Slide Handouts for

Risk Management for Healthcare Interpreters

These slides are meant for reading,
rather than presenting

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Risk Management

The process of making and carrying out decisions that will help prevent adverse consequences and minimize the negative effects of accidental losses on an individual or an organization.

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Case Studies

- **Case 1**: Investigation of Surgical Procedure Leading to Removal of Wrong Kidney on Spanish Speaking Patient
- **Case 2**: Death of Infant Patient with Apnea After Repeated ER Visits and ER's Failure to Obtain Complete History from Spanish Speaking Parents
- **Case 3**: Deaf Patient Dies After Receiving General Anesthesia Against His Wishes that He Was Unable to Express

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A State's Department of Public Health's Investigation of Surgical Procedure Leading to Removal of Wrong Kidney on Spanish Speaking Patient

Case Overview

Male patient scheduled for kidney removal

Patient with comorbidities, high risk

Speaker of Spanish

Outcome: removal of the wrong kidney

- Case 1: Wrong Kidney Removed

Site Marking with Patient Involvement

Patient interviews conducted with the patient's son interpreting

Son didn't know which kidney was to be removed

Son translated surgical consent form for father and "assumed" the document was correct

Patient's care plan said to use interpreter to explain the plan of care

No evidence that a Spanish-speaking provider explained plan of care to patient

Surgeon reported patient may not have known which kidney was to be removed

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Investigation Findings

The hospital failed to provide the patient with several standard safeguards and rights:

- Clinical Privileges
- Universal Protocol: Prevention of Wrong Patient, Wrong Procedure, Wrong Site Surgery/Procedure
- Right to receive information in patient's primary language

- Case 1: Wrong Kidney Removed

Investigation Findings

"The facility's failure to implement policies and procedures for Medical Staff led to the removal of the incorrect kidney of Patient. Further, it led to Patient's mistakenly signing a consent for removal of the incorrect kidney. This is a deficiency that has caused a serious injury or death to the patient, and therefore constitutes immediate jeopardy within the meaning of the Health and Safety Code…"

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- Case 1: Wrong Kidney Removed

Patient's Son's Perspective

"Before surgery, they marked the right side. I didn't have a clue what side… they told me they found a tumor on the kidney…"

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- Case 1: Wrong Kidney Removed

Patient's Son's Perspective

"I translated the document (the surgical consent) for him (Patient). I didn't know if the right or left side was correct. I assumed it was correct."

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- Case 1: Wrong Kidney Removed

Clinical Perspective

"Order and consent verified with Patient, x-rays, other Data." was circled "Yes." The section which indicated "surgical site/ side verification, " was reviewed. The section which indicated "Site/Side confirmed with patient, surgeon," was blank. The "Side" was circled, "Right."

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- Case 1: Wrong Kidney Removed

An interview conducted with Surgeon on July 16, 2009 … Surgeon stated. *"The patient may not have fully understood which kidney…"*

Clinical Perspective

There was no documented evidence that patient was provided information about his diseased left kidney, options, use of anesthesia, of possible risks and complications by staff member. There was no documentation found to indicate a Spanish speaking clinician reviewed the consent Patient signed…"

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- Case 1: Wrong Kidney Removed

Risk Management Perspective

Lack of use of a qualified interpreter

Use of family member to interpret consent forms and to verify site/side to be operated on

Inadequate *"time-out"* – the meeting between the surgical team and the patient –

Inadequate documentation

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- Case 2: Death of Infant with Apnea

Hospital Found Negligent in the Death of Infant Patient with Apnea After Repeated Visits to Emergency Room and Failure to Obtain Complete History from Spanish Speaking Parents

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- Case 2: Death of Infant with Apnea

Case Overview

Eleven-day-old female infant patient with a history of apnea

The patient stopped breathing while at home, was revived by family, and brought to the ER

This is a Spanish-speaking family and the firefighter noted the language difficulty

The hospital failed to obtain a complete history and failed to give proper discharge instructions to the parents

When brought to the ER the next day, the patient was placed in Intensive Care and subsequently died

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- Case 2: Death of Infant with Apnea

Clinical Sequence

At the hospital emergency room, a triage nurse evaluated the patient without an interpreter

Other providers took history from the patient's uncle, who used "broken English" and gestures; no interpreter was present

No mention has been made that the patient had stopped breathing or been revived by her uncle

A Spanish-speaking doctor later took history from patient's mother, ran blood tests, found no bleeding disorders

Patient released, family given handwritten instructions mostly in English on conditions necessitating return

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- Case 2: Death of Infant with Apnea

Clinical Sequence (Continued)

The next day, Patient stopped breathing again; father revived her and she was brought back to the hospital

Hospital interpreter was present this time

Next day: Patient Returns to Hospital

The patient was placed in intensive care and died as a result of oxygen deprivation due to undiagnosed lung infection

Patient was removed from life support systems after four days

Autopsy showed patient had lung infection that likely caused apnea

- Case 2: Death of Infant with Apnea

Risk Management Perspective

Failure to use a professional interpreter to take initial history

Multiple consequences as a result of the failure to use a qualified interpreter

In a wrongful death case, a court found the plaintiffs negligent, including:

- Should have made a more careful assessment of the patient
- Failure to diagnose her condition influenced by the lack of adequate communication

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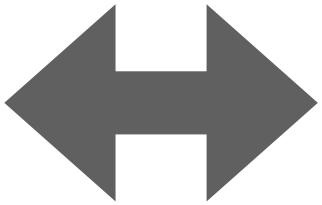
- Case 3: Death of Deaf Patient



Patient's mother alleges hospital violated his rights, ultimately resulting in his death, by failing to provide a sign language interpreter, even though he had requested one.

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- Case 3: Death of Deaf Patient

Case Overview

Male patient scheduled for non-emergency cyst removal

Patient was deaf and had allegedly requested a sign language interpreter

Patient did not wish to receive general anesthesia due to prior event

Patient received general anesthesia against his uncommunicated wishes

Outcome: Patient died due to cardiac arrest prior to outpatient surgery

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- Case 3: Death of Deaf Patient

Plaintiff's Perspective

Hospital failed to use interpreters in communicating with the patient:

The hospital did not communicate directly with patient the day before the procedure, though he could use a computer for telephone conversations

Patient requested an interpreter for the procedure but hospital did not provide one

Consent form was not explained to patient

Patient died after sedation

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- Case 3: Death of Deaf Patient

Plaintiff's Perspective

Patient's mother told the hospital patient wanted local anesthesia, but he was given sedatives

Consent form was for general anesthesia, which patient did not want because of prior history

Hospital acted against patient wishes

Without interpreter, nobody in the operating room could communicate with the patient

Patient was not able to express his wishes

When he became agitated, more sedation was administered

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- Case 3: Death of Deaf Patient

Defense / Hospital Perspective

"Hospital alleges that the plaintiff (patient's mother) and the patient were offered a sign language interpreter prior to the surgery and they refused."

"The hospital has ASL interpreter(s) on its staff and had a policy or guideline requiring two weeks advance notice in order to provide such interpreters for non-emergency procedures."

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- Case 3: Death of Deaf Patient

Risk Management Perspective

Failure to use a professional ASL interpreter based on what is alleged by patient's mother (plaintiff)

- Hospital contends that interpreter was offered but refused.

Provided that interpreter was refused, there may have been a lack of documentation of refusal of services of ASL interpreter

Hospital guideline requiring 2-week notice for scheduling ASL interpreters for non-emergency procedures potentially may have exposed hospital to risk of lawsuit

Reliance on doctor's office to inform hospital (interpreter services) of the need for an ASL interpreter for deaf and hard of hearing patients when scheduling, while doctors' staffs need to be trained about the need to make such requests.