Karma Healthcare Ltd
Support Service

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Type of inspection:
Unannounced

Completed on:
16 January 2026

Service provided by:
Karma Healthcare Limited

Service provider number:
SP2007009334

Service no:
CS2007166441

About the service

Karma Healthcare Ltd is a registered care at home service for people living in their own homes in the Inverclyde area. The service is available to older adults, adults under the age of 65 years and children and young people under the age of 16 years.

The service operates from an office base in Gourock and had a recently appointed registered manager in post. Support is provided at a range of times throughout the day. This includes support with a variety of tasks such as personal care, housework, food preparation and support with medication. At the time of inspection, the service was providing support to 113 people.

About the inspection

This was an unannounced inspection which took place from 7 to 13 January 2026 between the hours of 09:00 and 18:00. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- Spoke with 16 people using the service and seven of their family. We also received six responses from families to our questionnaires.
- Spoke with eight staff and management. We also received 17 responses from staff to our questionnaires.
- Observed practice and daily life.
- Reviewed documents.
- Spoke with two professionals.

Key messages

- People were happy with the carers who provided their support.
- People's wellbeing and safety was compromised because they had not received the right support at the right time.
- People did not always receive their medication at the right time.
- There were insufficient staff resources to effectively manage and deliver people's allocated support hours.
- The service lacked governance and effective leadership.
- Personal plans required to be in place and contain the right information about people.
- As a result of concerns about the service an Improvement Notice has been issued to the provider.

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?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak
How well is our care and support planned?	2 - Weak

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

How well do we support people's wellbeing? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, significant weaknesses compromised people's health and wellbeing.

People did not receive the right care at the right time because visit timings were inconsistent. Morning support often took place later than it should, and we saw that sometimes this was up to 16 hours after the previous evening visit. System safeguards for scheduling and managing timings were not being used effectively or appeared to be overridden. This resulted in people experiencing early, late and missed visits. Erratic visit timings had a significant impact on people who required medications at specific times, those who received assistance with mobility, continence care and pain management. Staff did not consistently administer time critical medication, and some people did not receive essential prescribed treatments which meant medication support was unreliable and placed people at risk of harm. Family members expressed to us their concerns about the impact of late or missed medication and throughout the inspection we saw examples of this for several people. This resulted in inconsistency and a lack of continuity of support, and left people and their families feeling insecure and anxious about the care received, in particular medications being given safely as they were prescribed.

People felt that the staff who provided support were caring and knew them well. They told us that they experienced warmth, kindness, reassurance and positive interactions with them. Most people we spoke with had the same issues with the service regarding timing and inconsistency, however almost everyone told us "when the staff get here, they are great" and they enjoyed the support given. However, these positives did not outweigh the concerns identified and the potential impact on people's health and their safety.

The quality of assessment and personal planning significantly limited staff's ability to provide safe and person-centred care. Important information about medication and changes in people's needs were not recorded, and some care plans did not reflect people's current mobility, sensory needs or risks. This meant staff did not have essential information required about people's needs or abilities. This meant that some people could be exposed to additional risk, having an impact on their comfort, and overall impact their health, safety and wellbeing.

For those family and representative who were registered and could access the service's electronic system they did find it useful in that they were able to see that their loved one had received their support visits and how they had been throughout the day. They could see the daily notes that had been added, what time staff had arrived and left, and if medications had been supported. If using the electronic system, families were able to see the visit rota, however, this changed so frequently that people did not always know who would be visiting them or when. There were times that people were visited by carers they did not know, which caused anxiety and could impact on the support they experienced.

Please see the required improvements detailed in the improvement notice dated 21 January 2026.

How good is our leadership? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, weaknesses outweighed these and had a substantial impact on the quality and reliability of the service people

received. While some staff were committed to improving outcomes for people, significant weaknesses in leadership, governance and oversight compromised people's safety and experience of care.

Quality assurance was not carried out reliably or effectively. Managers had previously developed systems to review practice and identify areas requiring improvement, but these had not been maintained. There had been no meaningful quality assurance activity for several months, and staff were unable to locate essential audit tools or trackers that had previously been in place. As a result, significant concerns such as medication errors, missed visits, poor continuity of care and incomplete notes were not detected or acted upon. This meant patterns of risk continued with no intervention, and people did not experience the improvements they should expect.

Where records were reviewed, such as daily notes or journals being checked by team leaders, there had been no follow-up actions taken to make improvements when these were identified. Findings had not been analysed or used to drive improvement in the service. Concerns raised by families about missed visits, communication problems or unsafe practice were not used meaningfully to learn or plan improvements. This resulted in repeated issues and growing dissatisfaction among people and relatives. Some relatives told us they contacted the local authority directly because they had lost confidence that problems would be listened to or resolved.

People should expect to be supported by trained, skilled and competent staff. Mandatory training records available were inconsistent and unreliable, and included staff who had left the service months earlier. Records demonstrated that training compliance levels were low, and did not evidence that staff had undertaken the necessary mandatory or person specific training to support people's assessed needs. Managers and senior staff frequently covered care visits themselves, often working excessively long hours. This left little capacity for managers to carry out supervisions or observations of staff practice to monitor practice and competence. There was very little reflection of practice by staff, and no opportunities to improve learning experiences (see requirement 1).

Care staff must be registered with an appropriate professional body such as the Scottish Social Services Council (SSSC); we could not see an effective system in place to track the registration of staff. This meant there could be staff working in the service who were not registered to do so. This further highlighted a lack of oversight of professional responsibilities and increased the risk of unregulated practice.

When we sampled scheduling records, we saw widespread staff early departures, late visits and missed or shortened support. Leaders did not have oversight and had not analysed this information to understand the impact on people or to plan improvements. Governance around staff scheduling was weak and contributed to unsafe and inconsistent care. We were told that there was a safeguarding system in place where schedulers should not alter people's priority visits or make changes. However, we saw that it was easily overridden by schedulers. These changes of timing had an impact on people's wellbeing.

Frequent changes in the management team and workload pressures meant leaders were often in a "firefighting" mode, covering care visits themselves. This left little capacity for quality assurance and management tasks such as auditing, oversight, supervision or improvement planning. As a result of this, previous inspection requirements and areas for improvement had not been met, and weaknesses had escalated.

Please see the required improvements detailed in the improvement notice dated 21 January 2026.

Requirements

1. By 24 March 2026, the provider must ensure that people are being supported by staff who are trained, knowledgeable and skilled in relevant areas of care and support. This must include, but not be limited to:

a) Accurate recording of compliance by staff in mandatory and person specific training including Dementia, Moving and Handling, Medication and Adult Support and Protection.
b) Observations of staff practice when they are supporting people, including medication administration.
c) One to one supervision of staff that ensures they have the opportunity to reflect on their practice and to make improvements when required.
d) Group learning experiences where staff and managers have opportunities to discuss and explore knowledge, skills and feedback.

This is in order to comply with Part three (Section 8) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that: "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes" (HSC 3.14).

How good is our staff team? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

People can expect to receive care from a service where there are sufficient staff with the right skills to meet their needs. We spoke with staff who were dedicated and caring, however, significant staff turnover and vacancies impacted on staffing levels, continuity of care, communication and effective staff deployment. Staff vacancies had remained unfilled for several months across key roles, including care staff, senior carers, team leaders and schedulers. These gaps in staffing were creating instability and affecting the service's ability to organise and deliver safe care.

Staffing levels were not sufficient to meet people's assessed needs. People did not know who would be arriving to support them, and some people received care from unfamiliar carers on a regular basis. This was particularly concerning for people with complex mobility or communication needs who required consistency with staff who understood their routines. Some people who had been assessed as needing two person support did not always receive it. This resulted in unsafe moving and handling practices and an increased risk of injury. Families told us that weekend supports were especially unreliable, with late or missed visits and a lack of communication about changes.

Visit timings were inconsistent and did not reflect people's assessed needs. Evidence showed large numbers of early departures, early arrivals, shortened visits and late visits. This meant that people did not always receive their full allocated support time. For some, this resulted in missed personal care, inadequate meal preparation, or shortened visits that did not allow staff to complete agreed tasks. The lack of narrative or oversight meant leaders were unaware of the impact these inconsistencies had on people.

Communication within the service was poor. People told us they often waited without knowing whether staff would arrive, and calls to the office were often not returned. When scheduling changes occurred, these were not routinely communicated to people or families. This created anxiety, uncertainty and, at times, distress. People who relied on timely support for medication, continence or mobility felt particularly vulnerable because they could not predict when support would arrive.

The cumulative impact of staff turnover and inconsistency affected people every day. Some people were left in bed longer than they wished, waited too long to access the toilet, or had limited opportunities for meaningful support. Delays in medication further compromised their health and wellbeing. Staff reported feeling stretched and unable to deliver the standard of care they wanted to provide.

Please see the required improvements detailed in the improvement notice dated 21 January 2026.

How well is our care and support planned? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses in assessment, personal planning and review. These weaknesses meant that people did not consistently experience care that reflected their needs, wishes or rights.

Personal plans were not reliable or accurate. Essential information about people's current needs were missing, out-of-date or incorrect. This meant staff did not have the information and guidance they needed to deliver safe and person-centred care. For several people, significant changes in mobility, continence or sensory needs were not reflected in their plans. These omissions increased daily risks such as falls, distress, missed support and loss of independence.

Initial assessments were not completed within expected timescales. We found no evidence that the provider carried out the required in person assessment within five days of a person beginning to use the service. In one case, a person had been receiving the service for three months and had no care plan created by the provider. This meant staff did not have a clear understanding of the person's needs, preferences or outcomes, and the service could not demonstrate that appropriate support had been agreed or reviewed (see requirement 1).

Personal planning processes were inconsistent and not supported by effective systems. Although the digital system had the functionality to support assessments and reviews; staff were not using it fully or consistently. Hard copy personal plans in people's homes were often missing, incomplete or not aligned with the information held by the service. As a result, staff struggled to access essential information when delivering care, and people could not rely on having a clear, up-to-date personal plan that reflected their needs.

Medication support was not integrated effectively into personal planning. Plans often did not list all prescribed medication or identify the care tasks required at each visit. Some people had no medication related tasks scheduled at visits even though they required support with the administration of medication. The lack of complete or accurate information about medication in personal plans for staff to follow increased the risk of omissions or errors in administration and put both people supported and staff at risk (see requirement 1).

People were not always involved in planning their support in meaningful ways. Some people told us they did not see their plans or were unsure what support had been agreed. Others had created their own detailed personal plan because they felt the service's documents were inadequate. Without clear and accurate personal planning, people's choices, preferences and outcomes were not documented or consistently respected or met.

These weaknesses in assessment and personal planning had a significant negative impact on people's day-to-day experiences. Staff were unable to reliably meet people's needs, respond to changes or ensure safe and coordinated care. This undermined people's confidence in the service and contributed to avoidable stress and risk.

Please see the required improvements detailed in the improvement notice dated 21 January 2026.

Requirements

1. By 24 March 2026, the provider must ensure that people experience safe, effective and person-centred care through timely assessments, accurate personal planning and regular reviews. To do this, the provider must, at a minimum:

a) Carry out an in-person assessment of need within five days of a person starting to use the service, ensuring the assessment identifies current needs, risks, preferences and desired outcomes.
b) Develop a short-term plan immediately following the initial assessment, and ensure it is fully accessible to staff delivering support.
c) Review the short-term plan within 28 days, updating it to reflect any changes in the person's needs, wishes or outcomes.
d) Ensure staff have access to the most up-to-date version of each person's plan at the point of care, whether in digital or paper format.
e) Implement a consistent review process, ensuring all personal plans are reviewed at least every six months, or sooner when people's needs change.

This is to comply with Regulation 5(1) and (2) 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: "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).

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 4 April 2025, the provider must ensure that there are robust quality assurance systems in place. They must be carried out competently and effectively, and in a manner which achieves improvements in the provisions of the service. To do this the provider must ensure:

a) Routine and regular management audits are being completed across all areas of the service being provided.
b) Internal quality assurance systems effectively identify any issue which may have a negative impact on the health and welfare of people supported.
c) Clear action plans with timescales are devised where deficits and/or areas for improvement have been identified.
d) Action plans are regularly reviewed and signed off as complete once achieved by the appropriate person.

This is to comply with 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 Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

This requirement was made on 14 January 2025.

Action taken on previous requirement

We found that some quality assurance activity took place in the months immediately following the last inspection. However, this did not continue. Evidence showed limited or sporadic use of quality assurance systems after the middle of the year, and managers were unable to demonstrate consistent audits or oversight. Where issues were identified, there was no evidence that action had been taken to address them. Quality assurance processes had not supported improvement and did not provide assurance about the safety or quality of the service.

This requirement has not been met and has been replaced by a required improvement in an improvement notice dated 21 January 2026.

Not met

Requirement 2

By 21 May 2025, the provider must ensure that the working culture in the service is inclusive and promotes a culture of learning, development and team work to benefit people's outcomes and experiences. To do this the provider must at a minimum:

a) Provide opportunities for staff to attend group staff meetings.
b) Ensure these opportunities are used to share their views and knowledge with colleagues and leaders, both on a one-to-one basis and during team meetings.
c) Ensure groups are small enough that managers will be able to support the group effectively.
d) Ensure that staff feedback from these meetings is used to improve the service and people being supported.

This is to comply with Sections (7) and (8) of The Health and Care (Staffing) (Scotland) Act 2019 (HCSSA).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14) and 'My care and support is consistent and stable because people work together well' (HSCS 3.19).

This requirement was made on 14 January 2025.

Action taken on previous requirement

We saw that one team meeting had been held since the last inspection. The meeting minutes showed limited opportunity for staff to share learning, discuss practice or contribute to improvement. One-to-one meetings, such as supervision, had taken place with around five members of staff, however this supervision did not follow the core principles for effective supervision as advised by the Scottish Social Services Council (SSSC). There was no evidence that staff feedback informed change or was used to improve the service.

This requirement has been incorporated into a new requirement under How good is our leadership?

Not met

Requirement 3

By 4 April 2025, the provider must ensure that managers carry out in-person assessments within five days at point of care. To do this the provider must at a minimum:

a) Contact the individual, or family member of the person being referred and arrange a home visit.
b) Carry out a written assessment of need with the person.
c) Produce a short term plan based on their needs.
d) Review the short term plan within 28 days and finalise the personal plan till time of review.

This is to comply with Regulation 5(1) and (2)(a)(b)(ii) and (iii) (Personal Plans) 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 Health and Social Care Standards (HSCS) which state that: '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' (HSC 1.15).

This requirement was made on 14 January 2025.

Action taken on previous requirement

There was no evidence that initial assessments had been carried out within the required timescales. All personal plans, including those for newer people, stated a review was required in six months. There should be a review within 28 days for the initial plan and a minimum review every six months. The digital system used by the service was not being used effectively to support assessment or review processes.

Most people had written care plans, but these were not available on the electronic system and paper personal plans were not consistently available in people's homes. This meant staff had limited access to personal plans. Some personal plans were out-of -date, inaccurate or did not reflect changes in people's needs.

This requirement has been incorporated into a new requirement under How well is our care and support planned?

Not met

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

To ensure people experiencing care are adequately supported with their care needs, the provider should ensure staff accurately complete care notes following each visit and ensure quality assurance systems are in place to establish consistency with staff practice.

Health and Social Care Standard: 3.18: I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.

This area for improvement was made on 14 January 2025.

Action taken since then

Care notes were being recorded in the "journal" area of the digital careline system. There were inconsistencies in how staff documented care delivered. We saw examples of where planned care was not completed and issues with medication practice were not identified or acted upon. Leaders had begun reviewing notes after the last inspection but had not sustained this practice.

This area for improvement has not been met.

Previous area for improvement 2

The provider should ensure that staff are informed and prepared for supporting people with Dementia. The service should provide training such as Stress and Distress, to ensure that staff are aware of how to best support people when they experience stress and distress.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "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).

This area for improvement was made on 14 January 2025.

Action taken since then

A discussion on dementia took place as part of new staff induction. However, we did not see any further dementia or stress and distress training being made available to staff or observations of practice. As a result, there was no evidence that staff had developed the competency needed to support people with dementia or people who experiencing stress or distress.

This area for improvement has not been met and has been incorporated into a new requirement under How good is our leadership?

Previous area for improvement 3

The provider should ensure that all staff are able to reflect on and discuss their current practice.

This should be achieved by:
1. All staff receiving timeous supervision.
2. All staff undergoing observations of practice by managers, which is then discussed with staff.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

This area for improvement was made on 14 January 2025.

Action taken since then

We could see that five supervisions and four practice observations had been carried out over a short period following the previous inspection. This level of activity was insufficient to ensure safe or reflective practice, nor did it provide assurance that staff competencies were monitored or supported.

This area for improvement has not been met and has been incorporated into a new requirement under How good is our leadership?

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How well is our care and support planned?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak

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