Healthcare Interpreter's Critical Incident Report #001

Submission Time: October 7, 2020

Section 2: Critical Incident Report

Incident Title	Omission of LEP's important statement
1. Provide relevant demographic information about the interpreter	I'm a female. I have a bachelor's degree, and I'm married with one child.
2. Provide relevant professional information about the interpreter	I'm a full time telephonic medical interpreter. I work at home as Mandarin interpreter doing consecutive interpreting for healthcare facilities (Hospitals, clinics, pharmacies). I work for a major interpreting company as a scheduled employee and work 40 hours a week on the phone. I attended a 70-hour interpreting training when I was hired and then a 40-hour advanced medical training one year later. I also completed a 40-hour online medical interpreting training program. I am certified by CCHI. During my scheduled shift, I receive on average 20 medical related calls a day.
3. Provide relevant cultural information about the interpreter	I grew up in northern China where Mandarin is the primary spoken language and there was no particular dialect in the town where I grew up. However, I have studied and worked in several different cities in southwestern, southern and central China since I graduated from high school, and I've travelled extensively throughout China so I feel very comfortable in understanding some regional cultures their dialects as well.
4. Provide relevant information related to the facility and appointment at which the incident took place	One day in early October 2020, I received a healthcare related call from a major hospital in New York city. As I collected the call information at the beginning, I got that this is a follow-up appointment with a pediatrician for a little girl. Since the patient was hospitalized and was not in a good condition, the mom spoke on her behalf throughout the conversation.
5. Provide relevant demographic information about the patient and/or their family member(s)	The patient is a little girl around 10 years old, and her mother is a young lady in her 30s, originally from southern China.
6. Provide relevant cultural information about the patient and/or their family member(s)	The parent and the patient are local residents and are familiar with the facility. Since the mother has been taking care of the girl for a while since she was hospitalized, she sounded very familiar with her daughter's condition, hence she stayed very calm and articulate during the whole conversation. She understands some English but doesn't feel

	comfortable speaking to the hospital staff in English, so she prefers to use the interpreter.
7. Provide relevant demographic information about the provider(s) involved the critical incident	The nurse practitioner was the only provider involved in the conversation. She is a young female, an employee of the hospital.
8. Provide relevant cultural information about the provider(s) involved the critical incident	The nurse practitioner is a formal staff of the hospital and is very familiar with the hospital setting and her domain of practice.
9. Provide relevant medical information: medical specialty, patient's condition/diagnosis, stage of treatment, prognosis.	The patient had kidney bleeding and was hospitalized one day ago when she was given blood transfusion to elevate her blood counts.

Element 1. B. Critical Incident

1. Describe what happened	When the mom settled in the room, the NP started by updating her the patient's blood work result: The hemoglobin level was 7, and that was before the transfusion completed yesterday. And on Monday next week she would be given another blood test. I relayed this information to the mom, and she fully acknowledged and added "I would like my daughter to have a blood work done today as well, so we can get her complete blood count and compare with the blood work to be done on next Monday, just so we can figure out if she still has the bleeding. If she still does, we'll make a decision on seeing a specialist." By this time, I was not given any detailed information about the girl's medical history, and all I could do was to listen carefully and try to get as much information as I could from the mom and the NP. I took key notes when I listened to the mom, but when I interpreted this statement for the NP, the piece of information of mom's concern about the *continuous* bleeding escaped from my short term memory because I was focused on her request about "having a blood test done on CBC." The NP agreed with mom on giving the blood work to the patient today. Mom felt reassured. But since she might have noticed my omission about the "bleeding" part, so she went on to readdress her request, "I bring about this request because I want to compare today's CBC with the CBC level on next Monday so we'll have an idea if she still has the internal bleeding." And it was by this moment that I realized I made an incidental omission from the mom's statement. I relayed the information to the NP completely and accurately this time, and the mom had no more concerns, and the conversation/visit was over.

2. What were your thoughts and assumptions during and after the incident?	During the incident I focused on the mom's request about "having a blood work today to check the CBC" during the listening and didn't take her statement about "continuous bleeding" as equally important, and didn't write this part down either, which resulted in the omission in the rendition. When the mom readdressed her request, she was actually trying to explain the reason of her request and at the same time gave me an opportunity to correct my omission. I did pick up this piece of information from her reiteration and was extremely grateful about her being so sensible.
3. What were your feelings during and after the incident?	During the incident, I actually sensed something was incomplete, and I recalled something about "bleeding" when I was about to finish the interpreting of the mom's request, but I didn't make notes about the "possible continuous bleeding,", and my short-term memory failed to trace that information clearly. When I heard mom readdress the request, I felt very guilty about omitting this very importance message. I was also very grateful that she readdressed it in a calm and firm tone so as to put more emphasis on the reason of the request.
4. What did you do in connection with the incident?	I picked up the omitted information when Mom readdressed the request and rendered the interpretation to the NP completely. And after the call, I took a detailed note about this incident and reflected on it later after my shift.
5. What has this incident meant to you since?	This incident gave me a heads-up on the important rule for a language conduit: to convey everything that is said by either party in its entirety and in the manner in which the message is delivered, that is, without OMISSION FROM, adding to, or distorting the message. Especially in medical setting, omission can lead to misdiagnosis and wrong treatment. Interpreters should strive to avoid any omissions by enhancing their short-term memory and note-taking skills in any occasion.
6. 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.	The interpreting problem in this incident is the omission in the interpretation of the LEP 's statement.

Element 2: Explain the incident

1. Why was the incident critical to you?	This incident was critical to me because it reminds me never to underestimate the LEP's seemingly less important information and always tried to understand the situation from their point of view and grasp the

	intention behind each and every word they utter, including the redundant words.
2. What did you consider the most demanding aspect of the incident?	The most demanding aspect of the incident is the assumption of "one part of the LEP's statement is more critical/important than the rest " thus the equal importance was not attached to the latter in the short-term memory and note taking.
3. How does the incident relate to the healthcare interpreting?	The incident is related to the demands of the healthcare interpreter's code of ethics
If yes, choose which ethical principles or values are applicable to the incident (check all that apply):	Accuracy and fidelity (to the speaker's message) Professionalism and abiding by ethics
4. What is the incident's criticality level?	Notable or reportable circumstance (A situation in which there was significant potential for harm, but no incident occurred.)

Element 3: Compare the incident to existing information

Compare the incident to existing standards of practice or application of ethical principles or organizational protocols.	According the NCIHC standards, this incident is related to the Code of Ethics item No.2--"The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its culture context." The interpreter picked up the information during the LEP's reiteration and corrected the mistake.
Supporting Quote 1. Passage (copy exactly from the source)	In the case of direct communication between a patient and a provider, message and the meaning conveyed are not censored except by the parties themselves. It is, therefore, necessary that the interpreter convey everything that is said by either party in its entirety and in the manner in which the message is delivered, that is, without omitting from, adding to, or distorting the message.
Title of the publication or source for Quote 1	NCIHC. A National Code of Ethics for Interpreters in Health Care
Page # for a publication OR URL of the specific webpage on which the quoted text appears for Quote 1	NCIHC-National Standard of Practice page 13
Supporting Quote 2. Passage (copy exactly from the source)	Ethical Principle 5; Accuracy and Completeness Performance measures a. Convery verbal and non-verbal messages and speaker's tone of voice

	without changing the meaning of the message. d. Reveal and to correct interpreting errors as soon as recognized.
Title of the publication or source for Quote 2	CHIA. California Standards for Healthcare Interpreters
Page # for a publication OR URL of the specific webpage on which the quoted text appears for Quote 2	Page 30

Element 4: Reflect about the incident

Why do I view the situation like that? How else could I interpret the situation?	During the incident I subconsciously assumed that the crucial/urgent part of her statement is to raise the request of the blood test, thus, the rest part of the statement became vague in my short-term memory. I should have taken notes (key words) of this piece of information as well.
What factors (process, human, equipment, environmental) have contributed to the incident?	There are two factors that have contributed to the incident: 1. The interpretation was provided remotely via a phone and the interpreter had no chance to see the LEP or maintain eye contact and get any possible hint by her body languages. 2. I didn't get enough background information about the patient (medical history, prognosis and treatment plan, etc.) before I started to render the interpretation to the LEP and the provider.
Do you think the incident could have been avoided or prevented? If yes, how?	Yes. It could have been avoided if I had taken more notes of the statement by the LEP, or if I had asked her for repetition/clarification.
Are there any factors that minimized or aggravated the severity of the incident? (Consider personal, organizational, or profession-level factors)	The severity was minimized by the LEP's reiteration through which the interpreter got an opportunity to pick up the missed information and relay it to the provider and avoided potential misunderstanding or irritation caused to the provider due to the nature of the LEP's request.
What are the root causes for the incident and what systems are involved in them ("lessons learned")?	The root cause of the incident is the interpreter made an assumption in the critical levels of the different pieces of LEP's statement instead of considering them equally important and taking necessary note accordingly.
Formulate possible risk reduction or improvement actions (What needs to	- Review/polish the National standard/code of ethics on a regular basis. - Enhance the short-term memory and note taking skill.

change?).	- Self-reflection after each incident. If possible, right journals about the reflection.
Provide suggestions about how to ensure that the action plan is accepted by responsible parties.	- The interpreter shall strive to monitor the entirety of the messages more closely by attentive listening and map the logical relationship between each section of the messages and continue to enhance note taking skills. - In case there is only general/incomplete information available before the interpretation begins, the interpreter shall try to seek more background information about the medical occasion if it's possible.

Element 5: Implicate – provide recommendations

1. What have you considered doing in this situation? Share any thoughts or suggestions on how to avoid a similar situation in the future or what steps are needed to prevent such incidents from occurring in the future.	To avoid such incidents from happening again, I plan to start journaling about the incidents and set up a reward-penalty program for myself so as to raise an alert more frequently.
2. How would you know that your proposed plan of action is working? Share your suggestions about evaluation of the effectiveness of a possible action plan.	Perform self-evaluation on a monthly basis by checking the numbers and severity level of the incidents until they are minimized.