

NURS-FPX4035 Assessment 1

Free NURS-FPX4035 Assessment 1: Enhancing Quality and Safety Sample

Course code	NURS-FPX4035
Course	Enhancing Patient Safety and Quality of Care
Assessment	Assessment 1
Deliverable	3-5 page quality-and-safety analysis with APA references
Quality-improvement focus	Preventing inpatient falls during toileting
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Model scenario notice. The patient, hospital, event details, baseline data, and performance targets are fictional and are included only to demonstrate a complete quality-and-safety analysis.

How to use this sample. Study the structure, evidence integration, clinical reasoning, and direct alignment to the scoring criteria. Replace the fictional organization, event data, and implementation assumptions with your own course-approved context and original analysis.

Academic integrity. This is an original educational model. It is not affiliated with or endorsed by Capella University and should not be submitted unchanged as a learner's own work.

Canonical sample page

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Enhancing Quality and Safety: Preventing Inpatient Falls During Toileting

Introduction. Inpatient falls are rarely caused by one careless action. They usually occur when patient risk factors, an unfamiliar environment, workflow pressure, communication gaps, and unreliable safeguards align. This paper examines a fictional fall with injury on an adult medical-surgical unit. The patient attempted to reach the bathroom without assistance during the night and sustained a hip fracture. The analysis proposes a patient-centered SAFE Toileting and Mobility Bundle that strengthens assessment, individualized planning, communication, patient engagement, medication review, and reliable execution.

Organizational setting and fictional event. Riverside Medical Center is a hypothetical 220-bed community hospital. On a 32-bed medical-surgical unit, Ms. L., age 78, was admitted with a urinary tract infection, dehydration, and weakness. Her history included hypertension, osteoarthritis, one fall in the prior year, and use of a walker. During the evening, she became intermittently confused, received a sedating sleep medication, and continued a loop diuretic. At 02:15 she tried to walk to the bathroom alone. The call light was behind her pillow, the bed alarm had been paused during linen care and not reactivated, and the bedside fall plan had not been updated after her condition changed. She fell near the bathroom and sustained a hip fracture. The case is fictional, but the contributing conditions are common and suitable for quality-improvement analysis.

Priority and scope. The unit's illustrative baseline is 4.6 falls per 1,000 patient-days and 0.9 falls with injury per 1,000 patient-days. Forty-two percent of recent falls occurred during toileting, and chart audits found that only 61% of high-risk patients had a bedside plan matching their current risks. In a real organization, the team would verify these figures through incident reports, EHR audits, staffing records, equipment checks, patient interviews, and direct observation before setting final targets.

Factors Leading to the Patient Safety Risk

Patient and clinical factors. Ms. L. had several interacting risks: advanced age, recent weakness, gait impairment, urinary urgency, prior fall, unfamiliar surroundings, fluctuating cognition, and medications that could worsen dizziness or alertness. Her risk was dynamic rather than fixed. A score recorded on admission could not capture later delirium, nighttime urgency, or medication effects. The failure to reassess after a change in cognition and medication exposure allowed a high-risk situation to develop without a matching plan.

Task and workflow factors. The unit relied on a generic "high fall risk" label instead of translating specific risks into concrete actions. Staff knew the patient was vulnerable, but the workflow did not specify scheduled toileting, one-person assistance with a walker, orthostatic precautions, or when the alarm could be paused. The call light was inaccessible, and the bed alarm was not restored. These are execution defects. A risk score has little value unless it produces an individualized plan that every team member can see and follow.

Communication and teamwork factors. The day-to-night handoff mentioned weakness but did not emphasize new confusion or toileting frequency. The nursing assistant was not included in a brief fall-risk huddle, and pharmacy was not asked to review the sedative and diuretic timing. TeamSTEPPS emphasizes clear responsibility, structured handoffs, and active patient involvement; these elements were incomplete in the event (Agency for Healthcare Research and Quality [AHRQ], 2025).

Environmental and organizational factors. Night staffing was lean, rooms were distant from the nurses' station, and responsibility for alarm checks was not explicit. The organization tracked quarterly fall rates but did not provide rapid feedback about process failures such as missing plans, inaccessible call lights, or alarm exceptions. Research on fall events supports a multifactorial view in which disease, excretion-related activity, environmental changes, and caregiver interactions combine rather than operate independently (Zhang et al., 2024).

Evidence-Based and Best-Practice Solutions

Use an individualized risk-plan-execution process. The central solution is the Fall TIPS model: assess each patient's risk factors, create a tailored prevention plan, and execute that plan consistently with the patient and family. AHRQ reports that this patient-centered toolkit has reduced falls in acute care hospitals and is designed for frontline nurses, leaders, ancillary staff, and rehabilitation professionals (AHRQ, n.d.). The Riverside adaptation would display each patient's current risks and matched interventions at the bedside and in the EHR.

Combine education with multifactorial action. A systematic review and meta-analysis found that patient and staff education had a measurable association with lower fall rates, whereas alarms or risk scores used alone did not consistently reduce falls (Morris et al., 2022). Therefore, the plan should not depend on a bed alarm. Education must be paired with scheduled toileting, safe mobility assistance, medication review, environmental controls, and reliable handoffs. Nurse-led programs are especially appropriate because nurses coordinate daily assessment, education, mobility, and escalation (Ojo & Thiamwong, 2022).

Engage patients and families through teach-back. Older patients may not recognize that hospitalization changes their mobility and judgment. Hill et al. (2024) found that patient education is more acceptable when it is individualized, respectful, timely, and connected to the person's own risks. The nurse should ask the patient to explain why assistance is needed, how to use the call light, and what the agreed toileting plan is. Family members should receive the same message so they do not unintentionally lower rails, silence alarms, or assist beyond the patient's capability.

Make safe toileting predictable. High-risk patients should receive purposeful rounding and toileting offers based on urgency, medications, intake, and usual patterns rather than a rigid schedule alone. The patient's mobility status, assistive device, footwear, path, lighting, and transfer technique must be verified. PT and OT should assess patients with new weakness, gait change, or repeated near falls. Pharmacy and the prescriber should review sedatives, antihypertensives, diuretics, and other medications that can increase dizziness or urgency.

Learn rapidly from near misses and falls. Every fall and serious near miss should trigger an immediate safety response, a nonpunitive post-event huddle, and a review of whether the risk assessment, plan, communication, equipment, and patient engagement worked. The purpose is not to find a person to blame. It is to identify which defenses failed and correct them before the next patient is harmed.

Reducing Organizational Costs

Falls create treatment costs, longer stays, diagnostic testing, staff time, reporting work, patient dissatisfaction, and potential payment consequences. In a large economic evaluation, inpatient falls were associated with substantial direct and total costs, while implementation of an evidence-based fall program was associated with net avoided costs and multi-year savings (Dykes et al., 2023). The Riverside plan is comparatively low cost because the core tools are available without licensing fees. Initial costs would include EHR configuration, posters, staff education, champion time, equipment maintenance, and limited PT/pharmacy support.

Cost reduction should be measured without creating pressure to underreport events. The finance and quality teams should track fall-related imaging, treatment, added length of stay, sitter use, overtime, and claims effects. A decrease in all falls, not only falls with injury, matters because even apparently noninjurious events generate evaluation and care costs. The plan also avoids waste by directing alarms, sitters, and intensive monitoring to patients whose individualized risks justify them rather than applying the same resource-heavy intervention to everyone.

How Nurses Coordinate Care for Safety and Value

The registered nurse is the coordinator who converts risk information into a visible and actionable plan. On admission, at each shift, after transfer, and after any meaningful change, the nurse reassesses risk factors and updates interventions. During bedside handoff, the outgoing nurse, incoming nurse, nursing assistant, patient, and family confirm the mobility level, toileting plan, assistive device, call-light access, and high-priority medication or cognition concerns. The nurse escalates orthostatic symptoms, delirium, or unsafe staffing to the appropriate clinician and charge nurse.

Nurses also lead learning and sustainment. Unit champions audit a small sample of beds each shift, coach staff in real time, and report barriers at daily safety huddles. The nurse manager reviews weekly run charts and process measures rather than waiting for quarterly outcomes. Nurses partner with PT/OT for mobility, pharmacy for medication risk, providers for clinical treatment, informatics for EHR prompts, and quality staff for data interpretation. These activities increase reliability while reducing duplication and delayed response.

Stakeholders Required to Drive Safety Enhancements

Stakeholder	Contribution to the initiative
Patients and families	Share goals and routines, participate in the tailored plan, use teach-back, and report barriers.
RNs, nursing assistants, and charge nurses	Assess and reassess risk, execute the plan, conduct handoffs and rounding, escalate changes, and collect process data.
Nurse manager and clinical educator	Set expectations, protect training time, coach staff, remove workflow barriers, and recognize reliable practice.
Physicians, advanced practice clinicians, pharmacy, PT, and OT	Address delirium, orthostasis, medication risk, strength, gait, equipment, and rehabilitation needs.
Quality, risk, informatics, finance, and executive leaders	Validate data, configure tools, review events, estimate costs, authorize resources, and sustain accountability.

Conclusion

The fictional fall was not the result of one isolated mistake. It emerged from dynamic clinical risk, weak reassessment, generic planning, interrupted communication, inaccessible equipment, and unclear ownership. Riverside should implement the SAFE Toileting and Mobility Bundle around a patient-centered risk-plan-execution process. The intervention is supported by current evidence, places nurses in a coordinating role, engages patients and families, and uses outcome, process, and balancing measures to protect both safety and value.

References

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Assessment Coverage Map

Scoring focus	Where addressed
Factors leading to a specific safety risk	Patient, workflow, communication, environmental, and organizational factors; relative contribution explained.
Evidence-based solutions and cost reduction	Fall TIPS, education, safe toileting, medication review, patient engagement, event learning, and cost analysis.
Nursing coordination	Assessment, bedside handoff, teach-back, escalation, interprofessional coordination, audits, and feedback.
Stakeholders	Stakeholder table links each role to implementation and sustainability.