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An Educational Program to Enhance Knowledge and Communication for Nursing Staff Who Care for Dementia Patients

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This is to certify that the doctoral study by

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Abstract

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MA, Columbia University 2010

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Dementia is a progressive chronic disease that requires skilled nursing care. Staff at a skilled nursing facility were not using best practices to prevent and manage the psychological and behavioral symptoms of dementia. The purpose of this DNP project was to implement a dementia care education to address this gap in knowledge. The question for the evidence-based educational project was whether the program increased knowledge, promoted positive attitudes, and increased confidence in dementia care staff. A 5-hour workshop was presented in person, twice in two weeks. The person-centered care model served as a framework for the project. Nursing staff ($N = 23$), most ($n = 13$) with 3 to 5 years of experience in health care, completed a survey containing demographic questions and items from the Dementia Knowledge Assessment Tool, Attitudes- Confidence Scale. Results for knowledge improvement showed total scores increased from 67.1% to 79.5% at the first and to 89% in 2 weeks. The analysis for knowledge test using Friedman test was significant, $X^2 = 43.07$, 2 *df*, $p < .001$. Increased frequencies showed improvements in areas of confidence and attitude related to care of dementia patients. Staff indicated less frustration, an important attitude associated with the care of the dementia patient, from 15 on the pretest, to 12 on the posttest and 2 staff members reported frustration on posttest after 2 weeks. Staff also indicated lack of confidence in communication which improved from 16 staff members on the pretest 69.6% to 100%, 23 on the posttest after 2 weeks. The robust educational approach to dementia care may resolve the knowledge deficit and promote positive attitudes among staff involving the care of vulnerable populations such as Alzheimer's and dementia.

An Educational Program to Enhance Knowledge, Practice Confidence for Nursing Staff Who Care for Dementia Patients

by

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Dedication

This project is dedicated to my immediate family and individuals who have inspired me to continue and complete this work with patience, persistence, and a vision for greater possibility.

Acknowledgments

I would like to express my special thanks of gratitude to all my instructors and mentors in my doctoral program, specifically those who contributed to this project. The program provided me with an opportunity to work on issues in dementia care education related to knowledge, confidence, and attitudes while being a dementia care nurse. Being in the program also motivated me to conduct an extensive search for supporting resources on practice recommendations and educational strategies. The knowledge that I gained may inform practice in all fields of nursing and at many levels.

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Section 1: Nature of the Project

Introduction

Dementia is progressive chronic disease that primarily deteriorates individuals' memory, thinking, behavior, and ability to perform daily routines independently. It affects each person differently. In 2017, there were 5.5 million people live with dementia worldwide; this number is estimated to rise to near 139 million by 2050, and it shows that is continuously rising in low- and middle-income countries due to limited resources (Alzheimer's Disease International, 2019). The World Health Organization (WHO, 2021) reported that the dementia rate increases by10 million each year globally, making the disease one of the most significant social and economic health crises of the 21st century. However, preliminary research studies suggest that better health and lifestyle may lead to a decline in the dementia rate in certain areas such as in Western Europe and parts in United States (Satizabal, et la, 2016).

Nurses care for patients diagnosed with dementia in various care settings. This includes acute care in hospitals or short-term rehabilitation and more extensive care in skilled nursing facilities or memory care and home-like environments such as group homes. Dementia impairs cognition and speech, but mainly affects communication starting in the early stages; this makes it difficult for patients to verbalize their needs as the condition progresses, but often remains unrecognized until later stages (Banovic et al., 2018). Dementia patients in later stages need more assistance and reminders for hydration and nutrition due to changes in brain function that impact their senses and overall functioning level for daily living (Meeks et al., 2018).

Because it is difficult for dementia patients to recognize and speak of changes in themselves or their environment, they may react in different ways, such as refusing care, displaying changes in behaviors like agitations, or having delirium (Meeks et al., 2018). Delirium is a severe condition that indicates worsening or sudden changes in an individual's mental state as a person becomes confused or more confused than usual and is often associated with increased mortality (Meeks et al., 2018). Nurses often find it challenging to recognize the underlying causes and manage care when patients have changes in behavior and confusion (Alzheimer Association, 2020). When caregivers get to know the person with dementia, they can identify and accept their ability to understand how to support them and meaningfully engage them in activities. Meeks et al. (2018) recommended that providers evaluate care practices regularly and make appropriate changes.

According to the American Psychology Association (APA, 2015) guidelines, creating and sustaining a dementia-friendly environment necessitates centering patients' individual needs and is contingent upon knowing the unique individual. Health care providers do so by establishing an interpersonal relationship based on the person-centered care (PCC) model and framework (APA, 2015). For nurses and care staff to receive dementia care training, health care organizations and outside experts and specialists need to offer collaborative and transdisciplinary team approaches for dementia care (Galvin et al., 2015). For this Doctor of Nursing Practice (DNP) project, I developed a dementia care education program for a dementia care community at a local facility to increase the nursing staff's knowledge about dementia knowing how changes may impacts the

patients' outcomes. The education is important because dementia care involves managing and preventing sudden changes in patients' behavior by identifying patients' needs. Certain behavioral changes among dementia patients are referred to as psychological and behavioral symptoms of dementia (PBSD), which often shown as aggressive behaviors that can be different among each person with dementia (Cohen-Mansfield et al., 2015). The educational program about dementia was provided to help staff with new understanding to identify the patient's needs, so that they could respond to them appropriately in the event of changes in behavior (see van Manen et al., 2021). In conducting the DNP project, I aimed to develop an educational program that would provide nurses with the knowledge they needed to effectively interact and work with dementia patients. In Section 1, I describe the practice problem and relevance, project purpose and nature, and significance.

Problem Statement

Local Nursing Practice Problem

The local nursing practice problem was the increased occurrence of PBSD among the patients in the 97-bed nursing care facility; 40% or more the facility's patients had dementia. Based on my prior observations, I noticed that most staff were unfamiliar with dementia symptoms, and many considered changes in behavior as an expected part of the disease outcomes. Research recommendations on using Interventions for managing and preventing PBSD include keeping the client engaged with the environment (Meeks et al., 2018). However, staff at this facility were not suspended with the resources on current recommendations and best practices related to preventing and managing these symptoms.

Local Relevance of Addressing This Problem

The relevance of addressing the local practice problem, as shown in recent data, was the increasing rate of hospitalized patients for behavioral reasons. Although facility leaders offered education and skill competencies on their newly hired staff during the orientation process, they provided education that was limited to tasks, with more emphasis on routine and skilled care for older adults without specifics in Alzheimer's disease and dementia. Overall, staff needed knowledge about PBSD as they were not versed in applying effective techniques specifics for dementia patient, and the staff annual competency review did not include dementia education. The increasing influx of older adult admissions with various degrees of cognitive changes continued to challenge the care team.

The lack of a well-designed program to educate staff about the nature of dementia and the value of dementia education led the team to be unprepared, with no competencies required for RNs, LPNs, and CNAs in dementia care, but demand continued to exceed resources. According to research, physical injuries and even trauma at work due to patient experiences of aggressive behavior may be resolved through ongoing dementia specific education for staff to be able to provide care for patients (Clifford et al., 2017). Thus, nurses and care staff could understand the patient's condition, so negative impacts of dementia would either be less or prevented. Yous et al. (2019) noted that certain experiences such as being physically injured or hit when caring for clients with dementia affect health care professionals' confidence and satisfaction with their job and may lead them to contemplate leaving the profession. Improving nursing staff's confidence and

knowledge related to dementia care may therefore has implications for staff members' job satisfaction and retention.

Significance of Project for Nursing Practice

The continuing growth of the older population, many of whom have dementia and dementia-related cognitive and behavior problems, has increased caregiver and nursing responsibilities. Evripidou et al. (2019) reported that leaders and managers in nursing homes had demonstrated a lack of knowledge about caring for older people that corresponded with negative attitudes about this patient population. They addressed the need to establish a solid theoretical framework that acknowledges the needs and individuality of people with dementia to ensure that their needs for their overall quality of life and well-being are met. Nursing education that focuses on dementia and dementia behavior and applying evidence-based practices are key to success in achieving this goal, according to Evripidou et al. (2019). Families rely on formal care facilities as a suitable environment that provides a better quality of life for dementia patients. Important reason for robust nursing education on dementia is that hospitalizations for the older adults in general and specially with dementia patients is not only risky, but it also results in other health risks, especially delirium besides the costs. Delirium is a common complication in hospitalized older adults and can lead to poor outcomes (Fazio et al., 2018).

Purpose

The Gap in Nursing Practice

The gap in practice that this DNP project addressed was nursing staff's lack of knowledge of dementia and care-related issues. In their systemic review of the literature,

Evripidou et al. (2019) identified a significant deficit in knowledge pertaining to the care of dementia patients among nurses. The researchers suggested that these findings were consistent over time. They also noted that lack of continuing education and insufficient organizational support for competency development contributed to ineffective dementia care.

Practice-Focused Question

The guiding practice-focused question for this DNP project was the following: Will the nursing staff education program increase knowledge, promote positive attitudes, and increase confidence in dementia care staff? In conducting this DNP project, I aimed to develop an educational program to increase nurses' knowledge and skills in therapeutic nursing interactions during care with dementia patients. A few staff, including three registered nurses (RNs), five licensed practical nurses (LPNs), and seven certified nurse aides (CNAs) working in the nursing facility that provides skilled nursing care and rehabilitation with close to 50% dementia patients, expressed concerns about reoccurring changes in behaviors among dementia patients.

The gap was the lack of knowledge of dementia and handling related behavioral changes. In response to this gap, I developed an educational program to provide the staff with knowledge about dementia and related behavioral symptoms with ways to manage behavioral changes following evidence-based research. Dementia patients are vulnerable to injuries and falls due to sudden behavioral and cognitive changes in communication (Meeks et al., 2018). The aim of this educational project was to create an easily accessed program that could be delivered both in-person and online as continuing education for

staff. The program included topics in how dementia patients' anxieties and behavioral changes can be managed. This education may enhance staff confidence and attitudes toward working with dementia patients.

The project improved nursing staff members' knowledge and enhanced their communication and interactions with dementia patients. This project illustrates the impact of knowledgeable interactions with dementia patients in professional care settings using numeric data and reliable tools. The educational program focused on recognizing patients' needs and how to manage the anxiety and aggressive behaviors in dementia and further in closing the knowledge gap. The practice-focused question was, Will staff education about dementia and associated behaviors improve the staff knowledge, confidence, and attitude about dementia care?

Nature of the Doctoral Project

The focus of the project was on providing knowledge about best–practice care for an underserved, vulnerable population with dementia and enhancing their quality of life through nursing education related to dementia and dementia care. For this DNP project, I created an evidence-based staff education program (see Appendix A) focused on the impact of improving knowledge about dementia among nursing staff. This doctoral project aligns with the Walden University (2019) *Manual for Staff Education: Doctor of Nursing Practice (DNP) Scholarly Project*.

The key component of this project was my initial analysis of the problem and its relevance to practice. I submitted a proposal and planned for implementation after approval, followed by evaluation of the effectiveness of the project. I formulated the

learning objectives and formative evaluation process using resources from the Dementia Knowledge Assessment Tool Version2 (DKAT2) by Toye et al. (2013), and Dementia Attitude-Confidence Scale (D-CAS) by O'Connor and McFadden (2010). I developed the education program as a workshop using Microsoft PowerPoint presentations for the teaching content. I conducted a pretest-posttest using a dementia knowledge, attitude, and confidence tool kit to evaluate the effectiveness of the program after each educational session. The participating staff (60% or greater) had agency, travel, and per diem experiences in nursing with long-term care, with various degree of formal education but limited to no training in dementia care. Their contracted time to work was limited to 13 weeks. Therefore, the second sessions of the educational program and testing for evaluations were held 2 weeks apart to evaluate and analyze the educational outcomes with the same participants. However, one positive outcome was that most of the participants decided to stay and continue to work for an extended period as permitted.

In the dementia care literature, there is a wide range of information about behavioral and cognitive changes and challenges in dementia care particularly in research involving evaluations and examination of dementia care educational programs in hospital settings (Gkioka et al., 2020). However, information on the experiences of care staff who provide hands-on, direct dementia care is limited, according to my review of the literature. This gap in the literature is concerning because facilities often do not provide such knowledge. This DNP project has the potential to fill this gap.

Significance

Many health care workers and leaders make continuous efforts every day to improve dementia patients' quality of life. However, dementia involves cognitive impairment that places a burden on staff to interact with patients effectively and becomes more difficult without a proper education; Research shows the positive impact of nursing education that is focused on dementia and positive nurse-patient interactions; this education impacts functional ability and quality of life among people with dementia (Bauer et al., 2017). There is solid evidence of positive and direct impact from intervention programs both for the patient and their caregivers, with more substantial evidence of improved communication skills and knowledge on individuals providing care (Nguyen et al., 2018). Stakeholders for this project were three groups of people: patients, nurses, and facility administration. This online workshop aimed to improve knowledge among nursing staff in a dementia care facility.

Contribution to Nursing Practice

The program developed for this project may contribute to the field of nursing practice and education. Administrators may perceive the program as positive and worthy to sustain because the project may bolster staff members' level of awareness and knowledge about dementia-care practices and nurse-patient relationship and care outcomes. In addition, the program also may provide knowledge that can be used to prevent unnecessary hospitalizations and complications related to dementia and to lower costs.

Potential Transferability

This project is potentially transferable to similar practice areas. Nurses in these areas also need knowledge specific to older adult patients with dementia (Bauer et al., 2017). Nurses within various clinical settings that include skilled-nursing and rehabilitations, sub-acute care, and hospitals may benefit from project findings.

Summary

In Section 1, I discussed the importance of dementia education among staff. Communication is part of the physical and social needs of dementia patients due to the debilitating nature of the syndrome and has a sizable impact on patients' health and well-being (Banovic et al., 2018). This section was an overview of the practice problem, barriers, and existing gaps related to the need for dementia education to enhance skills among staff at the therapeutic level to work with dementia patients in special care units. The studies discussed in Section 1 highlighted the problem with communication among dementia patients and the need for staff training to address patients' vulnerability to social isolation and changes in behavior.

In this DNP project, I aimed to offer recommendations and best practices for increasing knowledge about dementia among nursing staff at the local facility. The project may further facility leaders' understanding of the value of dementia care training and help to close the communication gap in the dementia care setting. The people working at, leading, and living in this dementia care facility may benefit from project findings. There may be an overall improvement and lessening of occurrences related to dementia behaviors and associated symptoms, which may benefit patients, families, and

facility staff. In Section 2, I discuss the theoretical framework for the project, the local background and context, and my role in the project.

Section 2: Background and Context

Introduction

Dementia, commonly caused by Alzheimer's disease, refers to the loss of memory, language, problem-solving, and thinking abilities, which are severe enough to interfere with the daily life of a person affected by dementia (Cohen-Mansfield, 2015). WHO (2017) suggested that dementia is one of the significant causes of disability and dependency among older people worldwide, with social, emotional, and psychological impacts on affected people. Because a person's ability to recognize, verbalize, or express their needs is impaired due to the process of dementia, nurses and care staff in dementia care require special skills to recognize and identify the needs of dementia patients (Nguyen et al., 2018). The purpose of this DNP project was to provide nurses with knowledge tools to better understand patients' needs when interacting with them. The practice focus question was, Will staff education programs about dementia care and behavioral changes increase nurses' knowledge, confidence, and attitude towards and about the needs of patients with dementia? I developed a staff education program to achieve the project aims.

Concepts, Theories, and Models

Communication is vital for people with dementia and is necessary to create good interactions between nurses and patients for various reasons. Communication is a face-to-face process of interaction that focuses on advancing the physical and emotional well-being of a patient (American Nurses Association [ANA], 2020). There are three essential elements of face-to-face communication: nonverbal behavior, tone of voice, and words

(Park & Park, 2018). However, nonverbal components of communications account for 90% of effective communication (Park & Park, 2018). In conducting this DNP project, I sought to improve nursing knowledge of dementia behavior and communications to bolster the therapeutic care delivered to dementia patients. The philosophy of PCC was consistent with the project goals.

Person-Centered Care

Person-centered dementia care is a widely used model and framework that is focused on the personhood and needs of individuals with dementia (Wu et al., 2020). Kitwood (1980) initially developed PCC. The model was further developed in various countries (Mitchel, & Agnelli, 2015). I focused on PCC framework a guiding principle for nurse-patient relationships and communication to facilitate a healthy and engaging environment for clients with dementia. The goal of establishing PCC is to provide meaningful connections between caregivers and recipients, the dementia care process, the care outcome, and the organizational structure (Wu et al., 2020). The approaches and conceptualization by Kitwood (1980) focus on preserving the personhood of an individual with dementia and addresses all aspects of changes in a person's body and mind within this process (McCormack & McCance, 2016). Kitwood studied the impact of dementia on individuals and provided evidence that a significant effect on the level of disability and well-being with dementia differs depending on the complexity of the situation and the individuals (Hampson & Morris, 2016). Kitwood's concept of personhood underpins four significant components of person-centered-care in dementia: (a) valuing people with dementia and those who care for them, (b) treating people as

individuals, (c) looking at the world from the perspective of the person with dementia, (d) a positive social environment in which the person is living with the dementia care experience (Wu et al., 2020).

Nursing care within the PCC model aims to foster a positive environment for individuals with dementia and those who care for them and teach what meaningful interactions are between them. The therapeutic relationship established by the nurse and involving an interpersonal exchange helps to identify a patient's needs; the focus is on understanding the perception of others and acting on them (Moreno-Poyato et al., 2021). The PCC model fit the aim of this project to identify the role of nursing and care staff in the dementia care model. Various studies have shown that the PCC model in dementia care improves health outcomes care quality for patients and caregivers' experiences (Wu et al., 2020). Furthermore, according to Santana et al. (2018), the PCC model enhances staff satisfaction when adopted in a practice setting.

I proposed dementia care education based on PCC model and found extensive literature in support to best dementia care practices using this model. McCormack and McCance (2016) proposed a PCC model of care that encompasses the ideas found in the following research review of the current review of the literature. The framework is formulated from prior empirical research regarding PCC practices used in working with older adults and the experience of caring within nursing.

The PCC nursing framework is a relevant tool for the gerontological care settings who are concerned about older adults with dementia. Various researchers have used McCormack and McCance's (2017) framework to promote an increased understanding of

PCC to generate practice-driven information and to identify what barriers and subsequent interventions in practice. McCormack and McCance defined a person in their research as "all those involved in a caring interaction and therefore encompasses patients, clients, families, carers, nursing colleagues, and other members of the multidisciplinary team" (page, 152). A collaborative network ameliorates the negative impacts of individual care management.

Prerequisites and Constructs

The cognitive changes often occurring in a person with dementia not only impact the person's functional and intellectual ability but also their motivation and mood. Although the PCC model may be relatively new, it encompasses a variety of views, theories, and conceptual models (van der Cingel et al., 2016). These include the four constructs highlighted within the framework as prerequisites, care environment, processes, and outcomes. Requirements focus on the attributes of the nurse, such as being professionally competent, developed interpersonal skills, commitment to the job, knowing self, and being able to demonstrate clarity of beliefs and values; The care environment highlights the context in which care is delivered, including systems that facilitate effectively shared decision-making*;* The person-centered process focuses on providing care through a range of activities; Finally, outcomes are the results of effective practices (Santana et al., 2018). The PCC model is premised on the notion that dementia is a condition that impacts each person differently with variations in how individuals respond to dementia. The goal of developing this educational program and content was to provide care staff with better strategies to assist them in identifying patients' needs and

responding to them accordingly. Doing so may allow staff to meet their patients' needs, improve care outcomes, and reduce costs related to hospitalizations and related behavioral changes or complications.

ADDIE Model for Staff Education

An Instructional Design System (IDS) model is used for developing this educational program. The ADDIE model (Analysis, Design, Development, Implementation, and Evaluation) by Jeffery et al. (2016) is utilized to formulate a staff education program. The model is known as a system approach to training (SAT). The Walden university *Staff Education Manual* guides this DNP project, focusing on PCC frameworks and dementia care techniques for target facilities to enhance nursing knowledge in dementia care and client interactions. To evaluate the unit orientation program within analysis phase by Jeffrey et al. (2018) as define and discover approach utilized to answer for why what, who, and how questions:

Why, What, Who, and How

To question why individuals living with dementia were at increased risks of what is known as behavioral and psychological symptoms of BPSD, which were related to improving the difficulty of their communication as the condition progresses from early to late stages. If left without proper intervention, PBSD worsens to an advanced level. The author referred to need as need-driven behavior (NDB), which causes distress both to caregivers and clients while impacting the quality of life among dementia patients, described as apathy, depression, agitation, and irritability; The author describes NDB as dementia-related behavior due to both factors: as patients increased difficulty to

communicate and caregiver's inability to comprehend those needs (Cohen-Mansfield et al., 2015).

The identified person was who would facilitate communication for dementia patients because the condition impairs a person's ability to speak and vocalize needs effectively. Zembrzuski (2019) approaches this as an important responsibility of the clinicians and providers in a direct patient-care environment. Finally, how needs were recognized through the communication techniques include how nurses know what is unique about each person they care for and what is important to them so that they act or intervene accordingly. In addition, in nursing, trust, involvement, and humor in practice are valued in a caring relationship, as emotions and compassion are acknowledged to create mutuality; the goal is to make choices possible for a person with dementia to make a structured environment flexible as restrictions can impact the person emotional well-being (Murphy & Maidens, 2016).

Researchers address environmental factors, which influence the responses of individuals with dementia, and reinforce their worth and feelings as the social persona opposed to social malignancy, which is considered as a way of being incapable with a sense of failure or being socially isolated and stigmatized (Terkelsen et al., 2019). The goal for this DNP project was to improve knowledge about knowing how to manage care with dementia patients as nurses gain a better understanding of patient's needs with the hope of a better clients' quality of life and day-to-day experiences of living with dementia, what is incurable, but can be less complicated.

Relevance to Nursing Practice

Communication in health care is vital. The goal for providing dementia education in health care services was for therapeutic reasons and essential for people with dementia for various reasons; according to the ANA (2020), nurses' job consists of four things: first, to perform physical exams and take health histories to make critical decisions using nursing judgment; second, is to offer counseling, education, and health promotion to patients and their families; third, to provide interventions and give appropriate treatment, and fourth, the nurse is responsible for care coordination by working collaboratively across health care with other health care professionals involved in each patient's care. The nurses' responsibilities are extensive, and a necessary component of them not only are the set of skills to complete tasks but adequate knowledge; One reason is that the progression from pre-clinical Alzheimer's disease to severe dementia is unnoticeable to the affected person causing them problems with memory and symptoms which interfere in daily activities from mild to moderate, and powerful forms of dementia result in physical disabilities (Alzheimer's society, 2021). Second, dementia is known as a process, which means it becomes increasingly difficult for a person to meet the needs and provide for oneself independently due to deficits in communication, physical functioning, and cognitive impairment (Cohen-Mansfield et al., 2015). Patient with Alzheimer's disease or dementia require care with focused on slowing the progression of the process and maintaining functioning and quality of life for affected individuals; These include maintaining physical safety, avoiding hospitalizations, maintaining mental stimulation, and remaining physically active (Fazio et al., 2018). The study recommends clinicians

take special responsibility when conducting an assessment with a good understanding of the affected individuals (Zembrzuski, 2019). The role of the clinical environment has been vital in providing the test of theory to practice in nursing education. Mackay and Basssendowski (2017) have historical perspectives on how evidence-based practice has continued to advance since the 1800s to minimize the theory-to-practice gap through undergraduates and graduate nursing educations and the nursing discipline in general. Thus, clinical environments are considered critical for testing theories in real-life situations. To accomplish this goal in dementia care, theory applications to the practice environment are of the core accomplishments of the project, more specifics in dementia care where clinicians and care staff are involved.

Best practice recommendation experts in Alzheimer's and dementia suggest when working with dementia people, is to consider communication as a critical component of therapeutic interactions to make the person feel empowered and belong regardless of how much they will remember or can do for themselves, which includes ways to

- create a supportive community in a dementia care facility
- know the person and person's reality
- establish meaningful engagement with an authentic caring relationship
- know the fundamental of care practices (Meeks et al., 2018)

Besides other empirical studies using the PCC model, McCormack and McCance (2016) offer an excellent logical presentation that fits the framework of nursing communication showing practical approaches in the dementia care environment to guide professionals. Research shows how communication difficulty as a barrier can worsen

behavioral and psychological symptoms of dementia (BPSD), creating disturbed perception, thoughts, mood, emotions, feelings, or actions, which means ways of communicating an unmet need; BPSD affects up to 90% of people who have dementia and is associated with poor outcomes such as distress for patients and families, long-term hospitalization, misuse of medications, and increased health care costs (Cohen-Mansfield et al., 2015).

Researchers suggest NDB are patterns of behaviors unique in everyone with dementia as verbal or specific expressions to make their needs known. Still, it becomes challenging for people around them and is often mistaken as a problem that requires medical interventions or hospitalizations. The author defines the associated behavioral and psychological symptoms with dementia as BPSD and explains how the unmet needs of a person with dementia can worsen to another form of behavioral symptoms called need-driven behavior (NDB); Cohen-Mansfield explains how symptoms originate from various possible physical, mental, social, and psychological distress that influences behavior among individuals with dementia.

Other researchers describe dementia as an umbrella term for several complex illnesses characterized by declining in cognition, emotional control, and social behavior; they suggest that overall symptoms of dementia may be due to a lack of physical and mental comfort, social contact, and desirable atmosphere, which can both drive from dementia-related impairments, and environmental factors (Terkelsen et al., 2020). The critical aspects of understanding unmet needs are assessing the type, associated behavior, and possible intervention to compensate for challenges associated with managing

problem behavior when working in dementia care settings. McCormick and McCance (2016) argued that dementia-associated symptoms and behaviors are related to the complexity of the situation and personhood; new approaches applicable to nursing for person and environment are towards healing by making connections to people and communities, focusing on individuals and how each one is impacted

Researchers address communication problems as a critical issue in dementia that impacts patients and their caregivers as contributing factors to the development and worsening of BSPD. Tible et al. (2017) defined BSPD as complex and multifactorial, divided into two factors: (a) patient factors as unmet needs, pain, acute illness, types and stages of dementia, brain changes, genetics, personality, and life history, (b) environmental factors, know the condition, caregiver distress, over and under-stimulation, lack of routine caring, quality/quantity, caregiver's knowledge, the infrastructure of care facility, and life events.

There is increasing attention on improving the quality of life in dementia care because understanding what a person with dementia says can be challenging, even unsafe, by missing out on a person's needs. However, strategies based on understanding dementia and communication itself may help professionals provide positive care (Murphy & Maidens, 2016). This means supportive care that is acceptable to clients is therapeutic.

The Role of Communication in Dementia and Alzheimer's Care

To teach how to best communicate and understand the need of dementia patients, the use of available literature was one method that was used for this project. It provided guideline information on communication needs and problems with the most up-to-date

information related to dementia care practices. Systemic review studies on dementia care communities indicate that knowledgeable skills and strategies would enhance nurse-patient relationships and care engagement. Because dementia condition is often the barrier to effective communication for patients, nurses benefit from special knowledge to up their skills when interacting for most therapeutic ways to understand the need of patients even when cognition or language is affected by dementia (Alzheimer's Association, 2019). Literature supports that these changes affect people with dementia so that patients rely on other means of communication, such as nonverbal and behavioral messages. For example, when dementia patients scream, it means pain more than anger, but it may also indicate dissatisfaction with the care being provided. However, nursing staff can play an essential role in interpreting these messages, and evidence suggests that successful communication largely depends on nurses' ability to adapt to the capabilities and needs of their clients with dementia (van Manen et al., 2021). Research suggests education can help nurses and other dementia care staff to experience and perceive less emotional and physical challenges; proper support and training for staff caring for people show a considerable number of positive results, including developing empathy and sharing knowledge and experiences, and a new appreciation by attending the workshop outside of their workplace (Windle et al., 2019). Other studies showed increased team self-rated health, work satisfaction, and sense of confidence with new knowledge when around dementia patients (Surr et al., 2017). The education programs were guided based on the PCC framework.

Effective communication is one of the critical aspects of patient care that improves the nurse-patient relationship with a profound effect on treatment outcome, and lack of communication skills (or not using them) harms services provided for the patients; practical communication skills among health care professionals are vital to adequate health care provision, and often result in positive outcomes including decreased anxiety, guilt, pain, and disease symptoms (Norouzinia et al., 2016). Difficulties with language are a common symptom among dementia patients. Banovic et al. (2018) studied how the communication difficulties as the consequences of nerve cell failure among dementia patients showing a decline in verbal expressions, using repetition, reading, and writing difficulties, and lessening their ability to understand. In research, no single method is recommended when communicating with dementia patients for various forms of dementia impact individuals differently. However, adapting is learning how each client expresses themself because it significantly impacts care outcomes; learning about the dementia process and associated behaviors helps communication (Banovic et al., 2018).

ANA (2020) recommends several therapeutic techniques for interactions with dementia patients to help keep them in a more positive state of mind. They include accepting and acknowledging patients' words and behaviors by using silence, recognizing, and listening actively to encourage patient engagement in conversations and activities. In other words, it is best to offer hope and humor when a patient experiences stressful places or events, and any confrontations must be avoided to help patients unless there is an established trust (ANA, 2020). However, to become skillful in therapeutic communications for dementia care, it is essential for to have a positive attitude and

become knowledgeable about the stages of dementia and differences in communication patterns among affected individuals to assist them better with care while understanding their needs (Meeks et al., 2018). Thus, when caring for dementia patients, knowledge in various aspects of care is valuable beyond learning about cognitive changes.

Dementia Care and Communication Goals in Different Stages

Dementia is a disorder in which all decisions need to be considered within the progression of the disease, the aims and preferences, and the potential alternatives to achieve them. Jennings et al. (2018) discuss stages of dementia with the approach of emphasizing the significance of sustaining individuals' well-being through physical functioning and engaging in meaningful activities; as the disease progresses, older adults prefer and plan to live at home, but caregivers are often concerned about client's safety, economic challenges, and autonomy of their loved ones to make decisions with growing concerns over fraud and financial abuse (Jennings et al., 2018). The authors' recommendations include assessing services and support over legal affairs and managing stress due to responsibilities poses as other issues when caring for individuals with dementia. Overall, it solidifies goals that people with dementia and their caregivers establish expectations and methods on attainment, which is early identification of needs by professionals and application of patient-centered care.

Early-Stage Dementia

In early-stage dementia, appropriate communication skills are specifically used depending on the stages of dementia as severity varies at the level of cognitive impairment; The identified needs focus on the individual's needs for activities and

instrumentals in daily living. Early-stage dementia is usually marked by mild to moderate memory loss, specifically the inability to recall recent events; the client often forgets any new information, misplaces items, needs more notes to remember tasks, or has other sudden behavior changes (Meeks et al., 2018).

The goal is safety, and the need is to assess any immediate risk for a person with dementia to perform tasks alone (Jennings et al., 2018). If no risk involving injury or harm exists, it is best to provide encouragement and continue to provide supervision as necessary (Alzheimer's Association, 2019). The need for observation with patience and good body language is vital as older adults with early-stage dementia may easily forget new information, repeat themselves, or ask the same question repeatedly; In addition, poor hearing and eyesight unrelated to dementia are expected, which makes it harder for them to communicate because not only missing conversation, but non-verbal communication is even more difficult if clients experience pain, illness, or medication side effects similar to clients without dementia (Zembrzuski, 2019).

Observing client changes in sleepiness, increased confusion, dizziness, or change in symptoms and other habits requires communication with other team members and decisions making, even communicating with a family member about what's been observed and noticed (Feast et al., 2016). The need for prompting in a person with early-stage dementia is to main activities of daily living such as eating, bathing, and dressing; the individual with dementia may also need help with daily instrumental activity at a more independent level (Meeks et al., 2018).

At an early stage, the care staff must use communication tactics needed to help the client maintain independence when possible; the best practice recommendation for direct care staff before aiding and giving directions to a patient is to ask clients what they need help with and provide them with time to accomplish the task at their own pace as rushing can increase confusion and frustration (Meeks et al., 2018). Educating staff in the direct care environment in contacting dementia patients about using the specific tactics to communicate to help communicate with clients more effectively (Nguyen et al., 2018).

Effective communication strategies include using simple steps, avoiding giving multiple directions at once, and using the positive statement instead of the negatives. It is also essential and therapeutic when communicating in a low-stress environment as memory loss can lead to overwhelmed feelings, which can complicate communication; sharing in a low-stress environment means eliminating distracting sounds such as television, ensuring adequate lighting, and speaking one at a time instead of all at once; include the client in conversation as ignoring the client can lead to feelings of isolation and depression; specifically including the client in conversation while speaking directly to them facilitates supportive and engaging exchange (ANA, 2020).

Middle–Stage Dementia

In middle-stage dementia, severe memory loss is more powerful, where some distant memory is still retained, but new material is quickly forgotten; this stage is typically the longest and lasts for several years; in middle-stage dementia, make it difficult to express thoughts, than perform routine tasks, and a person may be noticed jumbling words, having trouble dressing, or refusing to bathe; There may be personality

changes like becoming frustrated, angry, or acting out unexpectedly (Alzheimer's Association, 2019)

Staff, providers, nursing, and direct caregivers need to be familiar with the condition of each dementia patient, and care staff are encouraged to familiarize themselves with the symptoms as part of being prepared for challenges (Heerema & Apetauerova, 2019). It is important to use a low tone with patience and use a calm voice; the client may ask questions repeatedly but react with patience; a quiet voice assures the client instead of asking multiple and repeated questions; it may not help by answering their questions themselves. Providing relief helps as the client's conversation can involve more emotions behind the question requiring reassurance and support; provide written reminders if a client can read and help the patient handle some tasks independently (Alzheimer's society 2021).

In the middle stage, dementia demands flexibility and patience as the ability to function independently becomes more difficult; caregivers take on greater responsibility as daily routines need to be adapted, and structure becomes more critical (Meeks et al., 2018). Nursing intervention includes identifying the communication changes in behavior and abilities. It is essential to communicate the changes with a supervisor or decision-making family member as the provider visit may be needed to rule out the medication's illness or side effects (van Manen et al., 2021).

Late-Stage Dementia

Late-stage dementia involves severe memory loss where the only fragment of memory remains; the client may lose the ability to speak, walk, and hear; this stage

usually lasts a few years and end in older adult eventual death; the client's needs with late-stage dementia will change, and become more intense, and demanding as the client may have trouble eating, swallowing, walking, or difficulties together; the need for assistance with personal grooming and care increases, and clients become more prone to infection, particularly pneumonia
(Meeks et al., 2018).

The goal is to maintain dignity and quality of life; although the person with late-stage dementia will lose the ability to communicate, some essence of the person remains intact, and we can connect with them; with the absence of speech, there is more dependent on the other senses to interact with people in the world, and care can be provided through touch, sound, sight, taste, and smell; cooking the client's favorite meal, playing the music they love, reading from books, or magazines they enjoy or view family photo albums with them. In late-stage dementia, the person becomes nonverbal as the loss of brain cells impacts the speaking part of the brain. There is an increase in repetitive behavior and depression and anxiety (Meeks et al., 2018). Approach the person from the front and identify self to prevent irritability. Sleep changes can occur, showing the client being awake at night and sleeping throughout the day, requiring full assistance with activities of daily living (Meeks et al., 2018).

Use empathy and patience as this stage requires a greater understanding of the emotion behind words or sounds as clues to what older adults may be trying to communicate and mindfulness with the way words are spoken than actual statements regardless of the client's ability to speak and respond caregivers are encouraged to talk

with clients and talked to them about family friends and topics or activities that clients used to enjoy (Wanko Keutchafo et al, 2020). Empathy is one of the primary skills for good communication, where the nurse can convey understanding to the patient on a deeper and more personal level; it is therapeutic to help in establishing a trusting nurse-patient relationship, which includes non–verbal communication such as positive facial expressions, eye contact, touch as signs of respect and affection towards older adults (Wanko Keutchafo et al., 2020)

Acknowledge communication barriers and maintain eye contact at a high level and approaching at a high level or lower is preferred as standing above the client can make them feel threatened; reduce distractions by speaking calm voice, slowly, in a friendly tone; use patience in empathy and avoiding arguments is important by moving conversation around the issue. When the client is speaking incorrectly, to eliminate contradictions, provide simple directions one step at a time, and use yes or no questions when possible as the client needs more assistance with the activity of daily living, both have a basic and instrumental level such as: selecting and choosing proper clothing for the season and remembering the basic activities like bathing and eating (Dementia Care Central [DCC], 2020). Communication difficulties can cause a client to refuse, withdraw, and feelings of depression; to avoid a sense of exclusion and isolation, actively engage the client in a one-to-one conversation, and it is best to be flexible, patient, and supportive when the client tries to communicate (DCC, 2020).

Nursing Implications

Person-Centered Care training is essential for health care assistants who provide care for people with dementia. Through research studies, care responsibilities described in geriatrics to explore if health care assistants received education related to working with people with dementia will prepare them with essential skills to follow and conduct PCC. To gain a broader scope of practice, researchers focused on specific barriers such as challenges in providing PCC, communicating with staff and their families, and the relationship between these skills and their training and found a comprehensive understanding of the methods and attitudes toward dementia care that promotes realistic goals for the future (Fazio et al., 2018).

A study by McKeown et al. (2015) shows how life story works: understood, developed in practice, experienced by all participants, and affects the delivery and outcome of care; nurses caring for people with dementia exercise tools at their disposal and often health care providers enact PCC and do not recognize it with no desire to use it, but are unsure how to implement the practice. McKeown et al. (2015) state that a life story works as a dynamic approach to care by engaging the person with dementia through artifacts and detailed information about their life. Therefore, life story work is one method that can invigorate PCC.

The above literature review analyzes PCC as a holistic alternative to the medical model and standard care practices. Each category complemented the other by highlighting perceptions concerning individuals with dementia and its implications within the gerontological community. Dementia care goals and nursing implications synthesized

current knowledge and practice gap. Thus, depending on how the person is being valued or depersonalized, personhood produces relationships with others that can be nurtured or diminished. PCC can be learned using education and staff support.

Local Background and Context

Nurses as direct care staff work closely with dementia patients and are expected to know how to perform routine tasks to meet patients' physical and intellectual needs. However, the identified problem that challenged the team was unrelated to hands-on skills and more about dementia patients developing resistance to care. It often challenged staff to complete their task on time and smoothly with fear of patient aggression or anxiety. In particular care units, individuals with dementia showed various cognition and communication impairments that would limit them from expressing or verbalizing their needs. Based on PCC dementia care recommendations, staff knowing the clients enhances clients' individuality and ease in care being provided. However, staff showed no interest in these concepts and perceived dementia as unfavorable with lessening hope to practice in the clinical environment. More than 50% of the residents had mild to moderate cognitive challenges with minimal ability to have conversations with caregivers or remember them. While caring for dementia patients in various stages, staff described their difficulties dealing with refusals, and non-cooperativeness with care among older adult clients due to the impacts of cognitive impairments and dementia clients who mostly displayed anxiety and agitation, also delaying task completion with much resistance.

After attending several meetings with the people in charge of care processes, we discussed the benefits of developing and implementing a staff education program for the nurses. The administration was familiarized with knowledge tools and the PCC framework. The program was to help staff not only understand patients' needs and respond to them accordingly but experience less caregiving resistance while in a friendlier work environment. The facility is located within the community in the Northeast region. The facility consists of geriatric care units and provides skilled nursing for long-term care and short stay of older adult clients who also have dementia. Care staff had diverse work experiences, including part-time and per diem RNs, LPNs, CNAs, an on-site nurse practitioner. There were number of social workers and physical and occupational therapists as well as few other private practice providers of patients who were part of facility staff. However, non-nursing staff were not included in the dementia care education program.

Administration on-site described the staffing concern as a common challenge in practice due to shortage, leading to staff deficiencies in completing tasks. The problem was addressed as aggressive behavior and agitations of patients that refused care. Lack of adequate documentations was reported as another problem. However, the staff did not have much knowledge in describing behavioral changes and related symptoms of dementia patients to address in proper documentation. Besides the existing knowledge gap about dementia, many staff understood the syndrome as a clinically stable but severe cognitive impairment with progressive decline as an illness that only showed confusion and disorientations. The national Alzheimer project Act, NAPA, has created a significant

opportunity to build upon and leverage Health and Human Services (HHS) programs and other federal efforts to help change the trajectory of Alzheimer's disease and related dementias (U.S. department of health and human services, 2021). The Advisory Council has made recommendations to HHS for priority actions to expand, coordinate and condense programs to improve the health and outcomes of people with AD/ADRD to reduce the burden of these conditions on those with the disease, their families, and their caregivers in the society (NAPA, 2021).

Definitions

Behavioral and Psychiatric Symptoms of Dementia (*BPSD*): Barbosa et al. (2015) describe the symptoms as agitation and wondering, which can develop at least once among almost 90% of people with dementia; BPSD symptoms are often distressing for caregivers, and the main causes of stress, burnout, and job dissatisfaction among direct patient care staff; however, Kitwood (1998) argued that BPSD were not just the result of changes in the brain but a consequence of complex interactions between neuropathology and the person's psychological environment; based on Kitwood's conceptualization, many of the difficulties experienced by dementia patients are instead the results of threats to one's personhood than of the disease itself.

Dementia: Dementia is a syndrome (a group of symptoms) that has many causes. The symptoms are characterized as difficulty with memory, language, problem-solving, and other cognitive skills that affect a person's ability to perform everyday activities; Alzheimer's is the most common cause of dementia; other causes of dementia result from

various diseases and injuries that primarily or secondarily affect the brain (Alzheimer's Association, 2019).

Dementia Confidence and Attitude Scale (*D-CAS*): The tool consists of 20 questions developed by O'Connor and McFadden (2010) to measure attitudes of college students, direct care workers, and professional carers towards dementia. Questions have been used in different methods in various research studies for the same purpose. I selected six questions from the scale for this project. The self-reported questionnaire for confidence is seven items as part of D-CAS tool, which includes nine questions for measuring confidence or self-efficacy in provision of caring for people with dementia and is developed by researchers for dementia care studies (Gkioka et al., 2020). Appendix B contains the project survey questionnaire.

Dementia Knowledge Assessment Tool Version 2 (*DKAT2*): This assessment tool was developed to support formal caregivers of people with dementia, such as immediate families and the older staff population. DKAT2 is dementia specific knowledge questionnaire with 21 items and scoring criteria developed by experts in the field (Gkioka et al., 2020). DKAT2 tool is developed to support and build nursing knowledge and to evaluate outcomes of nursing knowledge related to dementia and understanding of dementia care.

Person-centered care model (*PCC*). PCC is one of the globally recognized theoretical frameworks used in a dementia care environment with the increasing focus on individuals with illness and recognition of their strengths and needs; Carl Rogers initiated the change to the traditional care model with more emphasis on the person and less on the

care task; the approach was an evolution from the medical model and further developed by Kitwood (1988) for people with dementia; Kitwood termed the negative social interactions as malignant social psychology due to clients limited ability to communicate **(**Barbosa et al., 2015).

Role of the DNP Student

My role as a DNP student was the initial steps to identify the problem related to practice, inquire about research, and review the best available evidence. My role as an interprofessional collaborator was to communicate what evidence suggests and how to translate that into practice. The American Association of Colleges of Nursing (2010) stated eight essentials of doctoral education for advanced nursing practice, which describes my academic role into what a doctorly prepared nurse should fulfill: The clinical scholarship and analytical methods for evidence-based practice**.** Scholarly and research are the hallmark of doctoral education (American Association of Colleges of Nursing, 2006). My initial activities as a scholar were basic search and ensuring the best available research evidence that is current and up to date with practice. Extensive research in the literature review is needed to study the communication problem in dementia care settings from various angles besides the research points of view. The role expanded my understanding to a new level in that this subject had the potential to remain open to further discussions and questions in various care settings that involve bedside nursing and leadership at the administrative level. My role as a nurse educator with a background in adult education and successful fulfillments in master's degree programs in academic and clinical settings have prepared me to incorporate findings from best

practices and utilize them in an educational context to develop a program. I created the program based on the program objectives, so after the completion of the program, the learners were able to

- provide a general description of dementia and Alzheimer's
- explain a current epidemic and overall population
- explain how communication differs for a person with dementia
- provide a brief description of patient needs in nursing interventions

My role as an educator was to identify the problem encountered by the majority and perceived as an issue in a clinical setting and search for current best evidence. Then, I used the evidence and studies to respond to practice-focused questions before conducting the final evaluation after the implementation. My long-term goal is to implement these dementia-focused research tools in broader practice to expand nursing knowledge about managing and communicating with dementia patients with cognitive impairments.

My clinical role in dementia care nursing was to present the program to stakeholders and evaluate the pretest and post-test results. The selected survey questions focused on knowledge, confidence, and attitude toward dementia care among staff used as statistical tools to measure and compare their main differences. The immediate goal was to evaluate the knowledge level using self-reported survey results. The goal in the clinical setting was to assess and use appropriate nurse-patient interactions used in the patient care environment and sustain it. My role was to create an education-oriented climate by helping staff with new clinical perspectives. My professional relationship at

the project site was not associated with practicum. They become more aware of patient experiences with changes to continue to seek further practice improvements.

Summary

Section 2 was an overview of the concepts and models related to the importance of dementia care knowledge and educational need for nursing and care staff in the project and systemic analysis application using the ADDIE model. The latest evidence and recommendations in using dementia care education were strategies for staff knowledge and training to lessen the dementia symptoms and delay the rapid decline and progression of symptoms. For this DNP project, focusing on Alzheimer's dementia was important because as the most form of the chronic condition among older adults, known as irreversible that, can be a progressive decline in mental and social function, it also counts for more than two-thirds of the dementia population (Alzheimer's Association, 2019). Nurses and care staff require exceptional communication skills to perceive, report, and intervene when caring for these individuals. Everyone is affected by dementia differently, but memory loss, impairment in judgment, and thinking with minor orientation increase over time. The PCC model of care and recommendations by the Alzheimer's Association for dementia care communication strategies provided a comprehensive view of the appropriate care practices for individuals with dementia utilized for educational context in this project. The project and the theoretical framework are relevant to nursing practice as each focus on patients as individuals and the environment. Both are components of nursing philosophy that guided this project, align with the staff education manual, and are essential of doctoral education for advanced nursing practice. PCC principles in a non-

medical model address dementia as a syndrome and process more than a disease. Recommendations are skillful communication for adequate social support to promote healthier living and better quality of life. For designing this teaching program, I focused on recommended strategy guided by the Walden University staff education manual and available resources to initiate system/problem analysis, research, evaluate, coordinate, and communicate my findings before the implementations. I used my data and evidence obtained from literature to illustrate the data collection, explain the analysis of proof with a practice-focused question, and discuss resources with analysis and synthesis in the next section.

Section 3: Collection and Analysis of Evidence

Introduction

Older adults with dementia require specialized care. This is because people with dementia are at higher risk for delirium, falls, rapid functional decline leading to the increased hospital stay, and other prolonged complications (Fazio et al., 2020). Specialized care is necessary to maintain quality of life, enhance cognition and mood, and foster a safe environment (Fazio et al., 2020). The estimated global cost of care for Alzheimer's disease in 2020 was $305 billion and is expected to increase by 2050 (Wong, 2020). Dementia patients are particularly vulnerable to safety issues and problems related to their inability to speak their needs (Zembrzuski, 2019). A communication gap among dementia patients is an environmental factor that may impact the patient outcome. It may further contribute to a decline in the function and quality of life of dementia patients, worsening of their behavioral symptoms, misuse of medications, increased hospitalizations, and increased cost (Feast et al, 2016). Thus, a lack of knowledge about dimension among the care team may contribute to poor communication with patients, which may negatively affect patients, staff, and the health care organization.

The practice site for this DNP staff education project was a 97-bed long-term care facility with dementia patients in various units. The facility is in the Northeast U.S. region. The facility continued to encounter higher influx of patients with dementia. One of the modifications that leaders made was designating a separate unit for dementia care to facilitate better care quality and prevent complications triggered by changes in behavior among dementia patients. The purpose of the staff education program was to

address staff's lack of knowledge by providing education in dementia-related symptoms, complications, and associated changes in behaviors. With this knowledge, staff may be able to identify and manage problems without agitations and experiences of aggressive behaviors.

Practice-Focused Question

The Northern region of the United States has a large population of older adults with dementia who need continuous care within formal care settings; there are skilled nursing facilities with dementia patients accounting for more than 60% of the entire patient population (Population Reference Bureau, 2020). However, caring for dementia patients requires a higher level of communication than routine skilled nursing care. The practice problem was the gap in knowledge among nursing staff about evidence-based dementia care and prevention strategies for patient agitation. The guiding practice-focused question for this DNP project was, Would the nursing staff education program increase knowledge, promote positive attitudes, and increase confidence in dementia care staff? I surmised that if the nursing staff education program employed the DKAT2 tool kit, they would have changes in knowledge, attitude, and confidence at significant values.

Sources of Evidence

As the population aged 65 and older continues to grow in the United States, caring for these residents in the long term becomes more demanding. Most of the population in long-term care settings requires assistance; however, dementia residents have many challenges to understanding and accepting the living activities needed for self-

care (Meeks et al., 2018). In most cases, residents become agitated and aggressive when staff are unable to identify their needs and related behavior (Fazio et al., 2020).

Published Outcomes and Research

The research evidence obtained for this project included research studies focusing on dementia care for dementia patients in institutions or other formal care settings and therapeutic interactions and communications between nursing staff and dementia patients. To find evidence, I conducted initial keyword searches using the terms *dementia*, *communication*, *conversation*, and *caregiver distress*. Database searches included CINAHL, Medline, APA PsycInfo, ScienceDirect, Academic Search Complete, SocIndex, ProQuest Nursing & Allied Health Database, and the Cochrane Database of Systematic Reviews. To support the relevancy of this project and in support of best practices, literature was limited to within the last 5 years. Inclusion criteria were added for systematic reviews and full-text peer-reviewed articles in English. I also searched the websites of the *Journal of the Alzheimer's Association*, *Journal of Dementia Care*, *International Journal of Nursing Studies*, and National Institutes of Health.

Advance search terms included *memory care*, *work injury prevalence in dementia care*, *dementia caregiver*, *nursing education*, *communication skills*, *neuropsychiatric symptoms of dementia*, *responsive behavior in dementia*, *managing dementia with aggressive behavior*, and *quality of life of dementia patients and caregivers.* Exclusion criteria included articles from conference abstracts and training programs for family caregivers or patients with dementia. Search results obtained for the past 5 years included over 65 abstracts. I reviewed all abstracts if they met the following criteria: mixed

methods, meta-analysis with qualitative-quantitative designs, original research, peer-reviewed articles, systemic reviews, and evidence-based practice guidelines.

After reviewing the resources, I excluded 29 articles. I selected a total of 36 that met the inclusion criteria. They included correlational and descriptive studies; cross-sectional surveys; experimental and nonexperimental randomized control trials; cohort studies; systematic reviews; and meta-analyses. I included a few in the literature review. The primary sources for this project addressed communication and education in health care. The online course review consisted of 22 modules by the Alzheimer's Association and principles of the PCC model of the online virtual education program. I also used the ADDIE model to guide the development of this educational program.

Evidence Generated for the Doctoral Project

I collected data from 23 of the 47 employed nurses within the facility who attended the program. The care staff worked with adults with dementia in the skilled nursing facility in various units. It was essential for nurses and other care teams to understand the special needs of patients with dementia as a communication gap existed between patients and care staff. I developed a nursing education program to address and close the practice education gap. The question I sought to answer was whether the dementia care education program would impact nursing knowledge at any level. The data were descriptive and came from a self-reported questionnaire.

The aim of this project was to provide an educational program for staff working with dementia patients that would improve staff members' knowledge, attitude, and confidence regarding care of dementia patients. The educational program was available to

all staff who worked full-time within the skilled nursing facility units that had dementia patients. Close to 50% of the patient population had some degree of dementia at the time of the project.

Participants

The participants included 23 nurse practitioners, RNs, LPNs, and CNAs who worked with dementia patients at a nursing facility in the Northeast U.S. region. I invited all the nursing staff employed in this site to participate. Not all participants were involved in direct patient care, but they had various roles that required them to interact with patients and worked at least one shift per month in the facility. Participation was voluntary. Age, gender, educational level, number of years in practice, spoken languages were not factors in recruitment process to participate in the program.

Procedures

The program was provided in class workshop and two time in five-hours sessions including 10 minutes break and repeated in two weeks with same participants. Opportunity with tools for dementia knowledge to use for assessment provided and attendance was awarded with paid educational hours, and a certification of completions. Up to 13 participants could attend each session according to the room size and occupancy restrictions comply with pandemic rules. Before and after the conclusion of the first program, participants were completed the set of numbered- color-coded survey questionnaires on demographics, dementia knowledge assessment (DKAT2) and attitude-confidence surveys. The same set of questionnaires were completed at 2 weeks after the completion of 5-hour session with same participants. The data lacked normality in

distribution and did not meet the assumptions for the parametric repeated measure in testing. Thus, the equivalent non-parametric Friedman test was used to measure the program significance and compare the difference in the means of each group of data.

Recruitment for participants took place days before the dissemination of the pretest. Starting one week prior to the initial survey at the facility, a flyer was posted in the staff break room with program information. The information included the purpose of the project, time, location, and the way that was provided. Initially 43 staff signed up to participate in the program including social workers, patient observers, physical/ occupational therapists, who worked directly with dementia patients, but education program inclusion was only for nursing staff, and then the group size was modified to 23 participants who completed the surveys three times at pretest, posttest and at repeated workshop for second posttest in the two weeks follow up. The participating individuals who worked permanently or contracted for any given time at this site had receive an online invitation to the program via email. The email consisted of a link to the handouts and power point slides, but pretest posttests distributed only on-site. An anonymous consent was provided. To encourage staff attendance, the plan was to provide 5 contact hours using the standard continuing nursing education formula of 60 minutes per 1 contact hour, which included a 10-minute break time (see Appendix A for an overview of the curriculum). Participants were also eligible for a paid education hour to attend the program during their off-work hours.

To provide the learners with nursing continuing professional development contact hours, a planning committee needed to gather at the site, which included the stakeholders:

nurse managers and nurse educators. My role for managing the program content was to create the program objectives, present the content, facilitate active engagement strategies and evaluation methods. A slight revision made to make the program presentations simplified and testing applicable for novice learners, and to avoid potential bias as many participants had limited to no college educations.

The program included the presentation of power point slides, learning activities, case scenarios, speaker notes, and review of handouts by participants. At the end of the education program, the nursing staff was able to

- Discuss dementia care-related encountered in the unit specific work environment,
- Discuss behavioral and physical manifestations of behavioral and psychological symptoms of dementia,
- Discuss how patient outcome may be impacted through nursing interventions and responses to the patients' needs,
- Identify evidence–based strategies to employ managing dementia-related behavioral changes and agitations.

The 5-hour session programs consisted of five sessions. Session 1 was the introduction of the program, and the objectives focused on dementia care and how it differed with other patients in a skilled nursing facility. Session 2 includes definitions of terms in addition to managing or preventing behavioral changes or problems. The assessment tool and brief review of non-pharmacological interventions were included. The third session focused on communication and behavioral challenges that are often

encountered among dementia patients and suggested strategies to manage or instead handle behavioral challenges. In Session 3, participants learned how dementia impacts communication, showing common problem behaviors with successful interventions. In Session 4, participants reviewed best clinical practices regarding safety, rationales to avoid psychotropic medications, restrains, and why encouraged various actives from assistance with daily living to self-care. The program concluded with Session 5, in which the participants and presenter discussed the importance of early care planning and how to identify and care for dementia patients with a high risk for poor outcomes, safety and ethical concerns surrounding care, as well as multi-disciplinary approaches to care that can involve family members, appropriate provider referral, and resources to provide support caregivers including Alzheimer's Association. (see also the curriculum in Appendix A).

Instruments

The participants in the program filled out pre, and posttest questionnaires with a selected identifier (numbers) that was only known to them. Same set of questions were used three time except color coded differently as pink for pretest with orange for posttest, and green for second posttest in two weeks follow up with color stickers for separate sets. The questionnaires included the 21-item dementia knowledge assessment tool (DKAT2), demographic data in addition to 6 and 7 items selected from 20 item dementia attitude and confidence scale as partial selections for usability and applicability in the field after content review and agreements by stakeholders. For the knowledge scale, the tool measures answers to questions as "yes", "no" or "don't know". Questions were scored

with 1 point for each correct answer; no points were given for both “no” as incorrect or “don’t know” answers. Thus, the total scoring results ranged from the lowest possible score of zero to the highest possible score of 21 counted as 100% for knowledge test. Reverse scoring done as 1 given for ‘no’ answer and 0 for ‘yes’ answer on eight questions on DKAT2 and two questions on D-CAS:

- Confusion in older person almost always due to dementia.
- Only older adult develop dementia.
- Knowledge likely causes of dementia helps to predict its progression.
- Incontinent always occurs in early stages of dementia.
- Sudden increases in confusion are characteristic of dementia.
- Changing environment makes no difference to a person who has dementia.
- It is important to always correct a person who has dementia when confused.
- Impossible to tell if a person in late stage of dementia is in pain

The scoring and measurement for attitude and confidence questions, using frequency chart was appropriate because tools employed partially to ensure that questions were fit and applicable in the field. Challenging clinical issues such as difficulties in working with dementia patients and difficult work of dementia care were helpful in identifying educational needs for current and future improvement projects at the site. The area of improvement for confidence includes assessing and recognizing dementia, managing agitation, and communicating with patients. The scales include six and seven item questions about dementia and care related issues. For questions and scoring in attitude and confidence, participants had to complete the survey questions scored as

"yes", "no" or "I don't know" answers. "Yes" answers were given score of 1; all other answers were scored as 0. Scores were summed to measure frequencies of positive and negative answers ranging from low score of 0 to high score of 23 (100%). The findings for the question on attitude and confidence scale displayed in Tables 2 and 3. Reverse scoring for the following two questions:

- I feel frustrated because I do not know how to help people with Alzheimer disease and related dementia.
- I am not very familiar with Alzheimer's disease and related dementia (ADRD).

To ensure the accuracy and consistency of the instrument being used, various studies that supported the validity and reliability of the tool were reviewed and used as reference, which shown consistent results with repeated measures. This includes studies by Gkioka et al. (2020). The study includes the highlight and the findings as high internal reliability for dementia confidence scale, adequate reliability for dementia attitude scale, and acceptable reliability for dementia for DKAT version 2 as dementia knowledge assessment tool.

Surr et al. (2017) raise a new concern about realistic connection of theory to practice with the effectiveness of knowledge transfer developed within educational settings specifically to the workplace. While it was important to encourage participants with active engagement, I assigned them in discussion groups to share their interesting experiences such as using case scenarios to relate that to their knowledge. Kirkpatrick (2016) refers to active engagement by using what participants are actively involved in as

what is relevance, which contribute to their learning experiences; Kirkpatrick describes relevance as an ultimate training value for the degree that attending participants will have everyday application to their everyday work otherwise training is the waste of resources (Kirkpatrick, 2016). For the DNP program, using Kirkpatrick model for evaluation, nonparametric Friedman test for statistical analysis and instrumental tool of measurement using DKAT2 and D-CAS used at each time for assessments and evaluation process. The four-level learning by Kirkpatrick model are: reaction, learning, behavior, and results. The program focused on ways to create a group of individual nurses who participated, learned, and found ways to apply the concepts of the program offered to their clinical environment to show all four levels of learning. Program aimed was to close the gap in nursing knowledge, and group discussions provided context applicable to evaluation.

Protections

The nature of the project involved no patients and no family members and had no experimental procedures. Staff completed the pretest-posttest without using their names and had to be staff and nurses who worked directly with dementia patients in the facility. The 27 participants included nurses and care staff working at various positions who worked at least one shift per month at the selected facility. In compliance with required ethical standards, I obtained approval for this project at the site and from Walden university institutional review board (IRB), which included consent form that provided to participants prior, and during the survey process. The IRB approval process was vital in protecting the right of human subjects while maintaining the credibility of the study. I followed the requirements specified in the Walden University for DNP staff education

manual. The IRB approval number 02-10-22-0441606 for this project in addition for any future funding or publication submission is for specified date.

Analysis and Synthesis

Questionnaire responses were entered into an access database, and the clean data were imported into software platform statistical tool (SPSS) for analysis. Descriptive statistics provided an examination of the demographic characteristics of program participants. A non-parametric Friedman test selected because it was the correct statistic for this continuous data which did not meet the assumptions of the parametric test. nonparametric Friedman test, an alternative to repeated measure, used to validate whether there was a statistical difference between the mean results of three groups with same test conducted each time. The Wilcoxon signed rank test used to compare the differences of pairwise data as dependent variables being measured with ordinal data and marked deviation from normality (Grove & Gray 2018). The SPSS version 28 was the statistical tool used to determine the differences in the total scale and in the subscales of knowledge, attitude, and confidence on the three different applications using self-reported questionnaire. Data were examined to determine if it met the assumptions of the inferential including but limited to normality and outliers. In addition, 4 surveys were eliminated due to missing data.

Summary

The research tools and Walden University staff education guideline were one method in presenting the DNP program educational content, which in this project was the importance of dementia knowledge, attitude, and confidence while in direct care process.

Besides teaching methods used to assist staff in identifying patients' behavioral changes, challenges, anxieties and agitations, the concerns and uncertainty from the care staff were important factors in developing this educational program. Thus, new reflections, responses, and interactive nurse-patient communications and responses considered valuable outcomes as the product of education. In other words, analysis of new data provided new insights in how knowledge combined with attitude and confidence are appropriate for patient care environment impacting both perceptions and knowledge each time at different level.

The presentations and the program context encouraged participation as need related to effective dementia-specific knowledge and good practices will likely to be in demand. The educational strategies are valued as the most responsive and helpful to staff and various literature support the validity, and reliably of tools employed in this program (Gkioka et al., 2020). In this section, I provided a brief description of identified practice problem and addressed the gap in a dementia care facility, with a summary of my search strategy to gather evidence and present the relevant practice model to support the program as an initiation that addresses practice problems using practice focused question. I have included my search strategies and analytical method to synthesize the literature review in support of the need of the local problem.

Section 4: Findings and Recommendations

Introduction

Dementia is a global problem and concern. It affects individuals' behaviors, personality, thinking, judgment, language, and movement. These factors not only can lead to social isolation, depression, and incontinence, but can also lead to stroke and death (Alzheimer Association, 2020)). This dementia care education program facilitated learning and knowledge improvement as staff could relate and apply the concepts. The program addressed a gap in nursing knowledge involving staff concerns and challenges related to providing dementia care. I based the content on evidence-based research. My goal was to bridge the gap in nursing knowledge through positive impacts on participants' confidence and attitude toward providing dementia care. This DNP project was centered around this question: Will staff education about dementia and associated behaviors improve the staff knowledge, confidence, and attitude about dementia care?

The project consisted of a 5-hour workshop presented two times (2 weeks apart) with a focus on dementia knowledge and care and related issues. I administered three sets of surveys. I compared the results of the educational program to determine its effectiveness in addressing the gap in nursing knowledge. As I discuss in this section, the dementia education training was an effective professional development and workplace education that met the needs of the local facility.

Findings and Implications

The total nursing staff (nurse practitioner, RN, LPN, CNA) who participated and completed the survey ($N = 23$) attended both workshops. The majority were female

(66%) White (56%) with a mean age of 32 and older (M = 32, SD = 2.79), and most participants (n = 13*)* with at least three to five years of experiences in health care. Participants worked at least one shift per month and were involved in either direct care or communications with dementia patients.

Table 1 shows the pretest- posttest and follow-up posttest 2 scores for the DKAT2. I gave a score of 1 for each correct answer with highest score being 21. A high score of 21 indicates that the participant achieved 100% correct answers on the DKAT2 tool. A low score of 0 indicates that the participant answered every question incorrectly. DKAT2 appears to be a useful tool for assessing knowledge towards dementia in professional staff and can differentiate correctly between people with high or low knowledge (Gkioka, 2020). The means and standard deviations (in parentheses) with 95% CI for the pretest, Posttest 1, and Posttest 2 were 14.17 (2.97), 16.73 (2.15), and 18.78 (1.20), respectively. These results show increases in knowledge acquisition from pretest (67.5%) to posttest (79.7%), and second posttest (89.4%) conducted 2 weeks later (Posttest 2). The nonparametric Friedman test was used to compare the three times knowledge data were collected; the findings were significant (X^2 = 43.07 2 *df*; $p < .001$). This indicates a statistically increase in knowledge scores from pretest to Posttest 1 and from Posttest 1 to Posttest 2.

I made a Bonferroni correction to accommodate multiple comparisons setting the level of significance at $p = 0.0167$ rather than the normal level of significance at .05. The Wilcoxon signed ranks test was used to evaluate knowledge improvement between each test. The difference between pretest and posttest was significant (X^2 = 21.00, 1 *df*, $p <$

.001). The difference between the pretest and Posttest 2 was also significant ($X^2 = 23.00$, 1 *df*, $p < .001$), as were the findings ($X^2 = 19.00$, 1 *df*, $p < .001$) between Posttest 1 and Posttest 2. The Wilcoxon signed ranks are displayed in Table 1.

Selected questions, including (a) the confusion in person is almost always due to dementia, (b) Alzheimer's disease as the main cause of dementia, and (c) movement is limited in late stage of dementia, had the lowest scores for knowledge. I used case scenarios so that participants could take charge of their learning and increase the knowledge level in both workshops. In the second workshop, participating nurses were able to apply the teaching contents effectively and to reflect on their new experiences.

Table 1

*Knowledge Test Scores (*N = *23)*

Test	*M*	95% CI for mean lower bound	95% CI for mean upper bound	*SD*	Wilcoxon signed rank test
Pretest	14.1739	12.89.21	15.4557	2.96421	Posttest-pretest paired *Z* = -4.072 *p* < .001
Posttest 1	16.7391	15.8060	17.6722	2.15781	Posttest 2-Posttest 1 paired Z =-3.850 *p* < .001
Posttest 2	18.7826	18.2618	19.3034	1.20441	Pretest-Posttest 2 paired Z = -4.217 *p* < .001

The frequency table was useful to compare and see the changes on attitude and confidence questions. Among the participants, the highest frequency responses in pretest were 15 (65.2%) on one question: "I feel frustrated because I do not know how to help

people with Alzheimer's disease and related dementia," but in Posttest 1, the frequency was 12 (52.2%). In the 2-week follow-up, it was low as two (8.7%). On the pretest, the frequencies on being unfamiliar with dementia, and knowing dementia patients use different forms of communications was as low as eight (34.8%). However, being unfamiliar was as low as four (17.4%) in 2 weeks posttest and knowing how dementia patients use different form of communication increased to 16 (69.6%) on both Posttest 1 and Posttest 2. The participants were actively involved in group discussions focusing on case scenarios and applied their past experiences in both workshops. Negative reactions (e.g., dementia patients are not easy to work with, and not having enough time to complete work in dementia care) were evaluated and acknowledged as group participations.

Table 2

Data for Selected Attitude Questions From Dementia Attitude and Confidence Scale (O'Connor & McFadden, 2010; N = *23)*

Item	Pretest *n* (%)	Posttest *n* (%)	Posttest2 *n* (%)
1. I feel frustrated because I do not know how to help people with Alzheimer disease and related dementia.	15 (65.2%)	12 (52.2%)	2 (8.7%)
2. Difficult behavior may be a form of communication for people with dementia.	8 (34.8%)	16 (69.6%)	16 (69.6%)
3. Every person with dementia has different needs.	12 (52.2%)	11 (47.8%)	18 (78.3%)
4. It is possible to enjoy interacting with dementia clients.	12 (52.2%)	12 (52.2%)	21 (91.3%)
5.I am not very familiar with ADRD.	8 (34.8%)	10 (43.5%)	4 (17.4%)
6. It is important to know the past history of a person with dementia.	11 (47.8%)	14 (60.9%)	15 (65.2%)

I observed and examined the frequencies in confidence questions to evaluate the totals across all three test results in addition to the individual questions. The frequency in most confidence questions increased moderately in Posttest 1. A perfect score of 100% was observed in Posttest 2 in 2 weeks for questions on "being able to understand the patient with dementia when they cannot communicate," "being able to manage a situation when client becoming agitated," and "knowing how to communicate with dementia clients," as shown in Table 3.

To address and focus on questions with low frequencies, I discussed and analyzed certain factors during and after each workshop. These included certain issues such as not

having adequate training, knowing how to differentiate between dementia and delirium, and not knowing how to communicate with dementia patients were addressed as important factors. One major improvement was considered showing higher frequencies in confidence in how to manage agitation from 15 (65.2%) to 22 (95.7%) in 2 weeks.

Table 3

Data for Selected Confidence Questions from Dementia Attitude and Confidence Scale (O'Connor & McFadden, 2010; N = *23)*

Item	Pretest *n (%)*	Posttest 1 *n* (%)	Posttest 2 *n* (%)
1. I feel able to understand the needs of a person with dementia when they cannot communicate well verbally.	9 (39.1%)	15 (65.2%)	23 (100%)
2. I feel able to work with people who have diagnosis of dementia.	10 (43.5%)	14 (60.9%)	19 (82.6%)
3 I feel able to identify when a person may have a dementia	15 (65.2%)	15 (65.2%)	22 (95.7%)
4. I feel able to manage situations when a person with dementia becomes agitated.	17 (73.9%)	14 (60.9%)	23 (100%)
5. I feel able to gather relevant information to understand the needs of a person with dementia.	15 (65.2%)	10 (43.5%)	14 (60.9%)
6. I know how to communicate with dementia patient.	16 (69.6%)	14 (60.9%)	23 (100%)
7. I feel able to interact with a person with dementia when they can communicate well verbally.	13 (56.5%)	13 (56.5%)	20 (87%)

There were no unanticipated findings, and both quantitative and qualitative findings from participants indicated that the workshops were value-added and contributed to the care of the dementia patient at the site. Although there is presently some dementia education on orientation at the site, all agreed that there is potentially a need for repeated workshops like this one at the facility. Overall, staff were positively affected by the workshop, and have been practicing the techniques to improve communication at the site. Potential social implications of the program include but not limited to increased knowledge in dementia and related care process. In response to knowledge and survey tools, program was complemented in many ways for the contributions to less occurrences and miscommunications among staff-clients and administrations.

Recommendations

The findings from this DNP project support the recommendations for training and continued nursing education in dementia care communities. Lack of knowledge about Alzheimer's and dementia is a barrier to good-quality dementia care. Resolving knowledge deficits can promote positive attitude and confidence of nursing staff in the care and assessment of vulnerable patients with cognitive changes such in Alzheimer's and dementia. The educational program facilitated a realistic connection between nursing role and dementia care needs using active participations and involvement in education. The underpinning practice based educational contents combined with theoretical framework and knowledge tools facilitated learning evaluations of program.

Overall, everyone learned how changes involved in cognitive function at any level can impact on activities of daily living, but role of collaborative professionals, and

caregiving staff contribute to effective care management. RNs addressed their challenges and explained ways in establishing good rapport and communications with patients and families. Dementia knowledge is important in care process; when the total staff scored higher on knowledge 14 < 19 with awareness of symptoms and dementia stages, they also had improvement in area of perceptions, attitudes, and confidence. According to PCC model, care staff make up the environment and possible for patients to reconnect with their community they live in.

The project also supports the recommendation of continuing education in dementia care which requires increased in staff participation and use of reliable tools as DKAT2 and partial dementia confidence attitude scale (D- CAS) to provide appropriate feedback and future improvement. The dementia care education is applicable at wide range of health care settings where increasing number of nurses expose and learn about dementia and dementia related issues in all types of care settings. Besides long-term and dementia care settings, more should benefit from evidence-based educational program will includes emergency room setting and other acute and subacute areas where majority of older adult visits for experiences of falls and other traumas while live with preexisting dementia or other unnoticed memory related problems without dementia.

Strengths and Limitations of the Project

The strength of the project was the evidence for knowledge improvement in dementia care through educational program. The use of reliable and valid tools for evaluating robustness also increased confidence in groups who had equal opportunity to share and value their experiences in dementia care. DNP project findings is an example

of providing support and demonstrating understanding to the increasing expectations of nursing force focusing on vigorous engagement over rigorous findings. Potential for transferability showing usefulness of the project contents for broader applicable areas in health care settings. In addition, the study was cost-effective in a way that required no major purchases in IT or software technology by minor use in papers and copies for surveys and handouts. The program was at no cost for participants. Paid hours participants had attended the program was awarded by employer.

A limitation was noted and related to the COVID-19 pandemics as classroom size was limited to maximum 13 participants. However, flexibility in timing provided opportunities on various learning activities (reflections, group discussions, case sharing experiences) which provided positive social change. In fact, the smaller group size may have been an advantage since smaller groups often foster better discussion among participants.

In addition, strategies to recruit greater number of participants would have contributed to better statistical analysis, however the small workshop size was very helpful for case study review, role play and dealing with the emotional aspect of caring for a dementia patient. For the educational program, it was an advantage. The small size of the workshop maximized discussion and interaction with the participants, who shared their common experiences in managing communications with the dementia patient.

Section 5: Dissemination Plan

The educational program developed for this project included a series of learning modules designed based on evidence-based practice recommendations and guidelines from current research. My goal was to make the education accessible for staff. Doing so may facilitate the sustainability of the program while closing the gap in practice through users' knowledge acquisition.

The staff education project showed significant changes at various levels. I plan to share the findings with the facility's management team so that they can incorporate the program within the organization's annual and ongoing trainings. I will share the project results and the staff education materials to enable possible repeat training with additional measurement. I also suggest a quality improvement project on the impact of the dementia education training in practice for dementia unit nurses. Participating nursing staff offered positive insights about their experiences in client interactions as they used the techniques recommended in the project to interact with dementia patients. I recommend using knowledge assessment tools combined with clinical occurrences of behavioral changes in clients to measure outcomes of quality improvement with changes in nurse-patient interactions.

Posters and Presentations

The primary goal for designing posters was to communicate the project in a clear and concise manner that is visually appealing and readable with a minimum amount of text and nonessential details. I displayed selected number of posters with figures and images of PCC frameworks and major themes of educational program at the local site for

viewing purposes and the reminder of the program contents. Positive comments from participants will be posted throughout the facility to acknowledge and reinforce new changes. Posters about the program topic, content outlines, objectives, and gained outcomes will hopefully be displayed in the facility conference and dining areas and offices so that they can be discussed and viewed by others. I also plan to disseminate poster presentations at the meetings of the emergency nursing local chapter as well as to share with group of nurses from acute care and trauma.

Publications

Selecting an appropriate publication is important for sharing the project results as widely as possible. Online journals of nursing include academic, peer-reviewed publications, which are widely used journals that provide the most relevant information. I may submit a manuscript to the *International Journal of Nursing*, the *Journal of Emergency Nursing*, and *Nursing Education Perspectives*.

Analysis of Self

DNP programs prepare graduates to lead and be scholar practitioners. As recommended by the American Association of Colleges of Nursing (2006), dissemination is vital for the work of graduates to diffuse new knowledge into practice. My role as an educator and project manager was bundled with set of skills and responsibilities not just to comply with each phase of the project, but to create plans and adjust at different levels for education, training, testing, and evaluation for as many participants as possible. However, the program could have been more inclusive and engaging to other health care staff. Many care staff in direct patient contact with dementia patients were non-nursing

staff; they included occupational and physical therapists in addition to staff from arts and recreations as well as social works. The educational activities were essential and dynamic, in my view.

My future professional goals include dissemination and publication of project findings. I plan to undertake evidence-based projects on various practice problems related to advancing dementia care in geriatric publications. It will be essential to create educational programs that best fit the needs of particular practice problems and situations. Considering the differences between care settings in various aspects, I will need access to clinical and educational tools to help with ongoing reviews of literature for up-to-date knowledge. I hope to contribute new quality improvements that are applicable, and evidence based.

Summary

The estimated increase in the U.S. aging population with a co-occurrence of Alzheimer's disease and dementia is alarming. However, skilled nursing may improve the quality of life for patients with these disease (Wu et al., 2020). The demand for direct care and people who make up the direct care workforce population will continue to grow (Meeks et al., 2018). This project offers insights on what strategies can be implemented in staff education that facilitate learning in how to prevent exacerbations of dementia-related behaviors. Care staff were able to receive the training necessary to provide dementia care despite the challenges and changes imposed by the COVID-19 pandemic. The DNP project focused on a 97-bed local skilled nursing facility with dementia patients in various units in the Northeast U.S. region. The nursing staff became familiar and

aware of current best practices and employed the recommendations for dementia care that was provided to them through the program. To manage care for those patients, nurses needed to have the training and knowledge by participating in evidence-based practices and programs. Participants expressed less frustration and uncertainty about dementia symptoms and more confidence when discussing care issues for dementia patients. Improving knowledge made the difference in how clinical staff approached and perceived their challenges and difficulties. The program helped nurses acknowledge the needs of patients and ways of responding to them.

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Appendix A: Curriculum and Dementia Knowledge Assessment

Learning Outcome(s): Provide an educational program to direct caregivers on dementia, with the intent of shaping communication processes positively.

Nursing Professional: Development Gain knowledge about EBP; Translation of research; Theory/Practice applications (person-centered care); Exercise tool; a positive attitude and increase confidence about dementia care

Patient Outcome: improved quality of life; engaged in activities; decreased use of psychotropic drugs.
Organizational Outcome: Lower cost, hospitalizations, adverse outcomes; improve reputations; improve positive effect as a result of improved care - delivery

Topical Content Outline	Time frame	References	Teaching method/learner engagement and Evaluation method
Session 1: • Alzheimer fact and figures • Trends • Statistics • Prevalence /epidemiology	60 min	Alzheimer's disease international (2021). *Dementia* statistic. Alzheimer Association. https://www.alz.org/downloads/facts_figures_2021pdf U.S department of health and human services (2021). National Alzheimer's project act (NAPA). https://aspse.hhs.gov/daltcp/napa/natplan.	PowerPoint Slides Videotapes Speakers note 10 minutes welcome and thank you an introduction Discussion, Q&A Evaluation method: questionnaire /pre-posttest survey
Session 2: • Definitions • Terms • Case studies related to Alzheimer's disease and dementia	60 min	National Alzheimer project act (NAPA*). Congressional Record*. 156. January 4, 2011, practice law 111-375 section 2, No 4a-4b Fazio., S., Pace., D., Maslow, K., Zimmerman, S., and. Kallmeyer, B. (2018.) Alzheimer's Association dementia care practice recommendations. *Gerontologist*, 58.	PP slides Video Speakers note 15 minutes Evaluation method: Test-taking / and pre-posttest survey
Session 4: • Dementia goals • Stages of dementia	60 min	Jennings, L. A., Palimaru, A., Corona, M.G., Gagigas, X.E., Ramirez, K. D., Zhao, T., Reuben, D.B. (2017). Patient and caregiver goals for dementia care. *Quality-of-life research an international journal of quality-of-life aspects of treatment, care, and rehabilitation, 26*(3). Dementia Care Central (2020). Stages of Alzheimer's and dementia: Durations & scales used to measure progression (GDS, FAST & CDR). *DCC/National Institute of. Aging*. https://dementiacarecentral.com/aboutdementia/facts/stages/#care	PP slides presentations Videotapes Case study Speakers note 20 minutes Evaluation method: Posttest
Session 5: • Application of Person-Centered Care model	60 min	Barbosa, A., Sousa, L., Nolan, M., & Figueiredo, D (2015). Effects of Person-Centered Care approach to dementia care on staff: A systematic review. *American Journal of Alzheimer's disease and other dementias 30* (8). https://doi.org/10.1177/1533317513520213 Cingel, M., Brandsma, L., Dam, M.V., Dorst, M. V., Valkaart, C., and Velde, C.V.D (2016). Concepts of person-centered: a framework analysis of five studies in daily care practices. Original practice development and research. *International practice development journal 6*(2),	Active learning strategy: Review handouts Answer 3 questions video Watch PP slide Speakers note 15 minutes

			Evaluation method: survey questions & posttest
END SESSION Thank you Celebrate learning/& New Knowledge	5-10 MIN	Meeks, S., Fazio, S., & Pace, D. (2018). Alzheimer's Association Dementia care practice recommendations. *Alzheimer Association* Kirkpatrick, J., D., Kayser, W. (2016). Kirkpatrick four levels of training evaluation. *ATD press* Fazio, S., Pace, D., Flinner, J., and Kallmyer, B. (2017). The fundamental of person-centered care for individuals with dementia. *The gerontological society of America*	Open to the discussion: Speakers note 2 minutes thank you Comments! Questions? Evaluation method: Program evaluation questionnaire

Appendix B: Survey Questionnaire

1. Gender

What gender are you going to register as?

1. Male
2. Female

2. Age

What is your age range?

1. 19 –25 years old
2. 26 – 35 years old
3. 36- 45 years old
4. 46 +

3. Ethnicity

State your ethnicity.

1. Caucasian
2. African American
3. Latino
4. Asian
5. Native Hawaiian or Pacific Islander

4. Type of professional/nurse

What are your career fields?

1. Nursing assistance
2. Licensed Practical Nurse
3. Registered Nurse
4. Advanced Practice Nurse

5. Education

what is the highest education degree or standard that you have completed?

1. No High School
2. High School
3. Bachelor's Degree
4. Master's Degree
5. Ph.D.

6. Marital status

What is your marital status?

1. Married
2. Single
3. Divorced
4. Widow
5. Separated

7. Years of practice

How many years have you been in practice?

1. Less than one years
2. 1-2 years
3. 3-5 years
4. 6-9 years
5. Greater than ten years

8. Employment

What is your present state of work?

1. Full-Time
2. Part-Time
3. Per Diem
4. Traveling Nurse

9. Language

What languages are you capable of fluently speaking?

1. English
2. Spanish
3. Multilingual

Selected Questions Adapted from Dementia Attitude and Confidence Scale by O'Connor & McFadden (2010)

Attitude Questions - 6 items	**Yes**	**No**	**Don't know**
1. I feel frustrated because I do not know how to help people with Alzheimer disease and related dementia.			
2. Difficult behavior may be a form of communication for people with dementia.			
3. Every person with Alzheimer and related dementia have different needs			
4. It is possible to enjoy interacting with dementia patients			
5. I feel uncomfortable to be around people with dementia			
6. It is important to know the past history of people with dementia			
Score			
Confidence – 7 items	**Yes**	**No**	**Don't know**
1. I feel able to understand the needs of a person with dementia when they cannot communicate well verbally.			
2. I feel able to work with people who have diagnosis of dementia			
3. I feel able to identify when a person may have a dementia			
4. I feel able to manage situations when a person with dementia becomes agitated.			
6. I know how to communicate with dementia patient. 7. I feel able to interact with a person with dementia when they can communicate well verbally.			
Scores			

Dementia Knowledge Assessment Tool Version 2 Adapted from Toye, C., Lester, L., Popescu, A., Mclnerney, F., Andrews, S., & Robinson, AL. (2014)

	YES	NO	Don't know
1.demenita occurs because of changes in the brain			
2.Brain changes causing dementia are often progressive.			
3. Alzheimer's disease is the brain cause of dementia?			
4. Blood vessel disease can also cause dementia.			
5. Confusion in an older person is almost always due to dementia.			
6. Only older adults develop dementia.			
7. Knowing the likely cause of dementia can help to predict its progression.			
8. Incontinence always occurs in the early stages of dementia.			
9. Dementia is likely to limit. Life expectancy.			
10. When a person has late-stage dementia, families can help others to understand that persons need.			
11. People who have dementia may develop problems with visual perceptions (understanding or recognizing what they see)			
12. Sudden increases in confusion or characteristics of dementia.			
13. On characteristic distressing behaviors may occur in people who have dementia. (e.g., Aggressive behavior in gentleperson).			
14. Difficulty swallowing occurs in late-stage dementia.			
15. Movement (e.g., Walking, moving in bed or chair). Is limited in late-stage dementia.			
16. Changing the environment (e.g., putting on a CD, opening or closing the blinds) will make no difference to a person who has dementia.			
17. When a person who has dementia is distressed, it may help to talk to them about their feelings.			
18. It is important to always correct a person who has dementia when they are confused.			
19. A person who has dementia can often be supported to make choices (e.g., What colors to wear)			
20. It is impossible to tell if a person who is in the latter stages. Of dementia is in pain.			
21. Exercise can sometimes be on benefit of people who have dementia.			