

# Fall Call Friday: Enhancing Fall Prevention Through Weekly Interdisciplinary Debriefs

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## INTRODUCTION

### Background

- Patient falls remain a persistent challenge to patient safety in the acute care setting, often resulting in patient injuries, prolonged length of stay, and increased healthcare costs
- In April 2024, the fall rate for hospitalized patients at Mount Holly Hospital was 2.15 per 1,000 patient days, which was above the system goal rate of 1.8 per 1,000 patient days, and the fall with injury rate was 0.55 per 1,000 patient days, which was above the system goal rate of 0.33 per 1,000 patient days
- Contributing factors included poor risk identification, inconsistent use of fall prevention protocols, and limited staff engagement, identifying an opportunity for a focused falls meeting to review opportunities for improvement

### Purpose

- To reinforce fall prevention practices and promote staff engagement and awareness through a weekly interdisciplinary meeting to debrief falls that occurred that week

### Framework:

- Quality Improvement project utilizing Plan-Do-Study-Act (PDSA) Framework

### Objectives of Poster:

After reviewing this poster, learners will be able to:

- Describe the purpose and process of post-fall debriefing
- Promote a culture of safety by engaging in regular peer-to-peer education and collaborative fall risk strategies

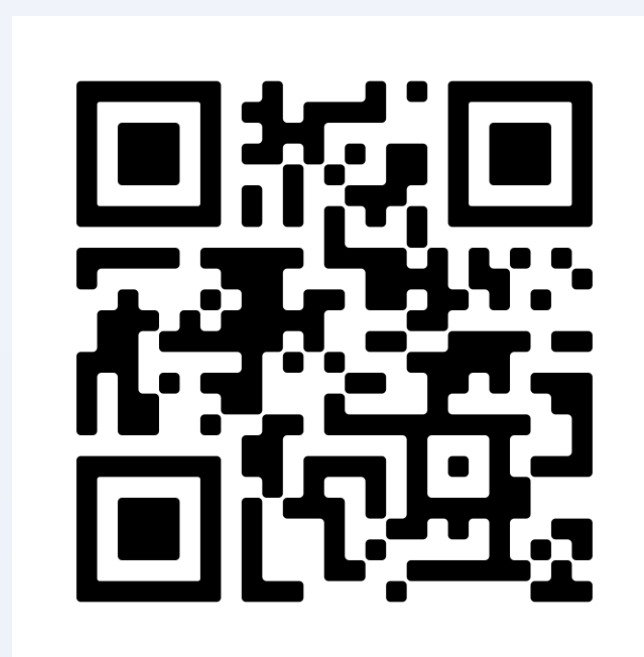
## METHODS

### Setting and Participants:

- Virtual meeting every Friday at 1300
- Participants included Chair and Co-Chair of the Mount Holly Falls Committee, Risk Safety Manager, Physical Therapy Manager, Clinical Nurses, Nurse Directors, Assistant Nurse Managers, and Advanced Nurse Clinicians

### Intervention/Process:

- Unit leadership is asked to join if a fall occurred on their unit that week
- Fall Call Friday debrief form distributed to Nursing Leadership to facilitate discussion (please scan QR code below to view the form)
- Takeaways from the call are emailed to all Nursing Unit Leadership teams to be disseminated to staff
- Pre-Intervention = January 2024 to April 2024
- Implemented May 14th, 2024
- Post-Intervention = May 2024 to May 2025



### Data Collection and Analysis:

- Data was analyzed using Mount Holly Hospital fall rates and fall with injury rates provided by Director of Nursing Outcomes

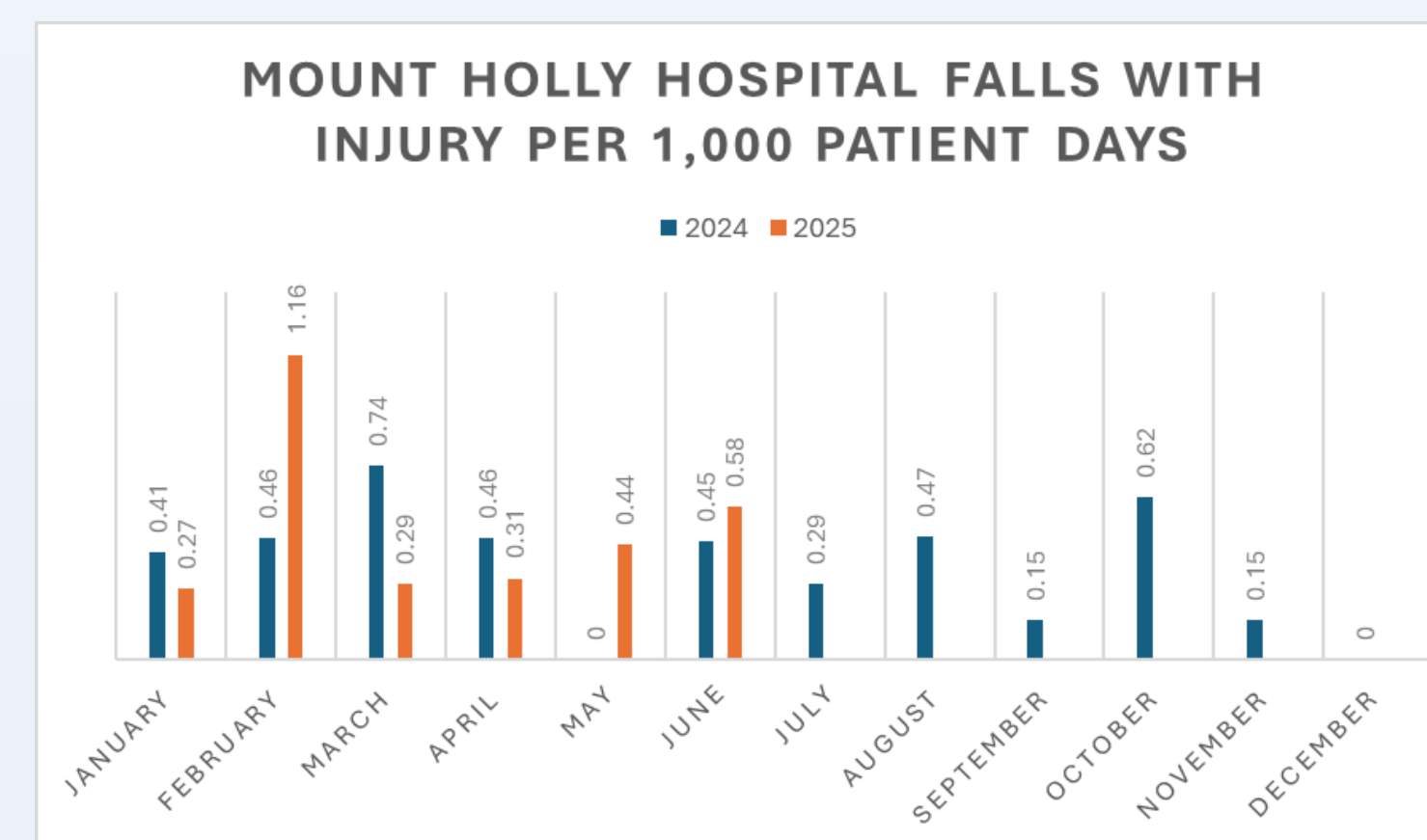
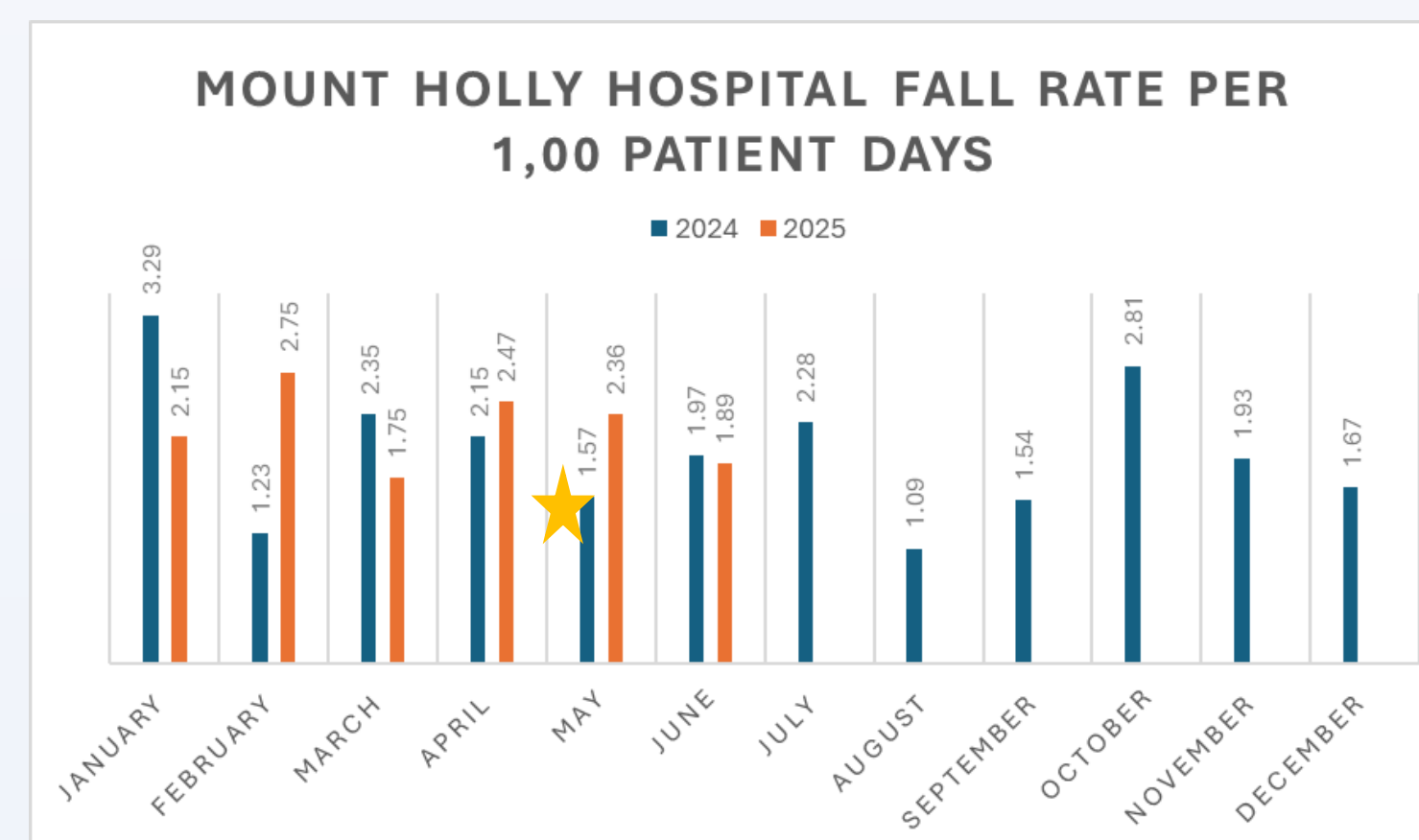
## RESULTS

### Key Findings:

- 10.22% reduction from pre-intervention fall rate (2.25) to post-intervention fall rate (2.02)
- 36.36% reduction from pre-intervention fall with injury rate (0.55) to post-intervention fall with injury rate (0.35)

### Actionable Data:

- Continue to utilize debrief process to further investigate fall events



## CONCLUSIONS

### Interpretation:

- Overall, the goals of identifying and addressing contributing factors to fall events and reducing fall events and falls with injury were achieved

### Relevance:

- Increases awareness about falls occurring in the hospital
- Identifies contributing factors and process gaps
- Provides support and strategy to prevent future falls

### Limitations and Future Directions:

- Limitations: may not always have actionable items each week and limited clinical nurse involvement
- Future Direction: include more clinical nursing staff on the call and share results with system-based fall council with goal to be replicated at another Virtua Hospital

## REFERENCES

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- Paxino, J., Szabo, R. A., Marshall, S., Story, D., & Molloy, E. (2024). What and when to debrief: a scoping review examining interprofessional clinical debriefing. *BMJ Quality & Safety*, (33)5, 314-327. <https://doi.org/10.1136/bmjqs-2023-016730>

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