**P.I.E.C.E.S.™**

**P.I.E.C.E.S. - A practical, effective approach to change and continuous improvement.**

P.I.E.C.E.S. is a best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behaviour changes. P.I.E.C.E.S. enables a comprehensive, inter-disciplinary approach and promotes continuous improved shared care practices through human resource development and changes in practice. The Person and Family are the centre-point of the TEAM.

### Physical

**Delirium! Think 4 M's**
1. Medicine: prescription, OCD, substance misuse
2. Microbiotics
3. Metabolic
4. Myocardial/Respiratory and other Medical disorders

**Causes of Delirium: I Watch Death**

- Infections
- Withdrawal
- Acute Metabolic
- Toxins, drugs
- CNS Pathology
- Hypoxia
- Deficiencies
- Endocrine
- Acute Vascular
- Trauma
- Heavy Metals


**Psychosis, Depression**

**Psychoses/Behavioural challenges**
1. Dangerous - dangerousness/how threatening
2. Distressing - how distressing to self
3. Disturbing - disturbing quality/disturbing to others
4. Direct Action - whether the resident is acting on them
5. Jeopardizing Independence or social interactions
6. Distant vs Present - occurring in the past or present
7. Definite (fixed) - full or partial insight; are they fixed vs. insight

**The Do's & Don'ts for Psychosis/Behaviour:**
- Do ensure the persons and your safety
- Do understand this is a response to a "real" perception of the individual
- Do focus on the effects on the person not the content (i.e. validate)
- Do distract
- Don’t confront the false beliefs

Remember the delusions may not emerge until a period of time has elapsed – it may take time to "organize" the delusion

**Signs of Depression. SIG: E CAPS**
- Sleep disturbed
- Interest decreased
- Guilt feelings
- Energy lower
- Concentration poor
- Appetite disturbed
- Psychomotor retardation or agitation
- Suicidal ideation


**DOS – Dementia Observation System**

1. Helps determine the % of time over 24-hr cycle that the person displayed a behaviour(s) of concern; helps team determine if behaviour(s) have responded to interventions and/or side effects to medications
2. Replaces opinion with measurable data by establishing the:
   - occurrence of specific behaviours of interest
   - frequency with which target behaviours occur
   - duration the target behaviours are displayed
   - frequency with which the target behaviours of greatest risk are displayed, in comparison with those behaviours that should be accommodated

**Guidelines for Selection and Monitoring the Use, Risk, and Benefits of Psychotropics**

- Why is the psychotropic being used or considered?
- How do I select the right medication?
- How do I monitor the response and side effects?

**High Risk Elderly Where Competency May Be an Issue**

6 Key Areas for Assessment:
1. Clinical
2. Capacity
3. Values & Preferences of Individual
4. Legal & least restrictive legal option, alternatives
5. Influences on our decision-making
6. Plan and reassessment; with specific indicators/triggers when to review

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The P.I.E.C.E.S. 3-QuestionTemplate

“A proven strategy for the Person and Family’s Team in collaboration and shared solution-finding”

The P.I.E.C.E.S. holistic approach to understanding the meaning behind a person’s behaviour comes from considering the person’s; Physical, Emotional, and Intellectual health, supportive strategies to maximize Capabilities, the individual’s social and physical Environment, and his/her Social self (cultural, spiritual, Life Story). P.I.E.C.E.S. provides a shared understanding of the often multiple causes and associated risks so that care planning recognizes areas of need & builds on the person’s remaining strengths. The person and family are the centre-point of every TEAM.

The 3-question template:
- Guides the systematic, comprehensive TEAM approach that helps make the best use of everyone’s energy and resources.
- Easily integrates into day-to-day individual and TEAM assessment process.
- Shapes TEAM conversation, both in-the-moment and more formal dialogue; asking questions prevents jumping to solutions too quickly.
- Produces the TEAM’s shared understanding of, and contribution to the care plan.
- Encourages individual and TEAM reflective thinking.

TEAM collaboration and shared solution-finding requires:
- Committing to the P.I.E.C.E.S. approach that places the person and family at the centre of every TEAM.
- Being present in conversations, validating all observations and concerns, and acknowledging unique contributions of TEAM members.
- Understanding the factors that support better performance (e.g. information, resources, incentives, knowledge and skills.
- Focusing efforts on the gap between current & better practices; seeks solutions that build staff capacity rather than laying blame.

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<tr>
<th>Question</th>
<th>TEAM Assessment Framework, Guidelines, and Tools</th>
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| Q. 1: What has changed? | Avoid assumptions! Always ask, what has changed?  
- Determine if the problem/behaviour represents a change.  
- Is the problem/behaviour new? If so, in what way and when did the change emerge?  
- Did the problem/behaviour already exist? If so, is it worse or different, and when did the change emerge?  
- Is the problem/behaviour long-standing and unchanged? If so, what else could have changed, for example, caregiver stress? |
| Q. 2: What are the RISKS and possible causes? | 1. Identify the RISKS and avoid assumptions!  
- Is there a risk? And if so for whom? Person, other individuals, staff, family, visitors  
- What is the risk? Remember the types of risks by using the acronym RISKs:  
  - Roaming (wandering)  
  - Imminent physical; risk of harm - frailty (e.g. delirium), falls, fire, firearms  
  - Suicide Ideation  
  - Kinship Relationships (risk of harm by the older person or to the older person by others that includes avoidance of the person)  
  - Self-neglect, safe driving, and substance abuse  
- What is the degree of risk? How imminent is the risk? Is the risk increasing?  
- Remember! For any intervention, consider both the potential risks and potential benefits. Be vigilant and carefully observe and assess the individual’s capacity to understand. |
| | 2. Remember, consider atypical presentation! Use P.I.E.C.E.S. to identify possible causes:  
  - Physical: 5 D’s: Delirium, Disease, Drugs, Discomfort, Disability  
  - Emotional: 4 D’s: Disorder Adjustment, Disorders of Mood, Delusional, Disorders of Personality  
  - Capabilities: ADL’s, IADL’s  
  - Environment: Consider: over/under stimulation, relocation, change in routine, noise, lighting, colours  
  - Social: Consider: social network, life story, cultural heritage  
- Intervention: What therapeutic approach, both nonpharmacological and pharmacological, may best address the person’s needs? What other investigations need to be undertaken? Use P.I.E.C.E.S.!  
- Interaction: Using what has changed and understanding of causes for interaction at bedside.  
- Information: Think P.I.E.C.E.S.! What information should be shared with other team members, family, if the person is moved or requires transfer? How is the information shared? What are RISKS Factors?  
2. Promote dialogue and shared TEAM solution-finding. |