**3-187 Assessment Process – Team Model**

**TIPS Question:**

My problem has been trying to work within a “team model” in our approach to a balanced, resident-focused plan of care. How can I implement a more “formal” assessment process in such an “informal” approach to management care?

**What are the significant factors you have learned as a result of working through the six-question template?**

- Proper progression of process in identifying problems & risks associated with behaviour

**Response:**

My reaction as I read through your question was that a P.I.E.C.E.S. assessment can be considered a more formal approach to planning care. However, in order for your assessment to be valid and as useful as possible, it must reflect the input of all of the Partners In Care involved with this person.

For instance, the first question of the 6-question template asking us to define the behaviour may seem simple but, if it only reflects **your** understanding of a behaviour then you may work your way through to strategies without addressing the behaviour that other team members are concerned about. Perhaps the behaviour is a concern for only one or two staff. In that case, does the balance of staff accept a behaviour as normal when interventions may improve the resident's quality of life? Alternately, are the staff with concerns new to this resident and therefore have a different level of understanding about the person?

If we jump ahead to question 5 and look at possible causes, the assessments that are suggested are certainly more formal. The advantage, of course, is that objective information is preferable to subjective impressions only. However, assessing for delirium would be next to impossible unless you had the input and understanding of the hands-on caregivers. Those who interact with residents during care can complete your picture of the resident and therefore confirm your findings.

Similarly, if we look at possible causes of behavioural change related to social history, different caregivers often hold different 'tid-bits' of information about a resident. They may interact with the family more often, see the resident at their best time of day or have the opportunity to witness a resident's reaction during a social event. In each case, their observations and collective wisdom add to your understanding of a resident's social history. Without this input, your picture of the person is limited. With it, you have the best chance of identifying possible clues in their social history related to the behaviour at hand.

I hope that you can see the link between the formal assessment and the informal network that enhances that assessment. The ability to more fully understand the resident through dialogue is the primary purpose of the U-first wheel. Consider how you can use this tool to engage in dialogue with the PSW's, other unregulated care providers and family. Draw in other resources to assist in this such as other P.I.E.C.E.S.-trained people in your facility, your Psychogeriatric Resource Consultant or the local P.I.E.C.E.S. network.

***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.*