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General metrics

12,224	1,701	80	6 min 48 sec	13 min 5 sec
characters	words	sentences	reading time	speaking time

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Writing Issues

15	6	9
Issues left	Critical	Advanced

Plagiarism

This text hasn't been checked for plagiarism

Writing Issues

7 Clarity

7 Paragraph can be improved

7 Correctness

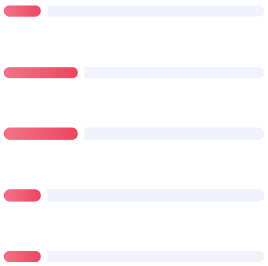
1 Citation style options

2 Incorrect punctuation

2 Ungrammatical sentence

1 Pronoun use

1 Incorrect verb forms



1 Delivery

1 Inappropriate colloquialisms

Unique Words

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unique words

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39%

rare words

Word Length

Measures average word length

5.6

characters per word

Sentence Length

Measures average sentence length

21.3

words per sentence

MPW-484744

8

Professional Practice Plan

Fall Prevention in Acute Care: A Practice Improvement Initiative

[Student Name]

[University Name]

[Course Number and Name]

[Instructor Name]

[Date]

Professional Practice Plan

Fall Prevention in Acute Care: A Practice Improvement Initiative

Patient falls in acute care hospitals are one of the most common and avoidable negative events in modern health care provision. Falls can be described as[1] unexpected drops to the ground, associated or not with injuries, and are identified by the Centers for Medicare & Medicaid Services (CMS) as healthcare-acquired issues with serious financial, legal, and clinical implications (Schoberer et al., 2022)[2]. About 10 percent of older patients in acute inpatient care will have at least one fall during their hospital stay, and over a quarter will have physical injuries that make their recovery process harder and result in longer hospital stays (Schoberer et al., 2022)[2]. Although fall prevention protocols have been widely implemented across hospital systems, fall rates remain higher than institutional benchmarks, and a gap persists between policy intent and clinical practice. This gap has been documented and is not due to a lack of tools, but to inconsistent use of multifactorial and individualized prevention measures and insufficient nurse-led patient interaction (Weber et al., 2024)[2]. This proposal seeks to fill such a gap in an urban acute care medical-surgical hospital by creating and implementing a structured, evidence-based fall prevention bundle. The current inpatient falls rate at the practice site is over 4.0 falls per 1,000 patient days, which is above the institutional safety rate of 3.1 falls per 1,000 patient days; hence, a quality improvement project that involves nursing staff training, customized fall risk assessment, and patient communication should be implemented to improve inpatient falls by 30% within 12 months of full implementation. This Professional Practice Plan explains the target population (at risk), outlines the

important stakeholders, and develops a clinical question to inform the proposed intervention.

Population

The intended group for this practice improvement initiative includes adult inpatients in the medical-surgery units of an urban acute care hospital. The patients in this program are adults who are 60 years and above and are at high risk of falls according to the Morse Fall Scale (MFS) with a score of 25 or above being regarded as high-risk persons of falls (Doody et al., 2025). A significant feature of this population is multimorbidity, where such conditions as heart failure, chronic obstructive lung disease, diabetes mellitus, orthopedic diagnosis, neurological (stroke and Parkinson disease) and post-operative recovery diagnoses are frequent. Impaired mobility, cognitive impairment or delirium, polypharmacy including balance or cognition-related drugs, incontinence, and assistive devices are some of the typical risk factors to include in such patients (Doody et al., 2025). Physical and cognitive risk dual vulnerability of high-risk fallers is evidenced by the fact that approximately 56% of high-risk fallers in such settings show measurable cognitive damage with reputable evaluation tools such as the Montreal Cognitive Assessment (MoCA) (Doody et al., 2025). The patients not covered by the initiative are those who are directly admitted to intensive care, are in hospice/comfort care, or have less than 24 hours' length of stay since they limit the potential of structured education and bundle implementation. The secondary population includes family members and informal caregivers that are present with the patient in the hospital throughout the hospitalization period and are influential participants in fall prevention education and post-discharge safety planning.

Stakeholders

This fall prevention initiative will only be successful with the meaningful involvement of interdisciplinary stakeholders across clinical, administrative, and patient-facing roles. The intended stakeholders include bedside registered nurses (RNs) and licensed practical nurses (LPNs) working in medical-surgical units. The tasks of these clinicians include fall risk assessment at admission and at every shift change, application of individualized fall prevention bundles, and systematic patient and family education. Their buy-in and competency development are core to the initiative because of their central role in care delivery. Monthly simulation-based educational activities involving nurses, based on actual case scenarios and unit fall data, will be used to develop assessment confidence and protocol adherence (Doody et al., 2025)[2]. Individualized communication with this group will focus on the clinical and professional significance of the initiative, including statistics on patient injuries from falls and the quantifiable effect of nurses' interventions on patient safety.

A second important group of stakeholders is unit nurse managers, the patient safety director, and the Director of Nursing, whose institutional power is key to policy adoption, resource mobilization, and performance monitoring. Such leaders will participate in quarterly data review meetings, where trends in fall rates, near-misses, and bundle compliance indicators will be discussed. The communication to this population will focus on organizational risk reduction, regulatory compliance with CMS requirements, and the proven cost savings associated with fall prevention programs, with an approximate 14,600 per 1,000 patient days avoided (Mulkey et al., 2024)[2]. The administrative stakeholders will be requested to officially lead the initiative[10] and to incorporate fall prevention measures into the unit performance scorecards to maintain accountability.

A third group of stakeholders includes the physical therapist, occupational therapist, pharmacist, and physician, who will help develop the multidisciplinary fall risk profile for each patient. Physical and occupational therapists carry out mobility assessments and assistive device recommendations; medication reconciliation by pharmacists to determine the presence of fall-potentiating agents; and care orders that indicate fall risk status are authorized by attending physicians. The work with these stakeholders will be supported by organized interdisciplinary rounding for high-risk patients and the implementation of fall risk flags in the electronic health record (EHR) system. The process of achieving their cooperation will be based on developing shared accountability through the introduction of a formal interdisciplinary fall prevention committee that will convene monthly to discuss incidents and optimize the bundle protocol in response to new evidence (Spoon et al., 2024)[2]. Although not institutional employees, patients and their families are also essential partners, as active engagement with and compliance with fall prevention advice have been associated with a significant decrease in incidents in acute care settings (Weber et al., 2024)[2]. The patients will become the players in their own safety rather than the subjects of care by being informed about their risk factors for falling, encouraged to seek help before regaining their feet, and reminded of the importance of assistive devices. Similarly, family members at the bedside can facilitate nursing care, monitor the patient, and promptly inform staff of any risks. A patient-centered, collaborative model would transform fall prevention into a clinical intervention into a shared responsibility that permeates the care environment and would eventually enhance the overall effectiveness of any organized fall prevention bundle.

Problem Question

To ensure the practice setting's methodological accuracy and applicability, the question guiding this initiative was framed in the PICO format. The PICO question will be the following: Among hospitalized adult inpatients aged 60 years or older and identified as being at high risk of falls on medical-surgical units (Population), does the application of a structured, nurse-led multifactorial fall prevention bundle, which includes individualized risk assessment with the Morse Fall Scale, patient and family education, environmental safety modifications, and interdisciplinary collaboration (Intervention), compared P (population) includes mentally and physically frail elderly admitted to acute inpatient units. The intervention (I) is a nurse-led, interdisciplinary, and staff-educated fall prevention bundle.

The current, disparate approach to fall prevention, where safety measures are not uniformly applied across shifts and across care teams, is the comparison (C) and results in inconsistent use of safety measures and gaps in patient monitoring. The outcome (O) is a quantifiable, irreversible decrease in fall rates, consistent with benchmarks for other quality improvement initiatives, in which fall rates were reduced to 2.54 per 1,000 patient days when structured bundles were implemented (Mulkey et al., 2024)[2]. These measurable benefits demonstrate the clinical significance of adhering to a coherent, evidence-based practice, provingndardization[11,12] not only makes nursing employees more accountable but also allows acenablesm,[11,12] system-wide changes in the number of preventable patient injuries.

Conclusion

The Professional Practice Plan has provided a detailed evidence-based plan to the[13] long-standing dilemma of inpatient falls in a medical-surgical acute care facility. The identified group of interest in the plan is hospitalized older adults with a high score on the Morse Fall Scale (60 years and above), as they present

complex clinical profiles with multimorbidity, cognitive impairment, polypharmacy, and mobility deficiencies. The most significant stakeholders, such as bedside nurses, unit managers, the patient safety director, interdisciplinary clinicians, and patient-family partners, have been outlined, as well as specific approaches to ensuring their interest and cooperation. The PICO question created to address this initiative offers a rigorous clinical model for evaluating the efficacy of a formalized nurse-led fall prevention package relative to current standard care, and a definite, quantifiable result: a 30 percentage-point reduction in the fall rate over 12 months. The rationale behind this plan is the already existing open-access literature that is indexed in PMC and reflects the intersection of clinical need, the responsibility of the institution, and the evidence-based practice standards. The proposed intervention may not only decrease the number of patients who suffer and increase safety outcomes but also lead to a considerable amount of cost savings and a safety culture in the practice organization.

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1.	~~can be described as~~ → are	Paragraph can be improved	Clarity
2.	*(Schoberer et al., 2022); (Weber et al., 2024); (Doody et al., 2025); (Mulkey et al., 2024); (Spoon et al., 2024)*	Citation style options	Correctness
3.	, with	Incorrect punctuation	Correctness
4.	*The patients in this program are adults who are 60 years and above and are at high risk of falls according to the Morse Fall Scale (MFS) with a score of 25 or above being regarded as high-risk persons of falls (Doody et al., 2025).*	Paragraph can be improved	Clarity
5.	*A significant feature of this population is multimorbidity, where such conditions as heart failure, chronic obstructive lung disease, diabetes mellitus, orthopedic diagnosis, neurological (stroke and Parkinson disease) and post-operative recovery diagnoses are frequent.*	Ungrammatical sentence	Correctness
6.	*Physical and cognitive risk dual vulnerability of high-risk fallers is evidenced by the fact that approximately 56% of high-risk fallers in such settings show measurable cognitive damage with reputable evaluation tools such as the Montreal Cognitive Assessment (MoCA) (Doody et al., 2025).*	Paragraph can be improved	Clarity
7.	, since	Incorrect punctuation	Correctness
8.	*The patients not covered by the initiative are those who are directly admitted to intensive care, are in hospice/comfort care, or have less than 24 hours' length of stay since they limit the potential of structured education and bundle implementation.*	Paragraph can be improved	Clarity
9.	~~that are~~ → who are	Pronoun use	Correctness
10.	to lead the initiative officially	Inappropriate colloquialisms	Delivery

11.	*These measurable benefits demonstrate the clinical significance of adhering to a coherent, evidence-based practice, provingndardization not only makes nursing employees more accountable but also allows acenablesm, system-wide changes in the number of preventable patient injuries.*	Ungrammatical sentence	Correctness
12.	*These measurable benefits demonstrate the clinical significance of adhering to a coherent, evidence-based practice, provingndardization not only makes nursing employees more accountable but also allows acenablesm, system-wide changes in the number of preventable patient injuries.*	Paragraph can be improved	Clarity
13.	address the	Incorrect verb forms	Correctness
14.	*The rationale behind this plan is the already existing open-access literature that is indexed in PMC and reflects the intersection of clinical need, the responsibility of the institution, and the evidence-based practice standards.*	Paragraph can be improved	Clarity
15.	*The proposed intervention may not only decrease the number of patients who suffer and increase safety outcomes but also lead to a considerable amount of cost savings and a safety culture in the practice organization.*	Paragraph can be improved	Clarity