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# FORT LAUDERDALE HOSPITAL

1601 E LAS OLAS BLVD, FORT LAUDERDALE, FL

## Violations dated for Mar 10, 2014

**VIOLATION:** RM Prog - Incident Reporting System

**Survey Type:** State

**Tag No:** H0410

Based on staff interview, clinical record review and review of Abuse reporting & Incident reporting Policy & Procedures, it was determined the facility Staff ID # \*\* did not follow the facility Policy and Procedures (P&P) to implement the Incident Reporting system concerning Incident Report for a reported alleged abuse event on \*\*/\*\*/ for \* of \* Patients (Patient #\*) sampled, as evidence by the facility Incident log not documenting an incident of reported abuse by Patient #\*.

The finding includes:

Clinical record review revealed Patient #\* was admitted via the Emergency department (ED) to the \*th floor Adolescent Behavioral Health Unit on \*\*/\*\*/ at \*\*:\*\*. AM.

Patient ID #\* was admitted to the facility involuntary and certified under the Baker Act for Psychiatric evaluation due to threats to harm self and others.

An interview on \*\*/\*\*/ at \*\*:\*\*. AM with the Mental Health Therapist, Staff ID #\*, revealed on \*\*/\*\*/, on the day of Patient #'s discharge from the facility, Staff ID #\* interviewed Patient #\* and his family (on \*\*/\*\*/ at \*\*:\*\*. PM). This interaction is documented in the clinical communication notes dated \*\*/\*\*/ at \*\*:\*\*. PM. The documentation of the interview disclosed Patient #\* has a history of violence toward the family and others, and alleges "He was hit by a kid in the unit." He was asked by Staff #\* who hit him but he could not identify the "kid." Patient #\* stated he could not identify the "kid." Staff #\* stated "her impression was, he was afraid to report the assault." Staff #\* investigated this allegation documented: I later went to the unit and asked kids and all of them denied." Staff #\* stated to the surveyor that she reported this incident to the Nurse supervisor, Staff ID #\*\*, Staff #\* did not visually see any injuries to Patient #'s face or lip on \*\*/\*\*/ at \*\*:\*\*. PM.

Staff #\*\* was briefly interviewed on \*\*/\*\*/ at \*\*:\*\*. AM during this interview he stated: "This alleged abuse was reported to me, but I did not make an incident report concerning the alleged abuse." Staff #\*\* further stated "I did not make an Incident Report due to the Patient being in the process of discharged home that day, and the mother stated she wanted to take the patient home now due to the dissatisfaction with his care here."

Staff #\*\* stated to the surveyor on \*\*/\*\*/ at \*\*:\*\*. AM, the facility P&P concerning the incident report criteria is as follows: "Anything not in the normal process of care should be generated in an incident report." Staff #\*\* continued to state: "An incident report was not done, it may have passed through the cracks and should have been placed in an Incident Report, but it was not."

The CNO stated on \*\*/\*\*/ at \*\*:\*\*. PM, "In my opinion the incident report was not done due to the Patient not knowing the alleged assailant's name and the fact the Patient went home soon after the allegations were presented to the staff, as such no further investigation may have been possible."

Review of the facility expectations for education and training for Abuse/Neglect reporting indicate on page # one (\*): An incident report will be completed on any event which is out-side the normal course of operation for the hospital and results in patient injury or has the potential for causing injury.

Review of the facility Policy and Procedures (P&P) for "Patient neglect and Abuse - reporting in-house" reveals on page # one (\*) paragraph # one (\*) "All cases reported will be investigated and followed-through or followed-up required. Paragraph #\* indicates the following: The individual reporting abuse to a staff member shall have this report passed on to the immediate supervisor, who

will make an immediate investigation of the charges." Further review of the second paragraph indicates the following:  
"Documentation of the reported incident shall be entered in the Patient's chart and an incident report filled out."

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