We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

### James Paget Hospital

Lowestoft Road, Gorleston-on-Sea, Great Yarmouth, NR31 6LA  
Tel: 01493452680

Date of Inspection: 11 September 2014  
Date of Publication: October 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

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<th>Result</th>
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<td>Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>Met this standard</td>
</tr>
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</table>


## Details about this location

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<tr>
<th>Registered Provider</th>
<th>James Paget University Hospitals NHS Foundation Trust</th>
</tr>
</thead>
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<tr>
<td>Overview of the service</td>
<td>The James Paget Hospital provides acute services to a local population of around 230,000, with a significant proportion being over the age of 75. It provides a range of services including accident and emergency and maternity as well as general medical and surgical treatment.</td>
</tr>
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| Type of services | Acute services with overnight beds  
Community healthcare service  
Dental service  
Hospice services |
| Regulated activities | Diagnostic and screening procedures  
Family planning  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
When you read this report, you may find it useful to read the sections towards the back called ‘About CQC inspections’ and ‘How we define our judgements’.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether James Paget Hospital had taken action to meet the following essential standards:

- Management of medicines
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 September 2014, talked with people who use the service and talked with carers and / or family members. We talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

We ask five key questions of services we inspect. Are they safe, are they effective, are they caring, are they responsive and are they well-led? Because this was a follow up inspection we focused on two of those five questions; are they safe, are they effective.

At our inspection on 27 and 28 November 2013 we found the service did not always protect people against the risks from unsafe management of medications. People were at risk from unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

Is the service safe?
At this inspection we found that the service was safe as medications management had been improved. Records of medication showed that medical, pharmacy and nursing staff communicated effectively about as required medication. Pharmacy and ward managers audited the management of medications and feedback to staff to monitor and improve safety.

Is the service effective?
We found that care was effective as records of care and key documents were completed appropriately. Patient care records included comprehensive assessment of risks and of the care provided. There were appropriate records showing that patients and relatives had been included in discussions about care.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Management of medicines</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should be given the medicines they need when they need them, and in a safe way</td>
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</table>

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At our inspection on 27 and 28 November 2013 we found the service did not always protect people against the risks from unsafe medicines management. We found there were minimal checks by pharmacist and that people's medicines were not being safely managed on the ward. There were storage and security issues affecting safety, and that when medicines were prescribed for 'as required' there was a lack of written information available to assist nurses to administer these medicines appropriately.

At our inspection visit on 11 September 2014 we visited five wards, including the maternity ward. We spoke with 26 staff, and examined 20 sets of patient's care records including medicine charts. We saw that the provider had implemented an action plan to improve the management of medicines.

There were clear policy and procedures for the prescription and administration of as required (PRN) medicines. Medicine charts included a section for additional notes between pharmacy, nursing and medical staff to enable good communication about prescribing orders and administration.

Staff told us that there had been education with a focus on PRN medicines following the previous CQC inspection. We saw there was new medicines guidance attached to medicine trolleys. The guidance outlined the process for ensuring that nursing staff administering medicines were aware which PRN medicines to give and in which order. Medical staff had a role in identifying and recording the priority for these medicines. We found five medicine charts that did not have the priority order of PRN medicines identified on them. In these cases nursing staff were able to describe the checking process and what they would do if they were unsure of which medicine to give first. We found that some medical staff had commenced working at the Trust in August 2014 and were learning the revised practices regarding PRN medicines.

We asked staff about security of medicines. A pharmacist confirmed that security codes on
medicine store rooms were changed at least every six months. There was a schedule for this across the whole hospital site. Entry codes on three of the wards where we checked had been changed in August 2014. Staff confirmed the schedule of changes as they had initially been locked out of medicine cupboards on return from leave following security code changes. We observed that staff maintained good security of medicines when undertaking medicine rounds, locking doors and trolleys when unattended.

We asked about planning of medicines for discharge. Each patient had an individual discharge plan and take home medicines (TTO) were part of this plan. There were clear responsibilities for ensuring TTOs were available for patients on discharge, including doctors prescribing medicines, discharge letters for GPs identifying what had been prescribed, pharmacy involvement and medicines being made available for patients on discharge. Two sets of notes that we examined were for patients being discharged and the TTO process was in place. Staff told us that discharge and medicine was discussed at multidisciplinary ward rounds.

Managers told us about regular audits of quality of care which included the checking of management of medicines. Audits were completed by pharmacy staff and ward managers from other ward areas to provide a peer check of arrangements. Staff told us that results and learning from the audits were shared at handovers, in communication books and at ward meetings.
Records

People’s personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our inspection on 27 and 28 November 2013 we found the service did not always protect people against the risks of unsafe or inappropriate care and treatment due to inaccurate records. We found some records did not have completed pressure ulcer assessment or records of precautions taken. Some records for medications were unclear.

At our inspection visit on 11 September 2014 we visited five wards, spoke with 26 staff, and examined 20 sets of patient's care records. We found that records were completed appropriately. The 18 medication charts we examined were appropriately completed. Prescribing and pharmacy staff had made clear entries and advice for staff respectively. Staff administering the medications made clear entries to show the treatment had been given.

We asked 13 patients and four relatives about the care they had received. Patients said that they had good information from staff, that they were involved in their care and staff discussed any options they might have. They were satisfied with the care delivered. Some patients told us there were not enough nurses. When asked why they thought this they were quick to say they had not experienced a lack of care but could see that nursing staff were stretched. Patients told us they were satisfied that their GP was informed about care in hospital and they had not had any delays to their discharge. Two patients told us they had good support to try to stop smoking, and one person had been provided with nicotine patches to alleviate cravings whilst in hospital. There was clear documentation of this in notes and the prescription chart.

The hospital used an Essential Assessment and Care Booklet as part of the patient care plan. This document outlined various risk assessments that were undertaken. These included risk of blood clots, nutrition, pressure ulcer, falls, and bed rails risk assessment. Following the assessments a plan of care was put in place to address the areas of risk identified. For example if the assessment identified a risk associated with tissue viability, then the SSKIN bundle was put in place to advise staff of the care to be delivered, including how often and in relation to moving, incontinence, nutrition and hydration. The care delivery was regularly reviewed and the risk reassessed in accordance with the bundle guidance.
We saw that risk assessments had been appropriately completed in the care records we examined. Staff had recorded the assessment of risk and the patient's needs with respect to safety of bed rails, falls risk, skin integrity for pressure sores, and the moving and handling needs of patients. Nutrition and hydration risk was assessed as part of admission assessments. We found in the records examined that staff had made regular review of risk and needs of patients during admissions of more than a week. In two care records we saw that no update had been made to the falls risk assessment since the patient had been admitted, but in both cases the risk had reduced as the person had recovered.

We saw that staff had completed regular observations including early warning scores to identify if patient's health was deteriorating. There was specific documentation for pathways of care for some conditions. In the stroke care ward we found patients had documents outlining the expected relevant assessment and care that should be provided to patients who were admitted following a stroke. Documents had been completed appropriately and these included records from the multidisciplinary team.

We also checked the documentation of 'do not attempt cardiopulmonary resuscitation' (DNACPR) status in patient's records. In the four care records where we saw this documentation there had been clear record of the discussion with the patient or the patient's close relatives. Staff told us about the clear process for DNACPR documentation and their role in ensuring that patients and family had the relevant information to enable them to make an informed decision. We saw that ward and other managers completed regular audits and gave feedback to staff about the quality of documentation to support patient care. Ward managers told us they had time allocated to undertake such monitoring duties and to attend governance meetings to learn from care provision across other departments.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
# How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>✓ Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
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</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
**Glossary of terms we use in this report (continued)**

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.
**Contact us**

<table>
<thead>
<tr>
<th>Phone:</th>
<th>03000 616161</th>
</tr>
</thead>
<tbody>
<tr>
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<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
</tbody>
</table>
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