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Development of a Practice Guideline for DNP Prepared Nurse Practitoners Working in Long-Term Care Facilities

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MSN, Indiana Wesleyan University, 2008

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Clinical evidence-based practice guidelines providing recommendations for health care decision making have become vital components of long-term health care practice in the United States. Frequently changing guidelines have complicated nurse practitioners' (NPs) efforts to implement evidence-based practice into the daily care that they provide to patients. The purpose of this project was to develop an evidence-based practice guideline for doctoral-prepared NPs working in long-term care facilities. This project is important because practitioners use practice guidelines to provide patients with the most appropriate, evidence-based care. Kolcaba's comfort theory was used to guide this project. Kolcaba's theory holds that comfort exists in 3 forms: relief, ease and transcendence. Comfort theory, with its emphasis on physical, psychospiritual, sociocultural, and environmental aspects of comfort, will lead to a proactive, diverse, and multifaceted approach to providing patient care. A complete practice guideline was developed for doctoral-prepared NPs. For the review of the scholarly evidence, an electronic search that yielded 34 articles was completed. Twenty-six of these articles were excluded because the articles were more than 20 years old and/or focused on a specialty. Findings from the 8 articles were used to develop the practice guideline, which was reviewed by an advisory committee of 7 experts. The AGREE tool was used by the advisory committee to provide feedback on the quality of the practice guideline. Implementation of the practice guideline will take place in a facility in Indiana that currently uses 3 NPs. A doctoral-prepared NP will evaluate the practice guideline annually for patient trends including hospital readmission and infection rates.

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Dedication

I dedicate this project to my beloved sister, Nicole Renee Johnson and my amazing father, Pat George Franklin, both of whom unexpectedly passed away during the development of this project. It comforts me knowing that you are together again and resting in the arms of our Lord. I love and miss you both.

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Section 1: Nature of the Project

Introduction

According to the Henry J. Kaiser Family Foundation (2013), in 2013 there were approximately 201,642 nurse practitioners (NPs) in the United States approximately 5% of these professionals held a doctorate degree. The foundation estimated that 4% of all U.S. NPs work in long-term care settings or with the older adult population (kff.org, 2013). This number should continue to rise as more people in the United States are living past the age of 65. The increased number of persons older than 65 years will lead to increased health care demands. According to the Centers for Disease Control and Prevention (CDC) (2013), the demands associated with long-term care could pose the largest challenge for both personal resources and public resources (CDC, 2013).

To assist with addressing the challenges posed by an aging population, the health care community, nursing in particular, needs to continue to grow and advance. On October 25, 2004, member schools of American Association of Colleges of Nursing (AACN, 2012) voted to proceed with the *Position Statement on the Practice Doctorate in Nursing.* According to the AACN (2012), this vote called for moving the current level of preparation necessary for advanced nursing practice from the master's degree to the doctoral degree by the year 2015. Before the vote, an AACN task force conducted 3 years of research and consensus-building with a variety of stakeholder groups about the need for a practice doctorate in nursing (AACN, 2012). The primary function of health care is to provide the best possible care to patients, families, and communities. DNP-prepared NPs can offer a good blend of clinical, organizational, economic and leadership skills that

are acceptable, economically feasible, and which significantly impact health care outcomes (AACN, 2012).

AACN's (2012) call for more nurses with doctorates in nursing practice (DNP) is understandable given changes in the United States' health care system. Some of the factors building momentum for the change in nursing education include the expansion of knowledge underlying practice, increasingly complex patients, concerns about the quality of care and patient safety, shortages of nurses and doctorally-prepared nursing faculty, and increasing educational expectations for health care team members (AACN, 2012). This complex environment will require a higher level of scientific knowledge and practice expertise to assure superior patient outcomes (AACN, 2012). The Institute of Medicine, the Joint Commission, Robert Wood Johnson Foundation, and other professional organizations have also called for a revamping of educational programs that prepare U.S. health care professionals (AACN, 2012). In offering the DNP, nursing is in line with other health care fields, such as medicine (MD), dentistry (DDS), pharmacy (PharmD), psychology (PsyD), physical therapy (DPT) and audiology (AudD). The Institute of Medicine (IOM) has suggested that all disciplines need to raise the bar in leadership training. The DNP degree comes with more responsibility as a health care professional, and offers increased credibility to meet the demands of a modern health care system and its increased complexity (Zaccagnini & White, 2011).

Background

In spite of its increasing prevalence in the health care setting the role of the DNP-prepared NP is new and still poorly defined. According to Zaccagnini and White (2011),

the percentages of DNP-prepared nurse practitioners are increasing, but still remains a very small groups (Zaccagnini & White, 2011). Transitioning from the Masters in Science of Nursing (MSN) to the DNP is not intended to just increase the nurse practitioner's level of clinical expertise; it should also increase the nurse practitioner's organizational, economic and leadership skills (Zaccagnini & White, 2011). Proponents of the DNP-prepared NP understand the impact clinical expertise and advanced education can have on patient outcomes (Zaccagnini & White, 2011). The increased educational requirements of DNP-prepared nurse practitioners can and will improve the U.S. health care system and our older adults.

Long-term care facilities include a broad range of health, personal care, and supportive services that meet the needs of older adults or other adults whose capacity for self-care is limited because of an acute or chronic illness, injury, physical, or mental disability; or other health-related condition (CDC, 2013). In exchange for Medicare and Medicaid payments, certified long term-care facilities agree to give each resident the best possible care (Barba, Hu, & Efird, 2011). Specifically, these facilities are required to help attain and/or maintain the highest possible physical, mental, and psychosocial well-being of their residents (Barba et al., 2011). Unless it is medically unavoidable, long term-care facilities are responsible for ensuring that the condition of their resident's does not decline (Barba et al., 2011). Establishing and implementing a practice guideline for the DNP-prepared NP in the long term-care setting is one way to establish a framework for clinical practice and to improve residents' outcomes (Barba et al., 2011).

According to experts, practice guidelines have implications for health care cost, quality, access, patient empowerment, professional autonomy, medical liability, rationing, competition, benefit design, utilization variation, and more (Carryer, Gardner, Dunn, & Gardner, 2007). Practice guidelines are not a new concept. Many professional organizations have been developing practice guidelines for over 50 years, and guidelines concerning suitable care can be located in ancient writings (Carryer et al., 2007). The concept of practice guidelines that is new is the stress that is being placed on systematic, evidence-based guidelines and the interest in processes, structures, and incentives that maintain the successful use of practice guidelines (Carryer et al., 2007). Properly used clinical practice guidelines will provide the residents of the long-term care facility with standardized care, improved quality care and reduce risk (to the resident, health care provider, and the insurer) (Carryer et al., 2007).

For this project, I selected a long-term care facility as my setting because these facilities are often "overlooked" for implementation of new guidelines (AACN, 2012). The practice guideline for this project was developed for use by any DNP-prepared NP in a long-term care facility. In 2012, the Centers for Disease Control and Prevention (CDC), reported that there were 15,673 long-term care facilities in the United States. These facilities include a total of 1,383,488 residents occupying 1,703,213 beds (CDC, 2013). The care needs of the residents in long-term care facilities have become more complex as the residents often have multiple co-morbidities and poly-pharmacy. Residents and families expect that the resident will be given quality, individualized care that meets their needs (Van der Horst & Scott, 2008). According to Van der Horst and Scott (2008), only

55-70% of care is based on current evidence and 20-25% of care is unnecessary or potentially harmful. They view practice guidelines that integrate evidence-based recommendations as essential for health care professionals in providing quality care and improved patient outcomes (Van der Horst & Scott, 2008).

I developed this practice guideline to be used by any DNP-prepared NP working in a long-term care facility. As a current member of The Coalition of Advanced Practice Nurses of Indiana (CAPNI), I enlisted the assistance of the CAPNI group to help with the promotion of the practice guideline. CAPNI was formed in 1999 as a grassroots movement. It brought together local Advanced Practice Nurse (APN) groups from all over the state of Indiana and formed a state level professional organization that focused on issues affecting the healthcare environment in Indiana (www.CAPNI.org., 2015). The group is dedicated to furthering the understanding and advancement of the APN role at the local and state levels, and to protecting the role in the legislative, administrative, and clinical realms (www.CAPNI.org., 2015).

The practice guideline was posted for DNP-prepared NPs working in long-term care facilities on the CAPNI website which has wide reach among Indiana APNs. Permission to post the guideline was granted by the Region 10 representative on the CAPNI board. Posting the practical guideline to the CAPNI website allows for easy access for Indiana APNs.

Problem Statement

According to the Indiana State Department of Health Division of Long-Term Care (ISDH), there were 529 long-term care facilities in Indiana as of January 1st, 2014 (Barth,

2015). The ISDH is responsible for state licensing and federal certification programs for long-term care facilities in Indiana. According to the ISDH, 333 (63%) long-term care facilities in Indiana utilize NPs (Barth, 2015). Across Indiana, long-term care facilities are changing to include not only the typical geriatric patient but also complex and medically unstable post-hospital care. For this reason, long-term care facilities have a higher need for highly trained and committed health care providers, such as the DNP-prepared NP, willing to provide care frequently and on-site to facility residents (Barth, 2015).

The ISDH reports that only about one quarter of long-term care facilities with NPs have implemented clinical practice guidelines (D. Barth, personal communication, February 4, 2015). A practice guideline for the DNP-prepared NP in a long-term care facility will assist in guiding clinical practice and ensure that residents of the facility are receiving the most efficient and up to date care based on current practice guidelines. Van der Horst and Scott (2008) clearly state that practice guidelines are increasingly viewed as critical components of quality care in the long-term care setting. According to AACN (2012), the DNP-prepared NP will have expanded scientific knowledge that will be required for safe nursing practice in an increasingly complex health care system.

Purpose Statement

APNs, in particular NPs with a DNP degree, are in an excellent position to propose scientifically-based recommendations to reduce cost and improve overall health care quality, documentation, and outcomes (Zaccagnini & White, 2011). Zaccagnini and White (2011) clearly state that the DNP-prepared nurse practitioner has much to add to

the national plan for health care delivery and reform (Zaccagnini & White, 2011). The purpose of the proposed project was to develop a practice guideline for DNP-prepared NPs in long-term care facilities. A practice guideline for the DNP will be used to facilitate the role of the DNP-prepared NP in a long-term care facility.

According to Watters (2008), practice guidelines that promote interventions of benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life for the resident. For the residents of the long-term care facility, the greatest benefit that could be achieved by the implementation of a practice guideline is improved health outcomes (Watters, 2008).

Conceptual Model

The conceptual model identified for this project was Kolcaba's comfort theory (Kolcaba, 2001). First developed in the 1990s by Katherine Kolcaba, the comfort theory is a nursing theory. This theory was used to guide the development of a practice guideline for the DNP-prepared NP working in a long-term care facility. The theory is considered to be a middle range theory that has the ability to guide the practice and philosophy of all healthcare providers (McEwen & Wills, 2011). Comfort is described as the event of being supported through having the needs of relief, ease, and transcendence met in four contexts of experience physical, psychospiritual, social, and environmental (McEwen & Wills, 2011). The process of assessing the patient's comfort and needs, developing and implementing appropriate interventions and evaluating the patient's level of comfort following the interventions is the definition of nursing (McEwen & Wills, 2011). A NP can change any or all aspects of the patient, family or surroundings to improve the

patients comfort level (McEwen & Wills, 2011). I believe that the development of a DNP specific practice guideline for use in long-term care facilities will improve resident outcomes, therefore improving their overall comfort.

Outcomes

The primary role of the NP is the provision of direct patient or population care. According to Zaccagnini and White (2011), several researchers have documented the effect that APNs have on health outcomes, including the ability to deliver excellent quality, cost-effective care with high levels of patient satisfaction. The DNP-prepared NP is able to work autonomously, apply advanced clinical practice skills, adopt a leadership role, manage health care delivery systems, and influence health policy (AACN, 2012). With the additional education at the doctorate level, the nurse practitioner in a long-term care facility will be better prepared to navigate the increased complexity of the ever-changing health care system (Zaccagnini & White, 2011). Practice guidelines focus on assisting the DNP in making decisions. A well-developed, evidence-based practice guideline can play a crucial role in the assessment and the quality of the health care provided. Practice guidelines that are clear and concise should prevent and/or help identify and remedy the overuse of care, underuse of care, and poor provision of care (Carryer et al., 2007).

Health care has changed in the last 20 years. People are now living approximately 10 years longer than they did in 1989 and medical advances have brought huge breakthroughs in patient care (CDC, 2013). DNPs must position themselves to emphasize the influence they have on the health care of the individual and the population.

Access to safe, efficient, and affordable health care is a concern shared by all Americans; the DNP is in an excellent position to assist with providing all of these. The outcome of this DNP project was the development of a practice guideline for the DNP-prepared NP in a long-term care facility that will provide the residents of the facility with safe, effective and efficient primary care.

Nature of the Project

The method for the development of the practice guideline for DNP-prepared NPs in long term care facilities was linking them to current practice guidelines that have been established and utilized for practitioners in the acute care setting (Bell, 2012).

Definition of Terms

I use the following terms throughout this document:

> Clinical practice guidelines: Clinical practice guidelines are official recommendations and may include screenings, diagnosis, treatment and management of specific conditions (Singleton & Levin, 2008).
>
> Nurse practitioner (NP): According to the AACN (American Association of Colleges of Nursing) (2012), A nurse with a graduate degree in advanced practice nursing, who NP is able to provide a broad range of health care services, which may include; obtaining patients' histories, performing physical exams, ordering laboratory testing and procedures, diagnosing, treating and managing diseases,

writing prescriptions, making referrals to specialists, and performing certain procedures (AACN, 2012).

Long-term care facility: A facility that provides rehabilitative, restorative and/or ongoing skilled nursing care to patients in need of assistance with activities of daily living. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral facilities, and long-term chronic care hospitals (Barba, Hu, & Efird, 2011).

Doctor of Nursing Practice (DNP): A professional degree that has a focus on the clinical aspects of the disease process. The DNP is intended to be the nursing equivalent degree with other health care doctorates such as psychology, medicine and dentistry (AACN, 2012).

Standards of care: A written statement describing the rules, actions, or conditions that direct patient care. Standards of care guide practice and can be used to evaluate a provider's performance (Van der Horst & Scott, 2008).

Scope of practice: Defines the limits and boundaries of those practice activities within which various advanced practice nurses may legally practice.

Project Question

The question for this DNP project was: What evidence based literature is required to develop a practice guideline for DNP-prepared NPs in order to improve the care in long-term care facilities? The residents who reside in long-term care facilities are now more medically complex because hospitals are discharging patients "sicker and quicker" and hospitals are now focusing on reducing readmission rates. For this reason, long-term care facilities have a higher need for highly trained and committed health care providers, such as the DNP-prepared NP, willing to provide care frequently and on-site to facility residents. A practice guideline for DNP -prepared NPs in long-term care facilities will help guide clinical practice and ensure the residents of the facility are receiving the most efficient and up to date care based on current practice guidelines.

Relevance to Nursing Practice

The primary purpose of the DNP-prepared NP in the long-term care facility is to provide a complete assessment, treatment plan and evaluation for common and more difficult geriatric conditions. Providing a complete assessment and comprehensive treatment will assist in the prevention of unneeded hospitalizations and promote earlier discharges from hospitals (Sangster-Gormley, Martin-Misener, & Burge, 2013). Since the financial consequences established by the Centers for Medicare and Medicaid (CMS) were instituted, organizations such as long term care facilities are being challenged to

improve care being provided to patients in an effort to reduce hospital readmission rates. Implementing practice guidelines for DNP-prepared NPs is one effort that long term care facility can utilize to provide better care for its residents.

The practice guideline to be utilized in long-term care facilities was established for the DNP-prepared NP because this is the "wave of the future" and will soon be the norm. The field of nursing has been called to move the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate-level by the year 2015. Although this practice guideline was developed for the DNP-prepared NP, it could also be utilized by a MSN-prepared NP in a long-term care facility.

Potential for Social Change

According to the CDC (2013), the elevated fertility in many countries during the two decades after World War II, will result in an increased number of people aged 65 and over during the next two decades. The growing number of older adults increases demands on the public health system and on medical and social services, including long-term care facilities (CDC, 2013). Chronic diseases, which affect older adults disproportionately, contribute to disability; diminish quality of life, and increased health and long-term care costs (CDC, 2013). A practice guideline that is specific to the long-term care facility resident will help provide the resident with safe, effective and efficient care by doctorally prepared NPs.

Practice guidelines should include valuable information that can save providers time weeding through separate research studies to find information (Van der Horst & Scott, 2008). According to Van der Horst and Scott (2008), guidelines are just that –

guidelines. They are not standards; so, with that comes the flexibility to adjust them to fit the organization's unique care philosophy, specific care issues and the residents' needs. Most practice guidelines are broad recommendations meant to assist practitioners in a variety of settings (Van der Horst & Scott, 2008).

Assumptions and Limitations

The biggest assumption regarding practice guidelines for DNP-prepared NPs working in long-term care facilities was that the guidelines were accurate. Inaccurate or flawed practice guidelines harm the provider by providing inaccurate information and clinical advice, both of these compromises the quality of the care being provided to the resident.

The limitation of this project was that this practice guideline was developed in the state of Indiana and the clinical practice of doctoral prepared NPs may vary in other states. As a result, this practice guideline may need to be modified or adapted for other long-term care facilities.

Summary

Development of a practice guideline for the DNP-prepared NP in long-term care facilities was the main purpose of this project. According to Barba, Hu, and Efird (2011) practice guidelines are broad recommendations that are meant to assist practitioners in a variety of settings. Practice guidelines are increasingly viewed as vital components of quality care in the long-term setting (Barba et al., 2011). A facility specific project will improve the care and resident outcomes in the long-term care facility.

In Section 2, a review of the literature was completed. This section of the proposal examined the literature regarding the role of the NP in a long-term care setting and the benefit of practice guidelines. For the review of the scholarly evidence, numerous searches were conducted electronically and the following databases were used: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline and PubMed.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

My purpose in carrying out this project was to develop a practice guideline for DNP-prepared NPs working in long-term care facilities. According to the American Academy of Nurse Practitioners (2007), NPs are licensed independent practitioners who practice in ambulatory, acute and long-term care facilities as primary and/or specialty care providers (Zaccagnini & White, 2011). Until recently, those in the profession have viewed a master's degree as providing adequate preparation for a NP to function in an advanced nursing capacity (Zaccagnini & White, 2011). However, the health care field is increasingly complex and health care providers will need additional skills and training to improve the quality of care that they provide to patients (Zaccagnini & White, 2011). Health care providers will need improved assessment skills, the knowledge and ability to perform complex therapies and interventions and the experience to provide care to the patients and families in an environment that is becoming increasingly complex and ever-changing (AACN, 2012).

According to Zaccagnini and White (2011), an improvement or change in health care delivery should benefit a population, not just a single patient or practitioner. In this case, the population that was targeted was DNP-prepared NPs who provide care to residents in long-term care facilities. The literature review conducted supports the validity of the problem as very little information was located. Scholarly support for this project included the use of nursing theory to provide the conceptual framework for the project.

Literature Search Strategy

In this section of the project I examined the literature regarding the role of the NP in a long-term care setting and the benefit of practice guidelines. For the review of the scholarly evidence, I conducted numerous electronic searches and the following databases were used: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline and PubMed. Articles that were older than 10 years were eliminated. The terms used for the search included: nurse practitioner, doctorate prepared nurse practitioner, DNP, nursing home, long-term care facility, and practice guidelines. My search yielded 34 articles. Many of the articles that were found were practice guidelines for specific disease conditions such as hyperlipidemia, diabetes, congestive heart failure, and depression. I excluded 26 of these articles because the articles were more than 20 years old and/or focused on a certain specialty, such as cardiology, pulmonology, or endocrinology. Eight articles were maintained and will be discussed in the review of the literature.

I was not able to locate any articles that were specific to practice guidelines for the DNP-prepared NP working in a long-term care setting. Three articles offer clinical practice guidelines for older adults and for use in nursing homes. Several of the articles found using the key words “nurse practitioner” were not specific to the doctoral prepared NP. This is probably related to the fact that the DNP is still a relatively new degree. The gap in the literature is a clear indicator of the necessity of this project. The following articles were discussed according to design, sample, method, findings and limitations.

Review of the Literature

The study in the literature review was a sub-study of an in-depth case study of eight long-term care facilities. The purpose of the study by Colon-Emeric et al. (2007) was to identify barriers to, and facilitators of, the diffusion of clinical practice guidelines and clinical protocols in nursing homes. The design for this study was a qualitative analysis and the settings were four randomly selected nursing homes. Rogers' Diffusion of Innovation model was used to guide the study design (Colon-Emeric et al., 2007). The 35 participants included nursing home staff, physicians, nurse practitioners, administrative staff, nurses, and certified nursing assistants. The researchers found that the most frequently cited barriers by physicians were provider concerns that the clinical practice guidelines were "checklists" that replaced clinical judgment, perceived conflict with resident and family goals, limited facility resources, lack of communication between providers and across shifts, facility policies that overwhelm or conflict with the practice guidelines, and Health Insurance Portability and Accountability Act regulations interpreted to limit certified nursing assistants access to clinical information. The limitations for this study included the small sample size and the fact that the study only included four sites.

A qualitative study by Klardie, Johnson, McNaughton and Meyers (2004) explored the use of interventions selected from 10 clinical practice guidelines and investigated the potential effects of recommended interventions on patient outcomes. Klardie et al., (2004) indicated that developing an evidence-based clinical practice entails the integration of current research and clinical practice guidelines into daily treatment

decisions by providers. The study illustrates a framework for understanding and applying principles of evidence based practice. The implementation of interventions recommended by clinical practice guidelines and the interventions' potential effects on patient outcomes were explored. One limitation of this study was the restrictive nature of the specific clinical practice guidelines used (Klardie et al., 2004). The clinical practice guidelines used for this study were specific to certain medical conditions such as diabetes mellitus and hyperlipidemia. Findings of the study demonstrated that evidence-based clinical practice guidelines allow NPs to deliver cost-effective, quality health care that reflects innovative research while incorporating the individualized needs and preferences of the patient (Klardie et al., 2004).

The purpose of the study by Resnick, Quinn and Baxter (2004) was to test the feasibility of the implementation of clinical practice guidelines for pain management and falls and fall risk, in a long-term care facility. Resnick et al. (2004), used a single-group repeated measures design for the quantitative component. The settings for the study were 40 long-term care facilities in Maryland. Thirty-two of the 40 facilities that participated in a training program for clinical practice guideline implementation were interested in implementing clinical practice guidelines, and 23 volunteered to participate in the study. Thirteen of the facilities implemented the falls and fall risk clinical practice guidelines, 10 facilities implemented the pain management clinical practice guidelines, and eight facilities implemented both clinical practice guidelines (Resnick et al., 2004). Evaluation of the falls clinical practice guideline was based on 127 randomly selected cases preimplementation and 119 randomly selected cases postimplementation from the 23

facilities. Qualitative data was also collected from 20 of the 23 facilities Directors of Nursing. According to the results of the study, in those facilities that did implement the clinical practice guidelines, there was evidence that the guidelines were implemented and utilized. Qualitative data lead to four major themes including challenges to the implementation of the clinical practice guidelines, benefits of implementation, process recommendations and recommendations for changes in the clinical practice guidelines (Resnick et al., 2004). Resnick et al. concluded that the study provided support for the feasibility of clinical practice guidelines in facilities that voluntarily attempted to implement the guidelines. Additionally, the findings provided useful suggestions for how to facilitate the implementation process (Resnick et al., 2004). Limitations for this study include the limited sample size and the geographical area of the study being contained to only one state, Maryland.

The purpose of the study by Mutasingwa, Ge, and Upshur (2011) was to examine the applicability of ten common clinical practice guidelines to elderly patients with multiple comorbidities. For the purpose of the study, elderly was operationally defined as anyone older than 65 years of age. A content analysis of published Canadian clinical practice guidelines for the following chronic conditions: diabetes, hyperlipidemia, dementia, congestive heart failure, depression, osteoporosis, hypertension, gastroesophageal reflux disease, chronic obstructive pulmonary disease and osteoarthritis were conducted (Mutasingwa et al., 2011). The authors concluded that many existing clinical practice guidelines discussed the elderly population and only a handful addressed issues related to the elderly with comorbidities. Based on these findings, Mutasingwa et

al. (2011) proposed that ideal practice guidelines should consider an open discussion about patients' preferences, benefits of treatment interventions in advanced age, time to benefit from treatment, trade-offs for function over disease control, as well as acknowledgment of uncertainty (Mutasingwa et al., 2011). The findings of the study indicated that only a handful of clinical practice guidelines adequately address important issues common in the care of elderly patients (Mutasingwa et al., 2011). Adequate clinical practice guidelines for the elderly are of particular importance given the demographic transition. This study had a few limitations. The first limitation was that the study only included 10 clinical practice guidelines for the most common chronic conditions that are seen in the elderly. Second, there was no validated instrument to evaluate applicability of clinical practice guidelines to elderly with comorbidities (Mutasingwa et al., 2011).

The purpose of a quantitative study by Grol et al., (1998) was to determine which attributes of clinical practice guidelines influence the use of guidelines in decision making in clinical practice. The subjects included 61 general practitioners who made 12,880 decisions in their contacts with patients. The study design was observational and the study related the use of 47 different recommendations from 10 national clinical guidelines to 12 different attributes of clinical guidelines. Findings from this study indicated that an increase in the number of clinical practice guidelines produced and implemented in the U.S. and other countries has prompted studies and discussions on their value and effectiveness (Grol et al., 1998). According to Grol et al. (1998), the scientific validity and reliability of the guidelines received the most attention. Less

attention was paid to the features of guidelines that may determine their use in clinical decision making. The authors, concluded, to date, research on clinical practice guidelines has been scarce. The goal of research should be to implement guidelines in clinical practice, unfortunately, too many practice guidelines do not remain in regular use (Grol et al., 1998). A limitation of this study was the fact that 36% of the recommendations that were used in the study were considered to be too vague and not specific enough, leading to provider non-compliance.

The next study was conducted in 35 nursing homes maintained by the Department of Veterans Affairs (VA). The purpose of a cross sectional study by Berlowitz et al. (2003) was to examine quality improvement and clinical practice guideline implementation in nursing homes, its association with organizational culture and its effects on pressure ulcer care in the facility. Nursing homes differed significantly in the extent of their implementation with scores on a 1 to 5 scale ranging from 2.98 to 4.08. Implementation was greater in nursing homes with an organizational culture that promoted and emphasized innovation and the benefits of teamwork (Berlowitz et al., 2003). According to the findings, there was no significant association between quality improvement implementation and adherence to guideline recommendations on abstracted from records and rate of pressure ulcer development. According to Berlowitz et al. (2003), past research has suggested that more than 75 percent of nursing homes practice some type of quality improvement activities and clinical guidelines and that the adaption of these practices is influenced by both institutional and market factors. However, these results were based on surveys of nursing home administrators, which may not capture the

true extent of pressure ulcer guideline implementation within the organization (Berlowitz et al., 2003). Limitations of this study included a lack of evidence regarding the effectiveness of Quality Improvement in nursing homes and the limited amount of adequately trained staff working in the long-term care facility (Berlowitz et al., 2003).

A descriptive study conducted by Barba et al. (2011) focused on differences in nurses' satisfaction with the quality of the care in acute care and long-term care settings. The self-selected sample included 298 registered nurses and licensed practical nurses that provided care in 89 long-term care and 46 hospitals in a southern state (Barba et al., 2011). Independent t-tests were used to examine differences between the long-term care and acute care settings. In this study, participants in long-term care had a greater satisfaction with the quality of geriatric care than those in acute facilities. Nurses surveyed for the study considered institutional practices that supported the use of evidence-based policies and clinical guidelines, adequate and appropriate resources, administrative commitment and support of specialized geriatric nursing knowledge and skills as essential to quality geriatric care.

Barba et al., (2011) concluded that the best way to ensure quality care was by using professional standards and practice guidelines to guide the practice environment. Geriatric experts in a variety of disciplines have developed best practices for the care of older adults based on the research; however, there was little evidence that these guidelines were being used in daily care of the long-term care facility residents (Barba et al., 2011).

This study was relevant to the project and to clinical practice because modification of geriatric practice environments and leadership commitment to evidence-based clinical practice guidelines can and do improve the nurses' perception of quality of geriatric care (Barba et al, 2011). According to Barba et al., limitations of this study were the self-selected, convenience sample and geographic location, which limited the findings beyond the sample.

The objective of the next study by Dosa, Bowers and Gifford (2006) was to evaluate the quality of the federally mandated Resident Assessment Protocols (RAPs) by measuring the adherence to established criteria for clinical practice guidelines. The design of the study was quantitative and the setting was 23 nursing homes in the United States. Each RAP was evaluated using the Institute of Medicine review criteria for measuring the quality of clinical practice guidelines (Dosa et al., 2006). Criteria included measurements of RAP validity, reliability, reproducibility, clinical applicability, clinical flexibility, clarity, format, scheduled review, expertise needed to complete, multidisciplinary process, and resources needed to complete. According to Dosa et al. (2006), two reviewers, geriatricians with expertise in nursing home medicine, evaluated each RAP on the degree of compliance with each criterion using a 2-point scale for each criterion. The authors concluded that overall, no individual RAP met all of the review criteria. Notable deficiencies in the RAPs included poor validity, documentation, reliability, clinical flexibility, and clinical applicability. There were a number of limitations for this study. First, scoring of the RAPs was based on the opinion of the authors. The second limitation was that the authors of the study were not experts in RAPs. Finally, it is unclear whether merely changing the RAPs to address some of their shortcomings was enough to make their use more prevalent (Dosa et al., 2006).

Conceptual Model

Kolcaba's comfort theory was used to guide the development of the clinical practice guidelines for the DNP-prepared NP. The theory is considered a middle range theory that has the potential to direct the work and thinking of all healthcare providers

(McEwen & Wills, 2011). Holistic comfort is defined as the immediate experience of being strengthened through having one's needs for relief, ease, and transcendence met in four contexts of experience physical, psychospiritual, social, and environmental (McEwen & Wills, 2011). Nursing, including the DNP-prepared NP, is described as the process of assessing the patient's comfort needs, developing and implementing appropriate nursing interventions, and evaluating patients' comfort following nursing interventions (McEwen & Wills, 2011). To enhance comfort, a NP can manipulate any aspect of the patient, family or institutional surroundings (McEwen & Wills, 2011). The development of a DNP specific practice guideline for use in long-term care facilities should improve residents comfort and subsequently improve patient outcomes.

Summary

With an ever increasing expectation for positive health care outcomes, care must be delivered with validated systems such as the use of a practice guidelines to help reduce the variations in care practices, reduce potential negative effects of old practices, discourage outdated practices, assist in avoiding errors and eradicating care issues that are less effective.

A practice guideline for long-term care DNP-prepared NPs needs to be validated by colleagues, patients, and physicians and include the latest evidence-based findings from clinical practice, thereby keeping pace with advances in the profession. Findings

from the literature show that a practice guideline for the DNP-prepared NP could provide a new and effective method of improving care in long-term care facilities.

According to Van der Horst and Scott (2008), practice guidelines are assembled in a variety of formats. Some of the more complex guidelines have accompanying documents that are a condensed, easier to read and use version. Many guidelines include summarized information in graphs, flowcharts and algorithms that help the user understand and highlight the guideline's key recommendations (Van der Horst & Scott, 2008).

In order to address the issue of variability of practice guidelines quality, an international team of practice guideline developers and researchers created the Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument (Singleton & Levin, 2008). Since being released in 2003, the AGREE instrument advanced the science of practice guideline appraisal and rapidly became the standard for practice guideline evaluation and development (Singleton & Levin, 2008).

Section 3: Methodology

Introduction

The purpose of this project was the development of a practice guideline for DNP-prepared NPs in long-term care facilities. From the literature, practice guidelines promote interventions of benefit, discourage ineffective interventions, and have the potential to reduce morbidity and mortality and improve quality of life for the resident (Watters, 2008). Generally speaking, the way clinical practice guidelines are developed can strongly affect their potential for effective use by practitioners (Watters, 2008). Planning for successful implementation of a practice guideline should start with the development of the practice guideline and continue through cycles of revisions (Watters, 2008). Practice guidelines should be specific, comprehensive, and flexible enough to be utilized in everyday clinical practice (Watters, 2008). The resulting practice guideline should be logical, clear and easy for the intended user to follow (Watters, 2008).

The practice guideline for this project was developed using Kolcaba's comfort theory as a guide. The comfort theory framework suggests that a culture of comfort can be achieved by implementing a practice guideline that lead to improved patient outcomes (Kolcaba, 2001). The comfort theory has six basic concepts: health care needs, nursing interventions, intervening variables, patient comfort, health seeking behaviors, and institutional integrity (Kolcaba, 2001).

According to the comfort theory, the provision of comfort is an essential feature of nursing practice in that nurses assess the patient's comfort needs, develop and implement appropriate plans of care, and evaluate the patient's comfort after the care has

been implemented (Kolcaba, 2001). These skills are the core of practice for the DNP-prepared NP (Kolcaba, 2001). The use of this model relates to and supported the development of this project by guiding the development of the practice guideline for the DNP-prepared NP. The primary goal of the DNP-prepared NP in a long-term care facility is to provide residents and their families with safe, effective care to bring them to a state of comfort.

Guideline Development

In the past 10 years, clinical practice guidelines have become a familiar part of clinical practice. Practice guidelines help practitioners to provide effective care and ensure a standard of care among providers that are intended to improve patient outcomes (Singleton & Levin, 2008). Clinical decisions at the bedside, rules of operation at clinics and hospitals, and spending health care dollars by the government and insurers are being influenced by practice guidelines (Woolf, 1999). Practice guidelines are official recommendations and may include screenings, diagnosis, treatment, and management of specific conditions (Singleton & Levin, 2008). The guidelines may offer specific instructions or screening tests to order, how to provide medical or specialty services, how long patients should stay in the hospital, or other details of clinical practice (Woolf, 1999).

Currently, most states require NPs to use clinical protocols to guide their practice (Singleton & Levin, 2008). According to Singleton and Levin (2008), NPs may either develop their own practice guidelines or adopt standard practice guidelines accepted by their state of practice. According to Van der Horst and Scott (2008), practice guidelines

are assembled in a variety of formats. Some of the more complex guidelines have accompanying documents that are a condensed, easier to read and use version. Many guidelines include summarized information in graphs, flowcharts, and algorithms that help the user understand and highlight the guideline's key recommendations (Van der Horst & Scott, 2008). Guidelines are designed to support the decision-making process in patient care (Singleton & Levin, 2008).

In order to address variability in the quality of practice guidelines, an international team of practice guideline developers and researchers created the Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument (Singleton & Levin, 2008). Since being released in 2003, the AGREE instrument advanced the science of practice guideline appraisal and rapidly became the standard for practice guideline evaluation and development (Singleton & Levin, 2008). The AGREE tool is intended to be used by policy makers, guideline developers, healthcare providers, and educators (Singleton & Levin, 2008).

According to Singleton and Levin (2008), the tool features six quality domains (scope and purpose, stakeholder involvement, rigor of development, clarity and presentation, application, and editorial independence) which are assessed using 23 items. A study conducted by MacDermid et al. (2005) evaluated the reliability and validity of AGREE tool to assess the quality of practice guidelines. The study included 69 providers that were classified as generalists, specialists or researchers. Reliability between pairs of appraisers indicated low to high reliability depending on the domain and number of appraisers. The highest reliability achieved exceeded 0.79. The authors concluded that the

construct validity of the AGREE instrument was supported in that expected differences on rigour of development domains were observed between expert panels using the tool versus non-expert users. Validity was also supported by the correlation observed between overall assessment and the rigour of development domain. MacDermid et al. (2005) concluded that the findings suggest that the AGREE instrument is reliable and valid when used to assess the quality of clinical practice guidelines.

Based on the copyright notice, the AGREE Instrument is the product of an international collaboration. The tool may be reproduced and used for educational purposes, quality assurance programs and critical appraisal of clinical practice guidelines (MacDermid et al., 2005). Therefore, no written permission to use the tool was required (www.agreetrust.org). To improve the reliability of the AGREE instrument, there should be more than one appraiser for the practice guideline (MacDermid et al., 2005). For this reason, I established an advisory committee of seven members. A 4-point Likert scale, from strongly agree (4) to strongly disagree (1), is scored for each item within a domain. Independent domain scores are the outcome, which allows the appraiser or developer, on the basis of the domain score review, to give a subjective and appropriate assessment of the practice guideline (Singleton & Levin, 2008). The AGREE instrument is generic and can be applied to clinical practice guidelines in any area of practice including those for diagnosis, health promotion, treatment or interventions (MacDermid et al., 2005).

Practice guidelines should be carefully implemented. What works in one long-term care facility may not necessarily work in another. Van der Horst and Scott (2008), suggest that a combination of implementation strategies may be more effective than one

single strategy. The example that Van der Horst and Scott (2008) gave is that if 30% of the patient population have dementia, falls, wandering and incontinence then several relevant recommendations can be cross-referenced to ensure that recommendations do not contradict one another and the most pertinent recommendations need to be used in combination to offer care that fits with residents' needs.

Project Design and Approach

This evidence-based project was designed to develop a practice guideline for DNP-prepared NPs working in long-term care facilities. A long-term care facility in central Indiana was used in the development of this practice guideline. This facility was selected because a master's prepared NP has been utilized in the facility for over 5 years so the residents and the staff are well acquainted with the practices of the NP, therefore making the transition to the DNP-prepared NP with a practice guideline an accepted transition.

Multiple strategies and activities should be used to effectively create the proper influence to impact the target population and achieve the desired effect (Hodges & Videto, 2011). For this DNP project the target population was DNP-prepared NPs who practice in long-term care facilities. Hodges and Videto (2011) clearly state that the target population should be involved in the selection of the goals and the objectives of the program, in this case the development of the practice guideline. The target population should be involved in the planning and implementation of the project, this will help develop a sense of ownership. Ownership is vital for their involvement in and acceptance of the program. According to Hodges and Videto (2011), the target population can and

should provide the planners with the necessary insight into the target population that could make or break the efforts toward the desired goals of the program. The target population could be involved by establishing a coalition or an advisory board. The participants were DNP-prepared NPs who practice in long-term care facilities in Indiana. The DNP-prepared NP's critical thinking and selective use of theoretical knowledge provides for a comprehensive assessment and accurate diagnosis of the long term-care resident. The comfort theory coupled with the review of literature was used in the development of the practice guideline for DNP-prepared NPs in long-term care facilities.

According to Zaccagnini and White (2011), federal regulations require all projects involving human subjects be reviewed by an institutional review process. The review of this project was completed by an institutional review board (IRB), a committee that was responsible for ensuring that human rights and safety are protected and the project is in compliance with federal regulations. According to Zaccagnini and White (2011), the project developer must submit information about the proposed study to the IRB. The chairperson for the IRB will decide whether the project is exempt or should be presented to the committee for review (Zaccagnini & White, 2011).

DNP Project Outline

1. Part I - Assessment
    A. Rationale - generates, collects, and integrates data from a variety of sources in order make appropriate clinical judgments and decisions (Bell, 2012).

   B. Measurement criteria includes promoting and protecting health by assessing for risks associated with the care of acute and chronically ill residents (Bell, 2012).

2. Part II - Diagnosis
   A. Rationale - diagnoses and prioritizes actual or potential healthcare problems as the basis for designing interventions for the restoration of health or to meet a resident and/or their family's goals (Bell, 2012).
   B. Measurement criteria includes individualizing the diagnostic process based on the uniqueness of the resident including the resident's individuality, cultural differences, spiritual beliefs, gender, race, ethnicity, disabilities, lifestyle, socioeconomic status, age, use of alternative medicines and family configuration to improve the comfort of the patient (Bell, 2012).
3. Part III - Outcome Identification
   A. Rationale - assuring that the resident and the healthcare team identify expected outcomes of care as the basis for developing the plan of care (Bell, 2012).
   B. Measurement criteria includes collaborating with the resident's family and the interdisciplinary team in establishing desired restorative, curative, rehabilitative, maintenance, palliative and end-of-life care outcomes to assist in the comfort of the patient (Bell, 2012).
4. Part IV- Planning

A. Rationale - prepares a plan of care that is sufficient in depth to guide the interdisciplinary team in achieving the desired outcomes for the residents of the long term care facility (Bell, 2012).

B. Measurement criteria includes developing the plan of care to reflect the actual and anticipated needs of the resident and family, and includes their values and beliefs regarding nursing and medical therapies (Bell, 2012).

5. Part V - Implementation

   A. Rationale - accountable for planning, implementing, or delegating therapeutic interventions delineated in the interdisciplinary plan of care (Bell, 2012).

   B. Measurement criteria includes performing and delegating interventions in a safe, appropriate and ethical manner (Bell, 2012).

6. Part VI - Evaluation

   A. Rationale - modifies the plan of care to optimize resident outcomes through evaluation of the resident's changing condition and their response to therapeutic interventions to provide optimum comfort for the resident (Bell, 2012).

   B. Measurement criteria includes performing a systematic and ongoing evaluation of each resident in order to assess the effectiveness and appropriateness of interventions (Bell, 2012).

Project Evaluation Plan

The practice of the DNP-prepared NP is characterized by the application of appropriate theories, research and evidence-based practice to explain human phenomena. This guideline will provide a basis for appropriate nursing interventions and evaluation of patient-oriented health outcomes. The DNP-prepared NP's critical thinking and use of theoretical knowledge provide for a comprehensive assessment and accurate diagnosis of the patient's responses to health problems. Theory and research will guide the DNP-prepared NP's analysis of data, intervention choices, methods of implementation and the evaluation of resident outcomes (AACN, 2012). According to the AACN (2012), it is difficult to accurately evaluate the effects of implemented practice guidelines. While there will always be uncertainty in clinical practice, ensuring that practitioners have appropriate guidelines to follow will bring more evidence to bear on clinician and patient decision making (AACN, 2012).

Project evaluation is a crucial part of planning a program and should be constructed so that it demonstrates the program accomplishments, program improvement, and whether the program goals and objectives are being met (Hodges & Videto, 2011).

Advisory Committee

An advisory committee, who had 14 days to respond, reviewed the project. Appendix 1 includes the instructions for the advisory committee on how to use the AGREE Instrument. Appendix 2 is the AGREE Instrument.

Evaluation of project will be ongoing. The DNP student will be responsible for the annual review to ensure that the practice guideline is still beneficial and current for DNP-prepared NPs in long-term care facilities.

Summary

This evidence-based project was designed to develop a practice guideline for DNP-prepared NPs in long-term care facilities. The project was designed to show that the development of practice guidelines can improve the overall comfort and care of the residents in the long-term care facility. The target population was the DNP and/or MSN-prepared NPs practicing in Indiana in long-term care facilities. The sample was DNP-prepared NPs with clinical practices in long term care facilities in Indiana. Evaluation of this educational project will be ongoing. This project will be evaluated annually by the DNP student to ensure that the practice guideline is still beneficial to the practice of DNP-prepared NPs in long-term care facilities.

The next section, Section 4, will include an evaluation and discussion of the projects findings. The strengths and the limitations of the project as it was implemented will also be discussed. The DNP student will provide an analysis of self in the role as scholar, practitioner, and project manager, drawing connection between this project and the present state and long-term goals.

Section 4: Evaluation/Findings and Discussion

Introduction

The purpose of this project was the development of a practice guideline for DNP-prepared NPs in long-term care facilities. From the literature, practice guidelines promote interventions of benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life for the resident (Watters, 2008). Generally speaking, the way clinical practice guidelines are developed can strongly affect their potential for effective use by practitioners. Planning for successful implementation of a practice guideline should start with the development of the practice guideline and continue through cycles of revisions. Practice guidelines should be specific, comprehensive, and flexible enough to be utilized in everyday clinical practice. The developed practice guideline should be logical, clear and easy for the intended user to follow. The development of this practice guideline was supported by the facility as evidenced by their participation in the development of the guidelines. The findings of this project revealed that the staff of the facility felt that the developed practice guidelines were beneficial for the residents in their facility. Grot et al. (1998) concluded that research on clinical practice guidelines shows that they are beneficial and clinically necessary, despite the fact that research has be somewhat scarce.

Currently, most states require NPs to use clinical protocols to guide their practice (Singleton & Levin, 2008). According to Singleton and Levin (2008), NPs may develop their own practice guidelines or may adopt standard practice guidelines accepted by their state of practice. Practice guidelines are assembled in a variety of formats. (Van der Horst

& Scott, 2008). Some of the more complex guidelines have accompanying documents that are a condensed, easy to read and easy to use version. Many guidelines include summarized information in graphs, flowcharts and algorithms that help the user understand and highlight the guideline's key recommendations (Van der Horst & Scott, 2008).

Evaluation/Findings and Discussion

The need for clinical practice guidelines in long-term care facilities has never been greater than now, especially considering hospital initiatives to reduce readmission rates (Zaccagnini & White, 2011). According to section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program (CMS, 2015). This program requires Centers for Medicare & Medicaid Services (CMS) to reduce payments to hospitals with excess readmissions for certain diagnoses including acute myocardial infarction (AMI), congestive heart failure (CHF), pneumonia, acute exacerbation of chronic obstructive pulmonary disease (COPD) and elective total hip and knee arthroplasties (CMS, 2015). An established clinical practice guideline can ensure safe care and improve patients' outcomes (AACN, 2012). Long-term care facilities are changing to include not only the typical older adult, geriatric patient but also the complex and medically unstable post hospital care (Van der Horst & Scott, 2008). For this reason, long-term care facilities have a higher need for specially trained and committed health care providers, such as the DNP-prepared NPs, who are willing to provide care frequently and on-site to facility residents. A practice guideline for the DNP-prepared NP in a long-term care facility will help guide clinical

practice and ensure that residents of the facility are receiving the most efficient and up to date care based on current practice guidelines. Experts increasingly view practice guidelines as critical components of quality care in long-term care settings (Van der Horst & Scott, 2008).

An advisory committee reviewed the project. This was an important aspect of the project because the DNP-prepared NP must use a systems leadership approach to ensure that organization wide changes in care delivery have the ability to provide improvements in health outcomes and improve patient safety (AACN, 2012). According to AACN (2012), a systems leadership approach is a methodology used to create sustained high performance in conditions of high complexity and uncertainty (AACN, 2012). The advisory committee included seven members. Two members were DNP-prepared NPs who currently practice in long-term care facilities. The five other members included facility representatives such as the administrator; director of nursing; medical director, and two facility unit managers. I sent the practice guideline and AGREE questions to the advisory committee members via email. The advisory committee had 14 days to review the project content. All advisory committee members reviewed and returned their completed AGREE tools within the allotted 14 days.

The AGREE tool consists of 23 key items organized in six domains (AGREE, 2010). The tool's developers intended for each domain to capture a separate dimension of the guideline quality. Each item was rated on a 4-point scale ranging from 4 'strongly agree' to 1 'strongly disagree', with two mid-points (3 'agree' and 2 'disagree'). The scale measures the extent to which a criterion has been fulfilled. The six domain scores

are scored independently and should not be combined into a single quality score (AGREE, 2010). Although researchers may find the domain scores useful for comparing guidelines and deciding on whether or not to use or to recommend a guideline, it is not possible to set thresholds for the domain scores to mark a "good" or "bad" guideline.

The first domain, Scope and Purpose, concerns the overall aim of the guideline, the specific clinical questions and the target population. The questions in this domain include; is the overall objective of the guideline described specifically, is the clinical question covered by the guideline described specifically and is the patients to whom the guideline is meant to apply described specifically. The advisory committee members gave a combined score of 79% for this domain. Upon reviewing the results, the question with the lowest score was the one regarding whether the clinical question covered by the guideline is specifically described. This question received five 3s and two 2s. According to Mutasingwa et al. (2011, p. 254.), clinical practice guidelines have been criticized as being "diagnosis driven rather than patient driven." Diagnosis-specific clinical practice guidelines are particularly challenging to apply to the older adult with multiple comorbidities (Mutasingwa et al., 2011). For this reason, this guideline was developed to not be diagnosis or disease specific.

The second domain, Stakeholder Involvement, focuses on the extent to which the guideline represents the views of its intended users. The questions in this domain include; does the guideline development group include individuals from all relevant professional groups, did the developer include patients' views and preferences, are the target users of the guideline are clearly defined and was the developed guideline piloted among targeted

users. Two questions related to the seeking of patients' views and preferences and whether the guideline has been piloted among target users were considered not applicable for this domain. The advisory committee members for this domain gave a combined score of 93%.

The next domain, Rigour of Development, relates to the process used to gather and synthesize the evidence, the methods to formulate the recommendations and update them. The advisory committee gave a combined score of 83%. The questions in this domain included; were systematic methods used to search for evidence, was the criteria for selecting the evidence clearly described, was the methods used for formulating the recommendations clearly described, the health benefits, the side effects and risks have been considered in formulating the recommendations, there is a link between the recommendation and the supporting evidence, the guideline has been externally reviewed by experts prior to this publication and a procedure for updating is provided. The only question in this domain that was not applicable was question number six. According to Haynes and Haines (1998), evidence and guidelines must be understood by providers if they are going to be applied and utilized. Understanding new material can be a slow and tedious process that is not aided by traditional continuing education. Clinical practice guidelines frequently assist the provider to bridge the gap between knowledge and practice (Haynes & Haines, 1998).

The fourth domain, Clarity and Presentation, deals with the language and format of the guideline. All questions were considered applicable and a combined score of 85% was given for this domain. The questions in this domain include; were the

recommendations specific and unambiguous, were the different options for management of the condition clearly presented, key recommendations are easily identifiable and was the guideline supported with tools for application. To be effective and beneficial, clinical practice guidelines must be clear and concise, and developers' conflicts of interest must be disclosed to ensure trustworthiness, according to the National Quality Measures Clearinghouse (NQMC/NGC) editorial board (Stevens, 2010). The score of 85% for this domain demonstrates the advisory committee feels this practice guideline is clear and concise.

Applicability was the fifth domain and it pertains to the likely organizational, behavioral and cost implications for applying the guideline. In this domain, two questions were considered not applicable. The three questions in this domain include; were the potential organizational barriers in applying the recommendations discussed, were the potential cost implications of applying the recommendations considered and the guideline presents key review criteria for monitoring and/or audit purposes. The score for this domain was a 64%. Upon reviewing the completed AGREE tools, two committee members disagreed with the question that the guideline presented key review criteria for monitoring and/or audit purposes. Although this domain received the lowest score, it does not mean that this is an area of weakness. This domain originally had three questions, two of these questions were not appropriate for this project and therefore, not applicable. With only one question remaining this one question was more heavily weighted than the other domains, which explains the lower score.

The sixth and final domain was Editorial Independence. Editorial Independence concerns independence of the recommendations and acknowledgement of possible conflict of interest from the guideline development group. The questions in this domain include; is the guideline editorially independent from the funding body and any conflicts of interest of guideline development members have been recorded. This domain produced a score of 100%.

The final question on the AGREE tool was related to Overall Assessment and would the reviewer recommend this guideline for use in practice. All committee members would strongly recommend this guideline for use in practice. The main objective of this project was to develop and implement a practice guideline for the DNP-prepared NP in the long-term care facility. Upon implementation, the DNP-prepared NP will review the practice guideline annually to ensure the guideline is still appropriate.

The conclusion from the advisory panel review of the practice guidelines suggests that improvement might be required in the areas of the clinical question being specifically described and key review criteria for monitoring and auditing purposes. Two committee members suggested that they did not feel that the clinical question(s) covered by the practice guideline were specifically described. This practice guideline was designed to be user friendly and not disease or diagnosis specific. Two committee members also suggested that the practice guideline lacked the key review criteria for monitoring and auditing purposes. At this point, auditing and monitoring will be completed by the student on an annual basis. Auditing and monitoring tools were not included in the

practice guideline to keep the guideline user friendly and appropriate for implementation among practitioners.

The care needs of the patients in long-term care facilities have become more complex, as the patients often have multiple co-morbidities and poly-pharmacy. There is a greater expectation by patients and families; the patient will be given quality, individualized care that meets their needs (Van der Horst & Scott, 2008). According to the authors, approximately 30 to 45% of care is not based on current evidence and 20 to 25% of care provided is either not necessary or is potentially harmful. The implementation of evidence-based recommendations provided in a practice guideline ensures the provision of quality care that will lead to improved patient outcomes (Van der Horst & Scott, 2008).

Implications

Implications for Policy

Clinical practice guidelines have the ability to help patients by influencing public policy (Woolf, 1999). Woolf (1999) clearly states that practice guidelines often call attention to under-recognized health issues, clinical services and preventive interventions and to neglected patient populations and high risk groups, such as those patients in a long-term care facility. Services and benefits that may not have been previously offered to patients may be made available as a response to newly implemented clinical guidelines.

Implications for Practice

Evidence-based clinical practice guidelines have been shown to improve the consistency of care that is provided (Woolf, 1999). According to Woolf (1999), patients with identical clinical problems receive different care depending on their clinician, hospital, or location. Clinical practice guidelines offer a remedy, making it more likely that patients will be cared for in the same manner regardless of where or by whom they are treated (Woolf, 1999).

The principal benefit to clinical practice guidelines is to improve the quality of care that is received by the patients. It has been shown in rigorous evaluations that clinical practice guidelines can and do improve the quality of care. (Woolf, 1999) For the residents in a long-term care facility, the greatest benefit that could be achieved by clinical practice guidelines is to improve the resident's health outcomes. According to Woolf (1999), practice guidelines, such as the one developed for the DNP-prepared NP, that promote interventions of proven benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life.

Implications for Research

As evidenced by the gap in literature, clinical practice guidelines, especially in the elderly and long-term care setting require more research. Evidence-based research provides the basis for all clinical practice guidelines and recommendations. The problem is that the healthcare industry is rapidly and ever changing. For this reason, research for clinical practice guidelines should be completed on a continuous basis.

Implications for Social Change

Developed clinical practice guidelines, protocols and care pathways, according to Woolf (1999), are common in American hospitals and health plans, where they are used for quality improvement and cost control. Clinical practice guidelines also offer the patient and or family the benefit of information. Practice guidelines empower the patient and the family to make more informed healthcare decisions and to consider their personal needs and preferences in choosing the best option (Woolf, 1999). In a healthcare system with limited finances, clinical practice guidelines that improve the efficiency of health care can reduce spending and free up resources for other necessary healthcare services.

Strengths and Limitations of the Project

The strength of this project was that the developed practice guideline is somewhat broad and could be utilized in more areas of practice than just long term care. Additional strength of this project is that the staff of the facility where the guideline was developed was familiar with the NP and their practice so their workflow was not interrupted by the project development. The final strength of this project was the development of a workable practice guideline for the DNP-prepared NP in a long-term care facility.

The limitation of this project was that this practice guideline was developed in the state of Indiana and the clinical practice of doctoral prepared NPs may vary in other states. As a result, this practice guideline may need to be modified or adapted for long-term care facilities in other states.

Recommendations

Clinical practice guidelines are becoming a standard part of clinical practice. An evidence-based practice guideline helps ensure proper documentation, follow-up and prompt treatment. Treatment plans for each patient should be individualized based on patient need, circumstance, and wishes (AACN, 2012). A collaborative method is necessary when conducting health promotion research. Collaborative research is research that is carried out by two or more participants. Collaborative research can result in more reliable results.

Summary

The creation of practice guidelines is an effective way of producing basic standards in which health care professionals can adopt current practices. The implementation of a practice guideline for the doctoral prepared NP in this long term-care facility will improve patient satisfaction and improve patient outcomes. Since the use of clinical practice guidelines is still relatively low, developed guidelines must be easy to understand and user friendly to encourage implementation and continued use. Future research should include the development and implementation of disease specific practice guidelines. These practice guidelines should include the diseases/conditions that most frequently affect the elderly, such as diabetes mellitus, hypertension, hyperlipidemia, Alzheimer's disease, and hypothyroidism.

Section 5: Scholarly Product

Dissemination Plan

I selected the long-term care facility as my study setting because these facilities are often "overlooked" for implementation of new practice guidelines (AACN, 2012). The gap in the literature clearly shows that long-term care facilities are frequently overlooked for new interventions. The practice guideline for this project was developed and will be used by a DNP-prepared NP practicing in a long-term care facility. My plans for disseminating the project include having the practice guidelines placed in a new employee orientation manual that will be given to new NPs orienting in the facility. Because the facility is part of a corporation that includes many other long-term care facilities with NPs, it is possible that all facilities within the corporation will be using this developed practice guideline, thus expanding the circulation of my work.

I also believe that the guidelines that I developed are pertinent to others outside my study setting. By submitting a manuscript for publication to a peer-reviewed nursing journal, I can disseminate my project research to a broader nursing audience. Two possibilities are *Journal for Nurse Practitioners*, which is the official publication of the American Association of Nurse Practitioners and *Nurse Practitioner*, which is published by Lippincott, Williams and Wilkins. Dissemination in the two different types of journals would enable me to reach the broadest nursing and professional audience.

As a current member of the CAPNI group, I also plan to disseminate the developed clinical practice guideline on the organization's member website. The practice guideline will be posted and available for the NP member to review and use at their

discretion. According to AACN (2012), passive approaches to project dissemination are less effective than active approaches, dissemination does not occur spontaneously and the process of dissemination needs to be tailored to a variety of audiences (AACN, 2012).

Self-Analysis

One of my favorite quotes from Mahatma Gandhi is "Live as if you were to die tomorrow. Learn as if you were to live forever" (Gandhi, n.d.). I firmly believe that as adults, we should never stop learning and growing. My skills as an APN and a leader have grown tremendously over the years. My goal is to inform other healthcare providers about the benefits and improved outcomes related to the development and implementation of evidence-based clinical practice guidelines. I aim to continue advancing in my profession, become a spokesperson for the implementation of clinical practice guidelines and advocate for improved healthcare in the long-term care setting.

Role as a Scholar

My research interests include (a) use of clinical practice guidelines in the long-term care facility and (b) the benefits of having a NP in a long-term care facility. I will consider future research in the areas of diagnosis specific clinical practice guidelines as identified in the advisory committee feedback for this project. I will continue to evaluate and disseminate the findings of this project in various forums using different media. My goal is to have every NP in my group using my practice guideline for the DNP-prepared NP in their long-term care settings.

Role as a NP

As a scholar practitioner, I will measure my professional growth and development in terms of how effectively I disseminate the findings of my scholarly project. Research and scholarly projects are only beneficial if they are disseminated and made available for other students and professionals to use. My professional focus will continue to be on improving the care that is provided to the patients in the long-term care setting.

Role as a Project Manager

The expectations and the experiences of the DNP project challenged my writing and project development skills. I am very clinically oriented and analytical. For this reason, in depth writing is sometimes a challenge for me. I tend to write the way that I speak. The project also reminded me that changes in health care frequently do not come easily or quickly. As a DNP-prepared NP, I would like to continue to use my knowledge, expertise in practice and optimistic outlook to develop and implement other important health care projects.

Summary

The creation of practice guidelines is an effective way of producing basic standards to guide health care professionals' work and decision-making (Wolff, 1999). The implementation of a practice guideline for doctoral prepared NP in the long-term care facility will improve patient satisfaction and improve patient outcomes. Future research and potential projects should include the development and implementation of disease specific practice guidelines. These practice guidelines should include the

diseases/conditions that most frequently affect the older adults, such as diabetes mellitus, hypertension, hyperlipidemia, Alzheimer's disease, and hypothyroidism.

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Appendix A: AGREE Appraisal Instrument Instructions

AGREE Appraisal Instrument

Instructions for use:

Please read the following instructions carefully before using the AGREE instrument.

1. Structure and content of the AGREE instrument

AGREE consists of 23 key items organized in six domains. Each domain is intended to capture a separate dimension of guideline quality.

a. Scope and purpose (items 1-3) is concerned with the overall aim of the guideline, the specific clinical questions and the target patient population.
b. Stakeholder involvement (items 4-7) focuses on the extent to which the guideline represents the views of its intended users.
c. Rigor of development (items 8-14) relates to the process used to gather and synthesize the evidence, the methods to formulate the recommendations and update them.
d. Clarity and presentation (items 15-18) deals with the language and format of the guideline.
e. Applicability (items 19-21) pertains to the likely organizational, behavioral and cost implications of applying the guideline.

f. Editorial independence (items 22-23) is concerned with the independence of the recommendations and acknowledgement of possible conflict of interest from the guideline development group.

2. Documentation

Appraisers should attempt to identify all information about the guideline development process prior to appraisal. This information may be contained in the same document as the recommendations or it may be summarized in a separate technical report, in published papers or in policy reports (e.g. guideline programs). We recommend that you read the guideline and its accompanying documentation fully before you start the appraisal.

3. Number of appraisers

We recommend that each guideline is assessed by at least two to four appraisers as this will increase the reliability of the assessment.

4. Response scale

Each item is rated on a 4-point scale ranging from 4 ‘Strongly Agree’ to 1 ‘Strongly Disagree’, with two mid points: 3 ‘Agree’ and 2 ‘Disagree’. The scale measures the extent to which a criterion (item) has been fulfilled.

• If you are confident that the criterion has been fully met then you should answer ‘Strongly Agree’.

• If you are confident that the criterion has not been fulfilled at all or if there is no information available then you should answer ‘Strongly Disagree’.

• If you are unsure that a criterion has been fulfilled, for example because the information is unclear or because only some of the recommendations fulfil the criterion, then you should answer ‘Agree’ or ‘Disagree’, depending on the extent to which you think the issue has been addressed.

5. User Guide

We have provided additional information in the User Guide adjacent to each item. This information is intended to help you understand the issues and concepts addressed by the item. Please read this guidance carefully before giving your response.

6. Comments

There is a box for comments next to each item. You should use this box to explain the reasons for your responses. For example, you may ‘Strongly Disagree’ because the information is not available, the item is not applicable, or the methodology described in the information provided is unsatisfactory. Space for further comments is provided at the end of the instrument.

7. Calculating domain scores

Domain scores can be calculated by summing up all the scores of the individual items in a domain and by standardizing the total as a percentage of the maximum possible score for that domain.

Example

If four appraisers give the following scores for Domain 1 (Scope & purpose):

	Item 1	Item 2	Item 3	Total
Appraiser 1	2	3	3	8
Appraiser 2	3	3	4	10
Appraiser 3	2	4	3	9
Appraiser 4	2	3	4	9
Total	**9**	**13**	**14**	**36**

Maximum possible score = 4 (strongly agree) x 3 (items) x 4 (appraisers) = 48

Minimum possible score = 1 (strongly disagree) x 3 (items) x 4 (appraisers) = 12

The standardized domain score will be:

$$\frac{\text{Obtained score} - \text{minimum possible score}}{\text{Maximum possible score} - \text{minimum possible score}}$$

$$\frac{36-12}{24}$$

48-12 = 36 = 0.67 x 100 = 67%

Note:

The six domain scores are independent and should not be aggregated into a single quality score. Although the domain scores may be useful for comparing guidelines and will inform the decision as to whether or not to use or to recommend a guideline, it is not possible to set thresholds for the domain scores to mark a 'good' or 'bad' guideline.

8. Overall assessment

A section for overall assessment is included at the end of the instrument. This contains a series of options 'Strongly recommend', 'Recommend (with provisos or alterations)', 'Would not recommend' and 'Unsure'. The overall assessment requires the appraiser to make a judgment as to the quality of the guideline, taking each of the appraisal criteria into account.

Instructions carefully before using the AGREE Instrument.

Appendix B: AGREE Appraisal Instrument

SCOPE AND PURPOSE

1) The overall objective(s) of the guideline is (are) specifically described.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

2) The clinical question(s) covered by the guideline is (are) specifically described.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

3) The patients to whom the guideline is meant to apply are specifically described.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

STAKEHOLDER INVOLVEMENT

4) The guideline development group includes individuals from all the relevant professional groups.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

5) The patients' views and preferences have been sought.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

6) The target users of the guideline are clearly defined.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

7) The guideline has been piloted among target users.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

RIGOUR OF DEVELOPMENT

8) Systematic methods were used to search for evidence.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

9) The criteria for selecting the evidence are clearly described.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

10) The methods used for formulating the recommendations are clearly described.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

11) The health benefits, side effects and risks have been considered in formulating the recommendations.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

12) There should be explicit link between the recommendations and the supporting evidence.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

13) The guideline has been externally reviewed by experts prior to this publication.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

14) A procedure for updating the guideline is provided.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

CLARITY AND PRESENTATION

15) The recommendations are specific and unambiguous.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

16) The different options for management of the condition are clearly presented.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

17) Key recommendations are easily identifiable.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

18) The guideline is supported with tools for application.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

APPLCABILITY

19) The potential organizational barriers in applying the recommendations have been discussed.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

20) The potential cost implications of applying the recommendations have been considered.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

21) The guideline presents key review criteria for monitoring and/or audit purposes.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

EDITORIAL INDEPENDENCE

22) The guideline is editorially independent from the funding body.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

23) Conflicts of interest of guideline development members have been recorded.

Strongly Agree 4 3 2 1 Strongly Disagree NA

Comments:

OVERALL ASSESSMENT

24) Would you recommend these guidelines for use in practice?

_____ Strongly Recommend

_____ Recommend (with provisions or alterations)

_____ Would not Recommend

_____ Unsure

Appendix C: Guideline I--Assessment

Guideline I. Assessment

The DNP-prepared NP in a long- term care facility collects data for the long term care resident (Bell, 2012).

Rationale
The DNP-prepared NP generates, collects, and integrates data from a variety of sources in order make appropriate clinical judgments and decisions about orders, procedures, treatments and the resident's plan of care (Bell, 2012).

Measurement Criteria
The DNP-prepared NP:

1. Independently performs and documents a complete history and physical examination for the resident of the long term care facility.
2. Prioritizes data collection according to the resident's immediate condition and needs.
3. Collects data in a continuous process in recognition of the nature of the acute and chronic illness.
4. Collects data using appropriate assessment techniques, relevant supporting diagnostic information and diagnostic procedures when appropriate.
5. Will utilize physiologically and technologically developed data to determine the residents' needs or conditions.
6. Distinguishes between normal and abnormal psychological and behavioral changes in acute and chronically ill residents.
7. Assesses for interactive effects of poly-pharmacological and nonpharmacological interventions.
8. Promotes and protects health by assessing for risks associated with the care of acute and chronically ill residents, such as:
    a. Physiological risk: medication side-effects, immobility, impaired nutrition, immunosuppression, fluid and electrolyte imbalance, invasive interventions, therapeutic modalities and diagnostic tests.
    b. Psychological risk: impaired sleep and communication, crisis related to threat of life, self-image, medication side effects, home and educational environment and altered family dynamics.
    c. Healthcare system risks associated with the care of institutionalized residents: including but not limited to, multiple caregivers, polypharmacy, and discoordination of care continuity, care planning, or communication with family or between multiple care providers.
9. Assesses the needs of families of the residents.
10. Integrates data from all available resources to ensure that the pertinent data is complete.
11. Synthesizes, prioritizes, and documents the database in a form that:

a. is confidential, understandable, and retrievable by all members of the healthcare team.
b. minimizes the potential for error, and
c. establishes accountability (Bell, 2012).

Appendix D: Guideline II--Diagnosis

Guideline II. Diagnosis

The DNP-prepared NP in a long-term care facility analyzes the assessment data in determining diagnoses for the long term care resident (Bell, 2012).

Rationale

The DNP-prepared NP diagnoses and prioritizes actual or potential healthcare problems as the basis for designing interventions for the restoration of health or to meet a resident and/or their family's goals (Bell, 2012).

Measurement Criteria

The DNP-prepared NP:

1. Formulates the differential and working diagnosis through the analysis and synthesis of data from a variety of sources, using critical thinking and diagnostic reasoning skills, previous experiences, and evidence based-practice.
2. Formulates diagnoses that encompass both nursing and medical problems.
3. Orders, performs, interprets, and supervises diagnostic tests and procedures that contribute to the formulation of differential diagnoses, working diagnoses and residents plan of care.
4. Prioritizes diagnoses based on the interpretation of available data and the complexity of the residents condition.
5. Collaborates and consults with the interdisciplinary healthcare team, the resident and family when developing differential diagnoses, working diagnoses, and prioritizing the resident's problems.
6. Revises and reprioritizes diagnoses based on new and ongoing resident data and the resident's clinical status.
7. Diagnoses complications of acute and chronic illness considering multiple comorbidities.
8. Individualizes the diagnostic process based on the uniqueness of the resident including the resident's individuality, cultural differences, spiritual beliefs, gender, race, ethnicity, disabilities, lifestyle, socioeconomic status, age, use of alternative medicines and family configuration (Bell, 2012).

Appendix E: Guideline III–-Outcome Identification

Guideline III. Outcome Identification

The DNP-prepared NP in a long-term care facility identifies expected outcomes individualized for the resident (Bell, 2012).

Rationale

The DNP-prepared NP assumes a leadership role in assuring that the resident and the healthcare team identify expected outcomes of care as the basis for developing the plan of care (Bell, 2012).

Measurement Criteria

The DNP-prepared NP:

1. Derives expected outcomes from the residents diagnosis.
2. Identifies expected outcomes that incorporate scientific evidence and are achievable through implementation of evidence-based practices.
3. Identifies expected outcomes that are consistent with the resident's present and potential capabilities, as well as the residents values, culture and environment.
4. Identifies expected outcomes mutually with the resident, family and other healthcare providers.
5. Identifies expected outcomes taking into account the benefits and costs for the resident, family, the facility and society.
6. Establishes intermediate goals that reflect measurable incremental indicators of progress in achieving expected outcomes.
7. Modifies expected outcomes based upon changes in the resident's condition or wishes.
8. Promotes optimal outcomes by minimizing risk and promoting and protecting the health of the residents.
9. Collaborates with the resident's family and the interdisciplinary team in establishing desired restorative, curative, rehabilitative, maintenance, palliative and end-of-life care outcomes (Bell, 2012).

Appendix F: Guideline IV--Planning

Guideline IV. Planning

The DNP-prepared NP in a long-term care facility develops a plan of care that prescribes interventions to attain expected outcomes for the resident (Bell, 2012).

Rationale

The DNP-prepared NP plans care that is sufficient in depth to guide the interdisciplinary team in achieving the desired outcomes for the residents of the long term care facility (Bell, 2012).

Measurement Criteria

The DNP-prepared NP:

1. Is individualized, dynamic, and can be applied across the continuum of long term care.
2. Integrates knowledge of rapidly changing pathophysiology of acute and chronic illness in the resident.
3. Incorporates input from the interdisciplinary team.
4. Prescribes the diagnostic strategies and therapeutic interventions (both pharmacological and nonpharmacological) needed to achieve expected outcomes.
5. Utilizes evidence based-practice.
6. Incorporates health promotion, health protection, and injury prevention measures that are specific to the resident.
7. Facilitates the resident's transition between and within healthcare settings (admitting, transferring, and discharging).
8. Incorporates mutually agreed upon plans for restorative, curative, rehabilitative, and maintenance healthcare, as well as palliative and end-of-life care.
9. Develops the plan to reflect the actual and anticipated needs of the resident and family, and includes their values and beliefs regarding nursing and medical therapies.
10. Incorporates considerations of cost and quality benefits in planning care for the resident.
11. Provides residents and family with information about intended effects and potential adverse effects of prescriptive therapies.
12. Documents the plan of care in a manner of the interdisciplinary healthcare team, to minimize the potential error (Bell, 2012).

Appendix G: Guideline V--Implementation

Guideline V. Implementation

The DNP-prepared NP in a long-term care facility implements the interventions identified in the interdisciplinary plan of care for the resident (Bell, 2012).

Rationale

The DNP-prepared NP has the authority and is accountable for planning, implementing, or delegating therapeutic interventions as outlined in the interdisciplinary plan of care (Bell, 2012).

Measurement Criteria

The DNP-prepared NP:

1. Prescribes interventions consistent with the established interdisciplinary plan of care.
2. Prescribes and performs diagnostic, pharmacologic and therapeutic interventions consistent with the nurse practitioner's education, practice and state regulatory requirements.
3. Performs and delegates interventions in a safe, appropriate and ethical manner.
4. Collaborates with the interdisciplinary healthcare team to implement the plan of care.
5. Implements interventions to support the resident with a decline in condition, as appropriate to the resident and family's wishes.
6. Documents interventions in a manner that:
   a. is confidential, understandable, and retrievable by all members of the interdisciplinary healthcare team.
   b. minimizes the potential for errors.
   c. establishes accountability for the provision of professional services (Bell, 2012).

Appendix H: Guideline VI--Evaluation

Guideline VI. Evaluation

The DNP-prepared NP in a long-term care facility evaluates the resident's progress toward the attainment of anticipated goals (Bell, 2012).

Rationale

The DNP-prepared NP modifies the plan of care to optimize resident outcomes through evaluation of the resident's changing condition and their response to therapeutic interventions (Bell, 2012).

Measurement Criteria

The DNP-prepared NP:

1. Performs a systematic and ongoing evaluation of each resident in order to assess the effectiveness and appropriateness of interventions.
2. Incorporates the use of quality indicators, scientific evidence, and the risk/benefit analysis of the treatment process when evaluating the patient's progress toward expected outcomes.
3. Utilizes interdisciplinary collaboration and multiple data resources as appropriate.
4. Modifies the plan of care based upon evaluation of outcomes.
5. Documents the evaluation process, and provides the results to appropriate healthcare providers.
6. Consults and makes appropriate referrals as needed, based on the evaluation process (Bell, 2012).

Appendix I: Institutional review board (IRB) number

My IRB approval number is 07--08—150407183.