### National Audit of Care at the End of Life 2018 – Key findings at a glance

#### Recognising the possibility of imminent death
- **36 hours**
  - Median time between recognition and death
- **89%**
  - Case notes recorded that the patient might die imminently

#### Communication with the dying person
- **68%**
  - Case notes recorded discussions with patients about medication, nutrition and hydration, or a reason why these did not take place
- **67%**
  - Families/carers reported communication was sensitive ‘definitely’, or ‘to some extent’

#### Communication with families and others
- **62%**
  - Case notes recorded that families/carers had the opportunity to discuss the patient’s plan of care
- **84%**
  - Case notes recorded families/carers were notified of the patient’s imminent death

#### Involvement in decision making
- **81%**
  - Families/carers reported that the patient was either involved in decision making as much as they wanted to be or were unable to be involved
- **80%**
  - Case notes recorded discussions by a senior clinician regarding CPR with families/carers

#### Individual plan of care
- **62%**
  - Case notes recorded an individualised plan of care
- **75%**
  - Families/carers felt hospital was the right place for the patient to die

#### Needs of families and other
- **56%**
  - Case notes recorded that the families/carers needs were asked about
- **82%**
  - Families/carers felt supported by the hospital staff after the patient’s death

#### Families’ and others’ experience of care
- **80%**
  - Families/carers felt the quality of care provided to the patient was good, excellent or outstanding
- **76%**
  - Families/carers felt the quality of care provided to themselves was good, excellent or outstanding

#### Governance
- **68%**
  - Case notes recorded discussions with patients about medication, nutrition and hydration, or a reason why these did not take place
- **67%**
  - Families/carers reported communication was sensitive ‘definitely’, or ‘to some extent’

#### Workforce
- **97%**
  - Hospitals have access to a specialist palliative care service
- **94%**
  - Organisations have an identified member of the board with responsibility for end of life care

#### Organisational audits
- **302**
  - Organisational audits
- **11,034**
  - Case Note Reviews
- **790**
  - Quality Surveys

#### Case Note Reviews
- **80%**
  - Families/carers felt the quality of care provided to the patient was good, excellent or outstanding
- **76%**
  - Families/carers felt the quality of care provided to themselves was good, excellent or outstanding

#### Quality Surveys
- **92%**
  - Organisations have specific care arrangements to enable rapid discharge home to die
- **80%**
  - Families/carers felt supported by the hospital staff after the patient’s death