National Audit of Care at the End of Life 2021
Mental Health Spotlight Audit
Key findings at a glance

46 Trust/Health Board overviews (T/HB)

54 Hospital/site overview (H/S)

75 Case Note Reviews (CNR)

481 Staff Reported Measures (SRM)

(CNR – Cat 1_2)

75%

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

(CNR – Cat 1)

98%

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

82%

Case notes recorded an individualised plan of care

38%

Case notes recorded a preferred place of death as indicated by the patient

(CNR – Cat 1)

85%

Patient's hydration status was assessed daily once the dying phase was recognised

(CNR – Cat 1)

95%

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

(T/HB)

100%

Trusts/HBs have guidelines for how to respond to/learn from, deaths of patients

(H/S)

44%

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

61%

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

48%

Staff felt supported by their specialist palliative care team

(SRM)

74%

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

2. Category 1. It was recognised that the patient may die