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Feature Article

Caring for people with dementia in residential aged care: Successes with a composite person-centered care model featuring Montessori-based activities

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ABSTRACT

Person-centered models of dementia care commonly merge aspects of existing models with additional influences from published and unpublished evidence and existing government policy. This study reports on the development and evaluation of one such composite model of person-centered dementia care, the ABLE model. The model was based on building the capacity and ability of residents living with dementia, using environmental changes, staff education and organizational and community engagement. Montessori principles were also used. The evaluation of the model employed mixed methods. Significant behavior changes were evident among residents of the dementia care Unit after the model was introduced, as were reductions in anti-psychotic and sedative medication. Staff reported increased knowledge about meeting the needs of people with dementia, and experienced organizational culture change that supported the ABLE model of care. Families were very satisfied with the changes.

Introduction

There is increasing interest in models of care for people with dementia. Current care challenges are universal and related to the complexity of needs of people with dementia, regardless of the context of the health system.[1,2] Challenges include addressing behavioral and psychological symptoms of dementia, training residential care staff – many of whom have very basic or few qualifications in dementia care – and physical environments that are often not designed to support resident needs.[3–10] Despite dementia being a terminal condition, the quality of life of people with dementia can be greatly enhanced through the care received. Up till now there has been no single model of care identified that can meet all the complex needs of people with dementia and their supporting families. However, many aged care models have increasingly embraced person-centered care as an underpinning principle.[11–15] Presently, aged care services and dementia care models are commonly developed by merging aspects of existing models of care, with emerging evidence from published and unpublished studies, and are influenced by government policy.

The purpose of this paper is to describe the development of a composite model of care and its impact on people with dementia. The model is based on person-centered principles,[16,17] a social ecological model[18] and the Montessori method.[19] The paper reports on the evaluation and results of a pilot project exploring the new model's feasibility.

Method

Description of the intervention: development of the ABLE model

The model was developed by an Australian geriatric health service to improve the level of dementia care to its residents. The model is person-centered and incorporates Montessori principles and activities. These aspects were designed to build on the capacity and inherent abilities of residents through a number of system changes at an organizational level, in partnership with: family members, general practitioners (primary care physicians), a remote accessed consultant geriatrician, a physiotherapist, dietician,

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speech pathologist and graduate nurses. These changes included staff education, environmental changes and a new philosophy of care that identified, emphasized and built upon the current abilities of the residents. The aim was to help extend and retain those abilities, and to maximize residents' quality of life. The name of the dementia unit was also changed to the "Memory Support Unit (referred to as the 'Unit')", to better convey the care provided.

The ABLE model of care was first conceived as a quality improvement project in 2011. It was trialed in a 15 bed care unit for ambulant people with dementia, in a rural health service in Victoria, Australia. As described in Table 1, the model developed four core areas of focus: (A) Abilities and capabilities of the resident; (B) Background of the resident; (L) Leadership, cultural change and education; (E) Physical environment changes.

The rationale for development and implementation of the ABLE model was provided by feedback received from residents' family members about care provided in the Unit. The Board, Chief Executive Officer, other leaders, staff and residents' families, also recognized that many residents had unmet needs. These unmet needs were evidenced by pacing, wandering, physical and verbally aggressive behavior, the appearance of being 'sad and bored', and the high level of daytime sleeping observed among residents.

To better address resident and family needs, management changed the existing care model from the traditional 'biomedical' approach involving medication, to that with a 'person-centered care' focus, incorporating Montessori principles and activities.[19] This decision was premised on the Montessori approach, which demonstrably engages people meaningfully in activities that could potentially improve their lives.[11,20,21] The intervention was implemented with a part-time project manager who was an experienced aged care manager and registered nurse. A part-time dementia consultant, who was an experienced mental health nurse with expertise in applying Montessori principles to dementia care, was also employed. In addition a new full-time position, 'cognitive rehabilitation therapist (CRT)', was created, replacing the leisure and lifestyle staff role. The CRT was a Montessori 'champion' for Unit staff on a day-to-day basis, and also facilitated the transitioning of new residents and their families from pre-admission to admission. The CRT was an enrolled nurse, and was trained in Montessori principles for dementia care. To maintain continuity of care, existing interested health service staff, including registered nurses, enrolled nurses, personal care attendants and environmental services staff were recruited for the project. Agency and casual staff were not employed on the Unit. The care model also included the development of a written protocol for admission and transition, to improve these processes for both residents and their families.

Stakeholder engagement

Pre-implementation and during planning, the project manager and dementia consultant met with local general practitioners (GPs), health service staff and residents' families to engage them in the project: a strategy which proved important for the sustainability of the ABLE model. Throughout the model development, consultation and communication occurred between staff, residents, residents' families and project leaders, including the nurse unit manager (NUM), CRT, dementia consultant and the project manager. The NUM also worked closely with the two local GPs to review residents' medications periodically.

Education and training

Education sessions were conducted by the dementia consultant for all eighteen staff working in the Unit, including nursing staff, care staff and environmental services staff. The education sessions, comprising two days of dementia care training and two days of Montessori activity training, were attended by all memory support Unit staff. There was also ongoing support during the 18 month period of study from the dementia consultant, including one day a month consultation and phone and email correspondence for the CRT. Support from the CRT and project manager was also provided to other staff.

Environmental changes

Photographs and video recordings of the Unit environment and surrounds were captured over an 18 month period, with the consent of staff and residents (or their substitute decision-maker). This provided a record of the stages of implementation over the pilot duration for all stakeholders. The internal environment was changed from a bland, hospital-style environment to a colorful, home-like space, designed to support the memory of the residents and to aid in enhancing their abilities. Signage[9,10] designed in black and yellow was installed to provide memory prompts, and staff started to wear large print, clearly visible name badges. Some 'interactive' wall space was introduced to provide interesting tactile

Table 1
Summary of ABLE model core components.

	Component	Description
A	Abilities and capabilities of the resident	Capabilities assessed included both cognitive and physical capabilities, evaluated using standard clinical assessment processes. The approach was designed to enable residents to be as independent as possible and to contribute to and have a meaningful place in their small residential community. The care team focused on the individual rather than their dementia diagnosis, and especially residents' capabilities and abilities, rather than their perceived deficiencies and losses.
B	Background of the resident	In this core area, staff collected background information about residents, including their life stories and interests, their likes, dislikes, skills and dreams – a critical aspect of ABLE. It facilitated a person-centered approach to care by enabling staff to support residents to undertake roles and activities that were appropriate and meaningful to them. Resident's stories were collected to promote interest and capabilities-based activities for each resident. Stories were collected via discussion with residents and their family members over several sittings, and were documented in a range of ways including written descriptions and visual displays of meaningful and personal items.
L	Leadership, education training and organizational culture change	In this core area, strong, supportive leadership from the Board and Chief Executive Officer to managers and team leaders was crucial for the process of change. Organizational cultural change was facilitated by education and ongoing support and training for staff.
E	Physical environment	The ABLE model facilitated a change to both the external and internal environment, and supported person-centered, ability- and capability-focused care to the residents. The changes created different spaces within the Unit to cater for the varying needs and interests of residents, and included additional signage and other memory aids. Prior to the development of the ABLE model the physical environment of the Unit was described by some staff and family members as 'clinical' and 'soul-less'.