Fall 12-5-2021

Bedside Handoff in the Emergency Department

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A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

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December 5, 2021

Executive Summary

In Emergency Departments (ED's) nationwide common issues related to patient safety, communication, and throughput are areas of focus for nursing leadership. Recent changes in value-based purchasing have led to an increased focus for organizations on patient satisfaction and quality outcomes. Medicare links paid for performance bonuses to quality measures at 70% and patient's perception of care at 30% (Geiger, 2012). To improve perception of quality of care in the ED, it is important to look at the means of communication occurring nurse to nurse and nurse to patient.

A standardized bedside handoff was implemented in the ED at The Methodist Hospitals to increase patient satisfaction and decrease negative quality outcomes within the department. Previous report handoff was performed at the nurses' station without any patient or family involvement leading to a decrease in patient satisfaction scores. A pre and post implementation survey was utilized to determine nurse satisfaction prior to process implementation which is an indicator for sustainability. Press Ganey data was collected by the quality department to compare patient satisfaction scores pre and post standardization of handoff and utilized as supporting evidence for bedside handoff. Data collected supported an increase in overall patient satisfaction scores and an increase in nursing overall which was consistent with alternate research.

Recommendations moving forward include continued monitoring of Press Ganey and quality data to ensure a positive impact of bedside handoff on reported metrics. To maintain sustainability in the ED, continuous education and monitoring for compliance will ensure that evidence-based practice changes are maintained. The division of nursing will be rolling out standardized bedside handoff to the inpatient nursing units to ensure consistency within the organization.

Rationale for Implementation

Successful handoff is defined by the Joint Commission as a “transfer and acceptance of responsibility for patient care that is achieved from one caregiver to another” (Campbell et al., 2018). Variations in handoff occur nationwide with the two most common types being report given in front of a computer in the nurse’s station and the evidence-based method of bedside handoff. Models of communication have been trialed throughout the organization, but no standardization of process has been achieved. Despite studies such as those by Kerr et al., (2014) showing a low nurse preference rate for bedside handoff at 11%, the push by patient satisfaction surveys continues to be involving patients in their plan of care.

Locally many attempts have been made to institute standardized bedside handoff without successful hardwiring of the process. Despite expectations being set by management, staff continues to temporarily adopt the process for the trial period and then revert to nursing station report once complete. To successfully change practice, it is important to understand the nursing barriers that have prevented sustainability. Barriers to implementation were consistent with those found in the research of Manges and Groves (2019) such as concern for patient privacy and lack of knowledge by bedside nurses. Nursing stated they felt as though it was a “critique of their nursing care” (Kerr et al., 2014) and often felt the oncoming shift was dismissive of the care they provided. Less seasoned nurses are more likely to experience anxiety and feel under pressure when giving bedside handoff. These barriers noted are consistent with nursing concerns locally, so the question becomes; is it possible to successfully change bedside handoff in the ED and how can nursing leadership make this change to provide a positive impact on patient care?

Emergency departments are high acuity, rapid volume clinical units where patients are frequently discharged in quick succession. Often, patient conditions change rapidly which leads

to multiple changes to the patient's initial plan of care. Due to this type of environment, care handoff in the ED can be rushed which leads to vital patient information not being communicated. To reduce the opportunity for occurrences of errors, a standardized approach to bedside handoff is essential.

Not only does bedside handoff decrease the potential for errors, but it also increases the patient's involvement in their plan of care. Patient satisfaction is measured by sources such as Press Ganey which focuses on nurse courtesy and patients being informed about their plan of care. White et al., (2018) found that bedside handoff is a relationship builder between staff and patients that can assist in meeting the benchmarks set by Press Ganey. In addition, the study performed by Kerr et al., (2014) reports an increased confidence in the nursing care when included in handoff. When patients have a relationship with their caregivers and trust them, they are more likely to be satisfied with their care.

Literature Synthesis

The two main types of bedside handoff models found through the literature review were situation, background, assessment, and recommendation (SBAR) and patient presentation, visualization of patient and orientation to oncoming shift, vital signs, input and output, treatment and diagnosis, admission or discharge, and legal issues (PVITAL) (Kerr et al., 2014; Smith et al.,2018). SBAR is taught throughout most nursing programs and is the most common communication method utilized in nursing. The PVITAL method was introduced in the United Kingdom as a set of guidelines more specific to care rendered in emergency department settings.

Developing the framework for which the bedside handoff will be based upon is essential to the success of implementation. Throughout numerous studies, nurses voiced concerns related

to thoroughness of report being given when care is handed off from the previous shift. A systematic approach to bedside report, combined with increased patient involvement, will assist in decreasing communication gaps which may lead to poor patient outcomes such as falls and medication related errors (Oxelmark et al., 2020; Villalona et al.,2020). Additionally, a study by Dalqhuist et al., (2018) found utilizing a standardized handoff process reduced the length of stay which decreased the potential for developing a pressure related injury.

Patients consistently reported an increased in satisfaction when they were included in the report process and felt as though they were better informed about their plan of care. This partnership between the patients and nurses led to increased confidence in the nursing care and increased the likelihood to meet the benchmarks set forth by Press Ganey (Kerr et al., 2014; White-Trevino & Dearmon, 2018). Despite the initial resistance of nursing, post implementation rounding showed that bedside shift report improved the accountability of the handoff process which ensured that all tasks were carried out and better prepared them to speak with their patients or physicians in relation to care (Campbell & Dontje, 2018; Faloon et al., 2018; Sand-Jecklin & Sherman, 2014).

Stakeholders

Methodist Hospital is a not-for-profit, community based, safety net hospital with two campuses. Methodist was named as a Magnet organization in 2017 and is accredited as a chest pain center, primary stroke certified, and is a level III trauma center. Data such as patient satisfaction scores, medication errors, fall data, throughput metrics, and wounds not documented upon arrival will be required to address the PICOT question. Additionally, costs related to falls, medication errors, and wounds will be collected to offset any financial impact.

The key stakeholders in this change process will be the director of the ED, ED managers, charge nurses, staff nurses, ED educator and the patients. The success of the implementation increases when leadership supports the rollout of evidence-based projects (Laukka et al., 2020). The ED managers and the Director of the ED will collaborate and share the responsibility for monitoring handoff processes for compliance and providing support to staff during the implementation process. Charge nurses within the ED will serve as mentors and super users of the process after the education phase of the process. The largest impact of the process change will be felt by the staff nurses as they will be altering their practice methods in a time when they are already challenged with short staffing, increased daily patient volumes, and increased boarder patients. The patients will be considered stakeholders as they will be directly impacted by the implementation of bedside handoff and ultimately determine if the impact is successful or not.

Implementation

To support a positive environment that is conducive to change, close collaboration with staff will be optimal to determine their barriers to bedside shift report and reasons for which implementation has failed previously. This will be addressed in the pre-implementation survey (Appendix A) conducted with the ED nurses. Foreseen barriers are demand on time, concern for patient privacy, and knowledge deficit by less experienced nurses.

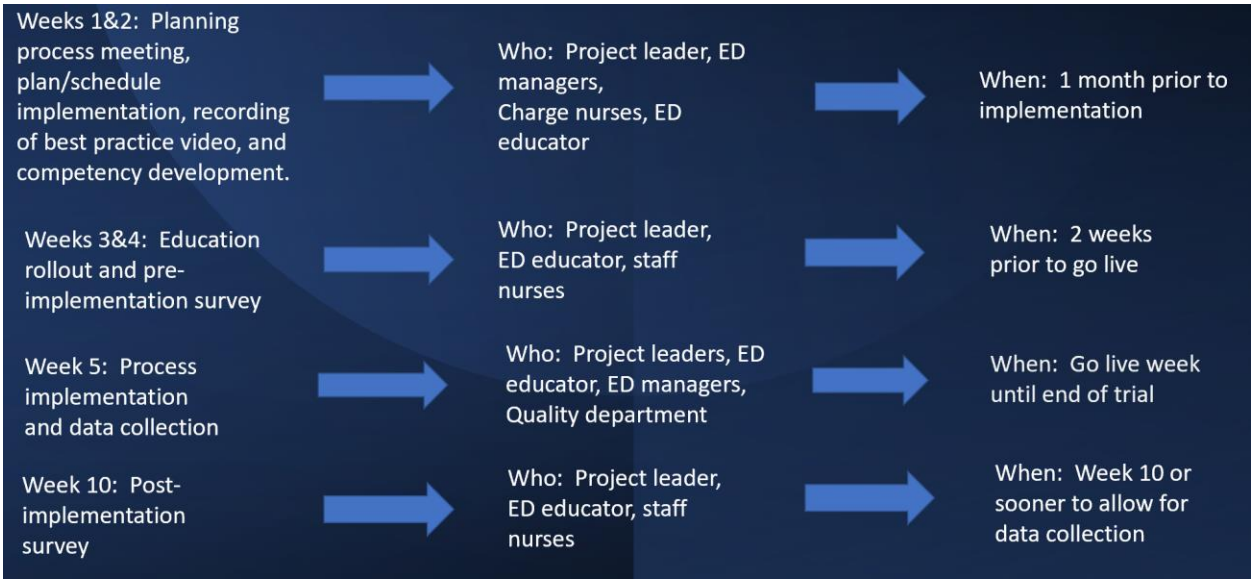
Prior to launching the process change, nurses will attend classes that focus on the why behind the change and the benefits of implementation. Education will be provided in a three-step process which will include a video which demonstrates proper handoff, role playing of handoff, and a competency check off process for return demonstration. Implementation will increase communication occurring with handoff and accountability for task completion. Often the ED staff perception is that day shift leaves all the admissions for midnights and that midnights leaves

orders incomplete for the day shift to initiate. Accountability within each shift for task completion will foster an environment of trust.

The initial two weeks of implementation began one month prior to the bedside handoff implementation and consisted of a planning meeting to determine when the launch date would be, development of competencies, and recording of the best practice video for training (Small et al., 2016). The stakeholders for this phase included the ED director (project leader), ED managers, charge nurses, and ED educator. Next step of implementation occurred during weeks three and four. During this phase, education was provided to the nursing staff, the pre-implementation survey was handed out and data was compiled. Week five of implementation consisted of the roll-out of the evidence-based change project with continued data collection by the quality department. ED managers, educators, and project leader monitored shift change to ensure that nurses complied with the bedside handoff process, addressed any concerns, and provided staffing support. The final step of the implementation process was to analyze data collected by the quality department related to patient satisfaction, quality outcomes, and the post-implementation survey.

Figure 1

Implementation Flowchart



Data Collection Methods

Anonymous pre-implementation surveys were provided to all fifty-two staff nurses that worked between the two emergency departments with one hundred percent completion rate. Of those surveyed, seventeen nurses were travel nurses who had been with Methodist Hospitals for less than three weeks. The gender breakdown of surveyed nurses was fourteen male nurses and thirty-eight females. At completion of week nine, post implementation surveys were given to the same fifty-two staff nurses. Data was compiled and compared between the pre and post implementation surveys to determine effects of implementation.

The quality department submitted monthly data trends for the nursing quality score card (Appendix B) and the ED specific scorecard (Appendix C) to analyze for changes in reportable metrics. Due to the organization reporting structure, we were only able to obtain one month of post implementation quality data as reports are not generated until the fifteenth of the following month. The increase in COVID numbers within the hospital prevented the collection of medication related errors from pharmacy due to staffing issues.

Cost and Benefits

Improvements in quality metrics and patient satisfaction scores will reduce the cost of hospital associated injuries such as falls, wounds, and medication related errors. According to research performed by Johns Hopkins (2003) the average cost related to a fall injury is $34,294, wounds average $20,000 to $150,000 (AHRQ, n.d.), and medication related errors average $4,128 (Pinilla et al., 2006). In addition, Methodist Hospitals will receive an increase in financial reimbursement if patient satisfaction scores continue to trend in a positive direction post implementation. Financial security of an organization will be of benefit to all who are employed as it will provide additional resources for supplies and wages.

Training for bedside handoff had minimal financial cost to the organization. Each nurse required two hours of training which was paid as non-productive time at an average rate of $36 per hour with a final cost of $1,872 for the fifty-two nurses who participated in the process rollout. The cost for the ED educator and managers is a neutral cost as they are salary. Both the educator and manager were able to alternate their schedules to accommodate the need for leadership presence on the night shift. When comparing the cost and benefits, the return on investment for the organization far exceeds the cost related to implementation of bedside handoff.

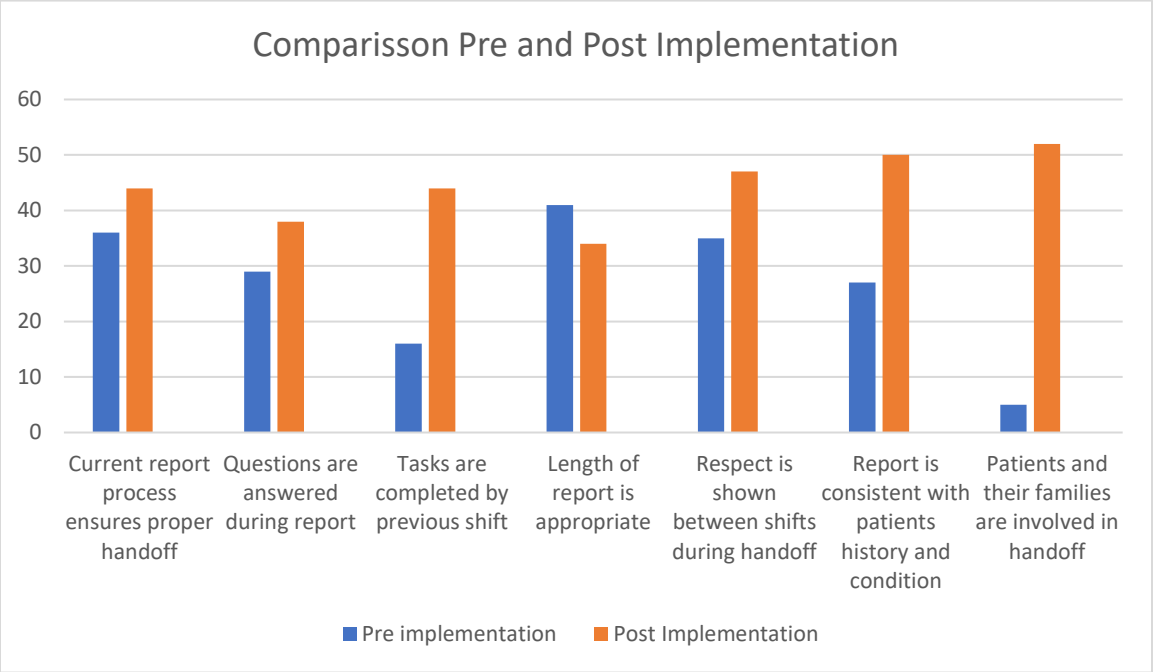
Discussion of Results

Surveys presented to the nursing staff pre and post implementation were analyzed and data was compiled to determine nurse satisfaction with the report process using a five point Likert-scale (Figure 2) (Chladek et al., 2020). Staff satisfaction increased with standardization of bedside handoff which was consistent with previous research studies. Increases were noted in all categories except for length of report is appropriate. When speaking with staff, they felt as

though bedside handoff was a lengthy process that led to increased tasks and questions from patients and their families. Staff in the ED had previous exposure to bedside handoff from work experience at alternate facilities and prior attempts at implementation within Methodist Hospitals.

Figure 2

Pre/Post Implementation comparison



N=52. This graph compares data from pre and post implementation surveys to determine nurse satisfaction.

The ED scorecard was utilized to analyze patient satisfaction with the ED and nursing overall. Overcrowding in the ED was experienced during the implementation time frame, due to COVID, which has been linked to decreased patient satisfaction scores (Tekwani et al., 2013). Overcrowding is shown on the ED scorecard (Appendix B) with the increased hold and bypass hours experienced during this time frame. The Methodist Hospitals was compared to like hospitals in the Press Ganey database to determine the percentile rank score for each month. Due to lack of complete data reporting, only one month of comparison was available. From

September to October, an increase was seen in Press Ganey scores in both the overall ranking and nursing scores. Standard overall scores improved from the 27th percentile overall to the 55th from September to October. Likewise, an increase from the 20th percentile overall to the 41st percentile was seen in overall nursing.

The quality nursing scorecard reports out on falls and wounds within the hospital at the end of each month. At completion of this implementation, only one month worth of data was available for comparison and was a roll up of all the nursing units. This limited reportable data for quality metrics did not show improvement in quality metrics post implementation of bedside handoff. To support the reduction of cost related to poor quality outcomes, data collection will need to be ongoing and breakdown by unit will be necessary to remove any skewing of the data from one unit to the next. Due to COVID related staffing issues, data on medication related errors was unavailable for reporting out.

Recommendations

Bedside handoff was successfully implemented in the emergency department at Methodist Hospitals despite the unexpected barriers to implementation including lack of data support. Due to the time constraints of the semester, we were unable to determine long term sustainability and further monitoring will be necessary. In addition, ongoing data collection will be utilized to monitor effects of implementation on money saving efforts.

The nursing leadership team has decided to implement the process house wide after the first of the year based on improvements seen in patient satisfaction scores. Introduction to bedside handoff will be presented at the general staff meeting so that expectations can be set for nursing prior to education roll out. Widening the scope of implementation will benefit the quality of care provided to all patients and positively impact the financial health of the organization.

References

Agency for Healthcare Research and Quality, (n.d.). *Are we ready for this change?* December 4, 2021, https://www.ahrq.gov/patient safety/settings/hospital/resource/pressureulcer/tool/pu1.html.

Campbell, D. & Dontje, K.(2018). Implementing bedside handoff in the emergency department: A practice improvement project. *Journal of Emergency Nursing, 45*(2), 149-154.

Chladek, M. S., Doughty, C., Patel, B., Alade, K., Rus, M., Shook, J., & LIttle-Weinert, K. (2021). The standardization of handoffs in a large academic pediatric emergency department using I-PASS. *BMJ Open Quality*, 10(3), e001254.

Dang, et. al. (2019). Models to Guide Implementation and Sustainability of Evidence Based Practice. *Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice (4th edition, 389-393).* Philadelphia: Wolters Kluwer.

Dalquhuist, R.T., Reyner, K., Robinson, R.D., Farzad, A., Laureano-Phillips, J., Garrett, J.S., & Wang, H. (2018). Standardized reporting system use during handoffs reduce patient length of stay in the emergency department. *Journal of clinical medicine research,* 10(5), 445.

Faloon, D., Hampe, H., & Cline, T. (2018). Effects of multimethod intervention on bedside report compliance and patient satisfaction. *Critical Care Nursing Quarterly* 41(2) 129-41.

Geiger, N. F. (2012). On tying Medicare reimbursement to patient satisfaction surveys. *AJN: The American Journal of Nursing*, *112*(7), 11.

Johns Hopkins HealthCare Solutions. (2020, November 3). *Falls cost U.S. hospitals $34 billion in direct medical costs*. December 4, 2021, https://www.johnshopkinssolutions.com/article/falls-cost-u-s-hospitals-30-billion-in-direct-medical-costs/.

Kerr, D., Mckay, K., Klim, S., Kelly, A., & Mccann, T. (2014). Attitudes of emergency department patients about handover at the bedside. *Journal of Clinical Nursing, 23*(11-12), 1685-1693.

Klim, S., Kelly, A.M., Kerr, D., Wood, S., & McCann, T., (2013). Developing a framework for nursing handover in the emergency department: An individualized and systematic approach. *Journal of Clinical Nurisng, 22*(15-16), 2233-2243.

Laukka, E., Huhtakangas, M., Heponiemi, T., & Kanste, O. (2020). Identifying the roles of healthcare leaders in hit implementation: A scoping review of the quantitative and qualitative evidence. *International Journal of Environmental Research and Public Health*, *17*(8), 2865.

Manges, K. A., & Groves, P. S. (2019). Exploring the hidden functions of nursing bedside shift report: A performance, ritual, and sensemaking opportunity. *Journal of Nursing Care Quality*, *34*(3), 256-262.

Methodist Hospitals (2021). www.methodisthospitals.org

Oxelmark, L., Whitty, J. A., Ulin, K., Chaboyer, W., Gonçalves, A. S. O., & Ringdal, M. (2020). Patients prefer clinical handover at the bedside; nurses do not: Evidence from a discrete choice experiment. *International Journal of Nursing Studies*, *105*, 1034-44.

Pinilla, J., Murillo, C., Carrasco, G., & Humet, C. (2006). Case-control analysis of the financial cost of medication errors in hospitalized patients. *The European Journal of Health Economics*, *7*(1), 66-71.

Sand-Jecklin, K. & Sherman, J. (2014). A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. *Journal of Clinical Nursing*, *23*(19-20), 2854-2863.

Small, A., Gist, D., Souza, D., Dalton, J., Magny-Normilus, C. & David, D. (2016). Using Kotter's Change Model for implementing bedside handoff. *Journal of Nursing Care Quality, 31*(4), 304-309.

Smith, C.J., Buzalo, R.J., Anderson, N., Michalski, J., Warchol, J., Ducey, S., & Barnecki, C.E., (2018). Evaluation of a novel handoff communication strategy for patients admitted from the emergency department. *Western Journal of Emergency Medicine, 19*(2), 372.

Tekwani, K. L., Kerem, Y., Mistry, C. D., Sayger, B. M., & Kulstad, E. B. (2013). Emergency department crowding is associated with reduced satisfaction scores in patients discharged from the emergency department. *Western Journal of Emergency Medicine*, *14*(1), 11.

Villalona, S., Boxtha, C., Webb, W. A., Cervantes, C., & Wilson, J. W. (2020). "If at least the patient could not be forgotten about": Communication in the Emergency Department as a predictor of patient satisfaction. *Journal of Patient Experience*, 7(6), 1015-1021.

White-Trevino, K. & Dearmon, V. (2018). Transitioning nurse handoff to the bedside: Engaging staff and patients. *Nursing Administration Quarterly, 42*(3), 261-268.

Appendix A

Pre/post Implementation Survey

Question	1-very satisfied	2-slightly satisfied	3-neutral	4-slightly satisfied	5-dissatisfied
1. The current report process ensures information is properly handed off					
2. My questions are answered during report					
3. Tasks are completed by the previous shift					
4. Length of report is appropriate					
5. Respect is shown between shifts during report					
6. Report given is consistent with patient's history and condition					
7. Patient's and their families are included in handoff					

Appendix B

ED Scorecard

Quality Initiatives	YTD 2020	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	Target
Door to Bed	12	11	8	5	5	5	5	5	5	6	5			6	10 mins
Door to Doc	25	14	13	11	11	9	7	7	11	8	6			10	20 mins
Door to Discharge	206	200	197	180	184	180	149	148	159	165	163			173	180 mins
Bed Req to Assign	245	442	242	131	149	153	174	198	228	395	302			241	60 mins
Decision to IP	332	532	322	227	245	261	279	309	352	527	407			346	120 mins
Door to IP Admit	564	771	539	406	436	453	494	518	541	744	617			552	300 mins
LWBS	0.78%	0.36%	0.15%	0.96%	0.15%	0.14%	0.08%	0.07%	0.13%	0.16%	0.03%			**0.22%**	<2%
Patient Satisfaction	YTD 2020	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	Target
Standard Overall	44	57	77	23	83	39	37	23	36	27	55			46	50th Percentile
Standard RN	40	59	88	18	87	46	21	19	37	20	41			44	50th Percentile
Standard MD	44	60	73	9	76	32	56	25	31	10	61			43	50th Percentile
Volume Statistics	YTD 2020	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	Target
ED Visits	**25645**	2108	1886	2316	2420	2668	2474	2644	2756	2552	2322			24146	
ED Admissions	**7237**	604	577	678	667	721	620	621	655	591	578			6312	
Hold Hours	YTD 2020	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	
ED Hold Hours	**27747**	3498	1502	2125	2471	2956	3189	3577	4831	6176	4976			35301	
ICU Hold Hours	**2919**	294	190	199	145	251	246	197	320	777	592			3211	
IMCU Hold Hours	**9872**	1151	489	812	1173	1138	1291	1357	2121	2937	2418			14887	
Bypass Hours		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	
Bypass Hours		154	24	6	31	47	37	99	141.5	456.8	525.9			1522	

(Methodist Hospitals, 2021)

Appendix C

METHODIST HOSPITALS NURSING SCORECARD 2021																	
Nursing Quality Initiatives	YTD 2020	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Target	Benchmark Source
HAPI Stage III & IV	0.225	0.34 (2)	0.15 (1)	0.01 (1)	0.00	0.02(2)	0.128 (9)	0.05 (4)	0.016 (1)	0.028 (2)	0.081 (6)				0	Internal Benchmark
HAPI STAGE II	0.843	1.18 (7)	0.15 (1)	0.11 (7)	0.08 (6)	0.11(8)	0.085 (6)	0.119 (9)	0.08 (5)	0.087 (6)	0.17 (13)				0.5	Internal Benchmark
HAPI Unstageable /DTI		0.43 (27)	0.17 (9)	0.09 (6)	0.18 (15)	0.15(11)	0.21 (15)	0.106 (8)	0.048 (3)	0.146 (10)	0.37 (27)				0.5	Internal Benchmark
Acute Care Total Falls/1000 patient days	2.17	3.86 (21)	3.67 (22)	2.74 (20)	2.22 (13)	2.34(14)	2.16 (14)	2.68 (17)	2.61 (19)	2.31 (14)	2.8 (17)				≤3.58	Internal Benchmark
Acute Care Total Falls w inj/1000 patient days	0.38	0.33 (2)	0.33 (2)	0.82 (6)	0.17 (1)	0.66(4)	0.15(1)	0.316 (2)	0.412 (3)	0.165 (1)	6.8 (4)				<0.50	Internal Benchmark
Rehab Total Falls/1000 patient days	7.40	1.71 (1)	1.6 (1)	2.8 (1)	1.82 (4)	2.44(1)	3.15 (1)	8.15 (3)	4.92 (2)	10.8 (3)	3.36 (1)				≤5.00	Internal Benchmark
Rehab Injury Falls/1000 patient days	0.74	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.62 (1)	0.00				<0.50	Internal Benchmark
CLABSI /1000 CL days Qtr Rates	1.157			0.317			1.164			2.1					0.595	VBP CMS SIR Rate
ICU NL	5.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	1.0	1.0					NHSN
ICU SL	2.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0					NHSN
SL Neuro ICU	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Med. Surg. Units	8.0	0.0	0.0	0.0	0.0	3.0	0.0	1.0	3.0	1.0	0.0					NHSN
Step-Down Units	6.0	1.0	0.0	0.0	1.0	0.0	0.0	2.0	1.0	2.0	1.0					NHSN
Neo-Natal ICU	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0					NHSN
Rehab	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0					NHSN
Oncology Unit 4W3	3.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
CAUTI /1000 cath days Qtr, Rates	0.383			0.806			0.202			0.195					0.676	VBP CMS SIR Rate
ICU NL	0.0	0.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
ICU SL	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
SL Neuro ICU	3.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Med. Surg. Units	2.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0					NHSN
Step-Down Units	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0					NHSN
Oncology Unit (4W3)	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Rehab	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
NNICU	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
C-DIFF Qtr. Data Rates	0.587			1.114			0.458			0.450					0.544	VBP CMS SIR Rate
ICU - Monthly Count	11.0	2.0	2.0	2.0	0.0	0.0	0.0	1.0	0.0	1.0	1.0					NHSN
Med-Surg Monthly Count	15.0	0.0	2.0	1.0	0.0	2.0	1.0	0.0	1.0	0.0	0.0					NHSN
Step-Down Units Monthly Count	6.0	0.0	0.0	4.0	0.0	1.0	1.0	0.0	2.0	1.0	2.0					NHSN
Oncology (4W3) Monthly Count	4.0	2.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0					NHSN
Rehab	3.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	1.0					NHSN
Mother/Baby	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
MRSA	0.779			0.758			0.858			0.000					0.727	VBP CMS SIR Rate
ICU - Monthly Count	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Med-Surg Monthly Count	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Step-Down Units Monthly Count	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Oncology (4W3) Monthly Count	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Rehab	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN
Mother/Baby	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					NHSN

(Methodist Hospitals, 2021)