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Reducing Feelings of Unpreparedness Experienced by Registered Nurses Assigned the Care of Covid-19 Positive Individuals with Intellectual and Developmental Disabilities

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**Reducing Feelings of Unpreparedness Experienced by Registered Nurses Assigned the
Care of COVID-19 Positive Individuals with Intellectual and Developmental Disabilities**

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Abstract

Background: Nurses assigned the care of individuals with intellectual and developmental disabilities (IDD) individuals, practice within a fragmented healthcare system. Nurses face barriers of patient competence and capacity to consent, communication challenges, a shortage of specialty providers, and fiscal limitation. The COVID-19 pandemic triggered requests from registered nurses, for guidance related to the care of individuals with IDD and diagnosed with the Severe Acute Respiratory Syndrome Coronavirus-2, the COVID-19 virus.

Purpose: The purpose of this project was to reduce, through the administration of in-service, feelings of unpreparedness experienced by registered nurses caring for individuals with intellectual and developmental disabilities and at risk for COVID-19 infection.

Method: Nurses enrolled in an IDD course offered by a local university, school of nursing were asked to participate in this research project. The object of the project was to assess the reduction of feelings of unpreparedness experienced by nurses likely to be assigned to care for COVID-19 positive individuals with IDD. The convenience sample of registered nurses enrolled in an IDD course, and consenting to participate in the project, received a 15-item pre- and post- in-service Likert scale survey project.

Results: Fourteen of 18 possible professional nurses enrolled in an IDD course, consented to, participate in the study. The participants completed the 15-item pre-post in-service Likert scale survey evaluating feelings of unpreparedness when the care of COVID-19 positive individuals with IDD. The post-in-service Likert scores reflected an improvement in pre- and post-survey scores in the four areas evaluated, knowledge, nursing practice, affective, and implementation. For questions evaluating nurse knowledge, a 0.97-point increase occurred between pre- and post-

survey scores, for nursing practice, a one-point increase, for questions evaluating nursing affect, a .13-point increase and for scores evaluating implementation strategies, a 0.57-point increase.

Keywords: Intellectual and developmental disabilities, COVID-19, unpreparedness, under-preparedness, policy, nurse curricula

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Reducing Feelings of Unpreparedness Experienced by Registered Nurses Assigned the Care of COVID-19 Positive Individuals with Intellectual and Developmental Disabilities

Introduction

Lerner and Pollack (2015, p.752) define an intellectual disability as, “a disability characterized by significant limitation both in intellectual functioning, reasoning, learning, problem-solving, and adaptive behavior”. Deinstitutionalization is defined as the permanent transition of individuals with intellectual developmental disabilities (IDD) from state-operated facilities to community-based services, to improve the quality of life for the population served or the replacement of institutional living with community living. For individuals with intellectual or developmental disabilities, trends of deinstitutionalization began in 1967 and have resulted in the closure of approximately 209 facilities, and the loss of training environments for IDD nurses (Lerner & Pollack, 2015). The permanent closure of the state-run facilities revealed an absence of the specialized clinical infrastructure needed to train nurses to support individuals with IDD (Lewis, 2015). The opportunity for nurse exposure to and quality contact with individuals with IDD associated with improved patient outcomes and the development of positive attitudes toward individuals with IDD diminished with state-run facilities' closure. Individuals receiving home and community-based services may be at risk due to receipt of care from nurses insufficiently prepared and without a system of replenishment of IDD-trained nurses. And further, the unmitigated health decline resulting in acute and chronic illness diagnosis threatens inflation of the approximately \$500 million of federal funding, which represents the portion of federal funding currently allocated for community support services for people with IDD (Friedman & Spassiani, 2017).

Nurses responsible for the provision of home and community based (nursing) supports may function independently, reinforcing feelings of unpreparedness regarding their ability to meet the healthcare needs of individuals with IDD (Auberry, 2018). Further, the absence of IDD-specific content and practical experience from standardized undergraduate nursing curriculum results in the loss of a student nurse's introduction to the spectrum of disability presentations (O'Reilly et al., 2018). Individuals with IDD experience limitations of understanding and expression (Desroches, 2022). Nurses assigned the care of individuals with IDD will need to execute various methods of assessment to detect and address health decline. In the absence of skills needed to assess the unique need of individuals with IDD, nurses may rely on unskilled staff to recognize symptoms of health decline or miss the symptoms, thus increasing the risk of mortality (Jaques et al., 2018).

Individuals with IDD report communication challenges with healthcare providers (Spassiani et al., 2020), incidences of avoidance, and the absence of inclusion in their own treatment planning (Spassiani et al., 2020). Barriers to communication of COVID-19 related symptoms indicating health decline, and attempts to self-advocate, may be diminished over time, or present differently for an individual with IDD and vary based upon the individual's level of functioning. Consequently, patients may not receive needed care from acute care medical facilities and providers because of a limited understanding of variations of patient presentation, communication, potential responses to treatment, and an inability to advocate for self (Desroches et al., 2021). Health care providers may also choose to communicate with caregivers and not directly with the IDD individual receiving care. This avoidance of direct involvement of the IDD individual in health care planning may cause barriers to quality care and affirm assumptions of stigma and discrimination for the individual (Spassiani et al., 2020). The avoidance or the

failure to include the IDD patient in decisions regarding care is attributed to the fast-paced, high stress, high patient turnover in medical settings, insufficient comfort or time needed to engage, and insufficient time to assess and adequately treat the IDD patient (Spassiani et al., 2020). State institutions offered student nurses exposure to individuals with IDD and instructional practice of educating nursing students about the treatment needs of individuals with IDD, activities that mitigate feelings unpreparedness experienced by registered nurses. (Peiris-John et al., 2021).

Before the COVID-19 pandemic, research confirmed that "Nurses feel unprepared when caring for a patient with intellectual disabilities" (Lewis et al., 2016, p.1473). Additionally, community nurses assigned the care of persons with IDD find themselves practicing within a fragmented healthcare system or navigating a team of clinical providers failing to communicate or coordinating services. Nurses assigned the care of individuals with IDD face challenges associated with determination and confirmation of (the IDD) patient's competence, capacity, ability to consent, shortage of specialty providers, and fiscal limitation. The existing fragmentation encountered by nurses was contributed to by a transition from a medical model of care to a social model, focused on the elimination of the need for nurses in the lives of persons with IDD (O'Reilly et al., 2018a). In the 1800s, nurse training programs were developed, and the specialty formally acknowledged. During the mid-20th century, a second shift, from the medical model of care to a more socialized model of support, resulted in dissolution of any semblance of a structured nursing process for caring for individuals with IDD, despite the continued demand for specialized medical care (Wilson et al., 2018).

Confirmation of a COVID-19 diagnosis, increased risk of spread, rapid onset of symptoms of health decline, and increased potential for lethality for members of the IDD population has exacerbated nurse concerns regarding preparedness. (Desroches et al., 2021).

People with IDD have a higher prevalence of specific comorbidities, such as hypertension, heart disease, respiratory disease, and diabetes, which are risk factors for poor outcomes from COVID-19 (Turk et al., 2020). Studies of the impact of COVID-19 on the IDD population confirm that mortality among people with IDD is 2.2 times higher than the overall COVID-19 case fatality rate for the general population (Desroches, 2021).

In summary research confirmed that feelings of (nurse) unpreparedness are associated with the loss of training environments caused by trends of deinstitutionalization.

State facilities or developmental learning centers offered registered nurses an introduction to IDD presentations when experiencing a decline in health. Along with facility closures, was the loss of opportunity to develop skills required to render competent care. In addition to an increased susceptibility to mortality and morbidity, the lack of policy mandating continuity of care exacerbated the feelings of unpreparedness reported by nurses assigned the care of COVID-19 positive individuals with IDD.

Problem Statement

The unmitigated health decline resulting in acute and chronic illnesses threatens inflation of the approximately \$500 million of federal funding allocated for community support services for people with IDD (Friedman & Spassiani, 2017). Research confirmed that coordinated efforts to mitigate, evaluate, and detect symptoms of infection and disease progression is beneficial to individuals with IDD (Mills, 2020). Marginalization, the placement in a position of powerlessness or unimportance is experienced by minority groups inclusive of women, people of color, and low socio-economic standing (Kantamneni, 2020). For persons with IDD, unmitigated risk continues to place individuals with intellectual and developmental disabilities at risk for becoming a model of predictable morbidity and mortality for marginalized groups (Sabatello et

al., 2020). Further, crises inflate the risk of disparity due to limited resources (Kantamneni, 2020).

Competent nursing practice is established through the development and execution of specialized skills related to the needs of the target population (O'Reilly et al., 2018). "IDD nursing is complex and considered outside the realm of common nursing practice" (Auberry, 2018, pg. 23). IDD nurses receive little to no formal education or exposure to working with individuals with IDD prior to entering formal practice. IDD related content is not present in IDD curricula, due to funding scarcity and lack of nursing informed faculty (Auberry, 2018). IDD nurses often work in non-traditional care settings, to include but not limited to day programs, residential homes, schools, and clinics. As such, (IDD) nurses, when practicing in non-traditional care settings, are not given the authority of unlicensed staff to whom clinical tasks may be delegated or proxied, and amid uncertainty of the legality of the practices (Auberry 2018). Equally inadequate to the formal training of nurses on the provision of care for IDD persons, is the training of physicians and other healthcare professionals (Auberry, 2018). Nurses are responsible for providing skilled care to IDD individuals across multiple environments, including hospitals, congregate living settings, day programs, family homes, or in a private residence. Care is provided with the support from direct care staff, and within varied geographical locations, urban, suburban, and rural (Jaques et al., 2018). For clinicians, the loss of adequate training environments and practical experience project deprioritization of the needs of the IDD population and renounce the skills nurses need to provide specialized care to persons with IDD in diverse settings (O'Reilly et al., 2018).

Individuals with IDD experience a higher prevalence of conditions such as hypertension, heart disease, respiratory disease, and diabetes (Turk, 2020). Further, individuals with IDD

experience morbidity and mortality from preventable illnesses such as aspiration, fecal impaction, and the side effects of polypharmacy (Wilson et al., 2020). Preliminary confirmation of Turk's (2020) hypothesis asserted that individuals with IDD and COVID-19 diagnoses have higher fatality rates due to circulatory, endocrine, and pulmonary pathology prevalence. Additionally, deinstitutionalization and the resulting transition from the medical model to the social model resulted in the establishment of smaller residential living arrangement in community environments (O'Reilly et al., 2018a). However, for those receiving home and community-based services, deinstitutionalization did not eliminate the risk of virus contraction created by residing in congregate residences services (Wilson et al., 2019).

When the COVID-19 pandemic started in 2020, clinical experts in IDD received an abundance of outreach from nurses requesting practice guidelines. Inquiry into measures implemented to address and mitigate the risk of health decline and subsequent COVID-19 exposures revealed challenges to nursing execution of the most basic nursing interventions. Nurses experienced challenges ranging from acquisition of personal protective equipment, implementation of infection control protocols, and execution of structured assessment intended to confirm symptomology of declining health and resulting treatment, planning, and intervention (Desroches et al., 2021)

Smaller three- or four-person residence require multiple direct support staff to address the needs of individuals with IDD residing in community (Hotez et al., 2021). Congregate settings, such as residential group homes serve as environments for infectious spread (Landes et al., 2020), and a lack of policies and protocols failed to facilitate appropriate public health outbreak response (Mills, 2020). Individuals experiencing health decline due to COVID-19 diagnoses

require more community-based skilled nursing to mitigate further deterioration and assess, implement, and evaluate the efficacy of treatment.

When prepared, nurses play an essential role in recognizing and treating individuals with IDD experiencing health decline related to COVID-19 diagnosis. This project evaluated the impact of in-service on feelings of unpreparedness experienced by IDD nurses when caring for COVID-19 positive individuals.

PICOT Question

For nurses assigned to COVID-19 positive individuals with IDD, what was the impact of in-service based on the assessment and treatment, on feelings of unpreparedness?

Review of Literature

Search Strategy

The formulation of the clinical question and focus of the evidence-based practice resulted from a literature search using the following databases: Cochrane Library, PubMed, CINAHL, Science Direct, and Education Source. The search generated international publications related to the selected topic. The following search terms developed the inventory of publications reviewed: intellectual disabilities, coronavirus, COVID-19, nurse, nursing, inequality in health, practice standards, nursing education, perception, and health checks. The review included research articles published in English between 2013 and 2021; included in the literature review were articles addressing needed nursing education and training, policy and procedures and protocols to address the need of COVID-19 positive individuals with IDD. Excluded from the literature review were articles featuring spectrum disorders and deletion syndrome; diagnosis may occur independently of intellectual disability (Tummers et al., 2020). The Severe Acute Respiratory

Syndrome Coronavirus-2 (SARS-CoV-2 or COVID-19) classification as a novel virus helped to establish date search parameters.

The database search identified 185 studies and eight applicable studies via manual review of reference lists; this resulted in the identification of 193 total studies. Prescreening resulted in the retention of 49 studies; 144 studies were discarded due to a focus on bates as the source of infection, absence of the reference of the individual with ID, non-relational topics, absent focus on ID nursing, publish date beyond five years or publication in a foreign language. The 49 remaining studies were reviewed for the strength of evidence; 25 additional studies were excluded due to weakness of the evidence, duplicative content, and focus on law related to consent.

This project's three critical foci became the focus of the literature review: (a) the absence of core content from nursing curricula and correlation to feelings of unpreparedness, (b) the heightened risk to individual with IDD, and (c) the absence or lack of robust public policy, and health care emergency planning. Synthesis of evidence-based research will establish the foundation of the focus of the student investigator's quality improvement project: to facilitate nurse competence, innovation, and performance when presented with the responsibility of caring for an individual with IDD diagnosed with COVID-19.

Insufficient Training

There is a deficit of published research driving evidence-based practice of nurses caring for individuals with IDD (Auberry, 2018). Available research such as Smeltzer's (2005) survey of the presence, integration, and prioritization of IDD related content into the schools of nursing curricula revealed fundamental oversights or educational strategy that inadvertently results in challenges of effective implementation of the nursing process when caring for the IDD

individual. First, respondents to randomized sample of survey revealed a definition of disability that included elderly, pediatric and psychiatric mental health population, and were less inclusive of young and middle-aged adults with physical disability and more exclusionary of members of the intellectual and developmental population. Second, schools of nursing prioritized the development and instruction of content that prepared nursing students for National Council Licensure Examination (NCLEX) examination; further stating, "if it is not tested [by NCLEX], we don't teach it" (Smeltzer, 2005 p. 214). Finally, the majority (89% and 77%) of respondents reported using the medical or rehabilitation model to teach disability related content. Trends of deinstitutionalization and the American Disabilities Act of 1990 drove social and interface models focused on overcoming social and environmental barriers and person-centered treatment and planning that is inclusive of the individual. Social interface models do not align with existing models of nursing education. This misalignment of training and practice models drive unfavorable views and experiences for practicing nurses.

Policy and Emergency Preparedness

Per the World Health Organization (WHO), the purpose of national health policies and strategies is to define a country's health care vision for the public or populations experiencing health disparities and to set forth initiatives to ensure the general population's health, and the health of people experiencing disparity. Sabatello (2020) asserts that the field of public health has just begun to recognize the challenges to the ID population. Past pandemics, such as the H1N1, offered to warn of population impact in the absence of policy, guidelines and accommodating and protecting vulnerable people such as individuals with IDD. Federal Agencies, such as FEMA (Federal Emergency Management Agency), emphasized the necessity of governmental dominion in protecting individuals with IDD. When developing and

implementing emergency planning to prevent communication barriers, discrimination, and healthcare rationing, there is evidence that recommendations remain unheeded. New York's 2015 Ventilator Allocation Guidelines remain an example of oversight of impact on the population. Latitudinal interpretation of the law could result in triage allowance for treatment eligibility during periods of health care rationing and removal and reallocation of personal ventilators of IDD individuals requiring this form of mechanical support (Sabatello et al., 2020).

Heightened Risk Due to COVID-19

Individuals with IDD have a higher prevalence of conditions that establishes heightened vulnerability during the COVID-19 pandemic. Preliminary confirmation of Turk's (2020) hypothesis asserted that individuals with IDD and COVID-19 diagnoses have higher fatality rates due to circulatory, endocrine, and pulmonary pathology prevalence. The transition from the medical model to the social model resulted in deinstitutionalization and a fertile environment for infectious spread. A portion of the IDD community resides in congregate settings such as group homes, and the presence of policies and protocols that facilitate appropriate outbreak response (Mills, 2020).

The Impact of COVID-19 to the IDD Community

Lessons from the H1N1 pandemic occurred in the form of recommendations from the Centers for Disease Control (CDC) informing the public health community that members of the disability population with challenges of mobility and cognition were at heightened risk of "development of influenza-like complications" (Sabatello et al., 2020, p. 1523). As the COVID-19 pandemic persists, discussions of medical rationing are evidence of the collapse of the acute medical care infrastructure (Andrews et al., 2020). Tools and algorithms used to determine recipients of life-saving care incorporate implicit bias, judgment regarding the quality of life

(Sabatello et al., 2020), or pinged upon clinical frailty determinations that are questionably applicable to the population of individuals with ID (Alexander et al., 2020).

Research studies corroborate the synergistic impact of absent nurse training on the needs of individuals with intellectual and developmental disabilities during the current health crisis. The term pandemic was included in the literature appraisal process. Further, Tummers et al. (2020) confirmed through analysis that despite scant availability of studies offering investigative findings of the impact of the COVID-19 virus upon the population of individuals with intellectual and developmental disabilities, the number of articles available through open research datasets was sufficient to establish influence.

Conceptual Framework

Assessment, planning, intervention, and evaluation are the problem-solving processes nurses implement to address patient health decline. For the population of individuals with IDD, co-occurring higher prevalence rates of chronic illnesses and communication challenges place individuals with IDD diagnosed with COVID-19 at heightened risk of morbidity and mortality (Peiris-John et al., 2020). The individual's health decline scenario is a metaphoric representation of the practice of IDD nursing, the process of diagnosis, assessment, planning, intervention, evaluation, and continual implementation of improvement strategies to address the assessed deficit.

Lippitt's Seven-Step Change Framework applies to implementing this DNP project, focused on Reducing Reported Registered Nurse Feelings of Unpreparedness, in the care and support of the COVID-19 positive individuals with IDD, utilizing Pretest and Posttest design. Lippitt's Change Theory emphasizes implementation of change by focusing on communication skills, rapport development, problem-solving, and established evaluation (Mitchell, 2013). The

actualization of Lippitt's Change Theory has seven phases: diagnosing the problem, assessing motivation and capacity for change, assessing change agent's motivation and available resources, selecting progressive change objectives, choosing the appropriate role of the change agent, maintaining change, terminating the helping relationship (Mitchell, 2013, p.33).

Phase I: Diagnose the Problem

The documented challenges faced by nurses caring for individuals with intellectual and developmental disabilities; this was confirmed by nurse communication of feelings of "unpreparedness" when caring for individuals with IDD (Auberry, 2018), coalesced with the COVID-19 health crisis, there is a risk of health care rationing (Auberry, 2018).

Lack of education regarding population: When assigned the clinical responsibility of treating the IDD patient, the nurse may encounter distinct morphology, methods of communication, or responses to traditional clinical pathways. For health care professionals, the educational preparation to care for patients with IDD for nurses is minimal. Traditional academic curricula do not prepare the emerging nurse to engage, assess and recognize signs of health decline, acquire collateral information, modify communication and assessment procedures, detect health changes, or develop care plans that support the IDD patient. Nurses have reported receiving no formal training, practice experience, or orientation to the care of individuals of the IDD population (Auberry, 2018).

Population health care complexity: "Chronic health conditions among individuals with IDD include aspiration, dehydration, constipation, seizure, motor deficits, allergies, otitis media, gastroesophageal reflux disease, diabetes, dysmenorrhea, sleep disturbances, thyroid disorders, mental illness, communication, vision and hearing impairment, and oral health problems" (Auberry, 2018, p. 24). Individuals with IDD may experience these chronic health conditions may

occur independently or simultaneously. Nurses implement interventions based on the conduction of patient assessment however, for persons with IDD, the transition to home and community-based services often results in team support of the patient. Nurses may become reliant on member of the individual's psychosocial support network and elect to acquire information from members of the support team to complete assessment, planning, interventions, and evaluation activities.

Varied practice settings/Varied care principles and role for nursing across settings:

Nurses may be assigned to care for the patient with IDD in various locations, each setting presenting challenges to providing care (Auberry, 2018). Nurses may rely on caregiver's report to obtain needed information to complete assessment, to avoid possible communication challenges when assessing for pain or changes in condition or avoid communication with the IDD patient altogether. The hospital environment may trigger for IDD patients, the manifestation of behavioral challenges, which may lead to the use of chemical and mechanical restraints and subsequent side effects or injuries (Spasiani et al., 2020). In community settings, nurses perform independent evaluation of individuals in health decline and decide when to seek higher levels of care. Nurses require training, delegating skilled tasks, and rely upon identifying and notification of the status change by non-licensed entities to whom the nurse has no supervisory authority (Auberry, 2018). The transition to home and community-based services has a component of community living support that may result in the determination of home health nursing for individuals with chronic, complex medical conditions. Nurses are faced with interruption of nursing care delivery by legal guardians that attempt to direct skilled care inconsistent with physician orders. The lack of evidence-based interventions to guide the nursing practice and care of people with IDD is related to the nurses' education on the healthcare model. Policy trends

driving deinstitutionalization to a social model of home and community-based services have occurred without the evolution and standardized development of a nursing model of care to support the individual transition, despite complexity (O'Reilly et al., 2018).

Phase II: Assess the Motivation and Capacity for Change

The COVID-19 National Health Crisis establishes a heightened risk of morbidity and mortality for individuals with IDD that results in inadequately trained nurses. Nurses will need to be prepared to adapt the existing clinical practice to meet the individual's needs with IDD diagnosed with COVID-19 (Cuypers et al., 2020). The absence of foundational training and protective public for people with IDD is a threat to a responsive and prepared nurse workforce.

This quality improvement project's singular goal was to facilitate nurse competence, innovation, and performance for caring for an individual with IDD diagnosed with COVID-19. The DNP project will include implementing methods of Learning Transfer, an effective way of acquisition of nursing knowledge, and transfer of content into practice (Ignatavicius, 2016). The post in-service survey assessed learner perception of application of in-service content up return to the workplace. The success of the DNP project was based upon study participants perception of feelings of preparedness and their capacity to change practice when caring for a COVID-19 positive individual with IDD. The student investigator evaluated three factors indicating population capacity to change; the confirmation of the target population's skill set, formal system, and process available to facilitate change agent ability to execute quality initiative, and organizational culture or values. Statewide outreach from nurses practicing in diverse settings established a receptive audience.

Phase III: Assess the Resources and Motivation of the Change Agent

Research identifying the impact of COVID-19 to the health of people with IDD was sparse, as was the guidance to nurses regarding the assessment and treatment of infected and at-risk individuals with IDD (Landes et al., 2021). As a director of a state clinical office, my team is responsible for oversight of a portion of the IDD population residing in Georgia. Responsibilities of the office include the confirmation of residential and clinical provider response to changes of condition of individuals with IDD in receipt of home and community-based services. Nursing requests for clinical guidance of how to mitigate and contain the spread and support individuals with IDD infected with COVID-19 served as the motivation for this quality improvement project.

Phase IV: Choosing Progressive Change Objects

In May 2021, the project implementation plan was drafted to evaluate the strengths, weaknesses, opportunities, and threats to the successful implementation through analysis and finalizing the DNP implementation plan, including timetable and deadlines. The planning and preparation phase of project implementation plan occurred from May 2021 through mid-September 2021. The implementation and analysis portion of the implementation plan occurred from September 2021 through January 2022. The final phase extended from November 2021 to May 2022.

Phase V: Choosing the Appropriate Role for the Change Agent

Having access to data generated by clinical oversight of a portion of the state's IDD population generates information indicating practice deficiencies. Data analysis establishes the requisite to address the identified clinical practice deficiencies; the nurse subject-matter expert develops clinical practice training content to address identified deficiencies.

Phase VI: Maintain Change

Results of the pre- and post-in-service surveys will be communicated to the organizational leadership of state agencies and providers of HCBS agencies. Participants of the study were informed of the applicability of in-service to other areas of assessed practice challenge. Included in communications will be recommendations of methods for use of in-service to improve nurse practice within state and providers agencies.

Phase VII: Termination

Project Participants will train nurses to identify practice guidelines to develop content applicable to the ID individual's clinical care. Lippitt's change theory contains an element of the nursing process; this establishes the benefit of familiarity with stakeholders involved in the nurse practice change and rationale for intervention, the motivation underpinning nurse practice. Lippitt's change theory is a framework; when implemented proactively, facilitates the address of foreseeable challenges (McKeon, 2009). The execution of this DNP project with a familiar framework to ID nurses will facilitate the application of training strategy to other areas of deficient practice, a primary function of phase six of Lippitt's theory, the maintenance phase.

Implementation and Evaluation

Methodology

The IDD population continue to face social, policy and now medical disparities. The population of individuals with IDD residing in the community, living longer, and experiencing milestones of advanced aging is growing, and the number of individuals with IDD projected to reach advanced age will have doubled by 2030 (McGinley et al., 2021). The conditions associated with aging include a higher prevalence than the general population, of conditions of cardiac, endocrine, and respiratory functioning; conditions associated with poorer COVID-19 outcomes (Turk et al., 2020), and driving the need for stronger social, medical, public practices

and policies (McGinley et al., 2021). A quasi-experimental project integrating pre-in-service survey/post-in-service survey design was administered to the convenience sample of 14 registered nurses enrolled in an IDD course. The course was developed in partnership with a state agency and offered through the local university school of nursing in the southern United States and has been offered for the last five years to nurses specializing in IDD. One instructor was assigned to deliver the course content; and was conducted remotely, synchronously, and asynchronously through the university distance learning platform. The registered nurses enrolled in the course were eligible for project participation.

Inservice content was developed to highlight the issues of social, medical and policy issues facing the IDD population during the COVID-19 pandemic and administered as adjunct content to course enrollees consenting to participate in the qualitative project. In this qualitative project, the methodology used to determine the sample size is based upon the number of registered nurses available in the potential participant pool. The maximum number of IDD course participants was 20, therefore the maximum number project participants was 20. The age range of the subjects to be enrolled in the project is 18-89 years. Minors were not eligible to become members of the participant group. The course facilitator emailed the pre-in-service link to all participants consenting to participate in the study. After the administration of pre and post in-service surveys, Likert ratings were compared, and examined for differences.

Subjects/Recruitment

The IDD course was available to registered nurses employed with providers of IDD services or employed with the state agency responsible for the administration of Home and Community-based Services (HCBS) to individuals with IDD and clinical oversight of their care. Registered nurses were chosen because of the oversight responsibilities for individuals in HCBS

services and the risk of COVID-19 infection to IDD individuals. Oversight responsibilities include routine assessment of individuals with IDD to identify decline in health, the need for implementation of risk mitigation interventions, to include but not limited to the development and training of direct care staff to implement health care plans.

Nurses enrolled in the IDD course, were invited to participate in the qualitative study. The requirement for course enrollment was employment in IDD nursing, a group of nurses likely to be assigned to care for the COVID-19 positive individual with IDD. The IDD course, which was offered through the university school of nursing, was an optimal place to obtain the sample of participants, because the course objectives included development and improvement upon existing IDD nursing experience. The declaration of a public health crisis created a demand for clinical guidance and a need for nurse education related to the assessment for and mitigation of health decline related to COVID-19 infection (Desroches et al., 2021).

The IDD course was administered remotely to participants. Nurses received a copy of the invitation script and consent via email and were invited to participate in the study during the day of orientation for the IDD course. Nurses who chose to participate in the project completed and returned consents electronically and secured on a password protect laptop owned by the student investigator

Setting

A nationally ranked local university offered access to registered nurses specializing in IDD nursing through the offering a course focused on the history of IDD and nursing. The course was developed through partnership with a state agency responsible for the administration of home and community-based services (HCBS) to individuals with IDD, and in response to outreach from the network of IDD providers, providing HCBS through Medicaid waiver. IDD

Providers of HCBS employ or contract with registered nurses assigned the direct care or oversight of the provision of skilled nursing to individual with IDD, establishing the group of enrolled nurses as an ideal site for conduction of the project.

Instrument and Tools

"Learning self-efficacy, defined as learners' confidence in their capability to learn specific subjects; it is crucial for enhancing academic progress; learning self-efficacy is positively correlated with academic achievements and effective learning strategy use" (Kang et al., 2019, p. 1). The Learning Self Efficacy Scale (L-SES) is a scale or generic assessment tool developed to measure the learning self-efficacy, or the belief of one's ability to perform clinical skills. The L-SES is adaptable to reflect assessment of target clinical skills and was replicated for this project (Kang et a l., 2019). The modification of the survey items was based upon the project-related research. For this project, the L-SES was adapted to measure the registered nurse's confidence in applying targeted skills reviewed during in-service. (Kang et al., 2019),

The pre and post in-service survey was developed using Qualtrics (Qualtrics, Provo, UT), the online survey tool. The platform was used to distribute and collect data, analyze, and visually display results. The pre- and post-in-service survey was administered to the sample of 14 nurse participants between September 28th, 2021 and January 2022, via emailed links. Nurses consenting to participate in the project received a web-based in-service as adjunct content to the existing course content; each nurse participants received the in-service after completing the pre-in-service survey. The in-service focused on five core elements: history, education/training, policy, adoption, and assessment and risk mitigation strategies implemented to address the needs of like populations. The consents and de-identified surveys are secured in a labeled electron file, located on a secure server; de-identification was achieved by electing the anonymization

capability during the development process of the survey. The content is accessible via a password-protected laptop owned by the student investigator and stored in a private locked office.

Results

Respondents were asked to evaluate and rate 15 items in the pre-in-service survey using a 5-point Likert scale and one question establishing fundamental education. The scale measured the items on a continuum from strongly agree to strongly disagree, with a neutral response as an optional rating. The survey prompted respondents to rate statements related to knowledge, practice, affect, and implementation.

Data was exported and converted into Microsoft Excel and uploaded into Statistical Package for the Social Sciences (SPSS) statistical software (SPSS Inc., Chicago, Ill., USA). The 14 registered nurses received in-service and surveys electronically. After the analysis of responses with SPSS, Cronbach's alpha was found to be 0.930 for the pre-survey answers, indicating good internal consistency (Kim, n.d.). After the in-service, the Cronbach's alpha was 0.996, again demonstrating internal consistency for the 14 participants surveyed (Kim, n.d.). The 15 items in the modified L-SES were reliable and consistently measured self-efficacy of the pool of participants in-serviced. The Qualtrics software was used to calculate the mean, mode, variance, and standard deviation (SD) for each component analyzed.

Fundamental Education

Thirteen participants responded to the item evaluating feelings of preparation to care for individuals with IDD through fundamental nurse training. One participant did not respond to the statement evaluating preparation through basic training. The mean score among respondents was 2.62 (SD=1.21). Of the 13 responses, the largest percentage of respondents, 61.54% or eight of

the responders, somewhat disagreed their fundamental nursing training adequately prepared them to care for individuals with IDD.

Nursing Knowledge

Fourteen participants responded to four statements evaluating feelings about knowledge related to care, protocol development, interview strategies, and skills integration when caring for individuals with COVID-19 positive IDD.

Sufficient Knowledge

Before in-service, the mean score among respondents was 2.86 (SD=1.12). Of the 14, the largest percentage of respondents, 42.86% or six respondents, somewhat agree with possession of sufficient knowledge of how to care for COVID-19 positive individuals with IDD. No one responded with a strong agreement. After in-service, the mean score among respondents was 4.43 (SD=0.82). Of the 14 respondents, 57.14% or eight respondents, strongly agree with possession of sufficient knowledge of caring for COVID-19 positive individuals with IDD.

Contribute to the Development of Nursing Protocols

Before in-service, the mean score among respondents was 3.21 (SD=1.01). Of the 14 responses, the largest percentages, 35.71% or five participants, responded with a rating of somewhat agree and neither agree nor disagree with their perceived ability to develop nursing protocols for COVID-19 positive individuals with IDD. No one responded with a strong agreement. After in-service, the mean score among respondents was 4.43 (SD=1.05). Of the 14 responses, the largest percentages, 64.29% or nine participants, responded strongly, agreeing with their perceived ability to develop nursing protocols for COVID-19 positive individuals with IDD.

Ability to Perform Patient Interviews

Before in-service, the mean score among respondents was 3.86 (SD=0.83). Of the 14 responses, the largest percentages, 42.86% or six participants, responded with a rating of neither agree nor disagree with their perceived ability to implement clinical strategies taught during the in-service. No one responded with ratings of strongly agree or somewhat disagree. After in-service, the mean score among respondents was 4.43 (SD=1.05). Of the 14 responses, the largest percentages, 64.29% or nine participants, responded with a rating of strongly agree with their perceived ability to implement clinical strategies taught.

Integration of Physical Assessment

Before in-service, the mean score among respondents was 4.00 (SD=0.76). Of the 14 responses, the largest percentages, 42.86% or six participants, responded with a rating of somewhat agree with their perceived ability to integrate physical assessment skills, evaluation of behavior, interview, and review. No one responded with ratings of strongly agree or somewhat disagree. After in-service, the mean score among respondents was 4.50 (SD=1.05). Of the 14 responses, the largest percentages, 71.43% or 10 participants, responded with a rating of strongly agree with their perceived ability to integrate the skills of physical assessment, evaluation of behavior, interview, and review.

Nursing Practice

Fourteen participants responded to three statements evaluating feelings about nursing practice related to identifying dynamics the relationship between the nursing process and discussed care strategies and comfort with exercising autonomy when caring for individuals with COVID-19 positive individuals IDD.

Identification of Dynamics Contributing to Feelings of Unpreparedness

Before in-service, the mean score among respondents was 3.57 (SD=1.12). Of the 14 responses, the largest percentage of responses, 57.14% or eight respondents, somewhat agree with their ability to identify the dynamics contributing to feelings of unpreparedness experienced when caring for a COVID-19 positive individual with IDD. After in-service, the mean score among respondents was 4.57 (SD=1.05). Of the 14 responses, the largest percentage of responses, 78.57% or 11 respondents, strongly agree with their ability to identify the dynamics contributing to feelings of unpreparedness when caring for a COVID-19 positive individual with IDD.

Ability to Explain the Relationship Between the Nursing Process and Care

Before in-service, the mean score among respondents was 3.43 (SD=0.98). Of the 14 responses, the largest percentage of responses, 50.0% or seven respondents, somewhat agree with their ability to identify the dynamics contributing to feelings of unpreparedness experienced when caring for a COVID-19 positive individual with IDD. After in-service, the mean score among respondents was 4.43 (SD=1.05). Of the 14 responses, the largest percentage of responses, 64.29% or nine respondents, strongly agree with their ability to identify the dynamics contributing to feelings of unpreparedness experienced when caring for a COVID-19 positive individual with IDD.

Comfort with Exercising Autonomy

The mean score among respondents was 4.36 (SD=1.11). Of the 14 responses, the largest percentage of responses, 64.29% or nine respondents, strongly agreed with their ability to exercise autonomy in the clinical management of COVID-19 positive individuals with IDD.

Affective

Before and after the administration of in-service, 14 participants responded to four statements evaluating feelings about nursing practice related to allotting additional time to review collateral information, knowledge gained from in-service, and plan to seek information related to the care of COVID-19 positive individuals with IDD.

Will Allot Additional Time Reviewing Additional Content

Before in-service, the mean score among respondents was 4.43 (SD=0.62). Of the 14 responses, the largest percentage of responses, 50.0% or seven respondents strongly agree with plans to allow additional time to review collateral information when caring for COVID-19 positive individuals with IDD. After in-service, the mean score among respondents was 4.50 (SD=1.12). Of the 14 responses, the largest percentage of responses, 78.57% or eleven respondents, strongly agree with plans to allow additional time to review collateral information when caring for COVID-19 positive individuals with IDD.

Belief Knowledge Will Be Gained from In-Service

Before in-service, the mean score among respondents was 4.43 (SD=0.62). Of the 14 responses, the largest percentage of responses, 50.0% or seven respondents strongly agree with acquired knowledge from in-service. After in-service, the mean score among respondents was 4.50 (SD=1.05). Of the 14 responses, the largest percentage of responses, 71.43% or ten respondents, strongly agree with acquired knowledge from in-service.

Will Pay More Attention to Information Related to the Care of COVID-19 Positive Individuals with IDD

Before in-service, the mean score among respondents was 4.43 (SD=0.62). Of the 14 responses, the largest percentage of responses, 50.0% or seven respondents, strongly agreed with plans to pay more attention to information related to the care of COVID-19 positive individuals

with IDD. After in-service, the mean score among respondents was 4.64 (SD=1.04). Of the 14 responses, the largest percentage of responses, 85.71% or 12 respondents, strongly agreed with plans to pay more attention to information related to the care of COVID-19 positive individuals with IDD.

Will Actively Look for Information Facilitating the Care of COVID-19 Positive Individuals with IDD

Before in-service, the mean score among respondents was 4.36 (SD=0.72). Of the 14 responses, the largest percentage of responses, 50.0% or seven respondents, strongly agreed with plans to actively look for information related to the care of COVID-19 positive individuals with IDD. After in-service, the mean score among respondents was 4.50 (SD=1.05). Of the 14 responses, the largest percentage of responses, 71.43% or ten respondents, strongly agreed with plans to actively look for information related to the care of COVID-19 positive individuals with IDD.

Implementation

Before administration of in-service, 13 participants respond to four statements evaluating feelings about the ability to implement clinical strategies involving COVID-19 positive individuals IDD. One participant did not respond to the implementation questions. 14 participants responded to the post-in-service survey.

Ability to Imitate Steps and Actions Integrating Use of Tools Presented in In-Service

Before in-service, the mean score among respondents was 3.69 (SD=0.99). Of the 13 responses, the largest percentage of responses, 46.15% or six respondents, neither agreed nor disagreed with the ability to imitate steps and actions of integrating multiple tools and resources in providing care of COVID-19 positive individuals with IDD. After in-service, the mean score

among respondents was 4.50 (SD=0.82). Of the 14 responses, the largest percentage of responses, 64.29% or nine respondents, strongly agreed with the ability to imitate steps and actions of integrating multiple tools and resources in providing care of COVID-19 positive individuals with IDD.

Ability to Complete the Steps of Risk Mitigation Presented in In-Service

Before in-service, the mean score among respondents was 3.92 (SD=0.83). Of the 13 responses, the largest percentage of responses, 38.46% or five respondents, neither agree nor disagree with the assessed ability to complete the steps of risk mitigation strategies to support the COVID-19 positive individual with IDD. After in-service, the mean score among respondents was 4.57 (SD=0.82). Of the 14 responses, the largest percentage of responses, 71.43% or ten respondents, strongly agreed with the assessed ability to complete the steps of risk mitigation strategies to support the COVID-19 positive individual with IDD.

Intent to Monitor Assessment Skills for Opportunities of Improvement

Before in-service, the mean score among respondents was 4.23 (SD=0.70). Of the 13 responses, the largest percentage of responses, 46.5% or six respondents, somewhat agreed with the intent to monitor assessment skills for opportunities for improvement. After in-service, the mean score among respondents was 4.64 (SD=1.04). Of the 14 responses, the largest percentage of responses, 85.71% or 12 respondents, strongly agreed with the intent to monitor assessment skills for opportunities for improvement.

Monitor and Adjust Risk Mitigation Planning

Before in-service, the mean score among respondents was 4.23 (SD=.70). Of the 13 responses, the largest percentage of responses, 46.15% or six respondents, somewhat agreed with plans to monitor and adjust risk mitigation planning when caring for a COVID-19 positive

individual with IDD. After in-service, the mean score among respondents was 4.64 (SD=1.04). Of the 14 responses, the largest percentage of responses, 85.71% or 12 respondents, somewhat agreed with plans to monitor and adjust risk mitigation planning when caring for a COVID-19 positive individual with IDD.

Discussion

The results of this study represent the impact of the use of in-service on nurse perceptions of self-efficacy or the ability to apply newly acquired knowledge on feelings of unpreparedness. The in-service was associated with significant improvement in the realms of knowledge, practice, affect, and implementation; elements confirmed through research as impacting feelings unpreparedness. Increases in Likert scores represented a strong agreement with the efficacy of the in-service intervention. The motivation to acquire knowledge and the perception of the ability to access and attain specific information and skills can be associated with reducing feelings of unpreparedness experienced by nurses involved in the project. The lack of guidelines regarding the specialized needs of individuals with IDD the oversight of the IDD population during emergency planning establishes the need to expand the scope of health policies, evidence-based research, and training for nurses.

Practice Implications

In-service can positively impact and mitigate feelings of unpreparedness experienced by nurses assigned to individuals with IDD. The COVID-19 healthcare crisis has created an opportunity to establish effective methods of using in-service methods to prepare nurses to assess and treat individuals with IDD regardless of the cause of health decline. In-service content revealed systemic dynamics and social determinants impacting the nurse's ability to render informed care. Projected limitations of the project include the impact of the order of survey

questions on participant ratings. The time between pre-in-service survey and in-service allows for external influences upon the nurse's awareness of unpreparedness to impact post-survey data.

Summary

The results of this project indicate a positive outcome related to the reduction of the feeling of unpreparedness for nurses assigned to COVID-19 positive individuals with IDD. The project did not consider the impact of acknowledgment of unpreparedness as a modifier of those feelings; the survey did not assess this factor. Overall, the post-in-service Likert scores reflected an improvement in the four areas evaluated, with the largest increase reflected in the Practice portion of the survey and the smallest increase occurring in the Affective part of the survey. The project and survey scores establish an incentive to assess and address and evaluate the demand for additional research required to expand in-service models to mitigate challenges of caring for individuals with IDD, whose health may be negatively impacted by existing and new challenges to quality care.

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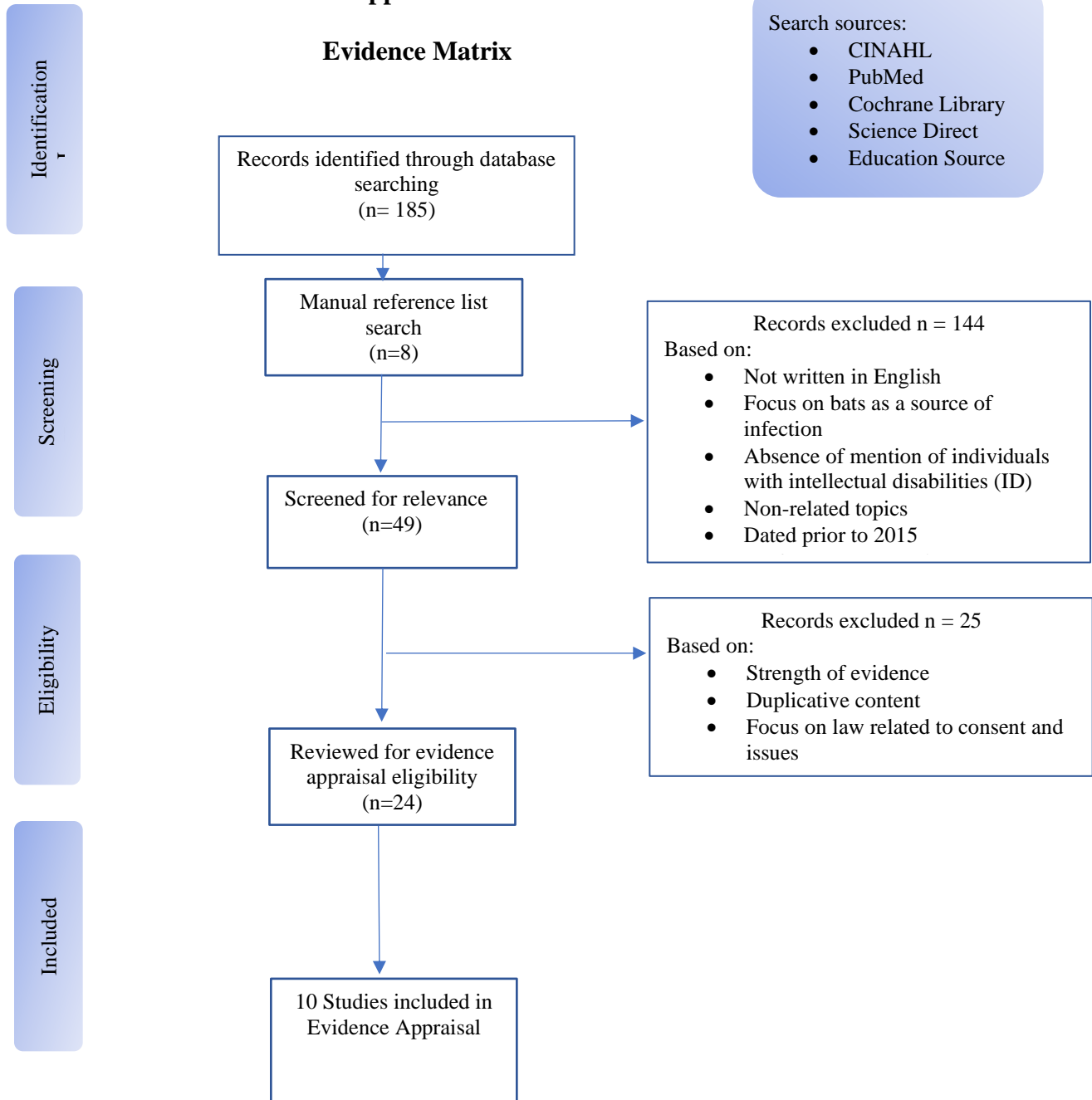
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Appendix A

Evidence Matrix



Appendix B

Project Implementation Plan

	Action Items	Action Needed	Date completed to be completed	Completed or Reason not completed	Revisions
Planning and Preparation	Confirm need for Emory IRB Approval	No additional action needed	May 16 th , 2021	Completed	
	Finalize GSU IRB Approval	No additional action needed	June 17 th , 2021	Completed	
	Prepare/Finalize recruitment material (Consent/Survey/Script)	Finalization of survey in Qualtrics	September 10 th , 2021	Completed	
	Meet with Dr. Osbourne about questionnaire	Establish meeting with Dr. Osbourne to review survey	September 1st-10 th , 2021	Completed	
	Meet with Emory Curriculum Instructor to schedule in-service	No additional action needed	May 15 th , 2021	Completed	
	Action Items	Action Needed	Date to be completed	Completed or Reason not completed	Revisions
Implementation and Analysis	Administer recruitment (appendices) Materials: Participant invitation letter <ul style="list-style-type: none"> ▪ Survey used to measure variables ▪ Informed Consent ▪ Participant Instructions 	Administration to occur during Emory Curriculum Orientation	September 20 th , 2021	Completed	

	Recruitment at project site	Recruitment to occur during Emory curriculum orientation	February 23, 2021	Completed	
	Conduct in-service	In-service to occur during course web-ex session	September 20 th , 2021	Completed	
	Conduct any needed follow-up	Upon identification of the need for additional participants or data points	September 30 th , 2021	Completed	
	Data collection	Participant recruitment and survey conduction	September 15 th - October 31 st , 2021	Completed	
	Consult with Dr. Osbourne re data analysis	Consultation to inform the data analysis processes	October 2021	Completed	

	Perform data analysis	Conduct and perform analysis of survey data	January, 2022	Completed	
	Abstract Preparation	Develop and submit to DNP Team	February, 2022	Completed	
	Action Items	Action Needed	Date to be completed	Completed or Reason not completed	Revisions
Project Finalization	Application for graduation	Submit graduate application	May 2021	Completed	
	Strengths, Weakness, Opportunities, Threat Analysis Report (SWOT)	Develop and finalize SWOT component of DNP Final Paper	November 15 th , 2021	Completed	
	Complete final chapters/develop final paper	Revise and finalize all elements the DNP Final Paper	November 30 th , 2021	Completed	
	Meet with DNP committee regarding project updates and data analysis results	To obtain DNP team comments and authorization to progress	September 2021, October 2021, November 2021	Completed	

	DNP project defense		Tentative: March 2022 Deadline: March 2022	Scheduled	
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Appendix C

Informed Consent

Georgia State University

Title: Reducing Feeling of Unpreparedness Experienced by Nurses Assigned the Care of COVID-19 Positive Individuals with Intellectual and Developmental Disabilities

Principal Investigator: Dr. Kimberly Hires, PhD, RN

Co-Investigator: Dr. Cheru Francis Atraga

Student Principal Investigator: Dana Nicole Scott

I. Purpose

You are invited to participate in a project. The purpose of the quality improvement project was to learn if an in-service reduces a nurse's feeling of unpreparedness when providing care to an individual with intellectual or developmental disability with COVID-19. You have been chosen because you are a nurse who is likely to be assigned to care for an individual with developmental or intellectual disability. Participants will be contacted by and can contact the student principal investigator by email. The participants will receive formal introduction and explanation of the course of project by the Student Principal Investigator at the beginning of the course. The project will be administered through the Emory University School of Nursing, Emory Nursing Experience Partnership. The Nursing Experience course is administered via a distance learning platform, the survey and in-service will be administered via the same method of instruction. When the quality improvement project will be conducted during months March 1st, 2021 through December 31st, 2021 and will terminate after 20 participants complete the project and participate in survey. Participation will be offered to each cohort of nurses registered to participate in the Emory University IDD Nursing Experience.

II. Procedures

If you decide to participate, you will receive a survey that will require you to respond to questions about your readiness to care for a COVID-19 positive individual with an intellectual or developmental disability. You will then receive a video in-service that will give you information about how you can care for an COVID-19 positive individual with intellectual and developmental disabilities. You will receive another survey after completion of the in-service. The in-service will take up to 90 minutes to complete and administered remotely by the student principal investigator.

III. Risks

In this project you will not have any more risks than you would if you participated in any other in-service related to nursing care.

IV. Benefits

Participation in this project may or may not benefit you professionally. You may learn more about how to care for an individual with developmental or intellectual disability who also has COVID-19. We hope to learn whether in-service lessens a nurse's feelings of unpreparedness when caring for a COVID-19 positive individual with developmental or intellectual disability.

V. Voluntary Participation and Withdrawal

Your participation in this project is voluntary; you can refuse to participate. If you decide to participate in the project, and then change your mind, you have a right to discontinue participation immediately. Discontinuation is permitted at any point during the in-service or survey. If you choose to no longer participate in the in-service, your choice will not impact your participation in other in-service offered in this setting.

VI. Confidentiality

Your answers to the survey and feedback will be kept private. The Principal, Co-Investigator, and Student Principal Investigators will have access to your responses. This information may be shared with Georgia State University Institutional Review Board Members (IRB). Your name and type of work will be obtained but will not be placed in the project or final data results.

VII. Contact Information

Questions or complaints about this project can be stated to Professor Kimberly Hires at khires@gsu.edu or Dana N. Scott at dscott74@student.gsu.edu.

VIII. Consent

If you are willing to volunteer for this research, please sign below.

Participant

Date

Student Investigator Obtaining Consent

Date

Appendix D

Question 1 Fundamental Nursing Education

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
My fundamental nursing training has prepared me to care for individuals with Intellectual or developmental disabilities. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have sufficient knowledge of how to care for COVID-19 positive individuals with ID. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can contribute to the development of nursing protocols for COVID-19 positive individuals with ID. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can perform individual/patient interviews implementing the strategies presented within the in-service materials (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I understand the process of integrating physical assessment, evaluation of behavior as communication, interview, and documentation review to plan and implement risk mitigation strategy (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Knowledge Pre-In-Service	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have sufficient knowledge of how to care for COVID-19 positive individuals with ID. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can contribute to the development of nursing protocols for COVID-19 positive individuals with ID. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can perform individual/patient interviews implementing the strategies presented within the in-service materials (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I understand the process of integrating physical assessment, evaluation of behavior as communication, interview, and documentation review to plan and implement risk mitigation strategy (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I can identify the dynamics contributing to the feelings of unpreparedness a nurse may experience when caring for COVID-19 positive individuals with ID. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can explain the relationship between the nursing process and strategies for caring for COVID-19 positive individuals with ID. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am comfortable exercising an autonomy in the clinical management of COVID-19 positive individuals with ID compared to practicing prior to COVID-19, but feel prepared to engage other clinical professionals for decision making (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

End of Block: Question 2

Start of Block: Question 3

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I will additional time reviewing additional content to address feelings of unpreparedness (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe I will gain knowledge from this in-service related to caring for COVID-19 positive individuals with ID. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I will pay more attention to information related to the care of COVID-19 positive individuals with ID. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I will actively look for information that will facilitate the care of COVID-19 positive individuals with ID. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Affective Pre-In-Service

End of Block: Question 3

Start of Block: Question 4

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I can imitate the presenter's steps and actions of integrating multiple tools and resources in the provision of care of COVID-19 positive individuals with ID. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can complete the steps of risk mitigation strategies to support the COVID-19 positive individuals with ID. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I will try to monitor my assessment skills for opportunities of improvement when care for COVID-19 positive individuals with ID. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I will try to monitor my risk mitigation planning and make indicated adjustments as needed. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix E

In-Service Resources

**REDUCING FEELINGS OF
UNPREPAREDNESS EXPERIENCED
BY NURSES CARING FOR**

COVID-19 POSITIVE

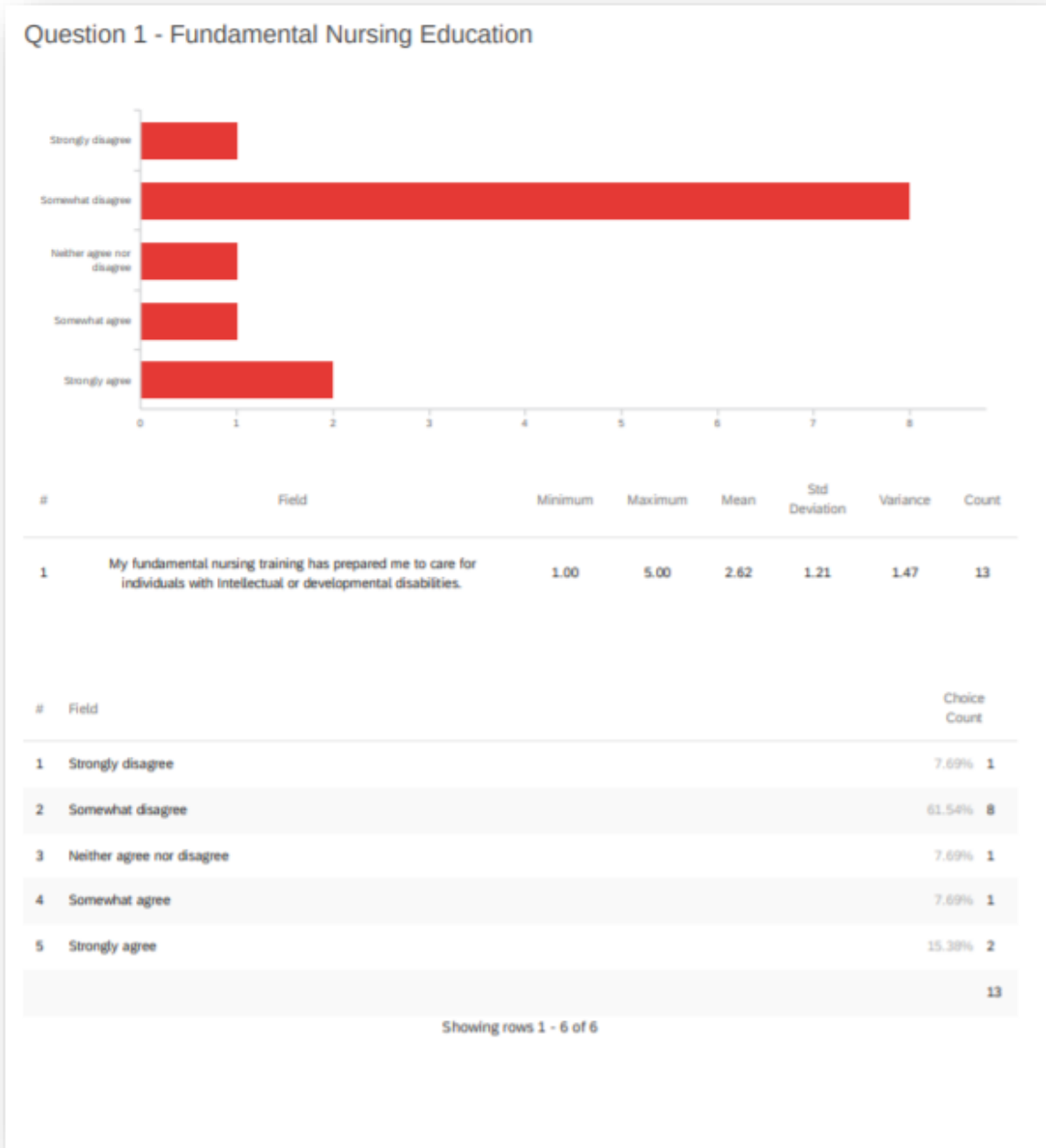
**INDIVIDUALS WITH INTELLECTUAL
AND DEVELOPMENTAL
DISABILITIES**

PURPOSE

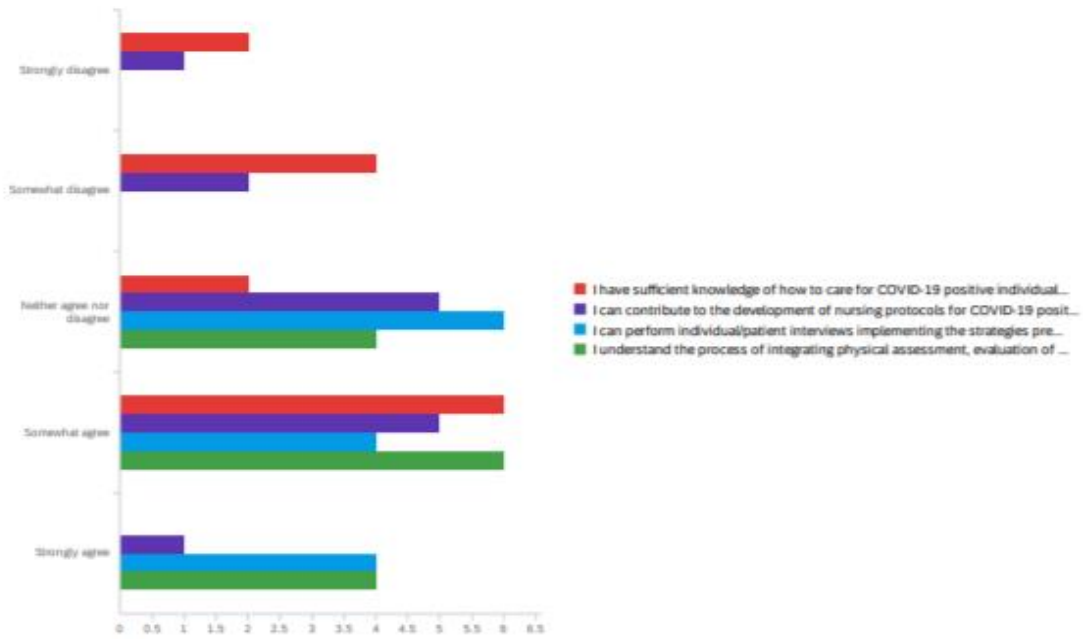
- **REDUCE** feelings of **UNPREPAREDNESS** by:
 - **The Problem:** Alignment of Dynamics
 - **Historical Context**
 - Provide **Education**
 - **Resource** Linkage
 - Evaluate

Appendix F

Pre-In-Service Results

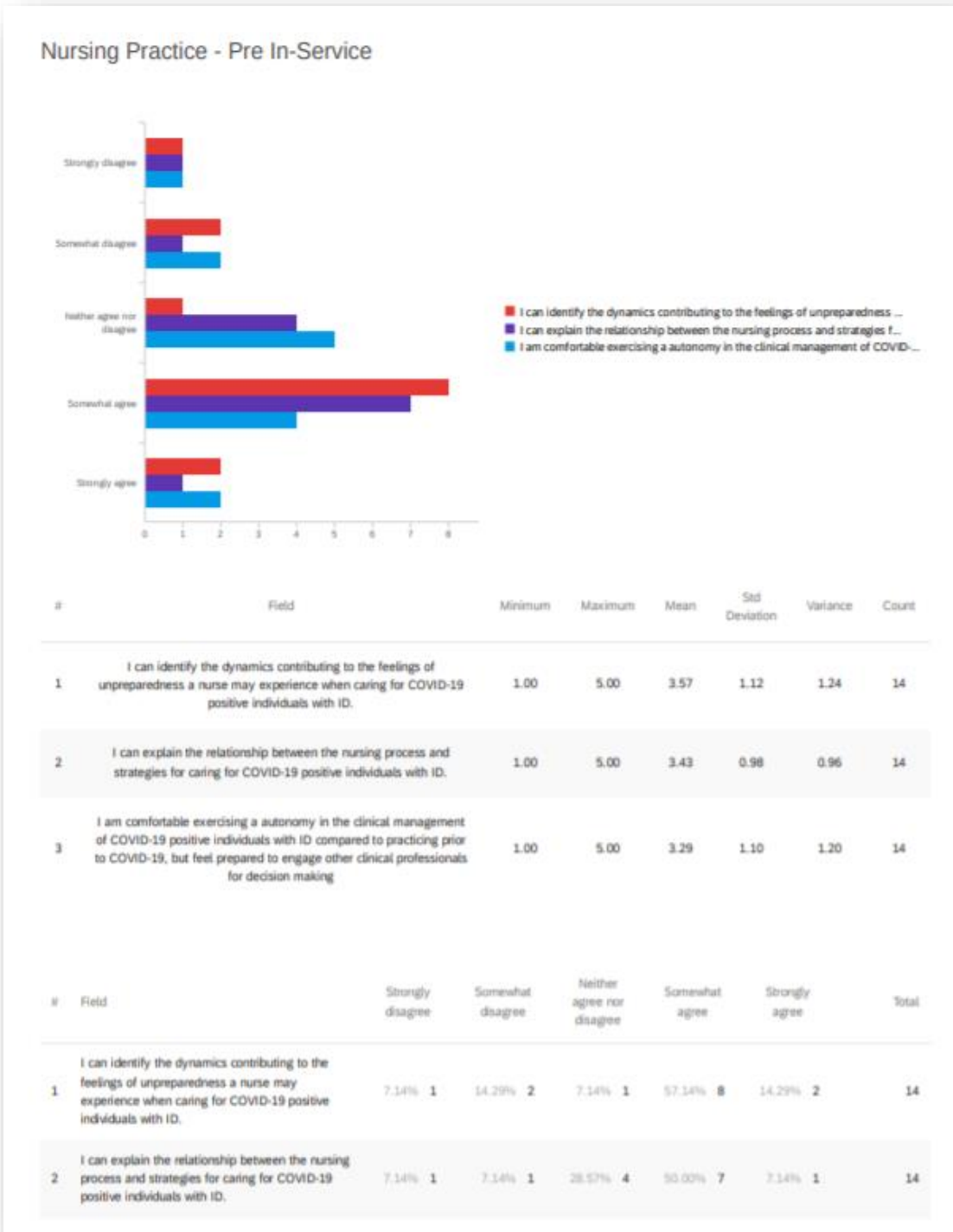


Knowledge - Pre In-Service



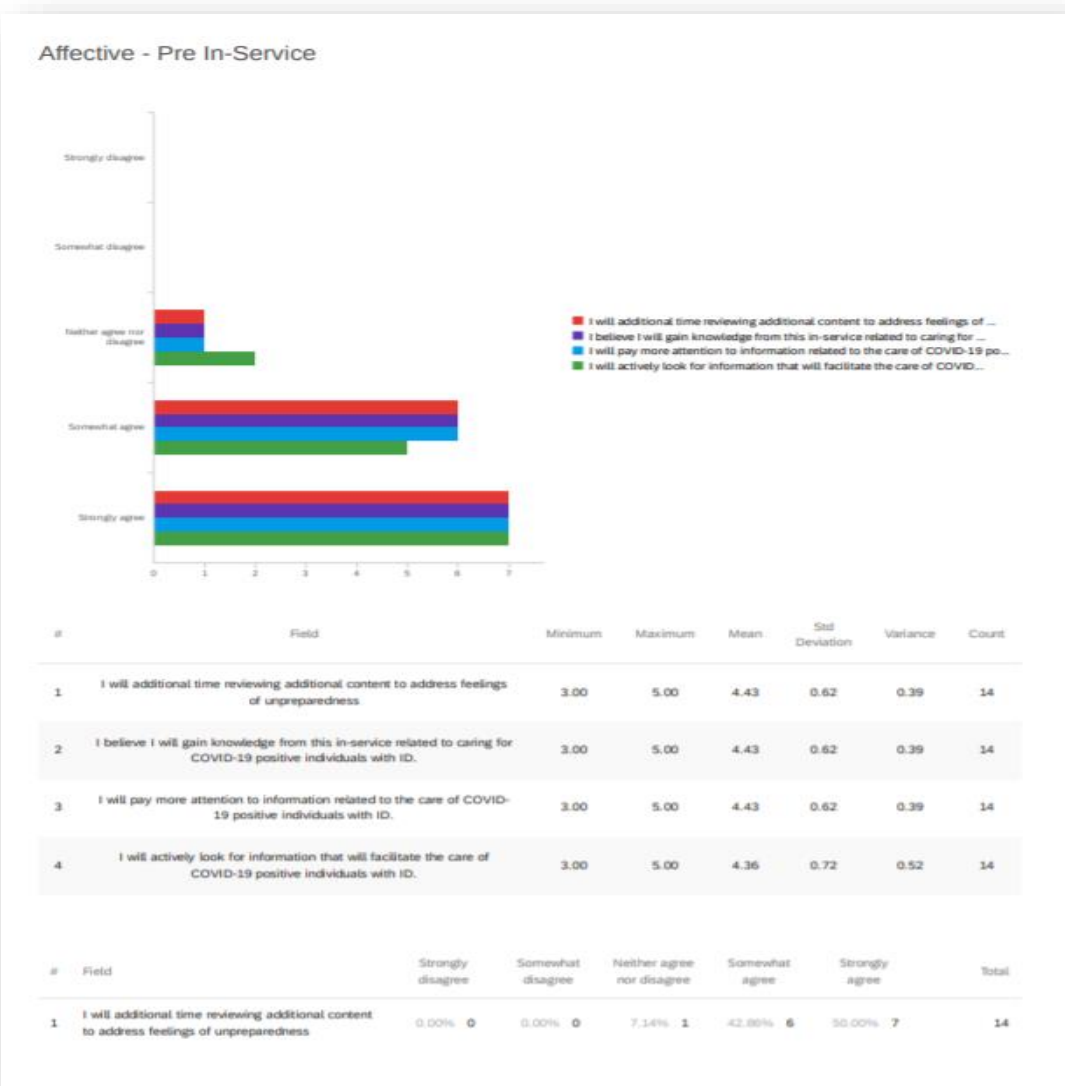
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I have sufficient knowledge of how to care for COVID-19 positive individuals with ID.	1.00	4.00	2.86	1.12	1.27	14
2	I can contribute to the development of nursing protocols for COVID-19 positive individuals with ID.	1.00	5.00	3.21	1.01	1.03	14
3	I can perform individual/patient interviews implementing the strategies presented within the in-service materials.	3.00	5.00	3.86	0.83	0.69	14
4	I understand the process of integrating physical assessment, evaluation of behavior as communication, interview, and documentation review to plan and implement risk mitigation strategy.	3.00	5.00	4.00	0.76	0.57	14

#	Field	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Total
1	I have sufficient knowledge of how to care for COVID-19 positive individuals with ID.	14.29% 2	28.57% 4	14.29% 2	42.86% 6	0.00% 0	14



#	Field	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Total
3	I am comfortable exercising a autonomy in the clinical management of COVID-19 positive individuals with ID compared to practicing prior to COVID-19, but feel prepared to engage other clinical professionals for decision making	7.14% 1	14.29% 2	35.71% 5	28.57% 4	14.29% 2	14

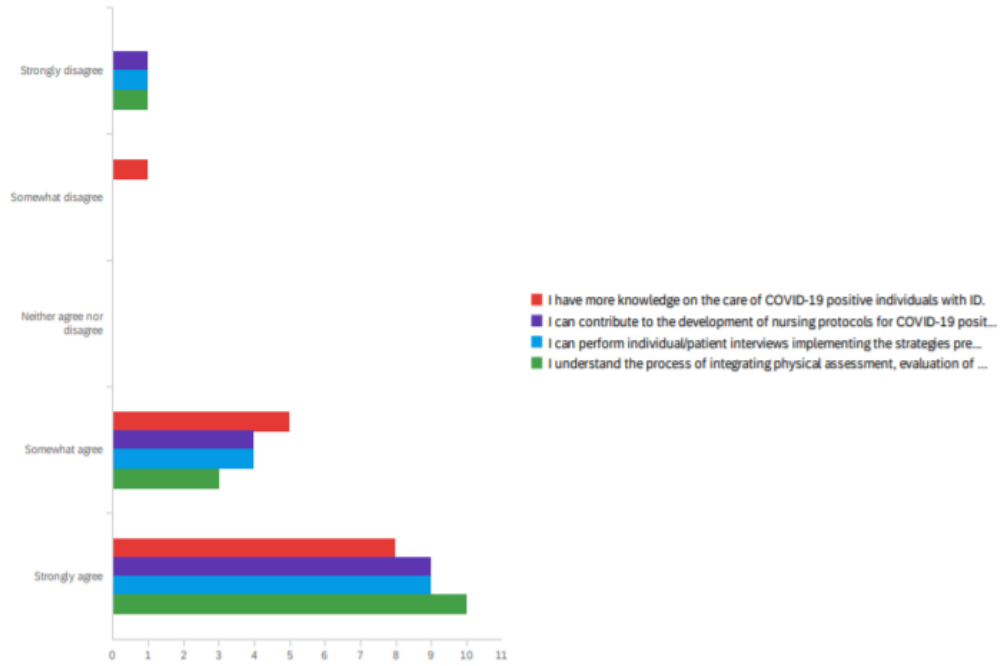
Showing rows 1 - 3 of 3



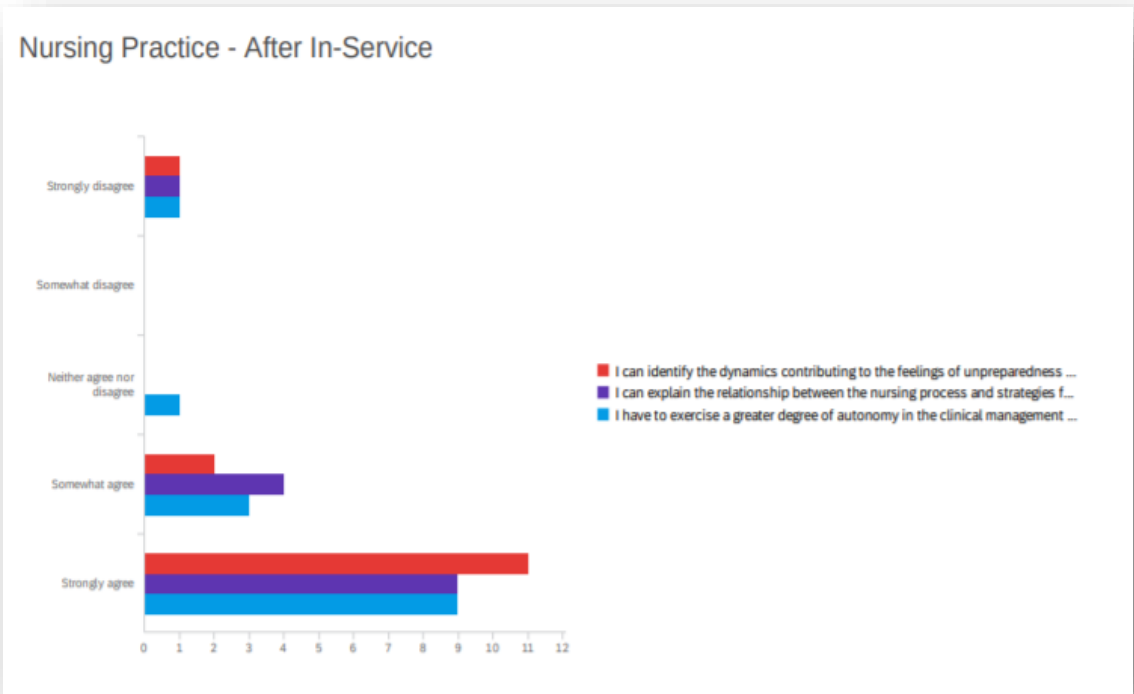
Appendix G

Post-In-Service Survey Results

Knowledge - After In-Service Survey

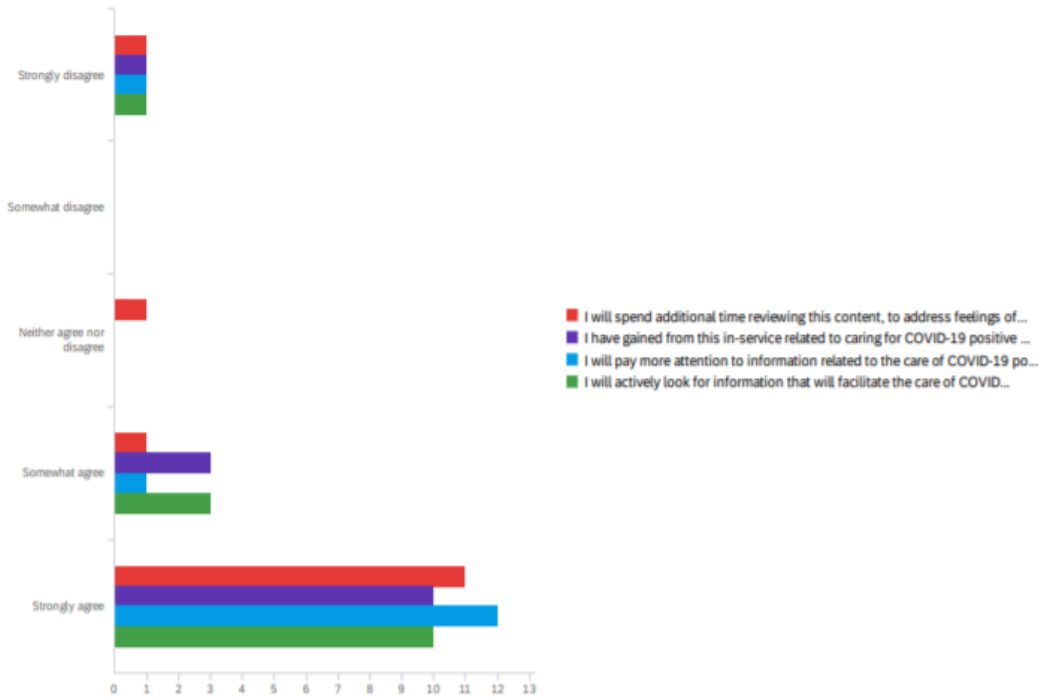


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I have more knowledge on the care of COVID-19 positive individuals with ID.	2.00	5.00	4.43	0.82	0.67	14
2	I can contribute to the development of nursing protocols for COVID-19 positive individuals with ID.	1.00	5.00	4.43	1.05	1.10	14
3	I can perform individual/patient interviews implementing the strategies presented within the in-service materials	1.00	5.00	4.43	1.05	1.10	14
4	I understand the process of integrating physical assessment, evaluation of behavior as communication, interview, and documentation review to plan and implement risk mitigation strategy	1.00	5.00	4.50	1.05	1.11	14



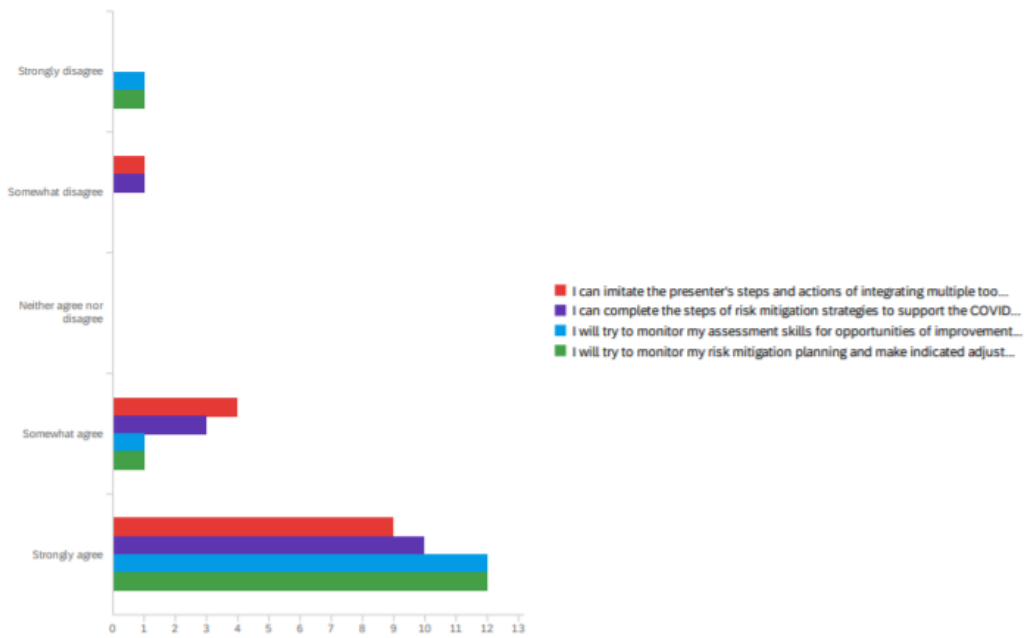
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I can identify the dynamics contributing to the feelings of unpreparedness a nurse may experience when caring for COVID-19 positive individuals with ID.	1.00	5.00	4.57	1.05	1.10	14
2	I can explain the relationship between the nursing process and strategies for caring for COVID-19 positive individuals with ID.	1.00	5.00	4.43	1.05	1.10	14
3	I have to exercise a greater degree of autonomy in the clinical management of COVID-19 positive individuals with ID compared to practicing prior to COVID-19, but feel prepared to engage other clinical professionals for decision making	1.00	5.00	4.36	1.11	1.23	14

Affective - After In-Service



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I will spend additional time reviewing this content, to address feelings of unpreparedness	1.00	5.00	4.50	1.12	1.25	14
2	I have gained from this in-service related to caring for COVID-19 positive individuals with ID.	1.00	5.00	4.50	1.05	1.11	14
3	I will pay more attention to information related to the care of COVID-19 positive individuals with ID.	1.00	5.00	4.64	1.04	1.09	14
4	I will actively look for information that will facilitate the care of COVID-19 positive individuals with ID.	1.00	5.00	4.50	1.05	1.11	14

Implementation - After In-Service



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I can imitate the presenter's steps and actions of integrating multiple tools and resources in the provision of care of COVID-19 positive individuals with ID.	2.00	5.00	4.50	0.82	0.68	14
2	I can complete the steps of risk mitigation strategies to support the COVID-19 positive individuals with ID.	2.00	5.00	4.57	0.82	0.67	14
3	I will try to monitor my assessment skills for opportunities of improvement when care for COVID-19 positive individuals with ID.	1.00	5.00	4.64	1.04	1.09	14
4	I will try to monitor my risk mitigation planning and make indicated adjustments as needed.	1.00	5.00	4.64	1.04	1.09	14

