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*School of Occupational Therapy*

Quality of Life for Individuals with Dementia within Long-Term Care: The Role of Occupational  
Therapy

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A capstone project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

Under the direction of the faculty capstone advisor:

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# A Capstone Project Entitled

Quality of Life for Individuals with Dementia within Long-Term Care: The Role of Occupational Therapy

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

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Quality of Life for Individuals with Dementia within Long-Term Care: The Role of Occupational  
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### **Abstract**

Long-term care facilities provide care to older adults, including individuals with dementia, and promote client-centered care through maximizing functional independence and cultivating one's quality of life (Moyle, Fetherstonhaugh, Greben & Beattie, 2015). Throughout the doctoral capstone experience (DCE), an occupational therapy (OT) student from the University of Indianapolis promoted the OT profession through the creation and implementation of an educational program for staff and therapists at University Heights Health and Living facility. A self-created needs assessment was conducted to evaluate existing knowledge of staff and therapists regarding dementia and quality of life. The DCE student utilized needs assessment results and evidence-based literature to develop the educational in-service and handout for staff and therapists. At the beginning of the educational program, participants completed a self-developed pre-survey. At the conclusion of the program presentation, the self-developed post-survey was administered to the participants to determine the effectiveness of the educational program, handout, and provide supplemental comments for future program improvement. Overall, staff and therapists self-reported ratings on their knowledge regarding dementia, quality of life and dementia staging improved after participating in the educational program. Both therapists and staff ratings of their self-perceived confidence with providing care for individuals with dementia increased as well. The Goal Attainment Scale (GAS) was utilized to appraise the outcome of the educational in-service and handout, which both exceeded the expected level of outcome. Overall, the results demonstrate the educational program and handout were successful and would be advantageous to continue to provide for therapists and staff at University Heights Health and Living facility.

## Quality of Life for Individuals with Dementia within Long-Term Care: The Role of Occupational Therapy

### **Literature Review**

Nearly 5.7 million individuals in America are currently living with Alzheimer's disease or some form of dementia, and this number is projected to grow to almost 14 million by the year 2050 (Alzheimer's Association, 2018). It is a common misconception that dementia is an aspect of normal aging (Butcher, 2018; World Health Organization [WHO], 2017). In reality, dementia is a progressive condition often characterized by various symptoms, including memory deficits, difficulty expressively communicating, as well as a reduction in one's functional skills utilized to complete activities of daily living (ADLs) (Butcher, 2018; Dooley & Hinojosa, 2004; Maki & Endo, 2018; Ojagbemi & Owolabi, 2017; WHO, 2017). Individuals with dementia may also experience disruptions in their sleep patterns and an increased difficulty with emotional regulation (Butcher, 2018; Maki & Endo, 2018). Agitation is often a symptom of dementia as a result of distress from an individual's needs not being met (Butcher, 2018). Unfortunately, there is no cure for dementia and as a result it has increasingly become a global concern (Butcher, 2018; Garcia et al., 2012; Klapwijk, Caljouw, Pieper, van der Steen & Achterberg, 2016; WHO, 2017).

### **Long-term Care**

Researchers have found that approximately half of individuals that reside in long-term care facilities possess a diagnosis of dementia and this number will continue to increase (Crespo, Hornillos & de Quirós, 2013; Harris-Kojetin et al., 2016; Moyle, Fetherstonhaugh, Greben & Beattie, 2015). The simultaneous physical and psychological decline associated with dementia are influential factors that accelerate the transition of individuals with dementia from the

community to a long-term care facility, due to the need of an increased level of care (Harris-Kojetin et al., 2016; Klapwijk et al., 2016; Moyle et al., 2015). Behavioral problems, such as aggression and wandering, are often factors used to determine whether an individual should be placed in long-term care facilities (Garcia et al., 2012). Transitioning from the community to long-term care can be difficult for individuals with dementia. This process may feel like a loss of choice, leading to separation between an individual with dementia and their loved ones, and decreasing their sense of social support. (Moyle et al., 2015; Watt & Konnert, 2007). Moyle and colleagues also noted individuals with dementia living in long-term care had an increased risk for loneliness and isolation (2015).

As an effort to reduce loneliness and isolation, long-term care facilities promote person-centered care as an approach to provide gold-standard quality care (Butcher, 2018; Moyle et al., 2015). However, Moyle and colleagues disclosed when staff are addressing challenging behaviors of an individual with dementia, care is often underlined by competence and safety, rather than the wishes and necessities of the individual at hand (2015). As a result, individuals with dementia whose wishes and necessities are not being met will often experience a decreased quality of life (Kane et al., 2003; Naylor et al., 2016).

### **Quality of Life**

Despite the lack of research conducted on quality of life in long-term care, this broad, all-encompassing construct is becoming a prevalent topic within the world of healthcare, emphasizing patient respect and improved quality care (Kane et al., 2003; Moyle et al., 2015). Quality of life is a multifaceted subject determined by one's perception of their life relative to their ambitions, intentions, and apprehensions, as well as the context and environment in which they reside (Klapwijk et al., 2016). However, the physical aspects often have a stronger

emphasis within intervention compared to other aspects, resulting in an imbalance and overall negatively impacting one's quality of life (Beerens et al., 2016; Lee, Cheng, Lin, Liao & Chen, 2018; Watt & Konnert, 2007).

Cultivating and preserving the quality of life of individuals with dementia is critical (Klapwijk et al., 2016; Moyle et al., 2015). In order to do so, there are many influences to consider. An individual's emotional state or mood is a significant contributing factor to fluctuations in perceived quality of life (Crespo et al., 2013; Lee et al., 2018; Naylor et al., 2016). For individuals with dementia, a depressed mood can be associated with not only an increase in physical dependence, but also a prevalence of negative behaviors (Crespo et al., 2013). Encouraging individuals with dementia to actively engage in daily activities, such as self-care, social participation and leisure, can improve an individual's mood resulting in an increased quality of life (Beerens et al., 2016; Dooley & Hinojosa, 2004; Moyle et al., 2015).

Although quality of life is influenced by many factors, assessment is feasible, but unfortunately, it is not always conducted in a comprehensive manner (Crespo et al., 2013; Klapwijk et al., 2016; Lee et al., 2018; Moyle et al., 2015). Standardized assessments usually do not account for a holistic view of one's perceived quality of life, whereas a structured interview may provide additional beneficial information (Kane et al., 2003). Oftentimes, it is overlooked that individuals with dementia can accurately express what factors may be hindering their quality of life (Crespo et al., 2013; Moyle et al., 2015). Researchers have found that relatives and caregivers of individuals with dementia have a perceived understanding that quality of life is impacted considerably by the level of functional impairment of the patient and often caregivers report a lower rating than the self-rating of the individual with dementia (Crespo et al., 2013; Klapwijk et al., 2016; Moyle et al., 2015).

### **Caregiving Provided by Staff**

Whether one is a relative or a staff member at a long-term care facility, caregiving for individuals with dementia is challenging (Dooley & Hinojosa, 2004; WHO, 2017). Oftentimes, long-term care facilities have limited resources for staff members to utilize when providing care, hindering their ability to promote the well-being of their patients (Garcia et al., 2012; Watt & Konnert, 2007). Promoting the well-being of individuals with dementia occurs through providing a level of care that preserves their level of independence respective to the stage of disease progression being experienced (Dooley & Hinojosa, 2004; Moyle et al., 2015). However, caregivers will often complete tasks or make decisions for individuals with dementia for their own convenience, diminishing the level of independence they experience (Moyle et al., 2015). Research notes that this may be due to staff lacking adequate preparation to care for individuals with dementia, precipitating a sense of guilt for not sufficiently meeting patient needs (Butcher, 2018). Elements of unpreparedness include, but are not limited to, a lack of education for staff and other various staffing issues within a facility (Butcher, 2018; Garcia et al., 2012). In addition, a caregiver with limited knowledge is often perceived as unwilling to provide quality care (Butcher, 2018). These barriers can cause significant emotional strain, such as depression, for staff members and result in burnout (Butcher, 2018; Dooley & Hinojosa, 2004). Also, research indicates that caregiver burden impacts treatment and consequently influences the quality of life of individuals with dementia (Dooley & Hinojosa, 2004). This alone demonstrates that there is a need for more support of staff by providing adequate education and training to aide in decreasing the burden of care they experience on a daily basis (Butcher, 2018; WHO, 2017). Establishing staff competence regarding dementia and quality of life can minimize the risks of

individuals with dementia residing in long-term care facilities (Butcher, 2018; Garcia et al., 2012).

### **Occupation-Based Model**

For this doctoral capstone experience (DCE) project, an educational in-service program was developed for all staff and therapists on the importance of quality of life for individuals with dementia residing in long-term care facilities. The program began preparing staff and therapists for future programming in relation to dementia staging through education emphasizing the topics of dementia, long-term care, and quality of life. As a result of the program, the staff and therapists reported an improved understanding of the progressing nature of dementia and how an individual's quality of life can be impacted, specifically in the long-term care setting. The Ecology of Human Performance (EHP) model was the theoretical guide for this DCE project. The focus of this model includes individuals of differing ages, as well as one's needs across their lifespan (Cole & Tufano, 2008). The EHP model accentuates a preventative, rehabilitative and health-promotion approach (Cole & Tufano, 2008).

The EHP model incorporates three important aspects: person, tasks, and context. *Person* includes cognitive, psychomotor, and other personal traits (Cole & Tufano, 2008). In relation to the DCE project, the person represented all of the employees who participate in resident care within the University Heights Health and Living community. It is important to understand all aspects of the staff and therapists. To implement the program, an in-service was provided for all employees interested in furthering their knowledge on individuals with dementia and their quality of life. By taking an interdisciplinary approach, individuals with a range of educational achievements and interests came together as a group, facilitated growth, and experienced a positive, knowledge-rich experience together. *Tasks* are behaviors that are essential to achieve

goals (Cole & Tufano, 2008). In regard to the DCE project, tasks were the job duties or occupations the staff and therapists participate in, such as assisting an individual with dementia with taking a shower. This in-service gave staff the opportunity to gain knowledge about dementia and better understand how it progresses, which in turn will facilitate an increased quality of life experienced by the individuals with dementia and decrease their burden of care. This decreased burden of care will lead to more job duties and occupations the staff and therapists can participate in. *Context* involves a person's surroundings, both temporal and environmental (Cole & Tufano, 2008). In relation to the DCE project, the physical context was the University Heights Health and Living community in which the staff and therapists work in. The temporal context was the shift or time of day in which the staff members work, as well as the current year. The other employees and residents in which a particular staff member interacts with were all components of the social context. Finally, the EHP model looks at person-context-task transaction, which identifies how a person participates in relation to tasks within their context and the impact on overall human performance (Cole & Tufano, 2008). When considering the person-context-task transaction within the employees' lives, there was an incongruence, often on account of lack of education, leading to their negative perceptions of the burden caring for individuals with dementia created. This imbalance validated that the EHP would be beneficial to use in the planning and implementation processes of program development, specifically for an in-service addressing quality of life of individuals with dementia residing in long-term care. By participating in the in-service, the staff and therapists reduced the imbalance and as a result, improved their perceptions of the importance of quality of life, caring for individuals with dementia, and overall occupational performance.

## Needs Assessment

### Screening

According to Hinojosa and Kramer (2014), screening is the process of analyzing relevant data gathered through observation or pre-assessment tools and determining if additional assessment is required. The screening process is an important first step in determining what evaluations are necessary, which contributed to a successful and rewarding intervention. Initially, the DCE student met with Rebecca Cochran, a Certified Occupational Therapy Assistant (COTA) and Senior Supervisor of the University Heights Health and Living facility in Indianapolis, Indiana. During the meeting, Rebecca gave the DCE student a brief background of the CarDon facility, Lifespan therapy, as well as a description of her own background and interest in working with older adults in the long-term care setting. The DCE student was given a tour of the facility, and the opportunity to ask Rebecca questions through a semi-structured interview about the day-to-day operations of the therapy department, including strengths and weaknesses. Rebecca noted the potential for program development, advocacy, and education for therapists and other staff members on the needs and quality of life for individuals with dementia.

The DCE student also met with Tricia Holmes, an occupational therapist and lead advocate for the future dementia staging program at the University Heights Health and Living facility. During the encounter, Tricia explained her personal background and interest in working with individuals with dementia. Tricia introduced the facility's current dementia staging program, shared thoughts on how it could be improved and offered ideas for future development and implementation. This led to a discussion on the barriers impeding successful implementation of this program, including lack of staff support and limited staff education on dementia and the importance of a staging program. Over the course of a week, the DCE student

held discussions with other various members of management within this facility. Clinical observations were also performed within a meeting of upper management personnel regarding the future of a dementia staging program at the site. A project idea utilizing the services of the student, which would be beneficial to the facility and their future goals, then evolved.

Ultimately, Rebecca and Tricia expressed the need for an educational program to promote and aid in the transition of utilizing a dementia staging program.

### **Evaluation**

Hinojosa and Kramer (2014) acknowledge evaluation is completed through an extensive process of collecting and defining pertinent data in order to holistically understand the client. Considering that the EHP, especially the person-context-task transaction, is the framework for this project, it was crucial to consider the client's feelings and beliefs, the interrelationships between the client and their context, and the effect on performance overall (Dunn, Brown, & McGuigan, 1994). After completing a thorough review of the literature and to further assess the specific needs of the client, two surveys were used for staff and therapists to self-report their level of knowledge regarding dementia and quality of life and to rate their satisfaction with their existing knowledge. According to Stein, Rice, and Cutler (2013), surveys are a valuable tool often used when assessing the general knowledge of a population, such as client attitudes and perceptions. The objective data gathered through surveys can serve as a guide for developing workplace strategies or educational programs (Stein, Rice, & Cutler, 2013).

The surveys were created by the DCE student and consisted of 12 total questions (See Appendix A). The first part of the surveys included questions regarding staff and therapist perceptions on understanding patient needs, meeting patient needs, and providing quality care. The second part addressed whether the staff and therapists had any previous participation in

programming for individuals with dementia and requested feedback on past programming or ideas for future programming. Although two separate surveys were utilized when collecting data from therapists and staff, the only difference was the title listed at the top, differentiating them for ease of scoring.

### **Results of Needs Assessment**

According to Bonnel and Smith (2018), a needs assessment allows one to collect baseline data that may demonstrate a lack of continuity in care and proceed with investigating a means for improvement. A thorough needs assessment was conducted through semi-structured interviews and survey data collection to identify areas of improvement within the facility. The general problem identified during the initial needs assessment interviews was in relation to staff education regarding dementia, quality of life, and the importance of a dementia staging program. A combination of convenience and purposive sampling was used throughout the screening and evaluation phase (Etikan, Musa, & Alkassim, 2016). A total of 27 employees completed the self-report survey, including 11 therapists and 16 nursing staff. The data from the first portion of the survey, consisting of multiple-choice questions, is shown in Table B1. Over 90% of the staff and therapists reported they had adequate knowledge on quality of life. Most of the staff either rated their satisfaction as extremely or very satisfied, and over half of the therapists rated their satisfaction as moderately and slightly satisfied. In regard to possessing adequate knowledge on dementia, nearly 80% of the staff and therapists agreed to some degree. Staff reported a higher degree of satisfaction with their knowledge, whereas therapists reported being less satisfied. Although nearly all the staff and therapists disclosed understanding the day-to-day needs of individuals with dementia, approximately one-third of therapists and staff expressed job duties, such as documentation, negatively impacted their ability to meet patient needs and provide

quality care. Nearly 70% of staff and therapists surveyed agreed to some degree of having adequate knowledge for addressing challenging behaviors.

The second portion of the survey contained open-ended questions requesting feedback for dementia staging programs utilized in the past and suggestions for future programming. The data collected from the open-ended questions was used to conduct an analysis on the strengths, weaknesses, opportunities and threats, often referred to as a SWOT analysis, and is shown in Table B2 (Bonnell & Smith, 2018). Bonnell and Smith (2018) disclosed that using a SWOT analysis can provide direction when outlining a clinical problem and allows for a better understanding of both positive and negative aspects. Despite the positive ratings of the multiple choice previously noted, many weaknesses and threats were documented in the open-ended questions. Overall, a lack of staff knowledge, education, and willingness to participate were frequently mentioned, along with increased time consumption.

Recruitment of participants did not occur specifically, as it was pre-determined by the education coordinator that this educational series will be mandatory for all employees. Participants of the educational program included all staff and therapists actively engaging in patient care to any extent. The educational in-service was held at various times over the course of a week and tentatively began week nine of the doctoral capstone experience.

### **Outcome Measures**

The Goal Attainment Scale (GAS) was utilized to appraise whether or not the overall goals of the DCE were met (See Appendix C). The GAS applies goal writing to determine the level of attainment through anticipated outcomes and numerical ratings (Turner-Stokes, 2009). At the time of the DCE student's arrival, there were no resources and no educational in-service programs being implemented. This level was rated as a -2, implying that it was much less than

expected. The next level was rated as -1, which amounts to less than expected. For this level, a resource and educational in-service would be provided by the DCE student that does not quite meet the expectations of the facility. The expected level of achievement was rated as 0, which was the level of the most likely outcome. The student would provide a resource and educational in-service that meets the expectation of the facility. The next level was rated as +1, which represented a level that equates to more than expected by the facility. The last level was rated as +2, which was the highest achievable level and was equivalent to much more than expected by the facility. The DCE student aimed to meet the expected level of outcome, however any positive rating would be acceptable. The DCE student collaborated with the site mentor to determine if the goal was met at the conclusion of the DCE.

To assess the effectiveness of the educational program, a pre and post-test survey was created for participants to complete at the beginning and end of the educational in-service. The survey consisted of questions rated on a 5-point Likert scale, ranging from strongly agree to strongly disagree, similar to the needs assessment surveys. The questions assessed whether the participants experienced an improvement in their knowledge and their satisfaction with their knowledge. There was also a comments section for participants to request further clarification for the next session on key points discussed during the current session. This questionnaire was created under the supervision of the site mentor and faculty mentor to ensure all questions were appropriate and fitting. The goal was for participants to gain knowledge and express satisfaction with the educational in-service presentation.

### **Compare and Contrast Areas of Occupational Therapy**

Within the occupational therapy (OT) profession, the objective of the screening and evaluation phases is to acquire important information about the client in order to create a client-

centered intervention (Hinojosa & Kramer, 2014). Various assessments can be used during the process of screening and evaluation that are often specific to a particular population, such as caregivers of individuals with dementia, or practice settings, such as acute care or long-term care. Martin, Gillies, Coker, Pizzacalla, Montemuro, Suva, and McLelland (2016), directed research on an educational intervention for staff in an acute care setting within Ontario, Canada. Researchers identified that caregivers within the acute care setting lack knowledge and confidence for implementing client-centered interventions when working with individuals with dementia, similar to the supporting literature for long-term care facilities (Butcher, 2018; Garcia et al., 2012; Martin et al., 2016). However, the researchers utilized a standardized educational program composed of literature-driven and evidence-based practice concepts, whereas the DCE student did not utilize a standardized approach (Martin et al., 2016). The program within the study was divided into 4 modules with a focus on one module each session, which is similar to the program at University Heights Health and Living facility. The program implemented within the acute care setting included interactive learning exercises completed in small groups, case studies, and video scenarios, whereas the program at the University Heights Health and Living facility will incorporate educational case studies of current residents and descriptive handouts for future reference (Martin et al., 2016). Furthermore, acute care settings are often large, as evidenced by the researchers recruiting a total of 468 participants in the intervention group alone; however, with a small long-term care facility no more than 100 participants are anticipated despite the mandatory status of this program (Martin et al., 2016).

### **Implementation**

The educational in-service program at University Heights Health and Living Community, led by the DCE student, was held during week 9 of the DCE. The educational in-service was

advertised on flyers that were displayed in common employee areas, as well as spread by word of mouth. Therapy and nursing directors also required the in-service as a mandatory event for all staff. The DCE student held the educational in-service at five different times over the course of a three-day period to ensure employees from all shifts were able to attend at least one of the sessions. Participants attended one 45-minute session which consisted of a pre-survey, an educational PowerPoint presentation, and a post-survey. After comprehensively reviewing the results of the needs assessment, three topics were chosen to be incorporated within the session, including dementia, quality of life, and dementia staging programming.

At the beginning of the session, participants completed the pre-survey (See Appendix D) consisting of 3 questions asking participants to rate their knowledge on dementia, quality of life, and dementia staging programming. The pre-survey consisted of 2 additional questions asking the participants to rate their confidence in providing care to individuals with dementia, and to provide any supplemental comments. As an introduction to the PowerPoint presentation and to build rapport with participants, the DCE student explained her role as an OT student and offered insight to her personal passion and experience supporting the creation of the educational program as her DCE project. Next, the objectives and goals of the in-service were outlined to further establish the DCE student's purpose. The program presentation (See Appendix E) content was developed through analyzing and synthesizing information gathered from textbooks and evidence-based literature. At the conclusion of the program presentation, the post-survey was administered to all participants. The post-survey (See Appendix F) consisted of the same content included in the pre-survey, as well as additional questions asking participants to rate aspects of the presentation and presenter overall. The data collected from both the pre and post surveys

provided the DCE student with feedback to measure effectiveness of the educational program. Participants were asked to turn-in both surveys anonymously at the conclusion of the session.

In addition to the educational in-service, the DCE student created a handout for all participants. The handout included content from the program presentation on dementia and was developed utilizing evidence-based literature. Content within the handout was organized in a sequential manner to follow the progression of dementia and contained a bullet-point list of key details and considerations. The handout was offered to all participants when exiting the meeting room at the conclusion of the session.

### **Leadership Skills and Staff Development**

The DCE student demonstrated various aspects of leadership, throughout the development and implementation phases of the educational program, resulting in a successful effective in-service. While developing the educational program, the DCE student utilized effective communication and exhibited confidence when advocating for the in-service and the resulting quality of life benefits for individuals with dementia. The DCE student demonstrated initiative while scheduling and attending meetings with the staff development coordinator, therapy supervisor, and other various management personnel, which led to the creation of the educational in-service. The DCE student also participated in many discussions with an occupational therapist about key information to include within the in-service regarding dementia and quality of life of individuals residing in long-term care.

Over the course of the implementation phase, the DCE student exhibited self-confidence as it was imperative for clearly and effectively presenting to the certified and licensed professionals. The DCE student was also enthusiastic, confident, and personable when interacting with the participants throughout each session. The DCE student exhibited

professional behaviors by adhering to ethical standards and promoting values such as trust and acceptance from therapists and staff. To advocate for the role of occupational therapy, specifically in the care of individuals with dementia, a handout with an overview of the completed program was created for staff and therapists. The DCE student also attended the staffing and clinical meetings each morning to advocate for the role of OT regarding fall interventions and dementia staging interventions for individuals with dementia. Through this process, the DCE student provided ideas, including cognitive assessments or positioning evaluations, and received feedback from nursing, which resulted in the promotion of interdisciplinary care.

Numerous professionals, including those within a skilled nursing facility, do not thoroughly recognize or understand the positive and beneficial role of OT. Therefore, educational programming, such as in-services, are critical to ensure quality care is provided to patients through interdisciplinary collaboration. The in-service promoted and encouraged staff development by educating staff on topics to improve the quality of care and quality of life of individuals with dementia. The literature review and needs assessment results demonstrated a lack of staff knowledge on dementia and quality of life, specifically in the long-term care setting. By implementing this educational in-service, the DCE student aimed to increase staff knowledge, as well as to promote the implementation of a dementia staging program within the facility's memory care unit. This educational program will continue to be utilized to educate staff and therapists on dementia, quality of life and dementia staging programming beyond the time of the DCE student's doctoral capstone efforts.

## **Discontinuation**

### **Outcomes**

Throughout the progression of the in-service sessions, obstacles occurred and the DCE student made appropriate adjustments. No one attended the first session despite the mandatory directive. Even with encouragement and explanation from the DCE student, some staff did not understand the purpose and importance of the educational program. Therefore, the DCE student adapted her approach to better accommodate staff through establishing rapport and ensuring participants were set up for success.

For sessions two through five, a total of 11 therapists and 24 nursing staff attended. The DCE student shared her purpose as a DCE student and expressed her personal passion for individuals with dementia. This strategy aided in rapport building and allowed participants to better understand the purpose of the educational program. Participants appeared to be receptive to this strategy as evidenced by increased eye contact and friendly facial expressions. At the conclusion of each session, most participants expressed interest in the handout by communicating they would use it as a reference when caring for individuals with dementia.

Overall, a few challenges emerged over the course of the three-day period in which the sessions occurred. The therapists who participated were receptive to the educational program and a good discussion occurred with two individuals after the session concluded. However, some of the nursing staff who participated were less receptive to the information and expressed displeasure with the mandatory attendance. The DCE student was cognizant when these instances ensued and attempted to remediate this outlook by adjusting the length of the in-service slightly to ensure each session was effective and met the needs of the participants. The DCE student provided holistic care to the participants through adapting the in-service to their needs,

which is a technique frequently used within the OT profession. In addition to exhibiting appreciation and respect for participant feedback, the DCE student established quality improvement by welcoming questions and feedback after the in-service presentation.

The GAS was utilized to appraise the outcome of the overall goals of the DCE, including the educational in-service and handout (See Appendix C). All goals were initiated at a level of -2, which was prior to the DCE student beginning her project. As the DCE progressed, the goal levels increased as the DCE student reached the level of attainment, as explained below. The first goal consisted of providing an educational in-service that met the expectations of the facility. The more than expected level of outcome (+1) was met at the completion of the DCE. The second goal consisted of creating an educational resource that met the expectations of the facility. The more than expected level of outcome (+1) was met for this goal as well. The positive rating for each goal were acceptable and provided support for continuing the educational program and hosting another DCE student to assist with further development of the newly created program.

A total of 35 employees completed the pre and post surveys, including 24 nursing staff and 11 therapists. The pre-survey (see Appendix D) was completed by the participants prior to the educational PowerPoint presentation to assess their knowledge on dementia, quality of life, and dementia staging programming, as well as to capture their self-perceived confidence regarding care for individuals with dementia. The data from the pre-survey is displayed in Figures G1 and G2. The participants rated their knowledge on a scale from one, representing no knowledge, to ten, representing exceptional knowledge. Similar to the results of the needs assessment, nearly all therapists and nursing staff rated their knowledge on dementia and quality of life as adequate, with staff scores averaging 7 and 8 respectively, and therapists scores

averaging 6.5 and 7.8 respectively. In regard to knowledge on dementia staging programming, nursing staff rated their knowledge as adequate with an average numerical rating of 6.5.

However, therapists rated their knowledge on dementia staging lower, with an average numerical rating of 5.9. Staff reported a higher degree of confidence with providing care for individuals with dementia with an average score of 8, whereas therapists rated their confidence with an average score of 7.8.

The post-survey (see Appendix F) was administered to participants at the conclusion of the educational PowerPoint. The data from the post-survey is displayed in Figures G1 and G2. Overall, staff and therapist self-report ratings on their knowledge regarding dementia, quality of life and dementia staging improved after participating in the educational program (See Figure G3). Both therapists and staff ratings of their self-perceived confidence with providing care for individuals with dementia increased as well. Also, most of the participants rated the educational in-service as good or excellent (See Figure G4). Finally, the DCE student thoroughly reviewed all surveys and concluded that the educational program was successful and a beneficial experience for the participants, as evidenced by majority of the participants rating the educational in-service as good or excellent.

### **Societal Needs and Sustainability**

Nearly half of individuals residing in long-term care facilities possess a diagnosis of dementia (Crespo et al., 2013; Harris-Kojetin et al., 2016; Moyle et al., 2015). Individuals with dementia are a vulnerable population and are at an increased risk for experiencing loneliness, isolation and a decreased quality of life (Moyle et al., 2015). Therefore, cultivating and preserving the quality of life of individuals with dementia through the promotion of well-being is critical (Klapwijk et al., 2016; Moyle et al., 2015). Promoting the well-being of individuals with

dementia occurs through providing a level of care that preserves their level of independence respective to an individual's experienced stage of disease progression (Dooley & Hinojosa, 2004; Moyle et al., 2015). Encouraging individuals with dementia to actively engage in daily activities, such as self-care, social participation and leisure, can improve an individual's mood resulting in an increased quality of life (Beerens et al., 2016; Dooley & Hinojosa, 2004; Moyle et al., 2015). Long-term care facilities often have limited resources for staff members to utilize when providing care, hindering their ability to promote the well-being of their patients (Garcia et al., 2012; Watt & Konnert, 2007). However, caregivers often complete tasks or make decisions for individuals with dementia out of convenience, diminishing the level of independence experienced by the individual with dementia. This also demonstrates staff lacks adequate preparation, including education, to care for these individuals (Butcher, 2018; Garcia et al., 2012; Moyle et al., 2015).

The educational program met the societal need of lack of staff education and increased preparedness by educating staff about the progression of dementia, the importance of quality of life, and discussing their role in the implementation of a dementia staging program. Research indicates that caregivers with limited knowledge can experience significant emotional strain and consequently negatively influence the quality of life of individuals with dementia (Butcher, 2018; Dooley & Hinojosa, 2004). Improving caregivers' understanding of dementia and quality of life was the main goal of the educational program. The DCE student also hoped the educational program would serve as the initiation to the first phase of the dementia staging program, which would result in an overall increased quality of life for individuals with dementia within the facility.

Occupational therapy practitioners are plentiful in the long-term care setting, creating an opportunity for a smooth transition for sustaining the educational program. In order to promote sustainability of the educational program, the DCE student established rapport with the lead OT and speech therapist (ST) spearheading the dementia staging program, as well as the staff development coordinator (SDC) who oversees new hire orientation and staff in-servicing. The DCE student compiled all resources into a google drive folder, which included the PowerPoint presentation, educational handouts, pre and post surveys, as well as an outline including topics for future modules to ensure sustainability of the program after the discontinuation of the DCE. The DCE student shared the folder with the OT, ST, SDC and site mentor to utilize moving forward. The DCE student also shared the anonymous feedback from participants regarding topics and questions they would like more information on for increased success with the continuation of the program. Additionally, the DCE student worked on creating additional handouts for staff that includes strategies for caregiving approaches broken down by each level of dementia. The DCE student advocated to management staff for the role of OT within the memory care unit, including collaboration with nursing for fall and dementia staging interventions for individuals with dementia.

### **Leadership and Advocacy**

Over the course of the DCE, the DCE student delved into program development and administration. The educational program generated positive outcomes for not only the participants, but also the facility to further progress their dementia staging program. The DCE student advocated for the role of OT in caring for individuals with dementia. The participants expressed a growth in knowledge of dementia, quality of life, and dementia staging programming as evidenced by the pre and post-survey responses.

The DCE student had numerous opportunities to engage in administrative duties, including but not limited to, attending meetings, running reports, and scheduling screenings. The DCE student also had the opportunity to independently prepare and lead an insurance meeting. Any issues or concerns that arose throughout the insurance meeting were addressed in a timely manner and reported to the site mentor. The DCE student also advocated for OT to provide an in-depth OT assessment for dementia staging to clinically and objectively determine whether a resident should reside within the locked memory care unit or if transitioning off the unit would be a safer option. The director of nursing, assistant director of nursing, and assistant executive director of the facility were extremely pleased and expressed interest in continuing to utilize therapy collaboration with all individuals, but more specifically individuals with dementia. The DCE student also received positive feedback from the OT and site mentor regarding this instance of advocacy.

Over the course of the DCE, the DCE student utilized professional communication when interacting with residents, staff, therapists, and other healthcare professionals. Assorted methods of communication were utilized, including text messages, phone calls, emails, and face to face conversation. Effective communication between associated individuals positively influenced the valuable outcomes of the DCE.

After personally experiencing the benefits of the educational program, the DCE student has a comprehensive understanding and appreciation for program development within long-term care facilities. The DCE student's knowledge of dementia and quality of life has grown significantly and has prompted effective interactions and interventions to be provided to individuals with dementia. Throughout the creation and implementation of the educational program, the DCE student recognized a need for education on dementia and quality of life, as

well as implementation of dementia staging programming. Furthermore, it is essential to continue to educate staff and therapists on dementia and quality of life in long-term care facilities, as individuals with dementia are a vulnerable population. Occupational therapists are licensed professionals with adequate training to provide education to staff and other therapists to advocate for improved quality of care for patients. At the conclusion of this DCE, the DCE student hoped that other professionals and long-term care facilities will discern the benefits of program development for staff and individuals with dementia.

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## Appendix A

**Staff Interview Questions**

- How would you rate your knowledge and understanding of quality of life?
  - Do you feel your knowledge of quality of life is adequate enough to provide the best quality care to the residents?
    - *Strongly agree*
    - *Agree*
    - *Neither agree or disagree*
    - *Disagree*
    - *Strongly Disagree*
  - How satisfied are you with this?
    - *Extremely satisfied*
    - *Very satisfied*
    - *Moderately satisfied*
    - *Slightly satisfied*
    - *Not satisfied*
- How would you rate your knowledge and familiarity with dementia?
  - Do you feel your knowledge of dementia is adequate enough to provide the best quality of care to individuals with this condition?
    - *Strongly agree*
    - *Agree*
    - *Neither agree or disagree*
    - *Disagree*
    - *Strongly disagree*
  - How satisfied are you with this?
    - *Extremely satisfied*
    - *Very satisfied*
    - *Moderately satisfied*
    - *Slightly satisfied*
    - *Not satisfied*
- With the amount of documentation, I have to complete on a daily basis, I feel that I am able to keep up with meeting patient needs and provide quality care?
  - *Strongly agree*
  - *Agree*
  - *Neither agree or disagree*
  - *Disagree*
  - *Strongly disagree*
- When interacting with the residents, I feel that I have adequate knowledge on the day to day needs of individuals with dementia.
  - *Strongly agree*
  - *Agree*
  - *Either agree or disagree*
  - *Disagree*
  - *Strongly disagree*



**Therapist Interview Questions**

- How would you rate your knowledge and understanding of quality of life?
  - Do you feel your knowledge of quality of life is adequate enough to provide the best quality care to the residents?
    - *Strongly agree*
    - *Agree*
    - *Neither agree or disagree*
    - *Disagree*
    - *Strongly Disagree*
  - How satisfied are you with this?
    - *Extremely satisfied*
    - *Very satisfied*
    - *Moderately satisfied*
    - *Slightly satisfied*
    - *Not satisfied*
- How would you rate your knowledge and understanding of dementia?
  - Do you feel your knowledge of dementia is adequate enough to provide the best quality of care to individuals with this condition?
    - *Strongly agree*
    - *Agree*
    - *Neither agree or disagree*
    - *Disagree*
    - *Strongly Disagree*
  - How satisfied are you with this?
    - *Extremely satisfied*
    - *Very satisfied*
    - *Moderately satisfied*
    - *Slightly satisfied*
    - *Not satisfied*
- With the amount of documentation, I have to complete on a daily basis, I feel that I am able to keep up with meeting patient needs and provide quality care?
  - *Strongly agree*
  - *Agree*
  - *Neither agree or disagree*
  - *Disagree*
  - *Strongly disagree*
- When interacting with the residents, I feel that I have adequate knowledge on the day to day needs of individuals with dementia.
  - *Strongly agree*
  - *Agree*
  - *Either agree or disagree*
  - *Disagree*
  - *Strongly disagree*

- When challenging behaviors arise from residents, I feel that I am adequately prepared for how to handle these situations.
  - *Strongly agree*
  - *Agree*
  - *Neither agree or disagree*
  - *Disagree*
  - *Strongly disagree*
- In regard to dementia programming within this building, have you been a part of any type of it?
  - *Yes*
  - *No*
  - If so, was it helpful?
  
  - If not, what made it unhelpful?
- In the future, a therapist will have developed a dementia staging program to implement when working with individuals with dementia. What are your biggest concerns in relation to this?
  - If you were provided individualized intervention plans for each resident outlining their stage of dementia and recommendations for approaches to ADLs, activities and etc., do you think this would be helpful and improve the quality of care provided?
    - *Strongly agree*
    - *Agree*
    - *Either agree or disagree*
    - *Disagree*
    - *Strongly disagree*
- If you were to design a dementia staging program to promote and improve the quality of life of individuals, what do you think is important to include?
  
- What barriers or threats do you perceive with establishing and implementing a new program?

Appendix B

Table B1

*Quantitative Data from Survey Responses*

<b><u>Question</u></b>	<b><u>Therapist Response Tally</u></b>	<b><u>Staff Response Tally</u></b>
Do you feel your knowledge of quality of life is adequate enough to provide the best quality care to the residents?	(3) Strongly agree (7) Agree (1) Neither agree or disagree (0) Disagree (0) Strongly disagree	(10) Strongly agree (5) Agree (0) Neither agree or disagree (0) Disagree (1) Strongly disagree
How satisfied are you with this?	(0) Extremely satisfied (5) Very satisfied (4) Moderately satisfied (2) Slightly satisfied (0) Not satisfied	(5) Extremely satisfied (8) Very satisfied (1) Moderately satisfied (1) Slightly satisfied (1) Not satisfied
Do you feel your knowledge of dementia is adequate enough to provide the best quality of care to individuals with this condition?	(3) Strongly agree (5) Agree (3) Neither agree or disagree (0) Disagree (0) Strongly disagree	(7) Strongly agree (8) Agree (1) Neither agree or disagree (0) Disagree (0) Strongly disagree
How satisfied are you with this?	(0) Extremely satisfied (6) Very satisfied (2) Moderately satisfied (2) Slightly satisfied (1) Not satisfied	(7) Extremely satisfied (7) Very satisfied (1) Moderately satisfied (0) Slightly satisfied (1) Not satisfied
With the amount of documentation, I have to complete on a daily basis, I feel that I am able to keep up with meeting patient needs and provide quality care.	(1) Strongly agree (5) Agree (1) Neither agree or disagree (4) Disagree (0) Strongly disagree	(8) Strongly agree (3) Agree (1) Neither agree or disagree (2) Disagree (1) Strongly disagree
When interacting with the residents, I feel that I have adequate knowledge on the day to day needs of individuals with dementia.	(2) Strongly agree (7) Agree (1) Neither agree or disagree (1) Disagree (0) Strongly disagree	(7) Strongly agree (6) Agree (1) Neither agree or disagree (0) Disagree (1) Strongly disagree
When challenging behaviors arise from residents, I feel that I am adequately prepared for how to handle these situations.	(1) Strongly agree (5) Agree (4) Neither agree or disagree (0) Disagree (0) Strongly disagree	(4) Strongly agree (9) Agree (1) Neither agree or disagree (0) Disagree (0) Strongly disagree

Table B2

*SWOT Analysis Derived from Qualitative Data from Survey Responses*

	<b>Strengths</b>	<b>Weaknesses (Internal)</b>	<b>Opportunities</b>	<b>Threats (External)</b>
<b>Current Dementia Staging Program</b>	<ul style="list-style-type: none"> <li>• Evidence-based assessment tools</li> <li>• Used to create individualized plans for patient care</li> <li>• Interdisciplinary approach</li> <li>• Education correlated with Relias</li> <li>• Developed an understanding of patient needs</li> <li>• Improved and refreshed understanding of dementia</li> </ul>	<ul style="list-style-type: none"> <li>• Never been implemented successfully within this facility</li> <li>• Stages don't necessarily match assessment tools utilized</li> <li>• Program is very broadly based on cognition, rather than dementia/ Alzheimer's</li> <li>• Lack of staff education on program</li> <li>• Quick change caused an increase of behaviors</li> <li>• Poor time feasibility for implementation</li> <li>• Requires a thorough training; time consuming</li> </ul>	<ul style="list-style-type: none"> <li>• To improve quality of life of individuals with dementia</li> <li>• To improve quality of care of individuals with dementia</li> <li>• Utilize a multi-dimensional approach to treatment</li> <li>• Utilize a dementia-based program</li> <li>• Promote a growth of knowledge for staff</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for increased burden of care/ duties of staff</li> <li>• Potential for a period of increased behaviors during transition</li> <li>• Lack of staff willingness to try new things and follow through with it</li> <li>• Lack of staff support</li> <li>• Insufficient staff knowledge on dementia/ quality of life topics</li> <li>• Time consuming</li> <li>• Difficulty keeping everyone on same page; confusion</li> <li>• High turnover rates</li> </ul>

Appendix C

Goal Attainment Scale

Success	Goal 1	Goal 2
Level of Predicted Attainment	0	0
Much More Than Expected +2	The OTS will provide an educational in-service program to staff and therapists that is “extremely satisfactory” per the report of the formative assessment results.	The OTS will provide a resource for therapists that is “extremely satisfactory” per the report of the site mentor.
More Than Expected +1	The OTS will provide an educational in-service program to staff and therapists that is “very satisfactory” per the report of the formative assessment results.	The OTS will provide a resource for therapists that is “very satisfactory” per the report of the site mentor.
Most Likely Outcome 0	The OTS will provide an educational in-service program to staff and therapists that is “satisfactory” per the report of the formative assessment results.	The OTS will provide a resource for therapists that is “satisfactory” per the report of the site mentor.
Less Than Expected -1	The OTS will provide an educational in-service program to staff and therapists that is “less than satisfactory” per the report of the formative assessment results.	The OTS will provide a resource for therapists that is “less than satisfactory” per the report of the site mentor.
Much Less Than Expected -2	The OTS will not provide an educational in-service program to staff and therapists.	The OTS will not provide a resource for therapists.

Appendix D

Pre-Survey

**Pre-session Survey:** *Please complete this portion of the survey prior to the start of the session.*

1. Please rate your knowledge of dementia.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

2. Please rate your knowledge of quality of life.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

3. Please rate your knowledge of dementia staging programming.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

4. How confident would you feel providing care to an individual with dementia?

No confidence 0 1 2 3 4 5 6 7 8 9 10 Exceptional confidence

5. Comments:

Appendix E

# Quality of Life of Individuals with Dementia Residing in Long-term Care

Caitlynn Strobel, OTS

University of Indianapolis

## Objectives:

- Improve understanding of Dementia
- Improve understanding of Quality of Life
- Understand the importance of dementia staging program
- Begin to understand the process of implementation
- Identify your role within the process of implementation

# Pre-Survey

*Please take a few minutes if you have not already done so, and fill out the pre-survey.*

Dementia



## Types of Dementia

Many, including but not limited to:

- Alzheimer’s disease
  - Most common; 70% of dementia cases
- Vascular dementia
  - Second most common; 17% of dementia cases
- Substance-induced dementia
- Dementia with Lewy body
- Pick’s disease
  - Also known as frontotemporal dementia

(Atchison & Dirette, 2012)

## Incidence and Prevalence

- Nearly 5.7 million individuals are currently living with some form of dementia
  - This number is projected to grow to almost 14 million within the next 30 years
- Dementia is becoming significantly more prevalent due to:
  - Increased life expectancy
  - Increase in medical advances
  - Aging baby boomer generation

Prevalence increases with age

Incidence is higher in women compared to men

(Atchison & Dirette, 2012; Ciccarelli & White,

### Factors *Increasing* Risk

- Hx of:
  - Depression
  - Head trauma with LOC
  - Electroconvulsive therapy (ECT)
  - Physical inactivity
- Abuse of:
  - Alcohol
  - Analgesics (pain killers)
- Vascular risk factors
  - High cholesterol; HTN; HBP
- Type II Diabetes
- Ethnicity
  - African American or Hispanic



(Atchison & Dirette, 2012)

### Factors *Decreasing* Risk

- Antioxidant exposure
  - Vitamin E
- Diet rich in fish
- Use of:
  - NSAIDs
  - Antihypertensives
  - Statins
  - Some histamine blockers
- Physical activity
- Exposure to mental stimulation/ cognitive training

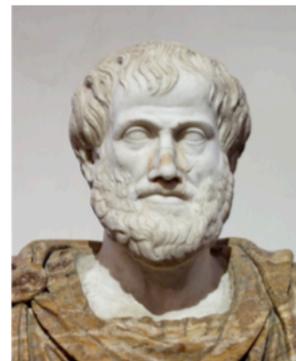


(Atchison & Dirette, 2012)

## Quality of Life (QoL)

### History of QoL

- Concept dates back to Aristotle
- First introduced in US for political reasons
- 1970s: term used to reference individuals



(Scaffa, Reitz, & Pizzi, 2010)

## What is QoL?



The world health organization defines QoL as:

*“An individual’s perception of their culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept affected in a complex way by the person’s physical health, psychological state, personal beliefs, social relationships, and their relationship to salient features of their environment .”*

(Scaffa, Reitz, & Pizzi, 2010, pg. 122)

## What is QoL? cont.



- A broad all encompassing construct
  - Reflects change over time of people and environment
  - Emphasis on patient respect and improved quality care
- Determined by an individual’s perception of their life relative to their ambitions, intentions, apprehensions, as well as the context and environment in which they reside
- General aspects include:
  - **Physical:** functional status; context/ environment; financial/ socioeconomic status
  - **Mental:** psychological; philosophical
  - **Social:** cultural; spiritual; political

(Kane et al., 2003; Klapwijk et al., 2016; Moyle et al., 2015; Scaffa, Reitz, & Pizzi, 2010)

## QoL within Healthcare

Often referred to as Health-Related Quality of Life (HRQoL)

*“Reflects a person’s sense of physical and mental health and the ability to react to factors in the physical and social environments.”*



(Scaffa, Reitz, & Pizzi, 2010)

## QoL

- An overall balance of all aspects is ideal for a positive perception of QoL
- However, when QoL is addressed within intervention, oftentimes the physical aspects are emphasized more so than other various aspects, which can result in an imbalance and overall impact one’s quality of life



(Beerens et al., 2016; Lee et al., 2018; Watt & Konnert, 2007)

## Influential Factors of QoL

- Level of engagement in purposeful activities (level of dependence)
  - ADLs: bathing; dressing; grooming; mobility
  - IADLs: meal prep/ clean-up; shopping
  - Leisure participation
- Emotional state/ mood
  - Depression
  - Feelings of pleasure, interest, satisfaction
- Health



(Scaffa, Reitz, & Pizzi, 2010)

## Influential Factors of QoL cont.

- Social interaction/ social connectedness
- Personal “control” over life
  - Decision making
- Community involvement
- Facility/ staffing factors



(Beerens et al., 2016; Crespo et al., 2013; Dooley & Hinojosa, 2004; Klapwijk et al., 2016; Lee et al., 2018; Moyle et al., 2015; Naylor et al., 2016)

# Dementia Staging Program

## Progression of Dementia

Level 1	No cognitive decline	baseline
Level 2	Very mild cognitive decline	forgetfulness
Level 3	Mild cognitive decline	early confusional stage
Level 4	Moderate cognitive decline	late confusional stage
Level 5	Moderately severe cognitive decline	early dementia
Level 6	Severe cognitive decline	middle dementia
Level 7	Very severe cognitive decline	late dementia

Global Deterioration Scale (GDS)

## Level 1: No Cognitive Decline

- “Baseline”
- Individual does not subjectively complain of memory deficit
- No evidence of memory deficit clinically



## Level 2: Very Mild Cognitive Decline

- “Forgetfulness”
- Individual begins to subjectively complain of “forgetfulness”
  - Misplacing items
  - Difficulties with recalling names of familiar faces
  - Not significant enough to cause a change in function
- No objective deficits regarding work or social situations
- Individual displays appropriate concern of symptoms noted



### Level 3: Mild Cognitive Decline

- “Early Confusional Stage”
- Individual begins demonstrating early “clear-cut” deficits
  - Getting lost when traveling to unfamiliar area
  - Misplacing/ losing valuable objects
  - Close family and friends notice individual’s deficit with word finding/ name recalling
    - Cannot remember names of new people
  - After reading, individual doesn’t retain much of what was read
- Objective deficits apparent with intensive clinical assessment
- Individual begins to experience denial
  - May experience anxiety (mild/ moderate levels)



### Level 4: Moderate Cognitive Decline

- “Late Confusional Stage”
- Clear-cut deficits are prominent
  - Not knowledgeable of current/ recent events
  - Has difficulty recalling portions of their personal history
  - Difficulty concentrating with tasks (Ex: serial subtractions)
  - Limited ability to perform IADLs (financial mgmt; travel; shopping)
- Complex tasks become more difficult (requires more cueing)
- Feelings of denial become more powerful
- Affect will flatten and distance themselves from challenging situations



## Level 5: Moderately Severe Cognitive Decline

- “Early Dementia”
- Requires some assistance to continue to live
  - No recall of address/ phone number; names of close family; school attended
  - Often disoriented
  - Can remember major personal facts (Ex: birthday; names of spouse/ children)
  - Can toilet and feed-self, but requires assistance with choosing appropriate clothing



## Level 6: Severe Cognitive Decline

- “Middle Dementia”
- Requires more assistance to continue to live
  - Oblivious to current/ recent events
  - May be able to identify season/ year
  - Requires assistance with ADLs (toileting/ incontinent; more cues for dressing)
  - Sundowning occurs
  - Can recall own name, but may forget spouse/ children names
  - Can distinguish between familiar and unfamiliar objects/ persons within environment
  - Changes in personality/ emotion
    - Delusional and obsessive
    - Anxiety, agitation/ aggression



## Level 7: Very Severe Cognitive Decline

- “Late Dementia”
- Extensive assistance is required to continue to live
  - Limited/ no ability to communicate verbally
    - Initially: few words or phrases
    - Later on: may express unintelligible sounds/ non-verbal
  - Becomes dependent with ADLs
    - Incontinent of bowel and bladder
    - Difficulty self-feeding/ swallowing (dysphagia)
  - General rigidity is present along with primitive reflexes



## Staging Process

- Therapist testing
  - OT and ST perform in-depth cognitive and physical testing to assess the patient’s current level of function and stage of dementia
- Therapist treatment
  - Over the course of a few weeks, therapist will provide treatment, assessing the appropriate interventions for the client, as well as determine what approaches work best for the individual with dementia

## Staging Process cont.

- Staff education and co-treatment for intervention success
  - After appropriate interventions and approaches are determined by the therapist, staff education and co-treatment will occur to improve carry-over and success
    - Staff education: a series of in-services starting with an intro, then progressing to more specialized content (staff burn-out; aggressive behaviors; wandering)

## Interventions to be Utilized

- Staging Board
  - Will include the names and current stages of patient's
  - A list of each stage broken down
    - What types of behaviors and interactions to expect
    - Common interventions associated with each
  - Located in a easy-to-access, common area for staff
  - Accessible for patient families too

## Interventions to be Utilized cont.

- Stage Suggestive Door Decor
  - The color associated with the patient's current stage will be displayed on either name placard or door decoration
- Patient Profile
  - To be completed with patient and/or help from family
  - To capture common memories and talking points when interacting with the individual with dementia

**We Need Your Help!**

## What do we need from you?

- **Support:**
  - Change can be challenging, and working as an interdisciplinary team is essential for success!
- **Patience:**
  - It will take time to thoroughly assess and create an individualized plan for each individual with dementia
- **Open-communication:**
  - If you have any concerns or suggestions that come up throughout this process, please feel free to reach out so we can work through it as a team!

## Post-Survey

*Please take a few minutes and fill out the post-survey.  
When complete, place them in a pile by the door on  
your way out.*

Thank you for  
your time!

Questions? Concerns? Comments?

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## Picture URLs:

- <https://www.brightfocus.org/alzheimers/article/what-causes-dementia>
- <http://www.dfsherdan.org/types-dementia>
- <https://www.verywellhealth.com/what-exactly-do-incidence-and-prevalence-mean-3860830>
- <https://www.lhsfna.org/index.cfm/lifelines/november-2013/assessing-dementia/>
- <https://en.wikipedia.org/wiki/Aristotle>
- <http://pavilionoh.com/long-term-care/>
- <https://waaids.com/item/463-good-quality-of-life-website.html>
- <http://mentalhealthzen.com/why-is-mental-health-important-to-maintain-good-physical-health/>
- <https://www.lifewire.com/balance-design-principle-3470048>
- <https://dailyaring.com/activities-for-seniors-puzzles/>
- <http://synerg.org/event/health-21st-century-skill-lunch-learn/>
- <https://www.theoldish.com/promoting-quality-life-long-term-care/>

Appendix F

Post-Survey

**Post-session Survey:** *Please complete this portion of the survey at the conclusion of the session. Please turn-in to the presenter before leaving the room.*

**PART A:**

1. Please rate your knowledge of dementia.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

2. Please rate your knowledge of quality of life.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

3. Please rate your knowledge of dementia staging programming.

No knowledge 0 1 2 3 4 5 6 7 8 9 10 Exceptional knowledge

4. How confidence would you feel providing care to an individual with dementia?

No confidence 0 1 2 3 4 5 6 7 8 9 10 Exceptional confidence

5. Overall, how would you rate the educational in-service?

Excellent                       Good                       Fair                       Poor

6. Comments: (what was most helpful, questions or suggestions for improvement)

1 = Strongly Disagree
2 = Disagree
3 = Neither agree or disagree
4 = Agree
5 = Strongly Agree
N/A = not applicable

**PART B:**

1. Objectives were clearly defined.	1	2	3	4	5	N/A
2. Learning objectives were met.	1	2	3	4	5	N/A
3. Content organized and easy to follow.	1	2	3	4	5	N/A
4. Handout was helpful.	1	2	3	4	5	N/A
5. The information presented will be useful for providing patient care moving forward.	1	2	3	4	5	N/A
6. The amount of information presented was adequate for the time allowed.	1	2	3	4	5	N/A

**PART C:**

1. Presenter was organized.	1	2	3	4	5	N/A
2. Presenter was well prepared.	1	2	3	4	5	N/A
3. Presenter was knowledgeable about topics discussed.	1	2	3	4	5	N/A
4. The style of presentation was adequate.	1	2	3	4	5	N/A
5. The meeting room was adequate and comfortable.	1	2	3	4	5	N/A

Appendix G

Figure G1

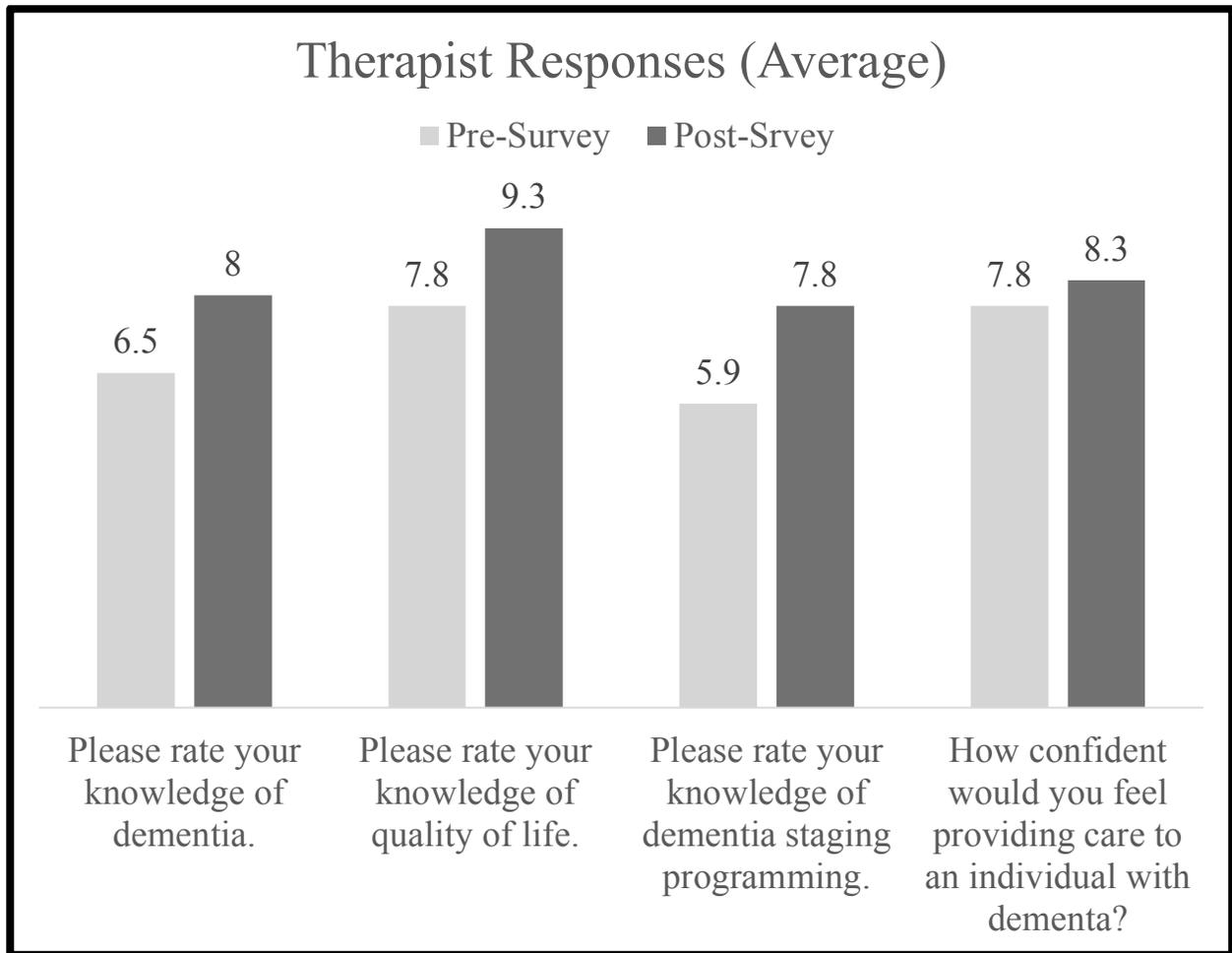


Figure G2

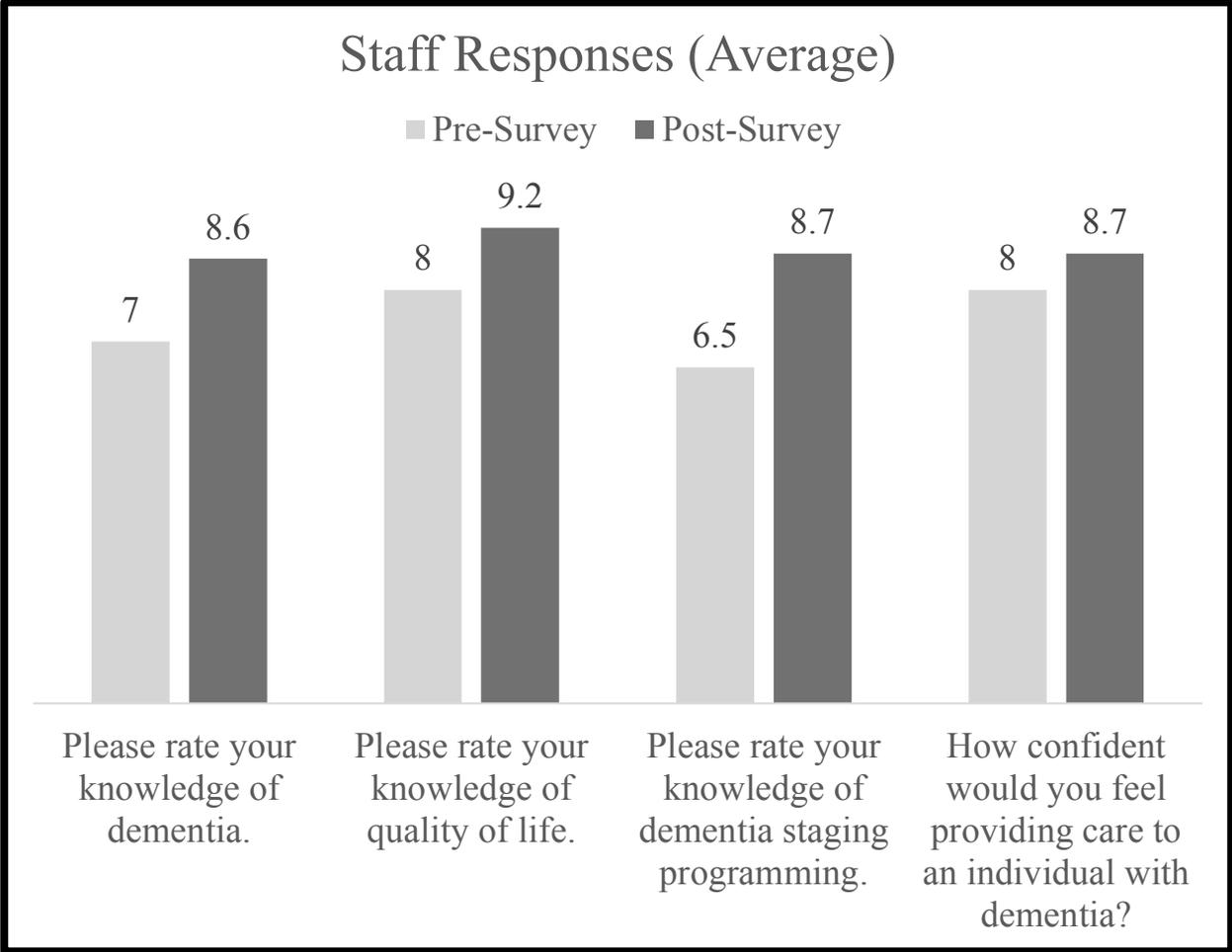


Table G3  
*Quantitative Data from Pre- and Post-Survey Responses*

<b><u>Item</u></b>	<b><u>Therapist Reported % Increase</u></b>	<b><u>Nursing Staff Reported % Increase</u></b>
<b>Please rate your knowledge of dementia.</b>	23.08%	22.86%
<b>Please rate your knowledge of quality of life.</b>	19.23 %	15%
<b>Please rate your knowledge of dementia staging programming.</b>	32.20%	33.85%
<b>How confident would you feel providing care to an individual with dementia?</b>	6.41%	8.75%

Figure G4

