THE IMPORTANCE OF COMPREHENSIVE NOTES AND RECORDS

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Introduction

Comprehensive clinical notes and records are an important part of patient care. Thorough records allow the treatment team to track a patient's history and to look for issues and patterns that may impact the patient's future care and recovery. In addition, good record keeping can benefit health care professionals and patients in the following ways:

1) It may assist the patient in succeeding in their personal injury lawsuit;
2) It may prevent the health care professional from having to testify in a court proceeding; and,
3) It protects the health care professional against baseless claims of professional negligence.

This paper will review the various ways in which thorough record keeping can assist both the health care professional and his or her patient.

How thorough record keeping assists in a patient's rehabilitation and recovery

We all know that a patient's recovery after a serious injury usually requires a team of multi-disciplinary professionals. The treatment team all works together towards the goal of helping the patient achieve maximum medical recovery. When a health care practitioner keeps thorough, legible, chronological and systematic clinical notes and records this assists the rest of the treatment team by providing them with an accurate record of the patient's condition, their participation in rehabilitation and a rationale for any treatment decisions. All of this information may be vital for the other team members when providing the patient with ongoing adequate and appropriate care.

How thorough record keeping can assist a patient in their lawsuit

Thorough clinical notes and records may also assist a patient in achieving success in their personal injury lawsuit. This is because thorough and complete records will document the patient's ongoing issues with pain and disability while also (hopefully) confirming that they have been regularly engaging in rehabilitation in an attempt to improve their condition. However, if clinical notes and records are to be helpful in a lawsuit they must meet a few criteria:

1. Legibility and Style of Writing

   It is very important that clinical notes and records be capable of being read and understood by a lawyer, judge or lay person. When records are not legible it often means that they are ignored by the decision makers at the insurance company or, if the matter goes to trial, by the judge or jury. When illegible records are crucial to proving a case, expensive transcription must be arranged. Many times it is the patient who must pay for the cost of that transcription.

   Clarity is essential to good record keeping. If the records are not written in a way that can be understood by lawyers, judges or lay people they are also often overlooked or ignored by the decision makers in the case. For example, if you are using short forms, the meaning should be clear. It is a problem when health care professionals use short forms that have more than one meaning without explanation.

2. Document each patient encounter in a chronological and systematic way

   Records are only of use to a court if they are complete and thorough. If the health care professional documents each patient encounter in a chronological and systematic way the parties to the lawsuit will be able to rest assured that they have a complete picture of all of the treatment that was provided to the injured party.

Another issue with record keeping which impacts on a patient's lawsuit are occasions when a health care professional fails to put something in their chart into a proper context. For example, writing "[Patient] had a great day today." in a chart might appear benign to the health care professional. However, what isn't recorded in the above entry is the fact that it was a great day because it was the first time the patient could walk unassisted for more than a few steps. Defence lawyers frequently take comments like "had a great day today" out of context to try to illustrate to a jury that the patient was doing very well shortly after they were hurt. They then try to argue that it doesn't make sense that the injured party is now demonstrating many impairments several years after the event when they "had a great day" only days or weeks after the injury. The defence lawyer will then try to lead an unwitting jury to the conclusion that the injured patient must be exaggerating their symptoms in an attempt to maximize their financial recovery. Therefore it is very important to ensure that all clinical notes and records are put into the proper context.

How thorough records prevent unnecessary court appearances

Section 35 of the Ontario *Evidence Act,* R.S.O. 1990, c. E23 allows lawyers to file business records made in the ordinary course of business (including clinical notes and records) as exhibits at trial to prove the truth of the facts contained in those records. Appropriate notice must be provided to the opposing side in advance of trial.

If a plaintiff's lawyer only wants to prove in court that his client attended at various appointments with a health care professional and received treatment on specified dates then it is a simple matter for him or her to file the complete clinical notes and records as an exhibit at trial pursuant to the *Evidence Act*. However, if the records are not complete and it is not apparent from a review of them what was done and when it was done, a health care professional may have to testify about his or her interactions with the injured party instead of having their records filed with the court. This wastes the

time of both the health care professional and the court. In addition, a defence lawyer is more likely to place a health care professional under summons (i.e. subpoena) to testify if it is not apparent from the clinical notes and records precisely what that health care professional did for the plaintiff and what his or her evidence would be at trial.

It is important to note that clinical notes and records cannot be filed as exhibits to prove a clinical diagnosis, opinion or impression. If a lawyer wants a health care professional to provide an opinion or diagnosis for use at trial then that lawyer needs to ask the health care professional to produce an expert medical-legal report in compliance with the *Rules of Civil Procedure* and to testify as an expert at trial.

How thorough records prevent unwarranted claims of professional negligence

All health care professionals owe an obligation to treat their patients in accordance with the relevant standards of practice for their profession. Over a long career, even the most diligent of health care professionals may face an unwarranted complaint of professional negligence from an unhappy former patient.

Most professional colleges have policies and guidelines regarding what type of record keeping constitutes appropriate record keeping.[1] In addition, legislation in Ontario governs how long records must be kept for certain professions and what those records must contain.[2] We recommend that a health care professional keep their clinical notes and records for at least 15 years because, in most cases involving adult patients, 15 years is the ultimate limitation period for commencing a claim under the *Limitations Act, 2002,* S.O. 2002, c. 24.

Most health care professionals see hundreds of patients a year. It would be unreasonable for them to remember each and every interaction they have with a

[1] For example, College of Physicians and Surgeons Policy Number:#4-12 (http://www.cpso.on.ca/policies-publications/policy/medical-records - Accessed on September 2, 2014).
[2] For example, Ontario Regulation 114/94, General, Sections 18, 19, 20 and 21, made under the *Medicine Act*, 1991, S.O. 1991, c.30.

patient. Maintaining proper clinical notes and records will allow a health care professional to prove what was and was not said and done in their meetings with a patient. When records are incomplete this will usually work against the health care professional and in favour of the complainant.

In addition, proper record keeping will support the fact that the health care professional is a diligent, informed and prepared person. Conversely, improper record keeping will present a picture of an unorganized and sloppy health care professional to the review board or court dealing with the complaint.

Conclusion

It is difficult to overstate the importance of thorough and complete record keeping. By ensuring that all clinical notes and records are chronological, systematic, legible and complete it will assist both the patient and the health care professional in all of the ways illustrated in this paper. If the reader has any questions about a specific case involving an issue relating to record keeping please feel free to contact the author at rmurray@oatleyvigmond.com or (705) 726-9021 xt. 346.