Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 24, 2023	
Inspection Number: 2023-1109-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Southampton Care Centre Inc.	
Long Term Care Home and City: Southampton Care Centre, Southampton	
Lead Inspector JanetM Evans (659)	**Inspector Digital Signature** Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2023.07.26 13:49:01 -04'00'
Additional Inspector(s) Janis Shkilnyk (706119)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 12 - 14 and 18 - 21, 2023

The following intake(s) were inspected:

- Intake: #00090637 - Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee failed to ensure that the home's medication management system provided safe medication management related to medication incidents.

In accordance with 11. (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

The home's LTC Medication Incident policy which was captured in their medication management system, stated that residents were to be assessed for any signs and symptoms of reaction to the incident, the Director of Care (DOC) was to gather all facts as to why the incident occurred, complete interviews with staff involved, record the facts, determine why the medication incident happened, document prevention of another occurrence, share this information with staff involved. In addition, they were to summarize findings and recommendations for discussion at quarterly PAC meetings.

Rationale and Summary:

Professional Advisory Committee (PAC) meeting minutes documented the number of medication incidents that had occurred in the last quarter. No analysis of these errors was completed for review.

A review of medication incident reports for two residents identified that the home's policy was not followed in regards to the steps required after a medication incident occurs.

Failure to follow the home's policy in relation to all the necessary steps when a medication incident occurs, resulted in missed opportunities for the home to identify trends and prevention future incidents, and could have impacted the resident's health.

Sources: PAC meeting minutes May 30, 2023. Medication incidents and clinical records for two residents, interview with the DOC, an RPN, LTC Medication Incident policy, last review date May 13, 2022.
[706119]