The Patient Chart: What's In It For You?

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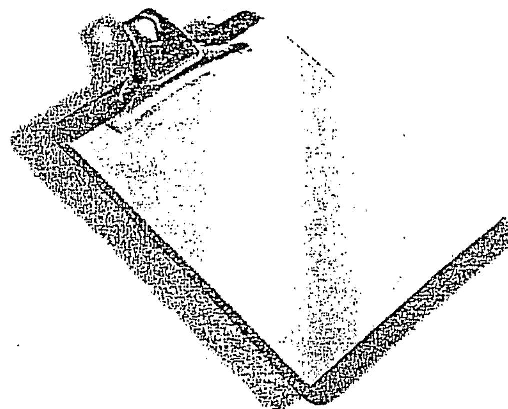

The first question any interpreter asks about an inpatient mental health assignment is, "Will I be safe?" Usually the second is "What is the client like?" Both can be answered before getting into an assignment by looking at the patient's chart. This article is an overview of information in a patient's chart, and how it answers concerns about safety and client characteristics.

Access to the chart

Mental health culture attaches its own values to a client chart. To clinicians the chart is not just a record of information; in very real ways, the chart is the client. Clients are unreliable reporters of information but a chart is considered reliable and unchangeable. It includes a social history which, to the extent possible, has been verified by other sources. It includes progress notes to report on events as recently observed and recorded by staff eyewitnesses. It outlines the course and rationale of treatments as determined by the treatment team. In a sense, nothing happens in the mental health setting unless it is documented in the chart. Access to charts is strictly controlled by facility policy and law as well as by an ethical responsibility to protect client confidentiality in all aspects of client care. Real penalties are attached to allowing unauthorized people to read or record things in a chart. So, how does an interpreter get that authorization? Working as a professional member of the treatment team, interpreters have it. How do you get a chart? Ask for it.

When you introduce yourself to your contact prior to your appointment, either by telephone or when you meet in the lobby or security checkpoint, let them know you expect an opportunity to review the client's chart. To work effectively with the rest of the treatment team you need information so you can do your job. How do you get that information? Know what you need. Know why you need it. Ask for it. If you are told no, let your contact know that someone will need to take time to tell you the information in order for you to be effective in working as part of the team.

Parts of the chart

A chart includes client history, diagnosis, medical orders, progress notes and a plan for treatment. Specific parts will vary according to the facility, accrediting organizations, and applicable laws. Other information may include telephone numbers for family members, podiatry and dental exams, living wills, financial budgets, and other items mandated by the facility's policies.

Since most of the information has no impact on interpreting, look particularly for:

1. Information directly impacting communication, including:
   - Social history (family, education, work history, etc.),
   - Possible sources of communication impairment (physical, pharmacological, cognitive, etc.)
   - Information that may aid communication (rationale for treatments, names of family members, content of delusions, etc.): and
2. Information directly affecting personal safety:

The treatment plan (we call ours ITP, Individual Treatment Plan, but names and abbreviations differ) takes some practice to decipher but is well worth it. It gives the full diagnosis as set out in the DSM-IV[1] as well as a list of client assets, problems, and recommended treatments. Diagnoses are given using a multi-axial system to name points of clinical significance, stressors, and their severity. The axes are: I) Clinical Disorders and Other Conditions That May Be A Focus of Attention; II) Personality Disorders and Mental Retardation; III) General Medical Conditions; IV) Psychosocial and Environmental Problems; and frequently but not always, V) Global Assessment of Function. Psychiatric diagnoses (Axes I and II) are described by specific sets of symptoms; so, knowing the diagnoses, you can work backwards to make a rea-

sonable general estimate of the client's temperament and personality. Consider this scenario: Suppose while you are interpreting the clinician asks the deaf client a question and there is no response. You may wonder if the communication failed because the client didn't understand or if the client is refusing to respond. Should you restate or rephrase the question the question? Should you ask the clinician for direction? Is the client's unwillingness to answer a manifestation of a clinical problem? Is the client hallucinating so badly it is impossible for them to focus on the question and respond? Is the client pretending not to understand because part of their antisocial personality disorder has shown that this has been an effective way of manipulating interpreters? Knowing the diagnosis can help to better assess the source of communication problems if asked for suggestions by clinicians.

Axis III, General Medical Conditions, should have "Deafness" noted. Axis IV may have some indication of Deafness as a source of social isolation, communication impairment, or adjustment difficulty. This may or may not be true depending on the individual client's circumstance and self-identity; it may be an indication of the treatment team's view of deafness. Either way, these may be themes that come up in therapy. Knowing this in advance may be helpful.

Global Assessment of Function is, exactly like its name, an indication of how severely a client's mental disorder impinges on their functioning. Do not confuse interpreter jargon "low function," "high function" for the same terms in psychiatric jargon. Remember, cultures use language in ways peculiar to themselves.

Treatment plans also outline the purpose of particular interventions in line with a program's philosophy. If you are unsure how philosophy can change your regular responses, ask your contact person before you get into the assignment. If the client interrupts and signs to you, what should you do? If another client interrupts and speaks to you, what should you do? If you are threatened or touched in an inappropriate manner by a hearing patient, what should you do? If, during leave-taking, a Deaf client hugs you, kisses you, says "I love you?" What should you do? What if a hearing patient, seeing this, tries to do the same? Program philosophy or policy may dictate specific responses to these or other situations.

Recent progress notes let you know whether the client has been agitated, aggressive, withdrawn or affected by some other observable mood which may influence communication or the willingness to communicate. They also give some indication of the degree of risk in the work. The best predictor of violence is a history of violence. If the client has been threatening and angry, be more cautious than you may be if they are well-rested and friendly. The dangers of this setting are often exaggerated, but it is the wise interpreter who prepares for all contingencies.

Another indicator of general mood and alertness is in medication orders. Interpreters need to know more than the spelling of medicines used in psychopharmacology. They also need to know the effects of common classes of medication and their use. A client who just received a large, unscheduled dose of Haldol will not only be unresponsive but may have just had a violent episode. On the other hand, a client who receives bi-weekly injections of Haldol and is scheduled to get a shot in a few days will probably be more easily agitated or perhaps more anxious than at other times.

Summing up

Knowing a patient's history, diagnosis, medications and treatment regimen does not change interpreters' responsibility for communication and linguistic issues related to therapy. It does change interpreters' interaction with the rest of the treatment team. It allows us to share with them as students of another culture, their culture; the culture of the mental health community. It allows us access to them as resources to further our professional development. Their values: client-centered therapy, collegiality and cross-disciplinary teamwork, individual worth and building mental health become values we share. Their language becomes something we are fluent with and their mores are things we are familiar with. As interpreters our role is different than those of diagnosticians, therapists and counselors, but in providing mental health services to the Deaf community, our involvement is vital.

References

[1] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC, American Psychiatric Association , 1994.

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