SPA-LTC
Strengthening a Palliative Approach in Long-Term Care

PALLIATIVE CARE CONFERENCE SUMMARY

Name of Resident: _____ Date of Birth: _____/____/____
(DD/MM/YYYY)

Purpose of Palliative Plan of Care Conference:

Participants:

Resident in attendance? ☐ YES ☐ No

Note: If resident is mentally capable for own health care decisions, resident must be present for palliative care conference to take place. Others attending are only included if resident gives permission.

Resident's future or acting SDM in attendance? ☐ YES ☐ No

Note: If resident is not mentally capable for own health care decisions, resident's SDM must be present for palliative care conference to take place. If the resident is mentally incapable for health decision-making, then the highest ranking SDM, according to the HCCA (see Tool on Capacity & Consent, Ontario only) will make decisions for the resident.

Health Care Providers & Family Members
(Family Members (may attend ONLY If capable resident/incapable resident's SDM agrees)

Name	Discipline/Position/Relationship

Key issues Discussed & Wishes or Goals Shared
Symptoms
Social/psychological /spiritual needs
Assessments/investigations
Other (eg., funeral home selection)

Care Planning and Treatment Plan

Treatments Consented to	Actions	Key Person(s) responsible	Review date

Time Conference Commenced: _____ Time Completed: _____

Physician's Name: _____

Check the appropriate box:

- ☐ Original placed in the resident's clinical notes
- ☐ Copy sent to Physician
- ☐ Copy Offered to participating allied health professionals
- ☐ Copy offered to the resident/SDM
- ☐ Resident's care plan and assessments reviewed and updated

Facilitator's Name:_____

Position: _____Signature: _____ Date: ___ /___ /_____/
(DD/MM/YYYY)