Guidelines for Writing a Critical Incident Report

These guidelines offer a structure for interpreters to report interpreting incidents that will:

- produce sufficient and consistent data, and
- enable data-driven decision making to avoid or reduce the risk of future incidents.

What is a Critical Incident?

Any event during the interpreting encounter in a healthcare setting that causes the interpreter to self-reflect about their decisions and makes the interpreter feel:

- doubt, frustration, anxiety, OR
- satisfaction in finding an optimal solution, OR
- the need to change/edit the existing interpreting practice or protocol.

Five Elements of a Critical Incident Report

1. Describe the incident

- Describe the incident in detail.
  - Choose a true situation (don't add or remove facts, etc.)
  - Be very specific
  - Give only what is necessary to understand the analysis/reflection
  - Describe the *context* of the incident
  - Describe the *actual* incident
- Identify the "interpreting problem" or the interpreter's actions or omissions of actions or other limitations in the system that had an important role in the critical incident.
- What were your thoughts and assumptions during and after the incident?
- What were your feelings during and after the incident?
- What did you do in connection with the incident?
- What has this incident meant to you since?

Confidentiality and Reporting Critical Incidents

- HIPAA rules apply!
- Do NOT include in the CIR any of names of the patient, provider, facility.
- Provide only relevant info about the patient, provider, facility, and yourself. Relevant - in terms of discussing the CI and making recommendations. You may change ("blur") the info in the CIR to some extent to preserve confidentiality.
- Assess relevance of the needed demographic info of all parties: age, gender, marital status, education level, employment status.
- Assess relevance of the needed cultural info of all parties: language, place of origin, religion, immigration status, familiarity with the culture of the other party.
- Assess relevance of the needed medical info: specialty, condition/diagnosis, stage of treatment, prognosis.
- Assess relevance of the needed facility/appointment info: type of facility, urban/rural, level/type of provider, type/order of appointment, interpreting modality (face-to-face, video, phone), existence of special protocols.
- Assess relevance of the needed interpreter's info: affiliation with the facility (staff-freelancer), familiarity with the subject matter, familiarity with the patient/provider/facility.

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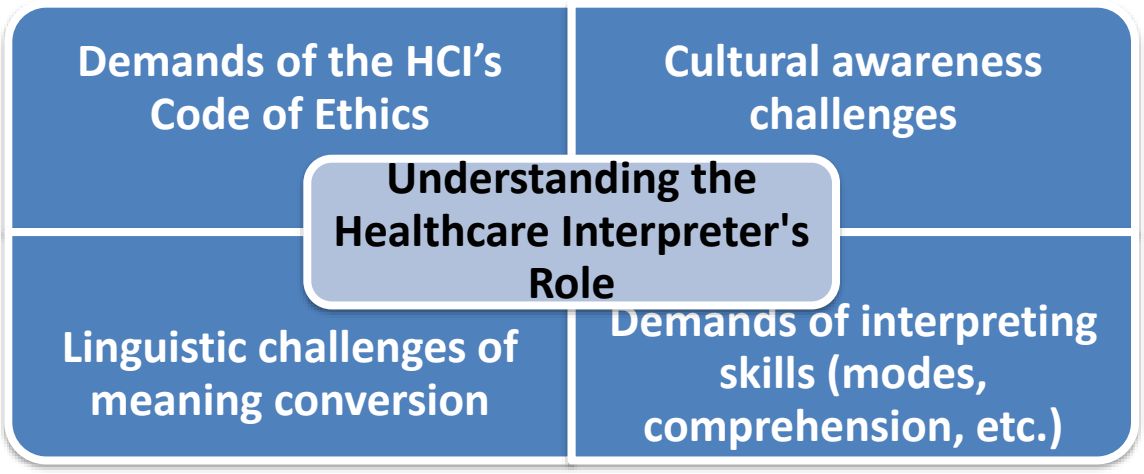
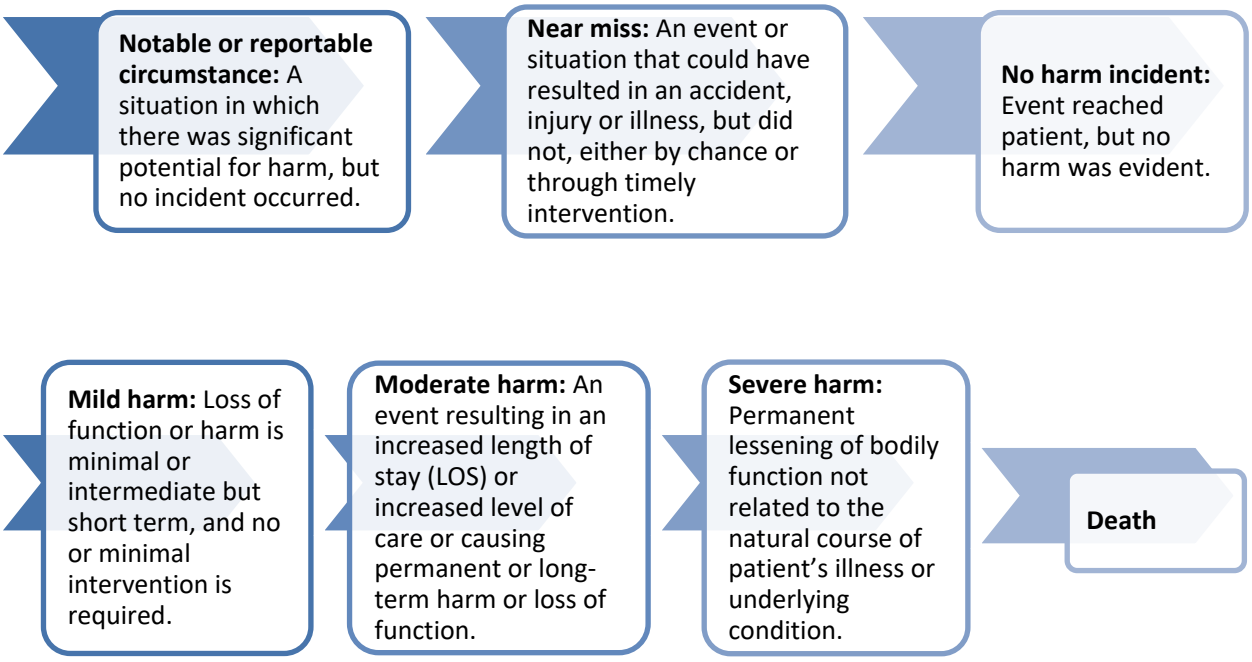
2. Explain the incident

- Why was the incident critical to you?
- What did you consider the most demanding aspect of the incident?
- Explain how the incident relates to the healthcare interpreter's role, ethical principles, or skills.
- Identify the incident's criticality level.

Incident Types by Interpreter Performance



Incident Types by Criticality



3. Compare the incident to existing information

- Compare the incident to existing standards of practice or application of ethical principles or organizational protocols.
- Find and *quote specific passages* in the healthcare interpreter publications or organizational policies that relate to the incident.

Primary sources to review and quote:

- The National Council on Interpreting in Health Care (NCIHC) – A National Code of Ethics for Interpreters in Health Care
- The National Council on Interpreting in Health Care (NCIHC) – National Standards of Practice for Interpreters in Health Care
- California Healthcare Interpreter Association (CHIA) – California Standards for Healthcare Interpreters
- International Medical Interpreter Association (IMIA) – Medical Interpreting Standards of Practice
- ASTM F2089-15 Standard Practice for Language Interpreting

4. Reflect

- Why do I view the situation like that? How else could I interpret the situation?
- Identify contributing factors (process, human, equipment, environmental).
- Assess preventability of the incident.
- Identify factors that minimized or aggravated severity of incident.
- Identify root causes and what systems are involved in them ("lessons learned").
- Formulate possible risk reduction or improvement actions (What needs to change?).
- Define how to ensure acceptability of the action plan.

Factors increasing risk of incidents		
Personal	**Organizational**	**Profession-level**
• Limited knowledge of healthcare interpreting • Limited healthcare interpreting skills • Unfamiliar environment/protocols • Distraction/inattention • Fatigue • Stress, hunger, illness	• Inadequate information • Poor procedures • Poor staff training • Time pressures • Insufficient staff • Inadequate supervision	• Poor/unclear or non-existent policy/protocol • Inadequate dissemination of information • Failure to enforce protocol

5. Implicate

- Provide recommendations how either the interpreter's actions during the incident or the new action plan can be used in practice or in developing a new policy, protocol, standard, etc.
- Communicate how to evaluate the implementation of the action plan.