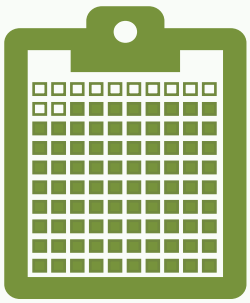
National Audit of Care at the End of Life 2019

Key findings at a glance

Recognising the possibility of imminent death



88%

Case notes recorded that the patient might die imminently

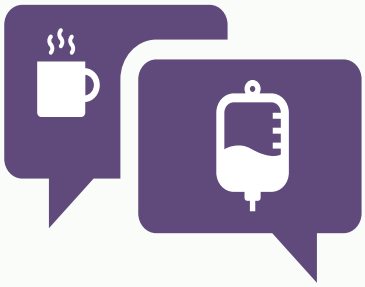
41 hours

Median time between recognition and death

Communication with the dying person 7.8

94%

Discussion with patients regarding individualised plan of care, or a reason why not recorded



80%

Discussion with patients regarding hydration options, or a reason why not recorded

Communication with families and others 6.9

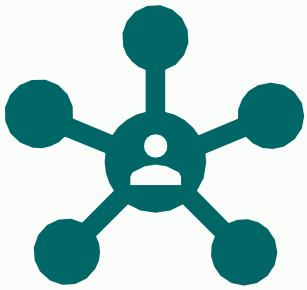
97%

Discussion with families/others regarding the possibility the patient may die, or a reason why not recorded

47%

Discussion with families/others regarding nutrition options, or a reason why not recorded

Workforce 7.4



99%

Hospitals have access to a specialist palliative care team

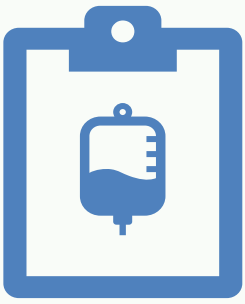
Individual plan of care 7.2

71%

Case notes recorded an individualised plan of care

80%

Families/carers felt hospital was the right place for the patient to die



77%

Case notes recorded patient's hydration status was assessed daily

Needs of families and other 6.0

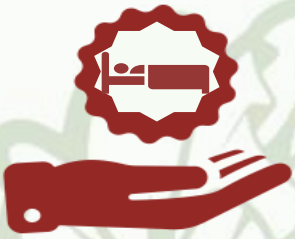
58%

Families/carers were asked about their needs

65%

Families/carers felt they were given enough emotional help and support by staff

Families' and others' experience of care 7.0



80%

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

75%

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

Participation

247
Organisational Level Audit

6,730
Case Note Reviews

1,581
Quality Surveys