APPENDIX A

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/99 Rischmüller

CLEARANCE CERTIFICATE	PROTOCOL NUMBER M060415
PROJECT	Assessing the Quality of Clinical Occupational Therapy records kept at LSEN Schools in the Western Cape
INVESTIGATORS	R Rischmuller
DEPARTMENT	Dept of Occupational Therapy
DATE CONSIDERED	06.05.05
DECISION OF THE COMMITTEE*	APPROVED UNCONDITIONALLY

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 06.06.26 CHAIRPERSON .....
(Professor A Dhai)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Mrs D Franzsen

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

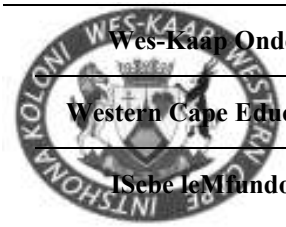
APPENDIX B

Navrae
Enquiries
IMibuzo
Dr RS Cornelissen

Telefoon
Telephone
IFoni
(021) 467-2286

Faks
Fax
IFeksi
(021) 425-7445

Verwysing
Reference
ISalathiso
20070302-0044



Wes-Kaap Onderwysdepartement

Western Cape Education Department

ISebe leMfundo leNtshona Koloni

Postnet Suite 45
Private Bag X22
TYGERVALLEY
7536

Dear Mrs R. Rischmüller

RESEARCH PROPOSAL: ASSESSING THE QUALITY OF CLINICAL OCCUPATIONAL THERAPY RECORDS KEPT AT LSEN SCHOOLS IN THE WESTERN CAPE.

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

Principals, educators and learners are under no obligation to assist you in your investigation.
Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
You make all the arrangements concerning your investigation.
Educators' programmes are not to be interrupted.
The Study is to be conducted from **2nd April 2007 to 30th May 2007**.
No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December 2007).
Should you wish to extend the period of your survey, please contact Dr R. Cornelissen at the contact numbers above quoting the reference number.
A photocopy of this letter is submitted to the Principal where the intended research is to be conducted.
Your research will be limited to the following schools: **Pro Ed House, Khayelitsha LSEN School, Tafelberg School, De Novo Youth and Education Centre, Pioneer School, Nompumelelo School and Athlone School for the Blind**.
A brief summary of the content, findings and recommendations is provided to the Director: Education Research.
The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Education Research
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000

We wish you success in your research.

Kind regards.

Signed: Ronald S. Cornelissen
for: **HEAD: EDUCATION**
DATE: 9th March 2007

APPENDIX C

Dear Principal / Occupational Therapist

I am currently doing research to develop a checklist to determine the quality of clinical Occupational Therapy records at LSEN schools. This is part of an MSc. Occupational Therapy degree which I am doing through the University of the Witwatersrand. I am also currently an Occupational Therapist working at Astra LSEN School. I would be most grateful if your Occupational Therapy Department would be prepared to participate in this research project.

Reasons for the study: Through my experience as an Occupational Therapist working at an LSEN school, I have felt that there are increasing expectations with regards to record keeping, yet less time to do it. Therefore I would like to assess what records are currently being kept at LSEN schools. I would also like to find out what records other Occupational Therapists feel are important to keep and what recommendations they have with regards to improving the quality of record keeping at LSEN schools.

What will be expected from your school if you participate in the study?
I will visit your school for one day. While I am there I would like to request that the Occupational Therapists working at the school complete a questionnaire regarding record keeping. Thereafter, I will randomly select 5 learner's Occupational Therapy records from each phase at the school as well as 5 past pupil's Occupational Therapy records. I have a checklist on which I will mark whether certain information is present or not. E.g. Is there a date of birth, what assessments are used, does it say how regularly the learner is treated, is each treatment session evaluated, is there planning for Occupational Therapy intervention etc. None of the information from the file will be recorded, I will just note whether the information is present or not.
I would like to assure you that your school's name and the name of the Occupational Therapist that completes the questionnaire will not be mentioned in the research report and will remain confidential. No names will be used on any of the data sheets.

What are the benefits of the study?
The results of this study will be presented to the Western Cape Education Department. This will assist in ensuring that expectations with regards to record keeping will be realistic and beneficial for Occupational Therapists. Recommendations with regards to record keeping will be shared with all the schools that participate in the study.

Can I choose whether or not the school will participate?
Yes. Participation is voluntary and there will be no consequences if you choose not to participate. You may also withdraw at any time without consequence.

If you have any queries, more information may be obtained from Renee Rischmüller at telephone number (021) 934 0155 or cellular phone number 083 656 2333.

If you are happy to allow your school to take part in the study, please read and sign the attached consent form.

Thank you

Renee Rischmüller

Consent form

I agree to allow _____ (name of school) to participate in the study “Assessing the quality of Occupational Therapy records at LSEN schools in the Western Cape” as outlined in the information sheet.

_____ _____

Principal’s name Signature

_____

Date

Consent form

I agree _____ to participate in the study “Assessing the quality of Occupational Therapy records at LSEN schools in the Western Cape” as outlined in the information sheet.

Would you like to receive feedback once the research is complete?

Yes	No

_____ _____

Therapists Name Signature

_____

Date

APPENDIX D

Checklist for records

1. Personal Information

		Yes	No	Yes	No
1.1.	Name				
1.2.	Gender				
1.3.	Date of birth				
1.4.	Address				
1.5.	Home language				
1.6.	Population group				
1.7	Religion				
1.7.	Referred by whom to LSEN school				
1.8.	Reason for referral to LSEN school				
1.9.	Emergency information / contact numbers				
1.10.	Grade / phase				
1.11	Academic results at the end of each grade / phase				
1.12	Interests				
1.13	Extra-mural participation e.g. sports, culture etc				
1.14	Discipline and consequences				
1.15	Name of Occupational Therapist				
1.16	Other				

2. Socio-economic information

2.1	Parent information				
	2.1.1. Names				
	2.1.2. Occupation of parents				
	2.1.3. Medical / disability history				
	2.1.4. Education				
	2.1.5. Contact numbers				
2.2	Siblings				
	2.2.1. Age				
	2.2.2. Gender				
	2.2.3. Education				
	2.2.4. Medical history				
2.3	Information on who child lives with				
2.4	Disability / child care dependency grant information / trusts / road accident fund information				
2.5	Type of dwelling and ownership				
2.6	Relevant client history, e.g. orphaned, father imprisoned etc				
2.7	Other:				

3. Medical History

3.1.	Diagnosis				
3.2.	Pregnancy History				
3.3.	Birth History				
3.4.	Developmental milestones				
3.5.	Operations				

3.6.	Illnesses				
3.7.	Present health status				
3.8.	Onset of Diagnosis				
3.9.	Allergies				
3.10.	Other				

4. Assessments

		Yes	No	Yes	No
4.1.	Referral information for Occupational Therapy intervention				
4.2.	Pre-admission assessments				
4.3.	Screening				
4.4.	Assessment of:				
	4.4.1 Gross motor abilities				
	4.4.2 Fine motor abilities				
	4.4.3 Speech and language				
	4.4.4 Sensory awareness				
	4.4.5 Perception				
	4.4.6 Cognition				
	4.4.7 Emotional / behaviour problems				
	4.4.8 Functional abilities				
	4.4.9 Corresponding problems outlined				
	4.4.10 Other				
4.5	Assessment methods reported in full				
	4.5.1 Standardised tests				
	4.5.2 Non-standardised tests				
4.6	Recommendation regarding placement				
4.7	Identify the level the child is currently at				
4.8	Interviews				
	4.8.1 With the referring teacher				
	4.8.2 With the child				
	4.8.3 With the parents				
4.9	Discrepancies between a child's performance and other's expectations				
4.10.	Teacher's expectations				
4.11	Identifying obstacles				
4.12	Dates of assessments				
4.13	Other:				

5. Treatment plan

5.1	Problems areas identified				
5.2	Strengths identified				
5.3.	Outcomes / objectives and / goals				
	5.3.1 Outcomes				
	5.3.2 Goals				
	5.3.3 Objectives				
	5.3.4 Goals are broader than objectives				
	5.3.5 Client's knowledge and agreement of goal				
	5.3.6 Time scales and review dates				

	5.3.7 Are goals written in educational terms				
5.4.	Client's personal aims				
5.5	After completion of treatment plan:				
	5.5.1 Outcome of treatment				
	5.5.2 Reasons for goals not obtained				
	5.5.3Outcomes correspond with goals				
	5.5.4Progress records				
5.6	View of client				
5.7	Interventions clearly and logically outlined				
5.8	Annual reports				

		Yes	No	Yes	No
5.9	User satisfaction – surveys to parents, student & staff for their opinions				
5.10	Provision and adaptation of equipment				
5.11	Home programs				
5.12	Collaboration with other professionals				
5.13	Contribution to IEP				
5.14	Determination of the most effective types of service delivery				
5.14.1	Direct				
5.14.2	Consultation				
5.14.3	Indirect (Monitoring)				
5.15	Equipment used				
5.16	Other:				

6. Treatment sessions

6.1.	Date of session				
6.2.	Time and / or duration of session				
6.3.	Group sessions				
6.4.	Individual sessions				
6.5.	Session aims				
6.6.	Behaviour during session				
6.7.	Activities used during session				
6.8.	Performance of activities				
6.9.	Outcome of session				
6.10	Amount of sessions recorded per year ……..				
6.11	Ongoing re-evaluations				
6.12	Attendance				
6.13	Other:				

7. Discharge Information

7.1	Discontinuing Occupational Therapy				
7.1.1	Client's status at end of Occupational Therapy intervention				
7.1.1.1	Physical status				
7.1.1.2	Functional status				
7.1.1.3	Social status				
7.1.1.4	Psychological status				
7.1.2	Reason for discontinuing Occupational Therapy				
7.2	Leaving school				

7.2.1	Client's status at discharge				
7.2.1.1	Physical status				
7.2.1.2	Functional status				
7.2.1.3	Social status				
7.2.1.4	Psychological status				
7.2.2	Reason for discharge				
7.2.3	Details of placement after discharge				
7.2.4	Follow-up information after discharge				
7.3	Discharge report				
7.4	Changes between initial and current status of functional ability				
7.5	Deficits with regards to performance areas and components				
7.6	Discharge plan				
7.7	Other:				

8. General

		Yes	No	Yes	No
8.1	Use of abbreviations – should be explained in full the first time that they are used in OT records				
8.2	Use of slang / colloquialisms				
8.3	Would records be understood by people who are not health professionals?				
8.4	Confidential				
8.5	Access				
8.5.1	Ease with which to file patient records				
8.5.2	Ease with which to locate patient records				
8.6	Good storage facilities				
8.7	Disposed confidentially				
8.8	Is handwriting legible?				
8.9	Is it easy to locate items within the records of each section				
8.10	Other:				

APPENDIX E

Dear Occupational Therapist

The following questionnaire is to determine what you, as an Occupational Therapist working at an LSEN school, feel should be included in each learner's file that is kept in the Occupational Therapy Department.

Please could you indicate the importance of each item on a scale of 1 to 5.
1 = This is not important to me
2 = Should sometimes be recorded
3 = Important to be recorded for me
4 = This is most important to me

When answering each item please think to yourself "Is it important for me to record this information" and not "Do I do this" e.g.
5.4. Client's personal aims
Now think to yourself "Is it important to **record** the client's personal aims?" and not "Is it important to know the clients personal aims?"

Please note that there are no right or wrong answers and that the questionnaire is to determine, through your experience, the importance of recording the various items.

If there is other information that you feel is important to record that has not been included in the questionnaire, please could you add it at "Other".

Thank you for your time

Renee Rischmüller

Checklist for records

1. Personal Information

		1	2	3	4
1.1.	Name				
1.2.	Gender				
1.3.	Date of birth				
1.4.	Address				
1.5.	Home language				
1.6.	Population group				
1.7	Religion				
1.7.	Referred by whom to LSEN school				
1.8.	Reason for referral to LSEN school				
1.9.	Emergency information / contact numbers				
1.10.	Grade / phase				
1.11	Academic results at the end of each grade / phase				
1.12	Interests				
1.13	Extra-mural participation e.g. sports, culture etc				
1.14	Discipline and consequences				
1.15	Name of Occupational Therapist				
1.16	Other				

2. Socio-economic information

2.1	Parent information				
	2.1.1. Names				
	2.1.2. Occupation of parents				
	2.1.3. Medical / disability history				
	2.1.4. Education				
	2.1.5. Contact numbers				
2.2	Siblings				
	2.2.1. Age				
	2.2.2. Gender				
	2.2.3. Education				
	2.2.4. Medical history				
2.3	Information on who child lives with				
2.4	Disability / child care dependency grant information / trusts / road accident fund information				
2.5	Type of dwelling and ownership				
2.6	Relevant client history, e.g. orphaned, father imprisoned etc				
2.7	Other:				

3. Medical History

3.1.	Diagnosis				
3.2.	Pregnancy History				
3.3.	Birth History				
3.4.	Developmental milestones				
3.5.	Operations				
3.6.	Illnesses				

3.7.	Present health status				
3.8.	Onset of Diagnosis				
3.9.	Allergies				
3.10.	Other				

4. Assessments

		1	2	3	4
4.1.	Referral information for Occupational Therapy intervention				
4.2.	Pre-admission assessments				
4.3.	Screening				
4.4.	Assessment of:				
	4.4.1 Gross motor abilities				
	4.4.2 Fine motor abilities				
	4.4.3 Speech and language				
	4.4.4 Sensory awareness				
	4.4.5 Perception				
	4.4.6 Cognition				
	4.4.7 Emotional / behaviour problems				
	4.4.8 Functional abilities				
	4.4.9 Corresponding problems outlined				
	4.4.10 Other				
4.5	Assessment methods reported in full				
	4.5.1 Standardised tests				
	4.5.2 Non-standardised tests				
4.6	Recommendation regarding placement				
4.7	Identify the level the child is currently at				
4.8	Interviews				
	4.8.1 With the referring teacher				
	4.8.2 With the child				
	4.8.3 With the parents				
4.9	Discrepancies between a child's performance and other's expectations				
4.10.	Teacher's expectations				
4.11	Identifying obstacles				
4.12	Dates of assessments				
4.13	Other:				

5. Treatment plan

5.1	Problems areas identified				
5.2	Strengths identified				
5.3.	Outcomes / objectives and / goals				
	5.3.1 Outcomes				
	5.3.2 Goals				
	5.3.3 Objectives				
	5.3.4 Goals are broader than objectives				
	5.3.5 Client's knowledge and agreement of goal				
	5.3.6 Time scales and review dates				
	5.3.7 Are goals written in educational terms				

5.4.	Client's personal aims				
5.5	After completion of treatment plan:				
5.5.1	Outcome of treatment				
5.5.2	Reasons for goals not obtained				
5.5.3	Outcomes correspond with goals				
5.5.4	Progress records				
5.6	View of client				
5.7	Interventions clearly and logically outlined				
5.8	Annual reports				

		1	2	3	4
5.9	User satisfaction – surveys to parents, student & staff for their opinions				
5.10	Provision and adaptation of equipment				
5.11	Home programs				
5.12	Collaboration with other professionals				
5.13	Contribution to IEP				
5.14	Determination of the most effective types of service delivery				
5.14.1	Direct				
5.14.2	Consultation				
5.14.3	Indirect (Monitoring)				
5.15	Equipment used				
5.16	Other:				

6. Treatment sessions

6.1.	Date of session				
6.2.	Time and / or duration of session				
6.3.	Group sessions				
6.4.	Individual sessions				
6.5.	Session aims				
6.6.	Behaviour during session				
6.7.	Activities used during session				
6.8.	Performance of activities				
6.9.	Outcome of session				
6.10	Amount of sessions recorded per year ……..				
6.11	Ongoing re-evaluations				
6.12	Attendance				
6.13	Other:				

7. Discharge Information

7.1	Discontinuing Occupational Therapy				
7.1.1	Client's status at end of Occupational Therapy intervention				
7.1.1.1	Physical status				
7.1.1.2	Functional status				
7.1.1.3	Social status				
7.1.1.4	Psychological status				
7.1.2	Reason for discontinuing Occupational Therapy				
7.2	Leaving school				
7.2.1	Client's status at discharge				

7.2.1.1	Physical status				
7.2.1.2	Functional status				
7.2.1.3	Social status				
7.2.1.4	Psychological status				
7.2.2	Reason for discharge				
7.2.3	Details of placement after discharge				
7.2.4	Follow-up information after discharge				
7.3	Discharge report				
7.4	Changes between initial and current status of functional ability				
7.5	Deficits with regards to performance areas and components				
7.6	Discharge plan				
7.7	Other:				

8. General

		1	2	3	4
8.1	Use of abbreviations – should be explained in full the first time that they are used in OT records				
8.2	Use of slang / colloquialisms				
8.3	Would records be understood by people who are not health professionals?				
8.4	Confidential				
8.5	Access				
8.5.1	Ease with which to file patient records				
8.5.2	Ease with which to locate patient records				
8.6	Good storage facilities				
8.7	Disposed confidentially				
8.8	Is handwriting legible?				
8.9	Is it easy to locate items within the records of each section				
8.10	Other:				

APPENDIX F
INTERVIEW QUESTIONS

What are your most important roles within the school?

Where are the learners' clinical occupational therapy records kept?

Where are the records for learners discharged from occupational therapy kept?

What type of records do you keep?

Who else has access to the records?

Is there a formal, organised filing system for clinical occupational therapy records in the occupational therapy department and/or the school?

Are there other general records for learners kept at the school?
If yes, where are they kept and do you have access to them?

APPENDIX G

DESCRIPTION OF THE SEVEN SCHOOLS SELECTED TO TAKE PART IN THE RESEARCH

School 1

Although this school was on the list of the Western Cape Education Department as an LSEN school, it functions more like a private school. The school caters for learners from Grade R to Grade 7. There is one class per grade and the number of learners in the classes is small. The learners come from high socio-economic areas within Cape Town.

There are 3 occupational therapists working at the school. They work privately and are not employed by the Western Cape Education Department. Parents pay medical aid rates for their children to attend therapy. All learners at the school have an occupational therapy assessment done prior to admission to the school. If occupational therapy is indicated for the learner, the learner must attend therapy for 2 years, unless it is terminated before that time. All the occupational therapists have been employed by the school in the past 6 months and only have 1 to 3 years prior experience.

With regards to record keeping, each occupational therapist keeps and maintains her own records as there is no central record keeping system in the department. Records are only kept for those learners that are currently receiving occupational therapy intervention

The occupational therapists are unsure of what must be done with past learner's records and don't know where these records are stored. They are unsure of what records are kept once the learners have left the school. End of the term reports are given to the office and are stored centrally in the learner's files. The occupational therapists did not know where the central files are stored or how to get access to these records.

Learners are seen in groups or individually. The researcher only observed records for individual clients and not for group clients. Learners are mainly seen in the

foundation phase, with a few learners in the intermediate phase receiving intervention. No learners received intervention in the senior phase.

Complete assessments are done on learners before treatment commences. Much time is spent in case discussions and input is given to IEDP's but this is seldom reported in the learner's files. A strong team approach is followed. The other members in the support team include a psychologist, physiotherapist and speech therapist.

As records are kept only for those learners who are currently receiving occupational therapy intervention the researcher was only able to assess 5 records of learners in the foundation phase and 4 records of learners in the intermediate phase. Therefore a total of 9 records were assessed at School 1.
All 3 occupational therapists completed the questionnaire.

School 2

At the time that permission to conduct research in schools was admitted to the Education Department there was an occupational therapist employed at this school. Once permission had been granted the occupational therapist had resigned and no occupational therapist had been reappointed as the post was reallocated to a different school.

Therefore the researcher was unable to collect data from school 2.

School 3

When the researcher contacted school 3 the occupational therapist's were willing to participate in the research but their headmaster said that it would take up too much of their time and was therefore not willing to give permission for research to be done at this school.

Therefore the researcher was unable to collect data from school 3.

School 4

School 4 is a Youth and Education Center for learners convicted of a variety of crimes. The school is approximately 5 years old. There is 1 occupational therapist at the school. She has worked there since the opening of the school 5 years ago. Other support team members include a social worker, nurse and psychologist. At present the posts for the nurse and social worker are vacant, therefore the occupational therapist is expected to fulfill their roles i.e. put in stitches, deal with families and court officials. There are approximately 40 boys at present, but the school is capable of accommodating 160 learners. The learners can follow an academic curriculum or a skills curriculum depending on their abilities, age and preference.

The occupational therapist mainly does initial assessments and crisis intervention. There is a strong team approach, even though the support team is much smaller at present. In the past the occupational therapist spent time doing play therapy with the learners, but as she is now expected to fulfill the nurse's and social worker's role, she no longer has time to do occupational therapy intervention.

The occupational therapist does pre-admission assessments of all new learners. This is usually in the form of an interview. The aim of the assessment is to decide in which class the learner should be placed, whether to follow the academic or skills curriculum as well as which life skills classes the learner should participate in. There is a central record keeping system as well as the occupational therapist's own record keeping system. All the learner's background information, social work reports, nursing reports and occupational therapy reports are kept in the central system. The occupational therapist records all correspondence with the learner, family and other role players in the central record keeping system. The central record keeping system is easily accessible to the occupational therapist.

The occupational therapist also has her own filing system in her office. The information kept in here is mainly occupational therapy assessments, the original interview questionnaires and answers as well as reasons for placement in a specific class.

At school 4 the academic stream consisted of 4 phases: foundation phase, intermediate phase, senior phase and FET phase. There is also a skills section. Files are also maintained for those learners that are on leave as well as for learners that are discharged. In some of the phases there were only a few learners.

The researcher assessed 3 files in foundation phase, 4 files in intermediate phase, 5 files in the senior phase, 2 files in the FET phase, 5 files in the skills section, 5 files for learners that are on leave and 5 files of learners that have been discharged. Therefore the researcher assessed a total of 29 records at school 4.
The occupational therapist completed the questionnaire.

School 5

When the researcher contacted school 5 the principal gave permission for the researcher to conduct research at the school and to contact the occupational therapists. The occupational therapists were not willing to participate in the research as they had not yet put a record keeping system in place for the year (the data collection was done in May).

Therefore the researcher was unable to collect data from school 5.

School 6

School 6 is a training center that caters for approximately 150 learners. The school is approximately 5 years old. The learners do not follow an academic curriculum but learn a variety of life and work skills. The learners reside mainly in the disadvantaged areas within the Western Cape and are picked up using the school's transport system. There is one occupational therapist working at the school. She has worked there since the opening of the school 5 years ago. The only other support team member is a nurse.

The occupational therapist does not see any learners either individually or in groups. She does not appear to provide consultation to teachers for learners either. She started a filing system when she first started working at the school but

has not used it since. She makes use of the nurse's filing system when needing information on a learner.

The occupational therapist fulfills a management role. She does interviews for new staff members, fills in statistics for the Education Department, shows people around the school and deals with admissions to the school.

The occupational therapist does not appear to do any assessment of learners on admission but merely relies on information from the Education Department. The nurse applies for information from the hospital regarding medical information about the learners.

As the school does not follow an academic curriculum it is divided into junior, intermediate and senior phases. These phases correspond according to age cohorts of the foundation, intermediate and senior phases of schools following an academic curriculum.

As the occupational therapist does not have a filing system, but uses the nurse's filing system, the researcher made use of the nurse's records for the data collection.

The researcher assessed 5 files in the junior phase, 5 files in the intermediate phase, 5 files in the senior phase and 5 files of discharged learners.

Therefore a total of 20 records were assessed by the researcher at school 6.

The occupational therapist completed a questionnaire.

School 7

School 7 is a large LSEN school catering primarily for learners with visual impairments, but over the last few years learners with a variety of other diagnosis have been accommodated within the school. The school caters for learners from Grade R till Grade 12. Learners can follow an academic curriculum or a skills curriculum. Those learners that follow a skills curriculum will complete their

schooling in the Vocational Rehabilitation class. The learners reside mainly in the disadvantaged areas within the Western Cape. There are hostel facilities for those learners living far away. Learners living within Cape Town are picked up using the school's transport system.

There are two occupational therapists employed by the school. The therapists have been working at the school for over 10 years. One occupational therapist works with younger learners, seeing them individually once or twice per week. The other occupational therapist focuses on Vocational Rehabilitation. Other support team members include a psychologist, nurse and mobility instructors.

The occupational therapists keep files for those learners that are presently receiving occupational therapy intervention. There are no files for pupils that received individual occupational therapy intervention in the past, but files are kept for past learners that participated in the vocational rehabilitation program. Reports are given to the teachers every 6 months. It is the teacher's responsibility to ensure that the reports are placed in the learner's portfolios. There is a central record keeping system in the school where all the learner's background information and school progress is kept. The occupational therapists seldom make use of the central record keeping system as it is cumbersome and time consuming to do so.

The learners must be referred by the teachers in order to receive occupational therapy intervention. Learners receive intervention mainly in the foundation phase with a few receiving intervention in the senior phases. No learners receive intervention in the intermediate and FET phase. Few formal assessments are done. The learners in the Vocational Rehabilitation class have an assessment done and a report written when they leave the school.

The researcher assessed 5 files of learners in the foundation phase, 3 in the senior phase, 5 in the Vocational Rehabilitation class and 5 files of discharged learners. Therefore the researcher assessed a total of 18 files from School 7.

The occupational therapists completed the questionnaire together.

APPENDIX H

Checklist for Occupational Therapy Records

This checklist has been developed to provide occupational therapists working in schools with a baseline regarding what information is compulsory to record in each learner's file and what information would be beneficial to the occupational therapy intervention process but is not compulsory.

It is recommended that occupational therapists evaluate their own records annually to ensure that they include all the necessary information regarding the learner and the optional information that is appropriate to their context.

In order to evaluate occupational therapy record keeping it is recommended to evaluate several learner's occupational therapy files who are presently receiving occupational therapy intervention as well as learners who have completed their occupational therapy intervention.

The left hand column contains items that can be considered compulsory in each learner's occupational therapy file. The right hand column contains items that are optional and will depend on the school's context and the occupational therapist's focus during intervention. Both columns should preferably be completed for effective record keeping.

Complete the checklist for each learner's file being evaluated by putting a tick in the box if the item is true for the learners file. Discharge information need only be completed for those learners who have completed their occupational therapy intervention.

Compulsory

General record keeping practices

- [ ] Explain abbreviations the first time they are used
- [ ] Confidential storage
- [ ] Ease to locate and file learner records
- [ ] Good storage facilities
- [ ] Disposed of in a confidential manner
- [ ] Legible handwriting
- [ ] Ease with which to locate items in a file

Background information

- [ ] Name
- [ ] Date of birth
- [ ] Gender
- [ ] Referred by whom to the school
- [ ] Reason for referral
- [ ] Home language
- [ ] Address
- [ ] Emergency contact numbers
- [ ] Name of Occupational therapist

Socio-economic information

- [ ] Who the learner lives with

Medical information

- [ ] Diagnosis
- [ ] Birth history
- [ ] Developmental milestones

Optional

Background information

- [ ] Grade
- [ ] Academic results
- [ ] Interests
- [ ] Extra-mural participation
- [ ] Discipline

Socio-economic information

- [ ] Parent information
- [ ] Relevant client history
- [ ] Type of dwelling
- [ ] Primary caregiver

Medical information

- [ ] Onset of diagnosis
- [ ] Illnesses
- [ ] Present health status

Assessment

- [ ] Pre-admission assessments
- [ ] Screening
- [ ] Outlining corresponding problems
- [ ] Use of standardized tests
- [ ] Assessment of gross motor abilities
- [ ] Assessment of fine motor abilities
- [ ] Assessment of speech and language
- [ ] Assessment of sensory awareness
- [ ] Assessment of perception

Assessment

- [ ] Assessment of emotional / behavioural problems
- [ ] Assessment of functional abilities
- [ ] Recording non-standardised tests fully
- [ ] Recommendations regarding placement
- [ ] Interviews with learner
- [ ] Dates of assessments
- [ ] Referral information to OT
- [ ] Identifying the level the learner is currently at

Treatment plan

- [ ] Direct intervention
- [ ] Outline of intervention
- [ ] The view of the client
- [ ] Collaboration with other professionals
- [ ] Consultations

Treatment sessions

- [ ] Individual sessions
- [ ] Date of session
- [ ] Behaviour during sessions
- [ ] Activities used during the session
- [ ] Performance of the activities
- [ ] Outcome of the session
- [ ] Attendance

Discharge information

- [ ] Reason for leaving school / OT
- [ ] Functional status at discharge
- [ ] Assessment of cognition
- [ ] Assessment of sensory integration
- [ ] Assessment of work
- [ ] Assessment of scholastic skills
- [ ] Interview with referring teacher
- [ ] Interview with parents
- [ ] Identifying obstacles
- [ ] Teacher's expectations

Treatment plan

- [ ] Problem areas identified
- [ ] Strengths identified
- [ ] Outcome of treatment
- [ ] Goals
- [ ] Objectives
- [ ] Client's knowledge & agreement of goals
- [ ] Time scales and review dates
- [ ] Client's personal aims
- [ ] Outcome of treatment
- [ ] Progress records
- [ ] Annual reports
- [ ] Provision and adaptation of equipment
- [ ] Equipment used during treatment
- [ ] Indirect intervention
- [ ] Are goals written in educational terms
- [ ] User satisfaction surveys
- [ ] Home programs
- [ ] Contribution to the IEDP

Treatment sessions

- [ ] Group sessions

- [ ] Social status at discharge
- [ ] Discharge report
- [ ] Session aims
- [ ] On going re-evaluations

Discharge information

- [ ] Details of placement
- [ ] Follow-up information
- [ ] Physical status at discharge
- [ ] Psychological status at discharge
- [ ] Changes between initial and current status of functioning
- [ ] Discharge plan