

| Items For Discussion | Objectives | Action Items (If Identified) |
|--|---|---|
| 1. Welcome and Introductions | Set the tone for the meeting and plan for attendees that will be leaving before the end. Resident/family highlights most important issue(s) they would like to address during the meeting. | |
| 2. Interdisciplinary Care Overview Quality of Life Discussion | Understand how the resident is doing from a holistic perspective, including challenges and risks. Discuss changes observed since admission, last care conference. Discuss 3 most important issues impacting quality of life. | |
| Goals Of Care And Future Health Preferences Discussion | | |
| 3. Medical Overview | Understand illness/frailty and decline. Discuss most likely future trajectory/prognosis. | <i>[Information from these sections to be recorded in the Goals of Care/Future Health Preferences assessment in PCC]</i> |
| 4. Resident Values, Beliefs | Understand the resident's story, and what is most important to the resident and family. | |
| 5. Goals of Care/Future Health and Personal Care Preferences | Discuss goals of care in light of current condition, beliefs, and values. Discuss impact of treatment/care decisions on goals. | |
| 6. Review of Emergency Contacts | Update PCC profile with any changes in emergency contacts. Refer to RCL for changes in contact type or ordering of contacts. | |
| 7. Follow-Up, Most Responsible Person(s) and Timelines | Summarize actions arising from the care conference and identify timelines for follow-up. | |

¹Plan of care: All resident information provided by the interdisciplinary team in both paper and electronic format formulates the plan of care.

²Care plan: A document outlining the plan of care – to be followed by the interprofessional team. Provides direction for the individualized care of the resident. Provides a road map to guide all who are involved with the resident's care. Flows from the resident's unique attributes. Organized by the resident's specific needs.