CRC Care Ltd
Support Service

CRC Care Ltd
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Type of inspection:
Unannounced

Completed on:
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Service provided by:
CRC Care Ltd

Service provider number:
SP2013012138

Service no:
CS2013319689

About the service

CRC Care Ltd is a privately owned company currently registered as a care at home service with the Care Inspectorate. The service provides support to adults with physical and sensory impairment living in their own homes and in the community. Support provided by the service includes personal care and support with medication to help people live independently.

CRC Care Ltd operates from an office base in Renfrew and provides assistance to people across Renfrewshire. Care staff were supported by the registered manager, operations manager, quality assurance manager, senior carers and office-based staff.

At the time of our inspection, the service supported approximately 320 people.

About the inspection

This was an unannounced inspection which took place on 8, 9 and 10 September 2025, between the hours of 09:00 and 20:00. The inspection was carried out by three inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, complaints, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we spoke with:

- 16 people and four of their relatives
- 15 staff
- one visiting professional.

We also took into account feedback received from care inspectorate surveys from 43 people, and/or their family members, 21 staff and one visiting professional.

Key messages

- We followed up on three areas for improvement at this inspection, two of these were met and one was not met. Three requirements and four new areas of improvement have been made at this inspection.
- People experienced warm, respectful relationships with staff, supporting emotional wellbeing.
- Staff training was strong, with high compliance and reflective practice enhancing care.
- Visit scheduling and poor communication meant some people did not receive their assessed support.
- Staff wellbeing was affected by rota pressures and transport issues, impacting morale.
- Catheter care practice and care planning documentation needed to improve.
- Leadership roles and governance lacked clarity, affecting oversight and accountability.
- The service did not consistently respond to adverse events, limiting learning and risking safety.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses. While we identified positive outcomes for people, there were areas that require improvement to ensure care is consistently safe, person-centred, and responsive.

People's experiences of care were largely positive. Most people we spoke with told us they were happy with the support they received. They described staff as respectful, kind, and cheerful. Several people said staff had become "like family," and shared examples of carers singing or making them laugh. This contributed to warm and trusting relationships. Consistent relationships with familiar staff were valued. People appreciated having regular carers who knew them well. This helped to promote emotional wellbeing and a sense of security.

The service responded well to changing needs in some cases. For example, referrals to occupational therapy were made when people's mobility changed, and visit durations were extended to ensure people received the right level of care. These actions helped maintain people's safety and dignity.

Skin integrity risks were not always well managed. We found that some people were in bed for prolonged periods overnight before their next care visit, increasing the risk of pressure sores. In one case, a person's support plan stated they should be repositioned frequently. Staff recorded this support as completed despite not carrying it out, and there was no documented rationale around why this had happened. This created inconsistency and risked care not being delivered in line with assessed needs. Care documentation lacked detail and consistency. Support plans asked staff to record food intake, but this was not always documented. Some staff ticked off care tasks without describing what care was delivered or how the person presented. This limited the ability to assess whether people's needs were met or to identify changes in people's health or wellbeing. (See area for improvement 1).

Medication support records were unreliable. Although both paper and electronic Medication Administration Recording systems (MAR's) were in place, we found inconsistencies in how medication tasks were recorded. Some tasks were ticked off even when visits had been cancelled, while others were left incomplete without explanation. This raised concerns about the effectiveness of oversight and could compromise people's health. (See area for improvement 2).

Areas for improvement

1.
To support effective monitoring and evaluation of people's needs, the provider should ensure staff record care in a descriptive and consistent manner.

This is in accordance with Health and Social Care Standards "I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty" (HSCS 3.18).

2. To ensure safe and consistent support, the provider should improve systems for recording medication support so this is easily trackable and monitored.

This is in accordance with Health and Social Care Standards "My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event" (HSCS 4.14) and "I experience high quality care and support because people have the necessary information and resources" (HSCS 4.27).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses. While there were some systems in place to support oversight and improvement, significant gaps in incident recording and governance limited their effectiveness.

The service had introduced a quarterly report of key performance areas. This included details around monthly audits of medication, care plans, missed visits and other performance areas. These were used to inform a live improvement plan. Some actions had been taken in response to audit findings, such as updates to the care app and improvements to care planning. These systems demonstrated a commitment to improvement and provided a foundation for oversight.

However, the reliability of data was undermined by inconsistencies in incident recording. Several notifiable events, including falls, medication errors, and service user deaths, were submitted to the Care Inspectorate but not logged internally. In one serious incident, staff gave conflicting accounts of an incident involving a person at significant risk of harm. This raised concerns about how staff respond to serious events and whether appropriate support and protection measures are in place. The lack of a clear process for reflection and learning meant that opportunities to improve practice and support staff were missed.

Incident records were stored across multiple locations, with no centralised system and unclear responsibilities for logging, and the completion of notifiable events to the relevant agencies. This fragmented approach made it difficult to identify patterns, ensure follow-up actions were taken, and provide assurance that people were safe. For people using the service, this meant that risks may not be properly recognised or addressed, and staff may not be equipped to respond consistently or effectively. (See requirement 1).

Leadership and governance arrangements lacked clarity. A new registered manager had been in post for several months, but the Director of the company, who was the previous registered manager continued to play an active role in the day to day operations of the service. Other senior roles were restructured, but job descriptions and responsibilities remained unclear. This led to conflicting information during the inspection and made it difficult to assess accountability. The lack of clear leadership impacted the service's ability to maintain oversight and deliver safe, well-managed care. (See requirement 2).

The service had not contacted the Care Inspectorate registration team despite significant growth, and current registration conditions no longer reflected the service's size or structure. This raises concerns about regulatory compliance and the provider's understanding of their responsibilities.

Feedback mechanisms were in place, including surveys for people using the service. While it was positive to see that some actions had been taken in response, there was no structured approach to sharing outcomes with the people who used the service. This limited the impact of engagement and missed opportunities to build trust and improve people's experiences. The manager took on board our feedback about the importance to share the outcomes of service feedback with people using the service. This will ensure that people feel involved in the development of the service, and that their views and opinions are recognised as important.

Overall, while there were some strengths in the service's approach to quality assurance and feedback, these were compromised by significant weaknesses in incident management and leadership. The lack of robust systems and clear accountability directly impacted the service's ability to deliver continuous improvement.

Requirements

1. By 21 December 2025, the provider must ensure that all accidents, incidents, and adverse events are consistently recorded, stored centrally, and notified to the appropriate authorities in line with regulatory requirements. This is to ensure people are protected from harm and that the service can learn from events to improve outcomes. To do this, the provider must, at a minimum:

a) implement a centralised and accessible system for recording all incidents, including deaths, falls, medication errors, and other adverse events

b) ensure staff are trained and supported to recognise and report incidents accurately and promptly

c) establish a process for reviewing incidents to identify learning, support staff, and improve practice

d) ensure all notifiable events are submitted to the Care Inspectorate in line with "Guidance on records you must keep and notifications you must make, 2025".

This is to comply with SSI 2011/210 Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities" (HSCS 3.20).

2. By 21 December 2025, the provider must ensure that leadership roles and responsibilities are clearly defined, documented, and communicated to support effective governance and safe service delivery. To do this, the provider must, at a minimum:

a) update and maintain accurate job descriptions for all senior roles, including the Registered Manager, Director, Coordinators, and Business Manager

b) ensure clarity on who holds overall responsibility for the management and quality assurance of the service

c) ensure all individuals in leadership roles are appropriately registered with the Scottish Social Services Council (SSSC) or The Nursing and Midwifery Council (NMC)

d) review and update the service's registration conditions to reflect current service size and structure.

This is to comply with: Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I use a service and organisation that are well led and managed" (HSCS 4.23).

How good is our staff team? 3 - Adequate

Quality Indicator 3.2. Staff have the right knowledge, competence and development to care for and support people.

We evaluated this quality indicator as Good, where several strengths had a positive impact on outcomes for people and clearly outweighed areas for improvement.

People using the service and their families spoke positively about staff. They described respectful, warm, and trusting relationships, with some highlighting the use of humour and kindness in interactions. These relationships contributed to a sense of safety and emotional wellbeing for people receiving care.

We found that the service had a strong and well-organised approach to staff training. A comprehensive training matrix was in place, and compliance with mandatory training was high, across key areas such as Adult Support and Protection, Medication management and Infection prevention and control. Staff also had access to supplementary face-to-face training throughout the year, particularly focused on practical support tasks, such as medication support. These sessions were supported by reflective practice, which helped staff apply their learning in real situations and improve the quality of care.

The induction process was thorough and included both online and in-person training before staff began delivering care. Senior carers played an active role in supporting new staff, providing on the job guidance and helping with rota planning and shift adjustments. This contributed to a supportive team environment and helped staff feel confident in their roles.

Supervision and appraisal processes were in place and improving. The new manager had updated the supervision pro forma to include staff personal development goals. We suggested that adding a section to record agreed actions could further enhance accountability and follow through. Most staff had received an annual appraisal, which recognised their strengths and identified areas for development.

Staff told us they felt well-equipped to meet people's needs and valued the breadth and quality of training available. They also had opportunities to request additional training where they identified a learning need, which supported a culture of continuous improvement.

We identified that staff did not always escalate concerns appropriately. This included incidents where people had fallen or experienced unplanned events. Delays in escalation may have compromised people's safety and limited opportunities for timely intervention. This has been discussed further under the section of the report "How good is our leadership".

Quality Indicator 3.3. Staffing arrangements are right and staff work well together.

We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

The service used a combination of methods to manage rotas and visit times/schedules. This included the use of an electronic system. Carers were assigned to consistent visits in the same location, known as "runs", typically within small teams of four to five staff. This supported continuity of care and was valued by people using the service.

When shifts were unfilled, cover was arranged through floating staff, shift adjustments, or staff working over their contracted hours. Carers used a mobile app to record visit times, this included a clocking in and out system when visits started and ended. If a carer did not clock in or out, the office had to manually enter visit times. Staff sometimes altered visit times without informing the office, which contributed to late visits and poor communication with people and their families. We saw that the manager had reminded staff of the importance of timely communication during team meetings.

We carried out a review of planned visit times versus actual visit times that had taken place, this showed that 146 out of 774 visits in one day had discrepancies of more than 10 minutes. Some visits were shortened by up to 50 minutes. We were unable to evidence any reason why people's visit duration did not meet their assessed support. This meant that people did not always receive care for the duration of their agreed support, which could compromise their health, wellbeing, and dignity. (See requirement 1).

We found that staff had mechanisms to raise concerns about their wellbeing during team meetings. Some staff described feeling burnt out and frustrated due to work-life balance challenges and rota planning. The service had began to withdraw and reduce the service vehicle scheme, which provides transport to carers to and from planned visits. Whilst it was positive to hear that the service was reimbursing staff for some of the additional travel cost this had created for staff, this was having a clear impact on morale. Staff told us that transport issues were affecting their ability to manage long working days, across a range of geographical areas, and they were no longer able to return to the office for rest breaks between visits. This may be contributing to staff stress and fatigue, which could affect the quality of care delivered. We were concerned by the tone of some management responses to staff concerns. In one meeting, comments made by leaders could be perceived as unsupportive, and may indicate a culture where staff do not feel fully supported. (See area for improvement 1).

Requirements

1. By 21 December 2025, the provider must ensure that people receive care and support for the duration of their assessed visit times to meet their individual support needs. To do this, the provider must, at a minimum:

a) implement a robust system to monitor actual versus planned visit durations

b) ensure staff consistently record visit times

c) audit discrepancies and take corrective action where visits fall short

d) improve communication between care staff and the office ensuring timely updates on visit changes are made, as well as informing people and their families of any changes to their support.

This is to comply with: Section 7(1)(a) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I am confident people respond promptly, including when I ask for help" (HSCS 3.17).

Areas for improvement

1. To promote the safety and wellbeing of staff, the provider should ensure that staff are supported to manage the demands of their role and feel listened to when raising concerns. This should include, but not be limited to, reviewing transport arrangements, ensuring access to rest breaks, and promoting a culture of respectful and supportive communication.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: "My care and support is consistent and stable because people work together well" (HSCS 3.19).

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses. While care reviews were generally inclusive and outcome-focused, weaknesses in care planning and catheter care, limited the service's ability to deliver safe, person-centred support.

Some people told us they were involved in developing their care plans, while others did not feel included in this process. Others were aware that they had a copy of their care plan at home and were content with their support, but did not actively engage with the documentation. This variation in involvement limited opportunities for people to lead and direct their own care.

Care reviews were being carried out approximately every six months, with a tracker in place to monitor completion. Reviews were conducted either in person or by phone and often included input from family or friends. This provided people and their families with opportunities to discuss if the care arrangements were right for them. This supported inclusive decision-making and helped ensure that people's views were heard. It was encouraging to see that reviews focused on what was working well and what needed to change. This helped to support a person-led approach.

Reviews sampled included outcome-focused discussions. For example, one persons review reflected satisfaction with care, and changes, such as medication prompts, had been implemented and reflected in the care plan. However, while some reviews led to timely updates, others did not. The service should consider how they can ensure care plan updates are consistently made following reviews.

Staff raised concerns about some outdated care tasks remaining on the care app, which gave staff details on what support was required at each visit. This may contribute to inaccurate recording and confusion about what support is required. Care plans sampled lacked meaningful personalised information about the people being supported. There was little detail about who people are, what matters to them, or who is important in their lives. This information appeared to be learned informally over time rather than embedded in the care planning process. The absence of this information limited the ability of staff, particularly new or temporary staff, to deliver person-centred care. (See area for improvement 1).

We identified concerns about catheter care, where it was unclear who made care decisions or whether these had been discussed with external health professionals. When we raised this with senior staff, we heard differing views and could not conclude that the support had been well assessed. The care plan incorrectly stated that the GP was aware of the support arrangements. We also noted other issues with catheter care plans. One had not been updated despite significant changes in the person's condition, while another person receiving catheter support had no care plan in place. Catheter care practice had the potential to put people at risk and showed a lack of oversight and escalation, while also limiting staff's ability to deliver safe and effective care. There is an outstanding area for improvement around catheter care from previous inspections which has not been met. Repeated issues suggest that care is not improving and require focused action. (See requirement 1).

Requirements

1. By 21st December 2025, the provider must ensure that catheter care is delivered safely and in line with best practice, with clear assessment and input from relevant health professionals. To do this, the provider must, at a minimum:

a) ensure catheter care plans are in place for all individuals receiving catheter support

b) update catheter care plans promptly when needs change

c) seek and evidence input from relevant health professionals for all catheter-related decisions

d) ensure staff follow safe practice and escalate concerns appropriately.

This is to comply with Regulation 5(1)(2)(Personal Plans) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My personal plan is right for me because it sets out how my needs are to be met, as well as my wishes and choices" (HSCS 1.15).

Areas for improvement

1. To support person-centred care, the provider should ensure that care plans include meaningful personalised information about the people being supported. This should include, but not be limited to, details about people's interests, relationships, preferences, and what matters most to them. This should help staff deliver care that promotes dignity, emotional wellbeing, and individual identity.

This is to ensure care and support is consistent with the Health and Social Care Standards which states that: "My personal plan is right for me because it sets out how my needs are to be met, as well as my wishes and choices" (HSCS 1.15) and "I am confident that the right people are fully informed about my past, including my health and care experience, and any impact this has on me" (HSCS 3.4).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

People should have confidence that if they raise a complaint the process followed will be robust. The provider should ensure follow up contact is made with people who have raised a complaint once the complaints process has been concluded. This should be clearly documented evidencing when communication has been made, with a record of the outcome of discussions and agreement to review any actions identified.

This is in accordance with Health and Social Care Standards "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "If I have a concern or complaint, this will be discussed with me and acted on without negative consequences for me" (HSCS 4.21).

This area for improvement was made on 12 November 2024.

Action taken since then

Sampling of complaints shows improvement. In most cases, outcome letters were sent and follow-up was attempted. Complaints were generally closed when no further contact was made by the complainant. There is evidence of meetings held with dissatisfied complainants, although these were not always consistently stored with the complaint files. We were satisfied that sufficient progress had been made, further consistency in documentation and integration of all related communications into complaint handling would enhance this further.

This area for improvement has been met.

Previous area for improvement 2

To ensure people using the service have confidence in the support being provided, the manager should explore opportunities to support staff to communicate in a way the person experiencing care understands and overcomes dialect and language barriers.

This is to ensure care and support is consistent with Health and Social Care Standard 3.12: "I can understand the people who support and care for me when they communicate with me".

This area for improvement was made on 31 January 2024.

Action taken since then

Supplementary training had been introduced as part of the induction programme for new staff; this includes Scottish dialects and colloquial language. This was helping to promote effective communication as well as build and maintain relationships between staff, people and their families.

This area for improvement has been met.

Previous area for improvement 3

To ensure people using the service have accurate, detailed and up to date personal planning records for catheter care that reflect how to deliver the planned support. The manager should have quality assurance arrangements in place to ensure consistency with recording and staff training.

This is to ensure care and support is consistent with Health and Social Care Standard 1.15: "My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices".

This area for improvement was made on 31 January 2024.

Action taken since then

Due to the lack of improvement in this area at the last two inspections and further concerns identified at this inspection, this will now form part of a new requirement.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question "How well is our care and support planned".

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	4 - Good
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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