

Code Star: Evaluating Falls When They Happen
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Union Hospital is a small community hospital in the New York metropolitan area. The community that we serve is predominately white, elderly blue collar retirees with Medicare insurance. Our most common DRG is congested heart failure and our patients tend to be readmitted frequently. In 2001 we recognized that our patients were falling and that our fall prevention activities were not being done consistently. We also realized that our staff needed education on the causes of falls and necessary preventive measures. The fall program has been very successful decreasing our fall rate from 12 falls per 1000 patient days to 4.7 falls per patient days (2005).

Every fall was audited by the staff and sent to the Manager of Patient Standards. Unfortunately many times the audit was not received until many days after the fall and information regarding the fall was missing. By the time the audit was reviewed, some of the patients had fallen a second or third time. Reasons for the fall that could have been easily fixed were missed.

During the summer of 2005 a new program was developed that was titled "Code Star". This program was based on the literature that recommended immediate assessment and evaluation of every fall. The goals of this program were to decrease falls by immediate evaluation and implementation of interventions, to increase the participation of all departments in fall prevention, to increase communication between departments regarding falls and to prevent patient injuries by preventing future falls. The entire hospital was educated to the process during a hospital wide Fall Awareness Day.

The process is initiated after a fall by the staff involved. Code Star is announced overhead with the exact location of the event. The Code Star team arrives within minutes. The responders include medicine, nursing, pharmacy, physical therapy, housekeeping, transport, facilities and security. When the team arrives the patient is assessed for any physical injuries and placed in a safe position. After the patient's condition is deemed stable or injury free the team evaluates the causes of the event. Nursing completes the documentation and follow through on new patient interventions. Pharmacy rechecks all medications (dose, timing, interactions, etc.), physical therapy evaluates the patient's gait, balance, etc and environmental issues are addressed with the ancillary departments as necessary. Education for bed alarm activation, communication with nursing staff, and side rail use has been reviewed with the housekeeping and transport staff on individual and department wide basis.

After the evaluation is done, recommendations are made and incorporated into the patient's plan of care. The staff is remediated immediately if our fall policy was not followed. During the first half of 2005 we had 11 patients that fell more than once for a total of 24 falls. There were a total of 25 injuries during this time period. After initiation of the program there were 8 patients that had multiple falls for a total of 16 falls. There were 9 injuries during the second half of the year.