



**FALL DOCUMENTATION CHECKLIST – All Clinical Units**

Patient Name \_\_\_\_\_ Room # \_\_\_\_\_

Date/Time of Fall: \_\_\_\_\_ Clinical Lead/Mgr/Supervisor Completing Form: \_\_\_\_\_

**\*\*ALL STATEMENTS TO BE TAKEN AT TIME OF FALL\*\***

**Security response is for documentation purposes only – Proceed with ALL steps below...**

RN responsible for patient: \_\_\_\_\_

Statement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff member discovering fall: \_\_\_\_\_

Statement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List **ALL** staff members responding to fall: \_\_\_\_\_

\_\_\_\_\_

Brief description of what the patient felt caused the fall (**interview the patient**):

\_\_\_\_\_

\_\_\_\_\_

**Post Fall Checklist/Mini Root Cause Analysis (select the appropriate response for each one below):**

1. Was **“Code Yellow”** Immediately called overhead by operator?      Yes      No
2. **Did staff STAY WITH PATIENT?**      Yes      No
3. Was a physical assessment performed and patient checked for injuries?      Yes      No
  - a. Was a Rapid Response call made for serious injury(s)?      Yes      No      N/A
    - i. Obtain a set of Vital signs (after initial set of vitals repeat if clinically indicated)
    - ii. Perform a Neuro check (after initial check repeat if clinically indicated)
4. Were pictures obtained of injury(s)?      Yes      No      N/A
5. Did the RN review the importance of calling for assistance prior to getting out of bed or chair with the patient?      Yes      No

6. Was a "Fall" sign above patient bed? Yes No N/A
7. Were "Yellow" socks on the patient? Yes No
8. Was a "Yellow" clip on patient arm band? Yes No
9. Was the call light in reach of the patient? Yes No N/A
10. Did the RN/tech conduct hourly rounding to check the 3Ps (Pain, Potty, Position)?  
Yes No N/A
11. Was bed/chair alarm was placed on patient? Yes No
12. Was patient moved closer to the nurses' station? Yes No
13. Was patient's physician called (**NOTE:** between 9p – 7a only when injury occurs; if no injury, notify physician at 7a) to inform him/her of the fall? Yes No
14. Did RN request appropriate interventions and orders from physician, if called?  
Yes No N/A
15. After review of video; were any inappropriate response(s)/behavior(s) addressed immediately?  
Yes No Video not available
16. If this was a sentinel event, were Julie and/or Tommy immediately notified? Yes No  
a. Julie: 636-789-2343 (Home number for emergency only)  
b. Tommy: 706-614-2666 (Cell)
17. Were family notified and reassured that the patient is receiving good care and that we have notified the physician? Yes No
18. Did the primary RN document the "facts of the fall" on a "Post Fall Follow-up" in Paragon on the "Daily Assessment"? Yes No
19. Did the RN activate the "Fall Alert Check Box" in Paragon?  
Yes No Already indicated as "Fall Alert"
20. Was a "**Fall Risk Re-assessment**" completed under the "Fall Tab" in Paragon? Yes No
21. Were the "**Fall Prevention Interventions**" updated? Yes No
22. Was the "**Care Plan**" updated? Yes No
23. Has screen one and screen two, of the "Compliance 360 Incident Report" and the "facts of the fall" document been completed with all of the above information? Yes No
24. Has the "Daily Huddle Post Fall Feedback" form been completed and posted on "Fall Update Board"?  
Yes No
25. Has the "Daily Fall Update" form been updated to include this fall? Yes No

**\*This form is to be completed in its entirety and e-mailed to following prior to the end of your day/shift:**

Email to: [FallNotificationGroup@sahstl.com](mailto:FallNotificationGroup@sahstl.com)

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**Nurse Manager** (name please print): \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Manager Comments/Recommendations:**

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**\*\*Not a permanent part of the Medical Record\*\***

**\*\*\*E-mail this form as directed above DO NOT COPY\*\*\***