Inspection Report

Name of Service: Muckamore Abbey Hospital

Provider: Belfast Health & Social Care Trust

Date of Inspection: 01 December 2025 – 08 December 2025

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1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Ms Jennifer Welsh Chief Executive Officer
Person in charge at the time of inspection: Billie Hughes, Co-Director Intellectual Disability Services, Muckamore Abbey Hospital	**Number of registered places:** 11 beds
Categories of care: Learning Disability (LD) Assessment and Treatment	**Number of patients accommodated in the hospital on the day of the onsite inspection:** 11
Brief description of the accommodation/how the service operates: Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides a regional, acute psychiatric inpatient service to adults from across Northern Ireland, aged 18 years and over who have a learning disability. Four wards are currently operational: one ward accomodates female patients and three wards accommodate male patients. Following a public consultation on 24 October 2022 regarding the future of MAH, the Department of Health (DoH) announced the planned closure of the hospital by June 2024. On 05 June 2024 the DoH announced an extension to the closure date to allow for the successful resettlement of patients into community settings. Resettlement remains a priority for the number of patients remaining in the hospital.	

2.0 Inspection summary

An unannounced inspection of MAH commenced 01 December 2025, and concluded with feedback to the Trust on 8 December 2025. The inspection team comprised; two care inspectors, a senior inspector and administration support provided remotely.

The purpose of the inspection was to assess and review patient experience to ensure patients are safe and continue to receive care and treatment that is appropriate to their assessed needs. Given that patient numbers have reduced as part of the resettlement process, it was important to gain a sense of what life is like for the small number of patients who are still living there. The inspection therefore focused on the following key themes: environment, staffing, adult safeguarding and patient experience. Key Lines of Enquiry (KLOE) incorporated patient's lived experience including physical and mental health; the use of restrictive practice and governance.

On the day of inspection, there were eleven patients accommodated across four wards with a small number actively transitioning to community placements. Following further resettlements

since the date of the inspection the number of patients accommodated at the hospital has since reduced, with four wards remaining operational across the hospital site.

There was evidence of patient-centred care that was delivered with compassion and warmth from a team of committed staff. Staff spoke about good working relationships between hospital staff and the Adult Safeguarding Team. Patients physical and mental health needs were monitored closely, appropriately addressed and the multidisciplinary (MDT) team knew the patients well.

The hospital environment appeared notably reduced in scale compared to previous inspections. Internal and external environments were stark reflecting the scaling down of the hospital site. Wards and communal areas were very quiet. Whilst essential functions were maintained, the overall atmosphere conveyed a sense of contraction with fewer staff and patients present than would normally be expected for a facility of this type. As more patients move into the community or alternative placements the risk of the remaining patients experiencing isolation increases, due to the impact of reduced opportunities for interaction with peers and access to onsite activities.

The onsite day care centre remains operational, with a reduced staffing compliment supplemented by ward staff.

Whilst the current arrangements are meeting the specific needs of the patient group, the isolated location of the hospital site and the number of wards which have been decommissioned has necessitated the need for additional security measures to ensure that patients and staff feel safe. The operational management of the site is likely to become more challenging in terms of staffing, security and overall maintenance as a result of the plans to decommission more wards after the patients living in the wards have been resettled. Contingency arrangements will need to be clear and implemented without delay to ensure that the physical, social, and psychological well-being of the small number of patients who remain and who do not yet have clear resettlement plans does not deteriorate.

Following formal feedback to Senior Representatives from the Trust on 8 December 2025, RQIA met with the representatives from the Strategic Planning and Performance Group (SPPG) and Department of Health (DoH) on 11 December 2025, to share findings from the inspection and RQIAs determinations with regards to the safe sustainability and viability of the hospital site as patient numbers continue to reduce.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property. Care and treatment is measured using The Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS, DHSSPSNI (March 2006) to ensure that services are safe, of high quality and up to standard.

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection team observed care delivery which included staff engagement with patients and general patient interactions. Where appropriate a formal structured observation tool was utilised.

Inspectors observed how patients spent their day; staffing levels; senior leadership oversight and ward environments. The inspection team also reviewed patient care records, patient resettlement arrangements and governance documentation.

Experiences and views were gathered from staff and patients.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout the ward inviting patients, staff and relatives to speak to inspectors and share their views and experiences.

Patients who were less able to tell us about how they found life in the hospital were observed to be relaxed in their surroundings and engaged well with staff.

Feedback from patients was largely positive with mixed views about the closure of the hospital. Patients understandably expressed anxiety while acknowledging the opportunity to have new experiences and most were now accepting of the closure and actively involved in their resettlement plan. They confirmed they had access to advocacy services. Some patients thought there were too many staff on shift at times contributing to feelings of being observed. This may also be due to the presence of additional in-reach staff from other Trusts who were there to develop relationships with patients and support transition work. This is discussed further in section 5.2.2.

The inspection team also spoke with a range of staff, many of whom had been working in the hospital for a long time. They spoke about adjusting to changes brought about by ward closures, being relocated to different wards to provide cover and the overall quietness of the hospital. Staff spoke about patients in a compassionate manner and no concerns were raised about patient care.

Due to the focused nature of the inspection, there was limited opportunity to speak with relatives although staff were asked to seek patient consent to contact them if needed.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The AFI's from the previous incidents inspection IN042711 in 19 July 2023 – 30 May 2024 were not assessed as part of the inspection. However AFI's which were carried over from IN042777 5 March – 6 April 2023 were assessed as having been met during this inspection.

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		Validation of compliance
Area for improvement 1 **Ref:** Standard 4.1 Criteria 4.3 **Stated:** First time **To be completed by:** 31 July 2023	The BHSCT must put in place arrangements for the effective oversight of the deployment of staff across the site. This should include planning and managing staff allocations and deployment in advance of shifts.	**Met**
	Action taken as confirmed during inspection: This area for improvement was met.	
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2023	The BHSCT must put in place arrangements for the management of recording, storage and effective oversight of supervision plan records.	**Met**
	Action taken as confirmed during inspection: This area for improvement was met.	
Area for improvement 3 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 July 2023	The Belfast Health and Social Care Trust must review substantive staff mandatory training compliance and put in place a mechanism for the oversight of this.	**Met**
	Action taken as confirmed during inspection: This area for improvement was met.	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environments against the Royal College of Psychiatrists' Standards for Acute Inpatient Learning Disability Services (5th edition, April 2024), to determine if they were conducive to the delivery of safe, compassionate and therapeutic care.

Wards which were once busy with activity no longer provided therapeutic space. This cannot fail to have an impact on patients as they observe the changes and gradual decline of the environment in which they have lived in for many years.

The fabric of the four remaining operational wards showed signs of deterioration. There were a number of internal windows which required replacement glass and were boarded up and flooring in some areas had begun to lift from the floor. Given the planned closure of the hospital the Trust were committed to prioritising essential, urgent repairs only, to promote safety, rather than maintain a therapeutic space.

An acceptable level of cleanliness was observed on the wards. Outdoor areas were safe for patients, however had not been maintained. Each ward accommodated a small number of patients with a mixture of pod style and communal living arrangements, tailored to individual patient need. Several vacant rooms had been repurposed for storage with signage indicating these areas were no longer accessible to patients. Some vacant rooms were being used to provide additional living space, which partially mitigates the impact on patients the downsizing of this hospital may be having.

While patients retained adequate space to move around freely, the reduction in patient numbers has created a quiet, stark atmosphere. There were limited opportunities for social interaction an essential component of therapeutic environments. This is discussed further in Section 5.2.4.

The Trust informed the inspection team of the plan to transfer the remaining patients into one ward in accordance with individual assessed needs. This will help to ensure that the remaining patients maintain some level of social interaction with their peers and reduce feelings of loneliness and isolation.

Additional security measures have been introduced on site to ensure patient and staff safety, however, the presence of security personnel may also affect how long-term patients experience what has been their home for many years. For some individuals, this visible change may increase anxiety or unsettle established routines, particularly at a time when the hospital continues to downsize and eventually close.

Fire risk assessments (FRA) were not up to date and fire doors were observed to be propped open. These issues were addressed before the inspection concluded with actions arising. The Trust should ensure these actions are addressed in a timely manner. Ligature Risk Assessments (LRA) were up to date and available on each ward.

5.2.2 Staffing

Staffing levels across the site have required continuous monitoring as patient numbers reduce and professional disciplines are relocated. However, further restructuring of staff will be required as more patients transition to community settings. This will have additional impact for patients, likely provoking further anxiety particularly for those patients who do not yet have an clear resettlement plan.

Staffing arrangements were reviewed through observation and discussions with a range of staff, and there was effective oversight of how staff were deployed across the site. Although the majority of staff working in the hospital were agency, consistency in care was maintained, as many of these staff had been working in the hospital for a significant period of time.

Staff spoke about patients in an empathetic and compassionate manner and the inspection team observed some very positive interactions.

There was good oversight from the senior managerment team with a senior manager remaining on site and the senior leadership team continue to visit the site regularly and remain accessible to staff, patients and relatives.

Occasionally, due to staff shortages, support is sought between wards and in response to incidents with reliance on staff personal alarms. Due to the space between wards, it is recommended that personal alarms are checked at least daily. Staffing levels will continue to reduce in line with the decreasing patient population, potentially impacting on the availability of emergency response and colleague support. However, the plan to move the majority of remaining patients into one ward will help to reduce risk.

There continues to be a MDT approach to care and treatment although a number of disciplines including; Speech and Language therapy (SLT), Podiatry, Physiotherapy and Positive Behaviour Support (PBS) had been relocated they remain accessible via referral and for patient review. Two occupational therapists (OT) remain on site and continue to support the resettlement process. Patients also have onsite access to psychiatry, medical staff and a GP.

5.2.3 Adult Safeguarding

Adult Safeguarding (ASG) is the term used for activity which prevents harm from occurring and which protects adults at risk where harm has occurred or, is likely to occur without intervention. Adult Safeguarding in MAH continues to receive a high level of scrutiny.

The overall management of ASG has not been adversely affected by the reduction in the number of patients, staff and wards. There was evidence of effective joint working between the hospital staff and the ASG team and communication was good.

An ASG team remains aligned to the hospital to provide support and guidance to staff as required. Whilst the ASG team had relocated communication and relationships remained positive. ASG processes and contact details for the ASG team were clearly displayed in each ward. This included details of who to contact outside of office hours.

Mechanisms were in place to promote ASG and share information. Designated Adult Protection Officers (DAPO's) conducted quality monitoring of ASG on a weekly basis, while an ASG assurance forum takes place on a monthly basis to review and monitor safeguarding referrals, as well as to identify trends and patterns. Learning and actions identified following ASG investigations were communicated appropriately with staff and implemented accordingly.

Inspectors reviewed open ASG referrals and spoke with the management team in relation to safeguarding arrangements. Staff demonstrated good knowledge and understanding of the ASG process, including what actions to take should an incident occur that met the threshold for an ASG referral. ASG incidents were reviewed by suitably trained members of the ward management team and screened appropriately. Protection plans were maintained at ward levels, available to all staff and reviewed regularly by the MDT. RQIA continue to be notified of ASG incidents in line with agreed processes.

5.2.4 Patient Experience

It is difficult to imagine the level of adjustment required for patients who have lived in MAH for most of their adult lives and there are mixed views from patients about their experience. It is inevitable they will have been affected by the planned closure of the hospital and there continues to be a level of uncertainty and anxiety for patients who remain living there. The service cannot offer the same therapeutic experience when large open spaces now feel empty and rooms which were previously accommodated by their peers, are now vacated and marked for storage. As the hospital closure progresses, the continued reduction of service availability including day care is likely to impact the remaining patients, limiting opportunities for engagement and structured activity outside of the ward environment.

Staff have nevertheless endeavoured to ensure patients are well cared for and continue to actively engage and communicate with patients and their relatives. This has helped to manage anxieties about resettlement and maintain trust during the hospital closure.

Observations across each ward showed that patients appeared comfortable in the company of staff. There was evidence of person-centred daily schedules in keeping with individual patient needs that provided meaningful activities and opportunities to engage in community life. The day care service was available on a more limited basis due to reduced day care staff but ward staff provided additional support to enable patients to utilise the service as much as possible.

There was no observed impact on meal delivery. Meal times were organised and relaxed, allowing staff to effectively support and observe patients in a compassionate manner. Visual menus offered a choice of appetising meals with information on individualised Recommended Eating Drinking and Swallowing (REDS) available and followed by staff. This provided assurance that patients were receiving the appropriate level within the International Dysphagia Standardisation Initiative (IDDSI). Refreshments and snacks were also accessible outside of mealtimes and patients had opportunities to prepare their own meals with support of staff to promote independence.

Wards continue to operate within the Positive Behaviour Support (PBS) framework. Person-centred PBS plans and easy read summaries were accessible for staff to support them to understand the needs of the patient.

Regular communication and engagement with patients and relatives had a positive impact on patient experience, helping to reduce anxiety and maintain trust during the hospital's closure process. 'Life at Muckamore' meetings took place on a regular basis to provide patients and relatives with updates regarding the closure of the hospital and discuss upcoming events. Real time patient feedback was actively sought ensuring patients' views were heard and considered. There was a clear focus on supporting patients to develop skills and prepare for community living. Feedback indicated, that while some patients had mixed feelings, anxiety about the changes alongside anticipation of new opportunities, most felt reassured by the ongoing support from staff and transparency of communication.

Physical and Mental Health

Patients remaining in the hospital include individuals with complex physical and mental health needs. Some patients were detained under the Mental Health (Northern Ireland) Order 1986 for assessment and treatment whilst others were voluntary but delayed in their discharge whilst awaiting suitable placements.

Medical and pharmaceutical provisions were in place, with arrangements to address out-of-hours needs. Professionals demonstrated a clear focus on patients' rights, stability, and wellbeing throughout the resettlement process. These measures have helped mitigate the impact of delayed discharge and maintain patient safety and dignity during a period of significant transition.

Restrictive Practice

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023 (the Regional Policy), provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion.

Restrictive practices were reviewed as part of patients' resettlement journeys, no concerns were identified and there was no evidence of any additional restrictions for patients as a result of ward closures.

Restrictive practice records were documented appropriately and consideration was given to restriction reduction plans.

The Mental Capacity (Northern Ireland) Act 2016 requires Deprivation of Liberty Safeguards (DoLS) to be in place for patients who are not detained under the MHO, lack capacity, are under continuous supervision or control, and are not free to leave the ward. Patient care documentation clearly identified patients subject to DoLS and consistently reflected care and treatment amounting to a deprivation of liberty. There was also evidence that this information was shared with the patient.

5.2.5 Governance

Good governance arrangements were in place which provided effective oversight of resettlement, the planned closure of the hospital and safety. There was evidence of good communication between professionals who remained focused on patient centred care and patient experience.

Effective communication systems were evident to support escalation of risk, analysis of themes and trends as well as evidence of outcomes and actions being shared. Daily safety huddles and weekly live governance meetings took place. MDT meetings occurred weekly onsite attended by a range of professionals with daily summaries provided for each patient.

5.2.6 Conclusion

The inspection evidenced the Trust's commitment to ensuring patients in the hospital experienced as little disruption as possible during the prolonged closure process. Staff demonstrated good engagement, and compassionate care was consistently observed. It was evident the Trust and relevant stakeholders are committed to achieving the successful resettlement of patients.

As more patients move into community placements, the Trust's ability to safely and effectively provide the appropriate care and treatment to the small number of patients remaining will become increasingly challenging. Environmental decline and changes, reduced staffing and onsite MDT availability is likely to prolong the uncertainty for patients which will be further compounded by the loss of onsite therapeutic opportunities as well as reduced peer interactions.

It is RQIA's determination that the Trust are committed to maintaining safety, security and stability. However, when patient numbers reduce to a very small number of individuals, the continued operation of a large institutional site becomes increasingly inefficient and difficult to manage effectively. When only five patients remain on site, the operational model is no longer proportionate to the scale of the environment and does not support safe, high-quality, or person centred care. This reinforces the need to expedite closure arrangements and implement formal contingency arrangements to transition the remaining patients to more suitable settings.

In order to ensure their continued well-being and a smooth transition to alternative placements, greater clarity is required about the formal contingency arrangements for the remaining patients. The Trust must work with the other relevant Trusts, the resettlement oversight board, SPPG and the DoH to ensure these arrangements are explicit. An area for improvement has been made.

Formal contingency arrangements for remaining patients should be implemented without further delay. An area for improvement has been made.

6.0 Quality Improvement Plan/Areas for Improvement

Areas of improvement have been identified where actions are required to ensure compliance with the Mental Health (NI) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care (DHSSPSNI March 2006)	
Area for improvement 1 **Ref:** Standard 6.1 Criteria: 6.3.1 (d)	The Belfast Health and Social Care Trust must work with the other relevant Trusts and key stakeholders to ensure formal contingency arrangements are in place for all patients. Ref: 5.2.6

Stated: First time **To be completed by:** Immediately	**Response by registered person detailing the actions taken**: BHSCT meet with the SET, NHSCT and SHCST fortnightly to plan resettlements and subsequently all Trusts meet with the DOH fortnighlty to report on plans and contingencies.
Area for improvement 2 **Ref:** Standard 6.1 Criteria: 6.3.1 (d) **Stated:** First time **To be completed by:** Immediate and ongoing	When the number of patients remaining in MAH has reduced to five, the Trusts and key stakeholders must ensure that formal contingency arrangements for these patients are implemented without delay. Ref: 5.2.6
	Response by registered person detailing the actions taken: This area for improvement will remain on the agenda at the Regional Oversight Board and taken forward by all HSCTs.

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