NATALYA MYTAREVA, M.A., CORECHI™ PRESENTS

CRITICAL INCIDENT PRESENTATION FOR HEALTHCARE INTERPRETERS: INTERPRETER ROUNDS

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Overview

1. **Healthcare rounds and Interpreter rounds**

2. **What is a "critical incident" in the context of healthcare interpreting? Types of critical incidents.**

3. **Why do incidents occur? How to turn a critical incident into a learning moment?**

4. **Five elements of a Critical Incident Report (CIR)**

5. **Practice: Writing a sample critical incident report**
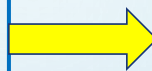
6. **What now? CIR Repository & Virtual Interpreter Rounds.**

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1. Healthcare rounds and Interpreter rounds

Definitions

Daily visit by the attending physician and team to all of that physician's patients on the ward.	**Rounds**
Methodology of medical education and inpatient care, consisting of presenting the medical problems and treatment of a particular patient to an audience of doctors, residents, and medical students.	**Grand Rounds**
A multidisciplinary panel sharing their experiences about a case or a theme related to the emotional impact of patient care that care team members experience.	**Schwartz Rounds**

Interpreter Rounds

Presenting to and discussing with

an audience of interpreters and language services managers:

➢ **situations that posed either *linguistic* or *ethics-related* challenges to the interpreter,**

➢ **possible solutions to them, and**

➢ **recommendations for further actions at a profession-wide level if needed (e.g. suggestions for research, establishing standards, etc.)**

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Why?

Reflection is an effective self-learning and teaching tool for professional growth.

On a personal level, reflection helps you to:

➢ **better understand your strengths and weaknesses**

➢ **identify and question your underlying values and beliefs**

➢ **acknowledge and challenge possible assumptions on which you base your ideas, feelings and actions**

➢ **recognize areas of potential bias or discrimination**

➢ **acknowledge your fears, and**

➢ **identify possible inadequacies or areas for improvement.**

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Why?

On a profession-wide level, reflection helps all of us to:

➢ **Identify peer-reviewed acceptable solutions and strategies to better detect, manage, and prevent problems**

➢ **Provide a mechanism for support to new interpreters**

➢ **Identify gaps and inadequacies in interpreting publications and training**

➢ **Create a database of incidents in healthcare interpreting**

➢ **Prepare for participation in Schwartz rounds, bringing the interpreter perspective to care delivery**

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2. What is a "Critical Incident"?

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A critical incident

Broad meaning:

something that happens, either positively or negatively, that makes you stop and think, or that raises questions for you.

Narrow meaning:

Any unintended event that occurs when a patient receives treatment in the hospital,

a) that results in death, or serious disability, injury or harm to the patient, and

b) does not result primarily from the patients' underlying medical condition or from a known risk inherent in providing the treatment.

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Which incident to select?

1. **One that relates to communication in general or interpreting specifically**

2. **One in which you were personally involved (not made up or heard about; if you are a manager – it can be one where you were asked to provide guidance about)**

3. **One about which you feel**
   - satisfied in finding an optimal solution, OR
   - doubt, frustration, anxiety, OR
   - the desire to change/edit the existing practice or protocol.

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Types of Critical Incidents

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Incident's Relation to Interpreting

Demands of the HCI's code of ethics	**Cultural awareness challenges**
Linguistic challenges of meaning conversion	**Demands of interpreting skills (modes, comprehension, etc.)**

Misunderstanding of the HC interpreter's role

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Incident's 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.

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Incident Criticality

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

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Sentinel *Event Policy* by The Joint Commission

A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

Such events are called "**sentinel**" because they signal the need for immediate investigation and response.

https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/

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3. Why do incidents occur?

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Human beings make "silly" mistakes

Regardless of their experience, intelligence, motivation or vigilance, people make mistakes. An error is "When someone is trying to do the right thing, but actually does the wrong thing." (*B. Runciman*)

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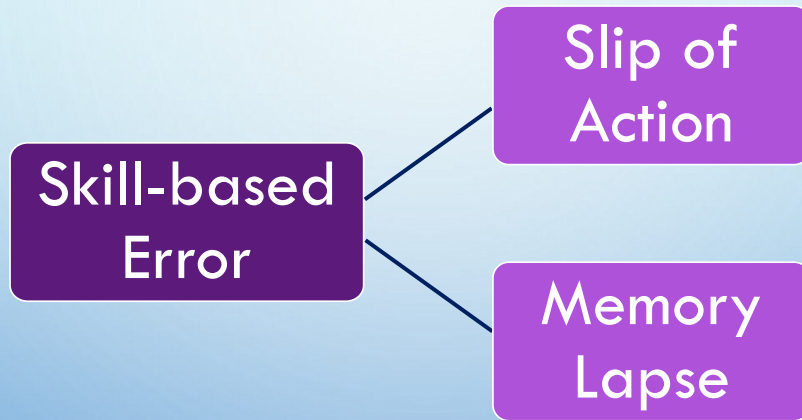# Human errors occur because of one of two main types of failures

Skill-based Error:

Actions do not go as intended - a so-called *error of execution*
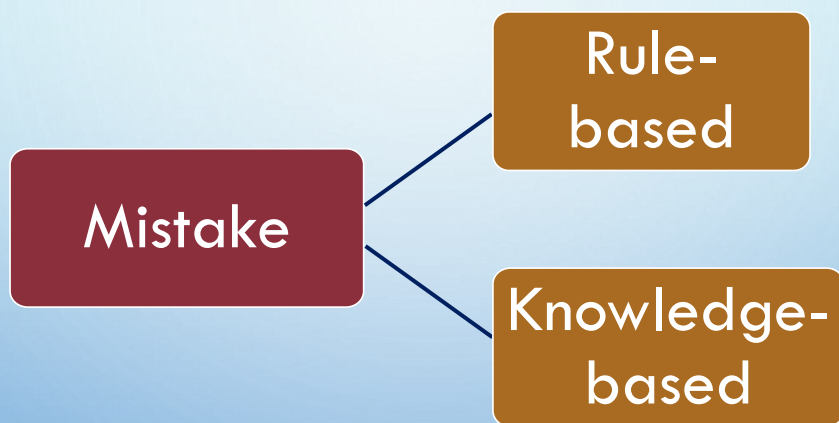
Knowledge-based Mistake:

The intended action is the wrong one – a *failure of planning*

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Slip of Action

Skill-based Error

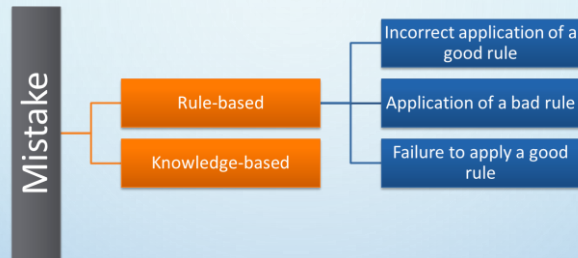Memory Lapse

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Mistake

Rule-based

Knowledge-based

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Mistake vs. Violation

**Failure to apply a good rule is also known as a violation.**

Violation: A *deliberate* deviation from an accepted protocol or standard of care.

Violations are classified as human error when the intentional action *does not achieve the desired outcome*, or results in *unanticipated* adverse consequences.

If a planned action (violation) *has achieved the desired outcome of damage*, it is not a human error and should be managed through the application of appropriate disciplinary measures.

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Mistake vs. Violation
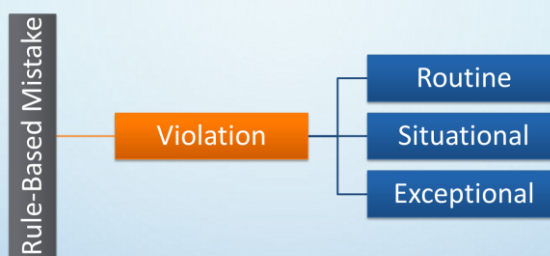
- A <u>routine</u> violation is one which is commonplace and committed by most members of the workplace.
- A <u>situational</u> violation occurs in response to situational factors, as a once-off. When confronted with an unexpected or inappropriate situation, personnel may believe that the normal rule is no longer safe, or that it will not achieve the desired outcome, and so they decide to violate that rule.
- An <u>exceptional</u> violation is a fairly rare occurrence and happens in abnormal and emergency situations.

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Violation of a bad rule

Violation of a bad rule, i.e. such as a procedure that, if followed correctly, would cause harm, is not a human error.

In such cases, a review of the rules and procedures is advisable.

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Turning a critical incident into a learning moment

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Factors increasing risk of incidents

| Personal	Organizational	Profession-level
• Limited HCI knowledge • Limited HCI skills • Unfamiliar environment/protocols • Distraction/inattention • Fatigue • Stress, hunger, illness	• Inadequate information • Poor procedures • Poor staff training • Time pressures • Insufficient staff • Inadequate supervision	• Policy/protocol poor/unclear or non-existent • Inadequate information dissemination • Failure to enforce protocol

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Conditions to learn through reflection

- ➢ **Preparation** – **when you enter into a new experience, try to identify opportunities for reflection.**
- ➢ **Understanding** – **you need to know what the goals and expectations of critical reflection are.**
- ➢ **Time to stop and think.**
- ➢ **A level of objectivity about yourself and the impact of your actions.**
- ➢ **Honesty.**
- ➢ **An open, non-defensive attitude to the experience.**
- ➢ **A focus on the deeper levels of meaning – moral, ethical, social and/or professional issues in addition to your emotional response.**

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4. Five elements of a Critical Incident Report (CIR)

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1. Describe

2. Explain

3. Compare

4. Reflect

5. Implicate
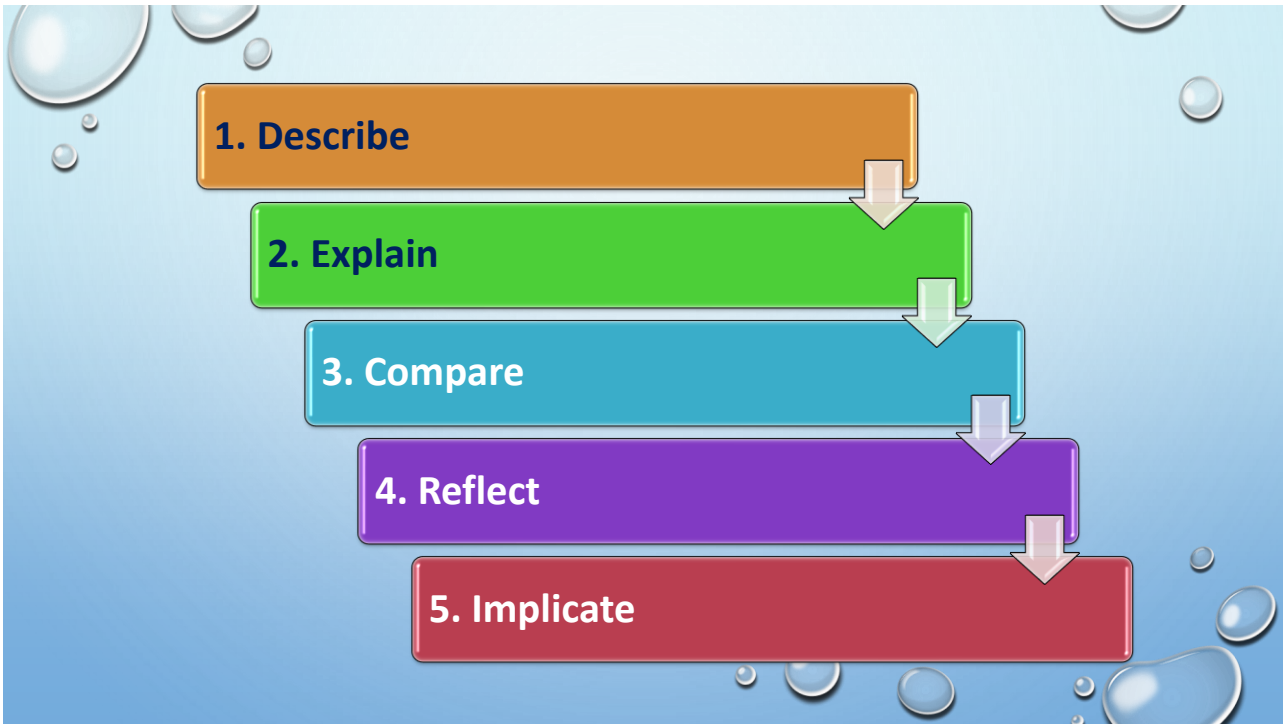
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1. Describe the incident

Describe the *incident* in detail.

- o **Choose a <u>true</u> situation (don't add or remove facts, etc.)**
- o **Be very <u>specific</u>**
- o **Give <u>only what's necessary </u>to understand the analysis/reflection**
- o **Describe the <u>context</u> of the incident.**
- o **Describe the <u>actual</u> incident**

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1. Describe the 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?

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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 HCI's role, ethical principles or skills

➢ Identify the incident's criticality level

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3. Compare the incident to existing info

➢ **Compare the incident to existing standards of practice or application of ethical principles or organizational protocols**

➢ **Find specific passages in the HCI publications or organizational policies that relate to the incident**

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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**

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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**

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## 5. Practice: Writing a sample critical incident report

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Sample Critical Incident Report

Incident Title	
Context of the incident	
Details of the incident	
Thoughts, feelings, concerns	
Demands	
Incident type	Relation to HCI and Criticality
Reference to literature	
Contributing factors	Personal, Organizational, Profession-level
Possible actions	
Impact on profession	

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1. Describe the incident

Specificity of the CIR
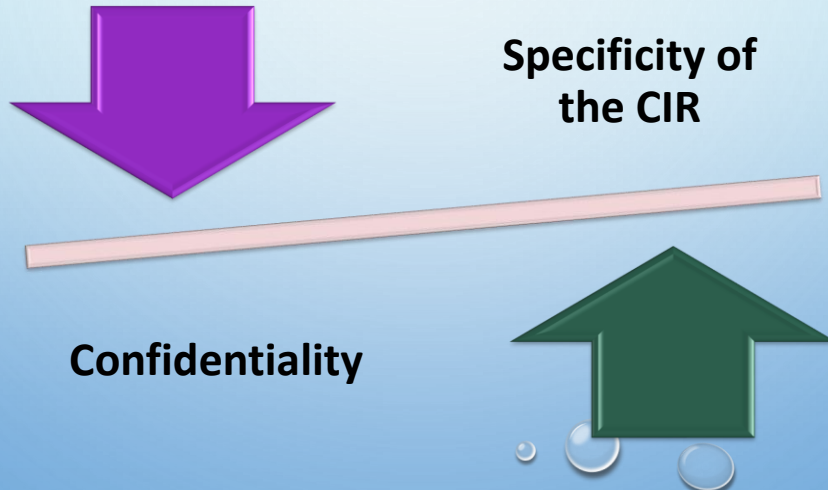
Confidentiality

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1. Describe the incident

Confidentiality & CIR

➢ **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.**

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1. Describe the incident

Confidentiality & CIR

➢ **Assess relevance of the needed demographic info of *all* parties: age, gender, marital status, education level, employment status.**

Blurring example: A real case has a 3-year old boy; in CIR – it's a 4-year old boy.

➢ **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.**

Blurring example: A real case has an interpreter from Spain and patient from Mexico; in CIR – the interpreter and patient share the language but are from different countries.

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1. Describe the incident

Confidentiality & CIR

➢ **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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1. Describe the incident

CIR Example

Incident Title	Patient doesn't share information with physician
Context of the incident	Interpreting for a child and his mother at the appointment to establish care with a new doctor.
Details of the incident	The nurse asked if there were any known diseases or medical conditions among the child's blood relatives. The patient's mother responded that there were not any. Because I know the family, I told the mother that it's important to tell the nurse about the lung tumor of her husband, and then, I relayed this information to the nurse.

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1. Describe the incident

CIR Example

Incident Title	Patient doesn't share information with physician
Context of the incident	Interpreting for a child and his mother at the appointment to establish care with a new doctor.

Incident Title	Patient doesn't share information with physician
Context of the incident	Interpreting for a four-year old boy and his mother at the appointment to establish care with a new pediatrician. I have been interpreting for this family before, specifically, the boy's father who has been undergoing tests for a lung tumor. The wife accompanied her husband to these appointments, including to the biopsy one.

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1. Describe the incident

CIR Example

Details of the incident	The nurse asked if there were any known diseases or medical conditions among the child's blood relatives. The patient's mother responded that there were not any. Because I know the family, I told the mother that it's important to tell the nurse about the lung tumor of her husband, and then, I relayed this information to the nurse.

| Details of the incident | In reviewing the family medical history, the nurse asked if there were any known diseases or medical conditions among blood relatives. The patient's mother responded that there were not any. I told the mother that it's important to tell the nurse about the lung tumor of her husband, and then, I relayed this information to the nurse. The mother didn't say anything to me, but I felt she became distant. |

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1. Describe the incident

CIR Example

Thoughts, feelings, concerns	During the appt, I thought, "Why is she not telling about her husband's tumor?" Later that day I started wondering if I shouldn't have said anything.
Thoughts, feelings, concerns	During the appt, I thought, "Why is she not telling about her husband's tumor? What if it is important? What if it is genetic?" It was the first time I interpreted in pediatrics. I felt exasperated. I was also tired; it was my last appt for the day. Then, after the mother became distant, I felt uneasy. Later that night, I started wondering if I shouldn't have said anything. What if she wouldn't want me to interpret in the future?

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2. Explain the incident

CIR Example

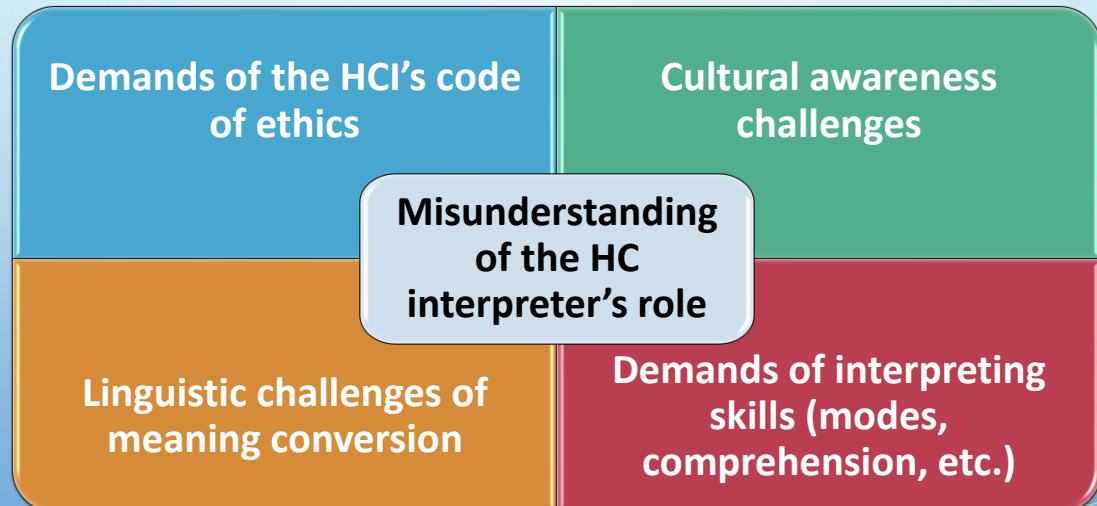| Demands	The most difficult part is to know how important that information about the tumor was for the boy's medical history.
Demands	The most difficult part is to know how important that information about the tumor was for the boy's medical history. And have I ruined the relationship with the mother?

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Incident's Relation to Interpreting

Demands of the HCI's code of ethics	Cultural awareness challenges
Misunderstanding of the HC interpreter's role	
Linguistic challenges of meaning conversion	Demands of interpreting skills (modes, comprehension, etc.)

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CIR Example

Incident type	
Relation to HCI	Demands of the HCI's code of ethics and misunderstanding of the HCI's role

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Incident's Criticality

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Severe harm:
Permanent lessening of bodily function not related to the natural course of patient's illness of underlying condition.

Death

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2. Explain the incident

CIR Example

Incident type	
Criticality	No harm

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3. Compare the incident to existing info

CIR Example

Reference to literature	Where will you look?

- ➤ **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**

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3. Compare the incident to existing info

CIR Example

Reference to literature	What will you look for?

- ➤ **Interpreter role**
- ➤ **When interpreter should intervene**
- ➤ **Impartiality, patient autonomy**
- ➤ **Advocacy**
- ➤ **Confidentiality**

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3. Compare the incident to existing info

CHIA Standards

1. **P. 44: "Interpreters cannot and should not be responsible for everything that everyone does, or doesn't do. But, if they happen to notice something starting to go wrong, it is reasonable to bring it to the attention of someone who can correct it before it becomes a problem, rather than sit back and watch a disaster unfold" (Kontrimas, 2000).**

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3. Compare the incident to existing info

CHIA Standards

2. **p. 26: "Interpreters maintain impartiality by attempting to: {...}**

b. Allow the parties to speak for themselves and to refrain from giving advice or counsel, or taking sides.

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3. Compare the incident to existing info

CHIA Standards

3. p. 27-28: "Interpreters demonstrate and promote respect for individuals by seeking to: {…}

b. Recognize that the concept of patient autonomy…

c. Recognize the expertise all parties bring into the interaction by refraining from assuming control of the communication…

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3. Compare the incident to existing info

NCIHC Code of Ethics

4. p. 10: "A rule of thumb when it comes to issues of confidentiality would be to rely on the core value of beneficence to determine who should know. In other words, might the patient's life be endangered if the provider of the moment is not given access to information that the interpreter already has? If the answer to this question is "yes," then the first course of action that interpreters should take is to encourage the patient to share this information directly with the provider. Only if this is not possible or the patient refuses to do so should interpreters consider disclosing the information themselves."

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3. Compare the incident to existing info

NCIHC Code of Ethics

4. p. 12: "The decision to disclose information should not be taken lightly. Such a decision should be taken only after every effort has been made to persuade the party from whom the information originates to make the disclosure themselves, explaining what information needs to be shared, with whom it needs to be shared, and why it needs to be shared."

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3. Compare the incident to existing info

NCIHC Code of Ethics

4. p. 13: "If interpreters are unsure of the course of action to be taken and *if there is time*, they should consult with their supervisor, the director of the interpreter service office or agency, or the ethics division of the health care organization. When there is no time for consultation, interpreters may have to make a decision based on their judgment as to what would be in the health care interest of the patient but should later discuss the situation at a supervisory session or a professional seminar."

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3. Compare the incident to existing info

NCIHC Code of Ethics

5. p. 15-16: " {...} interpreters do not judge the content of the messages in order to make decisions about what should be transmitted or not, or how it should be transmitted. It also means that interpreters do not judge any of the parties in the encounter. It means that interpreters respect the autonomy of each party in the encounter and their right to speak for themselves in the manner they wish to. It means that interpreters respect the right of the parties to make decisions for themselves; therefore, interpreters should not take sides or attempt to persuade either party.

Interpreters in the health care encounter understand that they are not there as primary participants in the interaction and, therefore, are not in a position to make decisions, to advise or counsel, or to speak for the other participants."

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4. Reflect

Factors increasing risk of incidents

Personal	Organizational	Profession-level
• Limited HCI knowledge • Limited HCI skills • Unfamiliar environment/protocols • Distraction/inattention • Fatigue • Stress, hunger, illness	• Inadequate information • Poor procedures • Poor staff training • Time pressures • Insufficient staff • Inadequate supervision	• Policy/protocol poor/unclear or non-existent • Inadequate information dissemination • Failure to enforce protocol

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CIR Example

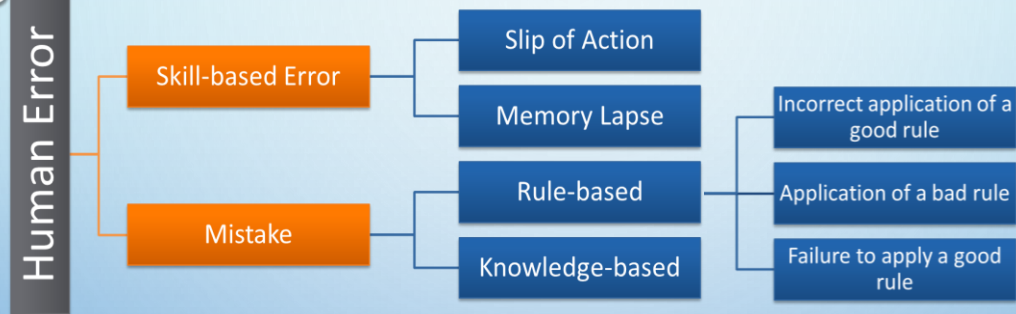| Thoughts, feelings, concerns	During the appt, I thought, "Why is she not telling about her husband's tumor? What if it is important? What if it is genetic?" It was the first time I interpreted in pediatrics. I felt exasperated. I was also tired; it was my last appt for the day. Then, after the mother became distant, I felt uneasy. Later that night, I started wondering if I shouldn't have said anything. What if she wouldn't want me to interpret in the future?
Demands	The most difficult part is to know how important that information about the tumor was for the boy's medical history. And have I ruined the relationship with the mother?

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CIR Example

Contributing factors	
Personal	Unfamiliar environment Fatigue
Organizational	? Possible but we need to know more about the context: Has this interpreter received training in the code of ethics? Did the code of ethics remain at the knowledge-level vs. skill-level? Why?
Profession-level	Is there a clear and sufficient decision-making guidance in the existing literature?

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What kind of error is it?

Human Error

Skill-based Error
- Slip of Action
- Memory Lapse

Mistake
- Rule-based
  - Incorrect application of a good rule
  - Application of a bad rule
- Knowledge-based
  - Failure to apply a good rule

The intended action is the wrong one – mistake.

Was it knowledge-based or rule-based?

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CIR Example

Possible actions	

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4. Reflect

CIR Example

Possible actions	➢ Consult with supervisor or provider or experienced interpreter about how important the knowledge of father's tumor is for child's medical history. ➢ In a similar situation in the future, transparently, remind the patient that such an info may be important and leave it up to the patient to decide to share or not. ➢ Focus on the current appointment and not on the whole history of interpreting for a patient (& family). Deliberately think of a blank slate.

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5. Implicate

CIR Example

Impact on profession	

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5. Implicate

CIR Example

Impact on profession	Write or suggest someone else shall write an article on patient's autonomy and interpreter's impartiality with more examples than exist in the codes of ethics.

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Incident Title	**Patient doesn't share information with physician**
Context of the incident	Interpreting for a four-year old boy and his mother at the appointment to establish care with a new pediatrician. I have been interpreting for this family before, specifically, the boy's father who has been undergoing tests for a lung tumor. The wife accompanied her husband to these appointments, including to the biopsy one.
Details of the incident	In reviewing the family medical history, the nurse asked if there were any known diseases or medical conditions among blood relatives. The patient's mother responded that there were not any. I told the mother that it's important to tell the nurse about the lung tumor of her husband, and then relayed this information to the nurse. The mother didn't say anything to me, but I felt she became distant.
Thoughts, feelings, concerns	During the appt, I thought, "Why is she not telling about her husband's tumor? What if it is important? What if it is genetic?" It was the first time I interpreted in pediatrics. I felt exasperated. I was also tired; it was my last appt for the day. Then, after the mother became distant, I felt uneasy. Later that night, I started wondering if I shouldn't have said anything. What if she wouldn't want me to interpret in the future?
Demands	The most difficult part is to know how important that information about the tumor was for the boy's medical history. And have I ruined the relationship with the mother?
Incident type	Demands of the HCI's code of ethics and misunderstanding of the HCI's role. Criticality: No harm
Reference to literature	Codes of Ethics: CHIA, NCIHC – Respect, Autonomy, Impartiality, Confidentiality {Actual quotes}
Contributing factors	Personal: Unfamiliar environment, Fatigue Organizational & Profession-level as applicable
Possible actions	➢ Consult with supervisor or provider or experienced interpreter about how important the knowledge of father's tumor is for child's medical history. ➢ In a similar situation in the future, transparently, remind the patient that such an info may be important and leave it up to the patient to decide to share or not. ➢ Focus on the current appointment and not on the whole history of interpreting for a patient (& family). Deliberately think of a blank slate.
Impact on profession	Write or suggest someone else shall write an article on patient's autonomy and interpreter's impartiality with more examples than exist in the codes of ethics.

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6. What now?
Virtual Interpreter Rounds

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The CIR Repository

➢ **Interpreters submit CIRs via an online form hosted by CCHI – the link and webpage will be available by 8/20.**

➢ **CIRs that meet all the criteria are published in the Repository. Criteria and sample CIR will be available on the website.**

➢ **Submitting a CIR to CCHI qualifies as a non-instructional activity in the "Research & Publications" category IF the CIR is published in the Repository.**

➢ **Certified interpreters receive *X* CE credit *if* their CIR is published in the Repository. The amount of CE units will be announced on the website.**

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Virtual Interpreter Rounds

➢ **At certain intervals (2 or 3 times a year), a selection is done to identify top 3-5 CIRs for an in-depth national discussion.**

➢ **A virtual *Interpreter Rounds* meeting is held by CCHI with a panel of experts to discuss the selected CIRs.**

➢ **Recordings of the Interpreter Rounds are available from CCHI's website.**

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Suggested Reading

1. **Fridlund B, Henricson M, Mårtensson J (2017) Critical Incident Technique applied in nursing and healthcare sciences. SOJ Nur Health Care 3(1): 1-5. DOI: http://dx.doi.org/10.15226/2471-6529/3/1/00125**

2. **Woloshynowych M, Rogers S, Taylor-Adams S, Vincent C. The investigation and analysis of critical incidents and adverse events in healthcare. Health Technol Assess 2005;9(19).**

3. **Elliott, Malcolm. Reflective thinking: turning a critical incident into a topic for research. 02/02/2004. - https://www.nursingtimes.net/clinical-archive/leadership/reflective-thinking-turning-a-critical-incident-into-a-topic-for-research-01-01-2004/**

4. **Critical Incident Reflection - From RMIT University, a resource for nursing students: https://emedia.rmit.edu.au/learninglab/content/critical-incident-report-nursing**

5. **Reflective writing and critical incidents (From Monash University Research and Learning online) – https://www.monash.edu/rlo/assignment-samples/medicine-nursing-and-health-sciences/reflective-writing-and-critical-incidents#What_is_a_critical_incident-1**

6. **World Health Organization (2012) Learning from error. - https://www.who.int/patientsafety/education/curriculum/course5_handout.pdf**

7. **Reason, James (1990). Human error. Cambridge University Press (UK), 1992.**

8. **Dweck, Carol (2006). Mindset: The New Psychology of Success. Random House Inc.**

9. **Tugend, Alina (2011). Better by Mistake: The Unexpected Benefits of Being Wrong.**

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Send your thoughts & comments to:

rounds@cchicertification.org

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