

CPD profile

1.1 Full name: Practitioner (early career)

1.2 Profession: Occupational therapist

1.3 Registration number: AB1234

2. Summary of recent work/practice

I work as a Band 5 Occupational Therapist in an acute mental health (MH) hospital in a rural setting. I report to a band 6 OT on clinical and professional matters and to the ward manager regarding day to day practice. I provide the occupational therapy (OT) input to an inpatient ward. I contribute to the OT department's extensive therapeutic group programme. I co-facilitate a horticulture group with a horticulturalist and I am supporting an IT group in gaining a qualification with the guidance of an IT trainer. The participants self refer in both groups. I record progress in individuals' notes and liaise with their care coordinators.

I have been qualified for just over four years, worked here for two years and have been a member of my professional body, the College of Occupational Therapists (COT), since I was a student. I carry out baseline assessments and have responsibility for prioritising and organising my own caseload, addressing occupational performance needs and skill deficits.

I collaborate effectively with professional colleagues within the Multi Disciplinary Team (MDT) and in clinical meetings to ensure OT treatment programmes are successful in contributing to a comprehensive treatment approach. This can mean working with other professions, explaining the role of occupational therapy and the relevance of other professions to the recovery of the service user. For example, I have recently worked with a physiotherapist and two physiotherapy assistants on rotation in order to educate them about the importance of physical exercise for the well-being of our service users.

My interest in and knowledge of mental health is growing as I work and use my day to day role as the foundation for reflection on my practice. Each group that I facilitate teaches me more about concepts central to my professional philosophy such as meaningful occupation and occupational deprivation. Part of my role is to visit service users in the home setting and support them in returning to their usual environment, overcoming any obstacles to a continued recovery. I am becoming particularly interested in the broader issues about integrating vulnerable people back into the local community and mainstream society through strengthening their self esteem.

Total words: 361
(Maximum 500 words)

3. Personal statement

Standard 1: A registrant must maintain a continuous and up-to-date and accurate record of their CPD activity

At university we were shown how to maintain a CPD portfolio, use it to inform both career development and personal development planning (PDP) and map progress within the frameworks imposed by our work settings. This prepared me well to continue with PDP and the appraisal system in place at my workplace. At my most recent appraisal, I discussed my broad career and specific CPD plans and gained approval from my line manager. (Evidence 2)

I learnt to keep track of my learning at university and I have maintained this habit since by keeping a reflective diary (Evidence 8, 10, 12). I try to write something, however brief, in my diary as often as I can and make myself review it monthly. I look at incidents that did not go as planned or have gone well and for any repeated patterns. In clinical supervision I can then reflect on what I have learnt and if there is anything I could do differently next time. Overall I use the diary to identify learning needs that emerge and provide evidence that relevant learning has taken place.

I enclose (Evidence 1) the summary record of my CPD over the past two years in order to show that I meet HCPC Standard 1.

Standard 2: A registrant must identify that their CPD activities are a mixture of learning activities relevant to current or future practice

I have used COT's post qualifying framework (PQF) to map and review my current capabilities and plan a career path for the future. This sets a profession specific direction that will help me to continue to ensure that I identify relevant learning needs in my PDP. I annotated pages in the PQF with comments as to which capabilities I felt confident about and those I wished to do further work on and identified that I am progressing towards a specialist role in MH OT (Evidence 3)

Since qualifying, I have developed an interest in the therapeutic use of groups; horticulture therapy and student education. My learning needs in the last two years have been centred in these three areas of clear relevance to my current practice. I am also developing deeper understanding of OT knowledge and skills to inform my future practice.

I have analysed the activities in this profile in order to show that there is a sufficient mixture between things from different categories in the HCPC guidance: running the horticulture group and the IT group and founding the journal club all constitute work based learning; doing the APPLE course is formal/educational; keeping my reflective

diary and my portfolio is self-directed learning, membership of my professional body, the Specialist Section MH and engagement with COT resources constitutes professional activity. The summary record of all my CPD activity provides further examples that a range of kinds of learning has been carried out. (Evidence 1)

Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery

Standard 4: A registrant must seek to ensure that their CPD benefits the service user

I have put my key learning examples under both these standards as in each case I want to show how I learned something that improved my practice (and so service delivery) to the benefit of service users.

I recently joined the Specialist Section for Mental Health (SSMH- a special interest group within my professional body, run by experts in the mental health field for OTs who want to share and develop their specialist expertise). I attended the SSMH's study day where the focus was on the recovery approach in MH and whether this is rhetoric or reality. This developed my capacity in critical thinking and deepened my understanding of current MH issues (Evidence 10). This fed into my reflection in my workplace and meant that I was more thoughtful in how I listened to my service users.

I now ensure at the end of group sessions that we ask members one thing they got from the session and anything they found a challenge. After the group these comments are recorded and with my co-facilitator we consider overall what went well, where the challenges lie, whether we could have done anything differently and identify any actions for the next session. (Evidence 5) We feed this back to service users when we review the progress of the group. This allows us to work with the members and develop the sessions to meet the needs of the group. At the end of a block of sessions we now give each group member a progress report outlining attendance and achievement.

I have worked for my current trust for nearly two years and during this time have established a journal club which also acts as a peer support group for colleagues at a similar stage in their career (Evidence 6, 7, 8). We discussed one article about horticulture's therapeutic benefit and another about the importance of activities in acute MH settings. (These articles had been suggested by colleagues in the SSMH above). Using aspects of each article I learned how to pick out bits from each one that gave evidence I could confidently transfer from the context described in the article to use in my workplace. Before this I did not feel I was able to pick and choose from parts of the evidence across articles and would only have read something that covered more precisely what I was doing in its title.

These articles and the work in the journal club helped me to understand for myself and then articulate in a clinical supervision session the significance of horticulture as meaningful activity. I could then clearly explain this to the service users in the horticulture group. This meant that they no longer said that they thought that they were

just taking part in a hobby group but instead were expressing the relevance of the group to their recovery. I believe that this is evidence in support of the benefit of my CPD in improving my practice so that I became better at motivating service users towards their recovery (Evidence 8). The work done by the horticulture group made a significant lasting change to an area of the hospital grounds, improving the look of the environment and creating a space that is productive (we grow vegetables and flowers) and led to further purposeful activity such as cooking and eating together (Evidence 4). I learnt from this how practical activity can have multiple positive consequences for a service and the service users.

I submitted an abstract for the College of Occupational Therapists' annual conference last year about the horticulture group that I help to run (Evidence 12). Although this was rejected and I was disappointed, it was a positive experience in the end because I was given helpful feedback which means I feel confident to try again in the future. This was a reminder about how it feels to fail or be rejected that has increased my capacity for empathy with service users who have low self esteem.

I recently completed the APPLE course which is the scheme for the Accreditation of Practice Placement Educators recommended by COT (Evidence 11). On this course I learnt to articulate my clinical reasoning more clearly. In contact with students I found the questions they asked useful because they made me think about my habitual practice and identify my clinical reasoning. Taking students on placement helps the service maintain its links with the local university, which has benefit to the team with ongoing learning opportunities and recruitment.

Reflecting on my use of language and terminology when talking to students has improved my communication with service users and I avoid unexplained specialised terminology. My communication skills have improved because I now consider who I'm talking too much more consciously. One practical action that arose from understanding more about communication skills was that I reviewed how I write care plans with service users. I now use a table format that service users find easier to understand and remember (Evidence 9). Further, as the APPLE course was inter-professional I gained skills in interaction with other AHPs. This has helped my confidence and led to me taking a more active role in MDT meetings, which my clinical supervisor has commented upon.

Total words: 1383
(Maximum 1500 words)

4. Summary of supporting Evidence linked to the HCPC standards that it meets

Evidence number	Brief description of evidence	Number of pages or description of evidence format	CPD standards this evidence relates to
1	Summary record of CPD activities	3 pages	Standards 1 and 2
2	Personal development plan	1 page	Standard 2
3	Annotated pages from PQF	2 pages	Standard 2
4	Photographs of the garden before and after service users' input	1 page	Standards 3 & 4
5	Completed Proforma of a group meeting review	1 page	Standards 3 & 4
6	Log of meetings of journal club	2 pages	Standards 3 & 4
7	Report summarising our discussions over six months	2 pages	Standards 3 & 4
8	Example of personal reflections on 2 articles and changes to practice	1 page	Standards 3 & 4
9	Pro forma for table for care plans	1 page	Standards 3 & 4
10	Certificate of attendance from SSMH Study Day completed reflective log	3 pages	Standard s 3 & 4
11	Apple accreditation certificate	1 page	Standards 3 & 4
12	Abstract, rejection notification and diary reflection	3 pages	Standards 3 & 4