Using Montessori Intervention in Dementia Care: Part 2

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- [Amy] All right. So once again, welcome to part two of Using Montessori Intervention in Dementia Care. And our presenter today is Amanda Stead. Amanda is an associate professor at Pacific University in Oregon, and she teaches courses in communication in aging, aphasia, progressive neurological disorders, end of life care and counseling. Her research is in the area of evidence-based education, language change in healthy aging, and dementia and the applications of technology to serve vulnerable populations. So, Amanda, I'm gonna hand over the floor to you. Welcome.

- [Amanda] Hello, everyone. Thank you so much for joining us today. I'm really excited to be offering this two part series, and I'm especially excited about what we're gonna cover today, which has some more Case studies and things related to some of our patients that are perhaps a bit lower functioning. So, here are my disclosures. And, as the introduction said, I am an associate professor at a small university outside of Portland, Oregon, called Pacific University. And one of the reasons that I am really excited about this content, is that we are able to offer, and as you can imagine, I'm the instructor for an entire course to graduate students dedicated to progressive neurological illness.

So, I spend a lot of time thinking about this work, we run programs in the community, I coordinate supervision, and we are doing this work out in our community right now. So, I'm speaking to you not only based on the evidence, but my experience in teaching it and implementing these interventions out in our community. I, like many people, found myself interested in working with patients with dementia, because, I had a family member, my grandmother got very unwell with dementia when I was in college, and I was in sort of end of my master's, beginning on my PhD, and started to really ask myself why I wasn't seeing more interventions focused for this population. And so, I have switched my focus and here we are. So, the learning outcomes for today is, we will explain how Montessori interventions can support persons with dementia, we will

identify different types of Montessori approaches and how to apply them to work with our patients, and we will list implementation steps of a successful Montessori intervention. All right, here we go. So, one of the things I just really wanna revisit is how We are going to implement Montessori, and what the rules of engagement in Montessori are. So, many of you may be familiar with the educational approach to Montessori, the way that children often engage in that educational sort of modality. And the idea, and the sort of premise of that is that you cannot give to the mind what you can't give to the hand. So, appealing to children's love through sensorial, through physical manipulation and application. Now, when you try to extrapolate this and think about, so why does this work with our patients with dementia? Well, we know that their cognitive status is impaired.

And so, what we're going to do is we're going to appeal to their strengths through that sensorial touch, and we're going to make sure that we are providing them with opportunities to engage in learning and activities, in a way that takes the burden off of some of their cognitive impairment. So we're not gonna keep bombarding them with the areas in which we know are impaired. The other really foundational part of Montessori is that, each activity has got to have a beginning, a middle and an end. So, a beginning looks like an introduction or an offer of participation. The middle is really defining where we're doing the work.

Work is a way that we talk about Montessori a lot. And the end is one of the most important sort of pieces. Is that the activity in almost all cases should have a logical completion. So it should feel achievable and completable, because that is what provides our participants and our clients with the opportunity to get that positive sort of feeling of success of completion. The other thing we wanna think about, is when we're doing Montessori, is we want to, when possible, choose preferred activities that really play to people's strengths and their potential. So being thoughtful about which activities we bring forward to our participants. So, where we sort of left off last time, if

you had the opportunity to see part one, is we were we were discussing the different types of Montessori. And what we really need to explore is the type of Montessori that looks a little less regimented, and looks more sensorial. So sensorial sort of based Montessori is a little bit different than activity completion. Because what we're trying to do is we're trying to approach our more moderate severe, severe clients, with the opportunity to engage in a sensorial based task to meet some of the goals we have, which are often related to management of negative behaviors, increasing in engagement communication or priming, so that they can engage in a subsequent activity. So, here is some examples of some sensorial only materials.

And selfishly, I put these in here. And these materials happen to be created by students that are my students. And what these specific materials are, are they're just regular old kitchen aprons, we pick 'em up off of Amazon for like a dozen for 20 bucks. And then what we do is we apply a variety of interesting, tactile, colorful, sometimes thematic, sometimes not materials to them. And the idea is that this is something that can be worn by a resident placed on their lap, displayed on the table, and that it allows a more severely impacted client to explore and get engagement through their strength of touch. Grab my little arrow here.

So this one is sort of beloved to me. So, these are all pipe cleaners. So that very specific material braided sun, these flowers. This is actually a pocket, you can put your hands into, there's zippers fur. One of the benefits of this one is that they have a variety of different types of fabric and materials to sort of explore. This is often a great material for our patients that are fidgeting or fussing with something in particular. Oftentimes, they couldn't. I have given materials like this or given aprons to client who, for instance, had a wound on their arm, and they were picking up that wound. And so, it was a way to redirect that energy to something safer. This second apron has this wonderful beaded pearl string, which I love, and it's sort of based on like kitchens and gardens. So there's things in the pockets, there's different materials on the outside, things you

can open and close, things you can shake. So just making it exploratory. Same one, this tie can be tied and untied, there's zippers, things in the pocket. The other thing I think is a wonderful thing to think about if you're gonna give materials like this, is to stuff the pockets with something that's weighted. So that heavy sort of like beanbag feeling on someone's lap can be really stimulating and help draw them back to engaging in that material. Here's some other examples and sort of sensorial base and experiential materials. This is a picture of some participants who engaged in building these Montessori sensorial wristlets. So we took scrunchies and attached to them with any variety of wonderful sensorial based things. And my favorite thing about building Montessori materials is you can go to the goodwill, you can go through your junk drawer, you can go dig out all those crafts supplies that you were aspirational about. And the idea is to make them interesting and tactile. This is a concept that I think a lot of people are familiar with, this idea of this like busy board.

So, things to open, shot ring, punch pole, unlock, move up and down. And certainly, we wanna consider, I think, sort of the optics of appropriateness with that. But when I think about, like, does a material look appropriate for a geriatric patient? I think often what I think about is that, I don't wanna choose optics over the clients happiness. So, if the client is really happy engaging in the material, and optically, you're getting pushback that that material looks juvenile or it looks pediatric, I think part of that is an opportunity to reframe for some of the folks giving that feedback about what is the goal here. Is the goal that optically we want it to look okay, or is the goal that our client is engaging meaningfully, is that they're redirected from their behavior, is that they're having the opportunity to engage more safely in their environment? So, I definitely think we need to take the opportunity. The baby doll is a long held sort of controversial item in dementia care. So, some facilities have like full baby stations, and some places are vehemently against them. And I just think if you exist in a setting that's really against the baby doll, I would just say that's an opportunity for dialogue to reconceptualize, like what the goal is and why this material is appropriate, and playing to client's strengths

over optics. So, this material here on the left, and I have a few things like this, are just like, I'm not gonna call them junk boxes, but you know, they're junk boxes in a lot of ways. So it's like rope and gloves and a jar full of poker chips and some little tchotchkes in the jar on the top and some notebooks. And the idea is that this is just a material that if you presented it to one of your clients, provides them with the opportunity to engage and explore in sort of a non failure sort of way, and to take the pressure off of a lot of the confrontational questions or task-based work that our clients are receiving on a daily basis.

The material on the right is a pillow that was also created as part of my course. And it's just a regular pillow. And we've sort of adorned it with any number of different fabrics, ribbons, buckles, and things to explore. So these are things that can be left in the room of your client or on their bed or in a facility, and it's a way to, again, as our patients are trying to find something productive to do, can be introduced to them intentionally to meet our goals. So, here is one of the few case studies I'd like to present to you and really think through, because when I started working in dementia care, I think I had a hard time conceptualizing what the outcomes were gonna be. So I had a lot of tools and not a lot of understanding of implementation all the time.

So, for example, if we're gonna think about behavior, which is one of the most important and I think prevalent reasons to pick up patients with dementia, so 78 year old, recent uptick in behaviors following a return to memory care after a stay in skilled nursing for a fall. So, the first thing I wanna address is, this is so extraordinarily common. So we know any transition in setting often causes a functional decline, we know falls often cause a functional decline. And that's your opportunity, right? So that change in prior level of function to go ahead and pick these patients back up and say, my patient before was engaging safely in their environment, and now the behaviors have really upticked. There's a lot causality here because they went through a facility transition in another medical incident. So, now the patient is visibly anxious and easily

agitated by both residents and staff. Patient is often seen crying in the room. So, this for me is such a classic patient, particularly in residential memory care. And this is often a patient we see in home health also, because the patient has returned home to a primary caregiver, but the patient is not functioning at the level they were before and they're more anxious. Anxiety is a behavior issue. Agitation and anxiety also are related to a decrease in safety. So we know when patients are anxious and agitated, their likelihood of a safety event or an adverse outcome goes up extraordinarily. And you know this. When you're having a moment, you don't always make the best decisions. And now, if we layer on a legitimate cognitive impairment on top of that, it's really a recipe for a bad outcome.

Also, I think it's really important that we don't normalize anxiety and crying in patients with cognitive impairment, because if one of our primary goals is maintenance of quality of life, then the onset of sort of extraordinary emotional outbursts should be something we should be picking patients up for. Okay, we have a patient who's demonstrating a lot of anxiety and agitation. Here we go. So, what can we do? Well, if we wanna think about how we're gonna use Montessori with this patient, the first question I'm gonna ask is, "Is this patient a candidate for Montessori?"

And since we've covered so many different types of Montessori, I think the answer is usually, yes. at least in my experience. The only folks with dementia, I don't have a ton of great outcomes with using Montessori, are patients that are more mild. And those patients are candidates for a myriad of other therapies. So, that's not a big deal. So, okay. Now I'm going to think about, how do I apply Montessori to manage behavior? Well, if we break behavior out again into its two pieces, and think about prevention, and then secondary to that, deescalation. So, how can we introduce Montessori activities to this patient to prevent the anxiety and agitation in the first place? Well, is there a time of day where anxiety or agitation is peeking, or a scenario where it's peeking? If so, what we wanna do is offer a preferred activity to this patient right prior

to that, to sort of mitigate any transitional time or movement into that anxious space to begin with. Alternatively, if all of a sudden our patient is agitated, a good thing for us to do is to, one, explore what Montessori materials we can offer to that patient that will bring them into a state of engagement, to bring their anxiety and agitation down. So, if we can redirect that energy through the use of Montessori, so whether that's a bolt kit, or that's an apron, or that doing laundry, whatever the sort of type of Montessori is, the goal is to redirect that patient's energy out of anxiety and agitation, and no place to put that, and focus it into a tangible sensorial activity which plays to their strengths. We do this, first, by doing the work of exploring what types of Montessori the patient is attracted to and benefits from.

So that's part of our work as a skilled clinician is, does this work for prevention and deescalation, in what form, with what offer? And then on the back end, really training caregivers doing caregiver education and functional maintenance plans. So the staff in a facility or a residential caregiver can say, "Oh, I feel my father started to get anxious, "I'm gonna go get that material "so that we cannot go to this darker place right now." So, the prevention and deescalation of behavior is just such a frontline opportunity for us. And something that I see a lot in facilities, particularly, where there isn't a lot of engagement, is that, you know, idleness does not breed good behavior.

So when people don't have anything to do and nothing to engage in, or the activities being presented at a facility or within the home are too high level for patients, then we see people sort of turn inward. And that can create a lot of anxiety and negative behaviors. So, we really need to make sure that our patients are having the opportunity to engage in an activity where they can feel successful and get that positive bump, and also provide the opportunity for behavior mitigation and communication. So, when we think about curating the environment, how are we gonna do this as therapists? And this is really dependent on your setting y'all. So, if you are in a hospital, curating the environment is probably a non starter. Hospitals look the way they look for a reason.

But, you can talk to caregivers about that. If you work in skilled, if your patients have any access to common spaces or thinking about their rooms, so you can consider this on a short term basis. Home health, this is a wonderful opportunity to think about, and also thinking about our patients who are living in residential facilities. So, assisted living, long term care, memory care, in particular. So, here is a great example. And when you look at this picture, what I really hope you're thinking is, look at all that stuff. And so, of course, there are some things in here maybe we wouldn't want to absolutely have offered to all patients with dementia. So we're gonna be careful about curating which materials are ultimately appropriate. But this is to give you an idea.

So what this is, is imagine this in someone's home or garage or a back wall in a residential facility, or a little nook and cranny and a common area and skilled, and it's a place where people can go, fuss with the things on the wall, tinker with the materials, explore. I love the little tiny drawers and the tiny little things that open. We wanna make sure that the things in there are ultimately safe. So being thoughtful about the residential sort of compendium you have in your facility. But the idea is that this is a whole area that's dedicated, that exists in that person's space, where you can either redirect them to the space, right?

So if someone is escalating a behavior, you can say, "Let's go visit our workbench. "I wonder if there's any new materials over here." And that offer, and then bringing someone to that space, I think better yet one of the distinct advantages a Montessori area has or the creation of dedicated activity spaces has, is that they have the ability to be discovered and engaged by freely by your patients. And so, this is an opportunity where maybe we don't have to constantly redirect, but that patients would stumble upon, discover, or spend time within, solving the problems of prevention in the first place or the problems of social engagement, as we see people congregate around areas that are interesting or have more people in. The other thing I think that you can really focus on, you know, when patients are transitioning from a mild to moderate, you

can train through space retrieval or vanishing cues errorless learning, thinking about visiting the space over and over again. When I'm feeling anxious, I go to my workbench. When I'm feeling anxious, I go to my workbench. And training this sort of procedure to go seek out these spaces while people are still able to map on some new learning. I love a workbench by the way. Oh, here's some more. So, thinking about like a little vanity area, and I have seen vanity areas that have like boxes full of vintage gloves, or a hat rack on the wall, mirrors and combs and brushes. Thinking about not only things to tinker with, but things that are related to previous lives and roles and identities we held.

So, the procedure for brushing your hair or the procedure for looking in a mirror or filing your nails, is a procedure that holds on a lot longer than the name of a nail file or the name of a brush. And so, not only for our patients that have some of that procedural memory that can engage in a meaningful independent way, but also these materials are visually interesting and can provide an area, again, for redirection and exploration. The laundry, and I know, I love having this conversation with people. Everyone is like, why would I ever want to do laundry ever again? Because, you know, I don't know about y'all, but I do a lot, a lot of laundry. I'm not sure I've been done with laundry since my children were born, certainly.

But, one of the things that is really challenging about working with folks with dementia, is that they don't have a lot of purpose or work, right? So they don't have anything to engage in meaningfully in their environment often. Families and residential memory care are thinking, "Wow, I'm spending a lot of money, "why is my mom doing her laundry?" Well, the reason offering laundry is really interesting is because it's a super familiar procedural tasks that a lot of people understand. Laundry also has a clear completion point. So, a basket full of clothing is a limited sort of opportunity. So once it's folded or once it's hung up, it's good. I love clothes pins and hanging things on line, folding thing and pile, even if people just take 'em out, sort 'em and put 'em all

back in the bin. The idea is that there isn't really a right way to do it, but that it's providing that opportunity for us to think about behavior management, communication and socialization. So, the short sort of offer there is create a laundry station, even if it's nobody's laundry, it's just like random laundry you picked up or random clothes from goodwill, and put 'em in a basket and put 'em on a table or put 'em next to an ironing board or put 'em by a clothesline, and I will bet the bottom dollar that folks will go over there and engage in that procedure. Again, whether redirected or self discovery. And when people finish a load of laundry, they feel like they did it, right? That successful positive bump. And this is again, what residents are not receiving. What folks with dementia do not receive is positive feedback and positive engagement in their environment.

They're being told no, all day, every day, in a series of massive redirections. And that is a very diminishing position to be in. So providing people with opportunity to feel successful, mitigates behavior and increases communication. Socks. So, I love matching socks, sorting socks. If you go on to Amazon, you can buy a thing of 50 kids pattern sock pairs for like $25 or $15 or something. And you just put 'em in a big old basket, you walk up to someone and you say, "Ah, I haven't had time to match all of these socks." And you just sit down, you dump 'em out on the table and you start matching them.

And nine times out of 10, you will get help. Now, will they always be matched correctly? No, but the goal of therapy is not to match socks, the goal of therapy is to engage our residents so that they can meet the goals we have prescribed for them. So, all those single crazy socks you have leftover in your own laundry, throw them in a bin and they can become Montessori tools for you. I am a big advocate of stationary, mail stations, letter writing, mail delivery, arts and crafts, in ways that make a person feel like they are engaging with the outside world in a task that was once really considered independent space and meaningful. I think you can fill out postcards, you can provide

letters, opportunities for people to write things, you can have in and outbox, you can have things to read, stacks of Christmas cards. Again, you can go by the Dollar Tree and pick up a whole bunch of Thank You cards and just put 'em out. Let people write Thank You cards to anybody, who cares. 'Cause the goal is not an accurate Thank You card, the goal is to engage, and so that can really work. And the crafting sort of kit on the side, I think is a wonderful opportunity to think about flower arranging, sewing materials, stamping, that a lot of people remember had these primary identities, tasks, procedures, before they were not well. And so, all we're doing is reintroducing things that have often been removed in their current lifestyle to meet our goals. Here's a couple other examples. And so, the picture on the left with the sort of snack bar, I know probably no one has ever seen a snack bar quite that nice in a residential facility, or are opportunities where we have to provide one on one meals, in hospitals and skilled, can look a little bit different.

But, is there an opportunity to provide some autonomy with drinks or snacks or breakfast, so that patients can engage in what was a normal task? Right? So, buttering toast, thinking about peeling the outside papers off of muffins, fixing your own water, making tea. And where we can get into a pinch with food and drink is really in individual settings restrictions on access, and often, again, the patient profiles within that building. So, we had been working in a building for a long time with a program, and we had worked to get coffee and water and things available to the residents, you know, to fulfill that sort of, one, hydration need and independence, but also to create this little area that we could keep redirecting them to. And then what had happened is there was a resident that moved in whose profile was a little bit different, and was really prone to lack of monitoring, further sort of oral behaviors. And that one resident, in order to maintain safety, had caused us to remove sort of all the food and water station. And that's not uncommon, right? So sometimes we're building things for our lowest functioning residents, if you live in a more common residential setting. But again, if you are in home health, or we're training caregivers to implement these things,

these are the things that provide positive engagement for residents with dementia out in the world, which by proxy, again, meets our goals of communication, behavior management, socialization and quality of life. This little box on the right is full of strings and straps and wonderful things. So again, it's a little area where you could have these sort of materials related to engaging. You can stack several of these boxes in one place. So, a facility that we have a program at has an entire wall of activity boxes you can pull out, depending on the resident. And again, that's great. So the residents can wander over there and grab something off the wall and engage in it, or a caregiver or a therapist can go over there and grab one and use it also. Here is another case study. And this one I wanted to really focus on priming.

So, if anybody understands the concept of priming, it's speech pathologists in people who love cognition. The idea that our residents with significant cognitive impairment, can go from like zero to highest functioning at the drop of a confrontational question... Excuse me. It's really fascinating. So, we know that when residents with dementia are idle, that in order to sort of get them to engage at their functional peak, it takes a minute of engagement. So, we can use priming as a tool to help us get to those confrontational questions.

So 10 minutes of engaging in a Montessori activity, to then be able to turn around and say, "Oh, Miss Betty, "I see that you've been holding your stomach. "Are you hurt?" And then being able to ask them more cognitively-loaded question because we've sort of woken up their system. And the analogy, I think, sort of have a computer going from that sleep mode to the functional mode. When I open my laptop, it takes a couple of minutes for me to be able to do work. And so, this is an opportunity we need to take advantage of, to make sure that what we're measuring is accurate and related to what that patient can actually do. Very few of us function at our peak all day long. But, if we need to ask confrontational questions, if we need to have a patient engaged in a more strenuously cognitive activity, like eating, maybe we take the opportunity to prepare

them for that heavy cognitive load. So, here's the example. 84 year old has been recently losing weight, is eating little at the dining table, and they easily lose focus while dining, and they have difficulty loading utensils. This is a patient I wish we would pick up more often, because, I don't have to talk to y'all about dysphasia. That has always been our quickest pathway to patients with dementia. And in a lot of cases is the only opportunity we've had to see patients with dementia. But let's talk about eating as a function of cognition. So, lots of folks with dementia don't have dysphasia and yet are not eating. And they're not eating because it takes a lot of attention and procedural skill and executive functioning, to engage in the task of eating in a shared dining room or eating a meal or thinking about food.

So, we have patients that lose weight and are lacking caloric intake, not because they don't want to eat, but because they can't crack the procedure and the executive functioning of eating, or they can't pay attention to the task at hand. So, they're not losing weight because of the dysphasia, but because of the attention. Now, because that's cog, that's us, and we can easily pick up these patients. So, what we can do in terms of priming, is prior to mealtime, we can help understand. So as the skilled clinician, we recognize this patient is not attending at mealtime.

We know that if the patient isn't gonna eat independently, what's gonna happen is they're gonna move to one to one feeding, one on one feeding, which is problematic for a myriad of other reasons we won't go into now. So, as the skilled clinician, the question you're asking yourself is, "I wonder if this patient is primed a little bit more, "a little more alert and awake. "When they enter that eating space, "will they eat more or attend better to their meal time?" So, we work on finding a preferred activity, a Montessori activity, 10 or 15 minutes prior to meal time, work with that resident in a super noncognitively heavy way, but in a way that really plays to their sensorial strengths. And then, we take them to meal time and see if there is this added benefit or added intake because they are more primed. Additionally, it can be true that that

patient responds better to cueing, because they are more functionally alert from having the opportunity to engage their cognitive system in a more successful way. So, priming is a missed opportunity for us that can give us the opportunity, to really make sure we're measuring the right thing. We have to make sure we're not taking like functional data all the time on our patients if we have just approached them, because that doesn't always represent what they're capable of. So, how are we gonna do this? One of the hardest things about having successful interventions with patients with dementia, is that we have got to slow it way down. There is nothing about our settings that wants us to be slow. Productivity standards are on believably high. And the pace at which we move, the pace at which we talk, the pace at which we are even like moving from room to room, and residents can be aware of that, or just the briskness in our movements can really set a tone.

'Cause remember, our residents or in-clients with dementia do not always recognize why we're there. And if someone is moving briskly around you, it can create some anxiety. So first, we really wanna have that zen moment before you walk into a space with your client, to really slow it down. When you present that opportunity, the first thing you have to do is remember, and it seems so obvious, but we just have to tell ourselves like, the goal is not to fold the laundry, the goal is not to match the pictures, the goal is not to touch the sensorial apron.

The goals we're measuring are related to our scope, behavior, communication, socialization. I know I sound like a broken record. But, redundancy can be wonderful in a lot of ways. So, there isn't a right way to do it. And if the patient isn't doing it the right way, we wanna make sure we're not signaling that that's the case, unless the patient is doing in an unsafe way, and then that's something we make an adjustment to. The goal is the engagement in stimulation to the benefit of our outcomes. Also embedded within Montessori, you can really start to take the opportunity to reminisce. One thing that patients with dementia experience a lot of, is task talk. So it's just directive task based

world. Well, okay, Miss Betty, we're gonna brush your teeth now. Okay, Miss Betty, it's dinner. Okay, Miss Betty. And I'm sorry, y'all, I always say the name Miss Betty 'cause Betty was my grandmother's name, so it's like my go-to sort of name. But it's a lot of directive sort of talk. Instead of being like, "Wow, I love the color your nails are painted. "When I got married, "I painted my nails this beautiful gold." And that provides the platform and opportunity for someone to sort of pick up the reminiscent. Like you've just introduced a topic of weddings, the topic of marriage, a topic of beauty. And people can often pick up that conversational line or not. And instead of you being like, "Miss Betty, what was your wedding like?" You're just offering a non-confrontational opportunity. So, we want our activities to be error-free.

So if you ever get the sense that your activity is frustrating, move on, pick something else. And we want people to be successful at it. So we wanna offer them an opportunity, 'cause right, we're not trying to restore cognitive function, that is not the goal here. We wanna offer people an opportunity to have that feeling of success, that we know they're not always getting on a task-based world, in which they're the person existing as a person being cared for.

So, you're gonna start with the invitation. And invitations, again, and I covered this a little bit in my first sort of part one of this, but they look like offers without asking questions. I think the best ones are. So sometimes they're just saying, "Wow, I dropped my laundry basket on the weigh in, "I guess I need to refold this," instead of just sitting down and folding it. Sometimes I'm like, "Oh, no, all of these are unsorted. "I'm hoping you can help me." So I'm still not asking a yes/no. Sometimes I just sit down next to residents and start doing the activity, and let them observe me for a minute, and then over time I hand them some materials from the activity. So, we're gonna offer an invitation. And remember when you ask yes/no questions to people with dementia, they'll often tell you no, because they're not interpreting what you're asking. So we want to make an invitation that shows them that they can be successful, that it's

inviting, and that it's not pressure-filled. I mean, if they still don't wanna do it, they don't wanna do it. And that's fine, too. That's about finding preferred. We wanna consider sensory impairments. So thinking about, is your material too tiny for someone who has a lot of rheumatoid arthritis in their fingers? Is it too sort of visually dependent on a patient we know has a lot of low vision issues? Thinking about hearing impairment always and always. We know a lot of our patients with dementia do not wear hearing aids. And so, thinking about making sure you can be successful. Thinking about their motor capabilities.

So, how much mobility do they really have in extremities, in terms of moving. If you have a Montessori area, and they're not very mobile, are you really expecting them to go over to it, or will they need an assist in doing that? I love the opportunity to present Montessori materials to your patient to reach a goal in public, because if there are other residents around, sometimes it provides that sort of secondary stimulation to them and the opportunity to socialize. We know that part of the cognitive impairment in persons with dementia impacts their ability to initiate conversation, that's often misinterpreted as a lack of desire or ability to communicate.

We have to remember that they do not have the cognitive ability, that sort of frontal engagement to say, "Oh, you know, I'm gonna start a conversation right now, "here we go." So providing that opportunities for cross-socialization and initiation. Initiation is the key to interfacility socialization. So if you can crack that code and create an environment where multiple people are engaging in an activity, you have won the socialization race. And, this is also a way for us to meet our new sort of challenge, to engage in group activities. So, one of the things that is really prevalent is when we do group work with folks in either geriatric care or even in short-term or long-term rehab, is that sometimes the group work, and I'm not saying it's always done by us, because the problem is, is it's often not done by us, is that it is way too complicated. And we see a lot of this like cog game, right? So, name all the items in a category. But that's

the problem. Like, they can't do that. And we know that it's not gonna, for these folks in particular, provide a restorative benefit. So, give yourself permission to not work on activities that look restorative. Again, we're sort of recentering our goals. So, how are we gonna increase communication, socialization, safety, functional living in our environment? Well, it's about providing opportunities to people to meaningfully engage. And so, that can look like a shared flower or arranging task. So, if we want to meet our burden of group therapy, Montessori is a prime activity that can meet a whole bunch of goals. One challenge I have certainly seen in taking my students to work in memory care, is that speech pathologists have this habit of talking a lot. And, because we're often introducing Montessori materials to patients who are more moderate or severe, that talking, it can be a real cognitive burden.

So, when we're doing Montessori work, we really want to try to show more, demonstrate more without using our words all of the time. And when we are using the words, making sure that they're intentional and meaningful in the sort of pursuit of our individualized goal. When you approach someone with a Montessori activity, and you're trying to figure out if this is going to be the right solution to their problem or to meet your goal, practice with the material and demonstrate with them. So don't just drop and go, that's not skilled intervention.

What it is, is really sharing that space and modeling how to manipulate and use that activity. Now, imagine a world that someone came up to you that you didn't know, or maybe recognize, but you don't totally understand why they're there, and they put something in front of you, that you didn't know what it was, and then they walked away, how weird and bizarre and maybe intimidating that would be? And we have to sort of put ourselves back in our clients shoes. And remember, like they aren't oriented. They're not mapping a lot of great short term memories over. They might not know who you are. No, they may not know what that box full of things is. So, giving them the opportunity to see how to engage and model how to engage them material is

important. When you choose something that's relevant or preferred, your chance of engagement weigh up. Which is why, again, folding towels, rolling silverware, folding laundry, matching socks, fussing with work benches and sewing, these are familiar activities and can often lead to a higher success. We want a person to be successful at. Again, 'cause we're not trying to restore their cognitive function, we're trying to meet our goals through this type of vessel or this approach. So, here are the goals that we want to consider writing for our patients that are often used, when we're thinking about doing a Montessori intervention.

So, if you want to write goals about priming for memory heavy tasks, or ADLs, things like eating, things like asking confrontational questions, things like engaging in assessment, this is a great way to think about it. Behavior prevention and deescalation, those are really high on my list, really important for quality of life, communication and socialization, of course, and quality of life and caregiver training. If we trained all of our caregivers who have someone with dementia living with them, how to do Montessori work, I really believe that the quality of life for that person with dementia and equally importantly that caregiver, could greatly increase.

'Cause it would decrease those opportunities of negative behaviors, it would increase opportunities for positive engagement and socialization, which is what we know our caregiver is really craving. So, Montessori materials should be aesthetically pleasing. They can be plucked from your everyday environment. I bet you if you all got off this talk and you just walk through your house, you can make yourself four or five buckets Montessori materials. You can use external cues or templates. So thinking about a sign that says, fold clothes here, and a picture direction of how we would do that. We love materials that don't have a lot of extraneous markings on them. So if you're gonna have blocks or manipulatives, they don't have to have letters or writings or description. If you're using materials like condiment things, like a picnic basket or something, take all the labels off so people don't try to read them. We also want to, I think, think about

how we're packaging our Montessori material. So either in designated areas, trays or boxes, where things can be presented and removed, presented and removed or directed to. Here's my last sort of case study. So, 69 year old patient that has been reserved and withdrawn for several weeks. When asked how they're doing, they seem confused, unable to respond appropriately. Approaches group activities, but then leaves shortly after they begin. This is again super common. So, how can we use Montessori to increase this person's communication and socialization? Well, one, what does that group activity look like? Are they getting invitations to participate in things they feel like they're successful at?

Maybe instead of asking them how they're doing, right away, we can first engage them in something that is pleasurable and plays to their strengths. And then we ask those follow up questions and try to problem-solve if there's something more specific happening. I think, when again, we think about group activities and environments, things have to look doable, achievable and understandable. And often, our lower functioning residents are left out of that piece. So, when they walk up to group, is it someone sitting at the front of the room talking with a whiteboard or something or making a list? That might be really intimidating if you're disoriented and you're having a hard time understanding functional language.

So, we can bring Montessori materials in either proceeding or as the primary activity to facilitate better communication and socialization. So, the outcomes for Montessori, the things we wanna think about are; enhanced engagement participation, improved ability to independently perform a task and improve participation in groups in particular. What you're not measuring is the change in impairment level testing. We are not trying to improve cognitive status, we are trying to solve a particular problem arising at a particular moment, that is impacting a patient safety and quality of life. And I will advocate forever and ever, that inability to communicate and low communication is absolutely a safety issue. And I can say that having been a family where we had a bad

outcome because of poor communication. So, absolutely, increase in communication leads to increased patient safety. Montessori can increase your engagement, socialization, communication, sense of purpose in community. Montessori can be used to decrease anxiety and agitation, wandering depression, isolation and boredom. All of these things can lead to bad outcomes. All of these things can lead to adverse events. And absolutely, all of them result in the poor quality of life for both caregiver and the person with dementia. These are certainly areas worth targeting. So, people have the need to be successful. All people have to be successful.

Montessori can provide us with a pathway towards that. Being happily engaged in a satisfying activity can reduce some of the most disruptive things we see in dementia that impact quality of life and safety, like agitation, anxiety and depression and anger. So we can see immediate improvements in safety by implementing and trying out some of these methods to solve these behaviors specifically. Some of the evidence related to Montessori has been shown to have an impact in what we call sundowning. Right? So this is often an uptick in behaviors in mid late afternoon. And there have been studies showing that if you introduce activities, proceeding what is the typical onset of sundowning, that it can reduce the need for sedatives and antipsychotics in patients with a lot of behavior.

And I don't know about y'all, but pharmacology is our frontline strategy to behavior management isn't my preference. And the inclusion of more Montessori materials and activities can increase quality of life, which is certainly the pursuit of all of us. They're evidence-based, they're absolutely evidence-based. I'm definitely not talking to you about a pitch, something that's aspirational. The evidence is on our side, the science says that works. Our practice based evidence from my vantage point, I've seen it work, I've been implementing it for years in our settings. The goals are gonna be related to communication, behavior, engagement and priming. Montessori approaches are so easy, and so easy to take data on. I just really encourage you to explore in what ways

you could try to introduce these, to solve some of the challenging problems you're having with clients. And I just wanna thank you so, so, so, so much. And now I'm gonna answer some of your questions. So, I got a question. "What do you recommend for someone "with moderate severe dementia "for FaceTime visits during COVID?" Oh, what a great question! I have played videos of Spanish dancers, but would like to provide a variety of things that might capture her interest online, not sensory, because it's online. That is a really interesting question. So I think what I would wonder is that, if this person with severe dementia who is at home, is there an opportunity for caregiver training to implement some of the more sensorial versions of Montessori. 'Cause, it certainly wouldn't be traditional Montessori if they can't touch it.

So, I think maybe I would, if you wanted try to implement more sort of traditional Montessori, consider working with whoever that resident is living with, that patient is living with, and walking them through some of this problem solving and data taking from a caregiver training standpoint. So if we just want to provide visual stimuli, I would definitely, I think the idea of dancing is a great idea. So something that isn't word heavy or auditory comprehension heavy. The evidence behind music with patients with dementia is pretty extraordinary.

So, I might stay in the vein you're in and focus on engagement or redirection through the use of preferred music and maybe visuals. But I think you're on the right track. COVID, my goodness, what an interesting set of challenges we have as if we didn't have them before. It's just made a lot of intervention harder. And telehealth would never be my first choice for significantly cognitively impacted patients, unless you have a significant support of a caregiver. I also have another question. "Why do we need to have more choices "like you showed us in the living room? "Don't you think it may create more confusion?" I think it depends on the resident and the situation. So, part of the problem in some residential facilities is that there kind of aren't any choices, and there's kind of no areas. So if that's the situation, you're either in skilled or long-term

care, memory care, I would suggest trying to create any area to sort of start with. When people like live in the home, and their homes are already pretty visually busy, one of the things often we can do is thinking about that environmental modification of, one, decluttering and sort of making spaces visually appealing, but then providing sort of a dedicated area where a resident could engage safely in materials, or have like a reliable, like there's the laundry basket, the laundry basket is always right there. And they could choose to fold things or engage. It's definitely not a put all the things out there. But let's put something out there and then you're going to see how it's working and if it's the right fit. So it's definitely not an overwhelming, overstimulating environment that would lead people to be less successful. Although, if you look at some of the successful respite centers in the US, they are definitely sort of like tchotchke, filled, reminiscent, period-based houses, that have sort of all the stuff and all the sort of activity stations, and the baby changing station, and the babies and the hat, and sort of all of it that provides sort of an endless opportunity for engagement. So, I think we have seen that that is an option, certainly. I think it's about trial and error and consideration of that individual sort of situation, and your setting, certainly.

- [Amy] Thank you so much, Amanda. There was another question that came in. And someone was commenting about the frustrations also related to COVID, of not being able to get into nursing homes as usual to work with patients, and also to work with staff, like nursing activity coordinators and so forth. And so, I think she was getting out the question of, do you have any recommendations for resources or how can we share some of this information with that other nursing home staff that are actually there in the nursing home, since they're not sitting in on these webinars? I noticed that you do have a reference list, and perhaps there's some materials there that might be useful to share with other staff. Or do you have any other suggestions on how to convey some of this info that you've given us?

- [Amanda] Yeah. What a great question? We are certainly being challenged by the certainly current situation. I have given talks like this to many sort of provider networks, rehab agencies, activity directors. And you know what's so interesting? Is that if you make even a simple pitch, like let's say, you've recorded like a five minute video on your phone and you sent it to them, you're like, let me teach you about like this amazing behavior management strategy I learned. And you sort of rattle off like a summary of some of this and you show them a couple materials, I think that that's one way we can think about sort of like the short-term in-service, short term training, sort of model right now. And Teepa Snow definitely has some free videos and webinars on behavior management and hand over hand. She does great stuff on feeding. I think I would start with really small ass. Like, hey, if you have a patient with a behavioral issue, try to first, offer them a material or offer them some towels, and see if that is a good redirection strategy for them.

Like help them problem solve. One of the things I've noticed is that as the therapist in some residential settings, is that the caregivers are paying really close attention to what we're doing. And at first, they think we're kind of silly that we're sitting around with the residents folding towels, and then they see that it's super effective. And demonstration is the best sort of proof in the pudding. So, I think, encouraging them to try something super simple that doesn't put them out without a lot of information. And it's hard to have towels as a safety issue. So I haven't found a lot of pushback on that. So, if you can go up to your facility and drop like a laundry basket from the Dollar Store full of a bunch of hand towels and say, "Hey, I want you to dump these out on the table "in front of your residents that are struggling, "and see if this helps you with behavior," that might be a really low entry point for you. I think some of the feeding work has to wait till we're back, because I think we have a lot of work to do, in terms of the cognitive aspects of feeding. I think if you wanna in-service, offer them the lowest entry point. And it sounds so silly, but for me, it's folding towels, and you won't get a lot of pushback on it. And they will see that it solved their problem. And you will get the

buy-in you need and then you could see implementation for that. So, I would check out Teepa Snow. There's some great videos. If you just go to YouTube and you type in Montessori and dementia, you can find wonderful things. Or just do Google image search. So, there is good stuff out there. Record little snippets and make little ass. I don't think anyone has time. I mean, y'all did, thank you. For like a big continuing education in service now. But I mean, maybe throwing a bone their way with something really simple might work. I really fear that our current situation with COVID is challenging our ability to serve these patients at all. Amy, anything else?

- [Amy] No, that's great. Thank you so much, Amanda. I loved all the images and the descriptions of these activities that I think the clinicians that are here can just, once they can get back into the facilities, if they're not right now, they can put into play immediately. And I know everybody appreciates that. So, thanks to our audience for being here today. We really appreciate it. Again, if you missed part one, that's in the library in recorded format. Amanda, thanks so much. I loved this two part series and we appreciate all of your time. Thanks for being here.

- [Amanda] Great, thank you.