

Therapy Assistant Practitioner: Demonstrating Practice Logbook



Name: Claire Louise Wright

Supervising Therapist/ Mentor: Kevin Munson

Date commenced: 8th February 2024

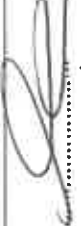
The content page includes a check list of evidence to be collected with columns to help correspond the continents.

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1. Log of supporting documents from mentor:		
a. Log of assessments and goal setting.	1-3	A
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The Therapy Assistant Practitioner (TAP) demonstration of competencies in the following areas:			
1. Log of supporting documents from mentor:	Details to include:	Date of completion:	Mentors signature:
a. Log of assessments and goal setting.	A completed initial assessment or detailed screening form, including evidence of patient centred goal document.	18 Feb 24	
b. Log of a wide range of assessments.	A minimum of three assessments completed, demonstrating a range of skills and tools.	18 Feb 24	
c. Log of clinical interventions within scope of practice.	A minimum of three interventions completed, demonstrating a range of skills within scope of practice.	28 Feb 24	
d. Log of a risk assessment and how it informs practice.	A completed risk assessment within the workplace, which can include clinical practice or department procedure. This can include case notes, reports, DATIX or professional discussion, which consists of risk identified, how the learner managed the risk and informed progress.	8 APR 24	
e. Report on learner's time and workload management.	A completed report with mentor's feedback of the learner's time and workload management. The report can be completed on a word document and will need to be signed and dated. The report will need to include an example of how the learner demonstrates good time and workload management.	8 APR 24	
f. Log of compliance with mandatory training.	A copy of the learner's compliance with mandatory training. Compliance is required to be 80% or above.	28 Feb 24	
2. Copy of a recent Personal Development Appraisal Review (PDAR).	A copy of the most recent PDAR document completed with supervisor / mentor. (02.09.23)	28 Feb 24	
3. Copy of recent supervision records.	A minimum of two supervision records, demonstrating attendance and contribution to supervision and agreement to actions. (3)	28 Feb 24	
4. Copy of peer review document.	An attached copy of the peer review document completed following observations of others presentations.	28 Feb 24	

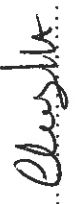
This logbook was completed by:

Mentor's name: ... Kevin Munson.....

Mentor's signature: 

Date: 8/4/24.....

Learner's name: ... Claire Louise Wright.....

Learners' signature: 

Date: 8/4/2024.....

Cohort two: Module two

Moule Code PJ14CY01: CDN188 / BMAC4020

Document completed: November 2023

Assistant Practitioner Assessment

Name: [REDACTED]

Present on assessment: [REDACTED] (Pt) [REDACTED] (husband) Claire Wright (AP)

Verbal consent gained: Yes

Address: [REDACTED]

Date of Birth: 28th January 1936

Role of AP explained: yes

Mental Capacity: Can person make decisions, provide accurate information in relation to risk, care and support needs, etc. (Is Best Interest Decision Needed?)

[REDACTED] has a dementia diagnosis and would not have capacity to make an informed decision regarding care needs.

Presenting condition: General deterioration, and self -neglect due to dementia, falls.

Health needs including medication (Self-medicate, Collection of prescriptions, dossette, independent, family support etc.):

PMH: type 2 diabetes. Polymyalgia. AF. Dementia.

Medication list: Calcichew. Digoxin. Linagliptin. Metformin. Prednisolone. Ramipril. Rivaroxaban.

Dementia medication (name unknown).

All medication in pharmacy filled dossette boxes except dementia medication which is dispensed via hospital. [REDACTED] is responsible for [REDACTED] medication.

[REDACTED] had a medication review recently and is on a new medication regime which started 10 days ago. As yet this does not appear to have had any effect on [REDACTED]

Dementia clinic are reviewing the dementia medication to see if this could be cause of extreme sleeping.

Personal care needs: (Ability to wash and dress, Showering, Continence, Tissue viability)

[REDACTED] states that she is independent with personal care etc. however this is not accurate and [REDACTED] is having to assist when able.

[REDACTED] reports that [REDACTED] has had episodes of incontinence but that she denies this.

Skin intact.

Meal preparation: (Dietary needs/Appetite, Weight loss/gain, Preparing/feeding self, transporting items, family support, meal delivery services)

All meals prepared by [REDACTED] Appetite is variable. [REDACTED] not always aware of whether she has eaten or not. Some weight loss in recent past but not sure of how much. Prescribed ensure drinks – doesn't always drink them.

Domestic Tasks: (Shopping, laundry, cleaning)

██████ is responsible for all ADL. He will sometimes take ██████ when he goes shopping, but this is not easy for him, he had a routine of taking ██████ to hairdresser and she had her hair done while he shopped, however this hasn't happened recently due to ██████ fatigue.

██████ employed a cleaner who would also sit with ██████ while he went out, however she is currently on long term sick following a medical issue of her own.

Family, friends and other support networks/services involved:

██████ son lives in village but has own medical issues and is reliant on ██████ for assistance with transport etc. as well. If he is well enough Son will sit with ██████ on a Tuesday night to enable ██████ to go out for 2 hours.

██████ son has a son who is autistic and has had to move into assistive living as his father is no longer able to care for him, and his daughter lives in Bridgend. Neither able to provide any physical assistance to ██████

██████ has an adopted daughter who is now living in York. Her children are all living away from home.

Equipment and Assistive Technology: (Key safe, access, lifeline, fall sensors etc.)

Key safe and life line in situ. CO and smoke detectors are in situ and linked to life line.

Mobility: (Walking, Outdoor, Indoor, Type of walking aid used, distance, basic gait analysis)

Previously independent with no aids. ██████ has stated experiencing weakness in her legs, legs described as giving way rather than a fall although she does go to the ground. ██████ has purchased a tri walker but ██████ is reluctant to use it. He has purchased a wheelchair for outdoor use but ██████ refuses to use it. ██████ resorts to walking in front of ██████ and walking backwards holding her hands. Have advised that this is a risk for both and he is aware of this. At times ██████ can mobilise with no issues.

Falls: (previous in last 12 months, most recent, circumstance around fall, fear of falling, trip, slip or fall, recent GP review/polypharmacy, footwear)

Balance:

ROM / Strength test: bilateral 5/5

Stairs Assessment: not assessed

Transfers:

Bed: Independent from double bed with no aids

Chair: independent but will ask husband for assistance. Armchair being raised today (COTs) and waiting for delivery of R&R chair

Toilet: independent

Environment: (Property type, Access, Stairs, Property ownership, Description of environment, Environmental risks)

Privately owned bungalow. No concerns re environment. [REDACTED] has strategically placed chairs around the bungalow to allow [REDACTED] to stop and rest if required.

Risks: (Ability to call for assistance, Support Networks, Manual Handling, Recent illnesses, Exposure to Coronavirus. Is the individual an 'Adult at Risk'? If yes, please provide additional information)

[REDACTED] does have dementia which is sufficiently advanced as to put her at risk of harm should she be left alone. [REDACTED] is only left alone when she is sleeping in bed and has not (up to date of assessment) got out of bed independently while [REDACTED] is out.

Other considerations: (Religion, language, culture)

[REDACTED] is happy to converse in English.

Your wishes and personal outcomes: I don't need any help. I can manage on my own. I want to stay in my own home.

Leisure and Productivity: (Work, Volunteer, Hobbies, Interests)

[REDACTED] and [REDACTED] are founding members of the over 55 (old age) club in the village which meets on a Thursday afternoon. [REDACTED] was very involved with running the group. They still like to attend but this has been harder for [REDACTED] as she is so tired.

[REDACTED] is involved with the bowls club in the village and when able to get a sitter for [REDACTED] he likes to continue with bowling.

[REDACTED] was previously a very 'craft' involved person and was a professional hand knitter – working from home for prestigious designer/company. [REDACTED] has not been able to manage any crafts for approx. 18months.

Analysis:

[REDACTED] has taken on the role of full time carer for his wife and is heavily involved with providing assistance for his son who lives in the village as well. [REDACTED] dementia has progressed to the point where she is unable to manage any ADL independently, but is in denial of this and unwilling to knowingly allow [REDACTED] to help with personal care. [REDACTED] would benefit from assistance in the morning to assist with personal care and to try and establish a daily routine for getting up every day. [REDACTED] is currently sleeping for between 18 and 20 hours a day.

[REDACTED] is at risk of burn out and is acknowledging that he needs help.

Plan:

AP to attempt shower assessment. LTPOC if able for am call. [REDACTED] to trial exercises and skin care with [REDACTED] as she allows. AP to compile information on 3rd sector/ volunteer groups and private providers list.

Clinical Frailty Score: 7

Internal referral required? (OT/Physio) not at time of assessment

Completed by: Claire Wright

Date & time: (linked to Oracle) 1st February 2023

Appendix B. Evidence of assessment.

1. Initial assessment

Assistant Practitioner Assessment

Name: [REDACTED] known as [REDACTED]

Present on assessment: [REDACTED] (patient) [REDACTED] (Sister and carer) Claire Wright (AP)

Verbal consent gained: Yes

Address: [REDACTED]

Date of Birth: 10th December 1954

Role of AP explained: yes

Mental Capacity: Can person make decisions, provide accurate information in relation to risk, care and support needs, etc. (Is Best Interest Decision Needed?)

No issues noted at time of assessment

Presenting condition: Decreased mobility. Loss of confidence.

Health needs including medication (Self-medicate, Collection of prescriptions, dossette, independent, family support etc.):

PMH: Registered Blind – last eye test recorded 5% sight, however this was over 2 years ago and patient reports sight has decreased. Heart attack >5yrs. Stroke >5yrs. Stent in heart following heart attack. Type 1 Diabetes. Neuropathy in hands and feet. Reports numbness and general weakness in right arm since stroke. Ex drinker. Heavy smoker.

HPC: Fall – 1 mechanical fall >2-3years due to workmen not screwing flooring door strip down and [REDACTED] fell forward into bathroom, twisted as he fell and landed on toilet with hip and coccyx, caused muscle spasms in back and hip/leg. aching in back and hip area remains at times.

Medication list: Clopidogrel. Gabapentin. Bisoprolol. Metformin. Monosorb. Ramipril. Senna. Simvastatin. Insulin.

Personal care needs: (Ability to wash and dress, Showering, Continence, Tissue viability)

[REDACTED] is assisted with personal care by his sister [REDACTED] reports to being continent.

Meal preparation: (Dietary needs/Appetite, Weight loss/gain, Preparing/feeding self, transporting items, family support, meal delivery services)

All Meal preparation done by [REDACTED] **No reported weight loss.**

Domestic Tasks: (Shopping, laundry, cleaning)

[REDACTED] does all DADL

Family, friends and other support networks/services involved:

[REDACTED] has a small family network who provide assistance with all ADL.

Equipment and Assistive Technology: (Key safe, access, lifeline, fall sensors etc)

Mobility: (Walking, Outdoor, Indoor, Type of walking aid used, distance, basic gait analysis)

Appendix B. Evidence of assessment.

1. Initial assessment

Decreased mobility due to number of reasons – fear of falling because of sight loss and previous fall. Lack of motivation to regain independence as happy to allow other to complete tasks on his behalf. Because of COVID and enforced isolation [REDACTED] appears to be reluctant to re-engage in what was a previously active social life.

Falls: (previous in last 12 months, most recent, circumstance around fall, fear of falling, trip, slip or fall, recent GP review/polypharmacy, footwear)

I mechanical fall >2-3years due to workmen not screwing flooring door strip down and [REDACTED] fell forward into bathroom, twisted as he fell and landed on toilet with hip and coccyx, caused muscle spasms in back and hip/leg. aching in back and hip area remains at times.

Balance:

FUNCTIONAL ASSESSMENT OF BALANCE AND MOBILITY:

Sit to stand: (3 seconds or less) Yes

Timed unsupported steady stand: (up to 1 minute) not tested at time of assessment

Get up and go: (20 seconds or less) no – due to sight not mobility/balance issues

Strength in lower limbs 5/5

Strength in upper limbs 5/4 reduced in right

Grip strength – reduced grip in right

Gait – stride length: shortened

Gait – Speed: normal

Gait – heel strike:

Stairs Assessment: not required

Transfers:

Bed: not assessed at time of assessment

Chair: Independent

Toilet: not assessed at time of assessment

Environment: (Property type, Access, Stairs, Property ownership, Description of environment, Environmental risks)

Tai Tarian, ground floor flat in sheltered accommodation block. Warden assistance through intercom.

Door buzzer system in place however [REDACTED] unable to use as too close to assistance cord

Furniture is well spaced and layout suitable for [REDACTED] with walking aids. [REDACTED] reports that he tends to know where he is when he bumps into furniture, walls etc.

Appendix B. Evidence of assessment.

1. Initial assessment

Risks: (Ability to call for assistance, Support Networks, Manual Handling, Recent illnesses, Exposure to Coronavirus. Is the individual an 'Adult at Risk'? If yes, please provide additional information)

██████ is at risk of fire due to heavy smoking – floor around chair is scarred with burn marks. ██████ is at risk due to lack of sight.

Other considerations: (Religion, language, culture)

██████ is happy to converse in English

Your wishes and personal outcomes: I want to get back to walking with my walking stick.

Leisure and Productivity: (Work, Volunteer, Hobbies, Interests)

Prior to Covid ██████ would access community independently, and had a few close friends that he would meet regularly in town, however friends have died during COVID and ██████ no longer has the confidence to go out independently. ██████ was given a wheelchair (? where from) and now prefers to be wheeled than to walk.

Analysis: ██████ has full strength in all limbs. Restricted movement in both shoulders and a reduced grip on right side. ██████ is able to mobilise and does not get unduly out of breath when mobilising. ██████ is reluctant to listen to advice and has a habit of arguing when asked to do something. ██████ has expressed a desire to have an exercise program and is aware that he will need to complete these with family. ██████ has agreed to AP visiting to complete exercises and mobility practice. ██████ has expressed a desire to walk outdoors with walking stick, have noted as longer term goal.

Plan: Email exercise program to ██████ to complete daily with ██████. "visits for mobility and exercises with AP next week. Outdoor mobility practise when ready.

Clinical Frailty Score: 6

Internal referral required? (OT/Physio) No

Completed by: **Claire Wright**

Date & time: (linked to Oracle) **23rd February 2023**

Appendix B. Evidence of assessment.

2. Walking Aid Assessment

Walking aid assessment completed. Informed verbal consent gained for assessment and intervention.

S; Conversation was difficult due to ■ hearing loss and he has one hearing aid not working and one that does not work well, this in combination with ■ dementia symptoms ■ consented to assessment but stated that he did not know why I was bothering as nothing wrong with his walking and he does not fall over ■ denies any pain. ■ told me that he uses his stick all the time and he is very fond of it. He told me he never goes anywhere without it. ■ advised that ■ appears to be a bit moody this morning, which is not like him as he is usually quite 'chipper'. I suggested this could be due to my being there so early. Time given for ■ to finish his breakfast and his coffee ■ denied feeling unwell ■ told me he did not like people coming in and out when he did not know who they were.

PRESENTING CONDITION: General deterioration in self-care due to advancement of Dementia symptoms.

HISTORY OF PRESENTING CONDITION: Dementia

PAST MEDICAL HISTORY: (from OT IAx) Dementia. Visual impairment. Hard of hearing – has aids for both ears one doesn't work and one limited

DRUG HISTORY: (From OT IAx) Citrulline

SOCIAL HISTORY: Lives with wife who also has memory issues. Currently supported by Reablement – 3 single staffed calls daily, awaiting LTPOC.

FALLS HISTORY: Differing history received. From OT IAx: *Family report that he is having multiple stumbles, though no major trauma from any falls. His wife ■ reports he has had one or two trips whilst out in the garden, though no injuries.*

From Wife/Patient and support worker at time of assessment: ■ *has not had any falls since last year when he fell a couple of times in the garden. Collectively Wife, ■ and support worker state there are no concerns regarding ■ mobility currently as long as he uses his stick.*

PREVIOUS MOBILITY: *Distance, Aids, Stairs, Outdoors.* Not reported

PATIENT'S PERCEPTION OF NEEDS: ■ doesn't believe he has any problem with his walking. He uses a stick and feels safe with this. ■ states that he manages his stairs ok – as long as he has his stick and he holds on to the bannister.

PATIENT'S EXPECTATIONS: None as ■ does not believe he needs assessment

SUBJECTIVE ASSESSMENT: As above

OBJECTIVE ASSESSMENT: *Pain, Joint ROM, Strength, Balance, Present mobility*

FUNCTIONAL ASSESSMENT OF BALANCE AND MOBILITY:

Sit to stand: (3 seconds or less) Yes

Timed unsupported steady stand: (up to 1 minute) Not tested as requires stick at all times

Get up and go: (20 seconds or less) not tested

Appendix B. Evidence of assessment.

2. Walking Aid Assessment

Strength in lower limbs 5/5

Strength in upper limbs Not tested

Grip strength – ■ declined to have assessed

Gait – stride length: normal

Gait – Speed: slow but steady

Gait – heel strike: normal at time of assessment

INTERVENTIONS: Observed ■ completing transfers on/off bed and on/off sofa as part of his daily routine with support worker.

Observed ■ mobilising around bedroom (wooden floor), landing (carpet). Stairs (carpet, rail to left and bannister to right [ascending], hallway (wooden floor), kitchen and lounge.

A: No issues arising from any of ■ mobility at time of assessment. Stairs managed well with good, safe step - to technique, ■ takes his time and holds bannister with one hand and stick in other.

It would not be beneficial to ■ to try to introduce a RZF at the current time. He manages well with a stick and, despite dementia, is not known to leave it or forget to use it. Introducing a frame at this time is likely to cause ■ anxiety and he is unlikely to use it. It would cause issues regarding the environment, as there are a number of large rugs that would become a hazard while using a frame. It would also cause ■ anxiety and distress, as she does not want one in the house, as she does not believe that ■ needs one.

I do not think that ■ would benefit from mobility practise, as his current level of mobility is good, introducing sessions of mobility that he cannot understand the need for is likely to cause distress – as demonstrated this morning. An exercise program would not be beneficial or necessary at this time.

GOALS: To maintain current level of mobility

EQUIPMENT ISSUED: none

PLAN: Feedback to OT. Discharge patient from caseload, as no further needs identified at this time.

Appendix B. Evidence of assessment.
3. Recommendations for care

NPT Social Work/Therapy			TIMETABLE OF CARE		For use during COVID 19 Pandemic				
SERVICE USER	ID		Completed by: Claire Wright Email: claire.l.wright@wales.nhs.uk			Number of Hours per week		2hrs 20mins	
Name and DOB:			Date: 4 th July 2023			Number of Hours requiring Double Staffing per week		0	
Address:			Telephone: 01639 862780						
Telephone:									
NB – Please identify Daily Times and D/S Double Staffing or S/S Single Staffing									
TASKS TO BE CARRIED OUT			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning Call: Assist to apply cream to lower legs and feet if needed. Apply compression stockings. Monitor pressure area on bottom (min 3-x week) check lifeline worn.			SS 8am 20mins	SS 8am 20mins	SS 8am 20mins	SS 8am 20mins	SS 8am 20mins	SS 8am 20mins	SS 8am 20mins
Other relevant information Eg manual handling risk assessment environmental risk assessment			Previous stroke – left sided weakness combined with weakness following #arm mean that does not have strength in hands to apply own compression stockings. Compression was prescribed by Lymphoedema service and is for long term. Carers will need to monitor pressure area on bottom and ensure correct service is contacted should there be a breakdown. is newly diagnosed with Coeliac disease and is still adapting to new diet with good and bad days which affects her functional ability. 8am call allows to manage her medication around call. Level B for creams.						

Appendix C. Evidence of Clinical intervention

1. Exercise provision

S; Pre-arranged visit to patient's home. VCG. [REDACTED] reports that he is feeling well and happy to start doing his exercises. [REDACTED] advised that she had not yet received my email with exercise program so I advised that I would leave my copy of the exercises for her today. Also discussed number of times a day and what exercises [REDACTED] should be able to complete on his own, we agreed that standing exercises are to be done using the kitchen divider half wall as support. [REDACTED] left after this discussion. [REDACTED] told me that since my visit he has been consciously trying to keep his shoulders relaxed when walking and he hadn't been aware of just how tense and hunched he was until I had pointed it out to him. Encouraged [REDACTED] to continue to be aware of this and correct it as necessary, also when he is sitting as noted today that his shoulders rise and tense when he is engaged in discussion with someone. Demonstrated to [REDACTED] each exercise using hands on/physical touch to explain positioning etc. due to [REDACTED] sight loss. [REDACTED] happy with seated exercises and explained number and times daily to do each exercise. [REDACTED] happy with standing exercises and feels that his mobility is getting better. [REDACTED] advised that he is continuing to do his upper limb exercises that he had following stroke.

O; Entry granted by [REDACTED], who was just about to leave the flat on my arrival, [REDACTED] sitting in chair with cigarette which [REDACTED] told him to put out and she opened the kitchen window to get rid of the smoke. Demonstrated exercises to [REDACTED] as she will be assisting [REDACTED] with standing exercises, [REDACTED] reports that she is happy and advised if she needs assistance she will ask her daughter [REDACTED], who is a PT. [REDACTED] completed all exercises as prescribed:

Heel toe rocks in seated. Knee lifts in seated and leg extensions in seated. Mobilised to kitchen divider with 4 wheeled walker, completed marching on the spot and sideways walking. Transferred back to 4 wheeled walker and mobilised x1 around flat – kitchen to bedroom to lounge. [REDACTED] didn't feel he could manage a second circuit.

A: [REDACTED] presents as keen to complete exercises, need to take care that he is listening to and following instruction as he has a habit of 'doing his own thing'. [REDACTED] posture is better since being made aware of shoulder tensing and his mobility speed and stride length has already improved [REDACTED] has a habit of dragging his feet which he was unaware of.

P; [REDACTED] to continue with exercises. Visit Thursday 2nd March for further rehab.

2. Mobility practice.

S, pre-arranged visit to patient's home with Maria James (therapy tech). VCG. [REDACTED] reports to feeling well and states that he is keen to try outdoor mobility. Introduced Maria. [REDACTED] states that he is completing his exercises that I have given him and he feels that he is getting a lot of benefit from them; he advises that he no longer has any pain in his feet or lower legs and the numbness has gone. We discussed route for today's walk, [REDACTED] suggested a route that he used to do on his own daily, I explained to [REDACTED] that this was not a safe walk currently, due to scaffolding erected around the building opposite, which obstructs the pavement. Discussed safest route with Maria and all agreed that safest route would be to walk on road to pass the scaffolding. At end of mobility practise [REDACTED] advised that he is getting an ache in his arms, I explained this could be because we have asked him to use the walker more often than the trolley, so he is using heavier equipment. In addition, as we have been correcting his posture, and where he positions the walking, it could be that he is using other muscles and the ache should subside quite quickly. [REDACTED] stated that his nieces had mentioned going for a walk along Aberavon prior to going for a meal on Sunday, and asked if I thought it was ok. I told him I thought it was a lovely idea and would be good for him

O, [REDACTED] mobilised with safety walker across lobby to press button to open main door to allow access. [REDACTED] was already dressed in shoes and outdoor clothing and happy to go straight out for mobility practise. At [REDACTED] request, I entered the flat and collected his keys. With permission, I opened the kitchen window to allow thick cigarette smoke to clear before we returned to the flat. Mobilised out of main door and waited at top of ramp. Agreed route and explained to [REDACTED] where the new obstacles were. Mobilised down ramp to kerb, onto road and walked parallel to opposite building to end of scaffolding, mobilised up ramp back onto pavement and over to bench. Short seated rest for [REDACTED] on Bench. [REDACTED] states he normally walks past tree and around on pavement in a circle to go back to his own building – advised that we would not do that today as pavement has been dug up and filled in for water works and pavement is very uneven and unsafe. There is a small path in front of tree and we agreed to go that way. Mobilised back to own building and into flat. [REDACTED] needed constant prompts re posture and correct use of walker. [REDACTED] easily tires due to not having done anything for quite a while.

A; [REDACTED] will benefit from continuing exercises and advised to try to increase number of reps. Also, increase number of laps around flat during the day.

P; continue with mobility practise.

3. Shower transfers

Home visit 28th March.

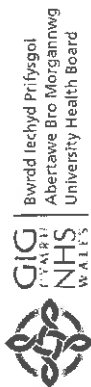
s. Pre-arranged visit to patients home. Patient advised that he is on his own as his daughter has gone out for the day; he told me is fine and is able to manage his own drinks and food and told me what he was planning to have for lunch and how he is going to prepare it. VCG. We discussed the issue of the shower and [REDACTED] happy to go to bathroom with self and trial different seats. We discussed falls group which [REDACTED] tells me he finds interesting, most especially the talks from the 'specialists' [REDACTED] advised that he was very interested by the talk from the dietician last week and believes he learnt a lot. We discussed discharge and agreed that I will discharge [REDACTED] when I have completed care and repair form.

O; [REDACTED] mobilised to stair lift with walking stick. Independent using stair lift. Walked to bathroom with walking stick. Demonstrated transfers in and out of shower cubicle with shower stool – not suitable for how [REDACTED] wishes to transfer and shower. Shower stool removed and drop down shower stool lowered. [REDACTED] trialled using drop down seat, which is suitable height and when using grab rail in situ [REDACTED] is safe with transfers. Advised [REDACTED] to turn on seat to make use of grab rail easier.

A; freestanding shower stool not suitable for [REDACTED]. He appears safe and independent with drop down seat and using grab rail, would benefit from a second rail next to shower.

P; complete care and repair referral for second rail in shower. Arrange collection of shower stool. Discharge patient

All Wales NHS Patient Manual Handling Risk Assessment Form



SECTION A: - Patient Details

Patients Name: [REDACTED]	Ward/Dept/Other: Home
Address: [REDACTED]	NHS No: [REDACTED]
Date of Birth: [REDACTED]	Weight: Not known
Independent – No	Stature: Tall ☐ Medium ☒ Short ☐
Signature C. Wright	Date: 21 st October 2023

SECTION B: - Consider all factors that could affect the patient's mobility

Relevant Medical History	Basal Cell Carcinoma (2021), HTN, Hearing Loss, Cataract. Arthritis. Lymphoedema.
Physical Disabilities	Limited Mobility, Fatigue, Breathless
Psychological/Mental Health	None
Pain Status	Back, Neck & Arms
Tissue Viability	Staff to monitor – currently under care of District Nurses as well
History of Fall(s)	Nil
Culture/Religious	Nil
Day/Night Variation	Nil

Attachments/Other Considerations	Nil
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If the patient's condition changes and/or if environment/location changes the assessment needs to be reviewed.

SECTION C: - Safer Handling Plan

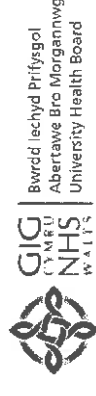
This safer handling plan should accompany the person at all times.

Task to be performed	Functional Mobility Level (for each task)	No. of staff	Equipment		Method
Turning in bed	A	0	Bed leaver, Hospital Bed,		Independent
Moving up / down bed	A	0	Bed leaver, Hospital Bed		Independent
Sit to edge of bed	A	0	Bed leaver, Hospital Bed		Independent
In and out of bed	B	1	Bed leaver, Hospital Bed,		Once sat on edge of bed, ensure bed is at its lowest height. Struggles to get her right leg into bed, requires AO1 to lift right leg into bed. Encourage her to lift her left leg independently into bed, but support if required. Able to get legs to edge of bed independently, and to sit on edge of bed. Uses hospital bed functions (may require assistance to use correct button) to raise bed to correct height for stand to RZF. function fluctuates and may need more assistance if feeling weak
Transfer bed to trolley				N/A	

Appendix D. Evidence of Risk Assessment

Transfer bed to chair / chair to bed	B	1	Bed leaver, Hospital Bed, Riser/Recliner, RZF or wheeled commode	See Bed transfers above. [redacted] will mobilise with RZF OR be wheeled on mobile commode to chair, depending on stamina. [redacted] can step transfer onto chair from wheeled commode [redacted] utilises riser recliner functions of chair independently to stand from/sit on chair.
Bed to mobile commode/ mobile commode to Bed	B	1	Bed leaver, Hospital Bed, Mobile Commode. RZF	step transfers under supervision
Repositioning in a chair	A	0	Riser/Recliner	Independent
Standing	B	1	RZF	Minimal standing due to fatigue under supervision with RZF
Mobilising	B	1	RZF	[redacted] and carer to assess fatigue/ stamina levels on each occasion. If Ok to mobilise [redacted] will walk with RZF and close supervision for short distances. [redacted] can do step transfers with RZF and close supervision to transfer form bed to commode or commode to chair etc. If unable to mobilise with RZF carer to use wheeled commode to transport [redacted]
Date of Assessment: 21 st October 2023				Patient's Name: [redacted]
Signature: C.Wright				Date of Birth: [redacted]

SECTION D: - Use in the Community and Exceptional Circumstances See environmental risk assessment



Environmental considerations	Hazards Identified	Action Taken	Environmental considerations	Hazards Identified	Action Taken
Space constraints on movement of handler/equipment	None		Bed – Double/low/height/ Movable/condition	None	
Access e.g. Beds/bathes/WC/ Passageways/	None		Temperature/ Humidity/ Lighting	None	
Stairs/Steps/Access	None		Equipment Power Supply	None	
Flooring	None		Pets/children	None	
Slip/Trip Hazards	None		Other e.g. lifeline telephone	None	
Seating Height / movable condition	None		Social Circumstances	None	

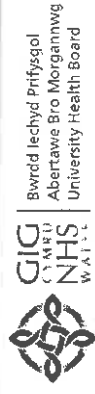
SECTION E: - Additional Measures Required – N/A

Are additional control measures required? If so, give details below

Can the additional measures be achieved? Yes/No Date (If no, please inform your manager and complete an IR1 Incident form)

Manager's Signature

**SECTION F: - All Wales NHS Patient Manual Handling
Risk Assessment Continuation Form**



Patient's Name: [Redacted] Date of birth: [Redacted]

Review Date	Review Result/Changes	Print Name	Signature

Guidance Notes: Patient Handling Risk Assessment & Safer Handling Plan

The assessment should be completed by a Registered Healthcare Professional (RHP). If a suitably experienced person who is not an RHP completes the assessment form, then it **must** be **checked** and **countersigned by an RHP**.

- **Patient Details:** Ensure correct addressograph is attached, or if not available write patient's details in the box.
- **Fully Independent:**
 - If **Yes**, sign the form, no more action required.
 - If **No**, complete the remainder of the form.
- **Risk of Falls:**
 - If **High**, ensure this is taken into account when prescribing techniques or equipment for the various manoeuvres with this patient.
- **Functional Mobility Level.**
 - Consider the level of the patient's functional mobility i.e. what the patient is physically able to do to assist with each task. Record this functional mobility level using **A,B,C,D or E** where indicated using the ArjoHuntleigh Mobility Gallery© below.

Mobility Gallery in detail	
	(A) Patient is independently mobile with the use of walking aids such as a walking stick or using a handrail at the side of the toilet. This type of patient would not require physical assistance for everyday situations, such as toileting, getting up from a chair etc. However may need minimal assistance in more difficult environments such as car transfers or transfers from the floor, hence an assessment form may still need to be completed.

	(B) Patient may require some minimal physical assistance with rising from a seated position, however is generally considered to be independently mobile with a walking frame when on his/her feet. If manual physical assistance is to be provided consideration should be given to the use of small handling equipment, possibly a handling belt or a standing device such as a Sara Steady or Rota Stand.
	(C) Patient has limited ability to stand. He/she may be able to bear weight on their feet in standing for short periods of time with support from one/two carers but is however unable to walk. Consideration should be given to the use of standing and Raising equipment to ease the burden of care during transfers and ensure safety for the patient.
	(D) Patient is unable to place weight through their feet and maintain and upright standing position. This patient may also find difficulty in sitting on a surface without support, i.e. on the edge of the bed. However they will be able to sit in a supportive chair or wheelchair. This patient should be assisted to transfer between surface to surface with the use of a passive hoist and appropriate sling. Consideration should also be given to the use of adjustable height furniture such as a profiling bed and variable height bath. Slide sheets should be used for in bed transfers.

	(E) Patient is not able to bear weight on their feet in standing and also has no active sitting balance, the type of chair required to support this patient may be a 'nursing type chair or tilt in space'. This patient generally receives assistance and care within the confines of bed, hence it is important that the height of furniture and the space around the bed is suitable to enable safe working practices and provision of high quality care. The type of equipment required to assist E is a passive hoist and also a suitably supportive hoist sling. Slide sheets will be required for the movement of this patient within the confines of the bed.
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weight, stature and height.

- **Sensory Factors:** Sensory deficit(s) can impact on the patient's compliance. Ensure glasses and / or hearing aid are available, functioning and used.
- **Risk Factors / Constraints:** This is to identify any other factors that could affect the patient's mobility, and/or may impact on staff or patient safety. Ensure patient's skin condition is taken into account.
- **Manoeuvres:** In order to ensure that the patient is handled in a consistent manner, these sections should prescribe the method, level of assistance, equipment and number of staff required, and any other information.
- **Other Relevant Information:** Ensure usual specialist footwear or prosthetic appliances are fitted correctly and recorded under other relevant information
- **Signature:** The RHP must complete, or at least countersign this section.
- **Other Specific Risks:** Additional risks along with measures taken to reduce these should be documented to reduce the risk of incident / injury.
- **Additional Resources:** Are additional resources are required? If so, what resource is needed, provide justification and specification for needing it and ensure the Manager is informed.
- **Reviews:** There is space to document 2 reviews, after which a new form should be completed to ensure legibility, instructions are clear and risks are highlighted.

The Patient Handling Risk Assessment & Safer Handling Plan MUST be sent with the patient to other wards / departments: e.g., Radiology, Theatres, etc.

REPORT ON LEARNERS TIME AND WORKLOAD MANAGEMENT.

CW is a very experienced Reablement HCW. She has responsibility to organise her diary, depending on the allocation of her patients either given to her by her supervisor or voluntarily picked up from an internal referral spreadsheet populated by therapists within the Reablement team.

CW is also a trade union representative, is valued by colleagues as such, and is used as a conduit when, matters arise within the team that require union intervention or advice.

Another aspect of CW's work responsibility is an instructional role within the team relating to specialised Reablement equipment, how it is used and applied. CW is used by team managers to instruct students, newly qualified staff and newly appointed permanent staff.

CW's work incorporates both Physiotherapy and Occupation Therapy duties and as such can range from quick call to deliver equipment to more lengthy visits incorporating checking and modifying exercise programs and also assessments of patients ability to carry out activities of daily living. In effect, a visit by CW could be 10 minutes or 90 minutes.

The geographical area that CW works in is large, and can take up to 30 minutes to reach the furthest part from the office. This travel time, to and from the office, and from patient to patient has to be factored in by CW and where possible she manages to cluster her visits together in the same close area to maximise her visiting times.

The more in depth and lengthy the visit, the longer the subsequent paperwork and possibly the interaction with colleagues will take. It is not unusual for paperwork to take almost as long as the visit to complete.

Taking into account all of the above, CW needs to plan her daily schedule carefully in order to accomplish her objectives in a timely and efficient manner. It is my experience that CW manages her time very effectively, the amount of time spent patient facing is proportionate to the time she spends with the necessary admin follow up. Like the rest of the team, on some days CW can spend up to 2 hrs out of her 7.5 hr day travelling, this would severely impact on her overall effectiveness if that occurred frequently and so her ability to plan her day is a high priority, and something which she is very proficient at.

Kevin Munson

Band 6 CRT Physiotherapist

Compliance and Competency

Enter any changes below. Click Add Competencies to add a new competence, or click Edit to update an existing competence. Click Review and Submit to finalise your changes, or click Back to return to the previous page. Click All Competencies to see a chronology of your competence record. WARNING: If a Competence End Date is not entered when the Competence Profile is updated, a validated End Date will be entered, based on the Competence Renewal Period. If a Competence End Date is entered, this will be saved on the Competence Profile.

Employee Name Wright, Mrs. Claire Louise
Employee Number 21893493

[Learner Home Page](#) [Add Competencies](#)

Compliance

All Competencies

Awaiting Approval

 TIP To view compliance for any additional assignments, select assignment from drop down and press Go

21893493 - Therapy Assistant Practitioner

Go

Compliance Percentage

100.0%

☐ Required Competencies Only

 TIP To view required competencies only, tick the checkbox and press Go

[Back](#)



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University Health Board

APPENDIX 3

**PERSONAL APPRAISAL DEVELOPMENT REVIEW FORM
(INCLUDING PERSONAL DEVELOPMENT PLAN)**

SECTION 1: PERSONAL DETAILS

Reviewee Name:		Job Title:	
Claire Louise Wright		Therapy Assistant Practitioner	
ESR No:	Department:	Delivery Unit/Corporate Directorate:	
21893493	NPT CRT	PPC	
Reviewer Name:	Due Date of PADR Review	Actual Review Date:	Name of Professional Body: (If Applicable)
Emily Goodwin	02.09.2023	17.07.2023	
Date of Revalidation (NMC/HCPC): (If Applicable)		Discussion regarding revalidation held: Yes ☐ No ☐	
To be completed at the end of the discussion: Rating of overall performance			
Unsatisfactory ☐	Satisfactory ☐	Good Band 8c and above ☐	
Incremental Progression agreed		Yes ☐ No ☐	Not Applicable ☒
Band 8c and above			
Increment earned/re-earned		Yes ☐ No ☐	Not Applicable ☒

PADR CHECKLIST:

The completed copy to be retained by Reviewee.



A copy retained by the manager.



Where pay progression is considered inappropriate contact your Senior HR Manager.

SECTION 2: VALUES AND BEHAVIOURS

How is the employee demonstrating the values and behaviours of the Health Board? **Refer to the ABMU Values & Behaviours matrix to aid your discussion.**

Caring for Each Other in every human contact in all of our communities and each of our hospitals.

Discussion summary including examples

Supporting colleagues. Taking on role of union rep (initially on an informal basis now formally becoming rep) during R&R process, acting as spokesperson in grievance meetings.

Supporting colleagues undergoing difficulties in work.

Supporting new rotational staff to settle into role and team

I have participated in team building sessions and have participated in staff surveys in order to help promote a better atmosphere and work place

Working Together as patients, families, carers, staff and communities so we always put patients first.

Discussion summary including examples

Working in patient centred manner, continuing to try to act in patients best interests at all times and help them to attain realistic goals through their rehab.

Working with the team, Therapists and support workers on patch.

Continuing to work on double calls with Physio's and OT's and also with other AP's/techs

Always Improving so that we are at our best for every patient and each other.

Discussion summary including examples

Continue to facilitate equipment training for new therapists – I have just renewed the training package on request of clinical leads and produced 2 new work books one for each profession

Mandatory training is up to date (100% complete)

I have undertaken other training that I felt would be beneficial –e.g. Civility saves lives.

Suicide awareness.

SECTION 3: PERFORMANCE

Core objectives (From Previous PADR)
1. Wheelchair training 2. Increase knowledge of specific medical conditions
Summary of supporting evidence Discuss progress made in achieving core objectives and how the reviewee has done this in relation to the HB values and behaviours 1. Wheelchair training Not achieved – no training available. 2. Increase knowledge of specific medical conditions Partially achieved as learning while working with patients who have these conditions. No formal training available. Will take advantage of any training as it becomes available, if able.
Ambitious objectives (From Previous PADR)
N/A
Summary of supporting evidence Discuss progress made in achieving their ambitious objectives and how the reviewee has done this in relation to the HB values and behaviour N/A

SECTION 4: MANDATORY AND STATUTORY TRAINING

Mandatory and Statutory Training (See Guidance for Statutory and Mandatory Training Topics)	
Incomplete ☐	Complete ☒

Discussion (to include reasons for incomplete mandatory training, plan for completing mandatory training, learning and reflection from completed training)

N/A

Where the reviewee has failed to complete Mandatory and Statutory training, pay progression will be withheld unless they have been prevented from undertaking the training through no fault of their own.

SECTION 5: SETTING OBJECTIVES FOR NEXT 12 MONTHS

Your objectives will need to be specific, measurable & achievable (SMART).

Your core objectives will need to be realistic and achievable and will be specific objectives within the current remit if your role

Ambitious objectives should stretch your boundaries but should be achievable within an agreed deadline(s) and be within your control.

When reviewing progress against these objectives, evidence could include: reflections, training programme, agenda, discussions & shadowing others.

	Core or Ambitious	Target Date	Action Proposed by Reviewee	Record Summary of Progress (How this will be achieved)
Objective 1				
Start Agored level 4 qualification. Waiting for confirmation from university over place	Core	2025	Course is for 2 years and starts Autumn 2023.	Gaining qualification
Objective 2				
Wheelchair training	Core	2024	To contact ALAC and request be put on list for any future training. Attend training	Attend training
Objective 3				
Union Rep training Have applied for place waiting confirmation	Core	Oct 2023	Attend training	Gaining qualification and becoming qualified staffside rep
Objective 4				
Objective 5				

Mandatory (all staff) Discuss work/life balance, awareness of Well-Being Service, current workload.	Core	Ongoing	Discussion in supervision. Assistance from GP re control of chronic condition and stress management. Continued risk	Supervision. 6 monthly risk assessment reviews with Manager/Clinical Lead
Objective 6				
Mandatory(if you manage staff) To ensure PDRs are completed for all staff who directly report to you and ensure ESR updated.	Core			

(Continue on separate sheet if necessary)

SECTION 6: PERSONAL DEVELOPMENT PLAN (PDP)

Agreed development need	What activities do I need to address my development needs?	What support/resources do I need?	Target date for completion/ review
Union Rep training	Complete 10 day training	Study leave. Place on course	Oct 2023
Update equipment Knowledge	Link with equipment stores to arrange additional training	Time. OT in equip store	Sept 2024
Increase knowledge and confidence of Physiotherapy interventions	Continue to work jointly with senior physio's	Guidance and help from Physios	Sept 2024

SECTION 7: REVIEWEE & REVIEWER SIGNATURE

REVIEWEE ADDITIONAL COMMENTS: (Not Compulsory)
Another hard year with a lot of changes within the team. More changes in the management team have led to many changes again in job role, leading to less job satisfaction, increased stress and long-term staff members leaving. There has been a lot of friction within the team and I have not felt particularly supported by management. Another change of supervisor in January and now about to have another change is leading to concern over who will be my

supervisor going forward and who will be my work place Mentor if I should get accepted onto the level 4 training.

The amount of stress and upset in the team as a whole has led to a number of 'team building' initiatives, which I don't have a lot of faith in and which are already failing in a number of ways. The introduction of unrealistic targets, micro management and mistrust are not helping stress or morale.

I have enjoyed the part I have played in assisting colleagues within my role as union rep and look forward to being able to expand on this when I have completed the training.

Reviewee

17th July

Signature

Claire Louise Wright

Date:

2023

REVIEWER COMMENTS: Please add any further supporting information if required.

Claire has continued to work hard this year, despite changes in team dynamics and management. Claire has met all the required objectives for her PADR. In addition, Claire has also managed to focus on opportunities for her professional and self-development and will soon become an in service union representative. In addition, she is hoping to complete the level 4 Agored training/ qualification, which will provide an exciting challenge.

I wish you every success in these opportunities and am sure you will excel.

Reviewer

Signature

Emily Goodwin

Date:

17.08.2023

REABLEMENT SUPERVISION FORM

Supervisee: Claire Wright

Supervisor: Emily Goodwin

Date: 24.08.2023

1. Clinical Practice: Examples include – complex cases / clinical competence / processes and systems / ethical issues / risk management / reflections on experience both positive and negative Caseload discussed in general with some specific cases discussed in more detail: Discussed caseload as a whole. Claire is picking up new referrals regularly and has a range of community and delegated referrals. Continue to get clarification from band 7's about complex cases and whether should be picking up when needing further information but this is sometimes difficult. ██████████ Client worrying about costs. On brokerage – Social worker request accepted. ██████████ Family difficulties regarding pressures on client and wanting package of care. Client is at the point of requiring long-term poc, family want to await for one sister to be home from holidays to discuss. Discussed eye drops and client being unable to administer himself, Claire has checked and they are 2 times daily any time but family are also administering an eye drop at 9pm. Numerous new patients taken on and visits booked in calendar. ██████████ – discussed new referral – not appropriate for AP.	Action agreed Claire to come to Emily for any support of caseload if feel not in AP remit with new guidelines. Claire to document discussions had with Band 7's about whether case is appropriate for AP. Plan: Claire to discharge. Plan: Claire to visit on Monday 28th August to have long term care discussions with client and if family are able to be present, then great, otherwise to discuss with ██████████ and then speak to family on phone at later time. Claire to find out whether there needs to be a certain gap between eye drops on tea call and the drops the family provide. Claire to discuss with Sian today re being allocated to physio.
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2.	Workload management: Examples include – prioritisation / time management / documentation and admin time Overall no concerns with Claire's ability to prioritise etc... Claire is still finding that being delegated cases does not save time, as a thorough review of case notes of delegated clients is required before seeing them. New referrals also taking lots of time to find out what needed – community.	Action agreed Claire to document all that she is doing, to ensure transparency. Claire is already doing this/
3	Supervision/working with others: Examples include – students / colleagues / MDT / progress with PDP / CPD Claire has applied for Agored level 4. Awaiting to register with uni awaiting for qualifications review. Union rep training Starting September 2023. GMB. Study leave approved.	Action agreed Claire to keep Emily updated.
4.	Resource Restrictions: Examples include – staffing / equipment / health and safety risks / training Equipment still issue, with availability in sub store and delivery delays from main stores.	Action agreed
5.	Personal Union rep training – Claire is looking forward to this. Is awaiting a date for a hospital appointment. Is trying not to let it worry her and is trying to put things in perspective more and trying to not let work affect her health. Discussed other personal issues Claire is dealing with and also discussed her utilising support, annual leave and sickness leave if required.	Action agreed
6.	Other:	Action agreed

Date of next meeting:

Signed: E.Goodwin
Supervisor

Signed: C.L.Wright
Supervisee

REABLEMENT SUPERVISION FORM

Supervisee: Claire Wright

Supervisor: Emily Goodwin

Date: 17.07.2023

1. Clinical Practice: Examples include – complex cases / clinical competence / processes and systems / ethical issues / risk management / reflections on experience both positive and negative Caseload discussed in general with some specific cases discussed in more detail: Discussed caseload as a whole. Claire is picking up new referrals regularly and has a range of community and delegated referrals. Continue to get clarification from band 7's about complex cases and whether should be picking up when needing further information but this is sometimes difficult. ██████████ – Long term recs completed. ██████████ – ██████████ placed on AP list, ██████████ went to speak with re: equipment as wasn't clear on spreadsheet what needed. Then transpired a fan area, so Claire looked into the referral. Luckily Claire saw complexities re: client progressing mobility (which was asked by ██████████) and tried to speak with Band 7 on 3 occasions but was unable to and then spoke with Band 6 physio who advised this was not for AP and lady had very complex fractures so not for AP or potentially not for our physio. Reluctant to speak to ██████████ as she is quite defensive. ██████████ – Support workers involved. Request to progress mobility from pulpit to zimmer or crutches. Claire went out and not appropriate for AP. Wasn't told was a double ██████████ – Became unwell again and now admitted again. Claire referred to ACT who went out same day and they then dialled 999.	Action agreed Claire to come to Emily for any support of caseload if feel not in AP remit with new guidelines. Claire to document discussions had with Band 7's about whether case is appropriate for AP. Emily to discuss with Band 7 supervisor. Emily to discuss with Band 7 supervisor. Discharged from caseload.
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2.	Workload management: Examples include – prioritisation / time management / documentation and admin time Overall no concerns with Claire's ability to prioritise etc... Claire is still finding that being delegated cases does not save time, as a thorough review of case notes of delegated clients is required before seeing them. New referrals also taking lots of time to find out what needed – community.	Action agreed Claire to document all that she is doing, to ensure transparency. Claire is already doing this/
3	Supervision/working with others: Examples include – students / colleagues / MDT / progress with PDP / CPD Claire has applied for Agored level 4. Has upcoming interview with university, to update when knows decision. Union rep training – awaiting confirmation that Claire is on the course. – Should start August 2023. GMB.	Action agreed Claire to keep Emily updated.
4.	Resource Restrictions: Examples include – staffing / equipment / health and safety risks / training Equipment still issue, with availability in sub store and delivery delays from main stores.	Action agreed
5.	Personal Union rep training – awaiting date. GMB. Is awaiting a date for a hospital appointment. Is trying not to let it worry her and is trying to put things in perspective more and trying to not let work affect her health.	Action agreed

6.

Other:

Claire has emailed [REDACTED] today as she has found that she is not being rota'd to do Saturdays, Claire had to request to work a Saturday in April as there was a gap in the rota, so she went to [REDACTED] to ask if she could work. Also in June, Claire only worked Saturday as she took the shift from [REDACTED]. [REDACTED] has replied but has not addressed Claire's point about not being rota's unless she had asked.

Claire's PADR was completed today.

Action agreed

Claire has taken on extra weekends for people off on sick etc... and has confirmed with Band 7.

Date of next meeting: w/c 14.08.2023

Signed: E.Goodwin

Supervisor

Signed: C.L.Wright

Supervisee

REABLEMENT SUPERVISION FORM

Supervisee: Claire Wright

Supervisor: Janine Clark standing in for Jasmeen Dawes while she is off

Date: 23 February 2024

1.	Clinical Practice:	Action agreed
	Examples include – complex cases / clinical competence / processes and systems / ethical issues / risk management / J T – knee replacement, new IAx for physio. Telephone review today and possible DC (close to DC) AJL – 2x calls a day (was 3x a day). Low BP, dialysis in the week and anxiety. Referred to dietetics, but not sure how long until seen. SALT referral to be discussed in Reablement. Physio input to cover while CW on ALeave, currently mobile with Rzf and EC with therapists only. CW to review Tues next week – possible shower dry run. CJ – internal ref from KG OT, not been to see her yet - Hopefully next week. Possible delegation to Tech for exercise calls with KG OT to oversee and delegate. MFH – Phone review today – was ill earlier in the week. Sensory support referral done, recurrent falls due to eyesight issues. HEP being followed. Possible DC soon. GW – unable to get hold of patient, internal referral from ND OT. To check bed transfers with patient. CW to contact GENTLE Care for an update as well. JR – Int Ref from ND OT. Physio input requested. Originally refused input but has since changed his mind and CW to see him next week Wed. Short intervention likely.	

2.

Workload management:

Examples include – prioritisation / time management / documentation and admin time

CW has been doing equipment training, manual handling training and has had annual leave to consider as well and this has made her weeks disjointed and has struggled to get into a rhythm and flow but this will improve once no longer has AL to take as frequently.

No issues raised with paperwork and processes since being back in work again.

Action agreed

3

Supervision/working with others:**Action agreed**

Examples include – students / colleagues / MDT / progress with PDP / CPD

Equipment training – has restarted and CW is catching up with new staff that need training. Sessions all booked.

Information needs updating as changes to Bed levers and legislation to come into effect.

CW to make a presentation to support learning for this training.

As part of a project for her AGORED level 4 CW has implemented a Pre and post training questionnaire for staff to give feedback.

AGORED level 4: CW has resumed her training post long-term sickness absence and has some catching up to do and a project as mentioned above. CW has passed her first module and she started module three this week. Essential skills is still being sorted as there are some teething issues with TEAMS meetings that need to be sorted out.

Meeting with Kev on Wed next week as part of course requirements.

Colleagues: Claire is concerned about an OT colleague in her room (CM), who has recently moved away from sitting next to her. CW feels that she was not aware that she had done anything to offend this individual and they have not come to speak her directly with any issues as such. However, it was mentioned in the office that CM had moved, as she was not happy with a response that CW gave to a general room wide conversation that was being had.

CW feels she was not the only individual who disagreed with CM however; she feels that she is the one being “blamed” for her responses. CW was unaware that this had caused any offence initially as the mood in the room was joking and jovial at the time. CW has no issue with CM moving desks and the situation at the moment as they are able to still work together amicably but just felt that she wanted to be heard in this situation and clarify in case anything was brought up in the future. No further action to be taken at this time.

4.	Resource Restrictions: Examples include – staffing / equipment / health and safety risks / training Hand washing training is out of date – CW was on LT sickness at the time the team was updated. On the list to be completed as and when training is arranged. ESR – 100% up to date Raizor training – some queries have been raised around whether or not we are able to train others to use this piece of equipment or not – Janine to Clarify and get back to CW with the outcome. Small aids training – Janine to clarify if Claire is still able to train others on these aids if she has not had any official Train the trainer type training as such. Will feedback to CW once I know.	Action agreed
5.	Personal: Examples include – coping with the demands of the job / stress management / coping strategies CW has some issues going on at home surrounding her mum, and things might change over time. CW is still struggling with her fibromyalgia and post COVID symptoms but is making steps to improve this by attending NERS scheme and yoga again.	Action agreed
6.	Other: CW on 2 weeks AL in March.	Action agreed

Date of next meeting: booked for 3rd April 2024

Signed: Janine Clark 23/2/24

Supervisor

Signed: C. Wright 23/02/24

Supervisee

Appendix:



**Therapy Assistant Practitioner:
Demonstrating Practice
Peer Review Feedback form**

This peer review feedback was completed by: Claire Wright

Date: 8th February 2024

The following tables will contain peer review feedback on presentations demonstrating quality improvement projects, using a PDSA cycle.

Feedback one:	Presentation topic: Provision of Ferrules
Congratulations	What does the presenter do well? What were the presenters' main points? Good introduction to topic giving good reasons for need for this service development. Included safety of patients. Explained how project would be carried out and results of the project. Identified further actions arising from the results of this project.
Ask for clarifying questions.	What aspects of the presentation were confusing or unclear? Why? Was a little repetitive in places. What suggestions (at least 2) do you have for the presenter, in order to improve this presentation? More use of diagrams/pictures to illustrate types of ferrules and condition ferrules against what they should be. How much resistance if any did you have from your qualified therapists to participate? Fast speaking – I struggled to keep up and process the information at times.
Request more.	What would you like to know more about the topic? What are the cost implications of changing ferrules over changing walking aid as this is an issue we have come across in our practise. Do you have any problems getting a supply of replacement ferrules. Do you have any methods of stopping people using walking aids inappropriately e.g. outside other than just education? for example do you provide an outdoor walker or just supply information on how to get one?
Evaluate its value.	What specific details would you take forward into your own practice? Trying to encourage therapists of all professions to become involved in checking ferrules, historically this has not worked in our department, and is not commonly carried out. we have set up a different system but this relies on taking AP's from their cases and currently this focuses on residential and nursing homes not individuals.
Summarize	What new information have you learnt? Has this influenced you to think differently? Not to think differently but has reminded me of the importance of everybody putting this into practise not just some of us.

Feedback two:	Presentation topic: Use of communication Aid
Congratulations	What does the presenter do well? What were the presenter's main points? Good introduction to Henry and reasons for the case study/PDSA. Description of what was done and how. Clear conclusion of following actions.
Ask for clarifying questions.	What aspects of the presentation were confusing or unclear? Why? How is the aid actually used and when. What specific suggestions (at least 2) do you have for revising the unclear parts of this presentation? Could have expanded a bit on how the communication aid is actually used and how Henry relates to the aid – does he dislike it for example Expand a little on how you wanted the staff to use the aid Closer pictures of the aid so can see more clearly.
Request more.	What would you like to know more about the topic? Would be interesting to learn more about the aid and how the support staff can use it to benefit the service user
Evaluate its value.	What specific details would you take forward into your own practice? Identified a learning need around communication aids. Not sure how much affect this would have on my practise as rarely have patients that would be reliant on communication aids of this complexity.
Summarize	What new information have you learnt? Has this influenced you to think differently? The versatility of communication aids. Importance of training all staff and staff implementing the training to gain most from the aid. Importance of having core staff supporting service users.

Feedback Three:	Presentation topic: Repetitive task training for stroke patients.
Congratulations	What does the presenter do well? What were the presenter's main points? Explained reason for project. Explained what patients were chosen for project and why. Good use of graphs to evidence results – easy to understand. No repetition. Liked hearing other benefits that were discovered as a by-product of the project that were not specifically targeted in the initial brief.
Ask for clarifying questions.	What aspects of the presentation were confusing or unclear? Why? Reason for choosing that particular repetitive task What specific suggestions (at least 2) do you have for revising the unclear parts of this presentation? Could expand on the reason for choosing this particular task. What effect this particular task could have on patient's general recovery. Expand a little on how repetitive task training is completed between group sessions
Request more.	What would you like to know more about the topic? How are you going to take this forward? is it just continue to run the groups with new patients or will you be looking to expand it at all? How do you envisage this technique/training continuing on patients rehabilitation specifically when back in the community
Evaluate its value.	What specific details would you take forward into your own practice? Difficult to answer this as a lot of our daily practise is using repetitive task training – with exercises and functional tasks. Would like to explore possibility of picking a specific task as a repetitive training and see if it makes a difference for our patients in the community.
Summarize	What new information have you learnt? Has this influenced you to think differently? Will be more mindful of using technique to full advantage.

