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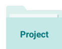

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Join the Revolution: How Montessori for Aging and Dementia can Change Long-Term Care Culture

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ABSTRACT

Efforts to improve the quality of life of persons with dementia in long-term care through the implementation of various approaches to person-centered care have been underway for the past two decades. Studies have yielded conflicting reports evaluating the evidence for these approaches. The purpose of this article is to outline the findings of several systematic reviews of this literature, highlighting the areas of improvement needs, and to describe a new person-centered care model, DementiAbility Methods: The Montessori Way. This model focuses on the abilities, needs, interests, and strengths of the person and creating worthwhile and meaningful roles, routines, and activities for the person within a supportive physical environment. This is accomplished through gaining the commitment of the facility's leaders, training staff, and monitoring program implementation. The potential for a culture change in long-term care environments is dependent on the development and rigorous evaluation of person-centered care approaches.

KEYWORDS: Dementia, person-centered care, DementiAbility, long-term care (LTC)

Learning Outcomes: As a result of this activity, the reader will be able to (1) describe the features of a person-centered care model; (2) list the range of outcomes that would contribute to an improved quality of life for the person with dementia; (3) describe the features of the DementiAbility Methods: The Montessori Way model; and (4) provide some examples of the types of engagement in activities and roles expected from implementation of this model.

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For the past two decades, there has been an explosion of research in the area of dementia care, with studies addressing the global nature of long-term care (LTC) settings to individual-specific treatment approaches with an emphasis on maintaining the quality of life of people with dementia and their care providers. An extensive evaluation of the quality of life in 350 assisted living and nursing homes, the Collaborative Studies of Long-Term Care,[1] revealed that residents with dementia had a better quality of life in care communities with specialized workers and with more staff training to encourage more activity participation.[2] Other notable factors included staff involvement in care planning, staff that provided choices and supported resident decision making, positive resident–staff communication, and the use of fewer antipsychotic and sedative hypnotic medications. The subsequent "culture change" movement attempted to transform the care provided in LTC from task-oriented to person-centered and to remodel the environment from "institutional" to "homelike."[3,4]

A variety of LTC models, including the Eden Alternative, Green House, Small House, Wellspring, and Pioneer Network, incorporate features of person-centered care (PCC),[5] the main tenets of which are to promote choice, dignity, respect, self-determination, and purposeful living in LTC. Several models focus on designing the physical environment to be more homelike; to reduce confusion, agitation, and depression; to improve social interaction and engagement; to prompt maintenance of daily living activities; and to trigger memory to maintain communication, social function, and mobility, which contributes to maintaining a sense of well-being.[6] Models such as Evercare,[7] which is a relationship-centered approach, and Aging in Place,[8] which provides services enabling the person to stay in the community instead of LTC, are other housing options for seniors, and these models are being evaluated for the strength of their evidence in improving quality of life for persons with dementia.

In the late 1990s, the Center for Medicare Services (CMS) became aware of the growing PCC movement that focused on putting resident choice before institutional efficiency. CMS regulatory leaders supported the principles of the movement and began to integrate these innovations as fulfillment of the mandates of the law and regulations. Since 2000, CMS has revised the guidance for over 20 key regulatory segments, called "Tags," to better reflect this shift in PCC priorities. For example:

> The facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. This includes actively seeking information from the resident regarding significant interests and preferences in order to provide necessary assistance to help residents fulfill their choices over aspects of their lives in the facility. (483.15(b), Tag F242)[9]

Although these key regulatory segments provide a framework for excellence in PCC, they have not been fully realized and adopted across the spectrum of LTC. In fact, systematic reviews of the growing body of literature on PCC approaches have yielded mixed results. Zimmerman and colleagues reported "insufficient strength of evidence for most organizational characteristics, structures and processes of care on health and psychosocial outcomes for persons with dementia."[10(p.1409)] Furthermore, there was only moderate evidence for the finding that pleasant sensory stimulation reduced agitation in persons with dementia. Li and Porock reviewed 24 studies of person-centered interventions and found some beneficial effects for residents' psychological well-being, along with decreased behavioral symptoms and psychotropic medication use, in residents with dementia.[11] Chenoweth and colleagues conducted a randomized controlled trial of PCC and/or person-centered environments in 38 homes involving 601 persons with dementia and documented improvements in quality of care interactions and resident emotional responses to care but no additive benefits for quality of life or agitation.[12] The strength of the current evidence for PCC approaches is limited by the variability in the level of detail in program descriptions, particularly the staff training and degree of program implementation by the staff. Rigorous measurement of

person-centeredness in the daily care offered by staff and received by residents is needed to confirm implementation. Li and Porock suggested that the care system (i.e., the institutional management environment) is critical for program implementation and the degree to which the management supports and helps the staff to carry out PCC needs to be documented.[11] Although most of the studies reviewed measured residents' well-being in terms of psychological functioning, physiological (sleep), mood, responsive behaviors (such as wandering, restlessness, agitation, verbal aggression, and exit-seeking) and daily functioning (activities of daily living) should also be included in outcome measures of well-being. Rigorous study design and improved measurement of treatment implementation and the treatment effects on residents' bio-psycho-social outcomes are still needed to guide development of future PCC approaches.

Another person-centered approach to dementia care, the ABLE model,[13] includes elements from a social ecological model and the Montessori method.[14,15] The four core areas of the model are (A) abilities and capabilities of the resident; (B) background of the resident; (L) leadership, cultural change, and education; and (E) physical environment changes. In 2011, the administrators of Rural Northwest Health in Australia decided to trial the ABLE care model on one unit of their facility.[13] The Wattle unit consisted of 16 residents (all of whom had a diagnosis of moderate to severe dementia based on the Psychogeriatic Assessment Scales[16]; 75% received antipsychotic or sedative medications at baseline, and mean Cohen Mansfield Agitation Inventory score was 80.0 [standard deviation 14.3][17]). The key features of the implementation included: (1) stakeholder engagement—prior to implementation, planning meetings were held with staff, residents, families, nurse unit manager, dementia consultant, cognitive rehabilitation therapist, and project manager; (2) education and training—18 staff received 2 days of dementia care and Creating Montessori Environments training and ongoing mentoring and support from a dementia consultant for 18 months; and (3) environmental changes based on Montessori principles—colorful, homelike interior spaces for specific uses (e.g., music, reading, physical activities, social interaction, domestic activities) included signage and name badges, interactive wall space, and exterior space contained many features of a rural home environment (e.g., chicken coop, raised garden beds, barbeque).

In an effort to document changes in "person-centeredness of care" as a function of the training, prior to the initiation of training, the staff and families were surveyed about the care environment, their knowledge of dementia and attitudes toward persons with dementia, the care organization, and the content of care provided using the Tool for Understanding Residents' Needs as Individual Persons.[18] Results of the survey administered 12 to 14 months after implementation documented improvement in staff knowledge about dementia, attitudes toward dementia, the person-centeredness of the care organization, and the content of the care provided. There was a total elimination (100%) of antipsychotic medication use and a reduction of the use of sedatives (from 67 to 2%). There was also significant reduction of resident-responsive behaviors due to unmet needs and behaviors that were observed happening several times an hour were reduced to once or twice per day, several times a day to less than once a week, and several times a week to never. Qualitative analysis of family surveys conducted 20 months after implementation revealed "overwhelmingly positive" responses.[13]

Independent observers made an unannounced visit to Wattle in June 2013 and reported that all residents engaged in activities without staff prompting (e.g., polishing silverware, polishing shoes, setting the table, rolling bandages, sorting silverware, washing and drying dishes) and several residents engaged in specific roles (e.g., updating wall calendar, offering beverages to peers, giving hand massages to peers, sweeping the floor, making their bed). All residents and staff wore a name badge, and when introduced to the visitor ("I'd like to introduce you to my friend from America"), the resident replied, "Nice to meet you, Michelle" (having read the name badge). The environment was observed to be "prepared" by the inclusion of clear signage on the walls (arrows and text indicating specific locations); personalized information on the

resident's door, (e.g., picture of kittens, family photograph, resident portrait); and a variety of attractive activity materials in clearly labeled containers stacked in an orderly fashion. Examples of this Montessori-prepared environment can be seen at https://www.youtube.com/watch?v=1LCRrcxlrXE and https://youtu.be/4rfOC-SUaI5c?list=UU4lqsTYPpNHqji8YsWpUy_g.

Clinicians who have watched these videos have suggested that this model of care would not be possible to implement in the United States for a variety of reasons. They assume persons with dementia would not be able to set the table, pour beverages for others, wash and dry dishes, and prepare/handle food items due to infection control concerns. Persons with dementia would not be able to make their own hot beverages or use an iron because they might hurt themselves. Clinicians have expressed skepticism that persons with dementia would require excessive prompting to remember to wear their name badge or would lose it. At Wattle, new residents are shown the bulletin board near the dining room where they find their name badge in the morning on the way to breakfast and where they put it after dinner on the way to their bedroom; with the development of routine and observation of other residents taking and putting their name badge on the board, residents actually require minimal staff intervention. Similarly, it is expected that staff workload would increase due to the need to prompt residents. Although this is true in the early stages of implementation, it is important to note that as residents adopt new routines they learn to engage, *unprompted*, in activities that are clearly labeled, such as "Please polish the silver" or "Please fold the napkins."

Another person-centered approach, DementiAbility Methods: The Montessori Way,[19] extends the tenets of PCC by expanding the focus on the abilities, needs, interests, and strengths of the person and by creating worthwhile and meaningful roles, routines, and activities for the person within a supportive physical environment. Montessori's philosophy was to enable persons to be as independent as possible, to have a meaningful place in their community, to possess high self-esteem, and to have the chance to make meaningful contributions to their community. Elliot's adaptation was designed to provide opportunities for adults with dementia to be enabled, engaged and enriched in a prepared environment. This is achieved by gaining the commitment of the nursing home's leaders with the purpose of facilitating major changes in the operation of the nursing home. This is accomplished by incorporating clear objectives into the organization's strategic plan, including the provision of a 2-day workshop on DementiAbility Methods for all staff, conducting follow-up visits to ensure implementation fidelity, and encouraging staff to become certified in the DementiAbility Methods.[20] Features of the DementiAbility Model include: (1) fact finding (know the person; program participant profile); (2) developing a program plan (focus on goals, roles, and routines; create activities and memory supports); (3) implementing the plan (in a supported environment); and (4) recording and evaluating outcomes (activity and outcomes record-keeping log). Certification requires individuals to work with three people with dementia, using all the tools provided in the workshop, documentation for each case, written exam, and a case presentation. The overall goal of this approach is to connect what is known about the patients in the past to their present abilities and to adapt the activities and the environment according to their needs, interests, and abilities. For example, someone who always enjoyed saying grace might read a large-print prayer card and lead the table in saying grace before each meal. The focus on meaningful and purposeful activities helps to maintain and enhance function. This can only be accomplished if staff members work as a team, ensuring that routines are put into place, activities are accessible for all to use 24 hours a day, and roles (such as making beds or folding laundry) are put back into the lives of those living in LTC.

Grandview Lodge in Dunnville, Ontario, has clearly demonstrated how the team approach can change the culture of care. After DementiAbility training and implementation,[20] a range of quality-of-care indicators improved: medication use decreased from an average of just over 11 medications per person to just over 4 per person, and decreases were seen in the number of falls and infection rates.[21]

In Miami, Florida, Brush has educated Spanish-speaking staff members in an assisted

living community about environmental assessment, and the DementiAbility Methods: The Montessori Way program (personal communication). Great progress has been made already toward a more person-centered, Montessori philosophy of care. For example, all staff members now wear large-print, high-contrast name tags clearly displaying their first names (residents' name tags have been ordered). Nursing assistants were taught how to make everyday activities meaningful. As a result, residents enjoy helping to make their beds, setting the table, sorting utensils, and pouring and passing out juice. The administrator formed a "memory book team," which reached out to families to help create a memory book for each resident living in the memory care section. Because of the staff willingness to embrace change, the atmosphere in the care community has changed from one of disengagement to one of bustling activity. Baseline data for family satisfaction and resident engagement have been collected and will be compared with data collected after the program is fully implemented.

It seems obvious that the environments created at Wattle, Grandview Lodge, and others by the implementation of PCC and Montessori methods for dementia would be the nursing home environment one would want to work in, and where one would want their own parents to live. How can the nursing home culture be changed? What is needed to convince the stakeholders and funders that this model of care is a worthwhile investment? There needs to be clear and compelling evidence of the types of outcomes that represent the highest quality of life possible for aging persons with cognitive challenges. Research studies designed to compare the effects of this new approach with usual-care nursing home environments are required. The treatment, DementiAbility Methods: The Montessori Way, needs to be described with sufficient detail to be replicable and to be implemented accurately. Standards for Montessori for Aging and Dementia training have been written, and trainer certification and facility certification programs are being developed under the auspices of the Association Montessori International.[22]

There is much hope for realizing this revolution in LTC culture and for improving the quality of life of persons with dementia through the development and rigorous evaluation of DementiAbility Methods: The Montessori Way.

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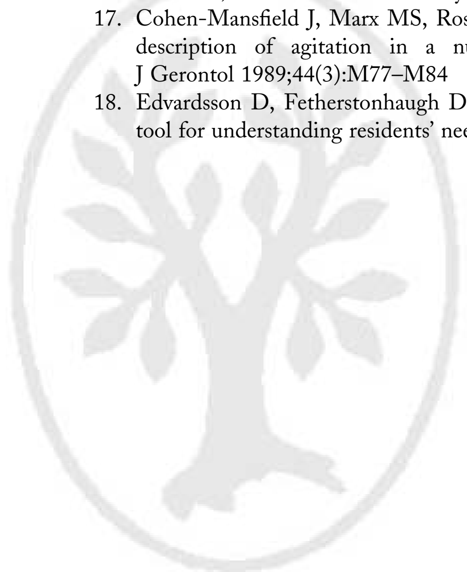

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