CHAPTER 6

CONCLUSION

Research into clinical record keeping by occupational therapists at LSEN schools in the Western Cape was deemed essential to establish the type and quality of records kept and the view of occupational therapists in the importance of keeping records. When the researcher approached the occupational therapists to participate in the research they all expressed that they thought that record keeping was important, yet they felt that they were not doing it as well as they should be and that their records were inadequate. One school declined to participate in the research as they felt that their records were inadequate.

The quantity and focus of record keeping of the various schools depends to a certain extent on the role that the occupational therapist plays within the school. In schools where there was only one occupational therapist, the occupational therapists did not maintain their own records, but made use of other team member's records. Where there was only one occupational therapist the occupational therapist seldom did regular direct intervention with learners. Yet, this study of record keeping does not comment on the role the occupational therapists fulfil within the school, but merely what they record within the learner's files.

Learners were placed in LSEN schools for specific reasons or disabilities, thus the type of assessments used and the type of treatment done, was very similar for all learners within the same school. Yet, the assessments done and type of treatment done differed vastly from school to school. The Western Cape Education Department indicates that the role of the school-based occupational therapist is to engage in therapy as well as academic, administrative, educational and disciplinary duties[5]. The necessity of delineating the roles and functions of a school-based occupational therapist within the context of the educational model as mentioned by Royeen[27] has been made clear in the results of this study.

It appears that there is no consistency with regards to record keeping and that each school works according to a different format. Each school has different

expectations: some schools require annual reports, others don't; some schools require the old occupational therapy records to be stored centrally, others don't. This lack of guidance with regards to record keeping affects the occupational therapist's adherence to both the type and distribution of records that need to be kept, resulting in records that are inadequate and insufficient.

The records that were kept differed from school to school and occupational therapist to occupational therapist, yet once an occupational therapist had developed his / her method of record keeping, it remained quite static from learner to learner. The information in the learners' files maintained by the same occupational therapist had very much the same information in each file. The occupational therapists seemed to record certain information as a habit, or because it was always done that way in the past, without thinking of the relevance to a specific learner. Occupational therapists require guidelines with regards to record keeping that ensure that their records are adequate, yet are flexible enough to be appropriate to each school's unique circumstances.

The occupational therapists taking part in this research project indicated that they would benefit from a checklist of what information is required in a learner's file in order to review their own record keeping. Therefore the adjusted checklist (appendix H) will be beneficial to occupational therapists working in schools as it will provide them with a baseline of 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.

The original checklist used in this study was developed through a literature review. It was very comprehensive with regards to what could be recorded in a learner's file, but was very lengthy. It would also be unrealistic to expect occupational therapists to record all the information mentioned in the checklist in the short period of time available to them to fulfil their administrative duties. Therefore it is necessary to provide occupational therapists with a more condensed checklist. In the case that an occupational therapist would like to maintain more comprehensive records he / she could make use of the initial checklist (appendix D) for guidance.

After comparing what the occupational therapists thought was important and what information was recorded most the researcher developed an adjusted checklist (Appendix H) based on the initial checklist (appendix D). Those items in the initial checklist that the occupational therapists thought were most important and were recorded most often in the learners' files were included in the adjusted checklist as compulsory (refer to page 82 for a list of the items). Those items that were considered to be important to the occupational therapists, but were only included in a few of the checklists, were included in the adjusted checklist as optional. Some items that were not included in the initial checklist but were suggested by the occupational therapists were also included in the adjusted checklist as optional (refer to page 83 for a list of the items).

Some items were not considered important to the occupational therapists and were seldom recorded, but were considered to be very important by the literature reviewed. Therefore these items were included in the adjusted checklist as optional. These items include: are goals written in educational terms, teacher's expectations, user satisfaction surveys, home programs and contribution to the IEDP.

According to Royeen occupational therapy services provided to learners must have a relationship to the educational goals identified for each student in the individualized education program[27]. Although literature says that occupational therapy intervention needs to be education focussed there is little literature that discusses how this would be different from the present occupational therapy approach. Therefore this should be researched further.

By categorizing some items as compulsory and others as optional the checklist is a practical solution to auditing the quality of occupational therapy record keeping in LSEN schools. It ensures that all the necessary information is kept, yet still remains flexible to ensure that the occupational therapist can maintain records that are applicable to the schools unique circumstances.

It is recommended that occupational therapists evaluate their own records using the adjusted checklist (appendix H) annually to ensure that they include all the

necessary information regarding the learner and the optional information that is appropriate to their context. Storage procedures should be standardised by the Western Cape Education Department with regards to records of learners who are currently receiving occupational therapy intervention as well as those that received intervention in the past.

Hippisley-Cox et al found that the quantity of information being stored in computer-based records is often better than when using paper based records[36]. In the research sample only one occupational therapist had access to a computer. Therefore none of the schools made use of computer-based record keeping systems. Yet, without the improvement in the quality of paper records the full benefits of computerization are unlikely to be realized. The onus for improving records lies with individual health professionals[37].

This study aimed to develop a checklist to evaluate and audit clinical occupational therapy records. This was achieved. The adjusted checklist was developed through making use of literature, the opinions of occupational therapists working in LSEN schools as to which records they think are important as well as evaluating existing occupational therapy records. The checklist can be used to ensure that in the future record keeping requirements are appropriate in terms of the job description of education therapists in LSEN schools and it can be used as a guideline to monitor and maintain the quality of occupational therapy records.

The type and quality of clinical records kept by occupational therapists at LSEN schools was determined using a checklist developed by literature review. It was found that although the general record keeping processes were good, the quality of record keeping was poor. Although the learner's personal information was recorded 55.3% of the time, socio-economic information, medical history and treatment session information occurred less than 50% of the time. The recording of assessment information, treatment plans and discharge information occurred less than 20% of the time. Further research needs to be done to determine the quality of occupational therapy records in LSEN schools using the adjusted checklist.

Incomplete and non-existing records influence the credibility of occupational therapy intervention. There is an inability of the occupational therapist to provide information on the learner's progress, strengths and weaknesses when this information is requested in the years following occupational therapy intervention. This in turn leads to an inability to prove that occupational therapy intervention has led to an improvement in a learner's academic progress. This compromises clinical and epidemiological research[11] and hampers evidence-based practice as the occupational therapist is unable to demonstrate that what he / she has done is effective[13]. It is difficult for practitioners to prove that they provided appropriate care should they be asked to do so in a professional or legal hearing[11] or demonstrate the use of valid and reliable measures and the effectiveness of therapy services to third party players[14] e.g. Department of Education if their records are poor. It also hampers audits of professional competence and clinical training[11]. There is also an increase in the cost of care through repetition of procedures[8] and undergraduate students are exposed to poor record keeping practices[11].

A questionnaire was used to determine which records occupational therapists think are important to keep in view of their clinical intervention. The results indicated that occupational therapists feel that virtually all areas of record keeping are "most important to me". This appears unrealistic and seems to be a very high standard that the occupational therapists would like to obtain. The researcher had presumed that the occupational therapists from various schools would have different priorities for record keeping and would prioritize the items according to their specific working situation. Yet it seems as though occupational therapists may be unable to prioritize what information is important for their working environment and clients and are therefore overwhelmed by the administrative work they expect themselves to do. This study is not meant to be an indication of what information occupational therapists believe is important, but rather what information is important to be recorded in the learner's files.

A further objective of the study was to make recommendations with regards to required record keeping in the job descriptions of education therapists working in LSEN schools. The job description of occupational therapist should include a description of the expectations with regards to record keeping. General guidelines

should be given with regards to the process of record keeping in general. It should be necessary to record information regarding the learner's personal information, socio-economic information, medical information, assessments, treatment plan, treatment sessions and discharge information.

The final objective of the study was to make recommendations as to the quality assurance of these clinical records. Occupational therapists working for the Western Cape Education Department participate in the IQMS (Integrated Quality Management System) annually. Audits of clinical occupational therapy records could be included in the IQMS where a peer and a superior evaluate the records of randomly selected learners receiving occupational therapy intervention. This is a more objective manner of assessing the occupational therapist's performance than viewing one treatment session performed by the occupational therapist, as is presently done.