



Patient
Advocacy
Service

INFORMATION | SUPPORT | EMPOWERMENT

Patient Advocacy Service Casebook 2025



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Foreword by Chairperson



Welcome to the fourth Annual Casebook from the National Advocacy Service for People with Disabilities (NAS) and the Patient Advocacy Service. The Casebook provides an insight into the work of both services, detailing the complex case work carried out by our Advocates, highlighting the challenges faced by the people we support and the positive impact independent advocacy can have on their lives.

The National Advocacy Service for People with Disabilities (NAS), which is funded by the Citizens Information Board (CIB), focuses on ensuring the rights of people with disabilities are upheld. It provides people with disabilities across Ireland with an independent, professional and free advocacy service that helps people to have their voices heard, make their own decisions and live their lives independently.

The Patient Advocacy Service is commissioned by the Department of Health (DoH) and provided by NAS. It provides people who wish to make a complaint about their care in a Public Acute Hospital or a Nursing home or people who have been harmed by a Patient Safety Incident with a free, independent, confidential and professional empowerment advocacy service. It helps to keep people at the centre of the complaint or incident review process and have their voice and lived experience heard to inform learning and quality improvement.

NAS and the Patient Advocacy Service have seen a year-on-year increase in the numbers of people seeking independent advocacy support. We want to share some of these lived experiences and highlight the issues and challenges that people are facing. The lived experience of the people

we work with helps to shape and guide the work we do. The Casebook highlights the vital role independent, professional advocacy can play in supporting people to have their human rights protected and promoted. Advocacy support is generally offered when people need specific and tailored information or support. You will read about the different forms of advocacy, including empowerment and representative advocacy, and you will see that these situations are often very emotive for both the people receiving advocacy support and our Advocacy staff. Our Services provide advocacy in relation to multi-faceted issues, for example, issues relating to housing, healthcare, nursing homes, social care and much more, including complex difficulties experienced by parents with a disability and by people impacted by healthcare.

This year we are sharing 15 case examples from NAS and 11 from the Patient Advocacy Service. I hope that these case examples provide you with rich insight into what our Services do, highlighting the importance of independent advocacy, showcasing the positive impact we have had on people and in communities across the country. Advocacy helps breach gaps in systems that leave people in difficult situations, it ensures best practice across public services, and it promotes positive systemic change when necessary.

Finally, I would like to thank anyone who accessed our Services in 2025. I wish to extend my thanks to the Citizen's Information Board for their continued endorsement of NAS and their ongoing support of our work. I would also like to thank the Department of Health for their guidance and support of the Patient Advocacy Service. On behalf of the Board, I would like to thank all the staff of both Services for their work ethic and dedication in providing high quality professional advocacy services.



Rosemary Smyth

Chairperson of the National Advocacy Service for People with Disabilities (NAS), which delivers the Patient Advocacy Service.

Note to Reader: all case studies included in this document have gone through a rigorous anonymisation process which involves changing identifying elements of the case to protect the anonymity of the person and advocate involved. This means that the location, age, gender and name of the people in these stories are likely to have been changed.

1. Trauma Informed Advocacy



Context

Anne brought her mother for a routine but specialist procedure at a hospital some distance from their home. During the appointment, some concerns were raised about Anne's mother's health, but she was not admitted to the hospital. A few days later, after an incident at home, Anne brought her mother to their local hospital. Her mother was seen in the Emergency Department (ED) but was not admitted as she was due to attend the other hospital for a follow up appointment. Sadly, a short time later, Anne's mother passed away at home. Anne had concerns about the care her mother received and contacted the Patient Advocacy Service for support to make a formal complaint.



Actions by the Advocate

When Anne contacted the Patient Advocacy Service, she was very upset. The Advocate was able to apply their Trauma Informed Care and Distressed Caller Training to support Anne and give her the space she needed to share her story and express her grief. The Advocate spoke with Anne about her options, and they agreed on an Advocacy Plan. The Advocate supported Anne to request her mother's healthcare records. When Anne received the records, some were missing and the Advocate provided information and explained about the Office of the Information Commissioner. The Advocate explained the HSE's Your Service Your Say complaints process to Anne and the stages involved. They supported Anne to draft a complaint letter and suggested that she could highlight the impact her mother's death had on her. The Advocate made suggestions to keep the complaint letter focused, outlining clear questions and the outcomes that Anne hoped to achieve. When Anne received a response to her complaint the Advocate went through the letter with her, step by step, to allow Anne space to voice her feelings.



Outcome

Anne received an empathetic and detailed response letter from the hospital which included several detailed recommendations for quality improvement. Anne was grateful for the thorough and genuine response that she had received but there were some questions that she felt were not fully addressed. The Advocate provided Anne with information on Stage 3 and Stage 4 of the Your Service Your Say complaints process. Anne was very grateful for the support provided to her by her Advocate. Anne said she felt empowered and that she was fully equipped to further pursue the complaints process by herself. Anne will keep in contact with her Advocate and feels assured that support is there if she needs it.



2. Poor Communication



Context

Martha attended a cardiology appointment at her local hospital for an ECG. Several of Martha's previous appointments had been cancelled and she had waited almost a year for this appointment. A nurse carried out the ECG and handed Martha a printout. Martha had never had an ECG before and did not know what to do next. Martha assumed that she should bring the ECG print out to her GP. Martha left the hospital but later received a phone call from the hospital stating that she should have waited for the Cardiologist to read the ECG print out and that she needed to return to the hospital. Martha immediately returned to the hospital but when she got there the Cardiologist had finished for the day. Martha was told she would need another ECG and that the earliest appointment was several months later. Martha made a verbal complaint about the poor communication, but she was dismissed. Staff did not provide Martha information on her right to make a complaint. Martha was frustrated as she had waited so long for this appointment and had concerns about her heart health. Martha contacted the Patient Advocacy Service for advice.



Actions by the Advocate

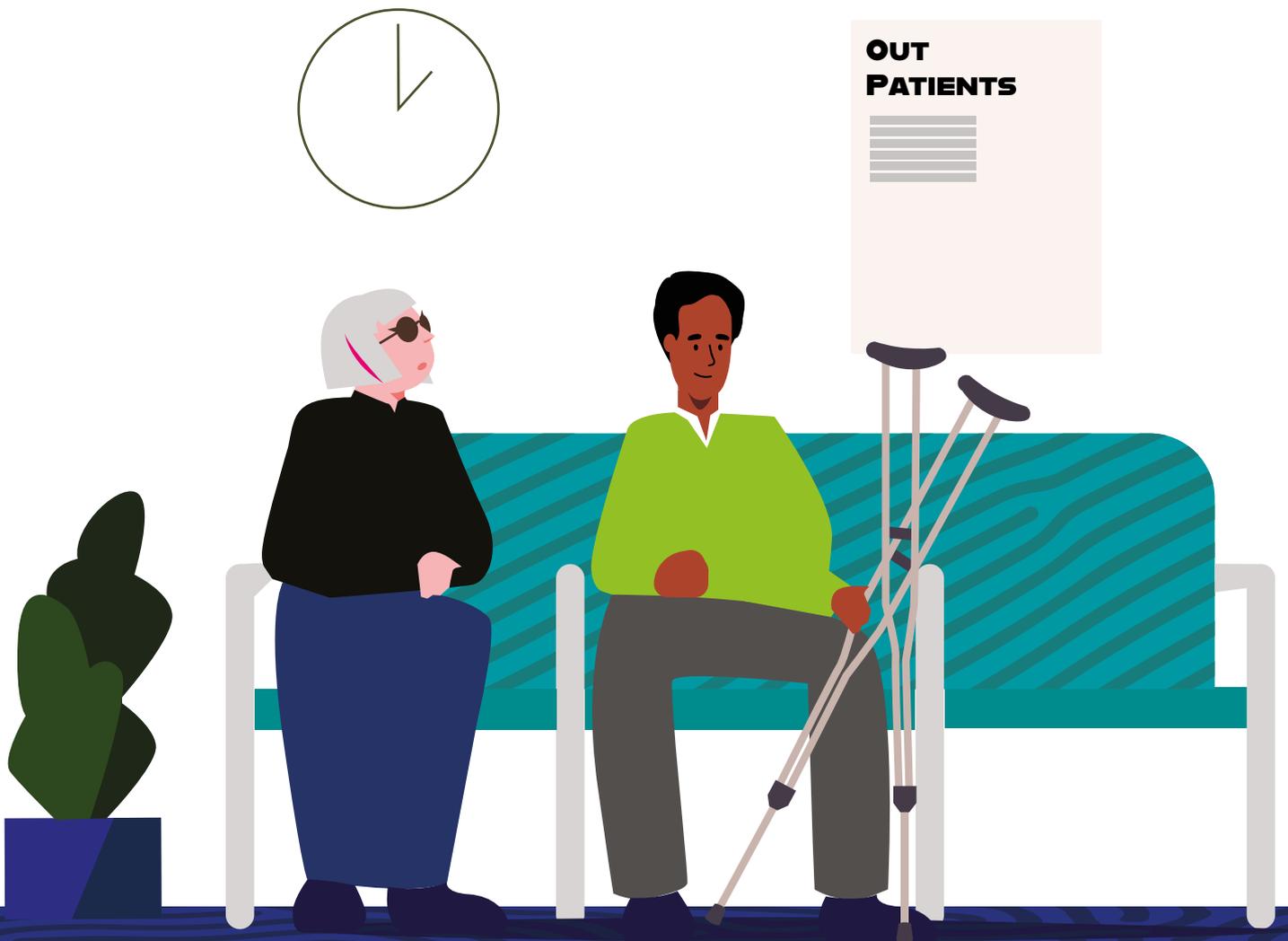
An Advocate from the Patient Advocacy Service listened to Martha and explained the HSE's Your Service Your Say complaints process to her. They explained to Martha that a verbal complaint was Stage 1 of the complaints process and staff should have facilitated her to raise her concerns on the day. The Advocate suggested Martha could make a Stage 2 formal complaint to the hospital. Martha wanted to highlight in the complaint that her initial verbal complaint was dismissed. The Advocate supported her to draft her complaint, referencing the relevant sections of the HSE complaints policy. Martha wanted to emphasise that she would have stayed at the hospital to see the Cardiologist if it had been clearly communicated to her. Martha wanted to ensure this would not happen to another patient. The Advocate supported Martha to structure the complaint letter to demonstrate the impact that the lack of information provided at the time had on her. Martha received a response to her complaint; however, it did not offer any learning or recommendations. Martha felt the hospital did not accept responsibility for the miscommunication and did not acknowledge the impact on her. The Advocate suggested Martha could request a Stage 3 review of her complaint.



Outcome

Martha received a response to her request for a Stage 3 review, which recommended the hospital should explain in their appointment letters that patients need to meet the Cardiologist after an ECG to review the results. The review suggested clear signage should be in place to inform patients that they must be seen by a doctor before leaving the clinic. It was also recommended that staff are made fully aware of the Your Service Your Say complaints process and how to correctly manage a Stage 1 verbal complaint. The Review Officer wrote to the hospital, requesting they communicate with Martha the steps being taken to implement the recommendations made.

Martha received correspondence from the hospital outlining the actions being taken to implement the recommendations. Martha was satisfied that her complaint led to positive changes and felt empowered by her Advocate.



3. Care and Treatment



Context

Louise was admitted to Resus following a serious accident. Louise was taken to theatre for a pain block and was then transferred to a cardiothoracic ward. Louise was then transferred to an orthopaedic ward where she experienced several issues with her care. A nurse moved Louise's bed suddenly, causing her pain but they did not apologise. Louise needed support with going to the toilet and on one occasion, when there were no staff around, she was left in the bathroom longer than she should have been. Louise complained of being in pain and her family repeatedly told staff that they were concerned about her. A week after being admitted to hospital, it was discovered that Louise had other serious injuries that were not detected on her initial admission. Louise required further surgery, and she spent time in the Intensive Care Unit (ICU). With her consent, Louise's partner contacted the Patient Advocacy Service for advice and support as they were concerned with the care she received.



Actions by the Advocate

An Advocate from the Patient Advocacy Service explained the HSE's Your Service Your Say complaints policy to Louise and her partner and supported them both to draft a formal complaint. When drafting the letter, the Advocate suggested that Louise outline a timeline of events from when she had the accident, outlining her time in hospital and the issues she had encountered with her care. The Advocate suggested that Louise identify the questions she wanted answered and the outcomes that she hoped to achieve. When the complaint letter was complete, Louise and her partner submitted it to the hospital.



Outcome

Louise received a comprehensive response to her complaint. Each issue was acknowledged, with several recommendations to improve the quality of care at the hospital and to help prevent Louise's negative experiences from happening to someone else. All care staff completed training called "Back to Basics" training which highlighted the importance of care standards. Staff received training in relation to the management of complaints and feedback. The ward where Louise was being treated has had an upgrade in facilities and more staff have been put in place. Louise received an apology for any hurt and distress that she had suffered.

Louise and her family were pleased with the outcomes from her complaint; however, she felt that the complaints officer offering an apology was not enough. Louise wanted to request an apology from the staff who were involved in her care during her stay in hospital. Louise's Advocate assisted her in corresponding with the hospital's Complaints Manager, who agreed that this was not an unreasonable request, and the hospital would work to facilitate this. Louise felt fully supported and empowered by her Advocate.



4. Misdiagnosis of a Rare Condition



Context

Eric's five-month-old child was diagnosed with a rare condition by a clinical consultant. The consultant suggested immediate surgery for the child and explained there were risks involved. Eric asked the consultant about getting a second opinion and was told this was not necessary as he would only receive the same information. Eric was worried about the surgery, especially as he had been told that the procedure was high risk. He decided to seek a second opinion from medical professionals who were experts in the condition and its treatment. Eric researched the rare condition and travelled abroad to access medical advice about the treatment plan his child had received. Eric received medical advice from three consultants who had expertise in the condition, and each advised that this rare condition was not present. Eric was also advised that the high risk to surgery would decrease as the child got older. Their expert opinion was not to do the surgery, and they provided a detailed care plan for Eric's child. Eric decided to ask the HSE for a reimbursement of the costs he incurred while seeking a second option and a care plan for his child. When he was refused reimbursement, Eric contacted the Patient Advocacy Service for support.



Actions by the Advocate

Eric spoke with an Advocate from the Patient Advocacy Service who explained the HSE's Your Service Your Say complaints policy to him. Together they created an Advocacy Plan. The Advocate supported Eric to access his child's medical records through Freedom of Information. The Advocate researched relevant policies for Eric. The Advocate supported Eric to write a Stage 2 formal complaint letter, which he submitted to the hospital requesting reimbursement of expenses incurred while seeking a second opinion. Eric received a response to his complaint with incorrect clinical information, and it was this information that influenced the decision not to reimburse the costs of seeking a second opinion. The response also stated that Eric had been offered a second opinion at appointments, which he had not. With support from their Advocate, Eric requested a Stage 3 review, detailing the incorrect clinical information that was included in the complaint response and requesting a meeting to discuss the complaint. Eric again requested full reimbursement of costs.



Outcome

The Stage 3 review upheld Eric's original complaint and he was fully reimbursed of all travel expenses and associated costs for the second opinion. Eric received an apology from the hospital, and the Clinical Director of the hospital has offered Eric an in-person meeting to discuss their lived experience. Eric was happy with the support they received from their Advocate and the outcome of his complaint.



5. Maternity Care



Context

Shortly after moving to Ireland, Maria discovered she was pregnant. English was not her first language. Maria had a previous history of miscarriages. She was referred to her local maternity hospital and attended all her appointments without any issues. When Maria was just over six months pregnant, she noticed some spotting and went to the Emergency Department (ED) of her maternity hospital. Scans showed that everything appeared fine and Maria was discharged. The following day, Maria passed a large clot and went straight to the hospital. Doctors carried out tests and advised that they were concerned that Maria had an infection and that they would need to deliver the baby. Maria was reluctant but was told there was a threat to her life unless the baby was delivered. Maria's baby was born and sadly passed away a short time later. Maria attended counselling for support with the trauma of losing her baby. When Maria felt that she was ready to raise concerns about her care to the hospital, she contacted the Patient Advocacy Service for advice and support.



Actions by the Advocate

Maria spoke with an Advocate from the Patient Advocacy Service and explained that she wanted clarity around her care and treatment, that she wanted to know if an earlier intervention might have led to a different outcome. Maria felt that at six months, it should have been possible to save her baby's life. Maria stated that due to the traumatic event, she could not remember much of what had happened. The Advocate applied their Trauma Informed Care training and gave Maria a safe space to share her story. After explaining her options to her, Maria agreed an Advocacy Plan with her Advocate to request her medical files under Freedom of Information and develop a chronology to gain clarity on dates and events. The Advocate supported Maria to read through her medical file, explain certain terminology and simplified medical jargon using Plain English. The Advocate supported Maria to create a chronology of events and to consult with her GP for additional clarity.

The medical records showed that Maria was earlier into her pregnancy than she had thought and was not yet six months. The Advocate provided information on current legislation and HSE policy. The records showed Maria had sepsis and the Advocate provided information about sepsis. The records showed that the hospital had involved several consultants in their decision making around Maria's care at the time.



Outcome

With information from her medical records Maria gained an understanding of what happened when she was in hospital, which she said gave her relief and comfort. Maria felt a sense of closure and decided not to pursue a complaint. The option was there for Maria to contact the hospital or her GP for further clarity on her clinical care. Maria was grateful for the support from her Advocate in helping her to gain understanding of her experience and clarifying the answers she needed.



6. Care & Treatment



Context

Kevin was involved in an accident and was transferred to his local Emergency Department (ED). Despite suffering from extensive injuries including a suspected neck injury, following triage Kevin waited several hours to be seen by a doctor in the ED. Kevin was not monitored by medical staff, he was not offered pain relief, and he did not receive any food or drinks. When Kevin was eventually reviewed by a doctor, he was sent for a CT scan, which showed fragments in the neck. Kevin was given a neck brace and was advised to lie flat and not to move. Kevin was concerned that when he was waiting to see a doctor, he was sitting upright in a chair without his neck being stabilised and that this could have caused further damage. Kevin was admitted to a ward in the hospital and spent two days as an inpatient. Kevin was not satisfied with the care he received while he was in hospital. When he was discharged, Kevin was concerned about the lack of information about how he should manage his injuries and the referral pathways for support in the community. Kevin contacted the Patient Advocacy Service for information and support.



Actions by the Advocate

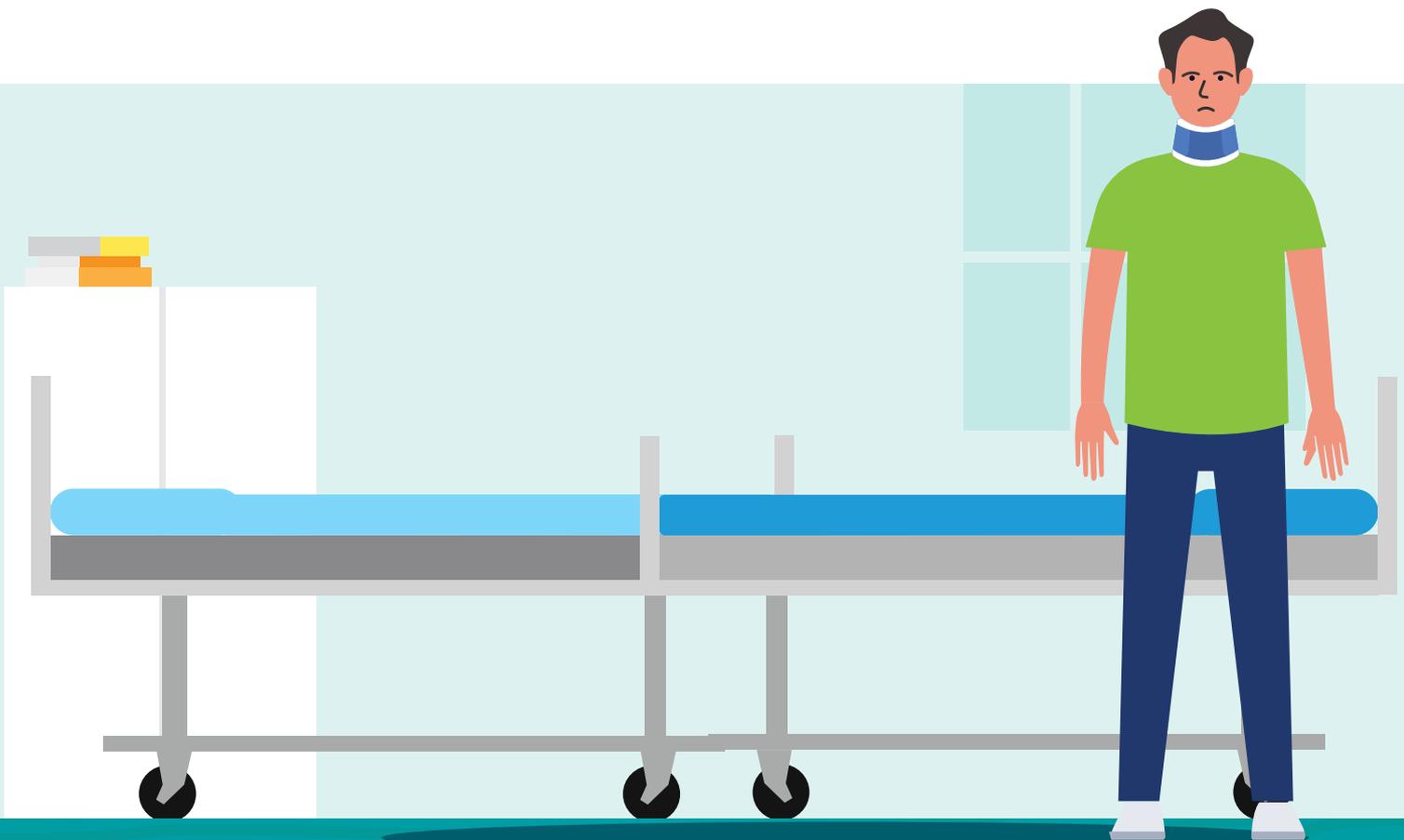
Kevin spoke with an Advocate from the Patient Advocacy Service who discussed the details of his experience with him. Kevin and his Advocate created an Advocacy Plan to support him to make a formal complaint. The Advocate supported Kevin to outline his complaint issues, the questions he wanted answered and the outcomes he hoped to achieve. Kevin was concerned that he still did not fully understand the injuries he sustained and that the hospital had not given him sufficient information. The Advocate suggested that Kevin include this in his complaint. Kevin's Advocate supported him to link his experience to the National Standards in Emergency Medicine, relevant HSE policies and HIQA Standards. The Advocate supported Kevin to draft the complaint letter and explained the HSE's Your Service Your Say complaints process to him.



Outcome

Kevin received a written response from the hospital, and he received a phone call from the Consultant who had treated him in hospital. The phone call allowed Kevin to ask questions and discuss his concerns. The Consultant apologised and offered Kevin an appointment to address his ongoing symptoms. This resulted in Kevin receiving follow up care in the community. The complaint response sincerely apologised for the delays experienced in the ED, acknowledging that hospital standards had fallen short and that waiting for a long time without appropriate assessment was unacceptable. The response apologised for other issues that Kevin had experienced as an inpatient and committed to using the feedback as a learning opportunity for all staff.

The hospital is committed to producing a discharge booklet for patients to ensure that they are fully aware of discharge plans, ongoing care and a point of contact within the hospital if they have any concerns. Kevin was happy with the outcome and the support of his Advocate.



7. Dignity and Respect



Context

Mary, who is in her 70's, has several health conditions. Mary had an appointment for blood tests at a public acute hospital. Her GP had given her a referral letter to take with her. Mary confirmed the appointment through an external online appointment platform that the hospital uses. She received confirmation of the appointment by text message and had fasted overnight in preparation for the blood tests. When Mary presented to the clinic, she was told in a dismissive manner that her bloods could not be taken. Mary was told there was a new system in place and that her referral from the GP should have come with additional documentation. Mary asked about the documentation and showed the text confirmation she had received. Mary said she was abruptly turned away and felt that staff were rude to her. As this had happened in front of other patients, Mary said she felt upset and humiliated. She also felt weak after fasting overnight. Mary left the clinic without being told what documentation she needed and what she should do next. Mary decided to contact the Patient Advocacy Service for advice and information as she had concerns about her care.



Actions by the Advocate

Mary spoke with an Advocate from the Patient Advocacy Service who listened to her story and suggested that she could make a complaint to the hospital about her experience. The Advocate supported Mary to structure her complaint letter. The Advocate suggested asking the hospital about the external online booking platforms to manage appointments and where the duty of care lies to inform patients if additional requirements are now in place. Mary wanted to emphasise the negative impact the experience had on her wellbeing and how helpless she felt on the day. Mary wanted to ensure that her experience was logged as a serious incident to highlight the impact it had on her. The Advocate supported her to make this request.

There were several administrative errors by the hospital in managing Mary's complaint, and the Advocate supported Mary to flag these in line with the HSE's Your Service Your Say complaint policy.



Outcome

Mary received an apology from the Clinic Manager. They said that improvements would be made in how staff communicated with patients. The Clinic Manager explained the new systems in place with regards to documentation but stated that Mary's appointment should have gone ahead despite only having the GP's letter with her. Further to this, the Clinic Manager told Mary that she should have received an update from the online booking system and that the system would be updated to ensure this does not happen again. The hospital stated that the incident involving Mary was recorded on the HSE's Incident Management System. This was an important outcome for Mary as she believed that formally logging her experience as an incident underpinned the serious nature of her complaint. Mary felt empowered and supported by her Advocate throughout the process.



8. Nursing Home – Contract of Care



Context

Jim, who is in his 80's, lives with dementia. Jim is a resident in a nursing home and his son Sean, visits him regularly. Sean had concerns about the care and treatment his father was receiving in the nursing home. There were two incidents where a carer was rough with Jim. Sean reported both incidents to the nursing home. Following this, the nursing home spoke to Jim and his family about requesting a private allied health professional to be involved with Jim's care. They did not explain why they were making this request. Jim and his family told the nursing home that they did not want the private allied health professional involved in his care. However, the nursing home gave full access of Jim's files to the private allied health professional, without consent, and allowed them to meet with Jim in his room. As well as not agreeing to engage with the allied health professional, Jim and his family were concerned about a potential conflict of interest given familial and friendship relationships between the private allied health professional and key members of the nursing home staff.

Sean decided to contact the Patient Advocacy Service for advice. While he was doing this, the nursing home contacted him to say they were terminating Jim's contract of care, with one month's notice. This caused incredible distress for Jim and became the priority concern.



Actions by the Advocate

The Advocate from the Patient Advocacy Service arranged a meeting with Jim and Sean to discuss consent, to agree that Jim was nominating Sean to support him to make a complaint, to identify the key complaint issues and what support the Patient Advocacy Service could provide. The Advocate provided Jim with information on Advanced Healthcare Directives and the Decision Support Service. In relation to the termination of Jim's Contract of Care with the nursing home, the Advocate signposted Sean to relevant services including the Competition and Consumer Protection Commission (CCPC), Nursing Home Ireland, and HIQA.

The CCPC provided information about nursing home contracts of care, that termination clauses can only be invoked for serious breaches and that there should be a fair and transparent process for termination, with an appeals mechanism in place which residents and their representatives are notified of.

The Advocate suggested to Sean that he should contact the Office of the Ombudsman in relation to the termination of Jim's Contract of Care as a matter of urgency and to ask if a stay of termination could be put in place whilst the complaint was being dealt with. With Jim's consent and the support of an Advocate from the Patient Advocacy Service, Sean decided to make a complaint to the Ombudsman.



Outcome

Following contact with the Office of the Ombudsman, a member of the Office engaged with the nursing home. Following several conversations with the Director of Nursing and the nursing home Board of Management about Jim's contract of care, the nursing home retracted the termination of contract notice and focused on rebuilding their relationship with Jim and his family.

Jim and his family were happy with the outcome and appreciative of the support provided by their Advocate. Jim is happy that he can stay living in the nursing home. The Advocate continues to provide support to Jim with his other concerns.



9. Communication



Context

Alex is in his 50's. At home one day, Alex became unwell and was taken to his local hospital by ambulance. Alex spent over a week in hospital and during this time he had several issues with his treatment and care. Alex spoke of poor communication, that staff did not introduce themselves, explain what their role was or what they were doing. On one occasion, Alex was waiting to have a procedure and had been fasting in preparation for this. The procedure was cancelled but Alex was not told why or when this procedure would take place. When he was discharged, Alex felt that this was done in a hurry and that his discharge plan was not discussed with him. Alex wanted to make a formal complaint about his experience and decided to contact the Patient Advocacy Service for support.



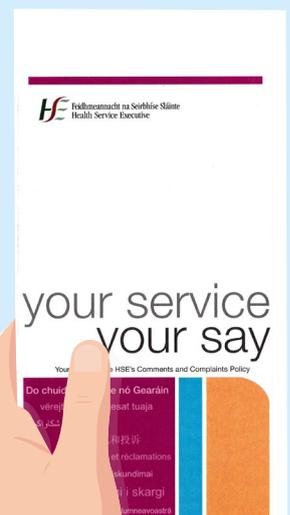
Actions by the Advocate

Alex met with an Advocate from the Patient Advocacy Service to discuss his complaint issues. The Advocate provided information on the HSE's Your Service Your Say complaints process, explaining the steps involved in submitting a formal complaint. The Advocate provided information on the HIQA Standards for Safer Better Care and the principles of the HSE's National Healthcare Charter and supported Alex to identify the standards and principles that his complaint issues related to. With the support of his Advocate, Alex identified the questions that he wanted to raise and his expected outcomes. The Advocate supported Alex to draft and submit a Stage 2 formal complaint. Alex received a response to the complaint but was not fully satisfied. The Advocate outlined the next stage of the complaints process and advised that Alex could request a meeting to discuss the complaint. Alex decided that he wanted a meeting with the hospital and the Advocate supported him to request a meeting. A meeting was offered and the Advocate supported Alex to prepare for the meeting and agreed to attend the meeting in a supportive role.



Outcome

While at the meeting with the hospital, Alex received an apology and an acknowledgement that communication had been poor during his stay in hospital. Alex was invited to participate in future training on communication for staff in the hospital. Alex told their advocate that they felt their voice was heard and were happy with the support from their Advocate.



10. Patient Safety, Dignity and Respect



Context

Bill is in his mid-50's and is partially paralysed. He has multiple health conditions that require regular medical intervention to maintain his quality of life. Bill can sometimes find communication difficult, especially when he is tired. Bill attended his local hospital as a day patient to have a procedure that he had undergone several times before. That night, when Bill was at home, he became very unwell. He was admitted to hospital where it was discovered that he was injured during the procedure. Bill was critically ill for some time. On several occasions Bill found himself unable to call for the nursing staff's attention as the call bell had been left outside of his range of movement. He was left with no option but to try to shout for assistance. Bill felt the medical team did not explain what had gone wrong with his procedure and why he had become so ill. He was left feeling traumatised after becoming so critically ill. Bill was also upset at having to shout for help from staff. Due to his concerns, Bill contacted the Patient Advocacy Service for support.



Actions by the Advocate

Bill spoke to an Advocate from the Patient Advocacy Service who listened carefully to his experience. The Advocate supported Bill to outline what he wanted to achieve from making a complaint. Bill wanted to understand what had gone wrong with his procedure and how it could be prevented from happening to someone else. Bill wanted to highlight how he felt discriminated against by staff due to his disability. The Advocate supported Bill to write his complaint which included a detailed account of his lived experience and an expression of the emotional harm he felt. The Advocate suggested that a meeting with the hospital might be helpful for Bill to share his lived experience, but Bill felt this would be too overwhelming and traumatic for him. Bill submitted his complaint with support from his Advocate. The hospital responded to Bill and apologised for the difficulties that Bill had in gaining staff's attention and stated they would make staff aware of the importance of having call bells within reach. The hospital decided to change their policies so that there was a greater wait time after day procedures. Bill's Advocate spent time with him to review the complaint response and to see if all of Bill's concerns had been adequately addressed. Bill did not feel the written response fully addressed the depth of hurt that he had suffered. The Advocate continued to work with Bill to try to find a resolution to his complaint.



Outcome

After some months of working and building trust with his Advocate, Bill felt empowered by their support and decided to have a meeting with the hospital. At the meeting Bill was given time and space to ask questions, to talk about his experience and express the fear and isolation he felt at being unable to call for help. Bill felt a sense of pride that he had spoken up and voiced his feelings. He felt satisfied that the hospital staff had listened and understood and that Bill's lived experience would promote positive change. Bill was empowered by his Advocate to have his voice heard.



11. Nursing Home – Dignity, Respect and Privacy



Context

Joe decided to move to a nursing home due to health issues. Joe was looking forward to a peaceful life and feeling safe in his new home. Sometime later, a new resident moved into the room next door to Joe. Joe found this person's behaviour very challenging – they were shouting, banging on the wall between the two bedrooms, and sometimes this person would try and come into Joe's room. Joe complained to the staff and was offered another room. However, it was Joe's will and preference to stay in the room he had.

Joe repeatedly reported his fears and how much this behaviour was upsetting his peace and quality of life. Joe was told by the Nursing Home staff that the other resident would be moved to another room. The situation continued for several months. Joe wanted to raise his concerns and make a complaint and contacted the Patient Advocacy Service for support.



Actions by the Advocate

An Advocate from the Patient Advocacy Service met with Joe at the nursing home. Joe was looking for support to make a formal complaint about his experience. Joe said that he was feeling unheard and that his concerns were not being addressed. The Advocate supported Joe to write a formal complaint outlining his issues and desired outcomes. The letter requested safeguarding support until the issue was resolved and to be informed of a definite date of when the other resident would be moving to another room.

Joe received a response from the nursing home that included a safeguarding plan that he agreed to. The response suggested that the other resident would be moving to a different room, but this was taking some time to arrange. The nursing home stated that they were monitoring the situation.

After a few months, the same issues with the resident began to happen again and it did not look like they would be moving rooms. A meeting was held between management, Joe and his Advocate. The nursing home stated the other resident would not be changing rooms. The owner said it could not facilitate moving the other resident to another room at that time. Joe suggested he would feel safer if there was a member of staff to accompany him to his room each evening and this was facilitated.



Outcome

Joe escalated his complaint to the Office of the Ombudsman as he felt his longer-term care needs and safeguarding were not being prioritised. The Ombudsman advised this was a difficult situation as it was necessary to balance the rights of all residents. Subsequently, with additional supports being provided to the other resident the situation improved. Joe felt less threatened and decided to withdraw his complaint.

Joe reported that the resident occasionally will still try to come into his room, but Joe feels empowered to manage the situation, he keeps his door locked and uses his call bell to seek support should he need it.

Joe felt fully supported by his Advocate and knows that the Service is there should he require support again in the future.





NAS is funded & supported by the
Citizens Information Board

The Patient Advocacy Service is funded and
supported by the Department of Health



An Roinn Sláinte
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