Jersey Care Commission

INSPECTION REPORT

Specialist Palliative Care Team
Hospice Home Care

Home Care Service

Jersey Hospice Care
Clarkson House
Mont Cochon
St Helier
JE2 3JB

9 and 10 September 2026

Date Published
19 November 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 Specialist Palliative Care Team Hospice Home Care. The home care service is operated by Jersey Hospice Care and there is a registered manager in place.

Registration Details	Detail
Type of regulated activity	Home Care
Mandatory Conditions of Registration	
Type of care	Nursing Care
Category of care	Specialist Palliative Care
Maximum number of care hours each week	225 hours
Maximum number of hours for nursing care	225 hours
Age range of care receivers	18 years and over
Discretionary Conditions of Registration	
The Registered Manager is required to complete a Level 5 Diploma in Leadership in Health and Social Care Module by 29 September 2028.	

As part of the inspection process, the regulation officers evaluated the service's compliance with the mandatory conditions of registration and additional discretionary condition required under the Law. The regulation officers concluded that all requirements have been met.

3. ABOUT THE INSPECTION

3.1 Inspection Details

This inspection was announced and notice of the inspection visit was given to the Registered Manager two days prior to the first inspection visit. This was to ensure that the Registered Manager would be available during the visit.

Two regulation officers were present. References to who gathered the information during the inspection may change between 'the Regulation Officer' and 'regulation officers'.

Inspection information	Detail
Dates and times of this inspection	09 September 2026 09:30 to 13:15 and 14:00 to 16:45 10 September 2026 08:45 to 13:30 and 14:00 to 17:15
Number of areas for improvement from this inspection	Four
Number of care hours on the week of inspection	126 hours
Date of previous inspection	15 October 2025
Areas for improvement noted at the last inspection	None
Link to the previous inspection report	RPT_SPC_Inspection_20251015.pdf

3.2 Focus for this inspection

This inspection included a focus on these specific lines of enquiry:

- **Is the service safe**
- **Is the service effective and responsive**
- **Is the service caring**
- **Is the service well-led**

4. SUMMARY OF INSPECTION FINDINGS

4.1 Progress against areas for improvement identified at the last inspection

At the last inspection, no areas for improvement were identified.

4.2 Observations and overall findings from this inspection

There was a clear organisational and governance structure. The management framework provides clear lines of accountability. The organisation also demonstrated a commitment to staff recognition, wellbeing and team morale, supported through a range of staff initiatives.

Changes to the service model, were embedding with clear referral and triage processes. Information detailing how the service can provide support was outlined on the organisation's website and leaflets.

Feedback from care receivers and a care receiver's representative was consistently positive about the staff's approach. Feedback from professionals external to the service highlighted the team's specialist expertise, effective advocacy, excellent communication and commitment to education and collaborative working.

Care records demonstrated comprehensive, person-centred and holistic assessments that reflected the individual wishes, preferences and priorities of care receivers. The multidisciplinary team's specialist skills and compassionate approach were evident throughout care records, professional discussions and during a multi-disciplinary team and a multi-agency meeting that were observed.

The organisation has established systems for incident reporting and review, with evidence that learning from incidents is shared with external health services to promote continuous improvement. In addition, the organisation provides statutory and mandatory training that reflects local legislative requirements, alongside additional specialist training relevant to clinical roles.

There were areas where improvements are required and these relate to staffing levels, training records, notifications to the Commission and ensuring follow-up activities are undertaken as planned.

5. INSPECTION PROCESS

5.1 How the inspection was undertaken

The Home Care and Support in the Community Standards were referenced throughout the inspection.[1]

Prior to our inspection visit, all the information held by the Commission about this service was reviewed, including the previous inspection reports, the Statement of Purpose, and notification of incidents.

The Regulation Officer contacted five care receivers and gathered feedback from four care receivers and one of their representatives. They also had discussions with the service's management and other staff. Additionally, feedback was requested from four professionals external to the service and provided by three.

As part of the inspection process, documents including policies, care records, incident reporting and staff files were examined.

At the conclusion of the inspection visit, the Regulation Officer provided verbal feedback to the Registered Manager and confirmed the identified areas for improvement by email on 17 September 2026 and in subsequent correspondence on 15 October 2026. Details of the follow-up actions required to evidence that improvements have been made were also set out by the Regulation Officer.

This report presents our findings from the inspection and outlines the range of observations made. Throughout the report, we may highlight any areas of good practice identified, along with suggestions where practice could be strengthened or further enhanced. Where specific improvements are required, these are set out in detail and accompanied by a defined improvement plan 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.

Key lines of enquiry	
Focus	**Evidence Reviewed**
Is the service safe	Discussions with the Registered Manager and other staff The service Statement of Purpose Referral and triage documentation Staffing rotas Staff files Training documentation
Is the service effective and responsive	Feedback from professionals external to the service Notifications to the Commission Discussion with the Registered Manager and other staff Service leaflets and the organisation's website
Is the service caring	Feedback from, care receivers, their representative and professionals external to the service Care records, including assessments, care plans, risk assessments, and daily care records Observation of a multi-disciplinary team meeting and a multi-agency meeting
Is the service well-led	Governance structure documentation Statement of Purpose Monthly provider reports Policies Discussion with the senior leader and mangers, staff in the Quality Team, and other staff Supervision records Feedback from a professional external to the service

6. INSPECTION FINDINGS

Is the service safe?

People are protected from abuse and avoidable harm.

The regulation officers discussed with the Registered Manager how the service had operated since the previous inspection. The Registered Manager explained that changes to the service model, introduced before that inspection, were continuing to become embedded. The service comprises a Specialist Palliative Care Team (SPCT) and a Living Well Team (LWT). The LWT supports people with progressive, life-limiting illnesses, while the SPCT provides additional support where specialist assessment and management are required.

The service includes a Multi-disciplinary Team Coordinator. All nursing staff in the team have specialist palliative care training and the Clinical Nurse Specialists (CNSs) are non-medical prescribers. Service delivery is supported by the organisation's medical team, including a Consultant and Associate Specialist in Palliative Medicine. Input from a palliative care pharmacist, physiotherapist and the Spiritual Lead is also provided.

The referral form had been revised to demonstrate the changes in the service model and the documentation was suitable for its intended purpose. The service has ‘Triage Action Cards’ which clearly outline the triage process. The service is described on the organisation’s website and within a suite of leaflets.

The service's Statement of Purpose, detailed nursing staff levels as:

- Three CNSs working 09:00 to17:00, five days per week.
- Five registered nurses in the LWT working 08:00 to 20:00, seven days per week.

The nursing staff rota demonstrated staffing levels, were at times, below those set out in the Statement of Purpose. In February 2026, the community LWT had one nurse rostered on five of seven days. In June 2026, there was one nurse on duty on six days and no nurse on duty on one day.

The Registered Manager advised the Regulation Officer that the organisation had decided not to provide temporary cover for one CNS during parental leave. Consequently, the service operated with only one CNS for an extended period.

At the time of the inspection, the service employed three CNSs and had recruited a paramedic who was due to commence work later in the year. However, one CNS remained within their induction period and vacancies within the LWT had not yet been filled. The service could not therefore demonstrate that sufficient numbers of suitably qualified and experienced staff were available at all times to meet the needs of care receivers. This is an area for improvement.

Recruitment practices were reviewed. The staff files examined contained a curriculum vitae, and application form. There were notes demonstrating that an interview was undertaken by appropriate staff and that questions were based on culture and values, skills and experience, and included clinical scenarios and technical knowledge. References and an enhanced Disclosure and Barring Service (DBS) check had been obtained prior to the individual commencing work. There was evidence of an induction program and a staff member recently recruited spoke positively about their recruitment experience. Overall, recruitment practices were clear, well documented and included appropriate pre-employment checks. Additionally, the team responsible for human resources demonstrated that the organisation has a system in place to ensure DBS updates are obtained within organisational timeframes which met the Commission's Standards.

The organisation's Core Training Framework 2026 document detailed the statutory and mandatory training relevant to local legislation and Regulations and national professional frameworks which staff are required to undertake. Additionally, clinical staff are allocated further training topics related to the health and social care conditions and management relevant to their role.

While this provides a clear training structure, the Registered Manager explained that, due to a change in the information technology (IT) system they were unable to identify what training had been undertaken by staff they line managed.

The Registered Manager had taken steps to address the issue, including formally escalating it to senior leaders in April 2026. However, at the time of the inspection, records demonstrating that staff had completed the required training were not available to the regulation officers. The Registered Provider should therefore ensure that accurate and up-to-date records of all training completed by staff are maintained and available for inspection. This is an area for improvement.

Is the service effective and responsive?

Care, treatment, and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

The Regulation Officer asked professionals external to the service to provide feedback on the team's strengths. A professional stated the team had *"excellent specialist palliative care knowledge and expertise".* Additionally, they explained that the team effectively advocated for care receivers and their representatives, provided *"responsive support and advice for community teams"* and demonstrated a *"commitment to education and sharing expertise".* Another professional commented that the team were skilled and knowledgeable and stated their *"communication is exceptional".*

During the inspection the regulation officers were provided with an example of how the team had supported a care receiver who wished to return to their home country following being diagnosed with a life limiting illness. The support described how the staff member explored the care receiver's wishes by adapting communication to the needs of the care receiver. The example illustrated a commitment to ensuring support was tailored to the care receivers wishes.

There was evidence that the organisation had an IT system in place through which incidents and accidents could be reported. There was evidence of learning from an incident, and the outcomes and learning had been shared with other health services. Additionally, regulation officers observed an incident being raised and discussed during a clinical meeting. Factors that may have influenced the event were explored,

and prompt and timely actions to respond to the incident and prevent reoccurrence were identified and agreed.

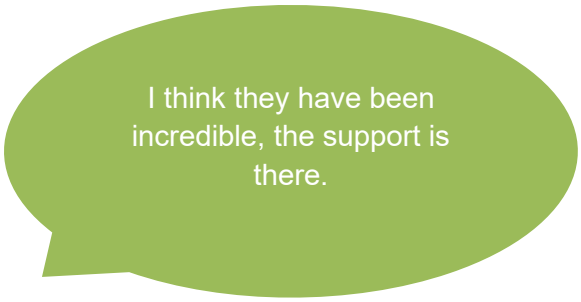
Whilst the service demonstrated effective internal processes, reporting notifications to the Commission did not meet the requirements of the Standards. The service is required to notify the Commission of the reportable events outlined in the Standards and the Commission's Notification Guidance. There had been four notifications to the Commission since the previous inspection.

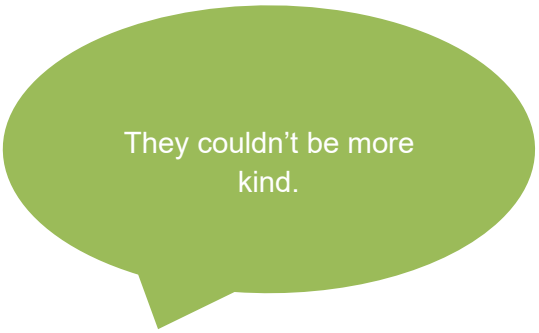
This was explored with the Registered Manager, and regulation officers explained that given the size of the service and its specialist provision, it would be reasonable to expect a greater number of notifications. The Commission had been made aware of an event that required notification but for which a notification had not been submitted. Additionally, the Commission had only been notified of low staffing levels on one occasion, though findings from this inspection showed that there had been several occasions when the number of nursing staff was low. This is therefore an area for improvement.

Is the service caring?

Care is respectful, compassionate, and dignified. Care meets people's unique needs.

Feedback from care receivers, a care receiver's representative and professionals was consistently positive about the staff's approach. Care receivers said:





More quotes are illustrated further in the report.

Care records showed that detailed initial holistic needs assessments were undertaken. The assessments were person-centred, and covered physical, psychological, social, spiritual, and financial aspects of care receivers' lives. The notes described the lives of care receivers before receiving a diagnosis of a life-limiting illness and the impact the illness was having on them and those important to them. Physical aspects of care receivers' health relating to comfort, movement, eating and drinking, and their ability to process information were detailed. Clear plans of care were set out, and the voice of care receivers and the things that were important to them were described.

The service used palliative care tools and clinical classifications to measure how care receivers managed daily activities and assess their level of need, and present condition including Australia-modified Karnofsky Performance Scale, Phase of Illness, and the Gold Standards Framework. These were documented in care records. Additionally, regulation officers observed this clinical information being used in the organisation's clinical multi-disciplinary morning meeting.

The meeting was chaired by the Palliative Medicine Consultant and attended by medical and nursing staff and a pharmacist. The clinical information was explored alongside the level of treatment care receivers wished to receive and where they had expressed, they would want to be when nearing the end of their lives. This resulted in professional, succinct and person-centred discussions that enabled care and support to be planned.

Whilst it was clear that care and support were delivered skilfully and compassionately, the inspection identified gaps in the completion and oversight of planned care and support. Although there was evidence of care being delivered as planned, records showed several follow-up actions that had not been completed as required. These included delayed or missed telephone calls, an overdue home visit and a professional discussion that had not been actioned. There was no evidence that these omissions had been identified through the service's monitoring arrangements, that their impact on care receivers or those important to them had been assessed, or that apologies had been offered where appropriate.

The Registered Manager acknowledged the findings and took steps during the inspection to address the immediate potential for harm. They reported that caseload reviews had identified missed calls although accurate data on the number involved was not available. They also advised that changes to the display of caseloads within the electronic care record system and to the booking system were in progress.

Whilst the issue had been recognised and actions had been taken; robust systems were not in place at the time of the inspection. Therefore, to ensure there are effective systems in place to ensure that follow up activities, including visits and telephone calls, are undertaken as planned is an area for improvement.

Is the service well led?

The leadership, management and governance of the organisation assures delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

There was evidence of a coherent and integrated organisational and governance framework. The structure includes a Clinical Governance Committee which branches into operational sub-groups in areas including, quality and safety, safeguarding and clinical policies and procedures. There was a management structure in place with clear lines of accountability. The organisation has a comprehensive range of policies and procedures.

The Statement of Purpose was reviewed, and amendments were required to enable the document to more clearly describe the service. The Registered Manager submitted and an amended the document during the inspection period.

There was evidence that an appraisal system was in place. However, the records reviewed did not provide sufficient assurance that staff supervision was being undertaken consistently in accordance with the Standards. The organisation recorded individual and group supervision sessions; however, the available records identified gaps in one-to-one supervision, and sufficiently accurate data was not available to confirm the overall frequency and completion of supervision.

However, there was evidence of staff support through both an external provider and internally delivered group supervision, which staff feedback was supportive. In addition, details of actions being taken to strengthen oversight going forward were provided. As a result, the regulation officers were satisfied that supervision is available, though it is recommended individual sessions be more clearly recorded.

Regulation officers were informed that the Chief Executive Officer had implemented a ‘Star Award’. Staff can nominate colleagues who have demonstrated commitment and team support. It was also explained that the Kitchen Team regularly provided a barbecue lunch and during the winter a roast lunch at a nominal cost to staff. A social committee also arrange events throughout the year that colleagues are able to attend. This demonstrated a positive commitment to staff recognition, wellbeing, and team morale within the organisation.

Furthermore, the Registered Manager, expressed that they were proud of how the team had adjusted to the changes in the service model. To support these adjustments, the organisation had arranged external support to reflect on team working. The professional who provided the support spoke highly of staff engagement. They explained that staff at all levels had been consistently open and constructive and had demonstrated a commitment to making meaningful changes to strengthen team effectiveness.

Staff said the following about their roles:



Care receivers said the following about staff:



Professionals external to the service said the following about the team:



IMPROVEMENT PLAN

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

Area for Improvement 1 **Ref:** Standard 6.3 Regulation 17 **To be completed:** by 03/12/2026	The Registered Provider must ensure that there are at all times sufficient numbers of competent, experienced care/support workers to meet the care and support needs of people receiving care. **Response by the Registered Provider:** **T**he Registered Provider notes this finding and wishes to clarify that the Statement of Purpose incorrectly states that three Clinical Nurse Specialists (CNSs) and five Living Well Nurses are on duty each day. These figures represent the total nursing establishment employed within the service, not daily staffing levels. With the exception of the staffing incident already notified to the Commission and referenced within the report, the service maintained its minimum safe staffing level of one CNS and one Living Well Nurse at all times. On occasion, the Registered Manager undertook a specialist nursing role as part of business continuity arrangements to maintain safe service delivery. This ensured that minimum staffing levels were met and that the needs of people receiving care continued to be safely supported. As staffing levels remained within the service's agreed minimum operating model, these occasions did not meet the threshold for notification. The Statement of Purpose will be amended to accurately reflect the staffing establishment and operational staffing model.

Area for Improvement 2 **Ref:** Standard 6.5 Regulation 17 **To be completed:** by 03/12/2026	The Registered Provider must maintain accurate and up-to-date records of all training completed by staff. These should include dates, topics, refresher schedules, and competency assessments, and must be available for inspection.
	Response by the Registered Provider: The Registered Provider acknowledges this finding. At the time of inspection, a recently implemented training records system experienced some initial teething issues, resulting in incomplete records. These issues have since been resolved, and all training records have been reviewed and updated. The Registered Provider is satisfied that records are now accurate, up to date, and available for inspection

Area for Improvement 3 **Ref:** Standard 7.2 Regulation 21 **To be completed:** With immediate effect	The Registered Provider must notify the Commission of such incidents, accidents or other events that have posed or may pose a risk of harm as specified by the Commission.
	Response by the Registered Provider: **T**he Registered Provider acknowledges this finding. This relates specifically to the notification of adult deaths. As a community-based service, we are not always the organisation responsible for verifying a death and had previously received advice from the Commission that death notifications were not required. This was due to multiple notifications often being submitted by different providers involved in an individual's care, which had led to discrepancies and inconsistencies in the information received. Following further clarification from the Commission regarding reporting expectations, the service has amended its practice and now submits notifications for all deaths. Appropriate processes are in place to ensure ongoing compliance with notification requirements.

Area for Improvement 4 **Ref:** Standard 6.2 Regulation 8A **To be completed:** With immediate effect	There will be systems in place to ensure that follow up activities, including visits and telephone calls are not missed.
	Response by the Registered Provider: The Registered Provider acknowledges this finding. At the time of inspection, the need for a more formal process to ensure follow-up activities were consistently tracked had already been identified, and revised procedures were being finalised. As a result, these were not available to demonstrate in full during the inspection. Robust systems have now been implemented, including a daily patient tracker that is reviewed and refreshed each day, daily operational meetings to review activity and outstanding actions, and documented processes to ensure follow-up visits and telephone calls are appropriately allocated, monitored, and completed. These measures provide assurance that patients are not missed and that follow-up activity is effectively managed.

To ensure there is clear evidence that the required improvements have been made, the following actions will be taken:

- The Provider must submit written confirmation to the Commission when the areas of improvement have been achieved.
- The Commission will monitor the notifications the service submits.

These actions will be used to track progress, confirm completion, and provide assurance that the necessary improvements have been achieved.

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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