

# UBS: Ensuring High Reliability Best Practices

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August 11, 2021



**EQIC**

EASTERN US QUALITY  
IMPROVEMENT COLLABORATIVE

# Agenda



TOPIC	PRESENTER
Unit-based safety EQIC program resources	Deborah Tuttle, RN, MPS, CPHQ, project manager, EQIC
<b>Overview of EQIC's unit-based safety model</b>	<b>Mary Reich Cooper, MD, JD</b> , medical director, EQIC, senior vice president, clinical services, Connecticut Hospital Association
<b>Foundations of a high reliability organization</b>	<b>Stephen G. Jones, MD</b> , associate professor of Clinical Medicine, Yale School of Medicine, medical director, safety and high reliability training, Yale-New Haven Health System
Q & A	Deborah Tuttle

# Unit-based safety



EQIC's UBS program supports hospitals in implementing cross-cutting practices at the unit level to reduce a broad range of hospital-acquired conditions and **promote safety across the board** by:

- building capacity for frontline staff quality improvement and patient safety at the point of care;
- integrating communication, teamwork and leadership;
- creating and supporting a culture of patient safety that can prevent harm; and
- cultivating high reliability in practices and protocols.

# Safety across the board goal



- Reduce all-cause harm by 9% or more
- Approaches
  - Monitoring data related to hospital-acquired conditions (HACs)
  - Providing programming related to HACs
    - UBS Wednesday webinars
  - Providing tools and resources to assist hospitals
    - Toolkits
    - Gap analyses
    - Discovery tools
    - eLearning modules
    - Webinar recordings

# Safety across the board

"No-harm across the board"

"Zero defects"

"Unit-based safety"

"All-cause harm"



ADE and Opioids



ASP, *C. diff*,  
MRSA



CAUTI



CLABSI



Culture



Falls



Health Equity



PFE



Pressure Injury



Public Health  
Emergencies



Readmissions



Sepsis



SSI



UBS



VTE



CMS all-cause harm



CMS emerging priorities

# EQIC UBS resources

[Home](#)[Who We Are](#)[Focus Areas](#)[Events](#)[eLearning](#)[Data Portal](#)[Contact Us](#)

Unit-Based Safety:

[Overview](#)[Top Prevention Highlights](#)[Tools and Resources](#)[Webinars](#)[Focus Areas](#)

## Tools and Resources

### Toolkits

- [Unit-Based Patient Safety and Quality Improvement Toolkit](#)

### Resources

- **Department-Level Gap Analyses**
  - [Recommendations on How to Use the Gap Analysis Tools](#)
  - [Critical Care Unit-Level Gap Analysis](#)
  - [Medical/Surgical Unit-Level Gap Analysis](#)
  - [Emergency Department Gap Analysis](#)

# Questions to consider

- What does “unit-based safety” mean to your organization? Your unit? How is your unit building its culture, safety processes and engagement?
- How is your organization using data to assess its harm-reduction efforts?
- How will your unit-based safety champions leverage the resources and examples shared today to further your work in the next 60-90 days?

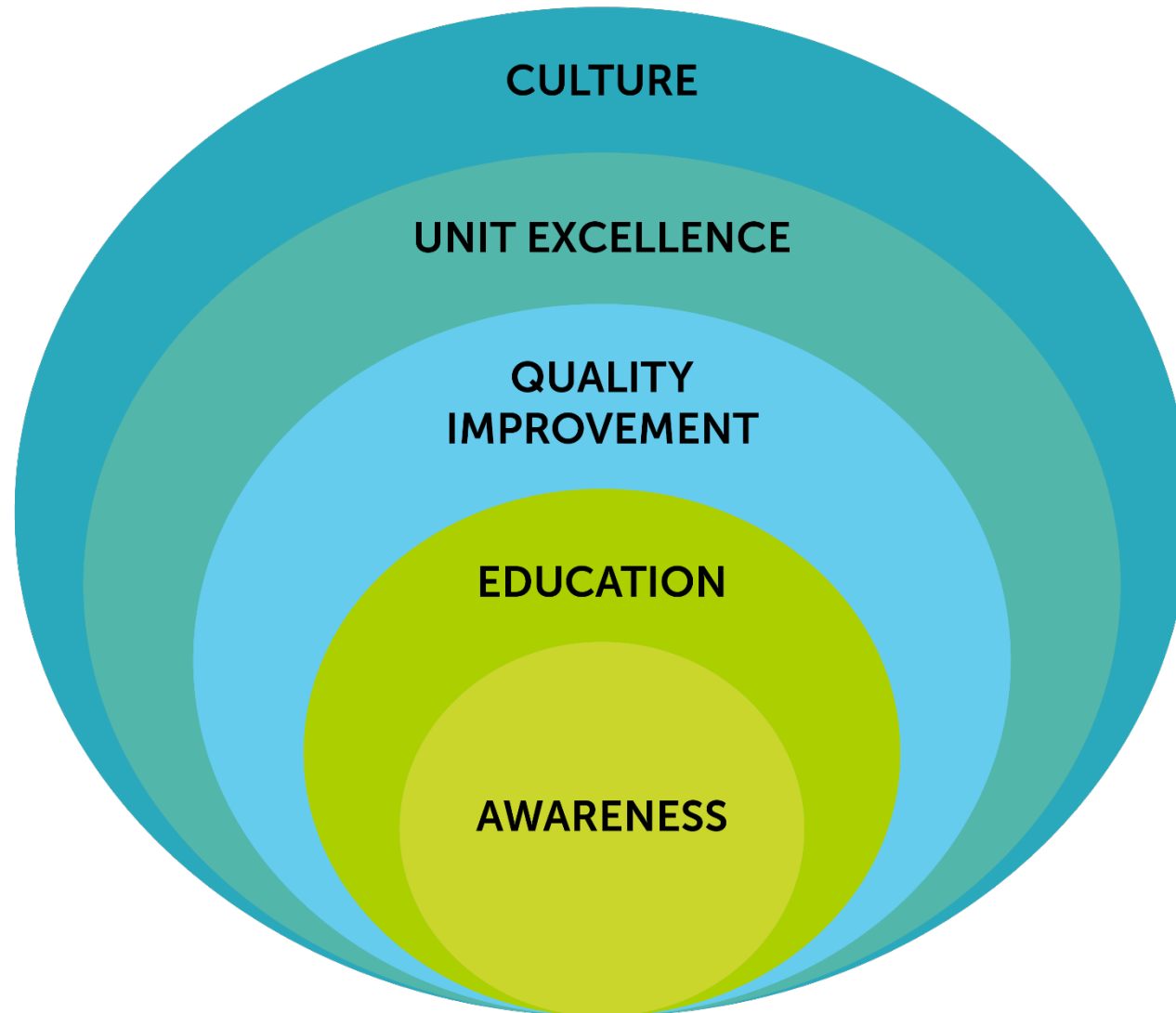
# Overview of unit-based safety principles

- Mary Reich Cooper, MD, JD

Medical director, EQIC

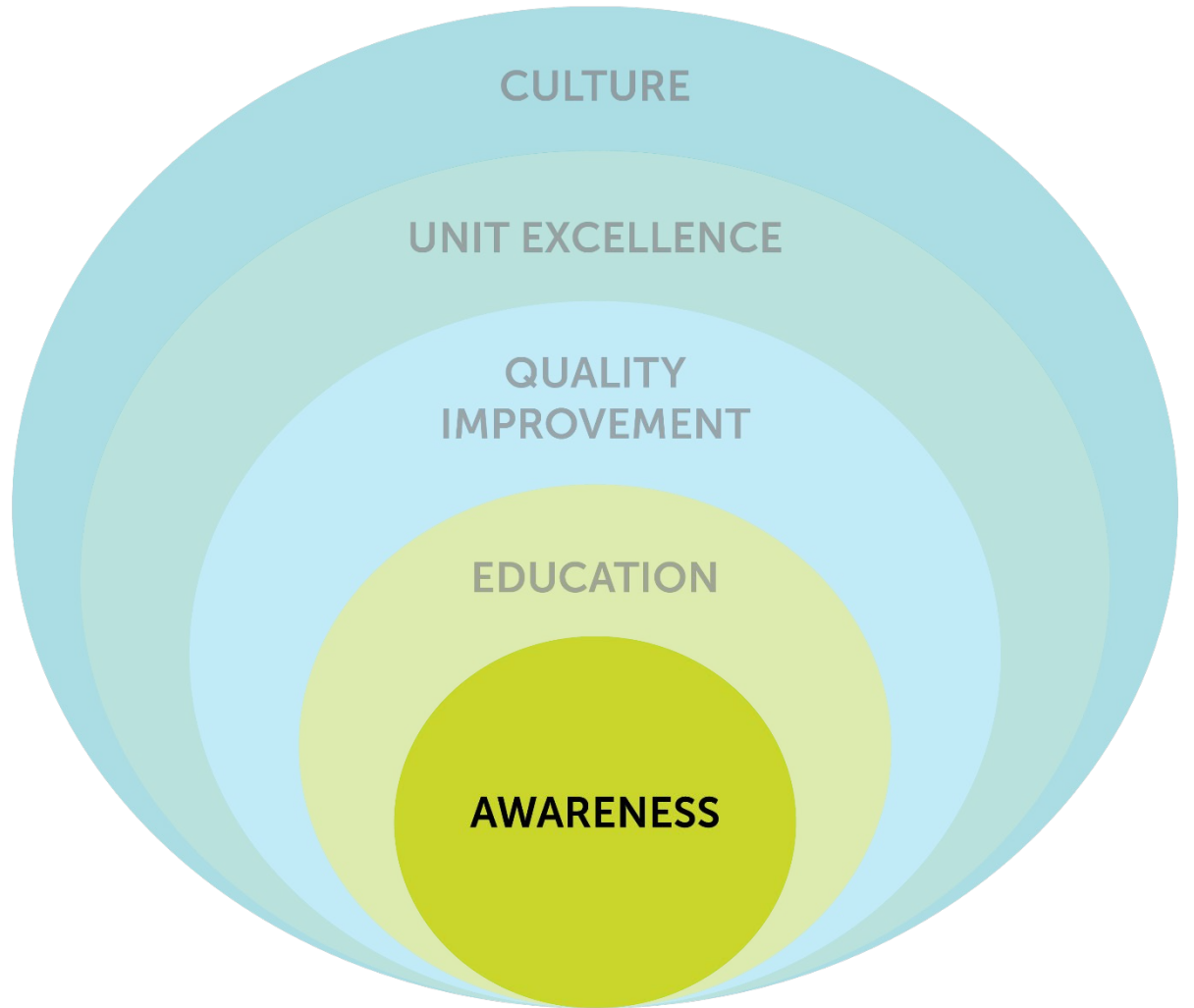
Senior vice president, clinical services, Connecticut  
Hospital Association

# Safety Across the Board: A unit-based approach



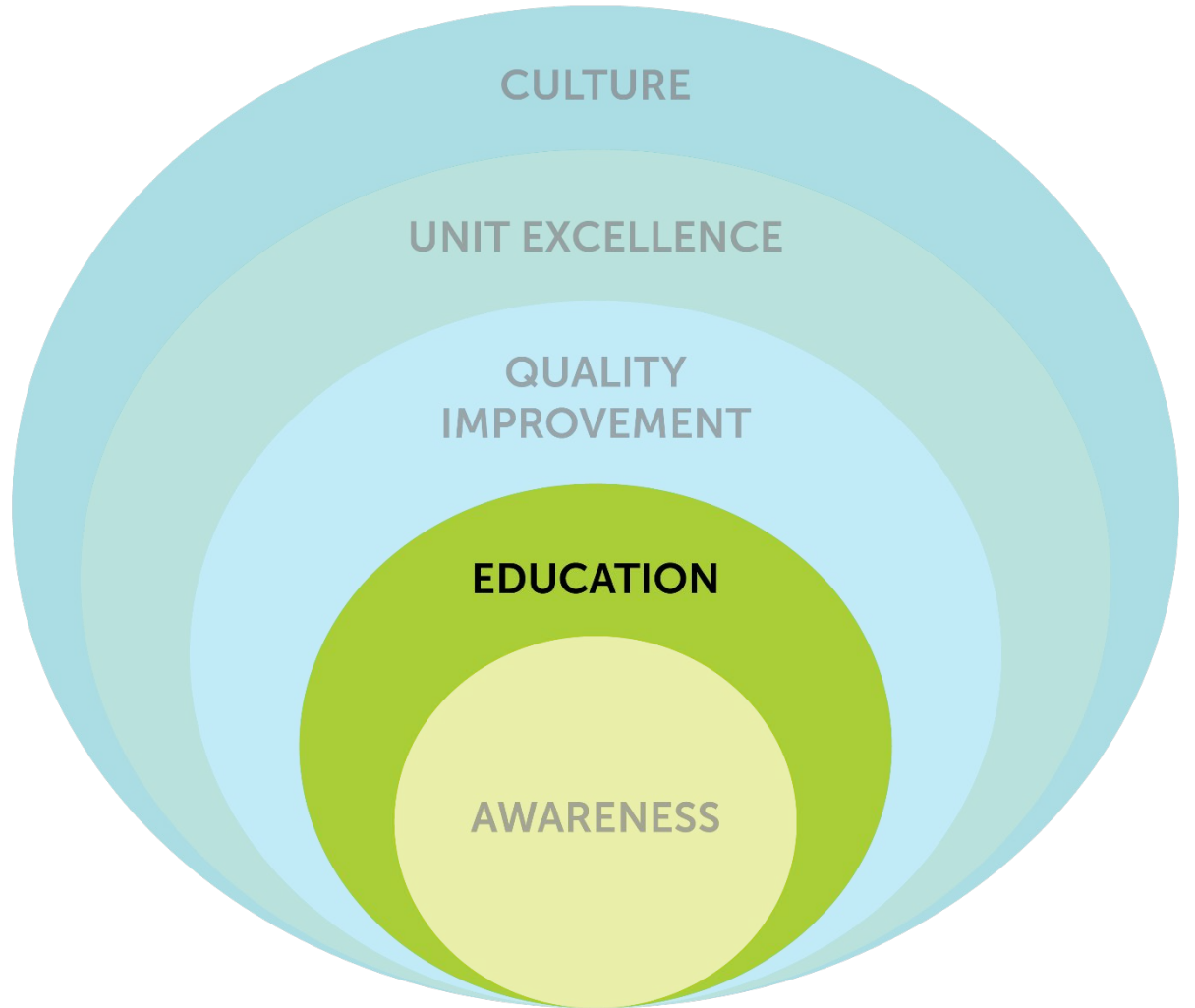
# UBS awareness strategies

- Situational awareness
- Daily safety checklists
- Purposeful rounding
- Staff empowerment
- Incident and near miss reporting
- Bedside report
- White boards
- Multidisciplinary safety huddles



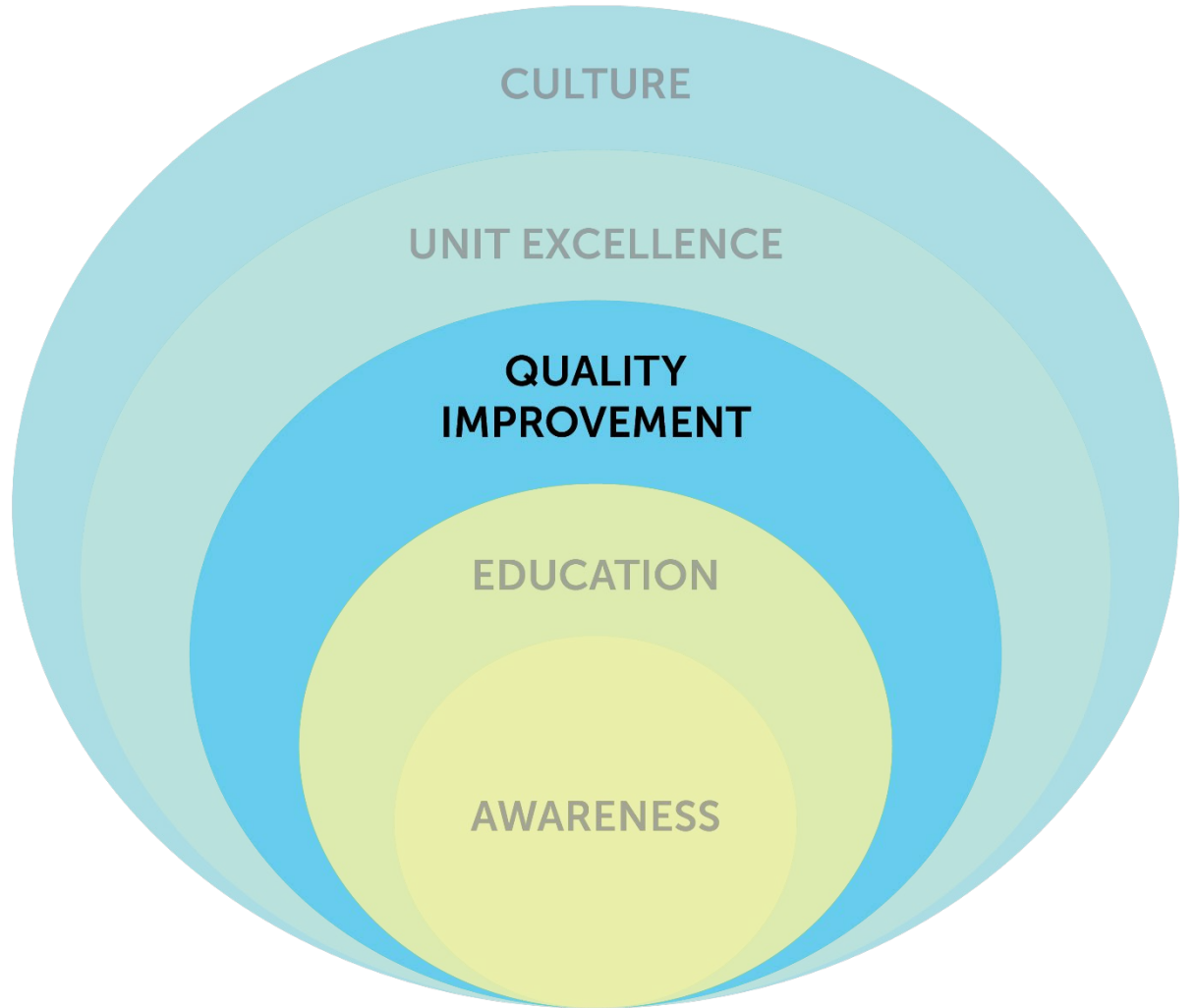
# UBS education strategies

- Onboarding and orientation
- Just-in-time education
- Debriefing
- Annual competencies
- Coaching and mentorship
- Patient engagement through teach-back



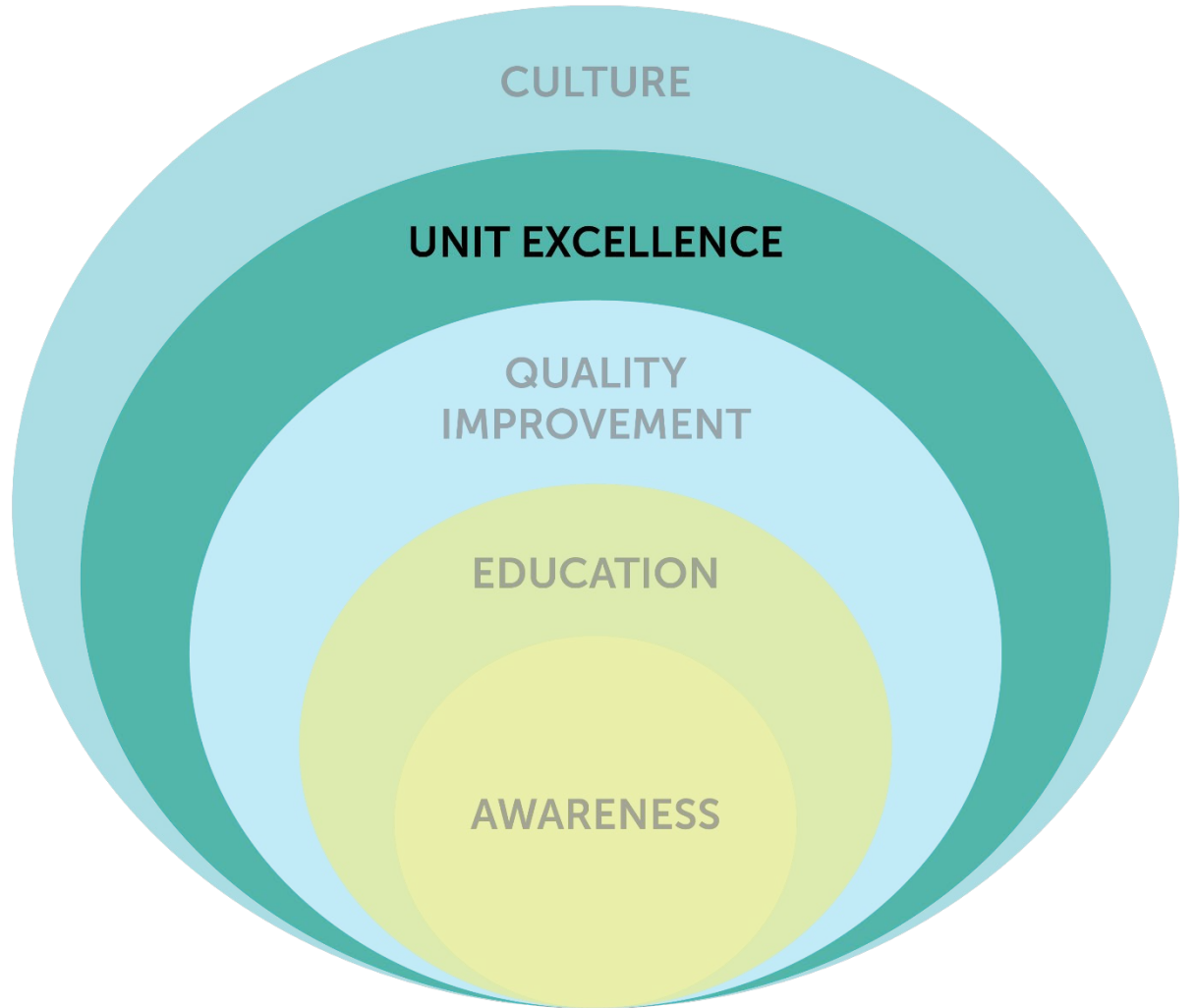
# UBS QI strategies

- PDSA cycles
- Process mapping
- Data collection and analysis
- Learning from near misses and incidents
- Root cause analysis
- FMEA



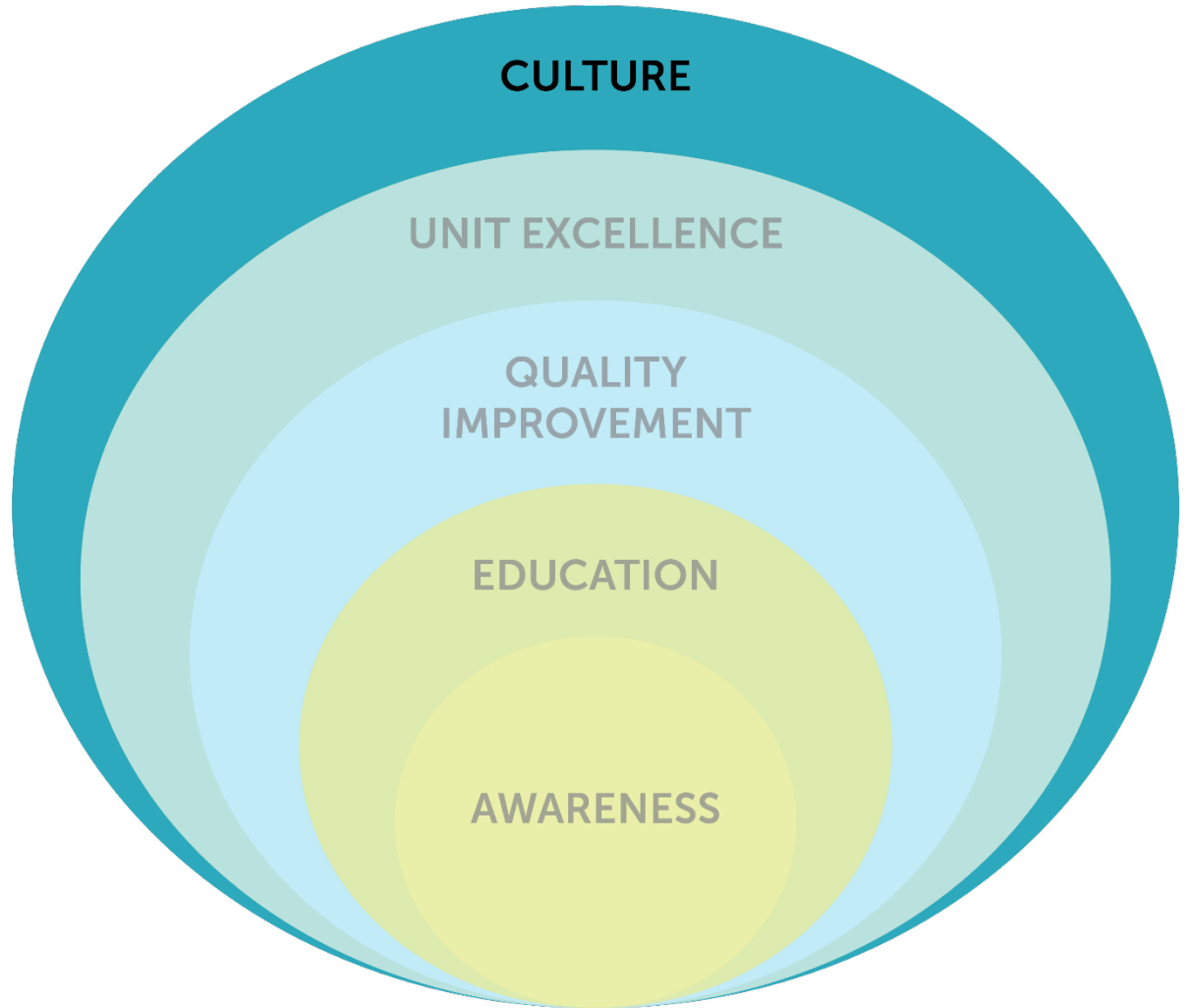
# UBS excellence

- Sustainability
- Safety champions
- Leadership rounding
- High-functioning multidisciplinary teams
- Workforce wellness
- Transparency and accountability
- Patient and care partner engagement
- Just culture
- Patient-centered care



# Unit-based safety culture

- High reliability
- Systems thinking
- Quality management methodologies
- Culture of safety
- Health equity
- Organizational learning
- Change management



# Ensuring high reliability best practices

- Stephen G. Jones, MD

Associate professor of clinical medicine, Yale School of Medicine

Medical director, safety & high reliability training, Yale-New Haven Health System

# Questions?

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# Thank you.

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## Next UBS Wednesday: Falls

September 8, 2021

1-2 pm