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Dementia-Spcific Education in an Assisted Living Facility

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Sharon Samarin

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Walden University
2018

Abstract

Dementia-Specific Education in an Assisted Living Facility

by

Sharon Dianne Samarin

MSN, University of Phoenix, 2006

BSN, University of Phoenix, 2005

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2018

Abstract

Providing competent, high-quality, and person-centered care is important in the healthcare environment, including the care for the aging and training of those who provide care. A knowledge gap in dementia-specific training was identified at an assisted living facility. The purpose of this project was to answer the question whether a dementia-specific educational staff training program would improve staff members' knowledge and application of dementia-specific competencies as well as caring behaviors. Watson's theory of human caring, the theory of planned behavior, and Leininger's framework of culture care were used to inform this project. The educational project evaluated the success of implementing nurse caring behaviors and a dementia-specific training program. Data collection included analysis of the responses of 20 facility personnel to a survey validating the needs assessment. Results of pre- and posttesting of each educational module demonstrated a statistically significant improvement (p =.0001), and observation of staff-resident interactions demonstrated 100% achievement on the competency checklist across all project participants. Qualitative analyses of data gathered from participants' discussions resulted in 4 themes: (a) the characteristics of dementia care, (b) individual caregiver attitudes, (c) knowledge deficit, and (d) the importance of caring behaviors. Educational training methods were found effective to elicit nursing staff behavior change and improve understanding of the dementia patient and requisite care, which represents a significant positive social change and enhanced care for the dementia patient in the assisted living facility.

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Section 1: Nature of the Project

Introduction

The Alzheimer's Association reports more than 5 million Americans of all ages are living with Alzheimer's disease (AD), and by the year 2050 this number could rise as high as 16 million. Healthy People 2020 (2016), reported in 2013 that AD "was the sixth leading cause of death, for all ages" (para 3), with dementia affecting "health, quality of life, and ability to live independently" (para 4). A major area of focus in addressing optimal care for this disease population is the appropriate training of the healthcare workforce in AD and dementia-related care (Healthy People 2020, 2016). The nature of this project was to strengthen clinical nursing practice through dementia-specific training, with the integration of the human caring theory (see Watson, 1988). This theory and its accompanying evidenced-based caring actions were practice strategies incorporated into the educational project. The concept of caring in healthcare provisions at interdisciplinary levels for AD and related dementia patients, with consistent expression and application of person-centered care, are relevant issues in healthcare today. To cultivate quality patient care and healthcare providers' satisfaction (Nasso & Celia, 2007), dementia-specific training with Watson's (2002) caring behavior theory and caring actions were used.

By addressing the facility gap in AD and dementia-specific competent care, the internal stakeholders, such as residents, physicians, nurses, unlicensed assistive personnel, and facility managers, will gain the education and resources of dementia care to effectively provide competent care to this population. External stakeholders, such as resident family and friends, clergy, hospice case managers, ombudsman, and community

members, gain insight and understanding as to the relevance of dementia-specific care. It is important for all stakeholders and representatives from the facility population to be involved and actively communicating "to ensure that all perspectives are considered" (Kettner, Moroney, & Martin, 2013, p. 52).

The implications of positive social change, as well as addressing a Healthy People 2020 (2016) objective in dementia-specific care training and knowledge to nursing practice, was the implementation and facility standardization of an evidence-based, nursing theory guided, dementia-specific educational training program procedure. This educational project program is applicable to other healthcare institutions and healthcare service units, with an outcome for ensuring all practicing nurses and those who interact with the cognitively impaired to receive the education to capably care for these unique individuals.

Problem Statement

AD and related dementias are considered a public health priority that need to be addressed (Health People 2020, 2016). Major issues have evolved in relation to the healthcare of the aging and the training of those who provide the most intimate care. A specific example was found in the assisted living facility study site, where there was a lack of dementia-specific training for staff, and no educational training procedure. Therefore, the project question was as follows: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care educational program increase knowledge, caring behaviors, and caring

competencies of those providing care, and lead residents with AD and other related dementias to improved quality of life?

According to Healthy People 2020 (2016), the elderly has a greater chance to develop long-lasting disease conditions and related debilities. These chronic conditions include diabetes, a known risk factor for AD, and related dementias. The concern was so great that in 2011 President Obama signed the National Alzheimer's Project Act (NAPA) (National Institute on Aging (NIA), National Institutes of Health (NIH), U.S. Department of Health and Human Services (USDHHS), 2015). The goal of this act was to have more in-depth research on AD and dementia-related disease, improved clinical care, and increased resources for those with the disease, including families, through the development of a national and coordinated plan (NIA, NIH, USDHHS, 2015). The national plan to address AD is reviewed each year, most recently in July 2017 (NIA, NIH, USDHHS, 2015).

One of NAPA's research outcomes specified that nurses and other providers who deliver care need to be specifically dementia-trained due to the unique challenges this population presents (NIA, NIH, USDHHS, 2015). The training content should include knowledge of disease trajectory, symptoms, approaches to care, goals of care, and basic overview and understanding of cognitive losses in AD and dementia (Alzheimer's Association, 2007).

A literature review of the Agency for Healthcare Research and Quality (AHRQ), National Institute on Aging, United States Department of Health and Human Services, Healthy People 2020, World Health Organization (WHO), PubMed, Medline,

Cumulative Index for Nursing and Allied Health, and the Walden University Library, indicated that there is a knowledge gap and lack of specific training within healthcare facilities.

I identified the facility knowledge gap in the lack of dementia-specific training of care providers using a questionnaire (see Appendix B), to elicit the staff's base knowledge of AD and related dementias, their individual beliefs on aging, and opinions and expectations of dementia competent care. During an initial participant discussion, I used a verbal survey with the participants, to obtain information on any previous dementia-specific education and experience. I documented in my field notes their responses. I compiled the results for each participant's initial questionnaire, as well as the verbal survey, pretest and posttesting as they related to AD and dementia-related educational topics, and skills observations.

Additionally, it was necessary that I develop a dementia-specific skill set that was consistent for staff to effectively provide care for persons with AD and other related dementias. I ensured this through staff didactic and hands-on educational training in dementia care competencies (see Appendix A), the application of these learned evidence-based practices (Haskins, 2016; Nasso & Celia, 2007), and using conceptual knowledge of caring behaviors theory (Watson, 1988), staff participants were able to acquire an appropriate and competent skill set.

The literature addressed evolving issues in relation to the healthcare of the aging and the training of those providing care (Healthy People 2020, 2016). However, current dementia-specific curriculum, standards, and regulations are state-limited or nonexistent.

A dementia-specific training program allows healthcare providers to limit or avoid some of the consequence's individuals living with AD and dementias experience. These include, but are not limited to, receiving inadequate, incompetent, and potentially dehumanizing care. For this project, dementia-specific training, evidence-based practice, and facility policy were guiding tools in addressing the lack of knowledge identified in staff regarding AD and dementia-related care.

Purpose Statement

The purpose of this project was the development, implementation, and assessment of specific nursing caring behaviors and the educational effect of dementia-specific training of facility staff. The positive outcome of this project is the development and implementation of a standardized dementia-specific training facility procedure to accompany an existing policy. The use of dementia-specific educational in-service training modules as a resource (see Nasso & Celia, 2007), with caring behaviors theory (Watson, 2002), addressed the facility's gap in knowledge and the project question as follows: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care educational program increase knowledge, caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life?

Nature of the Project

Using the conceptual knowledge of the caring behaviors theory (Watson, 2002) as an appropriate underpinning to provide optimal healthcare, I intended to educate and

assess the success of implementing nurse caring behaviors and dementia-specific training, as perceived by staff, residents, and their families in an assisted living facility.

Using specific AD and dementia-related educational modules, developed as in-service education by Nasso and Celia (2007), I developed activities, instruction, and demonstration of caring behavior actions (Watson, 2002) and addressed the facility staff's gap in knowledge. The project training prepared staff in the role of supporting and enhancing the residents' quality of life with the application of AD and dementia-related competent care skills. Facility staff exhibited success in demonstrating dementia-competent care, with an increased understanding postproject related to the unique challenges presented by individuals with cognitive impairment.

The sources of evidence for this project included an initial staff questionnaire to obtain beliefs on aging, and a verbal survey, through a discussion with participants, of their previous education/experience to identify gaps in knowledge of AD and related dementias. The staff received lecture materials I developed, and resource information, with each of the eight PowerPoint in-service presentations developed by Nasso and Celia (2007), a pretest and posttest with each of the eight educational modules to assist with evaluating comprehension of material by staff, as well as a skills demonstration and staff return demonstration to assess for competence. Occasional family presence and communication during the project implementation promoted staff understanding of their specific needs to encourage satisfaction. The project also included researcher-led physician and multidisciplinary team meetings with interactive discussion to cultivate improved understanding of AD and dementia-related care, and the evidence-based

necessity for competence in dementia care training of facility staff (see Healthy People 2020, 2016).

The data collected from the initial questionnaire, previous education/experience survey, skills return demonstrations, observations, and pretesting were thematically analyzed, categorized, and numerically coded. As I anticipated, specific themes emerged, with staff personnel recognizing a lack of knowledge in dementia-specific care, the understanding of AD, and the application of person-centered caring behaviors. This project addressed the anticipated themes and gap in knowledge through the dementia-specific educational training program. Evaluation of nursing staff dementia-specific caring behaviors in practice included continuous evaluation following each educational training module, demonstration of skill competencies, and cumulative evaluation at the end of the project program.

Significance

By addressing the facility problem, the internal stakeholders, such as residents, physicians, nurses, unlicensed assistive personnel, and facility managers, will have the education and resources of dementia care to effectively provide competent care to this population (see (NIA, et al., 2015). External stakeholders, such as resident family and friends, clergy, hospice case managers, ombudsman, and community members gain insight and understanding as to the relevance of dementia-specific care. It is important for all stakeholders and representatives from the facility population to be involved and actively communicating “to ensure that all perspectives are considered” (Kettner et al., 2013, p. 52).

Development and implementation of staff dementia-specific educational programs, policies, and procedures used at the assisted living site are transferable to other institutions and similar care facilities. Dementia-specific education, and encouragement of individuals working with the frail elderly to attain advanced knowledge and competence, contributes to nursing practice. In addition, staff are motivated to freely communicate ongoing educational needs, experience empowerment, and meet the goals of the employing organization through continuing education.

With the development of this educational project, a key consideration was discovering staff attitudes toward aging and illness. Prospective and current employees may have attitudes about working with the elderly that reflect the negative values society often attaches to the aging and the aged. A local positive social change and addressing a Healthy People 2020 (2016) objective in this area, was the development, implementation, and measurement of an evidence-based, nursing theory guided, dementia-specific educational training program.

Summary

Providing appropriate healthcare at interdisciplinary levels for AD and related dementia patients, requires staff training in dementia-specific awareness, education, and resident-staff interactions. The use of evidence-based dementia-specific educational materials (see Nasso & Celia, 2007), and the application of patient-centered (Morgan & Yoder, 2012) caring behaviors (Watson, 2002), cultivated quality patient care. Internal stakeholders acquired knowledge that filled the gap in practice, with external

stakeholders gaining an improved understanding of the disease process and challenges of providing dementia-competent care (see Nasso & Celia, 2007).

Section 2: Background and Context

Introduction

Researchers have noted that nurses and other providers who deliver care need to be specifically dementia-trained due to the unique challenges this population presents (NIA, et al., 2015). The assisted living facility under study had a knowledge gap in dementia care. AD and related dementias are considered a public health priority that need to be addressed (Healthy People 2020, 2016). The use of dementia-specific educational training and caring behaviors theory (Watson, 2002) addressed the research question as follows: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care educational program increase knowledge, caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life?

The purpose of this project was the development, implementation, and assessment of specific nursing caring behaviors and educational effect of dementia-specific training as perceived by staff, providers, residents, and their families in an assisted living facility. Watson's (1988) theory of human caring, the theory of planned behavior (TPB) (Ajzen, 1985), and Leininger's (1991) concept of health were used to inform this project.

Theories

Theory of Human Caring

The act of nursing and the concept of caring has been a basic tenet supporting the practice of nursing as early as the 1850s. Florence Nightingale identified trained nurses'

caring behaviors as “deliberate, holistic actions aimed at creating and maintaining an environment…to support the natural process of healing” (as cited in Sitzman, 2007, p. 8). Considering the philosophy and science of caring (Watson, 2008), Nightingale’s theory of nursing, focusing on the environment (as cited in Ali Pirani, 2016), clearly describes the relationship connecting nursing and caring. According to Parse (2004), “Based on overall consideration, the philosophy and science of caring reflects the interactive process nursing theories” (as cited in McEwen & Wills, 2011, p. 174). Watson (1988) advocated that human life is “a gift to be cherished – a process of wonder, awe, and mystery” (p. 17). A caring nurse goes beyond the fundamental caring actions of performing tasks and accompanies the task with a caring moment (Askinazi, 2003).

Watson’s (1988) theory was appropriate for addressing the evidence-based practice problem in this study. Watson believed that nursing can be a transforming process through which both the patient and nurse can be changed. Watson’s theory of nursing practice outlines basic premises of nursing and combines a humanistic and scientific approach to patient care. According to Watson, caring is a nurse’s identity, and when caring is fully actualized, a patient’s world can become more secure, brighter, richer, and larger. Watson’s theory outlines six actions that help nurses fully extend and attend to human care (Watson, 1988).

The first action includes establishing a caring relationship with patients (see Watson, 1988). Nurses should be open, honest, and receptive to the perception of the individual patient’s needs (Watson, 1988). Nurses should let the patient know they are interested in the patient’s total care by listening to the patient’s concerns (without

interruption) and by communicating clearly (restating what they have heard the patient say, clarifying what they believe the patient's meaning is); they support the nurse's role as a caring individual in touch with the patient's needs (Watson, 1988).

The second action is, to care for the patient holistically (see Watson, 1988). Nurses need to be aware of and sensitive to the patient's emotional and mental health in addition to their physical state of health (Watson, 1988). Indeed, physical, mental, and emotional health cannot be divided. Each influence one another. Where there is a physical injury, there is an emotional and mental response. The same applies for emotional and mental injuries. When asking questions, the nurse must be aware of physical as well as emotional and mental patient concerns, accepting nonmedical, psychological, and emotional concerns as legitimate needs from the patient and responding accordingly (Watson, 1988).

The third action includes behaviors demonstrating unconditional acceptance (Watson, 1988). The patient's insecurities tend to increase their sense of vulnerability, and the nurse must be sensitive to these. Acceptance and care must be provided regardless of the patient's appearance, emotional need, or compliance level (Watson, 1988).

The fourth action of nurses demonstrating care for patients necessitates a positive view with display of helpful support (Watson, 1988). The nurse can achieve this by showing caring behaviors, regardless of the patient's outlook or extent of positive feelings (Watson, 1988).

The fifth action includes the patient's promotion of health by using nursing knowledge and nursing interventions (Watson, 1988). Talking honestly to patients using language they can recognize, assisting patients in understanding their health care needs, including appropriate treatment, and educating patients in healthier patterns of behavior encourage optimal nursing-patient care (Watson, 1988).

The sixth action is to spend time with the patient that is free of interruptions, until questions have been answered at a mutually accepted level. Thus, allowing the patient to feel, in that moment, they are the most important (Watson, 1988). In the assisted living facility under study, this last caring action required conscious consideration of study participants. These considerations included educational reinforcement on time management, providing privacy, active listening, and staff presence in the moment (Askinazi, 2003).

The six actions stated above require the nurse to be consciously in awareness of the patient, viewing and caring about the patient holistically, and with purposeful intention. This may appear to be a daunting task; however, many nurses achieve these actions through caring behaviors that are often unconsciously performed. In this project, I considered the following: "Caring in this sense is not a matter of doing caring actions in a prescriptive way to obtain desired results; rather it is an approach that advocates caring as a state of being" (Sitzman, 2007, p. 10).

Theory of Planned Behavior

The theory of planned behavior (Azjen, 1985) and the related theory of reasoned action (TRA) (Azjen & Driver, 1991) investigated the relationship between behavior and

beliefs, attitudes, and intentions. Both the TPB and the TRA presume behavioral intention is the most important determinant of behavior (Azjen, 1985; 1991). According to these theories, behavioral intention is influenced by a person's attitude toward performing a behavior, and by beliefs about whether individuals who are important to the person approve or disapprove of the behavior. The TPB and TRA assumed all other aspects function through the theory's components, and do not separately explain the probability that a person will behave a certain way (Azjen, 1985; Azjen, & Driver, 1991).

The TPB differs from the TRA in that it includes one additional component, perceived behavioral control; this component has to do with people's beliefs that they can control a particular behavior. Azjen and Driver (1991) added this component to account for situations in which people's behavior, or behavioral intention, is influenced by factors beyond their control. They disputed that people might try harder to perform a behavior if they feel they have a high degree of control over it. In addition, Azjen and Driver (1991) believed that people's perceptions about controllability may have a central influence on behavior. According to the theory, attitudes toward behavior are shaped by beliefs about what is involved in the executing and outcomes of the behavior (Azjen & Driver, 1991). The presence or absences of things that will make it easier or harder to execute the behavior affect perceived behavioral control. Therefore, a contributory chain of beliefs, attitudes, and intentions compels behavior (Kelly, 2008).

The possibilities in the behavioral TPB seemed highly relevant to a nursing framework. In addition, the behavioral sciences are used to improve the effectiveness of nursing practice and the way in which the practical experience of nurses are used to

modify and improve behavioral science theory. However, scientific theory can only be used to guide practice when the values to be placed on the expected outcomes are specified (Azjen & Driver, 1991). According to Ryan (2009), "It is proposed that knowledge, in and of itself, does not lead to behavior change; however, knowledge and health beliefs are linked to engagement in self-regulation" (p. 166). Ryan (2009) also stated that, "healthcare professionals need to better understand how health behavior change is made and their role in facilitating and supporting change" (p.162).

Relevance to Nursing Practice

More than 5 million Americans of all ages are living with AD, and by the year 2050 this number could rise as high as 16 million (Alzheimer's Association, 2017). Individuals who have dementia are living at home in their communities, are in long-term care facilities, adult daycare facilities, and in assisted living facilities (see Justice in Aging, 2015). Within these areas, individuals with dementia interact with law enforcement, emergency care providers, social services personnel, and medical personnel such as physicians and nursing (Justice in Aging, 2015). Many "professionals, volunteers, and staff at every entry level and every aspect of health care…are encountering individuals with dementia" with minimum or "no training" (Justice in Aging, 2015, para 2), in the special care needs of this vulnerable population.

Studies have indicated that person-centered care, and dementia-specific training, are positive approaches in improving quality of life for individuals with dementia (Shultz, 2005). However, training requirements and standards vary among states (see Seegert, 2015). Justice in Aging (2015), reviewed dementia training standards in all 50 states,

finding there were forty-four states with laws regarding dementia training requirements for assisted living facilities, and fourteen states with laws pertaining only to Alzheimer's special care units. There were six states that did not have assisted living training requirement laws, and 10 states that had specific training requirements. All though training content had less variables, training hours varied from an initial orientation of eight to 24 hours, and a range of two hours to 12 hours as continuing education or in-service annually (see Justice in Aging, 2015).

General recommendations to address the gaps in dementia training include a training curriculum for providers that is outcome-based, with topics of the trainings to include review of AD and dementia, communication techniques, managing problematic behaviors, resident safety strategies, and family issues (Alzheimer's Association, 2017). One southwestern state recommendation was to develop a dementia-capable, and culturally competent, workforce that cares for older adults, and individuals with AD throughout the continuum of care. The strategies previously used in this state were (a) identifying and promoting best practice related to dementia care, (b) supporting of certification, licensure, and degree programs for gerontological nurses, (c) partnering with licensing and certification boards to recommend continuing education on AD and other dementias as a condition of license renewal for nurses and other health professionals, and (d) using competency-based training programs (Arizona Department of Health Services, 2015).

The educational project fills a gap in practice as noted in the literature. This is accomplished through the development, implementation, and assessment of a dementia-

specific, evidence-based, person-centered with specific caring behaviors training program. This program will be a standard orientation component, and an annual in-service topic. Effective training and care in practice are current and future healthcare concerns.

According to Watson, "authentic human-to-human caring is core to the professional theory-guided, evidenced-based practices, and caring-healing relationships affecting patient/system outcomes" (2006, p. 56). Kaur, Sambasivan, and Kumar state "caring behaviors of nurses contribute to the patients' satisfaction, well-being and subsequently to the performance of the healthcare organizations" (2013, p. 3193).

Azzi-Fini, Mousavi, Mazroui-Sabdoni, and Adid-Hajbaghery (2012), using caring behaviors framework, theory of caring, and a descriptive correlation study/Caring Behaviors Index/Patient Satisfaction Instrument, a significant positive correlation ($p < 0.001$, $r = 0.565$) was observed between caring behavior mean score and that of patient satisfaction.

Dabney and Tzeng (2013) using the concept of patient-centered care and the Gap Model of Service Quality, which focusses on customer perspective, four gaps in patient-centered care were identified. The outcomes reflect significance to nursing and clinical practice and suggest further research.

Dewar and Nolan (2013) used appreciative inquiry, observation, interviews, storytelling, and group discussion as their research method, as I used in my program project. The main findings were, therapeutic relationships are essential to achieving

excellence in care, and demonstrates considerable addition to compassionate relationship-centered care and provides a model for delivery of care in practice.

Godin, Gravel, Eccles, and Grimshaw (2008) conducted their study related to factors influencing health professionals' behaviors using the TRA and TPB. Godin, et al. (2008) reviewed studies that aimed to predict healthcare professionals' intentions and behaviors with a clear specification of relying on a social cognitive theory. The aim was met by demonstrating a gap between implications of clinical research evidence, and the routine clinical practice of healthcare professionals. However, the results suggest that the TPB appears to be an appropriate theory to predict behavior, where as other theories better capture the dynamic underlying intention.

Multiple educational training opportunities in dementia care are available as webinars, site-specific self-paced modules, and in some facilities as in-service, continuing education, or for professional development (see Alzheimer's Association, 2017), considering cost and budget constraints. The project implementation, interventions, and plan for sustainability of dementia-specific training, impacts nursing practice at the local facility and community level, and with dissemination there is potential for a broader application.

Local Background and Context

The practice setting for the doctoral study project was a rural assisted living facility in the southwestern United States. The owner/administrator had hired employees without formal training or education in dementia-specific care. A facility training policy was in place regarding dementia care, though lacked a specific procedure. Reviewing

and revising the policy, and adding a specific educational training process, would improve dementia capable caring behaviors by nursing, at multiple levels, improve quality of life, and satisfaction for residents, and allow for appropriately trained and competent staff (Alzheimer's Association, 2017).

The target population were the healthcare providers of residents with AD and related dementia, with potential comorbidities, at the assisted living facility site. The problem and concerns of caring for AD, and related dementias, stem from as early as 1986, with non-caring behaviors by nurses being cited in professional literature (see Reiman, 1986). These residents are often in uniquely vulnerable positions, nursing's relationship involves a high level of intimacy, and has the power to make their experience comfortable or unpleasant. It is our duty to care, and with effective nursing, at interdisciplinary levels, will be defined by a combination of human caring skills and technical competence (Roberts, 2013).

An effective dementia trained workforce is of local, national, and global concern (Surr, Gates, Irving, Oyebode, Smith, Parveen, Drury, & Dennison, 2017). In 2011, the NAPA was signed by President Obama and "called for an aggressive and coordinated U.S. plan" for Alzheimer's research (NIH, 2015, p.5). In addition, research was needed to provide improved clinical training and AD care, and family support services. In collaboration, the National Institutes of Health (NIH) sustains a structure for research that "supports…scientific discovery and translation into prevention and treatment" (NIH, 2015, p. 5).

The "Alzheimer's Disease Education and Referral Center (ADEAR) compiles, archives, and disseminates information about Alzheimer's disease for… health professionals, and its information…on causes, diagnosis, treatment, prevention, and caregiving are… researched, evidence-based, and reviewed for accuracy and integrity" (NIH, 2015, p. 5).

Objectives of Healthy People 2020 (2016), include the appropriate training of the healthcare workforce in AD and dementia-related care. Research (Healthy People 2020, 2016) has reported AD as the 6th leading cause of death in 2013 and affects "health and quality of life" (para 4).

Role of the DNP Student

The Doctor of Nursing Practice (DNP) prepares nurses for roles in clinical practice leadership, "clinical teaching environments, and action research arenas" (Terry, 2015, p. 4). Clinical scholarship is one role of the DNP student where "the scholar applies knowledge to solve a problem via the scholarship of application", through translation of knowledge to application (American Association of Colleges of Nursing (AACN), 2006, p. 11) of an identified problem. A global goal is to improve health outcomes for dementia (WHO, 2012).

The DNP practicum experience and practicum project afforded an opportunity for me to work in collaboration with the healthcare facility as a leader, and to educate in a best abilities approach that empowered staff participants with skills to promote evidence-based, dementia capable care, and the belief that a person with dementia is still whole and capable of experiencing optimal quality of life.

As an educator and per diem nurse for the practicum facility, I was familiar with the day-to-day operations, the multiple challenges of caring for AD and dementia-related residents, as well as family concerns. Through my observations of staff, residents, families, and communications with the facility administrator/manager, the need for training in dementia-specific care was identified, with a project plan developed.

I collected project data from facility staff, using an initial staff questionnaire and education/experience verbal survey, three group discussions, and continuous staff observations. I utilized an in-service education model developed by Nasso and Celia (2007) and conducted a dementia-specific training program for staff (see Nasso & Celia, 2007), (Fletcher, 2012) (AHRQ, 2013), with continuous evaluation following each module, and cumulative evaluation at the project's completion. Informational materials were also distributed to family members on request, and through open communication at family care conferences that I coordinated and led.

Summary

Effective dementia-specific training and care in practice are current and future global healthcare concerns (Healthy People 2020, 2016). A global goal is to improve health outcomes for dementia (WHO, 2015). The nature of the project was to address and educate assisted living staff on caring for, and meeting the needs of, residents with AD and dementias (Nasso, & Celia, 2007). The project included the use of caring behaviors theory (see Watson, 2002), and person-centered care (see Morgan, 2012), focusing on helping all nursing staff develop and refine behavioral strategies that will improve quality of life for AD and dementia residents, and job satisfaction for staff members.

The implications of the project outcomes were that educational/instructional methods I used were effective. The data collected from facility staff were compiled and evaluated. The identification of a gap in dementia-specific knowledge through staff self-assessment, pretesting and posttesting, a survey, questionnaire, and observation data, noted staff behavior changes, and improved understanding of the dementia patient (Hodges & Videto, 2011).

Section 3: Collection and Analysis of Evidence

Introduction

Major issues have evolved in relation to healthcare of the aging and the training of those who provide the most intimate care (World Health Organization [WHO], 2015). Researchers have indicated that there is a knowledge gap and lack of specific training within healthcare facilities. The local assisted living facility staff showed a gap in dementia-specific knowledge and training procedures.

The staff knowledge gap was identified using an initial questionnaire and a survey linked to AD and dementia-related education and experience. In addition, a competent, consistent dementia care skill set needed to be created to effectively manage care for persons with AD and related dementias (see Watson, 1988). Data from staff responses were collected, analyzed, categorized, and numerically coded. The use of dementia-specific educational training with caring behaviors (Watson, 2002) and person-centered care (Morgan & Yoder, 2012) addressed the facility's gap in knowledge. The purpose of this project was the development, implementation, and assessment of specific nursing caring behaviors and the educational effect of dementia-specific training.

Practice-Focused Question

The local assisted living facility staff showed a gap in dementia-specific knowledge and training procedures. The educational/instructional project was used to address the following question: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care

educational program increase knowledge, caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life?

The purpose of the project was to educate the staff in dementia-specific caring behaviors and person-centered care to fill their knowledge gap. In addition, at the completion of the educational and skill components of the project, evaluations of staff participants for improved understanding of the cognitively impaired residents, and a competency-based skills checklist on the application of caring person-centered care, were completed. This project included behavior change components of the facility staff (see Appendix E).

Two key operational definitions of the project required clarification (see Bicard, Bicard, & the IRIS Center, 2012). One key operational definition is the staff understanding of the cognitively impaired, AD and related dementia, residents. The intervention was the educational program instruction on the disease process, changes in cognition and function over time, and strategies to manage the residents during the five identified stages of the disease. The measurement for success included the staff pretesting and posttesting of the eight educational modules and observation of staff-resident interactions using the competency checklist (see Appendix E). The second key definition included the incorporation of the caring behavior theory (Watson, 1988) with the implementation in resident care of the six specific actions of Watson's (2002) theory and remaining person-centered during care delivery (Morgan & Yoder, 2012). These actions were measured by observation of staff-resident interactions, measurable educational

component testing, and the ability to be repeated with each resident contact (see Bicard et al., 2012).

Sources of Evidence

Facility sources of evidence included staff self-assessments, questionnaires, surveys, and observations of AD and related dementia base-line knowledge. A mixed-method organized review of literature on quantitative and qualitative studies on AD and related dementia training programs, and the translation to practice through application of Watson's (1988) theory of human caring were also used in developing the evidence-based, dementia-specific training program.

The databases searched were the Agency for Healthcare Research and Quality, National Institute on Aging, National Institute of Health, and United States Department of Health and Human services, Healthy People 2020, the World Health Organization, PubMed, Medline, Cumulative Index for Nursing and Allied health, and the Walden University Library, with the specific terms of *dementia*, *dementia-specific care goals*, *dementia training competencies, standardized dementia training curriculum, caring behaviors theory, and person-centered care*. The articles/studies revealed the need for a dementia-capable workforce, a national plan, to address the gap in healthcare provider knowledge, short- and long-term goals, and strategic plans that support the project's practice-focused question. These were all inclusive to the search terms, and exclusions were those articles or studies older than five years. However, some of the research literature cited in this project is dated, it is the most up-to-date information on the topic.

Although various search results supported the project practice-focused question and validated the need for specific dementia training, information obtained from one study was highly informative, as it reviewed existing training requirements in 50 states, the District of Columbia, and Puerto Rico (Justice in Aging, 2015). Findings from the review included state variables in training requirements, hours, and content with just one state requiring training and competency examinations (Haskins, 2016). Also, there were varied institutional generated requirements, such as the assisted living facility's goal of competent dementia care providers through my educational project (Justice in Aging, 2015).

These collected data lent supporting evidence to what is currently known and unknown in dementia care and management (Tariot, Ellison, Hall, & Egge, 2017). Also, various curriculum structures and content (Nasso & Celia, 2007), competency guidelines (AHRQ, 2013), and caring behaviors (Watson, 2006), for the identified problem and necessity to develop a dementia-specific training program (WHO, 2015) for facility staff to become capable and competent in dementia-specific care.

Evidence Generated for the Doctoral Project

Evidence generated from the DNP educational project addressed the knowledge gap in the facility staff's AD and related dementia understanding and specific strategies of care. Internal and external stakeholders agreed with the generated evidence, and the new orientation and training procedure to accompany the training and education policy currently in place stating, that the facility would ensure that all staff were dementia-

capable and trained specifically to care for the cognitively impaired AD and dementia residents.

After receiving Institutional Review Board approval (08-29-7-048266), facility staff were invited to participate in the educational project during an all-staff meeting, to assist in answering the project question as follows: In the assisted living facility with adults diagnosed with AD and other related dementias, will implementation of a dementia-specific care educational program increase knowledge, caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life?

Participants in the evidence collecting process included facility management team members, staff nurses, unlicensed assistive personnel, and certified nursing assistants. The individuals who agreed to voluntarily participate, were given consent forms to read and sign, which included information that the participant could withdraw from the project at any time. I retained the signed consent forms. The project purpose and plan were explained, confidentiality was ensured through unidentified responses, and ethical and cultural issues were addressed as well.

The number of participants who agreed to participate were 20 full- and part-time direct-care employees, which included the management team members. Facility management viewed this project as addressing the knowledge gap with empowerment, cultivating competence, and in alignment with the mission and goals of the facility, see Appendix A. Many of the participants were familiar with me and comfortable with

known communication strategies, educational techniques, and leadership style through previous staff in-service presentations.

All project participants were given instructions, and an opportunity to ask questions, regarding the self-assessment questionnaire (see Appendix B), and verbal survey. The questionnaire was distributed to participants and included their beliefs on, (a) aging and quality care, (b) demographics and dementia knowledge, and (c) caring actions to complete in a group setting, and with open discussion during the verbal survey. The questionnaire and education/experience survey were developed from information found on existing sources proven to be reliable and valid instruments of measurement (see Watson, 2009). An assessment of knowledge was achieved through the use of the prettest, and this same instrument was used at the conclusion of each module to assure that each participant was able to achieve the learning objectives (see Appendix D). All materials used in the program emerged from Nasso and Celia (2007). Copyright permission was obtained from Thomson Delmar Learning see Appendix F. The slides used to guide discussion are presented in Appendix C. Additional data were collected through my staff-resident observations using a competency checklist (see Appendix E), field notes/journal, and pretesting and posttesting of each educational module. All data collected were secured, kept confidential and anonymous prior and during the analyses. Data collected were also utilized to facilitate the initial and subsequent group discussions.

Analysis and Synthesis

The project program was instructional/educational, and included a questionnaire, an education and experience survey, pretesting and posttesting, group discussion,

reflection, and interviews, allowing for summation of the overall learning by staff participants at the completion of the program. The systems used for tracking, organizing and analyzing the collected data included a spread sheet containing pre and posttesting results, journal and field notes, and my observations of staff-resident daily care interactions. These collected data were numerically coded and entered onto a spreadsheet, readied for analysis using SPSS v.24. Data integrity was maintained using my secure computer program, and consistently reviewed for data input accuracy. There were no outliers or missing information that I observed. Descriptive statistics were used to analyze the participants beliefs on aging, requisite care of the dementia resident population, and gaps in dementia-specific knowledge. Non-parametric inferential statistics were used to compare pretest to posttest scores.

Summary

Seegert (2015) indicated there is a knowledge gap and lack of specific training within healthcare facilities. The local assisted living facility staff showed a gap in dementia-specific knowledge and training procedures indicating a need for an educational program. The knowledge gaps were validated using a needs assessment survey. The educational program included a pre and posttest, group discussions, and my observations of staff and resident interactions guided by a competency checklist. The educational/instructional project addressed the project question as follows: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care educational program increase knowledge,

caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life?

After receiving Institutional Review Board approval (08-29-7-048266), facility staff were invited to participate in the educational project during an all-staff meeting. The number of participants who agreed to participate were 20 full- and part-time direct-care employees. All project participants received instructions and an opportunity to ask questions regarding the self-assessment questionnaire, and verbal survey of prior education/experience with AD and related-dementias. Data collected were also utilized to facilitate the initial and subsequent group discussions, and to personalize significant points of the educational components.

The purpose of the project was to educate the staff in dementia-specific caring behaviors and person-centered care, to fill their knowledge gap. In addition, following the educational and skill components of the project, summative and formative evaluations of staff were used for identifying improved understanding of the cognitively impaired residents, and application of dementia-specific person-centered care. The results of the findings will be discussed in the following section.

Section 4: Findings and Recommendations

Introduction

A major area of focus in addressing optimal care for the AD and dementia-related population is the appropriate training of the healthcare workforce in AD and dementia-related care (Healthy People 2020, 2016). The use of dementia-specific educational training and interventions with caring behaviors (Watson, 2002), addressed the practice-focused question as follows: In the assisted living facility with adults diagnosed with AD and other related-dementias, will implementation of a dementia-specific care educational program increase knowledge, caring behaviors, and caring competencies of those providing care, and lead residents with AD and other related-dementias to improved quality of life? It was also important that I examine factors that could hamper successful implementation and sustainability over time (Hodges &Videto, 2011).

Findings and Implications

The purpose of this project was the assessment of specific nursing caring behaviors, interventions, and the educational effect of dementia-specific training in an assisted living facility. The facility knowledge gap in this area was validated using facility staff members' responses to an assessment survey related to AD and dementia-related topics (see Table 1).

Table 1

Dementia Self-Assessment

Question	Yes	To some extent	No	Lack of knowledge

Do you have prior dementia training	6	5	9	45%
Do you understand dementia	6	8	6	40%
Do you understand basic principles of care	6	7	7	35%
Do you understand daily care	5	8	7	35%
Do you understand eating challenges	4	7	9	45%
Recreation/activity challenges of those with dementia	4	4	12	60%
Common medical problems with dementia	4	4	12	60%
Coping skills of those with dementia	4	5	11	55%
Do you know how to promote positive environment	5	8	7	35%
Do you know how to care for caregiver (you)	4	4	12	60%

The educational program resources included eight dementia-specific care modules developed as in-service education by Nasso and Celia (2007), see Appendix A. I compiled facility staff educational activities, instruction, and demonstration of caring behavior actions (Watson, 2002), and addressed the facility staff's gap in knowledge by providing didactic content (see Appendix C) and through guided interactive discussion. By observing assisted living staff members provide care and using a competency skills checklist, I was able to assure that key elements of the educational program guided the aides' behaviors and demonstrated application of the needed skills and caring behaviors. The educational program was presented to staff participants over a 10-week period as a 2-hour staff meeting/in-service format at the facility. I gave each educational in-service to two groups of participants. These consisted of day and evening shift participants as Group 1, and the night shift participants as Group 2. Clinical application of dementia-specific skill interventions by staff were initiated in Week 3, and continued in Weeks 4, 6, and 8, with skill competence evaluated in Week 10. I instructed and demonstrated to all staff dementia care skills and caring behavior interventions in 3-hour blocks of time at

the bedside and during each shift's direct-care of residents. Reinstruction and demonstration were also given to individuals, as required through observation or by request.

Each educational module included a specific dementia-related topic, and opportunities to discuss, reflect, and ask questions as needed. Additionally, with several modules I included role-playing by staff as cognitively impaired residents. Through role-playing activities, staff understanding of the dementia residents' challenges were cultivated.

Using thematic analysis of data on attitudes and opinions collected from the initial staff questionnaire (see Appendix B) responses and pretesting of dementia-specific educational modules (see Nasso & Celia, 2007), four major themes were identified. These reflected the evidence-based content and included (a) what participants viewed as important characteristics of dementia care and why (Hodges & Videto, 2011), (b) individual attitudes, values, beliefs, and open communication, (c) the need to fill a knowledge gap in dementia-specific care (Nasso & Celia, 2007), and (d) the use of caring behavior (Watson, 2002) interventions. This type of need was identified as normative, where standards (Kettner et al., 2013) are available, though not in use or followed by the staff members. The facility had a policy on AD and dementia-related training. However, the facility did not have an accompanying educational procedure or process. Interactive group discussions, consisting of the 20 project participants, were structured as staff meetings and included the educational module materials and skills application review.

According to Merzel and D'Afflitti (2003), communication is a two-way process of exchanging or shaping ideas, feelings, and information which can potentially bring about behavior change. Within the group setting, interactive two-way communication gave positive input regarding the characteristics and care of AD and other dementias, as well as communication between staff.

Additionally, the identification of potential barriers (Hodges & Videto, 2011) to project implementation were then mitigated in real time. With group discussions, I found there were opportunities to explore areas of disagreement, observe for lack of interest, and identify staff members not ready or willing to participate in the change process. Those staff members, who were not ready or willing for the change process, did not prove to be a barrier to the project program. I directed my attention to the specific staff and their perceptions, with the knowledge that perceptions may change through reeducation. These implementation processes followed the guidance of Douglas (2011) and Hodges and Videto (2011) which were consistent with the Watson theoretical model (2009) in that, caring is learned behavior and that all caregivers have the potential for caring.

Theme 3, gap in knowledge, was addressed using the developed educational plan. This plan included didactic instruction (see Appendices A and C) and roleplaying. Roleplaying allowed for the staff members to be active participants in dramatized dementia-related scenarios. In the project, this led me to an observable increase in staff motivation, communication, and discussion of the issues, which was consistent with guidance from Merzel and D'Afflitti (2003) on implementation.

In addressing Theme 4, I discussed and demonstrated Watson's (2006) caring behavior actions, as interventions, to the staff. Each action was demonstrated step-by-step in a group setting, and individually as necessary or requested. Staff return demonstrations occurred during group clinical meetings, with further observation and researcher-guided instruction throughout the implementation process. I developed a dementia-capable skill checklist (see Appendix E, incorporating caring behaviors theory (Watson, 2002), using various studies with recommendations of dementia care criteria (see Justice in Aging, 2015). I documented my initial observations of each staff participant in providing dementia-specific care, mitigated aberrant behaviors in real-time, and used my documentation of staff participants' progress (individual scores on the pre and posttests) and success on their competency skills checklist for final evaluations.

Data analysis for this project was ongoing throughout the project. One of my goals in this project was to initiate and maintain a standardized training procedure, in line with required competencies of dementia care. This goal was achieved through analysis and evaluation of staff after project implementation. The participant's pretest scores on the dementia-specific educational modules ranged from less than 30% to 63%. After attending the dementia-specific educational modules, all 20 participants scored 100% on their posttest. The Wilcoxon sign ranks paired sample test demonstrated significance (2-tailed) at p=.000, indicating that the change in scores was not related to chance, and suggesting that the educational program had a positive impact on learning. In addition, all 20 participants successfully completed the competency skills checklist (see Appendix E) indicating that these staff members were able to integrate the knowledge provided in the

educational sessions and apply it to their daily practice in caring for patients with AD and other dementias. The dementia-specific education training program will now be a standard procedure for newly hired employees, and an annual in-service for competency evaluation. Internal stakeholders acquired knowledge that filled the gap in practice, with external stakeholders expressing an improved understanding of the disease process and challenges of providing dementia-competent care (see Nasso & Celia, 2007).

Recommendations

General recommendations to address the gaps in dementia training include a training curriculum for providers that is outcome-based, with topics of the trainings to include review of AD and dementia, communication techniques, managing problematic behaviors, resident safety strategies, and family issues (Alzheimer's Association, 2017). The educational program required knowledge of the facilitator in program instruction, and recommended topics of focus; it also has the ability for modifications and applicability, as well as any state-specific requirements. The educational program can be used to address AD and dementia knowledge gaps at the local or community level, and across institutional units of practice globally.

The agency goals were to support and enhance the quality of life of those affected with AD and related dementias through dementia capable staff training. The training and education project were essential in accomplishing this goal. The evaluation plan goals were achieved through education to train staff members in dementia capable care, including AD. Initiating and maintaining a standardized training facility procedure, in line with the facility's policy of required competencies of dementia capable care

recommended by Nasso and Celia (2007), were adopted by facility owner/administrator. Staff responses during the educational program were positive and acknowledged increased awareness in self, patient-centered-care, and the use of caring behaviors specific to AD and other related-dementias.

The educational project program was, and can be in other institutions, beneficial in addressing AD and dementia knowledge gaps, as it introduced staff to the stages of dementia, common aging changes, and the application of caring behaviors. In addition, the project allowed the staff to gain a better understanding of this unique population, specific care requirements, and contributes to nursing practice. The project enables staff to create environmental supports that maximize residents' remaining abilities, as well as promoting job satisfaction. The educational program empowers staff members to apply what they have learned by implementing acquired skills, and guiding principles (see Nasso & Celia, 2007). This project involved internal and external stakeholders and is applicable to similar healthcare institutions.

Through the DNP project, AD and related dementia training is now incorporated at the policy and procedure level as a standardized training procedure, with facility required competencies of dementia care (see Nasso & Celia, 2007) to be reviewed annually, and with each employee and incorporated into orientation for new employees. According to Kettner, et al. (2013), caring for AD and related dementia patients is dynamic with new knowledge emerging every day. Consequently, training must be updated accordingly.

Strength and Limitations of the Project

Initially, I was concerned a limitation of the project would be the sample size (n=20) of participating staff. However, this represents 40% of staff working at the DNP project site, and 100% on the unit specifically housing patients with AD and related dementias. This notwithstanding, the enthusiasm of the staff who did participate permeated the organization, and feedback from the staff members who did attend indicated the need to include others at the site.

A positive outcome and strength included, the multidisciplinary care team's active involvement, the ability as an educator to have one-on-one experiences with staff participants, and family members of patients at the site expressed interest in learning about AD and dementia-related conditions. Studies sponsored by the Alzheimer's Association (2017) indicate that family education is an important factor in considering the interactions with family members diagnosed with AD or dementia. With AD and dementia education, and discussions at family care conferences, improved understanding of residents' behaviors, and specific intervention strategies, were verbalized. Additionally, family members shared improved understanding of staff-resident interactions, behaviors, and the specific intervention strategies.

Summary

The educational program project resulted in a positive social change at the local assisted living facility that served as the DNP project setting, because it represents a major system change for this site. By improving staff understanding, and knowledge in practice of specific needs of individuals living with AD and dementia, the environment

became one of collaboration and team building. Enhancing communication at the site because of the educational program resulted in improved understanding by family members, facility staff, led to open and interactive conversations, that empowered staff and engaged family members in active participation, and represented another important positive social change.

Section 5: Dissemination Plan

Dissemination of knowledge and research can be approached through many methods, including PowerPoint presentations at conferences, seminars, or as an educational opportunity for colleagues and staff (White & Brown, 2012), as well as through journal articles. For this project, I used the format of PowerPoint slides with notes, resources, and references, for further personal inquiry, and for the project presentation.

The audiences consisted of nursing and management staff at the practicum site during an all staff meeting, stakeholder's from within the community at an open-door luncheon at the facility, during a family care conference, at an interdisciplinary team meeting, and at the local college of nursing to faculty members. At each presentation venue, participants received printed copies of the slide presentation, handouts, and had an opportunity for questions and clarification.

Using a visual presentation allowed for audience engagement and assisted me as "the purpose of the slides is to enhance the presentation of the content" (White & Brown, 2012, p. 247). Using graphics, contrasting slide colors, and a consistent simple font were also beneficial in keeping the audiences' interest and actively engaged (see Oermann & Hays, 2016). However, when considering professional verses lay audiences, the family and community presentations required adjustment in terminology, communication style, handout material, and sensitivity to these specific populations.

Through the designing of information disseminated, I managed and spoke to the message of project development, planning, interventions, implementation, and outcomes achieved, partially achieved, or not achieved (see White & Brown, 2012). Through dissemination to a local college of nursing faculty members, there was an opportunity to share and describe the project premise, concepts, methods, and research to produce an evidence-based change that cultivated staff competencies and quality improvement. A post-presentation discussion with the local college of nursing faculty included agreement that the AD and dementia person were currently minimally discussed in caring for the aged. At the end of the presentation, nursing faculty members agreed that a need to provide optimal care for this population was consciously evident. The educational project strategies would assist the incorporation of AD and dementia-specific training into student curriculum. The proposed curriculum changes from nursing faculty were further discussed with adjunct faculty and the dean of nursing. This was a positive outcome of dissemination through presenting the educational project to nursing faculty and graduate nurses of the immediate future.

Analysis of Self

The practicum experience was beneficial in advancing my knowledge in the areas of evidence-based practice, social health issues, behavior and change theories, the importance of stakeholder involvement, program design, planning, implementation, and evaluation. I was able to meet my learning objectives through the application of knowledge and skills obtained through the DNP project.

Being available and in sight of staff was beneficial as a leader to empower staff members through the change process as active participants (see Bowers, 2011) when questions arose, or when clarification and/or validation was needed. Leaders not only require knowledge of their staff but have a professional relationship as well to help the staff feel empowered (see Bowers, 2011) and are an integral part of the organization. Using questionnaires, surveys, observation, and discussion allowed me to analyze measurable outcomes of the evidence-based change project (see Pronovost & Lilford, 2011).

I was invited on several occasions to lead interdisciplinary team meetings by facility management. The interdisciplinary team consisted of an MD, nurse case manager, social worker, chaplain, agency managers, and staff as were available. I participated in interdisciplinary collaboration, took a leadership role, promoted evidence-based practice, and project goals. I experienced positive comments from participants and improved knowledge in collaborative skills, and the translation of evidence into practice.

It has been beneficial using leadership strategies (see Gifford, Davies, Tourangeau, & LeFebre,2011), incorporating the DNP essentials (see AACN, 2006), building staff and facility skills for translation of evidence, and creating transformation of the organizational system (see Bevan, 2010) through multidisciplinary levels, staff empowerment through the change process, and intra- and inter-professional collaboration. There is evidence from this project, and management reporting noted progress, in delivering competent care by staff with the change to dementia-specific and evidenced-based resident.

Watson's (2002) theory also influences facility nurse leaders, as it is applicable in a managerial and administrative role. The adage of leading by example is never truer than in the application of caring for the patient, self, nursing staff, and the organization (see Watson, 2006). As an advanced practice nurse leader, I had the opportunity and commitment to teach by example and demonstrate caring behaviors, thereby improving the patient care delivery environment. As an advanced practice nurse leader, being resolute in the development and emphasizing dementia-specific caring behaviors throughout the nursing clinical environment is essential for providing optimal nursing care (see Watson, 2006).

Throughout the practicum, there was collaboration among me, stakeholders, community members, case managers, staff members, and management, with the importance of a strong leadership model noted. I have appreciated the constructive feedback, guidance, and support from Walden faculty members and my preceptor.

Through "leadership… discovery and integration" (AACN, 2006, p. 11) I evaluated my project plan, with changes in delivery of educational materials and a leadership approach, that actively involved nurses and unlicensed assistive personnel in implementing evidence-based best practices, staff empowerment, collaboration, and sustainability of the practice change, for older adults with AD and dementia-related disease.

Summary

The DNP project was an educational dementia-specific training program (see Nasso & Celia, 2007). The focus was appropriate, in competent dementia capable care of

residents by assisted living facility staff and management. The intent was to cultivate improved quality care through improving staff knowledge of AD and other related dementias.

To ensure appropriate care of this vulnerable population, it required staff to demonstrate competence in dementia-specific care skills (see Haskins, 2016). A result of the dementia-specific training program was the development of a standardized procedure for the facility's dementia-specific training policy (see Healthy People 2020, 2016).

The project implications included that onsite educational methods were effective to elicit behavior change, improve understanding of the dementia patient, and the requisite care, as well as adding knowledge to the practice of nursing. A positive social change was the implementation of an evidence-based, nursing theory guided, dementia-specific, ten-week educational program, that could be implemented in similar settings.

According to Seegert (2015), a "survey of state laws around dementia training reveals a patchwork of requirements and standards across settings, licensure and personnel" (para 1). The survey also noted, "existing laws and gaps in training" and "required curriculums in all 50 states" (Seegert, 2015, para 2). Seegert (2015) goes on to say that the survey was the "first of its kind" to identify the "gaps and variations in mandated training" (para 3).

A key factor in employee retention in the assisted living facility, that is applicable to similar healthcare institutions, is discovering staff attitudes toward aging and illness. The facility staff were motivated to meet the goals of the employing organization of dementia-capable care, through communication, and dementia-specific education. In

implementing caring behaviors with a dementia-specific educational training program, staff also verbalized professional growth, and feelings of empowerment.

The acquisition and demonstration of competent evidence-based specialized skills improved staff self-esteem and increased their nursing practice knowledge base. Research indicates “professionals, volunteers, and staff at every entry level and every aspect of health care…are encountering individuals with dementia” (Justice in Aging, 2015, para 2), with minimum or “no training” in the special care needs of this vulnerable population.

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Appendix A: Program Training and Educational Goals, Objectives, and Activities

Goals	Objectives	Activities
To identify individual staff perception of quality of care, caring behaviors, health and cultural beliefs.	Describe how the influences of individual caregiving staff could reflect on how care is given.	Group discussion, questionnaires, individual reflection and expression.
To understand the causes of dementia and Alzheimer's disease (AD	Define the term dementia. List three types of dementia. Describe the seven stages of AD. Describe the importance of observation, reporting, and the role of caregiver. Describe how to report a change in resident's condition.	Understanding dementia lecture, PowerPoint slides, interactive group discussion, handouts, pre-and post-test.
To understand the basic principles of dementia care and caring behavior theory	List 3 major aspects of a care plan for a dementia resident. Describe the importance of routine for dementia resident. Describe breakdowns in communication process. Define person-centered approach. Define 3 principles of caring behaviors theory.	Basic principles of dementia care and caring behaviors theory lecture, PowerPoint slides, interactive group discussion, handouts, pre-and post-test.
To understand how to assist with daily care needs of dementia resident	Describe the plan of care regarding daily care needs. Describe the task breakdown technique for bathing. List possible causes of dressing difficulties. List five ways cognitive changes interfere with toileting.	Daily care lecture, PowerPoint slides, interactive group discussion, handouts, role-playing, pre- and post-test.
To better understand nutritional challenges	List components of a nutritional assessment. Describe how	Eating challenges with dementia lecture, PowerPoint

of dementia resident	cognitive impairments can lead to eating challenges. Name four interventions that support the dementia resident's physical environment when eating. Describe the relationship between eating and socialization. List four signs observed when a resident has difficulty swallowing (dysphagia).	slides, interactive group discussion, handouts, role-playing common difficulties during mealtime, pre-and post-test.
To better understand how to manage activities for cognitively impaired residents.	List seven ways purposeful activities enhance resident's quality of life. Describe what cognitive functions are needed to complete complex tasks. Describe four reasons for wandering. List five ways to prevent falls. Describe three features of a successful activity.	Recreation and activities lecture, PowerPoint slides, interactive group discussion, handouts, role-playing and describing language and memory skills for a task, pre-and post-test
To better understand the normal aging process and medical problems associated with dementia.	Describe the normal aging process. Describe differences between normal aging and dementia. Name four common medical conditions associated with dementia. List what is included in a pain assessment. Explain the symptoms observed in the late stage of Alzheimer's disease.	Common medical problems lecture, PowerPoint slides, interactive group discussion, handouts, role-playing as caregiver and resident in pain and late stage AD, pre-and post-test.
To educate the staff how a resident cope with dementia.	Describe how the diagnosis of AD impacts the resident, family, and society. List four common emotions experienced by the dementia resident. Explain the stages of grief.	Coping with dementia lecture, PowerPoint slides, interactive group discussion, handouts, role-playing as resident/family related to dementia diagnosis, pre-and post-test.
To educate the caregiver staff on the importance of maintaining a	Discuss the burdens of caregiving and caregiver burnout. Define the terms informal caregiver and formal caregiver. List five signs	Caring for the caregiver dementia lecture, PowerPoint slides, interactive group discussion, handouts, role-

healthy, caring, person-centered, and supportive environment.	and symptoms of burnout. Explain four techniques to reduce stress. Describe how the dementia resident is at an increased risk for elder abuse.	playing as, pre-and post-test.
Develop standard procedures for dementia capable staff	Continuous program planner observation of educational training and application of learned behaviors with final evaluation and acceptance.	Program planner consistent observations through weeks 2-10 with formative evaluation, concluding with summary evaluation and indications for agency continued evaluation of implementation into practice and procedures. (Nasso & Celia, 2007).

Appendix B: Beliefs and Aging Self-Assessment

Individual attitudes and expectations about aging, and the influence on roles of language, culture, race, religion, gender, values and quality of life, affect nursing practice policies and procedures developed to meet the needs of the assisted living facility residents. Consider these as you reflect and answer the following questions.

Thank you for your participation in this project. There are no right or wrong answers, just information that will promote discussion and the practice of patient-centered, dementia-specific quality care.

Knowledge and Background:

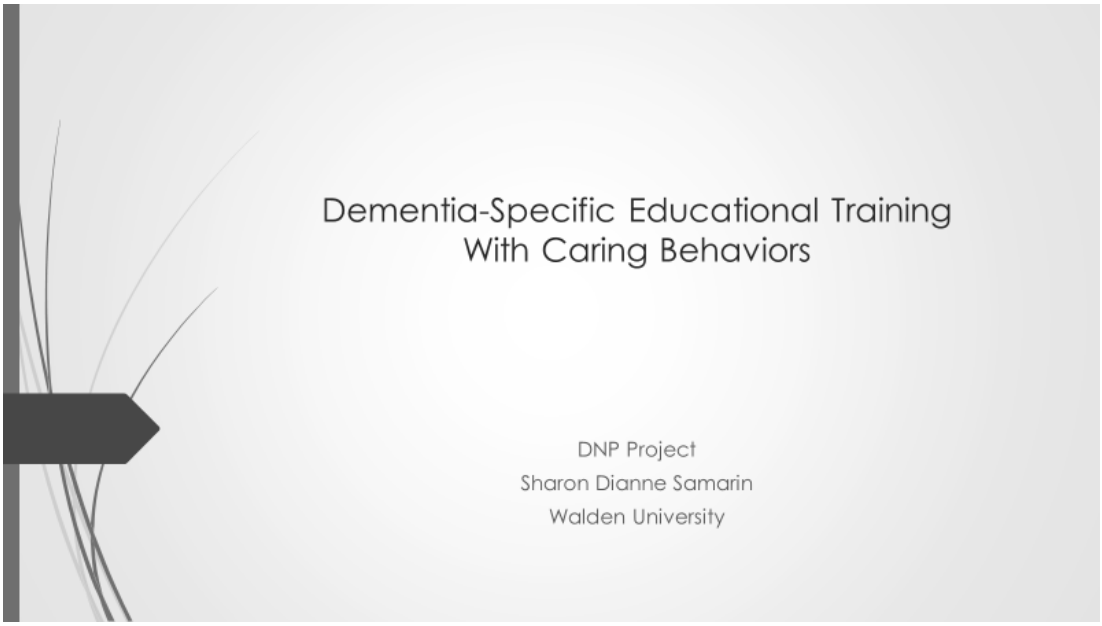
Have you had dementia training prior to this program?
Do you understand what dementia is?
Do you understand basic principles of care?
Do you understand daily care?
Do you understand eating challenges?

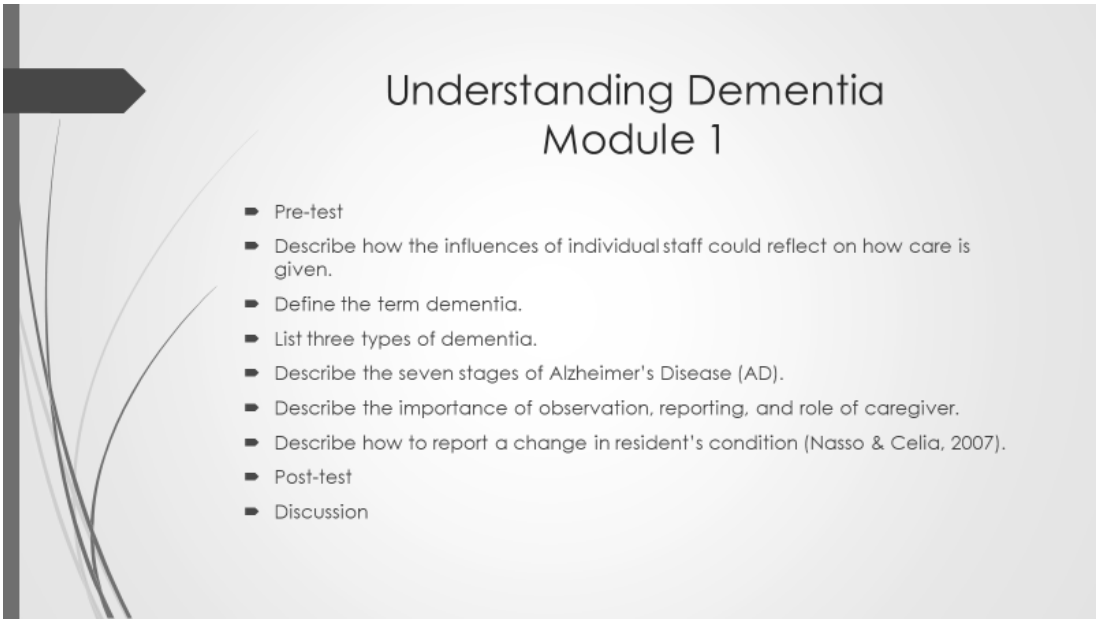
Do you understand the recreation/activity challenges of those with dementia?
Do you know about common medical problems with dementia?
Are you familiar with coping skills of those with dementia?
Do you know how to promote positive environment?
Do you know how to care for caregiver (you)?

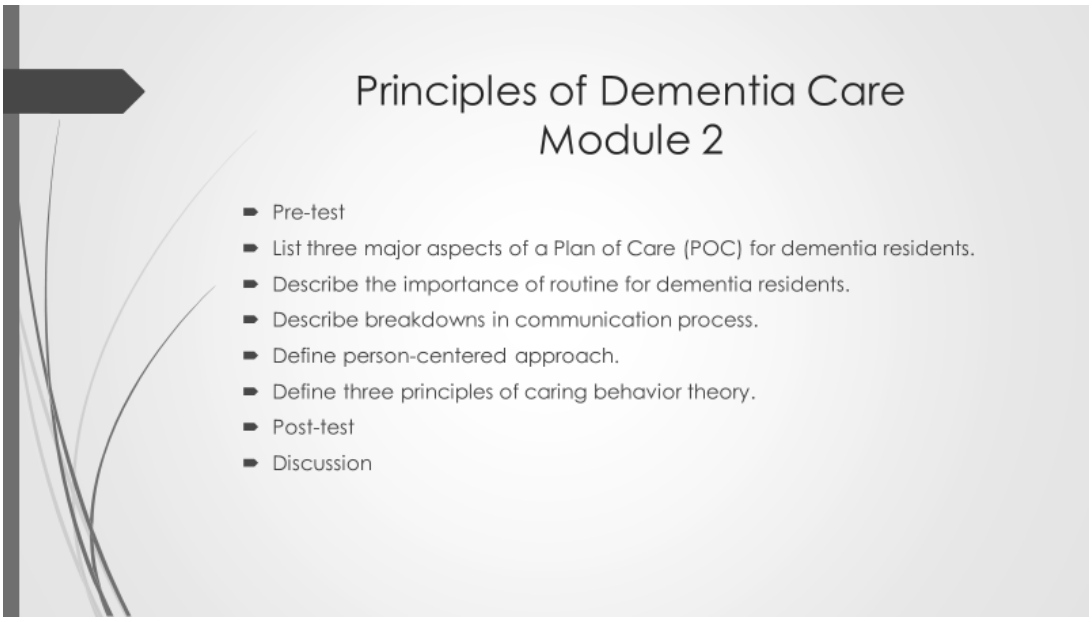
Attitudes and Opinions:

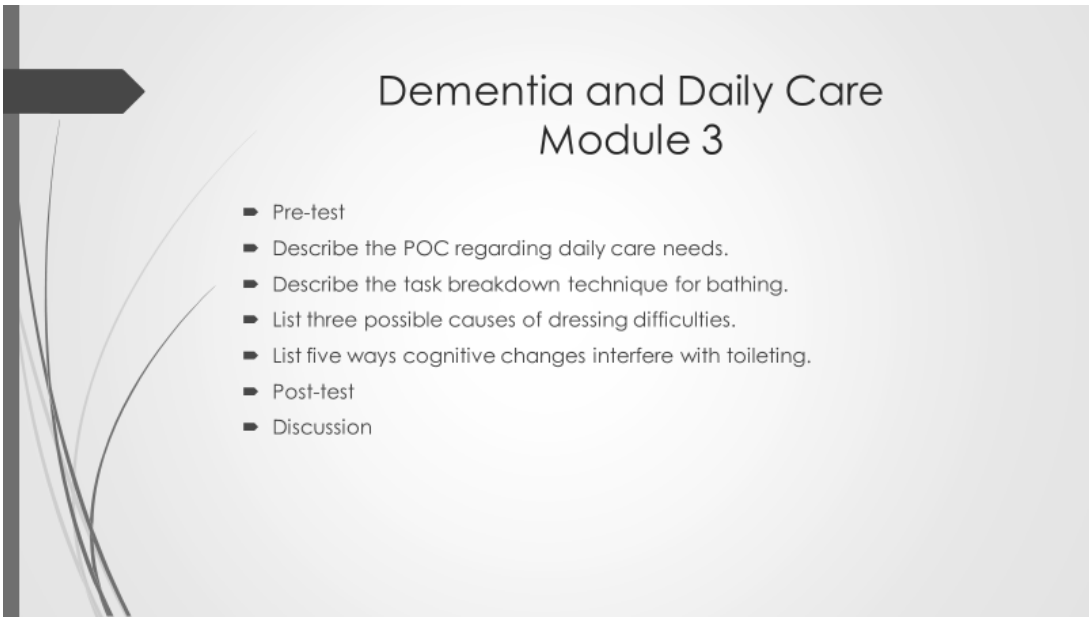
What are your beliefs on aging and quality care?
What is your definition of quality care?
How important are individual's race and religion in your providing of care?
How important are an individual's culture and values in your providing of care?
Do your personal attitudes affect your providing quality care?
Would your practice change to provide patient-centered, dementia-specific care with training?

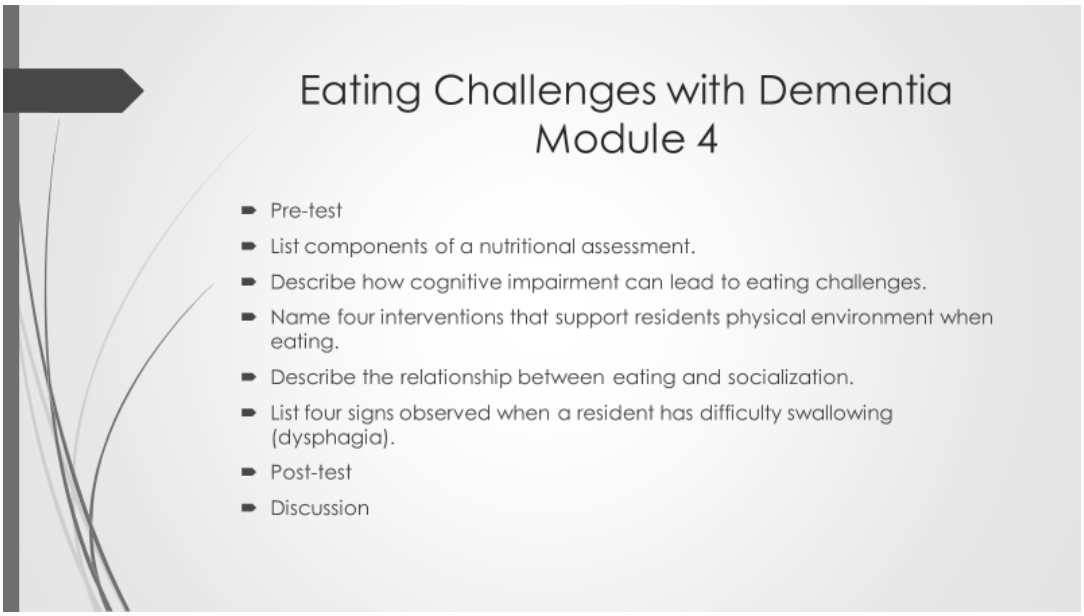
Appendix C: Dementia-Specific Training

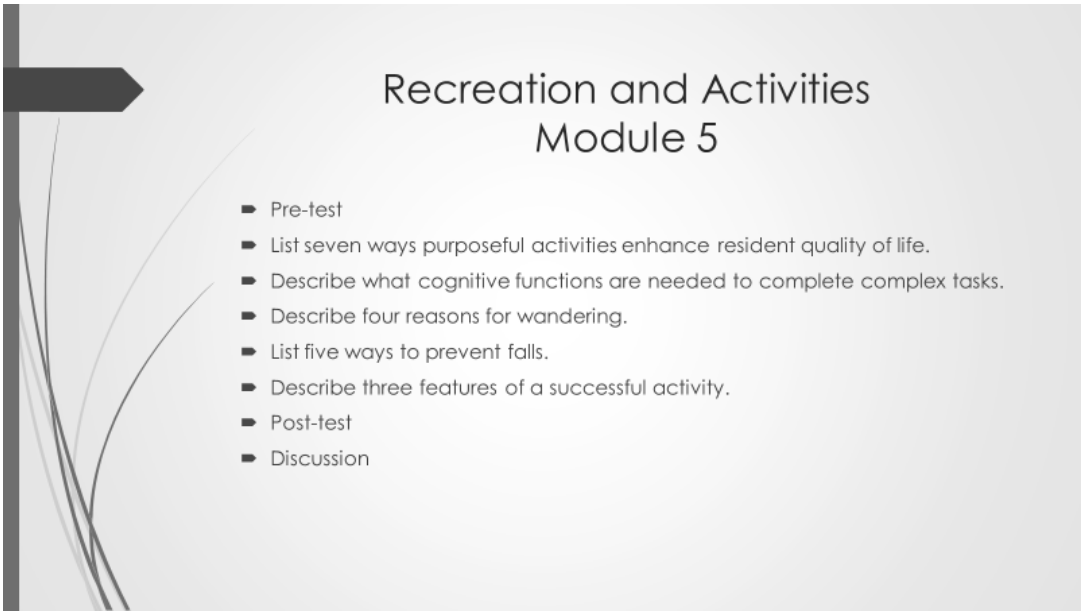


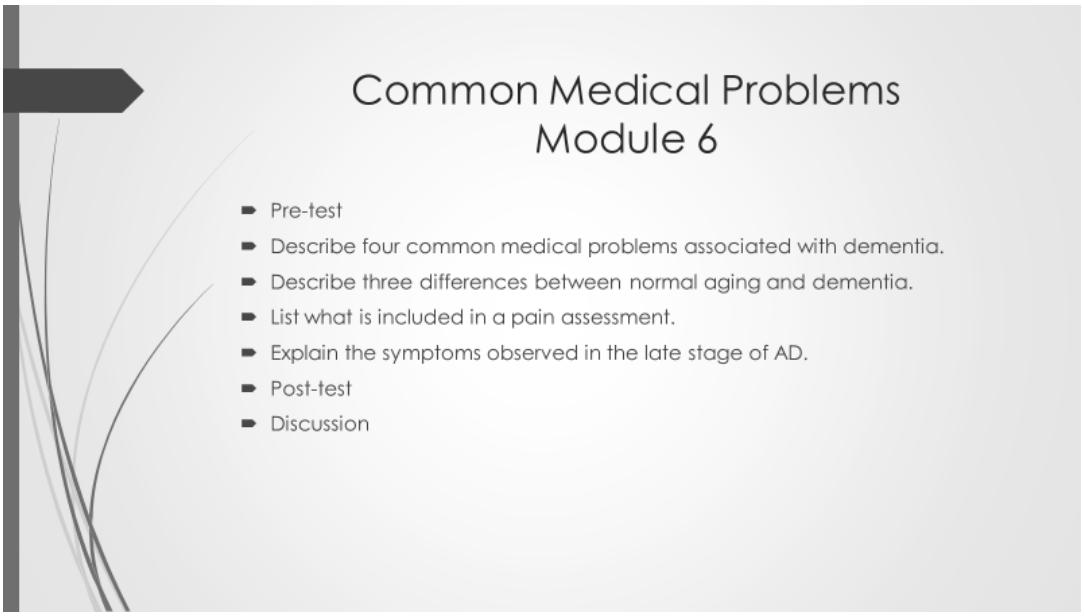


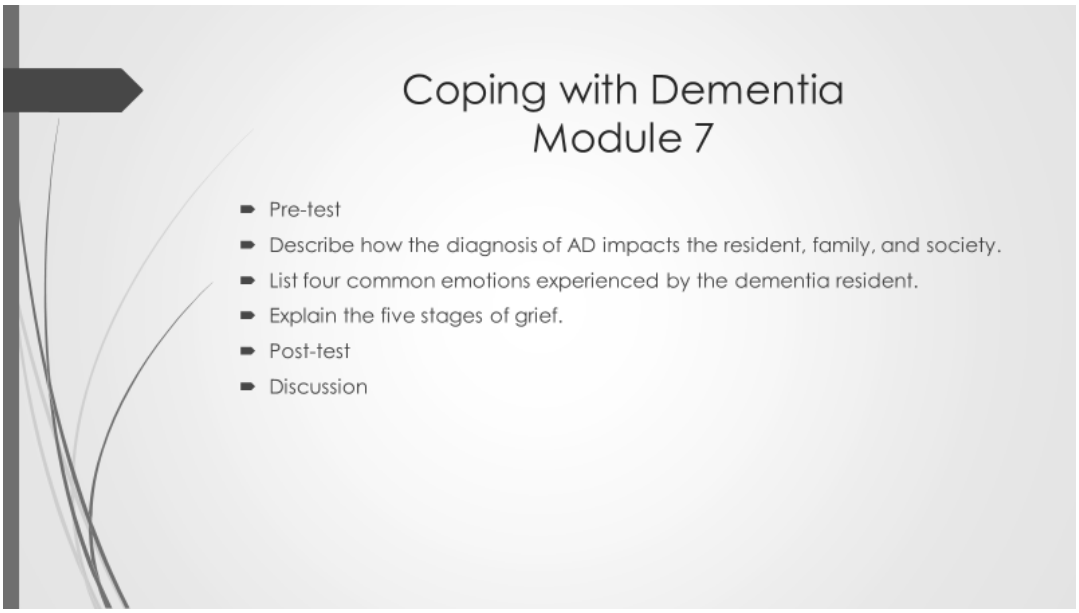

Principles of Dementia Care
Module 2
Pre-test
List three major aspects of a Plan of Care (POC) for dementia residents.
Describe the importance of routine for dementia residents.
Describe breakdowns in communication process.
Define person-centered approach.
Define three principles of caring behavior theory.
Post-test
Discussion

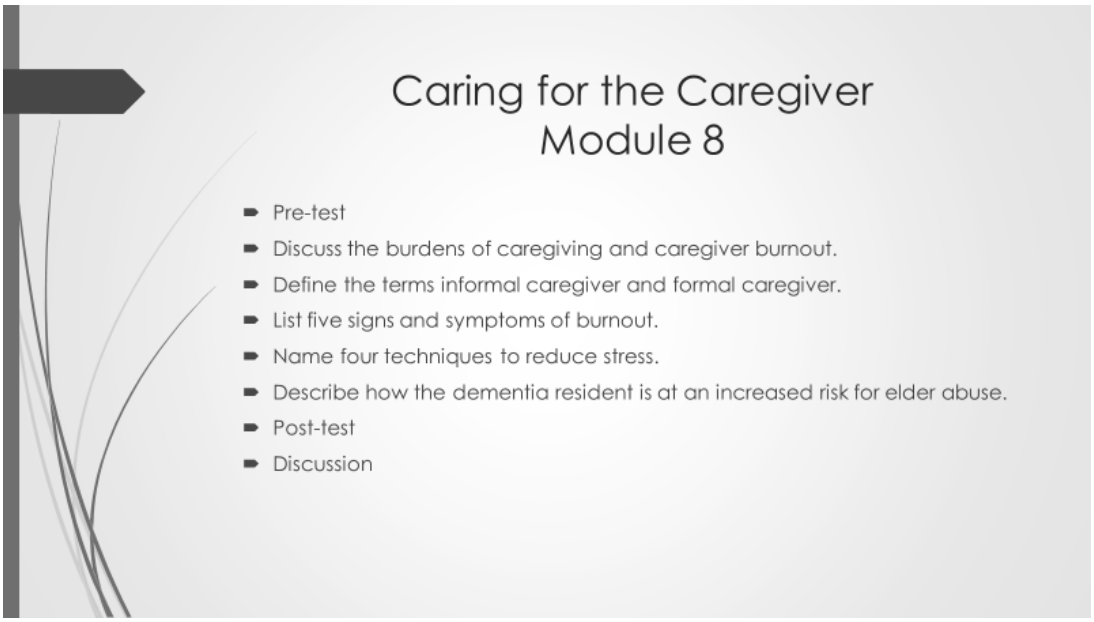

Dementia and Daily Care
Module 3
Pre-test
Describe the POC regarding daily care needs.
Describe the task breakdown technique for bathing.
List three possible causes of dressing difficulties.
List five ways cognitive changes interfere with toileting.
Post-test
Discussion


Eating Challenges with Dementia
Module 4
Pre-test
List components of a nutritional assessment.
Describe how cognitive impairment can lead to eating challenges.
Name four interventions that support residents physical environment when eating.
Describe the relationship between eating and socialization.
List four signs observed when a resident has difficulty swallowing (dysphagia).
Post-test
Discussion


Recreation and Activities
Module 5
Pre-test
List seven ways purposeful activities enhance resident quality of life.
Describe what cognitive functions are needed to complete complex tasks.
Describe four reasons for wandering.
List five ways to prevent falls.
Describe three features of a successful activity.
Post-test
Discussion


Common Medical Problems
Module 6
Pre-test
Describe four common medical problems associated with dementia.
Describe three differences between normal aging and dementia.
List what is included in a pain assessment.
Explain the symptoms observed in the late stage of AD.
Post-test
Discussion


Coping with Dementia
Module 7
Pre-test
Describe how the diagnosis of AD impacts the resident, family, and society.
List four common emotions experienced by the dementia resident.
Explain the five stages of grief.
Post-test
Discussion



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Appendix D: Educational Training Pre and Posttest

Module 1: Understanding dementia (True – False)

1. The term dementia is used to describe an individual with brain impairment impacting cognitive and memory functioning. __T __F
2. The most common cause of dementia is AD. __T __F
3. Brain cells are also called plaques. __T __F
4. Two risks factors of AD are age and heredity. __T __F
5. A common behavioral symptom observed with AD is numbness. __T __F

Module 2: Basic principles of dementia care

1. The most important aspects of caring for dementia residents are safety, routines, and communication. __T __F
2. A resident with dementia is requesting to see her deceased mother, you should reorient the resident to time and place and tell her that her mother is dead. __T __F
3. The communication process involves perception, evaluation, and transmission of information. The part of the brain affected with dementia is the perception due to damage to the temporal lobes of the brain. __T __F
4. When a dementia resident is uncooperative with dressing, the caregiver should ask the nurse to increase the resident's prescription medications. __T __F
5. A catastrophic reaction is an extreme emotional response to a trivial event, leading to sudden mood changes, crying, screaming, or even physical violence. __T __F

Module 3: Daily care

1. The best time to schedule personal hygiene is at the same time every day. __T __F
2. When assisting a resident with AD with a task be quick and to the point. __T __F
3. When a dementia resident refuses to bathe you should yell and demoralize them. __T __F
4. Are loose teeth, gingivitis, or halitosis good reasons to not give oral care? __T __F
5. Does providing privacy, and laying out the clothing in order of sequence assist a dementia resident with dressing? __T __F

Module 4: Eating Challenges

1. Hallmarks of end-stage AD include swallowing and eating problems. __T __F
2. Ideational apraxia is defined as a condition characterized by the refusal to eat or swallow because doing so causes pain. __T __F
3. Dysphagia is defined as difficulty swallowing associated with obstructive or motor disorders of the esophagus. __T __F
4. Observations of residents during mealtimes include amount eaten, the use of utensils, refusal of food, difficulty chewing and swallowing. __T __F
5. Four ways to increase resident's food and fluid intake are nutritional supplements, social gatherings, adjusting food textures and portion size. __T __F

Module 5: Recreation activities

1. Activities can fulfill psychosocial needs, provide the physical stress needed for normal cell growth, and define a person. __T __F

2. Sensory memory refers to the accumulation of facts and experiences over a lifetime. __T __F
3. According to the Alzheimer's Association, 60% of dementia residents wander. __T __F
4. Dementia residents may wander because he/she is looking for something, trying to leave due to fear, or attempting to fulfill previous responsibilities. __T __F
5. When developing an activity plan for a dementia resident, the primary goal is orientation and awareness of the environment. __T __F

Module 6: Common medical problems

1. The normal aging process, in the absence of disease, includes loss of intelligence. _T__F
2. Three common conditions AD residents may develop are dyspnea, hypothyroidism, and osteoporosis. __T __F
3. When assessing a dementia resident for pain, the caregiver should observe the resident's nonverbal communication for signs of pain. __T __F
4. End-of-life care refers to the care of the body after the person has died. __T __F
5. Symptoms of late-stage AD include severe cognitive decline, no orientation to time and place, and incontinence. __T __F

Module 7: Coping with dementia

1. AD affects individuals, families, caregivers, and society. __T __F
2. A common emotion felt by a resident with dementia is jealousy. __T __F
3. End-of-life care decisions should be discussed whenever the family feels ready to make the decision. __T __F
4. According to Elisabeth Kubler-Ross, the stages of grief are denial and isolation, anger, bargaining, depression, and acceptance. __T __F
5. Durable power of attorney is a document stating the end-of-life wishes for the resident. __T __F

Module 8: Caring for the caregiver

1. Symptoms of stress and depression are three times more common in caregivers when compared to noncaregivers. __T __F
2. Caregiver burden refers to the lack of physical strength to care for debilitating residents and family members. __T __F
3. The signs and symptoms of caregiver burden are individual and depend on a person's personality, belief systems, overall health, energy levels, and coping skills. __T __F
4. The most effective way to manage caregiver burden and burnout is to manage the environment. __T __F
5. The stress of caring for the elderly adult is a significant risk factor for abuse and neglect. __T __F

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Appendix E: Dementia-Capable Care Competencies

Rating code: 4 = adequate skills & able to work independently; 3 = moderate skills & needs limited supervision; 2 = limited skills & requires reinstruction; 1 = no skills or knowledge in this area.

Competency & Skill verification	Rating	Date	Rating	Date
A. Incorporates an assisting role into interventions for the cognitively impaired resident to facilitate quality care as a member of the healthcare team				
1. Demonstrates patience, flexibility, since of humor, team spirit, and a desire to work with dementia residents.				
2. Provides considerate, caring, dignified, respectful, person-centered care.				
3. Provides personal freedom from restraints, mental and physical abuse.				
4. Assists the resident to function at his/her optimal level of function and involves the resident as much as possible in decisions/choices, according to his/her functional abilities.				
5. Assists residents in meeting their psychosocial needs and becoming knowledgeable of the resident's background, interests, habits, family members, and functional needs and abilities.				
6. Involved in and assists with a variety of activity-focused care activities.				
7. Observes resident behaviors to describe triggering events and results of the behaviors to the healthcare team.				
8. Monitors for change in condition daily, and reports any changes in physical, social, behavioral or mental functioning.				
9. Utilizes the care plan for interventions and reports successful interventions to charge nurse and documents in resident record.				
10. Implements caring interventions to minimize the effects of disruptive behaviors and participates in care planning and staff meetings to evaluate effectiveness of these interventions.				
11. Recognizes signs of stress and strategies for coping with it in self, other caregivers, and family members.				
12. Identifies and collaborates with interdisciplinary team members and is aware of their functions.				
Comments:				
B. Demonstrates effective communication & interaction with cognitively impaired residents and their families.				
1. Supports the resident's family members, as participants in care.				
2. Demonstrates effective communication skills by establishing good eye contact, at eye level, attentive and in the moment.				
3. Maintains caring, person-centered, non-verbal behavior toward residents and family members.				
4. Displays respect for each resident and family member, maintaining compassionate, person-centered, caring behaviors.				
5. Uses a sincere and caring manner of voice when responding				

with person-centered support.				
6. Demonstrates considerations for cognitive, sensory, visual and hearing difficulties.				
7. Actively listens and responds to residents without correcting or challenging.				
8. Allows enough time for effective communication to occur and gives residents adequate time to listen and respond.				
9. Speaks clearly, slowly, in short sentences, using familiar words, with an empathetic and caring manner of voice.				
10. Diverts or redirects residents with an appropriate person-centered activity.				
11. Communicates with resident about what needs to be done and uses task segmentation to break down tasks into small steps, providing one instruction at a time.				
12. Provides suggestive words that the resident is searching for in a caring manner.				
13. Eliminates background noise and modifies the environment to maintain a calm therapeutic setting.				
Comments:				
C. Demonstrates effective interventions for managing difficult behaviors				
1. Provides comfort, physical gentle touch, caring behaviors, and reassurance of safety, as needed.				
2. Establishes and maintains a daily routine to avoid aberrant behaviors.				
3. Reduces stressors and removes excess stimuli in the environment.				
4. Prevents catastrophic reactions by awareness of the triggers or causes.				
5. Demonstrates appropriate interventions for resident who is screaming or yelling.				
6. Demonstrates caring, person-centered interventions to de-escalate a resident who is anxious.				
7. Demonstrates use of distraction strategies as a therapeutic intervention.				
8. Demonstrates therapeutic communication with family members and significant others during resident visits.				
9. Demonstrates coaching techniques to help other caregivers and family members cope with the dementia process.				
10. Provides activities to meet a resident need or personal background history.				
11. Monitors for behaviors indicative of pain, constipation, infection, etc.				
12. Provides time for rest periods to reduce risk of fatigue.				
13. Checks care plan for resident limitations and strengths.				
Comments:				
D. Provide caring assistance and sensitivity with ADL's, mobility, and therapeutic activities that will maximize function and well-being				
1. Implements therapeutic caring behavior activities appropriate for early, middle, and late stages of dementia, including end-of-life care.				
2. Demonstrates caring behaviors and person-centered strategies for promoting independence in all ADL's, as resident abilities allow.				

3. Promotes resident individuality through abilities, strengths and self-esteem, while respecting resident dignity and desire for control.				
4. Implements care strategies that provide stimulation and encourage ADL's without increasing resident anxiety or stress.				
5. Provides reassurance and gentle touch, as needed during ADL's, and re-approaches at another time if resident is not cooperative.				
6. Offers fluid intake before and after ADL care.				
7. Demonstrates effective shower/bath techniques.				
8. Demonstrates effective dressing/undressing techniques.				
9. Demonstrates effective toileting techniques.				
10. Provides privacy, during dressing, bathing, toileting and incontinence hygiene care.				
Comments:				
E. Apply nutritional interventions to maximize/maintain nutritional well-being in the cognitively impaired				
1. Promotes a calm and pleasing atmosphere that supports optimal functioning for eating activities or meal times.				
2. Maintains an environment which minimizes distractions during eating activities or meal time.				
3. Demonstrates the ability to adapt to the dinning experience that maximizes nutritional intake.				
4. Implements dietary modifications as needed to maintain nutritional status, appropriate weight, and hydration in a manner that the cognitively impaired resident will accept.				
5. Encourages residents at high risk for dehydration to drink more fluids.				
6. Monitor and documents meal and fluid intake.				
7. Monitors urinary output and bowel movements by observation and documentation.				
8. Reports to charge nurse the absence of bowel movements in 48 hours.				
Comments:				
F. Maintaining a caring and safe environment for the cognitively impaired				
1. Promotes a since of belonging in a caring and safe home-like environment.				
2. Limits harmful stimuli in the environment to minimize escalating behaviors or catastrophic reactions.				
3. Maintains a safe environment for residents and staff while de-escalating combative behavior.				
4. Implements appropriate interventions to minimize environmental stimuli that may increase a confused resident's agitation, such as noise levels, large groups, television, radio, etc.				
5. Maximize safety and security to protect residents from physical harm: uncluttered walkways, conducts frequent observational rounds, ensures exit doors alarmed, staff sight lines to outdoors areas, etc.				
6. Demonstrates/verbalizes appropriate actions to take to protect residents from psychological harm: when a resident striking out at another resident, behaviors are aggressively threatening to others, exposing self or sexually inappropriate				

in public area.				
7. Demonstrates the ability to maintain a safe environment for wandering resident (maintains functional key pad locking systems, 15-minute outdoor checks, outdoor seating, secured tables/chairs, level walkways, etc.).				
8. Provides person-centered attention and redirecting activities before purposeless wandering behaviors start.				
9. Checks feet and shoes to ensure good skin integrity and comfort.				
10. Implements and describes system/schedule to monitor resident location.				
11. Demonstrates knowledge of or use of elopement alarms, frequency of door checks, and other actions to prevent wandering.				
Comments:				

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