Behavioural **S**upport **T**eam Management for Residents with Dementia

P.I.E.C.E.S. Assessment Worksheet

Resident: _____

MRP: _____

Has resident been referred to GSS previously? YES ☐ NO ☐

If so, who was the Psychiatric Lead / Physician? _____

1 What has CHANGED?

What is the Behavioural concern?
Is it a change for this person because it is new? If so, when did it emerge?
Did the behaviour already exist?
If so, is it worse or different, and when did the change emerge?

Who is this a concern for? (eg. resident/family/staff) _____

2 What are the RISKS?

RISKS: What risk does this new behaviour involve?

1 = Never/None • 2 = Almost Never/Rarely • 3 = Occasionally/Sometimes • 4 = Often/ Frequent • 5 Nearly all the time/Constant

R	**ROAMING/WANDERING**	
I	**IMMINENT PHYSICAL RISK** (Frailty/falls/fire/weapon)	
S	**SUICIDE** (Expressed thoughts / plan / history)	
K	**KINSHIP (RELATIONSHIP)** (Risk of harm to relationships or others)	
S	**SELF NEGLECT** (Substance use / misuse)	

History of Delirium *(please check)*
YES ☐
NO ☐
UNKNOWN ☐

3 POSSIBLE CAUSES …Think PIECES!

Physical

Delirium — **CAM ASSESSMENT SCORE** *Circle all that apply* — A B C D

Disease — **Standing Order / Lab tests completed & addressed?** YES ☐ NO ☐

Discomfort — **PAINAD SCORE** ☐ — **NOPPAIN Checklist?** YES ☐ NO ☐

Disability — Eg. Does the resident have a disability which may be contibuting to behaviour?

3 POSSIBLE CAUSES …Think PIECES!

Physical

Drugs	**Medication review / MAR Completed**	**YES** ☐	**NO** ☐
	Has there been a medication change within the last 2 weeks?	**YES** ☐	**NO** ☐

Intellectual

Please rate the frequency of the following:
1 = Never/None • 2 = Almost Never/Rarely • 3 = Occasionally/Sometimes
4 = Often/ Freauent • 5 Nearlv all the time/Constant

Comments / Observations
(eg. recent change? / possible causes)

Amnesia	*Loss of memory*	
Aphasia	*Loss of Language*	
Agnosia	*Loss of recognition*	
Apraxia	*Difficulty performing familiar tasks*	
Anosognosia	*Loss of insight*	
Altered Perception	*Eg. Hallucinations*	
Apathy	*Loss of energy*	

Emotional

E.g. Irritability, withdrawal, loss of interest, decreased engagement, changes in appetite or sleep, delusions, hallucinations, psychosis, depression or suicidal ideation, anxiety, euphoria, or others (please state in more detail)

Capabilities

What are the person's functional abilities? *Please rate: 1 = Very Poor / None • 2 = Poor • 3 = Fair • 4 = Good • 5 = Very Good*

	Baseline	Current		Baseline	Current
Eating / Feeding			**Toileting**		
Hygiene / Grooming			**Ambulation / Transfers**		
Dressing			**Sleep**		
Most recent ADL score					

Environment

Observed environmental triggers

Eg. Over/under stimulation, relocation, privacy, use of restraints, lighting, colours, patterns

Lack of environmental cues (e.g. signs for bathroom)

Social

Eg. Values, wishes, beliefs, life story, social network, culture, spiritual, family relationships

Past memories / Traumas

4 **What is the ACTION? (What has been done so far?)**

Investigations / Interventions *(Please complete & check as appropriate)*

		COMPLETED	ATTACHED
STANDING ORDER SET		☐	☐
LAB RESULTS (previous 3 months)		☐	☐
LAST MEDICATION REVIEW		☐	☐
MAR (x 4 weeks)		☐	☐
REVIEW OF NURSE PROGRESS NOTES		☐	☐
CONFUSION ASSESSMENT METHOD (CAM)		☐	☐
DEMENTIA OBSERVATION SYSTEM (DOS) (x 2 weeks)	*OR*	☐	☐
COHEN MANSFIELD AGITATION INVENTORY (x 2 weeks)		☐	☐
GERIATRIC DEPRESSION SCALE	*OR*	☐	☐
CORNELL ASSESSMENT SCALE FOR DEPRESSION IN DEMENTIA		☐	☐
PAIN AD	*OR*	☐	☐
RAI HISTORY (most recent and previous)		☐	☐
MONTREAL COGNITIVE ASSESSMENT (MOCA)	*OR*	☐	☐
MINI COG		☐	☐

RELATIONSHIPS

FAMILY:

OTHER:

INTERACTIONS: *What care approaches have been tried and what were the results?*

INFORMATION: *How will the information be shared as a* ***TEAM***

Completed by: _____ **Date:** _____

Signature: _____