Assessment of record keeping at schools for learners with special educational needs in the Western Cape

Renee Rischmüller, MSc (OT)
Postgraduate Student, Department of Occupational Therapy, Faculty of Health Sciences, University of the Witwatersrand.

Denise Franzsen, MSc (OT)
Lecturer, Department of Occupational Therapy, Faculty of Health Sciences, University of the Witwatersrand

ABSTRACT

This study investigated occupational therapy record keeping at schools for learners with special educational needs (LSEN). A review of the records in the form of an audit on 76 occupational therapy files at four LSEN schools was completed using a checklist designed for the purpose of the research. Except for the general section on record keeping in the audit most of the information on the checklist was recorded less than 50% of the time in the learners' files. A number of factors including the roles and expectations of occupational therapists at the schools and a lack of clear guidelines from the Western Cape Education Department as to what should be recorded were found to influence record keeping. The quality of record keeping in terms of access, storage and retrieval was also considered. A redesigned checklist was drawn up to assist occupational therapists at LSEN schools to audit their records and to use as a guideline for improving the quality of the record keeping.

Key words: LSEN Schools, Record keeping, Checklist, Audit

Introduction

Democracy in South Africa resulted in changes within the education context with the introduction of policies that set out to create a single system of education for all learners. This plan for inclusive education, to be achieved within a twenty-year period was launched in July 2001[1]. However in their report on inclusive education in South Africa in 2007, Wildman and Nomdo indicated that the implementation has been delayed by a number of factors[2]. These factors include cost, lack of specialists to support teachers at mainstream schools and the delay in the development of district based support teams envisaged in the Education White Paper 6[1].

To overcome some of these problems the Western Cape Provincial Education Department proposed that the district-based support teams, which include therapists working in educational

settings, be co-ordinated by the already developed Education Management and Development Centres (EMDCs)[3]. The occupational therapists were to form part of these district-based support teams, in which they will be expected to provide "direct interventionist programmes to learners in a range of settings, and/or, serve as 'consultant-mentors' to school management teams, classroom educators and school governing bodies"[1:41].

However, only a range of competencies for the district based team has been defined by the Western Cape Department of Education[3] and the need for clarity on the roles and functions of therapists and others offering support to students with special educational needs, has been listed as a priority. The Western Cape Department of Education, in collaboration with the EMDCs, is developing these job descriptions as research on the role of the therapists in education support services has indicated a need for this[3].

The Education Labour Relations Council (ELRC) of the National Department of Education finalised performance standards for therapists in educational settings, in the Collective Agreement No 4 of 2005 - Integrated Quality Management System (IQMS) for School-Based Education Therapists and Psychologists[4]. This document which defines therapists working in the education department as "Educational Therapists" was intended to guide individual developmental appraisal and performance measurement for promotion of the therapists in educational settings. The evaluation instrument has two parts, one for the observation of the therapists in practice and the other for aspects that fall outside of the therapy room.

This evaluation, in line with international research, indicates that the role of the occupational therapists in educational settings is to ensure that the education of learners is promoted through engaging the learner with special needs in therapy in all occupational performance areas. This includes productivity in the academic and educational aspects, personal management as well as leisure by organising extra-curricular and co-curricular activities[5]. At present the two primary therapy roles of occupational therapists working in schools are assessment and intervention[6]. They perform initial and ongoing assessments, develop and modify adaptations to the context of the classroom and presentation of material as well as providing occupational therapy intervention to learners who qualify for these services[7]. They are also required to review and record the learners' developmental progress to make necessary changes to the intervention strategies. The development, recording, monitoring and evaluation of home programmes to support a carry-over of skills learnt in therapy to the home is also part of their responsibilities[5].

Occupational and other educational therapists are also to be evaluated in terms of aspects that fall outside of the therapy room such as aspects of professional development, contribution to the school, extracurricular involvement and other management skills. Record keeping has been identified as one of the therapy and management aspects for evaluation in the IQMS[4]. Kamens[8] indicated that in order to satisfy just the minimum expectations of the IQMS essential records, containing evidence of treatment planning and learner progress should be available. It is also necessary to have some evidence of the modification of the therapeutic intervention strategies based on assessment results[8]. This aspect is to be evaluated under learner assessment and development and administration of resources and records[4].

The professional responsibility of keeping adequate records is further emphasised by the Guidelines on Keeping of Patient Records Published by the Health Professions Council of South Africa (HPCSA) which indicates that records should include the learner's demographics, grade, test scores and attendance at therapy[9]. It is a requirement that occupational therapists working in educational settings keep detailed records on each learner attending occupational therapy at the LSEN school as well as on learners who attend therapy from surrounding mainstream schools[10]. Additional information on curricular and extracurricular program participation and discipline should also be included. Information indicating the learner's ability related to change in function (improvement, maintenance or regression) as a result of occupational therapy intervention should form an essential part of the records[11]. While it is not necessary for therapy sessions to be written out, planning of the therapy sessions must be clearly recorded[4]. This data must be recorded regularly for it to be useful in decision-making[10].

Record keeping is, therefore, an essential aspect of a therapy service and also serves many functions other than just supporting client care with a chronological profile of the learner's condition. In view of the proposed extended role of occupational therapists to 'consultant-mentors' records should also facilitate communication among professionals who contribute to the learner's care and provide an objective basis for determining the appropriateness, effectiveness and necessity of a comprehensive therapeutic intervention[12]. In addition parent, learner and staff surveys evaluating the effectiveness of occupational therapy intervention are also important[11]. Access to health information in the records is important for decision-making and strengthening management. When records are not maintained it is difficult to determine the impact of interventions or define the quality of the service provided[13].

Adequate record keeping also includes aspects such as filing, storing and retrieving records[9]. The retrieval of records is important for evaluating quality of care, preventing repetition of procedures, appropriate allocation and utilisation of resources, audits of professional competence, clinical training and the development of national health information systems[13,14]. It is a professional's duty and responsibility to maintain records and improve methods of record keeping as these records may be needed in litigation cases or for clinical research[12]. According to the HPCSA records should be stored in a safe place for at least six years, and in the case of children until they are 25 years old[9].

Jirikowic et al[15] and Engelbrecht[16] however point out that many school-based occupational therapists are faced with challenges such as: limited space, equipment and budgets, high caseloads. This results in limited time to provide direct services as well as inconsistent expectations regarding the responsibilities of occupational therapists in educational settings[15,16]. Record keeping, which is labour intensive and time consuming, is therefore often not seen as a priority for these therapists who are more concerned with learner treatment services[13].

Although therapists working in educational settings in the Western Cape are being evaluated according to the IQMS[4] the requirements for the records they need to keep have not been clarified. The IQMS only indicates that performance records should be easily accessed in order to provide insights into individual learner's progress. Furthermore, it indicates that record keeping must be comprehensive and up to date as well as meeting requirements in terms of accepted practices and/or departmental requirements[4]. The Western Cape Education Department has not provided guidelines for what should be included in the records against which the quality of those kept by occupational therapy records can be evaluated[5].

The objective of the current study was therefore to develop a checklist to audit clinical occupational therapy records at LSEN schools and then to audit and evaluate the records kept by occupational therapists in such schools. The factors affecting the quality of the records were also assessed by observation and interview with occupational therapists at the schools.

Method

A record checklist for use by occupational therapists in LSEN schools was developed. This was based on the literature, the requirements of the education department[5] and the legal requirements[9] related to keeping records. The checklist was deemed suitable for evaluating existing clinical occupational therapy records in LSEN schools.

The following eight sections, each with a number of items in them, were included in the final checklist: personal information, socio-economic data, medical history, treatment plan, treatment sessions, and discharge information[17] (see *Table 1*).

Table 1: Checklist for Record Audit

	1 Personal Information	**Recorded**	**Not Recorded**
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**		
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		
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		

...*continued on page 16*

Table 1: Checklist for Record Audit *...continued from page 15*

		Recorded	Not Recorded
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**		
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:		

A pilot study to check the content validity of the checklist consisted of auditing 20 learners' files at a LSEN school and eliciting the opinion of an experienced occupational therapist working at the same school was carried out. This led to the addition of a general section in which the quality of the record was evaluated and covered aspects such as the use of slang and colloquialisms and abbreviations/acronyms, maintenance of confidentiality, filing system used, ease with which the record could be located, storage facilities and the disposal methods for old records. Each record was also judged for it's clarity and whether it was understandable to others who might not have had medical training, but might need to access the information in the records[18].

Once the checklist was finalised a study to investigate several characteristics of the occupational therapy records in LSEN schools in the Western Cape was completed. A quantitative descriptive cross sectional research design with a retrospective record review was used. After ethical clearance was received from the Human Research Ethics Committee at the University of the Witwatersrand, permission to conduct the research to review the records was obtained from the Western Cape Education Department, the headmasters and the occupational therapists at the schools.

Seven of the 87 LSEN schools in the Western Cape, were selected using stratified sampling with the help of a statistician. The criteria for the selection of the schools considered in the stratified sampling included:

- the availability of an occupational therapy service.
- the EMDC in which the school is situated.
- the number of therapists employed by/ associated with the school.
- the type of learners varying from individuals with learning disabilities, visual impairments and intellectual impairments to young offenders.
- the presence of learners from higher and lower income homes.
- the presence of learners from rural and urban geographical areas.

Only four of the seven schools selected could be included in the research. At the other three schools, records could not be accessed as at two of the schools the necessary permission from either the headmaster or the occupational therapists could not be obtained. The third school no longer employed an occupational therapist.

Stratified simple random sampling was used in order to identify which learners' records would be evaluated. Five learners' records from each of the following sub-groups: foundation phase, intermediate phase, senior phase, further education and training (FET) phase and previous student records, were selected. Not all schools provided services for all the sub-groups and in some of the sub-groups there were less than five records. The number of records audited was 76 and the number at the various schools ranged from nine to 29.

Observations of the types of record storage, areas in which records were stored and access to records were made at each school. Confidentiality was ensured as in all data collection only codes were used to identify records and schools. Information on services offered by the occupational therapists at each school and their roles in the school were all ascertained through an interview with the therapists.

The results from the checklist were analysed using descriptive statistics to determine the percentage in the type and the quality of the records kept. Summative content analysis was used to review the roles and responsibilities of the occupational therapists at the different schools[19].

Results

Schools

The roles the occupational therapists played and the services they offered at the four schools in the study, differed. One of the four schools was a private school for learners from Grade R to Grade 7, where three occupational therapists in private practice provided individual and group therapy in the foundation and intermediate phases. A second school catered primarily for learners with visual impairments from Grade R to Grade 12. This school offered an academic curriculum and a skills curriculum. The two occupational therapists employed by the school provided individual and group intervention to the foundation phase learners and vocational rehabilitation to the learners in the senior and skill phases.

The other two schools consisted of a youth and education centre for learners convicted of a variety of crimes and a training centre in which the learners were offered a variety of academic and skills curricula. Each of these schools employed one occupational therapist but neither of them provided individual therapy as they were involved in management roles, intervention on an institutional level for all learners in the school, crises intervention as well as initial interviews and placements. The occupational therapist at one school did not maintain her own records but relied on the records kept by the school nurse.

Record Audit

The audit of the records indicated that none of the sections included in the checklist achieved a 100% in terms of the number of times the items in them were recorded (see *Figure 1*).

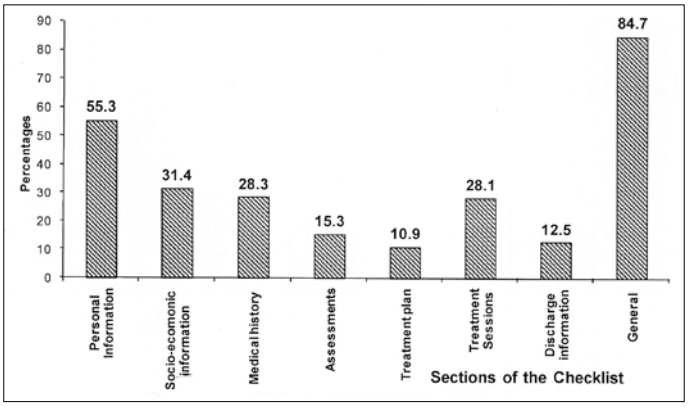

Figure 1: Percentage of information found in the records and entered into each section of the checklist

The only section that scored above 60% was general record keeping where all aspects scored 100% except for the items - 'Use of abbreviations' (88.2%), 'Good storage facilities' (75%), 'Disposed of confidentially' (73.7%), 'Is it easy to locate items within the records of each section' (61.8%) and 'Would records be understood by people who are not health professionals?' (61.8%).

With the exception of personal information, less than 50% of the information of the other sections were included in the records. The only aspect under personal information that scored 100% was the learners' name (see *Table 2*).

Table 2: Detailed breakdown of items recorded under personal Information

Detail Recorded	Percentage of time recorded
Name	100%
Date of birth	97.4%
Gender	82.9%
Referred by whom to LSEN school	80.3%
Address	77.6%
Reason for referral to LSEN school	76.3%
Emergency information / contact numbers	67.1%
Home language	65.8%
Name of occupational therapist	63.2%
Religion	43.4%
Grade / phase	42.1%
Discipline and consequences	27.6%
Population group	25%
Interests	23.7%
Academic results at the end of each grade / phase	7.9%
Extra-mural participation	3.9%

For all other sections the average percentage score for items recorded fell below 31%. Only two items, 'Diagnosis' and 'Who the learner lives with' scored above 50%. Three items scored above 40% with items relating to the teachers' expectations, therapy goals related to educational outcomes, physical and psychological discharge status and satisfaction with home programmes all scoring 0%.

The types of occupational therapy clinical records kept at the schools differed in terms of individual therapy or groups and vocational rehabilitation. The occupational therapists involved mainly in management roles offered very little or no direct therapy and therefore their records did not reflect occupational therapy intervention.

Other than the lack of consistency in what is recorded there are also differences in where records are kept as each school works according to a different format. Records are kept either in the occupational therapy department or in a general filing system. Good storage facilities were available in three of the schools. However in the fourth school, where each occupational therapist stored her own records independently of the other occupational therapists (sometimes in their suitcases to be taken home at the end of the day), storage facilities were considered inadequate.

In 50% of the schools the records were kept in the occupational therapy department and the access to records was scored as good in all schools. Only current records for learners receiving direct occupational therapy are kept at three of the schools. In schools where records for learners that have been discharged 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.

Discussion

Despite the limitation resulting from a 42.9% loss of schools from the selected sample there was diversity within the schools used for the study which represented diverse geographical areas and socio-economic groupings. There were also differences in the roles of the occupational therapists, the type and amount of therapy offered as well as the type of learners. It is of concern that occupational therapists at all of the schools were hesitant to participate and at one of the schools the therapists refused permission for the study because they had not yet developed a record keeping system.

It would appear that even with no access to guidelines for record keeping from the Western Cape Department of Education, occupational therapists were not even meeting the general requirements set out by the HPCSA and IQMS in their record keeping[4,9]. Many of the items on the checklist (*Table 1*) which form part of any occupational therapy service were not recorded in the learner's occupational therapy file.

Occupational therapists' adherence to both the type and distribution of records that need to be kept resulted in records that were inadequate and insufficient. Therapists were maintaining records in which information in most sections is reflected between 10% and 30% of the time (*Figure 1*). This related to an unacceptable level of performance and one which did not meet minimum expectations according the IQMS. This requires urgent intervention and support according to the performance assessment levels[4].

Some of the standards for professional and ethical record keeping set by the HPCSA were not maintained in the records audited in this study[9]. Although most records were stored in a safe place, they only included personal (identifying) particulars of the patient on average 55% of the time. The assessment and treatment sessions were reflected less than 30% of the time even though HPCSA requirements are that the time, date and place of every consultation and the assessment of the patient's condition be recorded 100% of the time. Guidelines from the HPCSA for good practice indicate that records should be kept for each learner in the LSEN school as each learner had been referred to the school due to a learning barrier or special need[9]. 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. Since this was not the case the questions that arose for further consideration were:

- whether the occupational therapist should play a role, either directly or indirectly, with all the learners in the school?
- should occupational therapist be involved in the initial interview and what and where should the records be kept?
- where should occupational therapy records 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?
- should the occupational therapists keep their own individual records for each learner?
- should occupational therapists also record some information in general files kept elsewhere in the school?

When learners' records were kept in a filing system in the occupational therapy department it was easy for both the occupational therapists and researcher to access files. Files kept in general filing system may not be easy to access but had the advantage that they

were easily accessible to all team members reducing unnecessary duplication and improving communication between team members. The general filing system does however make it difficult for therapists to maintain and to update specific occupational therapy information. Educational Development Plans (IEDP) of learners, which are recorded by the educator also have no description of occupational therapy intervention. This makes it difficult to quantify the service and benefit of occupational therapy within a given school as the record keeping may not be a true reflection of the quality of intervention and assistance provided by the occupational therapist.

No commitment to the provision of a system for the filing, storage and retrieval of learner records was seen in any of the schools. In only one school was the occupational therapist able to provide information on learners discharged from therapy. This leads to an inability to prove that occupational therapy intervention has led to an improvement in a learner's academic progress. It also compromises opportunities for clinical research[15] and hampers evidence-based practice as the absence of past records makes it difficult for practitioners to demonstrate the use of valid and reliable measures and the effectiveness of their therapy services to the learners' family, colleagues at the school and their employer[6] like the Department of Education. It also hampers audits of professional competence and clinical training[17]. There is also an increase in the cost of care through repetition of procedures and undergraduate students are exposed to poor record keeping practices[14].

Poor record keeping may have been influenced by a lack of management and accountability as none of the schools had a therapist appointed as the head of department. It was also clear that expectations of the services offered by the occupational therapists in the schools did not allow time for planning, collaboration and adequate completion of administrative duties[20]. In many cases therapists were required to do administrative work at home. This may affect the confidentiality of records. It seemed that the role of occupational therapists working in LSEN schools was not clearly understood by those that manage the schools and the therapists had difficulty in asserting themselves in ensuring that they do not take on roles outside those prescribed by the HPCSA as occupational therapy. These occupational therapists spent a lot of time on performing roles outside the scope of occupational therapy[21] and this had an impact in this study on the quality of record keeping. The problem was more prevalent in schools where there was only one occupational therapist.

The occupational therapists taking part in this research project indicated that they would benefit from a checklist covering the information which is required in a learner's file in order help them to review their own record keeping. Therefore an adjusted checklist (*Table 3* on page 19) that could be used by occupational therapists working in schools was designed. This checklist provides them with the information that it is compulsory to record in each learner's file as well as the information that would be beneficial to the occupational therapy intervention process but that is not compulsory.

By categorising some items as compulsory and others as optional the checklist should facilitate the audit of the quality of occupational therapy record keeping in LSEN schools. It ensures that all the necessary information is kept, yet still remains flexible enough to enable the occupational therapist to maintain records that are applicable to the schools unique circumstances.

Recommendations

It is recommended that occupational therapists evaluate their own records annually using the adjusted checklist to ensure that they include all the necessary information regarding the learner and the optional information that is appropriate to their context. The checklist can be used to ensure that in the future, record keeping requirements are appropriate in terms of the job description of therapists offering a service to LSEN schools and it can be used as a guideline to monitor and maintain the quality of occupational therapy records.

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. The confidentiality of the older records was also compromised as they were stored in boxes next to filing cabinets. Protocols need to be developed in this regard. Although occupational therapists rated the importance of disposing confidentially of records at 92% this was not achieved in practice and "knowledge of long term storage procedure" should be added to the checklist.

Although the use of computer-based records is a recommendation as the quantity of information being stored in computer-based records is often better than when using paper based records[22] in the research sample only one occupational therapist had access to a computer. Therefore none of the schools could make use of computer-based record keeping systems at the time.

The quality assurance of clinical records could be included in the audits of clinical occupational therapists working for the Western Cape Education Department when they participate annually in the IQMS[4]. Randomly selected learner records could be reviewed by a peer and a superior to evaluate the quality of the records and the therapy. This may be a more objective manner of assessing the occupational therapists' performance than viewing one treatment session performed by the occupational therapist, the system used presently.

Conclusion

Incomplete and non-existing records influence the quality 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.

The quantity and focus of record keeping of the various schools depend to a certain extent on the role that the occupational therapist plays within the school. As these roles differed greatly from school to school further research is required to determine what roles occupational therapists play in LSEN schools in the South African context. 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[21] has been made clear in the results of the current study.

The checklist developed in this study can be used to ensure that future record keeping requirements in terms of the job description of education-based occupational therapists in LSEN schools, is appropriate. The checklist can also be used as a guideline by the therapists themselves to monitor and maintain the quality of their records.

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Table 3: Checklist indicating essential and optional aspects for records in LESN Schools

Essential		**Optional**	
1. General record keeping processes			
1.1. Confidential storage			
1.2. Easy to locate and file learner files			
1.3. Easy to locate items within learner files			
1.4. Legible handwriting			
1.5. Disposed confidentially			
1.6. Explain abbreviations in full the first time they are used			
2. Personal information			
2.1. Name		2.10 Grade	
2.2. Date of birth		2.11 Academic results	
2.3. Gender		2.12 Interests	
2.4. Referred by whom to the LSEN School		2.13 Extra-mural participation	
2.5. Reason for referral		2.14 Discipline	
2.6. Home language			
2.7. Address			
2.8. Emergency contact numbers			
2.9. Name of Occupational Therapist			
3. Socio-economic information			
3.1. Information on who the learner lives with		3.2 Parent information	
		3.3 Relevant client history	
		3.4 Type of dwelling	
		3.5 Information about primary care giver	
4. Medical history			
4.1. Diagnosis		4.2 Pregnancy history	
		4.3 Birth history	
		4.4 Developmental milestones	
		4.5 Operations	
		4.6 Illnesses	
		4.7 Present health status	
		4.8 Onset of diagnosis	
		4.9 Allergies	
5. Assessments			
5.1. Referral information to occupational therapy		5.9. Pre-admission assessments	
5.2. Dates of assessments		5.10 Screening	
5.3. Interviews with learner		5.11 Outlining corresponding problems	

...continued on page 20

Table 3: Checklist indicating essential and optional aspects for records in LESN Schools *...continued from page 19*

Essential		**Optional**	
5. Assessments .... continued			
5.4. Assessment of emotional / behavioural problems		5.12 Standardised tests	
5.5. Functional assessment		5.13 Assessment of gross motor abilities	
5.6. Identifying the level the learner is currently at		5.14 Assessment of fine motor abilities	
5.7. Recording assessments used fully		5.15 Assessment of speech and language	
5.8. Recommendations regarding placement		5.16 Assessment of sensory awareness	
		5.17 Assessment of perception	
		5.18 Assessment of cognition	
		5.19 Assessment of sensory integration	
		5.20 Assessment of work	
		5.21 Assessment of scholastic skills	
		5.22 Interview with teacher	
		5.23 Interview with parents	
		5.24 Identifying obstacles	
		5.25 Teacher's expectations	
6. Treatment planning			
6.1. Direct intervention		6.6. Problem areas identified	
6.2. Interventions clearly and logically outlined		6.7. Strengths identified	
6.3. The view of the learner		6.8. Outcomes	
6.4. Collaboration with other professionals		6.9. Goals	
6.5. Consultation		6.10 Objectives	
		6.11 Learner's knowledge and agreement of goals	
		6.12 Time scales and review dates	
		6.13 Learner's personal aims	
		6.14 Outcome of treatment	
		6.15 Reason for goals not being obtained	
		6.16 Outcomes correspond with goals	
		6.17 Progress records	
		6.18 Annual reports	
		6.19 Provision and adaptation of equipment	
		6.20 Equipment used in therapy	
		6.21 Indirect intervention	
		6.22 Goals written in educational terms	
		6.23 User satisfaction surveys	
		6.24 Home programs	
		6.25 Contribution to the IEDP	
7. Treatment sessions			
7.1. Date of session		7.7. Attendance	
7.2. Individual sessions		7.8. Group sessions	
7.3. Behaviour during sessions		7.9. Session aims	
7.4. Activities used		7.10. Ongoing re-evaluations	
7.5. Performance of activities			
7.6. Outcome of session			
8. Discharge information			
8.1. Reason for leaving school / occupational therapy		8.5. Details of placement	
8.2. Functional status at discharge		8.6. Follow-up information	
8.3. Social status at discharge		8.7. Physical status at discharge	
8.4. Discharge report		8.8. Psychological status at discharge	
		8.9. Changes between initial and current status of functioning	
		8.10 Discharge plan	

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Corresponding Author
Denise Franzsen
denise.franzsen@wits.ac.za