



## KEY POINT SUMMARY

### OBJECTIVES

The purpose of this study was to quantify and reduce patient falls.

## The Experience of a Community Hospital in Quantifying and Reducing Patient Falls

Alcée, D.  
2000 | *Journal of Nursing Care Quality*  
Volume 14, Issue 3, Pages 43-53

### Key Concepts/Context

While patient falls always were reported to the Hospital Quality Management Committee and to the Nursing Quality Management Committee at John T. Mather Memorial Hospital, most reports were made anecdotally. There was no critical review of the cause and effect of falls nor was there any "trending" on a month-to-month basis. Questions raised about specific falls that resulted in patient injuries led Nursing Administration to conduct a retrospective review of all patient falls.

### Methods

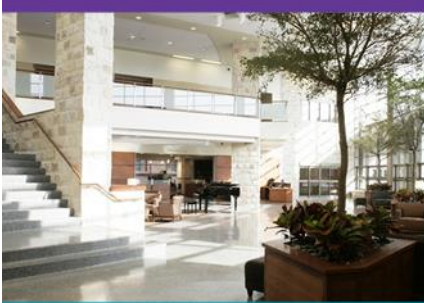
A retrospective review of patient falls in a 248-bed acute-care community hospital was conducted in order to quantify the number of patient falls and identify what factors resulted in these falls.

### Findings

The majority of patient falls (94 percent) led to no/slight/minor injury. Despite having a fall assessment program, falls cannot always be predicted or anticipated. Researchers found that more vigilance was needed in preventing falls.

### Limitations

Information was difficult to retrieve due to lack of documentation in nurses' notes or incident reports. Fall risk assessments were not done consistently nor were they completed accurately.



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## Design Implications

Patient monitoring devices should be used to mitigate falls. Electronic medical records and charting to assess and recover patient-specific information should be incorporated for the purposes of encouraging completion, accuracy, and timeliness.