SAFE Toileting and Mobility Bundle

NURS-FPX4035 Assessment 3 - Improvement Plan In-Service Presentation

- Audience: medical-surgical RNs, nursing assistants, charge nurses, educators, pharmacy, PT/OT, and quality partners
- Format: 45-minute in-service with demonstration, simulation, debrief, and evaluation
- Fictional trigger event: older adult fall with hip fracture during unassisted nighttime toileting
- Aim: prevent falls without unnecessarily restricting mobility

Presenter notes

Welcome participants and explain that the session follows a fictional fall with injury examined through a root-cause analysis. The purpose is learning, not blame. A patient with weakness, urinary urgency, changing cognition, and medication-related risk attempted to reach the bathroom alone. Several safeguards were missing or unreliable. This in-service introduces a practical bundle that makes the safe action easier during routine work and during busy night shifts. Emphasize that fall prevention does not mean keeping every patient in bed. The goal is safe, supported mobility and toileting. Staff will review the evidence, see the workflow, practice a realistic scenario, and give feedback before the pilot. State that the data are illustrative and must be replaced with verified organizational information in a real presentation.

Purpose, Goals, and Agenda

- Explain why the fall-prevention initiative is needed and how it addresses root causes
- Demonstrate the Screen-Align-Facilitate-Engage workflow
- Apply the bundle during a nighttime toileting simulation
- State each team member's role and escalation responsibility
- Evaluate confidence, skill performance, and remaining barriers
- Agenda: 10 min evidence/event; 12 min workflow; 15 min practice; 5 min debrief; 3 min evaluation

Presenter notes

Review the learning outcomes in observable terms. By the end of the session, participants should be able to identify dynamic fall risks, build a patient-specific plan, prepare the environment, complete a structured handoff, and respond when a safeguard is unavailable. The session includes active practice because staff need to perform the workflow, not only listen to a lecture. Invite participants to place nonurgent implementation questions on a parking board. Questions that affect immediate patient safety should be raised at once. Explain that the evaluation will ask about both knowledge and feasibility. A process cannot be sustained if it is clinically sound but impossible to use during real work.

Why Change Is Needed

- Fictional event: confusion + urgency + weakness + sedative + inaccessible call light + inactive alarm
- Patient attempted unassisted toileting and sustained a hip fracture
- Illustrative baseline: 4.6 falls and 0.9 injurious falls per 1,000 patient-days
- 42% of recent falls occurred during toileting; only 61% of plans matched current risks
- Falls cause physical harm, fear, longer stays, treatment costs, and staff distress

Presenter notes

Tell the event in sequence without naming or blaming an individual. The patient had several changing risks, but the plan remained generic. The bed alarm was paused and not restarted, the call light was inaccessible, and the handoff did not make the new confusion or toileting pattern salient. Explain that the baseline measures are fictional examples used to demonstrate how a unit establishes need. Dykes and colleagues found that inpatient falls create substantial direct and total costs, including falls without documented injury. The business case supports preventing all falls, while the ethical case is even stronger: patients should not experience avoidable injury or loss of independence during hospitalization.

What the Root-Cause Analysis Found

- Dynamic clinical risk was not reassessed after cognition and medication changes
- A generic high-risk label did not produce a tailored toileting and mobility plan
- Call-light access and alarm restoration were unreliable
- Handoff and role assignment did not create shared situational awareness
- Workload and distance delayed response
- Patient and family teach-back was absent
- Data arrived too late to support rapid learning

Presenter notes

Use this slide as a systems review. Ask participants which factors are within the control of the bedside team, unit leadership, and larger organization. Explain that replacing one alarm would not solve the problem. The improvement plan must address assessment, planning, equipment, patient engagement, communication, and feedback together. Encourage staff to describe workflow barriers without disclosing identifiable patient events. Capture common themes such as duplicate documentation, unclear mobility orders, inaccessible equipment, delayed pharmacy review, or difficulty finding a second staff member. These observations will inform the pilot's PDSA cycles.

The SAFE Bundle at a Glance

- S - Screen and reassess specific fall risks
- A - Align each risk with a visible, individualized plan
- F - Facilitate safe toileting, mobility, medication review, and environment
- E - Engage patients and families; escalate changes and unavailable safeguards
- The sequence is completed on admission, each shift, transfer, and after meaningful change

Presenter notes

Introduce the mnemonic. Screen means identifying specific risks such as urgency, delirium, weakness, orthostasis, prior falls, and high-risk medications. Align means matching each risk to an action and showing the plan at the bedside and in the EHR. Facilitate means making safe toileting and mobility happen through timely offers, correct assistance, equipment, and clinical review. Engage means using teach-back, including family, and escalating conditions that the bedside team cannot solve alone. The bundle is simple enough to remember but specific enough to guide action. It should be integrated into existing workflow rather than added as a separate paper task.

Step 1: Screen and Reassess

- Assess on admission, each shift, transfer, after a fall/near miss, and after clinical change
- Record specific risks, not only a total score
- Triggers: delirium, dizziness, new weakness, sedative/diuretic change, urgency, mobility order change
- Verify orthostatic symptoms, cognition, gait, assistive device, elimination pattern, and prior falls
- Escalate new or unexplained changes to the provider and charge nurse

Presenter notes

Demonstrate how a static admission score can become outdated. Use a sample patient who is independent in the morning but develops dizziness after medication and confusion overnight. The nurse should update the risk assessment and interventions immediately rather than wait for the next scheduled assessment. Emphasize that the purpose of screening is not documentation completion. It is to identify actionable factors. Ask participants to name one intervention for each risk. For example, urgency may lead to planned toileting; orthostasis may require slow position changes, vital signs, medication review, and assistance; delirium may require treatment of causes, frequent reorientation, family involvement, and closer observation.

Step 2: Align a Tailored Plan

- Make the bedside plan match the current EHR assessment
- State assistance level, device, toileting timing, footwear, alarm status, and special risks
- Confirm plan with RN, nursing assistant, patient, and family
- Use plain language and icons when appropriate
- Remove outdated interventions immediately to prevent conflicting instructions

Presenter notes

Show a fictional bedside plan. Avoid labels that tell staff only that a patient is high risk. The plan should say what the patient needs: one-person assist with walker, gait belt, toileting every two hours and before sleep, call before standing, and slow position changes. Explain that conflicting information is dangerous. If the whiteboard says independent while the EHR says two-person assist, staff and family may act on the wrong instruction. The nurse owns clinical validation, but every team member should be able to identify a mismatch and stop the process until it is corrected. Use interpreter services and accessible formats when language, vision, hearing, or cognition affects understanding.

Step 3: Facilitate Safe Toileting and Mobility

- Offer toileting based on urgency, intake, diuretic timing, sleep routine, and patient preference
- Prepare: call light, clear path, lighting, low bed, locked wheels, footwear, walker, gait belt
- Use the ordered assistance level and safe transfer technique
- Request PT/OT for new weakness, gait change, equipment need, or repeated near falls
- Request medication review for sedatives, antihypertensives, diuretics, and other contributors
- Do not use immobility or restraints as the default fall-prevention strategy

Presenter notes

Demonstrate room preparation and a safe transfer. Ask participants to identify hazards before the patient stands. Explain that scheduled toileting must be individualized; a rigid two-hour schedule may not fit a patient receiving a diuretic or one with a usual nighttime pattern. Safe mobility protects function and reduces deconditioning. The aim is not zero movement. Discuss when to involve PT, OT, pharmacy, and the provider. If an alarm is ordered, it is an additional cue, not a replacement for assistance, education, or observation. Morris and colleagues found that alarms alone did not consistently reduce falls, which supports a broader bundle.

Step 4: Engage, Communicate, and Escalate

- Teach-back: patient explains personal risks, call-light use, mobility help, and toileting plan
- Include family and caregivers in the same plan
- Bedside handoff: risk factors, recent changes, assistance level, next toileting offer, and open concerns
- Assign responsibility by name during huddles and high-risk periods
- Escalate equipment failure, unsafe workload, delirium, orthostasis, or repeated unsafe attempts
- Use a post-fall huddle for learning, not blame

Presenter notes

Model a short teach-back conversation: 'Because you became dizzy and weak tonight, please call before standing. Tell me what you will do when you need the bathroom.' If the patient cannot accurately teach back, the nurse changes the teaching method and increases support. During handoff, use specific language rather than 'fall precautions in place.' The incoming team should know the next toileting time and who will respond. TeamSTEPPS supports structured handoffs, huddles, task clarity, and patient involvement. Remind staff that escalation is expected when the environment is unsafe. A nurse should not silently work around missing equipment or an assignment that makes required observation impossible.

Roles That Make the Plan Work

- RN: reassess, update plan, teach, coordinate, escalate, and evaluate
- Nursing assistant: purposeful rounding, toileting, environment checks, and immediate reporting of changes
- Charge nurse: balance assignments, remove barriers, coordinate huddles, and support escalation
- Pharmacy/provider: review medications, delirium, orthostasis, and treatment plan
- PT/OT: mobility, transfers, strength, equipment, and safe activity plan
- Educator/champion/quality: train, audit, coach, analyze data, and run PDSA cycles
- Patient/family: share routines and goals, follow the agreed plan, and speak up

Presenter notes

Explain that shared responsibility is not vague responsibility. Each action needs an owner. The RN validates the plan, while the nursing assistant is essential to reliable toileting and observation. The charge nurse helps when competing demands make the plan impossible. Pharmacy, providers, PT, and OT address risks outside nursing's independent scope. Champions coach rather than police. Patients and families are active team members, not passive recipients. Ask each role group to identify one barrier they may face and one support they need. Capture requests for equipment, documentation changes, staffing adjustments, or language resources.

Practice Scenario: What Would You Do?

- Mr. J., age 81, is admitted with pneumonia and weakness
- At 22:00 he receives a diuretic and reports dizziness when standing
- At 23:30 he is mildly confused and tries to leave the bed
- The walker is across the room; the alarm battery is low; the call light is under the blanket
- In pairs, complete SAFE and prepare a 30-second bedside handoff

Presenter notes

Give pairs three minutes to identify risks and actions. Expected actions include reassessment, orthostatic and cognitive evaluation, notifying the provider as clinically indicated, moving the call light and walker within safe reach, replacing or repairing the alarm if part of the plan, scheduling toileting around the diuretic, using the correct assistance and gait belt, providing teach-back, updating the bedside and EHR plan, and briefing the nursing assistant and charge nurse. The handoff should identify what changed, what the patient needs now, and who is responsible for the next toileting offer. Observe whether participants focus only on the alarm. Redirect them to the entire individualized plan.

Skills Check and Debrief

- Skill 1: identifies at least four specific dynamic risk factors
- Skill 2: matches each major risk to an action
- Skill 3: prepares environment and equipment before transfer
- Skill 4: uses teach-back and includes family needs
- Skill 5: gives a concise handoff with named responsibility
- Skill 6: escalates unavailable safeguards rather than using an unsafe workaround
- Debrief: What helped? What would fail on a busy night? What should the pilot change?

Presenter notes

Use a simple observation checklist. Participants pass by completing all critical safety steps, not by reciting the mnemonic. During debrief, first ask what went well, then what was difficult, and finally what system change would make the process easier. This sequence keeps the discussion constructive. If a participant misses a step, provide coaching and repeat the scenario. Explain that training evaluation will include knowledge, observed skill, and confidence. However, high confidence alone is not proof of competence. The pilot will also measure actual process reliability and patient outcomes.

Measurement, Feedback, and Implementation

- Outcome: total falls, injurious falls, toileting-related falls, added length of stay
- Process: reassessment, plan match, teach-back, rounding, call-light access, alarm restoration, handoff, post-fall huddle
- Balancing: mobility time, restraints, sitter use, alarm burden, response time, overtime, documentation burden
- Days 1-30 prepare; days 31-60 eight-bed pilot; days 61-90 expand; months 4-6 sustain
- Weekly run charts and barrier feedback return to staff quickly
- Six-month aim: 30% fewer falls and zero repeat serious-injury event

Presenter notes

Explain the difference between outcome, process, and balancing measures. Falls may be too infrequent to show immediate change, so process measures reveal whether the bundle is being used. Balancing measures ensure that the team does not reduce falls by restricting mobility, increasing restraints, or creating unsustainable workload. Data should be returned quickly and in a form staff can act on. The implementation starts small, tests workflow, and expands only after key processes are reliable. Unit champions will conduct brief audits and coach at the bedside. Leadership will review barriers that require equipment, staffing, policy, or EHR changes.

Commitment, Evaluation, and Key Evidence

- Before leaving: write one action you will use and one barrier leaders must address
- Complete the one-minute evaluation and confidence rating
- Questions and feedback are part of the improvement plan
- Key evidence: AHRQ Fall TIPS; Dykes et al. (2023); Morris et al. (2022); Di Gennaro et al. (2024); Hill et al. (2024); Spoon et al. (2024)
- Thank you for protecting safe mobility, dignity, and independence

Presenter notes

Close by restating that reliable fall prevention is patient-centered, individualized, and team-based. Ask participants to write one personal practice commitment and one system barrier. The educator and manager will categorize the barriers and respond before the pilot begins. Review the reporting route for urgent safety problems. Invite questions and ask whether the communication format was clear and respectful. Explain that the toolkit from Assessment 4 will remain available after the session for evidence, scripts, checklists, and implementation guidance. Thank staff for speaking openly about workflow. Improvement depends on their experience and the organization's willingness to act on it. Cite the references shown and direct participants to the full reference list and links in the presenter materials.