SeeMe®
Understanding frailty together.

Care Conference Agenda

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.	*[Information from these sections to be recorded in the **Goals of Care/Future Health Preferences** assessment in PCC]*
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.

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