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, interdisciplinary 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 — *Often Urgent*

Delirium! Think 4 M's

1. **M**edicine: prescription, OCD, substance misuse
2. **M**icrobials
3. **M**etabolic
4. **M**yocardial/Respiratory and other Medical disorders

Causes of Delirium: I Watch Death

I Infections
W Withdrawal
A Acute Metabolic
T Toxins, drugs
C CNS Pathology
H Hypoxia
D Deficiencies
E Endocrine
A Acute Vascular
T Trauma
H Heavy Metals

Risk Factors for Delirium
1. Cognitive Impairment
2. Sleep Deprivation
3. Immobility
4. Visual Impairment
5. Hearing Impairment
6. Dehydration

Wise MG, Hilty DM, Cerda GM, Trzepacz PT. (2002) Delirium (confusional states). In: Wise MG, Rundell JR, editors. Textbook of consultation-liaison psychiatry: psychiatry in the medically ill. 2nd ed. Washington: American Psychiatric Publishing; 2002. pp. 257-272.

Confusion Assessment Method (CAM) – to help detect possible delirium

1. **Acute onset**
2. **Inattention**
3. **Disorganized Thinking**
4. **Altered Level of Consciousness**
5. Disorientation
6. Memory Impairment
7. Perceptual Disturbances
8. Psychomotor Agitation and Retardation
9. Sleep/Wake Cycle Disturbance

Key to Diagnosis
☐ Change (short time)
☐ Communication
☐ Capabilities

Consider delirium if 1 & 2 and either 3 or 4 are present
Inouye, S.K., van Dyck, C.H., Alessi, C. A., et al. (1990). Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine, 113: 941-948.

Identify & Assess Discomfort or Pain

Flags:

- **Emotional/behaviour changes**: increased intensity of dementia, depression or delirium
- **Physical changes**: gait, posture, appetite, and sleep patterns, elevated BP, increased respirations, diaphoresis, pupil changes

Assessment:

- 0-10 Rating. Faces Pain Rating Scale.

Intellectual

Detecting Cognitive Impairment (Mini Cog)

Flags: near misses, excuses, and confabulation

- Repeat 3 words and remember them House Tree Car
- Name as many four legged animals in one minute (average 15)
- Recall the three words
- DRAW A CLOCK Hand on for 10 after 11

Adapted from S.Borson http://www.cmecorner.com/macmcm/AAGP/aagp2003_07.htm

Also consider the MoCA© a cognitive screening test designed to assist Health Professionals for detection of mild cognitive impairment.
http://www.mocatest.org/

Emotional — *Psychosis, Depression*

Psychoses/Behavioural challenges monitor, observe, record **7 Ds**.

1. **D**angerous - dangerousness/how threatening
2. **D**istressing - how distressing to self
3. **D**isturbing - disturbing quality/disturbing to others
4. **D**irect Action - whether the resident is acting on them
5. Jeopar**d**izing Independence or social interactions
6. **D**istant vs Present - occurring in the past or present
7. **D**efinite (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

- **S**leep disturbed
- **I**nterest decreased
- **G**uilt feelings
- **E**nergy lower
- **C**oncentration poor
- **A**ppetite disturbed
- **P**sychomotor retardation or agitation
- **S**uicidal ideation

Dr. Carey Cross and reported in Jenike, M. (1989). Geriatric Psychiatry and Psychopharmacology: A clinical approach.p.36.Chicago:Yearbook Medical Publishers Inc

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

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; **P**hysical, **E**motional, and **I**ntellectual health, supportive strategies to maximize **C**apabilities, the individual's social and physical **E**nvironment, and his/her **S**ocial 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.

▶ **Q. 1 What has changed?**

▶ **Q. 2 What are the RISKS and possible causes?**

▶ **Q. 3 What is the action ?**

Question	TEAM Assessment Framework, Guidelines, and Tools
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? **Remember to think atypical!** Atypical presentations are very common in older persons.
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: **R** Roaming (wandering) **I** Imminent physical; risk of harm - frailty (e.g. delirium), falls, fire, firearms **S** Suicide Ideation **K** Kinship Relationships (risk of harm by the older person or to the older person by others that includes avoidance of the person) **S** 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 **Intellectual** 7 A's: Amnesia, Aphasia, Apathy, Agnosia, Apraxia, Anosognosia, Altered Perception **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 **3. Remember, all behaviour has meaning!** Use "P.I.E.C.E.S." to help you remember!
Q. 3: What is the Action?	**1. Use the 3 "I"s – Interventions, Interactions, and Information** to guide action. **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.