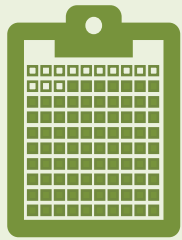


# National Audit of Care at the End of Life 2021

## Key findings at a glance

 171 Trust/Health Board overviews (T/HB)	 239 Hospital/site overviews (H/S)	 6,823 Case Note Reviews (CNR)	 3,118 Quality Surveys (QS)	 11,045 Staff Reported Measures (SRM)
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(CNR – Cat 1)

87%

Case notes recorded that the patient might die within hours or days



(CNR– Cat 1)

95%

Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care



(CNR – Cat 1)

98%

Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die



(CNR – Cat 1)

86%

Case notes recorded extent patient wished to be involved in care decisions, or a reason why not



(CNR – Cat 1)

73%

Case notes recorded an individualised plan of care



(QS)

57%

Families/carers were asked about their needs



(QS)

68%

74%

Care provided to families/carers

Care provided to the patient

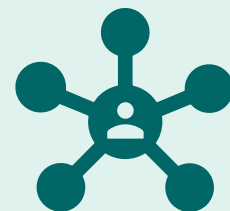
Families/carers felt the quality of care provided was good, excellent or outstanding



(T/HB)

99%

Trusts/Health Boards have guidelines on how to respond to/learn from deaths of patients



(H/S)

60%

Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week



85%

Staff feel confident they can recognise when a patient might be dying imminently



77%

Staff feel supported by their specialist palliative care team



(SRM)

80%

Staff feel they work in a culture that prioritises care, compassion, respect and dignity