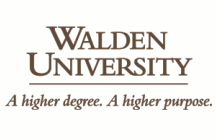

2016

Standardized Assessments, Care Planning, and Improved Quality of Life for Residents of Adult Family Homes

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2016

Abstract

The Relationship Between Standardized Assessments, Care Planning, and Improved Quality of Life for Residents of Adult Family Homes

by

John A. Rogers

MA, Washington State University, 2004

BSN, Washington State University, 2002

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

March 2016

Abstract

Quality of life for adults living in adult family homes requires further attention as the elderly population continues to grow and moves from minority to majority. There is a lack of data on residents in adult family home settings and their quality of life. The purpose of this project was to identify if individualized nursing care plans had an impact on the residents' quality of life in the adult family home. In this study, a registered nurse assessed the residents to create an individualized nursing care plan that would be implemented to improve quality of life. These care plans were comprised of 3 distinct nursing needs: risk of falls, self-care deficit, and nutrition imbalance less than the body needs. Each care plan was created with nursing-specific interventions that could be tested, replicated, and evaluated. A test of this premise was conducted using a sample of 6 residents in an adult family home. Only one resident met the criteria of mild to moderate dementia for testing. The single qualifying resident who participated in the project demonstrated improvement in her quality of life after the proposed intervention was implemented. This change was evaluated using quantitative data gathered with the Dementia Quality of Life assessment, and qualitatively with the caregiver and registered nurse evaluation tool. The interventions of the nursing care plans were relevant and as a result, the Dementia Quality of Life assessment did show an improvement in scores, which reflected an improvement in quality of life. Elderly adults with dementia living in an adult family home may benefit from individualized nursing care plans, which may improve their quality of life.

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Dedication

This project is dedicated to my husband, Berzain Vazquez-Rogers. Thank you for standing by me during my educational endeavors. Your patience and kindness are unsurpassed. To Mexico and back!

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Section 1: Nature of the Project

Overview of the Evidence-Based Project

Older adults use many health care services due to the increasing complexities of their health conditions. This population is at high risk for developing chronic illnesses and disabilities such as diabetes, arthritis, congestive heart failure, and dementia ("Healthy People 2020", 2015). According to Vincent & Velkoff (2010) it is projected that from 2010 to 2050, the population of people aged 65 and older will more than double to 88.5 million. Individuals will need to choose where they will live once they become unable to provide self-care. The options vary, and one may choose to reside in a skilled nursing facility (SNF), an assisted living facility (ALF), an adult family home (AFH), or may choose to receive private, in-home nursing. AFHs in the State of Washington have the option of becoming licensed to care for adults aged 65 and older who have been diagnosed with dementia. The patient population that is the subject of this practice improvement project is adult residents with dementia who reside in a Washington State licensed AFH with a dementia designation.

AFHs with the dementia designation of licensure present a unique, home like atmosphere that allows the residents to live in a controlled environment with skilled caregivers trained to care for dementia residents. AFHs are licensed and regulated by the State of Washington. This project focuses on those specifically monitored for patients with dementia. While the individual care varies, one of the key factors in making appropriate living arrangements is the residents' quality of life. The Washington Administrative Code (WAC) defined the quality of life as "caring for residents in an

environment that enhances each residents dignity and respect full recognition of his or her individuality, wants and desires" (WAC 388-76-10620). Residents' care needs vary. A resident may be a high functioning, independent individual; independent in some or all levels of activities of daily living; or require assistance with several or all activities of daily living to qualify living in an AFH, as long as their medical condition remains stable and predictable.

Problem Statement

In Washington State, there is no mandated or standardized admission process that requires a registered nurse to meet with and assess the resident and create a preliminary care plan prior to admission. Registered nurses are trained professionals with knowledge in biological, behavioral, health, and nursing science guided by evidence-based knowledge and licensed by individual State Boards of Nursing (American Nurses Association, 2010). A nursing care plan is founded on evidence-based practice and research and is aimed at providing individualized care to each resident. While the WAC has required that all potential AFH residents be screened by a registered nurse to ensure they are medically stable, the admission process does not require a full assessment and care plan be completed by a registered nurse. As previously stated, the patients who are the focus of this practice improvement project are adults with dementia, residing in a licensed AFH with the dementia designation; the project addresses the need for a registered nurse assessment and care plan intended to improve the residents' quality of life. Also of focus is the oversight of the implemented care plan as it is carried out on a day-to-day basis by a non-licensed aide. The registered nurse plays a key role in ensuring

the safe practice of medication assistance and management and the follow-through of the care plan by the health care aides.

Purpose Statement

The nursing admission process permits the evaluation of the resident's physical, psychological, and quality of life needs at the time of the assessment. The purpose of the proposed project is to develop and implement policies and practices to guide the use of a nursing assessment, care plan, and dementia quality of life evaluation with the intention of improving the quality of life of a resident of an AFH licensed within Washington State and holding the dementia designation.

Goals and Outcomes

As recommended by the Adult Family Home Quality Assurance Panel, (AFHQAP) (AFHQAP, 2012, p. 20), "owners or managers should be present at the time of screening and admission. By doing so, this practice reduces concern about inappropriate placement into the AFH environment." An example of inappropriate placement involves the admission of a resident whose health does not remain stable or predictable or requires on-site skilled nursing that cannot be delegated to a health care aide. Another example of an inappropriate admission would be a resident who is a flight risk due to exit-seeking behavior. By the WAC, the AFH is not a locked facility and may only have deterrents to prevent elopement. These deterrents may include personal call alarms, door alarms, call buttons, as well as motion sensors. A sudden change in health may necessitate the need for the resident to enroll in hospice, or if the change is acute and the resident does not qualify for hospice, then the resident must be seen at the emergency

room for evaluation. If the resident does not return to the baseline admitting condition and does not qualify for hospice, then readmission to the AFH facility is not possible. An example of a complex patient who meets appropriate admission criteria would be a resident who has dementia with comorbidities that are controlled. These residents typically have a glacial decline in condition with few hospitalizations. A preadmission assessment is performed by a registered nurse or other state qualified assessor possessing a master's degree in social services, human services, behavioral sciences, or an allied health field, in addition to 2 years of social service experience working with adults who have functional or cognitive disabilities (WAC 388-78A-2080). If a resident is not in a stable or predictable condition at the end of life, this resident must be enrolled in hospice and follow the hospice criteria (WAC 388-78A-2050). It is up to the assessment by approved, state-qualified assessors rather than the homeowner to determine if the resident is stable and predictable and can be housed in the AFH.

While the owner of the AFH has some input as to whether or not a resident is an appropriate placement, the assessment, when completed by an approved assessor, is what ultimately determines an individual's eligibility for placement. In the event that the potential resident does not qualify for an AFH, then other placement may consist of a boarding home or SNF, which was not the topic of discussion for this project. In order to improve the quality of the patient's care in an AFH, as well as the quality of their lives while in residence, the Doctor of Nursing Practice (DNP) project goals were as follows:

- design and implement evidence-based nursing care plans for the adult patient with dementia who is admitted to an AFH;

- develop policies, procedures, and a training program to ensure implementation of a standardized assessment and nursing care plan by a registered nurse or otherwise qualified individual takes place within 24 hours of admission;
- ensure ongoing care by non-licensed staff is under the supervision of a nurse for the adult resident(s) with dementia;
- develop policies, procedures, and implement practice to evaluate and monitor the resident and care plan, as well as make required adjustments as necessary for six patients in the DNP trial period of 2 weeks; and
- evaluate the impact of the nursing process on the elderly dementia patient's quality of life, for six test residents who reside in a selected AFH in the DNP trial period of 2 weeks.

Relevance to Nursing Practice

In 2011, the AFHQAP performed a review of the 2,803 AFHs in the State of Washington. From this report, recommendations were developed to reduce the incidence of neglect and abuse as well as to ensure compliance with licensing and enforcement issues regarding AFHs (AFHQAP, 2012, p. 20). This has become increasingly important, as the popularity of AFHs has increased since they were first developed in the 1970s as an alternative to nursing homes. Within the last 10 years, the number of AFHs has steadily grown from 2,070 homes in 2002 to 2,803 homes in June of 2012 (AFHQAP, 2012).

In the State of Washington, is the AFHQAP (2012) estimated that approximately 2,100 of the AFHs were operated by sole proprietors. These owners either resided in the

home or provided staffing with caregivers and a manager. This left approximately 700 homes operated by a multi-facility owner. Both models of ownership have resulted in both good and problematic care (AFHQAP, 2012). Problematic care has ranged from inadequate staffing, to undertrained staff, as well as standards of care that are inconsistent with the WAC, which governs the AFH (AFHQAP, 2012).

Nursing is a profession based on holistic care; health maintenance as well as health promotion are just as important as episodic care. Researchers have found that episodic health care is less effective and more expensive than comprehensive care (Markle-Reid, Weir, Browne, Roberts, Gafni, & Henderson, 2006). Immediate assessment and implementation of a care plan by a registered nurse prior to entry into an AFH is expected to reduce fragmented care and improve nurse sensitive performance indicators that can be measured.

Evidence-Based Significance

While many nursing assistants are competent in their role, they may lack the ability to apply knowledge and nursing skill (Hancock, Cambell, Ramprogus, & Kilgour, 2005). It is only through the training of the registered nurse and following the strict policies of the State of Washington that these care plans can be carried out effectively. While the nursing assistants are capable of performing delegated tasks that follow the state requirements, ongoing training is essential to provide appropriate care outlined in the care plan (Hancock, Cambell, Ramprogus, & Kilgour, 2005).

Poor communication patterns have contributed to poor behavioral outcomes in patients with dementia. Some examples include speaking in a patronizing way to

residents, speaking too quickly, or not allowing adequate time for the resident to respond (Williams, Herman, Gajewski, & Wilson, 2008). All care providers who are employed in an AFH with a specialty designation of dementia care participate in skill training to improve communication style. This is a minimum of 18 hours as defined by WAC 388-112-0045.

Registered nurses are well versed in applying care in a variety of settings by implementing any number of methods. Nursing care is instrumental in establishing a bond with patients and families as well as a holistic assessment to identify quality of life indicators (Graske, Fischer, Kuhlmey, & Ostermann, 2012). Further, in-depth assessment reveals any deficiencies in the ability of the resident to communicate his or her needs. If this occurs, the next best alternative can be provided through the primary care nurse who has established a bond with the patient (Graske et al., 2012). Nursing has been recognized as one of the top professions holding the trust of the public (Riffkin, 2014). Nurses are able to engage with patients and identify needs that might otherwise go unmet. This nursing perspective is insightful and intuitive. Nursing is a profession that utilizes a holistic approach when evaluating the needs of the patient, family, and community. The use of standardized documentation is essential for measuring the quality of care as well as improving quality of care (Jansson, Pilhamar, & Forsberg, 2009).

The capacity for an AFH that provides registered nurse support in the form of nursing care plans increases the ability of the patient to age in place and for the AFH to make appropriate accommodations for the needs of the residents (Thomas, Guihan, & Mambourg, 2011). While AFHs do not require a registered nurse be on site at all times,

many times the resident has a medical condition in addition to senile dementia, which, according to Washington state law, requires the oversight of a nurse. In this case, the staff at the AFH is required to have nurse delegation. This requires the staff to be trained in the administration of medication by a registered nurse who must train, document, and recertify specific delegated tasks as outlined by the State of Washington. Many other nursing functions are also delegated to non-nursing staff such as monitoring food and fluid intake, therapeutic communication, proper ambulation techniques, transfer techniques, as well as frequent repositioning and monitoring of resident safety.

Implications for Social Change in Practice

This project is dedicated to positively affecting social change for the vulnerable adults with dementia living in the AFH setting. The goal of this project has been the development, creation, and implication of strategies that will promote the worth and dignity in the older adults who live in AFHs in the southeast Washington region. Social change is designed to address social problems on an individual, institutional, community, national, and international level. Social change is necessary to improve the beliefs and values of fairness, opportunity, and diversity. Social change involves a collaboration of action from individuals close to the problem to develop solutions that address the problem. One area of concern for social change is the notion that DNPs all understand and define social change the same way. It is important that social change takes into account all views and that the values and beliefs of the dominant culture do not overshadow the beliefs of the minority (Davis, 1997). As appropriate care and the standards of care in AFHs have been inconsistent with the WAC, improving the standards

of care within the AFH is an ideal way to create and foster social change. The AFHQAP (2012) review was intended to ensure compliance with licensing and enforcement. This publication serves a large role within the AFH nursing community as it will serve to reduce inappropriate placements and unnecessary expenses for vulnerable adults who utilize such services.

As the population continues to age, the options for choosing care will place a greater demand on AFHs, SNFs, ALFs, and other entities providing care to older adults. Having the best understanding of the positive social change that AFH offers is one way to make a dramatic impact on this vulnerable population.

Limitations

Limitations to this project include the limited ability to generalize to other AFHs. While the rules and regulations remain the same, the AFH for which this particular practice improvement project was proposed has one nurse practitioner, as well as two on-call registered nurses. AFHs that are not owned and operated by nurse practitioners or registered nurses must decide if they are going to contract with such professionals who can participate in the development and modifications of resident care plans.

Many AFHs are owned and operated by people who have little or no medical background. The State of Washington has required workers of an AFH to have a nursing assistant registered, nursing assistant certified, or health care assistant certification. The health care assistant certification requires 5 hours of training in orientation to the facility and 75 hours of approved curriculum in core competencies and skills necessary to provide personal care effectively and safely (WAC 388-112-0001 through 388-112-

0410). AFHs that have a dementia designation also require specialty training in dementia as well as 12 hours of continuing education and certification through the state. Nursing assistants who are certified and registered have a required minimum of 75 hours of approved curriculum from the state and are required to have state certification, specialty training in dementia, and 12 hours of continuing education (WAC 388-12-0001 through 388-112-0410). Nursing assistants certified have obtained a certification from Washington State that has designated completion of core competencies. Currently, Washington State has grandfathered in nursing assistants who are registered but have not completed the state certification, as allowed by law (WAC 388-112-0003).

The WAC requires a registered nurse, or an individual with a master's degree in either social work, human services, or behavioral science, with 2 years of experience, to perform a screening prior to admission to an AFH (WAC 388-78A 2080). This ensures that the patient is in a stable and predictable condition prior to admission. Patients who are appropriately placed in an AFH usually have some capacity to perform activities of daily living, may have chronic illnesses, but do not exhibit symptoms indicating the need for acute, inpatient care. A patient who remains in a stable medical condition who is unable to provide care for him- or herself qualifies for an AFH. The WAC does not require that that a registered nurse complete and implement a nursing care plan at any time during the stay in the AFH.

Dementia designated AFHs can accept any level of dementia resident who has been diagnosed with dementia by a qualified medical provider. Typically, as indicated by the preceptor of this project, there is usually a mix of high to low functioning residents

with dementia at any given time within the adult family home. The one criterion is that a dementia diagnosis must be present prior to admission.

Definition of Terms

Common definitions and terms used in this paper have been found in the WAC sections 388-76-10000 through 388-76-11085 and other sources, which are relevant to the theoretical support for this project.

Adult family home (AFH): A residential home that has been licensed to provide room and board and specialized care to no more than six residents. These residents may not be related by blood, or marriage to any resident manager, caregiver or owner who lives in the home (WAC 388-76-10000).

Dementia: A medical diagnosis, dementia is a general term describing a group of disorders in which memory and thought processes (cognition) become impaired for a period of at least 6 months. Unlike mental retardation, dementia involves a change in thinking abilities relative to baseline (Reed, 2013).

Determining eligibility for AFH as per the WAC chapters 388-76-10330, 2012 through 388-76-10350: To determine patient eligibility for an AFH, the WAC sets out a defined screening process, which owners of licensed AFHs must provide prior to admission, by a registered nurse. Dementia is a condition that is evaluated and documented through a screening process that surfaces the following:

- Medical diagnoses reported by the resident, the resident's representative, family member, or by a licensed medical professional;
- The resident may require assistance with medication administration;

- The resident may exhibit behaviors that require additional care or the use of medical devices such as a wheelchair;
- The resident exhibits functional abilities that need supervision or assistance. These range from meal preparation, hygiene, ambulation, toileting, grooming and transferring; and
- Residents continue to retain personal preferences in choosing meals, activities, as well as sleep schedules.

Resident: The term *resident* refers to any adult unrelated to the provider who lives in the AFH and who is in need of care.

Vulnerable adult: According to the state of WAC (388-76-10000), a vulnerable adult includes a person who

- is 60 years of age or older who has the functional, mental, or physical inability to care for himself or herself;
- has been admitted to any facility;
- has been receiving services from home health, hospice, or home care agencies;
- is receiving services from an individual provider; or
- has been living with a functional disability in his or her own home, and who is directing and supervising a paid personal aide to perform a health care task.

Therapeutic communication: A process of specific strategies that encourages patients to express feelings through verbal and non-verbal means while conveying acceptance and respect (Northouse & Northouse, 1998).

Quality of life: As defined by Oleson (1990), as the subjective perception of joy or satisfaction with life.

Adult family home admission criteria with a dementia designation: Residents will be in a stable and predictable condition. Residents must not require skilled nursing interventions such as 24/7 Licensed Practical Nursing or Registered Nurses. All skills must be able to be delegated to health care assistants that fall within their scope of practice.

Summary

A needs assessment conducted on AFHs across the State of Washington by the task force and as part of a review of the WAC defined resident quality of life as providing care for residents that maintains or enhances dignity and recognizes the resident's individual want and desires (WAC 388-76-10620). However, the WAC did not provide any more specificity as to how to quantify quality of life in the elderly with dementia who live in AFHs (WAC 388-76-10620 through 388-76-10645). The AFHQAP (2012) recommended that AFH owners or resident managers review the initial assessment as well as develop a preliminary care plan prior to resident placement into the AFH, which is a function that is well suited for a registered nurse. AFHs are classified into three specialty designations, which include dementia, developmental disabilities, and mental illness. To qualify for an AFH with a dementia designation, the resident must have a diagnosis of dementia by a qualified medical professional with a licensure that allows them to make such a diagnosis. The differentiation of the various types of dementia does

not impact the ability to place a resident into this facility. The resident can be referred from their medical provider or be self-referred once they are over the age of 65.

All AFHs with a specialty designation are monitored in the same way and subject to the same disciplinary action as governed by the Department of Health. Prior to admission into the AFH, the patient is screened to determine if their medical needs are appropriate for such a setting, yet there is no required nursing care planning process required by the State of Washington at this time. The patient must be in a stable and predictable medical condition or be enrolled in hospice prior to admission or during the current stay (WAC 388-78A-2050). As many patients who reside in an AFH's have various levels of cognitive impairment, the Dementia Quality of Life (DEMQOL) screening questionnaire (Ready & Ott, 2003) will assist in creating a baseline and ongoing quality of life screening.

An AFH that is supported by 24-hour caregivers and access to registered nurses can identify health and functionality changes and immediately adjust nursing interventions on the care plan to meet these changing needs. Any change in the residents' condition from a stable and predictable condition requires a registered nursing assessment and modification of the nursing care plan. If the health of the resident does not appear able to return to baseline functioning, then the resident must be enrolled into hospice or immediately discharged from the facility to the emergency room for an evaluation. At this time, if they are no longer medically stable, these residents usually are then admitted to a SNF until they are stable and able to return to the AFH, or remain in the SNF. Registered nurses are trained in physical assessments and have the necessary skills to

identify changes in both physical and psychological conditions that may threaten a resident's health. By providing oversight delegation to the certified aides for the nurse-defined care plan, the residents continue to have ongoing access to nursing care. Taking a holistic perspective of the residents will help improve the quality of life through care plans, development of the AFH, and health promotion activities (Gillespie et al., 2009).

The purpose of this project is the development of policies and practices with the use of nursing directed care plans to guide resident care and improve resident quality of life. AFHs offer a unique living environment in which individualized nursing developed care plans offer the best opportunity for non-licensed health care staff to make an impact on the life of the residents whom reside in such facilities.

Section 2: Background and Context

Purpose

The purpose of this quality improvement project is to develop and implement policies and practices to guide the use of nursing care plans and dementia quality of life evaluation. This section examines the literature regarding the nursing care plan components that are specific to dementia residents as well as which components affect a resident's quality of life. In order to understand components that affect a resident's quality of life, it is best to understand the stages of dementia.

The different stages of dementia are summarized in Table 1 and best describe how far the level of dementia has progressed. Conversations with the preceptor of this project has revealed that many different scales may be used to assess levels of dementia such as a Mini Mental Status Exam (MMSE), or global deterioration scale for the assessment of primary degenerative dementia. Each resident will be screened for dementia using the mini mental status exam to find out their baseline functioning.

Table 1

Stages of Dementia

Diagnosis	Stage	Signs and Symptoms
No Dementia	Stage 1: No Cognitive Decline	Normal functioning, no memory loss, mentally healthy without dementia.
No Dementia	Stage 2: Very Mild Cognitive Decline	Normal forgetfulness associated with aging. Forgetful of names or familiar objects. Symptoms are not evident to loved ones or medical personnel.
No Dementia	Stage 3: Mild Cognitive Decline	Increased forgetfulness, difficulty concentrating. Decreased work performance. Loved ones start to notice decline. Average duration is 7 years to dementia.
Early Stage	Stage 4: Moderate cognitive decline	Difficulty concentrating decreased memory of recent events. Difficulty with finances, traveling and may be in denial of symptoms. Slight withdraw from friends, socializing becomes difficult. Cognitive changes can be detected by medical personnel. Average duration 2 years.

(table continues)

Diagnosis	Stage	Signs and Symptoms
Mid Stage	Stage 5: Moderately Severe Cognitive Decline	Major memory deficiencies and require some assistance to complete activities of daily living. Memory loss more prominent. May not remember address, phone number, time or day. Average duration is 1.5 years.
Mid Stage	Stage 6: Severe Cognitive Decline (Middle Dementia)	Require extensive assistance to carry out activities of daily living. Forget names of close family members and have little recall of recent events. Difficulty counting down from 10. Incontinence of bowel or bladder. Ability to speak declines. Episodes of delusions, compulsions and anxiety or agitation occur. Average duration is 2.5 years.
Late Stage	Stage 7: Very Severe Cognitive Decline (Late Dementia)	Patients lose ability to speak or communicate. Require assistance with most activities such as eating, toileting. Often there is a loss of psychomotor skills such as walking. Average duration is 2.5 years.

Note. Adapted from "The Global Deterioration Scale of Assessment of Primary Degenerative Dementia," by B. Reisberg, 1982, *American Journal of Psychiatry*, 139, pp. 1136-1139.and "Clinical Stages of Alzheimer's," Fisher Center for Alzheimer's Research, n.d. Retrieved from http://www.alzinfo.org/clinical-stages-of-alzheimers

Care Plans

A nursing care plan consists of a scientific problem solving method that is used to identify actual and potential problems with residents and uses a logical and systematic way of resolving these problems (Aydin & Akansel, 2013). The nursing process includes assessment skills such as gathering data and then selecting an appropriate nursing diagnosis that guides implementation of specific interventions, evaluation of same, and makes possible measurable outcomes. The nursing diagnosis is an evidence-based decision process that utilizes both the individual problem and family problem by the use of critical thinking (Aydin & Akansel, 2013)

One of the most important steps in the nursing process is the proper identification of problems (Junttila, Salantera, & Hupli, 2005). Nursing care is one of the most important indicators of successful health care. The development and use of care plans has been an instrumental tool in the standardization, individualization, and delivery of nursing care. It is essential that care plans for dementia patients take into account several overlapping factors.

The review of the literature demonstrated many behaviors of dementia that have a nursing diagnosis that can be resolved through key interventions. These nursing diagnoses are as follows:

- risk of falls;
- self-care deficit; and
- nutrition: imbalanced, less than body requirements.

The nursing process and care plans allow for critical thinking, assessing, and applying individualized theoretical knowledge to clinical practice, and are important elements to planning and implementing nursing care (Aydin & Akansel, 2013). The registered nurse who is trained in critical thinking and the use of evidence-based practice guidelines is best suited to ensure the correct diagnosis, define appropriate interventions, and initiate and oversee the full implementation of the care plan.

Two difficult aspects of caring for residents with dementia include the difficulties with ambulation and the risk of falls (Agency for Healthcare Research Quality, 2012) (AHRQ). Impaired cognition, impulsive behaviors, physical deconditioning, and impaired balance are all characteristics of dementia residents and place them at higher risk of falls (AHRQ, 2012). Residents at 65 years or more should be screened annually for fall risk (AHRQ, 2012). This screening is for residents who are at average risk for falls. If the resident is at moderate high risk for falls, this includes one or more falls (AHRQ, 2012). If the resident presents with multiple risk factors, which include two or more falls in the past 12 months, presenting following a fall, or having difficulty with walking or balance, then a screening assessment should be done every 6 months (AHRQ, 2012).

It is not uncommon for dementia residents to wander, and this may be for many different reasons. The resident may be wandering to find safety, looking for familiar surroundings when current surroundings are unfamiliar to them, or even wander in terms of elopement from a facility (Halek & Bartholomeyczik, 2011). Regardless of wandering aimlessly or if the wandering is goal directed, if a resident with dementia is wandering

unattended there exists a higher potential for falls. As the residents in an AFH are 65 years of age and older, multiple comorbidities often accompany their diagnosis of dementia, which place them at greater risk for weakness, instability, weaker bones, and falls.

Ray, et al. (1997) examined the effects in four areas of patient safety that could reduce the incidence of falls. The randomized control study was conducted over the course of 1 year and included 14 nursing homes. The inclusion criteria consisted of residents older than 65 years of age with a length of stay anticipated to be over 6 months. The residents were required to be ambulatory, have experienced a fall in the last year, and have individual safety problems. The intervention team was comprised of nurses, occupational therapists, and psychiatrists. This team created individual treatment plans and evaluated the residents. The residents were then evaluated based on four criteria, which included environmental and personal safety; wheelchair maintenance and safety; psychotropic drug use; and transfer and ambulation.

The intervention team made recommendations for each resident and care was coordinated through a falls coordinator who worked with the intervention team, residents, residents' families, staff and administration (Ray et al., 2013). A series of three 45-minute in-service education sessions were held for all patients in each home. The results showed that the study group had a decrease in the number of falls over a 3-month period at 44% ($p = 0.03$) versus the 54% ($p = 0.03$) in the non-study group. Ray et al. (2013) concluded that through individual interventions in nursing homes, there was a significant reduction in recurrent falls in high-risk patients that were deemed a fall risk.

Simple nursing interventions that can be used by non-nursing staff include the use of bed-alarms, wheelchair alarms, and personal alarms that sound when the resident stands or moves far enough to trigger the alarm. This allows the caregiver advance notice to check on the resident and assist with ambulation, without restraining the resident. The potential benefit for implementation of such a guideline would be the increase in quality of life as well as improved mental and physical functioning of the elderly resident.

When providing residents' activities of daily living (ADLs) such as bathing, many physical, emotional, and environmental factors must be taken into account; tasks such as being undressed and washed by a stranger may be frightening and humiliating for many residents. Research has demonstrated that staff and caregivers need to be aware of these agitated behaviors and develop appropriate methods in alleviating such behaviors (Skovdahl, Kihlgren, & Kihlgren, 2003). The nursing care plan offers the resident the best opportunity to reduce fear and anxiety and to complete their ADLs. Appropriate training of the caregivers in the use of patient-centered care, gentle touch, and soft voice has improved behaviors during bathing activities (Walent, 2009).

This gentle approach, when combined with a complete history and physical, discovers what previous perceptions or ADL practices the resident previously had, and then incorporates this practice into a care plan. The ADLs are not just rituals that have to be completed, but rather they are resident-specific tasks that are necessary for health and wellness (AHRQ, 2012). The specifics of the care plan include providing the resident with choices such as a preference to time or day they prefer to participate in the ADLs. Ensuring resident privacy, simple directions, continuity of caregivers, adjusting time

schedules so as not to be rushed, as well as patience, sensitivity, and gentleness are all important components that can be trained to non-nursing staff. It is most important to encourage the resident to participate as much as they are able in their delivery of care (AHRQ, 2008).

Rapp et al. (2008) examined the effectiveness of a multifactorial fall prevention program in pre-specified subgroups of nursing home residents. The study was designed to measure the time to first fall and subsequent falls during a 12-month intervention period. Participants consisted of 725 long-term residents with a median age of 85, of whom 80% were female. The intervention included education of staff and residents on the importance of fall prevention, education on environmental changes to reduce falls, recommendations to wear hip protectors to reduce fractures, as well as progressive balance and resistance training. Univariate regression analysis was performed, including a confirmatory test of interaction. The study results demonstrated that the intervention was most effective in those residents with cognitive impairment (Rapp et al., 2008). The control group experienced a hazard ratio (HR) of 0.49 with a confidence interval of 95% (0.35-0.69) compared to those who were cognitively intact with a hazard ratio of 0.91 and a confidence interval of 95% (0.68-1.22), which is a statistically significant change. In the control group, residents with a history of falls HR was 0.47 with a 95% confidence interval of 0.33-0.67 and in those with no prior fall history the HR was 0.77 with a 95% confidence interval of 0.58-1.01. The residents with urinary incontinence had an HR of 0.59 with a 95% confidence interval of 0.45-0.77 versus no urinary incontinence HR of 0.98 and a 95% confidence interval 0.68-1.42. In residents with no mood problems, the

incidence rate ratio was 0.41 with a 95% confidence interval of 0.27-0.61 in those with mood problems, the incidence rate ratio was 0.74 and a 95% confidence interval of 0.51-1.09, which is statistically significant. Rapp et al. concluded that, between different subgroups of nursing home residents, the effectiveness of multifactorial fall prevention differed. The four factors studied that were important to the determination of the response included cognitive impairment, history of falls, urinary incontinence, and depressed mood, (Rapp et al., 2008).

Engel, Kiely, and Mitchell (2006) examined the factors associated with satisfaction with care for health care proxies (HCPs) of nursing home residents with advanced dementia. The study consisted of 148 nursing home residents age 65 and older with advanced dementia and their formally designated HCPs. This cross-sectional study measured the dependent variable of the HCP score on the Satisfaction With Care at the End of Life in Dementia (SWC-EOLD) scale (range 10-40; higher scores indicated greater satisfaction). The independent variables of the resident characteristics analyzed were demographic information, functional information, functional and cognitive status, comfort, tube feeding, and advanced care planning. HCP characteristics were demographic information, health status, mood, advanced care planning, and communication. To identify factors independently associated with higher SWC-EOLD scores, a multivariate stepwise linear regression was used. The results of the study showed the mean ages + standard deviation of the 148 residents and HCPs were 85 + 8.1 and 59.1 + 11.7. The mean SWC-EOLD score was 31.0 + 4.2. After multivariate adjustment, the variables identified that were independently associated with greater

satisfaction was the time spent discussing advance directives, if providers were spending more than 15 minutes discussing advance directives with the care provider at time of nursing home admission (parameter estimate = 2.39, 95% confidence interval (CI) = 1.16-3.61, $p < .001$), greater resident comfort (parameter estimate = 0.10,95% CI = 0.02-0.17,$p = .01$), care in specialized dementia unit (parameter estimate = 1.48, 95% CI = 0.25-2.71, $p = .02$), and no feeding tube (parameter estimate = 2.87, 95% CI = 0.46-5.25, $p = .02$). The researchers concluded that the following modifiable factors that may improve satisfaction with care in advanced dementia included better communication; greater resident comfort; no tube feeding; and specialized dementia care (Engel et al., 2006).

Nutrition is an area where residents try to maintain as much control as possible until physically unable to participate. Literature to support best practices for nutritional intake when it comes to dementia residents is limited. An estimation of the calorie and protein method by determination of the portion of their meal consumed is one of the ways to ensure that adequate nutrition is being maintained (Berrut et al., 2002).

Beck, Damkjaer, and Beyer (2008) examined the effect of an 11-week multifaceted intervention comprising nutrition, group exercise, and oral care would have on nutrition and function in nursing home residents older than 65 years of age. There were 121 subjects placed into the 11-week randomized controlled intervention study. The goal was to improve nutritional status and function in elderly nursing home residents. The interventions included providing chocolate and homemade oral supplements, implementing group exercise twice a week (45-60 minute, moderate intensity), and oral

care intervention one to two times a week. Follow up visit were made four months after the end of the intervention. Assessments evaluated included; weight; body mass index; dietary intake; handgrip strength; senior fitness test; Berg's Balance Scale and the prevalence of oral plaque. The study showed that 121 subjects accepted the invitation and 62 were randomized to the intervention group. Six of these dropped out during the 11 weeks. There were 15 deaths in the intervention group and eight in the control group at the four month follow-up. The nutrition and exercise were well tolerated. After 11 weeks the change in percentage of weight $p = 0.005$, percentage of body mass index $p = 0.003$, energy intake $p = 0.084$, protein intake $p = 0.012$ and Berg's Balance Scale $p = 0.004$ was higher in the intervention group than the control group. The percentage of subjects whose functional tests improved was higher in the intervention group. Both groups lost the same percentage of weight after the intervention $p = 0.908$. The total percentage of weight loss from baseline to follow-up was higher in the control group $p = 0.019$. Oral care was not well accepted and the prevalence of plaque did not change. The study concluded that it is possible to improve nutrition and function in elderly nursing home residents by means of a multifaceted intervention consisting of chocolate, homemade supplements, group exercise and oral care (Beck et al., 2008).

Smoliner et al. (2008) examined the effect of a 12-week nutritional intervention with fortified food on nutritional and functional status in nursing home residents at risk for malnutrition. There were 65 nursing home residents, which included 62 at nutritional risk, and three were severely malnourished, according to the Mini Nutritional Assessment. Body composition was measured with bioelectrical impedance analysis.

Functional status was assessed with handgrip strength, peak flow, the Barthel Index, and the Physical Functioning component of the Short Form 36 questionnaire. Residents were then assigned to a group receiving the standard food of the nursing home or group with a protein and energy enriched diet and snacks. The control group showed significantly higher protein intake, whereas energy intake did not differ from the group on the standard diet. Both groups significantly improved most nutritional and body composition parameters during the intervention period. No convincing improvements in muscle function were noted. All participants showed decline in the Barthel Index and the Physical Functioning component of the Short Form 36 questionnaire. The study concluded that the standard food in this nursing home provided sufficient energy and macronutrients. Additional snacks were not effective in increasing energy intake. Improvement of nutritional status did not correlate with improvement of functional status (Smoliner et al., 2008).

It has been projected that the number of Americans with dementia will exceed more than seven million by the year 2030 and rise to between 11 and 16 million by the year 2050 (Alzheimer's Association, 2015). Currently, no cure for dementia exists. The number of Americans with dementia continues to grow, and increasing attention to quality of life in dementia residents has taken place. The purpose of evaluating the resident and their quality of life lies in the ability to preserve the capabilities of the individual and help them to achieve quality of life regardless of cognitive status (Gitlin & Earland, 2010).

Dementia is a progressive disease state and is characterized by three different stages. In the early stages of dementia, the residents may require simple verbal cues and gestures of support to maintain a lifestyle that is acceptable to their quality of life. In the intermediate stages of dementia, more assistance and offers of accommodation may be required so as the resident maintains their preferred lifestyle. In late stages of dementia, the resident's quality of life is preserved through the use of honoring previous choices that were observed through previous interactions prior to progression of the disease (Gallo, Fulmer, Paveza, & Reichel, 2000).

Evaluation of residents' quality of life with the DEMQOL instrument measures five domains of quality of life: the positive affect, negative affect, feelings of belonging, self-esteem, and sense of aesthetics (Ready & Ott, 2003). This scale is unique as it is the only scale developed that is to be administered exclusively to patients. To establish reliability and validity, the scale was created through an interactive conceptual and statistical process which included expert panels made up of dementia patients, caregivers, professional care providers as well as an in depth literature review (Ready & Ott, 2003). This interactive group found 5 recurrent domains that adequately represented quality of life. The use of a 5-point visual scale is useful in dementia residents as it is similar to a multiple choice. The questions on this scale are asked with descriptors, which helps the resident to understand and answer accurately. The scale was tested on 99 patients diagnosed with mild to moderate dementia. The internal consistency reliabilities were moderate to high at 0.67 to 0.89 with a median score of 0.80 (Ready & Ott, 2003). When

comparing mild to moderate dementia residents, no significant differences were noted in terms of scale reliability.

Summary

Residents in the AFH are at increased risk of not being able to communicate their needs effectively. This in turn, can result in a reduction of quality of life as their individual needs may not be respected. The use of an individualized nursing care plan to address specific needs for the resident, used in conjunction with the DEMQOL screening can provide improved quality of life for the residents in this setting.

Section 3: Collection and Analysis of Evidence

Approach

The purpose of this quality improvement project is to develop policy and practice guidelines and pilot protocols for the implementation of nursing care plans. DEMQOL screening for the improvement of quality of life for residents in the AFH was used to evaluate the starting point on admission and the impact of policy and practice guidelines on the patient with dementia in the specialty AFH. This section outlines how the project accomplished these development activities using the following steps:

- Assemble an interdisciplinary project team of stakeholders
- Review relevant literature and evidence
- Develop policy documentation and practice guidelines for use of the care plan and DEMQOL screening
- Develop implementation plan
- Develop evaluation plan
- Project Design/Methods

When reviewing the goals of this project, the use of quantitative and qualitative designs was considered. The DEMQOL screening tool uses a quantitative design to show if the resident experienced change. The registered nurse and caregiver evaluation tool was used to show qualitative changes. The combination of the two techniques allows a greater understanding of the experience for the residents involved. The use of the screening tools allows the project leader and the caregivers to gain insight into how the residents feel about their quality of care that they receive.

Interdisciplinary Project Team

As AFHs are usually owned individually and operated by the owner with additional staff, the team will be comprised of the owner, contracted registered nurse assessor, and any additional staff. The registered nurse was called on for knowledge, skills, and expertise in health care. As the team leader and writer of this project, I functioned as the facilitator of the team. The owner and additional staff members were utilized as having more daily interaction with the residents and were present for the implementation of care. Each member brings skills and knowledge to the team and helped to identify additional solutions, which would provide greater success to the project. The team met twice a week for the first 2 weeks in preparation for how the project would proceed, and then once a week thereafter. Once the team was educated in the purpose of the project and how to view the results, the project continued to move forward.

The literary review for the project was explained to the owner, registered nurse, as well as the caregivers. Once full understanding was indicated at the end of 2 weeks, the project proceeded forward. The team was instructed in use of the DEMQOL screening tool and the individualization of nursing care plans for the three areas that we were monitoring, which consisted of risk of falls, self-care deficit, and nutritional imbalance (less than body requirements). The registered nurse and caregiver evaluation forms were explained to the interdisciplinary team along with the importance of filling them out correctly.

Once the project was approved to proceed, and the preceptor and interdisciplinary team were ready, the DEMQOL screening tool was administered and, based on the information, the care plans were then modified. At the end of 2 weeks, the DEMQOL screening tool was once again administered and evaluated as well as the registered nurse and caregiver sheets completed. As the project leader, I then took the data and then analyzed them to determine if the nursing care plans did provide improvement in the quality of life for residents residing in an AFH.

Population and Sampling

The target population for this project included adult residents age 65 years or older with dementia living in an AFH with a dementia designation. The targeted number of participants was six, but due to exclusion criteria, only one resident met the requirements for the project.

Inclusion Criteria

- Adults age 65 years or older
- Mild to moderate dementia
- Male or female
- Living in an AFH in Washington State
- May include chronic illnesses

Exclusion Criteria

- Severe dementia
- Younger than 65 years of age
- Not living in an AFH in Washington State

- Unable to speak

Of the six residents who resided in the AFH at the time of data collection for this DNP project, only one qualified for inclusion into this practice improvement project. Five of the residents had severe dementia and no longer qualified for the DEMQOL testing of the practice improvement project. The data were collected by the DNP preceptor, but I was able to use them for the purpose of this practice improvement project. Data were reviewed under the oversight of a qualified preceptor at the AFH facility.

Review Evidence

It is important that a quality improvement project take into consideration the mission of the organization. The project has been tailored to meet the organizational values of caring, compassion, and companionship. Each member of the team has expressed interest in the project aligning with the mission of the organization as well as evidence-based practices. This interdisciplinary team was assembled at the AFH, which is located in Kennewick, Washington. The organization has a capacity for six beds, was originally founded in 1995, and is one of many AFHs serving the Tri City area. This organization collaborates with other SNFs, ALFs, and many geriatric physicians to provide appropriate placement for residents.

Existing Literature and Literature Strengths

I searched the following online databases for relevant articles between 2002 and 2013: Academic Search Complete, MEDLINE, PubMed, CINAHL Plus, and PsycINFO. After a literature review, it was apparent that quality of life in dementia residents continues to be an ongoing issue with limited research present. Taking a holistic approach

to residents of an AFH with individualized nursing care plans and health promotion activities will help to improve resident quality of life (Gillespie et al., 2007). The literature also reinforced that nursing care plans are a scientific problem solving method that is used to identify actual and potential problems with residents, and such a method uses a logical and systematic way of resolving these problems (Aydin & Akansel, 2013). One may conclude that developing a standardized nursing assessment with individualized nursing care plans will improve resident's quality of life.

Literature Weaknesses

The major limitation of this project was the lack of information that was specific to the AFH setting. AFHs are a unique living environment that allows the residents to live in a homelike setting with limited nursing monitoring. Another weakness noted in the literature was that all other studies had substantially larger numbers of subjects that were studied. The AFH setting is licensed to house no more than six residents. There are various levels of dementia present, which is an exclusion factor for quality of life assessments that were found.

Project Design

After considering the purpose of the project, a generic quantitative design was used. While there are many qualitative components that were discovered, the quantitative results obtained will attempt to quantify quality of life in the patient with dementia. The reason for selecting this project design was because it allowed me to gain further insight to what not only the resident reported, but how the caregivers and AFH owner reported about the interventions that led to improvements in the residents' quality of life.

Data Collection

The data collection method was the use of DEMQOL screening initially, then the use of individualized nursing care plans initiated and implemented. After 2 weeks of using the nursing care plans, the DEMQOL assessment was completed and the caregiver and registered nurse evaluation tool completed. All data were under the oversight of the preceptor. These data were collected for the sole purpose of completing the DNP project. The information was neither gathered nor intended for any other purposes than what has been mentioned. The evaluation tools were completed by five caregivers and one registered nurse who were employed by the organization. The information was used by the site and information shared with the project owner.

Protection of Human Subjects

Approval from the Institutional Review Board (IRB), number 11-18-14-0318717was obtained in order to conduct research involving human subjects. No risk or discomfort was involved in the collection of the data. All forms and evaluations were provided via the facility registered nurse and/or preceptor. Consent to participate in this project was obtained from the resident or power of attorney during admission to the facility. It is possible that the partners from whom data are sought do not adequately depersonalize data. However, before data were obtained, data de-identification expectations were confirmed.

Data Analysis

Data analysis consisted of evaluation of the DEMQOL scores prior to any nursing care plan initiation. After the individualization of the nursing care plans, the DEMQOL

assessment was once again administered, looking for improvement or worsening of scores. The caregiver and registered nurse evaluation tools in Appendix B were used to add credibility to and confirmability to the project. Themes of self-improvement were noted by the registered nurse and caregivers. The DEMQOL tool administered by the one registered nurse was based on a 4-point satisfaction scale for quality of life assessment. The four responses were *a lot* (4), *quite a bit* (3), *a little* (2), and *not at all* (1). Although internal consistency reliability was not tested for this project, the scale itself has been found to be internally consistent (α = .48 to .79) (Smith et al., 2005). The findings of this project showed that the participant was able to show improvement in their quality of life through the interventions. The one resident who did qualify for evaluation of the project had a Mini Mental Status Exam of 18, which indicated that the resident suffered from moderate dementia and could be scored on the DEMQOL scale. Once screened for moderate dementia, the resident was then provided the DEMQOL instrument and individualized nursing care plans were completed. The DEMQOL initial score was 56, which indicated the resident's quality of life was impacted negatively. Through the use of implemented care plans, the residents' 2-week follow-up DEMQOL score showed an increase to 84 points, indicating a significant improvement in the quality of life.

The one registered nurse and five caregivers initially completed the caregiver and registered nurse evaluation tools and then repeated them at the end of the 2-week evaluation period. The four responses were *not at all* (1), *only a little* (2), *some* (3), and *a great deal* (4) The evaluation tool results were totaled across the six respondents on the seven questions on the tool and then averaged. The initial score of all six employees

averaged 18 points. At the end of 2 weeks, the average scores of the six employees demonstrated significant improvement by the score increasing to 25, which demonstrated that customized care plans had the potential to improve the residents' quality of life. The caregivers' additional comments on the forms reported the resident stating "feelings of safety and security," "feeling better about themselves," and, "feeling cared for." All reports indicated improvement in the resident's quality of life.

The care plan implemented that contributed to the improved quality of life consisted of nursing interventions for risk of falls, self-care deficit, and nutrition imbalance: less than body requirements. The caregiver and registered nurse reported improvement in fine motor skills, gross motor skills, dressing, eating, and orientation. Much of the improvement was reported as a result of greater resident interaction and participation. Both caregivers and the registered nurse identified the resident as having a greater awareness and increased interest in caring for themselves. Allowing additional time and not rushing the resident appeared to have the greatest impact on improving the scores. The area that showed no impact was Question 5, which addressed an improvement in instrumental activities such as using a telephone book, dialing a telephone, understanding a medication label, opening a medication, or following a simple recipe. As the resident in the AFH is provided with assistance with medication, cooking, and all ADLs as needed, the resident did not appear to have any improvement in these areas.

Section 4: Findings and Recommendations

Findings

Policies and procedures were developed to ensure that a standardized assessment was completed on the resident at the time of admission. This assessment was then utilized to identify areas where nursing care plans and interventions could be implemented. Once the needs of the resident had been identified and the care plan created, the care plan was taught to all caregivers of the facility. The caregivers and registered nurse were then responsible for the ongoing monitoring of the resident, and the registered nurse will continue to make appropriate adjustments of the care plan based on the needs of the resident and do so monthly. Updates to the residents care plans will continue to be communicated to each caregiver at the time of implementation.

While the monthly monitoring of the policies and procedures fall outside of the timeline of this DNP project, a 2-week evaluation of the original assessment, reassessment, and the caregiver and registered nurse evaluation tool was conducted. The results were disseminated to the DNP preceptor, the caregivers, and registered nurse. While each group reported they saw value for the residents, ultimately my preceptor chose not to continue forward with the project past my 2-week implementation and evaluation. The policies and procedures for initial screening prior to admission continue to be in place as these are the regulations for the State of Washington. The use of the DEMQOL tool as well as the caregiver and registered nurse screening tools were discontinued; although it did have value for the residents, the company already felt overly governed and burdened with required forms and screening tools that are mandated by

Washington State Department of Health. While the care plans can be replicated for other residents in the future, care must be taken to ensure that they are individualized to meet the needs of the resident. It is this individualization that will add to the residents' quality of life experience.

As the resident was older than 65 years of age and had cognitive changes due to dementia, the resident was already classified as a fall risk. The individualized actions in the care plan were the use of a personal call alarm that would notify caregivers if the resident is attempting to stand. Motion sensors are utilized in the nighttime to ensure that if the resident places their legs over the side of the bed, then the night staff will be notified. The resident was toileted and repositioned every 2 hours to help reduce impulses to stand on their own. Daily activities were included to help stimulate the resident's psychological and physical needs to prevent impulses to walk without assistance. The resident was able to express a sense of safety, security, and well-being knowing that assistance was available 24 hours a day. This was a recurrent theme expressed through the registered nurse and caregiver evaluation tool. The resident expressed more confidence in themselves knowing assistance was available and reported less worrying about incontinence fears, which caused a great deal of stress and concern.

The registered nurse is responsible for evaluation of medications that place the resident at a higher risk for a fall. After evaluation of the medications, a discussion with the medical prescriber as to the necessity of the medication to ensure the benefit outweighs the risk is completed and any necessary changes are implemented. The registered nurse assesses the resident on a monthly basis making sure to notice any

decline in physical activity or general deconditioning that may place this resident at greater risk for falls. Care plans are then modified as needed to ensure the resident has adequate nutrition and physical activity to maintain strength, or proper referrals are implemented such as to physical therapy for reconditioning.

The next care plan addressed the resident's needs regarding self-care deficit. The resident was able to choose the time of day in which they preferred to bathe. This happened to coincide with the time and days of the week that a particular caregiver was present. This therapeutic relationship allowed the resident to not be frightened or humiliated by being undressed and assisted to bathe by a stranger. Privacy was assured and the resident was assisted in washing the areas that would not have been washed if no assistance was available. The continuity of the shower schedule and the same staff allowed the patient to not feel rushed and to participate in self-care. The themes discovered with the registered nurse and caregiver evaluation tool reported an overwhelming feeling of confidence and reassurance by the resident. The resident reported feeling able to meet all hygiene needs in a supportive environment. Instead of being rushed, the resident was able to enjoy the self-participation of care. Improvement in fine and gross motor skills as well as dressing was reported by the caregiver and registered nurse evaluation tool. The resident wanted to remain independent, and with allowing adequate time, proper verbal cues, and encouragement, the resident was able to demonstrate significant improvement within the 10-day period. The resident's self-report indicated satisfaction as a result of participating in ADLs without being rushed.

Once again, the resident was toileted and repositioned every 2 hours or as needed to prevent incontinence, or to prevent skin breakdown if incontinence had occurred. The resident was encouraged to ask for help in standing and ambulating. Stand by assist or the use of a gait belt helped the resident to maintain as much independence as possible. The resident is not rushed, but the priority of the day is for events to revolve around the speed and desires of the resident. Prior to admission into the AFH setting, the resident had an advanced directive, which outlined aspects of care they wished to be carried out. This care was respected and carried forth on a daily basis per the resident's wishes. The theme from the registered nurse and caregiver evaluation tool was one of less stress and anxiety. The resident expressed incontinence fear as aging took place. While occasional stress incontinence continued to occur, the resident knew that a toileting schedule was in place and that the call button was available and reported feeling confident that appropriate attention was being received. Overall health and wellness was frequently expressed by the resident in ensuring her basic activities of daily living were being met.

The last care plan that was initiated was nutritional deficit: less than body requirements. The resident's power of attorney or closest family member assisted with ensuring that the resident had a variety of foods they enjoyed. The meal times were standard with breakfast starting at 7 a.m., lunch at 12 p.m., and dinner at 5 p.m. The resident had the opportunity to choose what they wanted for breakfast each morning. Lunch and dinner were comprised of a weekly menu that alternates every 6 weeks. There is always the opportunity for a sandwich, or other dish if the meal is not to the resident's liking. The resident also has the ability to request a specific meal be prepared. To ensure

that adequate caloric intake was achieved, snacks were offered between breakfast and lunch, lunch and dinner, and before bedtime.

Staff is encouraged to sit at the dining room table and enjoy the same meal as the residents. Mealtime is encouraged to be a social interaction where the resident can sit and interact with peers and staff. Verbal cues and encouragement are used to assist the resident in eating. Being present during meals allows the staff to monitor if the resident likes the meal or to offer an alternative immediately rather than have the resident wait until the next meal. Physical activity is offered daily to help provide physical stimulation and support a healthy appetite. The resident is weighed monthly to monitor for any weight loss due to nutritional deficit. The registered nurse and caregiver evaluation tool was able to reflect comfort and reassurance for this resident. As a stable body mass index is already present, and no weight loss or gain prevented feelings of sadness or irritability. The resident reported enjoying the staff sitting at the dining room table and eating with the resident. The socialization prevented fears of being lonely and not having anyone to talk to. The caregiver and registered nurse evaluation tool demonstrated improvement with eating skills by allowing the resident to choose what they wanted to eat. The resident was able to demonstrate appropriate dexterity with eating utensils, as well as using the correct utensil for the correct food. The social interaction of the caregivers demonstrated improvement with orientation of time and date by writing on a menu board so that the resident could read the menu, date, and time of each meal. This theme resonated with each of the caregivers as well as the registered nurse.

The specific nursing care plan and interventions, once implemented, were able to show an improvement in the resident quality of life. Many reoccurring themes presented themselves within the registered nurse and caregiver evaluation tools, which were previously mentioned. These themes were consistent with the DEMQOL screening tool, which worked well in combination to discover what made an impact in the resident's quality of life.

Strengths and Limitations

A major strength of this project is that it has identified the need for further research specific to the AFH setting. Previous research has been completed in larger SNFs, which do not necessarily have the generalizability for the AFH setting. The major limitation of the project was the limited number of participants of the project. If all six residents were qualified for the project, the number would continue to be small. While this is generalizable to other AFH settings, the results are not statistically significant.

Implications

Based on the findings of the project, it appeared that small nursing interventions can offer big gains in the quality of life for dementia residents who reside in AFHs. The caregivers should focus on having the registered nurse provide changes to the care plans that coincide with the needs of the resident. This project provides insight to the overlooked populations that reside in alternative living environments. It is important to acknowledge that not all AFHs are owned and operated by a registered nurse. Therefore, implementing a standardized teaching approach for each home may prove to be challenging yet rewarding to those who reside in such an environment.

Section 5: Dissemination Plan

Dissemination

Dissemination of this project to the facility for higher education is through the use of discussion and a PowerPoint presentation. This has the greatest opportunity to capture as many important faculty members and students who may be interested in the very nature of this project. The same dissemination techniques will be used to capture important leaders who are in charge of governing and licensing of AFHs in Washington State. The very nature of this project should be of great concern and interest to local heads of the Department of Social and Health Services in Yakima, who currently oversee the AFH owned and operated by my preceptor. A greater role would include bringing this information to the state government, who have already developed a task force to help explore many other issues that concern AFHs.

Meaningful information such as my project has discovered would be important to discuss with local nursing programs, at which I have provided supplemental lectures in the past. These lectures have the opportunity to capture approximately 50 new nursing students at a time. During this stage of nursing training and development, this information would be most crucial to embody the care, compassion, companionship, and holistic approach that nurses offer their patients every day.

Analysis of Self

As a scholar, I am able to truly appreciate the role of the DNP prepared nurse in scholarship through demonstrating the ability to evaluate evidence-based practice, generate new information to guide clinical practice, and integrate new knowledge.

Through this educational journey, I have had the opportunity to grow as a clinician and a scholar. I have enhanced my ability to select a health-related problem and to analyze the facts, concepts, and theories to predict new outcomes for the improvement and enhancement of the delivery of health care. I have grown in the discovery of problems related to the delivery of health care and have been able to identify new solutions to enhance health promotion.

As a practitioner of health care, I have grown a deeper understanding for the complexities that are involved with the identification and implementation of evidence-based changes. The development of new knowledge is very challenging and care must be taken to ensure that new knowledge is based in facts and research.

Project Developer

As a project developer and academic scholar, my DNP project proposal went through a step-by-step evaluation process with multiple revisions. Through my committee I was able to receive feedback, which helped to strengthen my understanding of the research process. The DNP program taught me the importance of establishing a timeline and planning for unforeseen events. The IRB was instrumental in preparing me for future research. The DNP journey has been a self-fulfilling and rewarding experience for my personal and professional growth. This project has allowed me to challenge myself and to overcome obstacles in ways I would not have thought possible. The doctoral component of my education has opened possibilities that I have yet to discover for myself.

Conclusion

Adult residents age 65 years and older living in an AFH do show an improvement in their quality of life with the use of individualized nursing care plans. Despite the small sample size of this project, it is most representative of the typical AFH in Washington State.

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Washington Administrative Code 388-76-10000 through 388-76-11085

Washington Administrative Code 388-76-10330 through 388-76-10350

Washington Administrative Code 388-76-10620 through 388-76-10645

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Appendix A: DEMQOL and DEMQOL Proxy-Interviewer Manual

This information is provided as a public service by the Government of British Columbia, Box 9411, Victoria, British Columbia, Canada V8W 9V1**.**

Instructions for administration:
You will need a copy of the DEMQOL questionnaire for each interviewee and a separate card with the response scales printed large scale.

1. Introducing the questionnaire:
Ensure that the person with dementia/carer is comfortable and happy to participate

1.2 If the carer is also present during the interview with the person with dementia, explain that it is the person with dementia's feelings and understandings that you are interested in. Reiterate that there are no right or wrong answers.

1.3 Explain that you are interested in how people feel about things that happen everyday. Explain that you will ask some questions, for example about the activities that people do during a day, how they feel, their relationships.

1.4 Show the person with dementia/carer the response card and encourage the patient to hold it if appropriate.

1.5 Read verbatim the instructions on the front of the questionnaire.

1.6 Read aloud the practice question. Point to each response option on the response card as it is said. Ask the person with dementia/carer to either say or point to the response he or she has chosen. Probe the response using the suggested probe questions to check whether the respondent has understood the question. If the practice question is successfully completed then continue with the rest of the questionnaire. If the person with dementia/carer cannot complete the practice question, then attempt the first five questions. If the person with dementia/carer is still struggling, suggest that you take a break for 10 minutes. When the interview is resumed start at the top of the next section. If the person with dementia/carer is still struggling after 5 questions then stop the interview.

1.7 If the person with dementia/carer successfully completes the practice question, but cannot do the questions in the first section of the questionnaire then, attempt the first five questions. If the person with dementia/carer is still struggling, suggest that you take a break for 10 minutes. When the interview is resumed start at the top of the next section. If the person with dementia/carer is still struggling after 5 questions then stop the interview.

2. Administering the questionnaire items:

2.1 Read each question exactly as it is written. If there is an example in the question, this must always be read too. Read aloud each response option, pointing to each response as you say it.

2.2 When the person with dementia/carer has indicated his or her response, mark it on the questionnaire. Mark only one response for each question. If the patient does not or cannot answer an item (for any reason), record the response as missing.

2.3 Try not to prompt with the phrase "so that doesn't worry you at all? " as this encourages a yes/no answer. Instead use the phrase "how much does that worry you?" and repeat the four response options.

2.4 For each question read both the stem and the item content. If the person has difficulty with an item repeat both the stem and the item verbatim. If they still have difficulty then repeat second part of the stem (ie "..are you worried about") and the item content.

2.5 At the end of the interview go back to any missed items and if appropriate ask the person with dementia/carer to complete them.

3. De-briefing after the interview:

3.1 Explain that all the questions have now been answered.

3.2 Ask whether person with dementia/carer has any questions that he or she would like to ask. Answer any questions and thank the person with dementia/carer for taking part

4. Possible queries and responses - general:

4.1 doesn't want to complete the questionnaire
Tell the person with dementia/carer that participation is entirely voluntary. They are being asked to complete the questionnaire because it will help us to understand more about what people think is important for quality of life. If they still do not want to participate stop the interview and thank the person with dementia/carer.

4.2 stops completing the questionnaire because he/she does not understand
Specific prompts for not understanding or querying are given on the next page. In general if the person with dementia/carer does not understand a particular question, reread it verbatim, but do not re-phrase the question. If the person with dementia/carer does not understand the response options, re-read the response options verbatim but do not re-

phrase them. The question and the response options can be re-read as many times as is necessary, but if it is clear that the patient or carer does not understand then do not continue

4.3 is concerned that someone will look at his/her answers
Reassure the patient/carer that all of his/her responses will be kept confidential to the research team. Explain that names will be replaced by a study number so that the questionnaires are completely confidential.

4.4 asks you to interpret a question
Specific prompts for not understanding or querying are given on the next page. In general re-read the item verbatim. Do not try to explain an item. Suggest that the person with dementia/carer base his/her answer on what he/she thinks the question means. Rephrasing or interpreting a question can bias results. It is very important that the questions are read verbatim and only the standard prompts are used (see specific prompts given on next page).

4.5 answers "don't know" or wants to miss out a question
Acknowledge that it can be hard to choose a response, but encourage the patient/carer to choose the response option that most applies to him/her. If a patient/carer wants to miss out an item, explain to the patient/carer that all the questions are very important. They should try to answer all of the questions. If the patient/carer still does not want to answer a particular item, assure the patient that it is alright, then go on to the next item.

4.6 wants to know the meaning of his/her answers
Tell the patient/carer that all information is helpful and that there are no right or wrong answers. Remind the patient/carer that all the information is kept confidential and that we will look at what everybody says rather than anybody's questionnaire on its own.

4.7 asks why both patient and carer must complete the questionnaire
Explain that sometimes patients and carers have a different view. Both are useful and by asking questions to both carer and patient we can get a more complete picture of how people feel.

5. Possible queries and responses – specific:

5.1 if person answers simply "yes" instead of choosing one of the four response options: repeat the response options and ask him/her to choose one if still say "yes", ask him/her to choose from one of the three positive response options (ie a lot, quite a bit or a little) and record the one that they choose if still not clear which response option he/she means, repeat the three positive options again and record the one that he/she chooses if the person says two positive response options ask them to choose one and record it if necessary repeat the question verbatim

5.2 if person answers simply “no” instead of choosing one of the four response options: repeat the response options and ask him/her to choose if the person still just says “no” check with him/her if that would be “not at all” if necessary repeat the question verbatim

5.3 if person responds using their own phrase or form of words that is not one of the response options: repeat the question and the response options verbatim and ask them to choose one of the response options if they still don’t use one of the response options but are answering in a way that is relevant to the question, reiterate that they need to choose one of the four response options if they still don’t choose one of the response options, then accept their answer, but don’t score it, mark the questionnaire as missing and move on to the next questions

5.4 if person responds using the phrase “not a lot”: ask if they mean “a little” or “not at all” and record the answer given if the person is unable to choose between these two options then accept their response but don’t score it. Record the item as missing and allocate the appropriate code. Move on to the next question.

DEMQOL (version 4)

Instructions: Read each of the following questions verbatim and show the respondent the response card. I would like to ask you about your life. There are no right or wrong answers. Just give the answer that best describes how you have felt in the last week. Don’t worry if some questions appear not to apply to you. We have to ask the same questions of everybody.

Before we start we’ll do a practice question; that’s one that doesn’t count. (Show the response card and ask respondent to say or point to the answer) In the last week, how much have you enjoyed watching television? a lot quite a bit a little not at all
Follow up with a prompt question: Why is that? or Tell me a bit more about that.

For all of the questions I’m going to ask you, I want you to think about the last week.

First I’m going to ask about your feelings. In the last week, have you felt…….
1. cheerful? ** __a lot __quite a bit __a little __not at all
2. worried or anxious? __a lot __quite a bit __a little __not at all
3. that you are enjoying life? ** __a lot __quite a bit __a little __not at all
4. frustrated? __a lot __quite a bit __a little __not at all
5. confident? ** __a lot __quite a bit __a little __not at all
6. full of energy? ** __a lot __quite a bit __a little __not at all
7. sad? __a lot __quite a bit __a little __not at all
8. lonely? __a lot __quite a bit __a little __not at all
9. distressed? __a lot __quite a bit __a little __not at all
10. lively? ** __a lot __quite a bit __a little __not at all

11. irritable? __a lot __quite a bit __a little __not at all
12. fed-up? __a lot __quite a bit __a little __not at all
13. that there are things that you wanted to do but couldn't? __a lot __quite a bit __a little __not at all

Next, I'm going to ask you about your memory. In the last week, how worried have you been about…….
14. forgetting things that
happened recently? __a lot __quite a bit __a little __not at all
15. forgetting who people are? __a lot __quite a bit __a little __not at all
16. forgetting what day it is? __a lot __quite a bit __a little __not at all
17. your thoughts being muddled? __a lot __quite a bit __a little __not at all
18. difficulty making decisions? __a lot __quite a bit __a little __not at all
19. poor concentration? __a lot __quite a bit __a little __not at all

Now, I'm going to ask you about your everyday life. In the last week, how worried have you been about…….
20. not having enough company? __a lot __quite a bit __a little __not at all
21. how you get on with people
close to you? __a lot __quite a bit __a little __not at all
22. getting the affection that
you want? __a lot __quite a bit __a little __not at all
23. people not listening to you? __a lot __quite a bit __a little __not at all
24. making yourself understood? __a lot __quite a bit __a little __not at all
25. getting help when you need it? __a lot __quite a bit __a little __not at all
26. getting to the toilet in time? __a lot __quite a bit __a little __not at all
27. how you feel in yourself? __a lot __quite a bit __a little __not at all
28. your health overall? __a lot __quite a bit __a little __not at all

We've already talked about lots of things: your feelings, memory and everyday life. Thinking about all of these things in the last week, how would you rate…….
29. your quality of life overall? ** __very good __good __fair __poor
** items that need to be reversed before scoring

Appendix B: Caregiver and Registered Nurse Evaluation Tool

During the last 10 days have you encountered the resident….

Q1. Improve fine motor skills such as picking up coins, folding letters, or using a key in a lock?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents functional capacity. If so, can you provide some examples?

_____
_____
_____
_____

Q2. Improve in gross motor skills such as standing from sitting, opening and walking through a door, regular gait, tandem gait, or transferring an object across the room?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents falls risk. If so, can you provide some examples?

_____
_____
_____
_____

Q3. Improve in dressing skills?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents functional capacity. If so, can you provide some examples?

_____
_____
_____
_____

Q4. Improve in eating skills such as drinking from a glass, transferring food with a spoon, cutting with fork and knife, transfer food with fork or transfer liquid with a spoon?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents dietary needs. If so, can you provide some examples?

_____
_____
_____
_____

Q5. Improve in instrumental activities such as using a telephone book, dialing a telephone, understanding a medication label, opening a medication container, or following a simple recipe?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents functional capacity. If so, can you provide some examples?

_____
_____
_____
_____

Q6. Improve in dressing skills such as putting on a shirt, buttoning a shirt, putting on a jacket, ties shoelaces or putting on gloves?

- Not at all
- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents functional capacity. If so, can you provide some examples?

_____
_____
_____
_____

Q7. Improve in time and orientation such as stating the time on a clock, locating the current date on the calendar, correctly reading the calendar?

- Not at all

- Only a little
- Some
- A great deal

Tell me if, in your view, what the impact was (if any) of the training program on the residents functional capacity. If so, can you provide some examples?

_____
_____
_____
_____