1-206 P.I.E.C.E.S. on admission

TIPS Question:

As partners in care, what are the advantages to using a P.I.E.C.E.S. framework to assess possible applicants for admission to LTC?

Response:

As carers, one of your primary goals is to help residents adjust to their new living situation when a move into LTC becomes necessary. Inevitably, the transition involves communication between and among many partners in care; whether the person is moving from home into a LTCF, transferring between LTCFs, or being admitted from an acute care setting into LTC. One of your greatest challenges as a PRP will be to explore effective, positive and creative strategies to enhance communication with your partners in care (both internally and externally) to help meet the needs of residents newly admitted to your facility. Admittedly, it can be stressful for the resident, family and staff when this transition does not flow smoothly. However, when this occurs perhaps the most important question we can ask ourselves is, *what are we presently doing, and what more can we do as a care team to enhance communication with our partners in care?* I believe that looking for positive and creative opportunities in our partnerships with others can be very exciting and usually results in an improved quality of care for our residents and their families. I would like to offer a number of suggestions for your consideration and hope you that you find them helpful:

- Perhaps the most logical and manageable starting point is to take a step back and as a care team review the strategies you use to "get to know" the resident and his/her needs at the time of admission; and who are the partners in care who can help? You may not always be able to influence the information 'coming in' to your facility but you can meaningfully and creatively explore the opportunities for using the P.I.EC.E.S. frameworks to help gather as much information about the person as possible once h/she has been admitted.
- Many PRPs have started to develop admission protocols that include, for example, administering an MMSE/Clock following admission. The time frame can vary but often staff report doing the assessment anywhere from 2-6 weeks following admission (to allow a period of adjustment) but in time for the results to be shared with the physician, other members of the care team, and family at the initial care conference. This information can help to enhance understanding of the person's cognitive functioning (a prerequisite for establishing realistic and shared expectations), which may then have implications for how care is administered and the way staff interact with the person. The results also provide a baseline measure to allow meaningful comparisons in the future if changes in the person's condition are observed. Further, they help to 'flag' possible concerns that might require additional specialized assessment early on.
- A DOS can also be extremely valuable when administered soon after admission for a period of 7-14 days. This will help you to answer the question, *what is the rhythm of this person's day?* The results will allow you to objectively identify possible patterns of behaviour that might be concerning, thereby providing you with the information you need to meaningfully develop/adjust the care plan accordingly. This also enhances communication between and among the care team, including the family, in an objective and proactive way.
- Using the P.I.EC.E.S. frameworks will assist you to approach an understanding of the resident's needs when you begin to look at all aspects of the person (P.I.E.C.E.S.) and use a structured problem-solving when concerns emerge.
- All facilities have strategies in place to help them 'get to know' the person and the family but it is always a useful exercise to take a step back to see if the process can be improved. How is the information gathered, from whom, by whom, when, and how is it shared with the other members of the care team? The Alzheimer Society has a wonderful tool called the Personal Care Book that can be completed by the family (with support from the staff) and that provides treasured information about the person's family, previous accomplishments, likes/dislikes, usual routines, favourite memories, tips for communication, etc. You might want to connect with your local Alz. Society and request a copy to have a look at. Some facilities look for opportunities to share this tool with families prior to admission.
- In terms of your other external partners in care, you may want to connect with some of the PRPs in your area to share strategies and brainstorm together. In some areas they have developed P.I.E.C.E.S. Support Networks that meet on a regular or semi-regular basis to allow PRPs to share knowledge, skills and experience, and grow together. These networks often include other

partners as well, e.g. SWOGAN, Specialty Outreach Teams members, CCAC, Compliance Advisors, etc. While there is some work involved in bringing people together the benefits are tremendous when the focus is positive and future-oriented. If one does not exist in your area you and your partners may want to explore this possibility; remembering that you can start small and grow. If one does exist you might want to connect with the members.

- Looking for opportunities, in general, to meet with external partners in care to explore issues of shared concern can be very helpful. It is important to hear one another's perspective and problem-solve together. Often, if you can find one meaningful 'start point' where you can identify possible strategies together, and where you are likely to have success, more success will follow.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*