DTA Guest Lecture: Montessori Mealtimes: A Pathway to Person Centred Care for People Living with Dementia - 28 Jan, 2021

Audience Q&A's

QUESTIONS	ANSWERS
When the residents are asked to sit up for thickened fluids, does that mean they need to sit up on the hard chair? Or they can sit up in bed 90 degrees? Or comfy chair with pillow behind the back?	Positioning recommendations for meals are ideally made in consultation with allied health (speech pathology, physiotherapy and occupational therapy) – this allows recommendations and supports to be tailored to an individual resident. As a general rule, residents will always be seated as upright as possible – ideally, sitting out of bed and in a comfortable chair for meals.
Were there concerns that residents might select food which is not appropriate for their texture modified diet, with the Montessori Mealtime approach?	Staff supervision is important to support residents to select appropriate food – with careful planning as to what options are provided – this requires ongoing consultation with the resident and their family – ensuring dignity of risk is carefully considered. Some of the things we have considered / strategies trialed: Ensuring sufficient food options are provided (e.g. we had a fridge with different snack options displayed for those on modified diets); Having labelled food; Ensuring staff know residents and their dietary requirements really well – supported by relational and person-centred care; Training by speech pathologists and speech pathology students to tailor swallowing and mealtime care plans; Using a flipper file containing copies of the nutrition and hydration care plans, for staff to refer to if needed during mealtimes. If residents are providing the drinks trolley, then this is an important consideration; Need to have staff preparing the thickened fluids (still looking for opportunities for choice) and providing to those residents first, so resident pushing drinks trolley knows not to serve them (and is also supervised); As mentioned on the night, in our experience, people requiring modified diets are often more advanced in their dementia journey, so have reduced initiation and/or reduced mobility, so generally do not access the self-serve food / drinks on their own (requires staff assistance) – if this wasn't the case, we would come up with tailored strategies and solutions as a team with allied health input and again considering dignity of risk and quality of life factors
Wondering what your thoughts are on coloured crockery as opposed to the conventional white - depth perception, perceiving size of plates and colour presentation of food on plate	**Reasons I don't use:** More expensive, I would rather use the money for beautiful tablecloths; Harder to replace e.g. get slightly different shades of red; Better to have a really good quality crockery from hospitality company; Hard to make it not look kindergarten-y and hard to look elegant; If the resident has visual impairment, I could use other strategies e.g. prompt from staff to turn plate around; Overall I just found that if the residents were loved and well cared for, this was more important than the coloured crockery. **Strategies we recommend instead:** Plain coloured tablecloth – crease free, matches the colour theme, but contrast with coloured floor and colour of chairs; Patterned napkins – cotton is fine
How can it be implemented while COVID restitutions are in place?	Please check the Food Safety guidelines in your area, as they can be different in different countries. In Australia to our understanding, the only change to legislation was about social distancing. You can still offer choice, promote independence and show respect towards residents if they aren't able to enter the dining room (e.g., food trolleys, food trays which have opportunities for independence like tea pot / milk jug or toast and different spreads to spread one's own toast etc.). There are Food Safe guidelines on buffets – things like having sneeze guards (e.g., the glass between the person and the food, so you can see the food but are not breathing on it), and having long handed tongs so that hands are not going in to the food, and throwing out all food after 4 hours (which requires you to only have smaller amounts on the buffet). Regardless of COVID, residents preferred the staff to be the ones to put the food on their plates, as it was often hard to hold their plate, serve and potentially hold their mobility frame. We did provide a few tray mobiles for each dining room, and had to be mindful of the way the food was positioned on the bench (e.g., so there was room for the plate to rest in on the bench in front of the tray of food so the resident could just hold the serving implement).

How many residents are in these houses? We have settings where there is an industrial size kitchen trying to feed 60. There are some changes that could be made despite the size of the facility	In Fleming House (CHI) there were 14 residents, after renovations there were 17 residents. But there are 67 resident who live in the site in its entirety. In Cluny (VMCH) there were 12 residents. We have successfully implemented the buffet in facilities with a central dining room. One of the biggest hurdles was to have enough space to install the buffets, so may need to get creative in terms of storage / dual purpose aspects. You can start with trestle tables with table cloths, and bain-maries. The easiest meals to start with are morning and afternoon teas.
This question is very important for residents on modified diets who want and choose to have a cake or fruit or sandwitch but are not allowed, how do we offer choice?	We acknowledge that residents requiring texture modified foods are often not given choice. We have considered this in implementing the Montessori mealtime model – for example by trying to match the modified diet options to what other residents were offered rather than having their own separate menu (so they all able to enjoy the same dish). We started offering choices for modified snacks at morning / afternoon tea (residents did not have a choice prior) and where possible, this matched what the other residents were provided. It is wonderful to see innovation in catering and creative ways emerging for making delicious and appealing pureed, minced and moist and soft meals – this is an important space to watch!! There are products like Thicken Up that enable foods like scones to be modified for those on different diets. There is a recipe book, “Don’t give me eggs that bounce” which aims to help make meal times a pleasurable, social, and safe experience despite a diagnosis of dementia. Maggie Beer has also been doing work in this space. This would be a great topic for a future DTA presentation!
I am keen to know more about how you got around ‘high-care'/ fully assisted dementia residents missing meals due to under-staffing and over reliance on memory of carers’.	As mentioned as people came into the dining rooms at different times, it was harder to look around the dining room to see who was / wasn’t there. Also, some people preferred to eat in their rooms, which was respected. We had a laminated tick chart of all the residents’ names down the page and all the different meals across the page. We used a whiteboard marker to tick off once a resident had been provided their meal. It was then easy to see who still needed to be offered a meal. As far as staffing levels, I am aware that some organisations have a time limit for meal assistance per resident, which I find very disheartening, as often people who need assistance do take longer to eat – one of the residents at VMCH took two hours to eat her meals – this example was shared so positively by staff as an example of person-centred care and giving choice – following her preferences and allowing her to enjoy her meal at her pace. By having the meal times extended it did take the pressure off having everyone “fed” in a 20-30min period (in that time limit it isn’t actually possible to feed everyone properly if you look at staff ratios and number of residents needing assistance) – this allowed staff to focus less on mealtimes as a ‘task’ and to focus more on the residents and the mealtime experience they were creating – this was reflected in the increase in positive person work and relationships between staff and residents evident in the Montessori mealtimes. If you are short staffed you may need to look for creative solutions like altering staff break times, allowing staff to eat with residents (but still take a separate break), utilizing students and volunteers.
Getting a resident to assist with tasks such as putting cutlery away etc, does this meet current infection control guidelines?	It is important that you check your internal policies and procedures. When allocating job roles, the job roles need to match the skills and abilities of the person. If the role was associated with dining, then the residents involved would be able to comply with food safe regulations (for instance, washing hands prior). If they were not able to comply (e.g., coughing, touching face, etc) then they would not be selected for meal time roles, they may be involved in another task like gardening or sweeping – this takes continued conversation, discussion, problem solving and creative planning as a team. We completed a generic risk assessment for all job roles (e.g., not a risk assessment for each actual role, just one for residents doing household roles). Roles are completed collaboratively – with staff providing facilitation and support as needed – so residents are supervised when completing roles

How could we involve the residents living with severe dementia with the meal tasks? Could you give some example, please?	One of the easiest roles is folding serviettes, so I would try that to see if they have the ability. With regards to the self-service, start with offering a choice of two (“showing” the options available where possible to provide visual support) – this helps establish whether the resident can choose and express choice – training and mentoring staff to look for different signs of choice (e.g., what the resident says, where they are looking, what their body language and facial expression is telling us etc). During a meal, there is a possibility for residents to be more involved (e.g., if you scoop the food onto their spoon or load the fork and rest it on the side of the plate, the resident may then be able to bring it up to their mouth with or without guiding their hand). Allied health (OT, SP and PT) would be able to assist with techniques / equipment / strategies to enhance independence – we feel that this is a really important area for further research and tailored training for care staff. If the resident is in the later stages of dementia, and approaching more comfort care, then it is all about giving them a beautiful meal time experience when they are alert (e.g., not waking them up to eat at set times), making this a richly sensory experience (e.g., can they eat outside with the sounds of the breeze, birds; the feel of the wind and sun on their skin; considering the different tastes, smells and textures that can be incorporated into each part of the meal (e.g., ensure pureed meals aren’t all mixed together, ensuring staff communicate clearly to the resident what they are eating, such as “here is some pumpkin” “here is some chicken with gravy”) – all part of relational and person-centred mealtime care
Wondering how this approach fits with Foodsafe requirements in WA........	You need someone who really has their heads around Food Safe, like your catering manager or Chef (or your local Food Safe inspector) – it is important to bring these critical staff members into the innovation / leadership team – ensure they are trained in the Montessori model and have shared values – this will inspire their creativity and problem solving as part of culture change efforts. You need to get to the bottom of what is actually included in the regulations. Unfortunately, it is often internal rules / expectations that are barriers (e.g., “we have always done it that way”) rather than Foodsafe guidelines – this requires taking a step back from current practice and really interrogating why things are done in a particular way and where changes can and should be made. Risks need to be managed effectively, but you need to be focused on providing dignity of risk – e.g., there are always going to be risks, but there is also a massive risk of residents being not engaged / isolated / losing their independence… of overcare and excess disability – this is such an important balance and at the heart of implementing more consumer directed and person-centred care – we can’t let fear of risk hold us back, but it does take a collaborative and systematic approach to change practice! I recommend reading Anne Kelly’s book, “Forgetfulness, Feelings and Farnarkling: Reflections about aged care and how YOU can make a difference”.
What is staff/resident ratio? How are differences in dementia capacities allowed for? (There is a lot of emphasis on 'choice' but the skills in providing this for someone with dementia are not so easy and require training).	At the start of the CHI project, in the morning we had 14 residents in this unit, with 2 staff and a float. Once we had our renovations and increased to 17 residents, we had 3 staff (two on long shift, one on a shorter shift). However, ratios are a moveable feast, in this unit we initially had mobile residents, who required a secure unit. This meant they needed less hands-on assistance for ADLs. Once the residents started to decline, it meant that more were required 2 x @ for ADLs, which meant the ratios needed to be reviewed, as if 2 staff were assisting one resident behind closed doors, it meant that 1 staff member was then looking after 16!
How would this model work with dementai patients who cannot/ do not communicate?	Answered on the night - the Montessori approach is well suited to people with communication difficulties. It draws heavily on procedural memory and use of demonstration to facilitate roles and activities. Residents learn through "doing". That said communication difficulties do increase with progression of dementia - so please see earlier responses regarding working with residents in the later stages of the condition.
What safety measures are in place regarding boiling/hot water?	This comes back to dignity of risk. People know that boiling water is hot and that you need to take care when making a hot drink. In fact, residents have been making themselves hot drinks for 70+ years (this is a good example of procedural memory!). No residents have burnt themselves on the toaster or hot water or iron during our implementation, however risk of burns was included in our risk assessment. Some additional strategies could be labelling the hot water with “Caution Hot Water”, making sure the hot water is easy to access (e.g., we used tea pots or pump thermoses – I would not suggest the boiling water taps that are attached to the sink as they are too tricky for residents to use due to having to press multiple buttons at once and the water is too hot), providing tray mobiles so residents aren’t carrying hot drinks, providing supervision

Initally the recorded message said “Medication should be given during meal”. I’m working in dementia care with UNITING, however, nobody can promise that dementia effected person can take the medicine on time and during any meal.	Moving the medication away from a meal is almost a project on its own, it requires coordination with GPs, clinical nurse, med comp carers, etc. I don’t think it is fair to provide a bitter pill in the middle of a meal – not only does it not maintain someone’s privacy, but it can also impact on the taste of the rest of the meal Having a medication trolley in the middle of the dining room definitely takes away from the homely ambiance that we are trying to achieve. I’ve seen Metamucil sprinkled all over the top of a roast! I’ve also seen residents who are enjoying their meal and then their next spoonful is sickly sweet strawberry syrup that they weren’t expecting. At one low care site we created a wellness clinic, where residents actually attended the clinic rather than use the medication trolley. An EN manned the clinic, residents took a number to wait their turn, it gave them the opportunity to take more responsibility for their health (note: those who could not attend the clinic were still provided their meds in their room). We need to be mindful of residents being woken up to be given medications – is that the right approach, when there is research to suggest the benefits of natural wake times? We need to be mindful of the times GPs write up 4 hourly meds like Panadol (e.g., rather than 8am / 12pm / 4pm which hits 2 meals, could it be 11am and 3pm?). Of course, there are residents who need their medication to be eaten with food, and those who prefer to have their medications at meal time, so this would still be offered in line with their choices / preferences – discussed in consultation with residents and their families and determined through continued observation of residents during relational care. At some sites, where they could not achieve this, instead they left the medication trolley outside of the dining room, and then unobtrusively gave some residents their medication. For residents who do not wish to take their medication, then creative solutions are needed (e.g., wearing a doctor’s coat, letting them know what it is for - “This is for your back pain”, providing meds when more settled, etc.) – more opportunities for creative problem solving as a team! One of the real benefits of the Montessori approach that was evident in the research evaluation was that the model really promoted a “culture of innovation” and stronger “team work and collaboration” to come up with these creative solutions!
Do you think it is viable to set this style of person centered dining in an acute facility - if so do you have a plan to follow?	Even in acute settings, it is possible to provide more personalized (and more relational) mealtime care. Ideas could include using white boards in people’s rooms to include more personalized information (e.g., “I like to be called Marjory” or “I get worried about my daughter, so please remind me that she will visit each day at 11am”), encouraging families to bring in a small number of personal items to help the environment feel less clinical, or to put some signage in the room (e.g., toilet, bathroom), thinking about how the mealtime trays are set up and delivered to promote independence. With regards to meal times, it is so sad when our residents come back from hospital with weightloss as a result of not being given the assistance they require with a meal, so maybe improvements in hospital transfer documentation would assist continuity of care. See above for strategies that relate to residents who are more high care / comfort care. There are some acute rehab units and transitional care units which offer Breakfast Programs to help to regain people’s independence during meals (and to assess their safety to go home). I believe Fremantle Hospital in Western Australia has this program operating, so you could contact them. We would love to see Montessori principles implemented in an acute setting, please get in touch if you wish to collaborate. Anne Kelly has had experience working with acute services in South Australia to implement the Montessori approach – she is very happy to be contacted directly about this (anne@montessoriconsulting.com.au)

Inspiring would love to implement but how to get management on board?	Yes, this approach aligns perfectly with the standards. It is crucial to have management on board or it will not work – staff across all levels of the organisation need to be involved – taking a top down and bottom-up approach to implementation and innovation. For example, if management are admitting the wrong residents into the memory support units, or if they are hiring the wrong staff, or are not providing adequate training / resources, it will quickly undo all the amazing work you are doing. I suggest contacting Anne Kelly, who can provide training to management / boards. If a whole culture change is not possible, there are definitely aspects you can implement to improve the lives of residents, for example: creating partnerships with the local florist so that they drop you flowers that can no longer be sold, so residents can use them for flower arranging and other benefit from having the lovely flowers on their table; creating 5 things about me posters that are displayed somewhere to help staff get to know residents and to see the person behind the dementia. A good project plan with goals, implementation steps, and a budget, that is signed off by management, can help to get everyone on the same page. There are some online presentations that could be useful for management to watch, like the previous Montessori DTA presentations or the Montessori video clips available on the Montessori Consulting or AMA website – seeing and experiencing the benefits is the best way to get all staff on board!
Were more staff required?	In my initial proposal I did request more care hours, however it was not approved, so we achieved this with our existing ratios, as well as support from our project team to provide trouble shooting and on the floor role modelling. Amazingly it is actually quicker to serve people via a buffet than 1:1 delivery of meals, as staff aren't rushing back and forth
Thanks for sharing. Would like to ask if adapted feeding aids can be used in the Montessori approach? eg straw, plate guard etc	It is important to consider what crockery people with dementia are eating and drinking from. Is it fair that they eat from stained plastic mugs or mismatched cutlery? Often when new crockery is purchased, the new set goes to the frail aged section, and the older mismatched items are given to people with dementia as "they won't notice". But by setting the dining room beautifully it shows that all residents (all people) are valued and respected. We had a rule to have no plastic unless it was part of an assessed need. Adaptive equipment definitely has a place in the Montessori Approach, it is an example of using the prepared environment to overcome losses. Please access the support of nursing or allied health staff to prescribe adaptive equipment to assist residents to maintain their independence, as a means of a "compensatory" approach. The Montessori Approach also uses a "rehabilitative" approach by using activities to maintain or restore function, like practicing to pour rice into a cup to a certain level, then progressing to be able to serve hot drinks. Please watch the "Tren" clip on Youtube to see this style of intervention in action – there is an evidence base for these interventions
How long did this approach take to have running smoothly along with educating staff and getting staff to change their mindset?	Culture change is a slow process – takes sustained commitment and dedication. We made some really good gains in the year following our initial training, with simpler aspects like name badges, tea and coffee stations. We soon learnt the power of the model as a culture change tool. We started our research about 1.5 years into our journey, so we already had some aspects in place across the organisation, but the aim of this project was to trial all aspects of the model in a concentrated manner to create a Centre of Excellence that could be used to train other staff. In addition, we created a set of KPIs that all sites needed to strive towards, which included self-serve meals. I would estimate 2-5 years, and to sustain the model it requires continual training and leadership or the message can get diluted due to staff turnover. We had visits from Anne Kelly twice per year for a week at a time and during her visit she would train all new staff in the approach as well as offering a refresher for staff who either wanted to learn more, or who needed guidance to understand the model.
Do you allow your staff to eat with the residents to create that family feel?	Before I qualified, I worked in a site where staff could have a free meal if they ate with residents. I loved this, as it helped me to get to know the residents, and it was a great way of facilitating conversations amongst residents. Staff did not dine with residents in this project, but they did sit at the table with residents to be able to subtly assist (e.g., passing them the tea pots, tiered plates, etc). If residents are to dine with residents, it is important that they still get their full break away from the floor, to enable them to recharge and refresh. Staff dining with residents definitely fits with the model

Were any potential impacts (positive / negative) on nutritional intake assessed? Overall intake and nutritional content of meals consumed?	As part of our research we did examine residents' weight, however there was no statistically significant impact on weights (noting maintenance is positive in the context of dementia). It is important to consider that these residents were a long way into their journey, so did experience some weightloss as a result of declining health and palliation. From our observations it did appear the residents were eating more, and though I don't have data to support it, it just looked as though they were weller and happier. Many of the staff commented on this anecdotally in the staff interviews, however, it was hard to measure objectively (particularly through the video footage that the research team had access to). This is an important question for future research to explore – looking more specifically at nutritional outcomes. It is hard to measure 'clinical improvement', as most of the measures collected routinely in aged care are more to flag decline (e.g., falls, skin tears, weightloss). The project also did not extend the residents' life expectancy, but the residents did seem to live a better life right until their end of life – again this was commented on consistently by the staff in the interviews and something they really valued – this contributed to their work satisfaction and altruistic reward. At one site which had a high mental health population, we had to review what we offered on our snack stations, as residents were putting on weight, so we moved from muesli bars and biscuits to fruit and yoghurt
Infection control is a problem with dementia residents assisting to prepare meals.	Residents were involved in vegetable preparation – the vegetables were then cooked by the kitchen, which would kill any bacteria. As there is an increased focus on infection control with COVID, I would advise that creative solutions are trialled (e.g., instead of sharing condiments like jam and cream, individual servings are provided in tiny dishes so that residents can still serve themselves but not share). Our catering manager (CHI) indicated that actually it may be safer for residents to handle the food than staff – as residents aren't exposed out in the community! So, if residents can comply with the same Food Safe regulations as staff as well as being supervised then it is worth a try, just check your internal policies and procedures (and advocate for resident involvement if you need!)
What is your answer when staff say they are concerned about a resident choking so the buffet wont work and real reluctance to stop taking meal trays to rooms	One of the great things about Anne's Montessori training is the use of videos. Staff sit there thinking my residents are too high care or my residents wouldn't want to do that, and then you see clips of residents, just like yours, actually doing it, and loving it, and it shifts your perspective a bit. Training is important in shifting staff mindset. It is a misconception that people with dementia can't learn new things – once you have seen that they can – you will never underestimate them, you will always give them the opportunity to try new things, to be involved – to help them reach their potential! There is always something they can do. For example, at one site, we had a high care resident who had a job role to squirt aquim gel on everyone's hand as they entered the dining room, and she loved it! Staff do really want to look after residents, but they need to be taught how damaging "overcaring" can be, as residents can quickly become helpless if we take away all their opportunities to participate. And for this query we would add, wouldn't it be more dangerous to have tray service in people's rooms when people are unsupervised and could choke? At one site we used to have tray service and toast was cooked and put into a tray covered with alfoil, and slowly distributed along the corridors, you can imagine how cold / hard / dry it was by the end. So many of our residents commented that the thing they liked the most about the model was that they got "nice hot fresh toast"! Having a speech pathologist as part of your team can also help to work around the risk of choking and ensure staff feel adequately trained and supported to assist at mealtimes
Suggestions on how to implement these changes with minimum staff? For those facilities with no access to allied health, students, volounteers etc?	Consider starting with a small meal, like morning tea. Instead of doing trolley service, invite everyone to come together, set the room nicely, invite the manager to eat with residents. And you will feel the love in the air! People chatting, people feeling important that they are eating with the manager, people helping each other – from little things big things grow! If you are really short staffed this becomes a management issue

mealtimes were around 20 minutes pre Montessori model - how long were mealtimes when using Montessori model?	I was always amazed by how quickly meal times took place prior, and if you add up how many meal time assists there are, how long they should take and how many staff there are, meal times should almost go for 4 hours!!! Breakfast buffets were available from about 7am – 9am. Resident who wanted breakfast after this were provided tray service. The length of meals does need to be monitored as if staff start packing up early, it means residents rush which defeats the model and reduces the amount of choice. Interestingly at one site, residents came earlier and earlier to the buffet breakfast, it turned out that they actually wanted to eat breakfast earlier, and before the model we were making them wait until 8am! As mentioned, the model helped people not to rush off after a meal, similarly to when you eat with a meal with friends or eat out for a meal, so it feels much less task focused
I am also doing mealtime research and creating the education training program for staff in nursing home settings. Can I have more information about what the training program for staff was?	The training we received was from Anne Kelly. Anne offers elearning training in the Montessori Approach, please refer to her Montessori Consulting website. Elizabeth would love to develop a training package for meal times, so if you think this would be of use to you and your site, please contact her!
Did you need to change or extend kitchen staff shift times to accomodate the Montessori model at mealtimes?	There were changes to shift times. We started some shifts later, as when staff started too early, they tended to want to start waking people up to deliver personal care. We also changed shift times to enable an overlap for handover. At sites with a common dining room, at times we had to extend the kitchen hand hours to ensure someone was available to supervise the buffet as soon as the food went out
This is a great approach and very much in alignment with Kitwood and various other good care training approaches (too few of which are used or even known in Australia) but I am not clear what it is that is 'distinctive' about Montessori in this regard - perhaps it doesn't matter as long as it conforms to the best practice that we all want! What is the 'core' of this approach, that makes it stand out from others?	This is a great question and something we have discussed a lot as a research team and with the leadership group – we believe Montessori is an example of a person-centred approach – and does absolutely overlap with other approaches and care models out there. However, there is something about Montessori that does set it apart. Members of our team have had experience with other approaches and have recognized that there is something different about Montessori – maybe because it is ‘known’ (from Maria Montessori’s influence in education), it is also a ‘philosophy’, while highly practical – staff “get it” and it helps to get buy-in. The Montessori “mantras” and principles also seem to facilitate more relational care – improving relationships, connection and respect shown towards residents, without targeting this directly. We hope to continue this research to try and understand what the distinctive aspects are and what makes the approach special – that said, we agree – it is adherence to best practice that is most important! Elizabeth notes that the Montessori approach aligns perfectly with the OT Model (e.g., we want a fit between the person / environment / occupation to facilitate occupational performance). There is still much work to do to map the approach and core principles from children / education in to the aged care space. The clinicians who have commenced this work, are truly person-centred practitioners and so we are benefitting from years of clinical experience and passion. For more information about the Approach, please see Elizabeth’s previous presentation “Montessori – but isn’t that for children?” on the DTA website, this maps principles from children to older adults
How do you encourage care staff that Montessori mealtimes benefits the residents, as most time the staff will not change their way of thinking and will always "do" things for the residents without them being allowed to "try" to do things for themselves	This takes training. Staff actually think they are doing the right thing by doing everything for a resident until they are shown a different way. As a society it is “polite” to do things for older adults e.g. to help them lift their shopping, to make them a cup of tea, etc. Statements like “everything you do for me, you steal from me” help to challenge staff perceptions, that it is ok to spoil residents now and then, but in general it is better for residents to do it themselves as it helps with their physical and emotional health. Once staff see what residents are capable of and the benefits, they do change their ways of working relatively quickly – it is one of those things – it helps to see it in action!

How do we put pressure on our aged care 'industry' to insist on minimum standards of staffing and staff training? The minimum is a lot higher than it is at present!	Hopefully positive change will occur as a result of the Royal Commission – the findings of the commission are certainly highlighting the need for more person centred, relational and compassionate care – the humanistic elements that have been stifled by the system – and that require a different type of training and support for staff. We have also been in sites where there are heaps of staff and heaps of hours and there is no better care… in fact you see staff doing things in pairs, or talking. The additional time is not necessarily invested into care. Unfortunately, a lot of training is dedicated towards compulsory topics like fire, infection control, and there isn't as much emphasis on person centred care. It is important to continue sharing the success stories and showcasing a better way of caring – showing what can be achieved when staff are appropriately trained, valued and supported
How is the buffet system possible in dementia care?	It is amazing to see what people with dementia can achieve when given the right supports. As seen in the video, these residents were living with moderate dementia, with the average MMSE of about 10. Yet they could still make choices! They could choose what drink they wanted and what they wanted from the buffet, as the food was right in front of them to select from. It is much harder for them to choose from a list, as it requires a higher cognitive load (e.g. they have to be able to understand and remember what say minestrone is, rather than just being able to view something and think "mm that looks nice, I would like some of that"). As seen in the case study, with the right supports this resident was able to set the table, make 2min noodles, eat with chop sticks and guess the flavour of chocolate
How are the Allied Health involved in the process?	Our sites are staffed with both OTs and Physios. The therapists had an active involvement in the model and were involved in the staff interviews evaluating outcomes. Physios managed equipment e.g., prescribing correct walking aids, determining who could safely use the tray mobile, ensuring people were positioned correctly; OTs – helped with the implementation of the culture change e.g., staff training, communication, role modelling, trouble shooting. The approach is very much aligned with the OT philosophy so OTs are well positioned to lead the approach. OTs also helped with maintaining independence through equipment provision and functional rehabilitation. We also formed a partnership with Curtin Uni, where they provided SP and OT supervisors and we hosted 30+ students a year. The students were very much involved in the model and helped to create: Individualised memory prompts – task breakdown, daily schedules, labels; Activity resources – activity boxes, interactive walls; Tool boxes – dysphagia, communication
Is there special training for this module of care?	I (Elizabeth) hope to create a training package on meals as I am very passionate about using meal times to promote a better life for residents, please email me if you are interested in being on my database
Do you think it is degrading for general residents to always be served cups of tea or coffee in plastic mugs? it makes me shudder	We agree, it is totally unacceptable for residents to drink out of stained beige coffee mugs. There is a belief that "residents will break them" but it is more likely to be a staff member to break crockery. We used fine china for our morning teas and nothing was broken. We need to advocate for our residents in this area. Please see above re crockery
what do you propose for dysphagia meals with this concept? I have experienced people with dysphagia being left out of all activities especially around the snacks and drinks	We agree, at one site, people on modified diets were not even given food with morning or afternoon tea, just their drink. We were excited about providing more choice for those on modified diets – it was wonderful to have the speech pathologists (including students) involved in this aspect of the innovation. Please see above re modified diet
Do you have evidence from families regarding any improvements/satisfaction with the home?	Families absolutely loved the approach. As part of our wider cultural change project, we completed in depth interviews with family members, which were then analyzed for themes. Families loved to see their loved ones involved, that their loved ones were loved and cared for, and felt that it felt like home. Families also felt that staff needed more time and that they needed more activities. Please refer to the presentation on the full culture change "A Community Not A Facility" to learn more about the responses from families

For residents with soft diets, what can we provide besides porridge?	Please see our responses above - we tried to align those on puree with what other residents were eating (often in residential care they generally eat the meal the following day, once the kitchen has had a chance to vitamise it). We were pleased to offer greater choice for snacks. Some sites did try the food molds. I personally prefer not to use the molds, as I prefer residents to eat fresh food rather than frozen – again it is great to see innovation in this space and more recipe ideas available to support more appealing modified diets – please get in touch if you would like additional ideas. The Lantern Project is worth following: http://thelanternproject.com.au/
I would like to know if further outcomes investigating resident's responses lessened after these implementations. i.e. reduction in wandering, aggression, anxiety etc etc.	In both MSUs we evaluated residents in terms of clinical indicators, cognition, behaviour and quality of life – we did not have time to present the full scope of the research completed in the presentation, but hope to publish this work soon – please do keep an eye out for the publications!. In Fleming we did not see a statistically significant change as a group – this research took place over 3 years, and many of the residents died during this time, as they were well into their dementia journey. We had approx. 5 residents who we had mapped through the full time period, and for individual cases we did see improvement in behaviour. In Cluny we did see improvement – we have looked at individual cases and in the first 3 months of entering the unit a number of residents showed an increase in independence and a shift in behaviour – like increased cooperation and reduced restlessness. We again hope to publish this work in the future. Please see the presentation "A Community Not A Facility" to understand more about the research results of the full culture change
Does certain crockery stimulate eating for residents living with dementia?	There is research to suggest that red can stimulate eating, which is why most take away outlets use red in their logos. There is also research to suggest that the use of contrast can help with eating, so that people can identify the food on their plate. I found that being loved and happy helped our residents to enjoy their meal times, meal times became a fun and sociable event where people just enjoyed eating. Please see above re crockery
Are the residents involved while cooking as well?	Yes, in food preparation e.g. peeling and cutting vegetable. Yes in finishing off food preparation from the kitchen e.g. icing cupcakes, baking scones. Our chef also did cooking demonstrations like how to dice onion / garlic. He also did special cooking sessions with residents from different cultures on their special cultural days
Are residents able to choose where they sit? Some residents are insistent that a particular chair or table is theirs alone and get upset at someone else sitting in their spot .	Yes, we agree, some people do get very territorial about their seat! In this model we had lots of changes to our seating plan e.g. sometimes long tables, some times individual tables, sometimes outside. People just seemed to sit where they liked on that day. Following the renovations, the dining room became u shaped, so there were almost two seating areas. This was very helpful, as we found our higher functioning residents preferred to sit at the same table with each other. And it also allowed us to seat residents who preferred to eat on their own, rather than being in the noisier / busier side. Many years ago, I heard a staff member comment that a new resident will "sit in the dead man's chair" meaning that a new resident will have to sit where the resident they replaced sat, I don't agree with this, if there is a seating plan, I think it needs to be carefully considered so that people can sit with people with common interests to facilitate friendships
What should an elderly person with dementia eat?	There is evidence to support the Mediterranean diet is the best diet to prevent dementia. I advocate for a healthy, balanced diet, with lots of protein to prevent malnutrition. I am also an advocate for choice, so if a resident wants two desserts then they can have two dessert. It is so important to engage a dietitian for input and support – this again requires a team approach
Buffet - self service or staff dispensing?	There are pros and cons for each. I did find that residents preferred to be served by staff, due to their frailty, and the need to juggle walking aids, plates, and serving implements. At our sites, we used the Chef to serve, and this was so helpful as the Chef really got to know the residents and their preferences, which helped with future ordering and ensured that the Chef was in the dining room, watching what people enjoyed / didn't enjoy and watching where people struggled e.g. if the meat was tough or if the vegetables were cut too big. It really helped the Chef to become part of the team, rather than being a separate entity

What would you find the ideal resident ratio per buffet set up? We have 20 residents per kitchenette.	There is no perfect number! We have had some issues with very small houses, as it is hard to offer a lot of choice as well as minimize food waste. 20 would be a great number, but the buffet would need to be of sufficient size to provide enough food at the correct temperature, and food would have to be regularly restocked. With the larger common dining rooms of 40 plus residents, at times we needed to form multiple stations e.g., a big buffet at the front for the food, and then two drinks stations, one on either side of the dining room
Was there a difference in staffing between the models? Does the Montessori model take more time or staff (in preparing and delivering meals etc).	See above. With regards to the catering team, in some ways it reduced pressure on them, as they needed to pre-plate meals previously. With the buffet style, residents assembled in a line and gradually received their meal
Did this approach address any malnutrition or prevent acquired complications?	This approach doesn't necessarily target malnutrition, but it is an added benefit, as people enjoyed their meals more, so were more likely to stay seated and enjoy their meal. Please see above re results on weights
We tend to expose the residents to home like environment and this includes fruits, snacks and drinks available in the kitchen area. it has been noticed that some residents help themselves to tea and coffee putting themselves at risk to injury, some residents on puree meals help themselves to fruits, again putting themselves at risk to choking since staff are busy attending to care needs. How do we prevent this and open the eyes of the management that in order to do this we should have enough staff to start off with?	As mentioned, we had a lead carer who needed to stay in the common area to supervise residents, this included supervision of the self-serve drink and snack stations. At lower care sites we have had tea and coffee stations set up in end lounges which are not supervised, and we have not had any issues, as mentioned, often residents who have reduced safety insight also have reduced initiation, so they are less likely to be able to be able to access the station without staff assistance (e.g., require prompting or physical assistance). If you are concerned, perhaps do not offer the drink / snack stations and focus your efforts on the self-serve meals which are supervised by staff
Would it be possible to look back at records to track any clinical improvements and reduced medical care/meds required? This will help build the financial business case.	Please see the presentation "A Community Not A Facility" which provides an outline of all the statistics. It is important to remember that our residents were far into their journey and already on a downwards trajectory, so improvement is not expected (but celebrated!), it is more about slowing the decline and maintaining (or unlocking) abilities – particularly if excess disability or overcaring has been present. We are not sure that clinical indicators are sufficient in measuring change, as they are better at measuring decline than improvement, and many of the measures for quality of life either have irrelevant aspects like "satisfaction with finances" which is no longer relevant – it is important to map the outcome measures to the changes you want to see or achieve! Overall, we have found the observations and staff and family interviews to provide the deepest understanding of the success of the model. We really like David Sheard's positive interaction scale, which measures the quality of interactions from abuse – neutral – positive interaction, we have also found use of the personal enhancing actions and personal detractors really helpful
How do you give medication without food? Usually residents like to eat little bit and then take medication.	Please see above re medication. I would try to honor residents' preferences, if they want it during their meal, then that is absolutely fine

1/3 of my residents have severe cognitive impairment. Involving them in Montessori mealtime is challenging which requires lots of training and coaching. Is there any training programme available or what are the training programme that was applied in this research	I agree, it requires a lot of training and support, but you can do it!! We used Anne Kelly, from Montessori Consulting, and I 100% recommend her, her knowledge and expertise has been an important part of our journey. Anne provides in-house lecture style training with great videos to promote an understanding of the model, and to help people to see it in practice. She also provides training in other areas that relate to the model (e.g., 3Ps Behaviour Management, Comfort Care, Fine Motor, Family training, Board level training, etc, and can help with behavioural strategies for particular residents. Anne also provides eLearning in the Montessori Approach, as well as an opportunity to receive an AMI Montessori competency (if you attend the training and then implement the knowledge by putting in place roles and activities). Anne used to visit 2 x year and this was crucial in maintaining momentum, as she would review each site's performance and teach us the next step in our journey, as well as training all new staff. Steps you can take to upskill in the model: Watch my previous presentations on the DTA website: What is Montessori https://dta.com.au/resources/montessori-but-isnt-that-for-children/; Montessori as culture change https://dta.com.au/resources/a-community-not-a-facility/; Join the Montessori Consulting Facebook page; Visit Montessori Consulting Website to see their training options; I (Elizabeth) have my own Facebook group called "Memory Box Collective", which aims to bring joy to older adults. I will be developing training packages which will be advertised on this page and to my email list, so please contact me directly if you wish to be on my distribution list, or join my Facebook group. If you are interested in researching your project, please approach our research team, we would love to be involved. I (Elizabeth) have my own Facebook group called "Memory Box Collective", which aims to bring joy to older adults. I will be developing training packages which will be advertised on this page and to my email list, so please contact me directly if you wish to be on my distribution list, or join my Facebook group. If you are interested in researching your project, please approach our research team, we would love to be involved