

Through the Montessori Looking-Glass: Barriers to Implementing a Montessori-Based Intervention

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Abstract

Montessori methods are used with individuals with dementia to create meaningful, inclusive, failure-free activities that enhance quality of life. This research qualitatively explored the barriers to implementing a Montessori-based intervention for people living with dementia in a 24-hr memory care setting. A lens comprised of key Montessori values and principles guided a content analysis of field note data to create an overall framework for understanding implementation barriers, which are rarely addressed in the literature. Interestingly, the four themes that emerged as barriers—the absence of respect, interdependence, meaningful activity, and structure—permeated implementation efforts and represent the opposite of Montessori principles. These findings confirm literature that identifies similar barriers across diverse interventions. Findings underscore the need for formal documentation of implementation barriers and extensive pre-implementation work to accomplish culture change in long-term care.

Keywords

challenges, content analysis, dementia, intervention, Montessori

Background

Many successful Montessori-based interventions (MBIs) have been used in care environments in recent decades (Bourgeois et al., 2015; Ducak et al., 2018; Fields et al., 2014; Orsulic-Jeras et al., 2001; Roberts et al., 2015). MBIs are broadly grounded in values of respect, dignity, independence, and adaptable structure (Ducak et al., 2018; Orsulic-Jeras et al., 2001). They seek to promote purposeful, meaningful activities that can be personalized based on one's abilities and complement federal standards for providing person-centered care (PCC; Koren, 2010). Despite the high variability of delivery and lack of standard best practices for MBIs, two recent reviews (Hitzig & Sheppard, 2017; Sheppard et al., 2016) found that MBIs create many positive outcomes for people living with dementia and their care partners.

Although few studies specifically address barriers to implementing MBIs in long-term care settings, Ducak et al. (2018) revealed limited funding and negative staff attitudes as barriers. Doyle and Rubinstein's (2014) review of challenges to delivering PCC to individuals with dementia found similar barriers, including lack of comprehensive understanding of the intervention by all staff, time constraints for direct care staff, and hierarchical power relations between levels of staff. Furthermore, community-wide communication breakdown is a

documented barrier to implementing PCC interventions for people living with dementia (Kolanowski et al., 2015). Identifying and removing these barriers must be prioritized to successfully implement MBIs, thereby better serving those impacted by dementia. The purpose of this research was to explore the barriers to implementing an MBI for individuals with dementia, as described through the facilitator's field notes.

Method

The field notes for this analysis were collected by the third author, an experienced Montessori facilitator ("facilitator"), as part of a larger project that implemented an MBI in a 24-hr memory care setting in southwestern Ohio (IRB protocol #01083). Unstructured observation, as documented through

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the facilitator's field notes, has been recommended and held in high regard as a means to gain a better understanding of the cultural context in which this project took place (Mulhall, 2003). The facilitator has 30 years of experience in adult and child education and formal training in education administration and team building. This analysis reports on the barriers to implementation as experienced through the descriptions and perspective of the facilitator. The facilitator did not participate in the analysis.

Orienting Method and Theoretical Framework

Deidentified field notes were uploaded into Dedoose software to facilitate data coding and analysis. The field notes were collected between December 2015 and March 2017 and were recorded chronologically in situ as well as at the end of each day or event. Field notes described observations, environmental descriptions, trainings, activities, events, and dialog with and between staff and residents (i.e., in-person, by phone, electronically). Consistent with the interpretivist/naturalist paradigm, field documentation used unstructured observation (Mulhall, 2003); a predetermined list or schedule of activities or behaviors was neither fixed nor expected. Although unstructured, the field notes demonstrated detail on daily encounters as a means to gain a better understanding of the cultural context in which the intervention was implemented.

Two resources (Ducak et al., 2018; Orsulic-Jeras et al., 2001) supplemented the facilitator's knowledge and documentation of Montessori principles to create a Montessori lens or theoretical framework to guide coding. Each resource contained between 15 and 17 guiding principles that were consolidated into a smaller, more manageable group of core values that eventually created theory-driven codes. The aim was to create a deductive theoretical lens, or "looking-glass," constructed from Montessori knowledge, to support code development and ultimately help make sense of the data as they related to the Montessori doctrine.

Analytical Approach and Technique

Field note data were analyzed using deductive qualitative content analysis (Elo & Kyngäs, 2008). A structured coding instrument was developed by distilling the Montessori principles into seven distinct codes to guide analysis: respect, interdependence, structure/guided, individualize/personalized attention, interaction, organized activity, and inactivity/passive. The first author developed the initial codebook, which consisted of five generations of codes and definitions. The first and second authors discussed and refined the codebook to fit the data. Subsequently, the field note excerpts were coded independently by the two authors, resulting in 89.4% agreement across the codes. Discrepancies were discussed and consensus reached with the exception of one excerpt (99.6% agreement).

Three methods of triangulation ensured trustworthiness of analysis and interpretation of the data. In addition to having a second data coder, codes and themes were dually processed with a content specialist in Dementia-Montessori (second author). An expert in qualitative methodology served as peer debriefer (Hadi & Closs, 2016). Finally, the 16-month period of prolonged engagement (Hadi & Closs, 2016) provided potential for the facilitator to build rapport with administrative and floor staff and residents, with whom she did not have any previous relationships. Staff roles are categorized into two main position types: administrative staff (e.g., executive team, managers, volunteer coordinator) and floor staff (e.g., activity director, nurses, nurse aides, housekeeping, dietary). Administrative staff encouraged the implementation of the intervention and provided assistance to the facilitator in organizing staff training sessions, intervention materials, and an informational meeting for residents and their families. Training content included the core Montessori tenets, providing choices and opportunities for meaningful work outside of the scheduled activities and strategies to allow residents to perform any task/activity with minimal assistance. These trainings were attended by nurses, nurse aides, and activities staff; it is noteworthy that administrative staff did not attend. With respect to the intervention, the activities director and nurse aides were assigned responsibility for engaging the residents with the activities.

Results

Four themes opposite to the Montessori values and principles of respect, interdependence, meaningful interaction, and structure emerged.

Respect

Respect is characterized as feeling a sense of admiration for others or having regard for the feelings, wishes, rights, or traditions of others (and of their property). Perhaps reflecting the larger culture of the facility, field notes revealed low levels of staff respect toward residents (e.g., staff on phones while with residents, staff doing creative activities designed for residents). Analysis of field notes also exposed that the facilitator experienced a continual *lack* of respect from both administrative and floor staff. Despite their initial support, administrative staff failed to respond to the facilitator's repeated inquiries and requests, leaving her without knowledge of what had been communicated to residents and staff. Furthermore, floor staff repeatedly disregarded the facilitator's written and verbal instructions and feedback on the MBI. This theme emerged during a training session with floor staff:

They talked when I was talking and acted as though I wasn't there sometimes. Nurse was angry, didn't want to be there, and told me so (had too much work to do). She looked at her phone off and on continuously. She looked, flipping through papers

and for 30 min did not look at me. Then she started to complain, openly. The two aides were telling me this was not their job, “It is all nice and all, but we have no time.”

This quote demonstrates the level of hesitation, and in some cases resistance, of floor staff. Similar examples of disrespect pervade the field note data: Floor staff disregard the facilitator’s specific guidance for engaging residents to create decorations for an upcoming event, instead purchasing store-bought decorations; floor staff prepared food for an event without involving the residents, as the facilitator requested. Throughout the MBI, staff disregarded instructions, interrupted trainings, were late or skipped trainings, and never responded to facilitator inquiries. This occurred despite administrative staff’s assurances that the floor staff were provided with the necessary time and resources to accomplish these tasks. Furthermore, this type of behavior continued through the facilitator’s attempts to positively engage with floor staff and build a collaborative approach to implementation, a recommended strategy for successful implementation (Ritchie et al., 2017).

Interdependence

Independence is a core Montessori value; interdependence complements independence and is appropriate for people with dementia who may require assistance. Interdependence is characterized as encouraging individuals living with dementia to complete a task or activity on their own with only the most minimal support required and includes missed opportunities for residents to be interdependent. This theme reflects the degree to which a person living with dementia was encouraged to complete activities of daily living (ADLs), instrumental activities of daily living (IADLs), and meaningful activities on their own or with minimal support. Despite the floor staff’s claim about allowing residents to complete their own tasks, analysis revealed that floor staff failed to foster interdependence in residents as the following example illustrates: “[Facilitator] asked question to nurse [regarding who dressed the residents]. She [nurse] said residents dress themselves. All feeding themselves, many move cups or utensils slowly to mouth but are pretty capable.” Although ADLs and IADLs were occasionally mentioned in field note data, the overwhelming majority of instances of (lack of) interdependence involved structured, purposeful activities the facilitator introduced through the intervention. This is due to the fact that the facilitator only observed in public areas of the care setting and had limited access to resident’s rooms, where most ADLs occur.

Interestingly, in the same field note, the facilitator detailed that the floor staff continually completed tasks for residents rather than providing minimal assistance to promote interdependence. For example, while assembling a potted plant activity, the following interaction occurred:

[Activity Director] comes over as I’m laying them [activity materials] out and asked, “Do you need any help doing this?” I asked her to get it started. She starts to ask aides if they want to paint a pot. I point out that this is for the residents, not a craft for the aides.

Frequently when the facilitator instructed staff to involve residents in activities, staff instead completed the activity for the residents with little-to-no resident involvement.

Meaningful Interaction

At the heart of Montessori culture is providing opportunities for meaningful engagement. Although qualitative inquiry does not usually focus on the frequency of code applications, two types of engagement were coded: 95 excerpts were coded as “interactions,” whereas six excerpts were coded as “individualized/personalized attention.” Interaction codes track everyday verbal and nonverbal reciprocated exchanges (beyond the provision of food and medication) among staff, residents, and facilitator. These commonly included brief conversations during meals, while watching television, or between groups of residents and floor staff about daily events. In contrast, individualized/personalized attention excerpts are focused, prolonged, one-on-one engagement that primarily occurred during MBI sessions between the facilitator and individual residents. The imbalance between interactions and individual personalized attention captures the story. As the facilitator engaged a resident watching television, the following excerpt connects this theme to the reality of a resident’s life in her preference for more meaningful activity:

I asked her when she was commenting on the TV if she liked to watch TV. [Resident]: “Yes and no. Sometimes I like to watch but I would rather be doing something. I want to be involved, you know? I want to feel like I am contributing, giving back, doing something.”

Structure

This final theme includes structured activities with intentional modeling of step-by-step instructions that promote user autonomy. Structure is central to the Montessori concept of the prepared environment in that it provides a safe space to stimulate purposeful activity and an adaptable structure to support engagement for individuals of all abilities. Excerpts coded as wanting (vs. having) structure and guidance were twice as likely to occur. For example, the facilitator documented a conversation with a nurse who shared, “‘There is no plan of care here.’ She [nurse] wants one and is used to one, doesn’t understand why there isn’t one at [care center].” However, when the facilitator introduced opportunities for increased structure and guidance, staff typically did not adopt the technique.

Discussion

Using a Montessori lens, the barriers to implementation were antithetical to the principles that have been credited for the success of MBIs (i.e., respect, interdependence, meaningful interaction, and structure). One theme in particular, respect, warrants further discussion. It is important to consider whether lack of respect might reflect a lack of buy-in or engagement, a common barrier in interventions across long-term care, where administrators and staff are frequently overworked and underpaid. In Montessori terms, lack of buy-in is suggestive of a lack of respect in that both are needed to support the interpersonal relational health necessary for successful implementation. Respect can be characterized as the feeling of admiration for others or having regard for the feelings, wishes, rights, or traditions of others. Violations of this were threaded throughout field notes, which created barriers to both respect and buy-in.

In general, these findings are not unique to MBI research; they contribute to an emerging literature that identifies similar barriers to both MBI and PCC interventions for people living with dementia. Staff hesitance and perceived resistance to attend trainings and facilitate MBI techniques mirror negative staff attitudes, resistance, and expressed lack of time to use new approaches to care (Doyle & Rubinstein, 2014; Ducak et al., 2018). Similarly, lack of clear communication, which is critical to successful implementation of PCC interventions (Kolanowski et al., 2015), also created barriers to training on the MBI.

Consistent with Hitzig and Sheppard (2017), barriers to implementation in the current study included a lack of staff involvement. The direct care workforce shortage in the current and other long-term care settings can inadvertently impact implementation of any well-intended intervention. In addition to being overextended, many floor staff demonstrated a task-oriented approach to care, which has been shown to interfere with meaningful one-on-one interaction with individual residents (Doyle & Rubinstein, 2014; Kolanowski et al., 2015). This highlights the importance of providing recognition and rewards to staff for administering the MBI. Furthermore, in the absence of best practices, these implementation issues can contribute to variability in how interventions are delivered (Hitzig & Sheppard, 2017; Sheppard et al., 2016). Future implementation attempts could benefit from the use of implementation sciences and principles from community-based participatory research in the design and implementation of interventions in care settings.

One limitation of this research is the fidelity of the intervention. Although administrative staff invited the research team into the facility and initially promoted the intervention to residents, family, and staff, they did not fully support the agreed upon preintervention training and ongoing support for staff. Nor did administrative staff hold the floor staff accountable for the implementation of the intervention. A second limitation is that the facilitator did not have formal training in engaging staff and problem-solving barriers

specific to long-term care settings. A third limitation is the pilot nature of this intervention, which prevented the research team from assessing contextual variables such as organizational readiness for change.

A final limitation of this analysis is that the field note descriptions are derived from one person's (the facilitator's) perspective. Unfortunately, data from other sources that could affect the successful implementation of the intervention, such as the staff's relationship with the facilitator, were not available. However, these findings are consistent with previously identified barriers. Nonetheless, conclusions are based on the facilitator's experience and cannot be universally applied to all memory care settings.

Providing meaningful activity within a structured environment built on respect and collaboration is the foundation upon which Montessori thrives. Without this foundation, the beneficial outcomes of an intervention cannot be realized. In exploring implementation of one specific MBI, we identified barriers similar to those reported in other MBIs and PCC interventions. Findings underscore the need for formal, systematic documentation of implementation barriers to facilitate intervention effectiveness and extensive preimplementation work to accomplish culture change in long-term care.

In traditional Montessori education, the concept of the prepared environment relies on the training and transformation of the teacher to cultivate and embody the principles that are essential to Montessori philosophy. By extension, in long-term care, preparedness requires transformation of staff prior to implementing the intervention. These two concepts (i.e., the prepared environment and teacher transformation) provide insight into how to overcome barriers to implementation. An intentional preimplementation phase could develop and empower staff, with the ultimate goal of creating a culture that results in better quality of life for individuals with dementia and their care partners.

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Ethical Approval


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