



Patient Safety Culture: Developing the Patient-Centered Team: Psychosocial Perspectives

Presentation to
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Collaborative**

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Overview

- High Performing Teams
- Patient Safety Culture/Just Culture
- Patient, Family, and Relationship-Centered Care
- The HCT and Quality/Safety Errors
 - Personal and Team Factors
 - Assessment
 - Interventions
- Questions and Discussion



Defining the Health Care Team

- A small group of health care professionals who function as a team to provide a specific group of health care services to a defined patient population, typically in a narrow range of care environments within a health care provider organization.



Characteristics of High Performance Teams: Terence Traut

- Participative Leadership
- Responsive
- Aligned on Purpose
- Communicative
- Task Focused
- Problem Solving
- Shared Responsibility
- Innovative
- www.entrepreneurismbible.com/business/kb_high-performance-teams.htm



Pearls

- “...The Secret of Care of the Patient is Caring For the Patient”- Francis Peabody, M.D.
- The Health Care Team is the core unit of health care delivery: The Patient is a core member of the Health Care Team.
- The HCT rarely provides better caring to patients/family members than they provide each other/themselves

The Priorities of Health Care

We diagnose and treat illness/disease

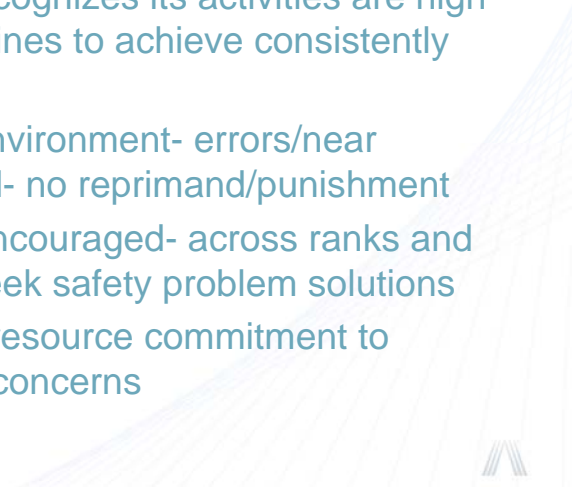
AND

We care for patients and
support their family members

Institute of Medicine: Six Aims For Health Care Improvement

- Safe
 - Timely
 - Effective (NQF Term is beneficial)
 - Equitable
 - Efficient
 - Patient-Centered
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AHRQ: Patient Safety Culture

- Organization recognizes its activities are high risk and determines to achieve consistently safe operations
 - A Blame-free environment- errors/near misses reported- no reprimand/punishment
 - Collaboration encouraged- across ranks and disciplines-to seek safety problem solutions
 - Organizational resource commitment to address safety concerns
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Organizational Culture Keys to High Patient Safety and Quality Performance

- Absolute leadership commitment/support
- Desire to “be the best”- benchmarking
- Alignment of provider incentives
- MDT care delivery model
- Serious process redesign/management resources and continuing efforts- VMPS example
- “learning organization”- continuous improvement
- Advanced healthcare IT systems- integrated process management and IT support
- Advanced “hand offs” management processes



Patient Centered Care: Definitions 2008 ABIM Foundation Forum

- IOM: care that is respectful of and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions
- AHRQ: Care process which lead to greater patient empowerment, improved patient-provider interaction; easier navigation through health care systems; and improved access, quality and outcomes.



Institute for Family-Centered Care: Health Care Delivery Characteristics

- Listens to and honors patient and family perspectives and choices
- Shares complete and unbiased information with patients and families in ways that are affirming and useful
- Encourages families and patients to participate in care and decision-making at the level they choose
- Includes patients and families on an institution-wide basis



IHI: Improving the Patient Experience of Inpatient Care- Draft October 2008

- Primary Drivers
 - Governance/executives demonstrate entire hospital culture focused on patient- and family-centered care (individual, microsystem, organizational levels)
 - Hearts and minds of staff and providers are fully engaged
 - Every care interaction anchored in respectful partnership related to patient and family needs
 - Hospital delivers reliable quality care 24/7
 - Care team instills confidence by providing collaborative, evidence-based care





Social Psychological Dimensions of the Health Care Team

- Size and Membership
 - Open vs. closed group
 - History and culture
 - Leadership/Management processes
 - Objectives, Tasks- Clarity
 - Interpersonal Closeness/Distance
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Social Psychological Dimensions of the Health Care Team

- Level of mutual respect, trust, and support
 - Tasks vs. care orientation
 - Communication patterns
 - Conflict management and problem resolution style
 - Quality of external relationships- up/down organization, other teams
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Social and Psychological Dimensions of the Health Care Team

- Small group dynamics- professional “family”
 - Individual personalities and relationship histories
 - Ethnic, cultural, religious, gender, age group differences
 - Dyadic, larger sub-group relationship patterns
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Psychological Keys to Understanding the HCT/Patient and Family Relationship

- The Parents-child relationship
 - Transference/countertransference
 - Like/love vs. hate
 - Cultural compatibility
 - Communication effectiveness
 - Compatibility of implicit HCT and patient role authority/responsibility models
 - The difficult patient
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Social and Psychological Dimensions of Health Care Team/Patient Relationships

- Patient Safety/Quality- HCT (and patient/family?) responsibility
- Degree of HCT commitment to patient education and empowerment, participation in care
- HCT level of communication, education, support of family members
- HCT openness to being challenged by the patient concerning care quality matters



Patient-Centered Care: Key Desirable Characteristics

- Patient's evaluation of care and care environment generally welcomed and respected
- Chronic Disease- Patients actively/constructively/collaboratively involved in personal life-style management related to health status (e.g., diet, exercise, weight management, substance abstinence, medication adherence, etc.)



Supporting the Patient Safety Culture/ Patient Centered Team

- Organizational leadership high priority commitment to the patient quality/safety culture and patient-centered care.
- Building/maintaining a “high-functioning team”
- Full understanding and voluntary buy in of the entire HCT/individual HCT members to the key principles of the Patient Safety Culture and the Patient-Centered Culture/care delivery model-
- The “core” of who we are and what we do



Supporting the Patient Safety Culture/ Patient Centered Team

- Internal HCT cohesion, pride, support
- Meaningful external organizational and internal team recognition and rewards for HCT commitment, care performance
- Work/professional self renewal- HCT and individual HCT members
- Ongoing education about and support for helping manage “problem” patients and their family members
- Strong external/internal support for coping with the common major work stresses.



Supporting the Patient Safety Culture/ Patient Centered Team: PS Support

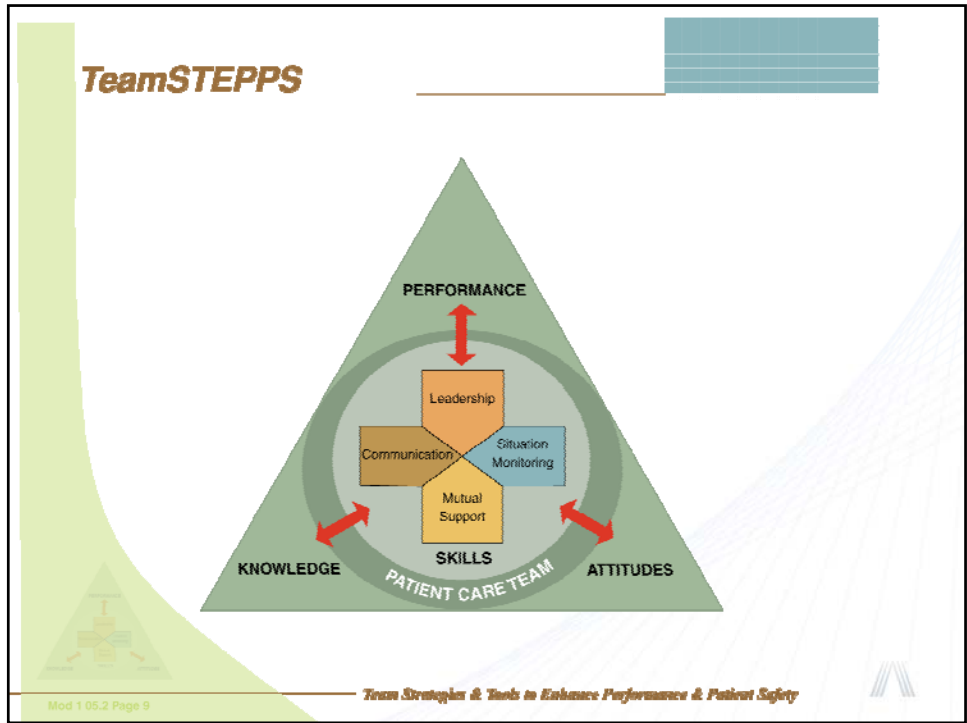
- Routine access to supportive care services:
 - Social Worker
 - Dietitian
 - Chaplaincy
 - Formal Pain/Symptom Management
 - Psychiatry and/or psychology
 - Palliative and end-of-life care services
 - Patient/family education specialist services
- Regular team meetings which include discussion of/help with managing “problem patients and/or their family members”- may include a mental health professional



Supporting the Patient Safety Culture/ Patient Centered Team

- Integrated, longitudinal MDT approach for patients with chronic disease
 - Inpatient, hospital outpatient, community health care and social services providers
 - Every care “fragment” related to long-term, care delivery plan
- Benefits of health care IT





A Perspective from The Just Culture: Errors and Consequences

- **Human Error**
 - Inadvertent Action
 - Console
- **At-Risk Behavior**
 - A choice: risk unrecognized/believed justified
 - Coach
- **Reckless Behavior**
 - Conscious disregard of unreasonable risk
 - Punish

The Just Culture Community, David Marx, J.D., President, Outcome Engineering, LLC, 2007

Individual HCT Staff Psychological Sources of Care Quality/Safety Errors

- General organizational cultural dysfunction and/or low staff morale
- Overwork, high work-related stress
- High levels of general life stress
- Task responsibility beyond competence
- HCT team membership status- marginalized, unempowered, unhappy/bitter, “burned out”- CPSS
- The unliked patient
- Poor patient/provider and/or family/provider communication and relationships



Recognizing The Sources of HCT Quality/Safety Errors

- In place, effective quality/safety error recognition and tracking processes
- General recognition that human factors, process factors, and systems factors all dynamically contribute to care errors.
- HCT/organizational expertise in identifying when human factors are the major source of errors
 - Personal performance issues, and/or
 - HCT function issues
- Expert, sensitive, non-judgmental information gathering about sources of performance problems



Intervening With the Human Factors Sources of Care Errors

- Utilize principles of the Just Culture
- Avoid blaming and oversimplifying
- Effectively addressing HCT-wide cultural and stress factors contributing to errors
- Effectively addressing personal HCT member stress, distress, CPSS, interpersonal conflict
- Educate HCT about assessing, understanding, managing and caring for the problem patient
- Access to supportive care services resources
- Perhaps restructure the HCT/seek to reshape the culture



HCT Stresses: Common Problem Patients

- The patient with “self-induced” illness/disease
- The substance abusing patient
- The “non-compliant” patient
- The threatening/violent patient
- The patient with suicidal behavior
- The patient with significant psychiatric illness
- The patient with organic mental disorder-delirium/dementia



HCT Stresses: Common Problem Patients

- The advanced disease/dying patient
- The highly dysfunctional family
- Cultural awareness, sensitivity, flexibility
- Individual HCT member/HCT “Burn out”
- Religious/spiritual/values “mismatches”
 - E.g., abortion

PERSONAL EXAMPLES

- 10 West Nursing Staff
- RICU First Patient
- AML Mother- Dying in the RICU
- “I am Sharp HealthCare”



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END OF PRESENTATION

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