“If we don’t get the TV back on, we’ll have to talk to each other:” Evaluating a Montessori-Based Intervention for Long-Term Care Residents with Dementia

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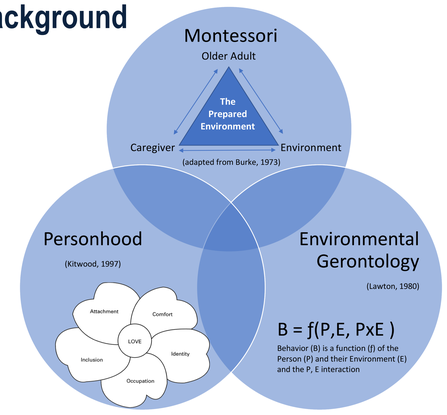
Abstract

Despite decades of research that demonstrates the efficacy of Montessori techniques for children (e.g., Lillard, 2012; Lillard & Else-Quest, 2006), application of these techniques to individuals with dementia is relatively new (e.g., Camp & Lee, 2011; Giroux, Robichaud & Paradis, 2010; Jarrott, Gozali, & Gigliotti, 2008; Orsulic-Jeras, Schneider, Camps, Nicholson, & Helbig, 2001). This research applies Montessori principles and Kitwood and colleagues’ work on personhood in the context of dementia (e.g., Kitwood, 1997; Brooker & Surr, 2005) to document the impact of Montessori-based environmental modifications on residents with dementia who reside in long-term care facilities.

Background



In an effort to promote culture change, we implemented Montessori-based social (e.g., staff training, daily routines that encouraged/allowed for choice, resident-led activities) and environmental (e.g., accessible activity stations, labels and cueing to promote spontaneous activity, activities created based on residents’ interests) modifications in long-term care facilities that provide care to individuals with dementia. The purpose of this research was to document the impact of these modifications. Specifically, we:

- Identified barriers and facilitators to implementing the intervention
- Provided examples of staff-resident interactions after the intervention and
- Compared behaviors and mood/engagement of residents before and after the implementation of the intervention

Methods

Data were collected at two long-term care facilities that provide care for residents with dementia; here we report data from one facility. These data derive from:

1) Thematic coding of field notes (i.e., existing facility documents, summaries of meetings and observational notes) and
2) Dementia Care Mapping (DCM; Brooker & Surr, 2005), a systematic method of observing a group of individuals with dementia and a process that can help improve the quality of care for individuals with dementia.

A total of 17 residents were observed in the public areas of the facility by a certified DCM “mapper.” Every 5 minutes the mapper recorded one of 23 Behavior Category Codes (BCCs). The mapper also documented specific interactions between staff and residents that either promoted or detracted from residents’ personhood. We reported on approximately 4 hours of DCM observations both before and after the implementation of the intervention.

Results

Barriers to Implementing the Intervention

- Theme 1: All Staff Acted as Gatekeepers to the Intervention/Research Process
- Theme 2: Staff Not Modeling Appropriate Behavior
- Theme 3: Staff Complacency and Disengagement
- Theme 4: Staff Devaluing Residents and/or Residents’ Needs
- Theme 5: Lack of Staff Follow-Through

Example of Staff Barrier

Setting: In the common area, at the end of group exercises:

Staff 1: *Now we can turn the TV back on…Goll it takes a long time for that TV to warm up, don’t it?*

[The residents chat with each other; staff gather around the TV]

Staff 2: *We might not get to watch TV today. We’d have to talk to each other. What would we do if we didn’t have TV?*

Resident 1: *Sleep*

Staff 2: *If there’s a red light the cable box is not on.*

Resident 2: *There’s a red light, I saw it.*

Staff 1: *If I don’t get this on, what will we do? Read a book? Write a letter?*

[The TV comes back on]

Staff 1: *All right!*

Facilitators to Implementing the Intervention

- Theme 1: Resident Engagement
- Theme 2: Residents’ Spontaneous Behavior/Activities

Example 1 of Resident Facilitator

Setting: Activity staff have gathered 20+ residents for a reading circle; but has passed out three different series of books – instead of all having one book – so residents get confused about which version they’re reading together [The text below is adapted from field notes]:

Staff 1: *Ok, read page 1 if you have book A…start on page 2 if you have book B…start on page 3 if you have book C.*

All Residents: *Where are we? What book do we have? I don’t know what’s going on!*

[Confusion & chaos]

Resident 1: (who is usually found sleeping in front of TV) *This is all wrong! We should all have the same book!*

Staff 1: (Repeats) *Ok, page 1 if you have book A…start on page 2 if you have book B…start on page 3 if you have book C.*

Resident 1: *All the people that have this book (shows hers) keep it and those that don’t, put yours down.*

[Resident begins reading to group and then asks the next person to read the next page and so on. She managed the book to the end and those without a book, listened]

Example 2 of Resident Facilitator

Setting: Residents are finishing breakfast:

Resident 1: (Getting up from breakfast table) Ok, it’s time to go outside!

[Group of 5 residents all get up together and walk toward door to the outside]

Resident 2: (Attempts to open door, but it is locked) Oh, well the door is locked – let’s wait here until we’re ready.

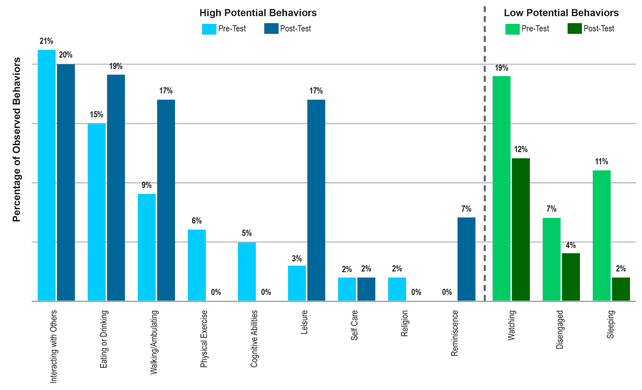
Resident 3: I’m excited to go outside for a walk!

[Group sits down at table nearby awaiting staff assistance]

Staff 1: (Unaware of the request, the staff person heads to the door) Hey, that sounds like a great idea to go outside after breakfast!

[All go outside]

Residents’ Behaviors Before and After the Intervention



Discussion

- After the intervention, residents:
  1) Engaged in individual and group Montessori activities, were more often engaged in purposeful activity and spontaneous behaviors/activities in the restructured environment and
  2) Demonstrated a greater proportion of high potential, and a lower proportion of low potential behaviors. This is encouraging, especially in light of the barriers to implementing the intervention.
- Our intervention focused primarily on direct care staff and environmental modifications for the residents. However, based on the identified barriers, more comprehensive environmental restructuring is necessary. Specifically, it is not sufficient to adapt the environment for residents—the environment must also be adapted for staff as well. Real culture change requires:
  1) “Top-down” and “bottom-up” buy-in at all levels of staff to change the social and physical environment
  2) Role-specific, specialized training for staff at all levels and
  3) An adaptive structure that meets the needs of residents and staff and encourages purposeful engagement, ultimately facilitating optimal personhood for all members of the community.

Citations available upon request.

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