



**Jersey Care
Commission**

INSPECTION REPORT

Tutela Jersey Limited

Home Care Service

**Ground Floor
CTV House
La Pouquelaye
St Helier
JE2 3TP**

**Inspection Dates
16, 21 and 30 January 2026**

**Date Published
5 March 2026**

1. THE JERSEY CARE COMMISSION

Under the Regulation of Care (Jersey) Law 2014 ('the Law'), all services carrying out any regulated activity must be registered with the Jersey Care Commission ('the Commission').

This inspection was carried out in accordance with Regulation 80 of the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 to monitor compliance with the Law and Regulations, to review and evaluate the effectiveness of the regulated activity and to encourage improvement.

2. ABOUT THE SERVICE

This is a report of the inspection of Tutela Jersey Ltd. The home care service is operated by Tutela Jersey Ltd and there is a registered manager in place.

Registration Details	Detail
Regulated Activity	Home Care Service
Mandatory Conditions of Registration	
Type of care	Personal care and personal support
Categories of care	Adult 60+, Dementia Care, Physical Disability, Mental Health, Learning Disability, Autism, Substance Misuse
Maximum number of care hours per week	2288 hours per week
Age range of care receivers	16 years 8 months +
Discretionary Conditions of Registration	
<ol style="list-style-type: none">1. The Commission has limited the number of total weekly hours of support which Tutela Jersey Ltd provides to a maximum of 2288 hours per week. Tutela Jersey Ltd may not exceed this total maximum weekly number of hours. This condition is to remain active until such time as the Commission is satisfied that it need no longer apply.2. The Registered Manager must complete a Level 5 Diploma in Leadership in Health and Social Care Module by 27 November 2028.	
Additional information	
<ol style="list-style-type: none">1. Absence of Registered Manager notification received in November 2025.2. The Regulation Officer has participated in two safeguarding investigations resulting in ongoing communication with the Provider concerning the review of their service and their consultation with an external HR advisor.3. Registration of a new Registered Manager in December 2025.	

1. ABOUT THE INSPECTION

3.1 Inspection Details

This inspection consisted of three separate visits, two of these visits were unannounced and took place at the service's office base. The third visit was pre-arranged with the Registered Provider and Registered Manager to enable care receivers and their families to be informed in advance and to provide consent for home visits. As part of the inspection, care receivers were visited in their own homes and support staff were spoken with. The inspection was carried out by two regulation officers.

The purpose of the inspection was to assess the service's ongoing compliance with the Regulations and Standards, following a number of significant concerns identified through recent safeguarding outcome meetings and complaints received by the Commission about the service. The concerns identified relate primarily to longstanding practices and arrangements within the service that were established prior to the current Registered Manager taking up their role. However, the Registered Provider has been aware of the issues, some of which were identified in previous inspection reports.

The Provider and Registered Manager were present throughout the inspection.

The inspection also triangulated information from multiple sources, including documentation, staff discussions, and observations of practice, to determine whether policies and procedures were being effectively implemented and whether improvements identified through previous regulatory activity had been embedded into practice.

Inspection information	Detail
Dates and times of this inspection	16 January 2026 – 09:00-15:00 21 January 2026 – 09:00-15:00 30 January 2026 – 09:00-15:30
Number of areas for improvement from this inspection	Twelve
Number of care hours on the week of inspection	2179.50 hours per week
Date of previous inspection Areas for improvement noted in 2025 Link to the previous inspection report	24 and 28 February 2025 One RPT_TL_Inspection_20250228_V2.pdf

3.2 Focus for this inspection

The inspection included a focus on the following themes:

- Review how the service has responded to safeguarding concerns and outcomes, including whether appropriate actions, learning, and improvements have been implemented.
- Assessment of the effectiveness of the current safeguarding arrangements, risk management processes, and escalation pathways.
- Examination of the themes and issues identified through complaints and evaluate the effectiveness of the Provider’s response, including management, investigation and learning.
- Evaluate the effectiveness of governance, leadership, and oversight arrangements in identifying risks, monitoring quality, and maintaining safe care practices.
- Evaluate the effectiveness of care planning staffing arrangements, and staff competence in supporting the delivery of safe, person-centred care.
- Seek assurance that effective management and leadership arrangements are in place to protect people from harm and that their needs are met in a safe, consistent, respectful and dignified manner.

4. SUMMARY OF INSPECTION FINDINGS

4.1 Progress against areas for improvement identified at the last inspection

At the last inspection, one of area for improvement was identified. An improvement plan was submitted to the Commission by the Registered Provider, setting out how these areas would be addressed.

The improvement plan was discussed during this inspection, and it was concerning to note that insufficient progress had been made to address the area for improvement. This means that the registered provider has not met the Standards in relation to recruitment processes, including ensuring that interview panels are complete, providing job descriptions, and implementing a structured system to ensure safe, fair and consistent staff selection. This will be discussed in more detail in the main body of the report.

4.2 Observations and overall findings from this inspection

The inspection identified a range of areas requiring improvement across safeguarding, governance, care planning, staffing, and risk management. While some positive staff engagement was observed during the visit, several processes were found to be inconsistent or not sufficiently embedded in day-to-day practice.

Safeguarding referrals had not always been made promptly, and incident reporting lacked consistency. Risk assessments and care plans were often outdated and did not fully reflect individuals' current needs, particularly in relation to communication, behaviour support, nutrition, and health requirements. Staff did not always have access to Significant Restriction on Liberty (SROL) documents, and some were unaware of the restrictions in place. Environmental risks were also identified, including inconsistencies with the smoking policy and an unassessed hot radiator which presented a potential risk to care receiver safety.

Staffing arrangements needed strengthening, with unclear rotas, inconsistent application of 2:1 support, and limited contingency planning. Staff interviews indicated that further support and training are required to build confidence in safeguarding, whistleblowing, and behavioural risk management. Documentation, including incident records and complaints handling, was inconsistent, with limited evidence of investigation or learning.

Recruitment and workforce processes also required improvement, with missing documents, incomplete induction records, and unclear boundaries within staff roles. Medication management needed further development, particularly in relation to protocols, staff competencies, and audit trails.

Although the new Registered Manager demonstrated insight into the challenges and engaged positively with the inspection process, the current systems do not yet provide the level of assurance required. Sustained and timely action is needed to strengthen governance, staff practice, and risk management with the overarching priority of supporting safe, high-quality care for all care receivers.

5. INSPECTION PROCESS

5.1 How the inspection was undertaken

The Home Care Standards were referenced throughout the inspection.¹

Prior to the inspection, all information held by the Commission about the service was reviewed. This included the previous inspection report, reviews of the Statement of Purpose, details of complaints provided to the Commission, details relating to safeguarding referrals and outcomes, and notification of incidents. Additional correspondence between the Commission and the Provider was also reviewed as part of the pre inspection planning.

The Regulation Officers visited four care receivers in their homes, spoke with staff members, and observed the support being provided. For those care receivers who, due to the complexity of their needs, could not provide direct feedback, observations and interactions with staff were used to inform the assessment. The regulation officers also met with the service's management team and other staff members. Feedback was requested from healthcare professionals; however, no responses were received.

As part of the inspection process, records including policies, care records, incidents and complaints, staff files and staffing rotas were examined.

At the conclusion of each inspection visit, the regulation officers provided feedback to the Registered Manager and Provider and confirmed the identified areas for improvement by email on 5 February 2026.

This report sets out our findings and includes any areas of good practice identified during the inspection. Where areas for improvement have been identified, these are described in the report, and an improvement plan is attached at the end of the report.

¹ All Care Standards can be accessed on the Commission's website at <https://carecommission.je/>

5.2 Sources of evidence.

Follow up on previous areas for improvement	
Focus	Evidence Reviewed
Safe recruitment	Samples of staff files
Focus areas for this inspection	
Focus	Evidence Reviewed
Safeguarding	Samples of staff files Safeguarding policy Smoking policy Whistleblowing policy Staff interviews Staff supervision Accidents and Incidents log Review of recent safeguarding events
Risk management	Risk assessments for staff and care receivers Care plans Contingency plan SROL Care receiver's environment Staff interviews
Complaints	Complaints log Staff files Complaints policy Review of recent complaints received
Governance and leadership	Statement of purpose Care planning Staffing arrangements Medication management Staff interviews Staff rotas

6. INSPECTION FINDINGS

Safeguarding

Responses to safeguarding concerns and outcomes, including whether appropriate actions, learning, and improvements have been implemented.

The inspection identified significant safeguarding failures, including delayed safeguarding referrals, inaccurate reporting, and limited learning from incidents. Evidence reviewed showed delays in submitting safeguarding referrals for care receivers, delays in investigations being provided to the Commission, and outdated risk assessments remaining in place despite known risks. In addition, regulation officers identified a pattern of repeated bruising injuries documented for one care receiver. These entries had not been appropriately escalated or analysed by the service in line with expected safeguarding and monitoring processes. This matter was brought to the attention of the Registered Manager and Registered Provider during the inspection for their immediate review and action.

Staff interviews highlighted significant gaps in knowledge, with staff unable to clearly explain safeguarding procedures, whistleblowing processes, or behaviour management strategies. Safeguarding knowledge was limited, and staff were unable to articulate expectations relating to behavioural risk management.

The service must ensure that staff receive appropriate training, supervision, and support to apply these procedures confidently and consistently.

The management team demonstrated a willingness to engage openly with the concerns raised, and the Registered Manager was committed to reviewing safeguarding practices and strengthening risk management arrangements.

Immediate action is required to ensure safeguarding concerns are identified promptly reported without delay, investigated thoroughly, and that learning is consistently embedded within care planning and practice.

Risk Assessment

Effectiveness of the current risk assessment and management processes, and escalation pathways.

Risk assessments reviewed were outdated, incomplete, and not reflective of current needs or risks. Staff were not fully aware of restrictions or risk management strategies contained within SROL documents, as these were not accessible to them.

In addition, risk assessments were not personalised or consistently followed by staff. Evidence included risk assessments dated 2024. There was also evidence that behaviour, epilepsy and communication-related risk assessments were outdated. It was further noted that risk assessments relating to staff suitability to provide direct support had not been adhered to.

The management team acknowledged these shortfalls during the inspection and engaged constructively in discussions regarding improvements to risk management. The Registered Manager has initiated preliminary actions to review key risk assessment documents.

The provider must ensure all risk assessments are reviewed, updated, accessible to staff, and consistently implemented.

Complaints

Response to complaints, including examination of the themes and issues identified, investigation and learning, and management follow up.

The complaints process was ineffective, with delayed responses, insufficient follow-up, and no demonstrable evidence of investigation or organisational learning. Evidence reviewed showed staff being moved between care packages rather than concerns being addressed, and an absence of recorded learning to inform service improvement.

Management acknowledged these weaknesses and engaged constructively in discussions about strengthening the process.

The service must ensure that complaints are investigated thoroughly, recorded accurately and that resulting learning is systematically embedded into practice.

Governance and Quality assurance

Evaluate the effectiveness of governance, leadership, and oversight arrangements in identifying risks, monitoring quality, and maintaining safe care practices.

Rotas were unclear and inconsistent with commissioned hours, and contingency plans did not account for management absence. Sleep-in shifts were not consistently recorded, and when this was queried, a staff member reported that it was assumed the earlier shift worker completed the sleep-in. Where 2:1 staffing ratios were required, there was evidence of inconsistent application. There was also evidence of staff working excessive hours.

These issues require immediate action to ensure staff arrangements are safe, planned, and fully compliant with regulatory requirements.

There were inconsistent professional boundaries and inappropriate working practices. Staff worked excessive hours, risk assessment requirements relating to staff were not adhered to, and rota management lacked effective oversight.

Clear boundaries and effective oversight must now be established and consistently maintained to ensure safe working practices.

The governance framework was ineffective, with limited audit systems, insufficient quality monitoring, and management oversight. Examples observed during the inspection highlighted a lack of leadership oversight, including unclear rationales for care routines and limited autonomy for care receivers.

Examples included a care receiver's bed left unmade, with staff unable to provide a rationale; clothing for another individual being stored outside their own room; and staff preparing lunch for a care receiver without involving them. Independent access to snacks was also limited. These practices may well have been appropriate; however, there was no evidence of a clear rationale, and they should have been reviewed to ensure they promoted autonomy and person-centred care. Staff were not aware of the need to reconsider these routines.

Management acknowledged the need to establish more robust audit, monitoring, and quality- assurance systems to support effective oversight and improvement. The service must implement effective governance systems that reliably monitor quality, identify risks, and drive timely improvement.

Delivery of safe and effective care and support

Effectiveness of care planning staffing arrangements, and staff competence in supporting the delivery of safe, person-centred care.

Documentation and record keeping were inadequate across care plans, incident records, and daily notes. Care plans were outdated, with essential information missing relating to communication needs, nutrition, behaviour support, and health requirements. Incident reporting was inconsistent, and notifiable events were not submitted to the Commission as required.

One example included a care receiver sustaining an injury that required hospital treatment. Although the incident had been recorded centrally and the required notification submitted, it was not reflected in the individual care records, meaning that health professionals referring to those records would not have been aware of the event. During discussions with regulation officers, staff understood the importance of accurate documentation and engaged constructively during discussions.

Care plans were not person-centred and did not reflect individuals' daily needs and wishes, including routines, communication requirements, medication parameters, and SROL documentation.

There was no evidence of organisational learning arising from incidents or complaints. Regulation officers reviewed recent safeguarding concerns and complaints and cross referenced these with individual care records. Care plans remained outdated despite the safeguarding history, and there was no evidence of any root cause analysis.

The service must ensure that care plans are detailed, person-centred, and provide clear guidance to enable staff to deliver safe and consistent care. Documentation must be contemporaneous, accurate, and reliably reflect the care receivers' current needs.

Medication management requires significant strengthening to ensure safe and consistent practice. Issues identified included the absence of PRN protocols and corresponding care plans, staff lacking Regulated Qualifications Framework (RQF) Level 3 medication training, incomplete in-house competencies, outdated staff signature lists, missing prescriptions, and a lack of evidence that staff were competent to administer a specific medication for a care receiver.

An example of this included an 'as required' medication to be administered to one care receiver in an emergency situation; however, the staff supporting the individual had not received any training or guidance as to how to administer it. Transcribing guidelines were not followed, and the audit trail for medication and incident management was not available. Urgent action is required to ensure medication practices are safe, staff are appropriately trained and competent, and governance arrangements are strengthened.

Management and Leadership

Effective management and leadership arrangements are essential to protect people from harm and that their needs are met in a safe, consistent, respectful and dignified manner.

Unsafe recruitment practices and poor workforce compliance were identified. Evidence included misplaced Disclosure and Barring Service (DBS) checks found at a later stage, unclear identification documents, and missing application forms and contracts, which the service explained were absent as staff files were being reviewed by an external Human Resources (HR) provider. When disciplinary records were requested, the regulation officers identified that some records were not held in a centralised location, resulting in them being deleted or not retained. Maintaining centralised information and records is essential to prevent the loss of key documentation.

There was an absence of induction records for newly recruited staff. One member of staff had recently joined the organisation, and their work history showed no prior experience in support work. It is concerning that there were no induction records to demonstrate that the individual had been inducted as the Standards require, nor were there any probationary review records evidencing their progress or development in the role.

Recruitment and employment processes must be reviewed and brought into full compliance to ensure that staff are safely recruited, appropriately supported, and demonstrably suitable for their roles.

There was insufficient managerial capacity and a lack of clarity around leadership roles. Staff interviews highlighted confusion around job descriptions, responsibilities, and reporting lines. Several staff members were unable to describe who they were accountable to, who provided their supervision, or the appropriate channels for escalating concerns. This lack of clarity contributed to inconsistent oversight and variation in day-to-day decision-making.

Evidence from staffing rotas, staff files, and discussions with staff indicated that job roles were not clearly defined, and expectations varied depending on who was on duty. Some staff reported receiving directives from a specific person, whilst others reported long periods without managerial contact. The absence of delegated leadership structures resulted in key decisions being delayed or made informally, without clear documentation or accountability.

Interviews also revealed uncertainty regarding the responsibilities of the newly appointed Registered Manager, senior staff, and office-based personnel. Staff were unclear about which tasks were managerial and which were part of their own roles, resulting in inconsistencies in the management of risk, incidents, and care planning.

Evidence gathered during home visits demonstrated the practical impact of this lack of clarity. Staff were unable to explain the rationale for certain routines or environmental decisions, including restrictive practices relating to food and personal belongings.

The lack of a structured leadership framework meant that essential governance tasks, such as audits, quality checks, and the review of incidents and complaints were not being carried out consistently. This was further compounded by unclear reporting lines, which limited the provider's ability to identify risks, monitor quality, and drive improvement.

In addition, some staff who assume the role of key worker and have responsibility for coordinating the staff teams supporting care receivers, do not have a Level 3 qualification as the Standards require.

Although work has commenced, with support from an external HR advisor, to review organisational roles; there is currently insufficient evidence that these changes have yet resulted in improved clarity or oversight.

While the newly appointed Registered Manager has demonstrated insight into the issues identified within this report, the pace of improvement remains insufficient, and the level of risk to people using the service continues to be significant. The Registered Manager has shown openness to regulatory feedback and a commitment to improvement; however, this must now translate into timely, measurable, and sustained action, which must be actively supported by the Provider.

The Registered Manager is required to submit and implement comprehensive action plans to address all identified areas for improvement.

The Commission is also considering further escalation and enforcement measures. Any actions taken, will be intended to support the service in restoring and maintaining compliance, with the overriding priority of ensuring safe, high-quality care for all care receivers.

IMPROVEMENT PLAN

There were twelve areas for improvement identified during this inspection. The table below is the Registered Provider's response to the inspection findings

<p>Area for Improvement 1</p> <p>Ref: Standard 4.1 Regulation 11</p> <p>To be completed by: With immediate effect</p>	<p>The service must ensure that effective safeguarding systems are in place to protect people who use the service from harm. Safeguarding concerns must be recognised promptly, referrals made without delay, investigations completed appropriately, and learning from incidents clearly identified, recorded, and reflected in care planning and practice.</p> <p>Response of Registered Provider:</p> <p>The General Manager and Assistant Manager are scheduled to complete Safeguarding Lead training on 30 March, after which they will assume responsibility as designated Safeguarding Leads. We are ensuring that all staff receive the necessary safeguarding training and remain up to date. Retraining is already underway, with 10 staff members having completed refresher training to date. The aim of this training is to support staff in identifying safeguarding concerns promptly and reporting them without delay. We have recruited both Quality Improvement Officers to strengthen education, training, and overall standards across services, plus a full time HR Office with a vast amount of HR experience who holds relevant qualifications to work alongside Law at Work. As part of their remit, the Quality Improvement Officers have been reviewing the safeguarding process to ensure systems are effective and that staff clearly understand how to make referrals.</p>
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	<p>We also have external HR support through Law at Work to assist with investigations. Investigation outcomes are shared with staff through team meetings and supervision sessions. These learning points are documented within supervision records and team meeting minutes, and relevant safeguarding outcomes are incorporated into individual care plans. To support consistent practice, we have produced a simple safeguarding flow chart to guide staff when a concern is identified, providing a clear sequence of actions to follow. In addition, we have added an appendix to the safeguarding policy containing all relevant referral forms.</p> <p>Quality Improvement Officers have been visiting projects to discuss safeguarding with staff teams, reinforce referral expectations, and promote confidence in the process.</p>
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<p>Area for Improvement 2</p> <p>Ref: Standard 4.7 Regulation 5, 8</p> <p>To be completed: 30 April 2026</p>	<p>The service must ensure that the care receiver’s risk assessments are current, personalised, and reflective of people’s individual needs and circumstances. Risk assessments must be accessible to staff, clearly understood, and consistently followed to support safe and proportionate care.</p>
	<p>Response by registered provider:</p> <p>The organisation has recruited a Registered Manager, Assistant Manager, and Quality Improvement Officer. They are currently reviewing all care plans and risk assessments with a view to making the necessary changes and improvements.</p>

	<p>This work will be carried out in consultation with clients, families, key workers, and support workers to ensure that all documents align with the guiding principles of a person-centred approach. The key areas of focus include Updating and Personalising All Risk Assessments Ensuring each risk assessment are tailored to the individual's needs, preferences, and support requirements. Ensuring Risk Assessments Are Accessible to Staff Copies of current risk assessments will be stored in every home, available at the point of care, along with quick-reference summaries to support staff decision-making.</p> <p>Ensuring Staff Understand and Follow Risk Assessments</p> <p>The Quality Assurance Officer is delivering regular training and support sessions with the teams to reinforce best practice.</p> <p>Embedding Risk Assessment into Daily Practice Risk assessments will be directly linked to care plans so that risks and support strategies are consistently applied. Strengthening Governance and Oversight Monthly risk reports and audits will be completed to monitor compliance, identify emerging risks, and drive continuous improvement.</p>
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<p>Area for Improvement 3</p> <p>Ref: Standard 3.9; 6.1; 9.3 Regulation 17</p> <p>To be completed: 30 April 2026</p>	<p>The service must implement effective staffing and contingency arrangements to ensure people receive safe and reliable care at all times. This includes clear plans for staff and management absence, safe staffing levels, appropriate skill mix, accurate rotas, controlled working hours, and the consistent application of commissioned support arrangements.</p>
	<p>Response by registered provider:</p> <p>To strengthen our on-call system, we will ensure all staff are fully aware of how to contact the on-call manager at any time. We are also implementing a clear reporting system that enables staff to promptly report unplanned absences or sickness. This will support effective shift coverage and reduce the risk of unsafe staffing levels. Safe staffing levels will continue to be informed by robust and regularly updated risk assessments. These assessments will be reviewed frequently, ensuring they remain accurate, and any progress or emerging challenges will be communicated to commissioners. A full staffing needs analysis will be completed for each care receiver, ensuring rotas reflect commissioned hours, 2:1 support arrangements, and individual dependency levels. To maintain safe staffing, we have developed dedicated, tailor-made teams for each project and client. Management and the Quality Improvement Officer will monitor these teams by spending time on site and reviewing practice. For management continuity, a General Assistant Manager is now in place.</p>

	<p>Systems are in place to ensure that both the Registered Manager and Assistant Manager are not absent at the same time.</p> <p>Rotas are produced four weeks in advance and shared with staff. When planning rotas, we ensure that clients who require additional skills—such as medication administration or driving—are matched appropriately with staff who have the required competencies. Senior management maintain oversight of the rota system, reviewing staff absence patterns and assessing whether the contingency plans in place for unexpected absence are working effectively.</p>
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<p>Area for Improvement 4</p> <p>Ref: Standard 2.6; 5.2 Regulation 7; 9</p> <p>To be completed: 30 May 2026</p>	<p>The service must ensure that records are complete, accurate, up to date, and reflective of people’s current needs. Care plans, daily records, and incident documentation must align, support continuity of care, and enable effective oversight and risk management.</p>
	<p>Response by registered provider:</p> <p>Senior management are reviewing current journal entries with a strong emphasis on improving the quality of documentation. The Quality Improvement Officer has developed a new journal entry template designed to capture detailed records of daily activities.</p> <p>Key Workers are now responsible for ensuring that all daily journal entries meet the required standard. In addition, monthly audits will be conducted to monitor and evaluate the quality of journal entries.</p>

	<p>A Documentation Alignment Audit is also being introduced. This process will check that:</p> <ul style="list-style-type: none"> incidents are accurately reflected in daily notes daily notes are consistent with the care plan risk assessments reference all relevant incidents safeguarding concerns are recorded appropriately across all relevant documents.
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<p>Area for Improvement 5</p> <p>Ref: Standard 7.2 Regulation 22</p> <p>To be completed: 30 April 2026</p>	<p>The service must ensure that complaints are managed in line with the service's policy and the Standards of Care. Complaints must be responded to in a timely manner, investigated appropriately, outcomes recorded, and learning identified and used to improve the quality of care.</p> <hr/> <p>Response by registered provider:</p> <p>A dedicated email address has been created for submitting complaints, and a dedicated complaints link is also available on our website and has been for some time.</p> <p>Once a complaint is submitted, an email alert is automatically sent to the managers. Managers have 7 days to acknowledge receipt of the complaint.</p> <p>A complaints timescale tracker has been introduced to monitor acknowledgements, investigation milestones, and final responses.</p> <p>Standardised acknowledgement and outcome letter templates have been created to ensure clarity, consistency, and professionalism in all communications.</p>
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<p>Area for Improvement 6</p> <p>Ref: Standard 2.6; 2.7 Regulation 9</p> <p>To be completed: 30 April 2026</p>	<p>The service must ensure that care planning is person-centred and supports people to receive care that meets their assessed needs and preferences. Care plans must include clear guidance on personal care, nutrition, communication, behaviour support, medication, and risk management to support consistent and safe practice.</p>
	<p>Response by registered provider:</p> <p>We are currently reviewing all care plans and risk assessments with a view to making the necessary changes and improvements.</p> <p>This work will be completed in consultation with the client, their families, key workers, and support workers to ensure that it aligns with the guiding principles of a person-centred approach.</p>

<p>Area for Improvement 7</p> <p>Ref: Standard 4.1; 7.2 Regulation 11; 22</p> <p>To be completed: 30 April 2026</p>	<p>The service must demonstrate effective systems for learning from safeguarding concerns, incidents, and complaints. This includes evidence of reflection, analysis of themes and causes, and actions taken to prevent recurrence and improve outcomes for people who use the service.</p>
	<p>Response by registered provider:</p> <p>We are holding monthly team meetings, as well as weekly administrative office meetings every Monday for updates and planning. These meetings explore absences, sickness, and any potential safeguarding concerns.</p> <p>Regular supervisions are held with the whole team, with additional supervision provided for anyone involved in incidents. Outside of formal supervision,</p>

	<p>the Improvement Officer has been engaging with staff on a 1:1 basis to discuss concerns, support practice improvements, and offer coaching and further training where necessary. We have introduced a weekly Learning Review Meeting, where management examine safeguarding issues, incidents, and complaints.</p> <p>We have also introduced post-incident debriefs for staff, focused on reflection, emotional impact, and learning.</p>
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<p>Area for Improvement 8</p> <p>Ref: Standard 6.3; 6.4 Regulation 17</p> <p>To be completed: 30 June 2026</p>	<p>The service must ensure that staff work within clear professional boundaries and in line with expected standards of conduct. Staff deployment must be safe, appropriate, and in accordance with risk assessments, and working practices must not place people using the service or staff at risk.</p>
	<p>Response by registered provider:</p> <p>The service will ensure that all staff work within clear professional boundaries and in accordance with the expected standards of conduct. Staff deployment will be safe, appropriate, and aligned with individual risk assessments. Working practices will support safe, ethical, and professional care delivery, and must never place care receivers or staff at risk.</p> <p>Registered Managers are in the process of developing boundary-focused training that addresses over-familiarity, inappropriate personal disclosures, and related issues. These discussions will also be integrated into supervision sessions.</p>

	Registered Managers will be conducting regular spot checks.
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<p>Area for Improvement 9</p> <p>Ref: Standard 9.4 Regulation 19</p> <p>To be completed: 30 June 2026</p>	<p>The service must establish and maintain robust governance and quality assurance systems. This includes regular auditing, monitoring, and review of care delivery, incidents, complaints, staffing, training, and records, with clear management oversight and timely action when concerns are identified.</p>
	<p>Response by registered provider:</p> <p>The service will establish and maintain robust governance and quality assurance systems. These systems will include regular auditing, monitoring, and review of care delivery, incidents, complaints, staffing, training, and record-keeping. Clear and consistent management oversight will ensure that concerns are identified promptly, addressed in a timely manner, and used to drive continual improvement in safety, quality, and service delivery. In conjunction with Law at Work, we have developed job descriptions that clearly define the responsibilities of the Registered Provider, Registered Manager, team leaders, and office-based staff.</p> <p>We also intend to develop a formal framework for Governance and Quality Meetings in the near future.</p> <p>The Registered Manager will be responsible for maintaining effective oversight of care delivery, incidents, complaints, and safeguarding.</p>

<p>Area for Improvement 10</p> <p>Ref: Standard 3 Regulation 11; 17</p> <p>To be completed: With immediate effect</p>	<p>The service must ensure that recruitment and employment practices meet regulatory requirements. This includes appropriate pre-employment checks, clear identification, complete personnel records, effective induction, and secure management of disciplinary and employment information to ensure staff are suitable and supported.</p>
	<p>Response by registered provider:</p> <p>The service will ensure that all recruitment and employment practices meet regulatory requirements. This includes completing appropriate pre-employment checks, verifying identity and suitability, maintaining accurate and complete personnel records, ensuring effective induction and probation processes, and securely managing disciplinary and employment information. These measures will ensure staff are safe, suitable, and supported to deliver high-quality care</p> <ol style="list-style-type: none"> 1-Pre-employment check list 2- We have developed interview questions with a scoring system to ensure fairness 3- Induction and probation under review 4- Urgent review of staff records.

<p>Area for Improvement 11</p> <p>Ref: Standard 3.3; 3.12; 8.2 Regulation 5; 17</p>	<p>The service must ensure there is sufficient leadership capacity and clear management arrangements in place. Roles and responsibilities must be defined, leadership appropriately delegated, and managers must provide effective oversight, support staff, and promote a positive and safe organisational culture.</p>
<p>To be completed: 30 June 2026</p>	<p>Response by registered provider:</p> <p>The service will ensure that there is always sufficient leadership capacity and clear management arrangements in place. Roles and responsibilities will be clearly defined, leadership will be appropriately delegated, and managers will provide effective oversight, support staff, and promote a positive, accountable, and safe organisational culture.</p> <p>1- Law at Work currently tasked with developing job descriptions, however, these have now been completed and will be implemented after the consultation period.</p> <p>2- New registered manager and assistance registered manager are now in post, not allowed to be off at the same time.</p> <p>3- Reinforcement of the 24/7 out of hours on-call system.</p> <p>4- Additional full time HR officer who has a vast amount of experience and qualified in HR.</p>

<p>Area for Improvement 12</p> <p>Ref: Standard 6.7; Appendix 8 Regulation 14</p> <p>To be completed: 30 April 2026</p>	<p>The service must strengthen medication management arrangements to ensure medicines are administered safely and consistently. This includes clear PRN protocols, medication-related care planning, appropriate training and competency assessment, compliance with transcribing guidance, and effective auditing and monitoring of medication incidents.</p>
	<p>Response by registered provider:</p> <p>The service will strengthen medication management arrangements to ensure that medicines are administered safely, consistently, and in accordance with regulatory Standards. This includes establishing clear PRN protocols, medication-related care planning, appropriate staff training and competency assessment, compliance with transcribing guidance, and effective auditing and monitoring of medication incidents.</p> <p>Medication care planning</p> <p>Checking training compliance and competency checks</p> <p>Enforcing daily medication stock check.</p> <p>Management maintaining medication oversight.</p>

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of the Care Commission during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, Standards and best practice.



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