help (6%; f = 15), and finding a quiet place or spending time alone (5%; f = 12). The top 5 resident behaviors staff members found the most challenging were yelling or hitting (20%; f = 46), manipulative interactions (16%; f = 37), repetitive questions (14%; f = 33), impatience and demanding (10%; f = 23), and rudeness or use of foul language (9.5%; f = 22).

Conclusion/Discussion: Results suggest that many nursing home staff may be experiencing a high level of stressful life situations and endorse many markers for compassion fatigue. Combined with the difficulty of nursing home work and the context of frequently caring for residents whose behavioral symptoms may create additional pressure, nursing home staff are likely at risk for stress-related negative outcomes, which could impact quality care delivery. Many may already be using healthy coping strategies, but may benefit from adding further stress management skills to their self care repertoire, especially during times when the work environment becomes especially difficult, such as following coworker terminations, numerous resident deaths, or the facility experiencing negative media attention. Interventions to address compassion fatigue include open discussion about these issues and investigating compassion satisfaction (the pleasure we derive from the work we do); addressing the emotional side of the job results in more satisfaction in the workplace and less fatigue. Additional suggestions include sharing the caseload among team members, especially difficult "cases", making self-care a priority, offering flexible work hours, and normalizing stress management in a supportive environment.

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Perceived Impact of the Namaste Care Family Program on People with Advanced Dementia, Nursing Staff, and Family Caregivers: A Qualitative Study

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Introduction/Objective: Many people with advanced dementia die in nursing homes. Family caregivers regularly judge quality of life as poor and may find it difficult to establish meaningful contact with their relative. The daily US Namaste Care program integrates personalized and palliative care with meaningful activities for people with advanced dementia. We adapted Namaste Care to involve family caregivers more and examined the perceived impact of Namaste Care Family on nursing home residents with advanced dementia, nursing staff, and family caregivers in the Netherlands.

Design/Methodology: Qualitative interviews with family caregivers, volunteers, and nursing staff were part of a randomized controlled trial (2016-2018) in 19 nursing homes, of which 10 implemented the Namaste Care Family program and 9 provided usual care. The interviews (n=11, from 3 nursing homes) took place 12 months after the start of the program.

Results: Preliminary results indicate that nursing staff and family caregivers experienced decreased behavioral symptoms of dementia, more active engagement in activities, and more verbal interaction with and between the residents. Nursing staff reported a positive effect of the program on how they experience their work (e.g. more relaxed, fun, rewarding, insecure in start-up phase), giving more time and attention to the residents, experiencing a shift in providing more person-centered care, and being more aware (e.g. of own behavior and its effect on residents, that residents need more attention and can still learn new things). Family caregivers experienced changes in how they perceive people with dementia ("there is still life inside people with dementia"); visited their relative more often; experienced improved contact with their relative, other residents and nursing staff; and reported that the experiences with the program affected their own feelings (e.g. feeling happy when seeing that their relative was enjoying him/herself, feeling encumbered to join a session).

Conclusion/Discussion: According to nursing staff and family caregivers, Namaste Care Family has a mostly positive impact on them and on the people with advanced dementia they care for. Further quantitative analyses will assess whether the effect on wellbeing of people with dementia and family caregiving experiences will be confirmed.

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Physician Perspectives and Practice Management of Blood Pressure Control in Older Patients with Hypertension

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Introduction/Objective: The American College of Cardiology (ACC), the American Heart Association (AHA), the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) all differ in their recommendations for hypertension management in older adults. The current study aims to examine physician practices for controlling hypertension in geriatric patients.

Design/Methodology: We conducted an anonymous online survey of physicians in hospitals, outpatient settings, and nursing facilities across a large health system. Chi-square was used for demographic group comparison and 2 sample t-tests for continuous measures.

Results: Of the 76 respondents, 33% were family medicine, 28% internal medicine, 20% nephrologists/cardiologists and 11% geriatricians. The majority (44%) were 1 to 5 years post-training, while 18% were residents or fellows and 38% had over 5 years post-training. Primary practice locations were hospital (46%), outpatient (39%), private practice (9%) and long term care (5%). Half (55%) of respondents indicated that they were the primary care physician responsible for managing the BP of at least 40% of their patients. For older adults, 44% of physicians indicated that their blood pressure goal was <140/80, while 35% had a goal of <150/80. When responding to clinical vignettes, the majority of respondents (63%) chose "lifestyle modification" for a 74-year-old man presenting with a BP of 145/94, pulse of 78/min and BMI of 28; 66% chose "continue current management" for a 73-year-old man with a BP of 145/74 pulse of 66/min and BMI of 18. Finally, 47% chose <130/80 as an acceptable BP for a 69-year-old woman with a BP of 101/63 pulse of 80/min, respiration of 14/min and BMI of 28.5, and 32% chose <140/80. The goal for BP control <140/80 was selected by 85% of cardiologists and nephrologists, 66% of internal medicine and 45% of family medicine physicians (p=.36). There were no significant practice differences between physicians in training (64%), physicians post-training 1-5 years (62%) and physicians with over 5 years of post-training experience (67%, p=.77). Finally, only 53% of physicians practicing in outpatient settings had a BP goal <140/80 for their older patients compared to 70% of inpatient physicians (p=.001). With regard to guidelines that most impacted their decisions, the majority (46%) elected JNC 8, coupled with professional experience, with 24% selecting ACC/AHA and professional experience, and 18% only JNC 8.

Conclusion/Discussion: In view of the inconsistency among national recommendations for treatment of hypertension, and the difference in individual physician practices, further research needs to guide decision making in optimizing management of blood pressure in older adults.

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Point Prevalence and Characteristics of In-House Antimicrobial Use in Nursing Homes, New Haven and Hartford Counties, Connecticut, 2017

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Introduction/Objective: National trends indicate an increase in the amount and complexity of healthcare delivery in nursing homes (NH). As this care is provided in relatively limited resource settings, there is concern