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Original article

Preventing falls during hospitalization: educational opportunities from the perspective of Nursing staff*

Prevenção de quedas na hospitalização: oportunidades educativas na perspectiva dos trabalhadores de Enfermagem

Prevención de caídas durante la hospitalización: oportunidades educativas desde la perspectiva de los trabajadores de Enfermería

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Abstract

Objective: to describe the educational opportunities identified by Nursing staff to prevent falls in hospitalized adult patients. **Method:** This is a qualitative, descriptive study with 21 Nursing workers from a university hospital in southern Brazil. Data collection took place from March to May 2020, with semi-structured interviews, submitted to Content Analysis. **Results:** workers described the need for educational actions to reach those involved in fall prevention, and the following categories emerged: Patient protagonism in fall prevention: education as a strategy for risk perception; The challenge of involving the family member/companion as an enhancer of care; Dialogicity in fall prevention: a reflection on daily practice. **Conclusion:** workers identified opportunities to invest in education and training, taking into account previous experiences and the social context, creating learning paths, testing new approaches to fall prevention, and improving their educational role.

Descriptors: Accidental Falls; Population Education; Health Education; Nursing; Hospitalization

Resumo

Objetivo: descrever as oportunidades educativas identificadas pelos trabalhadores de Enfermagem para prevenir as quedas de pacientes adultos hospitalizados. **Método:** estudo qualitativo, descritivo, com 21 trabalhadores de Enfermagem de um hospital universitário no sul do Brasil. A coleta de dados ocorreu de março a maio de 2020, com entrevistas semiestruturadas, submetidas à Análise de Conteúdo. **Resultados:** foram descritas pelos trabalhadores a necessidade de as ações educativas atingirem os envolvidos na prevenção das quedas, emergindo as categorias: Protagonismo do paciente na prevenção das quedas: a educação como estratégia para a percepção do risco; O desafio do envolvimento do familiar/acompanhante como potencializador do cuidado; Dialogicidade na prevenção das quedas: uma reflexão sobre o fazer diário. **Conclusão:** os trabalhadores identificaram as oportunidades de investimento na educação e na formação, considerando as experiências prévias e o contexto social, criando percursos de aprendizagem, testando novas abordagens para a prevenção de quedas e aprimorando seu papel educativo.
Descritores: Acidentes por Quedas; Educação da População; Educação em Saúde; Enfermagem; Hospitalização

Resumen

Objetivo: describir las oportunidades educativas identificadas por los trabajadores de Enfermería para prevenir caídas en pacientes adultos hospitalizados. **Método:** estudio cualitativo, descriptivo, con 21 trabajadores de Enfermería de un hospital universitario del sur de Brasil. La recolección de datos se realizó de marzo a mayo de 2020, con entrevistas semiestructuradas, sometidas a Análisis de Contenido. **Resultados:** los trabajadores describieron la necesidad de acciones educativas para llegar a los involucrados en la prevención de caídas, surgiendo las siguientes categorías: Papel del paciente en la prevención de caídas: la educación como estrategia para la percepción del riesgo; El desafío de la participación de la familia/acompañante como potenciador del cuidado; Diálogo en la prevención de caídas: una reflexión sobre la práctica diaria. **Conclusión:** los trabajadores identificaron oportunidades de inversión en educación y capacitación, considerando experiencias anteriores y el contexto social, creando caminos de aprendizaje, probando nuevos enfoques para prevenir caídas y mejorar su rol educativo.
Descriptores: Accidentes por Caídas; Educación de la Población; Educación en Salud; Enfermería; Hospitalización

Introduction

Preventing falls is still a challenge for leaders and health workers in hospitals, with repercussions on patients' functionality and quality of life[1-2] as well as on the support network, causing economic and social burdens.[3] In addition, there is an increase in costs,[3-4] in hospitalization days[3,5], and a tarnishing of the institution's image.[5-6] These factors can have a strong impact on healthcare workers,[7] given the social stigma it can cause in workers' private and professional lives[3,7] especially in Nursing teams, due to the bond they build by directly assisting patients who suffer injuries as a result of falls.

Falls are a relevant issue in Brazil, where the population is gradually getting older in all federal states. A recent publication showed 1,746,097 hospitalizations of elderly people due to falls within the Unified Health System (UHS) in Brazil between 2000 and 2020, at a cost of more than two billion reais.[3] Another investigation in a public hospital in southern Brazil found 395 reports of falls in 2019, 65.7% of which occurred in the elderly.[8] This justifies not only prevention strategies to promote elderly people's quality of life, but also inclusive practices, which can be explained by the amount of money needed to treat the damage caused by falls.[3] The analysis of falls identified intrinsic and extrinsic factors for the occurrence of the event, which is why it is said that prevention is multimodal.[7]

In this sense, just as important as identifying risk factors,[5] is encouraging adherence to standard operating procedures,[9] the application of predictive scales,[10] adjustments to the physical environment,[11] improvements in communication, the involvement of leadership and education, which has been highlighted in the literature[2,12-13] as a valuable fall prevention strategy. Thus, education aims to increase knowledge about the risks of falls, educating patients, their families, and carers on ways to prevent falls and avoid the resulting harm.[14]

The challenge of preventing falls needs to include multiple action strategies. Thus, improvements in educational interventions are pointed out as effective strategies, which result in greater patient adherence to institutional protocols, develop risk perception, add knowledge, and include them in the engagement of preventive plans, with verbal guidance given to patients, family members and companions being important.[15-16]

It should be borne in mind that patients who have not experienced a fall may find it more difficult to adhere to the guidelines, which justifies the need to adapt the education strategies individually.[16] Furthermore, incorporating and adjusting ways of creating relationships of trust between patient and worker,[17] promotes the patient's involvement in their care as a way of making sense of it, by dialogically identifying the repercussions and limitations on activities of daily living.[18]

By educating patients, their families, and companions, healthcare workers have provided them with knowledge, with the aim of reducing the gap between the risk they

perceive and the real risk of the patient falling in the hospital environment,[19] which is why healthcare workers need to invest in education as a way of improving patients' understanding and perception so that they can become involved in self-care.[13,17] However, the execution of the prescribed work does not always go according to plan,[14] but educational interventions make it possible to involve patients in prevention strategies, by making them aware of the risks and, consequently, adhering to care,[2,17] with an impact on patient safety.

In order to involve patients, their families, and carers, education as a fall prevention strategy needs to make sense, i.e. learning must be meaningful, including for the workers who sometimes need to be trained and sometimes need to train. In this way, this study is justified by the need to overcome the traditional educational logic that assigns the role of education to the professional, considering that the knowledge brought by patients and companions/family members can also enhance educational opportunities. It is from this perspective that Paulo Freire can be used in an educational perspective as an emancipating social practice and, above all, relevant to all those involved in the dialogical process of educating and being educated.[20]

The health field is undergoing constant technological changes that permanently demand the construction of knowledge, skills, and attitudes for the implementation of health care. In this changing materiality, the education of professionals needs to establish a reading of the changing reality, based on its daily problematization. When attending to the patient's needs, the worker is challenged by the unusual intersubjective encounter, which is not only objectified by the performance of techno-assistance procedures. This encounter can translate into moments of creating and establishing bonds, of choosing ways of producing life in a relationship of reciprocity.[21]

Based on the premise of dialogicity and the inevitability of knowledge construction, in the light of Paulo Freire, the aim of the research is to describe the educational opportunities identified by Nursing workers to prevent falls in hospitalized adult patients.

Method

This is an exploratory and descriptive study with a qualitative approach. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were used to guide the writing of the research report.

The research was carried out in a large general university hospital in the southern region of Brazil, a reference for highly complex patients. Among the twelve inpatient units that had fall events between July 2018 and July 2019, the five that had patients with falls classified as moderate to severe were selected. Regarding the classification of injury severity, they were classified as mild injury, which involves minimal or moderate damage, but with rapid duration and minimal interventions; moderate injury, in which the patient presents symptoms, requiring intervention, increased length of stay, and with permanent or long-term damage or loss of function; severe injury, which presents severe symptoms, major clinical/surgical or life-support interventions, permanent or long-term loss of function, or death.[1,7]

The sample included nurses and Nursing technicians working in these five hospitalization units and who were present on the work schedule on the day the researcher collected the data, in the respective shift in which the falls occurred. Nursing staff who had been working at the institution for less than a year, who were on vacation or leave of any kind, as well as those on temporary employment contracts at the time of data collection, were excluded.

The population (n=153) was made up of Nursing staff (nurses and Nursing technicians) from different shifts in the five inpatient units where falls occurred. The sample (n=21) was obtained randomly (simple draw). One worker declined the invitation and another was unable to attend due to complications in the unit. The sample therefore consisted of seven nurses and 14 Nursing technicians. The participants were drawn by lot in the presence of the unit's formal leadership, and for each work shift in which a fall had occurred, one nurse and two Nursing technicians were drawn by lot, except in two of the units, in which two falls occurred in different shifts, and two nurses and four Nursing technicians were drawn by lot.

Data collection took place between March and May 2020, through semi-structured interviews, with a script drawn up by the researchers, based on the literature that underpinned the study. Prior to the interviews, a pilot test was carried out with a

Nursing technician from a unit that was not part of the study, which made it possible to adapt the interview script in order to achieve the objective.

At the start of the interview, participants were presented with institutional data related to the frequency and characterization of falls, which were obtained from safety incident notifications and a retrospective search of medical records. Next, the participant was asked to reflect on a fall of a patient under their responsibility or of a colleague, identifying opportunities for improvement to prevent falls.

The interviews took place face-to-face, during the participant's work shift, at a previously agreed time, and in a reserved location within the research participant's work unit. The interviews lasted approximately 35 minutes, were audio-recorded, and later transcribed. When the interviews had been completed with all the participants chosen, data saturation was reached, i.e. when the information on the subject of the study began to repeat itself. The field notes were written up after each interview so that the information would not be lost.

The researcher knew most of the participants, as she worked at the institution. The moment of the draw and the invitation to the drawn participant was the first time the participant and the researcher met, except when the researcher already knew the participant due to previous working relationships. It was made clear to the participant that their participation was voluntary and that they could withdraw from the study at any time, without prejudice to or interference with their care duties or work relationship. The data was submitted to Content Analysis, applying the stages of pre-analysis, exploration of the material, treatment of the results, inference, and interpretation, without the use of software.[22]

The participants signed a Free and Informed Consent Term consenting to take part in the study. In order to maintain anonymity, they were designated alphanumerically, according to the sample group of origin and the sequence of the interview. The acronym NT was used for Nursing technicians and NUR for nurses.

The ethical precepts were followed, and it was approved by the National Research Ethics Committee and the participating institution under opinion No. 2,554,758 on March 21, 2018, which complies with Resolutions No. 466/2012, No. 510/2016 and No. 580/2018 of the Ministry of Health.

Results

Seven nurses and 14 Nursing technicians from the units where the falls occurred took part in the study, during their respective shifts. Of the nurses, all were female and aged between 30 and 52. There were 14 Nursing technicians, five male and nine female, aged between 36 and 65.

When asked about opportunities for improvement to reduce the number of falls, the Nursing workers identified education as a challenge. Thus, the following categories emerged: Patient protagonism in fall prevention: education as a strategy for risk perception; The challenge of involving family members/carers as an enhancer of care; and Dialogicity in fall prevention: a reflection on daily practice.

The workers' testimonies revealed education as a central dimension of falls prevention.

Patient protagonism in falls prevention: education as a strategy for risk perception

> [...] *information is fundamental because it's not just putting on a bracelet and saying that the person has a risk of falling, it's saying "Look, you can't get up, you're going to fall". Being clearer in terms of information, because sometimes you put the bracelet on and don't even say what the bracelet means, or you say 'risk of falling' and the patient doesn't even understand* [...]. (NUR 4)
> *I notice that sometimes people explain very technically, [...] and the person doesn't understand, you have to go up to them and say, "This little yellow bracelet is because you have a risk of falling".* (NT 7)

Health workers identified that information needs to make sense to patients, and for this to happen they acknowledged the need to use appropriate language, including considering that individualities need to be respected.

> [...] *every human being has the capacity to learn. [...] speaking clearly, because you can see the person's temper when they're underprivileged [...] speaking in such a way that they understand. [...] you have to explain and sometimes be very direct."* (NT 13)

Preventing a fall becomes a challenge when the risk cannot be glimpsed. What is not perceived as a risk is not valued.

> [...] *this risk of falling when the patient has no physical limitations and sometimes has very serious limitations so they can't get out of bed [...].* (NUR 2)

> *I think everything can be said in two ways, there's always one that's a little better than the other. But even so, I realize that when you explain it in a very empathetic way, patients are still offended when we lift the rails of a bed.* (NUR 7)

The aim of investing in patient education is to involve patients in their care, making sense of the Nursing team's instructions. It is also important to guide those who are close to the patients.

The challenge of involving the family member/companion as an enhancer of care

> *In addition to all these measures to prevent falls, it would be better to include the participation of family members in the care, which I don't think we're trying to do yet [...] family members have to be involved in the patient's illness. You can't do a good job on your own.* (NUR 1)
> *I reinforce education with this family member and companion. When I see that the bed is up* [...], I *explain why I'm lowering the bed.* (NUR 2)

Sometimes, when guidance doesn't seem to be valued, the Nursing staff even suggests more forceful measures with family members, which only alienates patients, family members, and companions from the professionals.

> *Having a companion with them, a family member, or a technician* [...]*. But another issue that perhaps contributes to the patient not falling is the family member. The companion who is there with them will also be expected to look after their relatives, as they are standing there, taking up space in the hospital. The family member is there but has no commitment, obviously, but it's their family member.* (NT 7)

Other times, they understood that failure is human, and the family member can also be forgetful, more than that, they realized that the level of education can make a difference in understanding care.

> *I think you should remind him or her, "Take a look at your family member, many falls happen with the family member next to you".* [...] *their level of education, there are patients you explain it to and they don't understand.* (NT 7)

The acknowledgment of companions is valued by the workers and, in a way, they empathize with them, by understanding the demands and needs of individuals who need to guarantee the continuity of other tasks outside the hospital environment.

> *I think there was something wrong with the orientation or something failed. Even if it wasn't us, because many patients get up on their own, some don't stay with their companion all night. Generally, the companion stays during the day, and at night he or she wants to leave to rest.* (NT 5)

Dialogicity in falls prevention: a reflection on daily practice

When they reflected on the role of the Nursing team in patient education, the workers noted the weaknesses that could be addressed.

> *I think it's often overlooked that perhaps they [patients] aren't adhering to the care. Reinforcing every day and every hour; maybe our fault as a nurse, as a technician, and as a member of the Nursing team is reinforcing every time since they don't pay attention.* (NUR 2)
> [...] *we used to have rounds of conversations in the early hours of the morning, and then we'd talk about various subjects, and it makes you feel renewed in your care, it renews you, you talk and the colleague brings you something new, and I think it's very important that this comes back because many things have been lost.* (NT 1)

The Nursing team identified opportunities to qualify their care, considering the clinical and care challenges, as well as reflecting on their practice in the face of knowledge that they seek to appropriate for dialogical work.

> *As well as involving family members in the care, making a checklist and passing it on on duty, reassessing the patient's senses at midnight, at the last dose of medication, patients who are alone, who are more at risk of falls, who are confused, reassessing at 3 a.m., entering the room, without waking him or her up.* (NUR 1)
> *The little book that the technicians have with the prescription, it is often not given due attention. If we paid more attention on duty to those who are at moderate risk, high risk is usually mentioned, maybe we should focus more on those who are at moderate risk of falling.* (NUR 3)
> [...] *from the age of 60 onwards, 30% of patients fall due to glucose problems, neurological problems, or orientation problems, and after the age of 80 this statistic rises to 50% of patients, so I went to find out why there were so many falls.* (NT 4)
> *I think that patients who are at risk of falling should stay closer to the clinic,* [...] *and maintain this care, go to the room more often [...] put yourself in the patient's shoes [...] there's nothing better because you give them peace of mind, that you're at their disposal [...] they'll be reassured and they'll call you, you can be sure of that.* (NT 8)

However, the Nursing team may consider care that does not match the patient's needs to be adequate, but because they do not detect other ways to reduce the risk and mitigate the damage, they use strategies that may not contribute to the patient's real needs.

> *If the patient is at greater risk, we try to take other measures, such as asking for a companion, or we try to contain the patient so that the risk is minimized.* (NUR 3)

Identifying the difficulties faced by the Nursing team also applies to carers and

family members. This is how the combined efforts of caregivers with shared goals can help reduce falls.

> *Considering that, as a rule, the companions fall asleep, it's not even a question of unwillingness, it's just that people are tired, many work during the day and end up falling asleep and it's not their fault, but it makes us feel a bit safer when there's a companion in the room.* (NUR 6)

Discussion

The process of learning and teaching takes place through knowledge, actions, and meanings being shared. Through permanent dialogic relationships between workers, patients, family members, and companions, health education needs to materialize from a perspective that problematizes reality,[23] in which the Nursing technicians and nurses involved can find the right ways to provide care and encourage self-care. This is how workers identify that the process of educating in health needs to meet the patient[16] through effective and affectionate communication, which takes into account the workers' previous knowledge and limitations.

This dialogic educational process must take place horizontally, and trust between one pole and the other is a consequence.[23] Individualities, whether they are patients, family members, or companions, as well as checking for understanding of what has been taught, need to be taken into account for the educational dialog to take place. In this way, Nursing workers mention that it is necessary to check what has been taught as a way of systematizing and staggering learning. This relationship of trust improves the perception of risk and the patient/professional relationship,[17] since the risk is not something tacit, as in the case of patients who have never experienced a fall[16] or for those who have no physical limitations, but the score on the predictive scale points to the risk of falling,[10] and, in addition, the expertise of the workers needs to be taken into account.

The Permanent Health Education Policy, instituted by the Ministry of Health in 2004 through Ordinance 198/GM/MS,[24] is inspired by some of the pedagogical presuppositions of popular education, or education for young people and adults, which in turn was developed based on Freire's pedagogical ideals. These include founding concepts such as meaningful learning and the pedagogy of problematization, or praxis.[25]

In Paulo Freire's studies on the learning process, there is an emphasis on valuing the accumulation of learning developed throughout the subjects' life history, with previous knowledge being the stimulus that gives meaning to new learning practices.[16-17,21,26]

Although many health workers mistakenly believe that the family member has an ongoing responsibility to stay with the patient,[27] a caveat is required. With an increasingly demanding daily routine and a high cost of living, many patients do not have family members to stay with them, nor do they have the financial resources to pay for a companion. Similarly, health institutions lack sufficient supplies, equipment, and human resources for the ever-increasing demands, due to the complexity of patients, the health crisis attributed to technical issues is often reduced to a developmental logic.[28]

The fact is that the companion should be valued as a barrier to the occurrence of falls.[7-8,15-16] However, they also need to be co-participant in the educational process, intending to recognize themselves as part of the surveillance, given the care needed to prevent falls and to identify situations not foreseen in the care prescription, in order to anticipate the possible risks related to the circumstances caused by the patient's unforeseen behavior.

To this end, the Nursing team is required to identify the most effective ways of building shared knowledge through qualified listening, so that the companion or family member is not only an extension of Nursing,[27] but also a barrier to preventing harm from falls. In the perception of the workers, this attribution, expected by Nursing, does not take place.

Encouraging knowledge has repercussions for the patient through greater autonomy in their care, when possible. In this way, knowledge can no longer orbit around the patient and their companion but permeate this relationship. This should be an opportunity identified by workers as a problematizing educational approach that considers the continuity of care after discharge. That's why it's important to train workers so that they recognize moments of learning, even though, on certain occasions, there is no availability to do so.[29]

The possibilities for education arise from the perspective of the patient and their family and carers, as well as from the need to qualify the professionals who care for this

patient, both by seeking to adapt the language and by offering situational data concerning the patient's risks. Education for patients and their families and caregivers must start with their vocabulary so that they can make sense of the situations they experience.[19]

Thus, there is no standardized education for patients and their families. It needs to be based on lived experiences and is sensitive to the context. This fact can be elucidated in the participants' statements when they identify the need to use accessible language to communicate with the interlocutor. And, as far as Nursing workers are concerned, it is only possible to teach when you understand that it is still possible to learn and when you are willing to look for something new every day. This is a relationship based on exchange, in which the teams are challenged to educate and the patients are challenged to learn what actually affects them.[23]

The challenge in adult education, faced with the triad of patients, family members, and carers, as well as the professionals involved, needs to be based on knowledge and, in addition, allow previous experiences to guide learning situations, as pointed out in the speeches. The identification of the need for qualification at work was demanded by the workers and is supported by this search.[23]

The recognition by Nursing staff of opportunities to qualify this orientation, contextualizing that a patient and companion who are advised on the risks of falling can improve adherence to institutional protocols, was evidenced. Just as important as investing in these individuals' education is equipping health workers to take on their role as educators in this process, taking into account the knowledge that is built up throughout their training and work practice.[20-21]

The training of the Nursing team, signaled as something important for care, transcends the dimension of practice. Investing in the education of and workers requires interactional skills, knowledge of the different ways of seeking the adherence of interlocutors, whether they are lay people or not, to this information.[8] Alternatives should include the use of active methodologies in the education process, continuing education during care, investment in adult education, empathy with others, and a focus on human value.[21] Recognition of these investments promotes safe attitudes and positive reinforcement for professionals, even when success is not achieved in the face

of all their efforts.

In Freire's Pedagogy of Problematization, the health worker's investigative gaze is instigated in everyday work, broadening their epistemological curiosity. Through the development of new knowledge, analysis, and interpretation of real problems, the worker is encouraged to seek unique and genuine answers to the health needs presented. In this movement, work reality constitutes a living and perennial space for learning, but at the same time a privileged locus for transforming practices.[23,29]

Worker-centered approaches, such as training and education, and encouraging them to be the vehicle for this information, take on a formal, formative perspective and can motivate the implementation of strategies to educate and raise awareness among patients, as well as valuing and encouraging this practice.[2] The important thing is to recognize the investment made by the workers when in their speeches they demonstrated the need to seek out new learning to discuss their experiences with colleagues, and even to proactively incorporate new knowledge into daily practice, such as using a checklist, staggering care in the face of the variability of the risk of falls, and more frequent reassessment due to changes in sensory perception, especially in unaccompanied patients.

Health workers need to show that the search for qualifications is intended to instrumentalize their work and give meaning to their practices, as in the speeches in which past practices are valued, in which the work process was discussed in conversation circles. Continuing education, based on problematizing the day-to-day issues of health work, plays the role of stimulating constant processes of awareness in the subjects about the critical nodes of care and the search to resolve them in a reflective and participatory way.[25] To this end, the pedagogical project of education needs to provide opportunities for methodologies related to this purpose.

When education is aimed at preventing the risk of falls, the analytical mapping of the causes and consequences that led to the risk, or to foreseeable or unforeseeable damage, must be thoroughly investigated and studied in the light of historically accumulated knowledge, but also based on new epistemological processes developed collaboratively by the team in search of solutions to tackle reality. When nurses and Nursing technicians start by problematizing the reality in which they carry out their

patient, family member, and/or companion education practices, they must turn to this reality in motion in order to transform it into a permanent and dialectical process,[29] with a view to having an impact on improving patient safety.

It is necessary to rethink how to ensure patient safety and maintain the family structure as, in most cases, this support will promote continuity of care. To this end, an alternative to be discussed is to involve volunteers and students in this care, equipping them in this practice, seeking to provide learning opportunities for volunteers and students and help these patients, with calls, travel, food, and as a companion, especially at night. Actions like these enable family members to maintain their work activities.

The fact that the study was carried out in just one institution can be seen as a limitation. In addition, the individual interview strategy used in this study considered problematizing education, built collectively with the integration of different subjects, their knowledge, and their experiences.

The results showed contributions to the prevention of falls in hospitalized adult patients, considering that educational processes are a tool for reducing these occurrences - without disregarding physical barriers. Thus, they demonstrated the importance of identifying investment opportunities in order to give new meaning to the care provided, through training approaches for workers and educational approaches for patients, their companions, and family members, in the light of Freire's framework. In addition, valuing the construction of subjects throughout their life history gives meaning to learning and makes it possible to subsidize reflection on care, constituting contributions to the discipline.

Conclusion

The Nursing workers questioned in this study pointed to education as a key factor in reducing the number of falls. In order to maximize the prevention of falls, it is important to invest in education and training, taking into account previous experiences, the subjects' linguistic universe, and the shared construction of knowledge. Given the above, a systemic approach to falls is essential, taking into account the social context and the experience of patients, family members, and companions, as well as the health workers who provide care, with the support of a theoretical framework.

Health education in the problematizing, meaningful, and emancipatory pedagogical dimension, applied to the care process, requires workers to permanently critically read the material reality that is imposed on their daily work in interaction with the members of their team, with the patient, family member, or companion. This inquisitive and dialogical stance on the reality that surrounds them, which at first is incipient, will improve as they search for answers to improve care in action.

In this process, the teams are creating learning paths, testing and retesting new approaches to preventing the risk of falls and strengthening this prevention from an emancipatory perspective, beyond the walls of health institutions. In a continuous process of learning, workers are challenged to improve their educational role and transform reality, fulfilling their pedagogical praxis.

Health education in the problematizing, meaningful, and emancipatory pedagogical dimension, applied to the care process, requires workers to read material reality critically on an ongoing basis reality, which is imposed on them in their day-to-day work in interaction with the members of their team, the patient, the family member, or the companion.

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