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.
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

### Demands of the HCI’s Code of Ethics
- Understanding the Healthcare Interpreter’s Role
- Linguistic challenges of meaning conversion
- Demands of interpreting skills (modes, comprehension, etc.)

### Cultural awareness challenges

Incident Types by Criticality

- **Notable or reportable circumstance:** A situation in which there was significant potential for harm, but no incident occurred.
- **Near miss:** An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention.
- **No harm incident:** Event reached patient, but no harm was evident.
- **Mild harm:** Loss of function or harm is minimal or intermediate but short term, and no or minimal intervention is required.
- **Moderate harm:** An event resulting in an increased length of stay (LOS) or increased level of care or causing permanent or long-term harm or loss of function.
- **Severe harm:** Permanent lessening of bodily function not related to the natural course of patient’s illness or underlying condition.
- **Death**
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**

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<th>Personal</th>
<th>Organizational</th>
<th>Profession-level</th>
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   | • 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.