FlexPath Assignment Help

NURS-FPX4035 Assessment 4

Free NURS-FPX4035 Assessment 4: Improvement Plan Tool Kit Sample

Course code	NURS-FPX4035
Course	Enhancing Patient Safety and Quality of Care
Assessment	Assessment 4
Deliverable	Resource repository with 12 annotated scholarly and professional resources
Quality-improvement focus	Implementation and sustainability of the SAFE Toileting and Mobility Bundle
Author metadata	Flexpath assignment help
Publication date	August 7, 2026

Model scenario notice. The hospital and improvement initiative are fictional. The external resources are real scholarly or professional materials selected to demonstrate a complete tool kit.

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-4-improvement-plan-tool-kit-sample

Improvement Plan Tool Kit: SAFE Toileting and Mobility Bundle

Target audience. Medical-surgical nurses, nursing assistants, charge nurses, educators, clinical champions, and interprofessional partners implementing and sustaining the inpatient fall-prevention plan.

How the toolkit is organized. The 12 resources are grouped into four practical categories: understanding risk and cost; designing evidence-based prevention; engaging patients and teams; and implementing, measuring, and sustaining change. Each annotation explains what the resource provides, why it is valuable, and when frontline staff or leaders should use it.

Quick-start sequence. Begin with the AHRQ Fall TIPS toolkit to understand the core model. Use the risk and cost resources to establish the local problem. Use the evidence resources to select interventions. Use the communication and implementation resources to train the team, test the workflow, and sustain reliable practice.

Category 1: Understanding Risk, Harm, and Organizational Cost

Zhang, Tan, and Sui (2024)

Zhang, J., Tan, L., & Sui, W. (2024). Quantitative analysis of the causes of falls in adult hospitalized patients based on the perspective of text mining. *Journal of Investigative Surgery*, Article 2397578. https://doi.org/10.1080/08941939.2024.2397578

Information and value. This study analyzes 2,772 adult inpatient fall reports using text-mining methods. It organizes recurring causes across patient condition, elimination activity, environment, and caregiver interaction. The resource helps staff move beyond a single-cause explanation such as "the patient did not call" and recognize how multiple conditions combine.

How and when to use it. Use it during RCA meetings, safety huddles, and annual education to build a broad contributing-factor checklist. Quality analysts can compare the study's themes with local incident narratives. Nurses can use the categories to ask better questions after a near miss: What changed clinically? Was the fall connected to toileting? Was the environment ready? Did the team share the same plan?

AHRQ PSNet (2024)

Agency for Healthcare Research and Quality. (2024, December 18). *The ongoing journey to prevent patient falls*. PSNet. https://psnet.ahrq.gov/perspective/ongoing-journey-prevent-patient-falls

Information and value. This current patient-safety overview explains the scope of hospital falls, common individual and organizational risk factors, the importance of individualized multifactorial prevention, and the role of safety culture and patient engagement. It also connects fall prevention with cost, implementation, and care across settings.

How and when to use it. Use it as an accessible orientation resource for new staff, champions, and leaders who need a concise evidence overview before working with detailed tools. The article is useful in leadership briefings because it explains why fall prevention remains difficult even when hospitals own alarms and risk scales. It supports a shift from purchasing isolated devices to implementing a complete evidence-based program.

Dykes et al. (2023)

Dykes, P. C., Curtin-Bowen, M., Lipsitz, S., et al. (2023). Cost of inpatient falls and cost-benefit analysis of implementation of an evidence-based fall prevention program. *JAMA Health Forum, 4*(1), e225125. https://doi.org/10.1001/jamahealthforum.2022.5125

Information and value. This large economic evaluation estimates the clinical and financial burden of inpatient falls and assesses savings associated with an evidence-based fall-prevention program. It shows that noninjurious falls also generate substantial costs and that prevention can produce net avoided costs.

How and when to use it. Use it when developing the business case, prioritizing staff education and champion time, or requesting EHR and bedside resources. Finance and quality leaders can adapt the cost framework to local data. Nurse managers can use the findings to explain why all falls and near misses matter, not only events with obvious injury. The article also helps prevent false economies such as delaying training to save short-term labor cost.

Category 2: Evidence-Based Prevention Design

AHRQ Fall TIPS toolkit

Agency for Healthcare Research and Quality. (n.d.). *Fall TIPS: A patient-centered fall prevention toolkit*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-tips/index.html

Information and value. Fall TIPS provides a practical, patient-centered three-step process: assess specific risk factors, develop a personalized plan, and execute the plan consistently. It includes bedside communication approaches and supports both high-technology and low-technology implementation.

How and when to use it. Use this as the core implementation resource. Educators can develop training and competency checks from it; informatics can connect risk factors to interventions; champions can audit whether the bedside plan matches the EHR and whether the patient knows the plan. It is especially appropriate when a unit currently relies on a generic fall-risk label or alarm without a patient-specific strategy.

Morris et al. (2022)

Morris, M. E., Webster, K., Jones, C., Hill, A.-M., Haines, T., McPhail, S., Kiegaldie, D., Slade, S., Jazayeri, D., Heng, H., Shorr, R., Carey, L., Barker, A., & Cameron, I. (2022). Interventions to reduce falls in hospitals: A systematic review and meta-analysis. *Age and Ageing, 51*(5), afac077. https://doi.org/10.1093/ageing/afac077

Information and value. This systematic review and meta-analysis compares hospital fall-prevention interventions. Education was associated with lower fall rates and odds of falling, while alarms, sensors, and scored risk tools used alone were not consistently effective. The review supports multifactorial, behavior-linked practice rather than reliance on equipment.

How and when to use it. Use it when selecting bundle components and when staff assume that a bed alarm is the entire plan. Educators can use the findings to justify patient and staff education. Leaders can use it to avoid investing in devices without workflow, teaching, and individualized interventions. The review is also valuable when evaluating whether a proposed practice is supported by evidence or only by local habit.

Di Gennaro et al. (2024)

Di Gennaro, G., Chamitava, L., Pertile, P., Ambrosi, E., Mosci, D., Fila, A., Alemayohu, M. A., Cazzoletti, L., Tardivo, S., & Zanolin, M. E. (2024). A stepped-wedge randomised controlled trial to assess efficacy and cost-effectiveness of a care-bundle to prevent falls in older hospitalised patients. *Age and Ageing, 53*(1), afad244. https://doi.org/10.1093/ageing/afad244

Information and value. This stepped-wedge randomized trial evaluates a care bundle for older hospitalized patients and reports a protective effect on fall risk along with cost-effectiveness findings. It demonstrates that a coordinated bundle can outperform routine practice in real hospital clusters.

How and when to use it. Use it to support adoption of a multicomponent bundle and to guide pilot design. Quality teams can compare the trial's bundle structure and measures with the local SAFE plan. Leaders can cite the study when explaining why staged implementation and economic evaluation are appropriate. The trial is most useful during planning, governance review, and decisions about whether the pilot should expand.

Category 3: Patient, Family, Nursing, and Team Engagement

Hill et al. (2024)

Hill, A.-M., Francis-Coad, J., Vaz, S., Morris, M. E., Flicker, L., Weselman, T., & Hang, J. A. (2024). Implementing falls prevention patient education in hospitals: Older people's views on barriers and enablers. *BMC Nursing, 23*, 633. https://doi.org/10.1186/s12912-024-02289-x

Information and value. This qualitative study reports older patients' and caregivers' views on barriers and enablers to hospital fall-prevention education. It emphasizes respectful, individualized, timely education that connects with the patient's circumstances and supports involvement rather than simply delivering information.

How and when to use it. Use it to design teach-back scripts, bedside posters, family education, and interpreter-supported communication. Nurses should consult it when patients resist assistance because they believe they are still independent. The resource helps the team frame education around dignity, goals, and changed hospital conditions. Patient-family advisors can use it when reviewing materials for clarity and acceptability.

Ojo and Thiamwong (2022)

Ojo, E. O., & Thiamwong, L. (2022). Effects of nurse-led fall prevention programs for older adults: A systematic review. *Pacific Rim International Journal of Nursing Research, 26*(3), 417-431.

Information and value. This systematic review focuses on nurse-led fall-prevention programs for older adults. It shows that nursing-led programs are viable and highlights education, behavior change, fall rates, and injury outcomes. The resource supports the nurse's leadership role in assessment, teaching, coordination, and evaluation.

How and when to use it. Use it in nurse orientation, shared governance, and champion development. Nurse managers can use it to define leadership expectations beyond completing a risk score. Staff can use the review to understand why nurses are positioned to connect medication, mobility, toileting, cognition, environment, and patient education. It is particularly useful when clarifying scope and accountability across RN and assistive personnel roles.

AHRQ TeamSTEPPS 3.0

Agency for Healthcare Research and Quality. (2025). *TeamSTEPPS updates*. https://www.ahrq.gov/teamstepps-program/updated/index.html

Information and value. TeamSTEPPS provides evidence-informed tools for handoffs, briefs, huddles, task assignment, mutual support, escalation, and patient-family engagement. The updated curriculum uses active learning and can be delivered in shorter modules that fit clinical schedules.

How and when to use it. Use TeamSTEPPS to standardize the communication elements of the SAFE bundle. Educators can build role-play and simulation around bedside handoff and escalation. Charge nurses can use briefs and huddles during high-risk periods. Staff should use named responsibility and closed-loop communication when a patient needs urgent toileting, an alarm fails, or staffing makes the plan difficult. Leaders can use the modular design for ongoing microlearning.

Category 4: Implementation, Measurement, and Sustainability

Spoon et al. (2024)

Spoon, D., de Lege, T., Oudshoorn, C., van Dijk, M., & Ista, E. (2024). Implementation strategies of fall prevention interventions in hospitals: A systematic review. *BMJ Open Quality, 13*(4), e003006. https://doi.org/10.1136/bmjoq-2024-003006

Information and value. This systematic review examines implementation strategies used for hospital fall-prevention interventions. It highlights that evidence alone does not guarantee adoption; successful implementation requires deliberate education, local adaptation, champions, audit and feedback, stakeholder involvement, and leadership support.

How and when to use it. Use it to build the implementation plan and avoid the common mistake of distributing a policy without changing practice. Quality leaders can map each strategy to an owner and timeline. Champions can use audit and feedback methods from the review to provide rapid coaching. The article is particularly valuable when a unit has had repeated campaigns that produced short-term attention but no sustained change.

McLennan et al. (2024)

McLennan, C., Sherrington, C., Suen, J., Nayak, V., Naganathan, V., Sutcliffe, K., Kneale, D., Haynes, A., & Dyer, S. (2024). Features of effective hospital fall prevention trials: An intervention component analysis. *BMC Geriatrics, 24*, 1023. https://doi.org/10.1186/s12877-024-05587-w

Information and value. This intervention-component analysis explores features associated with effective hospital fall-prevention trials. Tailoring the intervention, involving patients and families, and integrating the program with the local setting emerged as important features. The study explains why copying a checklist without adapting workflow may fail.

How and when to use it. Use it during pilot design and PDSA review. The implementation team can ask whether the bundle fits medication-pass timing, staffing, room layout, EHR workflow, and patient characteristics. Patient and family involvement should be treated as a required component, not an optional education step. The article is useful when balancing fidelity to evidence with thoughtful local adaptation.

Sultana et al. (2025)

Sultana, M., Taylor, C., McPhee, D., Chandler, A., Hyde, H., Yekinni, I., Sayeed, N., & Bessey, M. (2025). Reducing falls in inpatient older adults: Quality improvement initiative. *Health Services Management Research*. https://doi.org/10.1177/13872877251360031

Information and value. This quality-improvement initiative combines validated risk assessment with a fall-prevention bundle for hospitalized older adults, including those with cognitive impairment. The reported reduction in fall rate demonstrates how assessment, environment, monitoring, education, and community connections can be implemented together.

How and when to use it. Use it as an applied example when designing the pilot, selecting measures, and communicating achievable improvement. Nurse leaders can compare the project's components with local resources such as sitters, interpreters, alarms, environmental checks, and caregiver education. It is helpful during sustainment planning because it shows how QI methods translate evidence into routine operations rather than remaining a research recommendation.

Toolkit Use Map

Situation	Start with	Then use
Preparing the business case	Dykes et al.; AHRQ PSNet	Local incident, cost, staffing, and LOS data.
Selecting bundle components	AHRQ Fall TIPS; Morris et al.; Di Gennaro et al.	Map patient-specific risks to local workflow and equipment.
Training and patient engagement	Hill et al.; Ojo & Thiamwong; TeamSTEPPS	Teach-back scripts, bedside handoff, simulation, and role clarity.
Launching a pilot	Spoon et al.; McLennan et al.; Sultana et al.	Champions, PDSA cycles, rapid audit/feedback, and balancing measures.
Reviewing a fall or near miss	Zhang et al.; AHRQ PSNet	Chronology, contributing-factor analysis, and immediate plan correction.

Frontline Quick-Start Checklist

- Confirm current specific risks and update the plan after any meaningful change.
- Make the call light, mobility device, footwear, lighting, and assistance plan ready before the patient needs them.
- Offer toileting based on the patient's pattern, urgency, medication timing, and preference.
- Use teach-back and include family or caregivers in the same plan.
- Communicate changes during bedside handoff and assign responsibility by name.
- Escalate missing equipment, unsafe workload, delirium, orthostasis, or repeated unsafe attempts.
- After a fall or serious near miss, treat the patient first, update the plan, and participate in a nonpunitive huddle.
- Use the toolkit to answer the specific question rather than reading every resource at once.

Sustainability Plan

The repository should remain active after the in-service. The educator or quality champion should review links quarterly, replace outdated materials, and add locally approved job aids. New staff should receive the quick-start resources during orientation. Unit champions should use the evidence during monthly audits and after events. Leadership should review whether staff can access the toolkit from clinical workstations and mobile devices. The site should also state an owner and review date so staff know the content is maintained.

Assessment Coverage Map

Scoring focus	How the toolkit addresses it
Necessary resources	Twelve current scholarly or professional resources are organized into four implementation-critical categories.
Usefulness to role group	Each annotation explains information, skill, or tool provided and connects it to nursing, leadership, quality, or interprofessional work.
Value for risk reduction	Each resource is linked to a specific safety mechanism: risk analysis, tailored planning, education, communication, implementation, or measurement.
Reasons and relevant situations for use	Every annotation states when and how the target audience should use the resource; the use map provides scenario-based navigation.