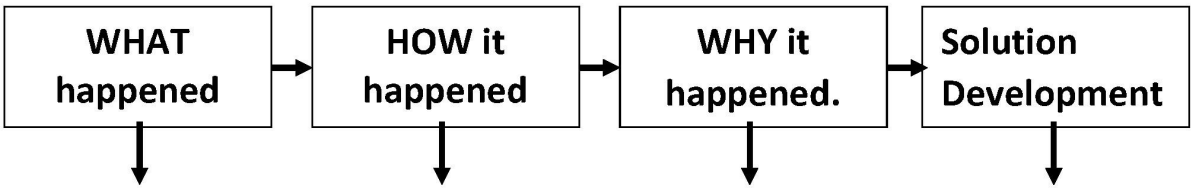
Themed reviews may identify fallibilities of the components of a safety system. For example, it may be that across all the reference cases a risk assessment was completed but the preventative measures were not actioned. Outputs of themed reviews can highlight these problems and identify safety recommendations. Themed reviews may provoke more questions than answers, and therefore may be best placed to link into a quality improvement project for ongoing monitoring and PDSA-style improvement cycles. A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and therefore doing a themed review should **always** result in some improvement efforts after this diagnosis.

The template follows the 4 crucial stages of an investigation to enable key issues to be identified:



- **Subject**

Following extensive consideration, the Mortality Review Working Group (MRWG) agreed to review cases relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) due to the number of concerns reported. The cases were chosen specifically because they were a concern. When identifying a topic for a thematic review it must be specific. In the cases where they had already been investigated these fed into the review others had to be investigated from scratch.

- **Method**

Organisations were required to review 4 cases from Jan 2022 to Jan 2023. This number of cases was decided from a pragmatic viewpoint, which was to balance the value of information which it would be possible to gain from a small number against the excessively heavy workload of clinical staff.

Key Issue	Improvement initiatives	By
Compliance 1 Key issue is to increase. understanding and knowledge of the DNA/CPR Framework	Good practice initiatives to increase understanding and awareness should include: ❖ Grand Rounds ❖ Mortality Review Websites ❖ Personal Development Plans ❖ Formal support networks ❖ Internal training programmes ❖ Individual reflection when a DNACPR is dealt with incorrectly, to enable improvement and learning of individual performance.	Organisations
	Ensure that there is a rolling programme of audits for DNACPR and Advance & Future Care Planning practice, (minimum every 2 years) usually led by local resuscitation officers, and that challenges and action plans are then presented to local HB/Trust Quality & Safety Boards (or equivalent clinical governance organisational oversight structure), and also staff involved, in order to swiftly address findings.	Organisations
	Ensure DNACPR policy's Natural Accepted and Anticipated Death (NAAD framework) apply jointly.	Organisations
	Explore option of mortality review process being included on ESR training.	Organisations
	Promote and continually disseminate existing ESR resource 'National DNACPR Policy for Wales. (See learning resources below) Best practice approaches and examples to be promoted and made known. Disseminate TalkCPR. Wales resources including treatment ladder approach.	DNACPR National Lead/Advance & Future Care Planning (AFCP) Strategy Group
	Develop an All-Wales competency framework regarding completion of DNACPR discussions and forms, that helps clarify how HCPs such as nurses and allied healthcare professionals can complete section 5.	DNACPR National Lead/Advance & Future Care Planning (AFCP) Strategy Group

Key Issue	Improvement initiatives	By
Improved record-keeping practices. Completion of DNACPR Form e.g. to always sign in section 6.	Improve communication on how senior responsible clinician signature should be added, which is clearly stated in national DNACPR policy.	Organisations
	Audit processes to identify quality of patient records regarding DNACPR, including section 6 of form.	
	Findings of audits to be presented to Quality and Safety Board of Health Boards	
There is uncertainty as to who can sign the form as a "Senior Clinician" (Section 6)	Improved understanding and knowledge of Framework: Dissemination of the DNACPR policy update version 4 (from 2020) which clarified who can sign section 5 and section 6 (see www.wales.nhs.uk/DNACPR). Some organisations appear to still have older versions of policy on their intranet. Encourage they all link to the NHS Executive Site that has the latest version www.wales.nhs.uk/dnacpr or https://executive.nhs.wales/networks/programmes/national-palliative-and-end-of-life-care-programme/resources-for-health-care-professionals/dnacpr/	Organisations
DNACPR form not completed correctly and/or handwriting illegible.	Address lack of understanding of the requirements and/or the implications of not complying with the All-Wales DNACPR Framework, in line with actions in POINT 1.	Organisations

Key Issue	Improvement initiatives	By
Discussion and decision not documented on the DNACPR form, documented in case notes instead. In this instance CPR was inappropriately commenced due to lack of knowledge about the DNACPR form.	Feedback to individuals in regard to record keeping issues included in appraisals and PDR, when form is incorrect/incomplete/illegible, as this is a serious communication issue and should be reviewed as such, including at clinicians' annual performance appraisal and development reviews (PADR)	Organisations
	An All-Wales competency framework regarding completion of DNACPR discussions and forms, that helps clarify which HCPs can complete section 5 and 6.	DNACPR National Lead/Advance & Future Care Planning (AFCP) Strategy Group
	Need for electronic All Wales DNACPR and AFCP electronic patient recording repository which does not rely on paper forms with variable handwriting but can be typed in print format.	NHS Wales Executive, Health Informatics Wales, WG & DNACPR National Lead/Advance & Future Care Planning (AFCP) Strategy Group

Key Issue	Improvement initiatives	By
clarification regarding reversing/cancelling a DNACPR decision. Uncertainly around the arrangements for reversal/cancelling of decisions should be addressed.	Clarify process and ensure it is widely communicated. See Actions in Point 1. There is a clear process for cancelling and reversing DNACPR decisions (section 7.3 of version 4.3 of DNACPR policy), which has been available since 2015. This is for paper formats.	Organisation
The time allocated to undertaking difficult discussions relating to DNACPR are often insufficient. Discussions are emotive and very sensitive but are often conducted in Clinical/ bedside, busy, noisy environments due to clinical pressures, that are not conducive to private discussions with patients and relatives.	Apply annual PADR process to identify individual's requirements and needs to support them with the challenging conversations, including exploring options to reduce impact of noisy environment where possible, finding quiet room space to talk to relatives. Escalate resource requirements to support DNACPR/end of life care via IMTP, business cases. It is noted that best timing for such discussions can be very challenging to judge and such conversations need to be offered sensitively in line with the national DNACPR Framework.	Organizations
Patients and relatives/next of kin report that they have not had DNACPR discussions, or cannot recall them with clinical staff, even though clinicians might record that these discussions have indeed taken place. This is of concern for relatives/next of kin where the patient has a capacity issue.	Staff to ensure that they accurately record discussions and agree with patients/relatives. Support a national electronic DNACPR repository, where a fully filled-in DNACPR is mandated (and cannot be saved if all sections are not complete). This could include a section that states *"I confirm that I have discussed this in full with both patient and significant other(s), and have given them the All Wales DNACPR information leaflet and form"* The above statement would need to be agreed, so that form can be saved to the record.	Organizations AFCP Strategy Group, Health Informatics Wales, and organizations