OCCUPATIONAL THERAPY REPORTS: EXPLORING BEST PRACTICE

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A dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of Master of Science in Occupational Therapy.

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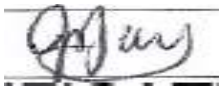
Declaration

I, Julie Mae Jay, declare that this dissertation is my own work. It is being submitted for the degree of Masters of Science at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.



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6th Day of June 2017

Dedication

I dedicate this project to the Department of Occupational Therapy at the University of the Witwatersrand. In my time of working there I was inspired by their passion to advance the profession of occupational therapy to meet the needs of the South African population, and the care and empathy they felt for the students in their charge.

Abstract

Introduction: Communicating about patient assessment and intervention is accepted as an essential requirement of the health professional's role. Current research indicates that this area of professional practice is the most routinely neglected. There is anecdotal evidence that reporting by occupational therapists, especially novice clinicians in South Africa, is of a poor standard, but as yet, there is limited research into this field. This study aimed to establish what occupational therapists view as current and best practice regarding report writing and the factors that influence their ability in writing profession specific reports.

Method: The study was completed in two phases. The first phase included six focus groups, carried out with occupational therapists in a variety of clinical and discipline specific contexts. The qualitative data were analysed to determine specific themes using an inductive approach. Several conflicts emerged leading to the second phase; a nominal group with subject matter experts where data were analysed using deductive content analysis.

Results: Three themes emerged. Generic occupational therapy reporting issues identified that therapists are subject to generic barriers that influence their report writing. The occupational therapy identity, highlighted that profession specific challenges, such as professional identity and the use of professional language are causing a disconnect in occupational therapists reporting on what they actually do. Thirdly, who is the audience, identified that the heterogeneous audience for occupational therapy reports can influence how findings are communicated. The disagreement as to how to overcome these challenges, lead to the subject matter experts in the second phase to provide recommendations to support best practice.

Conclusion: Several recommendations surfaced, including creating a protocol and training to aid occupational therapists in complying with regulations. Ensuring reports are occupational in nature was deemed as important. Further research to establish a bank of explanations for occupational therapy language in South Africa to support the professions identity and to ensure service user involvement was recommended.

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Definition of Terms

Documentation (noun) – the oxford dictionary defines documentation as material that provides official information or evidence that serves as a record [Pearsall, 1999]. Within the health care sector, patient documentation is frequently referred to as medical records.

Medical records – The documents pertaining to a patient's medical history, diagnoses and therapies, and status when last seen by health care providers. [McGraw-Hill, 2002]

For the purposes of this study, documentation will refer to all documents pertaining to a patient's care.

Record keeping – The activity of organising and storing all the documents, files, invoices, etc. relating to a company's or organisation's activities.

For the purposes of this study record keeping refers to the retention of records deemed important to patient care. This goes hand in hand with records management, which is the process of creating and maintaining records including storing and archiving.

Report – An account given of a particular matter, especially in the form of an official document, after thorough investigation or consideration by an appointed person or body [Pearsall, 1999].

For the purposes of this study a report refers to a document that presents information in an organised format for a specific audience and purpose. Sames identifies two types of reports in occupational therapy including assessment and discharge reports/summary. These two types of reports include continuation

reports (if appropriate), but will exclude all other types of documentation, such as progress notes and forensic or medico-legal reports [Sames, 2009].

Health literacy – can be defined as *"The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions"* p31-32[Nielsen-Bohlman et al., 2004].

Current practice – the oxford dictionary defines current practice as belonging to the present time; happening or being used or done now [Pearsall, 1999]. This definition therefore applies to what was happening in terms of report writing at the time of the study.

Best practice – this is closely linked to evidence based in practice to support what should be done rather than what is being done. *"Integrating the best research evidence with clinical expertise and patient values to achieve the best possible patient management"* p3[Sackett et al., 2000].

Guideline - A guideline aims to streamline particular processes according to a set routine or sound practice. Information intended to advise people on how something should be done or what something should be.

Abbreviations

OT – Occupational Therapy

HPCSA – Health Professions Council of South Africa

OTASA – Occupational Therapy Association of South Africa

AOTA – American Occupational Therapy Association

SME – Subject matter expert

NGT – Nominal Group Technique

MDT – Multi-disciplinary team

ICF – International Classification of Functioning

CPD – Continual Professional Development

CHAPTER 1 INTRODUCTION

1.1 Introduction

Communicating about patient assessment and intervention is accepted as an essential requirement of the health professional's role [Backman et al., 2008; Donaldson et al., 2004]. Occupational therapy practitioners compile reports to communicate with family members, other health professionals as well as to provide an accountable record of intervention. It is viewed as an essential skill, which is taught in most occupational therapy undergraduate courses in South Africa. Current research indicates that this area of professional practice is the most routinely neglected [Donaldson et al., 2004; Rischmuller and Franzsen, 2012; Sackley et al., 2004]. Many studies have aimed to understand the possible reasons for this neglect, however studies specific to occupational therapy practice are lacking [Buchanan et al., 2016; Rischmuller and Franzsen, 2012; Sackley et al., 2004].

Neglect of this area of practice can have far reaching ramifications to patient care, therapist's accountability as well as institutional reputation. This is obvious when medical aid schemes demand reports, whereas there is no similar requirement by funders of public health services which means the writing of reports may not be seen as an essential component of care within the government health sector. Furthermore, the large ratio of patient to therapist contact within the public health care sector in South Africa can lead to the routine neglect of aspects of care such as report writing, because time as a resource is scarce. There is also a dichotomy of care between the private and public sectors, where an inequality in resources and finance often results in disparity in the provision of care to South African citizens [Coovadia et al., 2009; McIntyre et al., 2007 a]. Many South African citizens are also vulnerable to poverty and sub-standard education, which has a profound effect on their health literacy. This affects their ability to be active role-players in their health care, due to their inability to understand communication around the health care process [Kickbusch, 2001; Nutbeam, 2008].

International studies have indicated that the reading level required to understand health professional reports needs to be at a university reading level or higher, which may isolate occupational therapy service users in South Africa [Donaldson et al., 2004; Harvey, 2006]. In addition to this, some of these international studies have also highlighted that the profession faces specific challenges around the language used to communicate the philosophy and values of occupational therapy, which can further alienate the reader of occupational therapy reports [Donaldson et al., 2004; Makepeace and Zwicker, 2014; Wilding, 2008].

There is anecdotal evidence that reporting by occupational therapists, especially novice clinicians in South Africa, is of a poor standard, but as yet there is limited research into this field [Buchanan et al., 2016; van Biljon, 2013]. This, along with recognising the challenges faced by those who use occupational therapy services within the South African context, highlights the need to explore if occupational therapists are able to write reports that are responsive to the needs of the population and the profession.

This study aims to ascertain the views of occupational therapists regarding the best practice and quality of profession-specific reports in Gauteng and the barriers and facilitators that influence this. The aim is that exploration into this area of practice can motivate for the development of guidelines by professional bodies to support best practice within occupational therapy practice in South Africa.

1.2 Statement of the problem

Currently there are no specific guidelines in place to support occupational therapists in South Africa regarding the writing and compilation of general occupational therapy reports. In South Africa, accountability within private and public practice by the national health body or professional organisations in monitoring clinician documentation writing standards is vague [Health Professions Council of South Africa, 2008b; Occupational Therapy Association of South Africa, 2005]. Clinicians can refer to generic legal requirements, e.g. Promotion of Access to Information Act (PAI) and the Protection of Personal Information Act (POPI) [South African Government,

2000, 2013]. This lack of specificity may lead to poor adherence of legal requirements and limited means in the ability of the occupational therapy clinician to convey the necessary information regarding patient care.

1.3 Purpose of the study

Further research is needed to understand what occupational therapists' views are into the current practice of writing profession-specific reports as well as the facilitators and barriers influencing this area of practice within South Africa. It is anticipated that the identification of best practice would aid compliant practitioners in reducing vulnerability to legal complication arising from sub-optimal and inadequate documentation and ultimately improve patient care.

1.4 Research question

What are occupational therapists views of the current and best practice of occupational therapy report writing in South Africa, and what are the influencing factors affecting their ability to write these reports?

1.5 Research Aim

To establish what occupational therapists view as current and best practice in profession specific report writing and the factors that influence their ability in writing occupational therapy reports.

1.6 Objectives

The study was carried out in two phases in order to answer the following objectives:

Phase 1

1. To explore issues influencing the current practice of report writing for occupational therapists within the South African context
2. To explore the views of occupational therapists regarding the factors affecting best practice and the quality of profession-specific reports

Phase 2

3. To establish recommendations to improve best practice in occupational therapy report writing

1.7 Justification of the study

The absence of clear guidelines as to best practice in occupational therapy report writing can make therapists susceptible to legal complications arising from inadequate documentation as well as impact on the public's perception of occupational therapy practice. It is anticipated that establishing best practice on the writing of occupational therapy reports would aid compliant practitioners in reducing vulnerability and support quality assurance in public and private occupational therapy settings. Further exploration into what is happening in current practice is needed to identify what occupational therapists perceive as being influential factors in their ability to write profession specific reports, and what they believe would constitute as best practice. This will then support the recommendation to establish guidelines for occupational therapy report writing that will be responsive to the needs of occupational therapists working within the South African context.

1.8 Outline of the report

Chapter 1: The first chapter aims to contextualise the need for the current study through presenting the problem, aim, objectives and justification for this study.

Chapter 2: The second chapter presents the current literature available around the issues affecting the practice of writing occupational therapy reports. Studies included are from international as well as local researchers. Current literature around contextual issues affecting the profession as well as therapists and service users within South Africa is also included.

Chapter 3: The third chapter presents the methodological approach used in the study. The study was carried out in two phases in order to answer the objectives of the study. Each phases' methodology is presented separately and sequentially.

Chapter 4: The results chapter is presented in two separate phases. Phase one precedes phase two.

Chapter 5: The fifth chapter includes the discussion following the results analysed from the study. This discussion utilises the results from both phase 1 and phase 2 of the study. The discussion is organised under headings pertaining to the objectives of the study. Limitations of the study are included at the end of the chapter.

Chapter 6: The final chapter serves to summarise and conclude the findings of the study, as well as to include recommendations for clinical practice and for further studies.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

Reporting on patient care is a critical component of the health professionals' work role, and should be viewed as a systemic part of the job process [Donaldson et al., 2004; Sames, 2009]. The documenting of patient assessment and intervention is the primary means of communication between health professionals, funders and other key stakeholders in support of patient care [Donaldson et al., 2004]. While documentation of patient care is seemingly an essential part of the healthcare process, research has highlighted that report writing is one of the most neglected aspects of the health professional's routine as it is seen as time consuming and without immediate benefit [Donaldson et al., 2004; Flynn and Parsons, 1994; Lundgren Pierre, 2001]. Implications of this neglect can be serious for the health care professional, service user and organisations alike. Poor reporting or misrepresentation of information can lead to litigation, economic loss as well as breakdown in relationships between healthcare provider and healthcare user [Bradshaw et al., 2014].

2.2 Importance of reporting in health care

Report writing and documentation (occasionally referred to as record keeping) is a chronological record of what has happened to the patient or healthcare user and this method of communication aims to ensure that assessment needs and continuity of care between various professions are met [Sames, 2009]. Professional reports have been described as:

> *"the tickets of safe passage for patients traveling to seek further care, and they are the visible currency of sanctioned co-operation among healthcare providers" p.174 [Lingard et al., 2004].*

Other than being a chronological record of care, documentation is legal proof of intervention. This legal requirement for many health professions is dictated by health profession regulating bodies who advise that every patient has the right to have sufficient evidence of their care process documented to ensure

the safety of the patient and to protect the clinician [Health Professions Council of South Africa, 2008b]. Documented patient records are the main defence for healthcare professionals should their actions be scrutinised [Ram et al., 2009]. Adequate record keeping can be seen as a means of providing evidence and information around risk assessment and so protecting the patient and the staff [Bradshaw et al., 2014].

Documentation of patient information and service provided is also seen as a source of data for clinical audit and research. High-quality record keeping supports quality assurance as adequate records allow for an in-depth assessment of care provided. They can be seen as an assessment of clinical competence of the health professional [Donaldson et al., 2004]. Patient records can also be used to support research and so progress the accountability of the profession [Pessian and Beckett, 2004]. As record keeping expresses the justification behind service provision, it can also be seen as a means for marketing the profession [Bradshaw et al., 2014; Ram et al., 2009].

2.3 Competency in health care reporting

One could argue that record keeping or reporting is part of the essential competences of being a health professional. In fact, demonstrating competence with both formal and informal written/verbal communication is an exit level requirement, set by the professional board for the training of occupational therapists in South Africa [Health Professions Council of South Africa Professional Board for Occupational Therapy Medical Orthotics/Prosthetics and Arts Therapy, 2010]. Regulatory bodies across the world aim to ensure the safety of the public through ensuring the competence of health professionals. Most regulatory bodies dictate that a general competency of all health professionals is that they can present and document their actions in a meaningful and inclusive way [Sottas, 2011].

Verma, Paterson and Mevdes in their study in 2005 aimed to understand the core competencies needed by medical, nursing, occupational therapy and physiotherapy professionals. They highlighted communication and collaboration between these healthcare professionals, individually and in

groups using verbal and written reports as a key competency area [Verma et al., 2005]. This is even more necessary in the current economic climate around the world where spiralling healthcare costs have incited a keen public interest into the effectiveness of all levels of care [Sottas, 2011]. In 2010, Frenk, Chen, Bhutta, Crisp, Evans, Fineberg, et al. argued that global dimensions of health, including leadership, management, policy analysis and communication skills, are not only essential but also neglected elements of the health curriculum to deliver such value for money [Frenk et al., 2010].

2.4 Worldview – Report Writing

Much of the research on documentation and report writing within the health professions has been done around medicine, nursing, dentistry and mental health. Most of these studies are specifically related to the writing, distribution and storing of patient records, and explore the validity of electronic health records, as well as the legal requirements for record keeping [Bradshaw et al., 2014; Ram et al., 2009]. Studies specifically on the writing of profession specific reports often refer to generic issues that affect report writing across all health professions.

These issues include reference to professional reports requiring high level of reading ability to understand them, which acts as an exclusionary factor for many, particularly for patients with no tertiary education [Donaldson et al., 2004]. Harvey highlighted in 2006, the challenges faced by many health professions when she researched profession specific psychology reports where a high level of reading ability was required. Various other issues, which affect the understanding of psychology reports, were also cited. These include insufficient training for novice clinicians and students resulting in inadequate or poorly worded reports, which affect understanding. More experienced clinicians also struggle to find the time required to write adequate reports and are prone to using jargon, as they feel that using simpler language reduces their credibility [Harvey, 2006]. Harvey (2006) identified that the need to provide a report which would be read by multiple audiences also influenced the understandability of these reports [Harvey, 2006].

Although Harvey's study was related to psychology reports only, which would possibly influence the generalisability of the results, other studies into the perceptions of professional reports have found similar issues. A study by Ng in 2014 identified that parents and children using audiology services can be at risk of being excluded from the care process through written reports due to the language used. Of concern was the naivety from the clinicians regarding the importance placed on these reports by parents. Parents were using the reports in order to receive and establish more authority when advocating for their child [Ng, 2014]. A study of trainee and experienced physicians referral letters identified that physicians are aware that language can affect readers' perception and understanding of professional reports, however less experienced clinicians are not aware of how to remediate this difficulty through appropriate language use [Lingard et al., 2004].

Mastoras Climie, McCrimmon and Schwean in 2011 acknowledged that psycho-educational reports generally have poor readability for service users and that there is often a poor link between the reason for referral and the recommendations made, as the reports primarily focus on weaknesses supported by generalised interpretations [Mastoras et al., 2011]. They suggest using the C.L.E.A.R framework when writing reports to ensure the reports are understandable and allow for a clear link between the reason for referral and corresponding answers. This approach advocates ensuring the report is client centred (C), that it links the reasons for referral to the assessment results (L) and that the report enables the readers understanding by providing concrete recommendations (E) whilst addressing strengths and weakness assessed (A). It is important that the report has an adequate level of readability (R) for the service user. Whilst this publication was not based on research, some useful recommendations on improving the readability and the efficacy of reports were provided. These recommendations can be generalised across health professions and have been highlighted in some the findings in other studies on report writing in occupational therapy as described below.

2.5 Worldview – Report writing in occupational therapy

Studies on report writing in occupational therapy have identified a lack of occupation-specific language, highlighting the conflict in representing the philosophy of occupational therapy within the traditional biomedical health context [Backman et al., 2008; Cederfeldt et al., 2003; Lundgren Pierre, 2001; Lundgren Pierre and Sonn, 1999]. It is apparent that the ability of occupational therapists to report on their practice has been challenging in various contexts. Lundgren Pierre and Sonn (1999) identified that it may be unclear as to what constitutes proper documentation amongst occupational therapists. Their study on eleven occupational therapists focused on the meanings attached to the concept of proper documentation. The study revealed that therapists are experiencing professional dilemmas regarding the use of everyday language and professional language, the different expectations from the various recipients of the reports and the difficulty expressing occupational therapy clinical reasoning in a medical context. The study, highlighted the importance of clarifying professional language [Lundgren Pierre and Sonn, 1999]. Lundgren Pierre in 2001 aimed to describe how occupational therapists record what they value in their daily work using document analysis and semi-structured interviews. Findings identified that, whilst documentation was completed in accordance with the occupational therapy process, the participants felt dissatisfied, as they were uncertain about naming some aspects of the professional process although they valued them highly [Lundgren Pierre, 2001].

The literature reveals the contradictory perceptions in occupational therapy report writing as Cederfeldt, Lundgren and Saldo in 2003 reported somewhat different findings. They acknowledged that modern society has adopted the language of medicine as a framework for describing and organising health services, however this often does not fit with occupational therapy's approach to occupational performance. Twenty occupational therapy records of stroke inpatients at a hospital in Sweden were analysed and revealed that occupational therapists regularly documented occupational performance areas [Cederfeldt et al., 2003]. Backman Kawe and Bjorklund reported similar

findings in their analysis of 100 occupational therapy case reports. The majority of the occupational therapy case reports reflected activity and holistic health notions; core philosophies of the occupational therapy process [Backman et al., 2008]. These studies analysed written documents but did not consider the occupational therapists perspectives and anxieties about their reports, which may have led to a limited view of the outcomes. Thus, whilst at face value, there appears to be compliance with reporting on the occupational therapy process, occupational therapists themselves may have had additional professional dilemmas and concerns that they were grappling with.

In 2004, Donaldson McDermott, Hollands, Copley, and Davidson explored parents' and therapists' perceptions of speech pathology and occupational therapy reports. The results acknowledged that these professional reports have multiple audiences and as a result, there is often a mismatch between the therapists' intentions for the reports and parents' expectations. The parents' primary expectation of the report is that it should be a source of information with practical recommendations. The researchers noted that the inclusion of profession specific jargon, led to confusion and the parents felt excluded from the therapy process. Whist some therapists in the study reported that they used 'simple' language to enhance understanding, others felt the inclusion of profession specific terminology or jargon was important for educational purposes so that parents could speak meaningfully to each other and to professionals [Donaldson et al., 2004]. It is evident from this study that there is a mismatch between the expectations of healthcare service users and service providers. The language used was a source of indirect exclusion for some healthcare service users and lead to negative interpretation. This was found to be true when jargon was used and the report only focused on limitations, which were supported by impersonal statements. The sample in the study by Donaldson et al. was limited to 18 parent participants and 14 therapist participants, thus generalisability may be questioned. The study came up with practical suggestions to improve the readability of professional reports; namely that a clear explanation with no jargon should follow directly after professional words to assist all readers of the report. This can also be

accompanied by verbal feedback to enhance understanding. Most of the report should be focused on the recommendations that are practical.

Donaldson et al. used the Flesch readability scale when investigating the readability of occupational therapy and speech pathology reports. This scale is used to calculate the degree of reading difficulty of a document. It was discovered that the reports for both professions require a reading level equivalent to a university education or higher, indicating that the general population would find the reports difficult to comprehend [Donaldson et al., 2004].

Another qualitative study into teachers' perceptions of occupational therapy reports by Vincent, Stewart and Harrison in 2007, established that participants in the study felt that occupational therapy reports were important. Participants placed high priority on these reports, as they were eager to seek specialist services to fill any gaps in their knowledge. Whilst they felt the reports were understandable, they felt the recommendations given were not always useful or practical. The teacher respondents stated they often sought further information and assistance by telephoning and speaking to the therapists and they were keenly aware of the lack of collaboration between the occupational therapists and the teachers. The sample of four respondents in this study was intentionally small, as the intention of the study was to gather rich in-depth data. Whilst generalisability of results is not appropriate, some useful suggestions for best practice were noted. This included the need for an occupational therapy report to be accompanied by verbal feedback. The authors highlighted that by not having a follow-up conversation with the report writer, the opportunity for increasing the awareness of the role of the therapist to the educator did not occur. The participants recommended having a follow-up procedure to the written report to ensure discussion about the assessment process and further collaboration regarding intervention [Vincent et al., 2008].

Makepeace and Zwicker explored parent perspectives of occupational therapy reports in the United Kingdom in 2014. Themes similar to those mentioned in

previous studies emerged from this qualitative study, namely that poor understanding of terminology and the tone, style and complexity of the report can affect the relevance of the findings for the audience. It was also reported that the main purposes of a report should be to answer the reason for referral or the referral question, act as an accurate record, and serve to provide relevant recommendations [Makepeace and Zwicker, 2014]. Their study also acknowledged the challenge of having heterogeneous audiences for occupational therapy reports. To overcome this challenge, the occupational therapist should strive to understand the audience they are writing for, possibly by identifying the primary and secondary audiences so their reports can be written accordingly. Other strategies, such as offering verbal feedback to the audience to support their understanding of the report, as well as offering occupational therapists templates for reports, may serve to improve the quality of their reports [Makepeace and Zwicker, 2014].

All these studies present a clear message in their findings; namely that the main principle of effective writing is the need to target the intended audience [Bell, 1995].

2.6 Contextual challenges in report writing in occupational therapy in South Africa

Professional report writing within the South African context can be seen to carry some additional challenges. The South African health sector is struggling to conceptualise its African roots against a traditionally westernised health system, along with crippling resource, facility and administrative issues affecting the ability to meet the needs of its population following an oppressive apartheid regime [Coovadia et al., 2009]. Only four published studies investigating documentation in occupational therapy practice in South Africa were found.

2.6.1 Completion and storage of reports

Two of the studies specifically highlighted poor compliance in the completion and storage of occupational therapy records, but did not relate specifically to the writing and readability of occupational therapy reports [Mlambo et al.,

2004; Rischmuller and Franzsen, 2012]. The study by Mlambo and Amosun in 2004 considered occupational therapy records for stroke clients in one hospital in South Africa. This study aimed to explore the contents of the records including information on basic demographics and comprehensive occupational therapy assessment, intervention and evaluation. The study determined that the occupational therapy evaluation, planning and progress were poorly documented with little reference to outcomes on termination of therapy. Whilst this study was limited in scope as it only focused on one client group in one hospital, it identified the risk for the credibility of the profession and the patients receiving occupational therapy if the occupational therapy process is being poorly documented. The reasons cited for poor documentation standards included the poor attitude of staff, lack of resources as well as lack of standardisation for reporting and use of jargon and therapy terminology [Mlambo et al., 2004].

These findings were supported by Rischmuller and Franzsen in 2012, in an evaluation of occupational therapy record keeping at schools for learners with special needs in the Western Cape. This study was however small with only 4 of the 87 identified schools being included in the sample, thereby possibly affecting generalisability of results. The study found record content and record keeping to be of an inadequate standard, identifying that poor management and a lack of accountability may be hampering record keeping [Rischmuller and Franzsen, 2012]. This challenge is widely acknowledged in writings about the South African health care system [Coovadia et al., 2009].

2.6.2 Lack of guidelines for report writing

Fragmented services between the public, private and medico-legal sector in South Africa also leads to incongruence in documentation standards [Coovadia et al., 2009; McIntyre et al., 2003; McIntyre et al., 2008]. While guidance should be sought from the regulatory and professional bodies, clarity about reports within the Occupational Therapy Association for South Africa's (OTASA) professional code of ethics is limited. The only specification to documentation is around providing…

> *"information to the patient in a form that will make it possible for information to be useful and understood"* *p. 2 [Occupational Therapy Association of South Africa, 2005]*

…which could also relate to verbal communication [Occupational Therapy Association of South Africa, 2005].

Equally, in the Health Professionals Council of South Africa's (HPCSA) guidelines on the keeping of patient records, all information relates to the recording of bio-psychosocial information with specific reference to clinical management, namely medication. Most emphasis in the HPCSA guidelines is on retention, storing and access to records with a small checklist at the end relating to good practice, the use of standardized formats and the alteration of documentation [Health Professions Council of South Africa, 2008b].

The South African government has recently established the Protection of Personal Information (POPI) act to ensure minimum requirements for the management of personal information. This act is mainly to provide guidance to ensure the rights of persons regarding their personal information are not violated [South African Government, 2013]. The act provides an overall code of conduct to which individuals must adhere to and relies on therapists in practice to interpret these correctly to ensure they are compliant when writing occupational therapy reports.

Two other South African studies on occupational therapy report writing focused on more specialist areas, such as communicating evidence-based practice in occupational therapy documentation [Buchanan et al., 2016] and the development of a report writing protocol for vocational rehabilitation services [van Biljon et al., 2015]. Both these studies focused on the practice of occupational therapy report writing and acknowledged that report writing is a competence-based skill requiring practice and guidance to ensure quality output. van Biljon, Casteleijn and Du Toit in 2015 and Buchanan, Jelsma and Siegfried in 2016 acknowledged that South African occupational therapists are at a disadvantage as there are no guidelines in place to assist with writing reports for specific circumstances neither are there specific postgraduate

training for the skill of report writing [Buchanan et al., 2016; van Biljon et al., 2015]. This was supported by the occupational therapists who took part in the study by Rischmuller and Franzsen who indicated that they would benefit from checklists and protocols to assist them in documenting occupational therapy interventions in a more standardised and understandable way, echoing the sentiments expressed from participants in the studies from Australia and the United Kingdom [Rischmuller and Franzsen, 2012].

Buchanan, Jelsma and Siegfried identified that an evidenced based approach to documentation is currently not used, and as a result data from records cannot be used to produce evidence. Whilst the researchers took a rigorous approach in data collection, including pilot testing their audit tool as well as rater testing and the use of grading rubrics to ensure accuracy, however data was limited to health facilities within one province of South Africa [Buchanan et al., 2016]. van Biljon, Casteleijn and Du Toit considered the practical creation of guidelines to assist therapists working within the public sector who have to write vocational rehabilitation reports [van Biljon et al., 2015]. The implementation of these guidelines had a consumer focus and aimed to assist therapists in presenting information effectively and to facilitate scientific thinking. This study took a rigorous research approach using a collaborative action research process to ensure that clinicians contributed to the creation of a guidelines protocol whilst evaluating its relevance in the field through reciprocal collaboration [van Biljon et al., 2015]. This study was however limited to the specialised area of vocational rehabilitation.

2.6.3 Reports for multiple audiences

Clinicians have an ethical responsibility to ensure the service users understand what is written about them, but also a moral responsibility to the profession to ensure they accurately carry out and portray the scope of the profession [Wilding, 2008]. These concerns have been addressed in research published in South Africa.

A large portion of the South African population has limited education and literacy skills [Coovadia et al., 2009; Spaull, 2015]. The General Household Survey 2015 identified that 15.4% of the South African population over the

age of 20 years are regarded as functionally illiterate (no schooling or who have not completed Grade 7) [Statistics South Africa, 2016]. This poses significant challenges for service users of occupational therapy to be able to read and understand occupational therapy reports. Individuals with limited literacy and education are likely to have poor health literacy, which has a direct correlation with poor health [Nutbeam, 2008]. Health literacy can be defined as

> *"The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions"* *p31-32[Nielsen-Bohlman et al., 2004].*

The literature around this topic has highlighted a longstanding concern between health and education. Having adequate health literacy enables individuals to read forms, labels and reports, to understand written and oral information and then to act upon the necessary directions. This leads to empowerment of the individual and has a direct impact on improving health outcomes [Kickbusch, 2001]. Research has shown that most health care providers are unaware of the poor health literacy levels of the populations they serve and that the service users are often too embarrassed to disclose that they do not understand [Kickbusch, 2001]. In a country like South Africa where the overall education level of the population is poor and many are living in a low socio-economic bracket, individuals and communities are at risk of adverse health effects [Nutbeam, 2008]. It can therefore be reasoned that occupational therapists need to take cognisance of the possible poor health literacy of the individuals they are treating and accommodate them accordingly when communicating with them. This can also be challenging when the majority of the population does not speak English as a home language, however most official communication and training of health care professionals occurs in English [Kickbusch, 2001; Statistics South Africa, 2016].

Rischmuller and Franzsen identified in their study that there is reduced understanding of documentation by persons who aren't health care professionals; with only 30% of the records being deemed accessible to others such as parents and teachers [Rischmuller and Franzsen, 2012]. This

is supported by van Biljon who emphasised a consumer focus as necessary to assist with ensuring the client is an active participant in the healthcare process. She states that

> *"Reports should be concise and specific and written in a professional yet clear way free of medical jargon so that non-medical persons can also understand it"* *p.13 [van Biljon, 2014]*

One could argue that healthcare service users do not routinely see patient records; hence the lack of focus on consumer related language, however there are written reports, which should be accessible to all [Nutbeam, 2008]. The reduction of medical paternalism that may exclude the client in terms of understanding their written report, was also suggested by van Biljon [van Biljon, 2014].

Along with limited guidance from the professional bodies, as well as the systemic and resource challenges within the South African context, the challenges for occupational therapists can be seen as complex when determining how best to communicate with service users. Practitioners are experiencing conflict in meeting the needs of service users in an inadequate health care system whilst maintaining professional integrity in a system that does not always encompass the morals and values of the profession.

2.7 Challenges for the profession

2.7.1 Professional identity

Regarding the literature around documentation, some principles, which apply to occupational therapy reports, could be extrapolated. Most barriers influencing health professionals in the completion of patient reports are applicable to occupational therapy, such as lack of time, poor training and lack of belief of the importance of report writing [Dimond, 2005; Donaldson et al., 2004; Pessian and Beckett, 2004]. Interestingly, studies specific to occupational therapy have highlighted a lack of professional identity, which also impacts on occupational therapists' ability to effectively report on their observations and interventions [Lundgren Pierre, 2001; Lundgren Pierre and Sonn, 1999].

Role understanding and effective communication are seen as core competencies for collaborative practice and health care outcomes as determined by a Cochrane IPE review in 2009, which established that the need for good inter-professional communication and collaboration to help coordinate patient care in an effective manner is essential. Despite this need, research indicates that such communication and collaboration can be challenging, as effective collaboration can be undermined by a lack of understanding of other professionals' roles and poor communication along with boundary encroachments [Suter et al., 2009]. This may be a common challenge within the occupational therapy profession, where the understanding and description of services may appear unclear to other professions.

Whyte and Hart (2003) have questioned whether a medical model is appropriate for describing any rehabilitation services since most rehabilitation interventions are not diagnostically, procedurally or pharmacologically based. Rather, rehabilitation can be seen as involving a set of structured experiences and teaching interactions between the clinician and client [Whyte and Hart, 2003]. Occupational therapy can be seen as struggling with this challenge as it exists within a variety of contexts but can be seen as having a social construct and a virtual reality. As activities, participation and action are at the centre of occupational therapy, this can lead to challenges in describing it [Creek, 1998; Lundgren Pierre and Sonn, 1999].

Turner (2011) highlights the historical challenges that occupational therapists have had with their professional identity suggesting that this is likely as a result of occupational therapists having a poor perception of themselves along with how they believe the profession is viewed by others. In her delivery of the Elizabeth Casson memorial lecture in 2011, Turner further describes the tension that exists between the aims of occupational therapy understood by therapists themselves and the realities of practice. As a result of this struggle, many occupational therapists who work in multi-professional teams, find it

difficult to assert their unique identity, which leads to a poor sense of professional self [Hayes et al., 2008].

Many attribute this to a perceived lack of understanding and respect for the profession by others [Turner, 2011]. Unfortunately, this struggle can be seen to have long historical roots, where occupational therapists' lack of ability to promote themselves has also contributed to the perceived lack of respect felt by practitioners. This perception has been uncovered in other studies attempting to understand the identity crises faced by occupational therapists in different settings [Ashby et al., 2013; Hayes et al., 2008]. It can therefore be reasoned that in order to gain acceptance in the patriarchal world of healthcare, occupational therapists began to adopt the presence and values of illness and remediating impairment, rather than the development and maintenance of health and well-being. There has been a growing concern amongst prominent voices in occupational therapy around the growing incoherence between practice and philosophy [Yerxa, 1994]. In fact, without a sound framework to help describe the philosophy of the profession, therapists can become philosophically lost, which may lead practitioners to seeing themselves as merely filling a gap rather than being truly occupational. Developing the occupational therapy identity then is about adopting a paradigm and having the ability to articulate it [Fortune, 2000].

Buchanan et al. in their study in 2016 evaluated the quality of occupational therapy patient records as evidence for practice and highlighted the incongruence between what therapists document and the core philosophy of occupational therapy [Buchanan et al., 2016]. This study illustrated the focus of occupational therapy records being on impairment rather than activity and participation, which is key to occupational therapy. The authors highlighted the conundrum of occupational therapy practicing within the medical model, which does not always match the values and philosophy of the profession [Buchanan et al., 2016]. Hence the conflict that is faced by many occupational therapists regarding fitting the profession's ideals into the mould required by the medical model and the service user requirements.

Adjustments to other professions' demands can entail a "colonisation" of the professional morals and identity for occupational therapists as stated by Lundgren Pierre and Sonn in 1999, for example, when occupational therapists write their reports in medical terminology/language. This can result in occupational performance deficits being construed as symptoms of illness with limited reference to occupation overall. This in turn can lead to an incongruity between professional convictions and what is documented, which can leave the occupational perspective unclear [Lundgren Pierre and Sonn, 1999]. Describing occupational therapy practice is therefore often problematic because it requires practitioners to draw on and communicate a range of knowledge from theoretical, factual, personal and service-user knowledge [Trevithick, 2008]. Ashby, Ryan, Gray and James in their 2013 study, determined that in finding effective ways to communicate the occupational perspective to other professionals, professional resilience was supported in occupational therapists. The study argued that a strong professional identity is essential in helping practitioners to resist the pressure to conform to knowledge and techniques borrowed from other disciplines [Ashby et al., 2013].

Studies have highlighted that one of the profession's future challenges is in finding and using professional language to bring about the paradigm shift of defining occupational therapy from a medical and diagnostic perspective to an occupational perspective [Cederfeldt et al., 2003]. This needs to be further explored across cultures, as a common term for occupation is lacking, and there is insufficient understanding of the relationship between health and occupation at a holistic level. It could be understood that natural health and occupation may be one in the same, however this becomes blurred in the face of modern, medically based research [Wilcock, 2007].

2.7.2 Professional language

Notably, the complexity of occupational therapy language has been highlighted as one of the most important barriers to occupational therapy reporting [Creek, 1998]. The literature highlights an important conundrum in occupational therapy; in that what occupational therapists do, may appear easy but the knowledge and reasoning behind their actions is more complex.

Most occupational therapists battle to put what they do into words [Creek, 1998]. Even though reporting may be challenging, occupational therapy documentation should present occupational therapy as distinct from other services. This is important for the identity of the profession, for the patient care plan and because purchasers and policy makers also need to know what they are buying and what they can expect from occupational therapy, therefore an accurate description is essential [Lundgren Pierre and Sonn, 1999; Phillips et al., 2010].

An added complexity is that the use of "occupational therapy language" in the attempt to represent the profession could be seen as the use of jargon, which as stated above, is largely regarded as poor practice in professional circles [Donaldson et al., 2004; Harvey, 2006; Makepeace and Zwicker, 2014]. This may be because occupational therapy language does incorporate the use of everyday terms, which may have different meanings when used in the profession. A notable example could be the use of the word "occupation", which for most members of the public could be defined as a job, a person's regular work or principal activity [Pearsall, 1999]. Within occupational therapy practice the word "occupation" is used largely to describe "*self-initiated, self-organized activity which is goaldirected … and contextualized in a specific environment over a span of time. It is energized by unique interests and expressed as skill, which enables people to be competent, participating, productive members of their culture; 'in place' by virtue of their capabilities, finding symbolic meaning through agency*" p.91[Yerxa, 2000]

The ambiguity is apparent and can cause confusion when a member of the public is reading an occupational therapy report. It could be reasoned that it may be cumbersome to describe this terminology as opposed to using concepts when reporting, even though the use of definitions has been recommended by some studies [Donaldson et al., 2004]. This challenge can influence the understanding amongst occupational therapists as to when and how to use occupational therapy language in their reporting.

The question that arises is whether occupational therapists within the South African context understand the importance of representing their unique identity of their profession through occupational therapy reports. Whilst the profession itself is facing this conundrum of using occupational therapy language, occupational therapists within developing countries such as South Africa face further challenges in catering for a population of service users who have poor literacy as one of their greatest barriers to engaging with the care process [Kickbusch, 2001; Nutbeam, 2008]. If there is general ambiguity as to the interpretation and understating of occupational therapy language, this may lead to further alienation of service users who are at risk of having poor health literacy.

2.8 Essentials in occupational therapy reporting

It is important to have a clear understanding of what occupational therapy reports may entail. Sames, (2009), describes three types of documentation in occupational therapy practice: the service initiation, service continuation and service termination documentation. Service initiation documentation should include an evaluation/assessment report covering factual data collected and interpretation thereof, as well as a proposed treatment plans with functional time-limited goals for the client. It should also show the need for occupational therapy service, to support financing. The continuation of the occupational therapy service documentation includes progress notes relating to continuous record keeping, which are used by many health professionals. The termination of services documentation can include a discharge summary, which highlights occupational performance at initiation and at close of intervention, along with recommendations for follow up. Reports should follow a standardised format, which is determined by each department or facility (Sames 2009).

Whilst the professional organisations in South Africa such as the HPCSA and OTASA may only offer limited guidance in the best practice of reporting on services [Health Professions Council of South Africa, 2008b; Occupational Therapy Association of South Africa, 2005], it is useful to look internationally

to understand how other occupational therapy organisations advise their practitioners on best practice. The American Occupational Therapy Association (AOTA) published guidelines for the documentation of occupational therapy in 2008 based on the Occupational Therapy Practice Framework: Domain and Process 2nd ed. The framework stated that the purpose of documented communication is to portray information about the client from an occupational perspective, to articulate the rationale for the provision of services and to provide a chronological record of the clients' status, the occupational therapy service provided as well as the outcomes and response to occupational therapy [Clark and Youngstrom, 2008].

The essentials of report writing, such as the use of profession-specific guidelines, should adopt a professional style, avoid jargon, be concise but complete and should stay within the author's area of expertise, which is supported by other experts in the field [Backman et al., 2008; Lundgren Pierre and Sonn, 1999; Pessian and Beckett, 2004]. This directive approach could serve as an effective strategy to guide therapists on how to construct their written documentation. One must consider the need to adapt the documentation to individual needs, which can be achieved only by using clinical reasoning, which is highlighted as being one of the fundamentals of reporting. Clinical reasoning is an expert skill, which assists the practitioner in understanding what is relevant and what is not [Chapparo and Ranka, 2000; Rassafiani et al., 2009].

The other fundamentals of reporting as noted by the AOTA indicate that practitioners must comply with all laws, regulations, payer and employer requirements, and that acceptable terminology should be used as defined within the boundaries of setting [Clark and Youngstrom, 2008]. These fundamentals can be seen as quite broad, highlighting that the onus of setting up specific contextual guidelines still need to be achieved within different settings. Documentation in practice must be specific to occupational therapy, which echoes the other studies highlighted above [Buchanan et al., 2016; Donaldson et al., 2004; Lundgren Pierre and Sonn, 1999; Makepeace and Zwicker, 2014].

2.9 Conclusion

From the reviewed literature it is apparent that majority of health professionals face challenges in delivering effective reports that meet the needs of the service user, the organisation and the context, as well as the heterogeneous audiences that are the receivers of these professional reports [Bell, 1995; Donaldson et al., 2004; Harvey, 2006; Makepeace and Zwicker, 2014]. Generic issues, such as lack of resources, human and other, as well as systemic issues and ethical issues, often impact on the aim of health professional reports in meeting their true purpose of being an effective communication tool [Buchanan et al., 2016; Mlambo et al., 2004; Rischmuller and Franzsen, 2012]. These issues are obvious throughout the global context and across professions, however there are added challenges when observing this practice within the South African context. This context is plagued with additional complexities, such as limited health literacy of much of its population, a flailing health system that cannot meet the needs of the population and a population who is at risk of additional health burden through poverty [Coovadia et al., 2009; Kickbusch, 2001; McIntyre et al., 2003; McIntyre et al., 2008; Nutbeam, 2008]. Health professionals, such as occupational therapists, have a challenging time meeting the needs of the population they serve within the constraints of the organisations they work due to these challenges.

Additional to these challenges are upholding the values of the profession through how it is communicated [Wilding, 2008]. International studies have highlighted that one of the profession's future challenges is finding and using their professional language to bring about the paradigm shift of defining occupational therapy from a medical and diagnostic perspective to an occupational perspective [Cederfeldt et al., 2003]. This requires further investigation for South African occupational therapists to enable them to communicate the occupational perspective to a population that has serious challenges with managing their health literacy [Kickbusch, 2001; Nutbeam, 2008]. The question that arises is whether occupational therapists within the South African context understand the importance of representing the identity

of their profession through occupational therapy reports and whether sufficient guidelines should be in place to support this area of professional practice.

CHAPTER 3 METHODOLOGY

3.1 Introduction

In order to investigate the views of occupational therapists as to what constitutes best practice in occupational therapy report writing, a qualitative research design was used. The research was designed as a two-phase project.

In the first phase, data were collected through focus group interviews with occupational therapists practising in a variety of contexts. Textual analysis of the transcribed data allowed for themes to emerge. This phase of the study sought to understand the experiences of clinicians and to ascertain their views on the practice of report writing. In order to guide this part of the research process, a social constructivist framework was adopted. Researchers who typically require multiple perspectives and deep understanding generally work from a constructivist approach [Creswell, 2009]. A central assumption of constructivism is that human beings seek an understanding of the world in which they live, which leads to subjective interpretations of experiences. These interpretations are often varied and personally and contextually constructed [Creswell, 2009].

In phase 2, any conflicts that were identified within the first phase were addressed through discussion and ranking of possible solutions by subject matter experts using a nominal group technique. This technique utilizes mathematical aggregation and behavioural methods of group judgments to determine the average probability from multiple experts [Delbecq et al., 1975; Potter et al., 2004]. Using multiple experts and combining the probabilities given by these experts is valuable in obtaining expert judgment in a given application [Clemen and Winkler, 1999]. The primary purpose of this analysis in addition to obtaining expert judgement was to develop a deductive matrix to assist with the content analysis of the transcribed data from the nominal group. The researcher also wanted to employ the principle of trustworthiness by ensuring the findings from phase 1 participants, the clinicians, was

validated by the findings from the participants in phase 2, the subject matter experts. This would then enhance the integrity of the findings [Bryman, 2006].

3.2 Phase 1

In phase 1 of the study, focus groups were used during which occupational therapists discussed questions around the factors influencing report writing, as well as what they viewed as best practice.

3.2.1. Study population

The contexts in which occupational therapists work may influence their views on report writing as well as the type of reports they are expected to write. Therefore for this study, occupational therapists who work within the private and public sectors and who work in academic departments were invited to participate.

3.2.2 Sampling

A purposive sampling approach was adopted to ensure participants had a range of experience as occupational therapy clinicians and worked in a variety of settings, namely public, private and academic [Creswell, 2012]. This involved sampling individuals with similar characteristics and is a common approach in selecting focus groups [Onwuegbuzie and Leech, 2007]. Initially the clinicians registered with the National Occupational Therapy forum for Gauteng as well as Gauteng OTASA (Occupational Therapy Association of South Africa) members were emailed and invited to participate in the study. The response rate was poor, not garnering enough participants for several focus groups. Subsequently participants were recruited by contacting therapists working in specific areas of practice, which enabled a sufficient spread of participants who met the inclusion criteria.

Inclusion criteria

- Practicing occupational therapists with more than 6 months experience and who write reports (assessment or discharge) as part of their practice.

or

- Occupational therapy lecturers. Academics were also included in this study population for their opinion from an educational view as professionals who evaluate occupational therapy reports.

The following exclusion criteria were employed:

- Clinicians who work in specialist areas such as medico-legal or forensic practice, as these therapists already had access to support and specialist templates following previous research [van Biljon, 2014]. This study aimed to ascertain the perceptions of generalist occupational therapists, to establish if there is a need for further support in this area.

3.2.3 Sample Size

Deciding on a sample size for a qualitative research poses challenges, as researchers are searching for experience. In the *Focus Group Guide Book,* Morgan states that three to five focus groups are usually sufficient to reach data saturation, with six to ten individuals per group being an appropriate number. He further notes that focus groups with less than six participants makes it challenging to keep the discussion going, whereas more than 12 participants makes it challenging for the moderator to manage [Morgan, 1997]. Initially one focus group per context (public, private, and academic) was run to allow for preliminary analysis. The researcher did not limit the number of focus groups, but rather continued the data collection until it was apparent that data saturation had been reached [Kidd and Parshall, 2000]. Focus groups were therefore continuously run until the point of information redundancy or saturation, which occurred when no new information of significance was attained for the development of themes [Tuckett, 2004]. Six focus groups were run in total.

3.2.4 Ethical considerations

Ethical clearance was applied for and granted by the University of the Witwatersrand Human Research Ethics Committee (Medical), Certificate number M.140490 (Appendix A). Motivation letters to the HOD and CEO/managing committee of hospitals where the therapists in the public context worked were sent to obtain permission to carry out the focus groups

(Appendix B). Participants in private and academic practice were approached in their individual capacity. All participants were provided with an information sheet (Appendix C) and required to sign informed consent (Appendix D) before taking part in the focus groups. Participants also signed permission to be audio recorded (Appendix E).

Stringent data management procedures were adhered to in order to maintain confidentiality of the participants although confidentiality could not be ensured due to the nature of the focus groups used. Participation was voluntary and there were no consequences to refusing to participate in the study. Participants were informed that they could withdraw at any time without consequence. Feedback from the study was available to participants on request.

Access to the REDCap (Research Electronic Data Capture) system, which was used to capture all the data, required training, as well as login and password details for security. For confidentiality reasons, no personal information was entered onto the system, with participants given codes for identification. The raw data was locked away in a storage cupboard within the occupational therapy department and only accessible by the researcher. The audio recordings of each focus group were saved in an mP3 format onto a cloud storage base, which was password protected.

3.2.5 Research procedure

Phase 1 of the study aimed to promote discussion and consensus from groups of participants. The researcher decided on using focus groups to enable the participants to relate their experiences amongst their peers with whom they share a common frame of reference. Participants were grouped according to the contexts in which they work. Focus groups are useful in promoting discussion, with participants having the space to comment and challenge each other's points of view [Creswell, 2012; Kidd and Parshall, 2000; Kielhofner, 2006].

Qualitative research methods, such as focus groups, inherently carry challenges in maintaining validity due to the subjective nature during inquiry and analysis [Reish, 2007]. The validity and meaningfulness of qualitative

data has more to do with the richness of data collected and therefore participants with experience in report writing in occupational therapy were purposively selected [Krueger and Casey, 2014].

3.2.6 Research instruments

3.2.6.1 Demographic Questionnaire

Participant characteristics were collected through the completion of a demographic questionnaire (Appendix F). This was done to assist with determining any relevance between the population used in the study and the findings. It also enabled further exploration of the results by understanding different groups' opinions within the study. By doing this, relevance to different readers of the study will be enhanced by enabling an interpretation of their own situation [Tong et al., 2007].

Information in the demographic questionnaire included details on whether the participants had any post-graduate qualifications and if they belonged to any special interest groups. This was incorporated to determine if these factors may have provided extra experience or support in the skill of report writing. Further information was sought around how long participants had been practicing as an occupational therapist. This was included to determine if this had any influence over their confidence and skill in writing profession-specific reports. Information on areas of practice was incorporated to assist the researcher in ensuring participants from a wide range of areas of practice had been included in the study.

3.2.6.2 Topic guide

A topic guide (Appendix G) was created to assist with facilitating discussion around therapists' perceptions of occupational therapy report writing in South Africa and the factors that influence this area of practice. By setting open-ended questions, the researcher ensured that there was some focus to the discussion. The order of the questions was carefully sequenced to promote discussion, by beginning with more general questions and ending with more specific questions, to enable conversation around what the participants believed should be included in an occupational therapy report.

3.2.6.3 Pilot study

These questions were piloted with two subject matter experts prior to using the questionnaire with the focus group participants [Davis and Morrow, 2004]. The subject matter experts included the researcher's supervisors, who are both qualified occupational therapists. The purpose of piloting the questionnaire was to check for relevance and understanding, as well as to ensure the objectives of the study would be met [Krueger and Casey, 2014]. No further changes were required to the questionnaire.

3.2.7 Data Collection

Three potential groups of participants from private, public and academic practice were identified.

Once permission was received, a copy of the consent forms for participation and audiotaping of the focus group interviews as well as a demographic questionnaire to be completed was sent to each potential participant. Paper copies of each of these forms were also brought to each focus group meeting or participants to complete if needed.

The researcher then travelled to the participants' place of work to carry out the focus groups. Whilst there was concern that this may place participants in a non-neutral situation, this limitation of the study was tolerated to promote participation and to reduce costs for the study participants. Once it was confirmed that all relevant paper work was completed, participants took part in the focus groups.

The researcher took certain steps to ensure the quality of data collected through the use of two recording devices as well as an observer, a qualified teacher with group experience, to keep track of which participant was talking. Throughout the group discussion the researcher took field notes to keep track of key issues discussed. This took the format of a spider diagram with keywords, outlining general topics discussed to assist with preliminary analysis. The researcher also kept a reflective journal into which entries were made after each focus group meeting. This assisted with reflecting on what had been discussed as well as for monitoring the facilitation process.

Feedback from the observer was included to assist the researcher in developing her group facilitation skills.

Following the completion of meeting the first four focus groups, a preliminary data analysis was done using the researcher's field notes and reflective journal to determine if information redundancy had been reached. The researcher broadly categorised the key issues into general themes, which were discussed with the relevant supervisors. This process highlighted that two of the groups in the public and private domain brought up some outlying information not evident in the input from the other focus groups. One of the groups made little reference to occupation during discussions but felt that their reports were of a good quality, which was in contradiction with what the other groups reported. Another concern raised was that clinicians felt they had the right to exclude certain information from reports and clients, which warranted further exploration. As a result, a further two groups were run in these respective contexts. Following a second preliminary analysis with the supervisors, it was then determined that no new data was emerging, and that information redundancy had been reached, hence no further focus groups were run.

3.2.8 Data management

The paper based demographic information was entered into REDCap (Research Electronic Data Capture) data management system. The audio recordings of each focus group were sent for transcription. Following the return of the transcriptions, the researcher read through each transcription with the audiotape to rectify any mistakes, as well as to begin the preliminary exploratory analysis of the data. This enabled initial immersion in the data. The original audio transcriptions as well as typed transcriptions were stored in their original format and all further analysis was done using copies of the transcriptions.

All documentation was systematically maintained to support reflexivity so allowing the researcher to readily access the data and continuously reflect on thoughts and interpretations [Kielhofner, 2006].

3.2.9 Data analysis

The demographics of the participants were represented in a descriptive format to provide a representation of their experience, postgraduate training and membership of interest groups.

A conventional content analysis, using an inductive method was undertaken to identify clinicians' perceptions of occupational therapy report writing. An inductive process allows for insights to surface without being limited to pre-determined theories or ideas [Kielhofner, 2006]. A stage-by-stage process was adapted to enable rigor in applying inductive principles into analysing the qualitative data. The coding process required identifying an important statement or moment and encoding it before trying to analyse what it meant [Fereday and Muir-Cochrane, 2006]. Ideally the code captured the essence of the phenomenon under discussion by the participants. This assisted with organising the data to start developing themes. The themes identified through the coding and analysis of the data assisted with interpreting what factors the participants viewed as being most influential on their ability to write reports.

Stage 1: Preliminary analysis**:** An iterative process was followed throughout data collection to check for information redundancy. Field notes from the researcher and observer as well as the reflective diary were reviewed by the researcher and supervisors to assist in checking for recurring or redundant information. This process was done three times throughout the data collection process, which assisted the researcher in determining whether sufficient information had been collected or whether further focus groups needed to be run [Tuckett, 2004].

Stage 2: Pre-coding**:** An initial immersion in the data was then done by reading through all the copied transcripts with the audiotape in order to identify any mistakes in the transcription. Notes were typed into the margins of the transcripts which enabled documentation of any initial thoughts or interpretations [Creswell, 2012]. These notes along with the reflective journal and field notes made by the researcher were jointly explored by the researcher and supervisor. This was to identify any personal biases of the

researcher that may influence the results. This was done prior to commencing coding of the data.

***Stage 3: Developing the code template*:** This process required coding of the text to form descriptions. Text segments were highlighted and then a word or phrase was assigned to describe the meaning (codes). Once the initial transcript had been read and coded in its entirety, the researcher and supervisor constructed a list of all the code words in order to group similar codes together. Redundant codes were discarded so that a manageable list of codes was identified. This process assisted with making sense of the data [Creswell, 2012].

***Stage 4: Testing the reliability of the codes*:** The researcher and supervisor then coded a section of the data together. The results were compared, and it was found that no further modifications to the code template were required.

***Stage 5: Applying template of codes and additional coding*:** This preliminary organising scheme or code template was then applied to the remaining data to identify any new codes that emerged. A qualitative data analysis computer programme was used to assist in this regard. The transcribed data from the six focus groups was entered into the MAXQDA12 software programme to assist with organisation and searching for codes in the remaining transcriptions of the raw data.

***Stage 6: Connecting the codes and identifying themes*:** To facilitate interpretation, themes were organised and given succinct phrases to describe the meaning assigned to each theme. Three overarching or core themes were identified and then organised into categories and sub-categories with code summaries.

The fourth aspect of the analysis organised the conflicts identified by the participants. These conflicts were identified as issues the participants couldn't agree on, but recognised as being crucial to assuring best practice in report writing. This then lead to the second phase of the study where experts were called in to discuss these conflicts using a nominal group technique.

3.2.10 Trustworthiness

In order to ensure accuracy of the findings, the researcher employed various techniques such as triangulation and data redundancy when collecting the data. Triangulation is the process of substantiating evidence from different participants which was done through the two phases of data collection with clinicians and subject matter experts [Creswell, 2012]. The principle of data redundancy was applied during the data collection process, where the researcher and supervisors conducted a preliminary analysis of the data to determine if sufficient evidence had been collected [Tuckett, 2004]. The researcher also ensured not to limit the amount of focus groups, but rather to continue the data collection until it was apparent that data redundancy had been reached [Kidd and Parshall, 2000]. Further methods of trustworthiness were also employed. Williams and Morrow 2009 identify three categories of trustworthiness to which qualitative researchers' must adhere. These are integrity or dependability of the data, equilibrium between reflexivity and subjectivity and clear communication of the findings [Williams and Morrow, 2009]. Due to the poor response from participants regarding member checking it was not sufficient to use this as a method of trustworthiness.

3.2.10.1 Integrity or dependability of the data

Integrity of the data requires a clear articulation of methods allowing for replication of the research study. Patton 2002 refers to "*a systematic process systematically followed*" [p.267][Patton, 2002]. The researcher ensured a detailed procedure was drafted from protocol stage, where several iterations of the process were documented until sufficient clarity and detail was recorded to ensure systemization of the process. Williams and Morrow also advise that researchers should present evidence that adequate quality and quantity of data have been collected. This was done through ensuring that participants could provide the richness of data required, through having a range of experience (6 months -10 years), as well as through working in a variety of contexts as per the inclusion criteria [Williams and Morrow, 2009].

3.2.10.2 Equilibrium between reflexivity and subjectivity

A balance between reflexivity and subjectivity allows for the researcher to remain self-reflective and to distinguish what comes from the participant and what comes from the researcher. This can be achieved through bracketing and journaling (Rolls & Relf, 2006). Bracketing is where the researcher acknowledges their prior knowledge and assumptions and makes an attempt to set these aside, to enable attending to the data with an unbiased mind. This can be done through interviews with a supervisor or colleague and should be done before, during and after data collection to identify any issues that may hinder the researchers ability to listen to the participants [Tufford and Newman, 2012]. From the outset the researcher kept a journal, which useful for managing the emotive reactions to some of the participants' comments, as well as for keeping track of any biases that may have influenced interpretation. Journal entries were made after each focus group meeting and during preliminary analysis, coupled with notes on the transcripts during analysis. The journal entries regarding the focus groups proved prompting neutrality throughout the interview process. These entries included reflection of the researcher's facilitation of the focus group interviews.

The journal entries and notes were used to enhance several bracketing interviews held with the researcher's two supervisors to unpack biases and emotions experienced through the data collection and analysis process. This process was distinct from supervision regarding the research process or methodology, and allowed for space to explore the emotions and biases experienced by the researcher [Rolls and Relf, 2006; Tufford and Newman, 2012]. A bracketing interview with one supervisor occurred prior to commencing the focus groups to unpack any biases the researcher may hold prior to collecting the data. A second bracketing interview was held mid way through data collection, to again address any biases that may influence the initial analysis of the data and to review the way the researcher was interviewing participants. A final interview was held after data completion, to review any emotions and opinions of the researcher that may influence data analysis. Another strategy to limit bias during the analysis of the data was to ensure that all views were presented. Creswell (2013) refers to this as

negative case analysis, stating that not all evidence will fit the pattern of a code or theme. He argues that it is necessary for the researcher to report on this ‘negative view’ in order to give a more realistic evaluation. The researcher ensured that divergent views were not ignored, by documenting conflicts that emerged.

3.2.10.3 Clear communication and application of the findings

Clear communication and application of the findings refers to the social validity of findings; that they need to be meaningful and easily interpreted. The overall aim of the study was to support quality assurance in the profession, and the researcher endeavoured to represent the findings to be easily interpreted and understood by the population concerned [Williams and Morrow, 2009].

3.3 Phase 2

The purpose of the second phase of the study was to build on the findings from phase 1 and to employ the principle of credibility by exploring if the findings from the first phase could be validated by the findings from phase 2 (subject matter experts). A second phase supported the integrity of the findings [Bryman, 2006]. The researcher sought to gain some consensus amongst these issues by engaging with subject matter experts through the nominal group technique (NGT). Conflicts, which arose in phase 1, were used as the triggers for the second phase of the study, which included a nominal group of subject matter experts. The discussion and aggregation of ideas in this phase ensured that the interpretation of the data from the focus groups was carried out by a range of experts rather than just the researcher, so preventing bias and allowing for a more balanced view [Creswell, 2013].

The nominal group technique is a special–purpose group process, to assist with decision making by establishing priorities of individuals, where several judgements need to be aggregated into a group decision [Delbecq et al., 1975]. Whilst this process allows for some definitive outcomes to be established, group consensus does not mean that exact answers have been found. Rather, many of the results are exploratory in nature and identify various solutions that may require further hypothesis generation and testing [Delbecq et al., 1975; Jones and Hunter, 1995].

3.3.1 Study population

As the researcher sought to gain expert opinion on the conflicts identified in phase 1, the study population consisted of subject matter experts within the field of occupational therapy. Identification of appropriate subject matter experts (SMEs) is key to promoting validity of a study [Landeta, 2006; Okoli and Pawlowski, 2004]. An SME can be identified as an individual at the top of his or her field, achieved through formal training and experience [Rassafiani et al., 2009]. Schell and Schell identify an expert occupational therapist as having at least 10 years of reflective practice through extensive practice of learned knowledge and skills [Schell and Schell, 2008].

3.3.2 Inclusion criteria

Studies exploring clinical competence in occupational therapy suggest that clinicians who have a minimum of 10 years' experience, a recognised bachelor's degree in occupational therapy, who have attended ongoing CPD workshops, who have a postgraduate degree/diploma and who are members of at least one special interest group/professional board member can be viewed as a SME [Rassafiani et al., 2009; Schell and Schell, 2008]. These participants need to be recognised as experts in their respective fields, either within academia, management or clinical practice.

3.3.3 Sampling

Purposive sampling was used to intentionally recruit professionals with the relevant experience to assist with understanding the phenomenon to be explored. All the SMEs who met the criteria and who agreed to be part of the study were included, leading to a total of eight participants [Creswell, 2012]. Leaders in the development of the NGT, Delbecq and Van de Ven, claim that the technique can accommodate up to 9 members in a group without the dysfunction of conventional interactive groups affecting the outcome [Delbecq et al., 1975].

3.3.4 Ethical considerations

Phase 2 fell under the same ethical clearance certificate from the University of the Witwatersrand Human Research Ethics Committee (Medical), Certificate number M.140490 (Appendix A). The researcher followed the same stringent data management procedures to maintain confidentiality of the participants.

Each participant was also required to sign a consent form for participating in the research (Appendix H) as well as a consent form for audiotaping the session (Appendix I).

The paper based demographic information was entered into REDCap data management system and participants were given codes for identification. All raw data was locked away in a storage cupboard within the occupational

therapy department. The audio recording of the nominal group was saved in an mP3 format onto a cloud storage base, which was password protected.

3.3.5 Research procedure

A nominal group technique (NGT) was used to gather data for the second phase of the study. The NGT is a formal consensus method used in research studies in various contexts to identify current opinions or to achieve agreement in particular topics [McMillan et al., 2014]. It is frequently discussed alongside the Delphi technique within literature, as a method to assist with the generation of ideas in relation to problems and solutions [Delbecq et al., 1975; McMillan et al., 2014; Potter et al., 2004]. The NGT has several advantages over the better-known Delphi Technique. Whilst it has the same objective in terms of generating ideas and solutions through a highly structured process, the NGT requires minimal pre-meeting preparation by the participants, and input is usually limited to a single two-hour meeting. Overall researcher bias is also limited due to the highly structured process [Potter et al., 2004]. The process starts by facilitating the generation of ideas in response to a conflict or problem, which are then deliberated and ranked in order of importance by the participants on an individual basis. It allows for equal participation by all participants, so avoiding the dominance of strong personalities, which can be a risk in other group settings [Delbecq et al., 1975; McMillan et al., 2014]. The most common uses for NGT include problem identification, developing solutions and then establishing priorities for action[Harvey and Holmes, 2012]. In this study it was primarily used for developing solutions to problems, which were the conflicts generated from the focus group interviews. The validity of this method has been explored by Van Teijlingen, Pitchforth, Bishop and Russell who found it to be a valid tool in collating expert opinion providing the facilitator does not override the diversity of opinion in order to create a quick consensus [Van Teijlingen et al., 2006].

3.3.6 Research instruments

3.3.6.1 Demographic Questionnaire

Participant characteristics were collected through the completion of a demographic questionnaire (Appendix J). Participants were purposively sampled to ensure they met the inclusion criteria for the nominal group.

Information included in the demographic questionnaire included details on the participants' post-graduate qualifications and membership to special interest groups as well as length of time in practice. These factors were all essential to be included as a subject matter expert [Rassafiani et al., 2009]. Information on areas of practice was also included to ensure participants represented a range of areas of practice in occupational therapy.

3.3.6.2 Cue cards

In order to facilitate the nominal group discussion, a series of cue cards/scripts (Appendix K) was created to facilitate the discussion as well as to ensure all three conflicts were discussed. The conflicts came up in the focus groups in phase 1 and represented areas that the focus group participants could not agree on. It was intended that the subject matter experts in phase 2 of the study would be able to provide some clarity on these conflicts as well as to support triangulation of the evidence collected in phase 1. The 3 conflicts discussed were:

1. *Therapists are in disagreement as to whether they should write one report or a variety of reports depending on their audience. Related to this is whether the report format should change depending on the clinicians' area of practice. What guidance could you give clinicians in this regard?*
2. *The use of OT language has therapists conflicted around OT language/jargon. They often use generic rather than OT words in their reports. How should clinicians manage the perception that other professionals and their clients and caregivers don't understand their reports? To add to that is the complexity of the SA context where so many receivers of the reports have English as a second language.*

3. *OT's are unsure of what must be included in terms of medical/clinical information e.g. medical history, diagnosis, test scores etc. What guidance would you give in this regard?*

3.3.7 Data Collection

The researcher identified known subject matter experts (SMEs) within the Gauteng area who worked in public, private and academia (as per the contextual requirements in the first phase) and contacted them via email to request participation. Potential participants were sent an email including the details of the study, ethical clearance and a demographics questionnaire to complete to ensure they met the inclusion criteria. Twenty-one SMEs were contacted and eight out of the twenty-one agreed to or were available to participate in the study. This was further decreased to six participants as not all participants could make the agreed meeting time a few days before the group. The researcher held the meeting at the University of the Witwatersrand Occupational Therapy Department at a time that was convenient to majority of the participants. A research assistant (supervisor to the study) assisted with running the group by typing up participant responses, after receiving training by the researcher in the process of running a nominal group.

A small tutorial room, to allow for intimacy of discussion, and to enable clarity when audiotaping the session, was chosen. Other technological equipment included a computer and data projector. This allowed the research assistant to type up the opinions and rankings in real time as discussed by the participants and project them onto the screen for ease of reading by the participants. A high-quality recording device was also used to enable the collection of qualitative data to support the findings. The researcher set up the room with tables in a "u-shape" to allow for participants to be able to see each other when communicating as well as to see the flipchart and white screen.

Each participant's place had a pile of cue cards, as well three pens in different colours. This was done so that the researcher could easily identify responses for each conflict discussed in the group. In order to assist the participants with understanding the conflicts, and with contextualising the issues at hand, the researcher introduced a short case (Appendix L) to illustrate the conflicts

novice practitioners may face with report writing as identified in phase 1. This was projected up onto the white screen at the start of the group.

A script/cue cards were developed to assist with the running order of the group (Appendix K). The researcher introduced the title of the project, the research process completed thus far and preliminary findings, and then the running order of the NGT process. As there were three conflicts to discuss, the NGT process was repeated three times over. The following is the outline of the running order of the nominal group process:

Step 1: Silent generation of ideas: Presentation of the conflict and silent generation of ideas (participants to write on cue cards).

Step 2: Round Robin: Each participant had a chance to express their ideas orally with no discussion from the group. Cue cards were stuck onto flipchart.

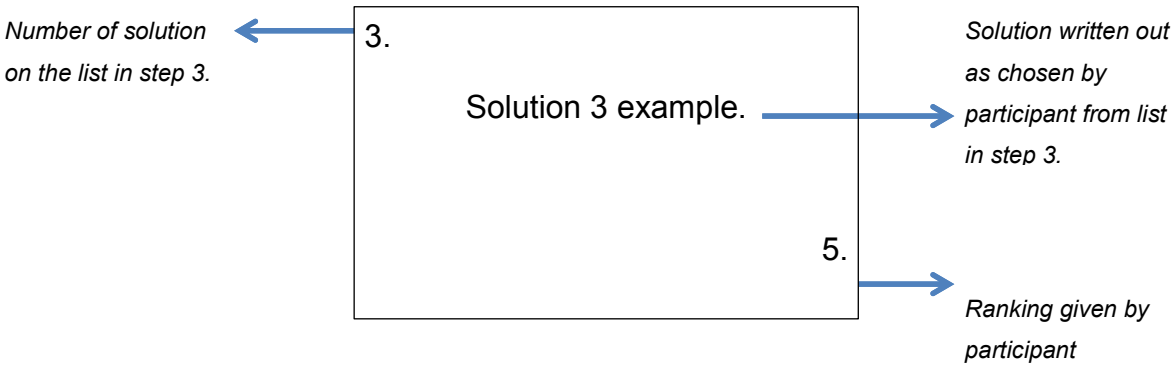
Step 3: Serial discussion for clarification: Discussion was facilitated amongst the group to clarify, as well as to combine, any overlapping ideas. The assistant researcher typed these onto a numbered table, which was projected onto the white screen. See example below.

1.	Solution 1 example
2.	Solution 2 example
3.	Solution 3 example
4.	Solution 4 example
5.	Solution 5 example

Step 4: Voting: Participants then voted on the ideas/solutions they thought best addressed the conflict. This process required each participant to choose the top priority solutions out of the total identified by the group.

The number of priority solutions chosen by participants varied per conflict and the amount of solutions that were identified. It is likely that group members can only accurately rank between 5-9 items with some reliability of judgement [Delbecq et al., 1975]. Participants were asked to write the solution of their

choice on a cue card with the number of the item on the top left corner. This was done with all the priority solutions chosen.



Participants were then required to choose the most important card and give it the highest ranking by writing this on the bottom right corner of the card. The process then continued in descending order to the least important. This procedure is purposefully slow to encourage group members to make carefully considered rather than hasty decisions [Delbecq et al., 1975].

The above process was completed for all three conflicts. Preliminary tallying of ranked votes was done whilst the participants had tea. Whilst the votes for conflicts two and three enabled the identification of clear solutions, for the first conflict there was no clear outcome, as too many solutions were generated.

It was decided then that participants would re-vote on the items for the first conflict by choosing the top 5 statements from the list of chosen items from the first vote. They were then asked to re-rank them in order of importance with 5 being the most important and 1 being the least important. The statements that did not make the top 5 ranking were eliminated. The above process was done by emailing the participants. Each group member was required to carry out this process individually and send the result back to the researcher who then re-tallied the votes [Hanekom et al., 2015].

3.3.8 Data analysis

The analysis of data from the nominal group and reporting of results can be carried out using both qualitative and quantitative methods. A quantitative analysis allows for the aggregation of judgements or ideas. To enable further validation of the findings, a qualitative approach can be used in analysing

individual comments when group discussions take place. Quotes from participants can be taken from the transcripts to help explain both individual and group thinking. This content analysis helps to provide improved clarity and depth in the explanation of results and as a result, the NGT is occasionally referred to as a mixed methods approach [Potter et al., 2004]. Whilst the researcher used an apparent mixed method approach in this phase, the aggregation and ranking of the statements (quantitative element) was primarily used as an activity to facilitate discussion. After identifying the top solutions through participant voting, the researcher then used these solutions as a matrix in which to organise the codes sourced from the qualitative data (audio transcripts). The data was analysed into a categorisation matrix in which the top ranked solutions to the conflicts were paired with qualitative data codes.

Rank ordering of results –

The quantitative analysis of data was achieved by aggregating and scoring methods, which were used to identify group priorities. Having group members make individual judgements and then expressing these mathematically can increase the judgemental accuracy of the vote. Delbeq, Van de Ven and Gustafon (1975) describe two methods for aggregating and ranking the data.

Rank ordering the data is the simplest and most often used voting procedure. This approach includes tallying the votes by each participant on each statement as described above. The researcher aggregated the votes for each statement made by each participant as well as the possible highest score that a statement could have received. The tally was then divided by the possible highest score and multiplied by 100 to obtain a percentage. This percentage was then used to identify which statements were ranked highest amongst the participants [Delbecq et al., 1975]. This was done by determining, which statements received higher than 30% in ranking overall.

Content analysis –

The researcher then used a deductive method to code the qualitative data, using the solution statements to populate the categorisation matrix. The audiotape of the nominal group was transcribed for analysis purposes. All the

data from the transcriptions were reviewed for content and coded with the corresponding categories. This assisted with establishing qualitative codes which supported or opposed the solutions decided upon by the group [Elo and Kyngäs, 2008; Potter et al., 2004]. As the matrix was structured, only aspects that fitted the matrix analysis were chosen, as the aim of the analysis was to support the aggregation of the quantitative data that was captured [Potter et al., 2004].

A staged approach was adapted to enable rigor in analysing the qualitative data [Fereday and Muir-Cochrane, 2006].

***Stage 1: Structured Matrix*:** A categorisation matrix was developed using the top aggregated solution elements as established by the subject matter experts within the group. All solution elements that achieved above 30% when aggregated were included.

***Stage 2: Pre-coding*:** An initial immersion in the data was then done by reading through all the copied transcripts with the audiotape to identify any mistakes in the transcription. Notes were typed into the margins of the transcripts which enabled the researcher to document any initial thoughts or interpretations [Creswell, 2012].

***Stage 3: Identifying codes according to matrix*:** This process required reading through the text and applying the deductive codes to aspects of the text that corresponded with a matrix category. This step was enabled by uploading the transcribed transcript into the MAXQDA12 software programme. This assisted with organisation and searching for codes in the remaining transcriptions of the raw data.

***Stage 4: Testing the reliability of deductive analysis process*:** the researcher and supervisor then reviewed the coded data together. No further re-organisation or re-coding was required.

3.3.9 Trustworthiness

Williams and Morrow's three categories of trustworthiness were once again used to establish trustworthiness of the data. [Williams and Morrow, 2009].

3.3.9.1 Integrity of the data

This includes the clear articulation of methods allowing for replication of the research study [Patton, 2002]. The researcher ensured a detailed procedure was drafted with sufficient clarity and detail. The researcher could not employ the principle of redundancy, as she was limited by the number of subject matter experts available within the Gauteng area. One must assume that by the nature of their status, subject matter experts will give the most well rounded view of the conflicts discussed. The researcher also ensured that all SMEs were from a variety of backgrounds that corresponded with the participants from the focus groups. A further criterion of data integrity is that evidence should be included as to how the interpretations fit the data. The researcher ensured that direct quotes were used to support the interpretation of the data [Stedman, 1995].

3.3.9.2 A balance between reflexivity and subjectivity

This was achieved through bracketing and journaling as in phase 1 [Rolls and Relf, 2006]. Journal entries were made after the nominal group meeting and during preliminary analysis. A bracketing interview was held with one of the researcher's supervisors to unpack biases that may have been present [Rolls and Relf, 2006; Tufford and Newman, 2012].

3.3.9.3 Clear communication and application of the findings

The researcher ensured that all interpretations were supported by participant quotes when writing the results of the study [Williams and Morrow, 2009]. By employing two methods of data collection, trustworthiness was maintained through triangulation, as collection of the quantitative aggregation of the votes was also supported by the qualitative quotes from the participants [Potter et al., 2004].

CHAPTER 4 RESULTS

4.1 Introduction

This chapter presents findings from Phase 1 followed by findings from Phase 2. Data from phase 1 was analysed using an inductive thematic content analysis. The categories and codes are presented across each practice setting namely private, public and academic for Theme 1, but not Theme 2 and 3, which were not setting dependent.

Conflicts in report writing were identified and defined from the data analysis in Phase 1, which were then addressed in Phase 2. The solutions to the three conflicts were generated in a nominal group. The results of Phase 2 using a deductive content analysis method are as presented. This analysis was based on the matrix developed from the aggregated scores of the solutions of the three conflicts in report writing identified from phase 1.

4.2 Phase 1

4.2.1 Demographic data

The demographic data of the participants from the six focus groups were arranged according to the practice settings namely the public sector, the private sector and the academy. Table 4.1 outlines the number of participants and focus groups held for each practice setting.

Table 4.1 Number of participants and number of focus groups for each setting (n=47)

Area of practice	Number of participants	Number of focus groups
	n	
Public sector	26	3
Private sector	15	2
The academy	6	1

Table 4.2 is a representation of the number of participants with postgraduate qualifications and the years' of experience since graduating of the participants in each setting. Over 60% of participants in the public sector had less than 5

years' experience. The experience of the participants in the private sector ranged equally from less than 5 years' experience to 10 years' experience. In the academy, the majority of participants had more than 16 years' experience with none of these participants having less than 5 years' working experience.

Table 4.2 Representation of participants' post graduate qualifications and participants' years of experience in the three different practice settings

Post graduate qualifications	Number of participant with post graduate qualifications	0-5 years	6-10 years	11-15 years	16-20 years	21+ years
	n(%)					
Public Sector	4 (15.3)	18 (69.23)	4 (15.38)	3 (11.54)	0 (0)	1 (3.85)
Private sector	4 (26.6)	6 (40.00)	6 (40.00)	1 (6.67)	1 (6.67)	1 (6.67)
The academy	6 (100)	0 (0)	1 (16.67)	1 (16.67)	2 (33.33)	2 (33.33)

All the participants in the academy held a postgraduate qualification, which is expected as part of their job requirements. Only 15.3% of government participants held a postgraduate qualification and just over a quarter of the private sector participants held a postgraduate qualification.

Member of Special interest group	n(%)	
Public Sector	14	53.8%
Private sector	9	60%
The academy	5	83.3%

Table 4.3 Representation of participants' memberships of special interest groups

Table 4.3 represents membership of any special interests groups. More than half of the public sector participants were members of one or more special interest groups as were 60% of the private sector participants. Over 80% of

the academy participants were involved in, and instrumental in, organising and managing special interest groups.

4.3 Thematic analysis of focus groups

Three themes emerged from the data

Theme 1: Generic occupational therapy reporting issues

Theme 2: The occupational therapy identity

Theme 3: Who is the audience?

Theme 1 was represented according to practice settings as different sub - categories related to the theme and categories emerged which were dependant on the settings in which the participants practiced. Theme 2 and 3 were analysed across the six focus groups as the data for all participants, irrespective of the setting they worked in, fitted into similar subcategories and codes.

4.3.1 Theme 1: Generic occupational therapy reporting issues

This theme sought to understand how participants viewed and described issues around the process of writing reports and is presented according to the practice setting, as views of the participants from the different settings brought up different concerns. Within the public sector, participants identified concerns that were ethical in nature as well as concerns with how to handle sensitive information. Confusion around patients' rights and responsibilities also played a part in the practice of writing reports. Focus groups with private sector participants demonstrated that occupational therapists are confused around the legal procedures regarding reporting as well as how to handle sensitive information as in the public sector. An issue particular to this sector was around billing for the practice of writing reports. Participants in the academy communicated that maintaining confidentiality was one of the key issues affecting report writing. All three sectors also identified barriers and facilitators to best practice. The inexperience of therapists was identified by all three sectors as being a significant barrier to best practice. The public sector appeared to be affected by contextual issues, such as lack of resources, inefficient processes, managing different languages and literacy of patients.

The private sector barriers related to medical aid requirements and billing in practice, whereas the academy highlighted difficulties with health literacy and divisions within health care in South Africa. All three sectors voiced that building therapist experience would facilitate best practice in reporting, with the public and private sector voicing that templates and being more prepared in the practice of report writing would facilitate best practice.

4.3.1.1. Category 1 Ethics

Table 4.4 Theme 1 Generic occupational therapy reporting issues: Ethics

Theme	Category	Sub-category	Codes (summary)
Generic occupational therapy reporting issues	Ethics	**Public sector**	
		OTs are aware of the need to be ethical	• confidentiality and consent • understanding legal and ethical issues
		How to report on sensitive information	• divulging information • leave it out?
		Patients' rights and responsibilities	• who does the report belong to? • communication with patient and other professionals
		Private Sector	
		OTs are confused around the legalese	• knowing the rules • which guideline to follow?
		What do OTs have the right to charge for?	• what should be charged for? • is it ethical to charge for written and verbal reports?
		How to handle sensitive information	• when should information be omitted, if ever?
		Academy	
		Maintaining confidentiality	• lack of control over information once in the public domain • clinical reasoning and judgement

The categories, subcategories and codes are described in the text below.

4.3.1.1.1 Public Sector

Understanding the ethical requirements of reporting on client information was brought up spontaneously in all three public sector focus groups; however it was not a topic that dominated the discussion between participants. Participants commented on the need to be ethical but offered limited detail on the legal and ethical policies and guidelines that inform public healthcare practice.

Subcategory 1: Occupational therapists are aware of the need to be ethical

Participants commented mainly on the need for confidentiality, and the importance of getting consent from the client before you released any information.

> *"Confidentiality. You have to get consent before you tell the employer anything."* ***GC3. p. 1***

There was an awareness that there may be limited control over who sees the information.

> *"I think for me also just to keep in mind all the legal aspects and that the report is not only going to be seen by you. There are other people that have access to it."* ***GC2. p. 5***

There was however, a lack of understanding around what exactly these legal and ethical requirements stipulated. Participants did not openly admit they were unaware of the specific ethical and legal stipulations around reporting, but gave the impression that they were concerned about what they should know.

> *"Like according to HPCSA you have to write in English?" "****GC1. p. 1***

Subcategory 2: How to report on sensitive information

Much of the information shared within the public sector focus group interviews pertained to managing sensitive information such as the clients' HIV status. Participants were aware of the possible implications of divulging sensitive information and how this could impact on the client. Discussion was mainly around reports for the employer or a member of the work place. It was acknowledged that the process around this is somewhat unclear.

> *"…will someone from HR read it and then you are not quite sure, especially with HIV and psychiatry with a stigma and so it's a little bit tricky."* ***GC2. p. 8***

The preferred approach by participants within this setting appeared to be to omit this information, rather than specifically understanding the legal and ethical policies that govern this. It was apparent participants would rather abstain from divulging this information as they felt it was "*not right*" ***GC1. p. 6***

> *"Ethical issues of oh you'd like to say that the patient is HIV positive... So you can't just go and say oh this is a general standard thing for assessment reports, that's not right."* ***GC1. p. 6***

Subcategory 3: Patients' rights and responsibilities

Participants from two of the public sector focus groups acknowledged that part of being an ethical therapist was including the client in the treatment process, as this was part of the clients' rights.

> *"I think you have a right as a patient to know what your treatment is..."* ***GC1. p. 5***

There was some exasperation however, as participants felt that clients generally did not take responsibility for being part of the treatment process as they don't routinely request or agree to be copied into reports.

> *"... we do offer them that option if they want to be copied into the report but they never do."* ***GC2. p. 9***

4.3.1.1.2 Private Sector

Participants within the private sector focus groups also voiced concerns over ethical issues that were related to writing occupational therapy reports pertinent to privately owned practices and those working for other occupational therapists.

Subcategory 1: Occupational therapists are confused around the legalese

Independent private practitioners were concerned about the legal governance around report writing, which they felt was unknown or confusing. They reported being unsure of all the legal requirements for reports.

> *"But I'm embarrassed to say I don't know those legalese like you can't use pencil you have to use pen, I don't know that."* ***PC1. p. 1***

There was also apprehension regarding rights and responsibilities of the practitioner versus the client around the dissemination of information. It was apparent that working as a private practitioner, participants feel they do not have the security of procedures and policies that may be in place in a larger organisation.

> *"Where does the responsibility lie? Does it lie with you as a therapist to inform XYZ or does it lie with the patient??"* ***PC1. p. 4***

Confusion was also apparent around who the information belonged to.

> *"Technically it doesn't* (belong to the OT)*, it's yours* (the patient's) *because you paid for it."* ***PC1. p. 4***

A single participant, who exhibited a more dominant personality, made most of the comments.

Subcategory 2: What do occupational therapists have the right to charge for?

An area of particular discussion around the right to bill or charge for specific reporting services indicated insecurity around this matter. Practitioners seem unsure of what specific services they have a right to bill for and were reluctant to bill for some related to reports and feedback.

> *"So we should be charging for all the reports and any extra time we use on the patient but unfortunately we don't, we are just not those type of people..."* ***PC1. p. 1***

The therapists in independent practice primarily voiced the lack of surety around this issue, with participants who worked in a group practice being less anxious about this issue.

> *"What should we ethically be able to charge for and you know involved in your clinical expertise?"* ***PC1. p. 2***

One of the group practitioners reflected on the processes in place and that perhaps the billing system does not accurately reflect the amount of work put in.

> *"Often our letters of motivation which we are trying to keep as concise as possible we don't actually bill for those as opposed to an insurance report, which can be five, six pages. Those ones we are billing for."* ***PC2. p. 4***

The insecurity around billing for reports may be due to a variety of factors, but it was clear that this affected the occupational therapists' perceptions of themselves as being undervalued compared to their counterparts within the health care system.

> *"Also the fact that we're devalued compared to physio. Our billing is a lot less than physio."* ***PC2. p. 3***

Subcategory 3: How to handle sensitive information?

Amongst the independent private practitioners there was some consensus that practitioners have the right to withhold certain information if they felt it was too much for the patient or family to handle, as was discussed in the public sector groups.

> *"…so then you are covered because as long as you know the patient could harm himself or would have a problem seeing this report then you don't have to give it to them."* ***PC1. p. 2***

This statement was however contested by one participant in the group, who had personal experience of dealing with information relating to the care of a loved one. This participant voiced that it should be up to the individual concerned to decide how they deal with the information.

> *"My brother had a head injury and I had to deal with it, I had to deal with it from a personal side. I want to know what's in that report…Each family is different I still think they need to be able to have access to that. You can't control how everybody is going to react."* ***PC1. p. 3***

Further debate was then had around to whom the information belonged. One participant voiced that it was unnecessary to include all patient information especially if dealing with illiterate clients. The solution was to omit the information rather than find another way of reporting it.

> *"So I think you really have to look at audience, have your template that can cut half of the thing off if you deal with illiterate people…you just share what is appropriate."* ***PC1. p. 4***

4.3.1.1.3 Academy

The academic participants offered some contribution towards perceived ethical dilemmas faced by practitioners when writing occupational therapy reports. Most of the discussion focused around the issue of confidentiality with some suggestions of how to manage this.

Subcategory 1: Maintaining confidentiality

The main discussion was around individuals not involved with client care having access to information. It was acknowledged that health care professionals are bound by certain ethical principles to manage client confidentiality, however once the information enters the public domain, individuals who aren't accountable to any legal requirements regarding confidentiality may have access to personal information.

> *"I am concerned where the focus is on people bound by professional council rules and not everyone who requests our reports are held by those legals."* ***AC. p. 4***

A solution was offered by one of the participants, relating to scope of practice. It was reported that if practitioners stay within their boundaries, it would cut down on the need to report on sensitive information.

> *"If we actually only focus on the reporting of the occupational profile and that is all we report on … then we have stayed within our boundaries and it will cut down some of the ethical issues."* ***AC p. 6***

Another participant felt that using clinical reasoning would guide practitioners on what to include and what to omit with regards to sensitive information.

> *"But then that would be when your clinical reasoning would come in, about what kinds of information to include."* ***AC. p. 5***

4.3.1.2 Category 2 Barriers to report writing

Table 4.5 Barriers Category for Theme 1

Theme	Category	Sub-category	Codes (summary)
Generic occupational therapy reporting issues	Barriers	**Public sector**	
		Language	• receivers having English as an additional language • not unique to OT
		Insufficient process	• what is required? • seeking clarification and collateral • management deficiencies
		No standard format for reporting	• written for different referral sources • trial and error
		Lack of resources - physical	• space • equipment
		Inexperience	• lack confidence • time it takes
		Private Sector	
		Ensuring reader understanding	• need to be understood by parents and teachers • literacy
		Medical aid stipulations	• duplication • length of report
		Practice needed	• inexperienced therapists gain skill beforehand • required for integration
		Academy	
		Appropriate in South African context	• healthcare literacy • language
		Division in healthcare	• lack of coordination between primary to tertiary care
		Experience counts	• lack of concise integrated reports

4.3.1.2.1 Public Sector

Much time was spent on participants voicing their concern around the barriers pertaining to best practice in report writing within the public sector. Concerns ranged from issues participants viewed as being outside of their area of influence, such as receivers of reports not understanding English, poor or

insufficient processes governing the exchange of information and lack of resources, to internal issues such as not having sufficient experience.

Subcategory 1: Language

Participants from all three public sector focus groups felt that most of their clients have difficulty understanding their reports as English is not their home language. There was acknowledgement that even with translation, information could be misunderstood or missed, which would have a negative impact on the clients' participation in their care.

> *"Also because of the language barrier, it is hard. I don't think that most of our parents will necessarily go home and try and read it again, because the English is like already a challenge in itself."* ***GC3. p. 5***

It was recognised that this barrier to effective report writing was a challenge faced by the clients as well as the therapists. While they acknowledged that clients might have difficulty understanding English, no suggestion was made to address this through the writing of the report.

Subcategory 2: Insufficient process

Many comments were made about the insufficient processes and systems participants experience working in the public sector. These related to a variety of issues such as duplication of referrals, lost files and management of logistical issues. An area that evoked significant discussion was confusion about what was required due to the poor clarity of referrals and the lack of information that accompanied them.

> *"Sometimes I'm not actually clear who I'm writing the report for. Because I get a referral, just the name and there is no indication was it the doctor that sent the child."* ***GC2. p. 4***

Referrers may request an occupational therapy assessment and reports but do not provide the detail. The participants then feel a large amount of time is spent seeking clarification on what is needed as opposed to carrying out the occupational therapy process.

> *"Another thing that frustrates me is just like the reason for referral. Often we would get people coming from the school or from somewhere and then they want an OT report, but we don't know why."* ***GC3. p. 1***

Related to this was the feeling that referrers and the clients themselves don't have sufficient information or are not able to communicate what is needed to

support the assessment process. This lack of, or unreliable information and the time it takes to source the correct information was felt to have an impact on the quality of the reports written by the occupational therapists.

> *"…we have to get the collateral which then takes more time. And the unreliability of information but that comes into the time issue when you are actually searching for that."* ***GC2. p. 5***

The issue of time available with the client was seen as being outside of the participant's control. This specifically related to this context as participants recognised that clients' socio-economic status and lack of access to resources could be influencing this. As clients have limited funds they have difficulty accessing occupational therapy services to enable a thorough assessment and intervention, which affects the quality of information in the report.

> *"Also, in terms of late referral, we are given a short time to complete the report. You often find that the patient is not able to come back because of financial constraints, so you have to assess them in that session not over a few days as you would have liked."* ***GC3. p. 2***

This poor management of information is also acknowledged as being systemic, and influenced by poor systems management within the institution, which in turn has an effect on the participants' time management.

> *"And sometimes the hospital nowadays is not good enough because they might have like three files."* ***GC2. p. 7***

It appears that some facilities are in place within this setting to enable better quality assurance with annual audits happening across various government institutions on record keeping, however the system does not allow for feedback, as the audit happens at the end of the year, and most community service therapists then leave that specific context after their one year contract.

> *"Ja, so like in our instance, we as comm serves are marked once and there's never any follow up to see have we improved, or it's then next year, when it's a new comm serve."****GC1. p. 6***

Subcategory 3: No standard format for reporting

Participants from two of the public sector focus groups acknowledged that not having a standard report format makes it difficult for therapists to know what to include or omit. This appeared to be a particular problem for novice therapists.

> *"There is no real standard format that we have to use. Sorry as much as a challenge but it's just knowing should I put that in, shouldn't I?"* ***GC2. p. 9***

Participants reported overcoming this by setting up templates for their departments. It was acknowledged that the HPCSA has online guidelines available regarding record keeping but it is felt that these aren't detailed enough to guide therapists in terms of the specific reports that need to be written.

> *"They're quite broad in the fact that you have to write in black ink, you have to have a date as a time and no, it's quite broad."* ***GC1. p. 9***

Subcategory 4: Lack of resources

Lack of resources, such as time for therapists to write reports and physical resources, was seen as a barrier across the three public sector focus groups. Physical resources such as not having enough "*…equipment or printer and paper, ink."* ***GC2. p. 1*** was a cause for concern, which participants felt affected their efficiency at producing occupational therapy reports.

> *"The reality of it is it's not going to happen, because we really are short of time and resources"* ***GC1. p. 4***

This extended to not having access to enough computers, which also added to the frustration and their perceived ability to write reports timeously.

> *"…but we have to share one computer, so then you are almost forced to make the report as short and quick as possible, because there are 3 or 4 other people who need the computer."* ***GC.3 p.1***

Participants reported having limited access to space overall, which affected the whole occupational therapy process and not just the writing of the reports. Participants voiced that this influences their ability to be confidential and ethical when providing feedback or explaining reports to clients.

> *"…difficulties with space so confidentiality or quiet spaces in a department to carry out assessment and then provide feedback."* ***GC2. p. 7***

Subcategory 5: Inexperience

Participants were open to acknowledging that their lack of experience also affected their ability to produce professional occupational therapy reports.

> *"But when you are the one writing the report, especially for a very complicated case, you don't know how to make it good sometimes."* ***GC3. p. 3***

The participants' comments related to not knowing what recommendations to include, as well as writing the report in professional language.

> *"Just in terms of knowing the right language or a professional way of putting that."* ***GC2 p. 3***
>
> *"So like not really knowing if this is the right recommendation for this patient."* ***GC2 p. 9***

It was also acknowledged that this inexperience also influences the length of time it takes to write a report, as novice therapists often find it takes longer to produce an occupational therapy report compared to their more experienced colleagues.

> *"Also, how often you have done them before. For instance, my first paeds report took hours."* ***GC3. p. 1***

4.3.1.2.2. Private sector

It must be noted that there were significantly fewer barriers to best practice in report writing perceived by the private practitioner participants when compared to the public sector participants. One specific barrier related to the private practice context was dealing with medical aid stipulations when writing reports.

Subcategory 1: Ensuring reader understanding

The private practitioner participants noted that the audience receiving the reports may have difficulty understanding what is written in occupational therapy reports.

> *"… but that's exactly what is happening, you need to know your audience. If daddy is an engineer and mommy is a whatever, put that stuff in but you are not going to put it into your underprivileged child."* ***PC1. p. 4***

Some concern was also voiced that the receivers of reports who do not have a health sciences education may also have difficulty understanding the reports.

> *"I think even nursery school teachers they don't know these things and then they start spouting forth and realizing they misunderstood somebody's report."* ***PC1. p. 3***

The solution to this barrier was to omit the information rather than find another way of reporting the information

Subcategory 2: Medical aid stipulations

This group of participants also identified that insufficient process affects best practice in report writing. The context dictated that this was primarily due to the stipulations of the medical aid companies who are the key funders to occupational therapy services within private practice. What is interesting to note is that issues with duplications also occurs within the private sector.

> *"In the outpatient setting there are often duplications…we end up all spending that time doing it because the medical aid wants that way."* ***PC2. p. 2***

A common complaint, which could be linked to ethical concerns of private practitioners, is the length of reports required by the medical aid companies. This could also be seen as a barrier due to the extra time required, and possible expense incurred.

> *"Often our letters of motivation which we are trying to keep as concise as possible … as opposed to an insurance report which can be five, six pages."* ***PC2. p. 3***

Subcategory 3: Practice in writing reports

The need to practice writing reports of acceptable quality was discussed by both the public sector and private sector groups of participants. Participants voiced the concern that "*a lot of young therapists are going straight into private practice after comm serve."* ***PC1. p. 3.*** They expressed concerns about both the content and structure of reports provided by novice therapists, particularly those unsupervised in independent practice. It was inferred that they should possibly spend more time within public sector practice.

Another common point of discussion was that many occupational therapy reports are too long, and that being able to summarise relevant information is a skill that is achieved over time.

> *"I think it comes back to our point of relevance. What is relevant for this report do I need to write a book?"* ***PC1. p. 4***

It was acknowledged that practice in writing professional reports helps with understanding and integrating the information. It was suggested that this be

practiced more with students and novice therapists so they are more skilled at writing and integrating information when they come to work independently in private practice.

> *"I would say more practice with the students; because it helps you process what you are actually going to do with the patient later on."* ***PC2. p. 1***

The barriers offered by the academic participants mirrored those expressed by the public sector participants, where areas of concern were mainly around the receiver having English as an additional language as well insufficient processes hindering best practice. The main area of concern was around the inexperience of practitioners, which was similar to both the private and public sectors.

4.3.1.2.3 Academy

Subcategory 1: Appropriate in South African context

The academic participants acknowledged that the majority of the South African population does not speak English as their home language, and therefore, understanding health and occupational therapy records is compromised by poor health care.

> *"The issue is also that there are people who speak multiple different languages, and now report writing is predominately in English, predominately. And let's be fair, for the majority of our population, English is not their first language."* ***AC. p. 2***

Subcategory 2: Insufficient process

Reference to this barrier by the academics was made primarily around the systemic inefficiency between the primary, secondary and tertiary health care systems.

> *"With the reporting I think there is a systems problem in South Africa at the moment between primary, secondary and tertiary - that this report that I write stays in my file cabinet and it doesn't actually go to the Primary Health Care Facility anywhere."* ***AC. p. 6***

Subcategory 3: Lack of experience

The academics agreed with the participants in private practice regarding lack of experience being a barrier to best practice in report writing. The emphasis

of the discussion was around the need for the experience level of therapists to improve if short integrated reports are to be written.

> *"My experience is that the younger the therapist with the less clinical experience, the longer the reports. As they get more experienced, the shorter the reports."* ***AC. p. 1***

It was acknowledged that novice therapists and students often use the report writing process for processing and integrating the information. Whilst this is necessary to assist with development, this is not the primary purpose of the report and may result in reports taking longer than expected to complete.

> *"You see why I think they can take a long time, is that the report is an actual; it is the fitting together of puzzle pieces of this individual. And the reason why it takes long is not necessarily not because of the writing that is attached to it, but it is the reasoning that goes into it."* ***AC. p. 3***

4.3.1.3 Facilitators to report writing

Table 4.6 Facilitators to report writing for Theme 1

Theme	Category	Sub-category	Codes (summary)
Generic occupational therapy reporting issues	Facilitators.	**Public sector**	
		Provide and use templates	• use a set structure • OT models and frameworks
		Giving verbal feedback with the report	• part of OT process • client centred
		Building experience	• develop skill under guidance • clinical reasoning
		Being prepared	• time • structure and adequate notes • keep copies
		Private sector	
		Use a structure	• based on published guidelines (ICF) • consistency and length
		Feedback meetings	• routine • family meetings
		Gaining expertise	• clinical reasoning • formal training
		Access to information	• electronic information
		Academy	
		Experience and professionalism	• enabled skill • length of reports

4.3.1.3.1. Public Sector

Participants from all three public sector focus groups were asked what strategies they felt facilitate best practice in terms of report writing. Participants across the three public sector contexts offered a variety of solutions, some of which they are already putting into practice.

Subcategory 1: Provide and use templates

All the participants from the public sector focus groups acknowledged that they would like to have a standard format to follow when writing reports. It was

felt that this may improve the standard of report writing for occupational therapists.

> *"And to just try and make it kind of standard across, because I know reports are different for different people but if you have got like the basics, the structure then at least we know all the reports are kind of a certain standard."* ***GC2. p. 9***

Some participants identified that their departments had already created their own templates for writing occupational therapy reports so that there is some guidance with regards to the structure of the report. This was to ensure that therapists are aware of what types of information to include in their reports, so that all reports coming from the department have standardised topics of information included.

> *"In terms of structure…because otherwise it gets quite ambiguous … then some OT's will include some information and not others."* ***GC3. p. 1***

It was felt that published frameworks or frames of reference used within the profession would also offer guidance of what to include or omit in occupational therapy reports. The common frameworks on which reports could be based acknowledged were the Occupational Therapy Practice Framework III (OTPF-III), and the Model of Human Occupation by Gary Kielhofner.

> *"For me it's that regardless of your background or which university you went to everything goes back to the practice framework."* ***GC2. p. 4***
>
> *"Like if you're using Kielhofner, then environment and all of the demands on the child need to come out in that."* ***GC3. p. 3***

Subcategory 2: Giving verbal feedback with the report

Ensuring verbal feedback accompanies the report when dealing with clients was a common theme across the public sector setting discussions. It was acknowledged that although this wasn't strictly timetabled as part of the occupational therapy process, it was necessary to ensure client understanding of their assessment and intervention.

> *"Well we don't have specific slots for feedback so we just squish them in whenever there is time but ja it works."* ***GC2. p. 4***

It was also felt that this was essential if occupational therapists were to be client-centred and so they should offer the client an opportunity to be part of the discussion in all aspects of the occupational therapy process.

> *"Otherwise you're not very client-centred. If you don't bring them into that assessment or re-evaluation process."* ***GC1. p. 9***

Subcategory 3: Building experience

Participants offered suggestions of what skills were needed to write professional occupational therapy reports as well as strategies to enable those skills. It was identified that various steps could be taken to improve ability such as:

> *"Don't get complacent. It is important to keep your skills up and go on courses".* ***GC3. p. 3***

It was also suggested that having a senior or more experienced colleague read through an occupational therapy report, offered a chance for individual development. This also supported accountability of the content recommendations by getting both professionals to sign off on the occupational therapy report.

> *"Proof read then you would both sign. So in terms of assisting development is there."* ***GC2. p. 5***

Participants communicated that clinical reasoning was the key skill that occupational therapists develop to assist them in making recommendations, as well as what information to include in professional occupational therapy reports to make them most relevant.

> *"The clinical reasoning's that gut feeling as OTs work. What to include, what not to include and how to portray it according to the referral."* ***GC2. p. 7***

Other attributes and skills noted were the ability to be patient and thorough – to ensure important information is not left out. Supporting this was also the need to be flexible, so whilst participants recommended having templates to support best practice, having the flexibility, possibly supported by sound clinical reasoning, would enable occupational therapists to only include information in the report that is pertinent or relevant.

> *"Patience and being thorough."* ***GC3. p. 1***
>
> *"Flexibility is a good skill. You can't rely on one template to carry you through everywhere. You still need to use your own initiative."* ***GC3. p. 1***

Overall it was acknowledged that report writing is part of the clinical skill set that has to be developed by occupational therapists in terms of their practice.

> *"And its clinical skill that we've had to develop in how to write a short report."* ***GC1. p. 9***

Subcategory 4: Being prepared

Another strategy that was offered by participants was being prepared when it came to sitting down and writing a report. Strategies included having sufficient time.

> "*Time for the assessment and then time for the report straight afterwards."* ***GC2. p. 9***

This was to ensure that not too much time elapsed between the assessment and the recording of the information. Another strategy was to prepare the structure of what you want to include in the report and ensuring you have the relevant information at hand.

> *"For me, it is the preparation before you start writing the report, so that you know how you want to structure it and know what you want to do with the information that you have."* ***GC3. p. 4***

This practice of ensuring that sufficient information is obtained would need to extend throughout the assessment process, by making sure all notes are thorough to aid in recalling the information.

> *"…so how much detail did you actually write there so that you can put that into your report, because it is difficult to remember stuff if you have set time to do your report later on."* ***GC3. p. 5***

It was suggested that being prepared extends beyond the preparing for and writing the report, but also includes having easy access to your report and relevant information should you need to offer feedback after the report has been distributed.

> *"It is also important for you to have a copy of the report so that you can refer back and say that is not what I actually said or meant."* ***GC3. p. 5***

4.3.1.3.2 Private sector

The data on the facilitators of best practice in report writing as discussed by the private sector participants was similar to that of the public sector participants.

Subcategory 1: Templates

Participants within the private sector acknowledged that having templates for report writing is helpful in guiding therapists regarding what to include and what to omit. Reference was made to published guidelines such as the ICF (international classification of disability and functioning), to assist with ensuring guidelines are comprehensive.

> *"Having examples or templates of reports, for each different type of [indistinct] think that the ICF requires a certain amount of information ... It's very helpful."* ***PC2. p. 5***

It was identified that most therapy practices routinely use templates, to assist with consistency and with managing the length of reports.

> *"It's fairly set and I think it's been set to help us with time management as well because often OT reports can end up quite long."* ***PC2. p. 1***

Subcategory 2: Verbal feedback

Verbal feedback was seen as a standard supplement to report writing in the private sector. It appears that this is offered either within a group or multi-disciplinary team (MDT) setting with the family as well as on an individual basis.

> *"So I discuss with my patient from the beginning."* ***PC1. p. 2***

Subcategory 3: Experience

In this sector, participants also acknowledged that with experience comes clinical reasoning, which contributes to best practice in report writing. "*The clinical reasoning is you know that little thing that we give."* ***PC1. p. 3***

It was perceived that practitioners have the responsibility of developing themselves in this area, and this can either be done by formal training, such as going on courses, or getting a more experienced colleague to read through the reports.

> *"And also what I find helpful is having someone check my reports."* ***PC2. p. 8***
>
> *"Doing courses on report writing because it's such a big part of our role."* ***PC2. p. 7***

Subcategory 4: Being prepared

As with the public sector participants, it was suggested that being prepared before, during and after the report writing process was considered essential in assisting with enabling best practice in report writing.

> *"I think an important point is having access to the information that you need. And having it readily available."* ***PC2. p. 3***

4.3.1.3.3 Academy

Subcategory 1: Experience and professionalism

The academic participants communicated that the main contributor to best practice was enabling experience and professionalism and this in turn would aid in managing the length of occupational therapy reports.

> *"I mean there is a process of going through the interpretation of the client case through engaging in the report writing process so I do think there is a change with the experience levels as to how much you really need to write."* ***AC. p. 4***

4.3.2. Theme 2: The occupational therapy identity

A second theme emerged across all six focus groups, and appeared to be an area of discussion regardless of the practice setting. This theme and its sub-categories were related primarily to two categories; there is a need for evidenced-based practice, and that there is evidence of an occupational therapy 'patriotism' emerging. Participants voiced issues that related to the philosophy of the profession with concern around the broad nature of occupational therapy lending itself to misunderstanding by other professionals and the public of the role of occupational therapy when reading reports. More research and evidence to support the efficacy of occupational therapy was suggested. Whilst frustration was evident by the participants, many voiced that they were passionate about the profession, and believed in its value towards the maintenance of a person's and a community's wellbeing, and felt this was communicated through occupational therapy reports.

Table 4.7 Categories, subcategories and codes for Theme 2: the occupational therapy identity

Theme	Category	Subcategory	Codes (summary)
The occupational therapy identity	A need for evidence based practice	A lot is lost in translation"	• OT is not understood by other professions • defensiveness • uniqueness not portrayed
		More occupational therapy research is needed	• responsibility to educate • provide evidence • lack of assertion
	Occupational therapy patriotism	We make a unique contribution to occupation	• pride in the profession • adds value
		We are adaptable	• broad range of skills • advantage and detriment

4.3.2.1 There is a need for evidence-based practice

This category identified the need for further research and evidenced-based practice to assist with promoting the profession. Two sub-categories were evident from the analysis; primarily that "a lot is lost in translation" when communicating what occupational therapy offers as a profession, and that "more occupational therapy research is needed" to empower the profession and promote understanding.

Subcategory 1: "a lot is lost in translation"

> *"…like we think we're always being attacked and sometimes like other professions are actually just purely lost in translation, literally."* ***GC1. p. 1***

This quote provided an overall descriptor for this sub-category. There was much discussion around the fact that many other health care professionals do not understand the role of occupational therapy and therefore the relevance of occupational therapy reports. This was frequently met with some exasperation that at a professional level this should not be occurring.

> *"But I mean on a professional basis we should not be having to explain ourselves in terms of this is what occupational therapy is."* ***PC2. p. 3***

It was acknowledged that the profession has evolved quickly over many years, which may have made it difficult for practitioners, never mind other professionals and the public, to understand the detail of what the profession reports on.

> *"But the fact that they're now able to brush their teeth, and have a bath by themselves and dress themselves no one sees. OT is so broad that no one ever gets the full picture."* ***PC2. p. 4***

One participant offered the explanation that some occupational therapy intervention happens behind closed doors due to the intimate nature of the problems dealt with, and that this may contribute to the lack of understanding of occupational therapy. This, along with the constructs and emphasis on occupation, which form the basis of the profession, can lead to misunderstanding by other professionals.

It was also acknowledged that the frustration and defensiveness of occupational therapists may be self-inflicted, where there is a need to prove the worth of the profession through sounding as scientific as possible when writing reports.

> *"our profession is like so growing and doctors don't exactly know what we do, I feel like if I explain myself in simple terms, it sort of undermines him, so if you use these magical words, it seems like you know what you're talking about"* ***GC1. p. 4***

Some participants felt this may be further self-perpetuated in the profession where practitioners do not describe the use of occupation within their reports and so feel the need to justify their existence in the health care team.

> *"But maybe some do not reflect the occupations in their reports and that is why they feel they have to justify."* ***AC. p. 3***

Sub-category 2: More occupational therapy research is needed

It was acknowledged amongst many participants that there is a need amongst occupational therapists to take responsibility and educate the public and other professionals on the services offered and goals of occupational therapy. *"We need to educate them on ourselves"* ***GC1. p. 4***

The challenge in doing this within the scientific and health community was acknowledged, as well as the need to support intervention with evidence, specifically around having a measurable outcome so that reports can be based on research.

> *"We're all trying to make our therapy like outcome based, so that there's a distinct, measurable outcome at the end of the day"* ***GC1. p. 1***

Practitioners felt that this carries inherent challenges within the profession, as there are many aspects to occupational therapy that are intangible or that are difficult to measure using traditional scientific methods. These aspects are therefore difficult to justify with evidence in occupational therapy reports.

> *"I think it's because I tried to look at it you know obviously there's certain things that can't be measured in what we do*." ***PC2. p. 1***

The perceived personality of the occupational therapist population was also voiced as being an inhibitor to being better known and respected within the health community. One participant viewed occupational therapists as unassertive with their more gentle nature contributing to the profession's perceived lack of respect. It was felt this contributes to other professions, possibly taking over some of the occupational therapy scope and reporting on the same interventions. This then adds to the confusion of the readers of reports as to what is unique to occupational therapy.

> *"We are very gentle people … We are not assertive enough. So other professions like physios are using play and doing washing and dressing."* ***GC.3 p. 3***

4.3.2.2 Occupational therapy patriotism

This category identified the emergence of a degree of patriotism, where participants communicated they were proud of the profession, and the unique service it offered which should be reflected in occupational therapy reports.

Subcategory 1: We make a unique contribution to occupation

This sub-category grouped together comments that saw participants describing a sense of pride in their profession. Participants communicated that occupational therapists are experts.

> *"We are the experts in what we do. We are the experts in occupation"* ***AC. p. 4***

Through this expertise, occupational therapists can be seen as the most qualified to make recommendations when it comes to a person's/community's occupations and this should be clearly reflected in their reports. "*I think we are the most qualified to recommend changes."* ***GC3. p. 5***

Some participants felt that the profession was already being recognised by the value added to the care of individuals, and that this was acknowledged through the reports written by occupational therapists.

> *"We prove our value. We're proving that what we do is valuable."* ***GC1. p. 6***
>
> *"Our reports are good and they like our recommendations and they use them.* ***GC2. p. 6***

Occupational therapists have a love for the profession and their clients so will continue to practice anyway. *"We love what we do so we don't mind."* ***PC1. p. 3***

Subcategory 2: We are adaptable

The adaptability of the profession was seen to be an advantage and a disadvantage. Participants acknowledged that practitioners had many skills so could fit into many situations. It was seen as a part of the professional requirements, as there are many skills occupational therapists are required to have in order to manage the many areas of human occupation. One of these skills is being able to report on these areas of human occupation effectively and understandably.

> *"Because there are so many things that we do … But it is also not a very old profession, so not many people know what it is about. They are aware of it, but don't know what it is about."* ***GC3. p. 5***

The comment above also acknowledged that as the profession is still 'young' many other health care professionals and the public are unaware of what occupational therapy entails. It was acknowledged that practitioners themselves tend to bend or flex into what a situation requires, indicating it could be a disadvantage, and why the audience has difficulty identifying with occupational therapy reports.

> *"Which we as OT's are quite good at the chameleon of changing into whatever our setting most wants at the precise moment"* ***AC. p. 2***

Overall however, there was a sense of pride that "*We don't fit for a reason.*" ***GC1. p.4***

4.3.3 Theme 3: Who is the audience?

The third theme emerged across all six focus groups, and was a pertinent area of discussion regardless of the context of practice. Two main categories emerged; namely that the audience does not understand occupational therapy terminology and that participants were conflicted about writing a report or various reports depending on the receiver, as occupational therapy reports are generally sent to a wide audience. Participants acknowledged that occupational therapy terminology is confusing for all audiences outside of the profession, and is further confused by therapists in practice who are not consistent with the terms used when writing occupational therapy reports. This inconsistency was also present when considering how many reports to write in order to accommodate the wide audience who receive reports in order to make them more understandable. There was also concern around the audience dictating what should be included in an occupational therapy report, and that therapists would lose their autonomy in ensuring the report is occupation based.

Table 4.8 Categories, subcategories and codes for Theme 3: Who is the audience?

Theme	Category	Sub-category	Codes (summary)
Who is the audience?	The audience doesn't understand OT language	OT terminology is confusing	• terminology not understood • striking a balance
		Terminology dependant on study and work context	• different terms for the same thing • conflict within profession
	Do we have one standard way of reporting or many?	Who are we writing the report for?	• writing for the audience • occupation based
		Someone is paying for - does the audience dictate	• patient or market dictate report contents OT should have autonomy in report contents

4.3.3.1 The audience doesn't understand occupational therapy terminology

This category of codes identified that there is a concern that the audience receiving the occupational therapy reports do not understand the terminology used by practitioners in the reports. Two subcategories emerged; identifying that overall occupational therapy language is confusing and can be changeable depending on the context in which it is used.

Subcategory 1: Occupational therapy terminology is confusing

There was a concern amongst a variety of participants that other professionals, such as doctors as well as those in other sectors such as teachers, do not understand occupational therapy terminology.

> *"Some of the other medical professionals do not understand our words"* ***GC1. p. 4***

It was acknowledged that understanding the terminology is difficult for occupational therapists themselves and that even the explanation could be as confusing as the occupational therapy term being used.

> *"…we get these terms and then the explanation would be just as like mind blowing as the term itself..."* ***GC1. p. 9***

Participants acknowledged the difficulty of wanting to make the reports simple enough for a lay person to understand, but at the same time not making it too simple, so that other professionals won't see it as a professional report.

> *"Sometimes for me I think it links with the professional word but writing my report in a way that it's easy for the parents to understand but I can take it to the principal as well and it won't seem too plain or simple."****GC2. p. 4***

There was acknowledgement that the profession needs to look at developing some uniformity with regards to terminology to enable better understanding for the readers of occupational therapy reports.

> *"we probably should get right within our profession is terminology and make sure that all OT's are using the same terminology"* ***PC2. p. 1***

Subcategory 2: Terminology dependant on study and work context

This subcategory identified that practitioners acknowledged that, although there are recognised models and frameworks to guide practice, different areas of work or study may influence which framework is used, and so influence the terminology used when communicating about occupational therapy intervention in reports.

> *"Everyone uses the basic occupation framework. Except we use different terms of it and we use some terms that others do not use"* ***AC. p. 5***

4.3.3.2 Do we have one standard way of reporting or many?

This category represents the conflict participants are facing around how many reports to write, as they are aware they have a large audience that receives occupational therapy reports, and that this is further complicated by the demands that are made by those paying for the reports.

Subcategory 1: Who are we writing the report for?

Throughout the six focus groups, the participants commented on the many and varied receivers of occupational therapy reports ranging from lay persons to professionals to corporate and government institutions. It was identified that depending on who requested the report would influence how the report would be written and what language would be used.

> *"how the referral comes into it and knowing where it is going and whose on a level of lingo to include....and things to include play a role."****GC2. p. 8***

Again the South African contextual conundrum was discussed, where language and education may affect the ability to understand a 'jargon-filled' report, and so practitioners are then required to write the report in simpler language or with reduced content.

> *"But like say the family is this uneducated Zulu family, you're not going to try and give them your OT jargon filled report, you're going to give them what they need to know, which is in normal English language."* ***GC1. p. 4***

Whilst many participants were eager to adapt the report to the receiver, it was acknowledged that ensuring it was occupational therapy 'based' so that it reads like an occupational therapy report was important.

> *"Ja, I think you do your OT report, but you adapt it according to the reader. But it still is OT based."* ***GC.1 p. 6***

Some participants went as far as to emphasise the use of jargon as important – especially when other professionals are reading occupational therapy reports.

> *"Jargon is important for us to communicate amongst professionals."* ***GC2. p. 4***

Subcategory 2: Someone is paying for it - does the audience dictate?

An area of concern identified by participants was that some consumers are paying for occupational therapy reports, which then allows them further licence around dictating what should be in an occupational therapy report.

> *"You need to identify who you are writing this for first of all I think that is very important and then who is paying for it? Who's paying for it is it going to and for that you got to tailor your report accordingly."* ***PC1. p. 1***

It was further noted that in some instances, if the receiver doesn't pay for the report, they are not eligible for a full occupational therapy report. *"So if the report is not charged for then they get just the summary."* ***AC. p. 2***

A suggestion was presented across two of the focus groups, which recommended that occupational therapists should spend more time understanding what the audience wants from occupational therapy reports. This would then guide practitioners on how to write their professional reports.

> *"Getting evidence of what the market is looking at can help us in looking at how others will read the reports.* ***AC. p. 4***

This was contradicted by various participants who felt that other professionals did not have the right or knowledge to dictate what should be in an occupational therapy report, as this would be dictating on the scope of practice of occupational therapy.

> *"So why are we trying to make ours more a doctor? Because at the end of the day you're not sending an OT report then, you're sending a report then that you think the doctor wants to hear, but then there's nothing about OT."* ***GC1. p. 8***

4.4 Conflicts identified in report writing

Several conflicts emerged from the data in the themes that warranted further discussion and review, as participants were unable to suggest solutions for these problems. These conflicts provided the basis for the second phase of the study, which sought further clarification from subject matter experts on these aspects of report writing.

4.4.1 Conflict 1: Do occupational therapists write one report or a variety

An area of conflict amongst participants was whether one report for all audiences, or several depending on who was receiving the report, should be written. A second conflict that fitted into this category was whether all occupational therapy reports should follow the same format regardless of the occupational therapists' area of practice or speciality.

Participants were divided into two camps around this issue. Several participants voiced that as a profession; practitioners should stick to an occupationally specific outline for all reports. This would then negate the writing of more than one report to all audiences.

> *"So if we actually stick to the occupations specific outline then they can be the same"* ***AC. p. 6***

Argument against this was supported by the themes above in relation to the issue of payment for reports as well as the audience not having an adequate understanding of English or education to understand a professional report, thereby motivating the need for two reports.

> "*I think there should be two reports. The professional's report and then the layman's report."****GC1. p. 2***

Some participants felt strongly that depending on the area of discipline and speciality, the professional reports would differ in how they would be written and what content may be included.

> *"I think that the difference comes in the field of practice. So the psych report will have a certain look and feel and the paeds report will have a certain look and feel..."* ***AC. p. 4***

4.4.2 Conflict 2: Occupational therapists are conflicted around using occupational therapy terminology /jargon

These discussions around what reports should be written led to the second conflict; around the use of professional terminology or occupational therapy 'jargon', as participants felt that as occupational therapists, the main focus of the report should be on occupation, with the reason for dysfunction being the only difference between reports.

> *"I don't think so. I actually think that as occupational therapists, if you focus on occupation, our reports shouldn't differ."* ***AC. p. 6***

Concern around whether to use occupational therapy terminology or jargon was voiced in all six focus groups. There was a tension between ensuring the reader of the report understands what is written but to still sound professional through using the appropriate terminology. Participants voiced strong concern that the readers of occupational therapy reports may not understand the terminology used by practitioners, as they may not have professional training, and would be alienated by the terminology used.

> "*How we word it in the jargon we use, and in the language we use could differ. As with a doctor I am able to use a certain language, however with the parents I might not be able to use the same language."* ***AC. p. 6***

There were some suggestions that occupational therapy terminology should still be used, but with an explanation.

> *"you want to make sure that everyone is on the same page with what you say, I would actually add a little appendix as a glossary of terms or definitions"* ***AC. p. 3***

Some participants still had difficulty accepting the use of 'jargon' or occupational therapy terminology being used in a report as they felt it would be unethical,

> *"I find that very unethical, when we write a report whoever it goes to, in a… jargon."* ***GC1. p. 4***

This was also strongly contested by some other participants who felt strongly that the use of occupational therapy professional terminology is important for maintaining the respect of the profession.

"I would use the jargon so that you're not undermined by the next professional who thinks they may be better than you or have more to offer, you know." ***GC1. p. 4***

4.4.3 Conflict 3: What must be included in terms of medical/clinical information e.g. diagnosis etc.

There was some debate amongst the participants around to what degree reports should be written in a medical format as opposed to an occupation-based format.

A debate emerged from the discussion participants had around the need for one or more report depending on the audience. There was some concern over the inclusion of standardised assessment scores. Some felt it was important to include as an addendum to support the observations and the assessment results.

"However, if we are focusing only on scores then that would remove the emphasis from these standardized tests and they are mainly there to support your conclusions…" ***AC. p. 4***

Some felt that putting in assessment scores and tests would only serve to confuse the reader, and may even cause problems with accuracy when re-assessment was required.

"They don't need to know the test names because it means nothing to them ..." ***PC1. p. 2***

With regards to inclusivity of medical history in an occupational therapy report, the debate was around the need for all medical information to be included or just the information pertinent to the occupational history.

"But I would not, OK this is a personal opinion, I am not going to write absolutely every medical condition that this person has ever had. It's the medical history that is relevant to the occupational profile" ***AC. p. 2***

Some participants felt it was imperative to the integrity of the report to include a detailed medical history and this was mainly influenced by area of practice or specialty.

"I think from a psych perspective... The medical history should also be in- depth and you need to make sure that all your information is there, so that the person that you are referring to, or the doctor has everything." ***GC3. p. 4***

4.5 Summary of results from phase 1

The aim of this phase of the study was to explore the views of occupational therapists on what influences best practice in writing reports.

From the six focus groups, three themes emerged. These included generic occupational therapy report issues. This theme appeared to be influenced by the context the participants were practicing in. So whilst all categories were the same, namely ethical issues as well as barriers and facilitators that influence best practice in report writing, the subcategories around this theme had some similarities and differences. With regards to barriers, the practitioners from the public sector are facing systemic and resource restrictions, whereas private practitioners find funders are influencing their practice. Over the six focus groups, it was clear that participants were aware of the need to be ethical but were unsure of the details regarding legal and ethical requirements for report writing. Interestingly, the private and public practitioners all suggested similar facilitators to best practice, including the need to enable development of experience in report writing, which was also highlighted by the academic group.

The remaining two themes were based on aspects of profession specific concerns, which have an effect on report writing and were analysed across all six focus groups, as context did not appear to influence the data produced. The second theme pertained to the emergence of an occupational therapy identity. This echoed some positive and some negative sentiments from the participants. Participants are proud of the profession and value its unique contribution it offers, however, they also acknowledged that occupational therapists can be the cause of their own demise by practicing with insufficient evidence based practice, as well as possibly being too adaptable to the requirements and needs of the public and other professions. The third theme identified that the audience plays a large role in the complexity of writing occupational therapy reports, particularly as the audience receiving reports is widely varied and many do not understand occupational therapy terminology. It was also noted that the audience largely dictates what is needed from the reports.

There were three conflicts that were highlighted in the focus groups around report writing for which no solutions could be suggested. These included whether:

- occupational therapists should write one or a variety of reports depending on the audience and speciality
- occupational therapists should use profession specific terminology
- medical information should be included and acknowledging the challenge of being occupational based in a medical setting

These conflicts formed the basis of the questions addressed by nominal group technique in Phase 2 of the study.

4.6 Phase 2

Phase 2 followed a deductive content analysis method. The conflicts that emerged from phase 1 were presented to participants purposively selected as subject matter experts (SMEs) so that solutions could be generated.

4.6.1 Demographics and years' of experience

The following tables outline the demographic representation of the participants involved.

Table 4.9 Areas of expertise represented by the nominal group participants

Participants		NGP1	NGP2	NGP3	NGP4	NGP5	NGP6
Practice Context	Private practice				X	X	X
	Public	X	X			X	X
	Community		X		X	X	X
	PHC		X			X	
	Academia		X	X	X	X	X
Field of practice	Adult	X	X		X	X	X
	Paediatrics			X		X	X
	Psychiatry	X	X			X	
	Physical rehab				X	X	X
	Hand therapy						X
	Research		X	X	X	X	X

Participants who participated in the nominal group had experience that covered many areas of occupational therapy practice, ranging from community practice, private and academia to adult, paediatric as well as psychiatric and physical rehabilitation (Table 4.9).

The mean years of experience represented by participants was 21.3 years. All participants had a masters or equivalent postgraduate degree as well as being members of one or more special interest groups (Table 4.10).

Table 4.10 Years of expertise represented by the nominal group participants

	Years' experience	Post graduate Qualification Masters or equivalent	Member of one or more special interest groups
NGP1	20	X	X
NGP2	34	X	X
NGP3	14	X	X
NGP4	15	X	X
NGP5	25	X	X
NGP6	20	X	X
Mean	21.3 years		

4.6.2 Deductive Matrix for conflicts addressed by the nominal group

The analysis of data from the nominal group was carried out using a combination of both qualitative and quantitative methods. After the participants generated solutions for a conflict, they voted on the solutions they felt most adequately addressed the conflict. The aggregated scores of each of these solutions helped generate the deductive matrix (Table 22), which was then used to organise the qualitative comments from the nominal group participants.

Three conflicts, which arose from Phase 1, were put to the participants for discussion to generate solutions:

Conflict 1: *"Therapists are in disagreement as to whether they should write one report or a variety of reports depending on their audience. Related to this is whether the report format should change depending on the clinicians' area of practice. What guidance could you give clinicians in this regard?"*

Conflict 2: *"The use of OT language has therapists conflicted around OT language/jargon. They often use generic rather than OT words in their reports. How should clinicians manage the perception that other professionals and their clients and caregivers don't understand their reports? Added to that is the complexity of the SA context where so many receivers of the reports have English as a second language."*

Conflict 3: *"OT's are unsure of what must be included in terms of medical/clinical information e.g. medical history, diagnosis, test scores etc. What guidance would you give in this regard?"*

The solutions were generated and ranked and were used to produce a solution matrix. All solutions that generated above 30% of the total possible vote were included in the matrix.

The second and third conflicts yielded clear results, however the first conflict was less clear as there were several solutions that ranked of similar percentage. The researcher determined this required a re-vote, which was done via email, by asking the participants to re-rank the statements above 30% into their top 5 choices.

This then yielded 6 clear statements to help answer the conflict.

Table 4.11 Conflicts and their aggregated scores

Conflict 1					Conflict 2.					Conflict 3.				
Solution no.	Solution Description	TA†	TP‡	%	Solution no.	Solution Description	TA†	TP‡	%	Solution no.	Solution Description	TA‡	TP‡	%
4	Determine the purpose of the report, report should answer the purpose	19	25	76.0	14	Comply with regulations	28	36	77.8	1	The purpose dictates the content of the report. (assessment/ discharge) (promotion/ prevention)	28	30	93.3
13	Have a policy/protocol/ guideline/ Standard Operating Procedure regarding reports	18	25	72.0	5	Focus of the report should be occupation-based	23	36	63.9	4	medical and personal and occupational history included must be pertinent to current presenting problem	22	30	73.3
16	Training in report-writing	12	25	48.0	3	Verbal feedback always necessary with reports (could be to multiple people, not just the person you have assessed)	14	36	38.9					
5	Prior to assessment, practitioner needs consent from the relevant authorised person (e.g. parent, or caregiver, or patient self) before disclosure	12	25	48.0	1	Use OT terminology with an explanation and put in brackets in the text	12	36	33.3					
12	Have a senior or more experienced OT read your report	11	25	44.0	4	Most time should be spent on recommendations and conclusions. You need to make them.	12	36	33.3					
7	Template for each area of practice, e.g. paeds, psych, physical	8	25	32.0										

† Total Possible
‡ Total Aggregate

Once the matrix was finalised, quotes extracted from the transcripts proved helpful in explaining both individual and group thinking and were coded based on the solutions voted as most important by the participants for each conflict.

4.6.3 Conflict 1:

Conflict 1 relates to the uncertainty practitioners experience around tailoring their reports to the audiences for whom they write. The following qualitative comments were taken from the transcript and coded according to the deductive matrix in Table 4.11 above.

Table 4.12 Qualitative comments sorted according to solutions generated for conflict 1 (C1)

Solution	%	Codes
C1.1 Report should answer the purpose	76	• The purpose should guide the contents
C1.2 Policy / Protocol /Guideline / Standard Operating Procedure	72	• Standards must be clearly set out
C1.3 Training in report-writing	48	• Colleagues battle to make the transition • Students and the novice practitioner have a different set of needs
C1.4 Practitioner needs to gain consent	48	• Consent is good practice • Professional behaviour and good manners
C1.5 Get a more experienced occupational therapists to read your report	44	• Someone with good English because it might not necessarily be a senior • Supervision mentoring will actually guide
C1.6 Template for each area of practice	32	• No one fits all kind • Some critical things that are in it. Using guidance, can adapt to it • Just utilise the relevant part • Risk losing a person's individuality in context because we work from a medical model

The six solutions, which received the most votes to answer the first conflict around the writing of one or multiple occupational therapy reports depending on the receiving audience and the speciality, are presented in Table 4.12.

Solution 1:

C1.1 Report should answer the purpose – 76% aggregated score

This solution highlighted the need of the purpose of the report, and that it is primarily for the audience. Purposes of the occupational therapy report mainly include communicating occupational therapy intervention to various audiences, depending on what the audience/referrer requests/needs. Overall, the feeling was that the report should always answer the purpose; this will then dictate how it is laid out, what content is included etc.

> *"I said the purpose of the report should guide the contents."* ***NG. p. 2***

It was also highlighted that practitioners need to make an effort to find out what the purpose of the report is. By taking these steps it will then assist the practitioner with understanding what should be in the report.

> *"So I guess it's really important to interrogate what the purpose of the report is."* ***NG. p. 3***

Solution 2:

C1.2 Policy/protocol/guideline/Standard Operating Procedure – 72% aggregated score

Participants indicated that each department/organisation/hospital should have guidelines or a standard operating procedure (SOP) to guide practitioners. These should be in line with legal requirements.

> *"That is standard operating procedures… Our hospital has got the policy, all reports going out of the hospital needs to go via the CEO."* ***NG. p. 3***

One participant noted that these policies also need to be clearly understood and a system needs to be in place to monitor progress.

> *"…quality assurance or standards must be clearly set out and monitored."* ***NG. p. 4***

Solution 3:

C1.3 Training in report writing – 48% aggregated score

It was highlighted in the nominal group that ongoing CPD (continual professional development) training should be made available to practitioners.

It was also acknowledged that report writing is a skill that is often hard to translate into practice.

> *"But how does the training of writing reports link to the reality of writing reports. And I think that maybe sometimes people, colleagues battle to make that transition**." NG. p. 2***

It was recognised that training and development should be ongoing and efforts should be made to assist the transition from student to therapist and from novice therapist to more experienced therapist. It was also noted that this may assist with decreasing the length of written reports.

> *"Student and being a novice practitioner…they have been doing things in a long format. And suddenly we are faced with a different reality and a different set of needs. So I think it's important that it mustn't be a dissertation." **NG. p. 4***

Solution 4:

C1.4 practitioner needs to gain consent – 48% aggregated score

This solution inadvertently gave the most direct answer to the conflict presented. If a report is going on to someone else, always gain consent from the person who the report is written about. This may reduce the need for writing multiple reports for different audiences.

> *"I think consent is good practice. And we need to be transparent with the other people we work with...." **NG. p. 4***

This solution may also then address the legal implications of managing personal information.

> *"We had a case that we used … in legal area where one parent wanted to use the child's case against other parent." **NG. p. 3***

It was also suggested that it's best practice in terms of professional behaviour to follow up verbally with the referrer.

> *"Personally I think it's good manners apart from anything else just to send a brief report back to someone who's referred someone to you." **NG. p. 3***

Solution 5:

C1.5 Get a more experienced OT to read your report – 44% aggregated score

Suggestions in this solution were to assist with the development of the skill of report writing as well as the other tacit skills of integration of information, summarising and clinical reasoning. It would also help the practitioner decide if the report is appropriate for audience and speciality.

> *"Supervision mentoring will actually guide, plus if you've had a lot of experience in writing, now it's actually refining that context in a different context with different demands.* ***"NG. p. 4***

It was also noted that getting support from someone who has a good command of the English language may be important to assist with professional terminology and ensuring ease of understanding.

> *"Or someone with good English it might not necessarily be a senior."* ***NG. p. 3***

Solution 6:

C1.6 Template for each area of practice – 32%

It was identified that a template may be needed, however practitioners need to have the skill to identify what parts of the template may be appropriate.

> *"And I don't think that there has to be a, you know one fits all kind of a situation but I do think that there should be some kind of critical things that are in it. And then people, with the guidance of people in charge in understanding the needs of their particular people, can adapt it."* ***NG. p. 3***

It was also noted that the emphasis of a report should be on the individual. So whilst templates are useful, each report will still need to be individualised to the person.

> *"…we treat them as supposedly individuals and as opposed to a diagnosis. And I think that that's one of the things is that we lose a person's individuality in context because we work from a medical model."* ***NG. p. 2***

The above solutions identified that the report should always answer the purpose it is intended for, and there should be a policy or guidelines in place to guide therapists in this regard. Training in report writing was offered as a solution, along with the need for the practitioner to always get consent. The last two suggestions included getting a senior to read your report, and then having a template for each area of practice.

4.6.4 Conflict 2:

Conflict 2 relates to practitioners' discomfort around using occupational therapy terminology/jargon in reports, and their need to be clearly understood by a variety of audiences, with differing levels of education and from a variety of linguistic groups. The following qualitative comments were taken from the transcript and coded according to the deductive matrix in Table 4.11 above.

Table 4.13 Qualitative comments sorted according to solutions generated to Conflict two (C2)

Solution	%	Codes
C2.1 Comply with regulations	78	• Some confusion relating to what is good practice and regulatory practice
C2.2 Focus of report should be occupation-based	64	• It's just a specific dysfunction that will be varied • The content should reflect the domains of the main purpose of the profession. • We shouldn't lose our professional identity
C2.3 Verbal feedback always necessary	39	• Report writing should not be the only one feedback • Its just good practice. • Verbal explanations and examples should be included
C2.4 Use occupational therapy terminology with an explanation	33	• OT jargon can always be explained • So define the jargon used • Focus on the core OT priorities but use layman's terms
C2.5 Most time spent on Recommendations & conclusions	33	• People only read the recommendations

Table 4.13 includes the five solutions, which received the most votes from the participants in answering the conflict around the use of occupational therapy terminology. Solutions were generated and ranked according to perceived relevance and importance.

Solution 1:

C2.1 Comply with regulations – 78% of aggregated score

It was apparent through the qualitative comments that there was some lack of clarity from the participants around the legalities of report writing.

> *"What is the legal situation? I mean who says it has to be in English?"* ***NG. p. 2***

It was communicated that practitioners should comply with whatever regulations were in place, although these suggestions referred mainly to issues around confidentiality etc. No specific reference was made to professional language use.

> *"…stating at the beginning of the report that it is confidential. Is that not good practice? Or is that related to only to specialist reports?"* ***NG. p. 3***

Solution 2:

C2.2 Focus of report should be occupation-based – 64% of aggregated score

Sixty four percent of the votes allowed this solution to be ranked as the second most important option for conflict 2. The qualitative quotes emphasised the need to be occupation-based so that the focus and scope of the profession should not be lost in reports.

> *"If the report has an occupational focus then the format will not be different it's just the specific dysfunction that will be varied."* ***NG. p. 6***

The importance of maintaining the professions identity was also acknowledged. Participants felt that even if the diagnosis/condition was different it will just be certain elements of dysfunction that will be varied but overall the occupational focus will be the same.

> *"It's just a specific dysfunction that will be varied and the content should reflect the domains of the main purpose of the profession."* ***NG. p. 1***

Writing in occupation-based language is important in order to advocate for the profession and should be in all reports, despite the challenges that come with doing that.

> *"If we really want to advocate and we want people to understand what we do then at some point there needs to be some of that in the report."* ***NG. p. 5***

Solution 3:

C2.3 Verbal feedback always necessary – 39% of aggregated score

Accompanying a report with verbal feedback ranked third, identifying that it is always good practice.

> *"Verbal explanations and examples will be included in the feedback with the OT jargon".* ***NG. p. 1***

This practice is not just particular to occupational therapy but happens in other professions.

> *"I think that the report should be accompanied by some form of other feedback… I know two doctors themselves that call each other…they discuss it. So I think it's good practice."* ***NG. p. 4***

It was implied that keeping occupational therapy terminology is important, so using verbal feedback to explain the terminology may be one way of overcoming poor understanding of reports by the receiving audience.

> *"I said that I thought that OT terminology is important and therefore report writing should not be the only one feedback."* ***NG. p. 3***

Solution 4:

C2.4 Use occupational therapy terminology with an explanation – 33% of aggregated score

As with the focus group participants, the subject matter experts were also not in agreement with a solution to this issue. Opinion was divided between those who thought using occupational therapy terminology was important and those who thought using layman's terms would be better.

Those who identified the use of occupational terminology as being important stated that it assists with maintaining professional respect, but that it can also be easily explained so should not be a barrier to understanding the report.

> *"OT terminology is important don't use generic and it should use language that contributes us to be viewed as experts."* ***NG. p. 6***

> *"OT jargon can always be explained and so use OT jargon."* ***NG. p. 1***

The location in the report where the jargon was explained was also emphasised to ensure ease of reading.

> *"So define the jargon used …not in an addendum but actually rather there in because I don't think most readers would bother to go look it up."* ***NG. p. 2***

Some participants disagreed on the use of occupational therapy jargon stating that using layman's terms was adequate as long as the core principles of occupational therapy were identifiable in the report – i.e. that the report would be reporting on occupation.

> *"So by not using jargon you don't necessarily have to give up on it. You can say brush your teeth instead of say do personal management."* ***NG. p. 2***

Solution 5:

C2.5 Most time spent on recommendations & conclusions – 33% of aggregated score

Participants emphasised under this point that not too much time should be spent on reporting on results background etc. as most readers are only interested in the recommendations.

> *"I often hear that … people are not necessarily going to read anything except the recommendations".* ***NG. p. 2***

They also alluded to occupation (function) as being the main emphasis of the document.

> *"The body of the documents should be on the clients function and the end should be on recommendations for further intervention".* ***NG. p. 2***

Overall solutions to this conflict included complying with regulations, ensuring the report is occupation based, making sure the report is accompanied by

verbal feedback, using terminology accompanied by an explanation and ensuring most effort and time is spent on recommendations.

4.6.5 Conflict 3:

Conflict 3 relates to therapists' uncertainty around the extent of medical information to be included in reports. The following qualitative comments were taken from the transcript and coded according to the deductive matrix in Table 4.11 above.

Table 4.14 Qualitative comments sorted according to solutions generated to conflict 3 (C3)

Solution	%	Codes
C3.1 purpose dictates the content of the report	93	• Include what is professionally relevant • The report should be short, succinct, distinctly describe problems and assessments findings and recommendations • The report should be geared towards the purpose for the reader
C3.2 occupational history included pertinent to current presenting problem	73	• Occupational history that contextualises the current problem • ICT10 codes will be a problem

Two solutions were voted in by the participants with a 93% and 73% ranking each.

Solution 1:

C3. The purpose dictates the content of the report – 93% of aggregated votes

Whilst this solution carried the same phrase as in conflict one, analysis of the data identified that participants were referring to including what is professionally relevant when reporting on medical information and history, as well as reporting on what is relevant to the audience. The purpose of the occupational therapy report is to report on occupational dysfunction. This top solution was voted for by 93% of participants.

> *"So the purpose will dictate the content and the detail of that content."* ***NG. p. 2***

It was stated that as long as the report is geared towards the reader, and to reporting on occupational dysfunction, the detailed medical information should then be kept in the daily notes rather than included in the report.

> *"The report should be geared towards the purpose for the reader. I've suggested if you fill medically the requirements in your patient records so you don't actually necessarily have to use all the jargon and the technical I did this and this."* ***NG. p. 2***

Participants voiced that keeping the report succinct was important and that reporting on the medical information, which is not occupationally relevant to the purpose, adds to the length of the report. Participants also commented that it is important to ensure the problems, assessments and recommendations are accurately described. This in turn may serve to widen the scope of the audience it can be sent to.

> *"So the report should be short, succinct, distinctly describe problems and assessments findings and recommendations. I mean that way you could probably send it to one more than one type of person."* ***NG. p. 6***

Solution 2:

C3.2. Occupational history included pertinent to current presenting problem – 73% of aggregated votes

Participants stated that therapists should only include what is needed and relevant to the current presenting problem in the occupational therapy report.

> *"Pertinent occupational history that contextualizes the current problem."* ***NG. p. 2***

> *"Unless it's really important for your assessment findings you don't really have to include it."* ***NG. p. 6***

It was acknowledged by one of the participants who worked in the private sector that occasionally there is a need for specific medical information or words to be included to support funding models.

> *"My thinking and that is really coming from a private hat on is I guess with ICD 10 codes etc. etc. It's really becoming a key thing and I mean to plan with the ICD 10 codes is to take them in the public sector as well."* ***NG. p. 4***

The solutions to this conflict were two-fold, namely that the purpose dictates the content of the report and this purpose includes the needs of the referrer. Secondly, that it is a report on occupational dysfunction, and to only include history pertinent to the current problem affecting occupation.

4.7 Summary of phase two results

Phase 2 of the study was conducted in order to seek some solutions to the conflicts raised by the participants in phase 1. Whilst definitive solutions to each conflict were not necessarily found, some suggestions for best practice were suggested and voted on by participants in the nominal group.

In order to manage the conundrum of writing one or a variety of reports depending on the audience; the nominal group participants identified that the report should always answer the purpose for which it was intended, and that having a policy/protocol in place would serve to guide practitioners around this issue, as well as having templates for different reports/areas of speciality. Further training and guidance from supervisors would also serve to assist practitioners on how to navigate the difficulty of having to write for multiple audiences and how to ensure reports are still individualised. It was noted that practitioners should always seek consent before sending out reports to multiple audiences.

The nominal group participants were also divided on the issue of the use of occupational therapy terminology, as were the focus group participants in phase 1. Although five solutions were identified, only two solutions were clearly preferred; namely that regulations of the organisation should be followed, and that the report should be occupation-based. The last three solutions were more balanced in their ranking. It was suggested that terminology could be used as long as it has explanations and is accompanied by verbal feedback but that the focus of the report should be on the recommendations.

With regards to the challenge of using medical information in reports, two solutions were clearly identified, which could guide practitioners in this regard. Namely, once again the report should answer the purpose of being a report

congruent with occupational therapy, and any information included should be pertinent to the occupational dysfunction.

CHAPTER 5 DISCUSSION

5.1 Introduction

The following chapter will aim to contextualise the results conducted in the field of report writing and occupational therapy. The discussion will commence with information concerning the demographics of the participants included in the study and then continue with discussion of the results in relation to each of the study's objectives. For this chapter, the results of Phase 1 and Phase 2 will be discussed together in order to indicate how the findings fulfil the objectives of the study. This study purposefully required participant sampling from specific occupational therapy practice contexts to assist in understanding the influence that these specific contexts may play on report writing. Sampling participants across different contextual groups facilitated the richness of the data collected, which was maximised to gather opinions from a representative population of occupational therapists.

5.2 Demographics and context

The demographics considered are the participants' years of experience as well as whether they have a postgraduate training or are members of a special interest group. Understanding the participants' level of experience was important as report writing is a learnt skill, which develops with experience and mentorship [van Biljon et al., 2015]. Postgraduate education or membership of a special interest group were considered as important in providing support and development in terms of clinical reasoning and skills such as report writing [Rassafiani et al., 2009].

The context in which the participants practiced also influenced their perceptions of report writing, particularly profession-specific reports.

5.2.1 Level of experience

The three groups from the three different settings presented with different levels of experience. It was noted that more than two thirds (69.23%) of participants working within the public setting had less than 5 years working experience, indicating that more than half of the workforce fell within the

novice category [Rassafiani et al., 2009]. This is probably due to the fact that occupational therapists are required to complete one year of community service in government institutions [Maseko et al., 2014] and whilst the demographic form did not specifically identify if participants were still completing community service, it can be assumed that a number of these young therapists stay on after their community service within the government posts. Reasons for this have been reported as a desire to work within the public sector to address the needs of the community as well as taking advantage of the benefits of working in a large organisation, where regular mentorship, quality assurance measures and regular remuneration are viewed as benefits [Grobler et al., 2009].

This novice level of experience in over half the workforce in the public sector has implications for the quality of occupational therapy reports written [van Biljon, 2013; van Biljon et al., 2015]. Whilst one of the facilitators identified one way to improving report writing was having a senior clinician read through reports, there may not be sufficient staff or time to enable this with only 11.54% of the staff in this sector having more than 10 years of experience.

The demographic data of the private practice group highlighted a more balanced level of experience with 40% of participants having 0-5 years' experience and 40% having 6-10 years' experience. A concern was raised within the groups that novice therapists were entering private practice too soon with little support or mentorship particularly when working as an independent therapist, which could affect their ability to write reports of adequate quality [van Biljon, 2013]. This was not a concern for participants working in a private practice with a number of therapists as they felt more supported and could receive or provide mentorship on report writing as needed.

The academic focus group only consisted of six participants. Majority of participants had over 16 years' experience (66.66%). This could be explained by the requirement of academic staff to have a degree of clinical experience before entering into academia. As academic staff are required to teach clinical theory and skill as well as mark students' reports, they are required to have a more advanced level of skill and understanding of report writing.

5.2.2 Postgraduate training and membership of special interest groups

Three aspects are needed to support clinical reasoning in occupational therapists, namely knowledge, reflection and intuition [Chapparo and Ranka, 2000; Schell and Schell, 2008]. Experts have a sense of what is relevant and what is irrelevant and are able to identify significant factors within complex data to help with making decisions. Expertise depends on practical knowledge as well as theoretical knowledge [Rassafiani et al., 2009]. It can be argued that engaging in postgraduate studies exposes clinicians to complex cases and information, allowing them to expand their knowledge and experience, so enabling skilful decision making, a skill imperative to writing reports, especially when needing to decide on what data is relevant.

The public sector group had the largest amount of participants (26) but the lowest percentage (15.3%) of those had postgraduate qualifications, which may relate to their lack of experience, as many clinicians may feel some clinical years of experience are required before pursuing further studies [Wijnen‐Meijer et al., 2010]. Public sector clinicians also cited a lack of resources, such as time or money, as reasons for not completing postgraduate studies. The 15.3% of public sector participants who had a postgraduate qualification were the more experienced therapists.

A higher percentage (26.6%) of participants in the private sector group had some form of postgraduate qualification, as these practitioners feel the need to study further in order to offer specialised practice and ensure evidence-based practice [Iles and Davidson, 2006]. All participants in the academic group had a postgraduate qualification, which is a requirement for academic staff. Whilst a post graduate qualification does not guarantee improved work performance, it does indicate that an occupational therapist has been exposed to critical thinking skills, evidenced-based practice and research which may assist with improving general clinical reasoning and writing skills [Rassafiani et al., 2009].

These skills and attributes may also be developed through membership of a special interest group, which offers opportunity for reflection and discussion

between colleagues around clinical work, as well as mentorship opportunities, where skills such as report writing can be supported. Approximately half of the participants in the public sector group were members of special interest groups. This was still less than the 60% of the participants in the private sector and 80% of participants in the academic sector that were members of special interest groups. Once again this may be a factor affecting the quality of report writing amongst the therapists in the public sector although the number of participants attending special interest groups was a positive outcome in this study. These groups provide an opportunity for keeping up to date with practice, which is important for writing relevant reports reflecting up to date evidence and clinical reasoning [Occupational Therapy Association of South Africa, 2005].

5.2.3 Effect of context on perceptions of report writing

When analysing the data it became evident that the different contexts where the participants practiced influenced their perception of the issues that were affecting their practice and ability to write occupational therapy reports. This study aimed to gather opinions from therapists across a range of different contexts to understand the broad issues affecting therapists. Certain exclusions were employed such as those from the education and medico-legal sector, as therapists working in these areas have specific contextual requirements regarding report writing. Academic staff were recruited to help diversify the data collected, as perceptions of these participants were around teaching students as well as a having a more distanced, and therefore objective, view of what they have observed in clinical practice. It was noted that the data collected from the academic participants were most similar to that of the public sector participants when reporting on generic reporting issues. Most students' clinical placements are at government institutions as opposed to private, hence the academic participants' exposure to contextual issues faced by public sector occupational therapists.

Participants from all three contexts discussed ethical issues as well as barriers and facilitators that affected report writing but the causes and triggers for these perceptions were different in each context. For example, the

participants in the government sector cited challenges mainly around resource issues, which included human as well as material and environmental resources. It is documented that resource restriction is experienced by many public health facilities in South Africa, as the services available aren't adequate enough to manage the needs of the South African population [Coovadia et al., 2009]. A lack of resources was not highlighted with the private context participants. This may be due to the more profitable nature of privately funded rehabilitation care.

Another common issue discussed was the effect of the insufficient processes used to govern the care pathway within the public health sector. This has been acknowledged by several experts as being problematic, mainly due to the rocky transition of health care management following the end of apartheid [Chopra et al., 2009; Coovadia et al., 2009]. Participants in the public sector focus groups acknowledged problems with referral duplications, lost files and lack of feedback following quality assurance audits. It was felt by participants that these issues stemmed from poor management. Interestingly, the private sector participants also acknowledged systemic issues, which affect the practice of report writing. The cause of these issues stem from a different source, namely the funding organisations and funding models, which therapists felt affected their autonomy in deciding what goes into an occupational therapy report.

Whilst the inclusion and exclusion criteria of the sample identified participants with similar characteristics within each sector, it was clear that the environment, in which the participants practiced, influenced the generic issues affecting the writing of these reports. Whilst there were some similarities, such as experience being a facilitator to best practice across all three groups, the nuances of discussion around the generic challenges and ethical concerns related specifically to private and public practice. The more specific issues around terminology and the audience understanding the role of occupational therapy, appeared more global in nature, in that all therapists shared similar opinions no matter where they worked. As a result, themes 2 and 3, which addressed objectives 2 and 3, were analysed across all three contexts.

5.3 Issues influencing the current practice of report writing for occupational therapists within the South African context

The first objective of the study was to explore the views of occupational therapists regarding issues influencing the current practice of writing reports in the South African context. This was addressed mainly through the focus groups. When questioned around this issue, participants were quick to point out ethical issues, barriers to best practice and facilitators in report writing in their current practice. These factors had some specific contextually influential elements across the three groups however, similarities also emerged in theme 1 (occupational therapy report writing issues). It must be noted that issues within this theme primarily related to generic issues that health professionals including occupational therapists, face when writing reports.

5.3.1 Ethical issues

Some similarities were noted across the three contexts regarding concerns with sensitive information and how to handle these concerns during report writing. The participants from the public context spoke specifically around managing information such as reporting on the HIV (Human Immunodeficiency Virus) status of a patient. This is a daily reality for therapists in South Africa with the HIV prevalence rate being approximately 6 700 000 - 7 400 000 people living with HIV [UNAIDS, 2015].

The concern raised by the participants in the public sector was mainly around divulging this information to a non-medical professional such as the employer or a member of the work place or the client themselves. The current approach by participants within this context appeared to be to omit this information, rather than specifically understanding the legal and ethical policies that govern this.

Amongst the independent private practitioners there was also some consensus that practitioners have the right to withhold certain information. The withholding of information, however, brought up a moral conflict and was contested by a participant who had first-hand experience of being involved in a situation where information had not been given. She felt that this practice

affects the autonomy of the patient and the family. This professional practice guideline is supported by OTASA code of ethics, which states: -

> "*The practitioner should not withhold any information or mislead the client in any matter that would limit his or her autonomy. Such information should be provided in a form and language which makes it possible for the information to be useful and understood without causing undue harm or engendering feelings of helplessness" p2[Occupational Therapy Association of South Africa, 2005]*

The participants could not come up with a different solution. Legislation such as the Protection of Personal Information Act (POPI) [South African Government, 2013] and other government policies have been established to guarantee minimum requirements for the management of personal information, and to ensure that the rights of persons regarding their personal information are not violated. Practitioners should adhere to this legislation. Amongst others, the legislation and policies entrenches an individual's right to give consent before their information is disseminated [South African Government, 2013]. The right to consent to disclosure is echoed in the HPCSA booklet 14, Guidance on the keeping of patient records [Health Professions Council of South Africa, 2008b]. Guidance around confidentiality is also included in the OTASA code of ethics, which states that for reports to be submitted to other parties, all information should be kept confidential unless consent is given by the client [Occupational Therapy Association of South Africa, 2005]. If the confidentiality of the report is considered then the patient must give consent for their report to be disseminated. Consideration around the ownership of the report is therefore needed. Does the fact that the corporate and funding bodies, such as medical aids, are paying for the therapy give them the right to dictate what to include in occupational therapy assessments and reports?

Participants from the private context in particular voiced ethical concerns around the billing of report writing. Therapists feel the corporate and funding bodies are making report writing more expensive than necessary by setting

demands in relation to what must be reported so that services are paid for. The ethical repercussions of the commodification of healthcare and rehabilitation practices are complex. If the emphasis of health and rehabilitation intervention is on making profit, this may result in the replacement of professional ethics with business ethics [Rowe and Moodley, 2013]. The report may then be seen as a product, which is owned, rather than a reflection of the patients care pathway. To note however, there is no agreement on the ownership of records internationally with Terry (2015) indicating "while patients have a legal right to their medical records" if they ask for them, the professional is the caretaker of the records and should control access to the records [Terry, 2015]. Thus there appears to be no best practice in who owns patient records, who should have access to a patients records and for whom they should be written.

Even though participants could name these policies and legal guidelines such as the POPI act and HPCSA guidelines, they admitted that they did not know the specifics and could not be sure how these impacted on the reports. Therefore, it appears that therapists either have not read or accessed or understood these guidelines and therefore cannot apply best practice according to these guidelines when considering confidentiality issues in writing occupational therapy reports. These findings have been supported by other research on report writing in South Africa [Buchanan et al., 2016; Rischmuller and Franzsen, 2012; van Biljon et al., 2015]. A concern addressed in these prior studies is the possibility that reports can be used for legal purposes, where a therapist can unwittingly become involved in litigation, if they do not understand the legislation around confidentiality and implement this in their reports. It would be in therapists' best interests to be members of professional bodies and special interest groups, where they can seek guidance and support in the legislation around report writing and dissemination of information. Interestingly, the participants from the academic context understood this issue as an overview to maintaining confidentiality. It was identified that if practitioners simply wrote what is pertinent just to occupation, they may then avoid these issues around confidentiality. One

could argue theirs may be a theoretical but narrow view that seldom matches the clinical context, specifically when referrers require specific information and the effect of context and personal history on occupation [Cross, 2001].

A group of participants in the public sector voiced ethical concerns related to the patients' rights and their ability to take responsibility for dealing with their records and act on recommendations made by practitioners in these reports. Their concern supported the role that professionals play in ensuring maintenance and dissemination of records while maintaining client centeredness during intervention, as is stipulated by governing bodies such as the HPCSA –

> "*Health care practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences*" *p7[Health Professions Council of South Africa, 2008a]*

Professional bodies such as OTASA [Occupational Therapy Association of South Africa, 2005] support this view but participants felt that clients often appeared apathetic in taking responsibility for understanding the implications of the reports and the affect on their healthcare. Participants felt clients were also indifferent in terms of implementing recommendations made in reports and therefore felt that by providing patients with written reports often did not achieve any outcome. The indifference or apathy to involvement in patient's' own care could be related to aspects of poor health literacy where poor understanding alienates health care users from access and effectively partaking in the health care process [Kickbusch, 2001; Nutbeam, 2008].

5.3.2 Barriers to report writing in clinical practice

Participants from all three contexts identified barriers to their current practice of report writing. Issues most plainly voiced in the public context included the material and environmental restrictions. Limitations such as lack of computers, paper, ink and space appear to be compounded by the lack of time experienced by clinicians, as they voiced that they struggled to manage

large caseloads. They felt that their restricted resources influenced their ability to keep up with providing effective intervention, as well as to keep up with administration tasks such as report writing, and to do both expertly. This lack of resources is a common issue experienced by most health care professionals in the South African public health sector, with health care organisations struggling to meet the needs of the population numbers [Coovadia et al., 2009]. Participants from all three contexts also identified poor health literacy, which is associated with most readers of occupational therapy reports in South Africa, as the greatest challenge in report writing. In their experience, many users of the South African health service use English as an additional language and have insufficient education/experience to adequately understand professional reports. Participants in the focus groups acknowledged that even with translation, information could be misunderstood or missed, potentially resulting in a negative impact on the clients' participation in their care. The participants' concern is supported by the 2015 General Household Survey of the South African population over the age of 20 of years, which identified that 15.4% are regarded as functionally illiterate (no schooling or who have not completed Grade 7) with women remaining most likely to be functionally illiterate across all age groups [Statistics South Africa, 2016]. Overall the proportion of the population who will graduate from upper-secondary school (grade 12) fluctuates at around 40% [Spaull, 2015]. This has a direct relationship to the health literacy of the population. Health literacy can be defined as

> *"The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions"* *p31-32[Nielsen-Bohlman et al., 2004].*

Low literacy in a population is associated with a range of poor health outcomes [Kickbusch, 2001; Nutbeam, 2008]. It can be reasoned then that a large majority of the South African population may not benefit fully from health care advice and may have worse health outcomes due to their poor levels of literacy and schooling, therefore affecting their ability to understand and process complex information around heath management [Nutbeam, 2008]. To further complicate the issue, the study by Donaldson, McDermott, Hollands,

Copley and Davidson determined that occupational therapy professional reports require a university reading level or higher to adequately understand and process the information. This indicates that regardless of schooling, most members of the general population find it difficult to understand professional reports [Donaldson et al., 2004]. The barriers faced by the majority of occupational therapists when writing professional reports are therefore two-fold. Firstly, many of the audience reading reports have inadequate literacy to understand health information, and secondly, occupational therapy reports generally require a university reading level to enable comprehension of the text.

The affects of poor health literacy can be alleviated by improving the quality of health communication, and enabling increased understanding among health professionals to the potential impact of poor health literacy [Nutbeam, 2008]. While the participants in the public sector acknowledged that clients have difficulty understanding reports, no suggestion was made on how to address this through report writing. It was felt that this is a problem that is perpetuated throughout the healthcare system, and so is not a problem unique to the occupational therapy profession. The participants in the private sector group reported that in order to be more accommodating to an audience with limited literacy, one simply needed to omit the information one felt would not be understood, rather than find another way of reporting the information. It could be suggested that changing and improving quality of health communication would serve to involve the service users more [Nutbeam, 2008].

The public sector and academic participants noted a second barrier to report writing relating to insufficient processes, including poor management of records and processes in public institutions. This barrier could be directly related to inadequate human resource capacity, which has been unevenly distributed between the public and private sectors, between geographic areas and between levels of care following the end of the apartheid regime. The absence of stewardship has been actively highlighted in relation to various components of the health sector [Coovadia et al., 2009].

At ground level, it is apparent that therapists are struggling with systemic issues, such as duplication of referrals and poor management of paper work. Participants expressed frustration related to inaccurate information provided on patient referral. The unreliability of information and the time it takes to source the correct information was felt to have an impact on the quality of the reports written by the occupational therapists. This appeared to be compounded by the fact that many clients have limited funds and so, have difficulty accessing transport to attend occupational therapy services for assessment and intervention. The therapist then needs to manage the situation and use clinical reasoning and skill in order to obtain the quality of the information needed for adequate reporting in the short time available. Inexperienced therapists may be at a disadvantage as the process may take them longer because they have limited decision-making skills, thus affecting the sufficiency of information they obtain and report [Rassafiani et al., 2009; Schell and Schell, 2008].

In the private sector, it was identified that therapists are finding it difficult to manage the impact of medical aid organisations dictating the process, content and timelines of occupational therapy reports. Since medical aid organisations are the key funders to most services including occupational therapy within private practice [McIntyre et al., 2003], they take on the role of the consumer. In order to receive payment for their services, therapists are required to fulfil the demands of the medical aid companies in relation to the content and length of reports. Participants identified medical aid companies' prescriptions around reports as being a barrier to efficient report writing since managing their demands and requirements are time consuming but often unremunerated. In identifying this barrier, participants have highlighted another professional predicament expressed in the literature; namely that the demands of external stakeholders may influence occupational therapy documentation to a greater degree than the core principles of the profession [Rosenheck, 2001].

Participants in all three contexts further identified that lack of experience was a major concern when considering the quality of occupational therapy report

writing. The participants from the public and academic contexts identified the effect that inexperience has on both the length of the report as well as the terminology used. Novice therapists were inclined to write longer reports as they used the process as a tool to help with clinical reasoning and integration of information. The study also highlighted that inexperienced therapists also have difficulty with using appropriate language and professional terminology. These two skills develop with time, experience and practice [Rassafiani et al., 2009; Schell and Schell, 2008; van Biljon et al., 2015].

The participants from the private practice context inferred that inexperienced therapists should possibly spend more time practicing report writing when in the public sector, where there is scope for more support and mentoring, which is seldom available in all private practices. Getting adequate practice while in the public sector becomes more important when a young therapist chooses to work independently after completing community service. Private practice participants acknowledged that therapists need the opportunity to write reports with some guidance in order to help develop integration and summarising skills.

Rassafiani, Zivani *et al*. in 2009 pointed out that the combination of insufficient processes in health services and inexperienced therapists can have a detrimental effect on the overall quality of occupational therapy reports [Rassafiani et al., 2009]. Participants in this study also reported a lack of accountability and unclear roles and expectations of therapists, particularly in the public sector, which further affects the inexperienced therapist's ability to navigate the complexity of writing adequate reports in a large organisation [Rischmuller and Franzsen, 2012].

A further barrier also exacerbates the inexperienced occupational therapist's lack of proficiency in report writing; a lack of any standard format for health reports, as reported by the participants in the public sector. In South Africa, at the time of this study, there are currently no specific guidelines for occupational therapy report writing. Whilst a study has been completed by van Biljon in 2015 to establish guidelines for vocational reports, specific guidance

for general occupational therapy reports is lacking [van Biljon et al., 2015]. Some participants indicated they were already using these vocational reporting guidelines in practice, but there was a call for more general guidelines to be established to support therapists. The participants in this study reported that there are also no known templates or formats for standardised report writing from the occupational therapy professional association, OTASA.

The current guidelines/policies in place include those from the HPCSA, which states that records need to be complete, concise and consistent and should use a standardised reporting format [Health Professions Council of South Africa, 2008b]. The language used in the HPCSA booklet 14, Guidelines on the Keeping of Patient Records, is clearly for medical doctors. The apparent lack of understanding of the practices and scopes of the other professions regulated by the HPCSA seems to make compliance with some of its recommendations, e.g. those contained in Booklet 14, difficult for practitioners who are not medical doctors. However, a study by Buchanan et al. (2016) indicated that with some modifications, the information provided from the guiding bodies, such as the HPCSA, can help clarify reporting for occupational therapists [Buchanan et al., 2016]. In addition to modifying the HPCSA guidelines, professional bodies or departments may use guidelines for reporting created in other countries, such as the United States [Clark and Youngstrom, 2008], but there are particular contextual challenges and issues unique to South Africa that need to be acknowledged in the report writing process. These uniquely South African factors include issues such as lack of resources, poor distribution of resources and the language and cultural diversity as represented in South Africa [Coovadia et al., 2009].

5.3.3 Facilitators to report writing in clinical practice

Participants in all three contexts reported on facilitators to enable better practice in report writing.

While public sector therapists identified the absence of report templates and guidelines as a barrier [Health Professions Council of South Africa, 2008b], many participants in the private context indicated that they have already

developed templates for standardised reports and use these to assist with ensuring consistent quality in their reports. Due to their ignorance of the content of regulatory policies and legislation highlighted above, these templates may not necessarily meet policy and legislative standards.

Whilst establishing guidelines was an initial aim of this study, it became obvious that occupational therapists are conflicted around what should go into a template. A more detailed process of investigation and exploration is needed to develop guidelines that are responsive to occupational therapy in the South African context. By having guidelines and a template, this should support inexperience and improve standardisation and overall quality of the report writing process in occupational therapy [Donaldson et al., 2004; van Biljon et al., 2015].

A facilitator related to having templates was the requirement for occupational therapists to be prepared before writing reports. Preparation involves outlining a structure of what a practitioner may want to include in the report and ensuring that the relevant information is at hand. Having templates would be useful in this regard, by guiding therapists on what information they may need to complete the report [Donaldson et al., 2004; van Biljon et al., 2015]. It was suggested that being prepared extends beyond preparing for and writing the report, but also includes having easy access to your report and relevant information should you need to offer feedback after the report has been distributed. This strategy has also been highlighted by van Biljon in the recommendations submitted for vocational reports [van Biljon, 2014].

Both the private and academic contexts identified the need to accompany the report with verbal feedback, which appears to be standard practice across the settings interviewed. Suggestions in the literature have been made that to enable better understating of a report, dissemination of the report should be accompanied by verbal feedback to aid in understanding [Donaldson et al., 2004; Makepeace and Zwicker, 2014].

Challenges were noted with both the private and public sector around being able to provide verbal feedback. These included being able to set time aside

for this and how to overcome the challenge of the receiver having English as an additional language. For privative practitioners specifically, there was the additional challenge around how to bill for verbal feedback, as there is no specific code offered through medical aids to facilitate reimbursement. Providing verbal feedback would also contribute to improving the quality of health communication, making it more responsive and understandable to the receivers of the reports [Nutbeam, 2008]. The subject matter experts (SMEs) in the nominal group also highlighted verbal feedback as being advisable to support greater understanding for the users of occupational therapy reports. It is possibly a pressing need to evaluate how this can be a standard or comprehensive part of occupational therapy services offered, to help address the challenges of time management, billing, and communicating in different languages in South Africa.

All three contexts highlighted that developing professional experience was a facilitator to best practice. Two factors were identified that related to developing professional experience; oversight by a senior or more experienced colleague and developing clinical reasoning. Having a senior or more experienced colleague read through an occupational therapy report offers a chance not only for individual development but also supports accountability of the content recommendations by getting both professionals to sign off on the report. Such support will then enhance the development of the necessary competency of being able to communicate the occupational therapy assessment, process and intervention [Verma et al., 2005].

Participants in this study communicated that clinical reasoning was the key skill that occupational therapists develop to assist them in making recommendations, as well as what information to include in the report to make it most relevant. Supporting the development of clinical reasoning is also the need to be flexible [Rassafiani et al., 2009; Schell and Schell, 2008], so whilst participants recommended having templates to support best practice, having the flexibility, possibly supported by sound clinical reasoning, will also enable occupational therapists to only include information that is pertinent or relevant.

5.4 The views of occupational therapists regarding the factors affecting best practice and the quality of profession-specific reports

The second objective of the study related to exploring the views of occupational therapists regarding best practice and the factors affecting the quality of occupational therapy reports within the South African context.

5.4.1 The occupational therapy identity

A prominent theme emerged from analysing participants' comments in relation to this objective. It was clear that the identity of occupational therapy, as viewed by therapists and others, is felt to have an impact on the quality of the reports written by occupational therapists. Participants were vocal in the call for further evidence to support the practice of occupational therapy. There was much discussion around the fact that many other health care professionals do not understand the role of occupational therapy. This was frequently met with some exasperation that at a professional level this should not be occurring. This is not just a problem in South Africa but has emerged through studies done globally. This lack of understanding of the occupational therapy role, as well as the lack of confidence and assertiveness felt by therapists, may influence their practice through reporting on generic health activities as opposed to the specifics of an occupational framework [Ashby et al., 2013; Fortune, 2000; Hayes et al., 2008]. The participants identified that part of the challenge is that occupational therapy happens behind closed doors due to the intimate nature of the problems with which are dealt. This may contribute to the misunderstanding of other professionals with regards to what is done or achieved within occupational therapy sessions, as it is not acutely observable. These concerns have been found to be true in other studies [Lundgren Pierre, 2001; Wilding, 2008]. There was a strong call from the therapists to support intervention with evidence, specifically around having measurable outcomes, which may be more recognisable and respected by the health community. This call for evidence-based practice is of a global nature, with therapists around the world identifying that it is necessary to protect the livelihood of the profession [Davis et al., 2008]. The therapists felt that evidence-based practice carries inherent challenges within the

profession, as there are many aspects to occupational therapy that are intangible or that cannot be measured in traditional scientific methods [Turner, 2011].

It is not just further research and evidence on the efficacy of treatment that is needed to protect the future of the profession, but also the way in which it is reported, so that the understanding and the marketing of the profession is adequately communicated. In fact, Davis, Zayat, Urton, Belgum and Hill stated in 2008 that the:

> *"…external forces that shape the documentation of occupational therapy should be examined if the profession is to communicate to stakeholders the evidence upon which treatment is based" p. 249[Davis et al., 2008]*

Many studies have reported that documenting on patient intervention is one of the most important aspects of communication in professional practice [Lundgren Pierre, 2001; Lundgren Pierre and Sonn, 1999; Tickle-Degnen, 2000]. This communication of intervention is key in ensuring others understand the benefits and purpose of occupational therapy. Occupational therapy is a multi-faceted and complex intervention that often does not fit into one category [Creek, 1998; Lundgren Pierre and Sonn, 1999]. Purchasers and policy makers need to know what they are purchasing so an accurate description is important to ensure the profession is not side lined [Bradshaw et al., 2014; Ram et al., 2009].

Regardless of the frustration, participants also identified that there is a sense of occupational therapy patriotism emerging. Participants' communicated they were proud of the profession and the unique service it offered. Participants acknowledged that occupational therapists have many skills and are adaptable so can fit into many situations, which is seen as a part of the professional requirements. It was also acknowledged that occupational therapists themselves tend to bend or flex into what a situation requires, indicating it could be a disadvantage due to possible loss of the profession's unique identity. This "hyper-flexibility" is possibly indicative of the profession

still being in a form of adolescence as reasoned by Turner in the Elizabeth Casson memorial lecture in 2011 [Turner, 2011]. Occupational therapy is regarded as a young profession, still being controlled in part by its 'big brother' medicine. Even though occupational therapy was born under the medical profession, its values differ from medicine. Occupational therapists however, often document/define their practice in medical terms in order to communicate with audiences [Lundgren Pierre and Sonn, 1999] and to receive funding from sources that are related to medical care [McIntyre et al., 2003].

The occupational therapy profession is starting to flex its muscles in part as it realises that it often does not fit under the medical umbrella. But having this degree of uncertainty can lead to insecurity around the scope of the profession [Fortune, 2000]. This degree of insecurity was evident across all three of the contexts interviewed, and in fact was noted by a participant with international work experience as being a worldwide issue, not just specific to South Africa [Ashby et al., 2013; Hayes et al., 2008; Turner, 2011]. Thus, while participants indicated that they are proud of their professional identity, the profession's situation within the medical fraternity results in some insecurity around roles and scope of profession as well as difficulties around establishing good scientific evidence for practice. These professional identity dilemmas affect report writing in the sense that occupational therapists are uncertain both of what to include in their reports and how their views on occupational performance will be received, particularly by role players steeped in the medical model.

5.4.2 Who is the audience?

The third theme speaks specifically to the heterogeneous audience of occupational therapy reports. Participants felt that this factor had a significant influence on the quality of the reports written by occupational therapists. Occupational therapy reports generally have a wide audience, ranging from other health care professionals, caregivers, corporate/provincial bodies and funders [Buchanan et al., 2016; Donaldson et al., 2004; Rischmuller and Franzsen, 2012]. A heterogeneous audience adds complication to report

writing because, the greater the variety in the audiences, the greater the range in varying requirements they are likely to expect from occupational therapy reports. This has therapists confused as to how they should write the report in terms of professional language and what content to include. It makes it difficult for occupational therapists to articulate their findings as well as what they do. Furthermore, having a diverse audience makes creating standardised templates and uniform reports difficult. Interestingly, occupational therapists are not unique: other professions, such as psychology, have been reported to struggle with writing reports to heterogeneous audiences and its resultant challenges as well [Harvey, 2006].

There is extensive debate in the literature about using occupational therapy jargon or not [Donaldson et al., 2004; Wilding, 2008]. Categories and subcategories that emerged in this study highlighted the concern occupational therapists have that the audience does not understand occupational therapy language by and large in the reports. It was acknowledged that occupational therapy terminology in itself is confusing; to the point where some occupational therapists themselves don't even understand. Several studies have identified that receivers of occupational therapy reports frequently find the occupational therapy jargon difficult to understand and that it should be written in layman's terms [Donaldson et al., 2004; Makepeace and Zwicker, 2014]. This issue relates back to health literacy described above and is a problem for a large majority of the South African population, who have insufficient education and speak English as an additional language.

Despite recommendations to use layman's terms, occupational therapists are concerned that by not using professional terminology, occupational therapy reports may come across as unprofessional. Should the reports be perceived as unprofessional, practitioners fear that they will not be taken seriously by other professionals, who also read occupational therapy reports. This fear could relate to the second theme around the occupational therapy identity, where a pervasive feeling of low professional self-esteem is noted. Interestingly, the low professional self-esteem is perceived to be self-perpetuated in the profession when practitioners do not use words unique to

the profession, or do not describe occupational performance in their reports, resulting in a continuous need to justify the profession. Another counterproductive habit arising from the fear of not being taken seriously and low professional self-esteem, is occupational therapists' need to sound more professional by using elaborate words in an attempt to garner more respect from other health care professionals [Donaldson et al., 2004; Wilding, 2008], which could have the unfortunate by-product of making the reports more difficult to understand. Another problem participants reported was that many occupational therapy reports do not contain 'occupational' words but rather use the term function, as opposed to occupation, when talking about occupational performance to the detriment of the profession.

Participants felt that occupational therapists' poor ability to articulate the actions and philosophy of occupational therapy, subsequently affecting the quality of report writing, was further influenced by the different models of practice, which are taught at different universities and used in different work places. The few studies done on reporting in South Africa acknowledge that this lack of standardisation of terminology can lead to an incongruity between professional beliefs and what is reported, which can cause ambiguity of the occupational viewpoint [Mlambo et al., 2004; Rischmuller and Franzsen, 2012].

Describing occupational therapy practice is difficult as it requires therapists to use a range of knowledge from different realms of theory, which can be scientific, practical, social and occasionally spiritual in nature [Trevithick, 2008]. But this description is critical in helping therapists to resist the pressure to conform to knowledge and techniques borrowed from other disciplines [Ashby et al., 2013]. An additional challenge is that the use of occupational therapy terminology is often seen as being the use of jargon, which many feel is unethical and poor practice [Donaldson et al., 2004; Harvey, 2006; Makepeace and Zwicker, 2014]. The challenge of using universal language for the profession is historical, with many theorists identifying that it is impossible to reproduce all the facets of human life into writing a single professional report [Yerxa, 1994]. This, however, is a challenge that South African occupational therapists need to tackle in order to establish what is

acceptable terminology to maintain the occupational therapy identity within the boundaries of the South African context [Clark and Youngstrom, 2008]. The importance of clear articulation cannot be overemphasised. Indeed, as stated by Wilding in 2008, occupational therapists need to become more articulate about what they do or risk other professionals moving in on the scope of occupational therapy practice [Wilding, 2008].

The issue of clear, uniform articulation of occupational performance then leads to the challenge of whether occupational therapists should write one report or a variety, depending on the audience. It was frequently identified by the participants that those who requested the report would influence how the report would be written and the language that would be used. The South African contextual conundrum of multilingualism, low literacy and levels of education is again noted, which would result in difficulty understanding a 'jargon-filled' report. Occupational therapists therefore feel they are then required to write the report in simpler language or with reduced content. Such a simple report may however, not meet the needs of a professional audience and so, two reports will need to be written, which had been recommended in other studies [Makepeace and Zwicker, 2014]. The challenges placed on the therapist need to be noted, as writing two reports is likely to increase the time demands on therapists, in addition to increasing the risk of omitting important information as noted by some of the participants. Some participants identified that maintaining an occupationally specific outline for all reports [Lundgren Pierre and Sonn, 1999; Wilding, 2008] may negate the writing of more than one report to all receivers, but the complexity of the language used by the profession cannot be ignored. Not all participants were in agreement with the above suggestion. It was voiced that if a receiver was paying, the report should be tailored specifically to their needs. This highlights the dichotomy of occupational therapy trying to survive and promote itself within the medical model, and the risk of other professions dictating the occupational therapy scope of practice [Lundgren Pierre, 2001; Turner, 2011; Wilding, 2008].

Participants also noted that different specialities in occupational therapy would call for certain specialist reports to have a different 'look and feel'. Again, participants were divided over this issue. Some participants felt that as occupational therapists, the main focus of the report should be on occupation for all specialities with the reason for dysfunction being the only difference. Other participants however, were adamant that specialism or areas of practice, called for very specific information, otherwise the essence of the report would be lost. Literature in this regard is limited, but one could link this argument to the use of occupational based language. The argument of using occupational therapy specific terminology and only covering information around occupation, which is the core value of the profession, should help with defining the scope and the individuality of the profession. If therapists write in terminology or report on areas not specific to occupation, there is a risk of overlapping in scope, or the adopting of the occupational therapy scope by other professionals [Lundgren Pierre, 2001; Wilding, 2008].

Thus, participants in this study found that the audiences of occupational therapy reports, in addition to the diversity and lack of uniformity of occupational therapy jargon and its resultant challenges for being understood, are factors that have far-reaching impact on writing occupational therapy reports. Participants found it difficult to reach consensus on some issues, particularly pertaining to what the contents of an occupational therapy report should be.

5.5 To establish recommendations to improve best practice in occupational therapy report writing

The third objective of the study was to establish recommendations to improve best practice in occupational therapy report writing. As the participants in the focus group were unable to establish some clear opinions or decisions around this, a nominal group was held with subject matter experts (SMEs) to seek some clarity on these conflicts established by the focus group data. The conflicts raised in the focus group include the following:

- *Conflict 1: Should occupational therapists write one report or a variety - Depending on receiver and the specialty.*
- *Conflict 2: Occupational therapists are conflicted around using occupational therapy language /jargon.*
- *Conflict 3: what must be included in terms of medical/clinical information e.g. diagnosis etc.*

5.5.1 Conflict 1: Should occupational therapists write one report or a variety - Depending on receiver and the specialty.

The conflict presented to the group was *"Therapists are in disagreement as to whether they should write one report or a variety of reports depending on their audience. Related to this is whether the report format should change depending on the clinicians' area of practice. What guidance could you give clinicians in this regard?"*

The nominal group process did not come up with one definitive solution but rather ranked possible solutions that could assist in answering the conflict. The most prominent ranked solution was that the report should answer the purpose, and this will then dictate content and layout and possibly how many reports should be written depending on the audience. Understanding the purpose of the report, for example, if it is for family or a professional audience, will dictate whether one or more reports need to be written [Makepeace and Zwicker, 2014; Mastoras et al., 2011]. Whilst the solution may appear simple, it can be argued that it takes experience and reasoning to implement. Understanding the audience and the requirements of the referrer are essential, and without interrogation into this or with guidance, a novice therapist may find it difficult to interpret. It could be argued that this solution would aid in guiding other solutions, such as having a policy or guideline, as well as compulsory/mandatory support from a more experienced clinician and or training [Clark and Youngstrom, 2008; Donaldson et al., 2004; Makepeace and Zwicker, 2014]. A policy/protocol to guide therapists was supported by 72% of the aggregated score. The nominal group members identified that each area of practice requires specific standard operating procedures/policies to guide practitioners. By having guidelines in place, novice and developing

therapists will have clearer direction on how to write reports and this may in turn serve to promote quality assurance. As with policies and guidelines, some specific criteria are relevant, such as the policy/guideline must also be clearly understood, and a process must to be in place to monitor compliance [Ram et al., 2009]. This may be challenging in contexts where systemic challenges prevail.

It was also highlighted through the nominal group process that therapists need training in the skill of report writing. Whilst training may serve to provide some knowledge and processes to assist a clinician, the translation of theory into practice is challenging. With the development of new skill, feedback and practice is essential, which therefore needs to be incorporated into suggested training [van Biljon et al., 2015]. The needs of the novice therapist must be acknowledged, as they need assistance in making their reports more succinct, which requires being selective in what relevant information is included. Many novice therapists actually use the reporting process to help with integrating assessment and collateral information rather than using the skill of report writing as a primary form of communication.

It was also noted that a therapist would need to gain consent when writing and distributing reports. This can be understood as the need for therapists to follow the legal requirements and practice professionalism. Ensuring that consent is gained from the patient, ensures their personal information is protected in accordance with South African law [Republic of South Africa Department of Health, 2011; South African Government, 2013]. Promoting improved communication between professions could be a way to assist in helping practitioners develop their professional behaviour. Vincent, Stewart and Harrison (2008) acknowledged this in their study on teachers' perceptions of occupational therapy reports. It was apparent that the lack of cross collaboration between professions leads to poor understanding [Vincent et al., 2008]. Such 'silo' working may contribute to restrictions faced by so many therapists, and inefficient service-user care due to insufficient processes

experienced in the health care institutions [Coovadia et al., 2009; McIntyre et al., 2008]. It cannot be ignored that in order to have this collaboration, consent from the service-user is always needed.

The last two solutions mirrored those taken from the focus groups, namely that a more senior therapist needs to read the report to enable professional development, and a template of sorts would be beneficial to assist practitioners. Seniors need to help develop novice practitioners not just on content but language and professional terminology as was recommended in the focus group interviews. The nominal group emphasised, though that while templates are beneficial, therapists still need to have skills to adapt the template to meet the needs of the individual.

5.5.2 Conflict 2: Occupational therapists are conflicted around using occupational therapy language /jargon

The second conflict presented to the SMEs was :

> *"The use of OT language has therapists conflicted around OT language/jargon. They often use generic rather than OT words in their reports. How should clinicians manage the perception that other professionals and their clients and caregivers don't understand their reports? Add to that is the complexity of the SA context where so many receivers of the reports have English as a second language."*

This conundrum around the use of occupational therapy terminology is not just a South African phenomenon but a global concern of occupational therapists as mentioned previously [Lundgren Pierre, 2001; Wilding, 2008]. This concern along with the health literacy needs of the population leads to multiple challenges faced by the receivers of occupational therapy reports, as well as the practitioners who write them [Nutbeam, 2008]. This lends itself to a debate between enabling health literacy versus maintaining occupational identity through the use of professional language or jargon. A key philosophy of occupational therapy is of empowerment and enablement [American Occupational Therapy Association, 2014; Polatajko, 2001]. One could argue

then that promoting health literacy through easier understanding of occupational therapy reports serves to enable the population being served by South African occupational therapists. Does this however, come at a professional sacrifice of the professions identity and language?

The primary suggestion made by the SMEs in the nominal group, was to always refer back to regulations that govern professional processes. As noted in the focus groups interviews, therapists are unsure of government or legal regulations, as they lack clarity, or there are no specific regulations within occupational therapy terminology or their area of work. Interestingly the subject matter exerts also demonstrated limited understanding of the details around this issue. Even though this was the most highly voted on (78%) the SMEs could not say what these regulations are or how they could be interpreted with regard to using professional terminology. The HPCSA booklet 14, on the keeping of patient records, mainly refers to the access, storing and retention of medical records. Guidelines on how to write these health records or vague, inferring records should be concise and not contain any self-serving or disapproving comments [Health Professions Council of South Africa, 2008b]. The national core standards for health only refer to the retention and storing of patient records [Republic of South Africa Department of Health, 2011]. The OTASA code of ethics, while containing more pertinent information to the profession, also does not give clear guidance in terms of the use of occupational therapy terminology, other than information must be provided in a clear and understandable manner [Occupational Therapy Association of South Africa, 2005]. It is evident then, that practitioners are lacking clarity and understanding in this regard.

This discussion around the use of occupational therapy terminology did identify a need to ensure reports are occupation based so as not to lose the integrity of the profession when trying to address these issues [Buchanan et al., 2016; Clark and Youngstrom, 2008; Wilding, 2008]. The SMEs also supported the suggestion from the focus groups that verbal feedback should always accompany a report as recommended in other studies [Donaldson et al., 2004; Harvey, 2006; Makepeace and Zwicker, 2014]. They acknowledged

that occupational therapy language can be difficult to understand, so it needs to be accompanied by an explanation, whether verbal and or written.

An occupational therapy report can serve to educate the public and other health care professionals on the profession's scope. There is a great concern amongst occupational therapists that other health care professionals and the public do not understand what occupational therapists do [Fortune, 2000; Hayes et al., 2008; Wilcock, 2007]. It can be argued that explaining terminology within professional reports is an ideal vehicle for education as reports are used primarily as a communication tool. As with the focus group participants some SMEs were divided over this issue. Some felt it cumbersome to describe terminology instead of using concepts when reporting, even though the use of definitions has been recommended by some studies [Donaldson et al., 2004]. Some nominal group participants felt that using only laymen's terms over occupational therapy jargon with an explanation would be sufficient. This may then also serve to address the health literacy issue in South Africa. A solution that was identified was that most audiences are only interested in the conclusion and recommendations, so the majority of effort should be spent on that specific part of the report. This solution echoes other studies, which identify that most readers want practical examples of recommendations[Donaldson et al., 2004; Harvey, 2006; Makepeace and Zwicker, 2014; Mastoras et al., 2011].

This study identified the tension felt between ensuring the reader of the report understands what is written, yet remaining professional through the use of the appropriate terminology. Some SMEs still had difficulty accepting the use of 'jargon' or occupational therapy language being used in a report going so far as to saying it is unethical. This was also strongly contested by some other SMEs who voiced that using occupational therapy language and professional terminology is important for maintaining the respect of the profession. What overrides the use or non-use of jargon, is understanding the needs of the population serviced, and the risk of exclusion many of them face due to their

'health illiteracy' [Kickbusch, 2001; Nutbeam, 2008]. This possibly calls for the exploration of a universal terminology within occupational therapy that is easily understandable, and possibly specific to the South African context.

5.5.2 Conflict 3: What must be included in terms of medical/clinical information e.g. diagnosis etc.

The last conflict presented to the SMEs was:

> *"Occupational therapists are unsure of what must be included in terms of medical/clinical information e.g. medical history, diagnosis, test scores etc. What guidance would you give in this regard?"*

This conflict was highlighted, as therapists are facing the challenge of being occupation based in a medical setting, which translates into what they are required to communicate in reports. This challenge is often faced by occupational therapists working in a medical setting, whose values do not fit with the values of the occupational therapy profession. Health in medicine is often viewed as an absence of disease or impairment, whereas occupational therapy views health as the ability to engage in meaningful occupations, which are valued by the individual [American Occupational Therapy Association, 2014]. This value system of the profession, does not lend itself to information being described in scores and numbers as is common amongst medical professionals. Interesting to note in this study was the strong push from academics for reports to be occupation based as per literature and theory however practitioners acknowledged that in context, it seldom works like that, especially when working in a private funding or medical model such as the large state hospitals. Occupational therapists find the way they report is often dictated by professions outside of occupational therapy, as these are the consumers of the service, which was also discussed in the study by Makepeace and Zwicker [Makepeace and Zwicker, 2014]. Practitioners need to weigh up the longevity of service, and to ensure consumers understand what the profession offers. The argument of health literacy as well as professional identity and respect again comes into play. Some participants in the focus groups felt that putting in assessment scores and tests would only serve to confuse the reader, and may even cause problems with accuracy

when re-assessment was required. However other participants felt it was important to include assessment scores to support the observations and the assessment results. They also acknowledged there is a need for outcomes based and evidenced based practice, so having measurable evidence is important for the advancement of the profession. Assessment scores and outcomes often focus on the components of dysfunction as opposed to the impact on the impact on the persons' occupations. This requires an experienced clinician to translate these scores into meaningful information. Ultimately the impact on the person's occupations and how this translates into practical recommendations is what is critical in an occupational therapy report [Buchanan et al., 2016; Clark and Youngstrom, 2008; Donaldson et al., 2004; Makepeace and Zwicker, 2014]. The SMEs offered two primary solutions; firstly that the report must always answer the purpose so as to meet needs of the consumer, and medical information included must be pertinent to occupational history or dysfunction so as to stay within scope of the profession. Again one could argue that a novice therapist will need guidance in understanding what information to include or leave out in this regard.

5.6 Conclusion

This study was carried out to explore best practice in occupational therapy report writing. The first phase highlighted several barriers and facilitators to best practice experienced by clinicians in the field. Some of these barriers and facilitators were seen as generic to all health care professionals, such as lack of resources, or the need for sufficient experience in writing effective reports. Some were deemed as specific to the profession, such as difficulty communicating occupational therapy terminology, which is understandable for the wide-ranging audience in South Africa, where many in the population are at risk of poor health literacy. As participants in the first phase had difficulty agreeing on best practice, a second phase of research with subject matter experts allowed for corroboration of the data from phase one, as well as identifying what would be best practice in occupational therapy report writing. Overall this study revealed several clinical recommendations. The recommendations may serve to guide further research to ensure occupational therapists have the necessary support in producing professional reports that

are of a high quality, that meet the needs of the service user and reader, whilst still maintaining the integrity of the profession.

CHAPTER 6 CONCLUSION

6.1 Summary of research study carried out

At the time of this research study there were no specific guidelines in place to support occupational therapists in South Africa regarding the writing and compilation of general occupational therapy reports. Anecdotal evidence was that the standard of reporting was poor [van Biljon, 2013]. This may partly be due to the limited guidance and monitoring available in the clinical setting, as well as limited clinician documentation writing standards by the regulatory body or professional association [Health Professions Council of South Africa, 2008b; Occupational Therapy Association of South Africa, 2005].

This study therefore aimed to ascertain the views of occupational therapy clinicians regarding the quality of profession-specific reports in Gauteng and the barriers and facilitators that influence report writing. It is hoped that the findings from this study will support the motivation for the development of report writing guidelines by professional bodies to develop quality assurance within occupational therapy practice in South Africa. It is anticipated that the creation of clear guidance will aid compliant practitioners in reducing vulnerability to legal complications arising from sub-optimal and inadequate documentation and that this will ultimately improve patient care.

The following research question was posed: What are occupational therapists' views of the practice of occupational therapy report writing in South Africa, and what are the influencing factors affecting their ability to write these reports?

In order to answer the research question the following objectives were created that were addressed over the two-phased study.

Phase 1: Six focus group interviews were carried out with occupational therapists working in public health, private practice and academia to explore the following objectives:

1. To explore issues influencing the current practice of report writing for occupational therapists within the South African context.
2. To explore the views of occupational therapists regarding the factors affecting the best practice and the quality of profession-specific reports.

The qualitative data were audiotaped and analysed using a content analytical approach in order to establish codes and themes. Several conflicts in the data analysis emerged requiring a second phase of the study to be carried out to explore the third objective.

Phase 2: The nominal group technique was used to establish consensus to the conflicts through seeking opinion from subject matter experts (SMEs). Three conflicts were presented to the SMEs, who formulated solutions, and ranked these solutions in order of importance and relevance to help explore objective number three.

3. To establish recommendations to improve best practice in occupational therapy report writing.

Data were analysed using quantitative and qualitative means. The solutions were ranked and ordered to create a deductive matrix. This matrix was used to sort the qualitative comments from the audio-transcripts of the nominal group. This served to enrich the data obtained from the nominal group to help validate the solutions voted in by the SMEs.

6.2 Summary of findings

From the six focus groups in the first phase of the study, three themes emerged. These included current issues relevant to report writing by occupational therapists in Gauteng, South Africa. This theme appeared to be influenced by the context in which the participants were practicing. Public health practitioners communicated they are facing systemic and resource

restrictions, whereas private practitioners find their practice is being influenced by funders. Over the six focus groups, it was evident that participants were aware of the need to be ethical, but were unsure of the details regarding legal and ethical requirements of practice. Private and public practitioners all suggested similar facilitators to best practice, including the need to enable development of experienced practitioners which was also highlighted by the academic group.

The remaining two themes were analysed across all six focus groups, as context did not appear to influence the data produced. The second theme pertained to the emergence of an occupational therapy identity. This echoed positive and some negative sentiments from the participants. Participants are proud of the profession and value its unique contribution it offers, however they also acknowledged that occupational therapists can be the cause of their own demise, by practicing with insufficient evidence based practice, using variable terminology as well as being too adaptable to the needs to the public and other professions. The third theme identified that the audience plays a large role in the complexity of writing occupational therapy reports, particularly as the audience receiving reports is widely varied and may not understand occupational therapy language. It was also noted that the audience largely dictates what is needed from the reports. These two themes highlighted conflicts in practice on which participants could not agree. These included whether occupational therapists should write one or a variety of reports depending on the audience and speciality, whether occupational therapists should use profession specific language, and how much medical information to include, acknowledging the challenge of being occupational based in a medical setting.

Phase 2 of the study was conducted in order to seek some solutions to the conflicts raised by the participants in phase 1. Whilst definitive solutions to each conflict were not necessarily found, some suggestions for best practice were suggested and voted on by participants in the nominal group.

In order to manage the conundrum of writing one or a variety of reports depending on the audience; the nominal group participants identified that the report should always answer the purpose for which it was intended, and that having a policy/protocol in place would serve to guide practitioners around this issue, as well as templates for different reports/areas of speciality. Further training and guidance from supervisors would also serve to assist practitioners on how to navigate the difficulty of having to write for multiple audiences and how to ensure reports are still individualised. It was also noted that practitioners should always seek consent before sending out reports to multiple audiences.

Interestingly, like the focus group participants, the subject matter experts were also divided on the issue of the use of occupational therapy terminology. Although five solutions were identified, only two solutions were clearly preferred, namely that regulations of the organisation/workplace should be followed, and that the report should be occupation based. The last three solutions were more balanced in their ranking. It was suggested that terminology can be used as long as it has explanations and is accompanied by verbal feedback, but that the focus of the report should be on the recommendations.

With regards to the challenge of using medical information in reports, two solutions were clearly identified, which could guide practitioners in this regard. Namely, once again the report should answer the purpose, hence be an occupational therapy report, and any information included should be pertinent to the occupational problem.

6.3 Clinical recommendations

Findings from the study indicate the following recommendations regarding best practice in report writing:

Reporting style and content

1. The report must meet **consumer** needs – by answering the purpose/referral.
2. **Templates** for different areas of practice should be developed – however coupled with guidance on how to adapt to the individual.

3. Reports should be **occupation based** – terminology can be used but must accompanied by explanation and verbal feedback.
4. Practitioners should focus on **recommendations**, which should be organised by domain and include practical examples.
5. **Medical** and **personal information** should only be included if it is **pertinent to the occupational needs** and presenting problem/s.

Therapist responsibilities

1. Practitioners should **obtain consent** from the relevant authorised person before dissemination and disclosure of the report.
2. **Verbal feedback** should accompany reports, especially to people using English as an additional language or who have low literacy – the purpose is twofold, i.e. to manage health literacy and professional relationships.

Education and training

1. **Training** for therapists in report writing is needed.
2. Professional development needs to be supported by **mentorship** from more senior clinicians (reading through and co-signing reports for novice therapists).
3. Support and development could be facilitated through **memberships of special interest groups** and **professional occupational therapy associations** such as OTASA.

Policy development

1. There is a need for **protocol/guidance** on occupational therapy reports (professional body or organizations) to aid in complying with regulations (HPCSA).
2. The policy/guideline must also be **clearly understood**, and a process must to be in place to **monitor compliance** [Ram et al., 2009].

6.4 Limitations

Whilst this study aimed to explore the views of occupational therapists around the practice of writing occupational therapy reports, the study had several limitations, which need to be acknowledged.

1. The relatively small number of therapist participants consulted may be perceived as a limitation,
    a. Focus group interview with only one group of participants from the academic context.
    b. Limited access to occupational therapists from the welfare or non-government context, as therapists approached were not available to participate.
    c. Limited access to SMEs, as insufficient availability of participants in Gauteng who met the inclusion criteria.

    However Gliner (1994) has argued that this criterion for rigorous research is not critical to the qualitative paradigm [Gliner, 1994].
2. The study only pertains to therapists in Gauteng, affecting nation-wide generalisability.
3. Some focus groups were carried put at participants' place of work, which may have placed participants in a non-neutral situation. This was tolerated to promote participation and to reduce costs for the study participants.
4. There may be limitations to the study resulting from assumptions made by the researcher as an occupational therapy clinician. The researcher attempted to ensure that the expertise and perspectives of participants, rather than the ideas or perspectives of the researcher, were captured in the interviews, by carrying out bracketing interviews with her supervisors.
5. The researcher knew some of the participants on a professional level, so this may have lead to reluctance on the part of the participants to disclose more controversial attitudes.

6.5 Recommendations for further research

Subsequent to this study the following recommendations for further research can be made:

1. Analysis of existing occupational therapy reports to determine quality
2. The development of occupational therapy report writing guidelines
3. The development of a training programme for therapists, in the use of report writing guidelines with auditing measures to evaluate effectiveness.
4. The development of templates for each area of practice with auditing measures to evaluate effectiveness.
5. Explore/develop a bank of terminology/recommended explanations for occupational therapy language in South Africa.
6. Explore perceptions of occupational therapy report audiences into the understanding and usefulness of the report.
7. Exploration of support for professional issues such as report writing, received by occupational therapists through professional organisations such as OTASA.
8. Exploration into measures to improve the quality of health communication; so as to better the involvement of service users who are at risk of poor health literacy.

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APPENDICES

Appendix A Ethical clearance certificate

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140490

NAME: (Principal Investigator)	Mrs Julie Jay
DEPARTMENT:	Occupational Therapy
PROJECT TITLE:	Occupational Therapy Reports: Exploring Best Practice
DATE CONSIDERED:	25/04/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Matty van Niekerk

APPROVED BY: _____
Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 21/05/2014

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate Hous University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned researc and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from th research protocol as approved, I/we undertake to resubmit the application to the Committee. I agree to submit

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix B Motivation letter for focus groups for public context organisations

Occupational therapy department
University of the Witwatersrand
Wits Education Campus
9 York Road
Parktown
2193
03.10.2014

To:

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3701

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Dear Sir/Madam

My name is Julie Jay and I am a Masters student at The University of the Witwatersrand School of Occupational Therapy. I am conducting this research as part of the requirements to qualify for a Master of Science Occupational Therapy degree. I would like to provide you with some information about a research project that I am undertaking in the hope of receiving permission for your organization to be included in the research.

This study will be conducted in Gauteng, South Africa according to the ethical guidelines and principles of the University of the Witwatersrand Ethics Committee, please see the ethics approval attached. It seeks to gather information on Occupational Therapists perceptions of writing profession specific reports within the South African Context. It will consist of focus group discussions, with 6-8 people per group, as well as nominal group with subject matter experts in this field. The study aims to develop a checklist to assist with guiding occupational therapists on best practice with regards to writing profession specific reports, as well as to serve as a quality assurance measure within different areas of practice.. It is anticipated the study will be completed by November 2016.

I would like to run a focus group with 6-8 of your occupational therapy staff as part of the first phase of my research. The discussion from the focus group will assist in identifying what are best practice guidelines for writing an occupational therapy report. The focus group participants' details will be completely anonymous (as can be seen from the demographic form), as no personal or organisational identifiable information is required for this research.

The results of the focus groups will be published in my research dissertation. However I will not be required to identify where the participants worked (only if public or private), as the aim is not an audit of occupational therapy departments reports.

I hope you will consider my request, as the ultimate aim of my research is to support with upholding the quality of the occupational therapy profession in all areas of practice.

Yours sincerely,

Julie Jay

OT0057347

Appendix C Information sheet focus group

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3701

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Good day,

My name is Julie Jay and I am a Masters student at The University of the Witwatersrand School of Occupational Therapy. I am conducting this research as part of the requirements to qualify for a Master of Science Occupational Therapy degree. I would like to provide you with some information about a research project that I am undertaking and to invite you to participate.

This study will be conducted in Gauteng, South Africa according to the ethical guidelines and principles of the University of the Witwatersrand Ethics Committee. It seeks to gather information on Occupational Therapists perceptions of writing profession specific reports within the South African Context. It will consist of focus group discussions, with 6-8 people per group, as well as an online Delphi review with subject matter experts in this field. The study aims to develop a checklist to assist with guiding occupational therapists on best practice with regards to writing profession specific reports, as well as to serve as a quality assurance measure within different areas of practice. The validation and reliability testing of this checklist will hopefully lend itself to the submission of guidelines to the professional board to support Occupational Therapists in writing reports for their practice. It is anticipated the study will be completed by November 2016.

I would like to invite you to participate in this research, by granting me permission to include you as a participant in one of the focus groups. This will take approximately 60-90 minutes of your time. The focus group discussions will be audio-recorded to provide the research team an accurate record of the discussion. These tapes will be transcribed and kept for 2 years if no publications are made or 6 years after publication.

As a participant in the research you can expect that all the information you provide will be treated in confidence. To this end, the following procedures will be adhered to in this project:

(i) No one outside the research team will have access to the information you provide

(ii) Your name and other identifiable information will not be published in our report

(iii) Recordings, notes and transcripts of the group discussions will be stored using codes, so no one outside the research team will be able to link the information provided to the names of the respondents.

Neither the researcher nor any member of the research team can however fully guarantee the confidentiality of the focus group discussions as the researcher has no control over what is discussed outside of the groups.

You will not be paid for participation in the study, but light refreshments will be served. There will be no costs involved for you, if you do take part and we don't anticipate that any harm will come to you through your participation in the research. The focus groups will be organized at a convenient time and location for participants where possible.

Please feel free to ask me any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. Results of the study will be made available on request.

If you would like to participate please complete the **consent** form and **demographic** form below and email it to **Julie.jay@wits.ac.za**. If you agree to participate I will contact you regarding further details.

Thank you in advance for your consideration

Julie Jay

Appendix D Focus group consent form

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3704

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Agreement to participation in study

Name:

Email address:

I agree to participate in the focus group. Yes:☐ No:☐

(Please mark with an x):

Appendix E Consent form for audiotaping focus group discussions

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3704

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Agreement to allow investigator to audiotape focus group discussions

The focus group discussions will be audio-recorded to provide the research team with an accurate record of the discussion. These tapes will be transcribed and kept for 2 years if no publications are made or 6 years after publication. To this end, the following procedures will be adhered to in this project:

I. No one outside the research team will have access to the audiotapes

II. Your name and other identifiable information will not be published.

III. Recordings, notes and transcripts of the group discussions will be stored using codes, so no one outside the research team will be able to link the information provided to the names of the respondents.

Name:

Signature:

Email address:

I agree to the researcher audiotaping and transcribing the focus groups.

Yes: ☐ No: ☐

(Please mark with an x):

Appendix F Demographic questionnaire focus groups

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3704

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Demographic information

Name:

Confirm email address:

Year of qualification:

University of qualification:

Do you have any postgraduate qualifications? (Please mark with an x):
Yes:☐ No:☐

Please specify:

Area of practice (please mark with an x): Public:☐
Private:☐

Academia: ☐ Health: ☐ Social: ☐
Education: ☐

Do you write occupational therapy assessment/discharge reports as a regular part of your practice? (Please mark with an x): Yes: ☐
No:☐

Do you work in medico-legal or forensic practice? (Please mark with an x):

Yes: ☐ No: ☐

Are you a member of a special interest group or a professional board member?

Yes: ☐ No: ☐

Please specify:

Appendix G Topic guide focus groups

1. General Exploration: “why do we need to write reports?”

Open ended list of factors/perceptions will be documented on a flip chart in the form of a mind-map. The intention is to use mind-mapping to generate a list of, ideas and images that are foremost in the participants’ minds.

2. Explore origins of perceptions: “What is happening in current practice?”

Open ended list of where the participants’ perceptions are generated from, for example their own experience, what they have observed of other clinicians/managers etc, feedback from clients, students they have supervised.

3. Further unpacking of the above two points

This next step is to unpack the topics raised in the first two points so as to ensure clarity of intended meanings. The intention here is to be driven by what the respondents say and especially to explore themes and concepts that seem interesting or are unusual. It is anticipated that this will lead to topic 4.

4. Explore what should be happening in practice: “what is then essential to include in an occupational therapy report?”

This step is aimed to explore what should be included in an occupational therapy report for inclusion in a checklist. The intention once again is to use mind-mapping to generate a list of ideas and images that are foremost in the participants’ minds.

5. Further explore the uniqueness of occupational therapy reports: What makes a report specific to the profession?

This question is aimed to trigger further exploration around the uniqueness of the profession and how this is represented in the reports written by occupational therapists.

6. What are the barriers/facilitators to the above?

The intention is to explore clinicians perceptions of what influences their ability to write adequate reports, that meet the needs of the client, the institution they work for and the profession.

Appendix H Informed consent Nominal group

Participant code _____ (for researcher only)

Informed Consent for participation in Nominal Group

Agreement to participation in study ref no (HREC) M140490

I ……. agree to participate in the nominal group for the study entitled:

Occupational therapy reports: Exploring best practice.

Signed: _____

Date: _____

Appendix I Informed consent to audiotape Nominal group

Participant code _____ (for researcher only)

Consent form for audiotaping nominal group discussion.

TITLE OF THE RESEARCH PROJECT: Occupational therapy reports: Exploring best practice.

PRINCIPAL INVESTIGATOR: Julie Jay

CONTACT DETAILS: Tel: (011) 717 3704

Cell: 072 896 3661

E-mail: Julie.jay@wits.ac.za

Agreement to allow investigator to audiotape nominal group discussion.

The nominal group discussion will be audio-recorded to provide the research team with an accurate record of the discussion. These tapes will be transcribed and kept for 2 years if no publications are made or 6 years after publication. To this end, the following procedures will be adhered to in this project:

I. No one outside the research team will have access to the audiotapes

II. Your name and other identifiable information will not be published.

III. Recordings, notes and transcripts of the group discussions will be stored using codes, so no one outside the research team will be able to link the information provided to the names of the respondents.

Signature:

I agree to the researcher audiotaping and transcribing the nominal group.

Yes: ☐ No: ☐

(Please mark with an x)

Appendix J Nominal group demographic information

Participant code _____ (for researcher only)

Nominal group participant demographic information

Year of undergraduate qualification:

University of qualification:

Please state your postgraduate qualifications:

Member of special interest group/professional board (please mark with an x):

Yes: ☐ No: ☐

If yes, please specify:

Area/s of practice (please mark with an x): Public: ☐
Private: ☐ Academia: ☐

Health: ☐ Social: ☐ Education: ☐

Other: ☐ please specify:

Appendix K Nominal group cue card

Nominal group cue cards

Hello everyone and thank you once again for volunteering to be participants in my research. The purpose of this nominal group is to help establish best practice in terms of occupational therapy report writing. This is to assist clinicians, especially novice OT's in this regard.

Firstly I need to confirm what I am referring to when I say OT report. An OT report is the report written by a clinician at various stages of the OT process, it could be after the assessment, a progress report or a report at the end of intervention. We are not referring to soap notes or green card notes. And we are specifically excluding specialist reports for vocational, medico-legal and insurance purposes as there are guidelines being developed to support that.

The exploration I have done thus far has been through conducting 6 focus groups with clinicians in public, private and academic settings. And the following primary themes have emerged after three rounds of analysis.

1. Pragmatic issues around report writing – clinicians appear to have a poor awareness of what guidelines are in place in terms of documenting patient information, as well as a misinterpretation of what these guidelines mean for practice. Clinicians are struggling with resources issues such as time, systemic issues as well as having limited experience in dealing with certain client groups.
2. The audiences dictates – the receiver of OT reports appears to have a strong influence over what should be included. Clinicians are experiencing significant conflict around the influence of the audience and the impact upon this skill.
3. An OT identity crises – there was a string message that clinicians feel the profession is misunderstood, but in some respects we are contributing to this misunderstanding by not describing accurately what we do.

Out of the focus groups there are some particular conflicts that require solutions. So it is just going to be these conflicts that we will focus on today.

This nominal group process is slightly different from traditional methods, but it has been designed by Delbeq and Van De Ven, the founders of NGT, specifically to create solutions to problems.

The order will be as follows:

1. Presentation of critical problem elements that have been identified with space to clarify further meaning of these through discussion.
2. Time for silent generation of ideas around solutions for these critical problems. You will notice you have three worksheets in front of you. One is for each problem. Under the ***solution component heading***, please write down as many solutions/ideas as you feel necessary to address the problem element. Under the ***resources*** column please add any resources e.g. documents/policies/practices that may compliment the solution/solving of the problem.
3. We will then have a round robin where everyone has a chance to offer their solutions. We will do this for each problem element with no discussion until the end.
4. Discussion time - to clarify understanding of items presented, and see if any can be combined/added/eliminated.
5. Voting – each participant will be required to rank each item in terms of importance. Again we will do this separately for each problem element at a time.
6. Whilst you have some coffee and refreshments Matty and I will tally the vote
7. We will then come back for discussion of the results and a re-vote if necessary. This is not to get an artificial consensus but to create the opportunity for refining items.

Your role in the group is as idea generators, to apply your knowledge to the problem to help develop a solution.

Present the BIG ISSUE *(BIG ISSUE doc)*

Case

Johannes Venter is a 7 year old boy from Krugersdorp. His father is a bricklayer and his mother is currently a stay at home mom, looking after Johannes and his three siblings. Johannes has been referred to occupational therapy by his grade 1 teacher for an assessment, as he is not coping with classroom activities. He is unable to read the board, and has difficulty reading text as well as writing. Johannes has a significant squint in both eyes which appears to be affecting his visual acuity and processing. The school nurse says he needs to have surgery to correct the squint. Following your OT assessment you are required to write a report on your findings to give to the school teacher, Johannes's father and to the ophthalmic surgeon.

What guidance would you give a novice OT to help her/him with writing the occupational therapy report/s?

The above is an example of what clinicians may face on a regular basis. The three conflicts or problem elements that have arisen are as follows.

1. Therapists are in disagreement as to whether they should write one report or a variety of reports depending on their audience. Related to this is whether the report format should change depending on the clinicians area of practice. What guidance could you give clinicians in this regard?
2. The use of OT language has therapists conflicted around OT language/jargon. They often use generic rather than OT words in their reports. How should clinicians manage the perception that other professionals and their clients and caregivers don't understand their reports. Add to that is the complexity of the SA context where so many receivers of the reports have English as a second language.
3. OT's are unsure of what must be included in terms of medical/clinical information e.g. medical history, diagnosis, test scores etc. What guidance would you give in this regard?

Stage 1: *(keep problem elements up on screen)*

Now we move onto silent generation of ideas for which we will have about 10 minutes. Just to give you an example of how you could structure this, this is telephonic feedback from one of the participants who couldn't be here....

Stage 2: *(Round robin stage 2 doc)*

We will now have a round robin where everyone has a chance to offer their solutions. We will do this for each problem element with no discussion until the end.

Stage 3: *(Discussion stage 3 doc)*

Now we have some space for discussion. The group may agree that if the items are sufficiently familiar they may be combined. However if there are slight differences, it will be better to keep them separate to enable more refined voting later on.

Stage 4: *(RANKING CARDS EG doc)*

We have now completed the entire list of ideas, have clarified the meaning of each idea, and have discussed the areas of agreement and disagreement. At this time I would like to have the judgement of each group member concerning the most important items on the list.

To accomplish this step please each pick up your index cards in front of you

If more than 8 items say the following. I would like you to select the 5 most important items from our list of…. Items. This will require careful thought on your part

12 on list = 5

20 on list = 8

As you look at each of the critical problems and their solutions which will be projected up for you, find an item which you feel is very important; please record the item on your index card.

Please place the number of the item in the upper left hand corner of the card. For exam if you feel number 5 is a very important item, you would write 5. Then write the identifying words or phrase on the card. Do this for each of the

…. most important items from our list. When you have completed this task you should have …. cards each with a separate phrase written on the card, with identifying numbers using the numbering system from our list of ideas on the projector.

We will do this for each problem element separately.

Do not rank-order the cards yet, spend the next few minutes carefully selecting the …cards. We will rank order all the cards together.

Are there any questions?

PROJECT (Voting stage 4 doc) problem element 1 then 2 then 3 (copy paste from discussion document during above script)

Instruct to place aside.

Once completed:

Please spread you cards out in front of you so you can see all of them at once. Looking at your cards, decide which one is the most important. Please write a number …. In the lower right hand corner and underline it three times. Turn that card over and look at the remaining cards, of those remaining, which is the least important? Write a number 1 in the lower right hand corner and underline that three times.

Please continue with the remaining cards.

Hand cards in,

Do the same with the other problem elements.

COFFEE AND TEA TIME

Julie and assistant count votes on the initial tally. (Copy and paste solutions in from previous documents)

Stage 5: *(initial Tally doc)*

Re-discussion if there are any anomalies. Clarification – not to gain artificial consensus. Caution group members to think carefully about any changes.

Step 6 : final vote (same as procedure 4 if required)*(Final Tally doc)*

Appendix L Nominal group case study

THE BIG ISSUE

Case

Johannes Venter is a 7-year-old boy from Krugersdorp. His father is a bricklayer and his mother is currently a stay at home mom, looking after Johannes and his three siblings. Johannes has been referred to occupational therapy by his grade 1 teacher for an assessment, as he is not coping with classroom activities. He is unable to read the board, and has difficulty reading text as well as writing. Johannes has a significant squint in both eyes, which appears to be affecting his visual acuity and processing. The school nurse says he needs to have surgery to correct the squint. Following your OT assessment you are required to write a report on your findings to give to the school teacher, Johannes's father and to the ophthalmic surgeon.

What guidance would you give a novice OT to help her/him with writing the occupational therapy report/s?