VCU College of Health Professions

Gerontology

CardinalCare
Virginia's Medicaid Program

Falls with Major Injury (Part I):

Causes, Risk Factors, and Care Paths

Tuesday, July 28, 2026 | 12:30 - 2:30 pm ET

Presenters: Laura Finch, Annie Rhodes, & Maureen Lillis
Series Host and Moderator: Gigi Amateau

While you waited, we asked you to think…

Welcome to All - and a Warm Welcome to Our Virginia Nursing Home Staff!

Thank you for everything you do for your community–

In the Q&A tab, please introduce yourself and we would love to know where you are in Virginia today.

Support

This series was created by the Virginia Commonwealth University's Department of Gerontology for the **Virginia Department of Medical Assistance Services (DMAS) Nursing Facility Quality Improvement Program (NFQIP) using Civil Money Penalty (CMP) Reinvestment Funds.**

VCU College of Health Professions
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Housekeeping

Questions During the Lecture
Use the **Q&A tab anytime;** use the **“raise hand”** feature to have your microphone unmuted during the Q&A segments

End-of-Session Survey
Complete and request your certificate

Certificates of Attendance
Only if attending at least 75% of the session and participating in at least 75% polls/questions

Group Attendance
The **registered attendee** should complete the exit survey and list all group participants

Materials
All posted at our webpage: https://tictoolkit.vcu.edu/learning-center/pathways/

Joint Accreditation Statement

JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, this activity has been planned and implemented by Amedco LLC and Virginia Commonwealth University, Department of Gerontology. Amedco LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Professions in scope for this activity are listed below.

Amedco Joint Accreditation Provider Number: 4008163

Nurses
Amedco LLC designates this activity for a maximum of 2.00 ANCC contact hours.

The Learner's Notification was sent yesterday and is now attached for your review. This document also contains information on how to obtain your CEs.

Hosts and Instructors

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Maureen Lillis, RN, MBA

Session Objectives

01

Clinical Hazards & Risks

Identify and evaluate multi-system clinical hazards and environmental risk factors that contribute to Falls with Major Injury (FMI) during patient care transitions.

02

Diagnostic Stewardship

Apply diagnostic stewardship principles to systematically investigate root causes of systemic instability and execute precise post-fall assessment protocols.

03

Tailored Care Planning

Formulate and execute a tailored fall-prevention care plan utilizing the **AHRQ Fall Prevention Toolkit** framework.

Clearly define and coordinate responsibilities across the interdisciplinary care team.

04

Psychological Safety

Promote psychological safety by encouraging open communication, shared learning, and timely reporting of fall risks, near misses, and opportunities for system improvement.

Agenda

01 Welcome

02 Falls with Major Injury: Why It Matters

03 Recognizing and Managing Fall Risk

04 Clinical Decision-Making and Documentation

05 Case Study and Group Application

06 Quality Improvement and Care Pathways

07 Team Discussion, Sharing

Chapter 02

Falls in Nursing Homes: National Burden, Morbidity, & Mortality

Annual Nursing Home National Burden

1.3M
falls among US residents

~50%
residents who experience at least one fall/year

30-40%
residents who fall *and* experience repeat events

65,000
hip fractures which occur annually among residents

~10% of all falls result in serious injury.

Health Impact

Leading Cause of Injuries

Falls are the leading cause of fatal and non-fatal injuries among adults aged 65 and older.

Common Consequences Include:

- Fractures and Traumatic Brain Injuries (TBI)
- Functional decline & loss of independence
- Hospitalization, fear of falling, and increased mortality

Virginia Focus

Over 900 deaths

Among adults over 65 from fall-related injuries in 2024

Sources: Agency for Healthcare Research and Quality. *Falls Management Program: A Quality Improvement Initiative for Nursing Facilities.* https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/index.html

Centers for Disease Control and Prevention. *Older Adult Falls Data.* https://www.cdc.gov/falls/data-research/index.html

U.S. Department of Health and Human Services, Office of Inspector General. (2025). *Serious Falls Resulting in Hospitalization Among Medicare-Enrolled Nursing Home Residents (July 2022–June 2023).*

US Economic Impact

During a one year study period (July 2022–June 2023)

42,864

Medicare-enrolled nursing home residents experienced serious falls resulting in hospitalization.

1,911

Resident deaths occurred following hospitalization for a serious fall.

$800M+

In **Medicare expenditures** for hospital care associated with these serious falls.

Source: U.S. Department of Health and Human Services, Office of Inspector General. (2025). *Serious Falls Resulting in Hospitalization Among Medicare-Enrolled Nursing Home Residents (July 2022–June 2023).*

Chapter 03

Why Do Falls Occur?

Common Risk Factors

- History of falls
- Gait and balance challenges
- Cognitive impairment or dementia
- Polypharmacy
- Vision impairment
- Muscle weakness
- Urinary urgency or incontinence
- Environmental hazards

Why do Risk Factors Matter?

- Identifies residents at high risk
- Promotes evidence-based prevention strategies
- Standardized post fall decision making
- Improves communication across care team
- Supports safer resident care
- Improved quality outcomes

Chapter 04

F689 42 CFR § 483.25(d) Accidents

The regulation requires facilities to maintain a **safe environment free of hazards** and to provide necessary **supervision** and **devices** to prevent accidents. Below are the three levels of fall severity:

01 No Injury

No injury, no pain, and no observable behavior change in the resident following the fall.

02 Minor Injury

Results in minor trauma requiring basic intervention.

Examples include:

- Skin tears & abrasions
- Lacerations & bruises
- Superficial hematomas
- Sprains & localized pain

03 Major Injury

- **Bone Fractures:** Any non-illness related break in the bone
- **Joint Dislocations:** Partial or complete dislocations
- **Neurological:** Head injuries with altered consciousness
- **Internal Trauma:** Severe injuries requiring hospitalization

Poll and Resources

Interactive Poll

In the past year, have you read your facility's falls risk assessment policy?

Resources

The Falls Management Program
A Quality Improvement Initiative for Nursing Facilities

Self-Assessment Tool
The Falls Management Program Companion Document

Quiz: Is this a fall?

Intentional sit on the floor to look under the bed (A&O resident)

Slow slide to floor from wheelchair

Found on floor and resident with cognitive impairment says they did it on purpose

Pushed over by another resident

Fainted and landed on chair from standing

A planned, controlled lowering of a resident by staff during a transfer when it is clear the resident cannot support their own weight

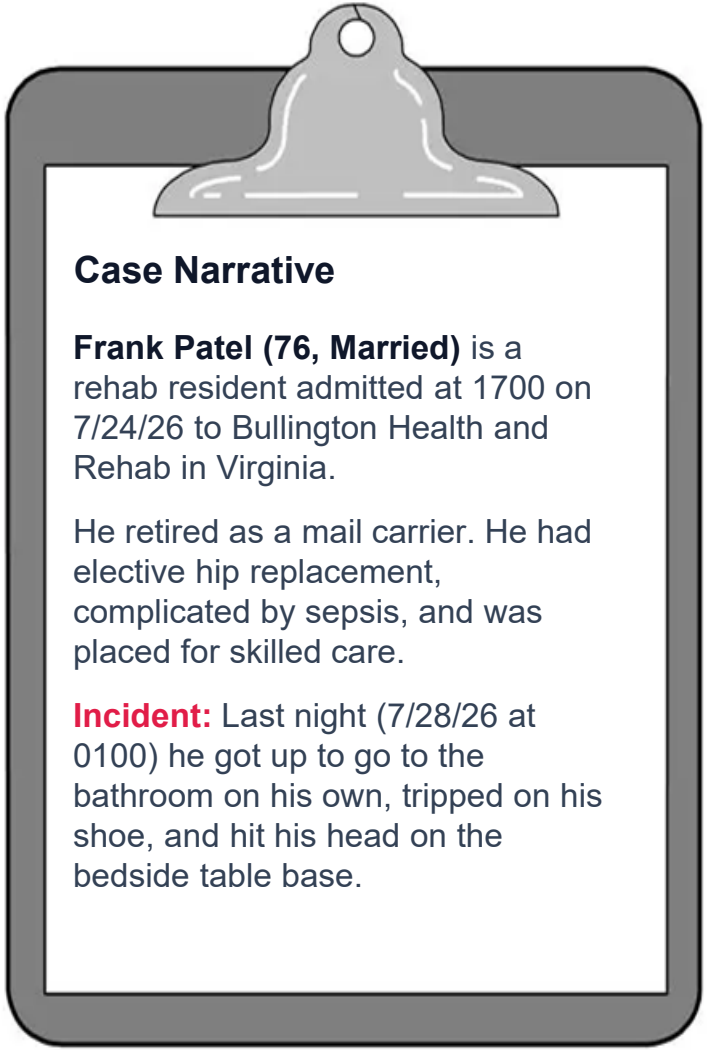
Found on floor no injury at all

Quiz: Is this a fall? Answers

Intentional sit on the floor to look under the bed (A&O resident)	FALSE
Slow slide to floor from wheelchair	TRUE
Found on floor and resident with cognitive impairment says they did it on purpose	TRUE
Pushed over by another resident	TRUE
Fainted and landed on chair from standing	TRUE
A planned, controlled lowering of a resident by staff during a transfer when it is clear the resident cannot support their own weight	FALSE
Found on floor no injury at all	TRUE

Chapter 05

Case Study



Case Narrative

Frank Patel (76, Married) is a rehab resident admitted at 1700 on 7/24/26 to Bullington Health and Rehab in Virginia.

He retired as a mail carrier. He had elective hip replacement, complicated by sepsis, and was placed for skilled care.

Incident: Last night (7/28/26 at 0100) he got up to go to the bathroom on his own, tripped on his shoe, and hit his head on the bedside table base.

Past Medical History

Arthritis, hypertension

Functional Status on Admission

- Requires supervision with walking with walker, set up for bath, eating, and upper dressing.
- Functional incontinence.
- Fall Precautions: Instituted on admission (no known history of falls).

Personal & Social Profile

Mr. Patel and his wife enjoy cruises and dancing. He plays Wordle and competes with staff.

Case Study: Initial Fall Assessment

Post fall assessment:

Full body check, no pain at hip, no injury noted

He denies prior to fall feelings of dizziness, chest pain, hip pain

Neuro checks are stable immediately and ordered for Q15min for one hour, Q30 min for one hour and hourly overnight.

At 0300 Mr. Patel has nausea and vomiting, slurred speech.

He is sent to the ED

Mr. Patel’s Fall Risk Factors

Root Cause Analysis & Contributing Clinical Factors

Clinical

Hip Surgery
Increases risk of fall for 6 months

Post-Sepsis Status
Associated delirium &/or myopathy

Age
Advanced age factor

Pharmacological

Pain Medication
Alters cognitive and motor reflexes

Antihypertensives
Increases risk of orthostatic hypotension

Environmental & Administrative

New Environment
Unfamiliar layout of the rehabilitation room

Friday Night Admission
Staffing transitions and weekend schedules

Mr. Patel’s Room

5 Whys of Mr. Patel’s Fall

Root Cause Analysis & Sequence of Events

Problem

Fall while attempting to toilet

Initial Question

Why did Mr. Patel fall?

1. **WHY?** Why did he get up without supervision?
2. **WHY?** Why did he not use his call bell?
3. **WHY?** Why did he need to toilet at that time?
4. **WHY?** Why did he trip over his shoes?
5. **WHY?**
   Please share your WHYs in the Q&A tab

POLL: New Admission: Fall Risk in Care Transitions

1. **Medication mishaps**: errors, polypharmacy, risky medications
2. Unidentified frailty
3. New environment
4. **Unclear communication** between LTC staff and hospital staff
5. **Inaccurate or absent mental status assessment** from previous setting (delirium v. dementia etc.)
6. **Availability of resident informed staff** at each setting
7. **Delayed discussion of end of life care** (or no decision)

Fall Precautions for Mr. Patel Prior to Fall

ACTIVE PHYSICAL PRECAUTIONS

- Bed lowest position
- Walker
- Call bell within reach
- Scheduled toileting rounds Q2H
- Vital signs TID
- Floor mats in place
- Transfer assist 1 for all mobility
- Dangling protocol (sit on edge of bed 2 mins prior to walking)

EDUCATION

- Mr. Patel and wife had education about all precautions
- Care plan addresses and documents precautions plan and education
- Nursing checklists for reminders
- Nurse on Duty instructed CNAs to follow precautions

Case Study: Noticing & Notifying Remain Paramount

Suspected Onset of Delirium

A part-time RN noted that Mr. Patel complained of being tired in the evening, raising concerns regarding delirium.

Delirium Can Be Missed

His social nature and baseline mentation make fluctuating delirium challenging to identify.

Cognitive Change Indicator

He is no longer able to complete or follow his usual Wordle routine in the evening.

Critical Questions

Who should the RN notify? Does she feel psychologically safe and supported to make this notification?

Review Activity: The following slides list risk factors. Let's evaluate if these align with Mr. Patel's fall history.

Case Study Update: Mr. Patel's Care Plan

Hospital Diagnosis & Medical Plan

Subdural Hematoma

Staff called the hospital to check on Mr. Patel and received the update regarding his condition.

Surgical Intervention

Burr hole surgery scheduled to address the hematoma.

Rehabilitation Plan

To return to Bullington for further rehabilitation following recovery.

Bullington Action Plan

- **Improve checklist** created with facility NP for admission assessment.
- **Whole Staff Huddles** using psychological safety techniques to incorporate Purposeful Rounding for the 4 P's.AHRQ Huddles Tool & Management Resource Kit
- **Ongoing huddles** utilized to drive rapid-cycle PDSA improvements.
- **Family Council** engagement by offering a specialist speaker on fall precautions.
- **Staff educator** will deliver continuing education on assessments and fall risks.

New Admission Assessment

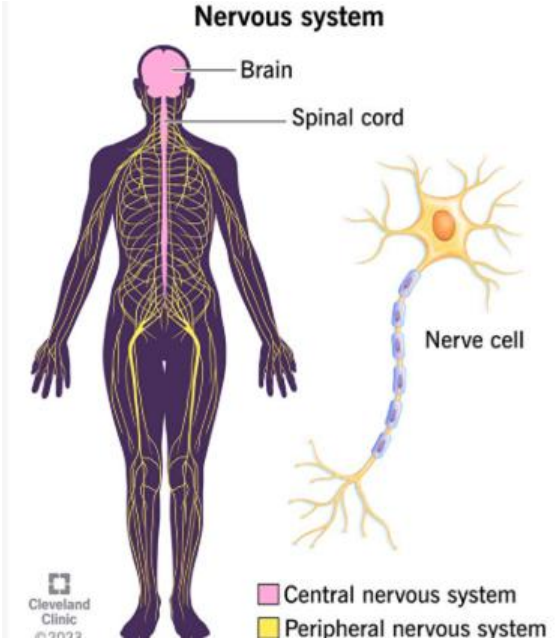
Checklist to Uncover or Determine Risk

Gait and Awareness Risk

Neurological Conditions

Neurological conditions can lead to tremors, rigidity, gait instability, imbalance, incontinence, cognitive impairment, and weakness.

Stroke
Parkinson’s Disease
Dementia
Normal Pressure Hydrocephalus
Multiple Sclerosis
Amyotrophic Lateral Sclerosis



Source: Cleveland Clinic - Nervous System

Lower Extremity Sensation

Neuropathy Risk

Certain conditions and clinical factors increase the risk of peripheral neuropathy and sensory loss in lower extremities.

Advanced Age (Age >75 lower extremity sensory loss)

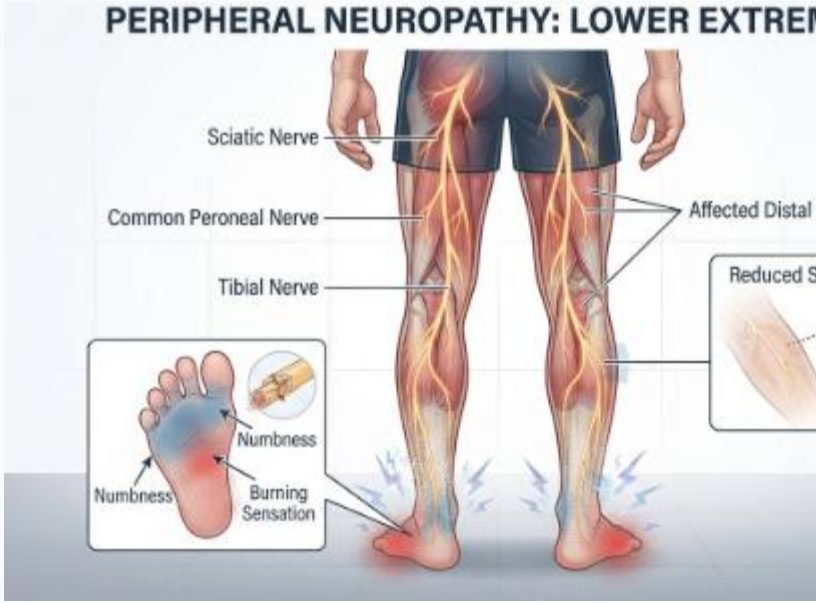
Smoking-Related

Diabetic

Foot Surgery or Injury

Joint Replacement

Ergonomic Risk (Work prolonged sitting or vibration)



Peripheral Neuropathy Pathway

Callaghan, B., et al. (2015). *Neurology*, 85(1), 71-79.

Heart and Circulatory Health

Cardiovascular Status

Key cardiovascular and circulatory conditions affecting stability, perfusion, and overall systemic health.

Orthostatic Hypotension

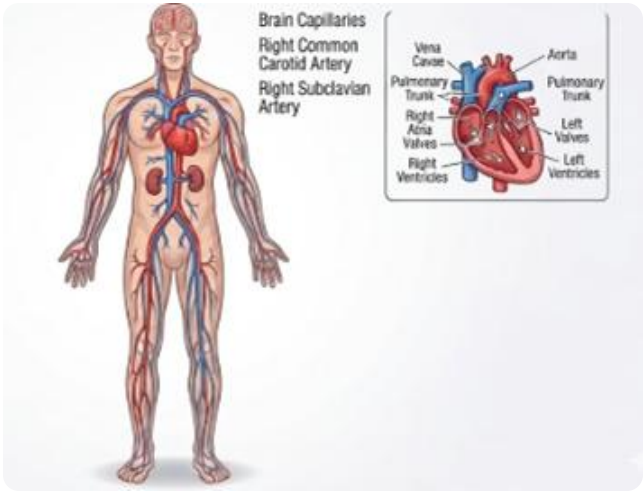
Congestive Heart Failure (CHF) (Fatigue, weakness)

Cardiac Arrhythmia (dizziness, syncope)

Aortic Stenosis (restricting blood flow)

Atherosclerosis (decreased perfusion)

https://pmc.ncbi.nlm.nih.gov/articles/PMC10243462/



Source: PMC10243462 - Circulatory Study

Joints and Strength

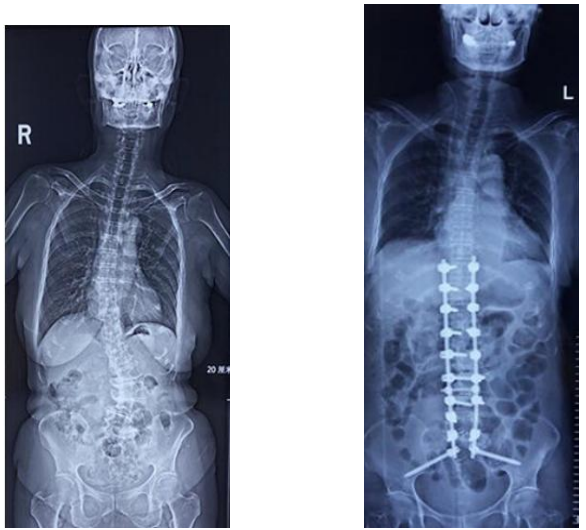
Musculoskeletal Status

Spinal Pathology (stenosis, history of spine surgery)

Severe Arthritis (restricted joint mobility)

Osteoporosis (decreased bone density)

Sarcopenia (less strength)



Pre and Post OP Scoliosis

January 2022

Journal of Pain Research 15:2171-2179

Sensory Impairments

Sensory Status

Vertigo

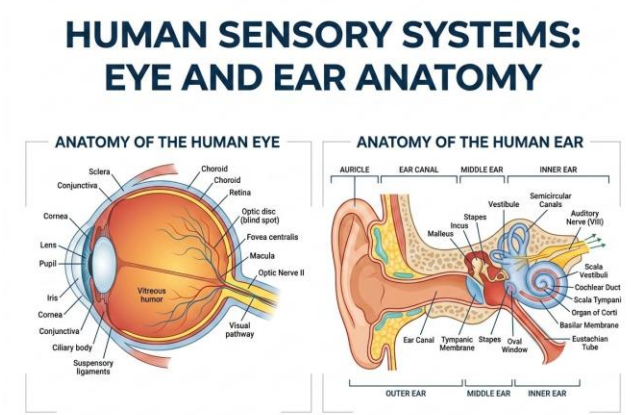
Cataracts

Macular Degeneration (central vision)

Glaucoma (peripheral vision field)

Diabetic Retinopathy (patchy vision)

Hearing Loss



Sensory Deficits & Balance Risks

Impaired vision and hearing significantly reduce spatial awareness, doubling the statistical risk of accidental falls in clinical settings.

Metabolic & Systemic Health

Metabolic Status

Diabetes

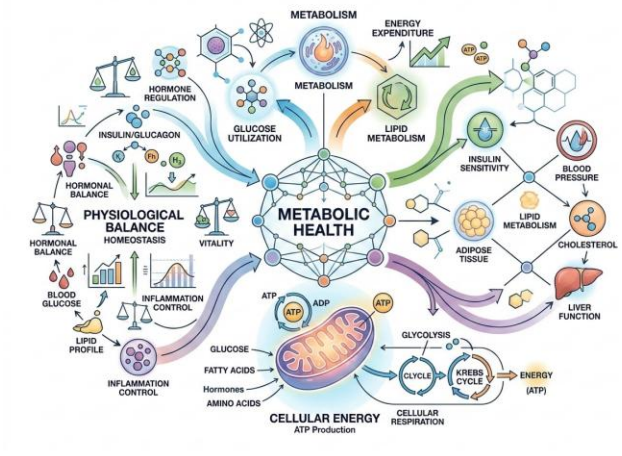
Chronic Kidney Disease

Vitamin B12 Deficiency (causes proprioception/nerve loss)

Anemia (hypoxia, dizziness)

Malnutrition

Infection



Systemic & Neurological Risks

Metabolic instabilities and deficiencies directly compromise peripheral nerve pathways, leading to neurological deficits, sudden dizziness, and a significantly higher clinical risk of falls.

Elimination & Cognitive Safety

Elimination & Acute Factors

Clinical assessment of physical urgency and acute issues directly impacting bathroom safety and orientation.

Urge Incontinence (overactive bladder)

Urinary Tract Infection

Constipation

Medication & Cognitive Safety

Pharmacological and neurological risk evaluation

Polypharmacy

Sedatives

Cognitive Impairment

Delirium

Beers List AGS Resource

Purposeful Rounding

The 4 P's of Reducing Fall Risk

Crucial touchpoints to evaluate during every resident interaction.

1. Pain
Assess patient comfort levels and address pain immediately.

2. Position
Ensure the resident is safe, comfortable, and properly aligned.

3. Possessions
Keep vital items (call light, water, phone) within easy reach.

4. Prompted Toileting
Actively offer bathroom assistance to prevent unassisted transfers.

The 4 P’s can be addressed by **anyone** who enters a resident room.

Scan the QR code below to view implementation scripts for the 4 P’s..

Scripts & Resources

Prepared by Mary P. Chiles, RN RAC-CT 3.0
Chiles Healthcare Consulting, LLC

The 4 P's of Reducing Falls

We've left you with hopefully improved assessment checklist,

tools to use for huddles such as

the **4Ps** and points of view on **transitions of care**–

more to come in our Huddle-Ups!

Now, as promised last time, we will dive into

psychological safety.

Chapter 06

Psychological Safety:
A Trauma-Informed Component of Care and Quality Improvement

Quality Improvement Series

Poll: Familiarity

Are you familiar with **psychological safety**?

- **A** I can define it, and I can practice elements of psychological safety at work
- **B** I can define it
- **C** I’ve heard of it and I think I know what it means
- **D** I heard of it but have no idea what it means
- **E** I’ve never heard of it

Why Psychological Safety?

Checklists, huddles, and the 4 P's only work if staff feel safe enough to notice, speak up, and report. That's **psychological safety.**

Before we Zoom INTO Psychological Safety, let’s zoom OUT to Trauma Informed Care.

Quality Improvement Series

Trauma-Informed Care

Trauma-informed care, while new to many nursing homes, is an extension of person-centered care. Similar to person-centered care, trauma-informed care is a strengths-based approach, placing residents' needs, values, preferences, and aspirations at the center of our work.

Trauma-informed care (TIC) acknowledges and responds to the effects of trauma on residents' physical, mental, social, and spiritual well-being. It involves understanding, recognizing, and responding to signs of trauma, integrating knowledge about trauma into organizational policies and care practices, and seeking to avoid re-traumatization.

For more details about Trauma-Informed Care including safety see other webinars in our series.

What Is Trauma-Informed Care?

A **strengths-based** framework that recognizes the physical, psychological, and emotional effects of trauma.

The question turns from *"What's wrong with you?"* to *"What happened to you, and how can I support you?"*

In the nursing home, this creates environments where both residents and staff feel physically and psychologically safe and empowered to regain control over decisions.

SAMHSA · Center for Health Care Strategies · American Academy of Pediatrics

FTAG 699 Phase 3-Trauma-informed Care: §483.25(m)

Under the Requirements of Participation, nursing facilities MUST provide Trauma Informed Care:

FTAG 699 Phase 3-Trauma-informed Care: §483.25(m)
The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Specific Sections of Guidance to Surveyors Relative Trauma Informed Care

Section	Title	Summary
F656	§483.21(b)(3) Comprehensive Care Plans	Care plans must be culturally competent and trauma informed.
F699	§483.25(m) Trauma-informed care	CMS intention of minimizing triggers and re-traumatizations and implementation date of 11/28/2019.
F726	§483.35(a)(3)(4)(c) Sufficient, competent staff	Nursing staff are sufficient and competent to provide culturally competent, trauma-informed care and services.
F740	§483.40 Behavioral health services	Behavioral health encompasses relative to resident well-being.
F742	§483.40(b), §483.40(b)(1) Treatment and services for residents with a history of trauma	Comprehensive assessment and ensuring residents with trauma history receive appropriate treatment and services.

AT A GLANCE

1

Safety

Create an environment that is welcoming and safe.

2

Trust & Transparency

Build and maintain trust among staff, residents, family members, and all community members

3

Peer Support

Stories and Lived Experience are key to growth, healing and trust

4

Collaboration & Mutuality

Power is shared between staff and residents; care is "with," not "to."

5

Empowerment, Voice & Choice

Residents are given real options and control over their own care.

6

Cultural, Historical & Gender Responsiveness

Practices actively recognize and address gender differences, historical traumas and culture

THE GAP

Healthcare structures and regulations emphasize physical safety

Physical Safety

Safe environments, supervision, and assistive devices. Reacting to hazards and documentable incidents after they happen.

It's easy to recognize the connection between physical safety and falls

1. Making sure rooms are comfortable and accessible
2. Stocking facilities with appropriate equipment like gait belts and hoyer lifts
3. Attending to the physical body of the resident via medication, physical therapies, movement .

DEFINITION

Zooming Back in: What Is Psychological Safety?

A shared belief and climate where that team members can express themselves and take appropriate interpersonal risks.

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Quality Improvement Series

Safety is an Expansive Concept!

Health and Safety

Physical Safety

Policies, actions, and tools that protect physical well being!

Psychology

Psychological Safety

A shared belief and climate where individuals can express themselves and take interpersonal risks

IHI Video on Psychological safety

Quality Improvement Series

Comparing Safety Frameworks

Physical Safety

- Safe environments, supervision, and assistive devices
- Reacting to hazards and documentable incidents

Psychological Safety

- Safe environment to admit mistakes, voice concerns, and ask questions
- Proactively preventing hazards before they lead to an adverse event

Quality Improvement Series

Three key things for psychological safety

01 . UNCERTAINTY

Remind of Uncertainty

we don't have all the answers: Using tools like the 5 Whys can help clarity

02 . FALLIBILITY

Model Fallibility

Invite input from staff and residents about how organizational policies could improve, like care transitions in Mr. Patel’s fall

03 . MESSENGERS

Embrace Messengers

Thank staff for showing up to work, being authentic and participating in resident care and quality improvement

Quality Improvement Series

Consider all types of safety for everyone

Health and Safety

Resident Safety

Policies, actions, and tools that prevent falls, pressure injuries

Encouraging residents to express preferences, be genuine and accepted in activities, meals and with staff

Psychology

Staff Safety

Providing Adequate equipment for care.

Soliciting feedback from staff about processes, colleagues and work environment

What Psychological Safety look like?

When people have psychological safety at work, they feel comfortable sharing concerns and mistakes without fear of embarrassment or retribution. They are confident that they can speak up and won't be humiliated, ignored, or blamed. They know they can ask questions when they are unsure about something. They tend to trust and respect their colleagues

Edmondson, 2023 · American Psychological Association

QI and Psychological Safety

Not all QI activities are Psychologically Safe, but all psychological safety is QI

Using a 5 Whys or a Fishbone Diagram

When using the 5 Whys or a fishbone diagram, ensure you are considering psychological safety:

1. Is it safe to report a medication error? Are the repercussions punitive or instructive?

1. Are huddles supportive and inclusive?

Quality Improvement Series

Psychological safety in Quality Improvement

01 . Individuals

Promotes personal well-being, reduces work-related stress, and creates a greater sense of belonging.

02 . Teams

Results in a greater willingness to discuss errors, share knowledge, and enhance trust among team members.

03 . Organizations

Leads to increased patient safety, better outcomes, higher job satisfaction, and a positive workplace culture.

Quality Improvement Series

Psychological Safety Recap

Psychology

What It Is

A climate where people feel secure and capable of changing. It enables respectful interactions where staff feel free to question, seek feedback, admit mistakes, and propose new ideas without fear of retribution.

Groups

What It Does

Acts as a critical teamwork competency that directly drives performance and well-being:

- Promotes effective communication
- Fosters stronger collaboration
- Enhances patient safety
- Supports professional well-being

Quality Improvement Series

Resources: Psychological Safety

Resource · 01

5 Ways to Improve Psychological Safety

Resource · 02

“Psychological PPE”: Promote Health Care Workforce Mental Health and Well-Being

Institute for Healthcare Improvement

Resource · 03

Workforce Well-Being and Joy in Work

Resources: Using the Huddle to increase physical and psychological safety: AHRQ Huddle Toolkit

Table 1. Benefit of Huddle and Expected Frequency

Benefit of Huddle	Expected Frequency
Engage team in thinking and talking about checklist use, communication behaviors, and related safety work	Expected to arise in huddle every day
Recognize issues in checklist use, communication behaviors, and related safety work to address by training, coaching, and revising tools and methods	Expected to arise in huddle one or more times each week
Identify issues that need escalation and resolution beyond the team and supervisor	Expected to arise in huddle typically less than once per week

Practice: Affinity Grouping to Create a Checklist

Process Steps

- Create a safe space: all ideas welcome, wild ones encouraged, no criticisms
- Give the team sticky notepads and markers
- Give one clear prompt: *"What is needed for a bed bath of a frail resident?"*
- Instruct participants to do silent brainstorming to prevent louder voices from driving groupthink
- Instruct each participant to record exactly one idea per sticky note
- Place all notes across the board or wall without any sorting
- Silently move similar ideas together

Collaborative brainstorming using visual aids and group synthesis.

Brainstorming, Affinity Grouping, and Multi-Voting Tool

Individual Level: Practical Recommendations

Factors specific to the team member — who they are and how they perceive themselves

THEME	WHAT YOU CAN DO	WHAT LEADERS CAN DO
Individual Differences	Take a self-assessment and debrief with teammates to build self-awareness of your working style.	Host recurring “Lunch & Learn” sessions exploring personality differences and their value to the team.
Team Member Representativeness	Attend training on communicating through conflict and challenging conversations.	Celebrate the value of diverse viewpoints and rotate meeting facilitators to amplify quieter voices.
Being Valued	Practice positive self-talk and reflect on wins to build confidence speaking up.	Establish coaching relationships and hold regular one-on-ones focused on growth and well-being.
Diversity of Expertise / Skill	Pursue interdisciplinary training to build shared understanding across roles.	Run exercises that minimize power differentials so all expertise levels feel able to contribute.

Source: Zajac SA, et al. Understanding Psychological Safety in Health Care. Jt Comm J Qual Patient Saf. 2025;51:534–547, Table 4.

Organization Level: Practical Recommendations

Factors in the broader environment — outside the direct control of any one team

THEME	WHAT YOU CAN DO	WHAT LEADERS CAN DO
Workload / Time Limits	Set boundaries and prioritize core responsibilities.	Conduct regular workload assessments and invest in workload-management tools.
Remote / Hybrid Work Environment	Seek out virtual touchpoints to build relationships with remote colleagues.	Fund reliable collaboration technology and virtual team-building activities.
Unprofessional Behavior	Build bystander skills to address microaggressions when you see them.	Establish clear, monitored reporting and a graduated accountability process.
Developmental Focus	Treat psychological safety as an ongoing practice, not a one-time fix.	Champion the topic consistently — town halls, newsletters, and funded training for all staff.
Perceived Repercussions	Use anonymous pulse surveys to safely flag communication concerns.	Foster a no-blame culture and visibly act on the feedback received.

Source: Zajac SA, et al. Understanding Psychological Safety in Health Care. Jt Comm J Qual Patient Saf. 2025;51:534–547, Table 4.

REMINDER

Trauma Informed Care -including psychological safety is organizational. It isn't just for residents, or just for staff.

It's an intentional part of culture — and it looks different depending on who you're supporting.

Chapter 07

01 Welcome

02 Falls with Major Injury: Why It Matters

03 Recognizing and Managing Fall Risk

04 Clinical Decision-Making and Documentation

05 Case Study and Group Application

06 Quality Improvement and Care Pathways

07 **Team Discussion, Sharing**

Practical Application

What Will You Put This into Practice?

Interactive Discussion

Please share any ideas you have had and put into practice to **decrease falls**.

Type your thoughts in the Q&A tab or raise your hand to have your audio open.

Recapping Today’s Session Objectives

01

Clinical Hazards & Risks

Identify and evaluate multi-system clinical hazards and environmental risk factors that contribute to Falls with Major Injury (FMI) during patient care transitions.

02

Diagnostic Stewardship

Apply diagnostic stewardship principles to systematically investigate root causes of systemic instability and execute precise post-fall assessment protocols.

03

Tailored Care Planning

Formulate and execute a tailored fall-prevention care plan utilizing the **AHRQ Fall Prevention Toolkit** framework.

Clearly define and coordinate responsibilities across the interdisciplinary care team.

04

Psychological Safety

Promote psychological safety by encouraging open communication, shared learning, and timely reporting of fall risks, near misses, and opportunities for system improvement.

REMINDERS

We will post a survey link in the Chat tab and will resend it with our follow-up message.

This helps us improve and most importantly, **lets you request your certificate of attendance.**

Certificates of Attendance will be emailed about a week after the event to those who:

✓ Attend at least 75% of the session

✓ Participate in at least 75% of polls, questions, or breakout activities

Attending as a group?

Please have the registered attendee complete the exit survey and list the names of all group participants.

Huddle-Up and Presenters

Stay in Touch!

Let’s continue this conversation.

Join us on **September 1** for the upcoming session:

Huddle-Up on Falls with Major Injury

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Resource Toolkit

AHRQ Fall Toolkit

What is included

This comprehensive toolkit provides critical resources for clinical teams:

- Teaching resources
- Presentation slides
- Worksheets & guides

Access the Toolkit

Scan the QR code below to quickly access all digital files and interactive materials on your device.

REFERENCE LIBRARY

Resources

AHRQ INITIATIVE

The Falls Management Program

A Quality Improvement Initiative for Nursing Facilities

ahrq.gov/patient-safety

AHRQ SAFETY PROGRAM

On-Time Falls Prevention

AHRQ's Safety Program for Nursing Homes

ahrq.gov/.../ontime

NATIONAL DATA

Older Adult Falls Data

Centers for Disease Control and Prevention

cdc.gov/falls/data-research

Thank You!

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Huddle-Up on Falls with Major Injury (part I)

Tuesday, September 1, 2026 | 12:30pm – 1:30pm

Instructors: Laura Finch, Maureen Lillis & Annie Rhodes
Series Host: Gigi Amateau

Today's registrants are automatically registered for this Huddle-Up