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A Clinical Practice Guideline for Managing Behavioral Problems in Persons with Dementia

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This is to certify that the doctoral study by

Ken Joseph Brinker

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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Abstract

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MSN, Kaplan University, 2010

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

As the baby boom generation ages, the demand for effective nursing care for patients diagnosed with dementia has greatly increased. The challenges associated with dementia include a patient's inability to focus, pay attention, and follow conversations. Patients often become forgetful, angry, frustrated, and aggressive with family members and caregivers. The medical providers and administrators at a long-term care facility needed assistance in developing a clinical practice guideline for managing behaviors demonstrated by patients with dementia. The project question centered on the identification of current evidence supporting a clinical practice guideline for nursing practice for unpredictable behaviors demonstrated by residents diagnosed with dementia. The project entailed the development of a suggested guideline based on the evidence. The guideline was found to be acceptable and was approved using the Appraisal of Guidelines for Research and Evaluation (AGREE) II tool. Using a scale of 1 to 7 (*strongly disagree* to *strongly agree*), a panel of experts selected a score of 2 or higher for each criterion within the six domains of the AGREE II tool with an average final guideline assessment score of 5. The panelists recommended the addition of caregiver safety components and levels of evidence to the guideline and a plan for the ongoing updating of the guideline. Use of the guideline may bolster safety and reduce job dissatisfaction and turnover among nursing staff at the project facility.

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Dedication

This doctoral project is dedicated to Dr. Diane K. Whitehead, my mentor and chair. It was because of her belief in me and her infinite patience, support, and guidance that I was able to complete this work. Also included in this dedication are my nursing students from over the years. They have shown me that pursuing a higher credential in nursing allows the nurse educator to become even better prepared and skilled to offer future nurses support and guidance, which are gifts that they so deserve. and are so worthy of.

Acknowledgments

I wish to acknowledge with gratitude my nursing colleagues who offered their support and encouragement throughout this process. I also wish to thank Mr. Michael Ginovsky, MSN, RN, my primary preceptor, for his guidance and patience over many field immersion experiences.

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Section 1: Nature of the Project

Dementia is a complex medical condition that has far-reaching implications for individuals and societies. It is defined as the loss of cognitive abilities that impairs reasoning and behavior to the point that daily living is disrupted (TheFreeDictionary.com, n.d.). Patients with dementia often exhibit behavior and personality changes due to lose of brain neurons in the frontal lobe. Patients lose the ability to focus and pay attention and have trouble following conversations and become forgetful, angry, and frustrated. Changes in medical issues including medications, pain, infection, constipation, or sleep disorders may cause behavior changes in patients with dementia (UCSF, 2020). Dementia and Alzheimer's disease are now among the major health care concerns across the United States and the world (National Institute on Aging, 2019).

The Centers for Disease Control and Prevention (2018) reported that 5 million U.S. adults 65 years of age or older were diagnosed with dementia in 2014, with a projected 14 million diagnosed by 2060. Experts at Healthy People 2020 have identified that 5.1 million persons in the United States age 65 and older suffer from dementia and Alzheimer's disease. Unless more effective modalities are developed to treat, manage, and prevent dementia, the number of cases may more than double by 2050 (McConnell & Matters, 2018). McConnell and Matters (2018) also posited the need to move beyond current situations due to inconsistencies in the depth and effect in teaching health care professionals the basics of the care of this population. The authors also recommended increasing the capacity of the workforce for improved care and moving health care

professionals and caregivers toward a shared competencies model in caring for older adults with cognitive impairment.

In the local dementia care community, caregivers have voiced concerns about their competency and ability to satisfactorily meet these new challenges. A clinical practice guideline was needed to provide guidance to caregivers for patients with dementia. These guidelines may increase caregivers' satisfaction in their roles and increase safety and decrease staff turnover. A practice guideline may support this specialty care and further understanding of the need for quality improved dementia care (Fazio et al., 2018).

Problem Statement

The gap in practice at an 83-bed rehabilitation and long-term care skilled nursing facility in the Pacific Northwest was the lack of knowledge of the staff on how to manage behavior changes in patients with dementia. The medical providers and administrators at this facility requested assistance in developing a clinical practice guideline focusing on managing behaviors demonstrated by patients with dementia. The facility administrators reported that over the past year there were injuries of both staff and residents due to mismanagement of patients. Sources of evidence supporting the need for this project were incident reports outlining acting out behaviors and injuries. Self-reports by care staff and focus groups held in staff meetings affirmed the difficulty of patient care and the need for guidelines. A review of organizational data showing increased staff turnover and dissatisfaction with their role in this facility also affirmed the need for a new guideline. The organization had staff resignations related to the chaos and unsafe events in the daily

care of the patient population diagnosed with dementia. This concern for individual safety led to increased turnover and job and role dissatisfaction.

Purpose Statement

This project addressed the knowledge gap in practice demonstrated by caregivers at the facility. I developed a clinical practice guideline to provide information on how to best address difficult behaviors exhibited by patients with dementia. The project question was the following: Based on current evidence, what is a recommended guideline for nursing practice for unpredictable behaviors demonstrated by residents diagnosed with dementia? A practice guideline that supports patient-centered care for patients with dementia may foster positive social change for patients with dementia, their families, caregivers, and the transitional care staff and administrators through improved caregiver and staff satisfaction and retention.

Nature of the Doctoral Project

The goal of this doctoral project was to develop an evidence-based clinical practice guideline on managing behavior issues with patients diagnosed with dementia. Effective management of anxiety and aggression and unpredictable behavior increases safety for staff and residents as well increase caregiver satisfaction and quality of life for the patient (Prusaczyk, 2019).

I followed the Walden University *Manual for Clinical Practice Guideline Development* in creating the project. A literature review of current evidence on best practices for dealing with difficult behaviors with patients with dementia provided resources for guideline development. Online databases from the Walden University

Library were accessed. Key words included *dementia spectrum*, *dementia specific behavior*, *caregiver safety*, *unpredictable behaviors*, *agitation and aggression*, and *behavioral management.* Inclusion criteria included peer-reviewed evidence published within the past 5 years written in English. Evidence was appraised using the Fineout-Overholt et al. (2010) grading tool. An expert panel used the Appraisal and Guidelines Research Evaluation (AGREE) II tool (Brouwers et al., 2010) to review the proposed guideline.

Significance

The primary stakeholders were the residents and their families. Additional stakeholders were the administration, nursing, and care staff. Training and education in the new clinical guideline may foster positive social change in the care environment. Another stakeholder is the care company itself in that a successful guideline and protocol has the potential to be adopted by care facilities in the system and achieve the intended outcomes.

Summary

A local rehabilitation and long-term care facility in the Pacific Northwest requested a clinical practice guideline to assist staff in managing difficult and unpredictable behaviors of patients with dementia-specific syndrome. Staff and residents had experienced injuries, and the care milieu was marked by intermittent fear. The practice-focused question for this project was, Based on current evidence, what is a recommended guideline for nursing practice for unpredictable behaviors demonstrated by residents diagnosed with dementia? In Section 1, I introduced the gap in practice, the

purpose of the project, the practice question, and the nature of the doctoral project. The significance of the project including stakeholders and relationship to social change was described. In Section 2, I discuss the model supporting the project; the evidence relevant to the project; and my role in project development, implementation, and evaluation.

Section 2: Background and Context

Introduction

Knowledge of best practices in managing unpredictable behaviors of patients diagnosed with dementia has been identified as a gap in practice for an 83-bed long term care facility in the Northwest United States. The practice question was, Based on current evidence, what is a recommended guideline for nursing practice for unpredictable behaviors demonstrated by residents diagnosed with dementia? In Section 2, I align Kolcaba's comfort theory with this project, discuss the evidence, and consider the relevance to nursing practice. My role and the role of the expert panel is also discussed.

Concepts, Models, and Theories

The theory framing this project was Kolkata's comfort theory. This theory supports nursing care that is inclusive of physical, psychospiritual, social, and environmental interventions (McEwen & Wills, 2019). The eight propositions of the comfort theory and the alignment to the project are described in Table 1.

Table 1

Alignment of Comfort Theory to Project

Comfort theory proposition	Alignment to project
Health care providers identify comfort needs of patients and family members.	Educate providers on how to identify individual comfort needs.
Nurses design and coordinate interventions.	Support education and consult resources for design and planning tools available within the frame of the project.
Intervening variables are considered when developing interventions.	Assessment tools available through the clinical practice guidelines place persons om a spectrum of variables in order to individualized care.
Health care team agrees on interventions.	Expert panel to review and give permission to proceed with project
Interventions are delivered in a caring manner.	Standards of quality care included in guideline,
As comfort increased health seeking behaviors of patients and families will increase.	Management of difficult behaviors *tools provided by project) reduces stress and provides a calmer atmosphere for seeking quality of life heath care behaviors.
Satisfaction will increase with improved comfort care.	A major goal of the project
Satisfaction with the institution will improve with improved comfort care to patients and families.	Stakeholder satisfaction for all because of quality assurance and improvement is another major goal of the project.

Note. Adapted from *Comfort Theory and Practice: A Vision for Holistic Health Care and Practice*, by K. Y. Kolcaba, 2003, Springer Publishing.

Comfort has been a goal of the nursing profession since Florence Nightingale (nurs. answ. Net, 2020) Kolcaba's theory supports a holistic outcome applied to the dynamic and multifaceted state of person, which describes those suffering from dementia and impaired cognitive disorder. Kolcaba and Kolcaba (1994) argued for an intra and interaction perspective in practice guidelines and the use of interventions to directly enhance the comfort of the sufferer (e.g., reducing fear and panic, agitation, and aggression of those with dementia). When their feelings of safety are increased through comfort, staff and caregivers may have more assurance of experiencing more safety. An effective guideline may bolster caregiver comfort and safety and improve patients' quality of life. It may strengthen the ability of caregivers to manage the challenges of problem behavioral management (Kolcaba, 1994; nurs.answ. 2020).

Relevance to Nursing Practice

The incidence of dementia is increasing, but complete awareness and knowledge of the disease has not increased. Late diagnosis of the disease caused by misinterpreted or even neglected symptoms reduces the choices resourced to provide currently relevant nursing care. This is especially the current difficulty of behavioral management that exists on the dementia spectrum that are difficult, unpredictable, and unsafe. This variability of behaviors can diminish the ability of nurses to meet the needs of patients fully and has become a concern. There is value for quality assurance and improvement in expanding the role of the practicing nurse to obtain the new knowledge necessary to recognize and management dementia behavior and be wells positioned for competent and more effective treatment and care (Gibson et al., 2018).

Behavior Changes with Dementia

Cognitive deficits in dementia, psychological symptoms, and behavioral abnormalities interact in a complex manner. These neurogenerative processes in many areas of the aging brain result in complex behavior changes that become difficult to manage (Tible et al., 2018). The National Institute on Aging (2017) reported that behavioral changes are difficult to manage and need to be understood. These changes include becoming worried, frustrated, upset, and angry easily; being depressed; hoarding; seeing things that are not there; wandering away; pacing continuously; engaging in unusual sexual behavior; being combative and hitting; and mistreating the environment.

Common Causes of Problem Behavior

The behavioral and psychological symptoms of dementia (BPSD) cause great suffering for the patients and caregivers that sometimes is more intense that the cognitive impairment itself. There exists a widen representation of affective, psychotic, and behavioral symptoms and signs. The causes and risk factors of BPSD include genetics and biological psychosocial and environmental factors. Most often, a combination of these, rather than a single factor or two, necessitates that a treatment plan be individualized to each patient, including the family and caregivers (Tible et al., 2018).

Current Approaches to Behavior Management

Until recently pharmacological treatment for dementia has been the first line of defense. There is increasing concern that it should become the second line approach and the increased encouragement of the non-pharmacological approach in the psychosocial and alternative realms be first line approach (National Institute on Aging, 2017)

Potentials of a wide range of interventions in psychosocial and alternative therapies are being used and assessed now but efficacy and standardization are still being systematically reviewed. Instead of the conventional lists of signs and symptoms, assessment of the patient's present and immediate condition is now becoming evidenced as necessary for best practice. This allows accurate judgement for the identification of the target behavior and its management (Tible, et al., 2018). BPSD are present in most persons with dementia; however, symptoms and signs are a variety of affective, psychotic, and behavioral systems. Psychosocial interventions are pivotal for the treatment of BPSD and should be employed and evaluated before a pharmaceutical(s) is used as the first intervention.

Local Background and Context

The care community in which this project was implemented is an 83-bed long-term care, rehabilitation, and skilled nursing facility. Sixty eight percent of residents suffer from some form of dementia or cognitive impairment. Mismanaging the unpredictable and difficult behaviors led to constant problems such as injury to patients and staff, firing of staff and rapid turnover due to the stress oof the unsafe environment. The facility administration identified management of these unpredictable behaviors as an important gap in practice. The administrator requested the development of a clinical practice guideline on best practices to manage unpredictable behaviors of patients with dementia for caregiver staff.

Role of the DNP Student

My role was to explore the current evidence on best practices for managing unpredictable behaviors for patients with dementia and translate the evidence into a clinical practice guideline for the facility. A clinical practice guideline informed the providers of best practices in managing difficult dementia behavior that is of the highest quality and best outcomes (Institute of Medicine, Committee to Advise the Public Health Service on Clinical Practice Guidelines, 1990). Addressing this practice gap by leading the facility toward the practice change of employing an effective clinical practice guideline supported my role as a Doctor of Nursing Practice- (DNP-) prepared leader.

Role of the Project Team

The project team 3-member expert panel included one psychiatric nurse ARNP, one family practice ARNP, and one member of the facility leadership who will review the draft clinical practice guideline. Final updates to the guideline were completed after the expert panel review. Clinical practice guidelines are statements that include recommendations intended to optimize patient outcomes informed by rigorous review of the systemic evidence available and determine the benefits against the risks before moving forward (National Academies of Science Engineering and Medicine (NASEN), 2018). The expert panel evaluated the proposed clinical practice guideline using the AGREE II tool and made recommendations for changes based on the guideline criteria.

Summary

Section 2 introduced Kolcaba's comfort theory and the theory alignment to the project. The relevance to nursing practice, my role and the role of the expert panel were

described. The local background and context for this project were explored. Section 3 described the procedures, protections and analysis used to develop the guideline.

Section 3: Collection and Analysis of Evidence

Introduction

Patients with dementia often exhibit behaviors that are difficult to manage. Unpredictable behavior's borne of the anxiety and panic of this thought disorder can become unsafe due to aggression or harm to self. A new and effective clinical practice guideline that supports and guides care staff may increase quality of care, job satisfaction, and safety by reducing injuries for both residents and staff.

Practice-Focused Question

The project question was, Based on current evidence, what is a recommended guideline for nursing practice for unpredictable behaviors demonstrated by residents diagnosed with dementia? I developed the project question based on a request of the administration to address a practice gap with the development of a clinical practice guideline addressing management of behavior issues with patients with dementia.

Sources of Evidence

Literature Review and Appraisal

The Walden University *Manual for Clinical Practice Guideline Development* informed the development of the project. A literature review of current evidence on best practices for providing patient centered care to address difficult behaviors with patients with dementia provided resources for guideline development. Online databases from the Walden University Library were accessed. Key words included *dementia spectrum*, *dementia specific behavior*, *caregiver safety*, *unpredictable behaviors*, *agitation and aggression*, and *behavioral management.* Inclusion criteria included peer-reviewed

evidence published within the past 5 years written in English. I appraised evidence using the Fineout-Overholt et al. (2010) grading tool. An expert panel used the AGREE II tool (Brouwers et al., 2010) to review the proposed guideline.

Level 1: Systematic Review or Meta-Analysis

Since the effects of Alzheimer's and dementia has risen to a major worldwide health concern, systematic and rigorous review and research has created evidence that the traditional approach to managing behaviors within the syndrome require new clinical practice guidelines and standards. A meta-analysis and systematic review estimating the risk of the perpetuation of problematical behaviors, especially aggression, in dementia. Evidence suggests that currently aggressive behaviors in Alzheimer's disease and dementia has become the most frequent and disruptive behavioral complication of cognitive impairment (Yu et al., 2018). Yu et al.'s (2018) study, which included the search of six academic databases according to a protocol, underscored the necessity of treatment of aggression and agitation of dementia as well as prevention of becoming worse over time. In their systematic review of nine major databases and a metanalysis of randomized controlled trials, Na et al. (2019) concluded that new guidelines and approaches were given equal importance to nonpharmacologic treatments as well as medications. Na et al. noted that the evidence indicates that these new approaches show improvement in the activities of daily living of dementia patients and therefore improvements their quality of life within the dementia spectrum.

Level II: Randomized Controlled Trials

In a randomized clinical trial by Thyrian et al. (2017), the researchers revealed that a new guideline for directly managing dementia behavior is lacking and should be implemented to increase the quality of life for persons experiencing dementia and to support their caregiver burden and families. The objective of this study was to determine if a dementia specific management protocol will increase the safety of sufferers and caregivers. The outcomes of the trial were also measured in terms of quality of life, caregiver burden appropriate, and inappropriate pharmacotherapy treatment of the symptoms of dementia. The conclusion was that care provided to specifically trained nurses in this collaborative care model can improve relevant patient and caregiver related outcomes.

Level VII: Expert Opinion or Consensus

There are numerous organizations that support patients with dementia. These organizations often develop guidelines related to the care and treatment of these patients. Patients. The most useful guidelines are available from the Alzheimer's Association (n.d.). The organization provides comprehensive guidelines for providers and caregivers related to daily activities and problematic behaviors. In a review of evidence-based nonpharmacological practices that can be used to address behavioral and psychological symptoms, Scales et al. (2018) listed aromatherapy, massage, pet and music therapy, reminiscence, and validation therapy, along with basic nursing care practices of bathing and mouth care. Challenges to implementing evidence-based guidelines that manage behavioral symptoms include the cost of training and implementation across care settings.

Administration adherence to guidelines and protocols is often not a priority in long-term care settings, Scales et al. (2018) observed.

Participants, Protections, and Procedures

A qualified representative from the site completed the site approval form for a clinical practice guideline development project. The site approval form was submitted to Walden IRB for approval to implement this project. Upon approval from Walden University IRB # is 01-25-23-0899520, the implementation of the project was completed using the steps outlined in the Walden University Manual Clinical Practice Guideline Development. The proposed clinical practice guideline was evaluated by the identified expert panel using the AGREE II tool (Brouwers et al., 2010). Participants completed the disclosure to expert panelist form for anonymous questionnaires prior to evaluating the proposed guideline. The data will be stored in my home for 3 years.

Analysis and Synthesis

The expert panel evaluated the proposed clinical practice guideline using the AGREE II tool (Brouwers et al., 2010). Subsequently all domains were scored with individual score of 1-7 employing a Likert scale. The panel was educated in the use of this process with the AGREE II User Manual. and the following directions were given to all members:

- Place a score of 1 (Strongly Disagree if the evidence in the domain contains no information that is useful and relevant to the AGREE II element or if the idea was poorly reported

- Place a score of 7 (Strongly Agree) if the criteria for the domain and full considerations there are met.
- Scores between 2 -6 indicate that the reporting of AGREE II item meets some of the required criteria.

Summary

Dementia and its behavioral management are a complex issue that requires broad perspectives and skills to resolve. Dementia requires a wide array of problem solvers. Providing new standards and practice guidelines is a necessary concentrated effort (McConnell & Matter, 2018). Section 3 discussed the sources of evidence and the evidence generated for this project. The protections, participants and procedures for the project were described. The analysis of the results was identified. Section 4 introduced the findings from the project implementation.

Section 4: Findings and Recommendations

Introduction

The gap in practice for the target 68-bed rehabilitation and skilled nursing facility was lack of an effective clinical practice guideline for the management of problem behaviors specific to patients with dementia. The administration and director of nursing requested that I create a guideline for caregivers to better manage behavioral issues. The goal was to increase safety for staff and help to increase caregiver role satisfaction and retention. The AGREE II assessment tool was used to provide quantitative date in the form of rating for seven domains and the average of the rating of three expert panelists. The summary panel consisted of three experts in the fields of mental health and cognitive impairment/dementia.

Results

Tables 2–8 include the data results from the six domains of the AGREE II tool and the final ratings and recommendations for the clinical practice guideline (see Appendix).

Domain 1: Scope and Purpose

All participants scored 7 for all criteria for this first domain rating the overall scope and purpose of the guideline. The average score for this domain was 7 (see Table 2).

Table 2

Scope and Purpose AGREE II Scores

Criterion	Scores			
	Expert 1	Expert 2	Expert 3	Average
The overall objective(s) of the guideline is (are) specifically described.	7	7	7	7
The health question(s) covered by the guideline is (are) specifically described.	7	7	7	7
The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	7	7	7	7
Average	7	7	7	7

Domain 2: Stakeholder Involvement

Domain 2 is stakeholder involvement. Participant scores for this domain ranged from 7 to 1 with an average of 5.6 (see Table 3).

Table 3

Stakeholder Involvement AGREE II Scores

Criterion	Scores			
	Expert 1	Expert 2	Expert 3	Average
The guideline development group includes individuals from all the relevant professional groups.	7	6	6	5
The views and preferences of the target population (patients, public, etc.) have been sought.	7	4	1	4
The target users of the guideline are clearly defined.	7	6	6	5
Average	7	5.1	4.8	5.5

Domain 3: Rigor of Development

Domain 3 included nine criteria related to rigor of development. The participant scores for this domain ranged from 7 to 2 with an average of 4.3 (see Table 4).

Table 4

Rigor of Development AGREE II Scores

Criterion	Scores			
	Expert 1	Expert 2	Expert 3	Average
Systematic methods were used to search for evidence.	7	2	2	3.9
The criteria for selecting the evidence are clearly described.	7	2	2	3
The strengths and limitations of the body of evidence are clearly described.	7	2	2	3
The methods for formulating the recommendations are clearly described.	7	2	2	3.9
The health benefits, side effects and risks have been considered in formulating the recommendations.	7	5	4	5.1
There is an explicit link between the recommendations and the supporting evidence.	7	5	2	3
The guideline has been externally reviewed by experts prior to its publication.	7	6	7	6.5
A procedure for updating the guideline is provided.	3	7	7	5
Average	6.8	3.9	3.8	4

Domain 4: Clarity of Presentation

Domain 4 included three criteria related to clarity of presentation. The participant scores for this domain ranged from 7 to 1 with an average of 6.3 (see Table 5).

Table 5

Clarity of Presentation AGREE II Scores

Criterion	Scores			
	Expert 1	Expert 2	Expert 3	Average
The recommendations are specific and unambiguous.	7	6	7	6.2
The different options for management of the condition or health issue are clearly presented.	7	7	4	6
Key recommendations are easily identifiable.	7	7	7	7
Average	7	5	5.5	5.9

Domain 5: Applicability

Domain 5 included five criteria related to applicability. The participant scores for this domain ranged from 7 to 1 with an average of 4.4 (see Table 6).

Table 6

Applicability AGREE II Scores

Criterion	Scores			
	Expert 1	Expert 2	Expert 3	Average
The guideline describes facilitators and barriers to its application.	7	6	2	5
The guideline provides advice and/or tools on how the recommendations can be put into practice.	7	6	2	5
The potential resource implications of applying the recommendations have been considered.	7	5	2	4
The guideline presents monitoring and/ or auditing criteria.	3	2	7	4
Average	8	4	3	4

Domain 6: Editorial Independence

Domain 6 included two criteria related to editorial independence. The participant scores for this domain ranged 7 to 2 with an average of 5 (see Table 7).

Table 7

Editorial Independence AGREE II Scores

Criterion	Scores			
	Expert1	Expert 2	Expert 3	Average
The recommendations are specific and unambiguous.	7	6	2	5
The views of the funding body have not influenced the content of the guideline.	7	6	2	5
Average	7	6	2	5

Overall Assessment

The average for the overall assessment rating was 4 to 7, with an average of 5 (see Table 8). All participants recommended the guideline for use.

Table 8

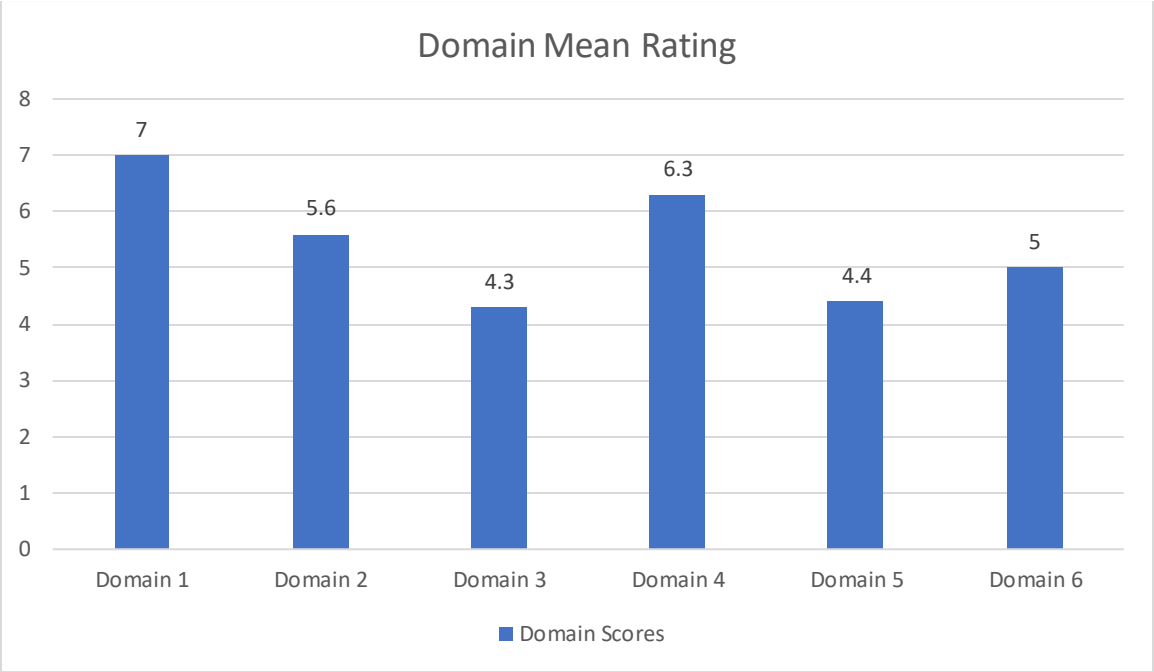
Overall Assessment AGREE II Scores

Criterion	Scores			
	Expert1	Expert2	Expert3	Average
Rate the overall quality of this guideline.	7	5	4	5
I would recommend this guideline for use.	Yes	Yes	Yes	100%

The areas of the guideline that had the highest rating of agreement for quality were the domains for Scope and Purpose and Clarity of Presentation (see Figure 1 for the mean rating by domain). The two areas that would benefit from further review for in a future development were Rigor of Development and Applicability. Providing more advice on advice and/or tools on how the recommendations can be put into practice may strengthen this guideline when applied in practice.

Figure 1

Mean Rating Score for Each Domain



Note. The domains are as follows: 1, Scope and Purpose; 2, Stakeholder Involvement; 3, Rigor of Development; 4, Clarity of Presentation; 5, Applicability; and 6, Editorial Independence.

Recommendations

Comments from the expert panelists included a suggestion to include a component for caregiver safety considerations and adding information on updating of the guideline. Another suggestion was adding the level of evidence and source of evidence to the guideline.

Strengths and Limitations of the Project

This project provided guidelines for providers caring for patients with behavior concerns that potentially could impact the safety of the caregivers. The project question and gap in practice were identified by the organization. The clinical practice guideline is supported with evidence. A limitation of the project was that only three people participated in the expert panel.

Section 5: Dissemination Plan

In this section, I discuss the initial implementation and dissemination of the new clinical practice guideline to the stakeholders. I discuss the education of the administration and staff of the local facility. This will be presented in the context of how the use of the guideline may benefit and support staff and residents thus potentially improving quality of care and role satisfaction. Logistics include accomplishing this through staff meetings and educational seminars and printed material. I plan to organize and lead these efforts in conjunction with the administration and the staff education and development coordinator.

If the new clinical practice guideline (see Appendix) is found effective and useful in the local facility, buy in may occur in the expanded facility system. A panel of experts can be formed to present the new guideline to corporate leadership. This could generate an effort to use the project throughout all system facilities.

One of the social consequences of the project can be is to support the families and other caregivers of those experiencing dementia. This potential outcome can be both for residents of care communities and other locations in the community such as private homes. Education and training programs as well as troubleshooting consultancy can become part of the fabric of community-based care. This goes beyond the walls of the original local facility, where it began as it disseminated to all points of dementia care.

Ongoing evaluation is needed to identify necessary modifications at the points of care. Research can provide new evidence-based practice recommendations for quality assurance and best practices as part of the continuing dissemination plan at the point of

care. I believe that the appropriate venues have been targeted for this project. They have been identified in the dissemination plan.

Analysis of Self

I am experienced in dementia care behavior management issues. I have spent many years among the mentally challenged in my nursing practice. With a DNP degree, I can enhance my knowledge and skills in this area and care for patients at even a higher level. This is the reason I chose this area for the doctoral project. Participation in the project, in all project roles and elements, has led me to decide to pursue further education in the mental health and cognitive impairment area. Doing this work has motivated me to continue teaching and expanded consultancy in the field. These have been my general goals throughout, but this project has rendered them more specific for me.

Scholar

A doctoral level project and development of a new clinical practice guideline requires increased ability to research the issues and find valid evidence-based data upon which to indemnify the conclusions and outcomes of the research. This knowledge may lead to effective recommendations for practice at the point of care. Scholarly writing at these higher levels is also necessary. Although it seemed difficult at times, this project development effort helped me to develop skills for evidence-based research and synthesis of conclusions and recommendations.

This project presented me the opportunity to become a higher-level nursing practitioner, using advanced research skills. I came to realize that such a role demands hard and consistent work and motivation. Time management was always a looming

challenge; there were issues in the completion of this project causing me to reinvent and renew motivation and a foreword plan after experiencing "life happens" difficulties. My major insight here was the deep importance of perseverance.

Project Manager

I became the project manager when I honored the request from the facility administration for a new clinical practice guideline for management of the dementia specific difficult behaviors. I began the project, conducted the research, arrived at recommendations, presented a proposal, and implemented and evaluated the project. I took on the responsibility of managing the project from inception to dissemination.

Summary

Dementia care is changing but too slowly in the health care system. This project presented a new clinical practice guideline (see Appendix) specific to more effective management of the behavioral management problems in caring for the exploding numbers of persons suffering from dementia in the present generation and those to come. The evidence reviewed for the project demonstrated that diagnosing and treating and caring for dementia and cognitive impairment is "canned" and is too limiting and narrow in treating the broad spectrum. Dementia care must become more individualized and person centered. Pharmacological approach should be a last resort only after all other measures are exhausted. It should not be the first and only first act of care and treatment as id too often is today. This clinical practice guideline reflects that focus.

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Appendix: Clinical Practice Guideline

This guideline was created to provide staff and caregivers at a long-term facility an evidence-based approach to care for patients with dementia who experience behavior and psychological symptoms associated with dementia (BPSD). The question that was used to guide development was: What best practices are recommended to develop guidelines for nursing practice to prevent and manage unpredictable behaviors demonstrated by residents diagnosed with dementia? This guideline may be used by staff and caregivers comprised of an interdisciplinary staff, support personnel, and other patient caregivers to address the needs of patients with dementia. The guideline was developed based on the review of evidence-based nonpharmacological practices that can be used to address behavioral and psychological symptoms. Effective management of BPSD with anxiety and aggression and unpredictable behavior is intended to increase safety for the staff and residents as well increase caregiver satisfaction and quality of life for the patient. It is recommended that this guideline be reviewed once a year to update and revise with any new evidence that will guide staff on BPSD. The guideline provideds key strategies for six domains: Communication, Environment, Hallucinations and delusions, Tasks, Activities, and Caregiver supports.

Domain/Key Strategies	Level of Evidence	Comments	Citations
Communication • Allow patient sufficient time to respond to a question. • Provide one to two step simple verbal commands. • Use a calm, reassuring tone. • Offer simple choices (no more than 2 at a time). • Avoid negative words and tone • Use a light touch to reassure, calm, or redirect. • Identify self and others if patient does not	Level 1V	Provides examples and suggestions on how to assist persons with dementia deal with communication issues. The idea is to give the person with dementia the chance for independent thinking without overwhelming demands.	Alzheimer's Association. *Treatments for behavior* (2022). https://www.alz.org/alzheimers-dementia/treatments/treatments-for-behavior Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *The Gerontologist, 58*(suppl_1), S10–S19. https://doi.org/10.1093/geront/gnx122

remember names. • Help patient find words to express him/hers.			
Environment • Remove clutter or unnecessary objects. • Eliminate noise and distractions while you are communicating or when patient is engaging in an activity. • Use simple visual reminders (arrows pointing to bathroom). • Dress patient in own clothing and keep possessions.	Level 3	Disturbing environmental factors must be addressed. A calm, and familiar, uncluttered, and quiet milieu is always best for most affective approach	Na, R., Yang, J., Yeom, Y., Kim, Y., Byun, S., Kim, K., & Kim, K. (2019). A systematic review and meta-analysis of nonpharmacological interventions for moderate to severe dementia. *Psychiatry Investigation*, *16*(5), 325–335. https://doi.org/10.30773/pi.2019.02.11.2

• Reduce excess stimulation and outings to crowded places. • Use lighting to reduce confusion and restlessness at night. • Use calendars, clocks, labels, and newspapers for time orientation. • Use color-coded or graphic labels (e.g., on closets, table service, drawers) as cues.			
Hallucinations/Delusions • Do not be overly concerned with hallucinations if they	Level 1	Nonpharmacological interventions in combination with a psychoeducational program, when applied first, can reduce the hallucinations in	Scales, K., Zimmerman, S., & Miller, S. (2018). Evidenced-based nonpharmacological practices to address behavioral and psychological symptoms of dementia. *The Gerontologist, 58*(S1), S88-

are not causing patient distress. • Redirect and distract delusional patient. • Answer decisively, then distract.		persons with dementia and caregivers' burden, as well.	S102 doi:10.1093/geront/gnz167
Tasks • Break each task into very simple steps. • Use verbal or tactile prompts for each step. • Provide structured daily routines that are predictable. • Reduce choices and provide a predictable routine. • Use color-coded or		Examples of helping patients with dementia manage tasks.	Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *The Gerontologist*, *58*(suppl_1), S10–S19. https://doi.org/10.1093/geront/gnx122

graphic labels (e.g., on closets, table service, drawers) as cues.			
• Introduce activities that tap into preserved capabilities and previous interests, • Introduce activities involving repetitive motion (washing windows, folding towels, putting coins in container), **Activities** • Set up of the activity and helping patient initiate may be necessary,	Level 3	Exercise and realistic and reachable activities have a positive effect on the management of dementia problem behsviors such as wandering to aggression and agitation	

• Reduce choices and provide a predictable routine. • Ensure tasks are simple so that the patient can complete them. • Explain directions in simple language. • Use distraction and redirection of activities to divert the patient from problematic situations.			
Caregiver Support • Understand that behaviors are not intentional.	Level 3	Alzheimer's caregivers frequently report experiencing high levels of stress. It can be overwhelming to take care of a loved one with Alzheimer's or other dementia, but too much stress can be	American Alzheimer's Association (2022)

• Learn how to relax the rules (e.g., no right or wrong in performing activities/tasks if patient and caregiver are safe). • Understand that with disease progression, patient may have difficulty initiating, sequencing, organizing, and completing tasks without guidance and cueing. • Go along with patient's view of what is true and avoid arguing or trying to		harmful to both of you.	

reason or convince. • Take care of self; find opportunities for respite; practice healthy behaviors and preventive doctor visits. • Identify and draw upon a support network. • Organization should provide ongoing education and support for caregivers.			