Evaluation of the Community "Putting the P.I.E.C.E.S. Together" Learning Initiative Report #1

Initiative #1: Staff Education and Training
Ontario's Strategy for Alzheimer Disease and Related Dementias

Fall 2005

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EXECUTIVE SUMMARY

- Twenty-five 2-day sessions were conducted across the province between October 2003 and November 2004. The time interval between the two sessions typically ranged from 1 to 3 weeks (one session was conducted across two consecutive days). More sessions were conducted in the Central South and Southwest regions of the province than other regions.

- Response rates on the pre-questionnaire and the Day 2 feedback questionnaire were 100% and 99%, respectively.

- The majority of respondents (83%) had a nursing background. Most respondents were employed in either a Community Care Access Centre (CCAC; 53%) or a CCAC contracted service agency (37%) and most respondents were case managers (51%) or nurses (31%).

- On the pre-questionnaire, most respondents (67%) indicated that their assessment of older individuals did not include a psychogeriatric assessment. The majority (90%) of those respondents that did include a psychogeriatric assessment in their assessment conducted these assessments in person within clients' homes.

- Most respondents reported that they were "quite confident" or "very confident" in their ability to assess physical health, intellectual capacity, emotional and spiritual health, functional capabilities, environmental factors, and social and cultural factors. Average (mean) ratings reflect that they were "quite confident" in their assessment abilities.

- Respondents reported that physical, cognitive, emotional, social/cultural assessment and assessment of service needs (community resources, placement assessment) were most often included in assessment of older individuals.

- Less than 34% of the respondents reported that they use the Folstein Mini-Mental or the Clock Test in their assessments. Less than 8% reported using the Confusion Assessment Method. Mean ratings of respondents' confidence in their ability to use the Folstein Mini Mental and Clock Test indicated that they were "fairly" confident in their ability to use these tools. In contrast, the mean rating for confidence in using the Confusion Assessment Method indicated that respondents were "slightly" confident in their ability to use this test; 18% of respondents were not at all confident in their ability to use the Confusion Assessment Method.

- Overall, a low percentage of respondents (less than 24%) were familiar with the Cornell Scale for Depression, and the Abilities Assessment. Very few respondents (less than 7%) were familiar with the Cohen-Mansfield Agitation Inventory and the Dementia Observational System.

- When asked to identify the assessment tools that they use as part of their psychogeriatric assessment, very few respondents (16) reported that they were not conducting assessments or that they did not use tools as part of their assessment (41). The Mini-Mental State Examination (MMSE) was the most frequently identified assessment tool.

- Respondents had been exposed to P.I.E.C.E.S. through in-services, workshops, overview sessions, meetings focusing on the P.I.E.C.E.S. material, through discussions in their workplace or other health care settings, participation in P.I.E.C.E.S. training, and discussions in academic courses or with other health care providers.

- Respondents identified a variety of things that needed to be in place to help them apply what they would learn in this initiative. Ongoing education and training, time to conduct assessments, access to assessment tools, and supportive materials (guidelines, case studies, references) were identified most often. Follow-up sessions and follow-up support were also identified as strategies to facilitate transfer of learning.

- The delivery of the Day 2 sessions was rated highly. Between 54% and 81% of respondents rated the pace of activity, volume and complexity of material, and opportunities to participate as "about right". Most respondents rated the P.I.E.C.E.S. educator team, interaction with other health professionals and the session, overall, as "very good" or "excellent". Similarly, most respondents rated the 16-hour program in terms of meeting the goals of the P.I.E.C.E.S. learning initiative as "very good" or "excellent". Average ratings reflect they thought these aspects of the program were "very good".

- At the end of the Day 2, most respondents reported that they were "quite confident" or "very confident" in their ability to assess physical health, intellectual capacity, emotional and spiritual health, functional capabilities, environmental factors, and social and cultural factors. Average ratings reflected that they were "quite" confident in their assessment abilities. Although, the mean ratings did not vary significantly from prior to the program to after Day 2, fewer respondents provided "slightly" and "fairly" confident ratings after Day 2 than prior to the session, more respondents provided "quite" confident ratings, and no respondents provided "not at all confident" ratings after Day 2 .

- After Day 2 most respondents reported that they were more confident (ratings of 4 and 5 on the 5 point rating scale: 1 = less confident, 3 = about the same, 5 = more confident) in their ability to assess various aspects of their clients' health and well-being. Fewer than 5% of respondents reported that they were less confident about their assessment skills after Day 2. Averages ratings reflect that they were more confident in their assessment abilities.

- Most respondents rated the wheel as "very good" or "excellent" in terms of its ability to develop a common baseline of knowledge, common language, approach to care, and method of education, and as means to guide dialogue with partners in care. Average ratings reflect that they thought these aspects of the wheel were "very good".

- Most respondents were able to provide examples of P.I.E.C.E.S. program learning that they applied following the first session. Twelve respondents indicated that they had not yet been able to apply any new learning to their clinical practice (several indicated that they had not yet had the time to do so). The use of the P.I.E.C.E.S. template (6 questions), the *U-First* wheel, the RISK assessment, and various other assessment tools were identified most frequently by respondents as the program learning that they had applied following the session.

- Supportive resources such as the *U-First* wheel, the P.I.E.C.E.S. manual, various laminates, handouts, quick references, the homework assignment, and the P.I.E.C.E.S. template were identified most often as things that facilitated application of learning following the first session.

1.0 OVERVIEW OF THE "PUTTING THE P.I.E.C.E.S. TOGETHER" COMMUNITY CLINICAL RESOURCE TEAM DEVELOPMENT PROGRAM

The "Putting the P.I.E.C.E.S. Together" Community Clinical Resource Team Development Program is a 16-hour (2 days and practical application) education program designed to develop psychogeriatric knowledge and skills and to enhance the clinical practice of Regulated Health Professionals (e.g., Registered Nurses, Occupational Therapists, and Social Workers) working in the community. It is targeted to health professionals who have responsibility for psychogeriatric assessments or case management of persons with Alzheimer Disease and related dementias. These professionals provide input into the care plan but do not necessarily directly supervise unregulated workers.

The goal of this education program is to promote a vision, common set of values, a common language for communicating across the system, and 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. The emphasis of this program is the enhancement of six core competencies to:

- detect or flag cognitive/mental health needs and associated behavioural issues;
- use the P.I.E.C.E.S. template to guide a systematic and comprehensive approach to these complex issues;
- use the recommended tools as appropriate to collect data;
- plan care with others;
- evaluate based on the goals developed through care planning; and,
- serve as a resource to others.

The P.I.E.C.E.S. learning initiative promotes the development of In-house Resource Teams to share the P.I.E.C.E.S. frameworks with the care team using informal learning strategies and to integrate this framework into daily practice, to provide support to staff, and to work with other partners in care (e.g., external specialty services).

This learning initiative was developed as part of the Ontario government's comprehensive, five-year provincial Strategy for Alzheimer Disease and Related Dementias. First implemented in 1998, P.I.E.C.E.S. training has been provided to long-term care home staff, Community Care Access Centre (CCAC) staff, and unregulated health care providers and their supervisors through the *U-First!* Learning Initiative.

Twenty -five Community P.I.E.C.E.S. sessions were conducted across the province between October 2003 and November 2004. The time interval between the two sessions typically ranged from 1 to 3 weeks (one session was conducted on two consecutive days).

Table 1 shows the distribution of sessions across the province. More sessions were conducted in the Central South and Southwest regions of the province than other regions.

Table 1: Distribution of Sessions across the Province (N = 25)

Region	Percent (Number)
Central South	24.0% (6)
Central West	8.0% (2)
Central East	4.0% (1)
Southwest	24.0% (6)
East	16.0% (4)
North	8.0% (2)
Toronto	12.0% (3)

*Percentages may not sum to 100% because of missing values.

2.0 EVALUATION OF THE "PUTTING THE P.I.E.C.E.S. TOGETHER" COMMUNITY CLINICAL RESOURCE TEAM DEVELOPMENT PROGRAM

As part of the evaluation of the "Putting the P.I.E.C.E.S. Together" Community Clinical Resource Team Development Program, respondents were asked to complete two questionnaires: one prior to the learning initiative and one at the end of Day 2. This report provides a summary of the information gathered from these questionnaires.

2.1 Response Rates

Table 2 provides a summary of the response rates for each of the evaluation questionnaires. Response rates on the pre-questionnaire was 100% and on the Day 2 feedback questionnaires 99%.

Table 2: Response Rates for Evaluation Questionnaires

Questionnaire	Percentage (Number) who Completed the Questionnaire (N=554)
Pre-training questionnaire	100% (554)
Day 2 feedback questionnaire	98.9% (548)

2.2 Results from the Pre-Training Questionnaire

Characteristics of Respondents

Information was gathered on the current role of the respondents. Table 3 provides a summary of their professional designations. The majority of respondents (83%) had a nursing background.

Table 3: Professional Designation of Respondents

Professional Designation	Percent (Number) of Responses
RN / RPN	82.7% (458)
Social Worker	8.5% (47)
Occupational Therapist	5.4% (30)
Physiotherapist	1.1% (6)
Other *	2.3% (13)

* "Other" includes: Case Manager, Nurse Practitioner, Crisis Worker, Manager and Education Consultant.

Most respondents were employed in either a Community Care Access Centre (CCAC) or a CCAC contracted service agency. Table 4 presents the types of agencies in which the respondents were employed.

Table 4: Types of Agencies in which Respondents were Employed

Type of Agency	Percent (Number) of Responses
Community Care Access Centre (CCAC)	52.5% (291)
CCAC Contracted Agency	37.0% (205)
Other*	8.3% (46)

Note: Percentages do not sum to 100% because of missing values.
* "Other" includes: Adult Day Program, College Instructor, Acute Care, Victoria Order of Nurses, Community Services, Elder Care programs.

Table 5 summarizes the roles of respondents within their organizations. Most respondents were case managers or nurses.

Table 5: Current Roles of Respondents

Role	Percent (Number) of Responses
Case Manager	51.1% (283)
Nurse	30.7% (170)
Social Worker	4.9% (27)
Occupational Therapist	4.5% (25)
Physiotherapist	0.5% (3)
Other*	7.9% (44)

Note: Percentages do not sum to 100% because of missing values.
* "Other" includes: Supervisors (Field Services, Client Services, Nursing), Managers (Nurse, Client Services, Community Services, Program), Coordinators (Care, Nursing, Client Services, Facilities, Placement), Education Supervisors and Coordinators, Nurse Practitioner, Psychogeriatric Resource Consultant.

Psychogeriatric Assessments

The majority of respondents (67%) indicated that their assessment of older individuals did not include a psychogeriatric assessment (see Table 6). The majority (90%) of those respondents that did include a psychogeriatric assessment in their assessment conducted these assessments in person within clients' homes (see Table 6).

Table 6: Does your assessment of an older individual include a psychogeriatric assessment and if yes, where is it conducted?

Inclusion of Psychogeriatric Assessment	Percent (Number) of Responses
No	61.9% (343)
Yes	33.9% (188)
If yes, where is it conducted? (N = 176)	
In-person, at home	90.3% (159)
Via telephone	1.1% (2)
Combined: at home and via telephone	4.5% (8)
Other**	4.0% (7)

* Percentages do not sum to 100% because of missing values.
** "Other" includes: in hospital (N = 5) and in office (N=2).

Respondents were asked to estimate the percentage of psychogeriatric assessments that they conduct within clients' homes. Respondents to this question (N = 146) reported that an average of 85% of the psychogeriatric assessments they completed were conducted within clients' homes (see Table 7).

Table 7: Percentage of psychogeriatric assessments conducted at home

	Mean % (SD)	Range
Percentage of psychogeriatric assessments conducted at home	85.3% (30.5)	0 – 100%

Respondents were asked to rate their level of confidence in their ability to assess a client's physical health, intellectual capacity, emotional and spiritual health, functional abilities, environmental factors, and social and cultural factors (see Table 8). Most respondents reported that they were "quite confident" or "very confident" in their ability to assess each of these factors. Average (mean) ratings reflect that they were "quite confident" in their assessment abilities.

Table 8: Confidence Ratings Prior to Workshop

How confident are you in your ability to assess a client's…	Not at All Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
Physical health?	1.1% (6)	3.8% (21)	16.8% (93)	50.7% (281)	26.2% (145)	4.0 (.83)
Intellectual capacity?	0.9% (5)	5.8% (32)	38.3% (212)	44.6% (247)	8.8% (49)	3.6 (.78)

Emotional and spiritual health?	0.4% (2)	6.5% (36)	38.3% (212)	43.3% (240)	10.1% (56)	3.6 (.78)
Functional capabilities?	0.4% (2)	2.7% (15)	18.6% (103)	52.7% (292)	23.8% (132)	4.0 (.76)
Environmental factors?	0.2% (1)	2.0% (11)	18.4% (102)	58.4% (324)	19.4% (108)	4.0 (.69)
Social and cultural factors?	0.2% (1)	5.4% (30)	37.4% (207)	44.2% (245)	11.2% (62)	3.6 (.76)

Note: Percentages do not sum to 100% because of missing values.

Respondents were asked to briefly explain what was included in their assessment of older individuals. The components they identified as part of their assessment are presented in Table 9. Respondents most often identified physical, cognitive, emotional, social/cultural assessment, and assessment of service needs (community resources, placement assessment).

Table 9: Components included in assessments of older individuals

"Physical Assessment"* (226)
- gait (4)
- Range of Motion (5)
- Chest assessment (6)
- Muscle strength and tone (4)
- Neurological assessment (1)

"Intellectual (Cognitive) Assessment"* (144)
- Memory (11)
- Problem solving (3)
- Cognitive status (86)
- Orientation (to time, person, place) (86)

"Functional Assessment"* (69)
- Activities of Daily Living (59)
- Transfers (4)
- Ability to read (15)
- Self-care (hygiene) (10)
- Mobility (32)
- Autonomy (4)

"Environmental Factors"* (89)
- Home Safety (69)
- Accessibility of residence (3)

"Social/Cultural Assessment"* (124)
- Supports (family, friends) (126)
- Leisure activities (social, recreational) (7)
- Family relationships (26)
- Social relationships (social functioning) (27)
- Caregiver assessment (supports, coping, burden) (14)
- Living arrangements (17)

*General reference was made to this type of assessment; specific tools were not reported.

"Emotional status" * (137)*
- Coping skills (26)
- Mood/behaviour (29)
- Psychological symptoms (depression, anxiety) (21)

Miscellaneous
- Medical history/health status (120)
- Financial situation (resources) (24)
- Equipment needs (assistive devices) (11)
- Medications (60)
- Spiritual assessment (26)
- Risk factors (16)
- Goals and expectations (12)
- Pain (15)
- Nutrition (26)
- Service needs (community resources, placement assessment) (122)
- Skin (wounds, integrity) (11)
- Hearing and Vision (6)
- Speech and Language (5)
- Client concerns (5)
- Bowel/Bladder routines (7)
- Sleep routines (1)
- Legal issues (1)
- Abuse (physical, substance) (4)

Methods (Sources of Information)
- Information (interviews) from family, caregivers (25)
- Observation (8)
- Diagnostic testing results (lab work, scans) (4)
- Hospital reports/charts (2)
- Other health care professionals (5)
- Telephone interviews (1)
- Tools/scales (134)
  - Beck Depression Inventory (1)
  - Braden Scale (2)
  - Clock Test (6)
  - Cognistat (2)
  - Cognitive Capacity Test (CCT) (3)
  - Cornell Depression Scale (1)
  - Functional Autonomy Measurement (SMAF) (1)
  - Geriatric Depression Scale (3)
  - Hamilton Depression Scale (1)
  - MDS/RAI (106)
  - Mini Mental State Examination (MMSE) (32)
  - MOS-General Health Survey (1)

*General reference was made to this type of assessment; specific tools were not reported.

Less than 34% of the respondents reported that they use the Folstein Mini-Mental or the Clock Test in their assessments (see Table 10). Less than 8% reported using the Confusion Assessment Method.

Table 10: Use of Assessment Tools

Use of Assessment Tools	Percentage (Number) Who Use the Tool
Folstein Mini- Mental	33.8% (187)
Clock Test	27.8% (154)
Confusion Assessment Method	7.6% (42)

Mean ratings of respondents' confidence in their ability to use the Folstein Mini Mental and Clock Test indicated that they were "fairly" confident in their ability to use these tools (se Table 11). In contrast, the mean rating for confidence in using the Confusion Assessment Method indicated that respondents were "slightly" confident in their ability to use this test; 18% of respondents were "not at all" confident in their ability to use the Confusion Assessment Method.

Table 11: Confidence in Ability to Use Assessment Tools

How confident are you in your ability to use…	Not at All Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
Folstein Mini Mental?	11.2% (62)	7.8% (43)	13.4% (74)	12.5% (69)	7.4% (41)	3.0 (1.35)
Clock Test?	10.6% (59)	8.1% (45)	12.3% (68)	12.1% (67)	4.2% (23)	2.8 (1.28)
Confusion Assessment Method?	17.7% (98)	4.7% (26)	3.1% (17)	12.6% (7)	3.6% (2)	1.6 (.96)

Note: Percentages do not sum to 100% because of missing values

Respondents were given the opportunity to comment on their confidence ratings related to their use of the various assessment tools (as listed in Table 11). Some respondents indicated that they were not using these tools. Others indicated that although they were aware of them, they do not use them; others were not aware of (or familiar with) the tools, or were using other tools (see Table 12).

Table 12: Comments regarding confidence in using the assessment tools

- Not using the tools (24)
- Aware of tools, but not using them (6)
- Not using the tools – not aware or familiar with them (3)
- Using other tools – RAI-HC, DVA Assessment (5)
- Miscellaneous
    "Not on intake. Have used tools in the past."
    "I request CCs to attach to RAI-HC."
    "Used in past Folstein and Clock test; feel confident."

Overall, a low percentage of respondents (less than 24%) were familiar with the Cornell Scale for Depression and the Abilities Assessment (see Table 13). Very few respondents (less than 7%) were familiar with the Cohen-Mansfield Agitation Inventory and the Dementia Observational System.

Table 13: Familiarity with Assessment Tools

Assessment Tool	Percentage (Number) who are familiar with these tools
Cornell Scale for Depression	24.0% (133)
Cohen-Mansfield Agitation Inventory	6.7% (37)
The Abilities Assessment	4.3% (24)
Dementia Observational System	6.1% (34)

Note: Percentages do not add to 100% because of missing values

Respondents were asked to identify the assessment tools that they use as part of their psychogeriatric assessment. Three-hundred and one respondents responded to this question; 16 reported that they were not conducting assessments and 41 reported that they did not use tools as part of their assessment. Respondents identified a variety of different tools that they use as part of their assessment (see Table 14). The Mini-Mental State Examination (MMSE) was the most frequently identified assessment tool. Some respondents commented on the assessment methods that they use (e.g., interviews, observation).

Table 14: Tools Used by Respondents as Part of Their Psychogeriatric Assessment.

Not Applicable (3)
Not conducting assessments (10)
Refer elsewhere for assessment (6)
Do not use assessment tools (41)

*"Comprehensive"** (1)
Minimal Data System (MDS) (14)
RAI – Home Care (RAI-HC) (44)

*"Cognitive Assessment"** (3)
Amsterdam Dementia Screening Test (ADS) (2)
Clock Test (52)
Cognistat (4)
Cognitive Assessment of the Elderly (CASE) (3)
Cognitive Competency Test (CCT) (15)
Cognitive Level Test (Allen) (1)
Competence Assessment Tool (CAT) (1)
Contextual Memory Test (CMT) (1)
Dementia Rating Scale (DRS) (1)
Mini-Mental State Examination (MMSE) (120)
Orientation to person, place, time (4)
Rivermead Behavioral Memory Test (RBMT) (1)
Short Term Memory test (1)
Short-Term Recall (informal) (13)
Total number of respondents reporting use of a specific cognitive assessment tool = 22

*"Physical Assessment"** (7)
Activities-specific Balance Confidence Scale (ABC) (1)
Berg Balance Scale (1)
Braden Scale (3)
MOS – General Health Survey (1)
Risk Assessment Scale (pressure ulcers) (1)

*"Mental Health Assessment"** (3)
Beck Depression Inventory (7)
Brief Psychiatric Rating Scale (BPRS) (1)
Caregiver Burden Scale for Family Caregivers (BSFC) (9)
Cohen-Mansfield Agitation Inventory (CMAI) (6)
Confusion Assessment Method (CAM) (3)
Cornell Depression Scale (6)
COTA Global Geriatric Mental Health Assessment (1)
Delirium Observation Scale (DOS) (2)
Depression Scales (not specified) (14)
Even Briefer Assessment Scale for Depression (EBAS-DEP) (2)
Geriatric Depression Scale (GDS) (11)
Michigan Alcoholism Screening Test – Geriatric Version (1)
Orientation to Life Questionnaire (1)
Short Anxiety Scale (1)
SIGECAPS (1)
Total number of respondents reporting use of a specific mental health assessment tool =66

Miscellaneous Tools
In-house tool (intake, forms) (10)
Mattlys Dementia Assessment (1)
Ontario Society of Occupational Therapists Perceptual Test (OSOT) (2)
PIECES (1)
Psychogeriatric assessment forms (2)
Total number of respondents reporting use of miscellaneous assessment tools = 17

* General reference was to this type of assessment; specific tools were not reported.

Total number of respondents reporting use of a specific physical assessment tool = 7	General assessment tools – not psychogeriatric (4) Combination – parts of various tools (2)
"Functional Assessment" (7)* Abilities Assessment Instrument (2) Functional Assessment Questionnaire (3) Functional Autonomy Measure (SMAF) (2) Independent Living Scales (ILS) (1) Safety Assessment of Function and the Environment for Rehabilitation (SAFER) (4) Timed up and go (TUG) (1) *Total number of respondents reporting use of a specific functional assessment tool = 13*	*Miscellaneous Domains* Abuse (1) Aggression (1) Behaviour (3) Coping (1) Environment (2) Pain (2) Safety (2) Verbal (1) Visual (1) Wandering (1)
Methods History-taking (6) Interviews/conversations/questions (13) Observation (8) Referral information (1) Team approach (2) Verbal (1)	

* General reference was to this type of assessment; specific tools were not reported.

Respondents were asked to describe any previous exposure they had to P.I.E.C.E.S. training. Respondents had been exposed to P.I.E.C.E.S. through in-services, workshops, overview sessions, meetings focusing on the P.I.E.C.E.S. material, through discussions in their workplace or other health care settings, participation in P.I.E.C.E.S. training, and discussions in academic courses or with other health care providers (see Table 15).

Table 15: Previous Exposure to P.I.E.C.E.S. Training

Participation in in-services, workshops, overview sessions, or meetings (26)
- "In-service at work."
- "Brief workshops done by preceptors who had taken PIECES training."
- "Co-worker previously trained with PIECES shared info at our SW Professional Development meeting."

Discussion within the workplace or other health care settings (co-workers, PIECES Resource Person/team meeting (17)
- "In a team meeting"
- "From fellow colleagues on our PIECES team"
- "At VON and the CCAC"

Participation in PIECES training (CCAC, or other sessions, U-First! training) (16)
- "LTC initiative approx. 5 -9 years ago."
- "Through training with CCAC."

Discussion in academic courses (e.g., Dementia Studies, Palliative Care) (7)
- "Included in Dementia Studies Course."
- "Took Palliative Level One which used the PIECES module."
- "Dementia (8 week class 1xweek evening class) – 3 years ago- reviewed the chart of PIECES during that course."

> *Discussion with other Health Care Providers (5)*
> • "Hospital – by the MD."
> • "Was part of inter-agency psycho-geriatric group that met regularly with Ken Le Clair for several years."
>
> *Miscellaneous (10)*
> • "Have read and used various assessments on the PIECES binder."
> • "Looked at the manual."
> • "Have heard of PIECES before but have not used it."

Respondents identified a variety of things that needed to be in place to help them apply what they would learn in this initiative (see Table 16). Ongoing education and training, time to conduct assessments, access to assessment tools, and supportive materials (guidelines, case studies, and references) were identified most often. Follow-up sessions and follow-up support were also identified as strategies to facilitate transfer of learning.

Table 16: Resources to Facilitate Transfer of Learning

> *"Support" (14)**
>
> *Organization/Management support (18)*
> • "Definition of my role that would encompass individual assessment."
> • "Support from and within the organization."
> • "Support from CCAC management that we should be using additional tools, for a home assessment."
>
> *Peer support (7)*
> • "Peer group support."
> • "Support from team members."
>
> *Expert Resource (support and ongoing consultation) (31)*
> • "Multi-discipline follow-up. It does no good to compile the information and not do anything with it."
> • "Availability of a key person to problem-solve with."
> • "Resource Person"
>
> *Resources*
> *Training and education (ongoing, use of tools) (81)*
> • "Ongoing training."
> • "Additional education on how to perform tests with clients."
> • "Proper training on assessment tools."
>
> *Follow-up sessions, feedback, and support (28)*
> • "Follow-up workshop."
> • "Support to help me through my first few assessments."
> • "Training and one day with a counsellor using the tools."
>
> *Access to Assessment Tools (67)*
> • "Access to recommended tools."
> • "More tools."
> • "Forms available for performing psychogeriatric assessments."

* General reference was to this type of resource; specific details were not reported

Supportive material (guidelines, case studies, manuals) (46)
- "Cheat sheets we can use while initiating the program."
- "Supporting list of references that can be easily accessed."
- "Guidelines and resource information to access routinely."

Time to conduct assessments (74)
- "Enough time for assessment (not rushed)."
- "Time allowed i.e., staffing available to cover access so all calls are covered."
- "Time to apply these skills in the workplace."
- "Time – opportunity to interact with partners in care."

Reduced caseload (5)
- "A reduction in case numbers"
- "Smaller case load for me to be able to do return visits (other than initial) on a regular basis."

Documentation (forms, charting) (6)
- "Charting system."
- "Forms or admitting chart for documentation."
- "How to summarize the material gathered into written assessment for use by care managers or other contractors."

Opportunities to practice and apply new information and skills (39)
- "Opportunity to practice with evaluation."
- "More opportunity to use tools so can become familiar with them and more confident."
- "Hands on experience."

Team approach to assessment and intervention (4)
- "Multi-disciplinary team (2 minimum) to compare observations."
- "Recognition of the value to team work – holistic approach to intervention."
- "Team approach."

Common/consistent elements (language, forms, assessments, communication) (21)
- "Common language across the board. Common written forms."
- "Consistency with use of tools/assessment so we are all speaking the same language."
- "Consistency in community – in facilities, by all health care workers."

Miscellaneous (19)
- "Access to community resources."
- "Good learning environment."
- "Review of caseload to apply appropriately."
- "Specialty designation."
- "Referrals need to be more clear and precise."
"Funding to support training of staff (field)."

* General reference was to this type of resource; specific details were not reported

2.3 Results from the Day Two Feedback Questionnaire

A total of 548 individuals completed the Day 2 Feedback form. Thus, results in this section are based on a denominator of 548.

Respondents were asked to rate their satisfaction with various aspects of the Day 2 session. The majority of respondents indicated that the pace of activity, volume and complexity of material, and opportunities to participate were "about right" (see Table 17).

Table 17: Ratings of the Day 2 Session

How would you rate your satisfaction with the following aspects of the session?	1	2	3	4	5	Mean (SD)
Pace of activity	Too Slow 1.6% (9)	3.6% (20)	About Right 53.5% (293)	10.8% (59)	Too Fast 0	3.1 (.53)
Volume of material	Too Little 0.2% (1)	2.0% (11)	About Right 55.3% (303)	11.7% (64)	Too Much .7% (4)	3.5 (.66)
Complexity of material	Too Basic 0.4% (2)	2.6% (14)	About Right 56.6% (310)	10.2% (56)	Too Complex 0.2% (1)	3.1 (.48)
Opportunities to participate	Too Few 0	1.3% (7)	About Right 81.0% (444)	15.7% (86)	Too Many 1.1% (6)	3.2 (.43)

Note: Percentages do not add to 100% because of missing values.

Most respondents rated the P.I.E.C.E.S. educator team, interaction with other health professionals, and the session overall as "very good" or "excellent" (see Table 18). Similarly, most respondents rated the 16-hour program in terms of meeting the goals of the P.I.E.C.E.S. learning initiative as "very good" or "excellent". Average ratings on these measures indicate that participants thought these aspects of the program were "very good".

Table 18: Ratings of Various Aspects of the Day 2 Session

Overall, how would you rate the following aspects of the session?	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
P.I.E.C.E.S educator team	0	1.3% (7)	9.7% (53)	41.0% (223)	47.6% (261)	4.4 (.71)
Interaction with other health professionals	.2% (1)	2.3% (53)	19.0% (104)	44.7% (245)	32.3% (177)	4.1 (.79)
Overall session	0	1.0% (9)	14.1% (77)	46.2% (253)	36.1% (198)	4.2 (.74)
The 16-hour program in terms of meeting the goals of the P.I.E.C.E.S. learning initiative	0	2.9% (16)	22.8% (125)	53.3% (292)	18.4% (101)	3.9 (.73)

Note: Percentages do not sum to 100% because of missing values.

Respondents were invited to provide comments in response to their ratings of the session. These comments are summarized in Table 19. The vast majority of comments were very positive in nature; however, a few suggestions for improvement were also provided.

Table 19: Ratings Related to Various Aspects of the Day 2 Session - Comments

Positive Comments:

Knowledgeable, effective educators (31)
• "Excellent facilitators – very knowledgeable, humorous, practical"
• "Presenters are very eloquent and interesting to listen to."
• "Excellent teacher – very knowledgeable, 'knows her stuff'!"

Positive reactions to the learning strategies used, particularly the case-studies (13)
• "Case based teaching style good for experiential learning style."
• "The case studies were also a good way to apply what we've learned."
• "Found the case studies and group work very beneficial."

Usefulness of the materials, e.g., lecture material, resource manual (33)
• "Great handbook/charts."
• "A lot of interesting and enlightening material."
• "This was the most useful conference I've attended in the last 5 years."

Good opportunity for discussion, interaction, and sharing (7)
• "I liked the format of interaction and meeting others in the field."
• "Enjoyed interacting with other health professionals."
• "Good to hear thoughts of other team members."

Overall satisfaction (20)
• "One of the most informative and enjoyable workshops."
• "Had a great time!"
• "Very enjoyable and informative both personally and professionally."

Other Comments*:*

High volume of material (21)
• "Too much to cover."
• "Information overload."
• "Too much material in 2 days."

Need for extended time frame to cover material (17)
• "I feel 5 days would be very beneficial."
• "Would like more than 2 days."
• "A 5-day training cannot be put in 2 days."

Confusing, disorganized manual (10)
• "Workbook not well organized."
• "Manual not clearly laid out – too much flipping back and forth, Lack of index in manual, color coded sections would help."
• "The material is helpful but information should be organized in better way (i.e., with tab for each session.)"

Problems with technology (5)
• "Need a command of audio-visual equipment. Flip charts were rarely visible."
• "Problems with computers on both days."
• "Unfortunate that the video required not working."

Suggestions for improvement (8)
- "Could you add a clearer view at beginning of 2nd day?"
- "I am concerned re: emphasis on tools to assess intellectual status. A handout re: Pros and cautions re: use of tools should be included."
- "Perhaps giving the reference book ahead of time and assigning reading would help."

Miscellaneous:
- "I find the language of the wheel "foreign" to what I'm used to, i.e., what is then next priority questions vs. what needs to be done now."
- "Room cold, fans noisy, food – no variety."
- "A lot of the focus seemed to be on long-term care and less on community care. Not always others to rely on for help; community resources often very limited".

At the end of Day 2, most respondents reported that they were "quite confident" or "very confident" in their ability to assess physical health, intellectual capacity, emotional and spiritual health, functional capabilities, environmental factors, and social and cultural factors (see Table 20). Average ratings reflected that they were "quite" confident in their assessment abilities. Although, the mean ratings did not vary significantly from prior to the program to after Day 2, fewer respondents provided "slightly" and "fairly" confident ratings after Day 2 than prior to the session, more respondents provided "quite" confident ratings, and no respondents provided "not at all confident" ratings after Day 2 .

Table 20: Confidence Ratings after the End of Day 2

How confident are you in your ability to assess a client's…	Not at All Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
Physical health?	0	2.6% (14)	15.0% (82)	55.5% (304)	22.4% (122)	4.0 (.71)
Intellectual capacity?	0	.9% (5)	30.5% (167)	52.9% (292)	11.9 (53)	3.8 (.64)
Emotional and spiritual health?	0	.7% (4)	29.2% (160)	52.9% (290)	11.9% (65)	3.8 (.65)
Functional capabilities?	0	.4% (2)	13.1% (72)	60.9% (334)	20.3% (111)	4.1 (.60)
Environmental factors?	0	0	13.7% (75)	61.9% (339)	19.2% (105)	4.1 (.59)
Social and cultural factors?	0	.9% (5)	25.4% (139)	56.4% (309)	11.9% (65)	3.8 (.64)

Note: Percentages do not sum 100% because of missing values.

After Day 2 most respondents reported that they were more confident (ratings of 4 and 5 on the 5 point rating scale: 1 = less confident, 3 = about the same, 5 = more confident) in their ability to assess various aspects of their clients' health and well-being (see Table 21). Fewer than 5% of respondents reported that

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they were less confident about their assessment skills after Day 2. Average ratings reflect that they were more confident in their assessment abilities.

Table 21: Comparison of Confidence Ratings after the End of Day 2

How does your confidence level compare with your level of confidence before this education program, as related to your ability to assess a client's…?	Less Confident 1	2	About the Same 3	4	More Confident 5	Mean (SD)
Physical health?	.4 % (2)	2.2% (12)	42.8% (235)	30.7% (168)	18.8% (103)	3.7 (.82)
Intellectual capacity?	.4 % (2)	4.2% (23)	22.6% (124)	43.2% (237)	24.1 (132)	3.9 (.84)
Emotional and spiritual health?	.6% (3)	3.5% (19)	29.0% (159)	40.7% (223)	22.8% (114)	3.8 (.83)
Functional capabilities?	.4% (2)	2.6% (14)	35.4% (194)	35.2 (193)	20.8% (114)	3.8 (.83)
Environmental factors?	.4% (2)	2.9% (16)	35.2% (193)	34.7% (190)	21.4% (117)	3.8 (.84)
Social and cultural factors?	.6% (3)	3.6% (20)	35.6% (195)	34.5% (189)	20.4% (112)	3.8 (.86)

Note: Percentages do not sum to 100% because of missing values.

Most respondents rated the wheel as "very good" or "excellent" in terms of its ability to develop a common baseline of knowledge, common language, approach to care, and method of education, and as means to guide dialogue with partners in care (see Table 22). Average ratings reflect that they thought these aspects of the wheel were "very good".

Table 22: Ratings of the Value of the Wheel

Using the 5-point scale, please rate the value of the wheel in terms of:	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Developing a common baseline of knowledge	.6% (3)	3.1% (17)	21.0% (115)	49.6% (272)	19.9% (109)	3.9 (.78)
Developing a common language	.6% (3)	2.6% (14)	20.4% (112)	48.5% (266)	21.9% (120)	3.9 (.78)
Developing a common approach to providing care to persons with ADRD	.6 (3)	2.4% (13)	20.4% (112)	47.3% (259)	23.2% (127)	4.0 (.79)
Developing a method to educate others on the job	.7% (4)	6.6% (36)	24.3% (133)	43.4% (238)	18.4% (101)	3.8 (.87)
Serving as a means to guide dialogue with partners in care	.8% (4)	3.1% (17)	21.9% (120)	46.0% (252)	21.7% (119)	3.9 (.82)

Note: Percentages do not sum to 100% because of missing values.

Respondents were asked to provide two examples of P.I.E.C.E.S. program learning that they applied following the first session. Twelve respondents indicated that they had not yet been able to apply any new learning to their clinical practice (several indicated that they had not yet had the time to do so). The use of the P.I.E.C.E.S. template (6 questions), the *U-First* wheel, the RISK assessment, and various other assessment tools were identified most frequently by respondents as the program learning that they had applied following the session (see Table 23).

Table 23: Examples of P.I.E.C.E.S. Program Learning that Respondents Applied Following the First Session.

Use of assessment tools (unspecified) (40)
• "Usage of assessment tools"
• "New tools to assist service providers and families in assessing client needs"
• "Enhanced assessment tools/skills"

Use of specific tools:
PIECES template (6 questions) (155)
• "Used the 6 questions PIECES to evaluate elderly client having increased falls"
• "Completed the PIECES template to a current client situation to enhance my understanding of the issues at hand"
• "Using the PIECES template to assess situation and plan strategy"

U-First wheel (142)
• 'Used wheel to discuss client situation with client's doctor"
• "Using the wheel, worked through intellectual and capabilities of client"
• "More specific assessment of client on admission using the wheel"

Other Tools:
• *Quick start reference card (12)*
• *Depression scales (15)*
• *Cohen-Mansfield Agitation Inventory (CMAI) (8)*
• *SIGECAPS (signs of depression) (35)*
• *RISK assessment (91)*
• *Mini-Mental Status Examination (38)*
• *Clock Test (18)*
• *ABC's of Behaviour (19)*
• *Pain assessment (6)*

Use of materials/information for a physical assessment (8)
• "Physical assessment re: respiratory status"
• "Physical assessment of new client"

Use of materials/information for an environmental assessment (5)
• "Assessing client's physical need, environment "
• "Client safety at home"
• "Environmental impact"

Use of materials/information for a delirium assessment (risk factors, I WATCH DEATH, CAM, DOS) (57)
• "Use of CAM when delirium was suspected and reviewing I WATCH DEATH"
• "Identified a delirium and was able to follow-up (physical causes)"
• "Use of tool to make decision re: family in crisis due to delirium of client, which was resolved"

Use of materials/information for a behaviour assessment (flagging behaviours, meaning of behaviours) (22)
- "Flagging – assessing client behaviour"
- "More focused on defining behaviour as opposed to using a general "label" during assessment."
- "Observation of clients with "behaviours" in LTC."

Use of materials/information for a cognitive assessment (differentiating the 3D's) (32)
- "I was able to differentiate clients with dementia vs. delirium"
- "Reassessed a particular situation exhibiting the signs of dementia"
- "Framework to complete an assessment of a cognitively impaired client"

Use of materials/information for a social assessment (history, life stories) (16)
- "Social assessment of family with son (workplace accident)"
- "Looking at social issues and knowing where the client came from"
- "Social – disturbed family dynamics and how to solicit information"

Development (organization) of an assessment approach or framework (38)
- "PIECES allowed me to better organize the information gathered during an assessment"
- "Problem-solving in an organized manner-identifying risks, causes, strategies"
- "Working through behaviours with a systematic approach"

Use of common language, terminology (18)
- "Using common language with service providers"
- "Use of terminology"
- "Other staff I work with have also done this training previously, so we can better share the language, model of system to assist our work"

Use of strategies related to behaviour management (4)
- "Reviewed strategies being used in response to client's behaviour"
- "Pro-attention strategy for behavioural intervention (3)"

Use of strategies related to interacting with paranoid clients (6)
- "Do's and Don'ts of interacting with a person who is paranoid'
- "Using Do's and Don'ts of interacting with a person who is paranoid when doing an assessment"

Use of information for teaching (peers, family members) (27)
- "Used wheel to discuss client situation with client's doctor"
- "Using information on delirium in teaching with daughter"
- "In dealing with PSW in providing education re: personal care for client and dementia"

Identification of problem/factors underlying a specific presenting issue (14)
- "Assessment of client in ER brought in with confusion, able to identify physical causes and need for admission"
- "Looking more at contributing factors to situations"
- "Increase in ability to identify the environmental and social factors that were impacting my client"

Care planning (guided by use of tools, information) (24)
- "Intervention planning"
- "I used the wheel to help develop my assessment and care plan for a client in crisis"
- "Doing an assessment on a resident to identify care requirements"

> *Problem-solving medication issues using pharmacology handouts (18)*
> • "Used the handout re: medication risks and effects"
> • "Reviewed clients medication and side affects causing problems"
> • "I used the pharmacology handout when problem solving with the health care team"
>
> *Engaged "team/partners in care" in collaborative effort to resolve problems (7)*
> • "The importance of "team" was reassessed and strengthened"
> • "How to better use others within the multidisciplinary team to assess and support client"
> • "Expanded my concept of "my" team – who are my partners in care?"
>
> *Miscellaneous (7)*
> • "Hallucinations vs. illusions – increase my ability to identify"
> • "Usage of PIECES website to find solutions for certain problem behaviours"
> • "I submitted a question to TIPS"
> • "Requesting lab work"

Respondents were asked to identify the factors that were most helpful to them in applying what they had learned in the first session. Their responses to this question are summarized in Table 24. Supportive resources such as the *U-First* wheel, the P.I.E.C.E.S. manual, various laminates, handouts, quick references, the homework assignment, and the P.I.E.C.E.S. template were identified most often as things that facilitated application of learning.

Table 24: Factors That Facilitated Respondent's Application of Learning Following the First Session

> Availability of Supportive Resources:
> *P.I.E.C.E.S Manual (72)*
> • "Using the PIECES manual – being familiar with it."
> • "Having the manual to review."
> • "Knowing that I have a thorough and complete book of resources in hand ready for use anytime."
>
> *U-First wheel (131)*
> • "Using the wheel to do a more holistic assessment – as a nurse you focus more on physical problems and can overlook the whole picture."
> • "The use of the wheel to assess risk on all aspects."
> • "The wheel – how to use it to enhance care."
>
> *P.I.E.C.E.S. template (53)*
> • "The PIECES worksheet with the questions really helped me in formulating my investigation or info gathering – it focuses my thinking and helps me to get started."
> • "Thinking of the questions in the template."
> • "Template – to help me organize thoughts and not miss a step in my assessment."
>
> *Assessment tools (46)*
> • "The various tools for assessment."
> • "Tools – MMSE, clock."
> • "Different kinds of tools such as CMAI, Cornell Scale for Depression and more."
>
> *Laminates/handouts/quick references (87)*
> • "The quick reference sheets are very helpful and I used them the most following the first session."
> • "The specific quick tip resource tools are excellent."
> • "Templates and laminated information to take with me in the community."

Videos (5)
• "The video on psychosis was very helpful"
• "Use of wheel /tools appropriately; video re: MMSE"
• "Film – Art of Possibility – Rule # 6, Shining eyes"

Use of acronyms (6)
• "The acronyms – Great!"
• "Repetition throughout the day of acronyms."
• "The acronyms. The more I use them the more I find them useful."

P.I.E.C.E.S. website (10)
• "Website risk assessment"
• " Websites are useful, up to date, encourage use"
• "Use TIPS on website."

Education/Training Related Factors:
Assessment framework (organized, structured, and focused approach to assessment) (34)
• "Organized, structured, standardized system – if used universally would be great."
• "Look at the whole person, look beyond the crisis to see the total picture."
• "Having guidelines to follow PIECES – being more aware and recognizing more readily the factors related to dementia. Observations were made from a different point of view."

Common approach to language, terminology, communication, assessment (8)
• "Colleagues/partners have similar language regardless of discipline."
• "The importance of team work and using a common language and approach/tools."
• "Putting the PIECES together for a common language."

Review of assessment tools (9)
• "Demonstration of tools."
• "Appreciate the tools provided, and the time spent to review/practice."
• "Appreciated the combination of information and demonstration of use of tools."

Case studies (27)
• "Case study with group interaction."
• "Study cases reviewed in class."
• "Examples going through the process."

Networking/discussions with other respondents/leaders (45)
• "Sharing of ideas was most useful, more sharing is best."
• "Networking/discussing with others the real life scenario."
• "Group discussion of case study."

Homework assignment (59)
• "Doing this case study and applying this learning to a "real case."
• "Practice tool on assignment."
• "Doing the assignment – pulling information and relating it to past experience."

Curriculum content (knowledge/awareness) (20)
• "Different symptoms as per different diagnosis, i.e., illusions/hallucinations."
• "Increase understanding of clients with dementia."
• "Knowing telltale signs of a potential problem and how to categorize."

Team approach to assessment and intervention (7)
- "Others to help – team."
- "Having resource back up and being able to access a team support system to develop care plan."
- "The importance of team work."

Independent review of manual/material (25)
- "Review of manual- resources."
- "Review of specific parts of the manual."
- "Self-review of manual."

Using the tools (practice) (35)
- "Applying the information and reflecting differently on the data."
- "Applying the PIECES framework in everyday situations helped me to expand my thinking about the concept and their application."
- "Practice using the wheel."

Peer support (3)
- "The support and encouragement of a colleague and interest of other colleagues who hadn't attended the session."
- "Continued support from colleague."
- "The fact that 19 of my peers also learned to apply it and can reinforce the concepts from here on."

Miscellaneous (7)
- "Teaching leadership."
- "Awareness of the need to ask more questions."
- "Bright eyes and Rule #6."

Respondents were invited to provide additional comments about this learning initiative. These comments are summarized in Table 25. The majority of comments were very positive in nature, indicating that they had enjoyed the sessions, facilitators, program content, and resources. Suggestions for improving the program were also provided, most of which were related to improving the presentation or organization of the supportive resources. Overall, there were few negative comments.

Table 25: Additional Comments

Positive Comments:
- Enjoyed the day/thank you (13)
- Excellent program/useful information (6)
- Excellent facilitators (knowledgeable, good teachers) (12)
- Great/practical/useful tools, resource materials, teaching materials (e.g. videos) (6)

Suggestions for Improvements:
- High volume of material requires extended time frame (3-day program) (6)
- Training on use of tools requires more practice time/examples (4)
- Reduce amount of time between sessions (2)
- Provide a more comprehensive description of the wheel on Day 1 (3)
- Improve resources (22)
    - provide visual chart linking PIECES components
    - laminate wheel and PIECES template, use tabs in manual
    - include an index
    - include a glossary of terms
    - include list of available community resources and crisis contacts
    - include capacity/functional assessment tools and safety assessment tools

Other Comments
- Utility of the information is limited due to health system constraints (e.g., insufficient number of visits for assessment, limited access to support services) (2)
- Resource material seemed more geared to long-term care then community settings (3)
- Sessions were disorganized (did not follow agenda, wheel not clearly described, information did not arrive prior to session) (3)
- Manual is disorganized (5)
  - ➢ no tabs
  - ➢ no index
  - ➢ too much flipping back and forth
  - ➢ some information was missing
  - ➢ too many acronyms

- Miscellaneous Comments (6)
  - ➢ don't show video after lunch
  - ➢ need to include family/client/caregiver as members of the care team
  - ➢ day 2 was rushed, incorporate PIECES into Dementia Studies
  - ➢ more information on Substitute Decision Makers and Power of Attorney
  - ➢ uncomfortable environment (temperature, chairs)

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