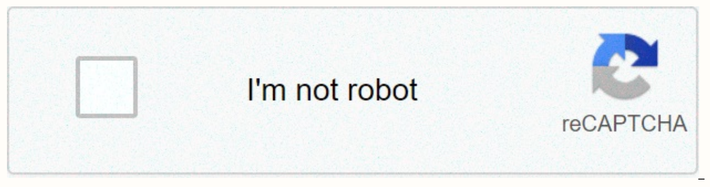

Continue

Ot process stages

Use the intervention business in occupational therapy (i.e., any activity which is meaningful to a person) in order to achieve a particular therapeutic result. The same activity can be used by different therapists but in different ways to achieve different medical goals. The same activity can be performed by the same doctor with different clients to achieve different goals! To illustrate this, consider gardening; A business that many people find worthwhile. The activity of sowing seeds in greenhouses. For a physician, it can be repetitively producing the upper limb and understanding the movements in a stroke patient's low-tone organ, to restore neural connections to motor movement through therapeutic neuroplasticity theory. For another therapist it may be teaching a learning disabled patient new skills in communicating with others and managing appropriate frustrations, in order to make successful socialising in the community and is more likely to achieve employment, through behavioural theory. The same activity, but done with different end goals that the therapist wants patients to achieve, and therefore different clinical reasoning behind it. In this respect, you do not do what you do, but why you do it. Interventions can be grouped according to the type of goal they are achieving: preparation purposefully business-based is difficult, but critical reflection is an important yet ethereal skill that all occupational therapists need to master. Part of completing a reflection is an intrinsic sense of discomfort (in fact the first stage of reflection described by Boyd & Falls 1983) so it's no wonder that many people can turn it off and even try to get through it without it, perhaps only taking token reflection to comply with CPD or course requirements. To begin with, reflecting on your actions is something that requires conscious effort after the event, but ultimately, according to Johns (2000), it will become an automatic thought process, even when you are in the middle of experiencing the event. When deciding which model to use, it can be helpful to find out which learning style you have, according to Honey & Mumford. You can relate these to the knowledge types shown in the Carper/Johns reflective model. Below is a rough guide to different models of reflection, and what conditions they are best prepared toward. They are ordered (in my opinion) easier to start than people who have been trying to break down and evaluate a situation, hoping to el light up more complex that build on the basics and shift their personal beliefs and challenge their beliefs. Gilly Bolton suggests practicing creative ways to reflect in her book Reflective Practice: Writing and Professional Development (Chapter 4). What? So what? ... Now what? Like the installation, you'll naturally find yourself going More experience with your analysis of an event benefits you with reflective models. Enjoy the ride! Good for +++++++ Gibbs Reflective Cycle (1988): Good old Gibbs. Basic, good starting point, six specific stages. Makes you aware of all the steps you go to when you experience an event. The criticisms are: superficial reflection - no referral to critical thinking/analysis/beliefs or viewing it from a different perspective (Atkins and Murphy 1993). There is no number or depth of inquiry questions as other models. ++++++++++ Read more OT process occurs when we systematically apply business principles in a practical situation. Many different models of the OT process have been developed, and they strive to guide a physician through the steps of applying professional theory to each practical customer situation. Some models may be more useful in particular situations or with special customers than others. Part of the artistry of having an OT, and the difference between being a technician and a professional, adopting a holistic approach and being able to use the most appropriate model for the unique mix of individual customer problems to achieve a positive outcome. Technicians follow the instruction to complete the procedures while professionals use a mixture of artistry with science to determine the best models and interventions for each unique patient. Oshawott: Some examples of Pokemon Otter's process OT process model through sports are below: PEOP person-environment-professional performance CMOP-E commercial performance e Canadian model and creative capability biopsychoorical model Max Ne's engagement of human business MoCA model MOHO Model Main Model Capability Approach Medical Model Kava (River) Model Social Disability Model Human Performance OA Professional Optimization Model OPM (A) Professional−Performance Model (Australia) European Conceptual Framework for Professional Medicine EHP Ecology Read More You can come across the first word, you can not, But if you're an OT you've probably used it without feeling before. Self-therapeutic use is a useful technique employed by an occupational therapist to engage customers and therefore have better results during the OT process. Essentially it's being aware of yourself (your verbal language, body language, which personal information you choose to share...) when you're interacting with a customer, and using your personality and interpersonal skills to create synergy and ultimately make the customer feel easily, motivated, and that they can trust you. Making a connection to use yourself medically, you should first be aware of your interaction with a customer to be able to customize them to suit the customer's style. It can be useful in order to consider certain models Provide your ideas, and guidance for a professional medical student who is just beginning to reflect on his therapeutic style. Taylor (2008) recently proposed a deliberate relationship model, which classifies six therapeutic modes — or types of customer-therapist interactions — into six categories. In Intentional Relationship Model (IRM) are mode: Read more This article considers the role occupational therapy can play in maintaining Earth's resources, and what people might have barriers to recycling. The ability to carry out a business can be affected by climate change, and businesses themselves can also influence climate change either by contributing or by helping to prevent it. Where the customer is acceptable, occupational therapists should encourage businesses to get used to environmentally sound methods. Occupational therapists may need to work with professionals who int knowledge their field since it itself is not an area of expertise for OTs. The authors suggest using the model of human occupation (MOHO) as a good initial framework for occupational therapists who want to incorporate an environmental perspective into their intervention. Some aspects of MOHO and the ways they affect sustainable practice are: Read more attractive Vona du Toit models of creative ability (or VdT MoCA for the remainder of this article) is a new kid on the professional block. Called developed by a South African woman - you guessed it - vona du Toit in the 1960s, it was later commonly used throughout South Africa. It was introduced to the UK in 2004, where it has been gaining popularity ever since. Petrica de Witt (2014) has updated the model in her recent chapter of the book Occupational Medicine in Psychiatry and Mental Health. Wendy Sherwood is an OT from the UK who is a big champion of the model and is expanding in the UK. Due to its novelty, MoCA doesn't have a lot of literature or evidence the basis surrounding it yet. The model was previously known by a few different names until frustration at this confusion it would be officially renamed VdT MoCA in 2010. It is an example of a move in the right direction as the lack of uniformity around occupational medical conditions is something that plagues discipline in general, and holds back its credibility with other professions as well as preventing appropriately significant comparisons of principles and evidence. The first thing to note is that the creative words used in the model do not mention the artistic potential, as is the performance of our friend below. Remember, creative = not creative Read more in this article, Havelka et al explains that the biomedical model was a valid model, while infectious diseases caused by a factor prevailed and were the main health problem for humanity, but now that chronic, lifestyle and non-infectious diseases with many Factor the main health issue is it is no longer effective or appropriate as the default model for health care. They are in favour of the biopsocial (BPS) model and say its implementation is taking a very long time. His criticisms of the current biomedical model are: the inhumane rapid improvement in advanced medical techniques between health care staff and patients has led to an increase in expenditure where only the rationing of health care technology led to health care will allow (as psycho-social leadership) reduces people to the minimalist i.e. the smallest ingredient - their cells - and the opposite to separate the mind and body and vice versa. Despite evidence for more chronic conditions (such as COPD or diabetes) to do so are increasing in Western countries such as England and Holland. These long-term conditions burden lower financial health care for the patient and achieve better quality of life need to be proactive in managing their situation. In this way, evidence shows that a biopsychosocial model will benefit patient wellbeing and produce these financial reforms. However the provision of care that begins with the medical, emotional or social needs of individual patients does not fit easily with the current Dutch health care system. So the biocychosocial model is a great idea - how to implement it? Read more Townsend et al (2006) writes that traditional roles of psychologists are being challenged by multi-disciplinary team (MDT) treatments now necessary in order to treat patients with chronic pain in accordance with the biopsychological model. MDT: Team Otter treatment of chronic pain was traditionally carried out according to a biomedical model-a patient was treated for chronic pain syndrome after a car accident but was not evaluated for PTSD, for example. Research has shown the efficacy of a biopsychosocial model in treating pain, where social and psychological factors are taken into account as well as biological. Turk (2002) reported patient benefits of biopsychosocial approaches (in relation to chronic pain) as an increase in functional capacity, low disability claims, and less illness as side effects of medical treatment or examination. Where treatment is not possible i.e. pain reduction, MDT will aim to maximize the functioning of the patient. Townsend et al describes a case study about a patient Ann who underwent an intensive 3-week program with an MDT to deal with her lower leg pain and end dependence on pain medication. In the case study, the role of OT in MDT was to incorporate various pain control strategies into daily life (ADLS) activities, for example using pacing techniques and appropriate body mechanics. They could have been potentially involved with functional evaluation and could have assisted with outcome measurements. Read more researchers sought to identify The tasks in preparing food were the most sought after for elderly women, and how they overcome these to continue preparing food as they aged. Food preparation was worthwhile for women as it was an important part of their self-identity. The COMP model was used to identify which tasks were important for women. The GOP model was then used by researchers to perform activity analysis for selected tasks. They found that the difficulty in completing tasks as older women was not just due to reduced biomedical functioning, but also environmental barriers. Often women had habitual functions for a long time and when their physical functioning declined slightly it id would not let them change the environment to facilitate easy task completion. This is how the environment had become inefficient because if it had changed women would also be able to carry out tasks with their reduced functions. This in practice shows an example of the biopsychosocial (BSP) model as it highlights the social/environmental factors (and affecting their physical functioning) affecting individuals, as well as traditional physical/medical factors according to the biomedical model, and highlights how other factors can affect or cause biomedical problems instead.
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Ekel E (2012) 'Elderly Women living in the Community and Food Preparation' In Geriatrics Physical and Occupational Therapy 30 (4) PP 344-360 344-360