

NKR 47: PICO 4, Bør geriatriske patienter med funktionsevnedssættelse tilbydes træning i hverdagsaktiviteter (ADL)

Review information

Authors

Sundhedsstyrelsen¹

¹[Empty affiliation]

Citation example: S. NKR 47: PICO 4, Bør geriatriske patienter med funktionsevnedssættelse tilbydes træning i hverdagsaktiviteter (ADL). Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Cichocki 2015

Methods	<p>Study design: Randomized controlled trial</p> <p>Study grouping: Parallel group</p> <p>Open Label:</p> <p>Cluster RCT:</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 83.92 (6.54) ● Gender (% male): 12.5 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 residential living facilities ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): 0/100 % <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 85.32 (5.11) ● Gender (% male): 13.6

	<ul style="list-style-type: none"> ● <i>Frail (yes/no)</i>: NR ● <i>Comorbidity (yes/no)</i>: NR ● <i>Undernourished (yes/no)</i>: NR ● <i>Impairment (body function and structure description) (yes/no)</i>: NR ● <i>Limitations (activity description) (yes/no)</i>: Y ● <i>Restriction (participation description) (yes/no)</i>: Y ● <i>Housing (rg. residential living, own home) % own home</i>: 0 (residential living facilities) ● <i>Living alone (%)</i>: NR ● <i>In risk of falling (yes/no)</i>: NR ● <i>Cognitive impairment (yes/no)</i>: 0/100 % <p>Included criteria: All participants of the study were residents within the participating RAC facilities aged 65+. Persons with no or mild physical and/or cognitive impairment were included.</p> <p>Excluded criteria: Exclusion from participation was restricted to severe physical impairment (eg, being bedridden) or severe cognitive impairment. The selection was based on the coordinator's judgment supported by professional nurses from the ward and resulted in the exclusion of approximately 45 persons (5%).</p> <p>Pretreatment: There were no significant differences concerning age, sex, and form of living (apartment vs nursing ward and intermediate care) between both groups.</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> weekly PA exercise, consisting of 20 units for 60 minutes each week. The units were compiled following a complex understanding of health and mobility, including biological, psychological, and social dimensions. The units targeted a wide range of areas like coordination, balance, strength, endurance, sensorimotor perception, breathing, abilities, and skills for managing ADL, and interpersonal skills. Regarding the needs of residents the program was focused toward low intensity (eg, 20 weekly exercise units) and variety of content. A "home-exercise program" comprising ten exercises was added to promote participants' capacity to exercise independently ● <i>Duration:</i> IG took part in weekly exercise, for 60 minutes each week over 20 weeks ● <i>Dose:</i> Regarding the needs of residents the program was focused toward low intensity (eg, 20 weekly exercise units) and variety of content ● <i>Personel:</i> Trainers were primarily staff members of the RAC provider with experience in PA training for elderly persons; supervisors were physical or occupational therapists, who at certain points got practically involved in units with difficult tasks <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> three social animation events with no specific focus on PA or associated skills ● <i>Duration:</i> Three sessions over 20 weeks ● <i>Dose:</i> three social events ● <i>Personel:</i> Not reported
<p>Outcomes</p>	<p><i>Vægt (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Mobilitet (Bevægelse og færden) (EOT)</i></p>

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Timed Up and Go
- **Unit of measure:** Seconds
- **Direction:** Lower is better
- **Data value:** Endpoint
- **Notes:** Only participants who used same type of walking aid or none walking aid at baseline and final test session were included in the analysis

Mobilitet (Bevægelse og færden) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Balance (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** COPM (Canadian Occupational Performance Measure)
- **Range:** ? think 0-10
- **Unit of measure:** Point
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** Tried to find range for this scale but not possible

ADL (inkludativ både ADL og IADL) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Forblive i eget hjem (ændring af bopælsstatus) (LF)

- **Outcome type:** DichotomousOutcome
- **Reporting:** Not reported

Fald (EOT)

- **Outcome type:** AdverseEvent
- **Reporting:** Not reported
- **Unit of measure:** Number of falls
- **Direction:** Lower is better
- **Data value:** Endpoint
- **Notes:** Numer of falls reported under section: Unexpected adverse effects: During the study trial, no unexpected adverse events or harm – eg, falls during exercise units or afterward due to less careful behavior – were reported. But not systematically collected why it is not used in the analysis

Serious adverse events (EOT)

	<ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Fully reported ● Data value: Endpoint ● Notes: During the study trial, no unexpected adverse events or harm – eg, falls during exercise units or afterward due to less careful behavior – were not systematically collected and therefore not reported.
<p>Identification</p>	<p>Sponsorship source: Financial sup-port for the research and/or publication of this article was provided by the Ludwig Boltzmann Society, a private non-profit association organizing research, funded by the Austrian Federal Ministry for Science and Research. No conflicts of interests</p> <p>Country: Austria</p> <p>Setting: Three residential aged-care facilities in Austria. The facilities offer a mix of assisted living and nursing care, combining different forms, ranging from apartments to nursing ward structures</p> <p>Comments: No further comments</p> <p>Authors name: Martin Cichocki</p> <p>Institution: Ludwig Boltzmann Institute health Promotion research</p> <p>Email: cicho@gmx.net</p> <p>Address: Ludwig Boltzmann Institute health Promotion research, Untere Donaustrasse 47/3, 1020 Vienna, AustriaTel +43 1 212 1493 10</p>
<p>Notes</p>	<p><i>Birgitte Grønhegård Jepsen</i> on 03/04/2016 18:25</p> <p>Select</p> <p>Måske ??? (I mangel af mere stringente studier???)P: Indbyggere i residential aged care (dvs min. hjælp til IADL) I: 20 sessioner Low Threshold Physical activity... C. 3 sociale arrangementer O: Bedret Eq5 D...</p> <p><i>Mette Merete Pedersen</i> on 20/04/2016 18:55</p> <p>Outcomes</p> <p>Jeg kan ikke finde nogle af de mulige outcome i artiklen - for mobilitet er der TUG og RSS, men du skrev at ganghastighed var det primære, og jeg har derfor ikke indtastet noget. Der er ikke en "add missing data tag", som beskrevet i din guide</p>

Risk of bias table

Bias	Support for judgement
<p>Authors' judgement</p> <p>Low risk</p>	<p>Quote: "Following a randomly generated list, the coordinators individually and pro-actively invited residents and informed them about the personal relevance of the program."</p>
<p>Sequence Generation</p> <p>Low risk</p>	<p>Quote: "To randomly allocate the participants, a computerized random number generator was used based on alphabetical lists of the participants' names. Assessors were blinded to allocation; the list for distribution was safely kept and not passed on to assessors of the baseline and follow-up assess- ment. After completed allocation procedures, participants were informed whether they belonged to the IG or CG."</p> <p>Judgement Comment: Assessors were blinded to allocation</p>

Blinding of participants and personnel	High risk	Judgement Comment: It is not clearly described if the personnel or participants were blind to group however it is in practice very difficult to blind in studies involving an training intervention
Blinding of outcome assessors	Low risk	Quote: "Assessors were blinded to the participants' group allocation."
Incomplete outcome data	High risk	Quote: "Primary analyses were performed for all participants who had taken part in baseline and post-assessment (Model I-Completers). The" Judgement Comment: The number and reasons for dropouts are described for both groups - more participants dropped out from the intervention group. The did not use ITT only per protocol More than 10% dropout at end of treatment
Selective outcome reporting	Low risk	Quote: "The PA program was conducted between October 2011 and June 2012 as a registered randomized controlled trial (ISRCTN25536408) using standardized assessments to measure the health status of participants before and after the intervention." Judgement Comment: The study has been preregistered and all preregistered outcomes are reported
Other sources of bias	Low risk	

Gitlin 2006

Methods	<p>Study design: Randomized controlled trial Study grouping: Parallel group Open Label: Cluster RCT:</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 79.5 (6.1) ● Gender (% male): 17.5 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): NR ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 63.8 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 78.5 (5.7) ● Gender (% male): 18.9 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR

	<ul style="list-style-type: none"> ● <i>Impairment (body function and structure description) (yes/no):</i> NR ● <i>Limitations (activity description) (yes/no):</i> NR ● <i>Restriction (participation description) (yes/no):</i> Y ● <i>Housing (eg. residential living, own home) % own home:</i> 100 ● <i>Living alone (%):</i> 59.7 ● <i>In risk of falling (yes/no):</i> NR ● <i>Cognitive impairment (yes/no):</i> N <p>Included criteria: All participants were aged 70 and older, cognitively intact (Mini-Mental State Examination (MMSE) score >23 on a scale ranging from 0 to 30) and English speaking; were not receiving home care; and reported the need for help or difficulties with two IADLs or one or more ADLs. These criteria were designed to enroll older people who experienced some difficulty with everyday activities but who were not totally dependent or homebound or receiving services to address functional problems</p> <p>Excluded criteria: Of the 331 persons who received the baseline home interview, 4% (n512) were ineligible based on MMSE scores and were excluded, resulting in a sample of 319</p> <p>Pre-treatment: No group differences were found at baseline</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> Occupational therapists (OTs) initially met with participants and conducted a semistructured clinical interview to identify and prioritize problem areas. For each targeted area, an OT observed the participant's performance for safety, efficiency, and difficulty and presence of environmental barriers. In subsequent sessions, the OT engaged the participant in problem solving to identify behavioral and environmental contributors to performance difficulties. Specific strategies were derived and equipment options provided. In the fourth session, the physical therapist (PT) provided balance and muscle strengthening and fall-recovery techniques. In the fifth session (telephone), the OT reinforced strategy use, and in the sixth session, the OT reviewed problem solving, refined strategy use, and provided education and resources to address future needs for environmental adjustments. Before the sixth contact, the area agency on aging ordered and installed home modifications (grab bars, rails, raised toilet seats), which were paid for through grant funds. Over the following 6 months, OTs conducted three telephone calls to reinforce the use of intervention-derived strategies and generalize these strategies to new problem areas. A final home visit was conducted to obtain closure. Because of considerable variability in home environments and functional difficulties, specific control-oriented strategies were individualized to the needs of participants, although the intervention was standardized in that each participant received four treatment components (education and problem solving; home modification; energy conserving techniques; and balance, muscle strengthening, and fall-recovery techniques) for specific targeted functional areas. Although the intervention program was based on traditional occupational and physical therapy techniques, a 26-28 minute approach differed from typical home care. First, the intervention focused exclusively on the areas participants themselves reported as problematic. In traditional home care, problem areas addressed by health professionals may not reflect client priorities. Second, interventionists served as consultants, helped participants solve problems, and offered strategy choices, whereas home care is more directive and prescriptive. Third, the intervention involved coordination between OTs and PTs to achieve an integrated approach, which is not always possible in home care. ● <i>Duration:</i> 6-month (four 90-minute visits and one 20-minute telephone contact from an occupational therapist and one physical therapy visit (90 minutes). Furthermore, three more telephone calls were done over the 6 months ● <i>Dose:</i> The 6-month intervention consisted of five occupational therapy contacts (four 90-minute visits and one 20-minute telephone contact) and one physical therapy visit (90 minutes). ● <i>Personnel:</i> Occupational and physical therapist

	<p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Participants who were assigned to the no-treatment control group did not receive any intervention contact. A the conclusion of the 12-month follow-up interview, control participants were provided educational materials on home safety and safe performance techniques ● <i>Duration:</i> 12 months ● <i>Dose:</i> No control intervention ● <i>Personel:</i> No personnel were involved beside the assessors
<p>Outcomes</p>	<p>Vægt (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p>Mobilitet (Bevægelse og færden) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: Selfreported mobility in six tasks (Likert scale 1-5) ● Range: 5-30 ● Unit of measure: Points ● Direction: Lower is better ● Data value: Endpoint ● Notes: Mobility Index : A mobility/transfer index was computed as mean difficulty across six items (getting in/out of car, walking indoors, walking one block, climbing one flight of stairs, moving in/out of chair, and moving in/out of bed. For each area, participants rated their perceived difficulty in the previous month from 1=no difficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty <p>Mobilitet (Bevægelse og færden) (LF)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: Selfreported mobility in six tasks (Likert scale 1-5) ● Range: 5-30 ● Unit of measure: Mean changes between groups ● Direction: Higher is better ● Data value: Change from baseline ● Notes: Reported as mean change fully adjusted for race, living arrangement, economic well-being, social support, and depressive symptoms at 12 month. Selfreported mobility/transfer index was computed as mean difficulty across sixitems (getting in/out of car, walking indoors, walking oneblock, climbing one flight of stairs, moving in/out of chair, and moving in/out of bed <p>Balance (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome <p>ADL (inkluderer både ADL og IADL) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: Selfreported ADL based on 6 tasks (Likert scale 1-5) ● Range: 5-30

	<ul style="list-style-type: none"> ● Unit of measure : points ● Direction : Lower is better ● Data value : Endpoint ● Notes : ADL Index : An selfreported ADL index was computed as mean difficulty across six items (dressing above waist, dressing below waist, grooming, bathing/showering, toileting and feeding). For each area, participants rated their perceived difficulty in the previous month from 1=no difficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty <p><i>ADL (inkludativ både ADL og IADL) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type : ContinuousOutcome ● Reporting : Fully reported ● Scale : Selfreported ADL dependency in six tasks ● Range : 5-30 ● Unit of measure : changes between groups ● Direction : Higher is better ● Data value : Change from baseline ● Notes : Fully adjusted changes between group are reported at 12 months ADL Index : A selfreported ADL index was computed as mean difficulty across six items (dressing above waist, dressing below waist, grooming, bathing/showering, toileting and feeding). For each area, participants rated their perceived difficulty in the previous month from 1=no difficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type : DichotomousOutcome ● Reporting : Not reported <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type : AdverseEvent ● Reporting : Not reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type : AdverseEvent ● Reporting : Not reported
Identification	<p>Sponsorship source : The research reported in this paper was supported by funds from National Institute on Aging Grant R01 AG1368</p> <p>Country : USA</p> <p>Setting : Urban community-living older people</p> <p>Comments : No comments</p> <p>Authors name : Laura N. Gitlin, PhD,</p> <p>Institution : Center for Applied Research on Aging and Health and Department of Pharmacology and Experimental Therapeutics, Division of Biostatistics, Thomas Jefferson University, Philadelphia, Pennsylvania; and Department of Health Care Sciences</p> <p>Email : laura.gitlin@jefferson.edu</p> <p>Address : Thomas Jefferson University, 130 S 9th Street, Suite 513, Philadelphia, PA 19130.</p>

<p>Notes</p>	<p><i>Birgitte Grønnegård Jepsen</i> on 03/04/2016 22:37 Select P: Ikke geriatrisk målgruppe, men subgruppe af ældre med 1-2 ADL pb men uden hjælp: 5XET kontakter over 6 mdr, 1 X Fys</p> <p><i>Julie Hansen</i> on 20/04/2016 20:10 Outcomes For LF outcomes (ADL + mobility) only the difference between groups were reported. OBS!</p>
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Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Study participants were stratified by race (white, nonwhite) and living arrangement (alone, with others) and randomized within each of four strata using random permuted blocks to control for possible changes in subject mix over time. The blocking number, developed by the project statistician (VWH), remained unknown to others. Randomization lists and four sets of randomization were prepared using double, opaque envelopes. The project director randomized each participant within 48 hours from completion of the baseline interview."
Allocation concealment	Low risk	Quote: "Randomization lists and four sets of randomization were prepared using double, opaque envelopes. The project director randomized each participant within 48 hours from completion of the baseline interview."
Blinding of participants and personnel	High risk	Quote: "The project codirectors (LW, SS) randomized participants, and trained interviewers who were masked to group assignment and study hypotheses and who had no role in the intervention interviewed them at 6 and 12 months." Judgement Comment: Participants were interviewed about mobility, ADL and IADL status no information on personnel blinding The patients were not possible to blind
Blinding of outcome assessors	Low risk	Quote: "The project codirectors (LW, SS) randomized participants, and trained interviewers who were masked to group assignment and study hypotheses and who had no role in the intervention interviewed them at 6 and 12 months." Judgement Comment: Outcome assessors and interviewers were blinded
Incomplete outcome data	High risk	Judgement Comment: Intervention group: 160 randomized, 6/160 lost to 6 months and 11/160 lost at 12 months. Control group: 159 randomized, 13/159 lost at 6 months and 23/159 lost at 12 months. No ITT used. Information on dropouts with causes are described, and the authors report that ITT are used for all participants - however the methods are not clear - and it is not clear if the participants lost to follow up are included in the analyses
Selective outcome reporting	Low risk	Judgement Comment: Protocol: not located all relevant outcomes seems reported
Other sources of bias	Low risk	

Gronstedt 2013

<p>Methods</p>	<p>Study design: Randomized controlled trial Study grouping: Parallel group Open Label: Cluster RCT:</p>
<p>Participants</p>	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) mean (SD): 85 (7.74) ● Gender (% male): 29 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): Y ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no) : Y ● Cognitive impairment (yes/no): Y <p>Control</p> <ul style="list-style-type: none"> ● Age (year) mean (SD): 84.9 (7.6) ● Gender (% male): 24 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): Y ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no) : Y ● Cognitive impairment (yes/no): Y <p>Included criteria: Participants from 24 nursing homes (4 Swedish, 9 Norwegian and 11 Danish) in the 3 countries were randomized to either an IG or a CG. Inclusion criteria were as follows: (1) age over 64 years; (2) need of daily assistance in a minimum of one personal ADL (P- ADL); (3) expected stay in the nursing home during the study period.</p> <p>Excluded criteria: Residents at a terminal stage of disease were excluded. In Denmark, a Mini-Mental State Examination (MMSE) score <16 points was added as an extra exclusion criterion following a decision made by the Regional Ethics Committee.</p> <p>Pre-treatment: There were no significant differences between the IG (n = 129) and CG (n = 112) regarding baseline values (table 1). The mean age was 85.0 (IG) and 84.5 years (CG), mean length of stay 25.0 (IG) and 24.4 months (CG), and about 75% were females. The participants had on average 3 medical diagnoses and used 6.5 drugs. About 75% were able to walk with or without walking aids, and</p>

	<p>around 60% were able to rise from a chair independently. The median PGCMS score was 11 points for both groups, which indicates 'middle-range morale', and 19 points on MMSE</p> <p>Intervention Characteristics Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> G was offered individually tailored physical and daily activities [19] . A team comprising 1 physiotherapist (PT) and 1 occupational therapist (OT) was responsible for the inter-vention at each location. When a resident was included in the IG, clinical assessments were carried out by both the PT and the OT, and an individual treatment goal was set in cooperation with the participant. The individually tailored programs consisted of phys-ical and daily activities in different combinations, depending on the goals and physical and cognitive function of each participant. The PT and OT responsible for the intervention recorded the total number of minutes each participant spent on each category of in-tervention [19] ● <i>Duration:</i> 10 -13 weeks intervention (93 min/Week) 74/ 100 participants registered ● <i>Dose:</i> (93 min/Week) 74/ 100 participants registered ● <i>Personel:</i> One physiotherapist and one occupational therapist <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Ordinary care and treatment ● <i>Duration:</i> Not relevant ● <i>Dose:</i> Not described ● <i>Personel:</i> Not described
<p>Outcomes</p>	<p>Vægt (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome <p>Mobilitet (Bevægelse og færden) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: self-selected speeds ● Unit of measure: (m/s) ● Direction: Higher is better ● Data value: Change from baseline ● Notes: self-selected and at maximum speeds (m/s) was tested for 10 m indoors. Self-selected speed is chosen as the data point <p>Mobilitet (Bevægelse og færden) (LF)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: Self-selected speed ● Unit of measure: m/s ● Direction: Higher is better ● Data value: Change from baseline ● Notes: self-selected and at maximum speeds (m/s) was tested for 10 m indoors. Self-selected speed is chosen as the data point <p>Balance (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported

	<ul style="list-style-type: none"> ● Scale: Bergs Balance Scale ● Range: 0-56 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Change from baseline ● Notes: Functional balance was assessed by the BBS . The scale consists of 14 tasks of relevance to everyday life. Scoring is based on the ability to perform items independently and to meet certain time or distance requirements. Each item is scored on a 0-4 Lick-ert scale, with 56 as the best possible score. <p><i>ADL (inkluderer både ADL og IADL) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: FIM, physical function subscale ● Range: 13-91 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Change from baseline ● Notes: Functional Independence Measure (FIM). FIM describes residents performance according to a 7-point scale, where grade 1 means total assistance and grade 7 means full independence. The instrument consists of 18 items, of which 13 address physical function (items a-m) and 5 social and cognitive functions (items n-r). Subscale ifor physical function (a-m) are used and results from the ITT analysis <p><i>ADL (inkluderer både ADL og IADL) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: FIM physical functionsunscale ● Range: 13-91 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Change from baseline ● Notes: Functional Independence Measure (FIM) measured at six month follow-up. FIM describes residents performance according to a 7-point scale, where grade 1 means total assistance and grade 7 means full independence. The instrument consists of 18 items, of which 13 address physical function (items a-m) and 5 social and cognitive functions (items n-r). Subscale ifor physical function (a-m) are used and results from the ITT analysis. <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome ● Reporting: Not reported <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent
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	<ul style="list-style-type: none"> ● Reporting: Not reported ● Notes: From the results paragraph: No major adverse events associated with the pre-scribed exercises and activities were observed. However the details considering which adverse events is not reported
Identification	<p>Sponsorship source: This work was supported by the National Society for Research on Aging, the Swedish Research Council, the Centre for Caring Sciences at Karolinska Institutet, the Swedish Order of St. John; King Gustaf V's and Queen Victoria's Foundation, Ageing and Health, Stockholms Sjukhem Foundation, the Norwegian Centre for Research, Education and Service Development, Teaching Nursing Home, Soebstad, the Norwegian Directorate for Health and Social Affairs, VELUX-Fondene, Occupational Therapy Education at the University College, Sjælland, and the Health Faculty at the University of Southern Denmark. No conflicts of interest</p> <p>Country: Sweden, Norway and Denmark</p> <p>Setting: Nursing homes in Sweeden, Norway, Denmark</p> <p>Comments: The study was a multicenter randomized, controlled clinical trial with a parallel-group design addressing nursing home residents from city areas in Sweden, Norway and Denmark. Participants from 24 nursing homes (4 Swedish, 9 Norwegian and 11 Danish) in the 3 countries were randomized to either an IG or a CG.</p> <p>Authors name: Kerstin Frändin</p> <p>Institution: Department of Neurobiology, Care Sciences and Society, Karolinska Institutet</p> <p>Email: Kerstin.Frandin@neuro.gu.se</p> <p>Address: Sahlgrenska Academy at Göteborg University, Wallingsgatan 6 SE-431 41 Mölndal (Sweden)</p>
Notes	<p><i>Birgitte Grønnegård Jepsen</i> on 03/04/2016 22:53</p> <p>Select</p> <p>P: Plejehjemsbeboere. Multicenter RCT N= 322 over 6 år, min hjælp til 1 adl . I Baseline står der at gennemsnit af diagnoser er 2, 9? , MMSE 19Intervention: Individuelt klinisk undersøgelse, mål, Individuelt træningsprogram på 5 kategorier. Outcome: FIM, BBS,</p>

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "After the stratification, randomization was carried out within each nursing home ward by the researcher at each center, according to random sample lists provided by a statistical adviser [19]"
Allocation concealment	Unclear risk	Judgement Comment: The method for allocation concealment is not described just that a randomized list were used
Blinding of participants and personnel	High risk	Judgement Comment: No information on blinding of participant and personnel but difficult to blind in this study design
Blinding of outcome assessors	Low risk	Quote: "The assessors were blinded to the group assignment and not involved in the intervention." Judgement Comment: However the FIM (measure of ADL function) were assessed by the primary nurse and I do not think she could possible be blinded to the intervention

Incomplete outcome data	High risk	Quote: "Missing data were handled as described under Measurements, and in some cases replaced by median scores [38], as described in a previous article [18]. The intention to treat (ITT) analysis was done by the last value carried forward method." Judgement Comment: Reasons for dropouts are shown in fig 1 and ITT analysis were used, few participants had missing values on test caused by missing items in tests. More than 10% dropout at end of treatment, high risk
Selective outcome reporting	Low risk	Quote: "countries, and the study is registered under Clinical Trials.gov (identifier: NCT00218842)." Copenhagen University Library" Judgement Comment: The phase II (follow-up study) is registered under clinicaltrials.gov however the description of outcomes is a bit unclear. Their secondary outcome only involves falls which is not recorded clearly in the study only fall-efficacy is obtained.
Other sources of bias	Low risk	Judgement Comment: However the intervention has a staff educational part and keeping the intervention confidential to the staff only in the intervention group is difficult inducing a risk for contamination

Kerse 2008

Methods	<p>Study design: Cluster randomized controlled trial</p> <p>Study grouping: NA</p> <p>Open Label:</p> <p>Cluster RCT: YES</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 84.4 (7.2) ● Gender (% male): 27 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no): Y ● Cognitive impairment (yes/no): N <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 84.1 (7.2) ● Gender (% male): 26 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y

	<ul style="list-style-type: none"> ● <i>Housing (eg. residential living, own home) % own home: 0</i> ● <i>Living alone (%): NR</i> ● <i>In risk of falling (yes/no): Y</i> ● <i>Cognitive impairment (yes/no): N</i> <p>Included criteria: Eligible residents were aged 65 years and over, able to engage in a conversation about a goal, remember the goal, and participate in a programme to achieve the goal (a proxy for cognitive state). Elderly people living in low level dependency residential care homes need assistance with most instrumental activities of daily living and at least two activities of daily living but can usually ambulate to some degree and feed themselves</p> <p>Excluded criteria: We excluded residents who were unable to communicate to complete the study measures, had anxiety as their main diagnosis, were acutely unwell, or were in a terminal state.</p> <p>Pretreatment: Characteristics of residents were mainly evenly balanced between the groups (table 1).</p>
<p>Interventions</p>	<p>Intervention Characteristics Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> the promoting independence in residential care (PIRC) intervention. The resident, assisted by the gerontology nurse, set a mutually agreed goal that had to meet two criteria: it had to be relevant and meaningful to the resident, and it had to promote progressive increases in physical activity. The goal setting often required one to two visits, depending on the resident's abilities. The gerontology nurse then completed a functional assessment and designed an individualised programme of physical activities based on repetitions of activities of daily living, such as rising from a chair, additional walking, or repeated transfers, aiming to improve the physical functions needed to achieve the goal ● <i>Duration:</i> Exercise activities were planned to be done daily or several times a day in short doses as part of the resident's usual activities for 6 months in total after that the staff was expected to implement/continue the intervention on their own ● <i>Dose:</i> The plan was developed in part as a template, such that if rising from a chair was challenging (and was needed as part of achieving the goal) the plan incorporated initially five sit to stands twice daily with increasing repetitions as the individual resident gained greater lower leg strength. The gerontology nurse provided support to the homestaff every week for the first month and monthly for the next six months. Support included visits; discussions about residents, exercises, and goals; and reviewing progress and renegotiating a new goal with enrolled residents when the first goal was met ● <i>Personel:</i> Gerontology nurse, physiotherapist, occupational therapist, healthcare assistants <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Residents in control group homes received usual care and were offered two social visits by a social science researcher to control for the attention received by the resident from the gerontology nurse visits. ● <i>Duration:</i> two social visits over 6 months ● <i>Dose:</i> Not relevant ● <i>Personel:</i> social science researcher
<p>Outcomes</p>	<p><i>Vægt (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p><i>Mobilitet (Bevægelse og færden) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported

- **Scale:** Timed up and go
- **Unit of measure :** sec
- **Direction :** Lower is better

Mobilitet (Bevægelse og færden) (LF)

- **Outcome type :** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Timed up and go
- **Unit of measure :** sec
- **Direction:** Lower is better
- **Data value :** Endpoint

Balance (EOT)

- **Outcome type :** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** % \geq 10 seconds tandem stande
- **Range:** 0-28
- **Unit of measure :** %
- **Direction:** Higher is better
- **Data value :** Endpoint
- **Notes:** Based on 7 different static balance tasks each measured on time and scored from 0-4 reported as % participants who were able to stand \geq 10 seconds in tandem stand (one of the 7 balance tasks)

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type :** ContinuousOutcome
- **Scale:** late life function and disability instrument (LLFD)
- **Range:** 0-100
- **Unit of measure :** points
- **Direction:** Higher is better
- **Data value :** Endpoint
- **Notes:** The scale consist on 2 subscales 1)function including dependency mobility tasks and 2)disability including dependency in ADL and IADL and social interaction so it is not a measure for ADL solely. Reported are the disability overall score which is the best measure for ADL

ADL (inkluderer både ADL og IADL) (LF)

- **Outcome type :** ContinuousOutcome
- **Reporting:** Not reported
- **Scale :** Late Life function and disability instrument
- **Range :** 0-100
- **Unit of measure :** points
- **Direction:** Higher is better
- **Data value :** Endpoint
- **Notes:** Only the function overall scale is reported and consists mainly of selfreported difficulty and dependency in mobility tasks - however the text is unclear compared to the table 2 and 3 (We measured self reported function with the late

	<p>lifunctionanddisabilityinstrumentvalidatedfor frail elderly people.²⁵The two main components, the functional and disability components, were administered at baseline and 12 months follow-up. Sub-domains included upper extremity function, basiclower extremity function, and advanced lower extremity function. The function component was also administered at six months) it seems that the function scale is administered at EOT and FT however the table show the opposite picture?? Therefore noting is reported at LF</p> <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Fully reported ● Scale: Falls ● Unit of measure: Number of falls ● Direction: Lower is better ● Data value: Endpoint ● Notes: Not clear if falls is measured within intervention time (6 months) or 12 months follow-up <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent
<p>Identification</p>	<p>Sponsorship source: New Zealand Health Research Council and AccidentCompensation Corporation. The funders had no involvement in the research design or conduct or in interpretation of results</p> <p>Country: New Zealand</p> <p>Setting: Low level dependency residential care homes</p> <p>Comments: No comments</p> <p>Authors name: Ngaire Kerse, associate professor</p> <p>Institution: Department of General Practiceand Primary Health Care, Schoolof Population Health, University of Auckland</p> <p>Email: n.kerse@auckland.ac.nz</p> <p>Address: University ofAuckland, Private Bag 92019,Auckland, 1001, New Zealand</p>
<p>Notes</p>	<p><i>Birgitte Grønnegård Jepsen</i> on 04/04/2016 00:26</p> <p>Select</p> <p>P: Residents long term care . "Low level dependencies I: Gerontologisk nurse, aktivitetsprogram, goalsettingC: Usual care - 3 sociale besøgO: Late life Disability and function scale, BalanceBør inkluderes</p> <p><i>Mette Merete Pedersen</i> on 20/04/2016 21:55</p> <p>Population</p> <p>Man kan ikke se ud fra tabel 1, om der er forskel ved baseline på de to grupperjeg er i tvivl om, hvordan jeg skal udfylde baseline characteristics. Ift cognition er de fleste normale, men C1 går ned til 5, som er mild impairment.</p> <p><i>Mette Merete Pedersen</i> on 20/04/2016 22:44</p> <p>Outcomes</p>

	Jeg kan kun finde ADL reporteret for patienterne delt på kognitivt besvær og ikke kognitivt besvær, så derfor ikke registreret
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Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	<p>SUPPORTING ANNOTATIONS We invited homes to participate in random order by using computer generated random numbers.collection of baseline data, a biostatistician not involved in recruitment randomised homes to the intervention or control group by using computer generated random numbers. We used randomisation by home (cluster) to avoid contamination between groups resulting from the intervention COMMENTS No comments</p>
Allocation concealment	Unclear risk	<p>SUPPORTING ANNOTATIONS Research nurses blinded to the group allocation of the homes used standardised methods to assess outcomes. COMMENTS The methods of allocation concealment is not described clearly</p>
Blinding of participants and personnel	High risk	<p>SUPPORTING ANNOTATIONS No annotations COMMENTST here was no blinding of personnel as they were trained in the intervention and difficult to blind the participants</p>
Blinding of outcome assessors	High risk	<p>SUPPORTING ANNOTATIONS Research nurses blinded to the group allocation of the homes used standardised methods to assess outcomes.residents in the home. 34 Research nurses blinded to the group allocation of the homes used standardised methods to assess outcomes. All intervention materials were removed from each resident's room before follow-up reassessment visits. Interventions Two trained gerontology nurses, one in seven of the 41 homes, a staff member or resident unblinded the assessor at some time during follow-up. This poten- tially affected measures on 56 activity participants and 41 social participants. COMMENTS No comments</p>
Incomplete outcome data	High risk	<p>SUPPORTING ANNOTATIONS No difference existed in the proportion of residents who were either admitted into higher level care or died during the 12 months of the trial between the activity group (55/330, 17%) and the social group (47/352, 13%) (P=0.61). We found no evidence of a difference in the rate of hospital admissions between the social group and the activity group (P=0.55) (table 6), nor any difference in the level of adverse outcomes (P=0.75). COMMENTS Dropouts and reasons are described in the flowchart and there were no differences between groups - however analysis are performed as per protocol and not ITT and dropout > 10%</p>

Selective outcome reporting	Unclear risk	SUPPORTING ANNOTATIONS No annotations
Other sources of bias	Low risk	COMMENTS No protocol are available, outcome measures seems ok None detected

King 2012

Methods	<p>Study design: Cluster randomized controlled trial Study grouping: no further comments Open Label: Cluster RCT: YES</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 80.5 (6.3) ● Gender (% male): 22.6 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 67.7 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N (95.7% AMTS > 7) <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 78.4 (6.5) ● Gender (% male): 30.1 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 50.5 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N (94.6% AMTS > 7) <p>Included criteria: All older people (65+ years) who received assistance from the home care agency were eligible for participation. Excluded criteria: Older people were excluded if there was an inability to participate in interviews due to poor health. Poor health</p>

	<p>included severe physical or mental health, which impeded the older person from being able to answer interview questions</p> <p>Pre-treatment: There is a significant difference in the variable living alone with more persons living alone in the intervention group</p>
<p>Interventions</p>	<p>Intervention Characteristics Intervention</p> <ul style="list-style-type: none"> ● Description: Restorative home care. Multifaceted intervention promoting independence. restorative care philosophy, enhanced training and supervision for paid caregivers, care management role, and goal facilitation. In addition, the intervention comprised an initial in-depth assessment of older people and a support plan incorporating repetitive activities of daily living (ADL) exercises for older people which was designed to optimise independence ● Duration: Paid caregiver contact with older people would range from daily to fortnightly, as a minimum. The participants were measured at two time points after 4 months corresponding to min. 3 months intervention and 7 months corresponding to 6 months intervention ● Dose: The paid caregiver adjusted the dose of the training and progress the exercises ● Personel: The paid caregivers undertook two training programs, developed by an external Tertiary provider, which were based on a restorative care philosophy designed to optimise independence in older people. The coordinator (experienced registered nurse) provided enhanced supervision for paid caregivers by undertaking compulsory 2 hour fortnightly meetings. Paid caregiver wages were linked to the competencies achieved through their training <p>Control</p> <ul style="list-style-type: none"> ● Description: The control group continued under the home care agency's usual care service. The older participants were all existing clients who continued to receive their usual care from the home care agency. Paid caregivers performed household activities or personal cares for the older people based on existing support plans. Support plans were prescriptive and stated whether the older people required help with various domestic chores (e.g. dusting, vacuuming, washing), and whether they were independent or dependent with personal cares. Paid caregiver contact with older people would range from daily to fortnightly, as a minimum. ● Duration: Home care was administered after the older persons need for help with practical or personal cares - various duration ● Dose: daily - at least fortnightly visits ● Personel: The paid caregiver minimum wage and travel allowances for the control group were matched with the intervention group. Three coordinators, who were not health professionals, oversaw all older people receiving usual care within the agency (including those not in this trial).
<p>Outcomes</p>	<p>Vægt (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p>Mobilitet (Bevægelse og færden) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported ● Scale: Timed up and go ● Unit of measure: seconds ● Direction: Lower is better ● Data value: Endpoint ● Notes: The write in the statistics that all treatment evaluations were undertaken ITT, however in the table 2 the n is lower than baseline. <p>Mobilitet (Bevægelse og færden) (LF)</p>

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Timed up and go
- **Unit of measure:** Seconds
- **Direction:** Lower is better
- **Data value:** Endpoint
- **Notes:** The write in the statistics that all treatment evaluations were undertaken ITT, however in the table 2 the n is lower than baseline.

Balance (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Nottingham Extended ADL
- **Range:** 0-66
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** The write in the statistics that all treatment evaluations were undertaken ITT, however in the table 2 the n is lower than baseline.

ADL (inkluderer både ADL og IADL) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Nottingham Extended ADL
- **Range:** 0-66
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** The write in the statistics that all treatment evaluations were undertaken ITT, however in the table 2 the n is lower than baseline.

Forblive i eget hjem (ændring af bopælsstatus) (LF)

- **Outcome type:** DichotomousOutcome
- **Reporting:** Not reported

Fald (EOT)

- **Outcome type:** AdverseEvent
- **Reporting:** Not reported

Serious adverse events (EOT)

- **Outcome type:** AdverseEvent

	<ul style="list-style-type: none"> ● Reporting: Not reported
Identification	<p>Sponsorship source: This research was made possible by funding from the University of Auckland Doctoral Scholarship. The funding source had no control over the design or analysis of the study, nor any influence on submission for publication</p> <p>Country: New Zealand</p> <p>Setting: Agency of home care for home dwelling older people</p> <p>Comments:</p> <p>Authors name: Anna King</p> <p>Institution: School of Nursing Faculty of Medical and Health Sciences The University of Auckland</p> <p>Email: a.king@auckland.ac.nz</p> <p>Address: Private Bag 92019 Auckland Mail Centre 1142 Auckland New Zealand</p>
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	
Allocation concealment	Low risk	
Blinding of participants and personnel	High risk	Judgement Comment: Not described but difficult to blind personnel and participants in this kind of study
Blinding of outcome assessors	Unclear risk	Judgement Comment: Not described clearly
Incomplete outcome data	Unclear risk	Judgement Comment: drop outs and reasons were described (around 16 %) and were equally distributed between groups. They write in the statistics that ITT was used but it is unclear which methods were used and it is also unclear according to the final outcomes if they used ITT
Selective outcome reporting	Low risk	Quote: "This trial was registered with the Australian New Zealand Clinical Trials Registry (ACTRN12606000256572)." Judgement Comment: All quantitative outcomes are reported.
Other sources of bias	Low risk	Judgement Comment: No further comments

Lewin 2013

Methods	<p>Study design: Randomized controlled trial</p> <p>Study grouping: Parallel group</p> <p>Open Label:</p> <p>Cluster RCT:</p>
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<p>Participants</p>	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 81.84 (7.19) ● Gender (% male): 29.9 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 51.2 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): NR <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 82.73 (7.70) ● Gender (% male): 35.5 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 42.4 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): NR <p>Included criteria: Older persons living in Perth suburbs who were referred for home-care services over 65 years of age; referred for personal care; and, able to communicate in English. Individuals may have been referred for a range of services in addition to personal care (e.g. domestic assistance, respite, nursing, or meals on wheels). The personal care criterion was used to reduce the potential for variation in the level of dependency between the two groups, a difficulty that was encountered in a previous non-randomised controlled trial</p> <p>Excluded criteria: diagnosis of dementia or other progressive neurological disorders, or receiving palliative care;</p> <p>Pretreatment: groups were somewhat different in terms of their characteristics, namely that the HLP group was less likely to have a carer and more likely to live alone.</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Description: In brief, the areas of functioning and types of interventions that are incorporated into HLP include the promotion of active engagement in a range of daily living activities using task analysis and redesign, work simplification and assistive technology where appropriate; strength, balance and endurance programmes for improving or maintaining mobility; chronic disease self-management; falls prevention strategies; medication, continence and nutrition management; and the improvement or maintenance of

	<p>skin integrity.</p> <ul style="list-style-type: none"> ● <i>Duration</i>: Individuals participate in HIP until they achieve their goals or for up to 12 weeks, whichever occurs first. ● <i>Dose</i>: Not described clearly. From the results section defined as three HIP visits for the intervention group or 3 hours of personal care for the control group but the time frame is not reported ● <i>Personel</i>: Home care service <p>Control</p> <ul style="list-style-type: none"> ● <i>Description</i>: Visit by a care Coordinator. This involved further assessment of individual needs, completion of a care plan and the commencement of direct care. The most common care plan included three personal care visits a week to assist with bathing/showering and a fortnightly housecleaning visit that included heavy laundry ● <i>Duration</i>: Not described ● <i>Dose</i>: Not described ● <i>Personel</i>: Not described
<p>Outcomes</p>	<p><i>Vægt (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Mobilitet (Bevægelse og færden) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Mobilitet (Bevægelse og færden) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Balance (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>ADL (inkluderer både ADL og IADL) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Partially reported ● Notes: Data are based on a subgroup of around 100 participants - there is no full ADL scale reported but only the development in independency in different tasks during the study period and follow-up. It is not possible to pool data in a meta-analysis consequently data are reported narratively <p><i>ADL (inkluderer både ADL og IADL) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Partially reported ● Notes: Data are based on a subgroup of around 100 participants - there is no full ADL scale reported but only the development in independency in different tasks during the study period and follow-up. It is not possible to pool data in a meta-analysis consequently data are reported narratively <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome

	<ul style="list-style-type: none"> ● Reporting: Not reported <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported
Identification	<p>Sponsorship source: This research was funded by an Australian HealthMinisters' Advisory Council priority-driven research programme grant and would not have been possible without the support of WA HACC and Silver Chain's commitment to delivering evidence-based care</p> <p>Country: Australia</p> <p>Setting: Community living older referred to home care for personal care</p> <p>Comments: Der er flere metodologiske problemer ved dette studie - ikke alle deltagere som er randomiseret til intervention har fået intervention men istedet usual care - derfor er resultaterne rapporteret som både ITT og as treated. Funktionsmål er rapporteret på baggrund af en subgruppe n (150 hvoraf kun omkring 100 er inkluderet i den endelige analyse) men der mangler generelt estimater som kan bruges i en metaanalyse så artiklens fund er beskrevet narrativt.</p> <p>Authors name: Gill Lewin</p> <p>Institution: Centre for Research on Ageing Curtin Health Innovation Research Institute Curtin University,</p> <p>Email: G.Lewin@curtin.edu.au</p> <p>Address: Curtin University, GPO Box U1987 Perth, WA 6845 Australia</p>
Notes	<p><i>Nkr 47 Geria on 31/05/2016 21:33</i></p> <p>Outcomes</p> <p>Data kan ikke pooler i en metaanalyse derfor beskrevet narrativt</p>

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	High risk	Quote: "eligible, and having determined that both HACC and HIP services were available, the system allocated the individual to either the intervention or con- trol group based on alternating tenths of a second. The Operator then followed the normal process for onward referral to the appropriate service."
Allocation concealment	High risk	Judgement Comment: However the randomization was broken of the operator in some older persons Quote: "The Operator then followed the normal process for onward referral to the appropriate service. The Operators could not therefore be blind to group allocation." Judgement Comment: The operator know the allocation

Blinding of participants and personnel	High risk	Quote: "However, participants would often talk about the type of assistance they were receiving from Silver Chain, so it was impossible to prevent Research Assistants from deducing over the course of the RCT whether the participant was in the intervention or in the control group." Judgement Comment: No blinding
Blinding of outcome assessors	High risk	Quote: "ants were blind to whether the individual was in the intervention or the control group." Judgement Comment: Research assistants were blinded to group allocation during the baseline assessment but it was difficult to hide group allocation during the follow up visits
Incomplete outcome data	High risk	Judgement Comment: Drop outs and reasons described > 10% ITT analysis used but not described.
Selective outcome reporting	High risk	
Other sources of bias	High risk	Quote: "Another unavoidable limitation of this study that minimized differences between the control and intervention groups was contamination of the intervention. Namely, HIP's development over several years has meant that independence and re-ablement have been incorporated into Silver Chain's lexicon and strategic vision. Consequently, home-care staff may be encouraging their clients to do more for themselves and thus improve their functional independence, even though it was not necessarily accompanied by a formal referral for HIP services or the suggestion that the individual may in fact no longer need home care." Judgement Comment: Furthermore the randomization was manipulated

Parker 2015

Methods	<p>Study design: Randomized controlled trial</p> <p>Study grouping: Parallel group</p> <p>Open Label:</p> <p>Cluster RCT:</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 79.5 (12.4) ● Gender (% male): 46 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): Y ● Limitations (activity description) (yes/no) (based on FTSTS): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): NR <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 77.1 (11.2) ● Gender (% male): 34

	<ul style="list-style-type: none"> ● <i>Frail (yes/no)</i>: NR ● <i>Comorbidity (yes/no)</i>: Y ● <i>Undernourished (yes/no)</i>: NR ● <i>Impairment (body function and structure description) (yes/no)</i>: Y ● <i>Limitations (activity description) (yes/no) (based on FTSTS)</i>: Y ● <i>Restriction (participation description) (yes/no)</i>: Y ● <i>Housing (rg. residential living, own home) % own home</i>: 100 ● <i>Living alone (%)</i>: NR ● <i>In risk of falling (yes/no)</i>: NR ● <i>Cognitive impairment (yes/no)</i>: NR <p>Included criteria: Eligibility for an SSR place included admission to the hospital from living independently at home, completion of a hospital care episode, medical stability, and an assessment that further personal care service was required to be provided in residential aged care. 14 Participants were also assessed as potentially benefiting from time to consider care options and additional therapeutic services.</p> <p>Excluded criteria: No diagnostic groups were excluded, and age of eligibility was not specified. People with cognitive impairment were eligible. Cognitive status of potential participants was measured by assessing health professionals using the Mini-Mental State Examination before referral to the research.</p> <p>Pretreatment: The intervention group differs at baseline with clinical relevant lower performance on two outcome measures (DEMMI, BBS)</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> Standard care twice weekly and furthermore the intervention group also received an individualized functional exercise program (FIT). The FIT program was developed by the participant's physiotherapist and primarily targeted walking and sitting-to-standing exercises ● <i>Duration:</i> Twice weekly for 30 minutes to practice the FIT, in addition to reassessing weekly and updating the target walking distance and number of sit-to-stand exercises. Participants were encouraged to practice 4 times daily, in addition to necessary movement such as moving to and from the mealroom ● <i>Dose:</i> Progression was done once weekly based on the participants' performance based on walking and sit to stand ability ● <i>Personel:</i> Physiotherapist to practice standard care and a research assistant to practice the functional exercise program <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Both groups received individualized standard physiotherapy programs within the SSR dependent on initial physiotherapist assessment findings. Standard physiotherapy comprised twice-weekly 1:1 treatments with a physiotherapist as well as appropriate classes such as chair based, balance, or hydrotherapy. Both groups were treated by the same physiotherapists, who were encouraged to treat all participants equally regardless of group ● <i>Duration:</i> Standard physiotherapy comprised twice-weekly ● <i>Dose:</i> Not described ● <i>Personel:</i> Physiotherapist

Outcomes

Vægt (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Mobilitet (Bevægelse og færden) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Partially reported
- **Scale:** de Morton Mobility Index (DEMMI)
- **Range:** 0-100
- **Unit of measure:** points
- **Direction:** Higher is better
- **Data value:** Change from baseline
- **Notes:** Reported as change value bu values are median (interquartile range)

Mobilitet (Bevægelse og færden) (LF)

- **Outcome type:** ContinuousOutcome

Balance (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Partially reported
- **Scale:** Bergs Balance Scale
- **Range:** 0-56
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Change from baseline
- **Notes:** Values reported are median (interquartile range)

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

ADL (inkludativ både ADL og IADL) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Forblive i eget hjem (ændring af bopælsstatus) (LF)

- **Outcome type:** DichotomousOutcome
- **Scale:** Discharge destination
- **Notes:** From fig. 2 discharged fro SSR to home versus (hostel + nursing home + hospital) out of participants who survived (intervention group 27 survived versus 32 in the control group)

Fald (EOT)

- **Outcome type:** AdverseEvent
- **Reporting:** Not reported

Serious adverse events (EOT)

	<ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported
Identification	<p>Sponsorship source: Disclosures: none, information on sponsorship is missing Country: Australia Setting: regional center in Victoria, Australia. There were 39 residential slow-stream rehabilitation (SSR) places available Comments: No further comments Authors name: Carol Parker Institution: La Trobe University, Bundoora, Victoria Email: cparker@bendigohealth.org.au. Address: Collaborative Health Education and ResearchCentre, Bendigo Health, PO Box 126, Bendigo, Victoria,Australia 3552.</p>
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Randomization, using random numbers designating group and inserted in sealed opaque envelopes, was undertaken by an independent researcher with no patient contact." Judgement Comment: Random numbers were used no information on how they were generated
Allocation concealment	Low risk	Quote: "random numbers designating group and inserted in sealed opaque envelopes, was undertaken by an independent researcher with no patient contact. It was not possible to blind"
Blinding of participants and personnel	High risk	Quote: "was not possible to blind the participants or therapists to group allocation during the intervention."
Blinding of outcome assessors	Low risk	Quote: "Discharge assessments were undertaken by the researcher who was blind to group allocation. Participants were encouraged not to tell the assessor which group they were in or what exercise they had been doing, to minimize the chance of the assessor becoming unblinded." Judgement Comment: Furthermore a physiotherapist assessed all participants before they were randomized
Incomplete outcome data	High risk	Quote: "Missing data are not likely to be random, as most data are missing either because of death or hospital readmission. As a result, where missing assessment measures occurred, the last observation was carried forward." Judgement Comment: All analysis were ITT and reasons for missing values were described More than 10% dropout at end of treatment
Selective outcome reporting	Unclear risk	Unclear
Other sources of bias	High risk	Judgement Comment: There is clinically relevant differences in DEMMI and BBS at baseline where the intervention group had lower values witch could bias the results

Parsons 2013

<p>Methods</p>	<p>Study design: Cluster randomized controlled trial Study grouping: No further comments Open Label: Cluster RCT: YES</p>
<p>Participants</p>	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 79.08 (6.93) ● Gender (% male): 28.7 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 63.9 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 76.9 +/- 7.61 ● Gender (% male): 38 (39.2) ● Frail (yes/no): NA ● Comorbidity (yes/no): NA ● Undernourished (yes/no): NA ● Impairment (body function and structure description) (yes/no): NA ● Limitations (activity description) (yes/no): YES ● Restriction (participation description) (yes/no): NA ● Housing (rg. residential living, own home) % own home: 100 ● Living alone (%): 61.9 ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N <p>Included criteria: Community-dwelling people older than 65 years (55y if Ma'ori or Pacific Islander) were eligible for entry into the study if they were new referrals for home care. The lower age criterion for Ma'ori and Pacific people was in line with the recommendations from the New Zealand Guidelines Group for assessment of older people with complex needs Excluded criteria: (1) severe cognitive impairment that may have compromised adherence to the intervention, defined as an Abbreviated Mental Test score of less than 7/10; and (2) referral for assessment for admission to a residential facility, carer support, or short-term services Pre-treatment: Differences were observed between the 2 groups in terms of participant characteristics (mean age, sex, ethnicity, living situation) and physical function at baseline (table 1). The effect of these differences was controlled for by stepwise development of the</p>

	<p>generalized linear mixed model, so that only variables showing a significant effect were included as fixed effects in the final model</p> <p>Interventions</p> <p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Description: The study intervention involved a needs assessor who used a goal-setting tool (Towards Achieving Realistic Goals in Elders Tool [TARGET]) during the initial assessment process of the participant to establish the aims of the rehabilitation episode. After assessment, a long-term goal was identified together with necessary short-term goals through a process of activity break-down to form a goal ladder. This included addressing areas of deficit such as falls risk, decreased muscle strength, difficulty with showering, and other personal cares that may have prevented the older person from attaining his/her goal. Based on the goal ladder, the home care coordinator developed concrete instructions for the home care aide in the form of a support plan, which comprised a detailed list of the tasks to be undertaken. This may have included the use of allied health professionals (occupational therapist, physical therapist, speech-language pathologist, dietitian) to provide expert guidance in the tasks required to attain a participant's goals. ● Duration: Individual according to the aim not reported ● Dose: Individual not reported ● Personnel: use of allied health professionals (occupational therapist, physical therapist, speech-language pathologist, dietitian) to provide expert guidance in the tasks required to attain a participant's goal <p>Control</p> <ul style="list-style-type: none"> ● Description: The usual care process used the SNA tool undertaken by a needs assessor randomly assigned to the usual care group. After completion of the SNA tool, the needs assessor worked with the participant to identify the services that would be provided and how many hours were required. This information was passed to the home care provider contracted to deliver services. The home care organization then prepared a support plan to meet the identified needs of the older person ● Duration: Individual according to the aim not reported ● Dose: Individual not reported ● Personnel: use of allied health professionals (occupational therapist, physical therapist, speech-language pathologist, dietitian) to provide expert guidance in the tasks required to attain a participant's goal <p>Outcomes</p> <p>Vægt (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p>Mobilitet (Bevægelse og færden) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported ● Scale: 2.4 meters gait speed from SPPB ● Unit of measure: Seconds ● Direction: Lower is better ● Data value: Endpoint ● Notes: Values are least squares mean ± SE, (95% confidence interval), or as otherwise indicated. *Modeling included ethnicity, perceived relationship between Needs Assessment Service Coordination and home care, Emotional Support Seeking Scale (a component of the Proactive Coping Inventory), and the number of hours of home-based support allocated by Needs Assessment Service Coordination. N is not described in table 2 - therefore n from figure 1 is used <p>Mobilitet (Bevægelse og færden) (LF)</p>
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	<ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Balance (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: Standing balance from SPPB ● Range: 0-4 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Endpoint ● Notes: Values are least squares meanSE, (95% confidence interval), or as otherwise indicated.*Modeling included ethnicity, perceived relationship between Needs Assessment Service Coordination and home care, Emotional Support Seeking Scale (a component of the Proactive Coping Inventory), and the number of hours of home-based support allocated by Needs Assessment Service Coordination.N is not described in table 2 - therefore n from fig 1 is used <p><i>ADL (inkluderer både ADL og IADL) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>ADL (inkluderer både ADL og IADL) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome ● Reporting: Not reported <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported
	<p>Identification</p> <p>Sponsorship source: Supported by the New Zealand Health Research Council Disability Research PlacementProgramme (grant no. 06/627) and by the University of Auckland.No commercial party having a direct financial interest in the results of the research supportingthis article has or will confer a benefit on the authors or on any organization with which the authorsare associated</p> <p>Country: New Zealand</p> <p>Setting: Community dwelling people over 65 with new referral for home care</p> <p>Comments: Only estimates based on an adjusted linear regression analysis are available</p> <p>Authors name: John Geoffrey Morgan Parsons</p> <p>Institution: School of Nursing, Faculty of Medical and Health Sciences, The University of Auckland,</p> <p>Email: j.parsons@auckland.ac.nz</p>

Notes	<p>Address: School of Nursing, Faculty of Medical and Health Sciences, The University of Auckland, Level 2, Bldg 505, 85 Park Rd, Grafton, Auckland 1142, New Zealand.</p> <p>Mette Merete Pedersen on 06/06/2016 22:18</p> <p>Outcomes Hej Christine. Jeg har ikke afrapporteret mobilitet og balance, for er ikke helt klar over, hvilke tal, du gerne vil have. De har jo rapporteret baseline og follow-up, men vil du gerne have forskel mellem de to?</p>
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Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Randomization occurred through a 5-step process. Step 1 involved collection of all referrals to the care coordination agency for home care from primary care physicians from February to June 2006. In step 2, the referrals were then separated into 4 geographic pods aligned to the care delivered by the needs assessment team. Step 3 involved the allocation of primary care practices to blocks within each pod. The number of blocks responded to the number and full-time equivalent of care coordination staff within each pod. The allocation was stratified in an attempt to ensure that there was parity across the blocks in relation to the number of referrals received. In step 4, the blocks within each pod were randomly assigned as either usual care or intervention. This activity was undertaken to ensure that equal numbers were allocated to each pod. Step 5 then involved the allocation of an individual needs assessor to each study group through the use of a numeric list randomly generated within Microsoft Excel. a The allocation of participants to each of the 2 study groups was undertaken by the administration staff within the needs assessment agency administration staff, and the allocation was not revealed to the research team until after consent had been obtained." Judgement Comment: The sequence generation was done using a numeric list randomly generated within Microsoft Excel.
Allocation concealment	Low risk	
Blinding of participants and personnel	High risk	Quote: "To avoid potential bias, the needs assessors randomly assigned to the usual care group were not trained in the use of TARGET and were not in contact with the assessors randomly assigned to the intervention group. However, the 5 contracted home care organizations all provided services to participants randomly assigned to both the usual care and the intervention groups, and this was recognized as a source of potential bias. The home care organizations were therefore only allowed to integrate activities into the support plan that were directly relevant to the issues identified in the needs assessor referral. Furthermore, home care aides were only paid for completing tasks outlined in the support plan. This was closely monitored by both the needs assessment agency (as a cost management strategy) and the research team who reviewed the content of every support plan." Quote: "Assessments were completed by experienced researchers blinded to group allocation." Judgement Comment: No further comments
Blinding of outcome assessors	Low risk	Judgement Comment: Group outs were low less than 10 % and equally distributed between groups, however it is unclear how the missing values were treated in analysis
Incomplete outcome data	Unclear risk	
Selective outcome reporting	Low risk	Quote: "Australian New Zealand Clinical Trials Registry Number: ACTRN12608000027314." Judgement Comment: They have generally reported all prespecified outcomes in the present paper or been explicit about that the outcome was reported in an earlier reported study

<p>Other sources of bias</p>	<p>Low risk</p>
<p>Peri 2008</p>	
<p>Methods</p>	<p>Study design: Cluster randomized controlled trial Study grouping: NR Open Label: Cluster RCT: YES</p>
<p>Participants</p>	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 86.8 (5.5) ● Gender (% male): 15 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 84.7 (6.7) ● Gender (% male): 17 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): N <p>Included criteria: The study was conducted in five residential care homes (subsequently called home... These homes volunteered their participation in the study as part of a partnership between the University of Auck-land and the residential care industry in the development of quality improvement programme. Two similar wings were identified by researchers and management staff and allocated to either the intervention or control group by the toss of a coin performed by an independent researcher [17]. All residents in each wing were then offered participation. ... residents regardless of cognitive or physical ability were eligible for participation and were invited to take part by research staff. Written consent was obtained from one senior management staff of the home. All residents or their family members,</p>

	<p>when participants could not consent for themselves, were invited to participate and gave written informed consent. Excluded criteria: Exclusion criteria for residents were: under the age of 65 years, admission for respite or terminal care; and quadriplegia Pretreatment: None</p>
<p>Interventions</p>	<p>Intervention Characteristics Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> The intervention was an activity programme developed by a trained gerontology research nurse and delivered by usual caregivers. The activities were redesigned to increase the resident's strength, balance and endurance through increasing the usual level of activity by repeating ADL. The residents' individualised plan was reviewed monthly at a staff meeting attended by the research staff, health care assistants and nurse manager. Goals were modified or reset by the resident, if requested, following the review meeting ● <i>Duration:</i> two times daily for 12 weeks and follow up 6 months ● <i>Dose:</i> Activity programme on daily basis ● <i>Personel:</i> Gerontology nurse and health care staff <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Residents received usual care and were offered the opportunity at the conclusion of the trial to participate in the goal setting physical activity intervention. ● <i>Duration:</i> Not relevant ● <i>Dose:</i> Not relevant ● <i>Personel:</i> Not relevant
<p>Outcomes</p>	<p><i>Vægt (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome <p><i>Mobilitet (Bevægelse og færden) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Scale: Timed up and go ● Unit of measure: sec ● Direction: Lower is better ● Data value: Endpoint ● Notes: It is not clear from the text of statistic what is reported Means with (SD) or (SE) <p><i>Mobilitet (Bevægelse og færden) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Scale: Timed up and go ● Unit of measure: Sec ● Data value: Endpoint ● Notes: It is not clear from the text of statistic what is reported Means with (SD) or (SE) <p><i>Balance (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported

	<p>ADL (inkluderer både ADL og IADL) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p>ADL (inkluderer både ADL og IADL) (LF)</p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p>Forblive i eget hjem (ændring af bopælsstatus) (LF)</p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome ● Reporting: Not reported <p>Fald (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Scale: self-reported ● Direction: Lower is better ● Notes: self-reported sustaining at least one fall over the intervention period <p>Serious adverse events (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported <p>Identification</p> <p>Sponsorship source: The authors would like to acknowledge the residential carehome industry which has contributed financial support. The Auckland Medical Research Fund (AMRF) and theAuckland University Research Committee supported thisproject by providing project grants</p> <p>Country: New Zealand</p> <p>Setting: Five low-level dependency residential care homes in Auckland, New Zealand</p> <p>Comments: No further comments</p> <p>Authors name: Kathryn Peri</p> <p>Institution: School of Nursing, University of Auckland, Auckland, New Zealand</p> <p>Email: k.peri@auckland.ac.nz</p> <p>Address: Not reported</p>
<p>Notes</p>	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Unclear risk	Judgement Comment: The method for sequence generation is not described
Allocation concealment	Low risk	Quote: "group by the toss of a coin performed by an independent researcher" Judgement Comment: Allocation concealment performed by the toss of a coin

Blinding of participants and personnel	High risk	Judgement Comment: Blinding not described but difficult to do in this study design
Blinding of outcome assessors	High risk	Quote: "research nurse blinded to the allocation, then collected baseline, 3- and 6-month outcome measures." Judgement Comment: Assessors were blinded
Incomplete outcome data	High risk	Quote: "Outcome analysis was by intention-to-treat maintaining all participants in their original groups." Judgement Comment: Missing with causes are shown in figure 1 and are equally distributed between groups. ITT analyses are used for missing values but the methods are not described More than 10% dropout at end of treatment
Selective outcome reporting	Unclear risk	Judgement Comment: No protocol is available and miss an ADL outcome which also include the participation level only mobility outcomes are shown to cover ADL
Other sources of bias	High risk	Quote: "Observations of research staff indicated that in two homes the control group residents were observed participating in activities with intervention group residents in the lounge or during walking group outings. Ways to minimise this contamination were discussed at the regular review meetings with all staff." Judgement Comment: Contamination is likely

Resnick 2009

Methods	<p>Study design: Randomized controlled trial Study grouping: Parallel group Open Label: Cluster RCT:</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 83.7 (8.1) ● Gender (% male): 23.1 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): Y ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 (nursing home residents) ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): Y <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 83.9 (8.3) ● Gender (% male): 16.9 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR

	<ul style="list-style-type: none"> ● <i>Undernourished (yes/no):</i> NR ● <i>Impairment (body function and structure description) (yes/no):</i> Y ● <i>Limitations (activity description) (yes/no):</i> Y ● <i>Restriction (participation description) (yes/no):</i> Y ● <i>Housing (rg. residential living, own home) % own home:</i> 0 (nursing home residents) ● <i>Living alone (%):</i> NR ● <i>In risk of falling (yes/no):</i> NR ● <i>Cognitive impairment (yes/no):</i> Y <p>Included criteria: Residents were eligible to participate in the study if they were aged 65 and older, had a Mini-Mental State Examination (MMSE) score of 11 or greater, had a life expectancy of longer than 6 months, and were not receiving skilled rehabilitation services. Participants completed their own consent if they qualified according to the Evaluation to Sign Consent Questionnaire. 57 If they were unable to consent, the resident signed an assent to participate, and the proxy was contacted to provide consent</p> <p>Excluded criteria: No further information than what is described in the inclusion criteria</p> <p>Pretreatment: No group differences besides differences in ethnicity</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> Educational component: All NAs were invited to attend a 6-week in-service program provided by an advanced practice nurse. The treatment sites were provided with a research restorative care nurse (RCN) WHO worked in the treatment facility for 20 hours a week over the 12-month study period. the RCN worked with the NAs to develop short- and long-term goals for the residents (e.g., what the resident was expected to do with regard to all ADLs); reviewed the NAs documentation of restorative care activities on each of the consented residents; served as an interface between NAs and the nurses, residents, families, and administrators with regard to restorative care activities; and provided ongoing encouragement and support to the NAs related to implementation of restorative care activities. ● <i>Duration:</i> Daily for 12 months. Of all care provided daily by NAs, an average of 70. (56.2) minutes consisted of restorative care, based on the NAs documentation on the Restorative Care Documentation flow sheets. ● <i>Dose:</i> Restorative care provided daily by NAs, based on 70 minutes included such things as verbal cueing to engage the resident in bathing and dressing (15 minutes), ambulation to the dining room with contact guard three times per day (10 minutes for each meal), walking to the bathroom four times a day (10 minutes each time), or putting the resident through passive or active range-of-motion exercises (5 or 10 minutes). ● <i>Personnel:</i> NA's (nursing assistants) + 1 advanced practice nurse. <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Usual care and NHs randomized to control were provided with a single in-service program on managing difficult behaviors. Approximately 30% of the NAs in these sites were exposed to the single educational session, and no follow-up education was attempted. The control site did not receive any information about restorative care, and they were not provided with a RCN ● <i>Duration:</i> Not relevant ● <i>Dose:</i> Not described ● <i>Personnel:</i> Nurse assistants

Outcomes

Vægt (EOT)

- **Outcome type:** ContinuousOutcome

Mobilitet (Bevægelse og færden) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** The Tinetti Mobility scale (subscale gait)
- **Range:** 0-12
- **Unit of measure:** points
- **Direction:** Higher is better
- **Data value:** Endpoint

Mobilitet (Bevægelse og færden) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Balance (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** The Tinetti Assessment Tool - balance subscale
- **Range:** 0-16
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type:** ContinuousOutcome
- **Scale:** The Barthel Index
- **Range:** 0-100
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** Scoring was based on proxy reporting from NAs who were providing care to residents was used

ADL (inkluderer både ADL og IADL) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Forblive i eget hjem (ændring af bopælsstatus) (LF)

- **Outcome type:** DichotomousOutcome
- **Reporting:** Not reported
- **Notes:** Not relevant nursing home residents

Fald (EOT)

- **Outcome type:** AdverseEvent
- **Reporting:** Not reported

	<p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported
Identification	<p>Sponsorship source: This study was supported by Agency for Healthcare Research and Quality(AHRQ) Grant R01 HS/MH 13372-01. AHRQ was involved in the data and safety monitoring board, as appropriate for a funding agency.</p> <p>Country: USA</p> <p>Setting: Twelve nursing homes in Maryland</p> <p>Comments: No further comments</p> <p>Authors name: Barbara Resnick</p> <p>Institution: University of Maryland School of Nursing</p> <p>Email: barbresnick@aol.com</p> <p>Address: 655 WestLombard Street, Baltimore, MD 21201</p>
Notes	<p><i>Pia Ravnsbæk BjæRge on 30/03/2016 21:53</i></p> <p>Select</p> <p>Plejhjemmsbeboere</p>

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Twelve NHs in the greater Baltimore area (Figure 1) were invited and agreed to participate; six pairs were created according to chain affiliation and size. One NH in each pair was randomly assigned to the treatment group and the other to the control group."
Allocation concealment	Unclear risk	Judgement Comment: Method not described
Blinding of participants and personnel	High risk	Judgement Comment: Blinding not possible in this study design
Blinding of outcome assessors	Low risk	Quote: "A team of evaluators who were blinded to randomization and unfamiliar with the details of the Res-Care intervention measured all outcomes."
Incomplete outcome data	High risk	Quote: "The intention-to-treat (ITT) principle was followed in all analyses used for assessing the effect of treatment on outcome." Judgement Comment: The methods for ITT is not described. Causes for dropouts and missing values are described More than 10% dropout at end of treatment
Selective outcome reporting	Low risk	Judgement Comment: No protocol available however outcome measures seem relevant
Other sources of bias	Unclear risk	Quote: "RCN in the control facilities, without self-efficacy based motivational interventions. It is possible that this oversight alone might affect the behavior of the NAs and the functional outcomes in nursing home residents." Judgement Comment: Contamination of control population is possible

Resnick 2011

<p>Methods</p>	<p>Study design: Cluster randomized controlled trial Study grouping: NA Open Label: Cluster RCT: YES</p>
<p>Participants</p>	<p>Baseline Characteristics Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): Baseline data for both groups 87.7 (5.7) ● Gender (% male): 20 ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0 ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): Y <p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): NR ● Gender (% male): NR ● Frail (yes/no): NR ● Comorbidity (yes/no): NR ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): NR ● Restriction (participation description) (yes/no): NR ● Housing (rg. residential living, own home) % own home: NR ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): NR <p>Included criteria: Residents were eligible to participate if they were aged 65 and older, currently living in the AL community, not in hospice or rehabilitation, and scored at least 11 on the Mini-Mental State Examination (MMSE) Excluded criteria: Residents were excluded from the study if they had a life expectancy of less than 6 months (documented by their primary healthcare provider). If residents did not pass the Evaluation to Sign Consent they were asked to sign an assent to participate, and a proxy was contacted to complete the consent process Pre-treatment: There is no descriptive data available in table form for control or intervention group the baseline data are shown together for the two groups. Therefore baseline characteristics for both groups are shown below the intervention column. Differences in baseline values were shortly described in the statistical paragraph: There were significant differences between the groups of residents at</p>

	<p>baseline with regard to outcome expectations (P=.03) and number of diagnoses(P=.001), such that those in the control group had higher outcome expectations for functional ability and more diagnoses</p> <p>Intervention Characteristics Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> A research Function Focused-Care Nurse (FFCN) coordinated and implemented FFC-AL with support from an interdisciplinary research team. The FFCN was a registered nurse who worked with the intervention sites 15 hours per week for the first 6 months of the intervention, 8 hours per week for the next 3 months, and 4 hours per week for the final 3 months of the intervention. To assure sustainability of the FFC philosophy, each treatment site identified a staff champion who worked with the FFCN to learn how to maintain FFC over time. The identified champion in each site was a licensed practical nurse. Working with the champion, the FFCN implemented the four components of FFC-AL ● <i>Duration:</i> daily for 12 months ● <i>Dose:</i> Not described ● <i>Personel:</i> Direct care workers (DCWs) - A research Function Focused-Care Nurse (FFCN) - An interdisciplinary research team <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> AL communities randomized to control received FFC-ED only. All staff in these communities were invited to attend an educational session on FFC. The education materials and length of the educational session was identical to that provided to the treatment group, with the exclusion of motivational techniques to engage residents in functional and physical activity. ● <i>Duration:</i> Not relevant ● <i>Dose:</i> Not relevant ● <i>Personel:</i> Direct care workers (DCWs)
<p>Outcomes</p>	<p>Vægt (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome <p>Mobilitet (Bevægelse og færden) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Scale: Walking 50 yards (subelement of Bartel Index) ● Range: 0-15 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Endpoint <p>Mobilitet (Bevægelse og færden) (LF)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p>Balance (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p>ADL (inkluderer både ADL og IADL) (EOT)</p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported

	<ul style="list-style-type: none"> ● Scale: Barthel Index ● Range : 0-100 ● Unit of measure : Points ● Direction: Higher is better ● Data value : Endpoint ● Notes: Outcomes reported at 12 month are used as the study last 12 month <p><i>ADL (inkludativ både ADL og IADL) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Not reported <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome ● Reporting: Not reported ● Notes: Nursing home residents <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Fully reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Not reported ● Notes: Different adverse event is reported in table 4 however they are not caused by the intervention
	<p>Identification</p> <p>Sponsorship source: This research was supported by the Robert WoodJohnson Foundation through the Interdisciplinary NursingQuality Research Initiative Grant Program.</p> <p>Country: USA</p> <p>Setting: Four assisted living facilities (AL) facilities with at least 100 beds.</p> <p>Comments: NA</p> <p>Authors name: Barbara Resnick and Sonya Ziporkin Gershowitz</p> <p>Institution: University of Maryland School of Nursing,</p> <p>Email: resnick@son.umaryland.edu</p> <p>Address: 655 West Lombard Street, Baltimore, MD 21201</p>
	<p>Notes</p> <p><i>Pia Ramnbæk Bjærge on 30/03/2016 22:37</i></p> <p>Select</p> <p>Er i tvivl om interventionen kan sidestilles med hverdagstræning...Desuden er målgruppen både ældre + 65 og medarbejdere...</p>

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Unclear risk	Quote: "All communities randomized" Judgement Comment: Methods for sequence generation not described
Allocation concealment	Unclear risk	Judgement Comment: Methods for allocation concealment not described
Blinding of participants and personnel	High risk	Judgement Comment: Not described but difficult to blind participants and personnel in this kind of study design
Blinding of outcome assessors	Unclear risk	Judgement Comment: Blinding of assessors is not described
Incomplete outcome data	High risk	Quote: "An intention-to-treat paradigm was followed." Judgement Comment: Reasons for drop-outs are well described and ITT analysis used but we have no information on how missing values were replaced More than 10% dropout at end of treatment
Selective outcome reporting	Unclear risk	Judgement Comment: No protocol available
Other sources of bias	Unclear risk	Judgement Comment: Generally the methods are poorly described throughout the study especially we do not know anything about randomization, health care workers and possible contamination of these

Sackley 2009

Methods	<p>Study design: Randomized controlled trial</p> <p>Study grouping: Parallel group</p> <p>Open Label:</p> <p>Cluster RCT: YES</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 86 (7) ● Gender (% male): 21 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0% (all living at residential homes) ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): Y

	<p>Control</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 84 (10) ● Gender (% male): 16 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): NR ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 0% (all living at residential homes) ● Living alone (%): NR ● In risk of falling (yes/no): NR ● Cognitive impairment (yes/no): Y <p>Included criteria: Participants from residential homes housing more than 5 beds, and provided the categories 'physical disability' and 'older people', that cared for residents with limitations and were dependent in ADL, all located in Birmingham, UK.</p> <p>Excluded criteria: Residents who scored below 5 or over 16 on the Barthel index were excluded from the study on the basis that the intervention would be considered too intense or insufficient for their needs, respectively. Residents who were admitted to hospital with acute illness and those admitted to the care home for end of life care were also excluded.</p> <p>Pre-treatment: the groups seem alike. Only a bit of difference in stroke aphasic depression questionnaire score and more seems emotionally distressed in the intervention group (n, %; 56(44)) than in the control group (40(33))</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Description: Physiotherapy was aimed at enhancing mobility and the ability to perform activities of daily living independently, and addressed components such as strength, flexibility, balance, and exercise tolerance. In addition, functional tasks such as bed to chair transfers, sit to stand, and walking or wheeling were practised. The occupational therapy intervention was developed using the consensus of an occupational therapy steering group (as described by Sackley et al).²⁶ Therapy was targeted towards improving independence in personal activities of daily living such as feeding, dressing, toileting, bathing, and transferring (for example, from bed to chair). The intervention arm also included an intervention delivered to the care home staff.²⁷ This involved a programme of staff training to provide practice in subsequently recruited between June 2004 and June 2005 in three phases to spread both therapist and assessor workload ● Duration: Residents in the intervention arm received a three-month physiotherapy and occupational therapy intervention. Mean of 16 visits from PT and OT ● Dose: The dose, frequency, and duration of both physiotherapy and occupational therapy were dependent on the goals agreed by the individual participant and the therapists and on progress throughout the intervention ● Personel: Physiotherapist (PT) and occupational therapist (OT) <p>Control</p> <ul style="list-style-type: none"> ● Description: Residents in care homes allocated to the control arm continued to receive standard care equal to that received before recruitment to the trial. Occupational therapy was not used routinely by any of the homes and physiotherapy was accessed only via general practitioner referral. None of the homes had an identified person with specific responsibility for mobility, training for activities of daily living, or the provision of adaptive equipment. The control group received the therapy intervention after the trial had ended

● *Duration:* Usual care. - The control group received thetherapy intervention after the trial had ended.

● *Dose:* Not described

● *Personel:* Not described

Outcomes

Vægt (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

Mobilitet (Bevægelse og færden) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Rivermead mobility index score
- **Range:** 0-15
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** The estimates are per protocol

Mobilitet (Bevægelse og færden) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Rivermead mobility index score
- **Range:** 0-15
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint
- **Notes:** 6 month follow up

Balance (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Not reported

ADL (inkluderer både ADL og IADL) (EOT)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Barthel Index
- **Range:** 0-20
- **Unit of measure:** Points
- **Direction:** Higher is better
- **Data value:** Endpoint

ADL (inklusive både ADL og IADL) (LF)

- **Outcome type:** ContinuousOutcome
- **Reporting:** Fully reported
- **Scale:** Barthel Index

	<ul style="list-style-type: none"> ● Range : 0-20 ● Unit of measure : Points ● Direction : Higher is better ● Data value : Endpoint ● Notes : 6 month follow-up <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type : DichotomousOutcome ● Reporting : Not reported ● Notes : Not relevant nursing home residents <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type : AdverseEvent ● Reporting : Not reported <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type : AdverseEvent ● Reporting : Not reported
Identification	<p>Sponsorship source : This study was funded by the Health Foundation and the NHSNational Institute for Health Research. The University of Birminghamacted as sponsors. The funders and sponsor had no involvement in thestudy design, data collection, analysis and interpretation, the writing ofthe report, or the decision to submit the paper for publication. Competing interests:None declared</p> <p>Country : UK</p> <p>Setting : Birmingham CityCouncil social services</p> <p>Comments : Trial registration ISRCTN79859980</p> <p>Authors name : Catherine M Sackley</p> <p>Institution : School of Health and PopulationSciences, Primary Care Clinical Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT</p> <p>Email : t.j.hoppitt@bham.ac.uk</p> <p>Address : University ofBirmingham, Edgbaston, Birmingham B15 2TT</p>
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "A cluster randomised controlled design was used to randomly allocate care homes to either the inter-vention arm or the control arm. Randomisation was performed by an independent principal statistician who used a computer generated randomisation list."
Allocation concealment	Unclear risk	Quote: "Treatment arm was revealed to the treating therapists only, thereby ensuring that allocation was concealed from the independent assessors responsible for all sub-sequent assessments." Judgement Comment: How the list was concealed is unclear. How the list was concealed is unclear.

Blinding of participants and personnel	High risk	Quote: "a computer generated randomisation list. Treatment arm was revealed to the treating therapists only, thereby ensuring that allocation was concealed from the independent assessors responsible for all sub-sequent assessments. Residents in the intervention arm received" Judgement Comment: Treating personnel was aware of allocation. It was not possible to blind patients.
Blinding of outcome assessors	Low risk	Quote: "Treatment arm was revealed to the treating therapists only, thereby ensuring that allocation was concealed from the independent assessors responsible for all sub-sequent assessments." Quote: "Assessments were carried out by two independent assessors blinded to cluster allocation throughout the trial. Assessments were conducted before randomisa- tion"
Incomplete outcome data	High risk	Quote: "Sensitivity analyses (using the same multilevel mod- els) were conducted on Barthel index and Rivermead mobility index scores. Data were used from all partici- pants who were assessed before randomisation and missing data were imputed through three mechanisms (best case scenario, worst case scenario, and missing mechanism). A further analysis was conducted using a complete data set (data from participants who pro- vided data pre-intervention and were not protocol vio- lators). No contradictory findings were found; therefore, only primary analyses have been reported in the results section." Judgement Comment: Missing values were accounted for and ITT analysis used Missing values were accounted for and ITT analysis used More than 10% dropout at end of treatment
Selective outcome reporting	Low risk	Judgement Comment: A protocol is available and they do not report several secondary outcomes f.x: bone density, Strength - hand grip dynamometer and Health economics - EuroQoL. However their primary outcome is reported and do not mean that it influence their main results as the study reports "negative" findings Protocol located (Trial registration ISRCTN79859980). In the protocol they prescribe that they will score QoL and depression as outcomes. These are not reported in the trials. Though, I don't think that this is an issue due to lack of reporting bias as all relevant outcome seems reported.
Other sources of bias	Unclear risk	Judgement Comment: Unclear as the control group got usual care corresponding to PT for residents who were referred. we dont have any information on the dose of PT in the control group which could potentially bias the findings

Tuntland 2015

Methods	<p>Study design: Randomized controlled trial</p> <p>Study grouping: Parallel group</p> <p>Open Label:</p> <p>Cluster RCT:</p>
Participants	<p>Baseline Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● Age (year) median (SD): 79.9 (10.4) ● Gender (% male): 29 ● Frail (yes/no): NR ● Comorbidity (yes/no): Y ● Undernourished (yes/no): NR ● Impairment (body function and structure description) (yes/no): Y ● Limitations (activity description) (yes/no): Y ● Restriction (participation description) (yes/no): Y ● Housing (rg. residential living, own home) % own home: 100

	<ul style="list-style-type: none"> ● <i>Living alone (%)</i>: 68% ● <i>In risk of falling (yes/no)</i>: NR ● <i>Cognitive impairment (yes/no)</i>: NR <p>Control</p> <ul style="list-style-type: none"> ● <i>Age (year) median (SD)</i>: 78.1 (9.8) ● <i>Gender (% male)</i>: 36.7 ● <i>Frail (yes/no)</i>: NR ● <i>Comorbidity (yes/no)</i>: Y ● <i>Undernourished (yes/no)</i>: NR ● <i>Impairment (body function and structure description) (yes/no)</i>: Y ● <i>Limitations (activity description) (yes/no)</i>: Y ● <i>Restriction (participation description) (yes/no)</i>: Y ● <i>Housing (rg. residential living, own home) % own home</i>: 100 ● <i>Living alone (%)</i>: 87% ● <i>In risk of falling (yes/no)</i>: NR ● <i>Cognitive impairment (yes/no)</i>: NR <p>Included criteria: People applying for, or referred to, home-based services were potential participants for the study based on their self-reported activity limitations. Some of the participants had been hospitalised due to an acute illness, while others were recruited after having gradually developed functional decline not needing hospitalisation or institution-based treatment. We included home-dwelling persons over the age of 18 years, who lived in the municipality, were able to understand Norwegian, and had a functional decline in one or more daily activities</p> <p>Excluded criteria: We excluded people if they were in need of institution-based rehabilitation or nursing home placement, were terminally ill, or were moderately or severely cognitively reduced (subjectively assessed by health-care providers based on observation and communication)</p> <p>Pre-treatment: No baseline differences</p>
<p>Interventions</p>	<p>Intervention Characteristics</p> <p>Intervention</p> <ul style="list-style-type: none"> ● <i>Description:</i> the intervention consisted of both general and individual features. Among the general features was a maximum rehabilitation period of 3 months. Further, as part of baseline assessments, the occupational therapist and physical therapist used the COPM to identify activity limitations perceived as important by the participant. Thereafter, this information was used to develop a re-habilitation plan. The therapists supervised the home-care personnel, some of whom had no formal education (assistants), in how to encourage and assist the person in the daily training. The focus was on stimulating the participants to perform the daily activities themselves, rather than letting others do it for them. Among the individual features were training in daily activities, adaptations to the environment or the activity, and exercise programs ● <i>Duration:</i> maximum rehabilitation period of 3 months. (Average 10 weeks mean 2.1 hour per week) ● <i>Dose:</i> individual dependent of specific need and goals and not described ● <i>Personnel:</i> occupational therapist and physical therapist used the COPM to identify activity limitations perceived as important by the participant. Thereafter, this information was used to develop a rehabilitation plan. The therapists supervised the home care personnel, some of whom had no formal education (assistants), in how to encourage and assist the person in the daily training. <p>Control</p> <ul style="list-style-type: none"> ● <i>Description:</i> Usual care was chosen as the comparator, as this is the conventional treatment offered to homebound persons in most

	<p>municipalities in Norway. For most participants, usual care meant receiving the compensating help they applied for, in terms of personal or practical assistance, safety alarm, meals on wheels, or assistive technology. However, for a few participants, it comprised rehabilitation assisted by an occupational therapist (n= 1) and/or physical therapist (n= 5) based on the participants' own efforts. Hence, the usual care was also diverse.</p> <ul style="list-style-type: none"> ● <i>Duration:</i> Usual care was not time-limited, and persisted after the 3 months intervention period if needed. (Mean 1.7 hour per week for 12 weeks) ● <i>Dose:</i> Individual dependent of specific need and goals and not described ● <i>Personel:</i> Care professionals
<p>Outcomes</p>	<p><i>Vægt (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p><i>Mobilitet (Bevægelse og færden) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported ● Scale: Timed up and go ● Unit of measure: seconds ● Direction: Lower is better ● Data value: Endpoint <p><i>Mobilitet (Bevægelse og færden) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported ● Scale: Timed up and go ● Unit of measure: seconds ● Direction: Lower is better ● Data value: Endpoint <p><i>Balance (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Not reported <p><i>ADL (inkluderer både ADL og IADL) (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: Continuous Outcome ● Reporting: Fully reported ● Scale: COPM activity performance sub scale ● Range: 1-10 ● Unit of measure: Points ● Direction: Higher is better ● Data value: Endpoint ● Notes: COPM is reported in two subscale activity performance and activity satisfaction. activity performance is used in the meta analysis <p><i>ADL (inkluderer både ADL og IADL) (LF)</i></p>

	<ul style="list-style-type: none"> ● Outcome type: ContinuousOutcome ● Reporting: Fully reported ● Scale: COPM ● Range: 0-10 ● Unit of measure: points ● Direction: Higher is better ● Data value: Endpoint ● Notes: COPM is reported in two subscale activity performance and activity satisfaction. activity performance is used in the meta analysis <p><i>Forblive i eget hjem (ændring af bopælsstatus) (LF)</i></p> <ul style="list-style-type: none"> ● Outcome type: DichotomousOutcome ● Reporting: Not reported <p><i>Fald (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Partially reported ● Notes: Reported in text <p><i>Serious adverse events (EOT)</i></p> <ul style="list-style-type: none"> ● Outcome type: AdverseEvent ● Reporting: Partially reported ● Notes: Reprted in text no adverse events related to treatment occurred during the data collection period
Identification	<p>Sponsorship source: HT, BE, and IK and local research assistants are sponsored by RegionalResearch Funds Western Norway, grant number 229759. In addition, the Norwegian Association of Occupational Therapists supported HT.</p> <p>Country: Norway</p> <p>Setting: Community</p> <p>Comments: The study have inclusion criteria that recruit persons if they are + 18 years of age and receive home care. We decided to include this study in the meta analysis as 95% of the persons in this study> 60 years of age (Table I)</p> <p>Authors name: Hanne Tuntland</p> <p>Institution: Department of Global Public Health and Primary Care, University of Bergen</p> <p>Email: Hanne.Kristin.Tuntland@hib.no</p> <p>Address: University of Bergen, Faculty of Medicine and Dentistry, P.O. Box 7804, 5018 Bergen, Norway</p>
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "The randomisation with an allocation ratio of 1:1 using a computer-generated permuted block randomisation sequence, with randomly selected block sizes of lengths 2 and 4, was performed by a biostatistician not involved in the assignment of participants to groups." Judgement Comment: No further comments
Allocation concealment	Low risk	Quote: "We concealed the allocation sequence in sequentially numbered, opaque, sealed envelopes. The allocation list was stored in a safe deposit box in a central office in the municipality. Neither health-care providers enrolling participants nor research assistants had influence on group allocation." Judgement Comment: No further comments
Blinding of participants and personnel	High risk	Quote: "The participants were urged not to reveal their group allocation to the research assistants during follow-up assessments. The success of the research assistants' blinding was recorded. Researchers conducting data entry and data analysis were blinded to group allocation." Judgement Comment: The study tried to blind personnel but not participants
Blinding of outcome assessors	High risk	Quote: "Blinding of research assistants had a success rate of 63 % at the 3-month and 64 % at the 9-month follow-up." Judgement Comment: They tried to blind the research assistant but the participants could not be quiet about their allocation in many cases
Incomplete outcome data	High risk	Quote: "All participants were analysed according to initial group allocation (intention-to-treat)." Judgement Comment: Drop outs (>10%) including reasons in figure 1 not related to treatment. ITT analysis used but method unclear
Selective outcome reporting	Low risk	Judgement Comment: The trial is registred NCT02043262 and all relevant outcomes are reported
Other sources of bias	High risk	Quote: "The improvements in the control group may also have been caused by contamination from the intervention arm of the study to the control arm. Due to problems with recruitment in a sparsely inhabited municipality, the intervention was implemented in all home-care districts in the municipality. Thus, it was not possible to avoid the situation where the same health-care personnel provided both the experimental and control interventions, however to different participants. Also, the significantly higher amount of co-interventions in terms of outpatient physiotherapy received by participants in the control group during the first 3 months might have had an impact." Judgement Comment: No further comments

Footnotes

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Data and analyses

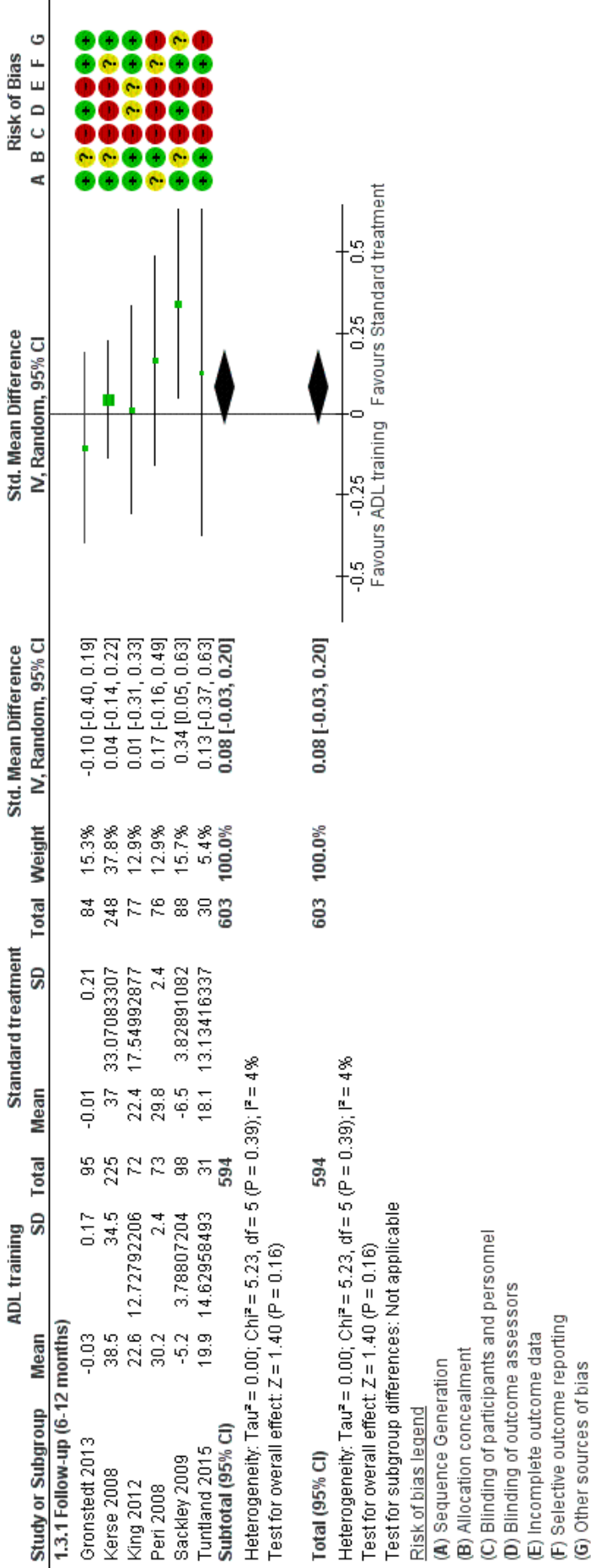
1 ADL training vs Standard treatment

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Vægt (EOT)	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable

1.2 Mobilitet (Bevægelse og færden) (EOT)	12	2749	Std. Mean Difference (IV, Random, 95% CI)	-0.04 [-0.15, 0.07]
1.2.1 End of treatment (12-52 weeks)	12	2749	Std. Mean Difference (IV, Random, 95% CI)	-0.04 [-0.15, 0.07]
1.3 Mobilitet (Bevægelse og færden) (LF)	6	1197	Std. Mean Difference (IV, Random, 95% CI)	0.08 [-0.03, 0.20]
1.3.1 Follow-up (6-12 months)	6	1197	Std. Mean Difference (IV, Random, 95% CI)	0.08 [-0.03, 0.20]
1.4 Balance (EOT)	5	1602	Std. Mean Difference (IV, Random, 95% CI)	-0.08 [-0.25, 0.08]
1.4.1 End of treatment (10-52 weeks)	5	1602	Std. Mean Difference (IV, Random, 95% CI)	-0.08 [-0.25, 0.08]
1.5 ADL (inkluderer både ADL og IADL) (EOT)	9	2447	Std. Mean Difference (IV, Random, 95% CI)	-0.10 [-0.22, 0.03]
1.5.1 EOT	9	2447	Std. Mean Difference (IV, Random, 95% CI)	-0.10 [-0.22, 0.03]
1.6 ADL (inklusive både ADL og IADL) (LF)	4	641	Std. Mean Difference (IV, Random, 95% CI)	-0.02 [-0.26, 0.23]
1.6.1 Time	4	641	Std. Mean Difference (IV, Random, 95% CI)	-0.02 [-0.26, 0.23]
1.7 Forblive i eget hjem (ændring af bopælsstatus) (LF)	1	59	Risk Ratio (IV, Fixed, 95% CI)	0.71 [0.43, 1.17]
1.7.1 Follow-up (time)	1	59	Risk Ratio (IV, Fixed, 95% CI)	0.71 [0.43, 1.17]
1.10 SAE (EoT)	0	0	Risk Ratio (M-H, Fixed, 95% CI)	Not estimable
1.10.1 End of treatment	0	0	Risk Ratio (M-H, Fixed, 95% CI)	Not estimable
1.11 Fald (Falls)	2		Risk Ratio (M-H, Fixed, 95% CI)	Subtotals only
1.11.1 End of treatment	2	788	Risk Ratio (M-H, Fixed, 95% CI)	1.08 [0.93, 1.25]

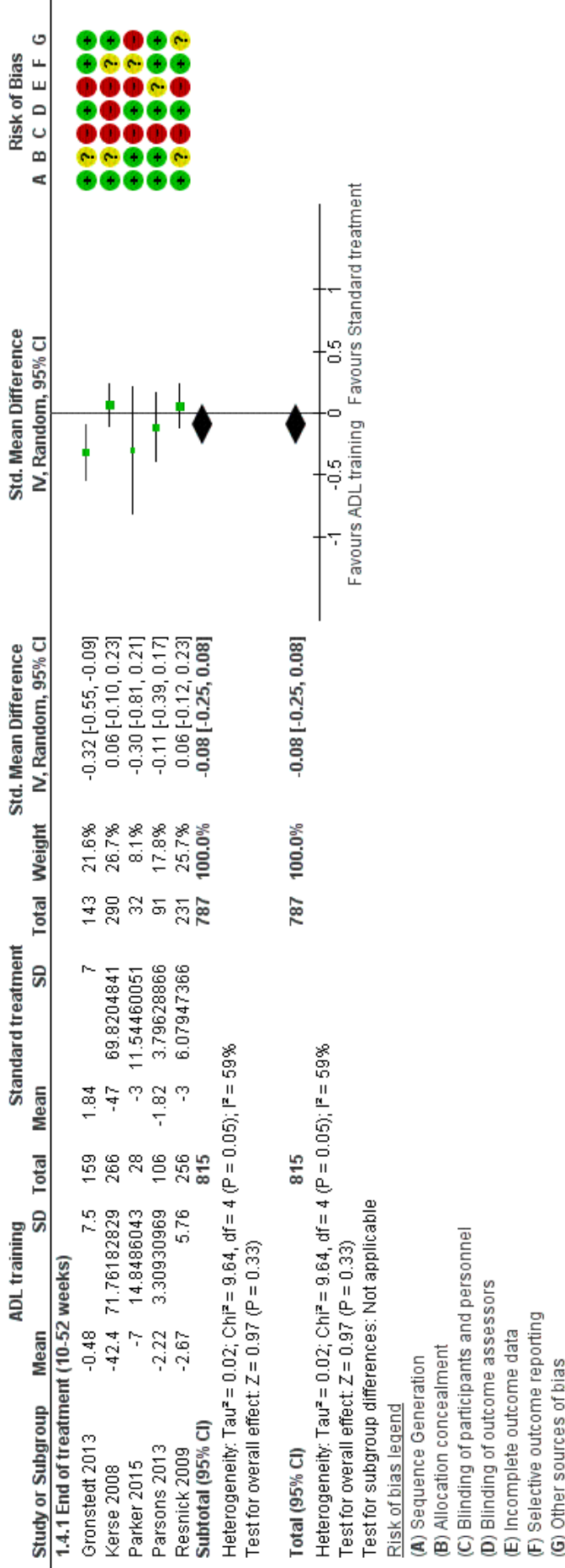
Figures

Figure 1 (Analysis 1.2)



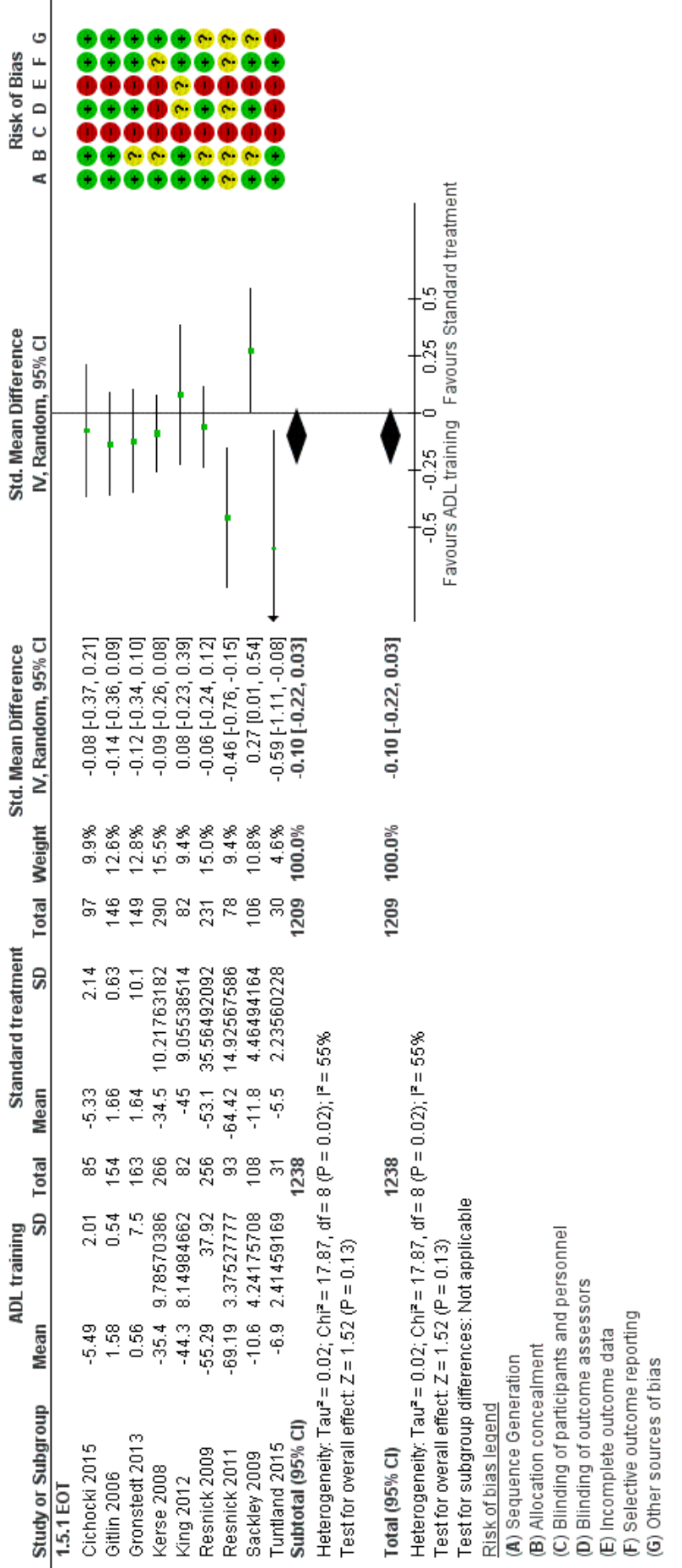
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.3 Mobilitet (Bevægelse og færden) (LF).

Figure 3 (Analysis 1.4)



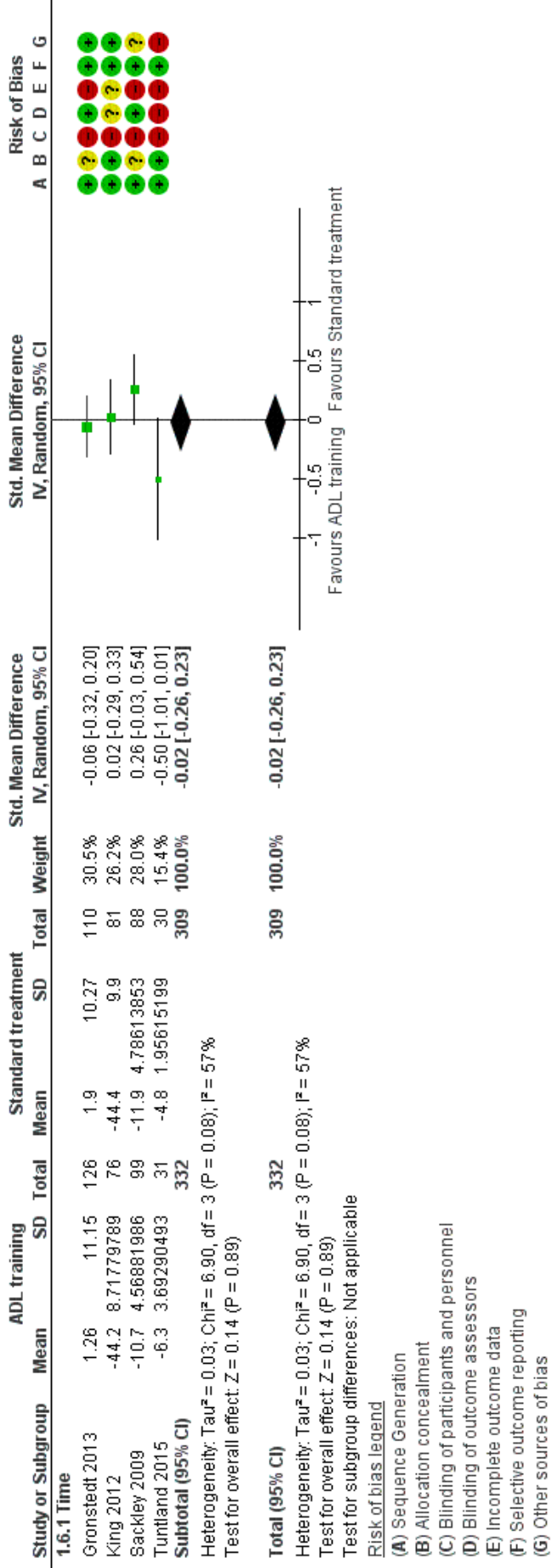
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.4 Balance (EOT).

Figure 4 (Analysis 1.5)



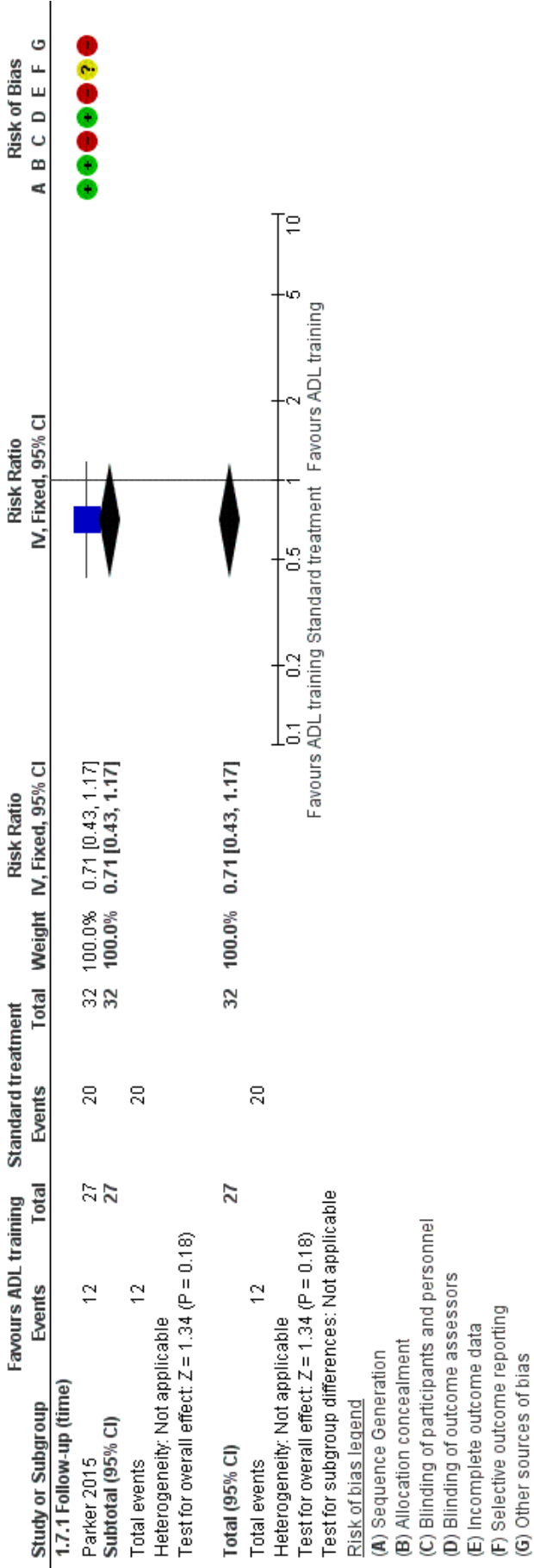
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.5 ADL (inkluderer både ADL og IADL) (EOT).

Figure 5 (Analysis 1.6)



Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.6 ADL (inklusive både ADL og IADL) (LF).

Figure 6 (Analysis 1.7)



Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.7 Forblive i eget hjem (ændring af bopælsstatus) (LF).

Figure 7 (Analysis 1.11)

