In addition to having behavioral symptoms, nursing home residents with dementia are one of the most functionally disabled groups living in nursing homes. Six months after nursing home admission, residents with dementia experience significant functional decline in personal hygiene, dressing, toileting, and eating. These declines are greater than would be anticipated with normal progression of dementia. Along with functional decline, nursing home residents with moderate to severe cognitive impairment spend most of their time in bed or seated and have little energy expenditure. To overcome these significant declines and to optimize quality life for those with dementia, the Function and Behavior Focused Care for the Cognitively Impaired (FBFC-CI) intervention was developed. FBFC-CI focuses on maintaining or improving function and physical activity while decreasing behavioral symptoms among nursing home residents with moderate to severe dementia. The intervention is theoretically based using the Social Ecological Model and Social Cognitive Theory and includes three components: Component I Environmental and Policy Assessments; Component II Education and Training of Nursing Home Staff; and Component III Ongoing Training and Motivation of Nursing Home Staff. The FBFC-CI trial was implemented in 12 nursing homes randomized to treatment or an education only control and included 336 residents. Outcomes focused on function, physical activity, behavioral symptoms and psychotropic medication use. Findings will be presented along with the evidence for treatment fidelity. The intervention was implemented as intended and as hypothesized, exposure to FBFC-CI resulted in improvements in physical activity, decreased resistiveness to care and decreased anti-psychotic use.

THE IMPACT OF FBFC-CI ON FUNCTION AND PHYSICAL ACTIVITY

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Residents with cognitive impairment are at risk for functional decline and decreased physical activity once they enter nursing homes. Contributors to this decline include cognitive status, age, multiple comorbidities, pain, behavioral symptoms (depression, apathy and aggression) and environmental factors (tethering patients with restraints, the use of alarms, restrictive positioning, limited space and unsafe areas). Twelve settings were randomized to FBFC-CI or education only and 336 residents included. The residents were 82 (SD=10) years of age, mostly female (n=242,72%), and white (n=199, 59%) with a mean Mini Mental State Exam score of 7.8 (SD=5.06). Exposure to FBFC-CI resulted in increased time in physical activity based on actigraphy and subjective reporting of activity. There was no change in function or chair rise. Increasing physical activity via exposure to FBFC-CI has the potential to help with overall health status and quality of life of residents with dementia.

THE IMPACT OF FBFC-CI ON BEHAVIORAL SYMPTOMS ASSOCIATED WITH DEMENTIA AND PSYCHOTROPIC USAGE

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Neuropsychiatric symptoms, such as delusions, hallucinations, depression, aggression, and agitation occur in two-thirds of nursing home residents with dementia. These behavioral symptoms are most likely to occur during personal care interactions and challenge and frustrate caregivers. Pharmacologic management of behavioral symptoms among residents with dementia has been minimally effective and is fraught with significant risks, such as, falls, fractures, delirium, parkinsonism, stroke, pneumonia, and death. FBFC-CI is a behavioral intervention focused on optimizing function and physical activity of residents with dementia during all care interactions. Residents in settings in which FBFC-CI was implemented had a decrease in resistiveness to care and a decrease in use of antipsychotics at four months post implementation of the intervention. There was no change in mood, agitation, use of antidepressants, anxiolytics or mood stabilizing medications. Importantly, there was no evidence that engaging residents with dementia in function and physical activity exacerbated behavioral symptoms.

TREATMENT FIDELITY IN THE FBFC-CI TRIAL

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Treatment fidelity was evaluated in the FBFC-CI trial based on delivery, receipt and enactment. Evidence of delivery was noted based on completion of Component I, evaluation of environments and policies; Component II, education of nurses; and Component III, motivational techniques (completion of goal forms for residents and use of self-efficacy based interventions). There was evidence of delivery of the intervention as 583 staff were educated (80% of all staff), environment and policy assessments were completed and motivation provided. Evidence of receipt was based on a mean test score after education of 9.79 (98% correct, SD=.56) and evidence of improvement in environments [baseline 13.5 (SD=2.07) increased to 15.12 (99%)] and policies [8.50 (SD=3.85) increased to 10.87 (SD=2.41)] that facilitated function and physical activity. Evidence of enactment was based on direct observation of staff indicating that the staff provided more function focused care for residents over the course of the 12 month study period study.