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Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

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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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2016

Abstract

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MS, Walden University, 2014

BSN, Coppin State University, 2012

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The patient centered care (PCC) model is recommended by the Institute of Medicine for individuals with intellectual and developmental disabilities. The problem identified in this quality improvement (QI) project was that PCC practices had not been included in the training curriculum within the organization. Framed within the plan-do-study-act model of QI, the purpose of this project was to develop an educational initiative on PCC that included a curriculum plan, a pretest/posttest, a protocol, a revision of the training policy, and an implementation and evaluation plan. Drawing upon the evidence-based literature and using a team approach, a curriculum plan on PCC practices was developed which included a pretest/posttest to evaluate staff knowledge on the curriculum before and after the training. Three content experts from the committee approved the curriculum and validated the pretest/posttest items. The content validation index was 0.99 showing that each item reflected the content and objectives of the curriculum. As well, a training protocol was developed which identified the steps for provision of the curriculum to maintain consistency for all users. The training policy was revised to set expectations for all staff for the incorporation of the PCC practices into the organization. This initiative will be implemented into the organization using Kurt Lewin's model of change to guide PCC practices. A recommendation was made to add a small section on "people's first language" to the training to preserve patients' dignity and respect during communication. This project contributes to social change by promoting PCC practices among healthcare workers thus limiting healthcare disparities and improving access for persons with intellectual developmental disabilities.

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Dedication

This project is dedicated in honor of my late parents, Marie Ngakam and Roger Nappi, who believed in me at an early age and taught me that education is the key to success. May you so rest in peace!

To all healthcare professionals who chose to practice in the field of intellectual and developmental disabilities, your patience and willingness to support and advocate for better care for this population reflect your eagerness to achieve equality of care and eliminate healthcare disparities.

Acknowledgments

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Secondly, I appreciate my family, friends, and colleagues who have been there for me from the beginning to the end, especially Mr. Andre Tchokouani, who motivated me even when I was so overwhelmed. You made sure to check on me on a regular basis and always provided me with words of encouragement. To Danie Joelle Hyotta, who told me, "The sky is your limit." You were a significant source of support and inspiration during the past few years. Unfortunately, you did not live long enough to see this day coming as cancer took you away on May 18, 2015. May your soul rest in peace!

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Third, to my beautiful and wonderful children, Sandy Shannen, Daryll, and Marilyn-Vera Ndeutchoua, who could not wait for this project to be over with. You told

your teachers and friends that your mother is a doctor. How sweet! I thank you for your patience and understanding during these years. I will eventually make it up to you.

Lastly, to my lovely husband, Rock Ndeutchoua, who could not wait to call me Dr. Ndeutchoua. I thank you for allowing me to pursue my dreams during all these years. You made this promise when we first met and stood by your words. I will always be grateful for that. You clearly understood my drive for excellence and made sure nothing kept me away from that. Thank you for your love, encouragement, and patience. You are my Rock!

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Section 1: Overview of the Evidence-Based Project

Introduction

The *Essentials of Doctoral Education for Advanced Nursing Practice* (American Association of Colleges of Nurses [AACN], 2006) prepares students to provide care to individuals with complex issues and challenging behaviors. The issue addressed in this doctorate of nursing practice (DNP) project quality improvement initiative was the inability of direct-support staff members, nurses, supervisors, or individuals planning or providing care to use person-centered practices within the healthcare organization where this project was conducted (see Appendix A). O'Brian and O'Brian (2000) explained the importance of paying attention to the person supported while creating a care plan in order to address issues that are deemed important to this person. This DNP project focused on Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking (AACN, 2006, p. 10). Strong leadership skills based on a transformational leadership style were used to develop a healthy working environment and increase productivity by empowering staff members (Kelly, 2013).

Person-centered care has been defined as care that is important to the individuals who receive care (Taylor & Taylor, 2013). Person-centered care, also referred to as patient-centered care (PCC), originated in North America in the late 1980s with the goal of improving the lives of individuals with intellectual and developmental disabilities (IDD; Robertson et al., 2005). This model of care has been studied nationwide and has been used to change and improve the way patients with IDD are provided with choices and opportunities to exercise self-determination in their care (Robertson et al., 2005). Robertson et al. (2005) reported that using person-centered care when treating individuals with IDD improved both the quality of services provided as well

as the quality of the healthcare outcomes. In addition, researchers have recommended that individuals should receive care based on their unique characteristics (Epstein & Street, 2011).

The initiative in this project took place in a long-term care organization located in an urban setting on the East Coast of the United States. The organization is a Medicaid-funded facility comprised of intermediate-care facilities for persons with intellectual disabilities (ICF-ID) and home and community based waiver programs. Nurses, direct-support professionals (DSP), and qualified intellectual disability professionals (QIDP) provide a comprehensive range of care including health promotion, disease management, care coordination, community services, and health maintenance (Centers for Medicare and Medicaid Services, 2013). The organization did not have a system in place to ensure that all direct-support staff members and nurses were trained in the principles of PCC.

As a result, the persons receiving care had not been offered opportunities or support to exercise self-determination in decisions that involved their well-being. For instance, nine out of 10 medical appointments and outing schedules were planned by staff members of the organization without any input from patients who were directly affected. The incident management review committee within the organization recently confirmed that the number of incidents resulting from behavioral outbursts had recently increased (see Appendix A: Gap Analysis). Some efforts had been made by the Department on Disability Services and the Developmental Disabilities Administration (DDS/DDA) to provide basic training in the principles and practices of person-centered thinking to six organizations in the district, including the organization where this quality improvement (QI) project took place. However, this training was offered only to middle and upper management. In the organization where this QI project took place, the 350 direct support staff members, nurses, and QIDPs providing immediate care

and coordinating services to patients were not all involved in the training, and there was no plan to implement these practices with these healthcare providers.

The American Association on Intellectual and Developmental Disability (AAIDD; 2014) published a position statement on improvement of the quality of care provided to people with IDD. This report emphasized the gap between the care being provided and the type of care that should be provided. In addition, this report explained the role that direct-support staff plays in achieving outcomes, which in turn depends on the quality of skills or trainings received from their organization (AAIDD, 2014). Individuals with disabilities have the right to design or participate in their own care planning process and should receive appropriate support to exercise self-determination. To achieve this objective, staff members must be trained on the philosophy of person-centered practices, which includes the process of self-determination (AAIDD, 2014).

Education is implemented through knowledge translation, which is essential in providing appropriate, effective PCC within this organization and in the community as a whole (Maslow, Fazio, Ortigara, Kuhl, & Ziesel, 2013). The social impact of implementing person-centered practices has been linked with patients participating in healthcare decision making and social inclusion. As a result, this DNP project educational initiative on PCC will help provide direct healthcare workers with appropriate and effective training in the principles and practices of person-centered healthcare delivery.

Background

Caring for individuals with disabilities after deinstitutionalization has historically been a very emotional process, and most workers providing care have become over-protective of the individuals assigned to their care (O'Brian & O'Brian, 2000). Most tasks related to daily living were performed for patients, and this seemed to be the best approach for providing care. In the

midst of providing the care that most healthcare workers thought was important for these individuals with disabilities, the IDD person's response to care provided to them was ignored (Taylor & Taylor, 2013). According to Parish (2005) individuals with IDD have the right to be viewed as "normal," and in fact, Parish coined the term "normalization," whereby caretakers were asked to see beyond patients' disabilities and diagnoses and to pay attention to them as human beings—with the same rights and opportunities and also deserving of the same respect and dignity as anyone else. Over the years, the need for person-centered planning became a requirement among many agencies providing care to vulnerable populations. However, this change in practice was implemented solely to meet the requirements of the agency, and no lasting changes were made to cultivate and nurture self-determination for people with IDD (Taylor & Taylor, 2013).

Between 2014 and 2015, some staff members at the study institution were exposed to person-centered thinking and were left to figure out how to guide staff training in a way that ensures understanding and implementation of these practices. However, staff members must understand the process of self-determination in order to provide the appropriate support to persons under their care. Patient safety depends on the quality of care that healthcare providers deliver (White & Dudley-Brown, 2012). In 2010, according to the United States Census Bureau, about 56.7 million individuals (19%) in the United States experienced disabilities. Approximately 12.3 million of these individuals were diagnosed with severe disabilities and needed assistance with activities of daily living or instrumental activities of daily living (U.S. Census Bureau, 2014). While the actual cost of care of people with IDD has not been estimated, research indicated that due to healthcare disparities, persons with IDD usually seek care in advanced stages of diseases, resulting in a higher cost of care (Ervin & Merrick, 2014).

The white paper *Valuing People*, published by the Department of Health in England (2001), recognized and acknowledged that individuals with intellectual disabilities should receive the support they need in order to act in a self-determined manner. PCC approach (see Appendix B) is a model of care that not only allows for but also encourages patients to participate in decisions that involve their care and take control of their lives (Taylor & Taylor, 2013). The use of PCC has been associated with improvements in quality of care that have resulted in improved patient outcomes (Maeng, Davis, Tomcavage, Graf, & Procopio, 2012). The Institute for Patient- and Family-Centered Care (IPFCC; 2014) relies on four core concepts to provide healthcare workers with an understanding of person-centered practices. These concepts include (a) dignity and respect of patients, (b) sharing of information with patients and families (or substitute decision makers), (c) participation of patients and their family members (or substitute decision makers) in the decision-making process, and (d) collaboration with other healthcare professionals to improve healthcare service delivery.

Problem Statement

The practice problem addressed in this DNP QI project was that person-centered practices had not been included in the training curriculum within the organization. Healthcare workers in the organization were equipped to provide effective PCC to patients with IDD. Current research in person-centered thinking has recommended that patients and other clients should be involved and encouraged to make decisions regarding their care (Dukes & Sweeney, 2009). In addition, Maslow, Fazio, Ortigara, Kuhn, and Zeisel (2013) affirmed that the training of staff members was an important component of staff development and readiness to provide PCC. Prior to the start of this QI project, there was no plan to train staff members in the principles and practices of PCC within the organization for which this QI project was developed.

Person-centered planning (see Appendix C: Essentials of Person-Centered Planning) allows patients to express thoughts, ideas, and strategies that are important to them. If staff members working closely with patients are trained to recognize preferences that make these patients happy, their choices and wishes will be incorporated as part of the patients' care plans (Martin & Carey, 2009). According to Dalton and Sweeney (2010), some individuals with IDD experience difficulty expressing themselves due to their level of disabilities. However, with proper training on communication and a clear understanding of behaviors using person-centered tools, these individuals will be able to participate in decision making and exercise self-determination (Dalton & Sweeney, 2010).

Purpose Statement

The purpose of this project was to develop an educational initiative focusing on PCC. The use of the evidence-based educational initiative will help fill the gap between the nonexistence of PCC in the organization and evidence-based practices that have been supported within the research literature to increase self-determination and assist individuals with IDD (Viau-Guay et al., 2013).

Goals and Outcomes

Following are the goals and outcomes for this project:

Goals

The goals of this QI project were to (a) address inequalities of access and efficacy of care within the organization where this QI project took place, (b) promote self-determination among persons with IDD, and (c) ensure that these persons gained the maximum benefits of PCC.

Outcomes

The following outcomes were produced for this project:

- Outcome I: Literature Review Matrix (see Appendix D).
- Outcome 2: Revised Training Policy (see Appendix E).
- Outcome 3: Protocol for Curriculum Sessions (see Appendix F).
- Outcome 4: Educational Curriculum (see Appendix G).
- Outcome 5: Pretest/Posttest (see Appendix H).
- Outcome 6: Implementation and Evaluation Plan (see Appendices I & J).

Theoretical Foundation

The plan-do-study-act (PDSA) model [see Appendix K] (Institute for Healthcare Improvement, 2010) was used to frame the project. PCC is based on the desire and choices of each person encountered, and one design is not suitable for all individuals (Robertson et al., 2005). The PDSA model is often used for continuous improvement and fits the context of healthcare in constant change (American Health Quality, 2013). This model operates in four cycles and can be repeated until the optimal goal is attained (White & Dudley-Brown, 2012). For this QI project, only the first three cycles (plan-do-study) were applicable. The "Act" components of the model will take place after I graduate from Walden University.

Lewin's change theory and force field analysis (White & Dudley-Brown, 2012) was originally rooted in social psychology and slowly became a decision-making tool in most organizations (see Appendix I). This theory was used to develop the implementation plan. The theory will be used to introduce, implement, evaluate, and sustain the use of person-centered practices within the organization for which this QI project was developed. This theory was chosen for two primary reasons: The first reason was that the theory guided the project leader in identifying and analyzing the forces that could support or oppose the change in order to decide

whether the change will be implemented using the force field analysis. The second reason was that Lewin's force field analysis supported the project leader in communicating the relevance of the QI project to the organization.

Lewin's theory (White & Dudley-Brown, 2012) was the most appropriate theory for implementation of this DNP project because past attempts to implement a change in this organization have presented a challenge to most staff members and other employees. Lewin's theory will guide the implementation process and ensure that staff members within the organization are trained effectively and consistently. Implementing the principles of PCC will promote normalization of individuals with IDD, which will result in increased empowerment and self-confidence (Brownie & Nancarrow, 2013). In order to achieve this goal outdated, ineffective, and unproductive practices need to be rejected and new practices should be implemented. In this study, these new practices included the application of person-centered policies and practices. In addition, the importance of encouraging individuals' unique characteristics and strengths was explained in order to promote self-awareness of healthy behaviors. According to White and Dudley-Brown (2012), changes such as these are best viewed as a gradual process. The current change will eventually affect all the departments and levels within the organization, and the use of the PDSA model was appropriate to plan and implement the change within the organization where this QI project took place. Additional explanation is provided in Section 2.

Nature of the Project

This DNP project was a QI initiative that will change the way care is being provided in the organization where this QI project was conducted. The PDSA model (Institute of Healthcare Improvement [IHI], 2010) was used to plan this project. In planning the work of the project, I

assembled and led a team consisting of stakeholders, other members of the organization, and a representative of the people receiving care. I conducted an extensive review of evidence-based research on PCC. I formed a team consisting of myself as the project leader, two person-centered coaches, one qualified intellectual disability professional (QIDP), two nurses, one residential coordinator, and a program director. This team met once every week for six weeks to discuss various tasks that were assigned during the course of the project and to form a consensus about the applicability of the products of this QI initiative. The analysis and synthesis of the research literature was presented to the project team and content experts for evaluation and applicability. This analysis guided the team in developing the educational initiative, which emphasized the core concept of PCC. Content validity of the pretest\posttest items was obtained from three content experts. The evaluation of both this QI project and the project leader was performed by the project team at the end of the project using a summative qualitative evaluation method.

Definitions of Terms

The following terms were used to guide this project.

Intellectual Disability: Intellectual disability is defined as a disability that occurs before 18 years of age and is characterized by significant limitations both in cognitive functioning and adaptive functioning (AAIDD, 2013).

Person-Centered Care (PCC): Person-centered care reflects the client's desires and needs, cultural beliefs, values, knowledge, and background. Sometimes family members and friends who have been involved in the person's life are integrated into the decision-making process at the request of the person supported or if the person is unable to make decisions on their own (McCormack, Dewing, & McCance, 2011).

Person-Centered Organization (PCO): A person-centered organization is one in which services are provided using person-centered practices (Robertson et al., 2005).

Person-Centered Planning (PCP): Person-centered planning is a way to help patients and other clients plan services based on their needs and desires. In other words, patients should be the focus and the center of decision making during healthcare planning (Taylor & Taylor. 2013).

Person-Centered Practices (PCP): Person-centered practices are concepts that involve the use of person-centered planning to provide care and allow people to participate in meaningful activities (IHI, 2005).

Person Centered Thinking (PCT): Person-centered thinking is a set of skills acquired through cultural learning to provide support to people while empowering partnership and accountability (Smull, 2012).

Person-Centered Tools: Person-centered tools help healthcare providers to better understand what is important to and for patients or persons supported. These tools include communication charts, reputation charts, matching charts (charts use to match the patient's personal characteristics with the appropriate staff), records of effective and ineffective practices, and other client-centered information (Smull, 2012).

Protocol: A protocol is a stepwise tool designed to maintain standards of care. For this project, the protocol and standards of care were for training. The use of a protocol ensures that the same level of training is administered across the organization (Flynn & Sinclair, 2005).

Assumptions

Grove, Burns, and Gray (2013) defined assumptions as statements that could be right or wrong due to the fact that there is no evidence to support them. For this DNP project, the

following assumptions were made regarding the impact of implementing PCC on outcomes within the organization:

1. Persons supported want to feel valued and respected, and they want to participate in decisions that involve their care (i.e., they will feel more valued, respected, and independent due to implementation of PCC).
2. Staff members want to implement best practices when caring for the people they support.
3. Training protocols are useful for training all staff members who work with individuals with IDD.
4. PCC, if implemented effectively, can improve the lives of persons with IDD and increase satisfaction.

These assumptions are necessary in evidence-based projects because they are used for clarifying and understanding the issue being addressed in order to move the project forward. As a result, assumptions help determine the project design (Grove, Burns, & Gray, 2013).

Scope

The scope of this educational initiative was extended to (a) intellectual disabilities nurses, (b) direct-support staff members, (c) QIDPs, and (d) all other staff members supervising these groups. The population included in this project was composed of staff members working with adults diagnosed with IDD residing in ICF/ID or home and community based waiver programs. The data derived from this project were provided by content experts and stakeholder team members.

Significance

This DNP project will serve as a QI initiative to improve outcomes of people with IDD through an evidence-based educational initiative. This initiative will be used to facilitate training of staff members in the principles of PCP to support self-determination of people supported in ICF/ID and home and community-based waiver programs (HCBP). Maslow et al. (2013) emphasized that training staff members in the principles and practices of PCC using a training plan was an appropriate way to translate knowledge into practice and will promote the widespread use of such practices within the organization. Furthermore, this project will assist in providing step-by-step information to healthcare workers in a manner that will enable them to support patients with complex health issues who also may be struggling with situational transitions (Laureate Education, 2011; McCormack & McCance, 2006).

A protocol for implementing PCP was integrated into the training curriculum and will contribute to advancing the policy of normalizing patients with IDD (Robertson et al., 2005). The main purpose of PCC is to provide compassionate and effective care based on patients' values and preferences. As mentioned in the Institute of Medicine (IOM; 2001) report *Crossing the Quality Chasm*, new evidence-based practices should be implemented to improve quality of care and safety of all patients. The use of a collaborative approach related to healthcare delivery will help eliminate the stigma of disability and present the patient as a person, not thru the lens of the disability, and the doctor as a person equally involved in decision making related to healthcare (Smith-Stoner, 2011).

Summary

This chapter presented an overview of the influence of PCPs on patient outcomes and satisfaction. In addition, the practice problem addressed in this DNP QI project was that PCPs

have not been included in the training curriculum within the organization for which the project was developed. Healthcare workers in the organization have been ill-equipped to provide effective PCC to patients with IDD. As a result, the goals of this QI project were to (a) address inequalities of access and efficacy of care within the organization where this QI project took place, (b) promote self-determination among persons with IDD, and (c) ensure that these patients gain the maximum benefits of PCC. Section 2 provides a review of the literature and presents the theoretical framework supporting this DNP project.

Section 2: Review of the Scholarly Literature

Introduction

The practice problem addressed in this DNP QI project was that PCPs had not been included in the training curriculum within the organization. This organization is comprised of intermediate-care facilities designed to support those with intellectual disability and medical complications and HCBP. The organization also supports health promotion, acute and chronic disease management, comprehensive physical and mental health, holistic care and services, and rehabilitative care. This organization promotes independence by serving persons with disabilities and supporting them in their efforts to function at the maximum level of their abilities (Medicaid.gov). The purpose of this project was to develop an educational initiative focusing on PCC. In 2005, the American Association on Intellectual and Developmental Disability launched a program called Support Intensity Training (SIS). The purpose of SIS was to train staff members to understand the meaning of person-centered care and the influence of PCC on patient outcomes. The purpose of this training also was to enable healthcare providers to identify the types of support that individuals with disabilities need and assist them in achieving their goals. According to the AAIDD (2014), measuring the effectiveness of PCC requires a clear understanding of the processes involved in implementing PCP. When any training program or change initiative is not sustained within an organization, employees and staff members tend to resort to old practices.

Even though minimal research has been conducted on the influence of PCC, various qualitative studies have focused on promoting self-determination among adults with IDD (Davis, Cornman, Lane, & Patton, 2005; McCormack et al., 2011; Rosemond, Hanson, Ennett, Schenck,

& Weiner, 2012). These studies have revealed that the need to implement PCP is paramount. The use of a training curriculum and training protocol to help staff members understand and implement this concept is important.

The following section presents the research literature on the PDSA model (White & Dudley-Brown, 2012) of quality improvement as well as Lewin's force field analysis and change theory. In addition, the following section describes how these two models will be applied to the implementation of the change within the organization. Finally, the following section describes PCC, the need for PCPs, and the best evidence for implementing PCPs.

Literature Search Strategy

The literature review for this QI project was carried out using the following electronic databases: CINAHL, Medline, ProQuest, PubMed, Cochrane database, and Google scholar. The literature review also includes information from books, professional journals, and allied health sources. In addition, government websites and information from professional organizations specializing in PCP were examined. The key terms used for database searches included the following: *person-centered practices, person-centered planning, self-determination, advocacy, intellectual and developmental disabilities, person-centered communication, protocol, training,* and *person-centered care.* The scope of the literature was limited to articles published between 1990 and 2015.

Plan-Do-Study-Act Model

The PDSA QI model (IHI, 2010) [see Appendix K] was used to develop this evidence-based educational initiative focusing on PCC. The PDSA model for improvement is a framework that has been used frequently to support QI initiatives (IHI, 2010). The model guides the change agent in developing, influencing, observing, and measuring outcomes of the change initiative

within the Medicaid-funded organization where this project took place. The PDSA model was the appropriate model for this DNP project because the PDSA model allows for the possibility of changing, revising, upgrading, adding, or reducing aspects of the process if they are not working as planned. The process allows practitioners to eliminate the unnecessary use of resources. In using the PDSA model, I answered three questions: (a) in which direction is the project leading the organization, and by when will the change initiative be completed, (b) How will the change be measured, (c) What changes would need to occur in order to improve current practices (Langley et al., 1996)? The PDSA model consists of four primary steps. Following is an application of each step of the PDSA model translated to the needs of the current project. I executed these tasks:

1. Plan: Form a team, define the goals to be accomplished, and identify appropriate metrics to measure progress.
2. Do: Perform a literature review, conduct meetings, develop the curriculum plan, create pretest/posttest questions, develop an implementation and evaluation plan, revise the training policy, and have the team complete a summative evaluation.
3. Study: Monitor outcomes after implementing the person-centered curriculum following graduation.
4. Act: Implement and evaluate the program after graduation.

Lewin's Change Theory and Force Field Analysis

Once the plans for this QI project have been developed, the next step was to implement these plans within the Medicaid-funded organization where this project was conducted. The change process, when implemented successfully within institutions, will improve the quality of services provided. Lewin's change theory (White & Dudley-Brown, 2012) adding the force field

analysis will guide the implementation of the QI project within this organization. This theory enabled me to identify the restraining and driving forces that can slow or speed the implementation stage as well as to identify strategies to create equilibrium within the organization.

Lewin's change theory occurs in three phases:

- Unfreezing: Identifying driving and restraining forces within an organization and subsequently finding equilibrium.
- Changing: Implementing the PCC curriculum across the organization. (This step will be completed after graduation.)
- Refreezing: Evaluating the program outcomes (White & Dudley-Brown, 2012). (This step will be completed after graduation.)

Dimensions of Healthcare

This QI project incorporated evidence-based research into practice for the purpose of improving the health of individuals with IDD. The IOM (2001) published six dimensions of healthcare intended to guide healthcare providers in improving their quality of care (IHI, 2015). According to the IOM (2010), healthcare must be safe, effective, patient-centered, timely, efficient, and equitable. This project addresses the specific IOM dimension of person-centered care, which has the potential to influence healthcare effectiveness and efficiency (IOM, 2001).

Literature Review

The research literature supports the idea that PCC, subsequent to a stepwise training curriculum on PCPs, improves health outcomes for individuals with intellectual disabilities (Michigan Department of Community Health, 2010). According to Viau-Guay et al. (2013), implementing PCPs when providing long-term care has been recommended to improve health

outcomes. The Agency of Healthcare Research and Quality (AHRQ; 2002) realized the importance of healthcare providers' knowledge about patient-centered care. The goal of this QI project is to equip healthcare providers with person-centered strategies that empower patients to become more involved in their own care. The use of these person-centered strategies will increase healthcare quality and patient satisfaction. Robertson et al. (2005) explained that staff members should not view this change as an added duty but rather as a learned behavior that was infused within the culture of the organization. In order to integrate PCC into this organization, staff members will need to change the mindset with which they approach their healthcare delivery and begin to keep the best interests of the patients in mind (i.e., "person-centered thinking"). Staff members will then slowly progress toward PCP, which ultimately will result in PCC

Person-Centered Planning

Person-centered thinking is the initial step in the process of PCP. Individuals with IDD comprise 19% of the population within the United States, and they should be provided with a milestone law that assures an equal-rights policy for people with disabilities, as stated in the Americans with Disabilities Act, and these individuals should be considered equal in terms of receiving effective care (O'Brian & O'Brian, 2000). PCP was initiated to provide people with intellectual disabilities opportunities to become involved in meaningful activities, to provide them with respect, and to provide them with dignity (Davis et al., 2005; O'Brien & O'Brien, 2000). An educational curriculum on PCC will prepare staff members to acknowledge patients' choices and cultural beliefs and the ability to the managers to match staff members' specific skills with the needs of each patient (David et al., 2005). Valuing the opinions of patients and other clients allows them to become involved in purposeful activities related to their healthcare.

Being a part of decision-making processes related to their healthcare plans allows patients to express what is important to them rather than simply acquiesce to the treatment that staff members think is important to them (Davis et al., 2005). PCP focuses on the strengths that individuals possess instead of their limitations, diagnoses, or disabilities (Taylor & Taylor, 2013). The application of PCP can make a valuable difference in the lives of patients and their perceptions of the healthcare process. For instance, I observed that medication administration, follow-up appointments, nursing interventions, and activities of daily living frequently have been problematic issues because these activities typically are scheduled without the input of patients or clients. The use and application of PCP helps patients to feel valued and respected, having a greater effect on their overall well-being while simultaneously decreasing the number of incidents reported as a result of acting-out behaviors (Department on Disability Services, n.d.; Frampton, et al., 2008). Training staff members to apply the practices and principles of PCP will not be effective within the Medicaid-funded organization for which this project was developed without (a) redefining the culture, (b) reshaping the way staff members communicate with each person they support, and (c) addressing the challenges of a learning culture (McCormack et al., 2011).

Organizational Culture and Communication

According to McCormack et al. (2011) one important area in healthcare that could become a barrier to safe and effective care within the Medicaid-funded organization where this project took place is communication. Simply put, communication is the process of sharing information between a sender and a receiver (MerriamWebster, 2015). This process could be done using verbal, gestures, drawings, or expressions. Effective communication between caregivers and patients leads to positive outcomes (Hafskjold et al., 2015). Due to many other

co-morbidities affecting their communication, many patients with disabilities have unmet needs; as a result, nurses and other staff members should be able to understand and interpret supplemental means of communication, such as gestures, sign language, communication charts, and picture-books to ensure that patients receive appropriate care (Grove & McIntosh, 2005). Grove and McIntosh (2005) explained that PCC is "not a one-time event," which means that staff members must be trained to understand the proper use and importance of person-centered practices and then apply these new practices (para. 1).

The methods by which staff members address patients most often consists of issuing imperatives or commands, which is out of alignment with person-centered communication practices (Dalton & Sweeney, 2010). Person-centered communication occurs when one individual (e.g., patient or client) supplies information to another individual (e.g., healthcare service provider) about what he or she wants, desires, perceives, feels, or understands (Dalton & Sweeney, 2010). If staff members do not take time to listen to and respect the wishes, desires, and preferences of patients effective communication will not occur. If these behaviors occurs repeatedly, patients and clients who have difficulty expressing their needs or wishes may become frustrated and may express their unmet needs through explosive behaviors, which can result in injuries (Dalton & Sweeney, 2010). Savundranayagam and Hummert (2004) recognized the negative impact of inappropriate communication and identified poor communication between staff members and patients in long-term care settings as "missed opportunities" and attributed these missed opportunities to the process of exerting power over patients and clients. In response to these "missed opportunities", staff members should be held accountable for problematic and disruptive incidents that could have been prevented by listening or paying attention to patients and clients. To prevent situations in which patients and clients act out, leadership should provide

staff members with necessary tools to understand their roles and responsibilities. An evidence-based training protocol featuring person-centered practices will provide a mechanism for staff members that will enable them to encourage and support individuals with IDD; in turn, these individuals will be empowered to exercise self-determination, which will improve healthcare outcomes.

McCormack et al. (2011) addressed the contextual challenges of PCC through practice development. They affirmed that organizations should maintain the development, application, and implementation of PCC to foster an effective culture of care. The application of person-centered care has been influenced by the culture of the workplace, the learning culture, and the physical environment (McCormack et al., 2011). Therefore, to meet the goals of this QI project, I will rely on "change champions" to positively influence the organization's overall culture and "PCC coaches" to support the organization's learning culture. To provide PCC, healthcare providers must understand what "person-centered" means, which essentially refers to care provided according to each person's desires, choices, culture, and beliefs (Tondora et al., 2010). When practicing PCC, the patient is the center of attention during the provision of care and should have input regarding decisions related to his or her healthcare. Staff members must be trained in cultural competency to understand the importance and influence of PCC (Tondora et al., 2010).

The Department on Disability Services and the Developmental Disabilities Administration (2015) mandated providers of long-term care to include end-of-life planning in individual support plans (ISPs). However, many staff members included in the team during ISP meetings are not comfortable initiating conversations about this topic. With proper training on person-centered practices, end-of-life planning can become less uncomfortable and a routine

aspect of the healthcare process. PCC is important in all instances and at all levels of care. According to Smith-Stoner (2011), the practice of person-centered care supports individuals and their families, even during difficult events. Staff members should be taught how to deliver PCC, which will help to ease stressful events encountered by families.

Organizational Learning Culture

The learning culture varies from one person to the other and could also influence the practice or implementation of this DNP project. The importance of learning styles was emphasized while training staff members in order to ensure that the culture of learning does not affect the implementation of person-centered practices within the organization (Gurpinar, Bati, & Tetik, 2011; Jordan-Evans & Kaye, 2005). The organizational learning culture can best be described by the way each person perceives learning, and this learning culture is associated with the way members of the organization may react towards tensions, mistakes, and innovations as well as how they understand achievement of effective outcomes (Kaye & Jordan-Evans, 2005). In an effective learning culture, all staff members are excited to work and ready to implement innovations because this type of environment fosters professional growth. Two studies (McCormack, Wright, Dewer, Harvey, & Ballintine, 2007; Senge, 2006) have acknowledged that a positive learning culture can contribute to the readiness of staff members to implement person-centered practices and sustain such practices within an organization.

Impact of Person-Centered Planning

Planning is a very important step in healthcare. Mansell and Beadle-Brown (2004a) confirmed that person-centered planning will most likely result in positive outcomes as a result of collaboration during the planning process. Sanderson (2002) indicated that person-centered planning supports the transfer of knowledge among staff members because person-center

planning enables staff members to be more alert and ready to identify patients' choices. Many other studies (Holburn, 2002; Holburn, Jacobson, Schwartz, Flory, & Vietze, 2004; Robertson et al., 2005) have affirmed that person-centered planning is associated with improved outcomes compared to the application of person-centered practices unaccompanied by person-centered planning. Taylor and Taylor (2013) reported other positive outcomes as a result of implementing person-centered planning, such as patients feeling respected and valued by staff members and other team members.

Person-Centered Care

The results of person-centered planning are most effectively implemented in the application of person-centered care. Past research studies (McCormack et al., 2011; Rosemond et al., 2012; White & Dudley-Brown, 2012) on this topic have suggested that most often the implementation of person-centered care has been carried out in healthcare organizations using (a) Kurt Lewin's change model to implement the change and (b) the logic model to evaluate the influence of PCC within an organization. These studies confirmed that effective implementation of PCC depends on how well staff members have been prepared and the degree to which leadership and administrators have communicated to them about the change, facilitation and support that was provided by the leadership, and the importance of embracing and sustaining the change within the organization.

The patient-centered care model places the patient at the center of the delivery of care. PCC, when properly applied, can lead to multidimensional positive effects. For patients, PCC provides meaning to activities which leads to a sense of self-worth. For nurses and direct support staff, PCC leads to a sense of accomplishment that, in turn, leads to job satisfaction (Brownie & Nancarrow, 2013). In addition, PCC improves interdisciplinary collaboration based on patients'

needs (Pence, 1997). Research has indicated that PCC improves continuity of care in nursing and increases collaboration among health professionals on behalf of their patients. Health professionals achieve this continuity and collaboration by minimizing the movement of patients through the hospital, providing autonomy to patients, and empowering staff members to plan and execute their work in ways that address patients' needs (Pence, 1997).

As a result, staff members' readiness to implement PCC is enhanced. The PCC training curriculum will guide the training process of person-centered care. Davis, Cornman, Lane, and Patton (2005) enumerated four elements that are considered to be the core values of person-centered care: (a) value and valuing, (b) individualized approaches, (c) the perspective of individuals, and (d) positive and social environments. Training should be offered to staff members to enable effective planning and implementation of PCC.

Nursing and Patient-Centered Care

The American Nurses Association (ANA, 2012) published a position statement that recognized person-centered practices as one of the core nursing competencies and professional standards for all nurses. Nursing care is based on patients' needs and preferences, and this nursing care should include family if indicated by the person supported in order to promote safe and quality care. The ANA position statement recommended that the nursing curriculum be based on patient-centered care as a means of preparing new nurses with appropriate training that enables them to value and use PCC to coordinate care (ANA, 2012).

Martin and Carey (2009) emphasized the role of nurses in person-centered planning. These researchers noted that despite patients' disabilities, nurses should integrate patients into the planning process. Patients tend to value the services they receive when they are included in important decisions that affect their healthcare and when these decisions make sense to them

(Martin & Carey, 2009). The role of nurses is to empower and support patients to create their own care plans using proper communication tools. Nurses are advocates for their patients and should possess the skills to recognize and interpret behaviors as a medium of communication with patients who have limited speech capabilities (Martin & Carey, 2009).

Slater, McCormack, and Bunting (2009) initiated and developed the nursing context index (NCI), an instrument used to measure the influence of nursing outcomes based on the implementation of person-centered practices. These authors validated the instrument (N +23) and internal consistency was measured using Cronbach's alpha. The results of this study indicated that the NCI was a reliable instrument with which to measure the influence of PCC nursing outcomes in healthcare settings and should be used to evaluate the quality of care provided by nurses who practice PCC (Slater, McCormack, & Bunting, 2009).

PCC is guided by the principle that patients come first and that healthcare should be standardized to offer the same opportunity of care during all patient encounters (Small & Small, 2011). This model of care was tested with 11,000 registered nurses and 800 advanced practice nurses at Cleveland Clinic. The results indicated that in order to implement a person-centered model effectively, nurses must be trained to change their minds and adapt to this new way of caring, which requires interaction and constant negotiations between patients and their caregivers (Small & Small, 2012).

In the report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM, 2001) identified patient-centered care as one of six keys for quality improvement within the healthcare system. Since that time, numerous publications have attempted to define and clarify the nature of patient-centered care and how person-centered care can be implemented. Hobbs (2009) explained that person-centered care has been poorly conceptualized, creating difficulties for

nurses in effectively putting person-centered care into practice. As an example of the degree to which person-centered care has been researched, 69 clinical research reports were synthesized to construct the literature review for this QI project. The results revealed that nurses are an integral component of patient interaction, and when appropriately implemented, PCC can lead to improved patient outcomes and increased patient satisfaction (Hobb, 2009).

PCC requires a change in organizational culture because the change is not a one-time event (McCormack et al., 2011). There are still great discrepancies in most organizations as a result of inconsistencies regarding how PCC should be contextualized. Some factors that influence the way PCC is implemented in healthcare organizations include the workplace culture, the learning environment, and the physical environment. When these factors are addressed, PCC becomes the standard of practice within an organization instead of being perceived as a collection of additional assignments for nurses and other healthcare workers (McCormack et al., 2011). An implementation program will help nurses to guide the implementation and standardize the process within the healthcare system.

Patient-Centered Care among Patients with Disabilities

Implementing PCC among patients with disabilities has been a common application in most healthcare settings as a way of normalizing individuals with intellectual and developmental disabilities (Robertson et al., 2005). Patients with disabilities rely on nurses and direct-support staff members to make their voices heard. This advocacy cannot happen without PCC being part of the organizational culture.

Although the role of nurses and other healthcare professionals providing care to patients with IDD has not been clearly defined when applying person-centered practices, Sanderson (2004) argued that staff members should be less involved in their patients' healthcare decisions

(2004). Healthcare workers should support and encourage patients to be in control of their lives as well as decisions involving their healthcare (Duffy & Sanderson, 2004).

Furthermore, many patients with IDD have refused care as a result of not being offered choices (Robertson et al., 2005). PCC has been implemented in long-term care to improve the patient experience as well as healthcare outcomes (Nadin, Orr, & Meagher, 2013). However, the usefulness of PCC in long-term care settings depends on (a) the level of comfort among staff members in adopting PCC, (b) the leadership in place, (c) the training program within the organization, and (d) the implementation plan (Viau-Guay et al., 2013). The relevance of an implementation plan was explored using an open-ended questionnaire among caregivers (n=392) in Canada working in long-term care facilities after one month of training on PCC. According to Viau-Guay et al. (2013), the results indicated that using person-centered practices was useful for staff members. However, staff members were not taught and therefore failed to develop the skills to maintain these PCC practices within the organization. This study emphasized that knowledge transfer, which is accomplished through training, needs to be integrated to the point of skill transfer in order to influence or change practice.

Summary

The literature review captures various elements of PCP that are currently practiced within the target organization. The development of an evidence-based educational initiative focusing on PCC will guide the planning and application of PCC within this organization. Overall, the researchers cited in the review of literature explained that persons with disabilities do not receive the care that they deserve due to staff members not being trained in the principles of person-centered care. PCP training should be ongoing to ensure sustainability of these practices within an organization (Viau-Guay et al., 2013). As Senge (2006) explained, the learning culture will

define how well the organization receives, implements, and sustains the use of person-centered practices within the organization. In fact, Smith-Stoner (2011) noted that the culture of the organization, with proper leadership, will create a better environment in which all staff members would like to work and therefore they will transfer this enthusiasm to the people they support, thus implementing person-centered care. The gap that this DNP QI project addresses will allow the organization (as well as other healthcare organizations in the designated area) to provide patient-centered care.

Section 3 describes the approach to the proposed educational initiative on PCC. In addition, Section 3 (a) defines the function of the multidisciplinary team; (b) reviews the evidence supporting PCC; (c) and explains ethical considerations, the implementation process, and the evaluation plan.

Section 3: Approach

Introduction

The purpose of this QI project was to develop an educational initiative focusing on PCC. Section 3 describes (a) the approach for developing the proposed educational initiative on PCC; (b) the interdisciplinary team and the importance of teamwork; and (c) the influence of good leadership, ethical considerations, and budget considerations on project development.

Approach

To develop this comprehensive educational initiative on PCC, the plan-do-study-act (IHI, 2010) model was used as a framework for the project. I led the team using organizational and systems leadership to guide the project team and directed all activities and processes.

This section provides details regarding the implementation of the PDSA cycle.

Step One: Plan. This step consisted of the following activities:

- I assumed a leadership role in order to facilitate all processes and activities involved in the project. Leadership strategies and interpersonal relationships were used to guide the organizational culture in developing this innovation.
- The project began by assembling the team, which consisted of myself as the project leader, nurses, qualified intellectual disability professionals, and other stakeholders (e.g., a person's advocate and the chief executive officer within the organization where this QI project was implemented).
- A timeline (see Appendix O) for achieving project milestones was established by the team along with methods to evaluate the success of the project (American Health Quality, 2013).

- An analysis and synthesis of the evidence-based research on PCC was conducted and presented by myself.
- After a review of the evidence on PCP was conducted, an educational curriculum focusing on the principles and practices of PCC, including a training protocol, was developed.
- The current training policy was updated to include PCC.
- Evaluation of the curriculum and protocol was conducted.
- Content validation of the pretest/posttest items was obtained.
- The implementation plan of this educational curriculum on PCC was developed using Lewin's theory of change (White & Dudley-Brown, 2012). This plan is discussed in Section 4 of this DNP project and will take place after I graduate from Walden University.
- A plan for evaluating the implementation of the QI project was developed using the logic model and is discussed in Section 4. This portion of the project will be conducted after graduation from Walden University.

Step Two: Do. This step consisted of the following activities:

- The project team supported the leader in designing the project.
- I directed the development of the QI project.
- Process evaluation by stakeholders was ongoing throughout the project development and reflected in the meeting minutes. Analysis and synthesis of the research literature and identification of best practices that address the current gap was presented by me to the team (Terry, 2013).

- The analysis of the literature guided the development of the educational initiative, which emphasized the core concept tool of PCC (Roberston et al., 2005).

Step Three: Study. This step consisted of the following activities:

- A formative assessment of the project by stakeholders was provided to monitor the development of the training curriculum.
- An assessment of the risk involved in developing and implementing this project was conducted using the force field analysis.
- An outcome evaluation of the project, leader, and products of this DNP QI project were conducted by the team and content expects (IHI, 2010).

Step Four: Act: The fourth step in the PDSA cycle is "act." The fourth step will involve reviewing the performance of staff and overall outcome of the final project implementation (Kettner, Moroney, & Martin, 2013). This step will be completed after I graduate from Walden University.

Interdisciplinary Project Team Description

A team is a group of people working together to achieve the same goal (Kelly, 2014). According to Kelly (2014), an effective team does not happen through random selection of individuals. Effective teams are designed following a meticulous and careful selection process. The project team was chosen based on team members' qualifications including their knowledge; skills; ability to recognize the need for the change initiative; and interest in providing safe, patient-centered, effective, and efficient care.

Team Building and Teamwork

As the project leader, I exercised leadership abilities by synchronizing methods of teamwork as drafted by the AHRQ (2003). This task was accomplished through the following skills and or activities:

- *Backup behaviors*: This skill involves the ability of the project leader to anticipate the needs of the team and the ability to balance the workload and avoid pressure as a result of the change process (Porter, Hollenbeck, Ilgen, Ellis, & West, 2003).
- *Adaptability*: This skill refers to the ability to adjust behaviors, resources, or the initial plan based on evolving information received from team members. Moreover, the DNP student was able to identify the need for improvement while remaining attentive to the internal and external environment of the project team (Cannon-Bowers, Tannenbaum, Salas, & Volpe, 1995; Klein & Pierce, 2001).
- *Team orientation*: This skill refers to the inclination of the project leader to consider other team members' comportment during interactions as well as the consequentiality of the goals of the team over an individual member's goal (Driskell & Salas, 1992).
- *Shared mental models*: This refers to my ability as the DNP student to foresee or predict the needs of team members and to find strategies to address these needs without interrupting the flow (Cannon-Bowers et al., 1995; Stout, Cannon-Bowers, & Salas, 1996).

- *Mutual trust*: I recognized mistakes, remained open to constructive criticisms, and acknowledged the abilities of team members to perform within their assigned roles during the development of this DNP project (Webber, 2002).
- *Closed-loop communication:* This skill refers to my ability as the project leader to follow up with team members regarding assigned tasks and activities to ensure appropriate understanding of the project (McIntyre & Salas, 1995).

The project team was comprised of the following members:

- As the project leader, I facilitated the progress of the project, coordinated activities for the project, and facilitated collaboration among team members.
- The program director, a supervisory staff member, assured that efforts were coordinated while supplying necessary outputs.
- One registered nurse supervisor assisted with specific issues related to patients' health.
- One QIDP assisted with the coordination of services and communicated specific issues encountered with staff members during coordination of care.
- After graduation, two PCP coaches will continue to provide training sessions and support to other leadership members to prepare for staff training and implementation of the QI initiative.
- The trainer assisted the team in presenting the current training curriculum and reported issues encountered during staff training. This team member will also describe some barriers that could slow the implementation of the curriculum.

The team met every week for six weeks on Friday from 1:30 p.m. to 2:30 p.m. to discuss the progress of the project, problematic issues, and inputs that could enhance the current project. Stanhope, Tondora, Davidson, Choy-Brown, and Marcus (2015) explained the value of leadership when implementing person-centered care in mental health settings. Stanhope et al.'s (2005) study revealed that transformational leadership would appropriately guide and sustain the use of a PCC protocol for staff training. PCC is an ongoing process and could be maintained in the organization through the involvement of leadership involvement and empowering staff members to implement PCP (Stanhope et al., 2015).

Project Team Meetings

Another important leadership skill that was essential in guiding the development of this DNP project was the ability to conduct effective team meetings (O'Dea, de Chazal, Saltman, & Kidd, 2006). Meetings should produce goal-oriented and outcome-driven synergy between two or more people. In healthcare, these interactions occurred face to face, at the same location, and at the same time (O'Dea et al., 2006). As the chairperson during these meetings, prior to each encounter I contacted all team members to gather any pertinent points of discussion and identified possible solutions prior to the meeting date and time. Successful meetings depend on how well the project leader can plan, schedule, and conduct meetings (Bostrom, Anson, & Clawson, 1993). Researchers who have conducted studies on leadership explained that an important element in conducting efficient meetings in healthcare settings is the ability to keep control of the meeting from the conception of the meeting right up until the minutes of the meetings have been ratified (Kelly, 2013; O'Dea et al., 2006). Maintaining control of the meetings was achieved by (a) extensive pre-meeting orchestration, (b) efficient use of the meeting environment, and (c) flawless management of team members' participation

(Kloppenbog & Petrick, 1999). To achieve optimal outcomes, the objectives of the meeting were sent to all project team members before each meeting (O'Dea et al., 2006).

Rationale

Despite the educational background, knowledge, and ability of healthcare providers, every patient should have the opportunity to be involved in the decision-making process regarding his or her care and should be the center of attention during healthcare planning (McCance, McCormack, & Dewing, 2011). The white paper "Valuing People," published by the Department of Health in England (2001), acknowledged that people with IDD have not been treated with dignity and respect as evidenced by the fact that patients were submitted to various treatments as a result of their behaviors (Robertson et al., 2005). The authors recommended that all staff members be trained in the principles and practices of PCC to enhance the quality of patient care and support the ability to achieve their dreams and aspirations (Robertson et al., 2005). To implement this recommendation, I displayed leadership abilities in conducting team meetings, which guided the development of the training curriculum on PCC within the organization. Pelzang (2010) affirmed that developing a curriculum to guide staff members' education on PCP was effective and created consistency in the training across the organization.

Organization and System Leadership

The *Essentials of Doctoral Education for Advanced Nursing* (2006) have described and explained the leadership skills and abilities required of nursing graduates if they are to lead successful quality improvement initiatives within an organization. Advanced practice nurses are trained not only to lead patient care, but to recognize each patient's individual needs (AACN, 2006). Leading an organization requires the ability to manage resources and the ability to maintain equilibrium between productivity and the quality of care. In addition, leading an

organization requires the ability to evaluate the cost effectiveness of care as well as the application of economic and financial resources to restructure effective and realistic healthcare delivery strategies (AACN, 2006). During the development of this DNP project, I exercised some of these skills which involved employing quality improvement strategies to enhance the care provided in the organization.

The Person-Centered Coach

A person-centered coach is trained to lead the implementation of person-centered thinking within an organization. A person-centered coach mentors other leaders and staff members and helps them understand the use of various person-centered practices, the application of these practices within a healthcare setting, and the impact of applying PCC on the outcome of each patient (Support Development Associates, 2012). In addition, a person-centered coach is able to identify what is working and what is not working within an organization's current practices (such as gaps or deficits that require changes in policies and procedures) and informs/advises upper management about the need for change. Furthermore, a person-centered coach models and advocates for positive behavioral changes in order to guide the culture of the organization (Support Development Associates, 2012). As a coach of person-centered thinking, I used my current knowledge about PCC as well as evidence-based research on the application of PCP to develop the educational curriculum plan and protocol.

Leadership Qualities

The performance of a team depends on the effectiveness of the leadership in place (Kelly, 2014). Although most leaders have not been trained to become leaders, the QI project leadership position comes with the assigned responsibilities and level of education. Leading a team can be very challenging due to issues arising from interpersonal relationships and the way ethical

dilemmas are resolved (Reeves, MacMillan, & Van Soeren, 2010). Kelly (2014) explained that having a complete understanding of mental models is crucial in implementing improvement efforts within an organization. Argyris (1991) expressed that to promote a good learning or improvement environment, leaders must be able to understand their own behaviors that could cause issues in the organization and rectify them. The use of mental models allowed me to maintain the focus of the team members on the project. Along with the team members, I defined the purpose, goals, and objectives of the team in order to meet the outcomes of this QI project .

Leadership in nursing supports organizational growth and the application of evidence-based research into practice (Newhouse, 2007). To implement and sustain the project within the organization, the team leader will encourage effective communication among the team members, identify barriers to implementation of the project, and find solutions to alleviate these issues. I used the knowledge of a person-centered coach and other leadership abilities to successfully guide the project.

Ethical Considerations

Even though the implementation of this DNP project will not take place until after my graduation from Walden University, there was no need to solicit informed consent from the participants. A data use agreement (see Appendix L) was obtained from the CEO of the organization where the QI project was conducted. Approval of the project development was sought from the institutional review board (IRB) at Walden University using Form A and Form B (see Appendix M: IRB approval). There was no risk to participants in this QI initiative.

Summary

The implementation of this evidence-based educational initiative has the potential to accomplish the Institute of Medicine (IOM) and Center of Medicare and Medicaid Services

(CMS) “mandate for safe, timely, effective, efficient, equitable and patient-centered care in a complex environment” (AACN, 2006, p. 3. Para. 1). With PCC patients will be offered opportunities to choose meaningful activities as well as opportunities to become involved in the initiation, implementation, and evaluation of their healthcare plan as well as other aspects of their lives. This section of the DNP quality improvement initiative addressed how the project was developed and will be implemented, evaluated, and sustained in order to fulfill the requirements of person-centered organizations. In Section 4 of this project, an evaluation of the findings, implications, strengths, and limitations of the project, and an analysis of self are presented. In addition, a presentation of the implementation and evaluation plan will be done after I graduate from Walden University.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of this QI project was to develop an educational initiative focusing on PCC. The goals of the QI project were to (a) address inequalities of access and efficacy of care within the organization, (b) promote self-determination among persons with IDD, and (c) ensure that these persons gained the maximum benefits of PCC. The outcomes of the project were:

- Outcome I: Literature Review Matrix (see Appendix D).
- Outcome 2: Revised Training Policy (see Appendix E).
- Outcome 3: Protocol for Curriculum Sessions (see Appendix F).
- Outcome 4: Educational Curriculum (see Appendix G).
- Outcome 5: Pretest/Posttest (see Appendix H).
- Outcome 6: Implementation and Evaluation Plan (see Appendices I & J).

Section 4 provides discussions, findings, and evaluation of the project. The implementation and evaluation plans, strengths and limitations, and contribution of this project to professional development are explained in this section. In addition, the applicability of this QI initiative to healthcare; the implications of the results on policy, healthcare practice, and research; and the contribution to social change are discussed. Finally, an analysis of self as a scholar, practitioner, and project leader was conducted and is presented here.

Discussion, Findings and Evaluation

The following sections present the outcomes of this QI project including the literature review, the revised training policy, the protocol for curriculum sessions, the educational curriculum, and the pretest/posttest content validation obtained from three content experts. These

experts were chosen based on their experiences in the field of disability services, quality assurance management, nursing leadership, and expertise in person-centered practices and implementation. The implementation and evaluation plan and the qualitative summative evaluation were completed by the project team.

Outcome 1: Literature Review

Discussion. I conducted an extensive literature review which resulted in a comprehensive analysis and synthesis of empirical research on PCC among individuals with intellectual disabilities. To complete this literature review, I used the Walden literature review matrix (see Appendix D). The matrix was emailed to three content experts for evaluation, and I also presented the matrix to the project team during the first and second team meetings to receive feedback about the applicability and acceptance of the matrix.

Evaluation. The evidence from the literature review was graded, with permission, using the Johns Hopkins Nursing Evidence-Based Practice Rating Scale (see Appendix V). The literature review matrix was reviewed and evaluated by the content experts. Comments returned by these experts indicated that the information from the literature review was rich and relevant for the development of the curriculum plan. These comments, along with the matrix, were in turn presented to the team who concluded that the matrix was excellent to generate the curriculum plan.

Data. None

Recommendations. The team felt the number of research reviews (N = 36) were appropriate to generate the curriculum plan.

Outcome 2: Revised Training Policy

Discussion. I presented the current policy to the team members and pointed out the gap that existed. The current policy did not include all staff members. Only direct support professionals (DSP) were addressed in the policy despite the fact the policy is directed at all staff members within the organization involved in planning, coordinating, implementing, and evaluating the care process. I emphasized the importance of adding nurses and other members of the team into the policy because they all received training at the time they were hired and then annually after that. The DDS/DDA training policy for DSPs (see Appendix U) classified the training into four phases: Phase I, II, III, & IV. In each of these phases, person-centered thinking is introduced, except in Phase II, which focuses on individualized and specialized training (DDS, 2013).

Evaluation. The revised policy was presented to the team members who agreed that the previously discussed items regarding the policy should move forward. The policy outlines the Department on Disability Services and Disability Administration (2013) standards of practice and training guidelines. The purpose of the policy was to ensure the delivery of consistent education to newly hired DSPs, all nurses, QIDPs, and residential coordinators as well as to provide them with ongoing training.

Data. None

Recommendation. The team recommended that the PCC objectives were applicable to Phase II training offered annually and following a new assignment. The PCC curriculum plan will be part of Phase II training annually and will be integrated into all other training phases including phase I, III and IV as an ongoing process to maintain sustainability. The policy was

presented to the chief executive officer for acceptability. The CEO will sign this revision prior to implementation, and a copy will be distributed to all location sites.

Outcome 3. Protocol for Curriculum Sessions

Discussion. During meeting sessions, the project team and I developed the protocol for the curriculum sessions training (see Appendix F), which will be used as a guide when implementing the curriculum educational plan. A protocol is a stepwise tool designed to maintain standards of care (Flynn & Sinclair, 2005). For this project, the standards were defined as consistency within the training curriculum content and the use of evidence. Using a protocol will help maintain consistency by ensuring the same level of training across the organization (Flynn & Sinclair, 2005). The protocol for curriculum sessions includes the purpose of the protocol, the goal of using the protocol, the content of the curriculum in seven modules, the content title of each module based on objectives in the curriculum, the mode of presentation and evaluation, and the time frame for the training. This protocol further describes the steps to follow during the training process and guidelines to follow to maintain consistency of the dissemination of the project across the organization.

Evaluation. The team revised, evaluated, and approved this protocol for clarity and applicability as related to the organizational policy and procedures.

Data. None

Recommendations. The team recommended 40 minutes for the test and that the training time would consist of two five-hour sessions. The minimum passing score will be 80%. The team further agreed on the frequency of the training as well as the applicability of the training to current DDS standards of training for direct-support professionals, nurses, and staff members supervising these groups. The team conveyed that the protocol is essential in guiding the

management team as they train staff members. The protocol should be a reference and followed as a standard of procedure across the organization.

Outcome 4: Educational Curriculum

Discussion. The educational curriculum (see Appendix G) was developed after I conducted a literature review on person-centered care practices and the benefits of effectively applying such practices in similar environments (Taylor & Taylor, 2013). IRB approval (see Appendix M) was obtained from Walden University prior to collecting all data involved in this project. The Johns Hopkins Nursing Evidence-Based Practice Rating Scale (Johns Hopkins Nursing, n.d) was used with permission to grade the evidence of this DNP initiative using the following URL: http:www.hopkingsmedecine.org/evidence-based-practice/jhn_ebp.html (see Appendix V).

The educational curriculum content was shared with three experts for evaluation using the expert evaluation of the DNP project/outline/content/evidence form (see Appendix P). A copy of the curriculum plan, the evaluation form, and the literature review matrix was emailed to the content experts. These experts compared the content of the curriculum with the literature review to ensure that the material provided met the objectives. These experts were chosen based on their experiences in the field of disability services, quality assurance management, nursing leadership, and experts in person-centered practices and implementation. The knowledge of these experts includes establishing contacts with families, setting tools to monitor delivery of services, and identifying measurement tools to improve the quality of human service outcomes for people with intellectual disabilities.

Evaluation. The evaluation was conducted using a two category scale of *"met" = 1* and *"not met" = 2* response scale. The evaluations were summarized (see Appendix Q) and the

results revealed that the seven objectives were met with a 100% acceptance rate. These results were presented at the team meeting. A comment returned by one of the experts indicated that "the proposed curriculum is very comprehensive and well researched; this curriculum will address the gap in knowledge of staff members working with people with IDD."

Data. All objectives received a *1 = met* score from the content experts revealing that the curriculum met the intent of the objectives (see Appendix Q).

Recommendations. One of the experts recommended adding a small amount of content to address the language used in PCP. Using the proper language will help staff members to change the way they address the people they serve. Another recommendation consisted of using simulation examples and case scenarios to keep staff members engaged during training..

Outcome 5: Pretest/Posttest Content Validation

Discussion. Pretest/posttest items were reviewed by an expert in assessment and measurement for evaluation of individual test item construction. Revisions were made to several of the items based on the suggestion of this expert to meet the criteria of test construction. The 18-item pretest/posttest was emailed (along with the curriculum plan, the literature review matrix, and the correct responses to the items) to the three content experts so they could determine the content validity of each item (see Appendix S). This process took between two to four weeks.

Evaluation. Content validity, in terms of this project, refers to whether the items identified for inclusion on the pretest/posttest adequately represent the domain of content addressed by the curriculum plan (Polit & Beck, 2004; Waltz, Striland, & Lenz, 2005). The test items were validated by three content experts using a four-point Likert scale using the following response options: *1 = Not relevant, 2 = Somewhat relevant, 3 = Relevant, 4 = Very relevant*. The

analysis of all three content experts' evaluations was done using the content validity index scale analysis (see Appendix T).

Data. Content Validation Index = .99

Expert Content Validity Index Scale Analysis (see Appendix T). According to the three experts' ratings of the 18 items, the content of the pretest/posttest was determined to be relevant. The scale-level content validity index (S-CVI) score was 0.99 instead of 1.00 because two content experts gave a score of 3 (*Relevant)* to the first two questions number. There were no comments related to the reason these scores were chosen. Considering the item content validation of 100% = 1.00, the experts rated the item content to be very relevant and highly valid (Polit & Beck, 2006).

Recommendations. The expert in assessment and measurement of the test item construct suggested that the items should be grouped by category--e.g., true/false, multiple-choice, and free-response questions. Minor changes in wording were made to several items to enhance their clarity. One of the content experts suggested adding "people first language" (addresses how staff communicate with patients with IDD) as part of the curriculum.

Outcome 6: Implementation and Evaluation Plan

Discussion. I presented both the implementation and evaluation plans to the team. All team members were aware of the long-term and short-term outcomes to look for during the evaluation process. The team identified the organizational culture as the biggest issue that could negatively influence the implementation. One way to resolve this issue is to involve the team early in the process (Kelly, 2014).

Evaluation. The team discussed the various learning styles and the culture of the organization as factors that could hinder or slow the implementation. Kurt Lewin's theory of

change model (White & Dudley-Brown, 2012) provided some insight into the project, and a force field analysis identified restraining forces (culture, learning ability of each staff member, nurses' caseload) that could slow the implementation and evaluation of the change within the organization.

Data. None

Recommendation. Both plans (evaluation and implementation) will be used to implement and measure the outcome process of the change in the organization. The short and long-term outcomes will be evaluated by location to assess the outcomes by locations.

Qualitative Summative Evaluation

Discussion. A summative evaluation is a process of evaluation conducted upon completion of a project to measure the outcome of that project, or what the project leader has achieved (White & Dudley-Brown, 2012). This type of evaluation process allows the researcher to identify areas of growth as well as areas that require improvement. After the last meeting, a 7-item Summative Evaluation Questionnaire (see Appendix V) was administered to assess (a) the team and stakeholders' involvement and participation in the development of the curriculum plan, the pretest/posttest, the protocol, and training policy revision; (b) my leadership of the project; and (c) the process, content, and products of my DNP quality improvement initiative project. The questionnaires were returned via interoffice mail. All participants in this evaluation were team project members and were selected based on their experience and ability to adjust to the change process.

Evaluation. All six members of the team returned the questionnaires. The responses were summarized and are presented in appendix (see Appendix W).

Data. Three themes emerged from the data and are discussed below. The team rated me based on my leadership abilities, the outcome products of this DNP QI project, and my role as a team leader during our meeting sessions.

Project team with student as a leader. One emerging theme was transformational leadership. The team noted that the project leader demonstrated transformational leadership through shared governance, empowerment, coaching, and mentoring (Baker, Day, & Salas, 2006). Each team member contributed to the development of the curriculum, pretest/posttest, and the protocol as well as the revision of the training policy. I directed and managed the team, providing guidance to the process and development of the curriculum plan and other items of the project. Some comments revealed that the success of the project team was related to team members' knowledge, skills, and attitudes that were specific to the project development.

Outcome products. A second emerging theme was a comprehensive curriculum plan (CP). The team felt that the curriculum plan will be a success if teamwork continues to be the preferred model in this organization. The CP will enable team members to facilitate the use of PCP in this organization.

The role of the student as the team leader. A third emerging theme was teamwork. Team members felt that I established an environment of teamwork and effective communication in which each person's contribution was appreciated, analyzed, and incorporated into the project. All team members were delighted to be part of this QI initiative development process. For example, one team member noted in the evaluation that "the project team leader was able to demonstrate effective meeting leadership; she allowed team members to express their point of view, and decisions were made based on a team effort". The team expressed that I remained focused and on task; was motivated to complete each meeting according to the agenda; and, most

importantly, listened effectively. Some comments from the evaluation expressed that I maintained a steady management style during meetings which facilitated a relaxed, agreeable, and cooperative environment.

Recommendations.

Suggestions for improvement. A fourth emerging theme was regarding the length of time the team was involved in the project. Two out of seven members of this team suggested allowing more time for the team to be involved in the project. These participants further suggested that they should have been involved early in the process throughout the project development and completion.

Implementation Plan

The implementation plan (see Appendix I) describes the theoretical foundations that support the goals and objectives of the educational initiative and evaluates the understanding of complex interventions that will be implemented to achieve these goals (Hodges & Videto, 2011). This educational initiative will be implemented in the organization using Kurt Lewin's model of change (White & Dudley-Brown, 2012). The implementation plan (see Appendix I) will be used to guide the introduction, application, and maintenance of person-centered practices in the organization (Hodges & Videto, 2011). The change process, when successful, contributes to the improvement of the quality of services provided. Implementing a protocol for staff training in this organization will require the input of all the service departments involved in coordinating services. Lewin's force field analysis perceives change as a state of equilibrium between restraining forces and the driving forces (White & Dudley-Brown, 2012). Lewin's theory was initially used to research how people change the way they eat in order to achieve weight loss (White & Dudley-Brown, 2012). For the purpose of this project, this theory was used to analyze

the influence of staff training on a change of practice within an organization (White & Dudley-Brown, 2012). Deci and Ryan (2012), in an article on the self-determination theory (SDT), noted the use of autonomy to boost patients' confidence in adopting a new practice, such as cigarette smoking cessation, for instance, was found to be effective. The use of PCP will result in self-determination which in turn teaches the person to become independent and able to take responsibilities, thus care for self. Learning about the change in early stages will smooth the change process. Restraining forces of the change most often derived from the fact people affected by the change were not provided an opportunity to participate in the decision involving the change (White & Dudley-Brown, 2012). Kurt Lewin's model of change is based on three stages which include unfreezing, changing, and refreezing (White & Dudley-Brown, 2012).

Unfreezing

During this stage, the project leader will engage all stakeholders and form a team that represents the target audience. The use of a force field analysis helped in identifying some restraining forces that could slow down the implementation process. Restraining forces here are related to the organization's culture, complexity of the care provided, nurses' caseload, and leaders not given extra time to be engage in the training process. Other restraining forces include the learning culture and the physical environment (McCormack et al., 2011). If policies are updated to ensure that support is provided to coaches and leadership to sustain person-centered care, there is a good chance that the project will be fully embraced (McCormack et al., 2011).

The Change or Move

During this stage, there should be a balance between the issues keeping the organization from moving forward with the project and the resources available to carry on the project. Factors that can encourage this process include, but are not limited to, financial recognition,

redistribution of caseload to allow coaches to be involved in massive training, and follow up on staff members.

Refreezing

After implementing the change, staff members will understand the importance of person-centered care and communicate effectively with patients or people supported to acknowledge the importance of communication in order to achieve the best standards of care. The organization should celebrate accomplishments and put a system in place to reward and recognize staff members, establish a measurement control system, and provide ongoing monitoring (White & Dudley-Brown, 2012).

Evaluation Plan

This DNP project, designed to facilitate person-centered care for people with intellectual and developmental disabilities, will improve health outcomes for individuals receiving support and services within this organization. According to Kelly (2014), data can be used in clinical settings to diagnose, treat, and monitor the effectiveness of interventions. When an improvement is initiated, constant evaluation should be conducted to evaluate the progress made or to compare the progress with outside metrics (see Appendix J). To evaluate this project, the logic model of evaluation (Hodges & Videto, 2011) will be used to identify the effectiveness of the curriculum once implemented. The logic model outlines the activities and processes of the project while defining the relationship among processes. According to the AHRQ (2005), the use of this model of evaluation allows the project leader to easily communicate what activities the interventions are providing and what the interventions intend to achieve, emphasizing the relationship between these two elements. Hayes, Parchman, and Howard (2011) defined the logic model as a framework that describes "the relationships between resources, activities, and results as they

related to a specific program or project goal" (p. 2). This model was chosen to assist in the formulation of assumptions about the educational curriculum (Hayes, Parchman, & Howard, 2011). Long-term and short-term evaluations of outcomes will be conducted based on the start date of the implementation--i.e., after three months for short-term evaluations and after 12 months for long-term evaluations. Evaluating the project allows practitioners to improve practices that have not been working and identify the degree to which the change has positively influenced the organization, the community, and the nation (White & Dudley-Brown, 2012).

Applicability to Healthcare

This DNP project, designed to facilitate person-centered care for people with intellectual and developmental disabilities, is a quality improvement initiative that will improve the quality of care of people with IDD. Person-centered planning is an effective method of planning care for persons with disabilities based on their unique qualities and strengths (Claes, Van Hove, Vandevelde, van Loon, & Schalock, 2010). In training staff members on this new process of care, persons receiving care or support will be seen for who they are, not their disability, thus providing them with opportunities to thrive and achieve their maximum potential. PCC supports community integration and participation, as well as opportunities to engage in the planning process and decision making. PCC also helps create positive relationships and achieve self-determination (Claes, Van Hove, Vandevelde, van Loon, & Schalock, 2010). According to McCormack et al. (2011), the application of person-centered care in an organization is not a one-time event nor a one-person issue. Therefore, this initiative should be embraced as a team in order to sustain these practices in the organization. PCC offers opportunities to create innovations in practice based on the choices, dreams, and aspirations of persons supported. Each

organization should identify strategies that foster teamwork as well as strategies that sustain a culture of PCP within the organization (McCormack et al., 2011).

Implications

The development of an educational initiative on PCC and the application of such practice within the organization will contribute to the transition from restrictive to least restrictive care plans and even more independent lives, thus improving overall health outcomes. These implications could have an effect on policy, practice, and social change.

Policy

The Affordable Care Act (ACA) was passed into law to improve the quality, access, innovation, and efficiency of healthcare for all Americans (U. S. Department of Health & Human Services, 2015). This law expressed the urgency of improving the quality of care while reducing the cost of the national healthcare expenditure. Person-centered care, if successfully implemented, can improve health outcomes (Robertson et al., 2005). Most adults with IDD have complex health issues and rely on Medicaid as their primary insurance (Ervin & Merrick, 2014). This cost was estimated to be $275.4 billion for acute problems and $122.7 billion for long-term care services and supports in 2014 (Ervin & Merrick, 2014). Research indicated that the lifespan of people with IDD has increased and driven more cost due to aging and health complications (Patrick, 1997). As a result, the need for additional supports has become eminent to avoid seeking care when the issue is complex, thus seek care in early stage of disease. The need of continuous quality improvements to support the self-determination of persons with IDD is essential in decreasing national healthcare costs (Ervin & Merrick, 2014; National Committee for Quality Assurance [NCQA], 2015).

In order to assure sustainability of person-centered practices across organizations caring for people with IDD, policies and regulations must be implemented and reinforced to maintain accountability (NCQA, 2015). This QI project addresses policy issues as part of the new requirements to improve healthcare quality set by the Center for Medicare and Medicaid Services, the Institute of Medicine (2001), the Affordable Care Act (2010), and the NCQA (2015) regarding the application of person-centered practices in all healthcare organizations (Department of Health & Human Services, 2015). In caring for people with IDD, providers should start with person-centered assessments--that is, assessments of patients' physical needs, mental needs, choices, and desires. Most importantly, providers should develop care plans with the people supported while making sure that what is important to the person receiving care is addressed (Ervin & Merick, 2014). According to the research and quality measurement of outcomes in organizations that have implemented PCC, vast improvements in outcomes and a reduction of healthcare costs have been realized (Ervin & Merick, 2014; NCQA, 2015).

Practice

Person-centered practice does not happen at once. Changing from the way healthcare is currently provided to person-centered practice requires a commitment to quality, results, and positive outcomes (McCance, McCormack, & Dewing, 2011). Many organizations are still working on the best way to implement this model to fit their practices. Research has suggested that PCC is complex and there are still gray areas in how this model should be implemented during care planning (McCance et al., 2011). This DNP project will serve as a guide to assure all staff members are adequately trained to provide PCC to the people supported.

In using the QI educational curriculum, the job of nurses and other staff members will become less stressful because they will learn to know the person they serve. With the use of

person-centered practices, the care plan will be developed with the person receiving care, allowing nurses to address issues that are important to the person supported. McCance et al. (2011) explained that using PCC in nursing as a framework requires four constructs: (a) professional competence, (b) the ability to apply interpersonal skills, (c) commitment to job responsibilities, and (d) the ability to understand self and have a defined set of values. Pender (Nursing Theories, 2012) in her health belief model (HBM), explained the necessity of involving patients in process of planning their care. PCC relies on the ability of the patients or persons supported to understand what is important to them and for them and in order to find a point of balance (Nursing Theories, 2012; Pender, Walker, Sechrist, & Frank-Stromborg, 1990). PCC can groom patients with the ability to take of control of their health and wellness.

As a primary care provider, I have encountered a great diversity of patients and advocated for supports and services that are based on their choices and desires. Primary care providers play an important role in the application and implementation of PCC. The PCC approach entails a multidimensional collaboration among all specialties and members involved with the person supported in order to establish consistency of services across the nation (McCance et al., 2011). Training of staff members in the practice of person-centered care will influence the practice in many positive ways--namely, shifting from focusing on diagnoses and disabilities to holistic care. CMS and the National Committee of Quality Assurance (NCQA, 2014) published outcome measures as a requirement for healthcare settings to improve the quality of care. One of these outcomes includes the use of PCC to improve the quality and efficiency of care. The metrics assure accountability of healthcare providers to maintain safe and efficient care. The IOM (2001), in a report entitled *Crossing the Quality Chasm*, emphasized the need to use person-centered care to improve the quality of healthcare.

An important component of PCC is communication. An observational study was conducted with 39 physicians and 315 patients randomly chosen to evaluate the use of person-centered communication as a tool to improve patients' outcomes and involvement in self-care (Oates, Weston, & Jordan, 2000). The study was conducted during a two-month period, and the results revealed that patients' perceptions of care were higher after implementing person-centered communication than before. PCC improved the quality of outcomes and increased efficiency, which led to a decrease of number of diagnostic testing and referrals (Oates et al., 2000).

DNP: Use of Research in Practice

The use of evidence-based research in practice is very important in translating new knowledge into practice, and DNP students should be equipped with the appropriate skill necessary to synthesize the research in practice (AANC, 2006). Research is used to gather, initiate, design, implement, and evaluate the knowledge being used in practice (AANC, 2006). The Patient-Centered Outcomes Research Institute (POCRI) was created by the United States Congress to provide funding opportunities for advanced nurses and to be part of the fast-changing healthcare system. The DNP prepares advanced practice nurses to be involved in research for continuous improvement of the nursing science. The use of research in practice assures that decision-making processes across healthcare agencies are based on evidence from research (Barksdale, Newhouse, & Miller, 2014). This DNP project will bring new knowledge and perspectives to the organization in order to change the way care is provided.

In planning care with the people supported, providers should use evidence-based guidelines to address issues. The Institute of Medicine (2010) recommended that advanced practice nurses should practice to the fullest extent of their education and knowledge. This does

not mean everyone should practice "freestyle" healthcare delivery, but rather nurses should practice based on the evidence and guidelines and education. This DNP project provides a framework for advancing the use of PCC in ICF-ID and home and community based waiver programs.

There are many researchers currently in the process of finding a common ground using the PCC framework (Morgan & Yoder, 2012). This DNP project can be further examined by researching the outcomes of quality indicators after implementation of PCC in ICF-IDs. Further research is also needed to evaluate the influence of person-centered care on positive health outcomes and the role of policy in the application of PCC in all healthcare organizations.

Social Change

This DNP QI project will contribute to social change by decreasing or eliminating healthcare disparities. People with IDD will have equal access to care and are entitled to better care. PCC will eliminate the stigma of the disability and redirect the focus to the person as a whole (O'Brian & O'Brian, 2000). This DNP QI project will contribute to a fully integrated community where patients or people supported have the same rights. Supporting people to take control of their health by engaging them in the process and empowering self-advocacy are a great social change that this DNP project is bringing to communities. The results of this DNP QI initiative in the long-term due to an increase of awareness of the use of PCC will play an important role in decreasing the cost of national healthcare (Robertson et al., 2005).

Strengths and Limitations of the Project

Strengths

This QI initiative was developed based on relevant literature on person-centered care and the application, implementation, and evaluation of such practice in healthcare organizations. The

project was evaluated and validated by content experts in the field of nursing leadership, quality assurance, person-centered care, and intellectual and developmental disabilities. The project team and stakeholders' expertise and readiness to embrace the initiative was a great strength of the project. A qualitative analysis of the evaluation of the project revealed a content validity index score of 0.99, which indicated that the QI initiative is of high validity (Polit & Becker, 2005). In addition, the curriculum plan included a wide range of outcomes that addressed the primary goals of implementing PCC.

Limitations

This DNP project was based on a gap analysis conducted in one organization providing care to persons with IDD, thus making the results difficult for generalization to other healthcare organizations (Grove, Burns, & Gray, 2013; Polit & Beck, 2006). Project team members were limited to registered nurses, licensed practical nurses, qualified intellectual disability professionals (QIDP), direct-support professionals, and all staff members supervising these groups, a broader range of staff members would be more helpful to identify other restraining or driving forces that could slow or speed up the implementation process. There is a need for future studies to evaluate the use of a curriculum plan when training staff members to implement PCC.

Analysis of Self

As a Scholar

The American Association of Colleges of Nursing (AACN, 2006) published the essentials of doctorate education for advanced nursing practice. In doing so, the AACN laid out eight essentials for guiding the doctorate of nursing (DNP) educational curriculum. During my DNP program, I had the opportunity to be exposed to all eight essentials of healthcare education. The AANC emphasized that DNP graduates must be proficient in initiating quality improvement strategies; initiating, applying, and sustaining changes in organizations; and initiating change at the policy level. This DNP project supports these proficiencies. As the leader of this DNP project, I learned strategies for implementing and sustaining changes in practice within an organization. This DNP project provided a unique opportunity to translate knowledge into practice as related to the use, synthesis, application, and dissemination of evidence based practice.

The doctoral student at Walden is prepared at a higher than normal level of professionalism and education standards. This DNP program has provided me with a starting point within my area of interest. As a family nurse practitioner, I thought that my only interest would be a focus on primary care. During my practicum, I noted that advanced nurses are playing a prominent role in fulfilling the goals of the healthcare reform for Healthy People 2020. To be a part of this great initiative, nurses must practice to the full extent of their education. A vital skill needed for this role is leadership, which was used at all levels and particularly when initiating and conducting my DNP QI project in the organization. My leadership style was mostly based on transformational leadership, which has supported my ability to generate

sufficient organizational measures based on research knowledge, education, and experience, thus leading to an improvement in patient outcomes and increase in patient satisfaction.

As a Practitioner

The Institute of Medicine (2010) expressed in its "Future of Nursing" report that nurses should practice to the full extent of their education and training. In order to assume that responsibility, nurses should seek and achieve higher levels of education. As a family nurse practitioner, I have embraced the passion of working with people with mental illnesses and intellectual and developmental disabilities. Serving as a primary care liaison for the new Medicaid Health Home program (addresses physical and psychiatric needs on the same umbrella) is one of the population health improvements that I have come to appreciate as a result of appraising evidence based research. As a practitioner, I learned to synthesize and apply evidence-based research to change practice and improve outcomes. This DNP project allowed me to expand my knowledge about initiating, developing, implementing, evaluating, and disseminating programs (ANCC, 2006).

This project helped me to improve myself as a professional and enhance my confidence in my writing ability. The project helped me become more aware of issues that the nursing profession is facing. My leadership abilities have tremendously improved and prepared me for more management positions. This DNP project is an innovation in the field of disability studies and will improve the way nurses and other staff members are trained in person-centered care. Every patient is unique and deserves to have a unique experience during patient care interactions. The use of person-centered practices can support the achievement of such goals. I am in the process of establishing an urgent care clinic that will facilitate access to care among community

members at the chosen location, and I believe that this project directly taught me a different approach to healthcare.

As a Project Leader

Leadership plays an important role in forming, sustaining, and improving the efforts of a team in completing a project (Kelly, 2013). Additionally, forming a team and holding professional and formal meetings in collaboration with the interdisciplinary team was a very exciting learning moment. According to the research literature, effective teamwork can result in the improvement of patient outcomes (Kelly, 2013). The leader must maintain certain abilities, such as coaching, mentoring, supporting, and evaluating improvement processes. Some ways of maintaining the team's involvement and effort included providing praises, incentives, and appreciation (Kloppenbog & Petrick, 1999). This project taught me to maintain an open line of communication with stakeholders to keep them abreast of the impact of the quality improvement initiative within the organization (Kelly, 2013). In order to achieve good results, a leader should be able to recognize the characteristics of good teamwork--that is, the ability to create a trusting environment. As an effective leader, I was able and prepared to deal with conflict in a constructive way as well as create a mutually respectful environment through commitment, accountability, and results (Laureate Education, 2011).

Leading this DNP project was a very important experience, and I surely enhanced my leadership skills during my DNP program. Some examples of leadership tasks included establishing timelines, defining the responsibilities of each member of the group, developing meeting agendas, and setting the pace of meetings during our meeting time (Laureate Education, 2011). This project allowed me to demonstrate my leadership and management qualities and strengths as recommended by the AACN (2006). I learned to collaborate with members of my

team, and all decisions reflected a process of active listening and selecting the best solution based on a synthesis of the evidence (Kelly, 2013). This team supported me during the development of all the products contained in this QI project.

Contribution to Professional Development

The DNP essentials articulate the skills and competencies that should be acquired as a DNP graduate. For the purpose of this project, I chose Essential II: Organizational and System Leadership for Quality Improvement and System Thinking (AANC, 2006). The DNP degree prepares DNP students to use existing research to drive new knowledge. This QI project built and strengthened my skills and knowledge in leadership, management, collaboration, and decision making (Hutchinson & Jackson, 2013).

The Walden University School of Nursing provided me with the highest academic preparation through the doctor of nursing practice (DNP) program. The DNP program taught me the scientific foundations of nursing practice and strategies to address current and future practice issues using evidence-based research to implement innovative ideas or programs. The DNP program at Walden University contributed to my professional growth and development by enhancing my knowledge of leadership, my clinical expertise regarding community health and population health issues, and facilitated my readiness to participate in positive social change (Walden University, 2015). This QI project increased my passion to advocate for equity of healthcare access among vulnerable populations and provided me with a different way to approach and treat people under my care. As a healthcare provider, I am more committed to ensuring that appropriate language is used when addressing people with IDD in clinical settings and treating patients based on their unique characteristics and desires.

Summary

This QI project will assist in bridging a gap in this organization and other facilities that provide the same supports and services to people with disabilities. The goals of this QI project were to address the inequalities of access and efficacy of care within the organization, promote self-determination among people with IDD, and ensure that these people gain the maximum benefits of PCC. To achieve these goals, I developed a curriculum plan and a protocol, including pretest/posttest items that will be used to train nurses, DSPs, and all staff members supervising these groups. The use of person-centered care was a recommendation from the Department on Disability Services Disability Administration (2013) and the Center on Medicare and Medicaid Services (CMS, 2014). PCC, if effective, can improve the quality of care of people with IDD as planning will become a collaborative approach.

Staff members will be trained based on the curriculum creating a consistency across the organization. The Department of Health and Human Services (DHHS) and the Center for Medicare and Medicaid Services (2014) developed quality metrics to improve the quality of care through accountability of healthcare providers (CMS, 2014). With this QI project, healthcare workers in this organization will be able to have an understanding of the four core concepts of person-centered practices, which include (a) dignity and respect of patients, (b) sharing of information with patients and families (or substitute decision makers), (c) participation of patients and their family members (or substitute decision makers) in the decision-making process, and (d) collaboration with other healthcare professionals to improve healthcare service delivery (IPFCC, 2014).

Section 5 presents the scholarly product dissemination plan, which includes the process and mode of translation to a larger audience.

Section 5: Scholarly Product

Introduction

The purpose of this QI project was to develop an educational initiative based on person-centered care to train staff members working with people with intellectual and developmental disabilities. The goals of this QI initiative were to (a) conduct an extensive literature review that featured an analysis and synthesis of empirical research on person-centered care among individuals with intellectual and developmental disabilities; (b) develop a protocol to guide management staff in training nurses, direct-support professionals (DSPs), and staff members supervising these groups in the principles and practices of person-centered care; (c) develop an educational curriculum that includes a curriculum plan and a pretest/posttest that incorporates the principles and practices of person-centered care; (d) revise the training policy to include PCC modules; and (e) develop an implementation and evaluation plan. These goals were achieved through the development of a curriculum plan, protocol, pretest/posttest items, and a revision of the training policy to include PCC. The outcome products were evaluated and validated by three content experts. This process resulted in content validity of the overall quality of the test items, and improvement of the educational initiative.

This section explains the dissemination process of this DNP project within the organization as well as at the community level and national levels. The following products were submitted to Georgetown University Center of Child and Human Development (CCHD) for scheduling of a presentation at the Developmental Disability Administration (DDA) Nursing Round Table:

- course objective (see Appendix X),
- project summary (see Appendix Y), and

- my resume.

The CCHD nurse educator completed a District of Columbia (DC) course application or CEU approval and submitted along with the above named documents to the Board of Nursing for continuous education credit approval for all nurses who will attend the presentation. An approval (see Appendix Z) was obtained and a presentation date will be chosen after I present my final defense. I will use a PowerPoint presentation for the educational session. The PowerPoint will be emailed to the Center of Child and Human Development DC and Developmental Disability Administration (DDA) Health Initiative for District of Columbia at least a week before the presentation date. The presentation will be open to a wide audience, including nurses, program directors, QIDPs, residential coordinators, and DSPs.

This QI project will meet the needs of the organization for which this project was developed. The outcome products of this project will be disseminated to a larger audience, thus contributing to a fully integrated community where patients with IDD have the same right and access to care as people without disabilities.

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Appendix A: Gap Analysis

Table A1

Gap Analysis

Current Practice	Planned Intervention	Desired outcomes	Gap identified
Patients and people supported are not involved in decision-making involving their care There is an increase in refusal of interventions such as medical appointments follow up, medication administration and increase of outburst of behaviors	All nurses and staff members will be trained on PCC using the developed training curriculum along with the training protocol	Staff will receive training guided by the developed comprehensive educational curriculum on PCC The current training policy will be revised to include PCC	Nurses and direct care workers are not trained on PCC There is no training curriculum on PCC The current policy does not have PCC curriculum Current care does not align with the recommendations of the Institute of Medicine in providing effective person-centered care.

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Appendix B: Person-Centered Care

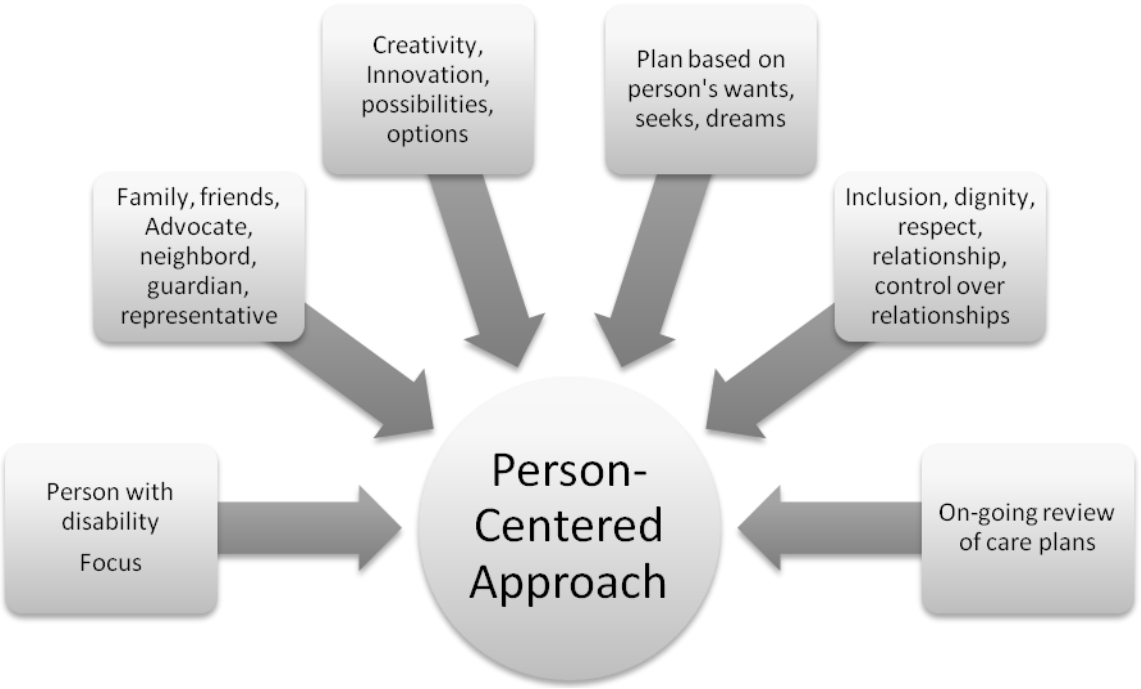

Figure B1. Person-centered care. Adapted from Nadin, Orr and Meagher, (2013). Good Practice Guidelines for Person-Centered Planning and Goal Setting for People with Psychosocial Disability. Australia

Appendix C: Essentials of Person-Centered Planning

Table C1

Essentials of Person-Centered Planning (PCP)

- Understanding the responsibility, the framework and the philosophy on person-centered
- PCP is a team approach with the patient (Family, Guardian, friend) as the center of attention
- PCP plan of action for the person with disabilities to understand goals and aspirations
- A fixed persistent purpose to go the extra mile to implement and evaluate person-centered care and reevaluate as needed.
- Freedom of all patients supported to make choice, think outside the square.

Acknowledge the complexity of person-centered care.

Adapted from Project Report for DisabilityCare Australia, (2013).

Appendix D: Literature Review Matrix

Laure B. Ndeutchoua, RN, MSN, FNP-C

Full References	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Research Methodology**	**Analysis & Results**	**Conclusions**	**Grading the Evidence**
Agency of Healthcare Research and Quality. (2014a). National Strategy for Quality Improvement in Health Care Report. Retrieved on 05/30/15 from *http://healthit.ahrq.gov/search/intellectual%20disabilities%2A%3C%5Cp%3*	National Quality Strategy	There are three aims and six strategies that guide the healthcare system as a whole.	National report on quality improvement	In this report, the importance of improving the quality of health of people, communities and nation is underlined. The framework used in this research was based on three aims explaining the importance of better care thru the application of person-centered practices.	The national quality strategy is a framework for quality improvement in healthcare. The report advocates for healthcare for all Americans.	II-A
Agency of Healthcare Research and Quality. (2014b). *Agency of Healthcare Research and Quality. (2014b). National Strategy for Quality Improvement in Health Care 2014 Agency-Specific*	National Quality Strategy	Quality improvement will change the way care is provided to improve the patient's experience.	National report on quality improvement	The framework used in this research was based on three aims and six priorities. The three aims are used to express the value for healthy people, communities and nations affordable care. Better care	The national quality strategy is a framework for quality improvement in healthcare. The report advocates	II-A

Plans. Retrieved on 05/30/15 from http://www.ahrq.gov/workingforquality/agencyplans/acl-specific-plan-nqs2014.pdf.				involves the application of person-centered practices which has become a national requirement in healthcare.	for healthcare for all Americans.	
Campinha-Bacote, J. (2011). Delivering Patient-Centered Care in the Midst of a Cultural Conflict: The Role of Cultural Competence. *The Online Journal of Issues in Nursing*, *16*(2), 5.	Middle range theory Campinha Bacote's Model of Cultural Competence	Cultural competence is important in planning and implementing person-centered care.	Descriptive research	Cultural competency is an important element in planning and providing person-centered care. The author analyzed the gap that could exist between patient's beliefs, health practices and the nurses' national guidelines.	Cultural competence will guide person-centered care thus allowing the patient to be valued and respected.	III-A
Davis, C. B., Cornman, C. B., Lane, M. J., & Patton, M. (2005). Person-centered planning training for consumer-directed care for the elderly and disabled. *Care Management Journals*, *6*(3), 122-130.	Middle range theory	The training program on person-centered care can contribute to better health outcomes of people with disabilities.	Qualitative study Case study with interviews and questionnaire	Many people with disabilities have unmet needs. A person-centered care training program will shift the focus of case management to care advising putting the patient in the center of the decision making process. Interviews were given to attendees to analyze their	PCC can make a great impact on health outcomes and patient satisfaction if staff are trained accordingly and if they understand the principles and practices	III-A

				level of comfort in providing PCC.	of PCC. PPC is a holistic approach of care that will cover both what is important to and for the person supported.	
Deci, E. L., & Ryan, R. M. (2012). Self-determination theory in health care and its relations to motivational interviewing: a few comments. *Int J Behav Nutr Phys Act*, *9*(1), 24.	Macro Theory	What it the importanc e of self-determinat ion theory in health related changes?	Qualitative study Clinical trials review	Self-determination theory (SDT) was compare to motivational interview to explain the role that SDT will play into patient's care plan and outcomes. A synthesis of clinical trials on SDT revealed that implementation of SDT in health care is a valuable instrument to independence and autonomy.	The use of SDT was suggested to increase patients' autonomy and involveme nt into their health care thus improved their health and wellness. SDT in an important step in making healthcare changes such as increasing physical activities, improving diet and smoking cessation.	III-B
Department on Disability Services. (n. d.). Office of	Practice Theory	Protecting and advocatin	Official guidelines requirements	The Department on Disability Services (DDS)	The implement ation of	III-B

right and advocacy (ORA) description. Retrieved on 2016/03/06 from http://dds.dc.gov/node/714542.		g for the rights of persons with intellectual and developmental disabilities.	for providers	established guidelines of care of people with disabilities namely the protection of their rights through the application of person-centered care.	PCC can allow persons supported to be the center of decision making involving their care, thus protecting the rights, choices and desires.	
Dignity of Risk Project, (2016). The Dignity of Risk is right to take risks when engaging in life experiences, and the right to fail in taking these. Retrieved on 10/04/2016 from http://dignityofrisk.com/what-is-the-dignity-of-risk	Community Project	Definition of dignity of risk	Descriptive, qualitative study	This project shed light on the term dignity of risk while engaging in the historical context of its importance related to people with intellectual disabilities. Persons with IDD should be allowed to experience events of choice even if deemed by the care providers to be risky. Many people learn by mistake and this should be the same for people with disabilities.	Dignity of risk is a project completed in 2011 to equip health care providers with the information needed to support older patients in decision making involving their care.	IV-A
Ervin, D. A., Hennen, B., Merrick, J., & Morad, M. (2014). Healthcare for	Middle range theory	People with IDD benefit from a unique	Qualitative study: Phenomenological	Healthcare for people with disability is not different from any other	Providing healthcare to people with IDD is a	III-B

Persons with Intellectual and Developmental Disability in the Community. Frontiers in Public Health, 2, 83		model of care that sees beyond the disability.		healthcare and should be accessible to the community. People with IDD should not have to belong to any community rather should be part of the community and receive equal treatment. When providers are able to see the patient and not the disability, creating person-centered care plans becomes a norm.	healthcare model that requires specific trainings for providers to be equipped with the knowledge needed to serve the population. According to Ervin et al. (2014) many people with disabilities tend to have a longer lifespan due to better healthcare.	
Friedman, B., Wamsley, B. R., Liebel, D. V., Saad, Z. B., & Eggert, G. M. (2009). Patient satisfaction, empowerment, and health and disability status effects of a disease management–health promotion nurse intervention among Medicare beneficiaries with	Middle Range Theory	Health promotion intervention can improve the quality of life of people with disabilities.	Quantitative research 24-Months randomized control trial	The study was conducted with a population of 766 participants with 383 receiving the intervention and 384 as the control group. This study evaluated the efficacy of nursing intervention based on	Empowering individuals to recognize the importance of preserving their own health contributed to health satisfaction and	I-A

disabilities. *The Gerontologist*, *49*(6) , 778-792				empowerment of people diagnosed with disabilities.	improvem ent of health outcomes.	
Grove, S. K., Burns, N., & Gray, J. R. (2013). The practice of nursing research: Appraisal, synthesis, and generation of evidence (7th Ed.). St. Louis, MO: Saunders Elsevier.	Middle Range Theory	Practicing nursing to improve outcomes based on evidenced -based nursing.	Quantitative and qualitative research Literature reviews	The authors explained effective and applicable standards in quality improvement projects.	Standards of care, utilization s review of quality improvem ents and literature synthesis for appraisal of evidence based research.	III-B
Hafskjold, L., Sundler, A., Holmstrom, I., Sundling, V., Dulmen, S. V., Eide, Hilde. (2015). Communication-Protocol: A cross-sectional study on person-centered communication in the care older people: The COMHOME study protocol. Retrieved on 2016/03/05 from http://bmjopen.bmj.com/content/5/4/e007864.abstract.	Middle range theory	Communi cation plays an important role in per-centered planning.	Qualitative Study International cross-sectional study with descriptive and comparative design.	Homes healthcare visits were recorded in a study sample of 500 patients in long-term care in which certain aspects of communication such as empathy, power distance, decision-making, preservation of dignity, and respect were explored.	The ability to recognize d downfalls in communic ation due to self-reporting will contribute to improvem ent on communic ation skill thus facilitatin g the implement ation of person-centered care in several	II-A

					countries.	
Helen Sanderson Associates. (n. d.). Person-centered practices. Retrieved from http://www.helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/whats-workingnot-working/	Practice theory	Skills needed to provide support to people with IDD	Descriptive analysis of person-centered practice tools	According to Hellen Sanderson and Michael Smull, developing person-centered plans requires the care provider to see the patient in a different way and using person-centered thinking. Person-centered tools provide staff members, nurses and other members of the interdisciplinary team with the ability to (1) better know and understand the patient, (2) acknowledge and recognize what is important to and for the person, (3) learn to communicate with the person, (4) learn to properly document communication and (5) match support based on the person's needs and choices.	The use of person-centered tools to change the way people providing care or supports think can lead to a smooth transition to person-centered care. When staff members learn to understan d the person supported, care plans change from generic to person-centered.	III-C
Hewitt, A. (*2014*) Presidential Address, 2014—Embracing	Practice Theory	There should be more emphasis	Expert Opinion based on Literature	According to Amy Hewitt 2014-2015 president of the	Self-advocacy is the model of	IV-B

Complexity: Community Inclusion, Participation, and Citizenship. Intellectual and Developmental Disabilities: December 2014, Vol. 52, No. 6, pp. 475-495		and resources spent on nurturing self-advocates that will speak up for themselves and become the center of decision making involving their care.	review	American Association of Intellectual Disabilities, people with IDD should be supported to become self-advocates. She mentioned that by doing this, healthcare will become personalized to each individual person's choice and needs.	care that should be use, supported and advocated in order to make implementation of person-centered care among people with intellectual disabilities.	
Institute of Clinical Research and Education, (n. d.). Effective communication. Retrieved from https://www.icre.pitt.edu/mentoring/effective.html on May 20, 2016.	Practice Theory	Effective communication can improve interpersonal relationships.	Based on clinical research	Communication was defined as the key aspect to improve the delivery of a message. The purpose of this publication was to define effective communication's strategies to use verbal and non-verbal communication, skills that describe and effective communicator, barriers of communication and strategies to conquer these barriers to promote good and effective	The Institute of Clinical Research put an emphasis on effective communication. This type of communication facilitates mentoring and interpersonal relationships.	III-B

				communication		
Kohn, N. A., Blumenthal, J. A., and Campbell, A. T. (2013). Supported Decision-Making: A viable alternative to guardianship? *Penn State law review, 117*(4), 1111-1157.	Middle range Theory	Supported decision-making can help people with disability to make informed decision.	Qualitative study Descriptive study	The authors defined supported decision's making as an alternative to guardianship. The guardianship process over the years had taken over people's rights and care planning was done solely upon the guardians' choices, which most often was far to be those of the patients.	Supported decision-making model of care allow people with IDD to receive the support needed to make their own choices and be involved in their care planning process. The least restrictive approach is always the best solution to person-centered care.	III-A
Loman, S., Doren, B., & Horner, R. (2011). Promoting Self-Determination for Adults: A Practice Guide.	Practice Theory	Promotion of self-determination by allowing people with IDD to experience and take risks.	National Gateway to Self-Determination	The ability to act in self-determined manner can be achieved based on 3 dimensions and a multitude of skills all referring to the ability to take decisions and be part of decision making involving their care and	In this guide, the authors explained the skills needed to achieve self - determination. The ability to allow person supported to be	II-A

				wellbeing. Theses dimension namely causal emergency/independence, proxy agency/inter-dependence and environment and opportunity to act.	expose to activities of their choices can expose them to a certain level of risk which constitutes the learning milestone to supported decision-making.	
Lotan, G., & Ells, C. (2010). Adults with intellectual and developmental disabilities and participation in decision making: ethical considerations for professional-client practice. *Intellect Developmental Disability*, *48*(2), 112-25.	Practice theory	Re-examination of assumptions made in taking care of people with IDD	Qualitative study Descriptive research	The importance of ethical principle related to care planning, decision making process, autonomy, empowerment, power-outer directedness and the ability of providers to respect patients in underlined as crucial elements to pay attention to during the transition from teenage life to adulthood. Lotan and Ells explained that, by making sure these above mentioned elements are	If patients or people supported are made aware and involved into decision making, they will experience more satisfaction. When people feel respected and valued, they tend to be more engaged.	III-A

				fulfill, the probability of exercising PCC and self-determination is elevated.		
NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2010). Instructional Manual. "The Road to Building Partnerships & Supporting Choices". Retrieved on 2016/03/04 from http://www.ncdhhs.go/document/person-centered-planning	Practice Theory	An appropriate content such a curriculum plan can make the application of person-centered planning a success	Qualitative Instructional manual based on national guidelines on person-centered care.	This manual was established based on national quality measures on person-centered care. These measurements evaluated the effectiveness and impact of interventions and policies as related to person-centered planning.	Person-centered care is needed in mental health and has proven to make a positive difference in health outcomes and satisfaction. There is a wide variety of tools available to understand person-centered planning and should be utilized based on the person's needs and interests.	III-B
O'Brien, C. L., & O'Brien, J. (2000). The origins of person-centered planning: A	Middle range theory	Person-centered care planning will result	Descriptive research and case studies	People with disabilities should be provided with appropriate	Person-centered planning can increase	III-A

community of practice perspective.		to improve outcomes		support to strive and reach their maximum potential. Person-centered care allow the person supported and the care giver to work together to improve the health outcome.	healthcare satisfaction. As citizens, choice and decision-making, advocacy and avoidance of label will make planning of healthcare more effective for people with disabilities	
Patrick, D. L. (1997). Rethinking prevention for people with disabilities Part I: a conceptual model for promoting health. *American Journal of Health Promotion*, *11*(4), 257-260	Middle Range Theory	Can empowerment of people with disabilities results to health promotion?	Derived from Pender's Health Promotion Model	The American Disability Act explained the importance of equal opportunity of healthcare access and services among for people with disabilities. Chronic disease management for this population becomes a challenge if this process is not addressed.	Promotion of health through empowerment, promotion of independence and self-determination contributed to improvement of the quality of life of people with disabilities.	III-B

Robertson, J. M., Emerson, E., Hatton, C., Elliott, J., McIntosh, B., Swift, P., . . . Joyce, T. (2005). *The impact of person centered planning*. Lancaster: Institute for Health Research, Lancaster University. England.	Middle Range Theory	What effect does implementation of person-centered care has on the life of persons with intellectual disabilities?	Quasi-experimental study	This research recognized the gap in application of person-centered care (PCC) during care persons with disabilities. A control trial was done using 25 people that were follow over a two years period to determine the effectiveness of PCC process during which the cost of PCP implementation and the factors that can affect PCC planning within the organization were analyzed.	There are positive effects of implementation of person-centered care. The benefit of PCC varies through the lifespan individuals.	II-A
Rogers, C. R. (1979). The foundations of the person-centered approach. *Education, 100*(2).	Middle range theory	What is Person-centered care and how does it contribute to change/	Qualitative research	According to Rogers (1979) person-centered approach is the only way of providing effective and efficient care. He explained the variety of appellations used over decades to express the uniqueness of each person during patient care interaction. Regardless of the setting, people should be	The application of person-centered practices in a healthcare setting will result to people becoming self-confident, more engage, and happy to participate	

				empowered, mentored and taught to recognize their abilities and support in their choices and decision making.	.	
Schalock, R. L., Brown, I., Brown, R., Cummins, R. A., Felce, D., Matikka, L., ... & Parmenter, T. (2002). Conceptualization, measurement, and application of quality of life for persons with intellectual disabilities: Report of an international panel of experts. *Journal Information*, *40*(6).	Middle range theory	Culture and cultural concepts have an impact on implementation and evaluation of person-centered care	Qualitative study Descriptive research	Evaluating the quality of life of persons with intellectual disabilities is a challenging process. While there are elements that many people with agree on, there are other elements that vary due to the culture and value difference.	This research article provides basic indicators that could be used to evaluate the quality of life of people with intellectual disabilities.	III-A
Simplican, S. C., Leader, G., Kosciulek, J., & Leahy, M. (2015). Defining social inclusion of people with intellectual and developmental disabilities: An ecological model of social networks and community participation. *Research in developmental disabilities*, *38*, 18-29	Middle range theory	Understanding social inclusion of people with IDD in various community settings.	Qualitative research study	Simplican, Leader, Kosciulek, and Leahy (2015) explained the meaning of social inclusion based on different contexts. They identified four models that should be taken in consideration when trying to explain social inclusion. Self-	Social inclusion along with self-advocacy with facilitate person-centered care in an organization. This care principle should be supported by	III-A

				advocacy was one of the main factors that when supported by the organization, social inclusion was least stressful for the person supported.	healthcare organizations, families and policy makers in order to make a big impact.	
Smull, M. (2012). Person Centered Thinking, SIS, ISPs and Quality of Life. American Association of Intellectual and developmental Disabilities. [PowerPoint Slides]. Retrieved from http://aaidd.org/docs/default-source/annual meeting/pct-and-sis6182012.pdf?sfvrsn=2.	Practice Theory	Providers should use person-centered thinking to plan for services.	Power point based on literature review of qualitative researches	The emphasis is put on improving the overall quality of life of the people we support. Person-center thinking approach allow the interdisciplinary team to draft with the person receiving their individual support plan. During meetings the person remains the center of attention and should be empowered to make choices and given to opportunity to explore new activities or way of doing things.	Person-centered thinking skills are acquired with the used of tools that allow the staff member, nurse and other member of the health care team to think differently during provision of care. When care plans are based on the person's interest, there is a great probability that this plan will be	IV-B

					implemented.	
Snow, K. (2016). People First Language. Retrieved from https://nebula.wsimg.com/1c1af57f9319dbf909ec52462367fa88?AccessKeyId=9D6F6082FE5EE52C3DC6&disposition=0&alloworigin=1	Practice theory	The use of appropriate language will support community inclusion of people with disabilities.	Expert analysis on changing disability services	In this article, the author addresses the use of language as part of the problem that people with disabilities face. The emphasis is place on changing the language used in order to improve the quality of the services rendered. People should not be labeled nor referred to as a diagnosis. Instead, the person must always be first and the diagnosis or disability will be second.	Community inclusion cannot happen without the change in language. According to U.S. Developmental disabilities Bill of Rights Act, "disability is a natural part of a human experience" (as stated in Snow, 2016). Therefore, the proper use of language that eliminates labeling can result in inclusion, freedom and promote respect of all.	III- B
Sowney, M., &Barr,	Grand	Effective	Qualitative	An analysis of	There is a	III-A

O., (2007). The challenges for nurses communicating with and gaining valid consent from adults with intellectual disabilities within the accident and emergency care services. *Journal Of Clinical Nursing*, *16*(9), 1678-1686.	Theory	communication can impact the quality of care of people with intellectual disabilities.	research Purposive sampling	challenges encountered by nurses was conducted on five general hospitals using a purposive sampling method. People with intellectual disabilities are often not included in decision making involving their care.	need of training staff nurses on proper an effective communication. This training will strengthen nurses' competence to care for people with intellectual disabilities namely provision of person-centered care.	
Stanhope, V., Tondora, J., Davidson, L., Choy-Brown, M., & Marcus, S. C. (2015). Person-centered care planning and service engagement: a study protocol for a randomized controlled trial. *Trials*, *16*(1), 180.	Middle range theory	Examination of the effectiveness of person-centered care planning (PCCP) implementation Impact of organizational variables on PCCP implementation Outcomes measure	Mixed-method research Randomized control trial of mental health organizations	The effectiveness of implementation of PCCP was studied in 280 participants including 70 from the leadership and 210 supervisors and direct support personnel. The interventions involved 12 months staff training and ongoing technical assistance	PCCP application can lead to better outcomes. With proper training and interventions to sustain the effort in the organization, PCCP can contribute to enhancement of the national	II- A

		for person-centered care planning			health care reform.	
Sunderland, A. (2007). Self-determination for persons with developmental disabilities: An RWJF national program. Retrieved on 2016/03/06 from http://www.rwjf.org/en/library/research/2007/10/self-determination-for-persons-with-developmental-disabilities.html.	Middle Range Theory	Can self-determination for person with IDD improve their health and healthcare as a whole?	Qualitative research and evaluation of national key indicators.	The Robert Wood Foundation's National Program Self-determination for person with developmental disabilities was a project working toward lowering the cost of the national healthcare cost through the use of person-centered practices to enhance the quality of care of these citizens.	The results implied that direct supports professionals must be trained in the principle of self-determination in order to assured quality of the services rendered.	IV-A
Support Development Associate. (2012). Go to guide for person-centered thinking skills. Retrieved on 2016/03/06 from	Grand Theory	The use of person-centered tools will assist staff members to know and understan	Qualitative using templates to gather patients/people supported information	The basic of providing PCC is the understanding of the person that is receiving care. These tools include Important to	The ability of staff members to understand the balance between	III-B

sdaus.com/toolkit.		d the person supported.		/Important for as the core component of person-centered thinking concept.	what is important to and important for the person receiving care will assist in finding a state of balance to promote and maintain the health and wellbeing of the persons with disabilitie s.	
Thompson, J. R., Bradley, V. J., Buntinx, W. H., Schalock, R. L., Shogren, K. A., Snell, M. E., ... & Gomez, S. C. (2009). Conceptualizing supports and the support needs of people with intellectual disability. *Intellectu al and developmental disabilities*, *47*(2), 135-146.	Middle-Range Theory	Finding a balance between the persons' needs and choices can improve the quality of services provided	Descriptive research	This article defined and explained types of services available to support persons with IDD. The American Association of Intellectual Disability supported the use of person-centered planning as the correct process to provide care.	The AAIDD in this review of the literature, changed the language to remove the stigma of disability. This call will allow providers to see the patient as a person	III-A

					and provide them with opportunities to explore various horizons.	
Ursel, K. L., & Aquino-Russell, C. E. (2010). Illuminating person-centered care with parse's teaching-learning model. *Nursing science quarterly*, *23*(2), 118-123	Descriptive theory	Parse's Teaching Learning Model could be a teaching tool for person-centered care.	Phenomenological study	The Parse's teaching learning model was used as a guide to apply learning into practice of implementation of person-centered care. The model describes the importance of recognizing human rights and respect of dignity during provision of care.	Making a difference in people's life is gratifying. The implementation of person-centered care by practicum students made a difference on the quality of life of patients in an acute care unit.	IV-B
Viau-Guay, A., Bellemare, M., Feillou, I., Trudel, L., Desrosiers, J., & Robitaille, M. J. (2013). Person-centered care training in long-term care settings: usefulness and facility of transfer into practice. *Canadian Journal on Aging/La Revue Canadienne*	Middle range theory	Would training of staff members improve the quality of care of patients in long-term care?	Qualitative study	In order to evaluate the effect of person-centered training of staff members in long-term care, open ended questionnaire was given to 392 employees one month after receiving the training. The questionnaire is based on	This study revealed that training of staff members is very important in applying PCC. However, in order to sustain the change in	III-A

du Vieillissement, *32*(01), 57-72.				healthcare practices while the training modules focused on theoretical knowledge and practical skills related to the type of care provided.	the organization, skills acquisition training and case scenarios of actual issues should be used for discussions to facilitate retention	
Wehmeyer, M. L. (2005). Self-determination and individuals with severe disabilities: Re-examining meanings and misinterpretations. *Research and Practice for Persons with Severe Disabilities*, *30*(3), 113-120.	Practice Theory	Self-determination would not be an option for all patient.	Qualitative study	The authors re-examine the level of disability of each individual person presented in order to define whether self-determination could be an appropriate option. Many care giver tend to mis-represent the person life plan. Therefore, engaging the person in the care planning process with the appropriate supports will make a difference.	Definition of self-determination among people with IDD.	
Winsor, S., Smith, A., Vanstone, M., Giacomini, M.,	Middle range theory	Synthesis of providers	Qualitative research	The use of PCC in specialized community	The use of PCC allowed	III-A

Brundisini, F., & DeJean, D. (2013). Experiences of Patient-Centredness With Specialized Community-Based Care: A Systematic Review and Qualitative Meta-Synthesis. *Ontario Health Technology Assessment Series*, *13*(17), 1–33.		and patients' experiences based on healthcare delivery model in the community using person-centered practices	Meta- synthesis	based services was evaluated based on the analysis of 29 qualitative studies on the interventions used in the community. Health promotion in the community could be more successful with the application of interventions using person-centered practices because patients learn to understand their health plan as they are part of the care planning process and remain in the center of decision making involving their care and well-being.	persons supported in the community to be more educated and aware of their diagnoses, treatments and interventions, thus contributing to improvement of health outcomes and patients' satisfaction.	

Appendix E**:** Revised Training Policy

STAFF TRAINING POLICY

POLICY STATEMENT

Metro Homes, Inc., shall provide opportunities for staff training and orientation which foster professional and personal development, serve to enhance the effectiveness of staff performance, and enrich the lives of persons supported by Metro Homes, Inc.

PURPOSE

This policy is to outline the standards recommended by DDS, and mandated and governed by Metro Homes, Inc. This policy outlines all of the trainings offered by Metro Homes, Inc. for the purpose of educating new hires, as well as providing ongoing training for the Direct Support Professionals (DSP), all Nurses, Qualified Intellectual Disability Professional (QIDP), and residential coordinators (RC).

IMPLEMENTATION PROCEDURES:

PURPOSE: The purpose of this procedure is to ensure that all direct support staff, all Nurses, Qualified Intellectual Disability Professional (QIDP), and residential coordinators (RC) are trained per DDS policy. Additionally, this procedure ensures that all staff are well informed on the trainings, the person conducting the training, the time, location, and materials being reviewed.

A. Before Hire:

1. All Staff will complete a written and verbal assessment (i.e. reading comprehension and math test at the time of the application, panel interview of Residential Coordinators, QDDP's, Nurses and Human Resources, and application process.
2. Potential staff will be required to take the new Phase I training (comprised of 9 modules) prior to hire. This Phase I training shall include Adaptive Equipment, health and Wellness, Human Rights part A&B, Introduction to Developmental Disabilities, Introduction to Socialization, Satisfaction, Universal Precautions, and Incident management. Potential staff will receive a score of 80% or better in order to be hired as a Direct Support Professional or all other positions named above at Metro Homes, Inc.
3. Once all of the requirements above have been satisfied, staff will complete the required

Human Resources standards according to the labor laws, before completion of hire.

B. <u>Orientation Training</u>

1. Each new employee shall be provided with up to a 3 day orientation to programs, philosophy, goals, objectives, and practices of Metro Homes, Inc. This shall include the introductory trainings to include but not limited to Incident Management, Universal Precautions and Infection Control, Hazardous chemicals, Fire safety, Vehicle safety, HIPPA (Health Insurance Portability and Accountability), CPI (Crisis Prevention Intervention,(**if needed**), and First Aid and CPR**.**
2. Each new employee shall participate in orientation training to include Phase II, prior to assuming the full responsibilities and duties of the position for which they are hired, and before they are assigned to the support of any individual. .
3. Phase II includes Individual Specialized In-service Training to include but not limited to the persons Individualized Support Plan (ISP), Behavior Support Plan (BSP), person-centered care (PCC), Health Care Management Plan (HCMP), ISP implementation BSP implementation, Nutrition, Specialized Dining Techniques, Transfer and Mobility Procedures, and Seizure Disorders.
4. Phase II training will be provided to the direct Support Professionals by the Nurses, QDDP's, and Residential Coordinators in the home that work directly with the individuals they will be supporting. Nurses, QIDPs and RCs will be trained by individuals supervising them.

5. Anyone that has not completed Phase I and Phase II shall not be qualified to work in the homes with persons with Disabilities within the District of Columbia, until completion has been documented.

C. Upon Hire

1. Direct Support Staff will receive ongoing training as part of the continuing education of supporting persons with disabilities.

2. The professionals of the individuals support team will provide training to include but not limited to ISP, BSP, HCMP, Health Passport, oral hygiene, signs and symptoms of illness, medication side effects, abuse, neglect, and exploitation, nutritional, physical therapy, occupational therapy, adaptive equipment training, lifting and transferring, and speech, per the individuals support needs identified in the ISP.

3. The Direct Support Staff, QIDPs, Nurses and RCs will complete Phase III (Core Curriculum) within 180 days of hire. This includes the following: (see DDS 3.3 Direct Support Professional Training Policy attached)

    1. Health and Wellness
    2. Choice and Decision Making
    3. Rights and Dignity
    4. Safety and Security
    5. Community Inclusion and relationships
    6. Satisfaction
    7. Professional Development
    8. RN competencies (for Registered Nurses only)

4. Direct Support Professionals, QIDPs, Nurses and RCs will begin, per DDS training policy, Phase IV within 2 years of the date of hire.

5. Direct Support Professionals, QIDPs, RCs, and nurses will complete annually, 20 hours of Enhanced Training, as well as meet the renewal requirements of Critical Health and Wellness, certified programs (e.g. CPR – annually, First Aid- every 2 years). All other staff will complete CEUs as required by regulations based on specialty board.

6. All DSP's shall complete 20 hours of enhanced training by the end of their second year, and annually thereafter.

7. Phase IV training includes but not limited to:

a. Health and Wellness

- Medication administration
- CPR/FA
- Adaptive equipment maintenance protocol
- Positive behavior strategies

b. Choice and decision Making

- Informed Consent
- Participatory Communication and Choice Making
- Person Centered Planning

c. Rights and Dignity

- Advocacy strategies
- Individual Rights

d. Safety and Security

i. Universal Precautions refresher
ii. Abuse Neglect and Exploitation
iii. Incident Management Investigation

e. Community Inclusion and relationships

i. Community development
ii. Supporting Relationships
iii. Supported Employment
iv. DSP in BSP implementation

f. Satisfaction

- Values/base decision making
- Person-centered care

g. Professional Development

- Coping with Stress and burn out
- DSP communication
- Current DD topics

D. TRAINING AND RECORD APPROVAL

- Each DSP, nurse, QIDP or RC must have a complete training record which includes the completion date, and verification scores for each training requirement prior to working alone at a direct service location.
- DSP's providing services on a temporary or interim basis shall comply with the training requirements of the staff for which they are replacing
- Any Staff working for a DDA provider outside of the geographic area of DC that provides direct supports to a person served by DDS MUST receive all of the required training outlined in this policy.
- All staff must achieve a score of 80% or better during the written competency verification process.
- Metro Homes, Inc. curriculum is the approved DDS curriculum per DDS standards.
- Metro Home, Inc shall use the Person-Centered Care (PCP) curriculum plan and protocol to train all staff during phase, II and III. This PCP curriculum plan resulted from evidence-based research on person-centered and DDS policy on person-centered thinking.
- Metro Homes, Inc shall submit to DDS training institute all the DSP's and professional staff names and hire dates on approved forms within 10 business days from the date of hire.
- Metro Homes, Inc. will neither share nor accept training records and/or test results with any other provider, unless it is an external accreditation (CPR/FA, TME, CPI).

E. TRAINING COMPLIANCE

a. Metro Homes, Inc. will train all full time, part time, and contractors per DDS policy.
b. Should full time, part time, and/or contractors not comply with training guidelines and recertification's in a timely manner, staff will be removed from individual contact and taken off the schedule, until such compliance can be proven in writing (i.e. certificates, training cards, and in-service signing sheets).
c. Should Metro Homes, Inc. not comply with training requirements, they shall be subject to disciplinary actions per DDS policy and CMS standards.

F. APPROVED TRAINERS

- Metro Homes, Inc. will designate one or more staff positions to coordinate staff training.
- The trainer will have at least three (3) years experience providing direct supports, or specific expertise, certification in the subject matter (Registered Nurse CPR/FA certification, CPI certification by accredited training program). For training regarding Adaptive Equipment Protocols, and Substitute Consent and Decision Making, the trainer will have participated in the DDS train the trainer course, and will use the DDS curriculum.
- For training regarding the PCP curriculum plan, the trainer must be a QIDP, RN, person-centered coach, or any staff member supervising these after participating to the train the trainer presentation, and will use the PCC curriculum plan and pretest/posttest.
- The designated trainer will possess a broad knowledge of supports and services for persons with intellectual disabilities. They shall further possess the skills to

organize and implement a training program.

- The trainer must be able to provide initial and ongoing training that enables the employee to perform his/her job effectively, efficiently, and competently.
- The trainer will assist in the coordination with other providers any needed training i.e. the plan for a BSP is written in the residential program. The

residential program trainer will coordinate training with the day program trainer.

- If the approved trainer is not the licensed professional, they will receive detailed training specific to the needs of the person (i.e. HCMP, ISP, and BSP) from the clinician or licensed professional prior to training any other person.
- Metro Homes, Inc. will ensure that there is a competency based assessment that is facilitated by the approved trainer, which will include, but not limited to on the job activities, hands on assessments, and or routine interviews with staff.
- Metro Homes, Inc. will maintain accurate and up to date training records.
- Metro Homes, Inc. will establish a written training plan to maintain compliance with DDS training requirements. The plan will include how training will be provided, the trainer completing the training, date, time, and location. A procedure will be developed to how training will be provided, and accompanied by a training calendar establishing the areas being covered.

- **RETENTION OF TRAINING RECORDS**
    - Training records will be maintained in the Human Resources Department, and in the electronic system set forth by Metro Homes, Inc.
    - The training records will contain the following:
        1. A list of required trainings/ training plan
        2. Training calendar with courses offered and dates of training
        3. Training curriculum with hand outs
        4. In-service sheets that include: Trainers name, title of the course, date of the course, name and signatures of attendees.
        5. Any certificates issued for a specialized training.

3. Metro Homes, Inc. will maintain training records for all staff members that have separated for a six (6) year period. The records will include:

    a. Competency verification forms and graded tests
    b. Metro Homes, Inc. sign in sheets
    c. An electronic training system

4. Metro Homes, Inc. will neither share nor accept training records and/or test results with any other provider, unless it is an external accreditation (CPR/FA, TME, CPI).

- **Compliance**
- Staff will be offered trainings on an ongoing basis. These trainings will be posted on the staff communication board for ongoing reference at the assigned homes/facility's location.

a. The Trainer, and/or Trainer will compile a training calendar to include but not limited to: Phase I, Phase II, Phase III, Phase IV, and all other required trainings for staff.
b. The Trainer and /or Trainer will update as needed, and communicate any schedule changes within 24 hours or the next business day to all.
c. The Training Department will work in conjunction with Human Resources to ensure that all trainings are communicated in advance of the offered training to ensure staff have adequate time to prepare for the training.
d. The Trainer will provide written notifications to Human Resources to distribute on the paychecks one week in advance of the payroll distribution.
e. Notices of scheduled trainings will be attached to the staff members' paychecks. This will be considered written notification for the staff.
f. Staff will attend trainings, which will be documented by the training in-service sheets to include: Trainers name/title, the topic being trained, the date, the time, and name of attendees, and their signatures.
g. Any staff not attending the scheduled trainings will receive a corrective action for failure to attend. Should there be extenuating circumstances, this should be documented by the supervisor, and Human Resources, and be communicated to the trainer immediately for rescheduling.
h. If a staff member receives an excused absence, there will be no penalty for not attending and should be rescheduled for the next training session. This excuse should be documented by immediate supervisor and communicated to HR and trainer (if applicable).
i. Should staff be scheduled for a second time for the same training, and fail to attend, staff will be removed from the schedule until the training is received. Should staff not receive the training within one month of being taken off the schedule, their position will be permanently replaced without notice.
j. Monthly house meetings are considered mandatory for all direct support staff working at that location for any reason i.e. temporary staff, on-call, etc. Staff MUST be in attendance each month

for the house meeting. Should the staff not show up to the meeting, and/or not be excused for extenuating circumstances (at the supervisor's discretion), staff will receive progressive corrective action up to and including termination for each meeting not attended. (Not attending house meetings is unacceptable, as staff are provided with important training and individual information focusing on person-centered care).

Appendix F: The Protocol

Training Protocol

Facilitating Person-Centered Care for People with
Intellectual and Developmental Disabilities

Purpose: The purpose of this training protocol is to provide a step by step approach on facilitating the implementation of person-centered care (PCC) educational curriculum within the organization.

Goal: The goal of this protocol is to provide a consistent guidance for training on person-centered practices for nurses, direct support workers, and other health workers supervising this groups or participating in the care planning process of the persons supported.

a. The training curriculum shall be part of phase II training yearly and core training.
b. Each session will be held in group of no more than 15 staff members to increase level of participation of each staff member.
c. The content will be taught in two trainings sessions of five (5) hours each (Day one and Day two).
d. Staff members must complete session one prior to be admitted in session two.
e. A Pretest/Posttest (18 question items) will be administered at the beginning (pretest) of the session one and at the end (posttest) of the training session two.
f. Allow 2 minutes for each test item which is a total of 36 minutes and four minutes for review and submission. Allocate 40 minutes for the total test time.
g. Minimum passing score is 80%. Staff members who do not meet this score must retest. If a staff is unable to obtain a passing score the second time, this staff must be retrained prior to retesting and follow the organizational procedure thereafter.
h. All scores will entered in each staff training file.
i. Management should rehearse part of PCC content during monthly meeting using case scenarios for skill acquisition.

Objectives	Content	Presentation and Competency evaluation	Time Frame
1	Overview of Person-Centered Care	PowerPoint Pretest/Posttest	Day One 5 hours
2	Person-centered Thinking	PowerPoint Pretest/Posttest	
3	Inclusion and Socialization	PowerPoint Pretest/Posttest	
4	Principle of Supported Decision Making	PowerPoint Pretest/Posttest	Day Two Training
5	Principle of Self-determination	PowerPoint Pretest/Posttest	5 hours Testing
6	Effective Communication	PowerPoint Pretest/Posttest	40 minutes
7	Person-centered Plans	PowerPoint Pretest/Posttest	

Appendix G**:** Educational Curriculum

Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

Problem: The problem identified for this DNP project is that person-centered practices had not been included in the training curriculum within the organization.

Purpose: The purpose of this DNP project is to develop an educational curriculum focusing on person-centered care (PCC). The curriculum will include a protocol to guide the management in training of nurses, other staff members involve in care planning and direct support staff on PCC to improve health outcomes.

Goal: The goal of this curriculum is to provide a consistent guidance for training on person-centered practices for nurses, direct support workers, and other staff members providing care or participating to care planning of the persons supported.

Objectives At the conclusion of this educational experience staff will be able to:	Content Outline	Evidence	Method of Presenting	Method of Evaluation P/P Item
1. Describe Person Centered Care (PCC) related to the purpose, background, significance, and proposed outcomes of PCC.	Introduction A. Overview of person-centered care (PCC) a. Purpose of PCC To provide care based on patient's • Choices, desires or dreams • Values • Culture To provide support that allows people receiving care to: • Participate in meaningful activities • Improve overall wellbeing b. Background of PCC Historical perspective after deinstitutionalization revealed that staff became: • Over protective	Robertson, J. M., Emerson, E., Hatton, C., Elliott, J., McIntosh, B., Swift, P., . . . Joyce, T. (2005) O'Brien, C. L., & O'Brien, J. (2000). Robertson et al., (2005)	PowerPoint Presentation Group discussion	1, 2, 3, 4, 5

	• Dictator of care – lack of patient involvement. • Rights of the person supported not respected. PCC can improved patient outcomes. PCC is a requirement for agencies caring for vulnerable populations c. Significance of PCC Changing the traditional way of care from the provider being in charge to the patient being the center of attention, decision making and stage of negotiation. • People feel valued and respected. • Eliminate the stigma of disability (see patient as a person, not a disability) d. Proposed Outcomes of PCC Person centered care can : • Improve the overall quality of care. • Contribute to better adherence to care • Allow patients to exercise self-determination • Promote independence despite the level of support needed • Patient will be in control of their lives	Agency of Healthcare Research and Quality. (2014a) Agency of Healthcare Research and Quality. (2014b). Maslow, K., Fazio, S., Ortigara, A., Kuhn, D., & Zeisel, J. (2013) NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2010) O'Brien, C. L., & O'Brien, J. (2000).		
2. Define the principle,	B. Person-centered thinking	Stanhope, V., Tondora, J.,	PowerPoint	5

significance and impact of person-centered thinking.	(PCT) a. Define PCT Skills and value sets acquired through cultural learning to: • Plan and provide support centered on patient • Empower partnership between patient and or families and care providers • Foster accountability b. Significance of PCT • Change in care planning process. • Tool guide to know the patient better • Foundation of person-centered planning • Person-centered care will be implemented c. Impact of PCT • Improve health outcomes • Simplifies work load • Allows flexibility and creativity in care planning • Contributes to use of person-centered care	Davidson, L., Choy-Brown, M., & Marcus, S. C. (2015). Smull, (2012) Winsor, S., Smith, A., Vanstone, M., Giacomini, M., Brundisini, F., & DeJean, D. (2013) Rogers, C. R. (1979) Campinha-Bacote, J. (2011). Davis, C. B., Cornman, C. B., Lane, M. J., & Patton, M. (2005).	Presentation	
3. Define inclusion,	C. Inclusion and socialization		PowerPoint	6, 7, 8. 9

socialization and dignity of risk related to people with IDD and apply examples to specific context.	a. Definition Social inclusion (SI) is the ability of a person with disability to be engage in activities dedicated for general public such as: • Relationship building • Faith connection • Finding a job • Choosing their healthcare providers • Sport activities • Community organization b. Context Social inclusion involves: • interpersonal relationship • and community participation SI refers to a wide range of scope based on the following factors: • individual, • interpersonal, • organizational • and community These Factors help to eradicate the barriers of disabilities namely: • Social interaction • Social Capital • Social Network • Independent living	Hewitt, A. (*2014*) Simplican, S. C., Leader, G., Kosciulek, J., & Leahy, M. (2015) Dignity of Risk Project, (2016).	Presentation Group discussion Case Scenarios	

	• Community participation • Feeling of belonging c. Dignity of risk Concept allowing people with disabilities to make risky choices that could either: • Positively (promote growth) or • Negatively (lead to disappointment) affect their lives. Dignity of risk can be supported by the care giver by: • Acknowledging the person's right to make their own decision • Supporting the person and or the family to make an informed decision. • Recognizing the person's choice even if this choice does fall in line with the care giver's choice. • Right to experience failure • Acting in the			

	person's best interest at all time.			
4. Described the principle of supported decision making related to the impact, value and the ability to encourage self-advocacy of people with IDD.	D. The principle of supported decision-making (SDM) a. Definition of SDM Innovative process put in place to provide people with IDD the support needed to make or communicate a decision. Supports could be in form of: • Relationships • Dispositions or settlements • Agreements b. Impact of Supported Decision-Making • Least restrictive while making the person to feel valued and respected • Promotes person-centered planning • Contributes to a greater sense of satisfaction • Positive engagement	Department on Disability Services. (n. d.). Office of right and advocacy (ORA) description Loman, S., Doren, B., & Horner, R. (2011) Kohn, N. A., Blumenthal, J. A., and Campbell, A. T. (2013) Thompson, J. R., Bradley, V. J., Buntinx, W. H., Schalock, R. L., Shogren, K. A., Snell, M. E., ... & Gomez, S. C. (2009)	PowerPoint Presentation Group practice	10, 11

	leading to increased outcomes c. Outcomes of SDM • Promotes self-advocacy • Promotes good communication between the person supported and care giver • Improves independence • Promotes opportunities for relationship building. • Promotes community inclusion and social E. Value based decision-making Decision-making based on what it right, not based on past experiences or personal beliefs • Values represents the needs • Needs are	Lotan, G., & Ells, C. (2010)		

	the motivation to achieve • Value of self-determination • Value of person-centered planning F. Promotion of self-advocacy with SDM • Can allow people with IDD to make informed choices • People with IDD will be able to voice their concerns, choices, ideas • Develop or start initiatives • Take decisions with			

	adequate support • Take decisions without influence of others			
5. Define self-determination and explain the means of supporting and promoting self-determination.	G. Principle of self-determination j. Definition Principle that gives one the ability to make decisions based on choices, desire or aspiration without coercion or influence. k. Significance • Empowerment • Encourage involvement in decision making • Ownership of responsibilities l. Supporting self-determination • By allowing persons supported to engage in activities of their choice • Promotes widespread of	Deci, E. L., & Ryan, R. M. (2012). Sowney, M., &Barr, O., (2007). Support Development Associate. (2012). Sunderland, A. (2007).	PowerPoint Presentation Role Play	12, 13, 14

	PCC • Leads to better outcomes m. Promoting self-determination • Simplifies person-centered planning • Leads to autonomy • Promotes health and wellness • People receiving care will be motivated to stay involve in their care plan • Person-centered Care plan will be implemented. • Person supported will feel valued and respected. • Person-centered practices will be sustained in the organization.			
6. Define and understand effective	H. Effective Communication 1. Definition	Institute of Clinical Research and Education (n.	PowerPoint Presentati	15,17,18

communication related to the use person-centered tools	Communication: Process in which a message is conveyed and involves at least 2 persons: a speaker and an active listener. Effective communication is characterized by the ability of the listener to: • Perceive the significance of the message • Make sense out the message 2. Language Language portraits notions and intentions that disclose our values and drive our actions. • People first language (PFL) is part of the disability right movement. • PFL sees and addresses the person first, then the disability. • PFL detaches the person from his or her the diagnoses. • PFL is an important tool to promote community inclusion and PCC. 3. Person-Centered Tools Tools that help care givers to better understand what is important to and important for the persons receiving care. These include: a. Important to/ Important	d.). Hafskjold, L., Sundler, A., Holmstrom, I., Sundling, V., Dulmen, S. V., Eide, Hilde. (2015). Snow, K. (2016). Helen Sanderson Associates. (n. d.).	on	

	for Way of sorting out the person's • Health and safety needs (important for) and • wishes, desire, or something that procures happiness, comfort, contentment, fulfillment and satisfaction (important to) b. Relationship circle Allows the person to communicate people that are: • Important to them • People that should be involved in the care planning • Issues involving these relationships and • finding ways to correct these issues c. Communication charts Allow staff to chart or document events during their shift as they occur. Helps in developing outcomes and sction d. Good days and bad days Allow staff to document	Smull, M. (2012)		

	things or events that makes the person happy or sad e. What works and what does not work Strategies to document the person's likes dislikes to eliminate triggers of behaviors to reach a ground of compromise.			
7. Describe person-centered plans while considering the role of the staff, the input and consent of the person supported and or their family member.	I. Person-centered care plan a. Health promotion outcome • People become involved, receptive and motivated to take actions. • Easy access to healthcare • Interventions are be implemented • Person-centered practices become a norm into the organization b. Informed consent • Give permission • to receive care or treatment	Davis, C. B., Cornman, C. B., Lane, M. J., & Patton, M. (2005). Ervin, D. A., Hennen, B., Merrick, J., & Morad, M. (2014). Friedman, B., Wamsley, B. R., Liebel, D. V., Saad, Z. B., & Eggert, G. M. (2009). Helen Sanderson Associates. Patrick, D. L. (1997). Schalock, R. L., Brown, I., Brown, R., Cummins, R. A., Felce, D., Matikka, L., ... & Parmenter, T. (2002). Stanhope, V., Tondora, J., Davidson, L.,	PowerPoint Presentation	16

	• Know the risks and benefits involve • Understands the consequences or and possible complications c. Role of the staff • Understands what matters to the person • Supports the person during healthcare planning to understands what works and what does not work • Set priorities and find compromise • Empower the person receiving care to remain involve • Celebrate each milestone achieved by the person	Choy-Brown, M., & Marcus, S. C. (2015). Simplican, S. C., Leader, G., Kosciulek, J., & Leahy, M. (2015). Robertson, J. M., Emerson, E., Hatton, C., Elliott, J., McIntosh, B., Swift, P., . . . Joyce, T. (2005). Wehmeyer, M. L. (2005).		

	supported d. Role of the person/patient • Ask questions • Be the center of attention by staying involved • Making choices and contributing to the care planning e. Role of the family • Voice concern • Remember it is about the person's dream • Support the person receiving care			

Appendix H**:** Pretest/Posttest

FACILITATING PERSON-CENTERED CARE FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

PRETEST/POSTTEST

Date: _____Staff Name: _____

a. Self-determination is the principle that gives the person the opportunity to make decisions based on their choice, desires or dreams without coercion or influence.
True or False

a. ☐ True b. ☐ False

b. Using your own words, define dignity of risk:

_____
_____
_____

c. In defining person-centered care, which of the following words first come to mind?
Select all that apply:

a. Choice and decision making
b. Aspiration or dream
c. Center of attention
d. Culture and values
e. Leadership and control

d. Person-centered care can change the way healthcare is provided. Which of the following is **not** considered to be an advantage of person-centered care?

a. Improves overall person's wellbeing
b. Self-determination
c. Felling of abandonment
d. Promotes independence

e. During planning or provision of care, to promote person-centered care, the person supported should always

a. Be the center of decision making
b. Be the patient
c. Depend on the team
d. Follow directions

f. Based on the history of deinstitutionalization, many staff members providing direct healthcare services to persons with disabilities became overprotective. What impact has this had on the people supported?
a. Lack of involvement
b. Friendship
c. Feeling of control by staff
d. a & c

g. To provide healthcare based on the person's choice or interest, staff members should change their way of thinking and change the way the person supported is perceived. Following this approach, staff member must have knowledge of :
1. Person-centered care
2. Person-centered thinking
3. Caring
4. Dictating

h. Mary likes to have her hair looking nice every day. Her individual support plan (ISP) made provisions for her to have her hair done every two weeks. To support inclusion and socialization, the supervisor will:
a. Have staff come to the facility to do her hair
b. Take Mary to a salon for people with disabilities
c. Take Mary to a beauty salon of her choice in the community
d. None of the above

i. Social inclusion can be applied based on the following factors.
Select all that apply:
a. Individual and Interpersonal
b. Organizational
c. Community
d. All of the above

j. What are some ways of providing support to the people we serve? Select all that apply:
a. Acknowledging their rights
b. Respecting their choices

c. Providing enough information to make an informed choice or decision
d. A, B & C

k. Name the benefits of support decision making. **Select all that apply**:
a. Person supported remain engaged
b. Self-advocacy
c. Improves independence
d. Relation building
e. All of the above

l. Each person supported has a set of values that makes them unique from others. Value –based decision making is based on:
a. Past experiences
b. What is right for the person
c. The nurse's decision to choose a provider
d. None of the above

m. Healthcare team members can promote and support self-determination by…
Select all that apply:
a. Empowering the person supported
b. Scheduling activities or medical appointment for the person
c. Helping the person in selecting the best treatment
d. A & C

n. Self-determination outcomes can be listed as follow:
Select all that apply:
a. Leads to autonomy
b. Promotes health and wellness
c. Simplifies person-centered planning
d. All of the above

o. Name the core principle of person-centered tools:
1. The relationship circle
2. Important to/ important for
3. Communication charts
4. Good days/ Bad days

p. Describe the basic elements of person-centered plan.
Select all that apply:

1. Person supported participates during planning
2. Informed consent
3. None of the above
4. a & b are correct

q. Communication is a process by which a message or knowledge is conveyed and involves at least 2 persons: a speaker and an active listener. What are some characteristics of effective communication?

A. Ability of the speaker to provide explanations

B. Ability of the listener to make sense out of the message

C. Ability of the listener to perceive the significance of the message

D. B and C

r. Changing the language used to address people with disability is an important element of community inclusion. Addressing a person by his or her name in lieu of the disability is referred to as the use of :

1. Person-centered
2. People first language
3. Inclusion
4. None of the above

Pretest/Posttest Answers Sheet

1. True
2. Concept that allows people with IDD to make risky choices that can negatively or positively affect their life.
3. a, b, c, d
4. c
5. a
6. d
7. b
8. c
9. d
10. d
11. e
12. b
13. d
14. d
15. b
16. d
17. d
18. b

Appendix I**:** Lewin's Model of Change Implementation Plan

Facilitating Person-Centered Care for People with
Intellectual and Developmental Disabilities

Purpose: To guide the implementation of person-centered practices within the organization thru staff training using a curriculum plan, updated policy and pretest/posttest questions items.

Goal: To assure a smooth transition of the change process namely the facilitation of use of person-centered practices within the organization.

Actions	Done by who	By when
Unfreezing	Project leader Management staff Compliance unit Human resources Stakeholders	August 30, 2016
Move/Change	Project leader Management staff Compliance unit Human resources Target audience (nurses, DSP, managers supervising these groups)	December 30th, 2016
Refreezing	Project implementation leader Management staff Compliance unit Human resources Target audience Stakeholders	April 30th, 2017 and thereafter

Kettner, P., Moroney, R., & Martin, L. (2013). *Designing and Managing Programs*: An effectiveness-based approach (4th ed.), Thousand Oaks, CA: Sage.

Source:

Kettner, P., Moroney, R., & Martin, L. (2013). *Designing and Managing Programs*: An effectiveness-based approach (4th ed.), Thousand Oaks, CA: Sage

Appendix J: Logic Model Evaluation Plan

Facilitating Person-Centered Care for People with
Intellectual and Developmental Disabilities

Goal: To evaluate the impact of the use of the training curriculum on person-centered practices within the organization and sustain the use of such practices within the organization.

Inputs	Activities	Outputs	Outcomes		Impact
-Staff	-Staff meetings in various locations	-All staff are trained on PCP	**Short Term**	**Long Term**	-Care is planned with the person
-Management	-Mid management meetings	-Change in practice	-All management staff (Nurse supervisors, QIDP, Program directors and DON) will be comfortable using the curriculum plan	-Skill building and acquisition during competency day	-Person supported are respected and their choices are valued
meeting time	-Report of small changes that have occurred since implementation of the curriculum	-Person-centered care		-People first language will be used	
-Trainer	-Group discussions		-All staff will be trained using the curriculum plan		-People are more engaged in self-care
-Information Technology	-Simulating lab - Power-point presentation			-Increase use of evidence-based guidelines	
-Interest in learning			-The revised policy will be during management meeting	-Person-centered practices will be sustained	-Inequalities and access to care improve
-Training space					-Self-determination of people supported
-Training				-Person-centered	

curriculum organization

-Pretest/

Posttest Items

Assumptions	**External Factors**
d. Persons supported want to feel valued and respected, and want to participate in decisions that involve their care (i.e., they will feel more valued, respected, and independent due to implementation of PCC).	Attitudes and beliefs
e. The number of incidents will decrease.	DDS policies
f. The training curriculum is useful for training all staff members who work with people with IDD.	
g. Providing care or support services will be less stressful.	
h. Adherence to interventions will increase	

Appendix K**:** Plan-Do-Study-Act Model

Table K1

Framework of the Project

Purpose: Development of an educational initiative focusing on person-centered care (PCC)			
Next step of the change	Person Responsible	When to be Done	Where to be Completed
Developing a comprehensive educational curriculum, a training protocol and updating current training policy	Laure Ndeutchoua	November-February 2016	Organization located in the East coast of the USA providing care to people with IDD

Plan

Task	Person Responsible	When to be Done	Where to be Completed
• Assemble a team • Create a time line • Analysis and Synthesis of evidence-based research on PCC • Determine the best evidence • Develop educational curriculum and training protocol • Revise current training policy to include PCC • Obtain content validation • Develop implementation plan • Develop evaluation plan	Laure Ndeutchoua	November-February 2016	Organization located in the East coast of the USA providing care to people with IDD

Assumptions	Measures of predicted outcomes
e. Person supported will want to participate in decision making f. Staff members want to provide best practices to patient	I. Ongoing evaluation J. Patient family satisfaction surveys K. Review of data of patients'

g. Training protocols are useful for consistence	refusal of services

(Table continues

Do
Identification of Risk
8. Leadership 9. Inadequate resources 10. Organizational Culture 11. Learning Culture
Organization of Activities of the Plan
1. Establish the team 2. Conducting meetings 3. Involve leadership and stakeholders 4. Communicate and involve all members of the team 5. Develop positive working attitudes within the team 6. Propose resources needed
Implementation of the Activities in the Plan
1. Develop the curriculum 2. Develop the training protocol 3. Update current training policy 4. Develop an implementation plan 5. Develop an evaluation plan

Study (To be done after graduation)
Measurement of outcomes after implementation Compare results to predictions

Act (To be done after graduation)
Review of the performance of the DNP student on the final project Adjustments of the curriculum as needed to add modifications based on implementation

Adapted from Institute of Healthcare Improvement, (2013). Science of Improvement: How to improve. Retrieved from http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Appendix L: Data Use Agreement

Program/lnitiative Oversight and Data Use Agreement

[redacted]

6856 EASTERN AVE NW, suite 376 Washington DC 20012 Phone: [redacted]

March 29, 2016

Our employee/practicum student, Laure Ndeutchoua, is involved in the Facilitating PersonCentered Care for People with Intellectual and Developmental Disabilities, a quality improvement initiative which will be conducted under our organization' s supervision within the scope of our standard operations. We understand that Laure Ndeutchoua seeks to write about this initiative as part of a doctoral study for Walden University. To this end, we agree to share a deidentified dataset with the student for research purposes, as described below.

I approve for Laure Ndeutchoua to modify our typical data collection practices as follows: Student will use data type 1 consisting of pretest/posttest for content validation and data type 2 consisting of open-ended questionnaire for stakeholder team members.

The Walden University Institutional Review Board (IRB) will be responsible for ensuring that the student's published study meets the university's ethical standards regarding data confidentiality (outlined below). All other aspects of the implementation and evaluation of the initiative are the responsibility of the student, within her role as our employee.

The doctoral student will be given access to a Limited Data Set ("LDS") for use in the doctoral project according via the ethical standards outlined below.

This Data Use Agreement ("Agreement"), effective as of 02/24/2016 ("Effective Date"), is entered into by and between Laure Ndeutchoua ("Data Recipient") and Metro Homes, Inc. ("Data Provider"). The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set ("LDS") for use in research in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program. In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. Definitions. Unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the "HIPAA Regulations " codified at Title 45 parts 160 through 164 of the United States Code of Federal Regulations, as amended from time to time.

2. Preparation of the LDS. Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable HIPAA or FERPA Regulations

3. Data Fields in the LDS. No direct identifiers such as names may be included in the Limited Data Set (LDS). In preparing the LDS, Data Provider or shall include the data fields specified as follows, which are the minimum necessary to accomplish the research: Student will use data type 1 consisting of pretest/posttest for content validation and data type 2 consisting of open-ended questionnaire for stakeholder team members.

4. Responsibilities of Data Recipient. Data Recipient agrees to:

   a. Use or disclose the LDS only as permitted by this Agreement or as required by law;

   b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

   c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

   d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and

   e. Not use the information in the LDS to identify or contact the individuals who are data subjects.

5. Permitted Uses and Disclosures of the LDS. Data Recipient may use and/or disclose the LDS for its research activities only.

6. Term and Termination.

   a. Term. The term of this Agreement shall commence as of the Effective Date and shall continue for so long as Data Recipient retains the LDS, unless sooner terminated as set forth in this Agreement.

   b. Termination by Data Recipient. Data Recipient may terminate this agreement at any time by notifying the Data Provider and returning or destroying the LDS.

   c. Termination by Data Provider. Data Provider may terminate this agreement at any time by providing thirty (30) days prior written notice to Data Recipient.

   d. For Breach. Data Provider shall provide written notice to Data Recipient within ten (10) days of any determination that Data Recipient has breached a material term of this

Agreement. Data Provider shall afford Data Recipient an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to agree on mutually agreeable terms for cure within thirty (30) days shall be grounds for the immediate termination of this Agreement by Data Provider.

e. Effect of Termination. Sections l, 4, 5, 6(e) and 7 of this Agreement shall survive any termination ofthis Agreement under subsections c or d.

7. Miscellaneous.

a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement to comport with changes in federal law that materially alter either or both parties ' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf

Partner Organization	Doctoral Student
me: [redacted]	Signed: [signature]
Print Name:	Print Name: Laure Ndeutchoua
Print Title: CEO	

Appendix M: IRB Approval

The Walden Institutional Review Board approval number for this study is 04-16-0395176/

Appendix N: Permission of Use of Grading Evidence Tool

Johns Hopkins Nursing Evidence-Based Practice Model and Tools

Thank you for submitting the requested information. You now have permission to use the JHN EBP model and tools.

Click here to download the tools. Reminder: You may not modify the model or the tools. All reference to source forms should include "©The Johns Hopkins Hospital/The Johns Hopkins University."

We offer an excellent online course about our model/tools. It is an engaging online experience, containing interactive elements, self-checks, instructional videos, and demonstrations of how to put EBP into use. The course follows the EBP process from beginning to end and provides guidance to the learner on how to proceed, using the tools that are part of the Johns Hopkins Nursing EBP model. Take a sneak peek of the course.

Click here for more information about our online course. Group rates available, email ijhn@jhmi.edu to inquire.

Do you prefer hands-on learning? We are offering a 5-day intensive Boot Camp where you will learn and master the entire EBP process from beginning to end. Take advantage of our retreat-type setting to focus on your project, collaborate with peers, and get the expertise and assistance from our faculty. Click here to learn more aboutEBP Boot Camp.

Appendix O: Proposed Project Timeline

Proposed DNP Completion Timeline				
Tasks	Activities	Period		Duration
1.	Literature Review	04/01/2015	05/01/2015	4 weeks
2.	Proposal Approval	05/15/2015	06/15/2015	4weeks
3.	URR approval	06/16/2015	06/30/2015	2 weeks
4.	Proposal Oral Presentation	07/05/2015	07/19/2015	2 weeks
5.	IRB Approval	07/20/2015	08/20/2015	4 weeks
6.	Team Formation	08/21/2015	09/18/2015	4 weeks
7.	Curriculum Plan (CP) Development	08/21/2015	10/21/2015	8 weeks
8.	Pretest/posttest development	10/21/2015	11/21/2015	4 weeks
9.	Policy Revision	10/30/2015	11/06/2015	1 weeks
10.	Implementation and Evaluation Plan Development	11/06/2015	11/13/2015	1 week
11.	Assessment & Measurement of tests Items by Expert	11/15/2015	11/30/2016	2 weeks
12.	Content Expert Evaluation of Literature Review Matrix and Curriculum Plan	12/01/2015	01/01/2016	4 weeks
13.	Content Expert Validation of Pretest/Posttest Items	01/01/2016	02/01/2016	4 weeks
14.	Summative Evaluation	02/05/2016	03/05/2016	4 weeks
15.	Final Project Committee review	03/30/2016	04/15/2016	2 weeks
16.	Final URR Review	04/16/2016	04/30/2016	2 weeks
17.	Final Form and Style Review	05/01/2016	05/15/2016	2 weeks
18.	Final Oral Presentation	05/15/2016	05/23/2016	1 week
19.	CAO Final Approval	05/30/2016	06/01/2016	10 days

Appendix P: Expert Evaluation of the Curriculum Plan

EXPERT EVALUATION OF DNP PROJECT/OUTLINE/CONTENT/EVIDENCE

Title of Project: Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

Student: Laure Ndeutchoua

Date:_____**Name of Reviewer:**_____

Products for review: Curriculum Plan, Complete Curriculum Content, Literature review Matrix

Instructions Please review each objective related to the curriculum plan, content and matrix. The answer will be a "yes" or "no" with comments if there is a problem understanding the content or if the content does not speak to the objective.

At the conclusion of this educational experience staff will be able to:

Objective 1:

1. Describe Person Centered Care (PCC) related to the purpose, background, significance, and proposed outcomes of PCC.

Met____ Not Met____Comments:_____

Objective 2:

1. Define the principle, significance and impact of person-centered thinking.

Met____Not Met
Comments:_____

Objective 3:

2. Define inclusion and socialization and dignity of risk related to people with IDD and apply examples to

Specific context.

Met___ Not Met____ Comments:_____

Objective 4

3. Described the principle of supported decision making related to the impact, value and the ability to encourage self-advocacy of people with IDD.

Met___Not Met__Comments:_____

Objective 5

4. Define self-determination and explain the means of supporting and promoting self-determination.

Met__Not Met__Comments:_____

Objective 6

5. Define and understand effective communication related to the use person-centered tools.

Met___Not Met__Comments:_____

Objective 7

6. Describe person-centered plans while considering the role of the staff, the person's input and consent of the person and or their family member.

Met___Not Met__Comments:_____

Appendix Q: Content Expert Evaluation of Curriculum Plan Summary

Met = 1 Not Met - 2

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Average Score
	1	1	1	1
	1	1	1	1
	1	1	1	1
	1	1	1	1
	1	1	1	1
	1	1	1	1
	1	1	1	1
Total….	7	7	7	

Recommendations: All the objectives were met based on all 3 evaluators' results experts approved curriculum at a 100% acceptance.

Appendix R: Summary of Expert Evaluation of the Curriculum Plan

Title of Project: Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

Products for review: Curriculum Plan, Complete Curriculum Content, Literature review Matrix

The instructions were to review each objective related to the curriculum plan, content and matrix. Each content expert was to provide a "yes" or "no" answer with comments as needed if there was a problem understanding the content or if the content did not speak to the objective.

For objective 1, all three experts marked "yes" explaining that at the conclusion of this educational experience all staff will be able to describe Person Centered Care (PCC) related to the purpose, background, significance, and proposed outcomes of PCC. There was no additional comment.

For objective 2, all three experts marked "yes" explaining that at the conclusion of this educational experience all staff will be able to define the principle, significance and impact of person-centered thinking. There was no additional comment.

For objective 3, all three experts marked "yes" explaining that at the conclusion of this educational experience all staff will be able define inclusion, socialization and dignity of risk related to people with IDD and apply examples to specific context. There was no additional comment.

For objective 4, all three experts marked "yes" explaining that at the conclusion of this educational experience all staff will be able to described the principle of supported decision

making related to the impact, value and the ability to encourage self-advocacy of people with IDD. There was no additional comment.

For objective 5, all three experts marked “yes” explaining that at the conclusion of this educational experience all staff will be able to define self-determination and explain the means of supporting and promoting self-determination. There was no additional comment.

For objective 6, all three experts marked “yes” explaining that at the conclusion of this educational experience all staff will be able to define and understand effective communication related to the use person-centered tools. There was no additional comment.

For objective 7, all three experts marked “yes” explaining that at the conclusion of this educational experience all staff will be able to describe person-centered plans while considering the role of the staff, the person’s input and consent of the person and or their family member. There was no additional comment.

As a result, all the 7 objectives were met without additional comments.

Appendix S: Pretest/Posttest Content Expert Validation

Facilitating Person-Centered Care for People with
Intellectual and Developmental Disabilities

Date: **Student Name:** Laure Ndeutchoua

Reviewer's Name:

Packet: Curriculum Plan, Pretest/Posttest with answers

INSTRUCTIONS: **Please check each item to see if the question is representative of the course objective and the correct answer is reflected in the course content.**

Test Item #

1 Not Relevant __ Somewhat Relevant__ Relevant Very Relevant__

Comments:

2 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

3 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

4 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

5 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

6 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

7 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

8 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

9 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

10 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

11 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

12 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

13 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

14 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

15 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

16 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

17 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

18 Not Relevant__ Somewhat Relevant__ Relevant Very Relevant__

Comments:

Appendix T: Content Expert Validity Index Scale Analysis

Table T1

Rating on a 18-Items Scale by Three Experts on a 4-point Likert Scale

Pretest/Posttest Items	Expert 1	Expert 2	Expert 3	Total rating	Item CVI
1	4	3	4	11	0.91
2	4	4	3	11	0.91
3	4	4	4	12	1.00
4	4	4	4	12	1.00
5	4	4	4	12	1.00
6	4	4	4	12	1.00
7	4	4	4	12	1.00
8	4	4	4	12	1.00
9	4	4	4	12	1.00
10	4	4	4	12	1.00
11	4	4	4	12	1.00
12	4	4	4	12	1.00
13	4	4	4	12	1.00
14	4	4	4	12	1.00
15	4	4	4	12	1.00
16	4	4	4	12	1.00
17	4	4	4	12	1.00
18	4	4	4	12	1.00
Total	72	71	71	214	0.99
Proportion Relevant	1.00	0.986	0.986	S-CVI 0.99	

I-CVI, item-level content validity index.
S-CVI/UA, scale-level content validity index, universal agreement calculation method
Adopted from Polit, D. F., & Beck, C. T. (2006). The content validity index.

Appendix U: DDS/DDA Direct Support Professional Training

http://dds.dc.gov/node/807122

Appendix V: Summative Evaluation

Qualitative Summative Evaluation Stakeholders/Committee Members

Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

Student: Laure Ndeutchoua
Thank you for completing the Summative evaluation on my project. Please complete and send anonymously via interoffice mail to: laure.ndeutchoua@waldenu.edu
A. This project was a team approach with the student as the team leader.

1. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.

Ans:

2. How do you feel about your involvement as a stakeholder/committee member?

Ans:

3. What aspects of the committee process would you like to see improved?

Ans:

B. There were outcome products involved in this project such as the curriculum educational plan on PCC, pretest/posttest and an update of the training policy to include PCC.

1. Describe your involvement in participating in the development/approval of the products.

Ans:

2. Share how you might have liked to have participated in another way in developing the products.

Ans:

C. The role of the student was to be the team leader.

1. As a team leader how did the student direct the team to meet the project goals?

Ans:

2. How did the leader support the team members in meeting the project goals?

Ans:

D. Please offer suggestions for improvement.

Appendix W: Summary of the Qualitative Summative Evaluation

This evaluation was based on four main points including (1) the way the team felt during the project development and my abilities to lead the team, (2) the team's involvement during the project development, (3) my role as a leader and (4) suggestion that the team had for this project.

All team members explained that they contributed to the development of the products of the QI project. According to them, I was able to direct the meetings, guiding the process and development of the curriculum plan, pretest/posttest, protocol and revision of the policy. The team member was able to contribute during the meetings as I conveyed an environment of free communication and respect. All team members reported that they were fully involved during and after the team meetings. They received meeting agendas before meetings and report of each session after the meeting had adjourned. The team felt that their participation in the outcome products was high, and they would not have wished to be different. All team members felt that I was able to establish an environment of teamwork and effective communication in which each person's contribution was appreciated, analyzed, and incorporated into the project. The team expressed that the team leader remained focused and on task; was motivated to complete each meeting according to the agenda; and, most importantly, listened effectively. Two out of seven members of the project team suggested Walden should allow more time to the team to be involved in the project. The rest of the team did not have any suggestion.

Appendix X: CEU Course Objectives

Capstone Project Submitted in Partial Fulfillment of the Doctor of Nursing Practice (DNP)

Title: Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities

By the end of this presentation, the audience will be able to understand the importance of having a curriculum developed to train nurses, direct support staff, and all other staff members supervising these groups through the:

- Description and identification of the gap in practice
- Description of Person Centered Care (PCC) related to the purpose, significance, and proposed outcomes of PCC.
- Explanation of the significance of this DNP quality improvement (QI) project
- Identification of the goals of training all staff members on PCC
- Description of outcomes products of this QI project
- Description of the project significance
- Explanation of the project design
- Project evaluation, strengths and limitations
- Implications of person-centered care in intermediate care facilities, and home and community based waiver programs.

Appendix Y: Course Summary Submitted to DC Board of Nursing

Facilitating Person-Centered Care for People with

Intellectual and Developmental Disabilities

by

Laure Bertille Ndeutchoua, RN, MSN, FNP-C

March 2017

Appendix Y

Course Summary

The Institute of Medicine (IOM) published six dimensions of healthcare intended to guide health care providers in improving their quality of care. This Quality improvement (QI) project addresses the specific IOM dimension of person-centered care, which has the potential to influence health care effectiveness and efficiency. Healthcare workers within organization where this QI project took place lack the education required to provide person-centered care (PCC) to persons with IDD. Framed with the Plan, Do, Study, and Act Model, the purpose of this project was to develop an educational initiative focusing on person-centered care (PCC). This initiative included an educational curriculum plan, a pretest/posttest to measure staff understanding of the training, a training protocol, a revision of the training policy, and an implementation and evaluation plan to be conducted after graduation. The developed curriculum was evaluated by 3 content experts using a 7-item met/not met format and findings revealed that all the objectives were met. Content validation of the pretest/posttest was done by 3 content experts using 18 items, 4-point Likert scale 1 = Not relevant, 2 = Somewhat relevant, 3 = Relevant, 4 = Very relevant. A descriptive analysis of the data using the content validity index scale analysis revealed a content validity index score of 0.99. A recommendation was made to add a small piece of language used, as changing the way staff members address people under their care can preserve the persons' dignity. The revised policy and the developed training protocol were approved by the project team with the recommendation to obtain the CEO signature of the policy before implementation. This project will contribute to social change by teaching and reinforcing

person-centered practices among healthcare workers in the field of disability services, thus limiting healthcare disparities by improving healthcare access for persons with IDD.

Appendix Z: Course Approval for CEU from DC Board of Nursing

MS

Reply

Fri 8/26, 15:42

You;

You replied on 8/26/2016 17:13.

Laure!!! As soon as I pressed send, this came through! **Congratulations!!!** It is approved! Let's keep in touch regarding the date so we can plan accordingly.

Michael

---------- Forwarded message ----------
From: <Notifications@cebroker.com>
Date: Fri, Aug 26, 2016 at 3:25 PM
Subject: Course Approval
To

CE BROKER®
Your Continuing Education Portfolio

Your course application titled Facilitating Person-Centered Care for People with Intellectual and Developmental Disabilities for GEORGETOWN UNIVERSITY CENTER FOR CHILD & HUMAN DEVT, UCEDD has been approved by the District of Columbia Board of Nursing. Please log in to CE Broker to advertise any offerings for this course for licensee viewing. Click the link in your Message Box to see course details.

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Please visit our website at http://ucedd.georgetown.edu/DDA/ for more information about Health and Wellness Standards, DDA forms, and the monthly nursing round table!

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