The Guam Memorial Hospital Authority Proudly Presents:

FALL PREVENTION PROGRAM

Roseann Apuron, RNC-OB & Jasmin Tanglao, RN

February 2018
OBJECTIVES:

AT THE END OF THE PRESENTATION STAFF WILL BE ABLE TO:

1. Recall the key elements of the GMHA Fall Prevention Program
2. Identify components of the Fall Risk Assessment Tools in the Clinical Setting for adult and pediatric populations.
3. Describe current and new nursing interventions for each risk level, for adults and the pediatric populations
4. Describe what to do after a fall incident.
5. Explain how everyone can be a team player in preventing falls here at GMHA.
IMPORTANCE OF THE PROGRAM:

- Patient Safety!
- Comply with Joint Commission Requirements: Reduce the risk of patient harm resulting from falls
- Initiate evidence-based practices to reduce the incidence of falls
- Continue to implement an Interdisciplinary approach to Fall Prevention Hospital-wide
- Continue our Mission:
- To Provide Quality Patient Care in a Safe Environment
WHAT IS A FALL?

- It is an unplanned descent to the floor (or extension of the floor, with or without injury to the patient: All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Include assisted falls when a staff member attempts to minimize the impact of the fall.
Patient falls affect between **700,000 to 1 million** patients each year.

- Falls rank among the most **frequently reported** incidence in hospitals and other healthcare facilities.

- In acute care and rehab hospitals, between **30-51%** of falls result in some **injury**.

- Up to **44%** of those injuries are ones that may **lead to death** (i.e. fractures, subdural hematomas, or excessive bleeding).

- Injured patients require additional treatment and sometimes **prolonged hospital stays**.

- The average cost for a fall with injury was about **$14,000** in 2015. Today, falls with serious injuries cost hospitals an additional **$27,000**.

- Falls with serious injury are consistently among the **Top 10 sentinel events** reported to The Joint Commission’s Sentinel Event database.

- Falls must now be **reported** to the Hospital Improvement Innovation Network (HIIN) led by CMS.
WHAT CONTRIBUTES TO A FALL:

Analysis of falls with injury in the Joint Commission Sentinel Event database reveals the most common contributing factors pertain to:

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, supervision, staffing levels or skill mix
- Deficiencies in the physical environment
- Lack of leadership
CONTRIBUTING FACTORS TO A FALL:

EXTRINSIC FACTORS

INTRINSIC FACTORS
EXTRINSIC FACTORS:

- Poor Lighting
- Medications
- Floor Surfaces
- Excessive Clutter
- Equipment Malfunction
- Footwear
- Inadequate Assistive Devices
- Furniture/Structural Design
INTRINSIC FACTORS:

- Previous Falls
- Reduced vision
- Unsteady Gait
- Musculoskeletal System
- Mental Status
- Age and Gender
- Urinary Incontinence
- Illness
- Inadequate Nutrition
PATIENT ASSESSMENT:

-xl Upon admission, and every shift, or with any ACOC,
-xl Fall Risk Assessment Tool:
  + Adults: The Morse Fall Scale (18 years and older).
  + Pediatrics: The Humpty Dumpty Falls Scale (age 3 months to 17 years).
-xl An Acute Change of Condition is a sudden, clinically important deviation from a resident’s baseline in physical, cognitive, behavioral, or functional domains. “Clinically important” means a deviation that, without intervention, may result in complications or death.
### Morse Fall Scale

#### Evidence-Based

- 6 areas of assessment:
  - Fall History
  - Secondary Diagnosis
  - Ambulatory Aid
  - Saline Lock / IV
  - Gait Transferring
  - Mental Status

#### Risk Factor Table

<table>
<thead>
<tr>
<th>History of Falls</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(25)</td>
<td>(0)</td>
</tr>
<tr>
<td>No</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (Two more medical Diagnoses)</td>
<td>(15)</td>
<td>(0)</td>
</tr>
<tr>
<td>No</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulatory Aid</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture</td>
<td>(30)</td>
<td>(0)</td>
</tr>
<tr>
<td>Cane</td>
<td>(15)</td>
<td>(0)</td>
</tr>
<tr>
<td>Nurse/Bedside/Wheelchair/Nurse</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV/Saline Lock</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(20)</td>
<td>(0)</td>
</tr>
<tr>
<td>No</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gait Transferring</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired</td>
<td>(20)</td>
<td>(0)</td>
</tr>
<tr>
<td>Weak</td>
<td>(10)</td>
<td>(0)</td>
</tr>
<tr>
<td>Normal/Bed Rest/Immobile</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Status</th>
<th>Rating</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forget/Limitations</td>
<td>(15)</td>
<td>(0)</td>
</tr>
<tr>
<td>Oriented to own ability</td>
<td>(0)</td>
<td></td>
</tr>
</tbody>
</table>

#### Total Score

- Level of Risk: Score of 0-24 = Low Risk
- Score of 25-44 = Moderate Risk
- Score of > 45 = High Risk

- Implement appropriate fall prevention strategies based on patient’s risk level

#### Morse Fall Scale

**Fall Risk Assessment Tool—Adults**

Guam Memorial Hospital Authority

Review/Revised Date:______ Approved Date:_______

Form #:_______ Stock #:_______

Patient ID
MORSE FALL SCALE RISK LEVELS:

- **Low Risk:** 0-24
- **Moderate Risk:** 25-44
- **High Risk:** Greater than 45

New Scoring System to determine Fall Risk Level

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>FALL RISK LEVEL (LOW, MODERATE, HIGH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score of 0-24</td>
<td>Low Risk</td>
</tr>
<tr>
<td>Score of 25-44</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td>Score of &gt; 45</td>
<td>High Risk</td>
</tr>
</tbody>
</table>

Implement appropriate fall prevention strategies based on patient's risk level

MORSE FALL SCALE
FALL RISK ASSESSMENT TOOL--ADULTS
Guam Memorial Hospital Authority

Review/Revised Date: _______ Approved Date: _______
Form #: _______ Stock #: _______
## ADULT MEDICATION ASSESSMENT:
### HIGH ALERT MEDS:

<table>
<thead>
<tr>
<th>Benzodiazepines</th>
<th>Antipsychotics</th>
<th>Anticonvulsants</th>
<th>Tricyclic Antidepressants</th>
<th>Sedatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>chlordiazepoxide</td>
<td>haloperidol</td>
<td>phenytoin</td>
<td>amitriptyline</td>
<td>phenobarbital</td>
</tr>
<tr>
<td>diazepam</td>
<td>chlorpromazine</td>
<td>carbamazepine</td>
<td>nortriptyline</td>
<td>zolpidem</td>
</tr>
<tr>
<td>clonazepam</td>
<td>quetiapine</td>
<td>gabapentine (if not renal dosed)</td>
<td>doxepin</td>
<td></td>
</tr>
<tr>
<td>alprazolam</td>
<td>risperidone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lorazepam</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the patient on 1 or more of these HIGH ALERT medications above?  
- Not Applicable  
- Yes  
- No

If yes, Document strategies to Recommend to physician to reduce medication related falls by clicking on boxes  
- Not Applicable  
- lowering the dose  
- tapering off the medication  
- discontinuing the agent  
- reducing overall fall-risk-inducing drug (FRID) load

Is this patient on any of these CAUTION Medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.
**ADULT MEDICATION ASSESSMENT: CAUTION MEDS:**

Is this patient on any of these CAUTION Medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.

<table>
<thead>
<tr>
<th>Opioids</th>
<th>Antihistamines</th>
<th>Muscle Relaxants</th>
<th>SSRI Antidepressants</th>
<th>Cardiovascular Agents</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>fentanyl</td>
<td>diphenhydramine</td>
<td>cyclobenzaprine</td>
<td>paroxetine</td>
<td>clonidine</td>
<td>metoclopramide</td>
</tr>
<tr>
<td>meperidine</td>
<td>hydroxyzine</td>
<td>baclofen</td>
<td>fluoxetine</td>
<td>doxazosin</td>
<td></td>
</tr>
<tr>
<td>morphine</td>
<td>promethazine</td>
<td>methocarbamol</td>
<td>sertraline</td>
<td>digoxin</td>
<td></td>
</tr>
<tr>
<td>hydromorphone</td>
<td>benztrapine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxycodone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hydrocodone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>butorphanol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>codeine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tramadol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the patient on 2 or more of these CAUTION medications above?

- Not Applicable
- Yes
- No

If yes, Document strategies to Recommend to physician to reduce medication related falls by clicking on boxes

- Not Applicable
- lowering the dose
- tapering off the medication
- discontinuing the agent
- reducing overall fall-risk-inducing drug (FRID) load

Note: Thrombolytics should be considered due to the risk of bleeding related to a fall incident... Important info to share in post fall huddle!
**PEDIATRIC TOOL:**

- The Humpty Dumpty Scale
- Evidence-Based
- 7 assessment criteria:
  - Age
  - Gender
  - Diagnosis
  - Environmental Factors
  - Response to Surgery/Sedation/Anesthesia
  - Medication Usage

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**THE HUMPTY DUMPTY SCALE**
(3 months – 18 years)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Less than 3 years old</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3 to less than 7 years old</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>7 to less than 13 years old</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>13 years old and above</td>
<td>1</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Neurological Diagnosis</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Alterations in Oxygenation Respiratory Diagnosis, Dehydration, Anemia, Anaemia, Syncope/Dizziness, etc</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Psych/Behavioral Disorders</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive Impairments</td>
<td>Not aware of limitations</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Forget Limitations</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Oriented to Own Ability</td>
<td>1</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>History of Falls or Infant-Toddler Placed in Bed</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Patient Uses assistive devices or infant Toddler in Crib or Furniture/Lighting (Tripled Room)</td>
<td>3</td>
</tr>
<tr>
<td>Response to Surgery/Sedation/Anesthesia</td>
<td>Patient Placed in Bed</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Outpatient Area</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Within 24 hours</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Within 48 hours</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>More than 48 hours/Now</td>
<td>1</td>
</tr>
<tr>
<td>Medication Usage</td>
<td>Multiple Usage of Sedatives (excluding ICU patients sedated or paralyzed)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Hypnotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antidepressants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barbiturates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laxatives/Diuretics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phenothiazines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Narcotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One of the Medications listed above</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other Medications/None</td>
<td>1</td>
</tr>
</tbody>
</table>

**FALL RISK LEVEL:**
7-11: Low Risk
12 or ABOVE: High Risk

**THE HUMPTY DUMPTY SCALE FALL RISK ASSESSMENT TOOL—PEDIATRICS**

[Form and patient ID fields]
HUMPTY DUMPTY FALL SCALE RISK LEVELS:

- Only 2 Levels
- Low Risk: 7-11
- High Risk: 12 or Above

<table>
<thead>
<tr>
<th>Medication Usage</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Usage of:</td>
<td>Sedatives (excluding ICU patients paralyzed)</td>
<td>Hypnotics</td>
<td>Antidiabetic Drugs</td>
<td>Laxatives</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Narcotics</td>
<td>One of the Medications listed above</td>
<td>Other Medications/None</td>
<td></td>
</tr>
</tbody>
</table>

**FALL RISK LEVEL:**
- 7-11: Low Risk
- 12 or ABOVE: High Risk

New Fall Risk level for Peds

**Total Score:**

**Fall Risk Level:**
PLAN OF CARE (POC):

- Implement POC based on the risk assessment score.
- A Fall Risk Care Plan will be initiated for patients indicated as High Risk.
- Risk level is either low risk, moderate risk, or high risk.
- POC shall be modified based on changes in the patient’s condition. Any significant changes in the patient’s condition must be communicated to all staff members involved in the patient’s care.
- Discontinue POC if no longer considered a fall risk
NURSING INTERVENTIONS (ADULT):
	• Low Risk (score of 0-24): Implement the Standard Fall Precautions:
	★ 1. Environmental orientation/re-orientation.
	★ 2. Call light use demonstrated and within reach.
	★ 3. Personal possessions within safe patient reach.
	★ 4. Handrails (bathrooms, room, and hallway).
	★ 5. Hospital bed in low position (while resting in bed); raise bed (when the patient is transferring out of bed).
	★ 7. Wheelchair wheel locks in "locked" position when stationary.
	★ 8. Patient footwear (nonslip, well-fitting).
	★ 9. Use night lights or supplemental lighting.
	★ 10. Floor surfaces kept clean and dry.
	★ 11. Keep care areas uncluttered.
	★ 12. Follow safe patient handling practices.
	★ 13. Place “Call Don’t Fall” visual cues in patient rooms.
	★ 14. Encourage daily exercise or ambulation to maintain strength and reduce risk of debilitation if possible.
NURSING INTERVENTIONS (ADULT):

- **Moderate Risk** (score of 25-44): Implement the Standard Fall Precautions and the following:
  1. Family members stay with patient or inform staff if leaving.
  2. An Alert clasp identifier for fall (YELLOW clasp) will be placed on the patient’s ID bracelet.
  3. Place a “Caution: Fall Risk” sign in front of the patient’s room. This is to alert hospital staff to monitor the patient closely for falls, and do “spot-checks” if passing by.
  4. Inform Rehabilitative Services via iMED application of patient’s risk level for Balance Screening.
  5. Emphasize on preventing falls, stress patient education, elaborating more on obtaining assistance when getting out of bed.
**NURSING INTERVENTIONS (ADULT):**

- **High Risk** (score of 45 and above): Implement the Standard Fall Precautions, Moderate Risk Interventions, and the following High Risk Preventative Measures:
  2. Include Fall Precaution in patient’s indicator profile (iMed).
  3. Re-educate patient and family on Fall Prevention Interventions-notify nurses if patient will be left alone in room.
  4. If situation permits, relocate patient closer to nurses’ station.
  5. Referrals or consults to address individual assessed problems (rehabilitative, dietary, social services, and pharmacy).
  6. **Environmental checklist** (every shift) to ensure the safety of the patient. Any nursing staff can perform this checklist and inform the appropriate department of the deficiency for corrective action.
NURSING INTERVENTIONS (PEDIATRICS):

**Low Risk** (score of 7-11): Implement the Standard Fall Precautions:

- 1. Assess elimination needs and assist as needed.
- 2. Keep call light within reach and educate on its functionality.
- 3. Place “Call Don’t Fall” visual cues in patient rooms.
- 4. Keep environment clear (unused equipment or hazards).
- 5. Orient/re-orient patient and family to room and unit.
- 6. Keep bed in low position with brakes on.
- 7. Place side rails X2, assess large gaps, use additional safety precautions.
- 8. Use of non-skid footwear for ambulating patients.
- 9. Use of appropriate size clothing to prevent risk of tripping.
- 10. Assess for adequate lighting, leave nightlights on.
- 11. Ensure patient and family education (parents and patients).
NURSING INTERVENTIONS (PEDIATRICS):

High Risk (score of 12 and above): Implement the Standard Fall Precautions and the following:

- 1. Place a “Caution: Fall Risk” sign in front of the patient’s room and initiate POC.
- 3. Family member involvement.
- 4. Educate Patient/Family regarding falls prevention: fall risk factors, appropriate transfer/ambulation needs, appropriate use of side rails.
- 5. Remove all unused equipment out of room.
- 6. Apply protective barriers if possible to close off spaces or gaps in the bed.
- 7. Evaluate medication administration times. Optimize medication administration times around safe functional independence of patient (ie. toileting, ambulating, etc.)
- 8. Location: Move patient closer to nurses’ station, if possible.
- 9. Environmental checklist (every shift) to ensure the safety of the patient. Any nursing staff can perform this checklist and inform the appropriate department of the deficiency for corrective action.
SIGNS IN ALL PATIENT ROOMS/AREAS:
ALERT CLASP:

- For Moderate Risk Patients
- Nursing Staff: Please place alert clasp on patient if applicable!
FOR MODERATE/HIGH FALL ALERT PATIENTS:

- For Moderate Risk (Adult) or High Risk (Pediatric) Patients
- Nursing Staff place this sign on the door to alert ALL STAFF of the patient’s risk for fall.
NO PASS ZONE:

On youtube, please watch this 2:27min video: The No Pass Zone- UC Health
NO PASS ZONE: (AS PER GMHA CLINICAL ALARMS POLICY (A-PS900))

- “IT is the job **OF ALL HOSPITAL EMPLOYEES** to assist patients, their families, our visitors and each other. A call light/bell indicates a need. All employees are expected stop and check when a call light is on.”
- The “NO PASS” rule shall apply
“NO PASS” RULE

➟ Never pass them by
➟ Observe patient privacy
➟ Provide what they are asking for if you can, OR
➟ Access someone who can
➟ Safety first, never put patients at risk
➟ Smile and use AIDET
AIDET

- **Acknowledge**: knock on door, wash hands, address by patient name, state purpose
- **Introduce**: staff name & occupation
- **Duration**: report to patient how long before someone can assist, stay with them
- **Explanation**: what you’re doing and why, in understandable language, ask if any questions
- **Thank you**: thank them for alerting staff and wash hands
WHAT ALL STAFF CAN DO:

- Reposition call light, telephone, bedside table, chairs, trash can, tissues or other personal items within reach
- Assist with making phone calls or answering the telephone
- Change TV channels or turn TV on or off
- Turn lights on or off
- Obtain personal items such as blanket, pillow, towel, washcloth, slippers and toiletries
- Obtain other items such as pens, pencils, books, magazines, etc
- Open and/or close privacy curtains
- Reduce clutter
- If entering an isolation room, follow proper PPE requirements
WHAT NON-CLINICAL STAFF CANNOT DO:

- Only NURSING STAFF can do the following:
  - Manage an IV and/or infusion pump
  - Offer pain relief
  - Remove meal trays or water pitchers
  - Assist patients with eating and drinking
  - Physically assist a patient
  - Turn off any alarms
  - Explain clinical matters/treatments, unless appropriate to your discipline
  - Raise or lower a patient bed
  - Transfer a patient between bed to bathroom, bed to chair, chair to bed, etc
  - If you are a non-clinical staff member responding to an alarm and determine if the patient is in immediate distress, call for help IMMEDIATELY!
NO PASS ZONE... REMINDERS:

- Do NOT Pass the patient’s room, ignoring the call light
- Notify nursing staff of the patient’s call if you do not notice anyone responding
- Knock on the patient’s door, ensure privacy, and as what the patient may need
- In LR or OBW Do Not Enter the patient’s room, please alert staff that the patient is calling
ENVIRONMENTAL CHECKLIST:

- Any nursing staff can complete the checklist
- Inform the appropriate department of any deficiency for corrective action

---

<table>
<thead>
<tr>
<th>Patient’s Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the bed at its lowest position?</td>
</tr>
<tr>
<td>Is the call button within reach of the patient, and functional?</td>
</tr>
<tr>
<td>Is there adequate lighting in the room?</td>
</tr>
<tr>
<td>Is the room free of clutter, electrical cords in pathway and free of hazards on the floor?</td>
</tr>
<tr>
<td>Are the brakes of the bed working properly?</td>
</tr>
<tr>
<td>Is the bedside table or personal items within reach of the patient?</td>
</tr>
<tr>
<td>Floors are not wet or slippery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Furniture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all furniture (beside table, recliners, chairs, etc) and medical equipment (particularly IV poles) functional? Furnitures are secured enough to support the patient?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all assistive devices/mobility aids functional and appropriate for the patient?</td>
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<tr>
<td>Is the patient wearing appropriate footwear? (rubber sole socks)</td>
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<table>
<thead>
<tr>
<th>Siderails</th>
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<tbody>
<tr>
<td>Are the siderails of the crib/bed working properly?</td>
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</table>
OTHER NURSING INTERVENTIONS:

- Shift Huddles to identify high risk patients on the floors
- Communication Boards
- Hourly rounding checking the 5 Ps: Pain, Position, Proximity- Personal Belongings/Call light , Pathway, Potty,
- 4 bed alarms: Tele-PCU, MSW, SW, SNU
ROUNDS CONDUCTED IN MED-SURG WARD:
NEW BED ALARMS:
PATIENT/FAMILY EDUCATION:

+ Upon admission- instruct on how to prevent falls. Outcomes of this education shall be documented appropriately.
+ In the event of a fall- the patient’s family shall be notified.
+ Upon discharge- patients identified as moderate or high risk for falls shall have discharge instructions provided to the patient and/or family regarding preventing falls at home.
PATIENT/FAMILY EDUCATION ON ADMISSION:

“Call Don’t Fall” Educational Material During Admission

Did you know?
- Falls and fall injuries are more common than strokes and can be just as serious.
- Children are at the same risk for falls even in the presence of a family member.

Ask yourself these questions...
- Do you have a history of falling?
- Do you have problems balancing or walking?
- Are you using assistive devices, such as a cane or walker?
- Do you have problems seeing or hearing?
- Are you taking more than two medications for chronic diseases such as hypertension, diabetes, and/or seizure or epilepsy?
- Do you experience occasional dizziness, depression, or disorientation/confusion?
- Do you feel dizzy or light-headed?

If you answered “yes” to any of these questions, you may be at risk for falling.

FALL RISK

A Special Note for FAMILY MEMBERS AND VISITORS

We appreciate your assistance in ensuring your loved one is cared for. During your loved one’s stay in the hospital, please make sure that:
- the strategies of preventing falls are maintained.
- You provide any information or data for your loved one may have that could cause harm to, or fall, such as a history of falling, the use of assistive devices, or an honest discussion about your ability or weakness.
- You inform more that your loved one will be alone, as you exit the unit. Often, these falls occur because our staff is not aware that the patient no longer has any visitors in the room.

CALL DON’T FALL.

FOR YOUR SAFETY

How You can Prevent Falls During your Hospitalization

GUAM MEMORIAL HOSPITAL AUTHORITY
10 Governor George Capusao Dr.
Phone: 671-447-2016

Why do falls happen?
- Falls may occur in the hospital because:
  - The medication you take, such as pain relief and blood pressure pills, may make you feel dizzy and disoriented.
  - Your blood and/or ordered treatments, such as anesthesia and surgery, may leave you weak and sedated.
  - The unfamiliar surroundings of a hospital room may leave you frightened and disoriented.

The staff and management of Guam Memorial Hospital would like to prevent fall occurrences while you are in our care. To do this, we have created this pamphlet to educate our patients and visitors of measures for preventing falls. Your participation in and cooperation with our Fall Prevention Program will help us in addressing our goal and prevent you from unnecessary injury.

What will happen now?
- Our nursing staff will do a general admission assessment which includes assessing for your risk of falling. It is important that you answer your questions truthfully as your ADL’s level determines the appropriate care or prevention.

There are different strategies that will be used to reduce your chance of falling. This brochure will highlight some strategies that you can do on your own.

Some Strategies to Prevent Falls
- Follow your physician’s advice order, such as diet.
- The treatment your physical therapist has in your plan is essential to your recovery.

Maintain your health professional’s sleep and rest well.
- Make sure your physician’s orders are getting into your home.
- Make sure your physician’s orders are getting into your home.
- Make sure your physician’s orders are getting into your home.
- Make sure your physician’s orders are getting into your home.

Always place your bed in the lower position.
- Be aware of the light in the adequate amount for you.
- Familiarize yourself in your surroundings.
- Your glasses and/or hearing aid.
- Use appropriate footwear, non-skid shoes.
- Place your personal items within reach.
- Decline the therapist in your room. Do not bring unnecessary items from home.
- You may have our resident automatic door, such as a doorbell or a button. Remember that it is in good condition, and that it is in your personal responsibility.
- When you have a door with a knob, always lock the door with the closest possible, and if you’re not going to be using the bathroom or going to the bathroom.
- Pay attention to caution signs, such as “Caution, wet floors.”

Use assistive devices appropriately, and ensure that you are in good condition before use.

Never lean or lean yourself on any piece of equipment such as IV poles or your walker table.
EDUCATION FOR FAMILY/FRIENDS:

SLIPS, TRIPS AND FALLS CAN HAPPEN TO ANYONE

- One-third of people age 65 years and older fall each year.
- Every 29 minutes an older adult dies from a fall.
- 1 out of 3 falls causes serious injury such as a head trauma or fracture.

PLEASE CALL!

DON'T FALL!

GUAM MEMORIAL HOSPITAL AUTHORITY
698 Governor Calvo Concepcion Rd.
Toa Baja, Guam 96913
Phone: 671-442-9695
Fax: 671-440-9646

FALL PREVENTION

CAUTION: FALL RISK

INFORMATION FOR FAMILY & FRIENDS

GMHA WOULD LIKE TO ASK YOU TO HELP YOUR RELATIVE OR FRIEND.

WE ENCOURAGE YOU TO STAY AT THE BEDSIDE AND HELP US MAINTAIN SAFETY.

GMHA staff will frequently assess the risk level: The risk level determines the level of assistance provided by staff. This is indicated by the fall risk symbol outside the room.

Together, we can ensure they:
- Do not fall or the risk of falling is reduced.
- Maintain or regain their independence and mobility.
- Don't stay in the hospital any longer than expected.

YOU can HELP keep your relative or friend SAFE

- Understand the level of risk and what assistance they require.
- Always ask staff prior to mobilizing your relative or friend, in case there are specific orders from the doctor or physical therapist.
- Provide reassurance for your relative or friend, especially if they are confused or trying to get out of bed.
- Ensure they use walking aids if prescribed.
- Walk with your relative—DON'T LEAVE THEM ALONE when they are walking or out of bed.
- Ensure their clothing is safe—flat shoes, not walking in socks, dressing gowns or pajamas are not dragging on the ground.

- Assist them to the toilet, or seek our assistance, but DON'T LEAVE THEM ALONE.
- Encourage them to do as much as they can for themselves, within their limitations.
- Leave the bed rails the way you found them. With the bed rails down, NEVER LEAVE THEM UNATTENDED.
- Ensure the nurse call light is within easy reach.
- Alert the nursing staff if you notice new episodes of confusion or unsteadiness.
- Please stop at the nurses' station when you have finished your visit or must leave the bedside. This enables nursing staff to know your relative or friend is now alone.
- Provide these items for safe walking—non-slip footwear (flat and well fitting), glasses, hearing aid, walking aid, if need be at home.
WHAT TO DO AFTER A FALL INCIDENT:

+ Immediate assessment by a registered nurse, rendering necessary first aid and treatment.

+ Assess the level of injury:
  - i. No injuries
  - ii. Minor Injury: Bruise, abrasion, minor laceration
  - iii. Major Injury: Fracture(s), head trauma, loss of function
  - iv. Death related to fall

+ The patient’s vital signs and level of consciousness shall be monitored and documented for the next 24 hours as follows:
  - First Hour: Every 15 minutes
  - Next Four Hours: Every 2 hours
  - Remaining Hours (in 24 period): Every 4 hours

+ The attending physician shall be notified immediately. Inform the physician of the extent of the injury (if any), the neurological status of the patient, and the current vital signs.
WHAT DO NURSES DOCUMENT?

- In the event a fall has occurred, the following shall be documented in the patient’s notes (iMED):
  - Remember: PALLOR
    + Physician notification of fall incident
    + Medical and nursing Actions that were taken.
    + Level of injury with descriptions
    + Location of the fall
    + Observations: Patient appearance at the time they were discovered
    + Patient’s Response to the fall, such as altered mental status, or presence of pain.
WHAT TO DO AFTER A FALL INCIDENT:

+ Complete the Patient Safety Form and the Post Fall Information Report (as soon as possible and before the end of the shift).
  - The completion of the Post-Fall Information Report shall involve the charge nurse, the patient’s primary nurse and nurse assistant, and any other staff member who witnessed the fall.

+ A “Post-Fall Huddle” shall occur immediately.

+ The Fall Prevention Team including the Interdisciplinary members will be notified of the fall through the Post-Fall Information Report attached in the Nursing Supervisor’s 24 hour report.

+ The Fall Prevention Team will meet to discuss reported falls and determine corrective actions to improve patient outcomes.

+ **Any death or major loss of function** related to a fall shall be **reported immediately** to the Patient Safety Officer/Risk Manager, Associate Administrator of Nursing Services and the Hospital Administrator.
POST FALL HUDDLE:

- **Who:** Primary nurse, Charge nurse, Nurse assistant, Hospital Nurse Supervisor on-duty and any other staff who witnessed the fall
- **What:** Discuss events surrounding the fall
- **Where:** At or Near Fall Location
- **When:** Immediately after the fall
- **How:** Use Post Fall Information Report to guide discussion
- **Why:** To try determine cause for fall and immediate corrective action
No Changes to this Form!
PERFORMANCE IMPROVEMENT:

- All fall occurrences are monitored by the Patient Safety Officer/Risk Manager and reported to Nursing Management, Patient Safety Committee, and the Performance Improvement Committee.
- The Interdisciplinary Team shall identify opportunities to reduce the risk associated with falls through preventative strategies, alternatives and process improvements.
## Performance Improvement Data:

### Monthly Fall Occurrences by Nursing Units

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Total Falls: 101

Total Falls: 63

Total Falls: 86
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PERFORMANCE IMPROVEMENT DATA:

YEARLY FALL OCCURRENCES

2013  2014  2015  2016  2017
AN INTERDISCIPLINARY APPROACH:

- Nursing Services Department
- Rehabilitative Services
- Dietetic Services
- Pharmacy Department
- Social Services
- Medical Services
INTERDISCIPLINARY ROLES:

Rehabilitative Services
- Will perform a functional screening on the identified patients.

Dietetic Services
- All inpatients are screened for nutritional risk by a member of the health care team within 24-48 hours of admission.

Pharmacy Department
- Review, Verification, Interpretation of Medication Orders. The pharmacist shall interpret all medication orders and resolve all questions or problems prior to dispensing medications.

Social Services
- Will conduct a Social evaluation of family or home situation for safe and secure placement at discharge.

Medical Services
- ** New component to team, important component for patient care.
YOUR INTERDISCIPLINARY FALL PREVENTION TEAM:

INTERDISCIPLINARY TEAM
- Nursing: Roseann Apuron & Jasmin Tanglao (Fall Committee Co-Chairpersons)
- Rehab Dept: Nora Garces
- Social Services: Ciena Materne
- Dietetic Services: Kristy Joy Mary
- Pharmacy: Jason Boyd
- Medical Staff: Dr. Kozue

NURSING UNIT REPRESENTATIVES:
- ER: Essel Kerr
- SSD/UC/Radiology: Belle Rada
- ICU: Alvin Resurreccion
- Hemo: Veronica Censon
- L&D: Carlo Losinio
- MSW: Sherena Rosadino
- NICU: Avelina Opena
- OBW: Joanna Morales
- OR: Sr. Seville Cabuhat
- Peds: Rosa Segovia
- SNU: Elizabeth Camacho
- SW: Maria Blanquita Torres
- Tele-PCU: Raven Agpaoa
5 KEY TAKE AWAY POINTS...

- Patient Safety is EVERYONE’S responsibility
- NO PASS ZONE- if you hear a call- check the pt
- Licensed staff are responsible for completing assessments, including adult medication assessments, and initiating care plans.
- All Nursing Staff can help with interventions
- Post Fall Huddles must occur!
THANK YOU....... FROM YOUR FALL TEAM!!

Questions and Suggestions??
THANK YOU!

- To ensure comprehension of this online course please complete the online examination on our GMHA Portal:
  - GMHA Fall Prevention Program Exam
  - Your URL is: testmoz.com/1595894
  - Please follow instructions on the next page in order to login
  - A score of 80% or greater is necessary to pass the exam. If you do not pass the exam, please re-take the exam until a passing score is achieved. Exams are timed and any questionable submissions will be reported to your Supervisors for disciplinary action.
USER NAME & PASSWORD:

- In ALL CAPS, Please Indicate your Unit as one of the following:
  - For Nursing: ADMN, ADMNNL (for non-licensed), SSD, RAD, ER, ICU, HEMO, LR, MSW, NICU, OBW, OR, PEDS, SNU, SW, TELE
  - For all other Depts: enter the first four letters of your department in ALL CAPS:
    - For example: PHAR for Pharmacy staff
    - followed by your first initial, full last name and employee ID number (found on your ID badge) with NO SPACES in between.

For Example:
- ADMNRAPURON123456

- Student Quiz Passcode: GMHA