Chapter 1

A Model for Collaborative Care and Changing Practice

Introduction

The P.I.E.C.E.S. learning and development strategy complements and provides a framework to integrate other educational programs and relevant bodies of knowledge. The framework enables a comprehensive, interdisciplinary approach that builds on knowledge and skills from a variety of sources and programs.

Over time the P.I.E.C.E.S. framework, tools, and learning strategies have changed in response to the evolving needs of those we serve; it continues to evolve in response to new knowledge, new experiences, and partnerships with other initiatives. Shifts are also occurring based on development in the field that enables ongoing improvements within teams, organizations, and across the system.

Background

The Ontario Government envisioned a comprehensive, system-wide approach to education on the core competencies and best practices for dementia and mental health care. Through the development of a common vision, a common language, and common approach to the care of older people in the long-term care sector, the Ontario Government provided a strong foundation for P.I.E.C.E.S. which is now used in many sectors (LTC community, acute care, emergency departments, and family physicians) and also inter-provincially. These collaborative relationships, along with evaluations and experiences and further research, have enriched the P.I.E.C.E.S. design and development and contributed significantly its evolution.

P.I.E.C.E.S. Definition

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. allows continuous improved shared care practices through human resource development and changes in practice.

P.I.E.C.E.S. provides a systematic approach to the common issues, diagnosis, and challenges of the older person at risk including those with aggressive behaviour.

P.I.E.C.E.S. offers a practical framework for assessment and supportive care strategies using a comprehensive interdisciplinary person-centred approach. Also included in the approach is a practical tool that promotes team dialogue and shared solution-finding.

P.I.E.C.E.S. conveys the individuality and importance of the various factors in the well-being, self-determination, and quality of life of the older person and his or her family.

P.I.E.C.E.S. provides a framework for understanding the often multiple causes as to why a person behaves the way he or she does and what resources are available to build on.

- The first three letters **P-I-E,** represent an individual's **P**hysical, **I**ntellectual, and **E**motional health.
- The **C** is the centre-piece or focus in care, i.e., maximizing **C**apabilities which promotes the achievement of the highest quality of life as possible for an individual.
- The **E-S** represent the environment that an individual interacts with (physical as well as the emotional environment) and the person's **S**ocial self (cultural, spiritual, "life story").

"Putting the P.I.E.C.E.S. Together" represents **P**hysical, **I**ntellectual, **E**motional, **C**apabilities, **E**nvironment, **S**ocial, and are the cornerstones of the philosophy and care of the P.I.E.C.E.S. approach

The P.I.E.C.E.S. approach provides:

- A common set of values.
- A common language for communicating across the system.
- A common yet comprehensive approach for thinking through problems to enhance the capacity of those providing care, services, and support to older adults with complex physical and cognitive/mental needs and associated behaviours.
- Tools and methods to support a collaborative care approach.

Cornerstones of the P.I.E.C.E.S. Approach

1. Person/relationship-centered approach
   - The person and/or family are meaningfully involved with the health care team and are active participants in the care process.
   - The lived experience of the person and/or family are valued and supported.
   - Expanding consumer knowledge is respected and contributes to the evolution of practices.

2. Leadership vision and action
   - Organizational leadership to continually improve performance using a wide-range of training and non-training interventions and change management strategies.
   - Leadership ensures linkages with individuals and families and collaborating with communities

3. Change informed by knowledge and experience (Rycroft-Malone et al., 2002)
   - From traditional research.
   - From field knowledge.
   - From the lived experience of the individual and family.

4. P.I.E.C.E.S. Learners
    - All members of the health care team learn and develop by respecting each others involvement, experience, and contribution to care planning and solution-finding.
    - Each learner has a role as leader in interdisciplinary care.
    - Each learner understands and respects consumer need for information, involvement, and to be informed.

P.I.E.C.E.S. Goals

1. A Comprehensive and Best Practices Approach to Assessment and Care Planning
    - The P.I.E.C.E.S. approach promotes the understanding of the older person with complex physical, cognitive/mental health needs and associated behavioural changes through a common vision, common language, and common approach.
2. Risk Management
    - The P.I.E.C.E.S. approach provides an effective means for detecting and preventing risk and for the identification of strategies to address risk management issues.
3. Implementation of Current and Emerging Best Practices
    - The P.I.E.C.E.S. approach provides strategies that enable the person, family, caregivers, family physician, teams, organizations, and systems to share best practices and knowledge from various fields of study now and in the future. This continuous improvement approach includes health promotion and disability prevention.
4. Interdisciplinary Care
    - The P.I.E.C.E.S. approach provides a practical way to promote and implement interdisciplinary care and shared solution-finding through its framework, complementary and supportive assessment tools and education. P.I.E.C.E.S. helps the team maximize health promotion and minimize unnecessary disability.
5. Integration and Collaborative Care (Shared Care)
    - The P.I.E.C.E.S. approach provides strategies and tools to enhance communication, collaboration, and sharing of information and data at multiple levels. The approach will move us towards a collaborative shared care process pivotal to interdisciplinary shared care which is the foundation for Primary Care Reform and Chronic Disease Management.

See Diagram 1 next page.

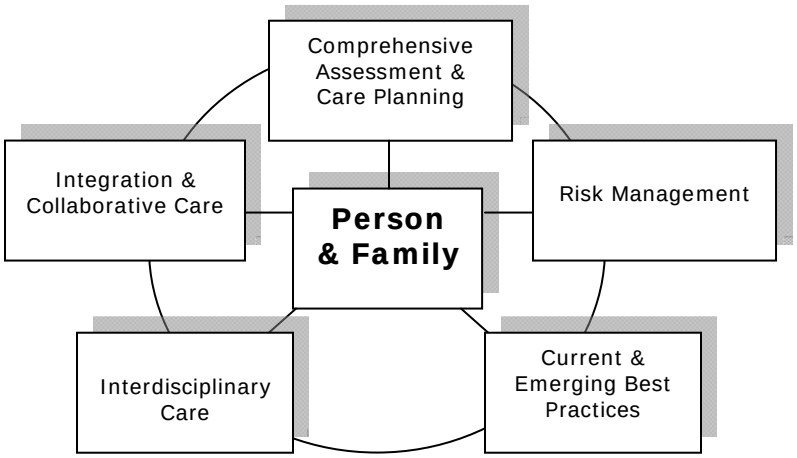


Diagram 1

The five P.I.E.C.E.S. goals support the fundamental core values of the person and family at the centre and a team approach to assessment and care planning.

Evaluation

The P.I.E.C.E.S. evaluation includes:

- The implementation of P.I.E.C.E.S. learning program and its impacts on participants, the person with complex physical and cognitive/mental health needs and associated behavioural changes and the family.
- Support for reflective practice and sustained quality improvement in participating organizations.
- Factors that help and hinder implementation and sustained impact of such initiatives.
- The benefit of the P.I.E.C.E.S. approach to enhancing collaboration, co-ordination across sectors, and in developing health care networks.

The P.I.E.C.E.S. Approach to Learning & Development

The P.I.E.C.E.S. learning and development approach has four elements:

1. Systems support and development
2. Organization support and development
3. Service provider learning and development
4. Evaluation and continuous performance improvement

- P.I.E.C.E.S. is based on current knowledge of adult learning concepts and performance improvement, ongoing evaluations, and ongoing experiences with the program.

- P.I.E.C.E.S. promotes a learning-through-dialogue approach and minimizes lecture time; it encourages small group work and information exchanges.

- P.I.E.C.E.S. includes case-based learning and depends upon the active participation and sharing of experiences by all learners.

- Participants learn how to systematically think through complex situations and have plenty of opportunity to test out their new skills during class and through workplace assignments.

This resource guide avoids duplication of the excellent resources already available. Additional resources are posted on the P.I.E.C.E.S. website www.piecescanada.com . This guide strives to be concise and practical and is by no means an all-inclusive reference for all of an individual's complex physical and cognitive/mental health needs and associated behaviour changes.

Target Audience

The P.I.E.C.E.S. learning programs are specifically designed for Health Professionals collaborating within interdisciplinary teams. The program is offered to staff who have responsibility for providing care to persons with complex cognitive/mental health needs and associated behavioural changes. P.I.E.C.E.S. is designed for those with an active role in the day-to-day assessment, planning, and delivery of direct care.

A complementary P.I.E.C.E.S. Leadership and Performance Improvement Program has been created for those in positions to supervise or support staff but are not involved in the day-to-day assessment, planning, and delivery of direct care. The program provides a practical approach for senior leaders (e.g. Administrators, Directors of Nursing/Care and Education Specialists) to move from education to effective change (skill and knowledge to practice).

P.I.E.C.E.S. is not a train-the-trainer program; it is a comprehensive learning strategy to develop the role of an in-house P.I.E.C.E.S. Resource Person (PRP). Each PRP who makes a commitment to P.I.E.C.E.S. is open and willing to learn in new ways and to study and practice new assessment and intervention skills. The PRP shares with others the knowledge and skills obtained through participation in P.I.E.C.E.S. In addition to senior management support, the in-house PRP receives support and encouragement from others including the in-house training department, clinical nurse specialist, and/or external resources such as preceptors, the P.I.E.C.E.S Clinical Resource Consultants, the Alzheimer Society and their Public Education Coordinators, and Specialized Outreach teams, among others, when they return to work to:

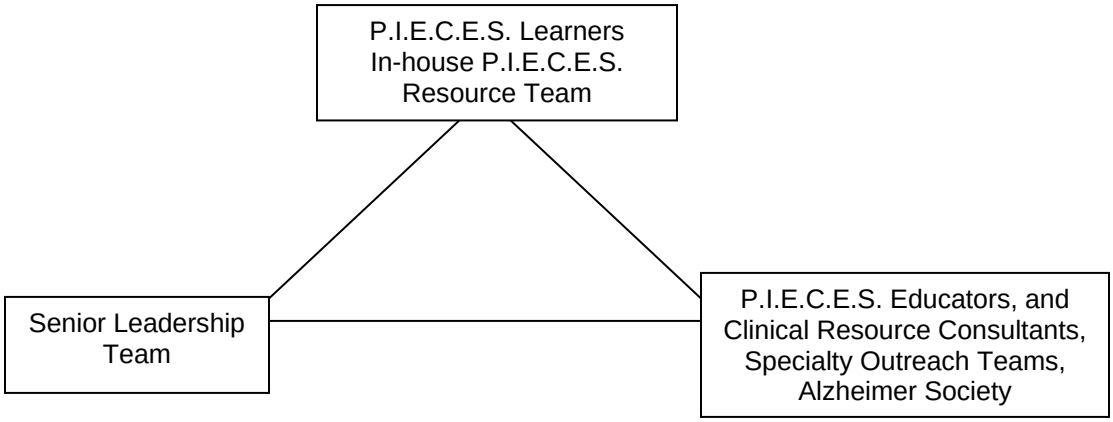
- Assess how team members are currently managing the cognitive/mental health needs and associated behavioural issues of persons

- Determine how those practices compare to what was learned through participation in the P.I.E.C.E.S. learning program

- Set realistic goals for improving day-to-day practices

- Develop practical strategies for imparting new knowledge and skills learned through participation in the P.I.E.C.E.S. learning program
- Develop strategies to encourage integration of new practices on a day-to-day basis
- Evaluate improvements over time

The strength and success of P.I.E.C.E.S., (i.e. practice changes) has proven to be through the development of P.I.E.C.E.S. in-house 'resource teams' (more than one PRP) who are supported by their senior leadership team and work collaboratively with external resources.



P.I.E.C.E.S Clinical Resource Consultants

The P.I.E.C.E.S Clinical Resource Consultants (PCRCs) are in place to support the in-house P.I.E.C.E.S. Resource Person(s) in terms of ongoing learning strategies. PCRCs have three roles serving as educators, consultants, and program developers.

Outreach and Specialty Services are also available to coach the in-house PRP with complex clinical situations.

Other supports in the system include, among others, the Alzheimer Society chapters and the P.I.E.C.E.S. Consult Group (www.piecescanada.com)

P.I.E.C.E.S Canada Website

The impact of advancing technologies has been positive allowing all the various partners to connect, share, and learn together very quickly!

The website for the P.I.E.C.E.S. initiative is www.piecescanada.com.

P.I.E.C.E.S.: Summary Chapter One

A Model for Collaborative Care and Changing Practice

2 complementary programs:

P.I.E.C.E.S. Senior Leadership and Performance Improvement Program

+

P.I.E.C.E.S. Learning Programs for Professional Staff

=

Foundation for Changing Practice

Senior Leadership and Performance Improvement Program	P.I.E.C.E.S. Learning & Development programs
This program is designed specifically for Senior Leaders who 'clear the path for the transfer of learning' into day-to-day practices. Program includes strategies to : • Understand P.I.E.C.E.S. framework and tools • Flag gaps between current performance and best practices within the organization • Interact with staff to select most appropriate P.I.E.C.E.S. candidates and develop implementation plan • Reflect on past experiences with training programs and explore the latest approaches to learning & development and performance improvement • Support change efforts in short and longer term • Engage team in collaborative performance improvement strategies and methods	Each program is designed specifically to develop the in-house P.I.E.C.E.S. Resource Person and interdisciplinary teams. Through cased-based learning, practical application, and networking, the program provides in-depth learning that includes: • Understanding and application of the P.I.E.C.E.S. framework and assessment tools • Range of strategies for interacting with the person and family • Exploring the need for reflective practice • Reporting strategies to enhance team communication • Supportive care strategies for the person and family • Shared team solution-finding method and tool for dialogue

Together these programs provide the foundation for a common vision, common language, and common approach.

Meaningful change to continually improve care and services for the person and family requires dialogue, partnerships, and best practices.

In-house P.I.E.C.E.S. Resource Person

Core Competencies and Performance Objectives

The P.I.E.C.E.S. program focuses on the development of six competencies to influence collaborative care and changes in team and individual practices and their associated organizations:

1. Detect or flag cognitive/mental health needs and associated behavioural issues.
2. Use the P.I.E.C.E.S. templates to guide a systematic, comprehensive, and team approach to complex issues.
3. Use the recommended tools to collect data.
4. Plan care with others (internal and external to the organization).
5. Evaluate based on the goals developed through care planning.
6. Coach other staff to develop the above five competencies in others.

P.I.E.C.E.S. Performance Objectives

Performance Objective #1:

As a member of the organization's P.I.E.C.E.S. Resource Team, the learner will demonstrate sensitivity and respect for the individuality of the person, family, and partners in care* to the extent she or he:

a) Recognizes the impact of attitudes, behaviours, life experiences, values, thoughts, and feelings on well-being and quality of life, from the perspective of:

- Self
- The person (resident/client)
- Partners in care which includes the family and the learner's colleagues

b) Serves as a role model and teacher, demonstrating practices consistent with (a) and:

- Respect the individual as he or she attempts to deal with responses to challenges caused by the impairment/illness.
- Recognize and support a person's worth, individuality, strengths, and abilities.
- Promote the active participation of the person in all aspects of the decision-making process recognizing the right of the person to take risks, refuse options, and make his/her own decisions according to mental capability and to the extent that this does not infringe upon the rights of another individual.
- Observe and describe the goals and evolving needs of the person and his/her family.
- Plan and implement strategies with the interdisciplinary team to meet the goals of the person and his/her family.

c) Evaluates performance and learning, with respect to impact of attitudes, behaviours, life experiences, values, thoughts, and feelings on well-being and quality of life, from the perspective of:

- Self
- The person (resident/client)
- Partners in care

* For the purpose of this Guide, *partners in care* is *an inclusive term* meaning care team members *including* the person, the family, the physician(s), the in-house P.I.E.C.E.S. Resource Person(s), clergy, dietary, activation, volunteers, and so forth and also including support from external partners such as a P.I.E.C.E.S Clinical Resource Consultant, the Alzheimer Society, and/or members of a Specialty Geriatric Outreach Team(s).

Performance Objective #2:

As a member of the organization's P.I.E.C.E.S. Resource Team, the learner will complete an assessment to flag complex cognitive/mental health needs and associated behavioural changes to the extent she or he:

a) Identifies the behaviour which could include:

- Agitation and restlessness
- Anxiety
- Apathy/failure to participate; withdrawn/crying
- Defensive behaviour
- Hearing and seeing things that do not exist
- Hoarding and/or rummaging
- Impulsivity
- Inappropriate sexual behaviour
- Intrusiveness
- Resistance to care
- Suspicious/accusing others
- Vocally disruptive behaviour
- Wandering

b) Identifies risk and the degree of risk

c) Assesses and monitors behaviour using:

A: antecedents (triggering factors)
B: behaviour (severity, frequency, timing, and duration)
C: consequences (responses to behaviour)

d) Identifies and documents possible causes of behaviour related to **(P) physical** causes:

- Queries delirium.
- Assesses functional problems including vision, hearing, bladder, and bowel.
- Assesses for pain and discomfort
- Obtains information from person's chart regarding medical history and status*
- Notes signs and symptoms consistent with substance abuse
- Is aware of the resource tools
- Lists all medications and monitors for effect on behaviour

e) Identifies and documents possible causes of behaviour related to **(I) intellectual/cognitive** changes:

- Uses cognitive assessment screening tools as appropriate.
- Records and documents criteria consistent with dementia.
- Notes symptoms of brain injury and other brain disorders.
- Obtains information regarding cognitive history and status.*

f) Identifies and documents possible causes of behaviour related to **(E**) **emotional/ psychiatric** health:

- Obtains information regarding emotional history and status.*
- Use of appropriate assessment and screening tools to note signs and symptoms consistent with:
  - mood disorders
  - psychotic disorders (schizophrenia, paranoia, etc.)
  - various types of anxiety disorders (post traumatic stress disorder, etc.)

g) Identifies and documents possible causes of behaviour related to changes in **(C) capabilities** related to aging or illness:

- Obtains information relating to history and status of person's capabilities.*
- Is familiar with appropriate functional assessment tools.

h) Identifies and documents possible causes of behaviour related to the **(E) environment:**

- Obtains information relating to history and status of person's environment.*

i) Identifies and documents possible causes of behaviour related to **(S) social and cultural factors**:

- Obtains information relating to history, life story, and status of social factors.*
- Obtains information about and gains appreciation of family needs and challenges; applies the P.I.E.C.E.S. framework to family (**P**hysical health, **I**ntellectual health including understanding of illness, **E**motional health, **C**apabilities, **E**nvironment and **S**ocial factor).

j) Recognizes and documents signs and symptoms of complex syndromes (i.e. the co-existence of two or more conditions).

k) Recognizes the need for further clinical and education expertise to ensure a comprehensive and holistic assessment (e.g. access P.I.E.C.E.S. Clinical Resource Consultants and geriatric outreach teams.).

l) Prepares and shares assessment findings with partners in care.

(* Information may be obtained from the chart and team including family)

Performance Objective #3:

As a member of the organization's P.I.E.C.E.S. Resource Team, the learner will use assessment data related to complex physical and cognitive/mental health needs and the associated behavioural changes to develop, implement, and evaluate an interdisciplinary action plan to the extent she or he :

a) Identifies risk and takes appropriate action in high risk situations.

b) Collaborates with the person and team, including the family/caregiver, to develop a shared understanding of the person's attempts to deal with challenges caused by the impairment/illness.

c) Identifies the communication patterns, values, cultural beliefs, coping styles, and learning aspirations/needs and modifies approach appropriately.

d) Networks with appropriate community resources to further the assessment and care planning (includes linking with P.I.E.C.E.S Clinical Resource Consultant, Specialty Teams, Alzheimer Society).

e) Establishes a system, with management and team, for observing and monitoring behaviour over time to evaluate the effects of non-drug and drug interventions, environmental changes, and care strategies.

f) Promotes information sharing and an exploration of interventions and interaction strategies with the resident and family/caregiver and care team.

g) Works with the care team to maximize health promotion and minimize unnecessary disability.

h) Makes improvements/adjustments to care strategies in collaboration with the resident, family/caregiver and care team, based on evaluation.

i) Reflects on learning and shares experiences with others to enhance individual, team, and organizational knowledge about providing care to elders with cognitive/mental health needs and associated behavioural issues.

Performance Objective #4:

As a member of the organization's P.I.E.C.E.S. Resource Team, the learner will serve as a resource to others in planning care for the person with complex physical and cognitive/mental health needs and associated behavioural changes to the extent he or she:

a) Works with management, the care team (including the person and family), and community resources to recognize and clarify common myths of aging and societal values with respect to aging and mental illness.

b) Identifies the strengths, contributions, and expectations of the person and family in the care of the person.

c) Documents symptoms and signs of stress in the team, including the person and family, related to providing care to the person with cognitive/mental health needs and the associated behavioural issues.

d) Identifies areas in which the team, including the person and family, require support or could provide support to others.

e) Collaborates with management and appropriate internal and external resource teams to develop strategies and implementation plans to:

- Decrease challenging behaviours and enhance well-being and the quality of life of the person
- Identify and maximize the use of available resources
- Develop confidence in care planning and care giving
- Assist team members in identifying their own needs for safety and continuous learning
- Define and facilitate resolution of critical incidents, thereby reducing subsequent stress
- Defuse and review stressful incidents

f) Works with management and appropriate internal and external resource teams to:

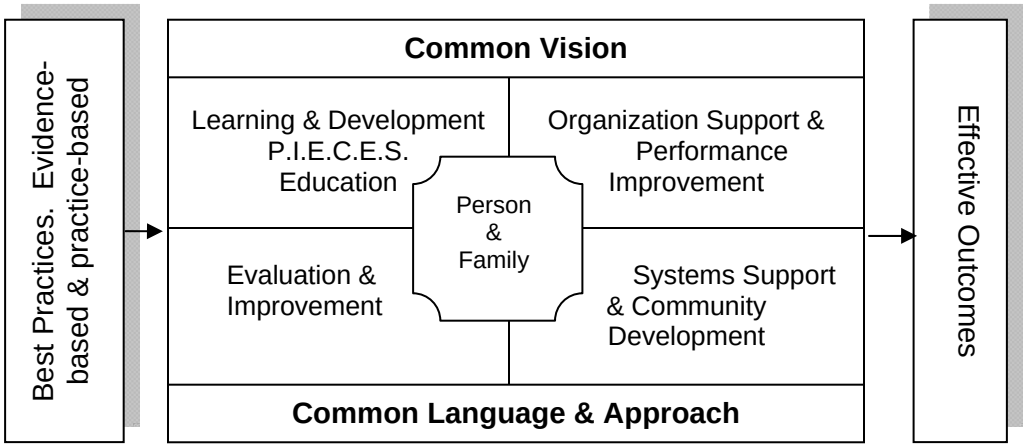
- Identify areas requiring improvement in performance.
- Develop strategies to improve performance which could include formal and/or informal learning programs or packages.
- Develop strategies to integrate changes into day-to-day practice including strategies to coach the transfer of new skills and knowledge.
- Develop ways to evaluate strategies related to improved performances, transfer of learning, and change in practice.

g) Takes a collaborative team solution-finding approach to accomplish a – f.

A Model for Collaborative Care and Changing Practice; Summary of Key Elements

Education in and of itself is not the answer to moving evidence to practice. Research and field experience from many bodies of study have identified critical elements that need to occur so that positive change and best practices can be realized. Activities that enable positive change in day-to-day practices include:

1. The development of practical and proven learning strategies and tools
   - P.I.E.C.E.S. provides a variety of learning options and practice opportunities; it takes advantage of advancing technologies to support learners. Formal processes for coaching learners are another important element of the P.I.E.C.E.S. education.
2. Organizational support by senior leadership
   - The P.I.E.C.E.S. approach includes providing senior leaders with education, practical strategies, and tools to help clear the path for the transfer of new skills and knowledge into day-to-day practices and to provide ongoing support to P.I.E.C.E.S. trained staff.
3. Systems support and community sustainability which include new ways in which communities deliver health care
   - The P.I.E.C.E.S. approach promotes working in partnership with community and system leaders to shape supportive policy and service options and working with individuals whose major focus includes supporting the P.I.E.C.E.S. goals and improving collaboration with specialty resources.
4. Methods to evaluate and promote ongoing improvements
   - P.I.E.C.E.S. evaluation is integral to each of its goals and each of the above elements; information and data comes from hands-on experience in the field and new and emerging evidence. Particular attention is paid to process evaluation given the goals of the programs.



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