

NURS-FPX4035 Assessment 2

Free NURS-FPX4035 Assessment 2: Root-Cause Analysis and Safety Improvement Plan Sample

Course code	NURS-FPX4035
Course	Enhancing Patient Safety and Quality of Care
Assessment	Assessment 2
Deliverable	Root-cause analysis template and 4-6 page safety improvement plan
Quality-improvement focus	SAFE Toileting and Mobility Bundle for inpatient fall prevention
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Model scenario notice. The organization, patient, event, baseline data, and targets are fictional. The RCA demonstrates systems analysis and does not represent an actual sentinel event.

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

<https://flexpathassignmenthelp.com/nurs-fpx4035-assessment-2-root-cause-analysis-and-safety-improvement-plan-sample>

Root-Cause Analysis and Safety Improvement Plan

Safety concern. This analysis continues the fictional inpatient fall described in Assessment 1. Ms. L., a 78-year-old patient with weakness, urinary urgency, prior fall history, and changing cognition, attempted to toilet without assistance and sustained a hip fracture. The purpose of the root-cause analysis (RCA) is to determine why the system allowed the event and to design a feasible plan that prevents recurrence.

RCA approach. The analysis uses a just-culture perspective, a chronological event review, a five-whys inquiry, and a contributing-factor matrix. The event is treated as a system learning opportunity. Individual accountability remains relevant, but the primary focus is on controllable conditions that shaped behavior and weakened defenses.

Event Chronology and Immediate Response

Time	Event	Safety implication
18:45	Evening handoff reports weakness and walker use but does not highlight new confusion or frequent toileting.	Dynamic risks are not made salient to the oncoming team.
20:10	Sedating sleep medication is administered; diuretic schedule remains unchanged.	Drowsiness, urgency, and orthostatic risk may increase.
23:40	Bed alarm is paused for linen care. Call light is placed behind the pillow.	Two key defenses are removed.
00:30	Patient asks for toileting help; assistance is provided but the next offer is not planned.	Need is recognized but not converted into a scheduled intervention.
02:15	Patient attempts to walk alone and falls near the bathroom.	Unassisted transfer reaches the patient.
02:18 onward	Rapid response, imaging, pain control, orthopedic consultation, disclosure, and event reporting occur.	Harm is treated, but prevention learning must follow.

Root-Cause Analysis

Five-Whys Analysis

Question	Finding
Why did the patient fall?	She attempted an unassisted nighttime transfer to the bathroom.
Why did she transfer without assistance?	She had urgent toileting needs, fluctuating judgment, and an inaccessible call light; the alarm was not active.
Why were safeguards unavailable?	The alarm pause had no forced restart check, the bedside plan was not updated, and responsibility for final room readiness was unclear.
Why was the plan not updated?	The workflow did not require reassessment after new confusion, sedative administration, or repeated toileting. Handoff focused on diagnoses rather than risk changes.
Why did the system allow this pattern?	Fall prevention was treated as a score and generic precautions rather than an individualized plan with patient engagement, cross-role ownership, rapid audits, and leadership feedback.

Contributing Factors and Degree of Contribution

Factor	Evidence in event	Contribution
Dynamic clinical risk	Confusion, weakness, urgency, prior fall, sedative, diuretic.	High. Created the immediate likelihood of unsafe self-transfer.
Missing reassessment and tailored plan	Risk status was not revised after clinical and medication changes.	High. Prevented matched interventions from being activated.
Alarm and call-light failure	Alarm remained off; call light was inaccessible.	High. Removed two defenses at the moment of need.
Handoff and role ambiguity	New confusion and toileting pattern were not highlighted; room-readiness ownership was unclear.	Moderate-high. Reduced shared situational awareness.
Staffing and workload	Night team covered a high-acuity assignment; response demands competed.	Moderate. Increased delay and reliance on imperfect barriers.
Patient/family education	No documented teach-back about changed mobility or toileting plan.	Moderate. Patient did not understand the immediate risk or agreed actions.

Evidence-Based Strategies

The evidence supports a tailored, multifactorial program rather than isolated alarms or generic labels. Fall TIPS formalizes the sequence of assessing individual risk factors, developing a personalized plan, and executing the plan with patients and families (AHRQ, n.d.). Morris et al. (2022) found that education was a meaningful component in hospital fall reduction, while alarm-only approaches were not consistently effective. A stepped-wedge trial also found that a multicomponent care bundle reduced fall risk and was cost-effective compared with routine care (Di Gennaro et al., 2024).

Implementation must be designed, not announced. Spoon et al. (2024) identified strategies such as education, champions, audit and feedback, workflow adaptation, leadership support, and stakeholder involvement. These strategies explain how the plan will reach practice. The unit should also use TeamSTEPPS tools to strengthen handoffs, huddles, task assignment, escalation, and patient involvement (AHRQ, 2025).

SAFE Toileting and Mobility Improvement Plan

Action	Process and rationale	Owner / target
1. Screen and reassess	Complete validated risk assessment on admission, each shift, transfer, after fall/near miss, and after a change in cognition, mobility, medication, or elimination. Document specific factors, not only a total score.	RN; >=95% completion by day 60.
2. Align a tailored bedside plan	Link each risk to an intervention and display the current plan at bedside and in the EHR. Verify walker, footwear, assistance level, call light, lighting, and alarm status.	RN + nursing assistant; >=90% plan match.
3. Facilitate toileting and mobility	Offer toileting based on urgency, diuretic timing, intake, and routine. Use gait belt/assistive device and correct staff assistance. Refer new weakness or instability to PT/OT.	RN/CNA/PT/OT; >=90% high-risk rounds.
4. Engage patient and family	Use plain language and teach-back: personal risks, call-light use, mobility help, footwear, and family role. Revisit after any change.	RN; >=85% teach-back success.
5. Communicate and escalate	Use bedside handoff and a brief fall-risk huddle. Assign responsibility by name. Escalate delirium, orthostasis, unsafe workload, and unavailable equipment.	Charge nurse and RN; 100% high-risk handoffs.
6. Learn from events	Conduct a post-fall huddle within 30 minutes when clinically appropriate, update the plan immediately, and complete a weekly multidisciplinary review of falls and near misses.	Quality champion; >=90% timely huddles.

Implementation, Measurement, and Sustainability

Phase	Activities
Days 1-30: Prepare	Confirm baseline data; map workflow; build EHR/bedside tools; identify two nurse champions per shift; test equipment; create microlearning and simulation.
Days 31-60: Pilot	Pilot on eight beds using daily huddles and twice-weekly audits. Run small PDSA cycles to correct documentation burden, alarm workflow, and role confusion.
Days 61-90: Expand	Extend to the full unit after process reliability reaches target. Share weekly run charts and patient feedback.
Months 4-6: Sustain	Embed competencies in orientation, monthly champion rounds, quarterly simulation, equipment preventive maintenance, and executive scorecards.

Outcome measures. Falls per 1,000 patient-days; falls with injury per 1,000 patient-days; percentage of toileting-related falls; and fall-related added length of stay. The six-month aim is a 30% reduction in total falls and zero repeat fall with serious injury.

Process measures. Timely reassessment, plan-risk match, teach-back success, scheduled toileting completion, call-light access, alarm restoration, bedside handoff, and post-fall huddle completion.

Balancing measures. Call-light response time, staff overtime, sitter use, restraint use, patient mobility time, alarm burden, and staff-reported documentation burden. These measures guard against reducing falls by restricting mobility or overloading staff.

Existing Organizational Resources and Priority

Priority	Existing resource	How it will be leveraged
1	EHR, incident-reporting system, and quality analysts	Build prompts, audit process reliability, calculate rates, and provide rapid feedback. Highest impact because the tools connect assessment, action, and learning.
2	Unit nurse manager, educator, and shared-governance council	Set expectations, train champions, run simulations, adapt workflow, and sustain accountability.
3	Pharmacy, PT/OT, geriatric consult, and providers	Review medications, delirium, orthostasis, strength, gait, and equipment; close clinical gaps beyond nursing scope.
4	Current beds, alarms, walkers, gait belts, non-slip footwear, and environmental services	Standardize availability, inspection, placement, and replacement before purchasing new technology.
5	Patient/family advisory council and interpreter services	Improve clarity, cultural and language access, acceptability, and real patient engagement.

Conclusion

The RCA shows that the fall resulted from several high-contribution system weaknesses: dynamic risks were not reassessed, a tailored plan was absent, the alarm and call light were unavailable, and handoff and ownership were incomplete. The SAFE Toileting and Mobility Plan responds directly to these causes through individualized planning, patient education, reliable toileting and mobility, team communication, rapid learning, and measured implementation. The plan is feasible because it uses existing organizational resources first and explicitly connects evidence to each intervention.

References

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Assessment Coverage Map

Scoring focus	Distinguished-level evidence in sample
Analyze the root cause	Chronology, five whys, contributing-factor matrix, and relative contribution ratings.
Apply best-practice strategies	Each strategy is connected to the identified cause and supported by current scholarly/professional evidence.
Create a feasible improvement plan	Six actions include owner, process, target, phased implementation, outcome/process/balancing measures, and sustainment.
Leverage organizational resources	Resources are identified and prioritized by potential impact.