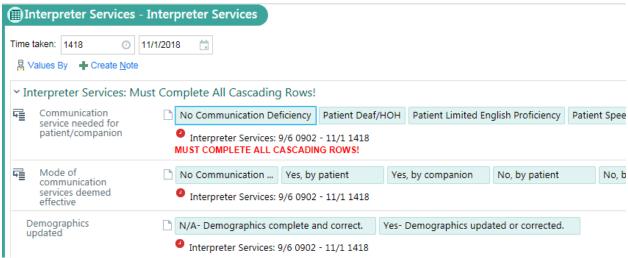


# Interpreter Services Documentation - Inpatient

All patients in Epic should be screened for the need for Interpreter Services. For the Inpatient units, this is done by nursing in the Admission navigator. Ongoing documentation of the use of interpreters should be done in the flowsheets activity. This tip sheet outlines the process for Interpreter Services documentation.

• In the Admission navigator, open the **Interpreter Services** section. This is also required documentation for all inpatients on admission as indicated by the clock



- If the patient has No communication deficiency and no services, demographics will Not need to be updated and you can click Close to move to the next section of the navigator
- If the patient needs a specific communication service, you must select the service needed from the list. Additional rows will cascade in specific to the service needed

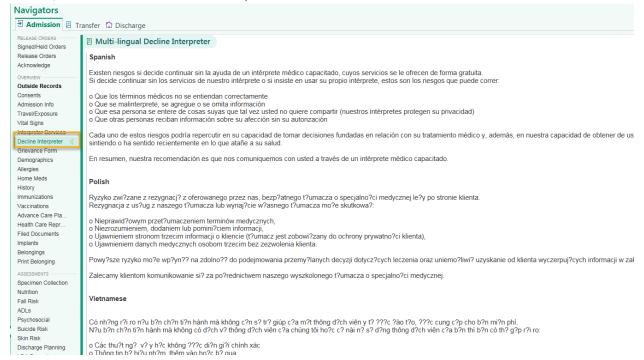


- Nursing staff are alerted in the row information in Red Bold letters that they must complete all
  cascading rows for the documentation to be correct
- If a Free qualified interpreter was offered, but the offer is declined, *Electronic signature will no longer* be used.

 English reading/speaking patients (HOH patients) should read the declination information in the next row and the nurse can document that the risks of declining were explained



 Non-English speaking patients will have the ability to review the risks in the next section of the admission navigator. Open the **Decline Interpreter** section. Multi-lingual patients can read the risks of declining in their own language. (We have Spanish, Polish, Vietnamese, Simplified Chines, Russian and Arabic available)



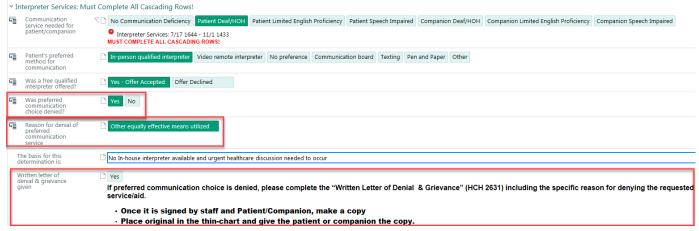
- If the patient cannot read, a translator will need to be used to review the risks with the patient or companion.
- Don't forget to return to the Interpreter Services section and document that the risks of declining were explained



### Special Considerations for patients that are Deaf or HOH

- Patients who are deaf/HOH have additional information that must be documented. They have the ability to determine their preferred method of communication and if we do not use the preferred method, the patient may file a grievance
- Document patient's preferred method of communication and was the preferred choice delivered. If you say No, the nurse will have to document the reason for denial of preferred communication method

#### and print out and sign the Written Letter of Denial & Grievance



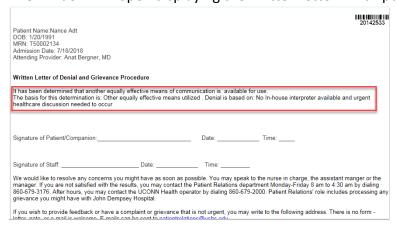
• The Written Letter of Denial & Grievance can be printed from the Admission navigator in the

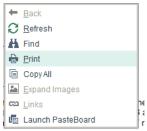


· Click on the blue hyperlink



The window will open displaying the written letter which pulls in your documentation





- You can right click on the letter to print at the nursing station
- Have the patient sign the letter, you sign as the nurse and make a copy.
- The patient receives the copy and the original is placed in the thin chart for scanning after discharge

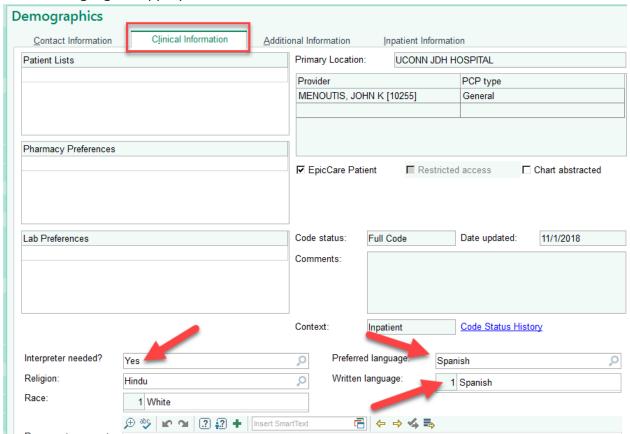


## • Update the Demographic Information

- If the patient requires an interpreter of any kind, the Demographics must be updated

രാ Demographics
Go to Demographics - General Tab 🤊

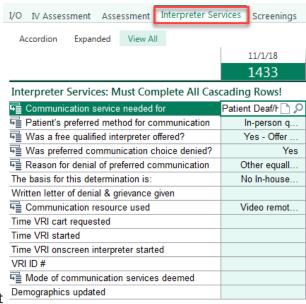
- Click on the blue hyperlink to open the Demographics activity
- Navigate to the Clinical Information tab and update the Interpreter Needed, Preferred language, and Written Language as appropriate



Return to the Navigator to complete the admission

### Document the Use of Interpreters During the Hospitalization

You can document the use of interpreters during the inpatient stay in your flowsheets activity



- There is a new **Interpreter Services** Flowsheet
- Or you can document at the top of the Screenings flowsheet

