CHAPTER 5

DISCUSSION

5.1. INTRODUCTION

Despite only four of the seven schools which were approached to participate in the review of their records agreeing to do so, there was diversity within the schools. The sample still included diverse geographical areas, socio-economic groupings with differences in the type, amount and role of the occupational therapy as well as the type of disability of the learners. Of concern is the fact that all of the schools were hesitant to participate as they felt that their record keeping was poor. One of the schools withdrew because the occupational therapists had not yet put a record keeping system in place and they felt that their record keeping was too poor to be able to participate. It thus seems as though most occupational therapists working in LSEN schools when approached about examining their records feel that their record keeping is inadequate. This research could therefore be of benefit to many occupational therapists in identifying the problems that exist in record keeping in LSEN schools and giving guidance with regard to what is expected of their record keeping.

The discussion will further consider the measurement instruments used in the research and the concerns about the record keeping in LSEN schools. This will include factors affecting record keeping like the roles occupational therapists are playing in LSEN schools and the distribution and type of record keeping.

The measurement instruments in the form of a checklist and questionnaire designed by the researcher contained the same items allowing a comparison of the occupational therapist's views of what should be kept in the clinical records with what is actually kept in the files. An "other" section was added to the checklist so that if some aspect of record keeping had been left out of the questionnaire the occupational therapists would feel free to add it to the questionnaire. The occupational therapists however seldom indicated that records had been left out, but used "Other" to clarify why they did not keep the records indicated in the sections on the checklist. Therefore the measurement instruments proved to have content validity as the checklist and questionnaire covered all the forms of records

that are kept by occupational therapists in LSEN schools as well as additional records that were not necessarily kept by the occupational therapists in all the schools.

Findings from the research indicate a number of factors which influence the record keeping at LSEN schools. These include:

- The requirements, or lack thereof, from the Western Cape Education Department with regards to record keeping for therapists and the systems in place to file, store and retrieve records of patients[8] and the specific elements and the type of records required
- The role the occupational therapist plays in the school and the services the occupational therapist provides at the school e.g. individual therapy, group therapy or consultation[30]
- Lack of time for planning and collaboration[30]. Occupational therapists are more concerned with ensuring that learners requiring their services obtain them, rather than ensuring that their record keeping practices which support the learner treatment are in place[11]
- Lack of professionalism amongst occupational therapists working in LSEN schools with regards to record keeping. There are standards that are set by professional bodies such as the HPCSA with regards to professional behaviour and these standards are not maintained in the occupational therapist's record keeping.
- Lack of accountability. There were no occupational therapists appointed as head of department at any of the schools that participated in the study. This lack of management and accountability may have an impact on record keeping. The occupational therapists are generally managed by the principal or deputy principal of the school. These people have very little, if any, knowledge regarding the standards of record keeping expected from health professionals.

5.2 THE ROLE OF THE OCCUPATIONAL THERAPISTS IN LSEN SCHOOLS

The types of occupational therapy clinical records kept at the schools differed as occupational therapists roles varied considerably at the four schools studied. At one school all the occupational therapists concentrated on individual intervention and some group intervention focusing on those learners in Grade R to Grade 4. At another school the occupational therapist's role included crises intervention, initial interviews and placements and previously play therapy had been done with some of the learners. Her main role included occupational therapy intervention on an institutional level for all learners in the school whereas intervention at the third school was divided between individual therapy for those learners following the academic curriculum and vocational rehabilitation for the school leavers. The focus during vocational rehabilitation was on ensuring constant contract work to develop work skills but no other groups for other skills e.g. life skills or hand function were held. Therefore different types of records were kept at the various schools in terms of individual therapy or outcomes of groups and vocational rehabilitation.

The occupational therapists at two of the schools were involved mainly in management roles with very little / no direct therapy either in groups or individually. In one case the occupational therapist was assisting in aspects of social care and nursing as these posts were vacant at the time of the study. In the other school the occupational therapist did have any contact with the learners and did not complete initial assessments or do any form of treatment with the learners or consultation with the educators. She had management and secretarial duties which included assisting with interviews for new staff members, transporting documents to the education department, showing visitors around the school and doing the school's statistics. Therefore records did not reflect occupational therapy intervention at these schools.

Therefore, it would seem that the role of occupational therapists working in LSEN schools is not clearly understood by those that manage the schools or the therapists and they have difficulty in asserting themselves in ensuring that they don't take on roles outside those prescribed by the HPCSA as occupational therapy. As these occupational therapists spent a lot of time on roles either outside

the scope of occupational therapy or on roles that excluded the role of an occupational therapy clinician, this had an impact in this study on the quality of record keeping. The problem was more prevalent in schools were there was only one occupational therapist.

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.

5.3. THE DISTRIBUTION AND TYPE OF RECORDS REQUIRED

The researcher had assumed that records would be kept in the occupational therapy department for each learner in the LSEN School as each learner had been referred to the school due to a learning barrier or special need. It was expected therefore that the occupational therapists would have files for all the learners in their school, as all learners should be receiving or have received occupational therapy intervention, either directly or indirectly.

The question arises whether the occupational therapist should play a role, either directly or indirectly, with all the learners in the school? Should they be involved in the initial interview and what and where should the records regarding the initial interviews be kept? Where and when should all other forms of intervention be routinely recorded? What and where should the records of learners no longer receiving occupational therapy be kept?

It appears that there is no consistency and each school works according to a different format. Records are kept either in the occupational therapy department or a general filing system. This lack of guidance and set policy in terms of record keeping affects the occupational therapists adherence to both the type and distribution of records that need to be kept, resulting in records that are inadequate and insufficient.

The general aspects of record keeping were considered to be important to the occupational therapists and the negative correlation (r=-0.23) indicated that what was being done scored higher than the importance allocated to these procedures. The record keeping processes, in place in two of the schools within the occupational therapy department and in other team members filing systems in the other two schools, achieved a score of 100% for more than half the items assessed under general record keeping.

Legibility and the use of slang/colloquialisms and abbreviations in the records did not prove to be of any concern when the records were reviewed. Only 65% of what was written in the records would be understood by people who are not health professionals as medical terminology or occupational therapy specific jargon was used. Even though 75% of therapists felt it was important that records should be understood by others, it was felt that as these records are confidential and should not be read by others. The occupational therapists write reports for people who are not medically trained regarding learners' progress using language that the person could understand and it is therefore not necessary for the person to have access to clinical records.

Since there were no specifications as to how to evaluate access to records the researcher evaluated the access by the ease with which the occupational therapist working with the records could locate or file the record. The access to the learner's occupational therapy records was evaluated as very good although in one school, where occupational therapists kept their own records, they did not have easy access to other records in the school's general record keeping systems. Some did not know where the general record keeping systems were or how to access them.

More than 86% of occupational therapists did reflect that access to records and good storage facilities were important to ensure that they can find records quickly and efficiently without wasting treatment time. They felt it would also increase their ability to maintain good records.

It would perhaps have been better to evaluate the ease with which an outsider (e.g. the researcher or a new occupational therapist) could locate or file learner records as aspects not identified by the therapists as being problems were found. When records were kept by the individual occupational therapist other team members had difficulty assessing them. The researcher also had to contact each occupational therapist individually in order to gain access to the files.

When files are kept in a filing system in the occupational therapy department it was easy for both the occupational therapists and researcher to access files. However, by not accessing or contributing to the general record kept for each learner and keeping specific clinical occupational therapy records, record keeping may be compromised because information from other team members may not be considered and information may not be shared with other team members. Files kept in general filing system may not be easy to access but have the advantage that all team members have access to all updated information about the learner.

Access to general records was affected by the location of the files as well as the type of filing system used, which in one case was not alphabetical by name. No source documents in terms of class lists were available to use the filing system and this compromised the researcher's access to these records. The advantages of a general filing system are that it reduces unnecessary duplication and it improves communication between team members. The disadvantage is that it is more time consuming to access the learner's records.

Although not listed in the checklist it became apparent that there are problems in only keeping records for learners who are currently receiving direct occupational therapy. In only one school could the occupational therapist provide information on the learner's progress when information is requested in the years following the

occupational therapy intervention. This 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].

The absence of past records makes it 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. 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].

In schools where records for learners that have been discharged from the school were kept there was no system in place for filing these records. They were put into boxes, either alphabetically or randomly resulting in poor accessibility. The confidentiality of these records was also compromised by storing the records next to filing cabinets. Although occupational therapists rated the importance of disposing confidentially of records at 92% this was not achieved in practice. In a future study “knowledge of long term storage procedure” should be added to the checklist.

Good storage facilities were available in three of the schools. However in the fourth school, where each occupational therapist stored the records independently of the other occupational therapists (sometimes in their suitcases to be taken home at the end of the day), which was considered inadequate. Unfortunately there were no criteria in the checklist for measuring confidentiality when records were removed from the school. Therefore the researcher had indicated that the confidentiality with regards to ensuring that only the specific professionals treating the child had access to the records was good. Yet, if the records were taken home at the end of the day, this presents problems with regards to confidentiality as there

is the possibility of the records being lost or stolen. There should have been more specific indications in the checklist of what constitutes good or poor confidentiality. Occupational therapists rated the importance of confidentiality at 96%.

Although 87% of occupational therapist felt the ease with which items within each section of the file could be located was important, this was only true in only 62% of the records. Initially it took the researcher a long time to find the information required for the checklist within the records. After the researcher had gone through several files maintained by the same occupational therapist, it became easier to do so and less time consuming. This depended on the structure of the occupational therapist's recording system (what columns/headings they used in their standard recording forms). This differed from therapist to therapist, but within each therapist's files the format was quite similar.

There is no set format from the Western Cape Education Department as to the format for recording information in learners' files. Many of the files did not seem to have any specific order in which records were stored.

There was also a significant difference between what the occupational therapists thought was important to keep in the records and what was recorded. The results of the questionnaire indicated that occupational therapists feel that virtually all areas of record keeping are "most important to me", yet in most of the sections less than 50% of the information was actually recorded. This may contribute to the occupational therapist's feelings of inadequacy with regards to their record keeping.

When considering the types of clinical records in the LSEN schools the following concerns were raised about specific elements.

5.4. SPECIFIC SERVICES OFFERED AND ELEMENTS WITHIN THE CLINICAL RECORDS

5.4.1. Background information Records

5.4.1.1. Personal Information

Personal information was recorded most often with 55.3% of records being complete and the section in which the occupational therapists indicated that 84.9% of the information was important.

As two of the schools used the general record keeping system other team members recorded the learner's personal information. In those schools where the records were only maintained by the occupational therapist, there was substantially less personal information. The occupational therapists may not have recorded this information because it is kept in the school's general record keeping system and they do not wish do duplicate this information, even though many of the occupational therapists do not have access to the general records.

The aspects that were recorded more than 80% of the time were the learner's name and date of birth, which are important in the assessment of the learner and in determining the expectations of the learner. The gender of the learner was not always explicitly mentioned, but could be deduced from the learner's name and appeared in pronouns such as he and she in the file.

A letter of referral or who the referral came from and why were also commonly recorded, so that feedback could be given to the person who had made the referral. The address and contact numbers were recorded in more than 70% of the learner's files. Information regarding the learner's socio-economic circumstances could be deduced from this and it also makes following-up on the learner easier.

Home language was recorded in more than 65% of the learner's files. This was important in terms of communication and so that suitable arrangements could be made to assist in communication if necessary. If the learner's home language was not English then this information is also important because most standardized tests have been standardized for English speaking learners.

The name of the treating occupational therapist appeared in only 63.2% of the records. In schools where there is only one occupational therapist it may not be necessary to record the name, but if the occupational therapist should leave and there are queries about the intervention carried out, it may be difficult to follow up on this. In some schools therapists treat learners of different ages or the files are kept by the occupational therapist that treats the learner. 20.8% of the occupational therapists felt it is not important to note which occupational therapist treats the learner. However this contravenes legal and procedural practice and the name of the therapist should appear on all reports and assessments[43].

Religious affiliation was noted in more than 40% of the records ensuring that the occupational therapist does not insist on the learner doing something that is not acceptable in their religion. Population group was seldom recorded and along with religion were the records that were deemed to be the least important by the occupational therapists. This may be because of discrimination in the past where occupational therapists do not feel that it is appropriate to classify learners according to religion or population grouping, as this might be interpreted as discrimination.

The grade the learner was only noted 42% of the time. According to the American Occupational Therapy Association, educational outcomes should be set for learners[27], therefore it is expected that the occupational therapists would to be working to achieve an outcome of enabling the learner to obtain the assessment standards of their grade which may not be possible if the grade is not recorded. Even if the occupational therapists were working from the learner's present level of functioning and age norms, there should be focus on grade norms too. Discipline and consequences were only noted where the occupational therapist played a role with regards to the discipline structure of the school which occurred only in one school.

It is of concern that interests, academic results and extra-mural participation were seldom recorded. Although these may not directly affect a learner's assessment and treatment, occupational therapy philosophy requires that the learner be seen

and treated in the context of all activities and environments in which they function. Occupational therapists, however, placed an importance of between 70 and 90% on recording these aspects indicating that they would take them into consideration even though they appeared in only 4-24% of records.

5.4.1.2. Socio-economic Information

The socio-economic information was recorded between 3-51% of the time in the records. Occupational therapists deemed socioeconomic status to be the least important of all information to be recorded and in some cases it was in the school's general records and not specific to the occupational therapy department. With regards to the recording of socioeconomic status, only who the learner lives with, parents' names and contact numbers are recorded more than 50% of the time. Other relevant client history and events in their earlier childhood that have led to their present learning barriers and special needs are recorded less frequently.

As the occupational therapists treat learners in the school setting it appears that they feel that the learner's socio-economic background does not have a great influence on their functioning at school. It is, however, clear in the occupational therapy literature that socio-economic status can have an effect on functioning[43] and it has been shown that learners with a lower socio-economic status have a poorer prognosis in terms of learning disabilities[44]. It may be that the information that the occupational therapists record with regards to personal management is sufficient to guide the therapist's assessment and treatment of the learner.

The lack of concern about the learner's socio-economic status also indicates that there may be little carry-over of what the learner has learnt at school from the occupational therapist to the home environment. If the occupational therapist does not have this information at her disposal then barriers within the learner's home environment cannot be accommodated and home programmes cannot be developed that are specific to the learner's context.

Jirikowic et al pointed out that a movement to provide community-based, family-centred services that minimize service fragmentation and increase service

coordination and continuity of care, challenges therapists to move from a biomedical approach of intervention to a socio-medical context. Thus therapists must take a more active role in building healthy communities[14]. Occupational therapists in LSEN schools, however, have not prioritized this role with regards to community based, family centred services with regards to understanding the importance of this aspect of record keeping.

5.4.1.3. Medical Information

Medical information is also kept in the school's general records, especially if the school nurse maintains the schools general records. The items considered important for the occupational therapists to record correlated to a greater extent (r = 0.59) with what was in their records.

Since the occupational therapists indicated that 90% of the medical history was most important to be recorded, this confirms that many still work within the biomedical model and not in the biopsychosocial or educational model. Even so, only the diagnosis was recorded in more than 60% of the learner's files, with all other aspects appearing less than 30% of the time. The diagnosis does guide the assessment, intervention and prognosis of the learner whereas the other medical information, which may have resulted in the learner's barriers to learning, may not affect the type of assessment or treatment that the occupational therapist will provide for the learner. Pregnancy history and developmental milestones were deemed by the therapists to be the least important medical information which should be recorded which is surprising as delayed developmental milestones are important indicators of possible future problems and causes for the learner's learning barriers and special needs. Allergies and present health status were seldom recorded even though they may have an affect on therapy.

Again, records that would result in a holistic approach to the learner and indicate areas of functioning that may need to be addressed are not kept and not seen as important to keep by the therapists working in the LSEN schools.

5.4.2. Therapy records

The clinical occupational therapy records under consideration are assessments, treatment planning, treatment sessions as well as discharge records. Only 15% of the items under assessments were recorded in the learner's files. This may be because little time is spent in direct therapy with learners in two of the schools.

The occupational therapists at school 4 and school 6 were involved mainly in management roles with very little or no direct therapy either in groups or individually. In school 1 and 7 treatment was either planned according to the referral information (in 17% of files) and pre-admission assessments (in 5% of files), rather than spending time doing a complete assessment of the learner.

The items "Reason for referral to occupational therapy" and "Identifying the level the learner is currently at" were the most important records identified by the occupational therapists that should appear in assessment records as these were used to determine which assessments were required and what the aims of treatment should be. Identifying the level the learner is currently at is important to form a base line for intervention to ensure that the "just right" challenge is given to the learner to prevent wasting valuable therapeutic time[45]. It is also important to identify what is realistic for the learner to be able to achieve with therapeutic intervention.

4.4.2.1. Assessments

The type of assessment used differed from school to school depending on the role of the occupational therapist within the school.

The dates of the assessments were regarded as important to the occupational therapists and were recorded in 34% of the files, whether the assessment was a standardized test, non-standardized assessment or interview. This is important so that comparisons can be made between the learner's initial functioning and present functioning and the length of time between assessments. It also gives an indication as to how often assessments are done and when reassessments need to take place.

Pre-admission assessments were recorded in only 5% of the files. The Western Cape Education Department is moving towards a system where the school does not assess learners prior to admission but the EMDC's do the assessments and placement of learners at appropriate schools. Therefore it is not necessary for the occupational therapist based at the LSEN School to do a pre-admission assessment. If the occupational therapy department at the school already works with a referral system then pre-admission assessments aren't necessary.

Screening assessments had been recorded in 15% learner's files where the learner did not receive occupational therapy treatment but had been assessed. This was used to determine whether learners may require further assessment or not. Only 70% of occupational therapists deemed screening as important. In one school complete assessments are done on all learners before admission to the school, therefore screening of learners within the school was not necessary. In the two other schools the occupational therapists seldom did direct treatment therefore screening of learners was unnecessary, as treatment will not be done for the learners. In school 7 the learners are referred by the teachers to occupational therapy so screening of all learners is not necessary.

Full assessments were rarely done on learners. The assessments that are done were completed in full with forms filled in and interview data recorded. Some form of standardized test was recorded in only 37% of learner's files. Visual perception was assessed in some learners at three of the schools. Other assessments were done depending on the referral or problems observed by the occupational therapist. Visual motor integration, draw a man, sensory profile, work history, emotional intelligence, body image, basic concepts, awareness and insight into disability were assessments that the researcher had not included in the options under type of assessment. These assessments are used to assess abilities that were included in the checklist, but were not specifically mentioned. Items that should be added to the adjusted checklist include: Sensory integration, Work evaluation and Scholastic skills.

Of the assessments that were used "functional assessments" were deemed to be the most important by the occupational therapists. This is in line with one of the definitions of occupational therapy according to The World Federation of Occupational Therapy:

> "Occupational Therapy is a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life"[46].

Recording emotional and behavioural problems was done in most schools.

Interviews appeared to be more important to the therapists than standardized and non-standardized assessments. Interviews with the learner identified by 96% of occupational therapists as important were the source of most assessments and were recorded in 33% of files. Interviews with the educator were considered less important than interviews with the learner or parent.

Recommendation for placement was recorded in 27% of the files. This is more than other items within the assessment section. This is important in schools where the occupational therapist does pre-admission assessments or vocational rehabilitation. In the other schools the occupational therapists may make recommendations in this regard but these are not recorded in the learner's occupational therapy file.

5.4.2.2. Treatment

The Western Cape Education Department requires occupational therapists to assess and record progress of all the learners managed and co-ordinate and control all the intervention strategies[5]. Yet, recording the treatment plan was regarded as one of the less important aspects of record keeping at 82.2**%**. This may be because occupational therapists believe that spending time in direct treatment of the learner is more important than recording the treatment plan and

that due to their experience it is not necessary to record the treatment plan as it is an internal process.

There were no specific treatment plans recorded in any learner's file at any of the schools. The researcher assessed items for the treatment plan by looking at the recording of individual sessions in order to determine which aspects of the treatment plan had been addressed. Even with this accommodation, treatment planning was only recorded in 11% of the files.

The strengths of the client were very seldom recorded. This may be because the strengths are not often used in the reason for referral, assessment and goals of treatment. In the development of IEDP's and in sensory integration treatment, identifying strengths is vitally important in ensuring that the learner's self-esteem is improved. It is also important for determining what activities are to be used and what forms of compensatory methods can be put in place, if necessary. Occupational therapists may make use of the learner's strengths within therapy but do not believe that it is as important to record these strengths.

There were only a few files where a list of problem areas was recorded and annual reports were not always found. According to the occupational therapists the most important aspect of the treatment plan is identifying problem areas. This goes hand in hand with assessment and forms the base of the treatment program. A problem list includes all the learner's problem areas and is used to develop treatment aims. The problem list is more comprehensive than the aims list this may be because the occupational therapist may not aim to treat all the problems but will bring the learner's other problems in consideration during treatment.

Annual reports were recorded in learner's files from the foundation and intermediate phases as it is in these phases where the learners receive direct intervention. In two of the schools the occupational therapist does not do direct intervention therefore they do not write annual reports. Of concern is that these reports were not thought to be as important as other aspects of the treatment plan. This may be because occupational therapists give continual written or verbal

feedback to educators and parents or that they feel that there is no purpose in giving regular feedback as their feedback is not being taken seriously. Many schools require annual reports, but occupational therapists feel that this is unnecessary. There are no guidelines from the Western Cape Education Department as to what information should be included in the annual reports. Although many schools require annual reports, it is up to the occupational therapist to decide on the format of the report and the information that is included in the report.

The recording of goals and objectives was problematic as well as the issuing of assistive equipment. There were goals written in the treatment sessions of those learners that receive direct intervention. But these goals were not written in a way that the success of achieving the occupational performance goals can be measured in educational terms. The occupational therapists may thus not be able to prove their intervention has produced the required result within the school setting. The challenge for occupational therapists is to continue to define what it is that we do, while demonstrating that what we do is effective[13]. Only 67% of occupational therapists indicated that it is important to write goals in educational terms, yet literature indicates that this is vitally important to ensure that occupational therapy is applicable in the school situation. In the past occupational therapy goals for disabled students have been stated in biophysical rather than educational terms; how their attainment relates to the educational progress of a student has not been evident to administrators, teachers and parents[24].

Occupational therapists felt that the recording of objectives and goals was important at 92%. The outcome is often the same for many learners and is usually very broad. Therefore occupational therapists find it repetitive and insignificant in terms of records. Jirikowic et al recommend that occupational therapists need to use outcome measurements as a framework for daily practice to determine the effectiveness of specific interventions and guide clinical decision-making[14]. With the increasing emphasis on inclusive settings, interventions are now an integral part of the total educational program rather than an isolated activity that occurs outside the classroom[24]. Occupational therapy intervention must be designed to

develop skills necessary for academic learning and vocational training within the learner's current and future educational settings[26].

Provision and adaptation of equipment was deemed to be important to record. This is important to ensure that equipment and resources are not wasted and that in the future the same adaptations can be made without having to reinvent the wheel.

There was no recording of home programs or surveys of user satisfaction. Occupational therapists may believe that home programs and contributing to IEDP's, which form part of the treatment plan, are not as effective as direct intervention. This is concerning as according to literature the role of the occupational therapist needs to change. Therapists must be responsive to new practice demands including increased accountability, changes in contemporary practices and service models and ongoing implementation of family-centred services. Professional attitudes, skills and strategies necessary to meet these demands include the ability to conduct, interpret and incorporate research into practice[14]. It appears from the occupational therapists' record keeping that they do not yet possess these skills.

User satisfaction was not regarded as important by any of the occupational therapists. This may be because the occupational therapists feel that they are the professional. This is in line with a medical model of thinking. Surveys may ask parents, students and staff for their opinions on the occupational therapy intervention. These surveys show where priorities differ between administrators, parents and students[31]. To be effective the occupational therapist needs to identify and respond to the teacher and parent's needs that are within the therapists' specific area of expertise[24].

The treatment sessions section had the highest correlation between what was recorded and the occupational therapists view of what was important to record ($r = 0.62$) although treatment sessions was one of the less important sections according to the occupational therapists with only 81% of the items being considered to be important. Yet treatment sessions were recorded more often than

the treatment plans. This may be because it is a retrospective view of what did happen and how the learner reacted to the intervention. This is important for writing reports and informing other team members. The occupational therapist might feel that writing the treatment plan is wasting time, as it might not be possible to implement treatment as planned. Occupational therapists are more concerned with ensuring that learners requiring services obtain them, rather than ensuring the record keeping practices supporting learner treatments are in place[11]. By looking at the treatment sessions the researcher could observe that there was progression within the treatment sessions and that they were planned.

The occupational therapists believed that it was important to note the date of sessions. The date of the session and number of sessions recorded per year were the items that were most often recorded as both these items were calculated from the dates in the file. This does not necessarily reflect the actual number of treatment sessions done as some may not have been recorded.

The time and duration of the session was seldom recorded and was not thought to be important. This may be because the occupational therapists see the learners according to a time-table which is not flexible once it has been set up. The sessions are usually approximately the same length for all learners therefore it would not be necessary to repeat this information for all learners and for every session. Thus the largest discrepancy occurred between the records recorded and the occupational therapist's view of their importance for the time and duration of session as well as group sessions and ongoing re-evaluations. Re-evaluations completed in the treatment sessions did not reflect the use of standardized and non-standardized tests but a description of the performance of activities. This indicates that the occupational therapists make use of very distinct “assessment” and “treatment” sessions and seldom combine the two.

Individual sessions were regarded as more important to record (92%) and were recorded more regularly than group sessions which were only done in one school and were recorded in 9% of records. There is no indication that they were recorded elsewhere other than the learners' files. Most occupational therapists recorded the

outcome of the session, focusing on goals of the session, behaviour of the learner, activities and performance of activities. Recording the behaviour of the learner during the sessions and the outcome of the sessions was thought to be more important to the occupational therapists than recording the activities used and the performance of individual activities. Recording the outcome of the session is important to indicate that the learner is progressing as planned by the occupational therapist.

The occupational therapists believed that it is more important to record direct intervention than consultations and indirect interventions. This is true for when patient records are required as a legal document in cases of professional litigation. Yet, it may be difficult to prove that occupational therapists have a role to play in schools if consultations and indirect interventions are not recorded. The absence of these records makes it difficult for practitioners to prove that they provided appropriate care should they be asked to do so in a professional or legal hearing[11].

5.4.2.3. Consultations

Although the view of the learner was recorded, this was often part of the assessment process and not during treatment. The learners' personal aims were only recorded in 5% of the files. Discrepancies between learner's performance, their own, other's and the teacher's expectations were seldom recorded. This may be an indication that the occupational therapist is not working together with the teacher. The teacher's expectations are important if the occupational therapist fulfils a consultation role and is making use of educational outcomes.

The recording of teacher's expectations was also not deemed to be very important by the therapists at 79**%**. As the occupational therapists work in school settings the researcher found this concerning because in a school setting the focus should be on education and the teacher's expectations. The teacher is part of the team who works with the learner and is a professional person that is trained to identify learning barriers and is the person who usually refers the learner for intervention. Therefore it would be assumed that the teacher would have valuable information that could be used to guide the assessment and treatment of the therapist.

Consultations and indirect interventions were not recorded often, this may be because consultations and indirect interventions are often not pre-planned and happen as the need arises. The occupational therapist may therefore not record this as intervention even though it had taken place.

Collaboration with other professionals was evident within the learner's files. This was mainly with regards to requesting information, giving information, case discussions and referring the client to other team members. Case discussions took place in two of the schools either as regular case discussions or during crisis situations. This aspect was also found to be very important to the occupational therapists at 88%. This may be due to the move from direct one-to-one therapy to a role of consultant due to lack of time and resources. It is also in line with contextually relevant approaches described by Engelbrecht who challenges occupational therapists to move away from curative problem-orientated approaches within the South African context and to extend the nature of their professional activities[29].

5.4.2.4. Discharge

Discharge information was the section with the second lowest recorded number of items (0% to 26%) included in the files of learners who had been discharged from the school. None of the occupational therapy departments kept files for those learners who were no longer receiving occupational therapy intervention, but were still attending the school. Therefore discharge information for learners that had been discharged from occupational therapy intervention but not discharged from the school could not be assessed.

The occupational therapists viewed recording the reason for discontinuing occupational therapy and the learner's status at the end of occupational therapy intervention and discharge from the school as important at 88% and 87%. A discharge report which was in the form of a work assessment report, focussing on the learner's functional and social status was written for all the learners discharged from the vocational rehabilitation unit in one school. This was the only school that had written discharge reports. "Details of placement" was recorded by one other school if a learner had left.

In a few cases there was evidence that the occupational therapist had followed up after the learner's discharge from the school. Follow-up information after the learner has left school was not seen as important by therapists. This is concerning as the outcome for occupational therapy at the end of a learner's schooling career should be to prevent disability, improve health and to fulfil the person's needs by achieving optimum function and independence in work, social and domestic environment[46]. If the occupational therapist does not record follow-up after discharge from school then they will be unable to assess whether the above was achieved.

Changes between the initial and current status of functional abilities was the most important item to record for the occupational therapists yet there were no records for changes between initial and current status of ability. This is significant, because in order to have evidence based practice occupational therapists need to be able to prove that what they are doing has an effect on the learner's functioning. In order to do this, initial and ongoing assessments need to be done. At present it is impossible to prove that the learner benefited from occupational therapy in any way as these records are not maintained.

There were also no discharge plans. The occupational therapist's role is to integrate the learner in the community so there should be some plan for how the occupational therapist plans to do so. A discharge plan and discharge reports were not seen to be as important as recording the change between the initial and current status of functional abilities. In vocational rehabilitation a discharge plan and discharge reports may be very important, but only one occupational therapist in the sample group did vocational rehabilitation which may have influenced the results.

Record keeping serves many functions, but primarily it serves to support patient care[7]. 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].

The absence of records makes it difficult for practitioners to prove that they provided appropriate care should they be asked to do so in a professional or legal hearing[11] and demonstrate the use of valid and reliable measures and the effectiveness of therapy services to third party payers[14] e.g. education department. It hampers audits of professional competence and clinical training[11]. There might be an increase in the cost of care through the repetition of procedures[8] if the occupational therapist does not realise that the client has already received intervention for a specific problem and that a different treatment approach would be beneficial.

Neal et al encourage occupational therapists to increase their involvement in multiple areas and levels of support[26]. This will include indirect interventions and providing consultation. Occupational therapists may see learners less frequently to monitor progress, develop home and class programs or issue equipment[14]. Therefore, although some learners may not require direct occupational therapy intervention, the above interventions should also be recorded.

Occupational therapists in LSEN schools usually provide direct intervention for younger learners. Therefore there were more files kept for learners in the foundation phase than in the other phases. Yet they may be involved in consultation and placement of older learners.

5.5. LIMITATIONS OF THE STUDY

Only one occupational therapist was included in the pilot study. This resulted in limited critique on the data collection tools and may be a limiting factor with respect to the results.

The study was limited by a small sample size. Only four of the seven schools that were approached participated in the research. Three of the schools that participated had fewer than five subgroups as they either did not have a Further Education and Training (FET) phase i.e. Grade 10, 11 and 12, a skills section or they did not store discharged learner's files.

The occupational therapy departments did not keep files for each learner in the school but only for those learners receiving occupational therapy intervention at the time of the study. None of the schools maintained records for learners that were discharged from occupational therapy intervention but were still attending school.

The study was aimed at occupational therapy records specifically, but the researcher had to make use of the general record keeping system in two of the schools as the occupational therapists did not maintain their own specific records.

There were no specific treatment plans in any of the learners' files. The researcher therefore assessed items for the treatment plan by looking at the recording of individual sessions in order to determine which aspects of the treatment plan had been addressed.

Certain items on the checklist caused confusion for the occupational therapists:

- The occupational therapist's responses indicated that they were not aware of the differences between outcomes, goals and objectives.
- The item "Use of slang / colloquialisms" in the General section

The amount of sessions per year had to be calculated by the researcher from the number of sessions that were recorded in the learner's file.

5.6. SUMMARY

Many of the items on the checklist were performed by the occupational therapists as part of their assessment and treatment, but the information was not recorded in the learner's occupational therapy file e.g. the occupational therapists may have

assisted with the IEDP of a learner, but the educator recorded this information in the learner's profile. Therefore there was no record of this assistance in the learner's file in the occupational therapy department. So the quality of the record keeping may not be a true reflection of the quality of intervention and assistance provided by the occupational therapist.

After comparing what the occupational therapists thought was important and what information was recorded most within each section the researcher developed an adjusted checklist (Appendix H). This checklist can be used by occupational therapists as a guide as to what is important in maintaining a record keeping system and what information to keep in the learners' files in an LSEN school.

Those items that the occupational therapists thought were most important and were recorded most often in the learners' files were included in the adjusted checklist. These items include:

- Background information: name, date of birth, gender, referred by whom to the LSEN 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 and developmental milestones.
- 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 occupational therapy, identifying the level the learner is currently at.
- Treatment plan: direct intervention, interventions clearly and logically outlined, the view of the client, collaboration with other professionals and consultation.
- Treatment sessions: date of session, individual sessions, behaviour during session, activities used during the session, performance of activities, outcome of session and attendance.
- Discharge information: reason for leaving school / occupational therapy, functional status, social status and discharge report.

- General: explaining abbreviations the first time they are used, confidential storage, ease with which to locate and file patient records, good storage facilities, disposed confidentially, legible handwriting, ease with which to locate items in a file.

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 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 checklist as optional.

These items include:

- 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, standardized tests, assessment of gross motor abilities, fine motor abilities, speech and language, sensory awareness, perception, cognition, interview with referring teacher, interview with parents, identifying obstacles, assessment of sensory integration, work, scholastic skills.
- Treatment plan: problem areas identified, strengths identified, outcome of treatment, goals, objectives, client's knowledge and agreement of goals, time scales and review dates, clients personal aims, reason for goals not being obtained, progress records, annual reports, provision and adaptation of equipment, equipment used and indirect intervention.
- Treatment sessions: group sessions, session aims and ongoing re-evaluations.
- Discharge information: details of placement, follow-up information, physical status, psychological status, changes between initial and current status of functioning and discharge plan.

The teacher's expectations were regarded as important by the occupational therapists, but were not recorded in any of the learner's files. According to

literature this item is very important therefore it should be included in the adjusted checklist as optional.

Some items were not considered important to the occupational therapists and were seldom recorded. These items include: are goals written in educational terms, user satisfaction surveys, home programs and contribution to the IEDP. Yet according to literature these items are important to the changing role of therapists within schools. Therefore they should be included in the adjusted checklist as optional.

The items that were considered to be the least important by the occupational therapists and were recorded the least in the learners' files were excluded from the adjusted checklist.

These items include:

- Background information: religion, population group
- Socio-economic information: sibling information, information regarding grants
- Medical information: pregnancy history, operations, illnesses, allergies
- Assessment: discrepancies between the learner's performance and other's expectations
- Treatment plan: are goals broader than objectives?
- Treatment sessions: time and duration of sessions
- Discharge information: deficits with regards to performance areas and components
- General: Although the item "Can the records be understood by people who are not health professionals" was thought to be important by the occupational therapists, it is not necessary to include it in the checklist as these records should be confidential and lay persons should not be reading them.

In the adjusted checklist no distinction should be made between discharge from occupational therapy and discharge from school as the same information was recorded for both of these sections.

The “General” section should be made the first section of the adjusted checklist as it was considered to be the most important section by the occupational therapists.