

The Role of a School-Based Physical Therapist

Most children with disabilities in the school system have one of the following diagnoses: Cerebral Palsy (various types), Spina Bifida, Muscular Dystrophy, Autism and Related Spectrums. Most of our children also have cognitive components associated with their diagnosis as well as vision or hearing issues.

As school based therapists, our job is to help our children function to their capacity within the school setting. This means that we are working towards adapting our treatment protocols to the classroom setting as much as possible. We are looking at working with the classroom teacher to help our children achieve their IEP goals. These goals should be the same for all professionals who come in contact with a child. The means by which each discipline reaches that goal may be different, but the end product should be the same.

As school-based therapists our goals should be functional and educationally related. Examples of such goals are:

- Improving sitting balance/trunk control so that the child can better participate in/attend to classroom related activities.
- Improving stair skills so that the child can more easily access his/her school environment and classes (gym, music, lunchroom, etc).
- Increasing standing tolerance (standing program) for classroom related activities and interaction with classmates.
- Improving wheelchair mobility (ramps, tight spaces, obstacles, elevators) in order to better access the school environment.
- Improving coordination and physical education skills for increased participation with peers in physical education, recess and play time.
- Improving a child's ability to carry a lunch tray back to his/her table in order to improve independence.
- Improving ambulation skills so child can transition between classes.

Hospital-based physical therapists may be much more specific in assessing tone and range at each joint, but school-based PTs may make more global/general assessments of these areas and relate the findings to function or lack of function. We may note that the student "has extensor tone in the lower extremities and flexor tone in the upper extremities with distal tone being greater than proximal tone." For range, we may note that it is all "within functional limits except for bilateral hamstring tightness, and ankle dorsiflexion to neutral only". When school-based therapist write reports, range, tone etc., should be recorded by functional measure and in every day, non-medical terms.

In hospital settings, PTs may find more parental involvement as parents come to visit their child regularly or bring child to appointments. In the school setting, you may need to be more proactive in order to increase parental/guardian involvement (write letters home, make phone calls etc).

Most school sites have team meetings where all related service providers can collaborate and share information. The emphasis is function related and all treatments should relate to the IEP goals.

The need to treat in a separate location is still a very important part of our therapeutic protocol. For example, when working on stretching or strengthening, it is often important for our child to be treated in an area that affords privacy. When working on new skills, an area that is quiet and presents few distractions is often necessary for optimal concentration. We also believe that a quiet and separate area gives our children the chance to “fail” without peer judgment or competition. Practicing a new skill with just the therapist and the child helps build confidence and skill level.

Often, working in the classroom may be distracting for the class. The therapist and teacher must determine how best to incorporate a child’s therapy into the days lesson. Ultimately, you should spend a percentage of your mandated sessions in the classroom in order to incorporate your therapy into a functional school related activity.

As school-based therapists we focus a great deal of time on seating and positioning and wheelchair repairs. We play a significant role in recommending new wheelchairs or wheelchair parts for our students. This will require us to speak with parents/guardians, wheelchair vendors and clinic personnel. All maintenance work should be entered on a log so that an accurate record can be kept for each child. When ordering new wheelchairs/parts always think long term. A child is generally entitled to 1 new wheelchair every 5 years. Make sure that what you recommend will be beneficial to the student for generally that length of time. If you are not sure what type of wheelchair or parts to recommend, you should consult with an experienced PT or OT. At minimum, you should have a clear idea or list of what the issues are so that you can problem solve with the wheelchair clinic coordinator, vendor, parent and child (if possible) during a clinic appointment. You may attend a clinic visit with the approval of your on-site supervisor.

School based therapists may assess children with orthotics on an ongoing basis since we work with our students throughout the year. Usually orthotics are ordered by outside therapists or clinics, but if we are the only therapist a child sees, this becomes part of our job description. This may also be true for walkers, standers, adaptive toilets etc.

****When determining the need for any equipment, we MUST discuss any and all recommendations with the child’s parent or guardian. Equipment often requires a doctor prescription and a letter of necessity before any order can be placed. Please be sure to discuss your plans with the child’s parents before making any decisions.**

New equipment which may be needed for school use (adaptive chairs, slant boards etc.), must be obtained through a Type 3 request. A meeting must take place between the school and the parents in order for this to occur. (See Type 3 procedures). This equipment is then placed on the child’s IEP and must be a part of the child’s everyday environment while he/she remains in school or until it is removed (via another Type 3) at a later date.

In the school setting you may find chart reviewing to be challenging at times. Many schools have established their own standards and have been diligent to establish a file/record for each child. Some have not. **NO CHILD SHOULD BE TREATED UNLESS AN UPDATED IEP IS LOCATED IN THE SCHOOL.** The only legally mandated documentation in the school system is the **IEP** and the **triennial** (done every 3 years). Therapists should maintain daily notes for each child on their schedule. A progress note, or year end summary should be placed in each child's permanent file.

It is always a good idea to remember that a child's IEP is what might be called a "living document". Changes in frequency, group size or even discontinuation of service should be an ongoing process throughout the child's time in the school system. Therapists should re-evaluate each child every year in order to determine their therapy needs.

Having good documentation, progress notes, etc. is always necessary to back up your decisions. Every child on your caseload should have a file or section in a notebook where you can record your treatment outcomes, plans, etc. Any correspondence with persons involved in a child's care, either written, phoned, or in person, should be dated and recorded.

As school-based therapists, you should keep accurate records on all your children in order to have substantiated documentation which will allow for professional decisions to increase treatment, decrease treatment or decertify a child from service. Providing needed service for our children is important, providing excessive service is not beneficial for anyone. Please use your professional judgment when determining mandates for your students.