BC Centre for Palliative Care

Consensus-informed Recommendations for A Standardized Form/Format for Levels of Intervention/Code Status in British Columbia: The **FLICS** Project

White Paper

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Introduction

British Columbia (BC) has been a leader in Canada, and in the world, in the area of Advance Care Planning for several decades, championing patient centred and goal-oriented care. Although only a small part of the Advance Care Planning process, Medical Orders for Scope of Treatment (MOST) forms (or equivalent), in either paper or electronic format, have played a vital role in communicating health care decisions across multiple settings of care. However, lack of consistency across Health Authorities in terms of terminology and wording in these forms was increasingly responsible for patient safety issues and medical errors, making it a priority to standardise this important communication tool across BC.

In early 2021 the BC Centre for Palliative Care (BCCPC), in response to requests from various stakeholders, began to explore interest in a consensus-informed standardized Form/Format to communicate Levels of Intervention & Code Status (the FLICS project). In addition to convening a Project Team and an Advisory Committee, the FLICS project included a literature review, Key Informant interviews, and a Delphi process to elicit input from Nurse Practitioners (NPs), physicians and other key stakeholders. The goal was to collate input and identify recommendations for a Standardized Form/Format for Levels of Intervention/Code Status across Health Authorities in BC.

The Advisory Committee for this project was composed of Health Authority (HA) representatives and key stakeholders. In 3 meetings (June 2021 & 2022 and September 2022) it identified widespread support for a consistent format for standardized Form/Format for Levels of Intervention/Code Status for adults in British Columbia. This included consensus regarding the content of the 6 key options and the designations to be used in both paper and electronic formats.

This paper describes the process and the final consensus-informed recommendations for implementation of a standardized Form/Format for Levels of Intervention/Code Status in BC. These recommendations will hopefully inform regional health authority leadership and policy makers in BC in their efforts to ensure that conversations and health care decisions regarding scope of treatment and code status are communicated in a standardized way across different settings of care throughout the province. While the FLICS team acknowledges the importance of a standardized form for pediatric patients, the scope of the FLICS project did not include pediatrics.

Methodology

The FLICS project had several research-based components that informed the recommendations for a standardized form/format for Levels of Intervention/Code Status:

Literature search

We performed a literature review utilizing PubMed using key words such as “Medical Orders for Scope of Treatment”, MOLST form, POLST, “Do Not Resuscitate + document” for studies published in English between 2010 and 2021. We also screened the references lists of relevant articles from the initial search for further publications.

Findings in the literature suggest medical order forms are a useful tool for ensuring that the treatment preferences of patients are honoured. There is strong support for the standardization of forms, as this is perceived to ensure consistency, facilitate the sharing of information, and increase the portability and efficacy of forms. These forms are preferred by healthcare providers. Literature supports the inclusion of relevant topics such as CPR (Cardiopulmonary resuscitation), intubation, non-invasive mechanical ventilation, etc. on a medical order form, with the form preferably being saved and accessible electronically. The terminology “Allow natural death” instead of DNR (Do Not Resuscitate) was also supported. Suggested aspects to avoid included incompatible order combinations, incomplete forms, conflation of DNR and DNI (Do Not Intubate) into DNR/DNI, and provision of an option for partial code order.

Key Informant Interviews

In spring 2021, we conducted ten key informant interviews with stakeholders representing each Health Authority, Providence Healthcare, and stakeholders from the Provincial Health Services Authority (PHSA) and Canuck Place Children’s Hospice who were exploring creation of a form specific to their setting and the pediatric population. As well we talked to two researchers who had done a study looking at MOST form utilization issues in Interior Health and Vancouver Coastal Health.

These interviews identified broad support for standardization of the Form/Format for Levels of Intervention/Code Status form but revealed concerns from the Health Authorities about minimizing suggested changes to existing forms and suggested broad timelines which would integrate proposed changes into initiatives already underway to transition forms to an electronic format. They stressed the need to allow for a process of change with possible support for change management.

We also heard examples of medical errors that had resulted from confusion over current terminology and lack of clarity about the combination of numbers and letters used to indicate level of intervention (e.g., M1, C1 and Option 1) as physicians often worked across several Health Authorities. A recent change initiative involving PHSA, Providence and Vancouver Coastal Health Authority towards simple and transparent numbering for each level of intervention was seen as a positive move towards standardization.

Advisory Committee Established

An Advisory Committee was convened, composed of Health Authority representatives, patient partners and key stakeholders. An initial meeting, which discussed the Literature search and Key Informant interview findings, confirmed support for a consistent format for standardized Form/Format for Levels of Intervention/Code Status, and the proposed Delphi Survey Process to reach consensus.

The Delphi Process

We utilised a Delphi survey process to elicit critical input from Health Authority leadership in Advance Care Planning / Medical Orders for Scope of Treatment, front line clinicians (Doctors of BC) and Nurse Practitioners (through Nurse Practitioners of BC), and the Advisory Committee, including patient and community partners. The study was approved by the UBC Research Ethics Board.

In 2 stages, we established consensus, determined within the Delphi to be >70% agreement, around:

- the need/wish to establish consistency in documentation of levels of intervention across BC,
- components to include in the format, and
- 6 levels of care to be included as options, one being full code/Attempt CPR.

All key stakeholders were represented in the two Delphi rounds, with 61 respondents in Round 1 and 63 in Round 2. It was felt that COVID greatly impacted the number of responses.

Discussion & Reflection Process

After the Delphi was complete, we held 2 further meetings of the Advisory Committee to consider and deliberate regarding next steps and final recommendations, considering both implementation issues and practical concerns resulting from the proposed changes. Clarification was provided on several issues:

- There were no proposed changes to the 6 existing categories – the 6 options remained virtually the same across most Health Authorities. Changes proposed focus on consistent naming and wording of each level of intervention.
- Leadership around implementation would be at the Health Authority level. The BCCPC's role was a convening and coordinating one to work towards and hopefully achieve consensus including input from front-line clinicians using the forms every day.

This final stage was a respectful and inclusive process, which deeply considered the implications of the proposed changes and timelines for change given that this was not a funded or mandated change initiative. Throughout the process, those who had already moved forward with change encouraged their peers. The goal of improved patient centred care remained the priority throughout. Consensus was reached at the final meeting in September 2022 regarding the following recommendations.

Recommendations

1) **All Health Authorities move to consistent naming, wording, and ranking of 6 Levels of Intervention/ Code Status in the MOST or equivalent form. Suggested wording is:**

   – **R: Attempt CPR.** Maximum therapeutic effort including intubation. Referral to Critical Care if indicated.
   – **M1: No CPR. Supportive care, symptom management and comfort measures only.** Allow natural death. Transfer to higher level of care only if patient's comfort needs cannot be met in current location.
   – **M2: No CPR. No Intubation. No referral to Critical Care.** Therapeutic measures and medications within the current location of care. Transfer to higher level of care only if patient's comfort needs cannot be met in current location.
   – **M3: No CPR. No Intubation. No referral to Critical Care.** Maximum therapeutic effort including admission to acute care hospital for medical/surgical treatment as indicated. *Transfer to different care setting if patient's medical or comfort needs cannot be met in current location*.
   – **M4: No CPR. No Intubation. Referral to Critical Care *if indicated*.** Maximum therapeutic effort.
   – **M5: No CPR. Intubation and referral to Critical Care *if indicated***. Maximum therapeutic effort.

2) **All Health Authorities include a space for additional comments or instruction regarding advance refusal of emergency treatment choices.** The following wording is recommended "In discussion with Patient/Resident/SDM, the following interventions would not be accepted in the case of an acute medical event (e.g. Blood transfusion)."

3) **Documentation regarding the conversation and who was present also be standardized.**

4) **Health Authorities will determine by individual internal policy:**

- Where resuscitation status during surgery or other procedures is documented
- The process and formats for patient education
- The population for which a MOST or equivalent form should be completed (e.g. all patients admitted to acute care as in VCH or only patients at risk). This was highly endorsed by Delphi respondents but as there are huge policy and practice implications it is not included as a recommendation to be included within a standardized form although it is included as an option.
- Validity of a patient's MOST (or equivalent) order from other Health Authorities (with patient transfers)

5) **Health Authorities will seek** approvals for these changes within their own structures and create a plan for implementation of the recommendations over the next 1–2 years for both electronic and paper formats. An Advisory Committee meeting could be planned within 3-6 months to address any issues arising from implementation as required.

6) **It is recommended that decision makers for advance Care Planning policy within Health Authorities coordinate their efforts** to integrate and improve uptake and efficacy of the recommended standardized form/format as one component of improving patient safety and goal-concordant care.

Flics Project Recommendations for a Standardized Most Form/Format

*This section to be included at discretion of Health Authority, dependent on MOST policy and patient population requiring MOST completion

CPR is medically appropriate and likely to be of benefit for the patient/resident in the event of a medical crisis. I have not discussed this with the patient or their substitute decision maker.

☐ *Attempt CPR (Please sign and date form below)*

MOST Order completed after discussion with:

1. ☐ Patient/resident who is currently capable to make their own medical decisions
2. ☐ Patient/resident who is **NOT** currently capable to make their own medical decisions

Role of person(s) consulted (choose one)

☐ Committee of Person
☐ Representative (Section 9)
☐ Representative (Section 7)
☐ Public Guardian & Trustee as TDSM
☐ None (incapable patient and no substitute decision maker available)
☐ Temporary Substitute Decision Maker (TSDM)

Person consulted (if not patient): ________________________________ Contact #: ________________________

Others:____ Date: _____________________________

Supporting documentation reviewed:

☐ Previous MOST
☐ Provincial No CPR
☐ ACP record
☐ Representation Agreement: ☐ Section 9 ☐ Section 7
☐ Advance Directive
☐ Other: ____

MOST Order / Designation:

☐ **R: Attempt CPR.** Maximum therapeutic effort including intubation. Referral to Critical Care if indicated.

☐ **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR**: No chest compressions or other direct means of restarting the heart) **this line to be included at discretion of the Health Authority, as it is not a specific level or designation, rather a separator to lead to the M1-M5 designations and may not exist in electronic records.

☐ **M1: No CPR. Supportive care, symptom management and comfort measures only.** Allow natural death. Transfer to higher level of care only if patient's comfort needs cannot be met in current location.

☐ **M2: No CPR. No Intubation. No referral to Critical Care.** Therapeutic measures and medications within the current location of care. Transfer to higher level of care only if patient's comfort needs cannot be met in current location.

☐ **M3: No CPR. No Intubation. No referral to Critical Care.** Maximum therapeutic effort, excluding critical care interventions. Transfer to higher level of care if patient's medical or comfort needs cannot be met in current location.

☐ **M4: No CPR. No Intubation. Referral to Critical Care *if indicated.*** Maximum therapeutic effort.

☐ **M5: No CPR. Intubation and referral to Critical Care *if indicated*.** Maximum therapeutic effort.

In discussion with Patient/Resident/SDM, the following interventions would not be accepted in the case of an acute medical event: (e.g. Blood transfusion)

MD/NP Name: MD/NP Signature:

Date: MSP #:

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of innovation and best practices
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