

Organisation: \_\_\_\_\_

# Summary: Residential care

## Palliative care case conference

Full name of client: \_\_\_\_\_

DOB (dd/mm/yy): \_\_\_\_\_

Purpose of case conference: \_\_\_\_\_  
\_\_\_\_\_

### Resident consent/substitute decision-maker (SDM) consent

My care provider has explained the purpose of a case conference and I give permission for my care provider to prepare a case conference. I give permission to the providers listed below to participate in the case conference and discuss my/my family member's medical history, diagnosis, and current needs.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dial-in telephone number: \_\_\_\_\_

Code: \_\_\_\_\_

Resident in attendance? Yes    No    If no, give reason: \_\_\_\_\_

Family members		
Name	Relationship	Attending in person (P) or teleconference (T)
		P    T
		P    T
		P    T
		P    T
		P    T
Health and care professionals		
Name	Discipline/position	Attending in person (P) or teleconference (T)
		P    T
		P    T
		P    T
		P    T
		P    T

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Start time: \_\_\_\_\_

Need (as appropriate): \_\_\_\_\_

Key Issues	Description
<p><b>Advance care plan</b></p> <p>Does this need to be reviewed? Does the person understand their diagnosis/prognosis?</p>	
<p><b>Symptoms</b></p> <p>For example: fatigue, anorexia, pain, nausea, dyspnoea, dysphagia</p>	
<p><b>Social/psychological needs</b></p> <p>For example: isolation, anxiety, depression What supports are being provided? What supports are needed?</p>	
<p><b>Assessments/investigations</b></p> <p>Can the client manage ADL's (Activities of Daily Living)? Do they need additional support?</p>	
<p><b>Carer/family issues or needs</b></p>	
<p><b>Other</b></p> <p>For example: general issues, housing issues, financial issues</p>	

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### Agreed action plan

Goal	Actions	Key person(s) responsible	Description

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Time completed:

General practitioner: \_\_\_\_\_

Tick appropriate box

Original placed in the resident's clinical notes

Copy provided to all participants

Copy sent to GP

Resident's care plan and assessment reviewed and updated

Palliative care case conference facilitator

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_