"Putting the P.I.E.C.E.S. Together Training Initiative"

Report on Follow-Up Interviews

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

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EXECUTIVE SUMMARY

Background

In an effort to expand the knowledge and skills of service providers caring for older persons with complex physical and mental health needs and associated behaviors, the Ontario Government, through its provincial Strategy for Alzheimer Disease and Related Dementias (ADRD), supported the implementation of the *Putting the P.I.E.C.E.S. Together* learning initiative. In the spring of 2003 all long-term care (LTC) homes in Ontario (N=555) were surveyed to obtain feedback on the P.I.E.C.E.S. learning initiative. A total of 439 homes completed this survey (79% response rate).

As a follow-up to this survey, interviews were conducted with a purposeful sample of LTC representatives to obtain an in-depth understanding of factors that have affected the implementation of P.I.E.C.E.S. in LTC homes. The purpose of this report is to summarize the methods and findings of these follow-up interviews.

Methods

The goals of this component of the evaluation were to:

i) describe the impact that the P.I.E.C.E.S. learning initiative has had in LTC homes;
ii) identify factors associated with the successful implementation of P.I.E.C.E.S. within LTC homes; and
iii) identify factors that have acted as barriers to the implementation of P.I.E.C.E.S.

In order to achieve these goals, in-depth interviews were conducted with representatives from LTC homes: those that were identified as being successful in their implementation of P.I.E.C.E.S. and those identified as having limited success with the implementation of P.I.E.C.E.S., based on data collected from the 2003 survey of LTC homes (*Survey of Long-Term Care Facilities: Feedback on the P.I.E.C.E.S. Initiative 2003*). Criteria to determine level of success were based on responses to specific questions in the 2003 survey; specifically: the rating of the success of P.I.E.C.E.S. within the home; frequency with which the In-house Psychogeriatric Resource Person (In-house PRP) served as a resource to other home staff; performance of the In-house PRP in serving as a resource to other staff; frequency with which the In-house PRP was involved in planning care with internal resources; and frequency with which the In-house PRP was involved in planning care with resources external to the home.

Using these criteria, LTC home "success" scores were determined. Homes were then ordered according to their success score from "most successful" to "least successful". Based on this ranking, a purposeful sample was drawn; the 8 highest ranked and 4 lowest ranked homes were selected to be interviewed. Interviews were conducted with individuals in these homes who had completed the evaluation survey in 2003. These individuals identified one other individual from their home who was familiar with the P.I.E.C.E.S. training, preferably the In-house PRP, who was also invited to be interviewed.

Telephone interviews were carried out with 20 LTC representatives, 15 representing the 8 most successful LTC homes and 5 representing the 3 least successful LTC homes. Interviews were conducted with Administrators (N = 2), Directors of Care (N = 8), Administrator/Director of Care (N = 1), and In-house PRPs (N = 9). The mean length of the interviews was 14.4 minutes (SD = 5.6; range = 5 to 30 minutes).

Key Findings and Conclusions

Overall, most participants had positive perceptions about the *Putting the P.I.E.C.E.S. Together* learning initiative, identified significant benefits for residents, staff, and families, and were supportive of its continued role in LTC.

Homes identified as having had success with the P.I.E.C.E.S. initiative were involved in a number of key P.I.E.C.E.S. related activities: assessment (data collection), case conferencing, care planning, staff education, provision of care, linkages and partnerships with external resources (PRP networks, other homes, Psychogeriatric Resource Consultants (PRCs), the Alzheimer Society, geriatric outreach programs).

Successful experiences with P.I.E.C.E.S. were attributed to a number of factors including:

- management support, particularly the provision of P.I.E.C.E.S. training for staff and time to assume the In-house PRP role (time to complete assessments, consult with other resources, provide staff education), willingness to provide necessary resources (tools, reference material, space), and to utilize resources made available to homes;
- the availability of more than one P.I.E.C.E.S. trained staff within the home;
- staff willingness to access and value their In-house PRP;
- PRC and physician support; and
- the transfer of knowledge from P.I.E.C.E.S. trained staff to front-line workers.

Time and staffing issues were identified most often as challenges to implementing P.I.E.C.E.S.

Many of the facilities identified as having had limited success with the P.I.E.C.E.S. initiative were minimally involved in P.I.E.C.E.S. activities and were primarily limited to assessments conducted to assist them with diagnosis and referral to external resources. Three of the twelve homes invited to participate in the interviews did not currently have a P.I.E.C.E.S. trained staff member and were not currently engaged in any P.I.E.C.E.S. related activities.

Limited success with P.I.E.C.E.S. was attributed to:

- the lack of P.I.E.C.E.S. trained staff (one was considered insufficient or the In-house PRP had left the home and was not replaced);
- the chronic shortage of registered staff in LTC, which limits their ability to send staff to training and to train several staff members, to provide them with designated time for P.I.E.C.E.S. activities, or to recruit staff with P.I.E.C.E.S. training;
- inappropriate use of the In-house PRP;
- lack of transfer of training;
- lack of strategies to sustain the initiative (mentoring, networking);
- lack of support from peers who are reluctant to complete recording forms or implement new care approaches; and
- minimal PRC involvement and support.

Almost all of the interview participants were able to identify at least one significant outcome of the P.I.E.C.E.S. initiative. Many participants cited the positive impacts of the program such as reduced disruptive behaviors, improved quality of life and care of residents, timely intervention, enhanced staff knowledge, skills, and confidence and reduced staff stress, improved linkages with external resources, and increased family satisfaction. For homes with limited success with the initiative, assessments to assist in diagnosis and referral and increased staff awareness of psychogeriatric issues were identified as relevant outcomes.

Many participants approved of continued support for P.I.E.C.E.S. (i.e., for staff training and designated time for P.I.E.C.E.S. activities) and hoped for continued expansion of the initiative.

1.0 INTRODUCTION

In an effort to expand the knowledge and skills of service providers caring for older persons with complex physical and mental health needs and associated behaviors, the Ontario Government, through its provincial Strategy for Alzheimer Disease and Related Dementias (ADRD), supported the implementation of the *Putting the P.I.E.C.E.S. Together* learning initiative. The objectives and implementation of this program have been described in a Project Report[1], the training manual[2], and evaluation reports have been generated for the 1999 training program[3], the 2001 program[4], and the 2002 program [5].

In the spring of 2003, all long-term care (LTC) homes in Ontario (N=555) were surveyed to obtain feedback on the P.I.E.C.E.S. learning initiative and to obtain feedback on the role of the Psychogeriatric Resource Consultants (PRCs), funded through Initiative #8 of Ontario's Strategy for ADRD.[6] A total of 439 homes completed this survey (79% response rate).

As a follow-up to this survey, interviews were conducted with a purposeful sample of LTC representatives to obtain an in-depth understanding of the impact of the P.I.E.C.E.S. initiative in LTC, the implementation of P.I.E.C.E.S. within homes, and the factors that influenced implementation. The purpose of this report is to summarize the methods and findings of these follow-up interviews.

2.0 METHODS

2.1 Objectives

The goals of this component of the evaluation were to:

i) describe the impact that the P.I.E.C.E.S. learning initiative has had in LTC homes;
ii) identify factors associated with the successful implementation of P.I.E.C.E.S. within LTC homes; and
iii) identify factors that have acted as barriers to the implementation of P.I.E.C.E.S.

2.2 Comparison of High Success and Limited Success LTC Homes

When the 2003 survey of LTC homes was developed, there were questions included that could be used to indicate a home's level of success with the P.I.E.C.E.S. initiative. These questions included the following (see Table 1):

[1] Project Report. Putting the P.I.E.C.E.S. Together: A Psychogeriatric Guide and Training Program for Professionals in Long-Term Care Facilities in Ontario – 1998-99. Woodbridge, ON: OANHSS, April, 1999.
[2] Ontario Ministry of Health and Long-Term Care. Putting the P.I.E.C.E.S. Together. A Psychogeriatric Guide and Training Program for Professionals in Long-Term Care Facilities in Ontario. October 1997.
[3] Evaluation Report. The Mental Health/Long Term Care Interface Training Resource Project. May 1999.
[4] Final Evaluation Report. Putting the P.I.E.C.E.S. Together Training Initiative 2001. February 2003.
[5] Evaluation Report. The Putting the P.I.E.C.E.S. Together Training Initiative 2002. February 2003.
[6] Survey of Long-Term Care Facilities: Feedback on the P.I.E.C.E.S. Initiative 2003. Part of Initiative #1: Staff Education and Training, Ontario's Strategy for Alzheimer Disease and Related Dementias. January 2004.

Table 1: Questions used to Determine Level of Success with the P.I.E.C.E.S. Initiative

Question	Response Options	
Self-assessed ratings of the success of P.I.E.C.E.S. within their home	1 = not at all successful 2 = limited success 3 = somewhat successful 4 = fairly successful	5 = quite successful 6 = very successful 7 = extremely successful
Frequency with which the In-house Psychogeriatric Resource Person (PRP) served as a resource to other home staff	never in some cases	in most cases in all cases
Performance of the In-house PRP in serving as a resource to other staff	1 = poor 2 = fair 3 = good	4 = very good 5 = excellent
Frequency with which the In-house PRP was involved in planning care with resources internal to the home	never in some cases	in most cases in all cases
Frequency with which the In-house PRP was involved in planning care with resources external to the home	never in some cases	in most cases in all cases

Using these questions, the authors identified the response options that would reflect a home with "high success" with the P.I.E.C.E.S. initiative and those that would reflect a home with "limited success". In order to be considered a "high success" or "limited success" home, all of the criteria had to be met. The two sets of criteria are presented in Tables 2a and 2b.

Table 2a: Criteria for "High Success" LTC Homes

Survey Question	Response options reflecting high success
Self-assessed ratings of success	"extremely", "very", or "quite" successful
In-house PRP as a staff resource	"in all cases" or "in most cases"
Performance ratings	"excellent", "very good", or "good"
Consultation with internal resources	"in all cases" or "in most cases"
Consultation with external resources	"in all cases", "in most cases", or "in some cases"

Table 2b: Criteria for "Limited Success" LTC Homes

Survey Question	Response options reflecting limited success
Self-assessed ratings of success	"not at all successful" or "limited success"
In-house PRP as a staff resource	"never" or "in some cases"
Performance ratings	"poor" or "fair"
Consultation with internal resources	"never" or "in some cases"
Consultation with external resources	"never" or "in some cases"

A total of 35 homes met the "high success" criteria and 22 homes met the "limited success" criteria. Descriptions of these homes are presented in Table 3.

Table 3: Description of the 35 LTC Homes that were Successful with P.I.E.C.E.S. and the 22 LTC Homes that had Limited Success with P.I.E.C.E.S.

	Successful implementation of P.I.E.C.E.S. (N = 35)	Limited implementation of P.I.E.C.E.S. (N =22)
Region:		
Southwest	3	4
Central South	4	1
Central West	4	3
Central East	7	1
Eastern	12	6
Northern	3	3
Toronto	2	4
Location:		
Urban	31	20
Rural	4	2
Number of beds:		
Mean	118 beds	120 beds
SD	84	74
Range	43 – 450 beds	38 – 289 beds
Type:		
Charitable	3	1
Municipal	4	3
Nursing Home	28	18
For Profit/Not for Profit:		
For Profit	12	16
Not for Profit	23	6

2.3 Interviews with LTC Representatives

Using these results, a purposeful sample of the 8 highest ranked and 4 lowest ranked homes was drawn. Representatives from these homes were invited to be interviewed.

The 8 highest ranked homes had the following responses to the survey questions that formed the criteria for level of success:

Survey Question	Responses reflecting high success
Self-assessed ratings of success	"extremely" successful
In-house PRP as a staff resource	"in all cases"
Performance ratings	"excellent"
Consultation with internal resources	"in all cases" or "in most cases"
Consultation with external resources	"in all cases" or "in most cases"

The 4 lowest ranked homes had the following responses to the survey questions that formed the criteria for level of success:

Survey Question	Responses reflecting limited success
Self-assessed ratings of success	"not at all successful" or "limited success"
In-house PRP as a staff resource	"never" or "in some cases"
Performance ratings	"poor"
Consultation with internal resources	"never"
Consultation with external resources	"never"

Letters were sent to the 2003 survey respondents in the eight homes identified as being most successful and the four homes identified as least successful in implementing P.I.E.C.E.S. The letters explained the purpose of this component of the evaluation, that participation in the interviews was voluntary and that any information shared would be kept confidential. The letters also identified whom the evaluators wanted interviewed: the person who completed the 2003 survey and someone familiar with P.I.E.C.E.S., preferably the In-house PRP.

Telephone interviews were carried out with 20 LTC representatives, 15 representing 8 LTC homes identified as being successful in their implementation of P.I.E.C.E.S., and 5 representing 3 LTC homes identified as having limited success with P.I.E.C.E.S. Of the 12 homes contacted to participate in the interviews, contact was made with nine individuals who had completed the 2003 P.I.E.C.E.S. evaluation survey on behalf of their home. For two of the homes contacted, the individual who completed the 2003 survey was no longer employed within the home. However, there were individuals involved with P.I.E.C.E.S. that could complete the interview. In one home, the individual who completed the 2003 survey was in a new position and opted not to participate in the interview and there was no one within the home familiar enough with P.I.E.C.E.S. to be interviewed. Thus, 11 homes are represented in this evaluation (8 "successful" and 3 "limited" success homes). Table 4 summarizes the response rate for the interviews.

Table 4: Interview Response Rate

Level of success	Interviews with individuals who completed the 2003 survey	Interviews with substitutes for the individual who completed 2003 survey	Interviews with a 2nd person familiar with P.I.E.C.E.S.	Total Interviewed
'Successful' homes (N = 8)	7	1	7*	15
'Limited success' homes (N = 3)	2	1	2	5**
Total				20

* One home did not currently have a P.I.E.C.E.S. trained staff member, though training is being planned for one staff member, therefore interviews with a 2nd person familiar with P.I.E.C.E.S. were conducted for seven of the eight homes.
** One individual who had completed the 2003 survey was currently in a new position and opted not to participate in the interview; two homes did not have an In-house PRP or any one else familiar with P.I.E.C.E.S.

Interviews were conducted with Administrators (N = 2), Directors of Care (N = 8), Administrator/Director of Care (N = 1), and In-house PRPs (N = 9). Table 5 provides a description of the 11 LTC homes that the interviewees represented.

The mean length of the interviews was 14.4 minutes (SD = 5.6; range = 5 to 30 minutes). All of the interviews were tape-recorded and transcribed. Consistent with a phenomenological approach to qualitative research[7], interview questions were designed to obtain reflective descriptions of the implementation and impact of P.I.E.C.E.S. Transcripts of the interviews were reviewed using inductive analysis to identify recurring themes in the data.

Table 5: Description of LTC Homes in which the Interview Participants Worked

	Homes Successful With P.I.E.C.E.S. (N = 8)	Homes with Limited Success with P.I.E.C.E.S. (N = 3)
Region:		
Southwest	0	1
Central South	2	0
Central West	2	1
Central East	1	0
Eastern	1	0
Northern	1	0
Toronto	1	1
Location:		
Urban	7	3
Rural	1	0
Number of beds:	M = 145 (SD = 111) Range = 43 – 361	M = 138 (SD = 97) Range = 47 – 240
Type:		
Charitable	1	0
Municipal	2	0
Nursing Home	5	3
For Profit/Not for Profit:		
For Profit	5	2
Not for Profit	3	1

3. 0 RESULTS

3.1 The P.I.E.C.E.S. Learning Initiative

Successful implementation of P.I.E.C.E.S.

Interview participants from homes identified as having success with the P.I.E.C.E.S. learning initiative provided a positive and more comprehensive account of their involvement with P.I.E.C.E.S. than those from homes with limited success with this initiative. All of the interview participants who had reported on the 2003 P.I.E.C.E.S. evaluation survey that the P.I.E.C.E.S. initiative was extremely successful in their home, continued to believe

[7] Munhill, P.L. (Ed.) (2001). Nursing research: A qualitative perspective (3rd Ed.). Boston: Jones & Bartlett.

this a year later. Similarly, for homes in which two people were interviewed, there was agreement between them that P.I.E.C.E.S. was extremely successful in their home.

Most of these homes currently have several P.I.E.C.E.S. trained staff members, many of whom have been given designated time to work on this initiative (i.e., time for assessment, case conferencing, care planning, staff education, provision of care, liaising with external resources). One Administrator described her home's experience with P.I.E.C.E.S.:

> *"We have four* [P.I.E.C.E.S. trained] *people, which is extraordinary I think. We dedicate one day a month when all of them are present in the facility. There are two registered nurses and two RPNs, and they spend an afternoon looking at who needs mini mental tests done, who's going to do them, who's going to do the work up… We have had virtually no psychogeriatric kinds of crises. Everything has been able to be managed proactively. Assessments done and treatments initiated. They track behaviors. They are very good at consistent care principles, and so the behaviors have just diminished and the quality of the resident's life is enhanced as there are no family issues. So from my perspective, as the Administrator, it's been worth every penny that we have spent in staff and designating that time"* (S2).

Similarly, other participants reported that P.I.E.C.E.S. training resulted in enhanced clinical practice. Many participants commented that their home was using assessment tools and learned behavior management strategies on a regular basis. The following are some of the experiences described by interview participants:

> *"It's just been a fabulous experience… We've just accomplished so much using the P.I.E.C.E.S. strategy and have found just wonderful ways of controlling behavior without medications, by isolating the times of day the person's behavior escalates."* (DOC-S3)

> *"We have 3-4 people trained in it and we meet on a monthly basis and we review anyone that we have assembled any of the P.I.E.C.E.S. information on, and we use the P.I.E.C.E.S. in our everyday work life."* (PRP – S12)

> *"They've* [P.I.E.C.E.S. trained staff] *used the respective tools on an ongoing basis and this is what they immediately think of when they're faced with behavioral issues of any kind. It could be depression, could be a delirium process. All of those kinds of things that are directly related to the knowledge base that they gained through the P.I.E.C.E.S. initiative."* (Administrator – S18).

Limited success with P.I.E.C.E.S.

Involvement with the P.I.E.C.E.S. learning initiative varied between homes identified as having success with P.I.E.C.E.S. and those with limited success. Participants from homes that were identified as having limited success with P.I.E.C.E.S. were often unsure of who and how many staff within their home had been P.I.E.C.E.S. trained and generally reported minimal activity related to the learning initiative. Several participants indicated that activity was limited to staff participation in training and that transfer of training to clinical practice had not occurred. Participants commented:

> *"Maybe 3 or 4 years ago one of the nurses here went and did the P.I.E.C.E.S. training. And at that time there was some education and also the person* [the PRC] *came to help us with a couple. That's kind of been our history [with P.I.E.C.E.S.]"* (Administrator-LS9).

> *"Specifically, for our facility we've had a few difficulties with the P.I.E.C.E.S. people coming back and sharing information with other staff, which is kind of the point of doing it." (*DOC-LS17).

Within these homes there was minimal use of the assessment tools and minimal use of the P.I.E.C.E.S. information in general. An In-house PRP commented: *"The information is invaluable and it's really helpful, but it's actually finding the time to do assessments and do it properly. We do the assessments, but we're not really using the information that we learned to full capacity."*(LS4)

All of the interview participants who had reported on the 2003 P.I.E.C.E.S. evaluation survey that the P.I.E.C.E.S. initiative had limited success, reported that a year later little had changed. Similarly, for homes in which two people were interviewed there was agreement between them that P.I.E.C.E.S. had limited success in their facility.

One Administrator believed that there is great overlap between the P.I.E.C.E.S. initiative, the Registered Nurses Association of Ontario (RNAO) Best Practices initiatives, and other dementia and delirium initiatives of the Ministry of Health and Long-Term Care. Her home had chosen to focus on the RNAO Best Practices initiatives because their educator was unable to support and sustain P.I.E.C.E.S. since she was not able to participate in the P.I.E.C.E.S. training.

3.2 Impact

Only two out of the 20 individuals interviewed indicated that P.I.E.C.E.S. had minimal impact within their home. One, an Administrator from a home in which P.I.E.C.E.S. had limited success, reported that the P.I.E.C.E.S. initiative has had no impact at all within her home: *"I can't see it having any affect, and I think one of the problems with P.I.E.C.E.S. is there's no outcomes to measure impact and there's no implementation, any follow up on how to implement it."* This home did not currently have any staff who were P.I.E.C.E.S. trained. Similarly, an Administrator from a home in which P.I.E.C.E.S. was reported to be highly successful indicated that while P.I.E.C.E.S. has resulted in a better relationship with Senior's Mental Health Outreach, the impact of P.I.E.C.E.S. within the facility *"has not been huge."*

Interview participants from homes that had limited success with P.I.E.C.E.S. and those that were from homes that had success with P.I.E.C.E.S. identified improved assessment and diagnoses and increased staff knowledge as positive impacts derived from P.I.E.C.E.S. In addition, interview participants from homes that had success with P.I.E.C.E.S. identified linkages with other resources and family satisfaction as positive impacts. Table 6 presents the various impacts associated with P.I.E.C.E.S. according to the interviewees.

Table 6: Impacts Associated with the P.I.E.C.E.S. Training Initiative

LTC homes with successful implementation	LTC homes with limited success with implementation
• Improved resident care and enhanced quality of life • Reduced negative behaviors and crises • Improved staff ability to identify and resolve the cause of problem behaviors • Improved timeliness of assessment and intervention • Improved staff awareness of depressive symptoms • Reduction in the use of medication and restraints to control behavior • Improved assessment (more comprehensive and thorough) • Improved knowledge and skills for staff who have	• Improved identification of dementia • Improved staff ability to identify the need for referral to external resources • Improved client focused and individualized approach to intervention

LTC homes with successful implementation	LTC homes with limited success with implementation
not taken P.I.E.C.E.S. training • Increased staff confidence in their assessment and intervention skills • Increased job satisfaction and perceived control • Increased enthusiasm and motivation for learning and professional development • Improved linkages with external resources • Increased family and resident satisfaction with care	

Successful implementation of P.I.E.C.E.S.

Resident care and quality of life

All participants from homes that had success with P.I.E.C.E.S. reported that the training has resulted in improved resident care and enhanced quality of life for residents. In particular, participants reported a reduction in negative resident behaviors that was attributed to their ability to identify and resolve causative factors and to do so in a timely manner thereby preventing the escalation of delirium and behavioral problems. Emphasis was placed on the importance of identifying causative factors rather than simply focusing on eliminating the disruptive behavior. An In-house PRP commented:

> *"If you're called to somebody with difficult behavior you go in right away saying okay what's the reason behind these behaviors instead of just labeling that person, I think that benefits the resident too. They're not labeled as an aggressive, non-compliant resistive person, and then everybody looks at them that way. Well is that a fair label? No, 90% of the time it isn't. There's challenges and things underlying that behavior that if you get to that you're going to give that person a better quality of life."* (S5)

Similarly, a DOC commented:

> *"Well, I think that certainly we've been able to help them quicker. We've been able to determine what is making the resident restless, or agitated or aggressive, and to deal with it in a more appropriate manner."* (S3)

Several participants also indicated that the P.I.E.C.E.S. training has made staff more aware of potential depressive symptoms in residents that would have otherwise been unrecognized or erroneously attributed to something else. Moreover, it was reported that P.I.E.C.E.S. has resulted in a reduction in the use of medication and restraints to control behavior. An Administrator commented:

> *It's a dramatic reduction in behaviors and also a dramatic change in staff attitudes towards behaviors. Whereas before, maybe if someone was having behavioral issues the first step would have been to get them on a medication to stop it. Now I have staff saying, for instance, 'Oh, she's really acting funny again. We need to get a urine specimen.' So the cause of the behavior is examined first instead of let's stop the behavior. That's the greatest impact."* (S8)

Several participants attributed enhanced quality of life for residents to the holistic approach taken in the assessment and treatment of residents. An In-house PRP provided the following example of how the P.I.E.C.E.S. assessment and care approach enhanced a resident's quality of life:

> *"We have assessed a client using the P.I.E.C.E.S., now we haven't made a total assessment there yet, but what I can tell you what we are doing…First of all the health care aide and the restorative care worker, they are looking at the ADLs, and this person's capabilities, what this client can do for themselves with, and how much help they need to do that. Do they need total assistance? Do they just need cueing with this part of their ADLs? They had a client that was able to wash themselves with a face cloth and soap, but only if she had a bar of soap. Our facility has dispensers, as I'm sure a lot of the homes do have dispensers with special soap in it. But the only way that she was able to wash herself without being totally cued in that that dispenser gave you the soap, was to use a bar of soap. And after a bar of soap was introduced she was able to wash herself without help from the staff. How wonderful that was for her."* (S6)

A comprehensive and thorough assessment was viewed as essential to developing innovative methods of care. An In-House PRP provided the following example:

> *…"They've* [PRPs] *also looked at the social aspects of how this person relates to her roommate or the roommates around her, or in the co-residents they relate to in activities and they're touching base with families. They're asking families: 'Well what did your loved one like to do when they were well? What was important to them? What kind of activities did they do during the day? What did they find that they got purpose out of?" And it's just been amazing what some of the families have related to the staff that they weren't aware of before. One lady, she liked to curl her hair and it was important that her appearance be impeccable to her, and she used to curl her hair and put it in rollers almost every night. So they decided, well we'll see if she can still do this. And what they did is they got her some rollers and gave them to her, put them down in front of her and asked her if she wanted to curl her hair, and she of course said, oh yes, that would be wonderful. They had asked her what kind of rollers she had had before, and what they had was the brush with the Velcro type that you just roll it and it kind of stays on its own, so they asked her about that and she said, oh yea, that'll be fine. But when she picked up the roller and started to put it in her hair she was trying to pick up another roller and shove it through. So we clued in to the fact that no indeed she had always used the brush type roller with the pins. So, they went out and they got that type of a roller with pins, and she could independently roll her hair every night and was quite happy doing that. And so here was an activity that was special to her, that the staff could have her do when she was agitated, and it gave her pleasure and she could do it all on her own."* (S6)

Similarly, another In-house PRP provided the following example, illustrating how a thorough assessment and medication review conducted within the home resolved several problems for a resident:

> *"I can think of one lady in particular that if we hadn't done the P.I.E.C.E.S. training or the P.I.E.C.E.S. assessment that we did, I'm not just sure where she would be now. I think when we started her assessment she was a very ill lady and we just, she had behaviors that we just couldn't understand where they were coming from and we kind of threw our hands up at one point and thought well, you know, maybe we need to have her admitted and have her taken off the medications and start fresh. But anyway, when we were sitting down we started looking at some of her medications and really looking at them from day one since she was in here, and what we had found out that she was on a couple of medications that really had bothered her physical health, like making her extremely sick to her stomach and the behavior of not wanting to get up and being kind of aggressive with us, with the staff because they were encouraging her to get up and to eat, and things like that. And so we just started on our own just kind of eliminating some of these that we felt that may be causing the problems and viola! We did it. Like she was a different woman. An absolutely different woman. So I think if we hadn't had this group you know, doing this P.I.E.C.E.S. assessment and really spending the time on one particular person, with everything so busy you know, you kind of, things like that kind of maybe get overlooked a little bit, and I think with our assessments we look at the real holistic person and we delve into their physical and*

> *their social and their mental needs, and really we can do a lot in house now that we probably couldn't do before, or didn't know anything about before.* (S7)

Staff knowledge and skills

Many participants indicated that the P.I.E.C.E.S. initiative has had a significant impact on improving the knowledge and skills of registered and unregistered staff, and particularly those who had not taken the P.I.E.C.E.S. training. An In-house PRP commented:

> *"We've had in-services regarding P.I.E.C.E.S. for our health care aides and our registered staff, and I think everybody has a better awareness of you know, what can cause behaviors and how to dissipate them, what to do when they occur, and so I think that has affected all aspects. Even our housekeeping staff have all had some information and I think everybody's more comfortable with it."* (S12)

Similarly, another In-house PRP commented:

> *"And actually I think we have a lot of people here doing interventions and understanding the whole process better. The health care aids as well without sort of really knowing formally of what they're doing, they are doing intervention a lot."* (S14)

Staff have become more aware of the various factors that can affect health and behavior, and how to effectively assess and manage difficult behaviors. Medication reviews were a component of the assessment process that many In-house PRP's identified as particularly useful to their clinical practice. Moreover, the P.I.E.C.E.S. initiative has provided a model for general resident assessment and care, not just for dementia. An In-house PRP commented:

> *"We're using the P.I.E.C.E.S. model in a lot of our team work that we do to assess the residents in all kinds of different things so we've really utilized that model and expanded on it here, on our own, and so its been a very positive thing for the facility"* (S6)

In general, it was reported that staff are more confident with their assessment and intervention skills, they have greater job satisfaction, and an increased perceived control within their workplace. One Administrator commented that staff confidence in dealing with psychogeriatric issues will be critical in the long-term as it appears that more individuals with mental health problems are being admitted to long-term care. When problems arise staff are less distressed and more confident about the potential to resolve issues because of their own improved skills or because they know that they have a proven in-house resource. An Administrator commented: *"I think there's a level of confidence among the unregulated care professionals that the professional staff are managing this well."* (S2). An In-house PRP commented:

> *"In our facility we've had a couple of* [staff] *with P.I.E.C.E.S. other than* [the PRPs] *and they have gone ahead and done cognitive testing and are able to come to us with somewhat of a picture before we even get there. So I think it too gives them some security and confidence in doing assessments…I think it's organized my work. You start and go down the acronym and you're able to organize your work more…So I think it's made me feel more confident in my assessments because I'm able to have a more organized way of doing it."* (S5)

Several participants indicated that improved awareness of the etiology of behavior problems and increased confidence with assessment has resulted in more timely identification and intervention. Moreover, staff are more confident in their ability to provide accurate and useful information when consulting with external resources regarding difficult cases. Several participants reported that they have developed a reputation as psychogeriatric

experts within their community, with local PRCs, the Alzheimer Society, local geriatricians and psychiatrists, and with families.

Participants indicated that the P.I.E.C.E.S. training has resulted in an increased enthusiasm and motivation for learning and professional development. A DOC commented:

> *"They* [staff] *have really soaked it* [P.I.E.C.E.S. training] *up like a sponge. They just loved it and got so much out of it and felt so much more knowledgeable in dealing with dementia...I do think it* [P.I.E.C.E.S. information] *filters out. I've had a number of staff ask me if they can take it and you know, they're just really keen on learning and see the knowledge that their co-workers have and they go to them regularly for advice and how to handle various situations…I think its made a number of staff very enthusiastic to learn more."* (S3)

Linkages with other resources

In general, many participants from homes identified as having success with P.I.E.C.E.S. indicated that they have improved their linkages with external resources to improve care for residents. In some cases this has involved increased linkages with other resources. This increase was attributed to greater awareness of the availability of external resources and greater awareness of how and when to use these resources. In other cases, linkages with external resources have decreased because homes are able to manage difficult cases in-house. However, interactions and information sharing with external resources were viewed as improved as homes are able to provide more detailed information to facilitate consultation and are more confident and comfortable doing so.

Some of the homes with P.I.E.C.E.S. trained staff have established stronger and closer relationships with:

- *Other facilities:* to assist them to use the P.I.E.C.E.S. training to its full potential; they have acted as resources to share and provide information about assessment tools and recording forms, interventions, and implementation strategies

- *Geriatric Mental Health Outreach Programs:* to provide case management for residents who are clients of outreach programs

- *Regional Geriatric Programs, local geriatricians and geriatric psychiatrists:* to consult on difficult cases

- *PRCs*: to consult on difficult cases

- *Alzheimer Chapters:* to consult on difficult cases

- *Palliative care teams:* to facilitate a P.I.E.C.E.S. type model for palliative care.

Family Satisfaction

Many participants believe that family satisfaction with resident care has increased as a result of P.I.E.C.E.S. As residents' problems are resolved and as families access knowledgeable staff they are less distressed.

> *"I think they see their residents being calm, fully engaged in life in that unit [specialized dementia unit]… The consistency of caregivers I think the family appreciate because they always know who's going to be there and who to ask questions of."* (S2)

Moreover, with information from P.I.E.C.E.S. trained staff, families have a greater understanding of the problem, how the home is assessing and attempting to resolve the problem, and how they can effectively participate in this process.

Limited success with P.I.E.C.E.S.

All but one of the interview participants from homes with limited success with P.I.E.C.E.S. were able to identify at least one positive impact that the initiative has had in their home. Although, some of these homes do not routinely assess residents or develop intervention plans based on assessment results, several participants reported that when they have used P.I.E.C.E.S. assessment tools, the information has assisted them in determining whether or not residents have dementia and the need for a referral to external resources. The following are some of the impacts described by some of the interview participants:

> *"The impact it has is mainly on doing assessments and knowing whether they're demented or not. That's the primary impact"* (PRP-LS4).
>
> *"Being able to identify, determine the cognitive ability of the resident."* (Administrator – LS1)
>
> *"I do think it's made staff more aware of looking for patterns and looking for triggers more so than just saying, 'oh, they're a sundowner' and that be the end of it."* (DOC – LS17).

According to the selection criteria of homes identified as having limited success with P.I.E.C.E.S., they have had limited participation with external resources as a result of P.I.E.C.E.S. Some of the participants from these homes indicated that as a result of P.I.E.C.E.S. they were better informed to make referrals to outside resources, but that referral patterns had not changed.

A DOC commented that as a result of P.I.E.C.E.S., interventions in her home have become more client focused and individualized, and thus more effective. She commented: *"I think we're more aware of doing specific interventions for that resident in particular, rather than just kind of doing a generic solution for everybody."* (LS17)

3.3 Implementation

A number of factors affecting the implementation of the P.I.E.C.E.S. training initiative within LTC homes were identified in this evaluation. Homes with limited success with P.I.E.C.E.S. identified factors that posed as barriers to their implementation of the initiative (see Table 7).

Table 7: Factors Affecting the Implementation of the P.I.E.C.E.S. Training Initiative

LTC homes with successful implementation	LTC homes with limited success with implementation
• Management support • Designated time for P.I.E.C.E.S. activities (assessment, data collection) • Availability of P.I.E.C.E.S. trained staff • Peer, PRC, and physician support and commitment • Effective learning strategies and resources used in training	• Lack of designated time for P.I.E.C.E.S. activities • Lack of available P.I.E.C.E.S. trained staff • Lack of staff support • Failure of P.I.E.C.E.S. to meet needs for tools and infrastructure for successful implementation (staff, space, resources)

Successful implementation of P.I.E.C.E.S.

Management Support

Management support was identified as one of the key factors contributing to the success of P.I.E.C.E.S. in LTC. Administrative support was deemed necessary for the provision of designated staff to the In-house PRP role and to ensure adequate time and staffing to conduct thorough assessments, to obtain necessary resources and to utilize resources made available to facilities, to consult with staff and external resources, to develop appropriate care plans, and to evaluate outcomes. An In-house PRP commented:

> *"The most important, is management. If they're not going to buy in to it then you have a very difficult time. I know when we get together with our resource people, they have a number of issues because they're coming from other facilities that are probably for profit, they maybe don't have the support of their management in applying this knowledge and being freed up, spending the time to go and assess the client, using the P.I.E.C.E.S., and to bring in a holistic approach. Now some of our resource people in some of the facilities in* [this county] *do have some of that support… Some of the others are struggling a lot because the management isn't supportive and certainly some of their groups, their people that they have employed there will come to us and they've asked us, how did you set up your program and what do you do at* [your home] *and looking at what we do so that they can maybe apply some of that to their facility."* (S6)

Management support has included: recognition of the course on learners' performance appraisals, personal letters of congratulations to learners that are retained in their employment files and sent to head or corporate offices of the facility, and recognition among peers so that their expertise is publicly acknowledged and supported.

Designated Time for P.I.E.C.E.S. Activities

One of the most important elements of management support identified by participants has been the designation of time to undertake P.I.E.C.E.S. activities. Interview participants from facilities that have been successful in their implementation of P.I.E.C.E.S. reported that they have designated time to conduct thorough assessments, ensure comprehensive data collection, consult with staff, physicians, and external resources, develop individualized care plans, and to assist staff with interventions. Time and staffing issues were identified as challenges to ensuring the successful implementation of P.I.E.C.E.S. Participants stressed the importance of ensuring that there is sufficient time allotted to P.I.E.C.E.S. activities and that there are sufficient numbers of P.I.E.C.E.S. trained staff to facilitate data collection, assessment, and to sustain care initiatives. Without designated time, many participants indicated that they would be unable to implement the initiative. An Administrator commented:

> *"Well, certainly in my case the availability of time, time I think is the biggest issue. I don't really think that somebody can be an effective P.I.E.C.E.S. person one day a month. And I know I have a colleague who works in a very big home for the aged and she has one day a month for 108 residents, and I think it would be impossible. Time would be the biggest issue."* (S8)

Similarly, a Director of Care commented:

> *"If the RN is doing everything else, it* [P.I.E.C.E.S.] *just becomes another task to try and fit in the day and sometimes that's impossible. In small homes when there just isn't the staffing flexibility, its very, very difficult to utilize this as well, I mean I'm not saying it can't still be done, but not to the same*

degree. In the larger homes, when there is that flexibility, you know, obviously you can give it more time, more effort and it can be done in a much, a much better manner." (S3)

Availability of P.I.E.C.E.S. trained staff

Several participants indicated that availability of several P.I.E.C.E.S. trained staff within the home contributed to the success of the initiative. This allowed for mutual support to assist non-P.I.E.C.E.S. trained staff with data collection, new interventions, and to share workloads (e.g., assessment and care planning). Moreover, particularly difficult cases were better served when several P.I.E.C.E.S. trained staff were involved in problem-solving. As discussed earlier, the benefit of designating several staff members to conduct assessments and care plan has resulted in the proactive management of dementia related challenges.

However, as P.I.E.C.E.S. trained staff leave their home, the home is challenged to continue the initiative. One participant commented that although her home's experience with P.I.E.C.E.S. has been positive, as trained staff members leave the home, the level of P.I.E.C.E.S. activity drops:

"We have had four staff as far as I know, have been through the training. One staff went on to another facility and the other staff has retired; the third one has been off on maternity leave for a couple of years, so it's mostly been just one staff. So as far as using the information as a learning tool for the rest of the staff, that has not happened."

Related to staff availability, a few participants indicated that a challenge to training staff is the cost of staff coverage. An Administrator described the funding challenges associated with ensuring that her home has enough P.I.E.C.E.S. trained staff:

"It's a money issue. I think you can only send one or two [staff]. *Well you wouldn't want to send any more anyway because it's quite involved and lengthy, but just I think the money issue because you have to replace that staff."* (S19)

Peer, PRC, and physician support and commitment

Support from peers, PRCs, and physicians was viewed as important to the success of P.I.E.C.E.S. Facilities in which P.I.E.C.E.S. has been successful have staff that are willing to use their In-house PRP as a resource, to accept and implement suggestions for assessment (data collection) and intervention, and are knowledgeable about and committed to the P.I.E.C.E.S. approach to care. Implementation of the P.I.E.C.E.S. initiative has also been supported by PRCs who have regular interactions with facilities for specific consultations and education initiatives. An Administrator commented on the role of home staff in contributing to the success of P.I.E.C.E.S.:

"The quality of our staff, their commitment to it, they are convinced that they can see the results. They would far sooner do it this way than be dealing with crisis and behaviors that are unmanageable." (S2)

Several participants indicated that initially non-registered staff and registered staff who had not taken the P.I.E.C.E.S. training were reluctant to complete recording forms and to implement new care approaches. One Administrator attributed the lack of willingness to document or record behaviors to the heavy workload. In general, most participants indicated that as staff experienced success as a result of their efforts, they have *"come on board"*. An In-house PRP commented:

"It has taken us a while to get the non-registered staff on board a lot of the time. I think more and more they are seeing the benefit of calling us now. But at one time you know, you'd give them, tell them care plans and talk over strategies, and they don't follow through with it, or we put out documentation to do, behavior monitoring or any of those kinds of things, and they're not completed. And you go and you

> *say: 'Okay I can't help you unless this is done.' And they just look at it as 'Oh my God, more paperwork!' What benefit is that?"* (S5)

Similarly, several participants indicated that physicians were initially not supportive of their efforts to implement P.I.E.C.E.S. and one In-house PRP reported that she continues to experience resistance with physicians who are not well informed about dementia and dementia-related interventions. Physician interest with P.I.E.C.E.S. assessment and intervention appears to have increased with staff enthusiasm, knowledge, and positive outcomes. An In-house PRP commented:

> *"I think we got quite a bit of resistance at first* [from physicians] *and that is because they didn't realize maybe what this was all about, and we do delve into medications pretty heavily, and I think maybe they were just a little afraid that we were telling them, those sorts of things…So, when we stepped in with the psychotropic suggestions they were very receptive to us… I guess they could trust our judgment. We always conferred heavily with them at first before we went any further, so we weren't stepping on their toes. And after that, that was fine. We're very well liked by the medical field."* (S7)

Learning strategies and resources used in training

Many participants reported that the assessment tools and P.I.E.C.E.S. binder were useful resources that they utilize on an ongoing basis and contributed to their success as In-house PRPs. A few participants reported that the networking component of the P.I.E.C.E.S. training has assisted them to sustain the initiative. One In-house PRP reported that in her area P.I.E.C.E.S. trained staff members across a number of facilities and agencies, including the Alzheimer's Society, CCAC, and acute care, meet at least once a month *"as a networking group":*

> *"… we bring in new forms. We bring in new techniques, that have been really good or things that have failed and it has been very, very helpful. So we leave at the end of each day with some good information…"* (S7).

Similarly, the design of the P.I.E.C.E.S. training facilitated knowledge transfer. An In-house PRP commented:

> *"I really really think that the way they did the group activities was really, really good. We had to get up. You had to perform working in groups. That was a benefit and actually it gives you an idea of how to formulate those discussions with staff at work. So I found that very helpful."* (S6)

Although many participants reported knowledge transfer within their facilities, several commented that increased education for non-P.I.E.C.E.S. trained staff continues to be a weak area of the initiative, as well as a challenge. Participants reported that facilities are challenged by heavy workloads and limited staff coverage to share P.I.E.C.E.S. information.

Finding time and continued support for connecting with other facilities as a networking resource was identified as a challenge to the implementation of P.I.E.C.E.S. The PRC was viewed as critical to supporting this. An Administrator commented that P.I.E.C.E.S. in her home has been limited by the inability of staff to network with other In-house PRPs:

> *"I honestly I think it's we really needed someone to link the facilities together and to keep us, the P.I.E.C.E.S. framework in focus for us, and I think more just talking with the other people that are involved…The P.I.E.C.E.S. Coordinator would make a difference, but maybe its just the coordinator we have, but I'd be anxious to see how its working in other areas. I really felt when we heard about that it was going to be a good idea, it would be one way of getting together every once in a while, even once every three months, to refocus and to talk problems out and that has not happened at all."* (S16)

Limited success with P.I.E.C.E.S.

Lack of time and P.I.E.C.E.S. trained staff

Time and staffing issues were identified most frequently as the most significant barriers limiting the development of P.I.E.C.E.S. An Administrator from a home that had limited success with P.I.E.C.E.S. identified lack of designated time for P.I.E.C.E.S. activities as a significant barrier to its development in her home:

> *"If you take people off the floor to train, when they come back they've still got their own job to do and they're expected to do it along with, and you don't have a dedicated position."* (LS1)

Similarly, a DOC commented:

> *"Dedicated time to work solely on that. That's something that I see in other facilities where it's been successful and that's what they have. They have dedicated time each week and that's what they're to focus on."* (LS17)

An In-house PRP from a home that had limited success, indicated that given other crises that occur in long-term care, P.I.E.C.E.S. gets *"put on the back burner and you don't get back to it, sometimes it's just the time and staffing."* (LS4)

A few interview participants attributed their lack of success with P.I.E.C.E.S. to the chronic shortage of registered staff in long-term care, which limits their ability to send staff to training and to train several staff members, to provide them with designated time for P.I.E.C.E.S. activities, and to recruit staff with P.I.E.C.E.S. training. An Administrator commented on difficulty associated with sending staff for training:

> *"Management support is there. They appreciate the concept of the idea, but again, they don't have control over the availability of registered staff that are here. When you don't have registered staff, it's difficult to replace them."* (LS1)

Similarly, a DOC commented that the lack of availability of P.I.E.C.E.S. trained staff has compromised its implementation:

> *One of our P.I.E.C.E.S. trained persons works mostly nights and so she isn't a big participant in the main stream of things. She feels limited. She doesn't come to the meetings because, of course, meetings are inconvenient for night staff. We had trained a second person and that second person actually ended up getting another job. She's still on our casual call in list, but she hasn't been back to the facility for some time."* (LS17)

Lack of staff support

Lack of staff support, particularly staff who had not taken the P.I.E.C.E.S. training, was identified as a barrier to the development of P.I.E.C.E.S. An Administrator, who had taken the P.I.E.C.E.S. training, provided the following illustration:

> "*We had a lady with a colostomy, very elderly. And she started to talk about having a baby and she'd be looking for the baby. And I deemed that whenever she did that it was because she was having trouble with her colostomy; she was either constipated or the colostomy needed changing. The staff would not agree with that. They even went out and bought a doll, a baby for her. It took, I would say it took me about six months to finally get them convinced that if she's talking baby, look at her colostomy."* (LS1)

Facilities that have had limited success with P.I.E.C.E.S. reported minimal interaction with their PRC. One Administrator suggested that PRCs are not used to their full potential because the intervention plans that they develop are not practical to implement in long-term care because they are too time consuming:

> *"Sometimes they're not always a help. It doesn't seem that it's always realistic. It's very time consuming, the treatment or the plan. For instance, if its toileting, the plan, book learning and the real world – sometimes they're realms apart."* (LS1)

Failure of P.I.E.C.E.S. to meet needs for tools and infrastructure for successful implementation

Several participants attributed the lack of success of P.I.E.C.E.S. to the initiative's inability to meet their needs for practical and useful tools and to create an infrastructure for the optimal use of the In-house PRP. One In-house PRP, from a home in which P.I.E.C.E.S. has had limited success, was disappointed with the tools provided and suggested the need for *"the more practical things, not this airy-fairy you know pie in the sky stuff. We're dealing with real human beings here and they're not predictable."* (LS4)

Limited success with the P.I.E.C.E.S. initiative was attributed to lack of knowledge transfer and limited and inappropriate use of the In-house PRP. A Director of Care commented:

> *"My understanding was that the P.I.E.C.E.S. people were to come back and share information with the other staff and when they see a problem on the floor, that they were to initiate doing some of this behavior mapping and suggest tools for assessing the resident. But it seems like it was more used as this a person who can do mini mentals for the residents when the doctors ask for mini mentals …We should be using the tools and trying to solve the problems and the psychogeriatric team is to back us up if we can't resolve problems."* (LS17)

Another Administrator attributed the lack of success of P.I.E.C.E.S. in her home to the challenge of providing staff coverage to support training initiatives that occur outside of the home. Alternatively, she suggested that P.I.E.C.E.S. training should be provided within facilities so that more than one staff member can attend.

One Administrator reported that staff who had attended the P.I.E.C.E.S. training were not pleased with the sessions:

> *"She's boring. That's literally what they told me. I don't know this person, but they said they don't go because its boring and the person has been some helpful with a couple of residents, but when they got right to care planning it was boring."* (LS9)

3.4 The Future of P.I.E.C.E.S. In Long-Term Care

Successful implementation of P.I.E.C.E.S.

Many participants from homes in which the implementation of P.I.E.C.E.S. has been successful have expressed concern that ongoing P.I.E.C.E.S. training will not be available to either sustain the initiative or to provide training to staff to replace P.I.E.C.E.S. trained staff that leave their home. Several participants also emphasized the need for continued education for front-line workers, particularly health care aides. An In-house PRP commented:

> "*I would like to see certainly more education for the health care aid, the health care aid is the person that sees the resident the most and we really only can react to what is recorded to us, or of course what is observed, but it's the health care aid that's doing the greater part of the observing and you know, I think it would be wonderful if there was some education for them."* (S10)

Moreover several participants expressed concern about the uncertainty of continued funding to sustain the In-house PRP and designated time for P.I.E.C.E.S. activities. An In-house PRP commented:

> *"We were up in the air as to whether our position would continue at all. And the only reason it wouldn't continue was because they wouldn't have the funding for it and so our administrator had to really go out there and work miracles. And they were able to work the miracles in order to get the funding from three different sources, to fund it, to continue to fund it. Otherwise, it would have been down the drain and I would have gone back to the unit, I wouldn't have lost my job, but I would have gone back to being an RN in charge of a unit of 100 people, or an area of 100 people, and I would continue to utilize my P.I.E.C.E.S. training, but I would not be able to expand on it in my own unit…It would be a real challenge."* (S6)

Interview participants shared some of their visions for P.I.E.C.E.S. in LTC:

- Continued P.I.E.C.E.S. training and support
- Full-time permanent In-house PRP positions
- Full and comprehensive assessments for all new admissions
- P.I.E.C.E.S. training for all registered staff
- P.I.E.C.E.S. training a condition of employment
- Increased training for front-line workers – to support the work of In-house PRP, to sustain assessment and intervention.
- Refresher sessions to maintain momentum
- Increased mentoring and bed-side teaching
- Increased use of networking sessions among homes and agencies
- P.I.E.C.E.S. training in nursing schools, including RPN and health care aide education programs, so that the new workforce is prepared.

Limited success with P.I.E.C.E.S.

Despite limited involvement with P.I.E.C.E.S., participants from LTC homes that had limited success with this initiative were considering strategies to facilitate its implementation. A DOC was hoping to change staffing patterns so that some time could be dedicated to P.I.E.C.E.S. activities, particularly routine screening on admission. Similarly, an In-house PRP planned to encourage her home to send more staff for training:

> *"I'd like to see more. I'd like to see it continue because I think if we keep pushing it, it eventually will have some effect. I think it's just a matter of being persistent… I think it's invaluable. If we continue to educate people eventually, hopefully, there will be a bigger impact for the residents."*

One Administrator, from a home that had limited success with P.I.E.C.E.S., commented that it was unlikely that their home would continue with P.I.E.C.E.S. because they were not committed to it and did not have a "champion" to ensure its implementation.

4. 0 CONCLUSIONS

Overall, most participants had positive perceptions about the *Putting the P.I.E.C.E.S. Together* learning initiative, identified significant benefits for residents, staff, and families, and were supportive of its continued role in long-term care.

Facilities identified as having had success with the P.I.E.C.E.S. initiative are involved in a number of key P.I.E.C.E.S. related activities: assessment (data collection), case conferencing, care planning, staff education, provision of care, linkages and partnerships with external resources (In-house PRP networks, other facilities, PRCs, the Alzheimer Society, geriatric outreach programs).

Successful experiences with P.I.E.C.E.S. were attributed to a number of factors including management support, particularly support for the provision of P.I.E.C.E.S. training for staff and time to assume the In-house PRP role (time to complete assessments, consult with other resources, and to provide staff education), willingness to provide necessary resources (tools, reference material, space) and to utilize resources made available to facilities, availability of more than one P.I.E.C.E.S. trained staff within the home, staff willingness to access and value their In-house PRP, PRC and physician support, and the transfer of knowledge from P.I.E.C.E.S. trained staff to front-line workers. Time and staffing issues were identified most often as challenges to implementing P.I.E.C.E.S.

Many of the facilities identified as having had limited success with the P.I.E.C.E.S. initiative were minimally involved in P.I.E.C.E.S. activities and were primarily limited to assessments conducted to assist them with diagnosis and referral to external resources. Three of the twelve homes invited to participate in the interviews did not currently have a P.I.E.C.E.S. trained staff member and were not currently engaged in any P.I.E.C.E.S. related activities.

Limited success with P.I.E.C.E.S. was attributed to the lack of P.I.E.C.E.S. trained staff (one was not enough, or the In-house PRP had left the home and was not replaced), the chronic shortage of registered staff in long-term care, which limits their ability to send staff to training and to train several staff members, to provide them with designated time for P.I.E.C.E.S. activities, or to recruit staff with P.I.E.C.E.S. training, inappropriate use of the In-house PRP, lack of transfer of learning, lack of strategies to sustain the initiative (mentoring, networking), lack of support from peers who are reluctant to complete recording forms or implement new care approaches, and minimal PRC involvement and support.

Almost all of the interview participants were able to identify at least one significant outcome of the P.I.E.C.E.S. initiative. Many participants cited the positive impacts of the program such as reduced disruptive behaviors, improved quality of life and care of residents, timely intervention, enhanced staff knowledge, skills, and confidence and reduced staff stress, improved linkages with external resources, and increased family satisfaction. For facilities with limited success with the initiative, assessment to assist in diagnosis and referral and increased staff awareness of psychogeriatric issues were particularly relevant outcomes.

Many participants supported continued funding for P.I.E.C.E.S. (i.e., for staff training and designated time for P.I.E.C.E.S. activities) and hoped for continued expansion of the initiative.

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