

Record Keeping

The Shiatsu Society and Balens have asked me to write an article bringing the importance of maintaining full descriptive records to your attention from your Insurance Company's point of view. With your help, we can continue to keep claims costs to a minimum, which in turn means we can retain the current low premium rates. As all qualified therapists are aware professional therapy training courses teach therapists to take full medical histories and keep detailed consultation records.

From an insurance point of view, it is essential. Indeed, if you haven't kept proper records you will be in breach of an important condition in your policy and you may not have cover for claims. Equally importantly, if the claim proceeds to court, without written records it is very difficult to defend you. It can often take years for cases to progress to court. Testimony that relies purely on the memory of the therapist is easily discredited. Even if the treatment you gave was perfectly appropriate, without good written records showing the history you were given, the matters discussed and the treatment administered, it is almost impossible to demonstrate that you acted appropriately. The court expects the therapist to show that they have acted in a professional manner and that they have fulfilled the "duty of care" that they owe to all their clients, and keeping good written records is an important part of patient care. Indeed, to practise without keeping adequate records could in its self be considered negligent, and will not present you in a good light should you ever find yourself defending a claim in court.

Most claims for negligence involve a dispute between practitioner and patient as to what actually took place during the relevant consultations. A court will be asked to decide whether to believe the patient, or the practitioner. Good written records should substantiate your account of events. For example: a completed pre-treatment questionnaire which includes details of the client's previous medical history and has been signed by the client is good evidence of the history given to you. Notes taken during the consultation will help to demonstrate that a full consultation has taken place. We have had claims which we have successfully defended where the client truly believed they had given the therapist full details of their medical conditions, even though they had not. The pre-treatment questionnaire supported the therapist's assertion that these details had not been provided, and therefore the therapist did not have the information to assess contraindications, or ask for a G.P.'s permission to treat. In other words, the records showed that on the information given to the therapist, she had acted appropriately..

A claim comes to mind where the individual stated they had visited a therapist and received a wax, which had caused severe burns. The therapist concerned was adamant that they had never treated the client, and although she had a very busy practice, we were able to show from the appointment book that the therapist always took full records (by matching appointments with records) and so as there was no appointment registered, or records for this individual, we argued the client had made a mistake (or dare we say was trying to make a fraudulent claim!).

Another claims scenario had a less favourable outcome. A massage therapist had been treating a client for some time and an allegation of malpractice was made for a neck injury the client had sustained. Upon our investigations we found that the client had been involved in a car accident and we believed that the neck injury was more likely to have been suffered in the accident than caused by the therapist. However the therapist who had taken an initial pre-treatment questionnaire had failed to keep her records up to date during subsequent visits. The therapist could not tell us the dates she had provided treatment, nor substantiate her recollection of the treatment given. Without these dates and details we could not accurately show that the injury had not been caused by the massage.

What constitutes appropriate records will vary from case to case depending on the information the client provides and the type of treatment you are performing. For instance if a client advises you of a contraindication which requires you to contact their G.P, the records should contain details of all this information and will therefore be more detailed than those for a client who presents no health problems. However as a rough guideline the minimum records we need are:-

- A pre-treatment questionnaire/consultation form which includes, name, address, telephone number, age, medical history, G.P's name, clients signature, the date.
- Records completed by the therapist during each consultation (whether it be a card or computer records) which record the date of each appointment, details of the current treatment including any equipment used, noting anything unusual or special advice given, clients comments regarding the treatment. On subsequent visits, the records must show that the therapist has checked the medical records, that they remain up to date and confirmation that there were no adverse reactions to the last
- Ideally, the records should also record information or advice given, including a note about handouts given or the substance of verbal advice

Unfortunately, we are in an increasingly litigious society, you only have to watch day time T.V to see the number of adverts for solicitors advising “no win no fee” services to see the evidence. It seems everybody is looking for someone to blame, should they experience problems. Actions are often taken by individuals where they name many parties in the writ, in the hope that it can be proved that one of these parties are responsible. The strength of your defence depends on you. Without you doing the proper groundwork by keeping full records you may find yourself facing an indefensible claim.. It really is as simple as “good records, good defence: no records, no defence”

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