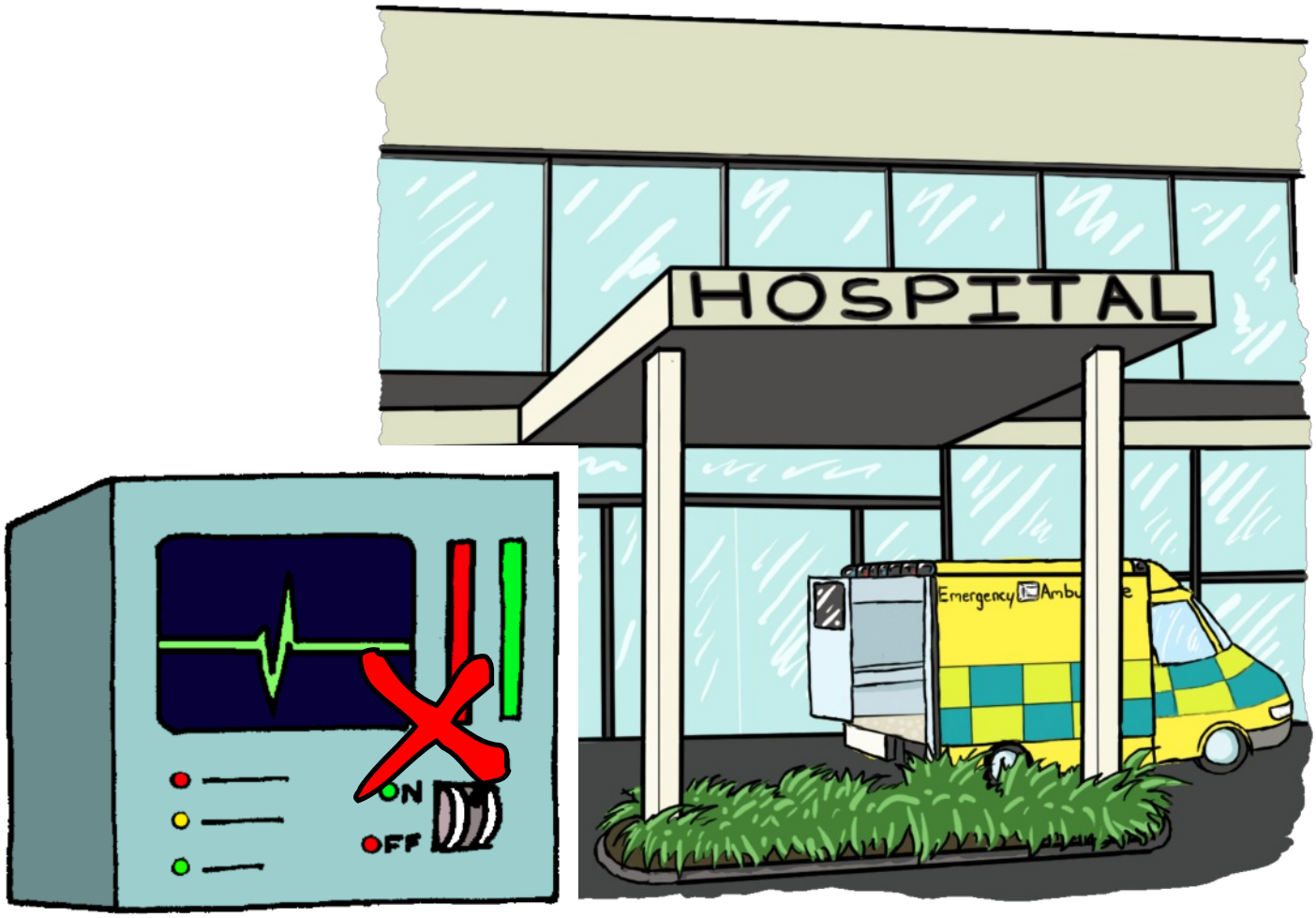

What happens when people die in hospital – learning to do better

Easy read version of ‘Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England’ – December 2016

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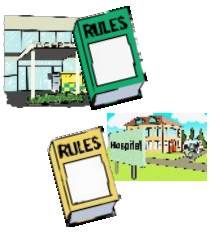
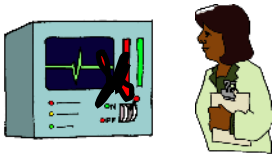




What this report is about

We are the Care Quality Commission – CQC.

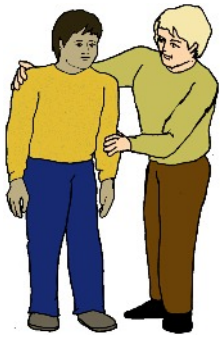
We check services to make sure they are giving good health and social care to people. Services such as:

- hospitals

- GPs

- care homes.

This report looks at what happens when someone dies in hospital:



- how families are treated when a family member dies

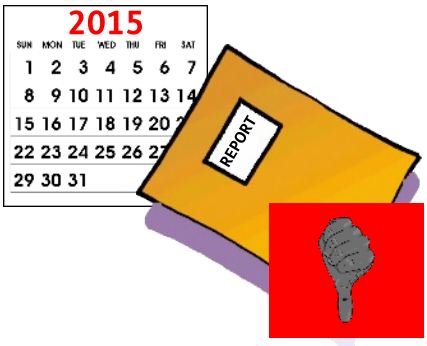
- what checks are done about how and why the person died

- how hospitals learn and make their services better.

Why we did this report

Connor Sparrowhawk was an 18 year old man with learning disabilities and epilepsy.

In 2013, he was in a hospital. He had a fit in the bath and drowned.



In 2015, a report about Connor's death said the hospital did not do things well.

They did not always have:

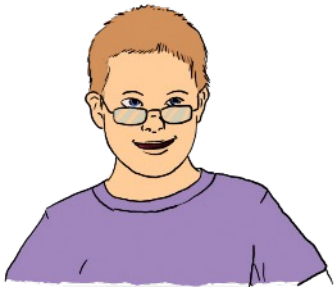
- good ways to make a record of when people die in hospital

- good checks on how or why a person died.

Department of Health

The Department of Health then asked us to look at what happens in hospitals all over England.

To help us to understand what happens when someone dies in hospital, we had 5 questions.



We were most interested in what happens for:

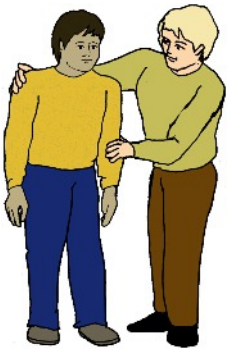
- people with learning disabilities

- people with mental health problems.

Our 5 main questions

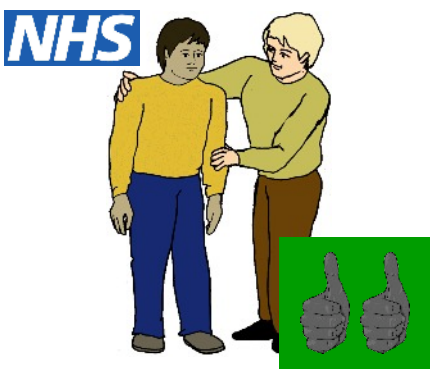
1. How are families and carers treated?

Families and carers are often not treated well, even though many hospitals say they want families to be involved with the care of patients.



Families and carers that have just lost someone they love need to be treated gently with kindness.

We asked families and carers how they were treated.

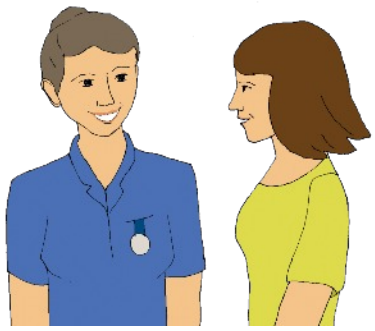


Some said they were treated very well. NHS staff helped them to understand what had happened and to **grieve**.

Grieve - this is when someone dies and you are very sad.

But some families and carers said they were treated badly. Staff did not seem to show that the death of their loved one was very important.

Families are sometimes not told what is going on with checks about the death. This upsets them more and means they do not trust the hospital.

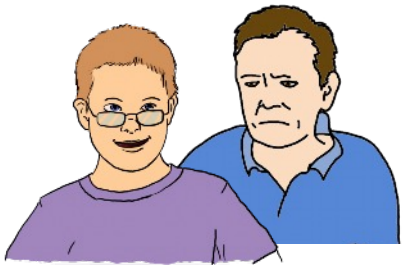


Some places are trying hard to do better. They listen to what families want and try to do it. More places need to do this.

How one hospital is doing well

One hospital is learning a lot from families. They write a report about why someone died for the family to read and to let them understand what happened.

The report is written in a way that is easy to understand. It answers all the questions the family asks.



2. What happens when someone with learning disabilities or mental problems dies?

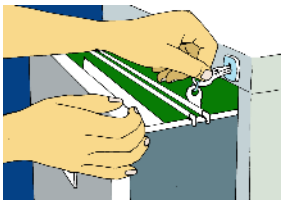
A person with learning disabilities or mental problems who is ill often sees staff from different services. Such as:

- a GP

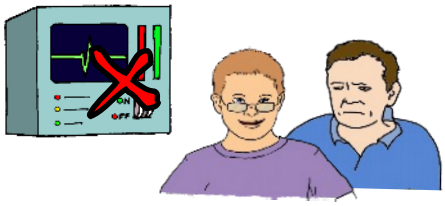
- a hospital
- an ambulance.

If they die, there are no rules to say who tells the staff from these different services about the person's death.

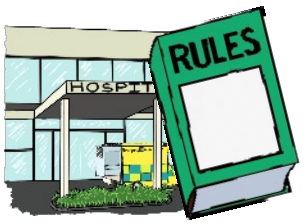
There are also no rules for good ways to:



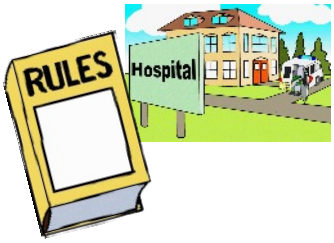
- make a record about when someone dies soon after leaving hospital



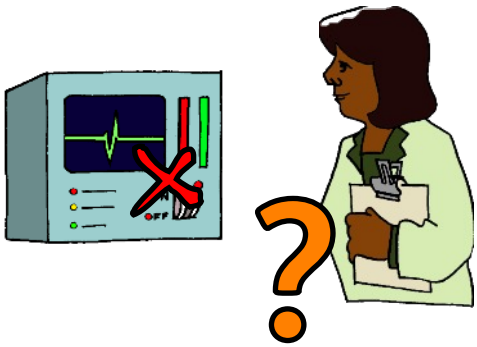
- make a record about when a person with learning disabilities or mental problems dies in hospital.



3. Is it clear when the death of a person needs checking on?



It is not clear. Different hospitals have different rules for this.



A decision needs to be made quickly after someone dies about checking why they died. But it is hard to get all the information from everywhere to make this decision.

4. How good are the checks?

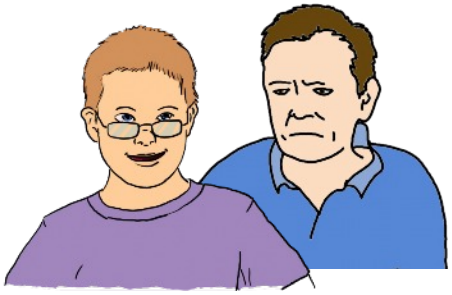
Staff who do the checks are not given:

- training on the best way to do checks

- time away from their usual jobs to do the checks.

Staff do not seem to know the rules on when checks must be done. This can mean that the checks are not good enough. And families may not be included.

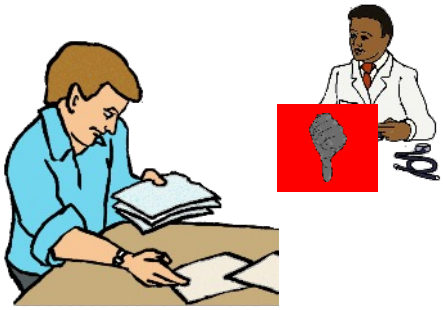
It is not always clear who needs to do the checks. This can mean that staff from other services who knew about the person may not be included.



So ways to do things better may be missed. Especially for a person with learning disabilities or mental problems.

5. Do hospitals have good ways to learn and make their services better?

There are no clear rules that say all deaths must be checked. Or for hospitals to share what they have learned to do better with others.

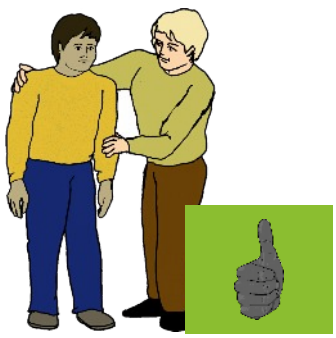


The top managers:

- only get information about checks on deaths that may be a problem. Such as when a member of staff may have done something wrong

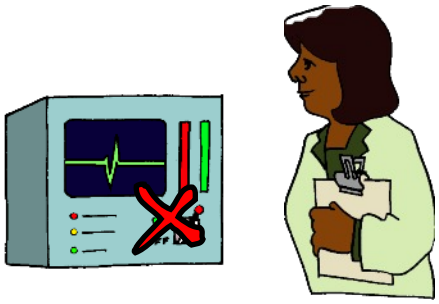
- do not always understand how to test if the checks are good

- have no training about what the checks mean and what they need to do.



Checks on how someone died may show better ways to treat people in future. Hospitals do not have good ways to make sure staff learn about this.

What next?



We need big changes to make sure everyone learns from the checks on how a person died.

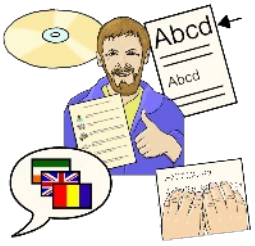
This should mean that patients get better care in future.

The Government, health services and other organisations should work together to make sure:

- there is one set of rules for checking why a person died

- families and carers are involved in these checks if they want to be

- information about a person's death is shared between services.



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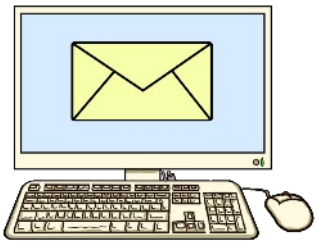

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