

**“Putting the P.I.E.C.E.S.
Together”
Training Initiative 2001**

Final Evaluation Report

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EXECUTIVE SUMMARY

Overview of P.I.E.C.E.S. Initiative

Through the Ontario Government’s comprehensive, multi-year provincial Strategy for Alzheimer Disease and Related Dementias, the “Putting the P.I.E.C.E.S. Together” 2001 Training Initiative was offered to professional staff in long-term care (LTC) facilities and CCACs. The overarching goals of the program were for participants to:

- gain new knowledge for assessing and managing an older person’s complex physical and cognitive/mental health problems and associated behaviours;
- increase the knowledge shared across a provincial network for improved care of older persons with complex physical and cognitive/mental health needs and associated behaviours;
- promote the growth and development of local LTC facility resources and community psychogeriatric partnerships to provide the best care to residents; and
- promote a common language among individuals who care for those with Alzheimer disease and related dementias as well as other mental health and associated behavioural issues.

The “Putting the P.I.E.C.E.S. Together” initiative was first implemented in 1998 and involved staff from LTC facilities across the province. Results from the evaluation of the 1998 program were used to update the content of the 2001 training initiative as well as its implementation. The 2001 “Putting the P.I.E.C.E.S. Together” training initiative involved the following components:

- Part One: 3-day intensive program of core curriculum held centrally (in Toronto)
- Part Two: practical application of skills from Part One
- Part Three: 2-day consolidation program held regionally
- Part Four: post-training support

As part of the “Putting the P.I.E.C.E.S. Together” training initiative, a comprehensive evaluation of the program was undertaken. The primary goals of the evaluation were to:

- evaluate the implementation of the P.I.E.C.E.S. 2000-2001 Training Initiative and its impacts on: participants, persons with Alzheimer disease and related dementias as well as other mental health and associated behaviour problems, and their caregivers;
- support reflective practice and sustained quality improvement in long-term care facilities and CCACs;
- identify factors that help and hinder implementation and sustained impact of such initiatives;
- evaluate the benefit of the strategy in enhancing collaboration, co-ordination across sectors and in developing health care networks; and
- evaluate the impact of using technology to help coach and sustain what was learned during the training initiatives.

Preceptors

A total of 86 preceptors, representing 44 Outreach Teams, attended the 2-day preceptor training session. On average, the preceptors had worked with their Teams for 5 years, with persons with Alzheimer disease and related dementias for an average of 11 years, and with the severely mentally ill for an average of 12 years. One third of the preceptors reported having some exposure to P.I.E.C.E.S. training and 60% reported using the P.I.E.C.E.S. framework in their practice.

Preceptors reported that the 2-day training session helped to improve their understanding in a variety of areas including: the use and interpretation of assessment tools; understanding and application of the P.I.E.C.E.S. framework; and clarification of their role as preceptors.

In the post-training questionnaire, preceptors’ average ratings of confidence in helping others learn the P.I.E.C.E.S. framework and taking on a role as P.I.E.C.E.S. preceptor indicated that they were quite confident in taking on these activities.

LTC Facility Participants – Pre-Training Questionnaire and 3-Day Session

There were a total of 345 long-term care (LTC) facility representatives who participated in the 3-day sessions and 314 who attended the final 2-day sessions.

The majority of LTC facility participants (94%) had a nursing background. On average, the participants reported having 8 years of experience in their current facility, 17 years of experience in their current profession, 12 years of experience working with persons with Alzheimer disease and related dementias, and almost 6 years of experience working with the severely mentally ill. One quarter of LTC facility participants reported having some exposure to P.I.E.C.E.S. training. For most of these individuals, this occurred through a coworker who had attended a previous training session.

The initial 3-day sessions were rated highly, with average ratings for various components of the 3-day session approaching “very good” to “excellent”. The average ratings for the P.I.E.C.E.S. educators and the 3-day session overall approached “excellent”.

When asked to rate: (i) their understanding of their role as a Psychogeriatric Resource Person and (ii) their confidence in taking on a role of Psychogeriatric Resource Person, the average ratings were somewhat lower, suggesting that more information and more support may be needed.

CCAC Teams – Pre-Training Questionnaire and 3-Day Session

There were a total of 42 CCAC Resource Teams that participated in the initial 3-day training sessions and 35 Teams that participated in the final 2-day sessions.

The majority of CCAC Team members had nursing backgrounds (84%). They reported having an average of almost 6 years working in their current CCAC, almost 16 years of experience in their current profession, an average of 9 years working with persons with Alzheimer disease and related dementias, and an average of 3 years working with the severely mentally ill. Less than 13% of participants reported having exposure to the P.I.E.C.E.S. training.

Average ratings of various components of the 3-day session ranged from “good” to “excellent”. The average ratings for the P.I.E.C.E.S. educators was between “very good” and “excellent” and for the 3-day session overall was “very good”.

When asked to rate: (i) their understanding of their role as a CCAC P.I.E.C.E.S. Resource Team and (ii) their confidence in taking on a role of P.I.E.C.E.S. Resource Team, the average ratings suggested that there was room for improvement.

Practical Assignments

As part of the training initiative, participants/teams were asked to complete a practical assignment that involved identifying a resident/client with cognitive/mental health needs and associated behavioural issues, applying the P.I.E.C.E.S. framework with this individual, and providing information on this experience.

A sample of 70 practical assignments completed by LTC facility participants were selected for review. An analysis of these cases revealed that the participants had a significant impact on many of these individuals. The behaviours exhibited most frequently in the sample selected were physical agitation, physical aggression,

verbal agitation and wandering. In terms of assessment tools, the MMSE and CAM were conducted at both pre and post time periods in over 50% of cases, and the CMAI and Cornell were conducted at both time points in at least 40% of cases. There was a statistically significant improvement in Cornell scores, and in both the disruptiveness and frequency of behaviours as determined by the CMAI from pre to post. As well, there were 5 individuals who screened positive for delirium during their pre-assessment, but only 1 who was still positive at post.

In terms of the CCAC Teams, all of the practical assignments were reviewed and analyzed (N=38). Assessment tools were conducted at both pre and post in a relatively small number of cases (e.g., ranging from 40% of cases for the MMSE to 8% of cases for the CMAI). Thus, it is more difficult to determine the impact of the CCAC Teams’ involvement in these cases. There was, however, a statistically significant improvement in the CMAI disruptiveness and frequency scores; although this only involved 3 clients.

LTC Facility and CCAC Participants – 2-Day Session

The 2-day session was also received positive feedback. The average rating for the session overall was “very good” and for the P.I.E.C.E.S. Facilitation team was between “very good” and “excellent”. Overall, the participants reported that holding the final 2-day sessions regionally provided them with opportunities to meet and network with other local resources, and to share experiences of what has worked well in their local communities.

When asked to rate their confidence in serving as resource people, the average ratings suggested that the participants were somewhat confident. However, the participants did report that their confidence in this area after the training had increased since that prior to the training. The participants also reported being fairly confident in working with both internal and external resources.

LTC Facility Participants – Post-training Questionnaire

Post-training confidence scores were significantly higher than pre-training scores in the following areas: flagging and understanding mental health problems in general; undertaking certain aspects of the P.I.E.C.E.S. assessment (i.e., assessing emotional and spiritual health, environmental factors, and social and cultural factors); the use and interpretation of assessment tools; and identifying potential side effects of psychotropic medications. Pre-training confidence scores were significantly higher than post-training scores in a few areas: working collaboratively with others and for two of the P.I.E.C.E.S. training objectives. However, average ratings of self-reported change in confidence indicated that participants’ were more confident after then training than they had been prior to the training in all areas.

Participants’ confidence in taking on the role of Psychogeriatric Resource Person decreased from pre to post-training. This difference was statistically significant. However, the average self-reported confidence rating indicated that the participants felt more confident about taking on this role after the training than they had before. The participants also indicated that they felt quite supported in taking on this role, particularly by their supervisors and facility administrators.

When asked to identify the barriers they would most likely face in trying to apply what they learned in the training, those most frequently identified were “work and time pressures”, “pressure from peers to resist change” and reported “lack of reinforcement”.

CCAC Teams – Post-Training Questionnaire

In all but a few areas assessed, post-training confidence ratings were higher than pre-training ratings. These differences were statistically significant in the following areas: working collaboratively with physicians; detecting and understanding a variety of mental health/behavioural concerns; assessing intellectual capacity; using and understanding some assessment tools; psychotropic medications; and in two of the training objectives. Average scores of self-reported change in confidence support these findings. In all but one case, these ratings indicate that the CCAC Teams’ confidence after the training was higher than it was prior to the training.

The CCAC Teams also reported an increase in confidence from before to after the training in taking on the role of P.I.E.C.E.S. Resource Team. This difference was not statistically significant. The self-reported change in confidence also indicates that the Teams were more confident after the training initiative.

When asked to identify what barriers the Teams were likely to face in trying to implement what they learned, the barriers identified most frequently were “work and time pressures”, “lack of reinforcement” and “pressure from peers to resist change”.

Supportive Technology

In order to provide support to the P.I.E.C.E.S. trained individuals after they returned to their workplaces, a number of strategies were developed and implemented. These strategies included:

- scheduled teleconferencing opportunities (i.e., TAP) to coach participants with the integration of new skills and knowledge into day-to-day practice and to clarify P.I.E.C.E.S. concepts and
- a service that provides timely fax or email advice on clinical and educational problems (i.e., TIPS).

The average ratings of the value of the Timely Information P.I.E.C.E.S. Service (TIPS) service in terms of supporting the training for both the LTC facility participants and CCAC Teams suggested that it was of some value to these groups. The participants identified having difficulty accessing the site and some were not always satisfied with the responses they received. Many of the respondents, however, found the service to be helpful.

Forty-five percent of LTC facility participants and 63% of CCAC Teams reported that they had searched the P.I.E.C.E.S. website. Thirty percent of LTC facility participants and 17% of CCAC Teams said that they had not because they did not have access to the Internet. Approximately 90% of LTC facility participants and 97% of CCAC Teams reported that they would use TIPS again in the future if it was available, and 95% of LTC participants and 100% of CCAC Teams indicated that they would like to have access to the P.I.E.C.E.S. website.

In terms of the Telephone Assistance Program (TAP), the average ratings of its value in helping participants apply and understand what they learned indicated that this service was of limited value to these groups. Some respondents seemed unclear about the purpose of TAP and how to use the service. Among those who did use the service, a number suggested that there be more sessions held with fewer participants per session, that there be an agenda for the sessions, and that the sessions be held on a more regular basis.

1.0 OVERVIEW OF THE “PUTTING THE P.I.E.C.E.S. TOGETHER” TRAINING INITIATIVE

Through the Ontario Government’s comprehensive, multi-year provincial Strategy for Alzheimer Disease and Related Dementias, the “Putting the P.I.E.C.E.S. Together” 2001 Training Initiative was offered to professional staff in long-term care (LTC) facilities and CCACs. The overarching goals of the program were for participants to:

- gain new knowledge for assessing and managing an older person’s complex physical and cognitive/mental health problems and associated behaviours;
- increase the knowledge shared across a provincial network for improved care of older persons with complex physical and cognitive/mental health needs and associated behaviours;
- promote the growth and development of local LTC facility resources and community psychogeriatric partnerships to provide the best care to residents; and
- promote a common language among individuals who care for those with Alzheimer disease and related dementias as well as other mental health and associated behavioural issues.

The “Putting the P.I.E.C.E.S. Together” initiative was first implemented in 1998 and involved staff from LTC facilities across the province. Results from the evaluation of the 1998 program were used to update the content of the 2001 training initiative as well as its implementation. The 2001 “Putting the P.I.E.C.E.S. Together” training initiative involved the following components:

- Part One: 3-day intensive program of core curriculum held centrally (in Toronto)
- Part Two: practical application of skills from Part One
- Part Three: 2-day consolidation program held regionally
- Part Four: post-training support

The 3-day sessions (Part One) were all held in Toronto during the spring of 2001. The 2-day sessions (Part Two) were held regionally in the fall of 2001 and involved both the LTC facility and CCAC participants. Graduates from the 1998 P.I.E.C.E.S. training, as well as preceptors from local outreach teams, were also invited to attend the 2-day sessions. The purpose of holding regional sessions was to enhance understanding of the resources available in each community and to foster communication and networking.

One of the main findings from the 1998 evaluation was the need for support for the P.I.E.C.E.S. trained individuals after they returned to their facilities. Specifically, the evaluation found that the education initiative had many benefits for the participants and the long-term care system, but that efforts were needed to reinforce, sustain and support gains achieved through the training. As a result, a number of strategies were developed and implemented in the 2001 initiative to help support these individuals. These strategies included:

- scheduled teleconferencing opportunities to coach participants with the integration of new skills and knowledge into day-to-day practice and to clarify P.I.E.C.E.S. concepts (TAP) and
- a service that provides timely fax or email advice on clinical and educational problems (TIPS).

Another difference with the 2001 program was the provision of training for the P.I.E.C.E.S. preceptors. The role of the preceptors was to coach and mentor the P.I.E.C.E.S. trained people. In order to ensure that the preceptors were familiar with the P.I.E.C.E.S. framework, a 2-day session was held prior to Part One of the initiative. The Preceptors were members of specialized outreach teams who were selected because of: their knowledge, skill and experience related to the care of persons with Alzheimer Disease and related dementias as well as other mental health and associated behaviour problems; their ability to develop positive relationships; and their ability to facilitate change and foster innovative approaches to complex issues.

2.0 OVERVIEW OF EVALUATION METHODS AND ACTIVITIES

As part of the “Putting the P.I.E.C.E.S. Together” training initiative, a comprehensive evaluation of the program was undertaken. The primary goals of the evaluation were to:

- evaluate the implementation of the P.I.E.C.E.S. 2000-2001 Training Initiative and its impacts on: participants, persons with Alzheimer disease and related dementias as well as other mental health and associated behaviour problems, and their caregivers;
- support reflective practice and sustained quality improvement in long-term care facilities and CCACs;
- identify factors that help and hinder implementation and sustained impact of such initiatives;
- evaluate the benefit of the strategy in enhancing collaboration, co-ordination across sectors and in developing health care networks; and
- evaluate the impact of using technology to help coach and sustain what was learned during the training initiatives.

2.1 Evaluation Components

2.1.1 Preceptors

Preceptors were asked to complete pre and post training questionnaires. The pre-training questionnaires were completed prior to the training session and used to collect information on: the characteristics of the preceptors and their outreach teams; their familiarity with, and use of, the P.I.E.C.E.S. framework; their abilities related to psychotropic medications; and their interactions with LTC facilities and CCACs in their areas. The post-training questionnaires were completed at the end of the 2-day training session and were used to: gather feedback on the training; identify gaps in knowledge and the need for additional support; and assess their confidence in serving as preceptors.

2.1.2 LTC Facility and CCAC Staff

LTC facility and CCAC staff were asked to complete four questionnaires: one prior to the start of training; one at the end of the 3-day session; one at the end of the 2-day session; and one approximately 6-weeks post training. The pre and post training questionnaires and the questionnaire used at the end of the 3-day sessions were different for the two groups (i.e., LTC facility and CCAC), although the type of information collected was similar. The same questionnaire was used at the end of the 2-day sessions for both the LTC facility and CCAC participants.

The pre-training questionnaires collected information on: the characteristics of participants and their organizations; confidence in various areas related to the assessment and management of persons with cognitive/mental health needs and associated behaviours; resource use; and barriers to transferring knowledge into practice. The 3-day questionnaire was used to gather feedback on the 3-day session and identify ways the P.I.E.C.E.S. trained people could be supported. The 2-day questionnaire was used to gather feedback on the 2-day session and assess confidence in a variety of areas. The post-training questionnaire was used to gather data on: confidence in various areas related to the assessment and management of persons with cognitive/mental health needs and associated behaviours, as well as their role as Psychogeriatric Resource People; their level of perceived support for this role and how they could be further supported in the role; and barriers to transferring knowledge into practice.

2.1.3 Supportive Technology

Feedback was gathered from the LTC facility and CCAC participants on the value of the technology used to coach and help sustain what was learned during the training initiatives, and how these technologies could be improved.

2.2 Data Analysis

Quantitative data were analyzed using SPSS. The data were summarized using descriptive measures such as frequencies, means and standard deviations. Qualitative data were examined and common themes extracted.

2.3 Organization of the Report

The following section (Section 3) provides a summary of the evaluation results for this initiative. The order that the results are presented in is as follows:

- Preceptor pre-training results
- Preceptor post-training results
- LTC Facility participants’ pre-training results
- LTC Facility participants’ results from the 3-day session
- CCAC participants’ pre-training results
- CCAC participants’ results from the 3-day session
- LTC Facility and CCAC participants’ results from the 2-day session
- LTC Facility participants’ post-training results
- CCAC participants’ post-training results
- Feedback on TIPS and TAP

Following Section 3 is the conclusions of the report, followed by the acknowledgements, references, and appendices. While the majority of the evaluation results are found in Section 3, some of the additional background information collected as part of the pre-training questionnaires is located in the appendices.

3.0 RESULTS

3.1 Preceptor Pre-Training Results

A total of 86 preceptors attended the 2-day Preceptor Training, representing 44 Outreach Teams. The preceptors were asked to complete a questionnaire prior to the training session and another at the end of training. A total of 74 pre-training questionnaires were completed (response rate of 86%) and 81 post-training questionnaires (response rate of 94.2%) (see Table 1).

The following provides a summary of these data. It should be noted that in some questions of the pre-training questionnaire, preceptors were asked to respond as individuals; in these cases, a denominator of 74 was used. In other questions, the preceptors were asked to respond on behalf of their whole team; for these questions a denominator of 44 was used.

Table 1
Preceptor Response Rates for Pre and Post Questionnaires

Attendance	# Pre-surveys Returned	Response Rate	# Post-surveys Returned	Response Rate
86	74	86.0%	81	94.2%

3.1.1 Characteristics of Outreach Teams and Preceptors

Table 2 provides a summary of the regional distribution of the teams across the province.

Table 2
Ministry of Health and Long-Term Care Region: Preceptors

Region	Percent (#) of Teams (N=44)
North	18.2% (8)
Central West	11.4% (5)
Central South	18.2% (8)
East	18.2% (8)
Central East	9.1% (4)
Toronto	6.8% (3)
Southwest	11.4% (5)

Note: Percentages may not equal 100% due to missing values.

In terms of the characteristics of the preceptors, Table 3 provides a summary of their professional designations. Over 50% were registered nurses, just over 17% were social workers and almost 15% were occupational therapists.

Table 3
Professional Designation of Preceptors

Designation	Percent (#) of Preceptors (N=74)
RN	54.1% (40)
Social Worker	17.6% (13)
OT	14.9% (11)
Other	12.2% (9)

Note: percentages may not equal 100% due to missing values

When asked about their years of experience, the preceptors reported that they had spent an average of just over 5 years with their outreach team (SD=4.99). They also reported an average of just over 11 years of experience (SD=6.41) working with persons with Alzheimer disease and other dementias, and approximately 12 years (SD=8.33) working with the severely mentally ill (see Table 4).

Table 4
Years of Experience of Preceptors

Numbers of Years Working With:	This Team	Persons with Alzheimer Disease or Other Dementias	The Severely Mentally Ill
Mean (SD)	5.14 years (4.99)	11.24 years (6.41)	12.02 years (8.33)
Range	0 – 22 years *	0.5 – 30 years	0 – 31 years

* Seven preceptors from 4 teams responded to this question with a zero. In 4 cases, the preceptors indicated that their team was new; in the other cases the preceptors did not indicate why they responded with a zero.

The preceptors were asked to estimate the percentage of their time spent with a variety of populations. A summary of these data is found in Table 5. Preceptors reported spending an average of 50% of their time dealing with persons with dementia and/or associated behavioural issues. Just over 20% of their time was spent dealing with persons with mood disorders, just under 20% with persons with medical problems and associated psychiatric difficulties, and just over 5% with persons with substance abuse.

Table 5
Percentage of Time Preceptors Spend with Various Populations

Percentage of Time Spent ...	Mean (SD)	Range
Dealing with Persons with Dementia &/or Associated Behavioural Problems	50.30% (23.38)	10 – 99%
Dealing with Persons with Mood Disorders	21.82% (18.65)	0 – 80%
Dealing with Persons with Medical Problems and Associated Psychiatric Difficulties	19.77% (19.93)	0 – 99%
Dealing with Persons with Psychoses	8.67% (10.28)	0 – 70%
Dealing with Persons with Substance Abuse	5.41% (8.83)	0 – 71%

When asked how their time was divided according to different activities, the preceptors reported that over 60% of their time was spent on clinical activities, almost 14% on educational activities, just over 10% on community development activities, and just over 8% on administrative activities (see Table 6).

Table 6
Percentage of Time Spent by Preceptors in Various Activities

Percentage of Time Spent in ...	Mean (SD)	Range
Clinical activities	63.08% (27.32)	0 – 95%
Education activities	13.83% (14.58)	0 – 80%
Community Development activities	10.22% (15.33)	0 – 90%
Administration activities	8.31% (13.29)	0 – 90%

3.1.2 P.I.E.C.E.S. Training and the P.I.E.C.E.S. Framework

The preceptors were asked to report on any previous experience they had with P.I.E.C.E.S. training. One-third of the preceptors reported having been trained in the “Putting the P.I.E.C.E.S. Together” framework (see Table 7). Among these individuals, 32% reported being trained by the P.I.E.C.E.S. Team, 28% reported serving as P.I.E.C.E.S. trainers or Facilitators in previous PIECES initiatives, and 32% reported that they had been trained through some other source (e.g., at a workshop in Niagara Region, by staff at Seniors Mental Health Services, by various other individuals, by the Ministry of Health, by reading the manual) (See Table 8). In terms of when the training was provided, almost 50% of these individuals were trained in 1998. Others were trained in 2000, 1999, 1993 and 1990 (see Table 9).

Table 7
Previous Experience with P.I.E.C.E.S. Training by Preceptors

Have You Had Any Training in P.I.E.C.E.S.?	Percent (#) of Preceptors (N=74)
Yes	33.8 (25)
No	66.2 (49)

Note: percentages may not equal 100% due to missing values

Table 8
Who the P.I.E.C.E.S. Training was Provided By

If Training Was Received, Who Provided It?	Percent (#) of Preceptors who Received Training (N=25)
P.I.E.C.E.S. Team	32.0% (8)
P.I.E.C.E.S. Trainer/Associate Trainer/Facilitator	28.0% (7)
Other *	32.0% (8)

Note: percentages may not equal 100% due to missing values

* “Other” includes: workshop in Niagara Region, staff at Seniors Mental Health Services, various people, Ministry of Health, by using the manual.

Table 9
Year in which the P.I.E.C.E.S. Training was Provided

If Training Was Received, When was it Provided?	Percent (#) of Preceptors who Received Training (N=25)
2000	4.0% (1)
1999	12.0% (3)
1998	48.0% (12)
1993	4.0% (1)
1990	4.0% (1)

Note: percentages may not equal 100% due to missing values

Over 60% of the preceptors reported using the P.I.E.C.E.S. framework in their practice (see Table 10). Almost 60% reported that they have had opportunities to reinforce P.I.E.C.E.S. in long-term care facilities and over 35% reported having such opportunities in community agencies (see Table 11).

Table 10
Use of P.I.E.C.E.S. Framework by Preceptors

Do You Use the P.I.E.C.E.S. Framework in Your Practice?	Percent (#) of Preceptors (N=74)
Yes	60.8% (45)
No	31.5% (26)

Note: percentages may not equal 100% due to missing values

Table 11
Opportunities to Reinforce P.I.E.C.E.S.

Have You Had the Opportunity to Reinforce P.I.E.C.E.S. in ...	Percent (#) of Preceptors (N=74)	
	Yes	No
Long-Term Care Facilities?	59.5% (44)	40.5% (30)
Community Agencies?	36.5% (27)	58.1% (43)

Note: percentages may not equal 100% due to missing values

The preceptors were also asked to rate how confident they are in teaching others the P.I.E.C.E.S. framework using a scale of 1 to 5 (where 1 = “not confident” and 5 = “very confident”). Their average confidence rating was 3.24 (SD=1.36) indicating that they were “fairly” to “quite” confident (see Table 12).

Table 12
Confidence of Preceptors in Teaching P.I.E.C.E.S. Framework to Others

	Not Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
How Confident Are You in Teaching the P.I.E.C.E.S. Framework to Others?	13.5% (10)	14.9% (11)	21.6% (16)	21.6% (16)	23.0% (17)	3.24 (1.36)

3.1.3 Use of Assessment Tools

The preceptors were also asked to indicate: (i) whether they use any of the following assessment tools and (ii) what assessment tools are used by their team as part of their standard assessment. Table 13 provides a summary of these responses. Over 80% of preceptors reported that they used Folstein Mini Mental State Examination, 81% reported using the Clock Test, 43% reported using the Cornell Scale for Depression, and 32% reported using the Cohen-Mansfield Agitation Inventory.

With respect to which scales were used by the Outreach Teams as part of their standard assessment, over 80% use the Folstein Mini Mental State Examination and 75% use the Clock Test. Less than 14% of teams used the Cornell Scale for Depression; almost 50% reported using another depression scale (e.g., Geriatric Depression Scale, the Hamilton Depression Scale). Only a few teams reported using the Cohen-Mansfield Agitation Inventory, Behaviour Flow Sheets, the Abilities Assessment, the Dementia Observational System, or the Confusion Assessment Method.

Table 13
Use of Assessment Tools by Preceptors and Teams

Assessment Tool	Percent (#) of Preceptors That Use Assessment Tools (N=74)	Percent (#) of Teams That Use Assessment Tools (N=44)
Folstein Mini-Mental State Examination	82.4% (61)	81.8% (36)
Other Mental Status Test *	35.1% (26)	25.0% (11)
The Clock Test	81.1% (60)	75.0% (33)
The Cornell Scale for Depression	43.2% (32)	13.6% (6)
Other Depression Scale **	63.5% (47)	47.7% (21)
The Cohen-Mansfield Agitation Inventory	32.4% (24)	11.4% (5)
Behaviour Flow Sheet	39.2% (29)	13.6% (6)
Other Behavioural Scale ***	24.3% (18)	4.5% (2)
The Abilities Assessment	9.5% (7)	2.3% (1)
Dementia Observational System	5.4% (4)	2.3% (1)
Confusion Assessment Method	6.8% (5)	2.3% (1)
Other Assessment Tools ****	29.7% (22)	29.5% (13)

Note: Percentages may not equal 100% due to missing values.

* “Other Mental Status Tests” include: KSCA (20.5%).

** “Other Depression Scales” include: Geriatric Depression Scale, Hamilton Depression Scale.

*** “Other Behavioural Scales” include: ABC, Behaviour Checklist, Global Impairment Rating Scale.

**** “Other Assessment Tools” include: Activities of Daily Living, AIMS, Caregiver Burden Inventory, Functional Activities Questionnaire, CAF, etc.

3.1.4 Psychotropic Medication

Preceptors were asked to rate their ability to: identify potential risks and benefits; identify purposes of the medication; identify the class of medication; identify potential side effects; and monitor an individual’s response to medications on a scale of 1 to 5 (where 1 = “poor” and 5 = “excellent”). Results are summarized in Table 14. Average scores were similar ranging from “good” to “very good”. The lowest average rating was 3.39 for their “ability to identify potential risks and benefits” and the highest was 3.64 for their “ability to identify the purpose of medication”.

Table 14
Ratings Related to Psychotropic Medication: Preceptors

How would you rate your ability to ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Identify potential risks and benefits?	4.1% (3)	23.0% (17)	18.9% (14)	36.5% (27)	17.6% (13)	3.39 (1.13)
Identify purposes of the medication?	2.7% (2)	13.5% (10)	25.7% (19)	29.7% (22)	27.0% (20)	3.64 (1.09)
Identify the class of medication being used?	2.7% (2)	18.9% (14)	21.6% (16)	25.7% (19)	29.7% (22)	3.60 (1.20)
Identify potential side effects?	5.4% (4)	20.3% (15)	21.6% (16)	28.4% (21)	23.0% (17)	3.40 (1.23)
Monitor an individual’s response to medication?	6.8% (5)	16.2% (12)	23.0% (17)	24.3% (18)	24.3% (18)	3.42 (1.24)

3.2 Preceptor Post-Training Results

Preceptors were asked to complete the post-training questionnaire at the end of the 2-day session. A total of 86 preceptors attended the second day of the training, 81 (94.2%) of which completed the questionnaire. These 81 individuals represented 47 outreach teams. Therefore, in this section a denominator of 81 is used for questions relating to individual preceptors and a denominator of 47 is used for questions relating to outreach teams.

The preceptors were asked to indicate how participating in the preceptor training helped to improve their understanding of the P.I.E.C.E.S. framework. Their responses are summarized in Table 15. Many of the preceptors noted that the training helped to clarify their understanding of the various assessment tools – how to use and score them. A number of preceptors also indicated that the training helped to increase their overall understanding of the P.I.E.C.E.S. framework and how the training initiative is organized. Comments also indicated that the training had increased the preceptors’ understanding of their roles within the initiative and what was expected of them, on the value of having an opportunity to network, and that the training helped to clarify their understanding of the overall Alzheimer Strategy.

Table 15
How the Preceptor Training Helped to Improve Understanding of the P.I.E.C.E.S. Framework

Tools (N=16)

- Understanding the tools for screening.
- We have been practicing P.I.E.C.E.S. model since 1998, therefore had a good knowledge base previously. Did find review of DOS: CAM: Cornell helpful & valuable
- Made P.I.E.C.E.S. easier to understand & use. Some of the tools I knew about, but had never used
- Reviewing the tools helped to understand how they are used in screening individuals.
- The 2 days were a very valuable review. The discussion of the scoring of screening tools was very helpful.

P.I.E.C.E.S. / P.I.E.C.E.S. Framework/Model Being Used (N=14)

- It has provided us with updated knowledge of P.I.E.C.E.S. a good framework for organized thinking. Good to know the new lexicon so we can be part of it!
- Working through an example & applying P.I.E.C.E.S. identifies how the framework is applied to individuals.
- Helpful to know what the learners will be learning about & the format (approx.) that will be used.
- I have learned the basic elements which make up the framework & had no previous knowledge of the P.I.E.C.E.S. program.
- Better understanding of P.I.E.C.E.S. framework, tools, & time lines. Better understanding of P.I.E.C.E.S. organization. Provide a more consistent approach to pt management

Clarification of Roles (N=9)

- Increase understanding of my/our role in “P.I.E.C.E.S.”. Good review of the training material.
- Very useful to be able to not only function as preceptor but to help provide education with P.I.E.C.E.S. trained staff.
- Reviewing the roles of individuals identifies what is expected from everyone
- Clarified program, role, expectations good review of content

Networking (N=4)

- Helpful meeting other preceptors & meeting some of the ‘lead educators’
- Good opportunity to network & share ideas.
- Networking with other preceptors helps greatly.

Understanding/Clarification of overall strategy (N=3)

- Good to understand the bigger picture i.e. interface with Alzheimer strategy
- Clarified methods of Ax & framework. Clarified over all understanding of project & long-term plan & where everyone fits in

Other (N=15)

- It’s really helped tremendously. Especially the second day - more hands on experience a lot more case studies would be beneficial
- A little different organizational framework than currently use. Important to know what LTC’s have been taught. Have used different teaching models in past with them
- Good overview as we weren’t involved with the first round of teaching in 98
- Enable me to ask questions & get feedback immediately from a variety of resources
- We came not knowing anything - both of us are new as the team has just been formed. Very informative
- Reviewing ensured we were administering in the standardized format

The preceptor teams were asked whether there were any aspects of the P.I.E.C.E.S. framework or training program for which they required additional explanation. Almost 40% responded “yes” (see Table 16). The specific aspects they identified are also summarized.

Table 16
Aspects of the P.I.E.C.E.S. Framework / Training Program For Which Preceptors Require Additional Explanation

	Percent (#) of Preceptor Teams (N=47)
No	61.7 (29)
Yes	38.3 (18)
Examples of Where Additional Explanation is Required ▪ Psychotropic medication (3) ▪ Tools (e.g., Abilities Assessment, CAM; choice of tools) (3) ▪ PRCs / Role definition (2) ▪ Practical application (2) ▪ Need to put what was learned into practice (2) ▪ P.I.E.C.E.S. QuickStart (1) ▪ Other (4) – examples: ▪ dementia – types and new treatment protocols and approaches ▪ how the learners will be integrating the framework into their practice ▪ wondering about smaller agencies like ours, will CCAC and LTC staff be informed	

Preceptor teams were also asked whether there were other areas where they felt they needed more training in order to fulfill their roles as preceptors. Forty percent of preceptor teams reported “yes” (see Table 17); the specific areas identified are also summarized.

Table 17
Is More Training in Other Areas Required to Help you Fulfill Your Roles as P.I.E.C.E.S. Preceptors?

	Percent (#) of Preceptor Teams (N=47)
No	59.6% (28)
Yes	40.0% (19)
Examples of Areas where More Training is Required ▪ tools (e.g., Cornell, CAM) (5) ▪ psychotropic medications (4) ▪ assessment of delirium (3) ▪ conducting physical and functional assessments (2) ▪ understanding lab values (1) ▪ P.I.E.C.E.S. Quick Start (1) ▪ list of who’s who (1)	

The preceptors were also asked to identify what support they needed in undertaking their roles as preceptors. Their responses are summarized in Table 18. A number of the preceptors indicated that there was a need to have opportunities to network with other preceptors (locally, regionally and provincially) regarding the preceptor role (e.g., how it is organized, what’s working well). Many of the preceptors also indicated that

there was a need for support from within their own organizations in terms of time and assistance in order to undertake this role. The preceptors also identified the need for support from LTC facilities and CCACs in terms of giving staff time to work with the preceptors and in supporting the P.I.E.C.E.S. framework. A few of the preceptors indicated a need for a back-up in case they were unable to answer questions that were put to them. As well, a few preceptors requested that they be given a copy of the slides and notes used for the presentation on psychotropic medications.

Table 18
Additional Support Required to Assist with Roles as Preceptors

Opportunities to Network and Share with Other Preceptors (N=18)

- List of trainers & associates for our area
- Collaborating with other preceptors in my region would be helpful
- Peer support.
- Feed back from other areas on how they are handling the preceptor role - what they are doing to support learners
- Think it would be helpful for P.I.E.C.E.S. preceptors from geographic areas to meet, look at involvement with LTC facilities/CCAC & divide up potential workload. Some collaboration approaches etc.
- Regional trainer & associates need to network (in person).
- I find it beneficial to observe a master trainer implementing the P.I.E.C.E.S. process with learners. On going information availability, consultation with resources. Yearly meeting as a group for some continuity.
- Ongoing support/networking from other preceptors & P.I.E.C.E.S. consultants

Support from Own Administration/Managers (N=9)

- My manager, my managers manager, & my managers, manager, manager
- Will need time allowed & support of co-ordinator. Documentation sent to co-ordinator/service explaining expectations - (small program / time limited). Will be able to identify after experience in working with learners. Will likely be accessing regional “lead” trainers
- Admin & team members support in use & review of P.I.E.C.E.S. model in clinical setting & case review

Administrative Support from Facilities/Agencies (N=8)

- Encouraging facilities in our region to participate. Will need to “sell” this further with our team & to CCAC in our region
- I need support from ministry personnel to help convince LTC facility & CCAC in my region to become involved with the P.I.E.C.E.S. program
- LTC administration & their support of learners.

Resource to turn to if need additional support (N=3)

- Identification of individuals who we can contact in case we have questions to help answer questions from the learners if we are unsure of how to deal with an issue
- Backup from RGP geriatrician re: any specific questions I cannot respond to

Psychotropic Medication Notes and slides (N=3)

Other (N=14)

- Material in French is a must
- The copy of the evaluations (pre + post survey) etc for CCAC, LTC, & PG (+ RPG) teams
- Perhaps building into TM Exchange time to review how it’s going in various areas. Will try to arrange Central East meeting over summer months (in a nice location) on a Friday
- The new web site & access to experts will be a big help!
- Consult the consultation team for direction

The preceptors were then asked to rate their level of confidence in: (1) helping others learn the P.I.E.C.E.S. framework and (2) taking on a role as P.I.E.C.E.S. preceptor. These results are summarized in Table 19. For both questions, the preceptors’ average ratings approached 4 or “quite confident”.

Table 19
Confidence of Preceptors Related to P.I.E.C.E.S. (N=81)

How confident are you in ...	Not Confident 1	Slightly Confident 2	Fairly Confident 3	Quite Confident 4	Very Confident 5	Mean (SD)
Helping others learn the P.I.E.C.E.S. framework (e.g., LTC facility & CCAC staff)?	0	1.2% (1)	25.9% (21)	46.9% (38)	24.7% (20)	3.93 (0.75)
Taking on a role as P.I.E.C.E.S. preceptor?	0	0	29.6% (24)	46.9% (38)	22.2% (18)	3.92 (0.70)

Finally, the preceptors were invited to make additional comments about the preceptor training or their role as a P.I.E.C.E.S. preceptor. Table 20 provides some examples of the comments that were made.

Table 20
Examples of Comments made by Preceptors

- Would have been nice to have more time on “the brain”, “psychotropics” & the Quick Start. Thank you for the training - it was very useful
- I am pleased to be able to participate & take on this role. I would like to see some sort of “accountability” function incorporated so LTC facilities will continue to use/practice the model. I would have like more time spent on psychotropic information as I am not a nurse & therefore feel this is a weaker area in my practice. Sped through psychotropics too quickly. Good job everyone!
- Agenda - should have done day 2 agenda first & then done day 1 second. Prefer case studies & video presentations on how to do screening tests
- Some aspects of the training was disjointed (e.g. jumping from topic to topic - going from the 6 questions to the practical application & then back to other templates - perhaps in future, it would be better to begin the training with what exactly P.I.E.C.E.S. is before going into asking how it can be taught, the case scenario etc. (Thank you for your time & energy - you obviously have put a lot of time & effort into this!)
- Initially day 1 group regions together, for the 2 days increase access for networking & building team relationships. Moving tables/groups about disruptive. Case study day 1 not very productive for nurses although input from compliance advisors valuable. Marge Dempsey [Brain and Behaviour Session] needed more time. Great retreat, charismatic presenters/facilitators. Food great, facilities good, a/v problems
- I think you should do a section on “being a preceptor.”
- What about enablement? Would like to know more about Kingston Scale
- Include more about diversity awareness
- What about French people?
- Great 2 days - should do it annually. Best support of all is just getting together with colleagues
- Thank you for your time & commitment!

3.3 LTC Facility Participants – Pre-Training Results

As part of the 2001 “Putting the P.I.E.C.E.S. Together” initiative, staff from LTC facilities were invited to participate in the training. Priority for training spaces went to LTC facilities that did not have a P.I.E.C.E.S. trained person in their facility and facilities with 200 beds or more.

A total of 345 LTC facility participants attended the initial 3-day training sessions. 341 (or 98.8%) of these individuals completed the pre-training questionnaire (see Table 21). LTC facility participants were asked to complete this questionnaire in conjunction with their facility administrator. This section provides a summary of the information obtained from this questionnaire.

Table 21
Response Rate for Pre-Training Questionnaire for LTC Facility Participants

Spring Attendance	# Pre Surveys Returned	Response Rate
345	341	98.8%

3.3.1 Background Information on LTC Facility Participants

Table 22 outlines the professional designation of the LTC facility participants who attended the training. Approximately 94% had a nursing background, less than 4% had a social work background, and less than 2% some other designation.

Table 22
Professional Designation of LTC Facility Participants (N=341)

Professional Designation	Percent (#) of Participants
RN	71.3% (243)
RPN	22.9% (78)
Social Worker	3.8% (13)
Other *	1.7% (6)

Note: percentages may not equal 100% due to missing values

* “Other” includes: occupational therapist, administrator/DOC, Special Care Coordinator.

LTC facility participants were asked to indicate the number of years of experience in a variety of areas. These data are summarized in Table 23. On average, the participants had spent 8 years in their current facility (SD=6.9), 17 years in their profession (SD=9.87), 12 years working with individuals with dementia (SD=7.23) and almost 6 years working with individuals with severe mental illness (SD=7.24).

Table 23
Years of Experience among LTC Facility Participants

Years of Experience in ...	Current Facility	Your Profession	Working with Persons with Alzheimer Disease & Other Dementias	Working with Severely Mentally Ill Persons
Mean (SD)	8.23 years (6.90)	17.06 years (9.87)	12.01 years (7.23)	5.80 years (7.24)
Range	0.5 – 30 years	1 – 40 years	0 – 33 years	0 – 33 years

When asked if they had any exposure to the P.I.E.C.E.S. training, over 70% said that they had not (see Table 24). In cases where they reported having some exposure, this usually occurred through a co-worker who had participated in a previous P.I.E.C.E.S. initiative.

Table 24
Previous Exposure to P.I.E.C.E.S. Training by LTC Participants

	Percent (#) of Participants *
No	73.3% (250)
Yes	25.2% (86)
If Yes, describe your previous exposure to P.I.E.C.E.S. **: - Co-worker took the course (N=35) - Through another course/in-service session/previous P.I.E.C.E.S. training (N=17) - Learning partner of P.I.E.C.E.S. 1998 participant (N=13) - P.I.E.C.E.S. manual (e.g., available in facility, previous graduate’s manual) (N=9) - Other (N=4)	

* Note: percentages may not equal 100% due to missing values

** Note: Multiple responses permitted.

3.3.2 Facility Information

Table 25 provides a summary of the regions from which participants’ LTC facilities were located.

Table 25
Ministry of Health and Long-Term Care Region for LTC Participants

Region	Percent (#) n=341
North	14.4% (49)
Central West	11.4% (39)
Central South	10.6% (36)
East	17.9% (61)
Central East	14.4% (49)
Toronto	12.0% (41)
Southwest	18.5% (63)

Note: percentages may not equal 100% due to missing values

In terms of the types of facilities participants work in, over 50% indicated that they worked in a for-profit facility. Almost 45% reported working in a not-for-profit facility, less than 1% in a chronic care hospital, and just over 1% in some other type of facility (see Table 26).

Table 26
Type of LTC Facility

Type of Facility	Percent (#) of Responses
For-Profit Nursing Home/Home for the Aged	53.1% (181)
Not-For-Profit Nursing Home/Home for the Aged	44.6% (152)
Chronic Care Hospital	0.3% (1)
Other *	1.4% (5)

Note: percentages may not equal 100% due to missing values.

* “Other” includes: dementia assessment unit; home for the mentally retarded; community assessment program; Psychiatric Hospital/CMHA.

In terms of the characteristics of these facilities, the average number of beds was 127 (SD=83.9), ranging from 20 to 456 beds (see Table 27). Over 50% of participants indicated that their facility was located in an urban area and 45% reported that their facility was located in a rural or isolated area (see Table 28).

Table 27
Number of Beds in LTC Facilities

	Number of Beds in Facility
Mean	127.3 beds
(SD)	(83.9)
Range	20 – 456 beds

Table 28
Urban/Rural Location of LTC Facilities

Facility Location	Percent (#) of Responses
Urban	54.0% (184)
Rural and/or Isolated	44.9% (153)

Note: percentages may not equal 100% due to missing values

Note: Additional information and characteristics of the LTC participants and their facilities can be found in Appendix B.

3.3.3 Transferring Training Into Practice

Participants were provided with a list of factors that have been identified as barriers to transferring knowledge gained during training initiatives to practice. The participants were asked to indicate their top three barriers from the list provided. Their responses were combined to create a variable indicating the total number of times a barrier was mentioned. These results are summarized in Table 29.

Over 90% of participants identified “work and time pressures” as one of their top three barriers. The second most frequently identified barrier was “pressure from peers to resist change” (58.9%), followed by “lack of reinforcement” (31.7%), “separation from inspiration of support of the trainer” (18.5%), “learner discomfort with change and associated effort” (16.4%), and “learner perception that training content is irrelevant” (12.9%).

Table 29
Barriers in Transferring Training Into Practice: LTC Participants

Barrier	Percent (#) of Participants who Identified This as One of Their Top 3 Barriers
Work and Time Pressures	93.5% (319)
Pressure From Peers to Resist Change	58.9% (201)
Lack of Reinforcement	31.7% (108)
Separation From Inspiration of Support of the Trainer	18.5% (63)
Learner Discomfort With Change and Associated Effort	16.4% (56)
Learner Perception That Training Content is Irrelevant	12.9% (44)
Insufficient Authority	10.9% (37)

Non-Supportive Organizational Culture	8.2% (28)
Ineffective Work Processes	7.9% (27)
Inadequate Equipment or Organization	7.0% (24)
Impractical Training Program	3.8% (13)
Poorly Designed/Delivered Training	2.3% (8)

Finally, the participants were provided with a number of statements and asked to rate the extent to which they agreed or disagreed with them. The statements related to factors in their workplace that would influence their ability to transfer the knowledge learned in the training initiative to their practice. Agreeing with the statements would indicate that the environments in which the participants work are conducive to knowledge transfer. Table 30 provides a summary of their ratings.

The average ratings for all five statements were between 3 and 4, suggesting that there was a trend toward agreeing with the statements (i.e., there was some agreement that their work environments were conducive to knowledge transfer).

Table 30
Agreement/Disagreement to Statements Related to Knowledge Transfer Factors: LTC Participants

Extent to which Participants Agree or Disagree with Statements	Strongly Disagree 1	Disagree 2	Neutral or Not Sure 3	Agree 4	Strongly Agree 5	Mean (SD)
I am clear about the expectations for my role as a Psychogeriatric Resource Person.	1.5% (5)	2.6% (9)	33.7% (115)	53.4% (182)	7.0% (24)	3.63 (0.72)
I have the necessary support to fulfill my role as a Psychogeriatric Resource Person.	2.3% (8)	6.5% (22)	39.0% (133)	40.8% (139)	8.8% (30)	3.48 (0.84)
I am aware of the reinforcements/incentives/ rewards for my work as a Psychogeriatric Resource Person.	0.9% (3)	3.8% (13)	41.3% (141)	42.2% (144)	9.4% (32)	3.57 (0.76)
I receive prompt and appropriate and appropriate feedback from supervisors or others on my day-to-day practice in dealing with mental health problems and associated behaviours.	0.9% (3)	9.1% (31)	20.8% (71)	55.4% (189)	11.4% (39)	3.69 (0.83)
I have the necessary skills and knowledge to perform successfully in my day-to-day practice related to cognitive/mental health problems and associated behavioural issues.	0	4.7% (16)	22.3% (76)	57.2% (195)	13.8% (47)	3.81 (0.73)

3.4 LTC Facility Participants – Results from 3-Day Evaluation

Of the 345 LTC participants at the 3-day session, 340 (98.6%) completed and returned the evaluation form. Thus, the denominator used in this section is 340.

Table 31
Response Rate for 3-Day Evaluation for LTC Participants

Spring Attendance	Number of 3-Day Evaluations Returned	Response Rate
345	340	98.6%

At the beginning of each day of the 3-day session, participants were asked to identify three learning goals. At the end of each of the 3 days, they were asked to rate the extent to which their goals had been met on a scale of 1 to 5 (where 1 = “not at all” and 5 = “completely”). Table 32 provides a summary of the most frequently identified goals over the 3-day period.

Table 32
Most Frequently Identified Goals over the 3-Day Session: LTC Participants

Goal Area	Estimated Frequency
Medication (e.g., psychotropic use, side effects, how to use, etc.)	236
P.I.E.C.E.S. in General (e.g., how to implement in setting, confidence in knowledge)	203
Assessment in General (e.g., learning new tools, gaining confidence in skills)	202
Behaviour (e.g., cause of difficult behaviour, treatment of difficult behaviour, etc.)	154
6-Question Template (e.g., what it is, how to use)	150
Coach Staff Members (e.g., share knowledge with staff, how to motivate staff)	150
Specific Diseases/Conditions (e.g., dementia, delirium and depression, Alzheimer)	114
Resources (e.g., what resources are available, how to access resources, etc.)	102
Time Management (e.g., how to implement P.I.E.C.E.S., etc. within time restraints)	83
Specific Assessment Tools (e.g., MMSE, Dementia Observation System, etc.)	59
Quick Start (e.g., what Quick Start is, how to initiate it, etc.)	57
Networking (e.g., within the course, with external and internal resources, etc.)	39
Communication/Support (e.g., with other health professionals, from doctors, etc.)	30

Participants ratings of the extent to which their three goals were met were collapsed across each day and are presented in Table 33. As indicated in the table, the average rating of the extent to which their goals were met increased with each day of training, from an average of 3.1 on Day One to 4.0 on Day Three. These results suggest that by the end of the training, many of the participants’ goals had been met.

Table 33
Extent to Which Goals Were Met Over the 3-Day Session: LTC Participants

	Day One	Day Two	Day Three
Mean (SD)	3.1 (0.78)	3.7 (0.63)	4.0 (0.58)
Range	1 – 5	2 – 5	2.33 – 5

The participants were asked to rate various aspects of the Day One session on a scale of 1 to 5 (where 1 = “poor” and 5 = “excellent”). Their responses are summarized in Table 34. The “Brain and Behaviour” session was the highest rated session on Day One with a mean rating of 4.52 (SD=0.65), indicating that the session was between “very good” and “excellent”. The session on the “Folstein and the Clock” was rated highly, as was the rating for Day One overall. The mean ratings for the other three sessions ranged from 3.74 to 3.97, indicating that all approached being “very good”.

Table 34
Ratings of Various Aspects of Day One: LTC Participants (N=340)

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Partners in Care Template	0.3% (1)	1.5% (5)	31.2% (106)	41.2% (140)	12.4% (42)	3.74 (0.73)
Brain and Behaviour Session	0	0.3% (1)	6.8% (23)	27.9% (95)	53.5% (182)	4.52 (0.65)
Psychoses Session	0.6% (2)	4.4% (15)	19.4% (66)	43.5% (148)	19.7% (67)	3.88 (0.83)
Introduction of Standardized Assessment Instruments	0	1.2% (4)	20.0% (68)	46.5% (158)	20.0% (68)	3.97 (0.72)
Folstein and the Clock Session	0	0.9% (3)	14.4% (49)	43.5% (148)	29.1% (99)	4.15 (0.72)
Day One Overall	0	0.6% (2)	11.2% (38)	49.4% (168)	27.4% (93)	4.16 (0.65)

The following provides a summary of some of the comments made regarding Day One.

Comments related to Day One:

- Folstein and Clock are okay to use as long as same people do testing.
- Not as familiar with Folstein Mini Mental as others, therefore, initially unsure of how to complete without any introduction prior to watching the video.
- More detail with assessment instrument and Folstein and clock.
- Enjoy the lesson on the brain and how it functions with all aspects of behaviour.
- Psychosis- needs to be better presented.
- I am very excited to learn more. Can't wait for day 2 and 3. Realized how much each resident is an individual and importance of Resident Focused Care.
- Examples of real life experience always adds to good learning!
- Excellent resource book.
- It was an interesting day. All presentations were well done. A variety of media was used. Videos, overheads, group discussion and question periods were good.
- Please always start from the basic, this would be a review for those who have used it but advantageous for consistency.
- You have to put a tremendous amount of work into these sessions. Respect of time lines.
- Dr. Norris was excellent - very informative and interesting! All trainers are very interesting to listen to. Knowledgeable and excited by the information they teach. Would have liked more time on Folstein.
- All aspects of Day 1 were interesting although my learning goals at this stage were not met. Any discussion regarding care of clients in invaluable and different ideas of approach to care is very helpful
- Enjoyed video & play acting on video. Not enough time given for group work.

The average rating for the Day Two session overall was 4.17, or between “very good” and “excellent” (see Table 35). All of the other average ratings hovered around 4, indicating a rating of “very good”.

Table 35
Ratings of Various Aspects of Day Two: LTC Participants

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
6-Question Template, #1 - #4	0	0.6% (2)	17.1% (58)	52.1% (177)	17.6% (60)	3.99 (0.65)
Cohen Mansfield Agitation Inventory	0	2.1% (7)	18.2% (62)	43.8% (149)	23.5% (80)	4.01 (0.75)
Dementia Observation System	0	1.5% (5)	15.0% (51)	46.2% (157)	25.0% (85)	4.08 (0.72)
6-Question Template, #5	0	0	12.9% (44)	51.8% (176)	22.6% (77)	4.11 (0.63)
6-Question Template, #6	0	2.1% (7)	19.7% (67)	43.2% (147)	21.8% (74)	3.98 (0.76)
Day Two Overall	0	0	11.8% (40)	47.9% (163)	26.5% (90)	4.17 (0.64)

The following provides a summary of the comments made related to Day Two.

Comments related to Day Two:

- Overall it was very good but too much content in a short 3-day period. Also, psychotropics should be added to Day 2. It is a very interesting topic but too rushed. Case examples should be limited to 2.
- Idea café – confusing at beginning.
- I enjoyed the variety of group assignments. A lot of good ideas came up by brainstorming with peers.
- If writing in work manual was a little larger, it would have been easier to follow.
- Change- go through manual prior to coming to course may benefit.
- Find it hard to take information in and store it - lots in 3 days.
- Psychotropic talk was excellent. Day 2 would have been better. Marge [M. Dempsey, Brain and Behaviour Session] was an excellent speaker – thoroughly enjoyed her talk. More experts in field for subject.
- I realize there are many time restraints, however I feel that touching on some helpful interventions to manage behaviours/symptoms would be useful.
- Picked up an amazing tip (water wings) and called back to my nursing home with the information.
- Good tools to assess what behaviours are and how to evaluate and score team, but need more info on evaluating and implementing results.
- Does it need a P+P to enforce the process?

- I thoroughly enjoyed the course but must admit I take this information back with me wondering if I will be able to be successful with the teaching. We are a small home already over budget. I work with many HCAs that have the attitude that they will not be in-serviced if they are not paid. We also have a skeleton staff. I feel the MOH has allowed us to "warehouse our seniors." There is so little time to implement, motivate and encourage learning. But, that's not your problem. After speaking with most of the girls here, I feel that we all have the same concerns. Even though we appreciate your efforts, until more dollars comes into the LTC system, this program is quite possibly too premature. I can't express the necessity for MOH LTC to listen to the concerns of LTC teams so excellent programs such as these can be more realistically implemented. (Please remember the lack of services to us in rural areas, the time to get residents assessed by specialists (up to several weeks).

- Facilitators did an excellent job of defusing negative comments regarding fund, lack of time to implement! Well done. I'm starting to forget it without the practice in the application of tools. I'm not sure if case study practice would be beneficial.

The various aspects of Day Three were all rated very highly, ranging from 3.94 for the “Overview of Next Steps of the Initiative” to 4.31 for the “Psychotropics Template” (see Table 36).

Table 36
Ratings of Various Aspects of Day Three: LTC Participants

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Delirium and Confusion Assessment Method Session	0	0.6% (2)	12.6% (43)	50.9% (173)	21.5% (73)	4.08 (0.65)
Depression and the Cornell Session	0	0.9% (3)	15.0% (51)	50.3% (171)	19.4% (66)	4.02 (0.66)
Psychotropics Template	0	1.2% (4)	5.3% (18)	35.0% (119)	30.3% (103)	4.31 (0.68)
P.I.E.C.E.S. Quick Start Session	0.3% (1)	0.9% (3)	12.9% (44)	46.5% (158)	22.9% (78)	4.09 (0.70)
Overview of Next Steps in the Initiative	0	0.9% (3)	17.9% (61)	44.7% (152)	15.3% (52)	3.94 (0.68)
Day Three Overall	0	0	7.6% (26)	43.5% (148)	29.4% (100)	4.26 (0.62)

The participants were asked to rate their satisfaction with various aspects of the 3-Day session. The average ratings for all aspects (i.e., the pace of activity, volume and complexity of material, and opportunities to participate) were between 3 and 3.5 suggesting they were “about right” (see Table 37).

Table 37
Ratings of 3-Day Session: LTC Participants

<i>How would you rate your satisfaction with the following aspects of the session?</i>	1	2	3	4	5	Mean (SD)
Pace of activity	Too Slow 0.6% (2)	4.7% (16)	About Right 57.6% (196)	21.5% (73)	Too Fast 3.2% (11)	3.25 (0.63)
Volume of material	Too Little 0	0.9% (3)	About Right 48.5% (165)	32.1% (109)	Too Much 5.6% (19)	3.47 (0.63)
Complexity of material	Too Basic 0	1.8% (6)	About Right 62.1% (211)	21.5% (73)	Too Complex 1.2% (4)	3.25 (0.50)
Opportunities to participate	Too Few 0	0.6% (2)	About Right 61.2% (208)	23.5% (80)	Too Many 1.8% (6)	3.28 (0.50)

Participants were asked to rate the P.I.E.C.E.S. Educators overall and the 3-Day session overall on a scale of 1 to 5 (where 1 = “poor”, 2 = “fair”, 3 = “good”, 4 = “very good” and 5 = “excellent”). Both aspects were rated very highly, indicating that both the P.I.E.C.E.S. Educators and the 3-day session were “very good” to “excellent”.

Table 38
Ratings of the P.I.E.C.E.S. Educators and the 3-Day Session Overall: LTC Participants

<i>How would you rate the following aspects of the 3-Day session?</i>	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
P.I.E.C.E.S. Educators Overall	0	0.3% (1)	5.0% (17)	35.0% (119)	46.8% (159)	4.49 (0.61)
3-Day Session Overall	0	0.3% (1)	5.6% (19)	41.5% (141)	39.7% (135)	4.40 (0.62)

The LTC Facility participants were then asked to rate some other aspects of the 3-Day session on a scale from 1 to 5 (where 1 = “not at all” and 5 = “completely”). In terms of the relevancy of the training and examples used, the average ratings exceeded 4.5, suggesting that both were very relevant (see Table 39). When asked if they were confident in applying what they’ve learned, the average rating was also very high (4.05) suggesting that they were relatively confident. The average ratings for the questions relating to their understanding of what is expected from them in the practical application and in their role as a psychogeriatric resource person were somewhat lower (3.63 and 3.64, respectively) suggesting that more information may have been needed. The average ratings for the questions relating to their confidence in three areas (i.e., taking on the role of a psychogeriatric resource person; working collaboratively with internal resources to improve care to residents in their facilities; and working collaboratively with external resources to improve care to residents within their facilities) were also somewhat lower (ranging between 3.53 and 3.90) suggesting that the participant may have been less confident in these areas.

Table 39
Ratings Related to the 3-Day Session: LTC Participants

	Mean (SD)	Range
Training relevant to issues within your facility?	4.53 (0.63)	3 – 5
Examples used relevant to your practice?	4.59 (0.59)	3 – 5
How confident are you in applying what you’ve learned?	4.05 (0.79)	2 – 5
How well do you understand what is expected from you in the practical application?	3.63 (0.69)	2 – 5
How well do you understand your role as a Psychogeriatric Resource Person in your facility?	3.64 (0.72)	1 – 5
How confident are you in taking on a role of Psychogeriatric Resource Person to others in your facility?	3.53 (0.80)	1 – 5
How confident are you in your ability to work collaboratively with internal resources to improve care for residents in your facility?	3.90 (0.73)	1 – 5
How confident are you in your ability to work collaboratively with external resources to improve care for residents in your facility?	3.72 (0.79)	1 - 5

The participants were asked to identify ways in which the 3-day session could have been improved. The most frequently cited suggestions were: (1) to increase the length of the 3-day session because of the amount of information presented and (2) to provide the manuals to participants ahead of time so the information could be reviewed (see Table 40). Other comments made related to the organization of the 3-day session, aspects requiring clarification; and the role of the P.I.E.C.E.S. trained individuals after they return to their facilities.

Table 40

How the 3-Day Session Could be Improved – Suggestions by LTC Participants

Most Frequently Cited Suggestions:

- Increase course to 4 or 5 days. Too much to absorb in such a short time.
- It would be helpful to have the binders before the 3-day session to give an overview before starting.

Organization of the 3-Day Session:

- More opportunities to practice with case studies.
- More discussion regarding interventions.
- More discussion on applications in our facilities. Time factor always an issue (everywhere)
- Time for question and answer period, especially on "drug day". Another 1/2 an hour on medications.
- Adding a section about coping mechanisms for staff dealing with behaviours.

Aspects Requiring Clarification:

- Clarity is an issue, perhaps more explanation given prior to a group assignment especially on day 1 and 2 when things are so new.
- I feel the Cornell scale should have been explained in greater detail i.e. which number to give for severity & why
- The way the books are set up is VERY confusing - what about have workbook pages and relevant section in manual the same colours - the pages should be numbered consecutively not repeating over and over; ++ confusing

Role of the Psychogeriatric Resource Person:

- I am the second resource person in our home, I am confident together with the support of our administrator and your web line, we will make a difference.
- Excellent course! I have a sense of my role but need to clarify what my facility expects of me - that I am not clear about.
- Have one individual specifically assigned a behaviour management nurse. Have specific time put aside weekly/daily to deal with behaviour problems.
- Enforce P.I.E.C.E.S. as a standard of practice to all LTC as well as in hospital facilities.

Other:

- P.I.E.C.E.S. education for physicians!
- Ready-made lists of video and books.
- Book a block of hotel rooms for participants to facilitate meeting & developing friendships/networks.

Participants were then asked to suggest other ways that they could be supported in their role as a Psychogeriatric Resource Person. The most common suggestions were: (1) fostering support among administrators, as well as other staff and physicians and (2) having opportunities to connect with other P.I.E.C.E.S. trained individuals, particularly those within their region (see Table 41). Other suggestions included: support from their preceptors and other resource people, and the development of resource tools (e.g., pocket cards).

Table 41
Additional Means of Support in PRP Role for LTC Participants

Support from Administration / Management / Others:

- Hope to have the team behind me, cooperation from MD and resource people as well as staff.
- Send out material to administrators and DOCS who have not attended P.I.E.C.E.S. before so that my task of getting them to buy into program will be easier because unless they set aside resources, it will be difficult to put it all into practice.
- We need amo to get Administrators and Boards to participate. In other words, we need to talk money. How this will help them.
- Compliance officers should be encouraged to talk to administrators about the need to use templates.
- Directions from management regarding expectations with my role.

Opportunity to Network with fellow Participants:

- Email addresses from our peer students / those in our regions whom attended 3-day session.
- Region or sub-regional meetings to discuss problems and possible solutions and as resources to each other. (both 1998 group and present.); can discuss "hard to solve" client situations.
- Talking with someone who has implemented change and how they got started to implement the change, any strategies?

Support from Preceptors:

- I'm not sure but from the experience of the other person in our facility, I will need LOTS of help and positive encouragement from the P.I.E.C.E.S. preceptors. Change is going to be very hard and a long, stressful process until the others see the benefits of this program. I do not give up easily, but will need support to maintain my motivation.
- Meeting routinely with preceptors (possibly monthly to 6 weeks)

Working with Others:

- Actually, our in house resource person at present (who has taken P.I.E.C.E.S. '98) is doing a great job. Has preceptors or out of house resource RN& psychiatrist visit once a month or available when needed. I really look forward to working with them.
- The social worker and I have already discussed getting together to talk over our roles, what I learned and how we can help each other. I am to make a presentation to staff on what I learned here. This will be hard to do because I learned so much and won't be able to share all the info.

Potential Resources:

- A laminated quick reference to the P.I.E.C.E.S. Quick start with partners in care written out and 6-question template on it. All in one spot with the suggestions for tools on it.
- Presentation was excellent. Have a plasticized page which states risk and “SIGECAPS” and has 6-question template written - pocket size to carry around.

Additional Learning/Training:

- Teach us more about ways to implement this!
- Need more in-services for HCA's to understand dementias, delirium, & depression (they are the front-line workers & are more keen on changes in behaviours)

Other

- An information letter to anyone could contribute to – encourage, keep informed, promote the use of the tools – may help resource people in facilities to increase their use.
- Examples of care plans using P.I.E.C.E.S..
- I would like to see job description of full time P.I.E.C.E.S. resource person & perhaps submitting a proposal to administrator. Maybe even if it was tried as a pilot project for a while
- Time to practice what I have learnt.
- Evaluation if I am making any difference or if it appears beneficial for residents quality of life in home. I will need to maintain contact with P.I.E.C.E.S. team and associates in order to feel confident that I am using my learning experience as well as possible.

Finally, the participants were asked to share other comments they had about the 3-day session or the P.I.E.C.E.S. Training Initiative. These comments are summarized in Table 42. Overall, the participants were very happy with the training provided during the 3-day session, although many commented on the vast amount of information that was covered.

Table 42
Other Comments related to the 3-Day Session or the P.I.E.C.E.S. Initiative by LTC Participants

- Glad to be part of the P.I.E.C.E.S. training but feeling overwhelmed on day 3 - information overload.
- The session was well organized and well taught, it moved quickly and the presenters used real life situations which help make the information real. I am excited about using the tools I've learned in my workplace and sharing my knowledge with other staff.
- Educators well prepared, good knowledge. Shared past experiences. Good use of experts. Great to be with others from across the province and share stories - learned how similar the facilities are.
- Need your expertise teachers. More examples about your own experience like - “I worked in this facility and I noticed this and this” what did you do? did you have to talk to family to get permission to use tools, did Dr. say you should, how did you inform staff what you are doing, who did you show & explain results. Do family have to be informed about the results etc. Thanks, love you all.

- 1 week training instead of 3 days. Continual follow-up - like a yearly refresher course - so that we are up to date with new technology, etc.
- Should be ongoing - the movement of staff within the health care system is phenomenal, therefore, ongoing opportunities for new staff training would be helpful. Training should be incorporated into current educational curriculum (i.e., BScN/SW/Psych/Gerontology....). For instance; I had exposure to ‘P.I.E.C.E.S.’ as the six part framework, and the 3D’s, and the assessment tools during the McMaster University Summer Institute in Gerontology: Geriatric Mental Health” in the summer of 1995 (also covered medications etc) so,.... If there could be either an equivalency ‘test’ and PRP designation, or refresher & ‘test’ to obtain PRP designation for those of us who have previous exposure.

- I attended the 98 training and thought it was great but wasn't given the time at work to apply any knowledge. Now I have been designated a certain amount of time I have found this training absolutely excellent and interesting and very, very helpful. Thank you.

- Liked the flip chart reminders of pertinent information around the room. Great opportunity to learn about other resources and to network with other facilities.
- Laminating "Quick Start" reference card that we could refer to when we've just starting out and can't "think" of the steps.
- DONs or Directors of Nursing should be taking the course to help the resource person implement the program & help other staff understand.

3.5 CCAC Participants – Pre-Training Results

For the CCAC P.I.E.C.E.S. training, each of the 43 CCACs across the province were invited to select between 2 and 4 individuals from their organization to be part of their CCAC P.I.E.C.E.S. Team. There were 42 CCAC Teams comprised of 141 individuals at the initial 3-day training sessions. All of the teams completed the pre-training questionnaires (response rate = 100%) (see Table 43).

Some of the questions in the pre-training questionnaire were to be completed by individual participants and others by the CCAC Team as a whole. For questions asking for individual level responses, a denominator of 141 was used. For questions that were to be completed as a Team, a denominator of 42 was used.

Table 43
Response Rate for CCAC Participants on Pre-Training Questionnaire

Attendance at 3-Day Session	# Pre-Training Questionnaires Returned	Response Rate
42 Teams	42 Teams 141 individuals	100%

3.5.1 Background Information on Individual CCAC Participants

The information in this section provides a description of the characteristics of individual members of the CCAC Teams.

Table 44 provides an overview of the professional designations of the individual CCAC participants. The majority of participants (84%) are RNs, 7% are social workers, and approximately 6% had some other professional designation.

Table 44
Professional Designation of Individual CCAC Participants (N=141)

Professional Designation	Percent (#) of CCAC Participants
RN	84.4% (119)
Social Worker	7.1% (10)
Other *	5.7% (8)

Note: percentages may not equal 100% due to missing values

* “Other” includes: OT, PT, psychological associate, gerontology, etc.

Table 45 provides a summary of the years of experience that the individual CCAC participants have in various areas. On average, the participants have been working in their present CCAC for almost 6 years and have been in their present profession for almost 16 years. In terms of working with various clientele, the individual participants have spent an average of 9 years working with individuals with Alzheimer disease or other dementia and 3 years working with individuals with severe mental illness.

Table 45
Years of Experience of Individual CCAC Participants

Years of Experience In ...	Present CCAC	Present Profession	Working with Individuals with Alzheimer Disease or Other Dementias	Working with the Severely Mentally Ill
Mean (SD)	5.8 years (3.36)	15.9 years (6.82)	9.3 years (5.41)	3.0 years (4.33)
Range	0.5 – 13.3 years	0 – 27.3 years	0 – 19.6 years	0 – 18.8 years

The individual CCAC participants were asked if they served as a resource consultant for other CCAC staff regarding clients with cognitive/mental health needs and associated behavioural issues. Almost 37% reported that they did; 61% reported that they did not serve in this type of role (see Table 46).

Table 46
Serving as a Resource Consultant for other CCAC Staff

Do You Serve as a Resource Consultant for other CCAC Staff regarding clients with cognitive/mental health needs and associated behavioural issues?	Percent (#) of Individual CCAC Participants
Yes	36.9% (52)
No	61.0% (86)

Note: percentages may not equal 100% due to missing values

The participants were then asked if they had any previous exposure to the P.I.E.C.E.S. training. Less than 13% of participants said that they had (see Table 47). Of those who reported having some exposure to P.I.E.C.E.S., most said this exposure came from in-services or other training opportunities.

Table 47
Previous Exposure to P.I.E.C.E.S. Training by CCAC Participants

Have You Had Any Previous Exposure to the P.I.E.C.E.S. Training?	Percent (#) of Individual CCAC Participants *
No	85.1% (120)
Yes	12.8% (18)
If Yes, describe your previous exposure to P.I.E.C.E.S.: - Through in-services/other course/training (N=14) - P.I.E.C.E.S. Manual (N=2) - Co-worker participated in past P.I.E.C.E.S. training (N=1) - Other *** (N=1)	

* Note: percentages may not equal 100% due to missing values.

** Note: multiple responses permitted.

*** “Other” includes: feedback from an organization.

3.5.2 Background Information on CCAC Teams

Table 48 provides a summary of the Ministry of Health and Long-Term Care Regions in which the CCAC Teams reside.

Table 48
CCAC’s Ministry of Health and Long-Term Care Region (N=42)

CCAC Region	Percent (#) of CCAC Teams
North	16.7% (7)
Central West	11.9% (5)
Central South	9.5% (4)
East	9.5% (4)
Central East	2.4% (1)
Toronto	11.9% (5)
Southwest	11.9 % (5)

Note: percentages may not equal 100% due to missing values

Table 49 summarizes information on the location of the CCAC teams (i.e., whether they are in an urban area, rural area, or urban/rural mix).

Table 49
CCAC Location (N=42)

CCAC Location	Percent (#) of CCAC Teams
Urban	14.3% (6)
Urban/Rural Mix	7.1% (3)
Rural	50.0% (21)

Note: percentages may not equal 100% due to missing values

3.5.3 Transferring Knowledge into Practice

Participants were given a list of factors known to affect the transfer of knowledge into practice and asked to indicate their top three barriers. Their responses were combined to create a variable indicating the total number of times a barrier was mentioned. These results are summarized in Table 50. The one barrier that was identified most frequently by CCAC Teams (over 80%) was “work and time pressures”. The next most frequently identified barrier was “lack of reinforcement” which was identified by 26% of Teams, followed by “pressure from peers to resist change” at 21%.

Table 50
Barriers in Transferring Training into Practice: CCAC Teams

Barrier	Percent (#) of CCAC Teams who Identified This as One of their Top 3 Barriers
Work and time pressures	81.0% (34)
Lack of reinforcement	26.2% (11)
Pressure from peers to resist changes	21.4% (9)
Non-supportive organizational structure	14.3% (6)
Insufficient authority	11.9% (5)

Ineffective work processes	11.9% (5)
Learner discomfort with change and associated effort	11.9% (5)
Separation from inspiration or support of the trainer	9.5% (4)
Impractical training program	2.4% (1)
Inadequate equipment or organization	2.4% (1)
Learner perception that training content is irrelevant	2.4% (1)

Finally, the CCAC Teams were provided with a number of statements and asked to rate the extent to which they agreed or disagreed with them. The statements related to factors in their workplace that would influence their ability to transfer the knowledge learned in the training initiative to their practice. Agreeing with the statements would indicate that the environments in which the participants work are conducive to knowledge transfer. Table 51 provides a summary of their ratings.

When asked if they were clear the expectations of their Team, have the necessary support to fulfill their role, are aware of the reinforcements/incentives for their work, and receive prompt and appropriate feedback from their supervisors, the average ratings were between 2.44 to 2.93 suggesting that the Teams tended to disagree with the statements or were neutral/not sure. When asked about the capability of their Team, the average rating was higher (3.71) suggesting that the Teams tended to agree that their Team has the capability to perform successfully. Finally, when asked about having the necessary skills and knowledge to perform successfully, the average rating was 3.04, suggesting that the Teams were neutral/not sure.

Table 51
Agreement/Disagreement to Statements Related to Knowledge Transfer Factors: CCAC Teams

Extent to which CCAC Teams Agree or Disagree with Statements	Strongly Disagree 1	Disagree 2	Neutral or Not Sure 3	Agree 4	Strongly Agree 5	Mean (SD)
We are clear about the expectations for our role as a CCAC P.I.E.C.E.S. Resource Team.	14.3% (6)	16.7% (7)	26.2% (11)	4.8% (2)	2.4% (1)	2.44 (1.05)
We have the necessary support to fulfill our role as a CCAC P.I.E.C.E.S. Resource Team.	4.8% (2)	4.8% (2)	47.6% (20)	9.5% (4)	0	2.93 (0.72)
We are aware of the reinforcements/ incentives/ rewards for our work as a CCAC P.I.E.C.E.S. Resource Team.	7.1% (3)	16.7% (7)	28.6% (12)	11.9% (5)	0	2.70 (0.91)
Our CCAC P.I.E.C.E.S. Resource Team receives prompt and appropriate and appropriate feedback from supervisors or others on our day-to-day practice in dealing with cognitive/mental health problems and associated behaviours.	7.1% (3)	16.7% (7)	21.4% (9)	19.0% (8)	2.4% (1)	2.89 (1.07)
Our CCAC P.I.E.C.E.S. Resource Team has the capability to perform successfully.	0	4.8% (2)	21.4% (9)	28.6% (12)	11.9% (5)	3.71 (0.85)
We have the necessary skills and knowledge to perform successfully in our day-to-day practice related to cognitive/mental health problems and associated behavioural issues.	2.4% (1)	21.4% (9)	14.3% (6)	23.8% (10)	2.4% (1)	3.04 (1.02)

3.6 CCAC Teams – Results from 3-Day Evaluation

Of the 42 CCAC teams that attended the 3-day training sessions, 41 (or 97.6%) completed the evaluation.

Table 52
Response Rate for 3-Day Evaluation: CCAC Teams

Attendance at 3-Day Session	# of 3-Day Evaluations Returned	Response Rate
42 Teams	41 Teams	97.6%

At the beginning of each day of the 3-day session, the Teams were asked to identify three learning goals. At the end of each of the 3 days, they were asked to rate the extent to which their goals had been met on a scale of 1 to 5 (where 1 = “not at all” and 5 = “completely”). Table 53 provides a summary of the most frequently identified goals over the 3-day period.

Table 53
Most Frequently Identified Goals over the 3-Day Session: CCAC Teams

Goal Area	Estimated Frequency
Assessment in general (e.g., knowledge, confidence, etc.)	39
Role as Resource Person/Group (e.g., integrate role into CCAC, knowledge, etc.)	22
P.I.E.C.E.S. in general (e.g., how to implement P.I.E.C.E.S., understanding, etc.)	20
Networking (e.g., with CCAC members in session, with partners in care, etc.)	18
Risk (e.g., assessing, minimizing, etc.)	17
Medication (e.g., polypharmacy, side effects, etc.)	15
Coach others in P.I.E.C.E.S. (e.g., how to educate others in P.I.E.C.E.S., etc.)	12
6-Question Template (e.g., gain a better understanding, etc.)	10
Resources (e.g., what resources are available, how to access them, etc.)	9
Specific diseases/conditions (e.g., learn more about dementia, delirium, etc.)	8
Quick Start (e.g., gain more knowledge, how to implement, etc.)	4
Behaviour (e.g., strategies to deal with difficult behaviour, etc.)	4

Participants ratings of the extent to which their three goals were met were collapsed across each day and are presented in Table 54. The average ratings regarding the extent to which their goals were met increased from Day One (average=2.95) to Day Three (average=3.55), suggesting that over the course of the 3-day session, many of the Teams’ goals had been met.

Table 54
Extent to Which Goals Were Met over the 3-Day Session for CCAC Teams

	Day One	Day Two	Day Three
Mean (SD)	2.95 (0.56)	3.46 (0.59)	3.55 (0.52)
Range	1.67 – 4.33	2 – 4.83	2.33 – 5

The participants were asked to rate various aspects of each day of the 3-Day session on a scale of 1 to 5 (where 1 = “poor” and 5 = “excellent”). The responses for Day One are summarized in Table 55. The highest average rating was for the “Brain and Behaviour session” with an average rating of 4.45. The other average ratings ranged from 3.21 for the “Partners in Care Template” to 3.89 for the session on the “Folstein and the Clock”.

Table 55

Ratings of Various Aspects of Day One: CCAC Teams

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Partners in Care Template	2.4% (1)	7.3% (3)	58.5% (24)	26.8% (11)	4.9% (2)	3.21 (0.76)
Brain and Behaviour Session	0	0	9.8% (4)	26.8% (11)	63.4% (26)	4.45 (0.66)
Psychoses Session	0	2.4% (1)	31.7% (13)	61.0% (25)	4.9% (2)	3.62 (0.62)
Introduction of Standardized Assessment Instruments	0	2.4% (1)	34.1% (14)	58.5% (24)	4.9% (2)	3.63 (0.60)
Folstein and the Clock Session	0	0	26.8% (11)	48.8% (20)	24.4% (10)	3.89 (0.69)
Day One Overall	0	2.4% (1)	19.5% (8)	65.9% (27)	12.2% (5)	3.81 (0.64)

The following provides a summary of the comments made regarding Day 1.

Comments regarding Day 1:

- I would have liked more on the brain- parts of the brain & behaviours resulting from damage to each part
- The brain & behaviour section seemed quite rushed, but the information was very good – it would have been nice to have more time to spend on this
- Goal 1 – needed more time to review & apply tools discussed. Video not effective for Folstein
- Overall a great and interesting day. I thought there would be a more in depth discussion of developing a resource team. Also a more in depth discussion on developing an effective care plan in approaching a psychogeriatric assessment with effective outcomes
- Day lacked continuity. Not enough clinical material.

In terms of Day Two, the average ratings were similar, ranging from 3.53 for the session on the “Cohen Mansfield Agitation inventory” to 3.82 for the session on the “6-Question Template, #6” (see Table 56). These ratings suggest that all of the sessions in Day Two tended toward being “very good”.

Table 56
Ratings of Various Aspects of Day Two by CCAC Teams

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
6-Question Template, #1 - #4	0	7.3% (3)	19.5% (8)	65.9% (27)	7.3% (3)	3.67 (0.67)
Cohen Mansfield Agitation Inventory	0	2.4% (1)	41.5% (17)	48.8% (20)	7.3% (3)	3.53 (0.64)
Dementia Observation System	0	2.4% (1)	43.9% (18)	41.5% (17)	12.2% (5)	3.56 (0.69)
6-Question Template, #5	0	4.9% (2)	19.5% (8)	61.0% (25)	14.6% (6)	3.70 (0.68)
6-Question Template, #6	0	2.4% (1)	22.0% (9)	61.0% (25)	14.6% (6)	3.82 (0.67)
CARE Template	0	2.4% (1)	22.0% (9)	48.8% (20)	7.3% (3)	3.65 (0.56)
Day Two Overall	0	0	22.0% (9)	68.3% (28)	9.8% (4)	3.79 (0.55)

The following provides a summary of the comments made on Day 2.

Comments regarding Day 2:

- It would be good to perhaps act out some dementia behaviours and have class evaluate rather than have all lecture material
- Looking for more specifics for behaviour management/risk management – specific ideas for specific behaviours. A lot of information requires ongoing learning & evaluation
- A lot of information is specific to identifying risk & behaviours but not “strategies” to manage. We have concerns with flagging issues, who is affected etc....but would have liked more information specific to problem solving strategies. How to manage difficult behaviours (implementation!). In addition for Day 1: overheads missing of practical ideas video did not work. Could have been better explanation of clock test. Many people unfamiliar with it & did not understand purpose & how to mark. *Capacity a very important area & no overheads for this. Really no need for group or facilitator explanation of letters of P.I.E.C.E.S.. We all know what physical, emotional, intellectual areas etc. mean/stand for. Why do we need a name (P.I.E.C.E.S.) for something we have always been doing – assessing clients? If we have not been doing this before this time we have not been doing our job as a case management.
- More emphasis on assessment on caregiver coping would be a great addition
- Would have been helpful to have obtained Black Binder prior to 3 day session – become familiar – ask questions/confirm points etc.
- No slides/overheads available for the very important issue of capacity.
- Missing O.H. would have been useful. Idea café should be repeated once more or once each day – (good examples in information sharing & partnering)
- Last session on flip charts & goals – I found rushed. didn’t get a lot out of it
- Clarke report – umbrella – older person

On Day Three, the highest average rating was for the session on “Polypharmacy” (average = 4.20), followed by the score for the “Three Day session overall”, and then the session on “Delirium and the Confusion Assessment Method” (see Table 57).

Table 57
Ratings of Various Aspects of Day Three by CCAC Teams

How would you rate ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Delirium and Confusion Assessment Method Session	0	0	17.1% (7)	70.7% (29)	4.9% (2)	3.85 (0.49)
Depression and the Cornell Session	0	4.9% (2)	9.8% (4)	68.3% (28)	9.8% (4)	3.80 (0.65)
Polypharmacy	0	0	9.8% (4)	43.9% (18)	34.1% (14)	4.20 (0.60)
P.I.E.C.E.S. Quick Start Session	0	2.4% (1)	17.1% (7)	65.9% (27)	7.3% (3)	3.84 (0.59)
Overview of Next Steps in the Initiative	0	0	31.7% (13)	51.2% (21)	7.3% (3)	3.68 (0.57)
Day Three Overall	0	0	14.6% (6)	68.3% (28)	9.8% (4)	3.91 (0.51)

The CCAC Teams were then asked to rate their satisfaction with various aspects of the 3-Day session. The average ratings for all aspects (i.e., the pace of activity, volume and complexity of material, and opportunities to participate) were between 3.02 and 3.22 suggesting they were “about right” (see Table 58).

Table 58
Ratings of 3-Day Session by CCAC Teams

<i>How would you rate your satisfaction with the following aspects of the session?</i>	1	2	3	4	5	Mean (SD)
Pace of activity	Too Slow 2.4% (1)	7.3% (3)	About Right 68.3% (28)	17.1% (7)	Too Fast 2.4% (1)	3.08 (0.62)
Volume of material	Too Little 2.4% (1)	0	About Right 65.9% (27)	26.8% (11)	Too Much 2.4% (1)	3.22 (0.59)
Complexity of material	Too Basic 0	4.9% (2)	About Right 80.5% (33)	9.8% (4)	Too Complex 2.4% (1)	3.02 (0.50)
Opportunities to participate	Too Few 2.4% (1)	0	About Right 73.2% (30)	22.0% (9)	Too Many 0	3.15 (0.59)

The Teams were asked to rate the P.I.E.C.E.S. Educators overall and the 3-Day session overall on a scale of 1 to 5 (where 1 = “poor” and 5 = “excellent”). The average score for the P.I.E.C.E.S. Educators was 4.24, indicating that they were rated between “very good” and “excellent”. The average score for the 3-Day session overall was slightly lower at 3.91, but still approached “very good” (see Table 59).

Table 59
Ratings of the P.I.E.C.E.S. Educators and the 3-Day Session Overall by CCAC Teams

<i>How would you rate the following aspects of the 3-Day session?</i>	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
P.I.E.C.E.S. Educators Overall	0	2.4% (1)	12.2% (5)	39.0% (16)	41.5% (17)	4.24 (0.76)
3-Day Session Overall	0	4.9% (2)	22.0% (9)	46.3% (19)	24.4% (10)	3.91 (0.83)

The CCAC Teams were then asked to rate some other aspects of the 3-Day session on a scale from 1 to 5 (where 1 = “not at all” and 5 = “completely”). The relevancy of the training and the relevancy of the examples used were both rated quite highly (i.e., average scores of over 4). The average scores for the other areas ranged from 3.07 to 3.65 suggesting that some clarification and additional information may be needed (see Table 60).

Table 60
Ratings Related to the 3-Day Session: CCAC Teams

	Mean (SD)	Range
Training relevant to issues within your CCAC?	4.28 (0.67)	3 - 5
Examples used relevant to your Team’s practice?	4.25 (0.69)	2 - 5
How confident is your Team in applying what it has learned?	3.17 (0.60)	1.75 - 4
How well does your Team understand what is expected from the practical application?	3.35 (0.68)	2 - 4.5
How well does your Team understand their role as a CCAC P.I.E.C.E.S. Resource Team?	3.07 (0.81)	1 - 4
How confident is your Team in taking on a role of CCAC P.I.E.C.E.S. Resource Team within your CCAC?	3.13 (0.76)	2 - 5
How confident is your Team in their ability to work collaboratively with internal resources to improve care for clients on your caseload?	3.65 (0.73)	2 - 5
How confident is your Team in their ability to work collaboratively with external resources to improve care for clients on your caseload?	3.41 (0.70)	1.5 - 5

CCAC Teams were asked to identify ways that the 3-day session could have been improved. Their comments are summarized in Table 61. A number of teams commented on the length of the session; however, their feedback was not consistent. Some of the teams suggested that the 3-day session be extended, while others said it could have been reduced. Some suggestions were also made about the content covered and organization of the session. There were also a few comments about the P.I.E.C.E.S. initiative in general.

Table 61
How the 3-Day Session Could have been Improved – Suggestions by CCAC Teams

Comments related to the Length of the Session:

- Slower re-cap. One more day for review.
- 3 days into 2 days

Comments related to the Content Covered and Organization of the Session:

- More case studies.
- Do mini-mental on each other.
- More detail on some aspects – i.e. delirium vs. dementia characteristics of each. Some information on capacity.
- Session on depression & Cornell was a little short. Dementia physiology could have been more in depth
- Emphasize role of CCAC more
- More complex material & specific interventions for problems (i.e. – difficult behaviours). (More assessment tools does not necessarily solve problems) (& help with identifying “next steps” & interventions)

Comments related to the P.I.E.C.E.S. Initiative:

- Would like to know prior to session what P.I.E.C.E.S. is/is about & what it would mean to our practice
- Recognize that with gaining knowledge & increased perceived expectation the reality of this being able to be added to current workload will require evaluation of need for more resources. This may not be possible with no increase in funding
- Would have been beneficial to receive pre-training information

The CCAC Teams were then asked to provide suggestions for additional ways that they could be supported. These comments are summarized in Table 62.

Table 62
Additional Ways to Support the CCAC P.I.E.C.E.S. Resource Team

Support of Management/Administration:

- If the P.I.E.C.E.S. team could do more education at the management/administrative level so they have a better understanding of this initiative and the benefits for the agency
- Our management team needs to “buy in” to promote a more uniform approach across our county. Could the P.I.E.C.E.S. Consultation Team make a formal written recommendation to our CCAC CEO regarding the importance of implementing this approach to our psychogeriatric population
- Reinforce importance of P.I.E.C.E.S. through OACCAC
- Adequate time allotted by CCAC management for follow through (i.e.) with assessments, teaching

Resource Materials:

- Plastic covered sheet, quick reference sheet (summarizing) 7A’s, RISK, P.I.E.C.E.S., 6 questions
- We need opportunities for practice and creating. We need quick cheat sheets created & paid by organization
- Material/resources to provide to other case managers, handouts/summary sheets etc.

Linkages to Other Resources:

- More linkage to resources available.
- On line discussion with other resource teams
- To link up with the facilitators for support after training & the preceptor
- Schedule a meeting with preceptor to share ideas regarding expanding use & sharing knowledge. Meet with

individuals from LTC who have attended P.I.E.C.E.S. training

- Encourage partners in care in our community to meet, collaborate, plan, develop strategies to provide comprehensive service plan, we need to know what each other does

Additional Training/Learning:

- They could spend some time with the psychogeriatric team seeing how experienced people use the tools and perhaps we could do the first few with them to improve confidence
- Yearly P.I.E.C.E.S. instructional updates

Other:

- Need to develop an action plan for CCAC resources team i.e. what we do and how we do it
- Team regular meeting to debrief regarding information
- Consultation about difficult cases (with consultation team).
- Lobbying for increased funding for care of these clients. P.I.E.C.E.S. educator to give overview to Access Centre staff
- It would be great to have ER nurses & community nurses trained as the “next” part of the continuum of care

Table 63 provides a summary of the types of comments made about the 3-day session overall. Some suggestions were made about the content that was covered and the organization of the session. Other comments were made about the need for more clarity prior to the program, and what understanding CCAC management has about the initiative and the expectations.

Table 63
Other Comments related to the 3-Day Session or the P.I.E.C.E.S. Initiative by CCAC Teams

Comments related to the Content Covered and Organization of Session:

- Less time for templates & more time for active problem solving. Would be more beneficial for explanation of tools before utilization. This would help interpretation, & scoring
- Wish there was more time for this – look at what other CCACs are doing/assessing psychogeriatric clients
- Various templates acronyms etc were not as well integrated. Last page gave a good diagram of the integration & should have been referred to throughout
- Put people in groups according to P.I.E.C.E.S. knowledge base (suggestion for future sessions).

Comments related to Management and Preparation:

- Was management at our CCAC aware of the impact of the P.I.E.C.E.S. training – implementation of P.I.E.C.E.S. objectives into the work place? We received little direction prior to attending P.I.E.C.E.S. training.
- Perhaps a little more information prior to attending. Really had no idea regarding agenda, expectations, what material would be introduced.

Other Comments:

- Very informative – information should be extended to all service providers as well.

3.7 LTC Facility Participants – Practical Assignment

As part of the *Putting the P.I.E.C.E.S. Together* Training Initiative, participants were to complete a “practical assignment” after the initial 3-day session. The purpose of the practical assignment was to enable the participants to apply the knowledge and skills they had learned in the initial 3-day session. Participants were asked to identify a resident who was exhibiting cognitive/mental health issues and associated behavioural problems and work through the P.I.E.C.E.S. framework with this individual. Participants were to then complete a series of questions about this experience and submit it as part of the requirements for the P.I.E.C.E.S. certificate. The type of information requested in the practical assignment included: the identification of the behaviour, an outline of the partners in care who became involved in the case, and pre and post assessments of the resident using the standardized assessment tools used in the 3-day session.

Because of the relatively large number of LTC facility participants, a random sample of 70 practical assignments was selected for analysis and review. The following provides a summary of some of the information obtained from these assignments.

Table 64 provides a summary of the types of behaviours exhibited by the residents in the sample. The most frequently occurring behaviours included: physical agitation, physical aggression, verbal agitation and wandering.

Table 64
Types of Behaviours Identified among Residents Assessed: LTC Assignments

Behaviours	Percent (and Number) of Cases *
Physical agitation	42.9% (30)
Physical aggression	40.0% (28)
Verbal agitation	34.3% (24)
Wandering	27.1% (19)
Verbal aggression	20.0% (14)
Depression	20.0% (14)
Delusions/Hallucinations	20.0% (14)
Resistive to care	18.6% (13)
Inappropriate sexual behaviour	12.9% (9)
Hoarding/Rummaging	12.9% (9)
Cognitive impairment	12.9% (9)
Exit seeking	10.0% (7)
Suicidal Ideation	2.9% (2)
Other **	10.0% (7)

* Percentages exceed 100% since more than one behaviour could be identified.

** “Other” includes: sleep disturbance.

Participants were asked to identify which partners in care they involved in working through an assessment of the resident. On average, the PIECES-trained individuals in the sample involved 3.39 partners in care, ranging from 0 to 6. The partners that were most frequently involved were: staff, family, physicians and other community services (see Table 65).

Table 65
Partners in Care Involved: LTC Assignments

Partner in Care	Percent (and Number) of Cases
Staff	90.0% (63)
Family	78.6% (55)
Physicians	68.6% (48)
Other community services	50.0% (35)
Other health professionals	32.9% (23)
Resident	8.6% (6)
Administrator	5.7% (4)
Volunteers	4.3% (3)
Average Number (SD) of Partners in Care Involved	3.39 (1.3) partners
Range	0 – 6 partners

Participants were also asked to record the scores of the assessment tools used with the residents they identified when they first began to work with them (i.e., pre-assessment) and after a number of strategies had been tried (i.e., post-assessment). In order to simplify the information the participants were asked to report, a table was created for the pre and post assessment tool scores. The scores that were specifically requested were for the Mini Mental State Examination (MMSE), Cornell Scale for Depression (Cornell), Cohen Mansfield Agitation Inventory (CMAI), and Confusion Assessment Method (CAM).

Table 66 provides a summary of the completion rates for each of these scales at: pre, post and both pre and post. As indicated in the table, the MMSE and CAM were completed at both pre and post in just over 50% of the cases sampled. The Cornell was completed at both pre and post in 40% of cases.

Table 66
Completion Rates of Pre and Post Assessments: LTC Assignments

Scale	Percent (Number) of Cases where Pre Assessment Completed	Percent (Number) of Cases where Post Assessment Completed	Percent (Number) of Cases where Pre & Post Assessments Completed
Mini Mental State Exam	70.0% (49)	60.0% (42)	52.9% (37)
Cornell Scale for Depression	51.4% (36)	44.3% (31)	40.0% (28)
Cohen Mansfield Agitation Inventory	57.1% (40)	45.7% (32)	45.7% (32)
Confusion Assessment Method	61.4% (43)	51.4% (36)	51.4% (36)

Table 67 provides information on the pre and post scores for the MMSE and Cornell. In terms of the MMSE, there was a small, statistically non-significant increase from pre to post scores in the sample that was analyzed. In examining the percent of clients who either improved (i.e., scores increased), stayed the same, or worsened (i.e., scores decreased) from pre to post on the MMSE, the data indicate that scores improved in 46% of cases and stayed the same in 29% of cases. In terms of the Cornell, there was a statistically significant decrease (i.e., improvement) from pre to past assessment scores among those sampled. In fact, scores improved in 75% of sampled cases where both pre and post assessments were conducted.

Table 67
Mean Scores and Pre-Post Change for the MMSE and Cornell: LTC Assignments

	MMSE (N=37)	Cornell (N=28)
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Scores		
Pre-assessment mean (SD)	12.7 (8.10)	14.6 (6.61)
Post-assessment mean (SD)	13.6 (8.05)	9.6 (5.82)
Mean difference	- 0.9	5.0 **
Change Pre vs. Post		
% (#) who improved	45.9% (17)	75.0% (21)
% (#) who stayed the same	29.0% (11)	10.7% (3)
% (#) who worsened	24.3% (9)	14.3% (4)

* p < 0.05; ** p < 0.01; p < 0.001

With respect to the CMAI, participants were asked to identify the CMAI items representing the 3 most significant behaviours and to record the “disruptiveness” and “frequency” for each of these behaviours. “Disruptiveness” refers to how disruptive the behaviour is to staff, other residents or family members. Instructions on administering the scale indicate that if the behaviour is disruptive to anyone, the behaviour is to be rated at the highest level for those for whom it disrupts. Disruptiveness is scored on a 5-point scale (where 1 = “not at all”, 2 = “a little”, 3 = “moderately”, 4 = “very much” and 5 = “extremely”). “Frequency” refers to the frequency with which the behaviour occurs; it is rated on a 7-point scale (where 1 = “never”, 2 = “less than once a week”, 3 = “once or twice a week”, 4 = “several times a week”, 5 = “once or twice a day”, 6 = “several times a day” and 7 = “several times an hour”).

Table 68 provides a summary of the most frequently identified items on the CMAI. Pacing/aimless wandering, cursing or verbal aggression, and constant unwarranted request for attention or help were the items most frequently identified in the sample.

Table 68
The Most Frequently Identified CMAI Items: LTC Assignments

Item Number and Description	Percent (Number) of Times Identified (N=32)
1: Pacing, aimless wandering	40.6% (13)
4: Cursing or verbal aggression	28.1% (9)
5: Constant unwarranted requests for attention or help	28.1% (9)
12: Making strange noises	25.0% (8)
6: Repetitive sentences or questions	21.9% (7)
29: General restlessness	18.8% (6)
7: Hitting (including self)	15.6% (5)
16: Trying to get to a different place	15.6% (5)
13: Screaming	12.5% (4)
22: Handling things inappropriately	9.4% (3)
27: Making verbal sexual advances	9.3% (3)

In each assessment (i.e., at pre and post), the LTC facility participants were asked to identify the 3 most significant CMAI items. The data from all of these items were used in calculating the disruptiveness and frequency scores at each assessment period. Pre and post data on the disruptiveness and frequency measures of the CMAI are presented in Table 69. There were statistically significant decreases (i.e., improvements) in both disruptiveness and frequency from pre to post assessment.

Table 69
Mean Scores and Pre-Post Change for the CMAI: LTC Assignments

	Disruptiveness (N=96)	Frequency (N=96)
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Scores		
Pre-assessment mean (SD)	4.56 (1.52)	5.44 (1.71)
Post-assessment mean (SD)	3.31 (1.67)	3.84 (1.71)
Mean difference	1.25 ***	1.60 ***
Change Pre vs. Post		
% (#) of items that improved	54.2% (52)	60.4% (58)
% (#) of items that stayed the same	34.3% (33)	29.2% (28)
% (#) of items that worsened	3.1% (3)	2.1% (2)

* p < 0.05; ** p < 0.01; p < 0.001

With respect to the CAM, Table 70 indicates that 5 individuals screened positive for delirium during the pre-assessment and only one at the post-assessment.

Table 70
Pre and Post Scores for the CAM: LTC Assignments

Confusion Assessment Method	Percent (Number) of Cases
Screened positive for delirium at pre	13.9% (5)
Screened positive for delirium at post	2.8% (1)
Change Pre vs. Post	
% (#) who improved (i.e., screened positive at pre and negative at post)	11.1% (4)

3.8 CCAC Teams – Practical Assignment

As with the LTC facility participants, the CCAC Teams were also asked to complete a practical assignment after the initial 3-day session. Because the number of practical assignments submitted by the CCAC Teams was relatively small (i.e., 38), all were able to be reviewed and analyzed.

The types of behaviours most frequently identified by the CCAC Teams included: cognitive impairment, delusions/hallucinations, and depression (see Table 71).

Table 71
Types of Behaviours Identified among Residents Assessed: CCAC Assignments

Behaviours	Percent (and Number) of Cases *
Cognitive impairment	60.5% (23)
Delusions/Hallucinations	36.8% (14)
Depression	28.9% (11)
Physical agitation	15.8% (6)
Wandering	15.8% (6)
Physical aggression	13.2% (5)
Verbal aggression	10.5% (4)
Resistive to care	7.9% (3)
Hoarding/Rummaging	7.9% (3)
Suicidal Ideation	7.9% (3)
Verbal agitation	5.3% (2)
Inappropriate sexual behaviour	5.3% (2)

Other **	15.8% (6)
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* Percentages exceed 100% since more than one behaviour could be identified.

** “Other” includes: risk and sleep disturbance.

The average number of partners in care that were involved was lower than in the cases described by the LTC facility participants (mean of 2.71). The partners in care most frequently involved included: CCAC staff, other community services, caregivers, and physicians (see Table 72).

Table 72
Partners in Care Involved: CCAC Assignments

Partner in Care	Percent (and Number) of Cases
CCAC Staff	63.2% (24)
Other community services	57.9% (22)
Caregivers	55.3% (21)
Physicians	47.4% (18)
Other health professionals	23.7% (9)
Client	13.2% (5)
Significant Others	10.5% (4)
Managers/Administrators	0
Average Number (SD) of Partners in Care Involved Range	2.71 (1.7) partners 0 – 6 partners

The CCAC Teams were also provided with a table to record pre and post assessment scores for the MMSE, Cornell, CMAI and CAM. Relatively few of these scales were completed by the CCAC Teams at both pre and post. The MMSE was the tool most frequently completed at both time points (in 40% of cases), followed by the CAM (in 24% of cases) (see Table 73).

Table 73
Completion Rates of Pre and Post Assessments: CCAC Assignments

Scale	Percent (Number) of Cases where Pre Assessment Completed	Percent (Number) of Cases where Post Assessment Completed	Percent (Number) of Cases where Pre & Post Assessment Completed
Mini Mental State Exam	73.7% (28)	42.1% (16)	39.5% (15)
Cornell Scale for Depression	23.7% (9)	21.1% (8)	15.8% (6)
Cohen Mansfield Agitation Inventory	15.8% (6)	7.9% (3)	7.9% (3)
Confusion Assessment Method	39.5% (15)	23.7% (9)	23.7% (9)

In terms of the MMSE, there was a small, statistically non-significant decrease (i.e., worsening) of scores from pre to post. However, for the Cornell there was a relatively large, although statistically non-significant decrease (i.e., improvement) in scores from pre to post (see Table 74). The reason for the non-significant result was likely due to the small number of cases where both pre and post assessment scores were available (N=6).

Table 74

Mean Scores and Pre-Post Change for the MMSE and Cornell: CCAC Assignments

	MMSE (N=15)	Cornell (N=6)
Scores		
Pre-assessment mean (SD)	19.9 (5.78)	9.83 (7.89)
Post-assessment mean (SD)	19.0 (6.57)	4.83 (3.82)
Mean difference	-0.9	5.0
Change Pre vs. Post		
% (#) who improved	33.3% (5)	66.7% (4)
% (#) who stayed the same	33.3% (5)	16.7% (1)
% (#) who worsened	33.3% (5)	16.7% (1)

* p < 0.05; ** p < 0.01; p < 0.001

In terms of the CMAI, pre and post assessment scores were only available for 3 cases. The CMAI items that were identified in those cases are shown in Table 75.

Table 75
The Most Frequently Identified CMAI Items: CCAC Assignments

CMAI Item	Percent (Number) of Times Identified (N=3)
5: Constant unwarranted requests for attention and help	66.7% (2)
6: Repetitive sentences or questions	66.7% (2)
18: Complaining	66.7% (2)
19: Negativism	66.7% (2)
30: Other	66.7% (2)

In each assessment (i.e., at pre and post), the CCAC Teams were asked to identify the 3 most significant CMAI items. The data from all of these items were used in calculating the disruptiveness and frequency scores at each assessment period. Table 76 shows that there were statistically significant decreases (i.e., improvements) in both the dsirruptiveness and frequency of behaviours exhibited in the clients identified by the CCAC Teams.

Table 76
Mean Scores and Pre-Post Change for the CMAI: CCAC Assignments

	Disruptiveness (N=9)	Frequency (N=9)
Scores		
Pre-assessment mean (SD)	3.44 (1.42)	3.33 (1.50)
Post-assessment mean (SD)	1.89 (1.05)	1.89 (1.17)
Mean difference	1.56 **	1.44 *
Change Pre vs. Post		
% (#) of items that improved	88.9% (8)	77.8% (7)
% (#) of items that stayed the same	11.1% (1)	11.1% (1)
% (#) of items that worsened	0	11.1% (1)

* p < 0.05; ** p < 0.01; p < 0.001

Finally, in terms of the CAM, 4 clients screened positive for delirium during pre-assessment and only 1 at post-assessment. Improvements were therefore seen in 3 cases (see Table 77).

Table 77
Pre and Post Assessment Scores for the CAM: CCAC Assignments

Confusion Assessment Method	Percent (Number) of Cases
Screened positive for delirium at pre	44.4% (4)
Screened positive for delirium at post	11.1% (1)
Change Pre vs. Post	
% (#) who improved (i.e., screened positive at pre and negative at post)	33.3% (3)

3.9 LTC Facility and CCAC Participants – Results from 2-Day Evaluation

A total of 517 individuals participated in the twenty 2-day sessions that were held (range = 17 to 37 per session). Of these, 507 (98.1%) completed the 2-day evaluation form (see Table 78). Thus, a denominator of 507 was used to calculate results in this section.

Table 78
Response Rate for 2-Day Session

Type of Participant	Number of Participants	Number of Evaluations Returned	Response Rate
LTC Facility Participants	314	312	99.4%
LTC 1998 Graduates	67	44	65.7%
CCAC Participants	136	129	94.9%
Type of participant not specified	--	22	--
TOTAL	517	507	98.1%

*Note: In 22 surveys, the type of participant was not specified; thus, the response rates associated with each type of participant may be underestimated.

Participants were asked to rate the 2-day sessions overall, using a scale of 1 to 5 (where 1 = “poor”; 2 = “fair”; 3 = “good”; 4 = “very good”; 5 = “excellent”). The overall rating across all 20 sessions was 4.03 or “very good” (see Table 79).

Table 79
Overall Rating of 2-Day Session

	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Overall Rating of the 2-Day Session	0.2% (1)	2.0% (10)	15.4% (78)	56.6% (287)	23.1% (117)	4.03 (0.70)

The participants were asked to rate their satisfaction with various aspects of the 2-Day session. The average ratings for all aspects (i.e., the pace of activity, volume and complexity of material, and opportunities to participate) were between 3.05 and 3.29 suggesting they were “about right” (see Table 80).

Table 80
Satisfaction Ratings Related to the 2-Day Session

<i>How would you rate your satisfaction with the following aspects of the session?</i>	1	2	3	4	5	Mean (SD)
Pace of activity	Too Slow 1.0% (5)	8.3% (42)	About Right 75.0% (380)	14.8% (75)	Too Fast 0.6% (3)	3.05 (0.54)
Volume of material	Too Little 0.6% (3)	2.8% (14)	About Right 73.6% (373)	20.1% (102)	Too Much 1.2% (6)	3.19 (0.52)
Complexity of material	Too Basic 1.0% (5)	4.9% (25)	About Right 75.0% (380)	16.4% (83)	Too Complex 0.6% (3)	3.12 (0.52)
Opportunities to participate	Too Few 0	2.2% (11)	About Right 66.9% (339)	28.0% (142)	Too Many 1.2% (6)	3.29 (0.52)

Participants were then asked to rate the Facilitation Team in a number of areas using a scale of 1 to 5 (where 1 = “poor” and 5 = “excellent”). These results are found in Table 81. The average ratings exceeded 4.45, suggesting that they were approaching “excellent” in each area.

Table 81
Ratings Related to the Facilitation Team

How would you rate the Facilitation Team in terms of ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Knowledge of P.I.E.C.E.S.	0	0.2% (1)	3.7% (19)	33.5% (170)	62.3% (316)	4.58 (0.57)
Skills displayed (including facilitation skills)	0	0.2% (1)	7.3% (37)	36.7% (186)	55.2% (280)	4.48 (0.64)
Professional behaviour	0	0	3.2% (16)	31.6% (160)	65.3% (331)	4.62 (0.55)
The Facilitation Team overall	0	0.2% (1)	3.4% (17)	36.7% (186)	59.6% (302)	4.56 (0.57)

Participants were then asked to rate various aspects of the training program using a 5-point scale (where 1 = “not at all” and 5 = “completely”). Average ratings of the relevance of the training and the relevance of the

examples used both exceeded 4, suggesting they were highly relevant (see Table 82). Average ratings of the participants’ confidence in applying what they learned and understanding their role as a resource person/team were somewhat lower (3.58 and 3.52, respectively).

Table 82
Ratings Related to the Training Program

	Relevance of Training	Relevance of Examples	Confidence in Application	Understanding of Role
Mean (SD)	4.32 (0.77)	4.33 (0.75)	3.58 (0.66)	3.52 (0.83)
Range	2 – 5	2 – 5	2 – 5	1 – 5

Tables 83 to 85 provide the results from participants’ confidence ratings in three areas: serving as a Psychogeriatric Resource Person, working with internal resources and working with external resources. For each area, the participants were asked to rate their confidence on scale of 1 to 5 (where 1 = “not at all” confident and 5 = “completely” confident). They were then asked to indicate how this rating compared with their level of confidence prior to the P.I.E.C.E.S. training using a scale of 1 to 5 (where 1 = “less confident”, 3 = “about the same” and 5 = “more confident”).

In terms of serving as a Psychogeriatric Resource Person, most participants rated their confidence as either 3 or 4 (mean = 3.49), suggesting that they were somewhat confident. When asked how this rating compared with their confidence prior to the P.I.E.C.E.S. training, most indicated that they were now more confident (see Table 83).

Table 83
Confidence in Serving as a Psychogeriatric Resource Person

	1	2	3	4	5	Mean (SD)
Confidence in taking on the role of Psychogeriatric Resource Person to others in your facility/CCAC?	Not at All Confident 0.4% (2)	8.3% (42)	41.0% (208)	43.2% (219)	Completely Confident 6.7% (34)	3.49 (0.75)
How does this compare with your level of confidence before the P.I.E.C.E.S. training?	Less Confident 3.2% (16)	7.9% (40)	About the Same 14.0% (71)	42.4% (215)	More Confident 32.5% (165)	3.94 (1.03)

The average confidence rating when asked about their ability to work with internal resources was 3.90 or quite confident. Most participants indicated that their confidence after the training was greater than it had been prior (see Table 84).

Table 84
Confidence in Working Collaboratively with Internal Resources

	1	2	3	4	5	Mean (SD)
Confidence in ability to work collaboratively with internal resources to improve care for residents in your facility/CCAC?	Not at All Confident 0	2.0% (10)	20.7% (105)	63.7% (323)	Completely Confident 13.8% (70)	3.90 (0.64)
How does this compare with your level of confidence before the P.I.E.C.E.S. training?	Less Confident 1.8% (9)	9.1% (46)	About the Same 19.1% (97)	39.6% (201)	More Confident 29.6% (150)	3.87 (1.00)

Similar results were obtained when participants were asked to rate their confidence in their ability to work collaboratively with external resources. The average rating was 3.77, and the majority of participants indicated that their confidence was higher than it had been prior to the training (see Table 85).

Table 85
Confidence in Working Collaboratively with External Resources

	1	2	3	4	5	Mean (SD)
Confidence in ability to work collaboratively with external resources to improve care for residents in your facility/CCAC?	Not at All Confident 0.4% (2)	4.1% (21)	26.8% (136)	55.4% (281)	Completely Confident 12.8% (65)	3.77 (0.73)
How does this compare with your level of confidence before the P.I.E.C.E.S. training?	Less Confident 2.6% (13)	8.3% (42)	About the Same 22.7% (115)	38.9% (197)	More Confident 27.2% (138)	3.81 (1.01)

When asked if it was valuable to have the final 2-day session held in one's own region with other P.I.E.C.E.S. trained individuals and some of the local resources present, the overwhelming majority of participants (484 or 95.5%) said "yes". Only 8 responded with a "no". The advantages and drawbacks of these regional sessions are summarized in Table 86.

Most participants indicated that regional sessions provided them with opportunities to meet others in their area, to network and share with these individuals, and provided them with people to contact for assistance in the future. Most were grateful to have this opportunity. There were, however, a handful of participants who did not see this as an advantage and suggested separate sessions for the LTC facility and CCAC groups. Many participants also recognized the benefits of having the 1998 grads present. Overall, the advantages outweighed any drawbacks.

Table 86
Advantages & Drawbacks of Holding the 2-Day Sessions Regionally

Advantages of Holding the 2-Day Sessions Regionally
▪ Opportunity to share approaches, applications, and stories of what worked and what did not ▪ Opportunity to get to know colleagues from local area; put faces to names (other P.I.E.C.E.S. trained individuals and preceptors) ▪ Opportunity to share information about local strengths, needs and strategies ▪ Enhanced understanding of local resources and each others’ roles and mandates ▪ Appreciate challenges that each sector is under; recognize that many of these challenges are common to other sectors; realize that “I’m not alone” ▪ Opportunity to discuss cases with own preceptor ▪ Identified other people who could be contacted if had questions, concerns, etc. ▪ Increased comfort in working with partners ▪ Saw the value of P.I.E.C.E.S. as a whole ▪ 1998 grads were updated on changes to P.I.E.C.E.S. ▪ Opportunity to have 1998 grads share experience and provide support to us ▪ Smaller group therefore more interaction and discussion ▪ Less travel therefore less costs; less time away
Drawbacks of Holding the 2-Day Sessions Regionally
▪ None ▪ Not enough time ▪ In some cases, CCAC and LTC staff did not interact much ▪ Examples not always relevant (to LTC or CCAC staff) ▪ Not always enough participants from CCAC ▪ Would have liked more 1998 grads; the fact that they were not reimbursed may have played a factor in this ▪ Would have liked to have had a physician present (in areas where there wasn’t one) to answer questions about psychotropics ▪ In some cases, suggested separate sessions for LTC and CCAC

The participants were then asked to identify ways that the 2-day session could have been improved. These comments are summarized in Table 87. Most individuals were very satisfied with the session and provided few suggestions on how it could be improved. Of those who did provide some suggestions, these included: more time for sharing ideas and experiences; more time spent on certain topics; more case studies; and having speakers available in person rather than on video.

Table 87
How the 2-Day Sessions Could have been Improved

▪ Cannot think of anything ▪ More time to share ideas, stories, practice with tools, etc. ▪ More time on certain topics (e.g., psychotropics, psychosis) ▪ More and/or new case studies ▪ More role playing ▪ Have speakers who are there in-person versus on video ▪ Hold 2-day session closer to 3-day session ▪ A few requested that sessions be held closer to their homes ▪ Various positive and negative comments made about: the food, the room, the seats, the AV equipment

3.10 LTC Facility Participants – Results from Post-Training Questionnaire

Of the 314 LTC facility participants who attended the final 2-day training sessions, 299 (95.2%) completed the post-training evaluation questionnaire (see Table 88). Thus, a denominator of 299 is used in this section of the report.

Table 88
Response Rate for Post-Training Questionnaire: LTC Participants

Attendance at 2-Day Session	# of Post-Training Evaluations Returned	Response Rate
314	299	95.2%

3.10.1 Pre-Post Confidence Ratings

The following series of tables presents the results from the confidence assessments that were made in the pre and post-training questionnaires. In the pre and post training questionnaires, participants were asked to rate their confidence on a 5-point scale (where 1 = “not confident” and 5 = “very confident”). These data were analyzed to determine whether there were significant differences between pre and post means using paired t-tests. The table present the mean pre and post training scores as well as mean pre and post score difference. A positive mean difference score indicates that the mean post-training score was higher than the mean pre-training cores. In other words, the confidence increased from pre to post training which is what one would expect if the training was successful. A negative mean difference score indicates that the mean post-training score was lower than the mean pre-training score (i.e., there was a decrease in confidence from before the training to after the training).

It should be noted that when SPSS calculates these t-tests, only cases without missing pre and post data are included. Therefore, the results are based on a smaller number of cases than actually may have completed the questionnaires at pre and at post.

In addition to the paired t-test results, data are also presented on the participants’ self-reported change in confidence. In the post-training questionnaire, participants were also asked to rate their level of confidence now (i.e., after the training) compared with their level of confidence before the training (using a 5-point scale where 1 = “less confident”, 3 = “about the same” and 5 = “more confident”). Evidence from the literature (Muchinsky, 1993) suggests that initial assessments of confidence may be inflated and that confidence may actually decrease during a training initiative as participants gain an understanding of the skills that are required and an appreciation for the complexity of the information. For this reason, participants were asked to make this second assessment (i.e., self-reported change in confidence). The information provided by this second assessment may provide additional insight into the pre-post comparison results.

Participants were asked to rate their confidence in their ability to work collaboratively with a variety of individuals/groups to improve care for residents in their facilities (using a 5-point scale where 1 = “not confident” and 5 = “very confident”). In all cases, pre-training confidence ratings were significantly higher than post-training confidence ratings (see Table 89). However, when asked to rate their confidence after the training compared with their confidence prior to the training, the average ratings all suggested that the participants reported being more confident (average ratings ranged from 4.12 to 4.37 using a scale of 1 to 5 where 1 = “less confident”, 3 = “about the same” and 5 = “more confident”).

Table 89
Confidence in Working Collaboratively with Others to Improve Care: LTC Participants

Confidence in ability to work collaboratively with the following people in order to improve care for residents in your facility ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Residents	4.45 (0.65)	4.10 (0.75)	- 0.35 ***	4.37 (0.73)
Family members/significant others	4.28 (0.70)	3.95 (0.77)	- 0.33 ***	4.28 (0.73)
Other staff members	4.34 (0.62)	3.97 (0.72)	- 0.37 ***	4.29 (0.72)
Volunteers	4.14 (0.72)	3.84 (0.85)	- 0.30 ***	4.12 (0.79)
Administrators	4.21 (0.66)	3.81 (0.82)	- 0.39 ***	4.16 (0.75)
Physicians	4.18 (0.70)	3.77 (0.83)	- 0.41 ***	4.21 (0.75)
Other health care professionals (including outreach teams & consultants)	4.05 (0.78)	3.67 (0.84)	- 0.38 ***	4.24 (0.74)
Other community resources	3.93 (0.81)	3.53 (0.90)	- 0.41 ***	4.13 (0.77)

* p < 0.05; ** p < 0.01; *** p < 0.001

Table 90 provides a summary of the pre and post confidence ratings related to the participants' ability to flag and understand various mental health and behavioural concerns. In 7 areas, average post-training rating exceeded pre-training ratings, and in 9 areas, pre-training ratings exceeded post-training ratings. However, in all cases the difference between means was relatively small. The only significant difference was in the rating related to flagging and understanding “mental health problems in general” where the average post-training score was significantly higher than the average pre-training score. As with previous table, the average ratings of self-reported change in confidence all exceeded 4, suggesting that the participants were somewhat more confident after the training than before the training.

Table 90
Confidence in Flagging and Understanding Various Concerns: LTC Participants

Confidence in flagging and understanding these concerns ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Agitation and restlessness	4.10 (0.71)	4.06 (0.69)	- 0.04	4.36 (0.72)
Anxiety	4.05 (0.71)	3.98 (0.73)	- 0.67	4.32 (0.72)
Apathy/failure to participate; withdrawn/crying	3.83 (0.81)	3.89 (0.78)	0.06	4.26 (0.70)
Defensive behaviour	3.73 (0.81)	3.77 (0.78)	0.04	4.22 (0.74)
Hearing and seeing things that do not exist	3.80 (0.84)	3.79 (0.79)	- 0.01	4.27 (0.70)
Hoarding and/or rummaging	4.04 (0.75)	4.02 (0.77)	- 0.02	4.24 (0.74)
Impulsivity	3.54 (0.90)	3.58 (0.78)	0.04	4.05 (0.77)
Inappropriate sexual behaviour	3.76 (0.88)	3.77 (0.81)	0.01	4.13 (0.77)
Intrusiveness	3.63 (0.85)	3.62 (0.77)	- 0.01	4.05 (0.76)
Resistance to care	4.16 (0.70)	4.12 (0.74)	- 0.04	4.37 (0.73)
Suspicious/accusing others	3.97 (0.77)	3.90 (0.74)	- 0.07	4.22 (0.73)
Vocally disruptive behaviour	3.98 (0.78)	3.94 (0.75)	- 0.04	4.25 (0.73)
Wandering	4.17 (0.70)	4.10 (0.71)	- 0.07	4.29 (0.75)
Challenging behaviours in general	3.76 (0.79)	3.77 (0.73)	0.01	4.30 (0.68)

Alzheimer disease and related dementias in general	3.87 (0.75)	3.89 (0.72)	0.02	4.39 (0.67)
Mental health problems in general	3.42 (0.85)	3.58 (0.74)	0.16 **	4.21 (0.68)

* p < 0.05; ** p < 0.01; *** p < 0.001

Participants were also asked to rate their confidence in their ability to assess the P.I.E.C.E.S. components. There were small, non-significant decreases from average pre to post ratings related to assessing a resident’s physical health and functional capabilities. There were increases in pre to post confidence ratings in all other areas, with those related to emotional and spiritual health, the environment, and social and cultural factors being statistically significant (see Table 91). The ratings of self-reported change in confidence all suggested that the participants were more confident.

Table 91
Confidence in Assessing the P.I.E.C.E.S. Components: LTC Participants

Confidence in ability to assess the following aspects of a resident ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Physical health	3.95 (0.76)	3.93 (0.72)	- 0.01	4.13 (0.78)
Intellectual capacity	3.53 (0.74)	3.60 (0.76)	0.07	4.26 (0.69)
Emotional & spiritual health	3.47 (0.77)	3.58 (0.73)	0.11 *	4.08 (0.72)
Functional capabilities	3.87 (0.78)	3.82 (0.77)	- 0.05	4.25 (0.72)
Environmental factors	3.69 (0.80)	3.80 (0.77)	0.11 *	4.29 (0.72)
Social and cultural factors	3.38 (0.82)	3.60 (0.77)	0.23 ***	4.11 (0.75)

* p < 0.05; ** p < 0.01; *** p < 0.001

When asked to rate their confidence in using and interpreting various assessment instruments, there was an increase from pre-training to post-training scores in all cases except one (other behavioural scales) (see Table 92). These pre-post differences were statistically significant for: the MMSE, Clock Test, Cornell, other depression scales, the Cohen Mansfield Agitation Inventory, the Behaviour Flow Sheet, the Dementia Observational System and the Confusion Assessment Method. Average ratings of the participants’ self-reported changes in confidence also indicated that their confidence had increased from before the training.

Table 92
Confidence in Using and Interpreting Assessment Tools: LTC Participants

Confidence in using these tools and interpreting their results ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Folstein Mini-Mental State Examination	3.09 (1.27)	3.62 (1.12)	0.53 ***	4.50 (0.69)
Other mental status test	2.00 (0.82)	2.86 (1.07)	0.86	4.30 (0.77)
The Clock Test	2.61 (1.29)	3.30 (1.18)	0.69 ***	4.48 (0.73)
The Cornell Scale for Depression	2.24 (1.23)	3.25 (1.22)	1.01 ***	4.34 (0.78)
Other depression scale	2.45 (1.50)	3.35 (1.23)	0.90 **	4.15 (0.83)
The Cohen-Mansfield Agitation Inventory	2.30 (1.32)	3.47 (1.21)	1.17 ***	4.41 (0.70)
Behaviour Flow Sheet	3.45 (1.11)	3.84 (0.99)	0.39 **	4.39 (0.71)
Other behavioural scale	2.75 (0.96)	3.25 (0.50)	0.50	4.15 (0.83)
The Abilities Assessment	2.46 (1.20)	3.04 (1.32)	0.57	3.98 (0.98)
Dementia Observational System	1.83 (1.15)	3.40 (1.14)	1.57 ***	4.43 (0.75)
Confusion Assessment Method	1.72 (1.10)	2.96 (1.27)	1.24 **	4.24 (0.90)
Assessment tools in general	3.02 (1.23)	3.28 (1.08)	0.27	4.30 (0.76)

* p < 0.05; ** p < 0.01; *** p < 0.001

Table 93 presents the results from the pre-post analysis of confidence ratings related to psychotropic medications. The only significant difference was an increase from pre to post-training scores in “identifying potential side effects” (mean values of 3.34 and 3.44, respectively). As with the other data in this section, the average self-reported change scores all indicated that the participants’ confidence had increased since before the training.

Table 93
Confidence Related to Psychotropic Medications: LTC Participants

Confidence in ability to engage in the following activities ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Identify potential risks and benefits?	3.25 (0.83)	3.31 (0.85)	0.06	4.22 (0.74)
Identify purposes of the medication?	3.55 (0.84)	3.54 (0.85)	- 0.02	4.28 (0.75)
Identify the class of medication being used?	3.43 (0.93)	3.48 (0.93)	0.04	4.24 (0.74)
Identify potential side effects?	3.34 (0.92)	3.44 (0.83)	0.11 *	4.24 (0.72)
Monitor the resident’s response to medication?	3.67 (0.86)	3.60 (0.83)	- 0.08	4.34 (0.71)

* p < 0.05; ** p < 0.01; *** p < 0.001

When asked to rate their confidence related to the P.I.E.C.E.S. training objectives, the average pre-training scores were higher than the average post-training scores. These differences were statistically significantly in two cases (demonstrating sensitivity and respect, and serving as a resource to others). The self-reported increase in confidence in all of these areas suggests that these results may have been due to the fact that confidence in these areas were over-estimated prior to the initiation of training (see Table 94).

Table 94
Confidence Related to the P.I.E.C.E.S. Objectives: LTC Participants

Confidence in the following areas ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Demonstrate sensitivity and respect for the individuality of the resident and the family, and community resource people.	4.34 (0.67)	4.22 (0.70)	- 0.12 *	4.27 (0.80)
Complete an assessment to flag cognitive/mental health needs and associated behavioural issues.	3.60 (0.89)	3.51 (0.85)	- 0.09	4.34 (0.68)
Use assessment data related to the cognitive/mental health needs and associated behaviours to plan, implement, and evaluate care strategies.	3.42 (0.95)	3.39 (0.89)	- 0.03	4.31 (0.68)
Serve as a resource to others in planning care for the resident with complex physical and cognitive/mental health needs and associated behavioural issues	3.51 (0.95)	3.33 (0.92)	- 0.18 *	4.22 (0.75)

* p < 0.05; ** p < 0.01; *** p < 0.001

It should be noted that in Tables 89 to 94, even though the average self-reported change ratings all indicated that the participants were more confident after the training, the average post-training ratings ranged from 2.86 to 4.22 (with the majority of ratings less than 4.00). This suggests that there is still room for confidence to increase.

3.10.2 The Psychogeriatric Resource Person Role and Issues of Support

Participants were asked to indicate how they planned to serve as a Psychogeriatric Resource Person in their facility. The most commonly identified ways included: working with the existing Resource Person; developing a Resource team; educating staff (various levels); working with internal resources; and working with external resources (e.g., preceptor, outreach team) (see Table 95).

Table 95
How LTC Facility Participants Plan to Serve as a Psychogeriatric Resource Person

Most Common Plans: ▪ working with existing Psychogeriatric Resource Person ▪ develop a Psychogeriatric Resource Team ▪ educate staff; enhance their knowledge and skills; show them the value of the frameworks; develop education packages ▪ work with preceptor and outreach team (e.g., assist with referrals and assessments; serve as their contact person; flag concerns); work with other external resources ▪ work with internal resources (e.g., DONs, education people, social workers, etc.) ▪ share tools; administer tools; encourage staff to use tools Other Plans: ▪ assist staff with problems as they arise; assist with assessment of residents; offer support and advice ▪ case conferences for residents who present challenges ▪ join or form Psychogeriatric Committee within facility ▪ introduce concepts and role to new staff at orientation ▪ set up a means to communicate information with staff

- serve as an example for other staff
- develop policy related to role and job description
- try to get management to understand the value and importance of the role
- don't know yet; unclear
- will not be serving as a resource person

Finally, the LTC facility participants were asked to rate their confidence in taking on the role of Psychogeriatric Resource Person to others in their facility. The results in Table 96 show that the participants' confidence significantly decreased from pre to post, although the participants reported being more confident after the training than they were before. Again, this result could have been due to the participants over-estimating their confidence in taking on this role prior to the training initiative. A similar result was also obtained in the evaluation of the 1998 P.I.E.C.E.S. Training Initiative (Stolee, 1999).

Table 96
Confidence in Serving as a LTC Facility Psychogeriatric Resource Person

	Pre- Training Mean (SD)	Post- Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Confidence in taking on a role as Psychogeriatric Resource Person to others in your facility regarding the cognitive/mental health concerns and associated behaviours of residents.	3.74 (0.85)	3.54 (0.77)	- 0.20 ***	4.33 (0.70)

* p < 0.05; ** p < 0.01; *** p < 0.001

Participants were asked to rate how supported they felt by various individuals/groups, in taking on the role of psychogeriatric resource person, using a scale of 1 to 5 (where 1 = “not at all” supported and 5 = “completely” supported). While all of the mean ratings were between 3 and 4, indicating that the participants felt somewhat supported, the highest mean ratings were given to the participants' supervisors (mean=3.97) and facility administrator (mean=3.90) (see Table 97).

Table 97
Support from Various Sources in Taking On Role of Psychogeriatric Resource Person in LTC

How Supported Have You Felt By:	Your Peers	Your Supervisor	Facility Administrator	Your Preceptor	External Resources
Mean (SD)	3.32 (1.07)	3.97 (1.11)	3.90 (1.16)	3.48 (1.33)	3.52 (1.19)
Range	1 - 5	1 - 5	1 - 5	1 - 5	1 - 5

The LTC participants were then asked to identify additional ways that they could be supported in their role as Psychogeriatric Resource Person. Their suggestions are summarized in Table 98. The most frequently cited suggestions included: having time to undertake their role; obtaining support from management to undertake their role; educating other staff about their role and about P.I.E.C.E.S.; having continued contact with their preceptors and local outreach teams; and having opportunities to meet/share with other P.I.E.C.E.S. trained individuals.

Table 98
Additional Ways the LTC Facility Psychogeriatric Resource Person Can be Supported

Most Frequently Cited Suggestions:

- time to serve as a Psychogeriatric Resource Person; having dedicated time to serve in role; funding to allow participants to serve in this role
- support from management to serve in this role (e.g., to assess residents; be able to serve as a resource; educate staff)
- educate other staff about their role and the P.I.E.C.E.S. frameworks
- continued contact with preceptor and outreach team; obtain a preceptor for those participants who do not have one
- opportunities to network with other P.I.E.C.E.S. trained individuals

Other Suggestions:

- follow-up training; updates on P.I.E.C.E.S. information; refresher sessions
- train DOCs, administrators and physicians about P.I.E.C.E.S. – this will help facilitate support
- train others in my facility as Psychogeriatric Resource Persons
- time to practice skills, increase confidence
- provide a list of P.I.E.C.E.S. trained individuals and their contact information
- guidelines regarding what’s expected of a Psychogeriatric Resource Person

3.10.3 Transferring Training into Practice

As was done in the pre-training questionnaire, participants were provided with a list of potential barriers to knowledge transfer and asked to indicate their top three barriers. Their responses were combined to create a variable that indicated the total number of times a barrier was identified. The top three barriers identified in the after the training were the same as those identified prior to the training (i.e., work and time pressures, pressure from peers to resist change, and lack of reinforcement) (see Table 99).

Table 99
Barriers in Transferring Training Into Practice – Identified Post-Training by LTC Participants

Barrier	Percent (#) of Participants who Identified This as One of Their Top 3 Barriers, Post Training
Work and Time Pressures	95.3% (285)
Pressure From Peers to Resist Change	59.5% (178)
Lack of Reinforcement	35.5% (106)
Insufficient Authority	18.1% (54)
Learner Discomfort With Change and Associated Effort	17.1% (51)
Ineffective Work Processes	11.0% (33)
Separation From Inspiration of Support of the Trainer	10.7% (32)
Non-Supportive Organizational Culture	10.4% (31)
Inadequate Equipment or Organization	7.8% (23)
Learner Perception That Training Content is Irrelevant	6.4% (19)
Impractical Training Program	2.3% (7)
Poorly Designed/Delivered Training	0.7% (2)
Other *	1.0% (3)

* “Other” includes: funding, language barrier, and the GAU and Outreach Team fill the need in a more authoritative manner.

3.10.4 Other Comments about the P.I.E.C.E.S. Initiative

Finally, the LTC participants were invited to make other comments about the P.I.E.C.E.S. Training Initiative. Their feedback is summarized in Table 100. The types of comments made generally fell into four areas: comments about the organization of the training; comments related to transferring what was learned into practice; comments about the need to train others in this model; and general comments about the initiative.

Table 100
Other Comments about the Putting the P.I.E.C.E.S. Together Training Initiative by LTC Participants

Organization of the Training

- need to be clear about the objectives of the training; this was not clear to some of the participants until the 2-day session
- time between sessions was too long; lost enthusiasm. One person suggested holding the 3-day session in the fall and 2-day session in the winter because summer is such a busy time.
- would have liked to have gone through more case studies
- more time on medications and tools
- more time on tools – how and when to use them; show how to administer them and how to interpret scores
- lot of information covered in 5 days; difficult to get a comfortable grasp on everything
- some would prefer all training to be local

Issues related to Transfer of Knowledge into Practice

- need specific time allocated to dealing with mental health needs; need dedicated funding to do so
- need to make sure information about training is shared with facility Administrators, including what’s expected of them in supporting the P.I.E.C.E.S. trained person
- time is a roadblock; some are looking at ways to break down the assessment and get others involved to assist, but time is still an issue

Training Others

- wish training was mandatory in all LTC facilities, or taught in colleges/universities
- need more than one person trained per facility
- want physicians to be trained
- want at least some of the information shared with other staff trained as well (e.g., PSWs, activation staff)

General Comments about the Initiative

- excellent training; last 2 days helped to reinforce learning
- excellent course; this will help LTC move into behaviour prevention
- gained a wealth of knowledge and confidence in assessing and managing dementia
- excellent content and facilitators
- motivational and inspirational
- would like refresher courses, updates
- time taken to be reimbursed is too long

3.11 CCAC Results from Final Questionnaire

All of the 35 CCAC Teams that participated in the final 2-day training sessions completed and returned their post-training evaluation questionnaires (see Table 101). Thus, a denominator of 35 is used in this section.

Table 101
Response Rate for Post-Training Questionnaire: CCAC Teams

Attendance at 2-Day Session	# of Post-Training Evaluations Returned	Response Rate
35 teams	35 teams	100%

3.11.1 Pre-Post Confidence Ratings

The CCAC Teams were asked to rate their confidence in working collaboratively with a variety of individuals/groups prior to the training and after the training. The differences between the pre and post means were relatively small. There was only one that was statistically significant; the CCAC Teams rated their ability to work collaboratively with physicians higher after the training than prior to the training (see Table 102). In the post-training questionnaire, CCAC Teams were also asked to rate their level of confidence now (i.e., after the training) compared with their level of confidence before the training (using a 5-point scale where 1 = “less confident”, 3 = “about the same” and 5 = “more confident”). The average ratings of self-reported change all suggested that the CCAC Teams were more confident in their ability to work collaboratively with the individuals and groups identified.

Table 102
Confidence in Working Collaboratively with Others: CCAC Teams

Confidence in ability to work collaboratively with the following people in order to improve care for clients in the CCAC catchment area ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Clients	4.15 (0.77)	4.22 (0.70)	0.07	4.14 (0.77)
Caregivers	4.19 (0.74)	4.19 (0.68)	0	4.11 (0.80)
Significant Others	4.15 (0.77)	4.19 (0.68)	0.04	4.12 (0.81)
Other CCAC staff members	4.15 (0.83)	4.15 (0.68)	0	4.01 (0.84)
CCAC management/administration	3.92 (0.94)	3.92 (0.85)	0	3.91 (0.87)
Physicians	3.31 (0.88)	3.65 (0.80)	0.35 *	3.96 (0.71)
Other health care professionals (including outreach teams and consultants)	3.85 (0.86)	4.15 (0.66)	0.30	4.14 (0.73)
Other community resources	3.92 (0.80)	3.88 (0.77)	- 0.04	4.14 (0.77)

* p < 0.05; ** p < 0.01; *** p < 0.001

The CCAC Teams were also asked to rate their confidence in detecting/flagging and understanding various mental health/behavioural concerns. All of the differences were in the expected direction (i.e., average post-training confidence scores were higher than average pre-training scores), and 8 of these differences were statistically significant. These data are further supported by the CCAC Teams’ average ratings of self-reported change which indicate that the Teams felt more confident after the training than before the training in all of the areas assessed (see Table 103).

Table 103
Confidence in Detecting/Flagging and Understanding Various Concerns: CCAC Teams

Confidence in detecting and/or flagging and understanding these concerns ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Agitation and restlessness	3.81 (0.68)	4.00 (0.62)	0.19	4.24 (0.67)
Anxiety	3.67 (0.62)	3.81 (0.56)	0.15	4.21 (0.66)
Apathy/failure to participate; withdrawn/crying	3.74 (0.76)	3.89 (0.75)	0.15	4.10 (0.73)
Defensive behaviour	3.59 (0.75)	3.81 (0.68)	0.22	4.04 (0.73)
Hearing and seeing things that do not exist	3.59 (0.69)	3.89 (0.58)	0.30 *	4.24 (0.75)
Hoarding and/or rummaging	3.70 (0.78)	4.11 (0.64)	0.41 **	4.24 (0.71)
Impulsivity	3.56 (0.80)	3.85 (0.53)	0.30	4.11 (0.75)
Inappropriate sexual behaviour	3.50 (0.91)	3.88 (0.59)	0.38 **	4.01 (0.75)
Intrusiveness	3.19 (0.94)	3.77 (0.65)	0.58 **	4.04 (0.77)
Resistance to care	3.78 (0.75)	4.04 (0.65)	0.26	4.19 (0.73)
Repetitive behaviour	3.74 (0.71)	4.06 (0.68)	0.32 *	4.11 (0.79)
Suspicious/accusing others	3.59 (0.80)	3.96 (0.59)	0.37 *	4.27 (0.72)
Vocally disruptive behaviour	3.74 (0.71)	4.00 (0.62)	0.26 *	4.21 (0.74)
Wandering	4.00 (0.88)	4.06 (0.66)	0.06	4.21 (0.74)
Challenging behaviours in general	3.67 (0.78)	3.81 (0.62)	0.15	4.30 (0.69)
Alzheimer disease and related dementias in general	3.65 (0.75)	3.92 (0.69)	0.27	4.30 (0.70)
Mental health problems in general	3.15 (0.77)	3.63 (0.84)	0.48 **	4.04 (0.78)

* p < 0.05; ** p < 0.01; *** p < 0.001

When asked to rate their confidence in their ability to assess the P.I.E.C.E.S. components, the average pre-post scores were in the expected direction in all cases but one functional capabilities (although the difference here was relatively small). The average ratings of self-reported change all suggested that the CCAC Teams were more confident after the training in all areas (see Table 104).

Table 104
Confidence in Ability to Assess the P.I.E.C.E.S. Components: CCAC Teams

Confidence in ability to assess the following aspects of a client ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Physical health?	4.19 (0.68)	4.26 (0.66)	0.07	4.06 (0.84)
Intellectual capacity?	3.59 (0.75)	3.93 (0.68)	0.33 *	4.20 (0.68)
Emotional and spiritual health?	3.59 (0.80)	3.89 (0.64)	0.30	4.03 (0.75)
Functional capabilities?	4.33 (0.68)	4.30 (0.67)	- 0.04	4.09 (0.85)
Environmental factors?	4.26 (0.71)	4.26 (0.66)	0	4.09 (0.78)
Social and cultural factors?	3.93 (0.87)	4.04 (0.81)	0.11	3.86 (0.88)

* p < 0.05; ** p < 0.01; *** p < 0.001

The results from the CCAC Teams’ pre-post confidence ratings in using and understanding various assessment tools are found in Table 105. In two cases, there was only one CCAC Team that provided both a pre-training and post-training rating (i.e., Behaviour Flow Sheet and Confusion Assessment Method) and, in another case, there were no teams that provided both pre and post ratings (i.e., other behavioural scales).

Thus, t-test could not be conducted. This failure to provide ratings for these scales may have been due to their lack of familiarity with them.

Among the scales for which paired t-tests could be conducted, the pre-post differences were in the expected direction and were statistically significant in 3 cases (i.e., the MMSE, the Cornell Scale for Depression and assessment tools in general). The average self-reported change scores suggested that the CCAC Teams were more confident after the training than before the training for all but one scale – the Abilities Assessment (mean = 2.83, SD=1.17).

Table 105
Confidence in Using and Understanding Assessment Tools: CCAC Teams

Confidence in using these tools and understanding their results ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Folstein Mini-Mental State Examination	2.75 (1.06)	3.42 (1.24)	0.67 *	4.16 (0.81)
Other mental status test	3.50 (0.71)	3.50 (0.71)	0	3.75 (1.04)
The Clock Test	3.09 (1.38)	3.18 (1.25)	0.09	4.09 (0.83)
The Cornell Scale for Depression	1.67 (1.00)	2.72 (1.44)	1.06 **	4.00 (0.82)
Other depression scale	2.75 (1.26)	4.00 (0)	1.25	4.00 (1.04)
The Cohen-Mansfield Agitation Inventory	2.00 (1.23)	2.60 (1.52)	0.60	4.00 (0.78)
Behaviour Flow Sheet	1.00 ^a	1.00 ^a	--	3.80 (1.10)
Other behavioural scale	-- ^b	-- ^b	--	3.60 (1.14)
The Abilities Assessment	2.50 (2.12)	3.00 (2.83)	0.50	2.83 (1.17)
Dementia Observational System	1.33 (0.58)	2.00 (1.00)	0.67	3.78 (0.83)
Confusion Assessment Method	1.00 ^a	2.00 ^a	--	3.82 (0.75)
Assessment tools in general	2.70 (1.34)	4.20 (0.92)	1.50 **	3.95 (0.95)

* p < 0.05; ** p < 0.01; *** p < 0.001

^a Only one team rated this item at both pre and post.

^b No teams rated this item at both pre and post.

The average pre-post differences in confidence related to psychotropic medications were all in the expected direction and statistically significant (see Table 106). The average scores for self-reported change in confidence supported these findings. However, it is interesting to note that these scores were lower than the self-reported change scores in other areas, perhaps suggesting that the CCAC Teams still lack confidence in this area.

Table 106
Confidence Related to Psychotropic Medications: CCAC Teams

Confidence in ability to engage in the following activities ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Identify potential risks and benefits?	2.30 (0.95)	3.00 (1.00)	0.70 **	3.64 (0.64)
Identify purposes of medication?	2.56 (0.89)	3.22 (1.01)	0.67 *	3.81 (0.71)
Identify the class of medication being used?	2.41 (0.97)	3.04 (0.94)	0.63 *	3.77 (0.72)
Identify potential side effects?	2.15 (0.86)	2.89 (0.85)	0.74 **	3.80 (0.62)
Monitor the resident’s response to medication?	2.19 (0.90)	2.96 (0.96)	0.77 **	3.75 (0.70)

* p < 0.05; ** p < 0.01; *** p < 0.001

When asked to rate their level of confidence in relation to the P.I.E.C.E.S. objectives, the average post-training scores were higher than the average pre-training scores in all areas, and in two cases were statistically significant. As well, the average self-reported change in confidence scores all indicated that the Teams were more confident after the training (see Table 107).

Table 107
Confidence Related to P.I.E.C.E.S. Objectives: CCAC Teams

Confidence in the following areas ...	Pre-Training Mean (SD)	Post-Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Demonstrate sensitivity and respect for the individuality of the client, caregiver(s), significant others, the team, and community resource people.	4.59 (0.57)	4.78 (0.42)	0.19	3.91 (0.85)
Detect and/or flag cognitive/mental health needs and associated behavioural issues.	3.93 (0.73)	4.13 (0.70)	0.20	4.31 (0.68)
Use information related to the cognitive/mental health needs and associated behaviours to plan, implement, and evaluate care strategies.	3.67 (0.68)	4.07 (0.68)	0.41 *	4.46 (0.56)
Serve as a resource to others in planning care for the resident with complex physical and cognitive/mental health needs and associated behavioural issues.	3.11 (1.16)	3.67 (0.78)	0.56 *	4.26 (0.61)

* p < 0.05; ** p < 0.01; *** p < 0.001

It should be noted that in Tables 101 to 107, even though the average self-reported change ratings all indicated that the participants were more confident after the training except one (the Abilities Assessment), the average post-training ratings ranged from 1.00 to 4.78. This suggests that there is still room for confidence to increase in many areas.

3.11.2 The CCAC P.I.E.C.E.S. Resource Team and Issues of Support

The CCAC Teams were asked some questions about serving as a P.I.E.C.E.S. Resource Team and support related to serving in this role.

When asked how their Team would serve as a CCAC P.I.E.C.E.S. Resource Team within their CCAC, a number of responses were provided (see Table 108 for a summary). For example, the CCAC Teams said they would educate staff about their role and share the information learned in the training (e.g., regarding detecting and flagging, dementia, etc.). They would also assist and educate staff in more informal ways (one-on-one, case conferences, staff meetings, teachable moments and assisting as requested). Some of the Teams indicated that they would develop various resources for staff in their agency, and also link them to other resources. They also said they would link with their external resources for both clinical and educational purposes. A few CCAC Teams were not yet certain how their role would evolve.

Table 108
How Team Plans to Serve as a CCAC P.I.E.C.E.S. Resource Team

- formal presentations to staff; educate them regarding detecting and flagging, dementia, etc.
- serve as a resource to staff; informal education (e.g., one-on-one; case conferences, staff meetings, teachable moments)
- share resource material with staff
- develop and share a quick reference tool for staff; develop Dementia Resource Guide for staff
- share information through the Internet; make links available on the Internet
- inform staff of the P.I.E.C.E.S. Resource Team and the Team’s role
- work with external partners (for clinical and education purposes); work with PRCs
- develop a comprehensive approach to dealing with these clients in our CCAC
- have arranged for other staff in CCAC to be trained to use the MMSE by our local outreach team
- undertake a pilot project
- role is still in development

When the CCAC Teams’ pre and post-training confidence ratings related to serving as a Resource Team were compared, the average post-training score was higher than the average pre-training score, although the difference was not significantly different (see Table 109). The average self-reported change in confidence score also suggested that the Teams felt more confident about serving in this role after the training than they did prior to the training.

Table 109
Confidence in Serving as a CCAC P.I.E.C.E.S. Resource Team

	Pre- Training Mean (SD)	Post- Training Mean (SD)	Mean Difference (post-pre)	Self-Reported Change 1 = less confident 3 = about the same 5 = more confident
Confidence of CCAC Team in taking on a role as P.I.E.C.E.S. Resource Team to others in your agency regarding the cognitive/mental health concerns and associated behaviours of clients ...	3.12 (1.30)	3.54 (0.82)	0.42	4.20 (0.61)

* p < 0.05; ** p < 0.01; *** p < 0.001

When asked how they could be further supported in their roles, many CCAC Teams indicated that they would like to ensure that they have support from management (see Table 110). Specifically, they want to have time to work with staff and partner with others, to have the importance of their role recognized within the organization, and to have commitment to the value of this role. The CCAC Teams also identified a number of networking opportunities that could provide them with additional support. For example, they wanted opportunities to network with other P.I.E.C.E.S. trained individuals, and to have access to their preceptors, PRCs, and outreach teams.

Table 110
Additional Ways the CCAC P.I.E.C.E.S. Resource Teams can be Supported

Support from Management ▪ time - to plan and implement strategies, to work with partners in care, to work with external resources ▪ to be given a defined role within our organization ▪ clear mandate from management regarding the degree of involvement they'll support, and the amount of time we can commit ▪ understanding by management of the P.I.E.C.E.S. program and how it can be incorporated into case managers' practice ▪ recognition of the importance of this role ▪ opportunity for further education in this area, as well as updates related to P.I.E.C.E.S. Networking Opportunities ▪ opportunities to connect with other P.I.E.C.E.S. trained individuals in LTC facilities and CCACs; opportunities to share information about the role that other CCAC P.I.E.C.E.S. Resource Teams are playing ▪ regular meetings with P.I.E.C.E.S. trained individuals in our region ▪ increased availability / access to preceptor ▪ mentorship from local outreach team and PRCs Other Suggestions ▪ clarification of the roles and mandates of various partners (e.g., PRCs, preceptors, etc.) ▪ funding from the Ministry to support a resource team ▪ train other CCAC staff and physicians ▪ development of psychogeriatric standards of care
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3.11.3 Transferring Training into Practice

As was done in the pre-training questionnaire, participants were provided with a list of potential barriers to knowledge transfer and asked to indicate their top three barriers. Their responses were combined to create a variable that indicated the total number of times a barrier was identified (see Table 111). The top three barriers identified after the training were the same as those identified before the training (i.e., “work and time pressures”, “lack of reinforcement”, and “pressure from peers to resist change”).

Table 111
Barriers in Transferring Training Into Practice – Identified Post-Training by CCAC Teams

Barrier	Percent (#) of Participants who Identified This as One of Their Top 3 Barriers, Post Training (N=35)
Work and Time Pressures	94.3% (33)
Lack of Reinforcement	40.0% (14)
Pressure From Peers to Resist Changes	31.4% (11)
Insufficient Authority	22.9% (8)
Separation From Inspiration or Support of the Trainer	17.1% (6)
Learner Discomfort with Change and Associated Effort	14.3% (5)
Ineffective Work Processes	14.3% (5)
Non-Supportive Organizational Culture	8.6% (3)
Impractical Training Program	8.6% (3)
Learner Perception That Training Content is Irrelevant	5.7% (2)
Poorly Designed/Delivered Training	5.7% (2)
Inadequate Equipment or Organization	2.6% (1)
Other *	5.7% (2)

* “Other” includes: geographical set up of our CCAC; finite personnel in some areas.

3.11.4 Other Comments about the P.I.E.C.E.S. Initiative

Finally, the CCAC Teams were invited to make any other comments about the “Putting the P.I.E.C.E.S. Together” training initiative (see Table 112). Overall, the CCAC Teams were very happy with the P.I.E.C.E.S. training and appreciated the opportunity to be part of the initiative. Some comments were made related to the content covered in the training sessions as well as the organization of the initiative, although these comments were usually made by just one CCAC Team.

Table 112
Other Comments by CCAC Teams Related to the P.I.E.C.E.S. Initiative

Comments related to the Content of the Initiative ▪ spend more time on tools other than the MMSE and Clock ▪ provide more strategies for the management of difficult behaviours ▪ more information on medications; the information provided was a simplified summary ▪ more family-based intervention strategies would be helpful ▪ more emphasis placed on the core competency “plan care and service strategies” ▪ the issue of resources that are actually available in the community needs more focus Comments related to the Organization of the Initiative ▪ <i>More appropriate for providers rather than CCAC coordinators. We would have liked more focus on the illness</i> ▪ <i>Due to our CCACs changes and new mandate, we believe we are at the “right place at the <u>wrong</u> time”. It has been difficult <u>at this time</u> to implement our proposal which in turn will help us meet our objectives.</i> ▪ <i>3 days of marathon lecturing in a closed environment is not conducive to learning or to implementing new info into practice; propose: pre-class reading; time constraints with the amounts of info to be presented lead to presentations of superficial information</i> Overall Comments related to the P.I.E.C.E.S. Initiative ▪ excellent tools/templates and learning opportunity ▪ would like regular updates and ongoing follow-up ▪ We would like to acknowledge the importance of this initiative. Fall training session facilitators were exceptional. We have received a comprehensive training with a “state of the art” package of psychogeriatric information and assessment tools. Sustainability will be our challenge. Other Comments ▪ should consider offering P.I.E.C.E.S. as a continuing education course at college/university ▪ Each CCAC should have clearly articulated the role of the participants in the P.I.E.C.E.S. training before the sessions started in the Spring. In [one area] it seems to be “Train the Trainer” and adult education focus is the mandate.
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3.12 Supportive Technology

In order to support the P.I.E.C.E.S. trained participants after the training, two strategies were implemented: TIPS (Timely Information P.I.E.C.E.S. Service) and TAP (Teleconference Assistance Program). Through TIPS, participants were able to submit clinical or educational questions, either through fax or email, and have these questions answered by specialists (usually within three working days). In order to successfully complete the P.I.E.C.E.S. training (i.e., receive a certificate), participants were required to complete the pre and post-training evaluation questionnaires and submit a TIPS question.

TAP involved scheduled teleconferencing opportunities for the P.I.E.C.E.S. participants. The goals of the teleconferences were to clarify P.I.E.C.E.S. concepts learned during the initiative and coach the participants in integrating their new knowledge and skills into their day-to-day practice. The teleconferences were facilitated by members of the P.I.E.C.E.S. Consultation Team.

Feedback was sought from the participants on both of these post-training support strategies.

3.12.1 Feedback on TIPS from LTC Participants

The LTC facility participants submitted a minimum of 368 TIPS questions. The actual number of questions submitted was likely higher since cases where the same question was submitted by more than one individual were not always recorded in the database. The majority of questions were in the areas of: medications, behaviours, and use of the assessment scales (see Table 113).

Table 113
Information on TIPS Questions Submitted by LTC Facility Participants

Number of TIPS Questions Submitted: 368
Topic Areas: ▪ medications (78) ▪ behaviours (52) ▪ scales (50) ▪ cognitive enhancers (18) ▪ what to do now / nothing seems to work (13) ▪ P.I.E.C.E.S. assessment/implementation (10) ▪ dementia (9) ▪ resources (9) ▪ depression (8) ▪ physician issues / working with physicians (8) ▪ legal issues / SDM / POA (8) ▪ risk (8) ▪ Partners in Care (7) ▪ staff issues (7) ▪ family issues (6) ▪ loneliness / suicide (5) ▪ lack of time (4) ▪ pain management/relief, palliative care (4) ▪ other (49)

* “Other” includes: delirium, herbal medications, QuickStart, PSW training, gaining trust, best care strategies, CMI funding, cultural diversity, EPS, drivers license, consistent approach, late onset schizophrenia, multiple diagnoses, practical assignment, environmental issues, evaluation of interventions, etc.

Participants were asked to rate the value of TIPS in helping them understand and apply what they learned during the initial 3-day session, using a scale of 1 to 5 (where 1 = “not at all valuable” and 5 = “very valuable”). The average rating was 3.28 (SD=1.02) suggesting that TIPS was of some value (Table 114). It should be noted that the participants were only asked to rate how helpful TIPS was in terms of supporting the training, not how helpful this service was overall.

Table 114
Value of TIPS in Helping Participants Understand and Apply What they Learned: LTC Participants

	Value of TIPS
Mean (SD)	3.28 (1.02)
Range	1 - 5

Participants were also asked how TIPS could be improved. Their suggestions are summarized in Table 115. Access to a computer and/or the Internet and, in some cases, to a fax machine, was identified as a barrier by numerous participants. Even some of those who did have access to a computer and the Internet but who were less familiar with navigating the Internet said that being more comfortable with these tools would have been helpful. A number of participants also said that they did not receive a response to their question, and some who did receive a response were not fully satisfied with the response provided (e.g., the length of time to receive response was too long; the response provided was not specific or thorough enough). However, a great number of participants were satisfied with the responses provided, and found them to be quite helpful.

Table 115
How Could TIPS Have Been Improved – Suggestions from LTC Participants

Use of TIPS / Access to TIPS

- some participants didn’t use TIPS, or used it only once, so found it difficult to evaluate
- some challenges accessing site and in knowing where to go once on the site
- if do not have access to a computer or the internet, cannot take full advantage of the resource
- more clarification needed regarding the type of question that could be answered – e.g., questions regarding the P.I.E.C.E.S. process, QuickStart, or a resident-related question
- would have liked to have shared the TIPS questions and answers at the 2-day session

Feedback

- some said they did not receive a response to their question
- some said the response took too long
- some said the response they received was prompt, informative and thorough
- others said the responses received were not always thorough or specific enough
- make the information sent back “email” printable
- should be able to reply if have questions about the response provided, or information was not thorough enough

Other

- as one becomes more confident with the information, may be more likely to use TIPS – don’t want to ask a dumb question
- no suggestions on how it could be improved
- it should not be mandatory
- the process was not difficult, it was forming a question and knowing when to submit it (i.e., prior to the intervention, post intervention, general question) that was difficult
- questions should be grouped together better – physical health, mental health, behaviours, aggression, etc.
- don’t change the phone number part way through
- hope it continues to be available to us and that we continue to access it

The participants were asked if they had searched the TIPS resource on the P.I.E.C.E.S. website (since the TIPS questions and responses were available there). Almost half (45.5%) of the participants said that they had searched the TIPS resource (see Table 116). Approximately 23% had not and another 30% had not because they did not have access to the Internet.

Table 116
Use of TIPS Resource on the P.I.E.C.E.S. Website by LTC Participants

Have You Searched the TIPS resource?	Percent (#) of Participants
Yes	45.5% (136)
No	22.7% (68)
No, no access to the Internet	30.4% (91)

* Note: percentages may not equal 100% due to missing values.

When asked if they would access the TIPS service again in the future if it was available, 90% of respondents indicated that they would; only 3% said they would not (see Table 117).

Table 117
Future Use of TIPS Service by LTC Participants

If Available in Future, Would You Use TIPS?	Percent (#) of Participants
Yes	90.6 (271)
No	3.3 (10)

* Note: percentages may not equal 100% due to missing values

In addition, 95% of participants reported that they would like to have access to the P.I.E.C.E.S. website (including the TIPS resource) in the future (see Table 118).

Table 118
Access to the P.I.E.C.E.S. Website for LTC Participants

Would You Like Access to the P.I.E.C.E.S. Website?	Percent (#) of Participants
Yes	95.0% (284)
No	2.7% (8)

* Note: percentages may not equal 100% due to missing values

3.12.2 Feedback on TAP from LTC Facility Participants

A total of 23 teleconferences were held for the LTC facility participants, ranging from 2 to 5 sessions per region (see Table 119). The total number of LTC facility participants in these sessions was 213. There were also 68 preceptors who participated.

Table 119
Overview of TAP Sessions for LTC Facility Participants

Total Number of Teleconferences: 23			
Number Per Region:			
East	5	North	3
Central East	3	Toronto	2
Central South	4	Southwest	4
Central West	2		
Total Number of Participants:		213	
Total Number of Preceptors Participating:		68	

Participants were asked to rate the value of the TAP service in helping them understand and apply what they had learned during the training initiative (using a scale of 1 to 5 where 1 = “not at all valuable” and 5 = “very valuable”). The average rating was 2.92 (SD=1.14) suggesting that TAP was of some value to the LTC Facility participants (see Table 120).

Table 120
Value of TAPs Service in Helping LTC Participants Apply and Understand what they Learned

	Value of TAPs
Mean (SD)	2.92 (1.14)
Range	1 - 5

Participants were also asked how TAP could be improved. Their responses are summarized in Table 121. A number of participants indicated that they did not use TAP. Some said it was because of their work schedule and/or the TAP schedule and others seemed not to know what TAP was or how they were to access it. For

example, a handful of people said that they did not receive information on the service, or said that no one had called them during the scheduled teleconference time.

Other comments were made about the organization of the TAP sessions. Numerous people indicated that they would have preferred to have fewer people on the line, to have an agenda that was circulated ahead of time, and to focus on the P.I.E.C.E.S. content and the discussion of specific cases. Of those who commented on the value of TAP, there were only two who said it was of no value; the rest said the experience was beneficial and a great opportunity to share and learn from others. A number of participants indicated that if TAP had been available to them on a more regular basis, it would have been more valuable.

Table 121
How Could TAP be Improved – Suggestions by LTC Participants

Use of / Access to TAP
▪ did not use TAP ▪ did not receive information about TAP ▪ provide more information about TAP and how to access it; a number of people thought that <i>they</i> would be called ▪ too restrictive regarding the times available; if missed session, it couldn't be rescheduled and organizers implied that you did not miss anything ▪ some unsure what TAP was ▪ some problems trying to connect
Organization of the TAP Sessions
▪ have more sessions scheduled and fewer people on the line at one time ▪ too many on the line at once; sometimes there were only a few who did all the talking ▪ it was sometimes confusing when people came into the call at different times and we had to stop and introduce everyone again ▪ some said they would have liked it closer to the end of their 3-day training session; others said it was too close to the end of their 3-day session ▪ would be more valuable if it was offered more than once or regularly – especially for those with limited support from resource teams ▪ need to have an agenda for the teleconference ▪ long time wasted waiting for people to sign in – a second session could have been scheduled ▪ some preceptors were not available; would have liked them on the call ▪ time difference between northwestern Ontario and southern Ontario was a problem – missed session because of time difference
TAP as a Resource
▪ prefer face-to-face meetings ▪ prefer 1:1 meetings ▪ positive experience to listen to others' ideas; learned more about the implementation of DOS ▪ it was of no value ▪ would be good to use TAP as a way to connect with other PIECE trained individuals (e.g., monthly, every few months)
Content of TAP Sessions
▪ focus on P.I.E.C.E.S. content / case studies rather than administrative information (e.g., funding) ▪ motivating; good opportunity to share and listen to others who have the same goal ▪ good to compare experiences with others

3.12.3 Feedback on TIPS from CCAC Teams

The CCAC Teams were asked to rate the value of the TIPS service on a scale of 1 to 5 (where 1 = “not at all valuable” and 5 = “very valuable”). The average rating was 3.16 (SD=1.27), suggesting that TIPS was of at least some value to them (see Table 122). Again, it should be noted that the participants were only asked to rate how helpful TIPS was in terms of supporting the training, not how helpful this service was overall.

Table 122
Value of TIPS in Helping CCAC Teams Apply and Understand what they Learned

	Value of TIPS
Mean (SD)	3.16 (1.27)
Range	1 – 5

The CCAC Teams submitted a total of 26 TIPS questions (see Table 123). The types of questions submitted focused in the areas of: psychotropic medications, risk, use of the assessment scales, and working with families.

Table 123
Information on TIPS Questions Submitted by CCAC Teams

Number of TIPS Questions Submitted: 26
Topic Areas: ▪ psychotropic medications (4) ▪ risk (4) ▪ scales (3) ▪ working with families (3) ▪ cognitive enhancers (2) ▪ QuickStart (2) ▪ dementia (2) ▪ other * (6)

* “Other” includes: abuse, P.I.E.C.E.S. documentation, Partners in Care, pain management, staff buy-in.

When asked how the TIPS service could be improved, a number of suggestions were made (see Table 124). Some of the Teams indicated that they had difficulty accessing the site. Others seemed unclear of the purpose of TIPS and the types of questions that should be posed. Other CCAC Teams said that the service was a useful one to them, and hoped it would be continued.

Table 124
How Could TIPS have been Improved – Suggestions from CCAC Teams

Use of TIPS ▪ more open to questions and more clear about the role ▪ some difficulty accessing site; make it easier to access all questions
Feedback ▪ more timely replies ▪ answers were process oriented not solution oriented, resulting in more questions ▪ continuation of the program; could be used as an ongoing resources ▪ share information that’s of value to everyone (e.g., email it out) ▪ no improvements needed; very helpful
Other ▪ not a problem with TIPS, but finding time to go online

CCAC Teams were asked if they had searched the TIPS resource on the P.I.E.C.E.S. website. Over 60% of the Teams reported that they had. Twenty percent reported that they had not searched the site, and another 17% indicated that they had not searched the site because they did not have access to the Internet (see Table 125).

Table 125
Use of TIPS Service on P.I.E.C.E.S. Website by CCAC Teams

Have You Searched the TIPS resource?	Percent (#) of CCAC Teams
Yes	62.9% (22)
No	20.0% (7)
No, no access to the Internet	17.1% (6)

* Note: percentages may not equal 100% due to missing values

When asked if they would use TIPS again if it was available to them, all but one CCAC Team responded “yes” (see Table 126).

Table 126
Future Use of TIPS Service by CCAC Teams

If Available in Future, Would You Use TIPS?	Percent (#) of CCAC Teams
Yes	97.1% (34)
No	2.9% (1)

* Note: percentages may not equal 100% due to missing values

Finally, when asked if they would like to have access to the P.I.E.C.E.S. website (including the TIPS responses), all of the CCAC Teams said that they would like to have access (see Table 127).

Table 127
Access to P.I.E.C.E.S. Website for CCAC Teams

Would You Like Access to the P.I.E.C.E.S. Website?	Percent (#) of CCAC Teams
Yes	100% (35)
No	0

* Note: percentages may not equal 100% due to missing values

3.12.4 Feedback on TAP from CCAC Teams

A total of seven TAP sessions were held for the CCAC participants (one session per region). There were a total of 103 individuals from the CCAC who participated, as well as 47 preceptors (see Table 128).

Table 128
Summary of TAP Sessions for CCAC Participants

Total Number of Teleconferences:	7
Total Number of Participants:	103

Total Number of Preceptors Participating:	47
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The CCAC Teams were asked to rate the value of the TAP service using a scale of 1 to 5 (where 1 = “not at all valuable” and 5 = “very valuable”). The average rating was 2.52 (SD=1.04) which suggests that TAP may have been of limited value (see Table 115). The CCAC Teams’ suggestions on how the TAP service could be improved are summarized in Table 129.

Table 129
Value of TAPs Service to Applying and Understanding Material: CCAC Teams

	Value of TAPs
Mean (SD)	2.52 (1.04)
Range	1 – 5

As with the LTC facility participants, not all of the CCAC Teams understood the purpose of TAP, and a number indicated that the sessions were not well organized. Like the LTC facility participants, they suggested that there be more sessions with fewer people on line, that there be an agenda for the calls, and that sessions be held more regularly. In terms of qualitative feedback on this service itself, some found the sessions very helpful, others said there was no need for this service (see Table 130).

Table 130
How Could TAP be Improved – Suggestions by CCAC Teams

Purpose of TAP

- purpose unclear, outcome not beneficial
- some were not aware of the date, time or purpose of call; needs to be more organized

Organization of TAP

- more sessions; fewer people on line; smaller group would allow for greater exchange of information
- sessions held more frequently
- have list of participants and an agenda circulated ahead of time
- inform us who our preceptor is ahead of time; provide information regarding who to contact regarding follow-up questions, etc.
- perhaps have specific topics for discussion and give people an opportunity to choose which topic interest them

Feedback on TAP

- no need for this service
- good idea; lacking organization
- useful to compare notes; helps you to feel supported

4.0 Conclusions

Preceptors reported that the training initiative helped to enhance their understanding of: the P.I.E.C.E.S. framework, the use and administration of assessment tools, their role in supporting the P.I.E.C.E.S. trained participants, and the overall strategy.

Preceptors also reported being quite confident in their ability to help others learn the P.I.E.C.E.S. framework and in taking on the role of P.I.E.C.E.S. Preceptors.

With respect to the LTC facility and CCAC participants, there were many similarities in the evaluation findings, but also a number of differences. For example, overall the LTC facility participants considered the training initiative to be a well-organized, relevant and valuable experience. While the CCAC Teams also reported positive comments about the training initiative, their average ratings related to specific sessions and the training overall were lower in comparison with those of the LTC facility participants.

The CCAC Teams also appeared to be less clear about the purpose of the training and what was expected of them after the training was completed, compared with the LTC facility participants. Some CCAC Teams thought the training would be more appropriate for their provider agencies. This lack of understanding is also found in the types of goals that were identified for the initial 3-day sessions. The types of goals identified by the LTC facility participants were more specific than those identified by the CCAC Teams (e.g., use and understanding of medications versus assessment in general).

The CCAC Teams’ ratings related to knowledge transfer were lower than those for the LTC facility participants. These findings are consistent with the comments made by the CCAC Teams about their management’s lack of understanding of the purpose and expectations of this initiative.

In terms of pre-post confidence assessments, confidence significantly increased in some but not all areas for the LTC facility participants. The LTC facility participants also reported being less confident in taking on the role of an in-house resource person after the training. However, results from LTC participants’ self-reported change in confidence consistently indicated an increase in confidence from before the training to afterwards. Because the LTC facility participants may have had a better understanding of the P.I.E.C.E.S. initiative and were likely to have had exposure to those who had previously taken part in the training, their confidence may have been higher. Once they participated in the training, they may have realized the amount of information to be covered and, hence, their confidence decreased. This possibility is consistent with the LTC facility participants’ comments about the vast amount of information that was covered during the training initiative and the need for more time to learn the concepts.

For the CCAC Teams, in almost all cases, post-training confidence scores were higher than the confidence scores from before the training. The CCAC Teams also reported being more confident in taking on the role of CCAC P.I.E.C.E.S. Resource Team after the training. The Teams’ self-reported change in confidence support these findings.

In terms of the practical assignments that were completed after the initial 3-day sessions, in many cases, pre and post assessments using the standardized tools were not conducted. This was particularly true for the assignments completed by the CCAC Teams. However, for those who did utilize the assessment tools, there were indications that resident outcomes were improved as a result of the interventions that were implemented.

In terms of support, the LTC facility participants identified the need for: time to serve in their roles, support from management to undertake the activities of an in-house resource person, education for other staff about the P.I.E.C.E.S. framework and their role, and continued opportunities to network with other P.I.E.C.E.S. trained individuals and other external resources. The CCAC Teams indicated that they required: support and direction from their management about their roles within their organizations, education for management about

the P.I.E.C.E.S. initiative and its objectives, and the opportunity to network with other P.I.E.C.E.S. trained individuals and external resources.

The three most frequently identified barriers to transferring knowledge into practice for both the LTC facility participants and the CCAC Teams were: work and time pressures, pressure from peers to resist change, and lack of reinforcement.

In terms of the supports that were implemented to assist the participants, TIPS was considered to be valuable in helping the participants further understand and apply the knowledge and skills attained during the training. Access to a computer and/or the Internet, however, was identified as a barrier, particularly for LTC facility participants. The TAP service was considered to be of less value to many participants. The comments related to the TAP service suggest that additional information about the purpose of this service and the protocol for accessing the resource may have been needed.

The link with the 1998 P.I.E.C.E.S. graduates was seen as positive approach to providing support to both past and current P.I.E.C.E.S. trained individuals. This, along with the positive feedback on the TIPS service, highlights the value of ongoing support to participants in this training initiative.

5.0 Acknowledgements

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6.0 References

Muchinsky, P.M., (1993). *Psychology Applied to Work: An Introduction to Industrial and Organizational Psychology*. Fourth Edition. Pacific Grove, CA: Brooks/Cole.

Stolee, P.T. (1999). *The Mental Health/Long-Term Care Interface Training Resource Project: Evaluation Report*.

APPENDIX A: Additional Preceptor Data

A.1 Characteristics of Outreach Teams

Table A1 presents the results on the number of specialists and other physicians associated with the Outreach Teams represented at the Preceptor training. Over 65% of the teams reported having at least one geriatric psychiatrist. The average number of geriatric psychiatrists per team was 1.43 (SD=1.41) with a range of 0 to 6. One third of the teams reported having at least one geriatrician affiliated with their team. The average number of geriatricians per team was approximately 0.5 (SD=1.23), ranging from 0 to 7. One quarter of the teams reported having other physicians working with their team. Examples of the types of other physicians included psychiatrists, Care of the Elderly family physicians, general practitioners, and residents. The average number of other physicians working with the teams was approximately 0.5 (SD=1.41), ranging from 0 to 7.5.

Table A1
Number of Physicians on Outreach Teams

	Geriatric Psychiatrists	Geriatricians	Other Physicians
Percent of Teams reported having at least one Specialist/Physician	66.7% (30)	33.3% (15)	25.0% (11)
Mean # of Specialist/Physicians (SD)	1.34 (1.41)	0.59 (1.23)	0.56 (1.41)
Range	0 – 6	0 - 7	0 – 7.5

The number of hours these specialists/physicians spend with the teams each week is summarized in Table A2. On average, geriatric psychiatrists spend just over 14 hours per week with the Teams (SD=11.96), ranging from 0 to 37.5 hours. The geriatricians spend an average of just over 7 hours per week (SD=12.3), ranging from 0 to 48 hours. Other physicians spend an average of 10.5 hours per week (SD=14.19), ranging from 0.5 to 40 hours.

Table A2
Number of Hours Specialists/Physicians Spend with Outreach Teams Per Week

	Geriatric Psychiatrists	Geriatricians	Other Physicians
Mean (SD)	14.6 hours (11.96)	7.45 hours (12.3)	10.5 hours (14.19)
Range	0 – 37.5	0 – 48	0.5 - 40

Table A3 summarizes the number of full time equivalents (FTEs) of other health care professionals and support staff with the teams. The average number of nurses affiliated with the teams was just under 2 FTEs (SD=1.33), this was followed by social workers (mean of 0.93 FTEs) and occupational therapists (mean of 0.61 FTEs). Thirteen teams reported having other types of staff associated with their team (e.g., program managers, researchers, recreational therapists). In terms of support staff, the average number of FTEs was 0.92 (SD=0.90).

Table A3
Number of FTEs of other Health Care Professionals and Support Staff on Outreach Teams

	Nurses	Social Workers	OTs	PTs	Psychologists	Other Clinicians *	Support Staff
Mean (SD)	1.87 (1.33)	0.93 (1.17)	0.61 (0.98)	0.08 (0.32)	0.11 (0.29)	1.64 (0.33)	0.92 (0.90)
Range	0 - 5	0 – 6.2	0 – 4.6	0 - 2	0 - 1	0 – 3.8	0 - 3

* “Other clinicians” include: program managers, researchers, mental health workers, recreational therapists, and RN Coordinator.

A.2 Interactions with LTC Facilities and CCACs

Preceptors were asked to estimate the percent of clients from their entire team’s caseload that reside in the community (i.e., their own home, apartment building, retirement home, etc.) versus a long-term care facility. The preceptors estimated that approximately 65% of their clients reside in the community, with percentages ranging from 0 to 100%, and that over 30% reside in LTC facilities, with a similar range of 0 to 100% (see Table A4).

Table A4
Percentage of Outreach Team Clients Residing in the Community and LTC Facilities

What Percentage of Clients Would You Estimate Reside In:	The Community	Long-Term Care Facilities
Mean (SD)	65.6% (23.00)	32.7% (22.51)
Range	0 – 100%	0 – 100%

82.4% (61) of preceptors reported that they visit at least one LTC facility in an average month. Almost 10% reported that they do not visit any LTC facilities in an average month. The average number of facilities visited per month was 3.91 (SD=4.24), ranging from 0 to 30 (see Table A5).

Table A5
Number of LTC Facilities Visited in an Average Month by Preceptors

	Number of LTC Facilities Preceptors Visit In An Average Month
Mean (SD)	3.91 (4.24)
Range	0 – 30

When asked to estimate the number of hours per month *they* spend in LTC facilities for various activities, the preceptors reported spending an average of 13 hours in LTC for clinical purposes, 4 hours for educational purposes and just over one hour per month for developmental purposes (see Table A6).

Table A6
Number of Hours Preceptors Spend in LTC Facilities for Various Activities in an Average Month

	Clinical Purposes	Educational Purposes	Developmental Purposes
Mean (SD)	13.17 hours (18.35)	4.07 hours (11.74)	1.36 hours (3.79)
Range	0 – 80 hours	0 – 88 hours	0 – 20 hours

Preceptors were also asked to estimate the proportion of time in a month *their Team* spends in LTC facilities for various purposes. The preceptors reported that on average, almost 40% of their team’s time in LTC is for clinical purposes, almost 10% is for educational purposes, and almost 3% for developmental purposes (see Table A7).

Table A7
Proportion of the Outreach Team’s Time Spent with Long-Term Care Facilities

	For Clinical Purposes	For Educational Purposes	For Developmental Purposes
Mean (SD)	38.3% (27.63)	9.9% (12.23)	2.9% (4.61)
Range	0 – 95%	0 – 50%	0 – 20%

Preceptors were also asked to estimate the percentage of their community-based clients who receive CCAC services (see Table A8). It was estimated that almost 70% of these clients had the CCAC involved, with estimates ranging from 0 to 100%.

Table A8
Estimated Percentage of Preceptors’ Community-Based Clients on CCAC Caseload

	Percentage of Your Community Clients Who Are Also on the CCAC Caseload
Mean (SD)	57.0% (26.22)
Range	0 – 100%

When asked to estimate the proportion of time *their team* spends with the CCAC for various purposes, the preceptors reported that 26% of their time is for clinical purposes, almost 5% for educational purposes, and 3.5% for developmental purposes (see Table A9).

Table A9
Estimated Proportion of Time Outreach Team Spends with CCACs for Various Purposes

	Clinical Purposes	Educational Purposes	Developmental Purposes
Mean (SD)	26.3% (24.53)	4.8% (6.69)	3.5% (5.04)
Range	0 – 95%	0 – 20%	0 – 20%

Preceptors were then asked how *their teams* would rate the ability of staff in the LTC facilities in their areas in a variety of domains (see Table A10). One of the difficulties in responding to this type of question involves the variability of staff both within and between LTC facilities. A similar issue arises in the question where preceptors were asked how *their teams* would rate the ability of staff in the CCACs in their area in these same domains (see Table A11). Therefore, caution must be taken in drawing conclusions from these ratings.

The highest average rating for both LTC and CCAC staff resulted from the question “How would you rate LTC facility (CCAC) staff in your area in their ability to demonstrate sensitivity and respect for the individuality of the resident and family, the team, and community resource people”. Average ratings for both groups were just over 3 (or “good”) (see Tables A10 and A11). Average ratings in the other areas for LTC facility staff were between 2.11 and 2.33 suggesting that their abilities were rated as “fair” overall. Average ratings of CCAC staff in the other areas ranged from 2.49 and 2.65, suggesting that their abilities were between “fair” and “good”.

Table A10
Ratings of LTC Facility Staff by Preceptors

How would you rate LTC Facility Staff in your Area re: their ability to ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Demonstrate sensitivity and respect for the individuality of the resident and family, the team, and community resource people	0	18.2% (8)	38.6% (17)	25.0% (11)	4.5% (2)	3.18 (0.83)
Complete an assessment to fag cognitive/mental health needs and associated behavioural issues	13.6% (6)	29.5% (13)	36.4% (16)	4.5% (2)	0	2.33 (0.81)
Use assessment data related to the cognitive/mental health needs and associated behaviours to plan, implement, and evaluate care strategies	18.2% (8)	43.2% (19)	15.9% (7)	6.8% (3)	0	2.11 (0.82)
Serve as a resource to others in planning for the resident with complex physical and cognitive/mental health needs and associated behavioural issues	11.4% (5)	47.7% (21)	22.7% (10)	4.5% (2)	0	2.21 (0.71)

Table A11
Ratings of CCAC Staff by Preceptors

How would you rate CCAC Staff in your Area re: their ability to ...	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5	Mean (SD)
Demonstrate sensitivity and respect for the individuality of the resident and family, the team, and community resource people	0	13.6% (6)	29.5% (13)	38.6% (17)	4.5% (2)	3.40 (0.82)
Complete an assessment to fag cognitive/mental health needs and associated behavioural issues	9.1% (4)	31.8% (14)	25.0% (11)	18.2% (8)	0	2.61 (0.95)
Use assessment data related to the cognitive/mental health needs and associated behaviours to plan, implement, and evaluate care strategies	13.6% (6)	29.5% (13)	20.5% (9)	18.2% (8)	0	2.49 (1.00)
Serve as a resource to others in planning for the resident with complex physical and cognitive/mental health needs and associated behavioural issues	9.1% (4)	29.5% (13)	27.3% (12)	15.9% (7)	2.3% (1)	2.65 (0.97)

The preceptors were then asked to rate the extent to which *their team* agrees or disagrees with two statements, using a scale of 1 to 7 (where 1 = “strongly disagree” and 7 = “strongly agree”). In both cases, the average ratings were just over 5 (SD=1.16 for LTC staff and SD=1.18 for CCAC staff), indicating that the preceptors teams tended to agree with the statements that the referrals to the teams from these groups are appropriate (see Table A12).

Table A12
Rate the Extent to Which Outreach Teams Agrees with the Following Statements

	Referrals to Your Team by LTC Staff are Always Appropriate	Referrals to Your Team by CCAC Staff are Always Appropriate
Mean (SD)	5.19 (1.16)	5.08 (1.18)
Range	2 - 7	3 - 7

Appendix B: Additional Information from LTC Facility Participants

B.1 Resource Use

One of the goals of the P.I.E.C.E.S. training is to increase participants’ understanding of the resources available to them, both internal and external to their facilities. Therefore, as part of the pre-training questionnaire, a number of questions related to resource use were asked. The following provides a summary of these results.

With respect to the number of residents transferred out of the facility in the 3 months prior to completing the questionnaire, the average number transferred was less than one regardless of transfer location (see Table B1). The range of responses, however, was quite variable. The number transferred to emergency departments ranged from 0 to 75, the number transferred to a psychiatric hospital ranged from 0 to 25, and the number to an acute care hospital (other than the emergency department) ranged from 0 to 17.

Table B1
Number of Residents Transferred Out of the Facility in the Past Three Months: LTC Facilities

Transferred <i>From</i> the Facility to the following ...	Emergency Department	Acute Care Hospital	Psychiatric Hospital	Special Behaviour Unit
Mean (SD)	0.88 residents (4.93)	0.42 residents (1.58)	0.50 residents (1.63)	0.17 residents (0.61)
Range	0 – 75 residents	0 – 17 residents	0 – 25 residents	0 – 5 residents

When asked about the number of residents being transferred back to the facility in the 3 months prior to completing the questionnaire, the average number of residents transferred back from an emergency department was 1.51 (range from 0 to 50 residents). In all other cases, the average number of residents transferred back to the facility was less than one (see Table B2).

Table B2
Number of Residents Transferred Back to the Facility in the Past Three Months: LTC Facilities

Transferred <i>Back</i> to the Facility from ...	Emergency Department	Acute Care Hospital	Psychiatric Hospital	Special Behaviour Unit
Mean (SD)	1.51 residents (5.30)	0.52 residents (1.36)	0.60 residents (2.05)	0.23 residents (0.67)
Range	0 – 50 residents	0 – 12 residents	0 – 25 residents	0 – 4 residents

Participants were asked to rate how often they use external and internal resources to assist them with residents with cognitive/mental health problems and associated behavioural issues using a scale of 1 to 5 (where 1 = “not very often” and 5 = “very often”). For both internal and external resources, the average rating was around 3, suggesting that there is some use of these resources (see Table B3).

Table B3
Use of External and Internal Resources: LTC Participants

	Use of External Resources	Use of Internal Resources
Mean (SD)	2.99 (1.19)	3.09 (1.41)
Range	1 – 5	1 – 5

The participants were also asked how many times in the 3 months prior to completing the questionnaire internal and external resources were used to: (1) assist with a clinical issue and (2) educate staff. Internal resources were used more frequently in both cases. Internal resources were used an average of 13 times to assist with a clinical issue, and an average of almost 6 times to educate staff in the 3-month period. External resources were used an average of 3.5 times to assist with a clinical issue and less than 1 time in the 3-month period to educate staff (see Table B4).

Table B4
Number of Times External and Internal Resources Were Used by LTC Facilities to Assist Staff in Past Three Months

	External Resources brought in to ...		Internal Resource used to ...	
	Assist with a Clinical Issue	Educate Staff	Assist with a Clinical Issue	Educate Staff
Mean	3.56 times	0.92 times	13.33 times	5.88 times
(SD)	(4.26)	(2.30)	(26.53)	(14.17)
Range	0 – 36 times	0 – 36 times	0 – 240 times	0 – 60 times

Tables B5 and B6 provide examples of the types of external and internal resources used. The external resources used most frequently to assist with a clinical issue involving cognitive/mental health problems and associated behavioural issues were: geriatric outreach/assessment teams, geriatric psychiatrists, and mental health associations. Geriatric outreach/assessment teams and Alzheimer Chapters were the external resources used most frequently to educate staff (see Table B5).

In terms of internal resources, the resources used most frequently to assist with a clinical issue involving cognitive/mental health problems and associated behavioural issues were: various types of nursing staff; the psychogeriatric resource person/team; and physicians. Nursing staff and psychogeriatric resource persons/teams were the internal resources used most frequently to educate staff (see Table B6).

Table B5
Examples of External Resources Used: LTC Facilities

External Resources Used ...	
to Assist Staff with a Clinical Issue	to Educate Staff
▪ Geriatric Outreach/Assessment Team (N=165) ▪ Geriatric Psychiatrist (N=35) ▪ Mental Health Association (N=25) ▪ Psychiatrist (N=18) ▪ Geriatrician (N=9) ▪ CCAC (N=7) ▪ Alzheimer Society (N=19) ▪ Other (N=47) ** ▪ No access to resources (N=2)	▪ Geriatric Outreach/Assessment Team (N=46) ▪ Alzheimer Society (N=68) ▪ Mental Health Association (N=10) ▪ Geriatric Psychiatrist (N=8) ▪ Geriatrician (N=5) ▪ Other (N=53) ***

* Note: multiple responses permitted

** “Other” includes: General Practitioner, Senior’s Program, MOHLTC, etc.

*** “Other includes: CCAC, MOHLTC, consultant, psychiatrist, etc.

Table B6
Examples of Internal Resources Used: LTC Facilities

Internal Resources Used ...	
to Assist Staff with a Clinical Issue	to Educate Staff
▪ RN/RPN/Registered Staff/Nurse Practitioner (N=71) ▪ Psychogeriatric Resource Person/Team (N=65) ▪ Physician (N=45) ▪ Psychiatrist/Geriatric Psychiatrist/ Psychotherapist/Geriatrician (N=40) ▪ Social Worker (N=30) ▪ DOC/DON (N=18) ▪ Behaviour Management Specialist/Team (N=14) ▪ Other (N=98) **	▪ RN/RPN/Registered Staff/Nurse Practitioner (N=61) ▪ Psychogeriatric Resource Person/Team (N=31) ▪ Physician (N=13) ▪ Social Worker (N=13) ▪ DOC/DON (N=11) ▪ Psychiatrist/Geriatric Psychiatrist/ Psychotherapist/Geriatrician (N=10) ▪ Behaviour Management Specialist/Team (N=8) ▪ Therapist (N=2) ▪ Other *** (N=42)

* Note: multiple responses permitted

** “Other” includes: activation department, volunteers, clinicians, etc.

*** “Other includes: videos, workshops, Alzheimer Society.

The participants were also asked to estimate the number of hours that specialty geriatric teams spend in their facilities each month. The average number of hours spent by specialty geriatric psychiatry teams was 3.72 hours (SD=7.06) and by specialty geriatric medicine teams was 2.44 hours (SD=7.99) (see Table B7).

Table B7
Average Number of Hours Per Month Spent in Facilities by Specialty Geriatric Teams

	Specialty Geriatric Psychiatry Teams	Specialty Geriatric Medicine Teams
Mean (SD)	3.72 hours (7.06)	2.44 hours (7.99)
Range	0 – 100 hours	0 – 72 hours

Finally, participants were asked to rate the level of care required by the residents in their facility compared with residents in other facilities on a scale of 1 to 5 (where 1 = “much lighter”, 3 = “about the same” and 5 = “much heavier”). Their average rating was 3.71 (SD=0.79), suggesting that they believe their residents require more care than residents in other facilities (see Table B8).

Table B8
Rating of Level of Care Required by Facility Residents Compared with Other Facilities

	Level of Care in Own Versus Other Facilities
Mean (SD)	3.71 (0.79)
Range	2 – 5

Appendix C: Additional Information from CCAC Teams

C.1 Resource Use

The CCAC Teams were asked to approximate the number of clients on their teams that had been transferred to an emergency department, acute care hospital (other than emergency), psychiatric hospital or special behaviour unit due to cognitive/mental health concerns and associated behavioural issues in the 3 months prior to completing the questionnaire. Table C1 provides a summary of their responses. An average of almost 9 clients had been transferred to an acute care hospital for these reasons, and an average of 7 to an emergency department. An average of 2 clients had been transferred to a psychiatric hospital or special behaviour unit for these reasons during the 3-month period.

Table C1
Number of CCAC Clients Transferred to Various Locations During 3-Month Period

CCAC clients transferred to ...	Emergency Department	Acute Care Hospital	Psychiatric Hospital	Special Behaviour Unit
Mean (SD)	7.2 clients (7.64)	8.6 clients (7.05)	2.2 clients (2.71)	2.4 clients (4.12)
Range	0 – 20 clients	0 – 20 clients	0 – 6 clients	0 – 10 clients

The CCAC Teams were then asked how many of the clients who had been transferred were transferred back to the community. Table C2 provides a summary of their responses. Of the clients who had been transferred, an average of 7 had been transferred back from emergency departments, an average of 6 from acute care hospitals, an average of 1 from psychiatric hospitals, and an average of 2 from special behaviour units.

Table C2
Number of CCAC Clients who were Transferred Back to the Community

CCAC Clients Transferred from ...	Emergency Department	Acute Care Hospital	Psychiatric Hospital	Special Behaviour Unit
Mean (SD)	6.9 clients (6.86)	6.2 clients (6.51)	1.0 clients (2.00)	2.2 clients (4.41)
Range	0 – 19 clients	0 – 20 clients	0 – 6 clients	0 – 10 clients

The CCAC Teams were also asked how many times in the 3 months prior to completing the questionnaire external and internal resources were used to: (i) assist with a clinical issue and (ii) educate staff. These results are presented in Table C3. External and internal resources were used almost an equal number of times to assist with clinical issues during this time period (16.8 and 17.5 times, respectively). External resources were only used an average of once during the 3-month period to educate staff; internal resources were used an average of 3.5 times.

Table C3
Number of Times External and Internal Resources Were Used by CCACs to Assist Staff in Previous 3-Month Period

	External Resources Used to ...		Internal Resources Used to ...	
	Assist with Clinical Issue	Educate Staff	Assist with Clinical Issue	Educate Staff
Mean (SD)	16.8 times (25.0)	1.0 times (1.7)	17.5 times (26.7)	3.5 times (11.9)
Range	0 – 100 times	0 – 8 times	0 – 90 times	0 – 60 times

Table C4 and C5 provide examples of the types of external and internal resources used. The external resources used most frequently to assist with clinical issues involving cognitive/mental health problems and associated behavioural issues were: geriatric outreach/assessment teams, Alzheimer Chapters and specialists. The external resource used most frequently to educate staff about these issues was the Alzheimer Society (see Table C4).

In terms of internal resources, the most frequently used resources to assist with clinical issues involving cognitive/mental health problems and associated behavioural issues were: mental health teams, case managers and placement coordination service. The internal resources used most frequently to educate staff were: elder abuse teams and case managers (see Table C5).

Table C4
Examples of External Resources Used: CCACs

External Resources Used ...	
to Assist Staff with a Clinical Issue	to Educate Staff
▪ Geriatric Outreach/Assessment Team (N=22) ▪ Alzheimer Society (N=11) ▪ Geriatric Psychiatrist/Geriatrician/Psychiatrist (N=10) ▪ Community Services (N=4) ▪ Canadian Mental Health Association (N=3) ▪ Physician (N=3) ▪ Adult Day Program (N=2) ▪ Other (N=28) **	▪ Alzheimer Society (N=5) ▪ Other (N=20) ***

* Note: multiple responses permitted

** “Other” includes: Family Services, Police, etc.

*** “Other includes: Canadian Mental Health Association, P.I.E.C.E.S., CCAC, etc.

Table C5
Examples of Internal Resources Used: CCACs

Internal Resources Used ...	
to Assist Staff with a Clinical Issue	to Educate Staff
▪ Mental Health Team (N=4) ▪ Case manager (N=4) ▪ Placement Coordination Service (N=3) ▪ Geriatric Outreach/Assessment Team (N=2) ▪ Social Worker (N=2) ▪ Other (N=17) **	▪ Elder Abuse Team (N=5) ▪ Case manager (N=5) ▪ Placement Services / Coordinator (N=3) ▪ Other (N=11) ***

* Note: multiple responses permitted

** “Other” includes: peer consultation, assessment team, etc.

*** “Other includes: education committee, Alzheimer Society, etc.

CCAC Teams were asked to rate how often external and internal resources were used to assist with clients with cognitive/mental health problems and associated behavioural issues using a scale of 1 to 5 (where 1 = “not very often” and 5 = “very often”). Both ratings averaged around 3 suggesting that both external and internal resources were used some of the time, and perhaps external resources more than internal ones (see Table C6).

Table C6
Use of External and Internal Resources: CCACs

	Use of External Resources to Assist with Clients with Cognitive/Mental Health Problems and Associated Behavioural Issues	Use of Internal Resources to Assist with Clients with Cognitive/Mental Health Problems and Associated Behavioural Issues
Mean (SD)	3.53 (1.14)	3.17 (1.49)
Range	2 – 5	1 – 5

The CCAC Teams were asked to estimate the percent of clients on their entire CCAC caseloads who have dementia. The average estimate was 18.9% (ranging from 1% to 60%) (see Table C7). The Teams were then asked to estimate the percentage of these clients who also had other needs. It was estimated that of these 19% of clients, 17% also had a mental health need, approximately 30% also had behavioural issues, and more than half had medical or physical needs.

Table C7
Estimates of CCAC Clients with Alzheimer Disease or Related Dementias and Other Needs

% of Clients in Entire CCAC with Alzheimer Disease or Related Dementias	
Mean (SD)	18.9% (15.1)
Range	1% – 60%
Of these Clients, What Percent Also have ...	
A mental health need?	17.2 % (23.8) 0 – 75%
Behavioural issues?	29.6% (28.1) 0.5% - 80%
Medical or physical needs?	51.6% (37.9) 0.7% – 100%

The CCAC Teams were also asked to estimate the percentage of clients in the entire CCAC caseload who have mental health needs. The Teams estimated that approximately 7% of their clients had such needs (see Table C8). Of these clients, approximately 17% were estimated to also have some type of dementia, 44% also had behavioural issues, and 41% also had medical or physical needs.

Table C8
Estimates of CCAC Clients with Mental Health Needs and Associated Behaviours as well as Other Needs

% of Clients in Entire CCAC with Mental Health Needs	
Mean (SD)	6.9% (5.6)
Range	0.5% - 20%
Of these Clients, What Percent Also have ...	
Alzheimer disease or a related dementia?	16.6% (25.8) 0 – 75%
Behavioural issues?	44.3% (40.5) 0 – 100%
Medical or physical needs?	41.1% (38.0) 0 – 100%

The Teams were then asked to rate how important it was within their CCAC to provide services to individuals with cognitive/mental health needs and associated behavioural issues, using a scale of 1 to 5 (where 1 = “not very important” and 5 = “very important”). The average rating was 4.66 (SD=0.77) indicating that providing services to this population is very important (SEE Table C9).

Table C9
Importance within CCACs of Providing Services to Individuals with Cognitive/Mental Health Needs and Associated Behavioural Issues

Within Your CCAC, How Important is it to Provide Services to Individuals with Cognitive/Mental Health Needs and Associated Behavioural Issues?	
Mean (SD)	4.66 (0.77)
Range	2 – 5

C.2 Knowledge and Skills

When asked if their CCAC has made use of other training opportunities or resources related to cognitive/ mental health issues and associated behaviours, 64% of the Teams responded “yes”; less than 3% responded “no” (see Table C10). The types of opportunities and resources identified include: local schools/hospitals, the Alzheimer Society, and various mental health sources.

Table C10
Has Your CCAC Made Use of Other Training Opportunities or Resources Related to Cognitive/Mental Health Issues and Associated Behaviours?

	Percent (#) of CCAC Teams *
No	2.4% (1)
Yes	64.3% (27)
If Yes, describe these other opportunities or resources: **	
▪ Local school / hospital (N=6) ▪ Alzheimer Society (N=4) ▪ Various mental health sources (N=3) ▪ Psychogeriatric Resource (N=2) ▪ P.I.E.C.E.S. (N=2) ▪ Other ***	

* Note: percentages may not equal 100% due to missing values

** Note: Multiple responses permitted.

*** “Other” includes: geriatric outreach, conferences, etc.

The Teams were then asked to rate these training opportunities or resources in terms of their usefulness in achieving a number of objectives, using a scale of 1 to 5 (where 1 = “not at all” and 5 = “completely”). These results are summarized in Table C11. The average ratings for each of the objectives ranged from 3.32 to 3.86 indicating that these objectives had been met to some extent.

Table C11
Ratings of Usefulness of Training Opportunity or Resource in Terms
of Meeting Various Objectives: CCACs

	i) Increased Understanding of cognitive/ mental health issues and associated behaviours	ii) Enhanced Skills in Assessing cognitive/ mental health issues and associated behaviours	iii) Enhanced Skills in Planning, Implementing and Evaluating Care Strategies for persons with cognitive/ mental health issues and associated behaviours	iv) Promoted Sustainability of (ii) and (iii)
Mean (SD)	3.86 (0.92)	3.54 (0.92)	3.38 (0.94)	3.32 (0.95)
Range	2 – 5	2 - 5	2 – 5	2 – 5

CCAC Teams were asked if a variety of different types of resources were available to assist case managers with clients with cognitive/mental health issues and associated behaviours. Just over one quarter of the teams reported that they had a designated individual within their CCAC with expertise in this area. Almost 20% of Teams reported having a designated resource team within their CCAC with expertise in this area, approximately 60% of Teams reported having links to community groups or committees that deal with this population, and over 25% of Teams reported having policies within their CCAC to assist case managers with this population (see Table C12).

Table C12
Availability of Resources to Assist CCAC Case Managers with Clients with Cognitive/Mental Health Issues and Associated Behaviours

Resource	Percent (#) of Teams Responding “No”	Percent (#) of Teams Responding “Yes”	If yes, describe ...
A designated individual within your CCAC who has expertise in cognitive/mental health issues and behavioural problems	42.9% (18)	26.2% (11)	- Specialized case manager(s) in geriatrics and/or mental health (N=6) - Specialized team of case managers in geriatrics and/or mental health (N=5)
A designated resource team within your CCAC who has expertise in cognitive/mental health issues and behavioural problems (that was in place prior to the P.I.E.C.E.S. initiative).	50.0% (21)	19.0% (8)	- Psychogeriatric team - Mental health team - Dementia care team
Links to community groups or committees that deal with cognitive/mental health issues and behavioural problems	9.5% (4)	59.5% (25)	- Geriatric outreach team / RGP (N=15) - Alzheimer Society (N=13) - CMHA / CMHC (N=6) - Dementia network / Mental Health Interface Committee / Network (N=4) - Other (N=10) e.g., ABI Association, Schizophrenia Society, Regional MH Services Committee, County Health Forum, etc.
Policies within your CCAC to assist case managers in managing clients with cognitive/mental health issues and behavioural problems	42.9% (18)	26.2% (11)	- Risk management policies (N=5) - Team conferences (e.g., re: hard-to-serve) (N=2) - Care pathway for dementia care - Policies related to Health Care Consent Act, etc. - Decision-tree regarding elder abuse - Case Manager Procedure Manual

The CCAC Teams were then asked some questions related to their provider agencies. The Teams were asked whether their provider agencies are expected to demonstrate the ability to assess and manage older individuals with cognitive/mental health issues and associated behavioural problems. Just over 50% of the teams reported that this was an expectation (see Table C13).

Table C13
Demonstration of Assessment and Management Skills by CCAC Provider Agencies

	Percent (#) of CCAC Teams
Yes	52.4% (22)
No	14.3% (6)

Note: percentages may not equal 100% due to missing values

For those CCACs that responded “yes”, they were asked how this was to be demonstrated; these responses are summarized in Table C14. In many cases, these skills are expected to be demonstrated through the RFP process through such activities as joint educational initiatives and providing a list of staff with expertise in this area. Other activities are also used to demonstrate these skills although not always through the RFP process (e.g., through partnership committees and plans and protocols).

Table C14
How the Assessment & Management Skills of CCAC Provider Agencies are Demonstrated (N=22)

	Yes, through RFP processes	Yes, but not through RFP processes	No	Not done now but would consider working with provider agencies in this area
Through joint education initiatives?	63.6% (14)	13.6% (3)	4.5% (1)	18.2% (4)
Through partnership committees?	31.8% (7)	31.8% (7)	13.6% (3)	22.7% (5)
By providing a list of staff with expertise in this area?	40.9% (9)	4.5% (1)	22.7% (5)	31.8% (7)
Through plans and protocols?	27.3% (6)	36.4% (8)	13.6% (3)	22.7% (5)
Other	0	4.5% (1)	0	0

Note: percentages may not equal 100% due to missing values

Finally, the CCAC Teams were asked to rate the level of care required by the clients in their CCAC compared with other similar CCACs, using a scale of 1 to 5 (where 1 = “much lighter”, 3 = “about the same”, and 5 = “much heavier”). The average rating was 4.83 indicating that the Teams thought that the clients in their own CCACs were much heavier to care for than clients in other similar CCACs (see Table C15).

Table C15
Rating of Level of Care Required in Your CCAC Compared with Other Similar CCACs

	Rating of the Level of Care Required by the Clients in Your CCAC Compared with Other Similar CCACs
Mean (SD)	4.83 (1.23)
Range	3 – 6