NCPS
Nebraska Coalition for Patient Safety

NCPS Reporting Committee Summary
Quarter 1 – 2026

Could this happen in your organization?

Patient Fall in Shower

A Nurse and CNA at the nurse's station heard a loud crash and when they went to investigate, they found the patient seated on the bathroom floor. The 80-year-old patient explained that she was washing her hair and bent over to rinse the shampoo from her hair. She then lost her balance and fell backwards to the floor landing on her bottom then hitting her head on either the door or the wall. She denied loss of consciousness.

The patient's physical condition was assessed and the following found to have a reddened area to the back of the head and an abrasion to her tongue and lip (she bit them as she fell). Further physical assessment found it was safe to assist her off of the floor and into a wheelchair. She was taken to the main part of the room and transferred to the recliner. The patient's primary nurse was notified of the fall. Ice was applied to her head, the cut was cleaned and a topical med applied along with a dressing, and her limb elevated. Imaging studies were performed, and results were normal.

Contributing factors:

- **Patient was taking meds known to increase Fall Risk**:
  - Cardiovascular agents (e.g., Alpha/Beta/Calcium Channel Blockers, Antiarrhythmics, Antihypertensives, Diuretics)
  - Analgesics (e.g., Opioids, Central Analgesics, NSAIDs)
- **Patient Factors:**
  - Patient overestimated their ability to ambulate and had refused the offer of a shower chair prior to the shower
  - Patient might have been hesitant to ask for help because of fear of losing independence.
- **Policies and procedures, including clinical protocols**
  - Morse Fall Scale does not take medications into account. Can this factor somehow be accounted for? Should a different fall scale be used when the patient is on such a medication?
  - Patient scored a 35 on Morse Fall Scale (24-45 is a moderate fall risk) yet PT deemed patient independent in room because bathing or toileting activities were not considered.
  - At what Morse Fall Scale rating is a patient flagged as a fall risk? This patient was not flagged though in the moderate range.
  - Is there clear clinical guidance regarding when a hospitalized patient is allowed to independently shower?
  - Is there clear clinical guidance regarding when a patient's status can be moved from fall risk to independent mobility?
- **Communication, other than at the time of handoff/handover**
  - Need to make certain patient understands that nursing assistance is available at all times.
  - Need to make certain patient understands they should not get up if they are not feeling well.
  - PT did not know patient planned on showering when they released the patient to be independent in their room.
- **Staff qualifications –** Morse Fall Scale rating is subjective; need to verify staff's competency in scoring it.

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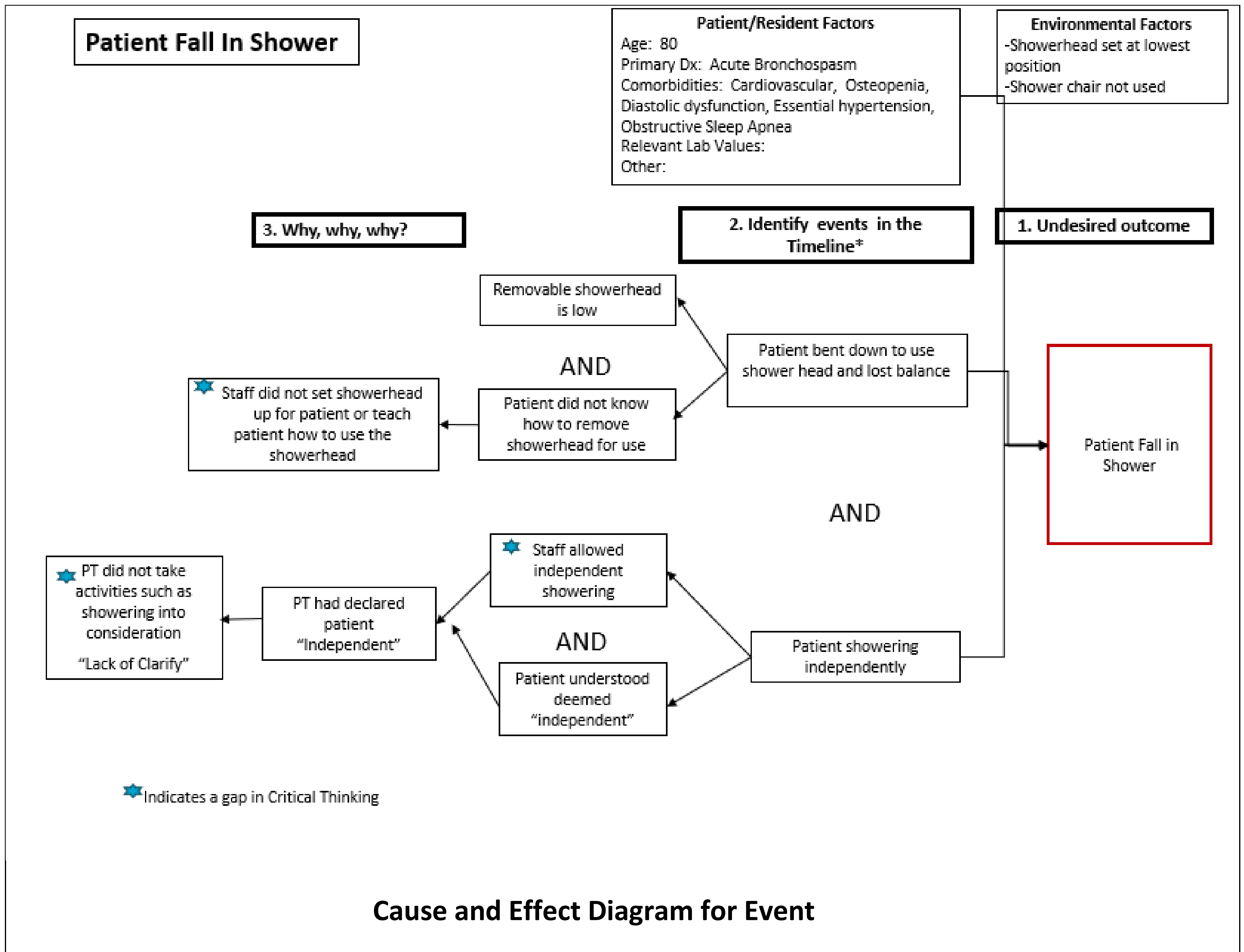

Cause and Effect Diagram for Event

Patient Fall in Shower	Yes	No	What action is needed?
Does your organization ensure that all staff responsible for completing fall risk assessments receive training and are competent in using the fall risk assessment tool appropriate for the patient population that they care for? [1, 2]			
Do your fall risk policies and procedures reflect current best practices for fall risk reduction and the use of common universal fall prevention interventions (i.e., bed in low position, call light and personal belongings within reach, declutter environment, floor clean and dry, orthostatic blood pressure checks, use of gait belts, handrails in bathrooms/hallways, assistive devices within the patient's reach, etc.)? ***See Interventions for Hospital Fall Risk Reduction***[3]			
Do your fall risk reduction policies link targeted fall risk interventions to specific risk factors (i.e., cognitive or emotional impairment, difficulty with mobility or activities of daily living, sensory impairments, medication, toileting needs). ***See Interventions for Hospital Fall Risk Reduction***[3]			
Does your staff training include tools for nursing staff to use to assess patient mobility and safe handling strategies? Does nursing staff have criteria directing them when to consider a referral to PT and/or OT? ***See Tool 3K: Algorithm for Mobilizing Patients***[4], ***Banner Mobility Assessment Tool*** [5], ***Clinical Excellence Commission "Give it a Go!" Guide***[6], ***ICU Mobilization***			

Test[7], *Veterans Affairs Safe Patient Handling App*[8] , and *Interventions for Hospital Fall Risk Reduction*[3], *Yellow Arm Band to Green Arm Band Checklist*[14]			
How do you know that different nurses' scores of an initial fall risk assessment would be similar and reassessments will be consistent for a patient that will be cared for over a longer period of time? Have you assessed the inter-rater reliability of the fall risk assessment tool? ***See*** ***Best Practices in Mobility Assessment to Decrease Fall Risk***[9]			
Does your organization have a multi-disciplinary team responsible for the fall risk reduction program? Do they perform the following activities? • Integrate fall risk reduction evidence from multiple disciplines • Establish fall risk reduction policies and procedures (e.g., risk assessment, interventions, reporting) • Conduct staff education on policies and procedures • Conduct audits and evaluations of fall risk reduction program and team performance • Collect, analyze, and learn from fall event data and audits/evaluation; modify program as needed • Communicate successes, challenges, and outcomes with key stakeholders and staff ***See*** ***Interventions for Hospital Fall Risk Reduction***[3]			
Do you routinely conduct post-fall huddles at the bedside as soon as possible after a fall? Does it include anyone who can contribute to the discussion to learn from the fall event (i.e., RN, CNA, PharmD, Rehab, MD/DO/PA/NP, Patient and /or Family)? Do attendees understand that its purpose is to determine what happened and why so that if needed the plan of care can be adjusted to reduce the risk of a repeat fall? Does it build trust? Do participants share knowledge? Are learnings shared across the organization? ***See*** ***Interventions for Hospital Fall Risk Reduction***[3],***TeamSTEPPS®***[11], ***Just Culture***[12]			
Does your organization have effective disclosure policies so that patients and their families are informed of unanticipated events and outcomes? ***See*** ***AHRQ's CANDOR toolkit***[13]			

References

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