other persons or stimuli on the ward and improve the level of engagement with the patient. I have also taken to offering a handshake to patients so that they are oriented to my presence/nearness. I feel that this may also be perceived as a comfort and/or communication device, as several patients with whom I've engaged have actively sought to take my hand in theirs.

Future Actions or Areas of Development

What further actions/development opportunities are needed as a result of this learning?

I think it would be helpful to have a one-off or recurring discussion forum wherein different solutions to the many and varied obstacles presented by dementia can be properly explored and refined as necessary. I feel that different communication methods and reasonable adjustments, notably to the immediate ward environment, could greatly assist patient-practitioner exchanges.

Record of learning activity

Title of your learning activity

In-service – Falls awareness

Date

June 2019

Number of CPD hours (optional)

Number of Participatory CPD hours (optional)

Description of Learning / Professional Development Activity

Please provide a brief summary of the learning activity

I attended a falls awareness in-service convened by a sen[illegible]sio and the AHP team lead. The session was greatly beneficial in terms of offering [illegible]ht as to the prevalence of slips, trips, and falls, both in and outside the hospital envi[illegible]nme[illegible]t, together with an overview of the common contributing factors. What was perh[illegible]s[illegible]lluminating about the session was the statistics pertaining to falls sustained by old[illegible]ults: namely, the fact that 1 in 3 adults over 65 will experience at least one fall each year, [illegible]e human cost of this (specifically in terms of injury, hospital admission, distre[illegible], impaired cognition, and reduced functionality), and the direct cost to the NHS, estimated at [illegible]billion per year [NICE guidelines, 2015].

The session was further enhanced [illegible]y [illegible]e l[illegible]vel of interaction between the convenor and attendees, which enabled a free[illegible]ow[illegible]g dialogue which assisted learning.

Key Learning Points

What did you learn as a result of undertaking this activity?

Though I had some awareness of the costs associated with falls – from undertaking the relevant LearnPro modules – I was still shocked by the damning statistic that around 1 in 3 older adults admitted to hospital following a fall are in the last 1,000 days of their lives. Furthermore, the significance afforded to causal factors such as inappropriate footwear and eyeglasses – relative to other factors such as poor balance, impaired cognition and frailty – gave me cause to consider both more readily in my interactions with patients.

Impact on your practice

What areas of your practice have you changed or improved?

Though I was previously mindful of both footwear and sensory issues I have become more vigilant, in ensuring that appropriate footwear is donned by patients before mobilising from their bed spaces and that bifocal lenses are avoided where possible.

Future Actions or Areas of Development

What further actions/development opportunities are needed as a result of this learning?

Guidance as to the appropriate methods for responding to a patient who has fallen would be very helpful. Having been in the position of responding to a patient who fell in an enclosed space with no other witnesses it would aid me in my practice to refine my method in effectively addressing similar situations.

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Record of reflective account

Reflective Account (Adapted from Gibbs, 1998, Model)

Title

Weekend duty

Date

February 2019

Description

What happened?

I reported for weekend duty on Saturday morning having been advised the previous day that my physio colleague had injured her back and would not make it in to work. When I arrived in the HUB I firstly logged all the new electronic referrals and telephoned the respective wards, to identify if any of the newly referred patients were to be discharged over the weekend. I sought to prioritise the patients which had been placed on the weekend list; however, one had been transferred overnight to another hospital and another required the assistance of a second AHP for a stairs assessment. I therefore went to see the only other patient on the weekend list, after which I worked my way through the new referrals, screening each and then initiating treatment as appropriate. I saw and discharged two patients in acute receiving, neither of whom had been referred electronically, and ultimately enlisted the assistance of a physio from the DME team to assist with the stairs assessment as per the weekend list. Though I had documented all patient contact timeously throughout the morning I ultimately spent around an hour at the end of the day documenting my afternoon work, as I did not wish to leave this until the following morning.

Feelings

What were you thinking and feeling?

As this was the first time in which I had been wholly responsible for managing the team's collective workload across eight medical wards I was a bit apprehensive about how I'd cope in the event of a large number of new referrals being made. I was relieved to find that there was somewhere in the region of 10-15 referrals, as opposed to a larger number, which could have made for a more difficult day. In the absence of my physio colleague I couldn't help but regard the situation as an opportunity to develop self-leadership skills, as I was ultimately responsible for ensuring the smooth running of the service. Notwithstanding the comparatively modest number of referrals, I was moved to clarify discharge dates at the earliest possible stage, so as to prioritise my caseload, as I was conscious of the unpredictability of acute receiving as well as the patients on the weekend list who each had to be seen. As the day wore on I gradually felt more pressurised, as I was abruptly summoned to acute receiving to review a patient who was earmarked for same day discharge, which ate into my time and made it harder for me to screen/see new patients in other downstream wards. I also had to make myself immediately available once the physio from the OPMC team had time to spare to see the patient for stairs practice. Ultimately, I wasn't able to screen the new patients in one specific ward, which was a source of some concern going into Sunday.

Evaluation

What was good and bad about the experience?

Good – I felt that I acquitted myself well, in terms of planning my day, prioritising my workload, and communicating well throughout with ward staff. I also utilised the limited resources at my disposal, ensuring that I was able to complete two stairs assessments, thereby enabling a patient in the acute receiving ward to be discharged. Overall, I worked very hard to screen all but three patients, two of whom were not medically appropriate; the other I discharged on Sunday morning.

Bad – As noted, due to time constraints I wasn't able to screen three patients. Likewise, I spent approximately one hour typing notes at the end of the day and did not leave the hospital until around 17:30.

Analysis

What sense can you make of the situation?

Though unfortunate, in terms of limiting my overall capacity, my physio colleague's absence ultimately compelled me to "think for myself", insofar as I had to plan and implement my strategy for screening/seeing as many of the new patients as time allowed, not to mention allowing time for patients on the weekend list. Though I was ultimately unsuccessful in screening all the newly referred patients I feel that this was an unavoidable by-product of being called at short notice to review a patient in acute receiving with only a couple of hours of the day remaining. (In any case, I was able to correct this the following day.) I believe I further developed my communication skills by interacting with various nursing staff across several different wards and amassing information pertaining to patients' fitness and discharge plans, where applicable, which assisted my decision making as far as the order in which I saw patients and the manner in which I engaged them. Overall, I gained an invaluable understanding of responding appropriately to a slew of new referrals and working under pressure.

Conclusion

What else could you have done?

Though I was ultimately hamstrung by being the only AHP within the team to report for weekend duty I might have managed to have screened the remaining three patients had I not commenced input with one or two patients in the afternoon. Ultimately, however, I was able to rectify this the following morning.

Action Plan

If it arose again, what would you do? Are there any development needs that could be included in your Personal Development Plan (PDP)?

In the event that I have to work solely at the weekend, or, indeed, during the week, I will undertake to establish at the outset if any patients are earmarked for discharge and prioritise these individuals accordingly much the same way as I did during this Saturday. I will only screen patients who haven't medically fit after having screened and physically assessed those patients who are deemed to be fit for input. Whereas I spoke to the DME physio around midday regarding the stairs assessment(s) I will hereafter seek to create an immediate dialogue with whichever other AHPs are on duty, to confirm their availability in the event that any patients require to be seen by more than one therapist. I will also try and be more timeous when documenting my contact with patients throughout the day.

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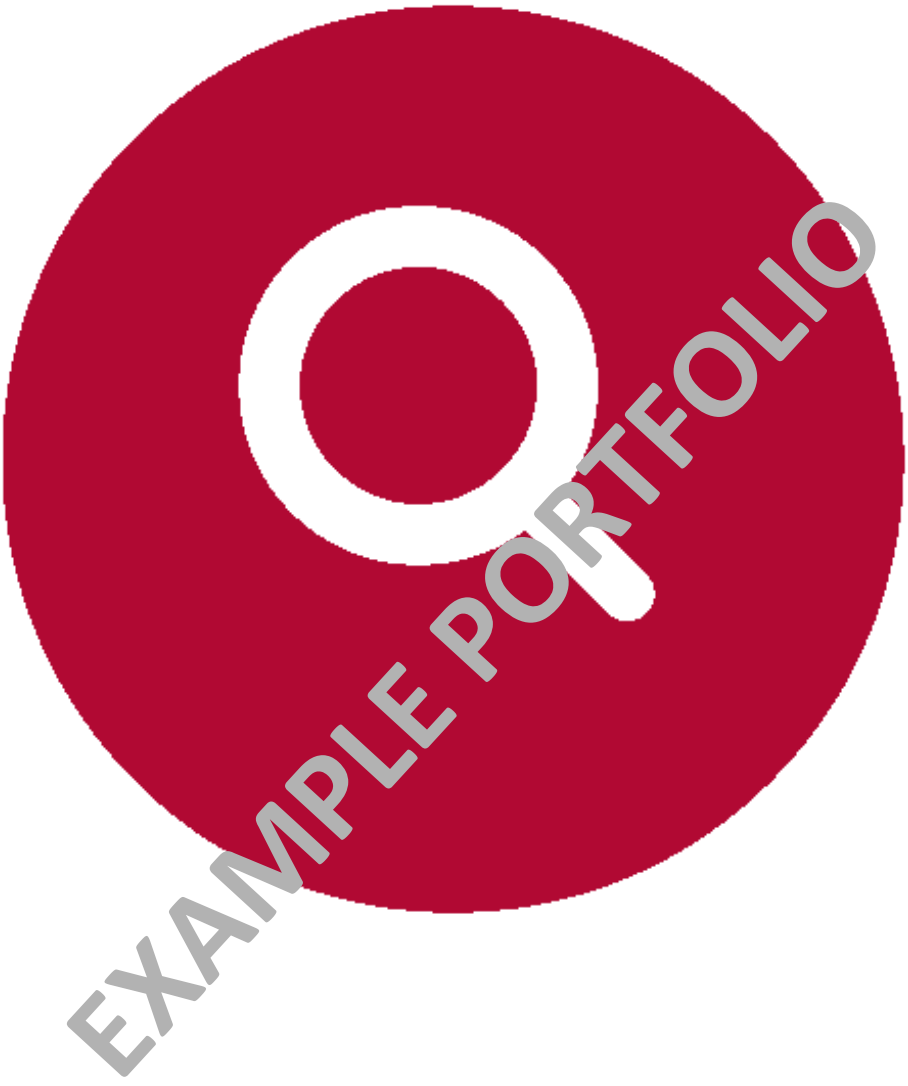

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With regards to the 4th Flying Start unit – Evidence, research and development – I have read the *Frailty assessment: clinical application in the hospital setting* paper by C W Wong.

I have summarised my formulations below and how this research will likely affect my practice.

The principle characteristics of frailty - namely, diminished strength and endurance, reduced physiologic function, and susceptibility to stress - have been evident, individually or collectively, in a number of patients which I have treated throughout my career as an occupational therapist, though particularly within my current rotation in geriatric medicine. Thus, the article resonated with me and broadened my level of awareness, notably of the different categories of frailty, such as pre-frail and non-frail, as well as reaffirming the fact that frailty itself is a reversible process, based upon the successful application of patient-centred and goal-orientated care.

The article serves to highlight the adverse outcomes associated with a positive frailty diagnosis, including falls, disability (defined as "difficulty performing ADLs and dependency (on others)"), hospitalisation (true of every patient I see), institutionalisation (particularly prevalent amongst patients with co-morbidities), and death. The screening and assessment of frailty can be achieved using conceptual models, such as the Edmonton Frail Scale, which are time-effective and fairly comprehensive, though the article champions multidisciplinary comprehensive geriatric assessment (CGA) as the "gold standard" for detection and management of frailty as per the evidence base at time of publication (December 2018). This essentially reinforces the methods undertaken by the different multidisciplinary teams which function across the older adult wards at the GRI.

The sections pertaining to the use of the concept of frailty within acute geriatric wards, end-of-life care, and in discharge planning are especially relevant to my current practice. Specifically, the combination of factors, such as acute medical problems, co-morbidities, functional and/or cognitive impairment, together with psycho-social factors, which may present in any given case, warrant or necessitates the input of multiple health professions, including medicine, dietetics, and occupational therapy, in clinical pathways. The virtues of CGA versus general medical care are best exemplified by the superior outcomes achieved by patients in a 2011 meta-analysis, including improved life expectancy, reduced functional decline and increased propensity for community dwelling as opposed to institutionalisation. Again, this quantitative research supports the use of CGA within acute geriatric wards.

The continuation of care, beyond hospital admission, is very much central to the prevention of further admissions and improved patient outcomes, as outlined in the 'Discharge planning' section. Specifically, early intervention post-discharge, underpinned by exercise and training and nutritional supplementation, can associate with patients returning to their pre-admission (or 'premorbid') state and thus reduce the risk of, or necessity for, readmission. As the article further elaborates, post-discharge management plans should ultimately not only be guided by the category of patient (characterised by level of frailty, cognition, and functional state), but also by the content of a pre-discharge CGA. Thus, a comprehensive assessment is advocated both at the outset and conclusion of treatment, to effectively guide the ongoing management of frailty, such as day hospital referral, interventions to mediate pressure areas and/or nutrition, or end-of-life care.

As far as my existing role is concerned the key 'take home' message from the article is that, although frailty correlates with adverse health outcomes, these can be counterbalanced by appropriate intervention and consideration of the multifactorial elements associated with hospital admission. Effective management of frailty is thus dependent on early detection, prediction of individual outcomes, and targeted interventions which are goal-orientated and person-centred. I am much more mindful of setting goals for patients using the designated goals document going forward, irrespective of whether they are frailty-positive, as this is exactly what the article promotes.

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