The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Broadways Private Nursing Home**

Provider: **Broadways Private Nursing Home Ltd**

Date of Inspection: **13 August 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation:	Broadways Private Nursing Home Ltd
Responsible Individual:	Mrs Barbara Sloan
Registered Manager:	Mrs Jacqueline Davey
Service Profile – This home is a registered nursing home which provides nursing care for up to 33 patients. The home is situated over three floors with the dining and communal areas on the first floor of the home. Patients have access to outside space on the roof top garden.	

2.0 Inspection summary

An unannounced inspection took place on 13 August 2025, from 10.00 am to 4.00 pm by care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 4 December 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to patients and that the home was well led.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

This inspection resulted in no areas for improvement being identified. All of the previous areas for improvement from the inspection undertaken on 4 December 2024 were addressed by the provider.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the

responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients who were able to share their opinions on life in the home said they were well looked after. Some patients may have difficulty telling us about their experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff.

Patient comments included "the staff are excellent", "the staff make time for you and are very good" and "I am happy here and content".

A relative spoken with told us "I am very happy with the care here, the staff are very responsive and the communication is good".

Staff spoken with said that Broadways was a good place to work. Staff said that they were satisfied with staffing levels, teamwork was good, the management team was approachable and they thoroughly enjoyed working in the home.

Four completed questionnaires were received following the inspection; all four questionnaires included positive comments. Two questionnaires were from relatives; the relatives commented; "I am so grateful to have xx in this amazing home, the manager and all her staff they look after xx as if they were family, 100% great care" and "Home from home". The further two questionnaires were completed by patients. The comments included were; "I am very lucky to have been moved here, the staff are warm and friendly and the manager and deputy manager look after everything" and "Everyone is very good to me, I feel safe, the girls (staff) look after me".

We did not receive any response from the staff online survey within the timescale specified.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Staff said there was good teamwork, that they felt well supported in their role, and that they were satisfied with the staffing levels.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff. Staff were observed to be chatty, friendly and polite to the patients at all times.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with the staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced neurological observations and sought medical assistance if required.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

Observation of the lunchtime meal confirmed that enough staff were present to support patients with their meal and that the food served smelt and looked appetising. The dining experience

was an opportunity for the patients to socialise and the atmosphere was calm, relaxed and unhurried. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The daily menu was displayed in the dining room. Patients commented positively regarding the food provided in Broadways. Two patients' told us the lunch was "lovely".

The importance of engaging with patients was well understood by the manager and staff. There was a range of activities provided for patients by activity staff. The planned activity schedule was displayed. The range of activities included social, community, cultural, religious, spiritual and creative events. Photographs were displayed of patients enjoying some recent activities in the home. Patients' needs were met through a range of individual and group activities. Activity records were maintained in a diary. We discussed that the current system of recording patient activities should be reviewed to include a more comprehensive individualised patient record and engagement with activities which includes an up to date activity care plan. This will be followed up at the next care inspection.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. It was observed that the home routinely did not include a choking risk assessment for patients; this was discussed with the manager and the manager was signposted to additional information sources to appropriately implement this risk assessment at minimum for patients who are assessed as requiring a modified diet. This will be followed up on the next care inspection.

3.3.4 Quality and Management of Patients' Environment

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was clean, warm and comfortable. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home. It was observed that a number of patient bedrooms did not have a lockable space; this was discussed with the manager who provided assurance that this would be addressed. Written confirmation was received post inspection from the management team that the process of fitting locks had commenced.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Jacqueline Davey has been the manager in this home since 7 March 2012.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Jacqueline Davey, Registered Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews