



Study protocol: A Montessori approach to dementia-related, non-residential respite services in Australia



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ABSTRACT

Given the social burden and significant cost of dementia care in Australia, finding evidence-based approaches that improve outcomes, maintain independence, and reduce the impact on patients and families is essential. Finding effective ways to train and assist the healthcare staff who support these individuals is also critical, as they are considered to be at risk of workplace stress, burnout, and other psychological disturbances which negatively affects standards of care. The current paper describes a protocol for evaluating the effects of a Montessori-based approach to dementia care, in non-residential respite centres. An 18 month prospective observational, cohort controlled design is suggested that will compare participants from a community respite service that has undergone a Montessori-based workplace culture change and those from a service that provides a person-centred ‘care as usual’ approach. To achieve this, the protocol includes the assessment of participants across multiple variables on a monthly basis including the cognitive, behavioural, and emotional functioning of clients with dementia, levels of caregiver burden experienced by informal carers, and burnout, compassion satisfaction and workplace engagement among respite staff. The protocol also employs a qualitative evaluation of program fidelity. This approach will provide further insight into the potential benefits of early intervention with Montessori approaches for persons living with dementia in the community, their caregivers, and the staff and volunteers who assist them.

1. Introduction

Dementia is a major public health problem with potentially devastating consequences for the quality of life of patients, their families, and caregivers. Marked by progressive cognitive impairment, memory loss, and behavioural disturbance, those afflicted can become increasingly dependent on others for activities in all areas of daily living (Grand, Caspar, & Macdonald, 2011). Dementia is the second leading cause of death in Australia (Bush, Fink, & Lei, 2016), and over 400,000 Australians were living with Dementia in 2016 (Australian Bureau of Statistics, 2017). This number is projected to increase by approximately 90% over the next 20 years (Brown, Hansnata, & Anh-La, 2017). Indeed the rising prevalence of dementia has led the Australian Government to recognise this condition as an area of national priority, encouraging programs that mitigate the escalating socioeconomic burden.

In addition to a focus on prevention and timely diagnosis, initiatives aimed at delaying the need for institutionalised care are particularly important. In a review of the *National Economic Costs of Dementia in Australia*, Brown et al. (2017) identified hospitalisation as the single largest direct cost of the disease. Moreover, placement in residential

care facilities has been associated with rapid deterioration in health, psychosocial challenges for patients and families, and increased mortality (Gaugler, Yu, Krichbaum, & Wyman, 2009). People with dementia also typically prefer to remain at home, and when not overly demanding, doing so can be a rewarding experience for those that care for them (Duggleby, Williams, Wright, & Bollinger, 2009; Lee & Cameron, 2004). Conversely, when caregivers are inadequately supported, the role is often overwhelming; so understanding not only the experience of those with dementia but also the burden on those providing care in the community is critical to delaying institutionalisation or hospitalisation.

The term ‘caregiver burden’ refers to the emotional, physical, social, and financial costs that result when the demands of caregiving exceed one’s resources (Chakrawarty & Dhanalakshmi, 2013). Caregiver challenges also intensify as patients degenerate due to progressive disorders such as dementia. Carers frequently become responsible for the management of all household duties, transportation, medications, food preparation, feeding, grooming, toileting, and dressing needs (Richardson, Lee, Berg-Weger, & Grossberg, 2013). As memory impairment is a cardinal feature of most forms of dementia, patients may

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fail to even recognise the person who is providing all of this care (Saavedra, Iglesias, & Olivares, 2012), yet they must continue to deal with bouts of extreme agitation, behavioural problems, personality changes, and difficulties communicating as their loved one may become progressively confused and mute (Jennings et al., 2015). It follows that caregivers report higher levels of unemployment, financial and psychological strain, and burnout than age-matched members of the general population (Richardson et al., 2013).

Over the last decade, researchers have found that caregiving for persons with dementia is associated with a number of adverse health outcomes including hypertension (Roepke et al., 2010), elevations in cortisol levels (Allen et al., 2017; Stalder et al., 2014) and an increased risk of cardiovascular disease (Mausbach et al., 2010). Caregivers report greater levels of stress, sleep disturbance, social isolation and loneliness, and are four times as likely to develop depression compared to non-caregivers (Richardson et al., 2013). Challenges to the health and well-being of the caregiver may in turn precipitate a worsening standard of care for the person with dementia and the eventual breakdown of their relationship (Schulz & Beach, 1999). Thus, in an attempt to support caregivers and delay entry into residential care, community respite services have been advocated as a possible solution.

Respite care refers to a supportive service, offered at home or elsewhere, which provides a temporary reprieve from caregiver responsibilities (Vandepitte et al., 2016). These programs operate under the assumption that providing relief to caregivers will ameliorate the associated stress, reinforce the caregiver relationship, and support the person with dementia to remain in the community (Lee & Cameron, 2004). However, despite the rational basis for this approach and high anecdotal support among caregivers, community respite services remain largely underutilised (Brodaty, Thomson, Thompson, & Fine, 2005). Furthermore, comparative research into the effectiveness of respite care in delaying institutionalisation is rare and results are equivocal (Lee & Cameron, 2004; Schoenmakers, Buntinx, & DeLepeleire, 2010; Vandepitte et al., 2016). Some authors assert the need for respite services to use their time with the client and caregiver more effectively and supplement day care models with opportunities for rehabilitation and skill development (Tang, Ryburn, Doyle, & Wells, 2011).

One model that may be useful in the aged care sector is based on the work by Maria Montessori and others in school settings. The Montessori philosophy has long been employed in childhood education as a means of enhancing well-being and the development of life skills (Montessori & Gutek, 2004). However, more recently, Montessori principles have been applied to supporting those living with dementia (Camp et al., 2017; Camp, Cohen-Mansfield, & Capezuti, 2002; Camp et al., 1997). At its core, the Montessori approach encourages continued success in meaningful activities that focus on maintaining adaptive functioning (Camp et al., 2002). Essentially, the Montessori approach aims to foster independence and encourages the client and all involved to collaborate in establishing meaningful roles for the individual in his or her community.

Studies investigating the use of Montessori approaches in residential care settings have shown promising results, with preliminary evidence suggesting that this method may enhance client engagement (Jarrott, Gozali, & Gigliotti, 2008), improve capacity for tasks of daily living (Lin et al., 2010), and reduce the occurrence of challenging behaviours (Van Der Ploeg et al., 2013). Following a systematic review of the literature, Sheppard, McArthur, and Hitzig (2016) identified strong evidence for the potential of Montessori-based activities to successfully rehabilitate problematic eating behaviours, mixed support for positive influences on affect and client engagement, and even some potential to improve cognition. They concluded that future research should examine the long-term benefits of Montessori-based dementia care (Sheppard et al., 2016). It remains unclear whether these benefits might also translate to reduced caregiver burden or delays in residential care admission, particularly if these strategies are employed relatively early in the disease and caregiving process. The potential impact of applying this approach

on formal care staff in facilities also requires examination.

Despite the emerging evidence and reported popularity of this approach among aged care administrators (Bourgeois, Brush, Elliot, & Kelly, 2015), implementing a Montessori-based model of care in community respite is no simple feat. The philosophy itself, which embodies an ethos of individualised care and empowerment, may stand in stark contrast to current practices which have traditionally framed staff as caretakers in a biomedical model of care. Moreover, while person-centred approaches are routinely advocated within the industry, the realities of limited organisational resources, poorly paid or unskilled staff, and counterproductive workplace cultures, negate efforts to put such standards into practice. Ducak, Denton, and Elliot (2016) investigated this phenomenon by interviewing staff in long-term care homes in Ontario, Canada. Using thematic data analysis, the authors identified insufficient funding and negative attitudes towards activities as the greatest perceived barriers to implementing Montessori approaches. They added, however, that the largely structural barriers to progressive cultural development within that facility were overcome with sufficient organisational, financial, educational, and individual support (Ducak et al., 2016).

Past research suggests that dementia-care workers may be especially vulnerable to occupational stress and burnout (Duffy, Oyeboode, & Allen, 2009). Professional burnout refers to a multifaceted work-related disorder of three dimensions: emotional exhaustion, depersonalisation, and perceived inefficacy (Maslach, Schaufeli, & Leiter, 2001). These dimensions include the endorsement of feelings of being over-extended, fatigued, and depleted; attitudes of negativity and cynicism towards clients or work; and a reduced sense of self-efficacy and accomplishment (Maslach et al., 2001; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). The effects of burnout on wellbeing are also well documented and the condition is associated with multiple adverse health outcomes, including sleep problems, pain, and alcohol abuse (Pedersen, Sørensen, Bruun, Christensen, & Vedsted, 2016; Peterson et al., 2008); musculoskeletal and cardiovascular diseases (Honkonen et al., 2006); clinical depression (Ahola et al., 2005); anxiety (Ding, Qu, Yu, & Wang, 2014); and job dissatisfaction (Maslach et al., 2001; Schulz, Greenley, & Brown, 1995).

Likewise, the organisational consequences of burnout can be severe and pervasive. Employee burnout is correlated with increased turnover and absenteeism, unproductive work behaviours, and reduced organisational commitment (Angerer, 2003; Cordes & Dougherty, 1993). These outcomes not only result in direct consequences for the organisation and the employees themselves, but also affect the individual's ability to effectively care for others (Barnett, Baker, Elman, & Schoener, 2007). Elevated stress and burnout among nursing home staff has been specifically related to higher levels of resident aggression (Brodaty, Draper, & Low, 2003), increased staff control over clients in respite facilities (Gwyther & Lyman, 1989), and reduced quality and quantity of staff-resident interactions in residential settings (Jenkins & Allen, 1998).

The Montessori approach appears to be antithetical to many of the noted organisational consequences of burnout and may serve to protect employees and clients by cultivating engagement and compassion satisfaction. When considering the implications of introducing Montessori methods to dementia care, Brenner and Brenner (2012) observed that the approach not only provides employees with a value system that may be used to engage clients and overcome difficulties, but also allows staff the freedom to leverage their own creativity and strengths. Once formal caregivers have successfully moved from a 'task orientation' to a 'person orientation', their role is ultimately transformed from that of a minder to a mentor (Brenner & Brenner, 2012). Applying Montessori principles may ultimately empower clients, caregivers, and staff, while supporting organisations to overcome industry challenges, meet accreditation standards, and adapt to future policy directions for aged care.

Tasked by the former Minister for Social Services, the Aged Care Sector Committee (2016) has communicated a 'roadmap' presenting the

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