Your Service Your Say

Anonymised Feedback Learning Casebook

Quarter 3 2025

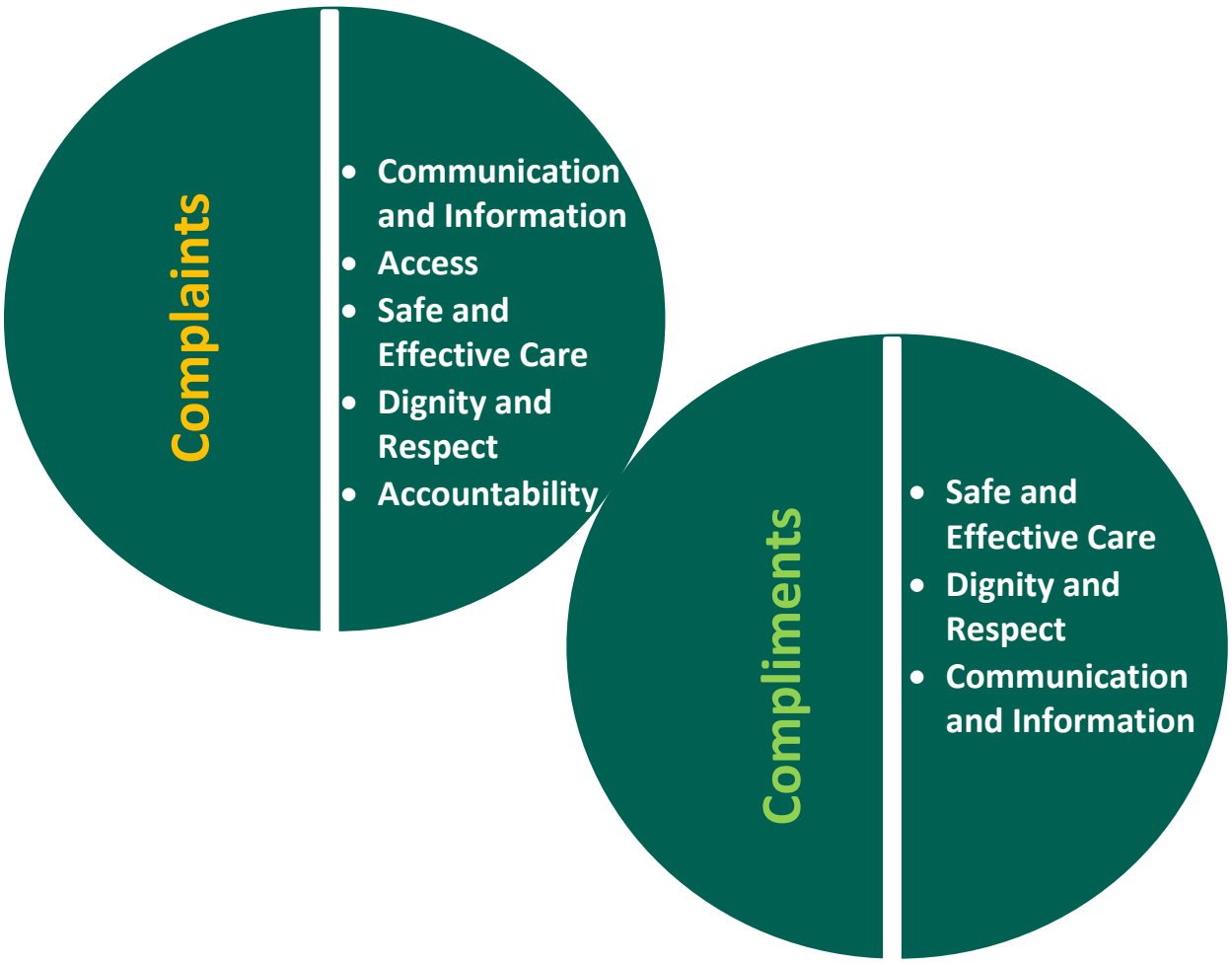
Introduction

Welcome to the quarter 3 edition of the 2025 national anonymised feedback learning casebook. The casebook presents a total of **13 cases** covering both complaints and compliments received by hospitals, community and national services.

The cases presented in the casebook contain themes and issues that need to be examined in the context of quality and service improvement. The learning gained from patient and service user feedback helps target and prioritise improvement efforts as well as highlighting good practice to be promoted and replicated.

The third quarter edition of the 2025 casebook features a total of **11 complaints**; 3 complaints from hospitals, 7 from community services and 1 from a national service, that were investigated along with their outcomes. The casebook also features **2 compliments;** 1 from a hospital and 1 from a national service that highlight the learning to be gained from positive patient and service user feedback.

Key Categories



Complaint Issues

Communication and Information

Communication and Information related primarily to how staff communicate as well as delays and failures to communicate with patients, services users and their families. The complaints presented feature issues of staff interacting with patients in a way that lacked compassion or empathy and which caused additional distress in an already stressful situation. The complaints also highlighted issues around staff interactions and how visible these are to patients who noticed disrespectful interactions and felt compelled to intervene. The issue of respectful interactions by staff also featured where staff discussed a service user's care amongst themselves in front of the service user but not with them, leading the service user to feel excluded and uncomfortable. When spoken to, the manner of the interaction made the service user feel unwelcome and insignificant.

Issues around delay and failure to communicate caused unnecessary upset and distress to family members when concerned about the care being provided to a loved one. A delay in communicating an incident to family members impacted on the trust and confidence they placed in the service. A failure to communicate to a family regarding a change in the medication of their loved one that resulted in a deterioration in their physical abilities contributed to a family's concern and upset.

Providing accurate information also featured under communication and information. The cases presented outline how providing incorrect information can cause unnecessary distress and frustration for families waiting for appointments as well as upset when expectations are not met due to misleading information.

Access

Access concerned issues with appointment delays and the pathways for referral and how people can be supported while waiting. The issue of resources under Access featured in a case where a service user, who was in receipt of a home care service delivering one to one 24/7 care, as was needed, was admitted for acute care in a hospital and how the monitoring needed and preferences expressed by the family were managed.

Access issues also related to a change in room facilities which resulted in unanticipated upset for the service user and consequently their family. While the change had been agreed in advance, the lack of appropriate or sufficient facilities should not displace one service user in favour of another, however well intentioned.

Safe and Effective Care

Safe and Effective Care issues concerned medication management and in particular the safe administration and recording of medication given to minimise errors. Medication issues also arose around the appropriateness of the medication prescribed and the dosage due to the escalating physical side effects experienced by the patient and witnessed by the family.

Safe and Effective Care also concerned diagnosis and featured a case where following a fall a service user in a residential facility did not receive a full body check which may have indicated the need for an x-ray that could have identified early the presence of a fracture.

Other complaint categories such as ***Dignity & Respect*** **and** ***Accountability*** were also identified within the cases.

Dignity and Respect concerned respectful interactions between staff and the need to remain professional, especially in front of patients and services users. In particular, staff to be courteous and respectful when delivering care to patients and service users; to ensure that they are included in discussions about them and treated in a way that respects them as an individual, their circumstances and upholds their dignity. ***Accountability*** related to responding to a family member's concerns and understanding the circumstances giving rise to them.

Compliment Categories

Safe and Effective Care

Safe and Effective Care concerned the outstanding care and expertise demonstrated as expressed by a patient towards the hospital staff that treated them following an accident and during which the patient felt genuinely cared for.

Safe and Effective Care issues also related to how the quality of processing, presentation and the secure delivery of requested healthcare records made the service user feel heard and respected throughout the process.

Dignity and Respect

Dignity and Respect concerned the delivery of care and the difference it made when care was delivered with compassion and kindness.

Communication and Information

Communication and Information related to staff keeping a service user informed as to the now and the next in relation to a request which was much appreciated.

.

HCAT Classification

Where HCAT has been applied to the complaints presented in this casebook, the rating has been assessed as:

The Healthcare Complaints Audit Tool or HCAT is an innovative method of classifying complaints developed by the London School of Economics (LSE). HCAT, which has been tested for suitability within the Irish healthcare sector, offers an improved classification system that will support the identification of systemic issues and trends within services leading to improvements in healthcare delivery and ensuring high standards of quality and safety

By applying HCAT to complaints, it can assist services to identify 'hot spots' for harm, i.e. an area in care where harm occurs frequently, as well as 'blind spots', i.e. areas in care that are not easily observed.

HCAT is now a mandatory feature of complaints recording on the national Complaints Management System (CMS).

Learning from feedback is fundamental in providing high quality healthcare services. Listening to and acting on the views, concerns and experiences of Patients, Service Users and their families enable us to guide decision making to improve services and provide the best possible care.

Publication of the casebook is part of the HSE's commitment to use Patient and Service User feedback as a tool for learning and to facilitate the sharing of that learning.

The casebook will be widely circulated to staff within the HSE and shared with Health Region Management who will consider the learning from these cases.

Hospital Services

Category: Communication and Information (*Communication Skills*); Access (*Appointment delays*)
HCAT Severity: N/A
HCAT Harm: N/A
Status: Not Upheld

Background to Complaint
A family member contacted the Patient Experience Office [PEO] to make a complaint in relation to their engagement with a member of staff on behalf of their father who attended a Chronic Illness Service. The family member expressed their parent's concerns in relation to the service's delay in triaging an internal hospital referral for her father. They reported that their father was in chronic pain continuously. When they contacted the service requesting an update they reported that the staff member was rude and lacked compassion and empathy.

Investigation
The PEO sought consent of the patient to progress this complaint.
The complaint was investigated by the Medical Consultant in the Service and the Directorate Management team.

The investigation found that the patient underwent a telephone review with a specialist nurse, which is a pathway for expediting patients through the service. The timeline between the telephone review and the detailed patient treatment plan occurred within 17 working days.

Subsequently, the patient was scheduled for a planned procedure, which was likely to occur within 8 weeks. This patient had their procedure 29 working days later.

Outcome/Learning
A written response was provided to the complainant outlining the actual waiting time experienced by the patient. It was expressed, on behalf of the Consultant, that the team remains acutely aware that both returning and newly referred patients are experiencing symptoms as they await medical review and intervention.

The Consultant added that this service pathway is significantly more efficient than the standard outpatient pathway, which typically involves a 16-month wait for review. The expedited process is a direct result of the team's proactive initiative and commitment to seeing patients as promptly as possible.

They affirmed that the team are committed to minimising delays through this new pathway and maintain a high standard of clinical effectiveness, even under considerable pressure.

While the consultant did not uphold this complaint, an apology was provided by the management team for the family member's experience in relation to staff communication.

This complaint highlights the importance of ongoing quality improvement initiatives and the relentless commitment from staff into improving patient pathways.

Hospital Services

Category: Safe and Effective Care (*Treatment and Care*); Dignity and Respect (*Delivery of Care*)
Status: Compliment

Background to Compliment
A patient was admitted to the Emergency Department [ED] following a snowboarding accident and subsequently required surgery for a broken arm under the Orthopaedic Service.

Nature of Positive Feedback
Following their discharge, the patient provided feedback. The patient expressed their deepest gratitude for the outstanding care and support received throughout their treatment and recovery.

A heartfelt note of appreciation was extended to the Doctor in the ED for their compassion and the care and kindness shown to both the patient and their family. Additionally, the Orthopaedic Surgeon received commendation, with the patient expressing that they felt genuinely cared for, nothing that the overall level of dedication, empathy, and expertise demonstrated by all involved was described as truly exceptional.

Outcome and Learning
This compliment provided assurance to staff regarding patient satisfaction with the quality of care provided. Receiving compliments and words of thanks can have a powerful and positive impact on staff wellbeing.

Hospital Services

Category: Safe and effective Care (*Medication*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Informally resolved

Background to Complaint
A Service User (SU) advised staff that they had been administered medication at the wrong time. The SU believed that they had been administered the evening medication during the day. This medication made the Service User feel drowsy and numbness in the limbs. Following a nap, the Service User felt better.

Investigation
Staff acknowledged the SU's concern. The SU was advised that a discussion had taken place with the nurses responsible for the administration of medication. There was no evidence to support that any errors had occurred with the administration of medication in the SU's Kardex (documentation system).

Outcome/Learning
The SU was reassured and underwent a medical review, including vital signs monitoring, all of which were within normal range.

Staff were reminded of the importance of strictly following protocols to ensure the safe administration of medication. The SU was informed that a report will be prepared following discussions with staff, emphasising the need for vigilance to minimise the risk of potential medication error incidents. The SU was satisfied with the response and did not wish to escalate the complaint further.

The matter was reviewed during the Multi-Disciplinary Team meeting. No changes to the SU's treatment plan were deemed necessary, and no further actions were recommended.

Hospital Services

Category: Safe and Effective Care (*Treatment and Care*), Access (*Accessibility / Resources*)
HCAT Severity: n/a
HCAT Harm: n/a
Status: Partially Upheld

Background to Complaint
The parent of a patient visited the complaints department to discuss inadequate monitoring of their child whilst an inpatient. The patient has a rare condition that requires 24/7 one-to-one care, including monitoring throughout the night. The parent has been granted a HSE homecare package of nursing care seven nights a week. On a recent admission to an acute setting, the hospital declined to take over payment of the home care nurses to come into the hospital to look after the patient at night. The hospital assured the parent that they would provide a Health Care Assistance (HCA), however the parent felt that a HCA was not medically qualified enough to care for the patient's complex needs. The parent felt dismissed and not listened to when they tried to raise this with relevant management. The parent was left with no choice but to sit with their child awake all night, which is not feasible for the parent when they are caring for the patient during the day, whilst also having a full-time job to provide for their family. The parent also wrote to the HSE with their concerns, who brought the complaint to the attention of the Regional Executive Officer and the hospital's Chief Executive Officer.

Investigation
The nursing leadership team were asked to examine the complaint and ensure the patient had been assigned appropriate care.

The Assistant Director of Nursing (ADON) confirmed that the HSE's policy when a patient with a homecare package is admitted to hospital is that only the first 48 hours are covered by the HSE. After that time, it is the responsibility of the acute hospital to cover the payment for the homecare nurses to attend on site.

The ADON risk assessed the situation each day and assigned either a nurse or a HCA to the patient overnight. The occupancy in the hospital at that time was low, with a good ratio of nursing staff to oversee a HCA observe the patient's care. The acute hospital also did not have a Service Level Agreement (SLA) with the agency used by the family for homecare and there was a significant cost difference.

The plan was discussed with the parent who still raised concerns regarding the continuity of care for their child. The patient was used to their regular home care agency nurses and understandably the parent would prefer to keep that continuity. They also feared losing those nurses while the patient was in hospital as they could be allocated to another client.

The acute hospital had raised this as an issue in the HSE Home Care Package/hospital system and previously met with the relevant person in the HSE to raise, but the HSE were clear on their position regarding the first 48 hours.

Outcome and Learning
The nursing team were able to use resources within the hospital to support the parent's request for one-to-one care during the patient's admission.

Thankfully the admission was not significantly long, and it is understood that the family did not lose their usual homecare nurses as a result.

Community Services

Category: Communication and Information (*Information*), Access (*Appointment*)
HCAT Severity: Low
HCAT Harm: N/A
Status: Upheld

Background to Complaint
A parent contacted the service via email to express their frustration and anger regarding their recent transfer from the Community Disability Network team (CDNT) to Primary Care. They were particularly upset about the prolonged waiting time before their child received any intervention. This delay caused significant distress and dissatisfaction, prompting them to formally raise their concerns.

Investigation
It was identified that the parent had been provided with an incorrect waiting time—specifically, they were informed that the wait would be twice as long as it actually was going to be. Upon recognising this error, immediate steps were taken to inform the parent and to support them during the waiting period. An appointment was arranged for the child at the Occupational Therapy (OT) Advice Clinic to offer interim guidance and resources.

Additionally, as the child had a diagnosis of dyspraxia, contact details for Dyspraxia Ireland, an organisation offering support specifically for children awaiting intervention on Primary Care waiting lists, was provided, ensuring the family had access to appropriate resources and community support while they awaited further assessment.

Outcome/Learning
The parent expressed sincere gratitude for the prompt and proactive contact made by Primary Care following their concerns. They appreciated the timely support provided, including the interim resources and the appointment at the OT Advice Clinic, which helped to alleviate some of the stress caused by the waiting period.

This case highlights the critical importance of providing accurate information regarding waiting times to families, as well as the value of offering interim support and resources while children await intervention. Moving forward, ensuring clear communication and prompt follow-up will be prioritised to improve patient experience and reduce frustration.

Community Services

Category: Dignity and Respect (*Alleged Inappropriate Behaviour*), Communication and Information (*Communication Skills*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Upheld

Background to Complaint
A service user, while attending a service, overheard a staff member make inappropriate comments to a colleague regarding a member of the public and then proceeded to operate in a bullying manner towards their colleague leading to the Service User having to step in. The service user advised that they felt ashamed of '*how we as a nation were representing ourselves'*.

Investigation
The matter involving the two staff was investigated and dealt with appropriately with follow up supervision provided.

Outcome and Learning
The Complaints Officer upheld the complaint and apologised to the service user for their experience. Assurances were given that such an interaction would not happen again. The service user accepted the sincere apology and was satisfied that the matter had been dealt with and appreciated the timely manner in which the matter was managed. The service user was complimentary of the staff providing the service while attending and confirmed their overall experience with the service was positive.

Management supervision was followed up with the staff involved and with their wider team.

This complaint highlighted the importance of appropriate redress at front line in compliance with HSE policy. The importance of communication and the manner of engagement was highlighted and addressed with all staff, to ensure the dignity and respect of service users and staff alike.

The matter highlighted the necessary HSE policies, procedures and guidelines for staff and their requirement in the administration of their role. This complaint was also a reminder to staff of the HSE's Code of Standards and Behaviour when dealing with members of the public and colleagues.

Community Services

Category: Communication and Information (*Delay and Failure to Communicate*); Safe and Effective Care (*Medication*)
HCAT Severity: Medium
HCAT Harm: Moderate
Status: Upheld

Background to Complaint
A complaint was received from a family member in respect of a service user residing in a nursing home. The service user had a diagnosis of Alzheimer's Dementia and had presented with increased agitation for a number of months. The family queried the medication and looked for someone to explain to them the course of medication and care being provided. The treating consultant was away and therefore this did not happen. The issue escalated as an increased dose of medication recently prescribed to the service user led to significant drowsiness as well as to the loss of their ability to walk and transfer unaided. The family raised concern about this and the medication dose was subsequently lowered.

Investigation
An investigation was carried out and it was determined that the treating consultant was on leave at that time. Upon the Consultant's return a full response was provided recognising all concerns raised in relation to care of the person and the prescribed medication together with an apology in respect of the delay and lack of communication.

Outcome and Learning
It was agreed that direct communication would be made with the family member going forward and that communication around care and medication would be ongoing.

Following the issuing of the response the family member expressed gratitude for the comprehensive response from the treating consultant.

The importance of communicating and consulting with families in relation to the care of a vulnerable person in a timely manner is highlighted in this case.

Community Services

Category: Communication and Information (*Delay and Failure to Communicate*); Safe and Effective Care (*Diagnosis*)
HCAT Severity: Medium
HCAT Harm: Moderate
Status: Upheld

Background to Complaint
A service user in a residential nursing unit who received one to one supervision was briefly left unattended while the staff member stepped out to get a cup of tea for the person. The service user in that moment, left their room and fell, hitting their forehead against the handrail on the corridor and landing on their left side. The nurse in charge was assisted by another to help the service user back into bed.

Physical observations were carried out and the doctor was informed. The Incident Management framework reporting was followed.

The doctor examined the person and found no sign of a fracture. External rotation of legs was done without pain and there appeared to be no shortening of limbs. The doctor advised staff to continue monitoring. A re-assessment was completed in the morning and a decision was made to transfer the service user to the hospital as they could not weight bear. On admission to the hospital it was confirmed that the service user had a fracture of the left hip.

A family member made a complaint in relation to the injury not being discovered and the family not being informed accordingly.

Investigation
The complaint was acknowledged.

An investigation took place into the circumstances that led to the fall, the reporting of the occurrence to family and the identification of the injury received by the service user.

Arrangements regarding the supervision of the service user was reviewed by the service as well as a review of the management of the incident. The extent of the injury should have been identified by the doctor and a full body check may have shown the fractured hip. The service user should have been sent to the hospital in the first instance for hip x-ray.

Though the Open Disclosure protocol was followed in respect of the incident, the extent of the injury was not discovered for it to be disclosed to the family at that time.

A full response was issued to the family member with an apology.

Outcome and Learning
While the family should have been informed of the occurrence in a timely manner, the extent of the injury would not have been known at that time.
However, it was determined that the service user should have received a full body check and been sent to the hospital in the first instance for hip x-ray.

This complaint highlights the importance of timely communication with family that ensures they are updated and included in the care of their loved one and reassures of being informed as soon as possible should an issue arise. This builds trust and confidence in the service being provided. Additionally, the complaint highlighted the need to perform full body checks to rule out injury as well as timely transfers to hospital for diagnostics following a fall.

Community Services

Category: Dignity and Respect (*Delivery of Care*); Communication and Information (*Communications Skills*)
HCAT Severity: Medium
HCAT Harm: Moderate
Status: Upheld

Background to Complaint
A complaint was received regarding communication between staff and a service user which was allegedly inappropriate and where the service user felt their dignity was challenged.

There was a dispute regarding the management of wound dressing and where it should take place. This service user had been referred by a GP to the Primary Care Centre for a dressing following a review of a procedure carried out in Hospital. The service user had become concerned about the wound, sought GP advice and was referred to the local Primary Care Centre. The GP sent a referral letter to ensure immediate care. The service user got a call that afternoon to attend the following morning.

When called into the treatment room by the nurse there was a second clinician in attendance. As the nurse was reviewing the wound dressing, a conversation took place that made the service user uncomfortable. The service user was questioned and was then advised that the centre did not have the necessary supplies to dress the wound.

The service user felt excluded when the nurses discussed the management of care among themselves and not directly with them. The nurses advised that the service user should not have attended the centre and that their GP's nurse should have managed the dressing. The person was asked whether their treatment was public or private in the hospital and was told to go back there leaving them to feel very unwelcome and insignificant during their attendance at the Primary Care Centre.

Investigation
This complaint was issued to the Primary Care Centre for review and a response sought. The Public Health Nursing team were asked to respond to the alleged mistreatment of the client. The complaint was upheld and recommendations were made on how to manage similar scenarios in the future. A response was issued to the client offering an apology regarding the management of the situation and offering an explanation in relation to miscommunication that took place. Care and support was offered to the client when necessary in the future from Primary Care Services.

Outcome and Learning
The complaint was upheld and recommendations were made on how to manage similar scenarios in the future. A response was issued to the client offering an apology regarding the management of the situation and offering an explanation in relation to miscommunication that took place. Care and support was offered to the client when necessary in the future from Primary Care Services.

The complaint highlighted the following learning for the service:

- Staff to be give due care and attention to a client's dignity and respect at all times during consultation.
- Staff to be aware that processes within the HSE may not be within the remit of a client's knowledge when seeking treatment.
- If there is miscommunication between services or an inappropriate referral, it must be dealt with professionally without making the client feel uncomfortable or a burden to the service.
- A swift resolution must be sought by staff to ensure continuity of care and a high level of service.
- Escalation of risk to the client's health deteriorating must be avoided and managed effectively.

Community Services

Category: Access (*Room facilities*), Dignity and Respect (*Delivery of Care*)
HCAT Severity: Low
HCAT Harm: N/A
Status: Upheld

Background to Complaint
A family member complained that their parent had been moved, from a single room in a Community Nursing Unit (CNU) to a twin room, and was disoriented as a result of the transition, which was distressing for both the service user and the family.

Investigation
In examining the issue, the Complaint Officer was made aware that at the time of the complaint, the CNU had limited individual rooms in its facility. In cases where residents were sharing with others in a communal space and were nearing end-of-life, requests were made to residents in single rooms to transfer temporarily to a shared space to allow the resident nearing end-of-life and their family have greater privacy at that time.

A HSE Capital & Estates Management plan is in progress at the Community Nursing Unit to address issues in relation to facilities and the physical environment.

The Complaints Officer confirmed that the resident's move had taken place following consultation with both the service user and their family.

While the service user and their family did agree to the move in the first instance, at the time it had not been anticipated how upsetting the change might be for the service user and consequently, the family.

The Complaint Officer fully understood and accepted that the resident had a right to remain in their own room, in familiar surroundings with their own belongings.

The Complaint Officer acknowledged that the rights of one resident did not diminish those of another, regardless of circumstance, and that moving residents from their own private space to accommodate the needs of others, even with informed consent, was not in keeping with either the standards or ethos of the service in relation to respecting individual rights and observing personal dignity.

Outcome and Learning
The complaint was upheld with an apology as appropriate.
Given the issue related to resources and the physical layout of the centre, a recommendation was not made by the Complaint Officer.

The Complaint Officer did ensure information was provided to the complainant and family explaining that measures were in place to address the issues via the ongoing Capital and Estates Management Plan.

Community Services

Category: Dignity and Respect *(Delivery of care*); Accountability (*Feedback*); Communication and Information (*Information*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Partially Upheld

Background to Complaint
The Complainant raised a complaint via YSYS regarding their dissatisfaction at the failure of the HSE to remove palliative care equipment from their home within what he stated was an agreed time. The equipment had been provided by the HSE while their spouse was being cared for at home in their final weeks. Four weeks had since passed and the Complainant stated that the failure of the HSE to remove the equipment was causing distress.

The Complainant emphasised that they had a very positive experience of the services prior to their spouse's passing, however the delay in removing the equipment was becoming an issue of concern.

Investigation
The designated Complaints Officer (DCO) screened the complaint and acknowledged receipt in writing, and then contacted the Complainant by phone to discuss the issue and outline the investigation process.

The DCO then liaised with the following HSE personnel who had engagement with the family:
- Palliative Care Manager
- Public Health Nursing Service
- Client Orders Equipment Office

The DCO provided each service with a copy of the complaint and requested a written response from each, outlining their remit and responsibilities with regards to the matter.

Outcome and Learning
Having considered the responses provided, the DCO did not uphold the complaint in relation to Issue 1, Dignity & Respect, but did uphold Issue 2, Accountability.

The DCO reached this determination having found that standard collections are completed four weeks from the date of request, as per the terms of the HSE contract with the Service Provider who provides this service. Accordingly, the DCO determined that the timeframe of the four weeks from the request being submitted, had not elapsed.

Notwithstanding this, the DCO acknowledged that for the family the time waiting on collection of the equipment was stressful and offered an apology in that regard, as it was noted that the expectation of a more prompt collection had been given to the family when they were told that the equipment would be removed "in a couple of weeks".

The DCO made a recommendation that a communication issue to all clinicians involved in the provision and supply of equipment to clients, emphasising the need to make it explicitly clear to families after a bereavement that collection may take up to four weeks. The DCO stated that in knowing the expected timeframe, it would make things easier for families rather than having an expectation of something that is not likely to occur.

It is noted within the complaint response that the equipment was collected during the course of the complaint investigation.

National Services

Category: Access (*Appointment*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Not Upheld

Background to Complaint
A service user expressed dissatisfaction about age eligibility for a screening service. They were unhappy that they would no longer be invited to participate in routine population-based screening. The service user wanted to know 1. Why people over 70 were no longer entitled to participate, and 2. Could the screening service consider extending the screening age range because they were worried about self-monitoring in the future?

Investigation
The Complaints Officer first met with the programme team to discuss the eligible age range and to identify how these age ranges were established.

The programme team explained that the service itself does not set the age parameters for screening. Instead, it is the National Screening Advisory Committee (NSAC), an independent advisory body which advises the Minister and Department of Health on all new proposals for population-based screening programmes and revisions to existing programmes. It was confirmed that the age range for all population-based screening programmes in Ireland are based on robust international evidence.

The Complaints Officer then requested information pertaining to the responsibilities for monitoring and reviewing the established age range and how a service user might go about voicing their preference for changes to the parameters. The programme team advised that, in Ireland, any changes to population screening programmes must first be approved by the NSAC. The Committee is independent of screening services and makes recommendations to the Minister for Health and the Department of Health. If accepted, these recommendations are communicated to the screening service, and the service begins planning to implement them. The programme team also explained that, while people over 70 are still at risk of getting cancer, they are not routinely invited for screening. The reason for that is because the available evidence demonstrates that the benefits of continuing to screen people over 70 does not outweigh the associated potential harms.

The programme team provided all of the available resources regarding what to do in the event the service user had any concerns or symptoms regarding the specific health area and advised on what they can do going forward to self-monitor..

Outcome and Learning
The Complaints Officer responded to the service user to acknowledge their concerns and to thank them for their feedback.

In the letter, the Complaint Officer reassured the service user that their feedback was important because the programme recognises how valuable understanding their service users' perspective about the screening service we provide.

The service user was advised on the direct pathway and given contact details to submit a request for changes to the programme. They were also advised there has been a recommendation submitted to the committee to extend some screening services to people aged over 70. This is currently under consideration by NSAC, who have asked the Health Information and Quality Authority (HIQA) to consider the evidence for this proposal.

Relevant advice on how to self-monitor and how to check for symptoms was provided to the service user. They were given guidance on the importance of being aware of what is normal for them so that if any unusual change occurs, they will recognise it and take the appropriate action. The Complaints Officer resourced and provided information links and leaflets on techniques for self-checking detection to the service user.

The Complaints Officer was cognisant to signpost the service user as they will no longer be invited to attend routine screening. They provided the relevant information on what to do if the service user had any worries about their health or had any concerns about symptoms. They were advised that routine screening is for well people within the population age range and is not for people with symptoms. They were provided with an alternative pathway if they have any concerns or symptoms concerning their health.

The issues raised in this complaint will be anonymised, recorded, and shared with the wider programme teams. This will raise awareness of the impact on this cohort of population regarding screening age eligibility.

National Services

Category: Communication and Information (*Communications Skills*); Safe and Effective Care (*Healthcare Records*)
Status: Compliment

Background to Compliment
The service recently received a Subject Access Request from a service user seeking a copy of their full screening history from the programme.

The request was acknowledged, and the service user was informed that the relevant team were currently processing the request and conducting the necessary searches. They were advised a response would be provided within one calendar month from the date the request was received.

The request was processed in line with the General Data Protection Regulations, and the records were issued securely to the service user within the statutory timeframe.

Nature of Positive Feedback
On receipt of their screening records, the service user expressed their gratitude to the staff members involved in processing their request and acknowledged their efficiency and professionalism during the entire process.

“I just wanted to extend my sincere thanks to you both for the way my data access request was handled. From the initial email to the secure delivery of the records and the inclusion of the cover letter, everything was communicated with such clarity and care.

It’s not often that a patient experiences this kind of responsiveness and respect in medical correspondence - especially without needing to navigate layers of bureaucracy around GDPR or FOI.

I really appreciated how straightforward and dignified the process was, and I felt genuinely heard throughout. Thank you again for your time and professionalism. It made a real difference."

Outcome and Learning
The team involved thanked the service user for taking the time to provide the positive feedback.

This compliment provides an opportunity to learn from good practice and was shared with the wider teams within the organisation to promote high standards of service delivery.