# Summary: Residential care

## Palliative care case conference

**Organisation:**

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

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Agreed action plan

| Goal | Actions | Key person(s) responsible | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

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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):** _____