Patient Advocacy Service - Public Data

Patient Advocacy Service

INFORMATION | SUPPORT | EMPOWERMENT

Patient Safety in the Community
20th January 2026

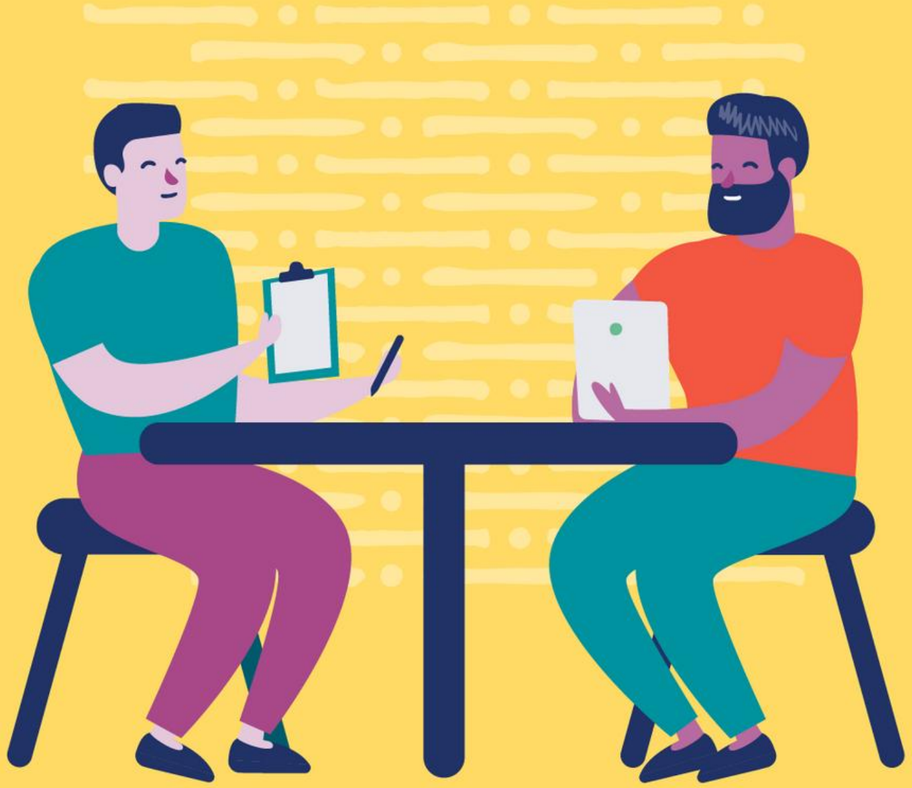
"Patient Safety Incidents; The experience of the Patient Advocacy Service"

Georgina Cruise,
National Manager, Patient Advocacy Service

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Patient Advocacy Service Remit:

To provide a **free, independent & confidential information, support** & **empowerment** advocacy to users of **public acute hospitals & nursing homes** wishing to make a **formal complaint** about the **care** they have received and in the aftermath of a **Patient Safety Incident**.



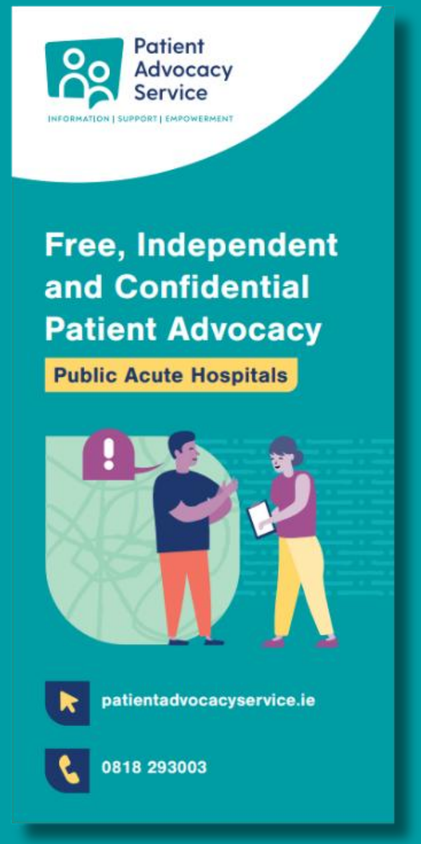
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- **Patient Advocacy Service launched in 2019.**
- **Over 10,500 people supported.**
- **Over 3,000 contacts in 2025, highlighting nearly 8,000 issues. 2025 had highest level on contacts since 2019.**
- **800 enquiries in 2025 outside of our remit.**
- **Of the 3,000 enquiries in 2025, 8% related to identifiable patient safety incidents.**





Independent Advocacy

- Support with Incident Management Framework.
- Implementation of the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023, Open Disclosure Framework, Incident Management Framework and Open Disclosure Policy.
- Data gathered, identifying themes and systemic issues. Information sharing and learning with relevant stakeholders is key in preventing future harm.
- Memorandum of Understanding with the HSE

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Incident Management Framework

Care | Compassion | Trust | Learning

NATIONAL OPEN DISCLOSURE PROGRAMME

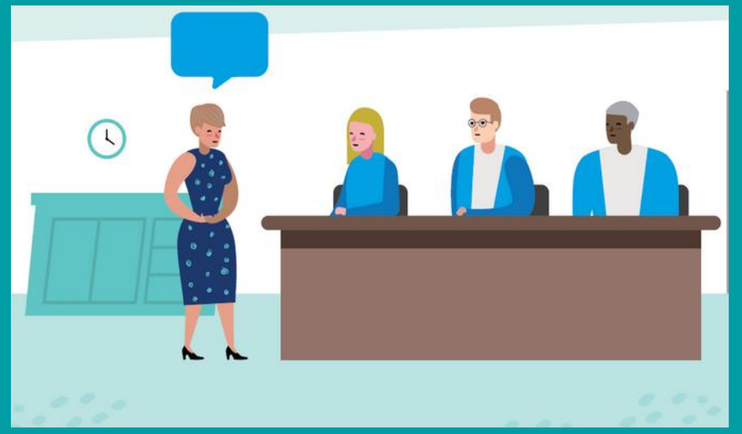
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

The Patient Advocacy Service and Patient Safety Incidents

Patient Advocacy Service

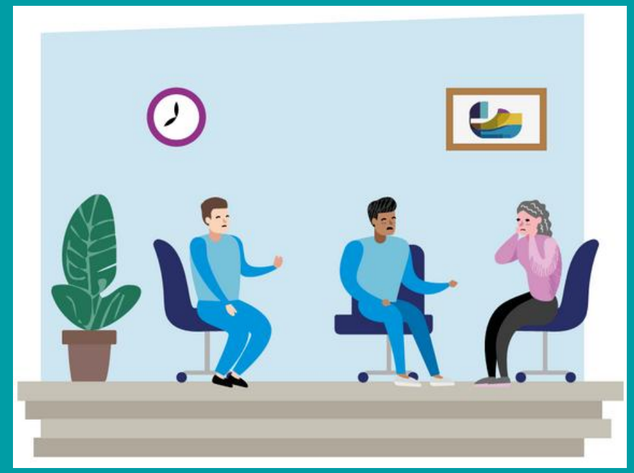
INFORMATION | SUPPORT | EMPOWERMENT

- Guidance with Open Disclosure process and Incident Management Framework.
- Trauma informed, skilled in active listening and have completed the Certificate in Patient Safety Complaints Advocacy.
- Can attend meetings in relation to the incident.
- Ensure the process is person centred.
- Provide information on other services and supports that are available.



Issues in relation to Incident Management

- Open Disclosure did not take place.
- Person unaware reviews took place.
- Patient Safety Incident highlighted through the complaints process.
- No Designated Liaison Person.
- Inconsistent communication with the Designated Liaison Person and Review Team.
- Review process falling outside timeframes.
- Review process traumatic for the person
- Process is not always person centred and can lack empathy.
- Knowledge of the incident happening again – No learning from incidents or quality improvement.



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Through our model of advocacy, we were able to support people to achieve various outcomes which not only helped them understand and resolve their issues but also provided the opportunity for learning and improvements within acute hospitals and nursing homes.

These included full acknowledgement and sincere apologies, policy adherence and changes, communication improvements, training and education, empowerment and emotional support and closure.



Case Study



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Communication plays a critical and foundational role in patient safety. Miscommunication can lead to adverse events and patient harm while effective communication can prevent misunderstanding and builds trust.

Communication is an element in around 60% of concerns raised with our service. As you can see from the above example(s) breaking down the barriers through open dialogue and patient involvement is essential for quality safe care.

Learning and feedback that utilise the power of the patient's voice and lived experience provide positive opportunities for risk reduction, learning, partnership and co-design.

A process is working well when it has good leadership, good communication and engaged staff. It should empower the service user, keeping them at the centre of the process and involved in decisions around their care, upholding their rights, listening to their lived experience and engaging in continuous learning.

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