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Improving Nursing Staff Knowledge to Provide High-Value Dementia Care

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Walden University

College of Nursing

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Kimone Johns

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and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Executive Summary: Staff Education Project
Improving Nursing Staff Knowledge to Provide High-Value Dementia Care
by
Kimone Johns

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

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Summary

This staff education project aimed to increase nurses' knowledge to provide high-value dementia care. At the project site, nurses indicated low self-confidence and knowledge in providing quality dementia care. Providing low-value care to persons with dementia (PwD) contributes to suboptimal clinical outcomes and poor quality of life and adversely influences nurses' satisfaction. Therefore, the project question addressed whether a staff education program would increase nurses' self-perceived ability and confidence to provide high-value dementia care. The staff education objective was to enhance patient-centered dementia care, provision of quality care that can improve quality of life (QoL) of PwD. Twenty peer-reviewed journal articles informed the project's development. A total of 10 nurses participated in the staff education project. Participants completed demographics and pretests, attended 2-hour staff education, and completed posttests and program evaluation questionnaires. Average pre- and posttest scores were analyzed via descriptive statistics. Postimplementation, 98.89% of participants indicated *confidence* or *high confidence* regarding confidence in working with PwD. Moreover, participants demonstrated a high level of satisfaction with the program. The staff education project facilitated social change by enhancing the nursing staff's knowledge to deliver high-value dementia care that is crucial in delaying disease progression, promoting QoL, prolonging survival, and lowering caregiver burden. Equity, inclusion, and diversity were facilitated via improved care quality for PwD and decreasing the socioeconomic burden of dementia to patients, families, and caregivers. Ongoing staff education can improve quality care for optimal clinical outcomes and QoL among PwD.

Background

Alzheimer's disease (AD), a leading cause of dementia, affects over 6.7 million Americans (Alzheimer's Association, 2023). Platen et al. (2021) reported that up to 31% of patients received low-value care resulting in increased costs and high mortality. Significantly, at the project site, nurses expressed confidence gaps in the care of PwD that contributed to suboptimal clinical outcomes and poor QoL. Some felt overwhelmed, stressed, and anxious when working with PwD, attributable to poor confidence levels. Moreover, the project site's nursing leadership raised concerns and expressed intent to increase nursing staff dementia care competence. Low self-perceived confidence in providing quality dementia care adversely influences nurses' care of patients, clinical outcomes, satisfaction, and quality of care (Schultz et al., 2020).

The project question was, “the following: Will an educational program improve nurses' confidence in providing high-value dementia care?” The project examined whether the effects of a staff education program would increase nurses' self-perceived ability and confidence to provide high-value dementia care. The objective was to enhance quality dementia care, support to dementia patients, and person-centered care of PwD to improve clinical outcomes and QoL. The overall aim was to increase nursing staff knowledge to provide high-value dementia care to enhance patient outcomes.

Several studies highlighted the burden of dementia and supported the utility of staff education in improving confidence, knowledge, and attitudes toward caring for PwD. A total of 20 journal articles were included in the review. The Johns Hopkins evidence-based model was used to grade evidence based on the strength of evidence informed by study designs. Two high-quality Level I studies (randomized controlled trials) were included. Michalowsky et al.

(2024) established that collaborative dementia care management (CDCM) decreased behavioral and psychological symptoms of dementia (BPSD), lowered caregiver burden, and improved cost-effectiveness. Possin et al. (2019) showed that collaborative care improved QoL; lowered caregiver burden, caregiver depression, and ED visits; and resulted in high satisfaction. One Level II study (systematic review) by Guzzon et al. (2023) established that the most cost-effective supportive care was multicomponent interventions such as indirect care management and some tailored occupational therapy forms. A total of 13 Level III studies were included with an overall good quality rating. Dhana et al. (2023) reported a high prevalence of dementia, indicating the need for quality care. Platen et al. (2021) indicated that LVC was prevalent and resulted in lower QoL and higher odds of hospitalization. Yang et al. (2022) reported moderate dementia care competence and inadequate knowledge of special PwD needs and dementia identification, prevention, and management of BPSD among nurses. Evripidou et al. (2019) indicated that nurses lacked management strategies, communication skills, knowledge, and confidence to provide quality dementia care. Additionally, Islam et al. (2020) reported that only senior nurses with greater years of experience dealing with PwD or those who had received training in PwD had higher dementia care competence. Further, Wang et al. (2022) reported that care aides did not have regular interactions with PwD. The impact of educational interventions was captured across studies. Chan et al. (2020) demonstrated cost-effectiveness and higher job satisfaction. Seltmann and Teichmann (2024) indicated the long-term impact of training. Adewuyi et al. (2022) and Islam et al. reported higher improvements for face-to-face modalities. Aspects of quality care for PwD were also captured. Lepper et al. (2020) established that integrating the needs of PwD promoted meaningful social relationships and can enhance QoL. Lee et al. (2023) recommended a supportive system, shared decision-making, staff collaboration,

interactions, and meaningful relationships. Wehrmann et al. (2021) highlighted the disclosure of disease, end-of-life care, decision-making, self-efficiency, care concordance, quality of life, and everyday life activities. Lastly, Mohr et al. (2021) recommended cognitive training, social contact, physical activities, daily living assistance, emotional support, environmental adjustments, support and education of caregivers, sensory enhancements, and organization of care to improve dementia care outcomes.

Two good-quality Level IV articles (a systematic review of clinical practice guidelines and a position statement) were included. According to Tahami et al. (2023), no neurocognitive tests can diagnose AD dementia, and guidelines recommended BPSD screening and approved treatments for cholinesterase inhibitors and memantine. Schultz et al. (2020) recommended several quality measures, such as dementia diagnosis disclosure, emotional support, caregiver education, screening for safety concerns, and advance care planning/end-of-life care. Lastly, two Level V studies (scoping/integrative reviews) with an overall low-quality rating were included. Both studies supported a patient-centered culture of care and leadership, collaboration and communication, and dementia care sensitive to PwD's preferences, behaviors, and needs and transitional care/care coordination (Hirschman et al., 2023; Karrer et al., 2020). Evidence supported implementing a staff education project to increase nurses' dementia care competence.

Project Development

The project aimed to increase nurses' self-confidence to provide high-value dementia care. The project steps included participant recruitment; participants signed informed consent, demographic and pretest surveys filled in ink, staff education (PowerPoint presentation), posttest and program evaluation, and data analysis. Participants were nurses working at the project site. A total of 10 nurses participated in the study. Nurses provided consent by filling out the

demographic questionnaire. Demographic data collected included gender, age, marital status, racial/ethnic background, highest educational qualification, nursing career fields, years of experience, and terms of employment (see Appendix A). Participating nurses completed a pretest questionnaire for baseline confidence scores (see Appendix B). Participants attended a 2-hour PowerPoint presentation, encompassing online video on addressing anxiety and agitation, simulation to handle a patient refusing to take medications, and group discussion to manage a wandering patient (see Appendix C).

Data collection entailed pre- and posttests. The outcome of interest was nurses' self-perceived and self-reported confidence in working with PwD. Pre- and posttest questionnaires collected participants' confidence levels related to identifying when a person may have dementia, understanding the needs of a person with dementia when they can communicate well verbally or when they cannot communicate well verbally, interacting with a PwD when they can communicate well verbally or not, managing agitation, gathering relevant information to understand the needs of a PwD, helping PwD feel safe in hospitals, and overall confidence in caring for PwD (see Appendix B). The questionnaire ranked confidence in working with PwD based on a Likert-type scale from 1 to 5. Higher scores indicated higher levels of confidence in caring for PwD. Participants were administered program evaluation questionnaires to gauge the effectiveness of the educational program. Participants rated their level of agreement on a scale of 1 to 5, with higher scores indicating more substantial agreement (see Appendix D).

Participants completed demographic, pre- and posttests, and program evaluation questionnaires in ink and paper by participants using the same unique identifiers for purposes of anonymity, privacy, and confidentiality. The information was transferred to a spreadsheet within a password-protected laptop. No unauthorized access to participant data was allowed. Data

analysis leveraged descriptive statistics. The program's effectiveness was determined by comparing average pre- versus post-tests to gauge participant confidence and knowledge level changes.

Results

Seventy percent of the participants were female. Ages ranged between 26–35 (40%) and 36–45 (60%). A total of 10% were divorced/separated, 20% were single, and 70% were married. The predominant racial/ethnic group was White (60%), followed by African American (30%) and Latino (10%). Seventy percent of participants were registered nurses with bachelor's degrees, while three were psychiatric and mental health registered nurses with master's (20%) and DNP (10%) degrees. All participants worked full-time at the project site. Forty percent indicated having worked for 3–5 years, 50% reported working between 6–9 years, and only 10% reported working for more than 10 years at the project site. Postimplementation, 98.89% of participants indicated *confidence* or *high confidence* regarding confidence in working with PwD compared to the preimplementation average of 35.56%. The improvement indicated higher self-perceived confidence scores in caring for PwD following the staff education project. The results are depicted in Table 1 and Figure 1 (graphical representation). All participants indicated *high confidence* that the program met its objectives, increased confidence to care for PwD, was impactful, could help educate nurses to improve their ability to care for PwD, and indicated that the speaker was knowledgeable about the program's content. Also, 80% indicated *high confidence* in implementing the program's content into the routine care of PwD.

Figure 1

Participants' Pre- Versus Posttest Average Confidence Scores

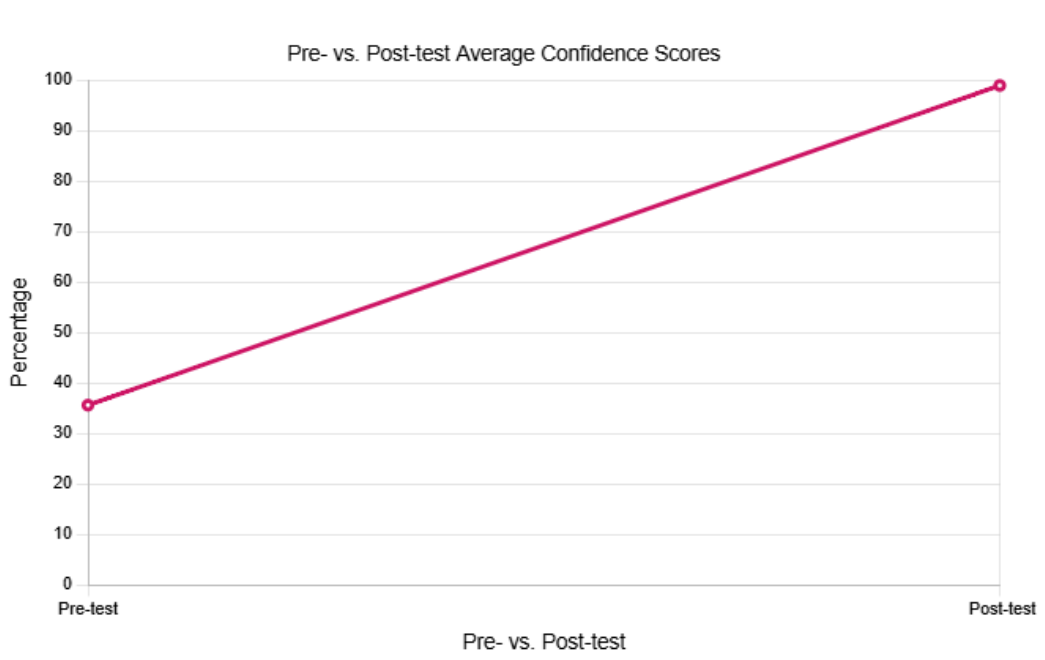


Table 1*Pre- and Posttest Findings Regarding Confidence Level*

Pre- and posttest questionnaire item	Pretest % (<i>n</i> = 10)	Posttest % (<i>n</i> = 10)
1. I feel able to identify when a person may have dementia. Confidence or high confidence	30	100
2. I feel able to understand the needs of a person with dementia when they can communicate well verbally. Confidence or high confidence	40	100
3. I feel able to understand the needs of a person with dementia when they cannot communicate well verbally. Confidence or high confidence	40	100
4. I feel able to interact with a person with dementia when they can communicate well verbally. Confidence or high confidence	30	100
5. I feel able to interact with a person with dementia when they cannot communicate well verbally. Confidence or high confidence	30	90
6. I feel able to manage situations when a person with dementia becomes agitated. Confidence or high confidence	30	100
7. I feel able to gather relevant information to understand the needs of a person with dementia. Confidence or high confidence	40	100
8. I feel able to help a person with dementia feel safe during their stay in hospital. Confidence or high confidence	40	100
9. I feel able to work with people who have a diagnosis of dementia. Confidence or high confidence	40	100

The project improved confidence among nurses to promote quality dementia care. Ten staff from the healthcare organization benefited from increased understanding on stages of AD, AD presentation and progression, dementia evaluation, PwD needs, priorities and preferences, communication skills, pharmacological management of dementia, BPSD management, patient-centered care, high-quality dementia care, and quality dementia care outcomes.

A few limitations must be considered. The staff education project utilized self-report confidence scores, which can be influenced by social desirability bias. It is possible that participants responded to depict that their scores did not deviate from expected professional standards of providing quality dementia care (Yang et al., 2022). The use of validated instruments could have improved the credibility of the findings. The study sampled a small number of participants ($n = 10$) from one mental health clinic, and therefore, the results and conclusions cannot be generalizable to other clinical practice settings.

The findings of the staff education project highlight the importance of continuing education for nurses to improve their competence in caring for PwD. The project highlighted the essence of practice development and advancement via educational opportunities for nurses to improve attitudes and knowledge towards care of PwD (Evrpidou et al., 2019). Ongoing and continuous learning to integrate the needs of PwD within staff education programs can improve quality care for enhanced patient outcomes and QoL (Wang et al., 2022). Healthcare organizations can implement educational opportunities with consideration for the educational needs and background of staff (Yang et al., 2022). Practical teaching methods and experiential learning experiences can improve dementia care skills (Adewuyi et al., 2022).

Conclusions

The staff education project improved nurses' confidence and knowledge to promote quality dementia care. Continuous staff education programs addressing the needs of PwD can improve quality care for enhanced patient outcomes and QoL (Chan et al., 2020).

Further recommendations include adopting collaborative care models to mitigate the economic and societal burdens of dementia and integrating multicomponent supportive care interventions to increase the cost-effectiveness of dementia care (Guzzon et al., 2023; Possin et al., 2019). A patient-centered approach, effective leadership, and sensitive care integrating PwD's preferences/needs are central to improved dementia care (Hirschman et al., 2023; Karrer et al., 2020). Nurses must integrate caregiver support and education, providing resources, information, and emotional support to decrease caregiver distress and burden. Quality dementia care should also integrate advanced care planning, palliative care counseling, and end-of-life care (Schultz et al., 2020).

AD is a progressive neurodegenerative disorder that results in behavioral and cognitive impairments that affect the daily lives of patients. AD is not curable, and available drugs only provide modest benefits when patients have mild disease (Tahami et al., 2023). Dementia progression is relentless. Medical, social, functional, and psychological sequelae elevate stress levels among caregivers and family members. Nurses' responsibilities when caring for patients with dementia include establishing daily routines, creating nursing care plans, aiding in activities of daily living (ADLs), assessing patient needs, caring for those with cognitive impairments and motor functioning deficits as well as assessing safety to prevent injury, and providing caregiver and family support and education (Wang et al., 2022). Low self-perceived confidence in caring for PwD affects nurses' ability to interact with family members and caregivers of PwD, engage in

shared decision-making and collaborative care practices, develop meaningful relationships with patients, and support caregivers of PwD. The staff education project facilitated improved understanding and confidence in caring for PwD. The program can be applied in other contexts to boost nurses' confidence in providing quality dementia care.

PwD are vulnerable populations, and high-value care is crucial to enhance health-related QoL, delay cognitive decline, and promote independent living with the community as long as possible. As Platen et al. (2021) reported, the majority of PwD received low-value care that increased healthcare costs. The staff education facilitated social change via enhancing nursing staff understanding and confidence to deliver high-value dementia care that is crucial in increasing QoL, prolonging survival, and lowering caregiver burden (Alzheimer's Association, 2023). Improving care quality for PwD, and lowering the socioeconomic burden of dementia for individuals, patients, families, and caregivers facilitates equity, inclusion, and diversity.

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Appendix A: Demographic Survey Questionnaire

Unique Identifier _____

Date: _____

1. What is your gender?

- A. Female
- B. Male
- C. Other: Specify _____
- D. I prefer not to say

2. What is your age range (Years)?

- A. 19 –25
- B. 26-35
- C. 36- 45
- D. 46-55

3. How do you define your Marital status?

- A. Single
- B. Married
- C. Separated/Divorced
- D. Widow/Widower
- E. I prefer not to say

4. What is your racial/ethnic background?

- A. African American
- B. Caucasian
- C. Latino
- D. Native Hawaiian or Pacific Islander

- E. Asian
- F. Other: Specify _____

5. What is your highest educational qualification?

- A. Diploma
- B. Associate Degree
- C. Bachelor's Degree
- D. Master's Degree
- E. DNP/Ph.D.

6. How would you define your professional/nurse career fields?

- A. Nurse assistant
- B. Licensed Practical Nurse
- C. Registered Nurse
- D. Advanced Practice Nurse
- E. Other: _____

7. How many years have you worked at this facility?

- A. < 1 year.
- B. 1-2 years
- C. 3-5 years
- D. 6-9 years
- E. >10 years.

8. How would you categorize your terms of employment?

- A. Traveling Nurse
- B. Part-time

C. Per Diem

D. Full-time

Appendix B: Pre- and Posttest Confidence Questionnaire

Unique Identifier _____

Date: _____

Circle the right answer

1. I feel able to identify when a person may have dementia.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

2. I feel able to understand the needs of a person with dementia when they can communicate well verbally.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

3. I feel able to understand the needs of a person with dementia when they cannot communicate well verbally.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

4. I feel able to interact with a person with dementia when they can communicate well verbally.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

5. I feel able to interact with a person with dementia when they cannot communicate well verbally.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

6. I feel able to manage situations when a person with dementia becomes agitated.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

7. I feel able to gather relevant information to understand the needs of a person with dementia.

- 1) No confidence

- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

8. I feel able to help a person with dementia feel safe during their stay in hospital.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

9. I feel able to work with people who have a diagnosis of dementia.

- 1) No confidence
- 2) Little confidence
- 3) Some confidence
- 4) Confidence
- 5) High confidence

This modified CODES questionnaire ranks healthcare personnel's self-perceived confidence in working with PwD based on a rating of "no confidence, little confidence, some confidence, confidence and high confidence," rating from 1 to 5, with scores ranging from 9 to 45. A higher score indicates a high level of confidence in caring for PwD.

Appendix C: Staff Education PowerPoint Presentation

High-Value Dementia Care

United Way
SNFPA.org
Widens Knowledge
December 2021

Background

- Dementia affects 6.7 million Americans (CDC, 2020).
- 10.7% of 65 years and 7.5% of 75 years suffer dementia.
- In 2025, dementia will affect 11 million Americans (Alzheimer's Association, 2021).
- California ranks fourth in highest prevalence of AD (California Health and Human Services, 2021).
- Dementia affects 700,000 individuals.
- 2021's dementia mortality rate was being 36% (100,000 total population) (CDC, 2020).

Outline

- Background
- Alzheimer's Disease Stages
- Evaluation/Screening
- Pharmacological management
- Nonpharmacological management
- Peds, practice and preferences
- Patient-Centered Care
- Collaborative dementia care (CDC)
- Care Coordination
- Integration of Technology
- Quality measures for HIE

Burden of Dementia

- The cost of dementia in the nation is around \$176 billion in 2021.
- Costs are projected to increase to \$1.1 billion in 2050.
- 7.5 million Americans provide non-professional care for PwD.
- 1.2 million direct care workers engaged in AD care between 2020 and 2030.
- The cost of unpaid caregivers in 2022 was estimated at \$193.5 billion.
- This accounts for 18 billion hours (Alzheimer's Association, 2021).

Goals/Objectives

Develop high-level confidence and self-perceived competency in:

1. Identifying PwD.
2. Understanding PwD's needs.
3. Gather relevant information of PwD to understand needs.
4. Interacting with PwD.
5. Managing situations when a PwD becomes agitated.
6. Helping PwD feel safe during their hospital stay.
7. Cover all conditions meeting with PwD.

Significance

- Pflanz et al. (2021) Low value care (LVC) was provided and was associated with lower QoL and higher rates of hospitalization.
- Plans need to improve dementia care competence and skills for dementia identification, prevention, and management of BPSD.
- With an increasing aging population in dementia, dementia's prevalence will rise.
- Plans need to develop knowledge, awareness, confidence, and skills to provide high-quality care.

Stages of Alzheimer's Disease

- **Preclinical** (no clinical AD signs): Biomarkers suggest pre-symptomatic development of AD pathology.
- **Mild** (early symptoms): Memory impairment, loss of instrumental activities of daily living (IADL).
- **Intermediate** (moderate symptoms): Memory impairment, loss of IADL, loss of cognitive function, and behavioral changes.
- **Severe** (late symptoms): Memory impairment, loss of IADL, loss of cognitive function, and behavioral changes.

Pharmacological Management

- Cholinesterase inhibitors (e.g., Donepezil and galantamine) to be initiated in early to moderate AD (memory, function, and cognitive level).
- The first MChR inhibitor (tacrine) was used.
- Donepezil (Tasmar) is the most commonly used cholinesterase inhibitor.
- Donepezil is used in mild to moderate AD (memory, function, and cognitive level).
- Donepezil is used in moderate to severe AD (memory, function, and cognitive level).
- Donepezil is used in severe AD (memory, function, and cognitive level).

Screening and Evaluation

- Review medical and family history.
- Review list of medications that affect cognition.
- Assessing functional/cognitive capacity, instrumental activities of daily living (IADL).
- Assessing behavioral, memory, cognition, and functional abilities changes.
- Neurological exam, dementia.
- Routine cognitive assessment (e.g., MMSE or preferred) (MCA) or MoCA.
- Medical status evaluation.
- Blood tests (CBC, CMP, TSH, and vitamin B12 levels). Rule out reversible causes.

Cholinesterase Inhibitors

Donepezil	Rivastigmine	Galantamine
Approved for treatment of AD.	Approved for treatment of AD.	Approved for treatment of AD.
Reversible inhibitor of acetylcholinesterase (AChE).	Reversible inhibitor of acetylcholinesterase (AChE).	Reversible inhibitor of acetylcholinesterase (AChE).
Approved in mild to moderate AD.	Approved in mild to moderate AD.	Approved in mild to moderate AD.
Approved in moderate to severe AD.	Approved in moderate to severe AD.	Approved in moderate to severe AD.
Approved in severe AD.	Approved in severe AD.	Approved in severe AD.

Imaging and Biomarkers

- Neurophysiological testing for AD.
- Genetic testing (APOE ε4 allele, amyloid precursor protein (APP), presenilin 1 (PSEN1), and presenilin 2 (PSEN2) for presenile AD).
- Cerebral imaging (CT and MRI) to rule out structural brain changes.
- Functional MRI (fMRI).
- Single-photon emission computed tomography (SPECT).
- Positron emission tomography (PET).
- Amyloid PET (Aβ-PET) for AD identification.
- Tau PET (Tau-PET) for AD identification.

Memantine

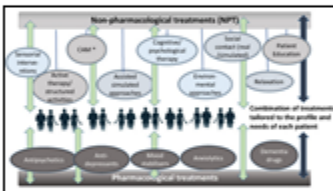
- Mechanism of action: Partial NMDA receptor antagonist.
- FDA-approved for moderate to severe AD.
- Side effects: Headache, dizziness, constipation, and blurred vision.
- Contraindications: Concomitant use of NMDA receptor antagonists (e.g., ketamine, nitrous oxide).

Non-Pharmacological Management

Symptom Control	Lifestyle Modification
<ul style="list-style-type: none"> • Memory training • Physical exercise programs • Social/cognitive stimulation • Supportive care 	<ul style="list-style-type: none"> • Anticholinergic avoidance • Minimizing stress • Treating hearing loss • Caregiving stress less • Optimizing sleep

Patient-Centered Dementia Care

Component	Objective
Continuum monitoring and assessment	Continually monitor and assess cognition, functional, behavioral, and psychosocial needs in relation to setting and the needs of caregiver/caregivers.
Setting care plan	Setting and treatment in care plan that is regularly evaluated and modified as needed including addressing care planning, setting about place of residence, and transition to care at discharge.
Self-management	Provide self-management tools to enhance the skills of the person living with dementia and caregiver in managing activities of daily and instrumental activities, managing the healthcare system, and engaging in activities related to person-centered goals.
 caregiver support	Identify areas of need caregiver to include in evaluation, assessment, care plan, and care planning and provide culturally sensitive support and resources designed to help the caregiver.
Psychosocial interventions	Identify and intervene about addressing the burden of cognitive, functional, behavioral, and psychosocial challenges in care in complex areas including care planning, care transitions, caregiver training.
Treatment of related conditions	Use stress to prevent and treat conditions related to Alzheimer's disease and related disorders, such as depression, falls, and anxiety. Coordination of care including behavioral and other healthcare services across hospitals, nursing homes, and ambulatory care.
Education management	Use evidence-based education management including describing conditions and disease cognitive effects, include efforts to increase education advance care and other advance opportunities for participation in research.



Collaborative Dementia Care

Components	Outcomes
<ol style="list-style-type: none"> I. Individualized treatment and care II. Medication management III. Information technology • Maximization of ICD-10 High level coding and care management intensity 	<ul style="list-style-type: none"> • Improved QoL of patients and caregivers • Decreased BPSD • Decrease caregiver burden • Adequate treatment with antidepressant, sleep, and other drug programs

- ### PwD Preferences
1. Receiving information about diagnosis as soon as possible.
 2. Participation in medical decisions.
 3. Engaged in tasks that keep them cognitively and physically active.
 4. Social interaction with simple, safe, and light exercises.
 5. Personalized and individualized care.
 6. To be treated with respect.
 7. To maintain close bonds with family at the end of life.
 8. Patients, accurate, and confident diagnosis, prognosis.
 9. Good communication.
 10. Involvement of family members/caregivers.
 11. Gender-aging fit care.

ICD-10	ICD-11
Alzheimer's disease	Alzheimer's disease (F00.0)
Frontotemporal dementia	Frontotemporal dementia (F07.0)
Other forms of dementia	Other forms of dementia (F07.1-F07.9)
Mild neurocognitive disorder	Mild neurocognitive disorder (6A05.0)
Major neurocognitive disorder	Major neurocognitive disorder (6A05.1)
Very mild neurocognitive disorder	Very mild neurocognitive disorder (6A05.2)
Mild to moderate neurocognitive disorder	Mild to moderate neurocognitive disorder (6A05.3)
Moderate to severe neurocognitive disorder	Moderate to severe neurocognitive disorder (6A05.4)
Severe neurocognitive disorder	Severe neurocognitive disorder (6A05.5)
Probable Alzheimer's disease	Probable Alzheimer's disease (F00.0)
Probable frontotemporal dementia	Probable frontotemporal dementia (F07.0)
Probable other forms of dementia	Probable other forms of dementia (F07.1-F07.9)
Probable mild neurocognitive disorder	Probable mild neurocognitive disorder (6A05.0)
Probable major neurocognitive disorder	Probable major neurocognitive disorder (6A05.1)
Probable very mild neurocognitive disorder	Probable very mild neurocognitive disorder (6A05.2)
Probable mild to moderate neurocognitive disorder	Probable mild to moderate neurocognitive disorder (6A05.3)
Probable moderate to severe neurocognitive disorder	Probable moderate to severe neurocognitive disorder (6A05.4)
Probable severe neurocognitive disorder	Probable severe neurocognitive disorder (6A05.5)

Care Coordination

- PwD are in need of and will greatly benefit from coordinated care and care coordination.
- **Medications:** Commonly health issues, diverse care needs, and complex medication regimens.
- **Comorbidities:** Emotional support, medication, community resources, connections to social services, and medication with advanced care planning.
- **Facilitators:** Interprofessional collaboration, referral care coordination of patients across diverse care networks.
- **Benefits:** Improves PwD outcomes and satisfaction, help PwD to locate resources, helpful information, comprehensive assessment, and direct care support services.

Quality Measures of HVC

1. Disclosure of dementia diagnosis
2. Support and education of caregivers
3. Screening for BPSD
4. Functional status assessment
5. Safety concerns screening and followup
6. Driving screening and followup
7. Palliative care counseling and advance care planning
8. Pain assessment and followup
9. Psychological management

Community Resources

• Regular services and	• Continuing care retirement communities
• Adult care centers	• Alzheimer's Society
• Residential care	• Alzheimer's Association
• Working homes	• Alzheimer's Disease Clinic
• Respite services	• Dementia Alzheimer Program
• caregiver Resource Centers	

Online Video and Simulation

- [How to use video for training series](#)
- [Agencies use virtual reality](#)
- [Alzheimer's Association: 10 ways to help someone with dementia](#)
- **Agitation:** refers to an ill-defined spectrum of abnormal hyperactive motor behaviors, such as wandering, leaving home, and physically or verbally aggressive behaviors, such as rejection of care.

Technology

- EMR: Communication, information gathering, telepresence, and data checks (Nov. 8 Aug. 2023).	- Benefits of EMR include: <ol style="list-style-type: none"> 1. Decreased health care cost 2. Preventing caregiver burnout 3. Increasing medication adherence 4. Reducing daily life 5. Reducing social life, and 6. Improved clinical outcomes.
- EMR: Improves diagnosis of comorbidities.	
- PwD can fill obligations and engage in social activities, and participate.	
- Apps improve social connectivity	

Simulation: Refusal to take medications

1. Pick a doctor or individual that the person with dementia wants to please. Tell him/her that the person wants him/her to take the medication.
2. Consider liquid medicine or crushing pills in food.
3. Sit down to offer medication instead of standing overhead.
4. Be patient if the person is refusing. Allow PwD to calm down before trying again.
5. Give most important medications first.

Appendix D: Program Evaluation Questionnaire**Unique Identifier:** _____**Date:** _____

Rate your level of agreement on a scale of 1 to 5, with higher scores indicating more substantial agreement.

1. How confident are you that the program met the agreed-upon objectives?

1. No confidence
2. Little confidence
3. Some confidence
4. Confidence
5. High confidence

2. How confident are you in implementing the program's content into the routine care of PwD?

1. No confidence
2. Little confidence
3. Some confidence
4. Confidence
5. High confidence

3. How confident are you that the educational program increased your overall confidence to care for PwD?

1. No confidence
2. Little confidence
3. Some confidence
4. Confidence

5. High confidence

4. Will the information in this training help educate nurses to improve their ability to care for PwD?

1. No confidence
2. Little confidence
3. Some confidence
4. Confidence
5. High confidence

5. How confident are you that the speaker was knowledgeable about the program content?

1. No confidence
2. Little confidence
3. Some confidence
4. Confidence
5. High confidence