

The Fall Legend Story: How 5 South Reclaimed Patient Safety

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BACKGROUND

Patient falls remain a recurring safety challenge in acute-care Medical-Surgical units. On 5 South, fall rates averaged **four falls per quarter from Q3 2024 through Q1 2025** before sharply increasing to **15 falls in Q2 2025**. Review of fall events revealed recurring patterns including toileting-related falls, gait instability, altered mental status, and inconsistent alarm use. **Communication gaps** during shift transitions, among float staff, and among team members responding to call-lights without full awareness of patient mobility needs led to inconsistent mobility-safety practices. These findings highlighted the need for a standardized, visible communication tool to ensure shared understanding of patient mobility needs.

PURPOSE

To evaluate the effectiveness of the **Fall Legend**, a standardized bedside communication tool, in reducing patient falls by improving staff awareness of mobility needs, fall-risk scores, and required assistive equipment.

METHODS

A multidisciplinary fall work group (RNs, charge nurses, CNAs) developed the **Fall Legend** to standardize communication of each patient's fall-risk level, required assistance, and necessary equipment.

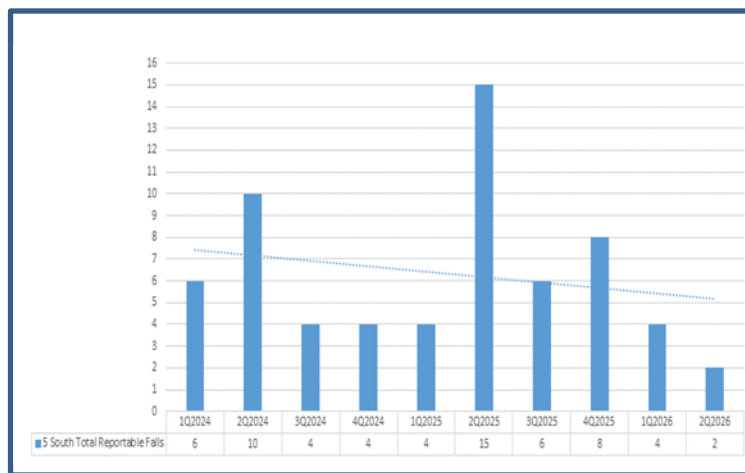
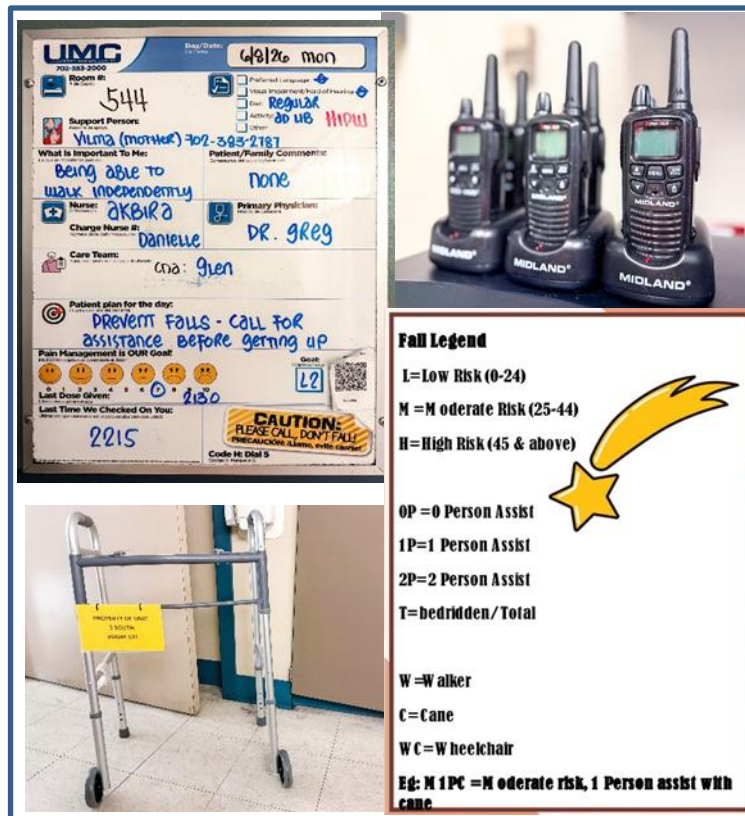
Workflow design:

Admitting RN assigns initial Fall Legend; updated by oncoming teams during bedside handoff; RNs document Fall Legend on the patient's whiteboard; CNAs translate the legend to door placards (later discontinued); reinforcement through huddles, charge nurses whiteboard checks, and laminated reference cards.

Barriers addressed:

Inconsistent fall score knowledge; float staff unfamiliarity; competing initiatives (new fall-risk tool trial, IAMSAFE rollout).

Process refinement: Education, workflow reinforcement, and removal of door placards in favor of whiteboard-only documentation.



RESULTS

Fall Trends (Q1 2024 – Q2 2026)

Most common fall activities:

Toileting-related activities (40% of all falls); ambulating without assistance; transferring/changing position in bed; unknown/unwitnessed falls.

Most common contributing factors:

Abnormal gait/balance (present in nearly every fall); AMS/cognitive impairment; altered elimination; dizziness/vertigo; medication side effects; behavioral/mental health issues.

Documentation gaps:

Missing Morse-Fall post fall reassessments; bed/chair alarms off; items not within patient's reach; telesitter non-notification; staff-present falls.

Impact of Fall Legend Implementation:

Fall rates returned to **4 falls per quarter**, matching pre-surge baseline; staff reported improved clarity and consistency in mobility communication; combined interventions (Fall Legend + walkie-talkies + standardized equipment availability) contributed to sustained improvement.

CONCLUSIONS

The **Fall Legend** significantly improved communication of patient mobility needs and contributed to a meaningful reduction in falls on 5 South. This project demonstrates that simple unit-driven communication tools – when reinforced through education, accountability, and workflow integration – can enhance patient safety and reduce preventable harm. Continued monitoring and iterative refinement are recommended to sustain progress toward **zero falls**.

REFERENCES

- Hempel, S., Newberry, S., Wang, Z., et al. (2013). Hospital fall prevention: A systematic review of implementation, components, and effectiveness. *Journal of the American Geriatrics Society*, 61(4), 584-592.
- Oliver, D., Healey, F., & Holmes, T.P. (2010). Preventing falls and fall-related injuries in hospitals. *Clinics in Geriatric Medicine*, 26(4), 645-692.
- Ganz, D.A., Huang, C., Saliba, D., et al. (2013). Preventing falls in hospitals: A toolkit for improving quality of care. Agency for Healthcare Research and Quality (AHRQ).
- The Joint Commission. (2017). Inadequate hand-off communication. *Sentinel Event Alert*, Issue 58.
- Nelson, A., & Baptiste, A.S. (2006). Evidence-based practices for safe patient handling and movement. *Orthopaedic Nursing*, 25(6), 366-379.
- King, B.J., & Pecanac, K.E. (2016). Bedside whiteboards: A systematic review of patient engagement and communication. *Journal of Nursing Care Quality*, 31(3), 265-271.

