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

Review information

Authors

Sundhedsstyrelsen[1]

[1][Empty affiliation]

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Characteristics of studies

Characteristics of included studies

Cichocki 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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 % Control ● *Age (year) median (SD)*: 85.32 (5.11) ● *Gender (% male)*: 13.6

	● *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*: 0 (residential living facilities) ● *Living alone (%)*: NR ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: 0/100 % **Included criteria:** All participants of the study were residents within the partici-pating RAC facilities aged 65+. Persons with no or mild physical and/or cognitive impairment were included. **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%). **Pretreatment:** There were no significant differences concerning age, sex, and form of living (apartment vs nursing ward and intermediate care) between both groups.
Interventions	**Intervention Characteristics** Intervention ● *Description*: 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, sensorimo-tor 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 ● *Duration*: IG took part in weekly exercise, for 60 minutes each week over 20 weeks ● *Dose*: Regarding the needs of residents the program was focused toward low intensity (eg, 20 weekly exercise units) and variety of content ● *Personel*: Trainers were primarily staff members of the RAC provider with experience in PA training for elderly persons; supervi-sors were physical or occupational therapists, who at certain points got practically involved in units with difficult tasks Control ● *Description*: three social animation events with no specific focus on PA or associated skills ● *Duration*: Three sessions over 20 weeks ● *Dose*: three social events ● *Personel*: Not reported
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)*

- **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 (inklusiv 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)

	● **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.
Identification	**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 **Country:** Austria **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 **Comments:** No further comments **Authors name:** Martin Cichocki **Institution:** Ludwig Boltzmann Institute health Promotion research **Email:** cicho@gmx.net **Address:** Ludwig Boltzmann Institute health Promotion research, Untere Donaustrasse 47/3, 1020 Vienna, AustriaTel +43 1 212 1493 10
Notes	*Birgitte GrøNnegåRd Jepsen* on 03/04/2016 18:25 **Select** Måske ??? (I mangel af mere stringente studier???)P: Indbyggere i residential aged care (dvs min. hjælp til IADL) I: 20 sessioner Low Theshold Physical activity... C. 3 sociale arrangementer O: Bedret Eq5 D... *Mette Merete Pedersen* on 20/04/2016 18:55 **Outcomes** 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

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Following a randomly generated list, the coordinators individually and pro-actively invited residents and informed them about the personal relevance of the program."
Allocation concealment	Low risk	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." Judgement Comment: Assessors were blinded to allocation

Blinding of participants and personnel	High risk	Judgement Comment: It is not clearly described if the personel or participants were blind to group however it is in practice very difficult to blind in studies involving an training intrervention
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 interventiongroup. 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	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *Age (year) median (SD)*: 78.5 (5.7) ● *Gender (% male)*: 18.9 ● *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 (%)*: 59.7 ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: N **Included criteria:** All participants were aged 70 and older, cogni-tively 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 peoplewho experienced some difficulty with everyday activitiesbut who were not totally dependent or homebound orreceiving services to address functional problems **Excluded criteria:** Of the 331 personswho received the baseline home interview, 4% (n512)were ineligible based on MMSE scores and were excluded,resulting in a sample of 319 **Pretreatment:** No group differences were found at baseline
Interventions	**Intervention Characteristics** Intervention ● *Description*: Occupational therapists (OTs) initially metwith participants and conducted a semistructured clinicalinterview to identify and prioritize problem areas. For eachtargeted area, an OT observed the participant's perfor-mance for safety, efficiency, and difficulty and presence ofenvironmental barriers. In subsequent sessions, the OT en-gaged the participant in problem solving to identify beha-vioral and environmental contributors to performancedifficulties. Specific strategies were derived and equipmentoptions provided. In the fourth session, the physical ther-apist (PT) provided balance and muscle strengthening andfall-recovery techniques. In the fifth session (telephone), theOT reinforced strategy use, and in the sixth session, the OTreviewed problem solving, refined strategy use, and pro-vided education and resources to address future needs forenvironmental adjustments. Before the sixth contact, the area agency on aging ordered and installed home modifi-cations (grab bars, rails, raised toilet seats), which werepaid for through grant funds.Over the following 6 months, OTs conducted threetelephone calls to reinforce the use of intervention-derivedstrategies and generalize these strategies to new problemareas. A final home visit was conducted to obtain closure.Because of considerable variability in home environ-ments and functional difficulties, specific control-orientedstrategies were individualized to the needs of participants,although the intervention was standardized in that eachparticipant received four treatment components (educationand problem solving; home modification; energy conservingtechniques; and balance, muscle strengthening, and fall-re-covery techniques) for specific targeted functional areas.Although the intervention program was based on tra-ditional occupational and physical therapy techniques,26–28its approach differed from typical home care. First, the in-tervention focused exclusively on the areas participantsthemselves reported as problematic. In traditional homecare, problem areas addressed by health professionals maynot reflect client priorities. Second, interventionists servedas consultants, helped participants solve problems, and of-fered strategy choices, whereas home care is more directiveand prescriptive. Third, the intervention involved coordi-nation between OTs and PTs to achieve an integrated ap-proach, which is not always possible in home care. ● *Duration*: 6-month (four 90-minute visits and one 20-minute telephone contacts from an occupational therapist and one physical therapy visit(90 minutes). Furthermore threee more telephone calls were done over the 6 months ● *Dose*: The 6-month intervention consisted of five occupa-tional therapy contacts (four 90-minute visits and one 20-minute telephone contact) and one physical therapy visit(90 minutes). ● *Personel*: Occupational and physical therapist

	Control ● *Description*: Participants who were assigned to the no-treatmentcontrol group did not receive any intervention contact. A tthe conclusion of the 12-month follow-up interview, con-trol participants were provided educational materials on home safety and safe performance techniques ● *Duration*: 12 months ● *Dose*: No control intervention ● *Personel*: No personel were involved beside the assessors
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **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 dif-ficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty *Mobilitet (Bevægelse og færden) (LF)* ● **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 *Balance (EOT)* ● **Outcome type**: ContinuousOutcome *ADL (inkluderer både ADL og IADL) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Selfreported ADL based on 6 tasks (Likert scale 1-5) ● **Range**: 5-30

	● **Unit of measure**: points ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: ADL Index : An selfreported ADL index was com-puted as mean difficulty across six items (dressing above waist, dressing below waist, grooming, bathing/showering, toiletting and feeding). For each area, participants rated their perceived difficulty in the previous month from 1=no dif-ficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty *ADL (inklusiv både ADL og IADL) (LF)* ● **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 changesvalues between group are reported at 12 months ADL Index : A selfreported ADL index was com-puted as mean difficulty across six items (dressing above waist, dressing below waist, grooming, bathing/showering, toiletting and feeding). For each area, participants rated their perceived difficulty in the previous month from 1=no dif-ficulty to 5=unable to do because of health problems. Highscores indicated greater difficulty *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 ● **Reporting**: Not reported
Identification	**Sponsorship source:** The research reported in this paper was supported by fundsfrom National Institute on Aging Grant R01 AG1368 **Country:** USA **Setting:** Urban community-living older people **Comments:** No comments **Authors name:** Laura N. Gitlin, PhD, **Institution:** Center for Applied Research on Aging and Health andwDepartment of Pharmacology and Experimental Therapeutics, Divisionof Biostatistics, Thomas Jefferson University, Philadelphia, Pennsylvania; and Department of Health Care Sciences **Email:** laura.gitlin@jefferson.edu **Address:** Thomas Jefferson University, 130 S 9th Street, Suite 513, Philadelphia, PA 19130.

Notes	*Birgitte GrøNnegåRd Jepsen* on 03/04/2016 22:37 **Select** P: Ikke geriatrisk målgruppe, men subgruppe af ældre med 1-2 ADL pb men uden hjælpI: 5X ET kontakter over 6 mdr, 1 X Fys *Julie Hansen* on 20/04/2016 20:10 **Outcomes** For LF outcomes (ADL + monility) only the fidderence between goups were reported. OBS!

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 randomi- zed 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 stat- istician (WWH), remained unknown to others. Random- ization lists and four sets of randomization were prepared using double, opaque envelopes. The project director ran- domized each participant within 48 hours from completion of the baseline interview."
Allocation concealment	Low risk	Quote: "Random- ization lists and four sets of randomization were prepared using double, opaque envelopes. The project director ran- domized 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 personel 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 blinden
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 analyzies
Selective outcome reporting	Low risk	Judgement Comment: Protocol: not locatedall relevant outcomes seems reported
Other sources of bias	Low risk	

Gronstedt 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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 **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. **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. **Pretreatment:** 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

	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
Interventions	**Intervention Characteristics** Intervention ● *Description*: 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] ● *Duration*: 10 -13 weeks intervention (93 min/Week) 74/ 100 participants registered ● *Dose*: (93 min/Week) 74/ 100 participants registered ● *Personel*: One physiotherapist and one occupational therapist Control ● *Description*: Ordinary care and treatment ● *Duration*: Not relevant ● *Dose*: Not described ● *Personel*: Not described
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome *Mobilitet (Bevægelse og færden) (EOT)* ● **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 *Mobilitet (Bevægelse og færden) (LF)* ● **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 *Balance (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported

- **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.

ADL (inkluderer både ADL og IADL) (EOT)

- **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

ADL (inklusiv både ADL og IADL) (LF)

- **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.

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

	● **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	**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 Edu-cation at the University College, Sjaelland, and the Health Faculty at the University of Southern Denmark. No conflicts of interest **Country:** Sweden, Norway and Denmark **Setting:** Nursing homes in Sweeden, Norway, Denmark **Comments:** The study was a multicenter randomized, controlled clinical trial with a parallel-group design addressing nursing home resi-dents from city areas in Sweden, Norway and Denmark. Partici-pants from 24 nursing homes (4 Swedish, 9 Norwegian and 11 Danish) in the 3 countries were randomized to either an IG or a CG. **Authors name:** Kerstin Frändin **Institution:** Department of Neurobiology, Care Sciences and Society, Karolinska Institutet **Email:** Kerstin.Frandin@neuro.gu.se **Address:** Sahlgrenska Academy at Göteborg University, Wallinsgatan 6 SE-431 41 Mölndal (Sweden)
Notes	*Birgitte GrøNnegåRd Jepsen* on 03/04/2016 22:53 **Select** 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,

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "After the stratifica- tion, 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 consealment 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 de- scribed under Measurements, and in some cases replaced by me- dian scores [38], as described in a previous article [18]. The inten- tion to treat (ITT) analysis was done by the last value carried for- ward method." Judgement Comment: Reasons for droupouts are shown i 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 Tri- als.gov (identifier: NCT00218842). Downloaded by: Copenhagen University Library" Judgement Comment: The phase II (follow-up study is registered under clinical trials. gov however the description og outcomes is a bit uncleart. Their secondary outcome only involves falls which is not recorded clearly in the study only fall-efficiacy is obtained.
Other sources of bias	Low risk	Judgement Comment: However the intervention has a staff educational part and keeping the intervention confidiential to the staff only in the intervention group is difficult inducing a risk for contamination

Kerse 2008

Methods	**Study design:** Cluster randomized controlled trial **Study grouping:** NA **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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

	● *Housing (rg. residential living, own home) % own home*: 0 ● *Living alone (%)*: NR ● *In risk of falling (yes/no)*: Y ● *Cognitive impairment (yes/no)*: N **Included criteria:** Eligible residents were aged 65 years and over, ableto engagein a conversationabout a goal, rememberthegoal, and participate in a programme to achieve thegoal (a proxy for cognitive state)Elderly people living in low level dependency residen-tial care homes need assistance with most instrumentalactivities of daily living and at least two activities ofdaily living but can usually ambulate to some degreeand feed themselves **Excluded criteria:** We excluded residents who were unable tocommunicate to complete the study measures, hadanxietyas their main diagnosis,were acutely unwell,orwere in a terminal state. **Pretreatment:** Characteristics of residents were mainly evenly balanced between the groups (table 1).
Interventions	**Intervention Characteristics** Intervention ● *Description*: 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 thephysical functions needed to achieve the goal ● *Duration*: 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 ● *Dose*: 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 mont hand 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 ● *Personel*: Gerontology nurse, physiotherapist, occupational therapist, healthcare assistants Control ● *Description*: 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. ● *Duration*: two social wisits over 6 months ● *Dose*: Not relevant ● *Personel*: social science researcher
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **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**: % >= 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 easc measured on time and scored from 0-4 reported as % participants who were able to stand >= 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 soleily. Reported are the disability overeall score which is the best measure for ADL

ADL (inklusiv 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 compaired to the table 2 and 3 (We measured self reported function withthelate

	lifefunctionanddisabilityinstrumentvalidatedfor frail elderly people.25The two main components,the functional and disability components, were admi-nistered at baseline and 12 months'follow-up. Sub-domains included upper extremity function, basiclower extremity function, and advanced lower extre-mity function. The function component was alsoadministered at six months) it seems that the function scale is administratet at EOT and FT however the table show the opposite picture?? Therefore noting is reported at LF *Forblive i eget hjem (ændring af bopælsstatus) (LF)* ● **Outcome type**: DichotomousOutcome *Fald (EOT)* ● **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 *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent
Identification	**Sponsorship source:** New Zealand Health Research Council and AccidentCompensation Corporation. The funders had no involvement in theresearch design or conduct or in interpretation of results **Country:** New Zealand **Setting:** Low level dependency residential care homes **Comments:** No comments **Authors name:** Ngaire Kerse, associate professor **Institution:** Department of General Practiceand Primary Health Care, Schoolof Population Health, University of Auckland **Email:** n.kerse@auckland.ac.nz **Address:** University ofAuckland, Private Bag 92019,Auckland, 1001, New Zealand
Notes	*Birgitte GrøNnegåRd Jepsen* on 04/04/2016 00:26 **Select** P: Residents long term care . "Low level depencies I: Gerontologisk nurce, aktivitetsprogram, goalsettingC: Usual care - 3 sociale besøgO: Late life Disability and function scale, BalanceBør inkluderes *Mette Merete Pedersen* on 20/04/2016 21:55 **Population** Man kan ikke se udfra 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 CI går ned til 5, som er mild impairment. *Mette Merete Pedersen* on 20/04/2016 22:44 **Outcomes**

	Jeg kan kun finde ADL reporteret for patienterne delt på cognitivt besvær og ikke cognitivt besvær, så derfor ikke registreret

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	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
Allocation concealment	Unclear risk	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
Blinding of participants and personnel	High risk	SUPPORTING ANNOTATIONS No annotations COMMENTST here was no blinding of personnel as they were trained in the intervention and difficult to blind the participants
Blinding of outcome assessors	High risk	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, oneIn 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
Incomplete outcome data	High risk	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 flowcharge and there were no diffrences between groups - however analysis are performed as per protocol and not ITT and dropout > 10%

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

King 2012

Methods	**Study design:** Cluster randomized controlled trial **Study grouping:** no further comments **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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) Control ● *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) **Included criteria:** All older people (65+ years) who received assistancefrom the home care agency were eligible for participation. **Excluded criteria:** Older people were excluded if there was an inabil-ity to participate in interviews due to poor health. Poorhealth

	included severe physical or mental health, whichimpeded the older person from being able to answerinterview questions **Pretreatment:** There is a significant difference in the variable living alone with more persons living alone in the intervention group
Interventions	**Intervention Characteristics** Intervention ● *Description*: Restorative home care. Multifaceted intervention promoting independence.restorative care philosophy, enhanced training andsupervision for paid caregivers, care management role,and goal facilitation. In addition, the intervention com-prised an initial in-depth assessment of older people anda support plan incorporating repetitive activities of dailyliving (ADL) exercises for older people which wasdesigned to optimise independence ● *Duration*: Paid caregiver con-tact with older people would range from daily to fort-nightly, as a minimum. The participants were measured at two time points after 4 months corresponding to min. 3 months intervention and 7 month corresponding to 6 months intervention ● *Dose*: The paid caregiver adjusted the dose of the training and progress the exercises ● *Personel*: The paid caregiversundertook two training programs, developed by anexternal Tertiary provider, which were based on a restor-ative care philosophy designed to optimise indepen-dence in older people.The coordinator (experienced registred nurse) provided enhanced supervision for paid caregivers by undertaking compulsory 2 hour fortnightly meetings.Paid caregiver wages were linked to the competenciesachieved through their training Control ● *Description*: The control group continued under the home careagency's usual care service. The older participantswere all existing clients who continued to receive theirusual care from the home care agency. Paid caregiversperformed household activities or personal cares forthe older people based on existing support plans. Sup-port plans were prescriptive and stated whether theolder people required help with various domesticchores (e.g. dusting, vacuuming, washing), andwhether they were independent or dependent withpersonal cares. Paid caregiver contact with older peo-ple would range from daily to fortnightly, as a minimum. ● *Duration*: Home care was administrated after the older persons need for help with practical or personal cares - various duration ● *Dose*: daily - at least fourteetsly visits ● *Personel*: The paid caregiver minimum wage and travelallowances for the control group were matched withthe intervention group. Three coordinators, who werenot health professionals, oversaw all older peoplereceiving usual care within the agency (includingthose not in this trial).
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **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. *Mobilitet (Bevægelse og færden) (LF)*

- **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 (inklusiv 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

	● **Reporting**: Not reported
Identification	**Sponsorship source:** This research was made possible by funding from theUniversity of Auckland Doctoral Scholarship. The fund-ing source had no control over the design or analysis ofthe study, nor any influence on submission for publica-tion **Country:** New Zealand **Setting:** Agency of home care for home dwelling older people **Comments:** **Authors name:** Anna King **Institution:** School of Nursing Faculty of Medical and Health SciencesThe University of Auckland **Email:** a.king@auckland.ac.nz **Address:** Private Bag 92019 Auckland Mail Centre 1142AucklandNew Zealand
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: droup 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 metods 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 Zea- land Clinical Trials Registry (ACTRN12606000256572)." Judgement Comment: All quantitave outcomes are reported.
Other sources of bias	Low risk	Judgement Comment: No further comments

Lewin 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**

Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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 **Included criteria:** Older persons living in Perth suburbs who were referred for home-care servicesover 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 **Excluded criteria:** diagnosis of dementia or other progressive neurological disorders, or receiving palliative care; **Pretreatment:** groups were somewhat different in terms of their characteristics, namely that the HIP group was less likely to have a carerand more likely to livealone.
Interventions	**Intervention Characteristics** Intervention ● *Description*: In brief, the areas of functioning andtypes of interventions that are incorporated into HIPinclude the promotion of active engagement in a rangeof daily living activities using task analysis and redesign,work simplification and assistive technology whereappropriate; strength, balance and endurance pro-grammes for improving or maintaining mobility; chronicdisease self-management; falls prevention strategies;medication, continence and nutrition management;and the improvement or maintenance of

	skin integrity. ● *Duration*: Individuals participate in HIP until they achieve their goals or for up to 12 weeks, whichever occurs first. ● *Dose*: 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 ● *Personel*: Home care service Control ● *Description*: Visit by a care Coordinator. This involved further assessment of individual needs, completion of a care plan and the com-mencement of direct care. The most common care plan included three personal care visits a week to assist withbathing/showering and a fortnightly housecleaning visitthat included heavy laundry ● *Duration*: Not described ● *Dose*: Not described ● *Personel*: Not described
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *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**: Partially reported ● **Notes**: Data are based on a subgroup of around 100 participantens - 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 *ADL (inklusiv både ADL og IADL) (LF)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Notes**: Data are based on a subgroup of around 100 participantens - 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 *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 ● **Reporting**: Not reported
Identification	**Sponsorship source:** This research was funded by an Australian HealthMinisters' Advisory Council priority-driven researchprogramme grant and would not have been possiblewithout the support of WA HACC and Silver Chain'scommitment to delivering evidence-based care **Country:** Australia **Setting:** Community living older refered to home care for personal care **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. **Authors name:** Gill Lewin **Institution:** Centre for Research on Ageing Curtin Health Innovation Research Institute Curtin University, **Email:** G.Lewin@curtin.edu.au **Address:** Curtin University, GPO Box U1987 Perth, WA 6845 Australia
Notes	*Nkr 47 Geria* on 31/05/2016 21:33 **Outcomes** Data kan ikke pooles i en metaanalyse derfor beskrevet narrativt

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." Judgement Comment: However the randomization was broken of the operater in some older persons
Allocation concealment	High risk	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 pre- vent Research Assistants from deducing over the course of the RCT whether the participant was in the interven- tion or in the control group." Judgement Comment: No blinding
Blinding of outcome assessors	High risk	Quote: "tants 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: Droup 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 mini- mised differences between the control and intervention groups was contamination of the intervention. Namely, HIP's development over several years has meant that inde- pendence and re-ablement have been incorporated into Sil- ver 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 indepen- dence, 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: Futhermore the randomization was manipulated

Parker 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *Age (year) median (SD)*: 77.1 (11.2) ● *Gender (% male)*: 34

	● *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 **Included criteria:** Eligibility for an SSR place included admission to thehospital from living independently at home, completion of ahospital care episode, medical stability, and an assessment thatfurther personal care service was required to be provided in residential aged care.14Participants were also assessed as poten-tially benefiting from time to consider care options and additionaltherapeutic services. **Excluded criteria:** No diagnostic groups were excluded, and ageof eligibility was not specified. People with cognitive impairmentwere eligible. Cognitive status of potential participants wasmeasured by assessing health professionals using the Mini-MentalState Examination before referral to the researche **Pretreatment:** The intervention group differs at baseline with clinical relevant lower performance on two outcome measures (DEMMI, BBS)
Interventions	**Intervention Characteristics** Intervention ● *Description*: 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 ● *Duration*: Twice weekly for 30cminutes to practice the FIT, in addition to reassessing weekly and updating the target walking distance and number of sit-to-standexercises Participants were encouraged to practice 4 times daily, in addition to necessary movement such as moving to and from the mealroom ● *Dose*: Progression was done once weekly based on the participants performance based on walking and sit to stand ability ● *Personel*: Physiotherapist to practice standard care and a research assistant to practice the functional exercise program Control ● *Description*: Both groups received individualized standard physiotherapy programs within the SSR dependent on initial physiotherapist assessment findings. Standardphysiotherapy 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 samephysiotherapists, who were encouraged to treat all participantsequally regardless of group ● *Duration*: Standard physiotherapy comprised twice-weekly ● *Dose*: Not described ● *Personel*: 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 (inklusiv 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)*

	● **Outcome type**: AdverseEvent ● **Reporting**: Not reported
Identification	**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.
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

Methods	**Study design:** Cluster randomized controlled trial **Study grouping:** No further comments **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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 **Included criteria:** Community-dwelling people older than 65 years (55y if Ma¨ori orPacific Islander) were eligible for entry into the study if they werenew referrals for home care. The lower age criterion for Ma¨ori andPacific people was in line with the recommendations from theNew Zealand Guidelines Group for assessment of older peoplewith complex needs **Excluded criteria:** (1) severe cogni-tive impairment that may have compromised adherence to theintervention, defined as an Abbreviated Mental Test score43of less than 7/10; and (2) referral for assessment for admission to a resi-dential facility, carer support, or short-term services **Pretreatment:** Differences were observed between the 2 groups in terms ofparticipant characteristics (mean age, sex, ethnicity, living situa-tion) and physical function at baseline (table 1). The effect ofthese differences was controlled for by stepwise development ofthe

	generalized linear mixed model, so that only variables showinga significant effect were included as fixed effects in thefinal model
Interventions	**Intervention Characteristics** Intervention ● *Description*: The study intervention involved a needs assessor who used a goal-setting tool (Towards Achieving Realistic Goals in EldersTool [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 o fdeficit such as falls risk, decreased muscle strength, difficulty withshowering, and other personal cares that may have prevented theolder person from attaining his/her goalBased on the goal ladder,the home care coordinator developed concrete instructions for the home care aide in the form of a support plan.which compriced a detailed list of the tasks to be undertaken. This may have included the use of allied health professionals (occupationaltherapist, physical therapist, speech-language pathologist, dieti-cian) to provide expert guidance in the tasks required to attaina participant's goals. ● *Duration*: Individual according to the aim not reported ● *Dose*: Individual not reported ● *Personel*: e use of allied health professionals (occupationaltherapist, physical therapist, speech-language pathologist, dieti-cian) to provide expert guidance in the tasks required to attaina participant's goal Control ● *Description*: The usual care process used the SNA tool undertaken bya needs assessor randomly assigned to the usual care group. Aftercompletion of the SNA tool, the needs assessor worked with theparticipant to identify the services that would be provided and howmany hours were required. This information was passed to thehome care provider contracted to deliver services. The home careorganization then prepared a support plan to meet the identifiedneeds of the older person ● *Duration*: Individual according to the aim not reported ● *Dose*: Individual not reported ● *Personel*: e use of allied health professionals (occupationaltherapist, physical therapist, speech-language pathologist, dieti-cian) to provide expert guidance in the tasks required to attaina participant's goal
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **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 meanSE, (95% confidence interval), or as otherwise indicated.*Modeling included ethnicity, perceived relationship between Needs Assessment Service Coordination and home care, Emotional Supporte Seeking Scale (a component of the Proactive Coping Inventory), and the number of hours of home-based support allocated by Needs Assessment Service CoordinationN is not described in table 2 - therefore n from fig 1 is used *Mobilitet (Bevægelse og færden) (LF)*

	● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Balance (EOT)* ● **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 Supporte 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 *ADL (inkluderer både ADL og IADL) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *ADL (inklusiv 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 *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Not reported
Identification	**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 **Country:** New Zealand **Setting:** Community dwelling people over 65 with new referral for home care **Comments:** Only estimates based on an adjusted linear regression analysis are available **Authors name:** John Geoffrey Morgan Parsons **Institution:** School of Nursing, Faculty of Medical and Health Sciences, The University of Auckland, **Email:** j.parsons@auckland.ac.nz

	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.
Notes	*Mette Merete Pedersen* on 06/06/2016 22:18 **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?

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 cor- responded to the number and full-time equivalent of care coor- dination 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 inter- vention. 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 organi- zations 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 organi- zations 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."
Blinding of outcome assessors	Low risk	Quote: "Assessments were completed by experienced researchers blinded to group allocation." Judgement Comment: No further comments
Incomplete outcome data	Unclear risk	Judgement Comment: Droup outs were low less than 10 % and equally distributed between groups, however it is unclear how the missing values were treated in analysis
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

Other sources of bias	Low risk	

Peri 2008

Methods	**Study design:** Cluster randomized controlled trial **Study grouping:** NR **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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 **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 controlgroup by the toss of a coin performed by an independent researcher [17]. All residents in each wing were then offeredparticipation. ... 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,

	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
Interventions	**Intervention Characteristics** Intervention ● *Description*: The intervention was an activity programme developedby a trained gerontology research nurse and delivered by usual caregivers. The activities weredesigned 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 monthlyat a staff meeting attended by the research staff, health careassistants and nurse manager. Goals were modified or resetby the resident, if requested, following the review meeting ● *Duration*: two times daily for 12 weeks and follow up 6 months ● *Dose*: Activity programme on daily basis ● *Personel*: Gerontology nurse and health care staff Control ● *Description*: Residents received usual care and were offered theopportunity at the conclusion of the trial to participatein the goal setting physical activity intervention. ● *Duration*: Not relevant ● *Dose*: Not relevant ● *Personel*: Not relevant
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **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 whar is reported Means with (SD) or (SE) *Mobilitet (Bevægelse og færden) (LF)* ● **Outcome type**: ContinuousOutcome ● **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) *Balance (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported

	ADL (inkluderer både ADL og IADL) (EOT) ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *ADL (inklusiv 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 ● **Scale**: self- reported ● **Direction**: Lower is better ● **Notes**: self-reported sustaining at least one fall over the intervention period *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Not reported
Identification	**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 **Country:** New Zealand **Setting:** Five low-level dependency residential care homes in Auckland, New Zealand **Comments:** No further comments **Authors name:** Katrhyn Peri **Institution:** School of Nursing, University of Auckland, Auckland, New Zealand **Email:** k.peri@auckland.ac.nz **Address:** Not reported
Notes	

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	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *Age (year) median (SD)*: 83.9 (8.3) ● *Gender (% male)*: 16.9 ● *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 **Included criteria:** Residentswere eligible to participate in the study if they were aged 65and older, had a Mini-Mental State Examination (MMSE)56score of 11 or greater, had a life expectancy oflonger than 6 months, and were not receiving skilled reha-bilitation services. Participants completed their own con-sent if they qualified according to the Evaluation to SignConsent Questionnaire.57If they were unable to consent,the resident signed an assent to participate, and the proxywas contacted to provide consent **Excluded criteria:** No further information than what is described in the inclusion criteria **Pretreatment:** No group differences besides differences in ethnicity
Interventions	**Intervention Characteristics** Intervention ● *Description*: Educational component: All NAs were invited to attend a 6-week in-service programprovided by an advanced practice nurse. The treatment sites wereprovided with a research restorative care nurse (RCN) WHO worked in the treatment facility for 20 hours a week overthe 12-month study period. the RCN worked with theNAs to develop short- and long-term goals for the residents(e. g., what the resident was expected to do with regard to allADLs); reviewed the NAs documentation of restorativecare activities on each of the consented residents; served asan interface between NAs and the nurses, residents, families, and administrators with regard to restorative care ac-tivities; and provided ongoing encouragement and supportto the NAs related to implementation of restorative care activities. ● *Duration*: Daily for 12 month. 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 Documen-tation flowsheets. ● *Dose*: Restorative care provided daily by NAs, based on70 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). ● *Personel*: NA's (nursing assistants) + 1 advanced practice nurse. Control ● *Description*: Usual care and NHs randomized to control were provided with a sin-gle 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.he control site did not receive any information about restorative care, and they were not pro-vided with a RCN ● *Duration*: Not relevant ● *Dose*: Not described ● *Personel*: 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 provid-ing care to residents was used *ADL (inklusiv 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

	Serious adverse events (EOT) ● **Outcome type**: AdverseEvent ● **Reporting**: Not reported
Identification	**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 andsafety monitoring board, as appropriate for a fundingagency. **Country:** USA **Setting:** Twelve nursing homes in Maryland **Comments:** No further comments **Authors name:** Barbara Resnick **Institution:** University of Maryland School of Nursin **Email:** barbresnick@aol.com **Address:** 655 WestLombard Street, Baltimore, MD 21201
Notes	*Pia RavnsbæK BjæRge* on 30/03/2016 21:53 **Select** Plejehjemsbeboere

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 methodds 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

Methods	**Study design:** Cluster randomized controlled trial **Study grouping:** NA **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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 Control ● *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 **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 least11 on the Mini-Mental State Examination (MMSE) **Excluded criteria:** Residents were excluded from the study if they had a lifeexpectancy of less than 6 months (documented by theresident's primary healthcare provider). If residents did no tpass the Evaluation to Sign Consent they were asked to sign an assent to participate, and a proxy was contactedto complete the consent process **Pretreatment:** There is no descriptive data available in tabel form for control or Intervention group the baseline data are shown toghether for the two groups. Therefore baseline characteristics for both groups are shown below the intervention coloum. Differences in baseline values were shortly described in the statistical paragraph: There were significant differences betweenthe groups of residents at

	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
Interventions	**Intervention Characteristics** Intervention ● *Description*: A research Function Focused-Care Nurse (FFCN) coordi-nated and implemented FFC-AL with support from aninterdisciplinary research team. The FFCN was a registerednurse who worked with the intervention sites 15 hours perweek for the first 6 months of the intervention, 8 hoursper week for the next 3 months, and 4 hours per week forthe final 3 months of the intervention. To assure sustain-ability of the FFC philosophy, each treatment site identifieda staff champion who worked with the FFCN to learn howto maintain FFC over time. The identified champion ineach site was a licensed practical nurse. Working with thechampion, the FFCN implemented the four components of FFC-AL ● *Duration*: daily for 12 months ● *Dose*: Not described ● *Personel*: Direct care workers (DCWs) - A research Function Focused-Care Nurse (FFCN) - Aninterdisciplinary research team Control ● *Description*: AL communities randomized to control received FFC-ED only. All staff in these communities were invited toattend an educational session on FFC. The education mate-rials and length of the educational session was identical tothat provided to the treatment group, with the exclusionof motivational techniques to engage residents in func-tional and physical activity. ● *Duration*: Not releant ● *Dose*: Not releant ● *Personel*: Direct care workers (DCWs)
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Scale**: Walking 50 yards (subelement of Bartel Index) ● **Range**: 0-15 ● **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**: Not reported *ADL (inkluderer både ADL og IADL) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported

	● **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 *ADL (inklusiv 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**: Nursing home residents *Fald (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Fully reported *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Not reported ● **Notes**: Different adverse event is reported in table 4 however they are not caused by the intervention
Identification	**Sponsorship source:** This research was supported by the Robert WoodJohnson Foundation through the Interdisciplinary NursingQuality Research Initiative Grant Program. **Country:** USA **Setting:** Four assisted living facilities (AL) facilities with at least 100 beds. **Comments:** NA **Authors name:** Barbara Resnick and Sonya Ziporkin Gershowitz **Institution:** University of Maryland School o fNursing, **Email:** resnick@son.umaryland.edu **Address:** 655 West Lombard Street, Baltimore, MD 21201
Notes	*Pia RavnsbæK BjæRge* on 30/03/2016 22:37 **Select** Er i tvivl om interventionen kan sidestilles med hverdagstræning...Desuden er målgruppen både ældre + 65 og medarbejdere...

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Unclear risk	Quote: "AL communities randomized" Judgement Comment: Methods for sequence generation not described
Allocation concealment	Unclear risk	Judgement Comment: Methods for allocarion consealment 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 especialy we do not know anythin about randomization, health care workers and possible contamination of thise

Sackley 2009

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:** YES
Participants	**Baseline Characteristics** Intervention ● *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 recidential homes) ● *Living alone (%)*: NR ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: Y

	Control ● *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 recidential homes) ● *Living alone (%)*: NR ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: Y **Included criteria:** Participants from residental homes housing more than 5 beds, and provided the categories 'physicl disability' and 'older people', that cared for residents with limitations and were dependent in ADL, all located in Birmingham, UK. **Excluded criteria:** Residents who scored below 5 or over 16 on theBarthel index were excluded from the study on thebasis that the intervention would be considered toointense or insufficient for their needs, respectively.Residents who were admitted to hospital with acute ill-ness and those admitted to the care home for end of lifecare were also excluded. **Pretreatment:** the goups seem alike. Only a bit of difference troke aphasic depression questionnaire score and more seems emotionelt distressed in the intervention group ((n, %); 56(44)) than in the control group (40(33))
Interventions	**Intervention Characteristics** Intervention ● *Description*: Physiotherapy was aimed at enhancing mobility and the ability toperform activities of daily living independently, andaddressed components such as strength, flexibility,balance, and exercise tolerance. In addition, functionaltasks such as bed to chair transfers, sit to stand, andwalking or wheeling were practised.The occupational therapy intervention was devel-oped using the consensus of an occupational therapysteering group (as described by Sackley et al).26Ther-apy was targeted towards improving independence inpersonal activities of daily living such as feeding, dres-sing, toileting, bathing, and transferring (for example,from bed to chair)The intervention arm also included an interventiondelivered to the care home staff.27This involved aprogramme of staff training to provide practice in subsequently recruited between June 2004 and June2005 in three phases to spread both therapist and asses-sor 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, andduration of both physiotherapy and occupational ther-apy were dependent on the goals agreed by the indivi-dual participant and the therapists and on progressthroughout the interventio ● *Personel*: Physiotherapist (PT) and occupational therapist (OT) Control ● *Description*: Residents in care homes allocated to the control armcontinued to receive standard care equal to thatreceived before recruitment to the trial. Occupationaltherapy was not used routinely by any of the homesand physiotherapy was accessed only via general prac-titioner referral. None of the homes had an identifiedperson with specific responsibility for mobility, train-ing for activities of daily living, or the provision ofadaptive equipment. The control group received thetherapy 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 (inklusiv både ADL og IADL) (LF)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Barthel Index

	● **Range**: 0-20 ● **Unit of measure**: Points ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: 6 month follow-up *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 *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Not reported
Identification	**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 **Country:** UK **Setting:** Birmingham CityCouncil social services **Comments:** Trial registration ISRCTN79859980 **Authors name:** Catherine M Sackley **Institution:** School of Health and PopulationSciences, Primary Care Clinical Sciences, University of Birmingham, Edgbaston,Birmingham B15 2TT **Email:** t.j.hoppitt@bham.ac.uk **Address:** University ofBirmingham, Edgbaston, Birmingham B15 2TT
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	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention ● *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

	● *Living alone (%)*: 68% ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: NR Control ● *Age (year) median (SD)*: 78.1 (9.8) ● *Gender (% male)*: 36.7 ● *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 ● *Living alone (%)*: 87% ● *In risk of falling (yes/no)*: NR ● *Cognitive impairment (yes/no)*: NR **Included criteria:** People applying for, or referred to, home-based serviceswere potential participants for the study based on theirself-reported activity limitations. Some of the participantshad been hospitalised due to an acute illness, while otherswere recruited after having gradually developed functionaldecline not needing hospitalisation or institution-basedtreatment. We included home-dwelling persons over theage of 18 years, who lived in the municipality, were able tounderstand Norwegian, and had a functional decline inone or more daily activities **Excluded criteria:** We excluded people if theywere in need of institution-based rehabilitation or anursing home placement, were terminally ill, or weremoderately or severely cognitively reduced (subjectivelyassessed by health-care providers based on observationand communication **Pretreatment:** No baseline differences
Interventions	**Intervention Characteristics** Intervention ● *Description*: the intervention consisted of both general andindividual features. Among the general features was amaximum rehabilitation period of 3 months. Further, aspart of baseline assessments, the occupational therapistand physical therapist used the COPM to identify activ-ity 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 inthe daily training. The focus was on stimulating the par-ticipants to perform the daily activities themselves, ra-ther than letting others do it for them. Among theindividual features were training in daily activities, adap-tations to the environment or the activity, and exerciseprograms ● *Duration*: maximum rehabilitation period of 3 months. (Average 10 weeks mean 2.1 hour per week) ● *Dose*: Individual dependend of specific need and goals and not described ● *Personel*: occupational therapistand physical therapist used the COPM to identify activitylimitations perceived as important by the participant.Thereafter, this information was used to develop a rehabilitationplan. The therapists supervised the homecarepersonnel, some of whom had no formal education(assistants), in how to encourage and assist the person inthe daily training. Control ● *Description*: Usual care was chosen as the comparator, as this is theconventional treatment offered to homebound personsin most

	municipalities in Norway. For most participants,usual care meant receiving the compensating help theyapplied for, in terms of personal or practical assistance,safety alarm, meals on wheels, or assistive technology.However, for a few participants, it comprised rehabilita-tion assisted by an occupational therapist (n= 1) and/orphysical therapist (n= 5) based on the participants'ownefforts. Hence, the usual care was also diverse. ● *Duration*: Usualcare was not time-limited, and persisted after the 3months intervention period if needed. (Mean 1.7 hour per week for 12 weeks) ● *Dose*: Individual dependend of specific need and goals and not described ● *Personel*: Care professinals
Outcomes	*Vægt (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Mobilitet (Bevægelse og færden) (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Timed up and go ● **Unit of measure**: seconds ● **Direction**: Lower is better ● **Data value**: Endpoint *Mobilitet (Bevægelse og færden) (LF)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Timed up and go ● **Unit of measure**: seconds ● **Direction**: Lower is better ● **Data value**: Endpoint *Balance (EOT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *ADL (inkluderer både ADL og IADL) (EOT)* ● **Outcome type**: ContinuousOutcome ● **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 perforamnce and activity satisfaction. activity performance is used in the meta analysis *ADL (inklusiv både ADL og IADL) (LF)*

	● **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 perforamnce and activity satisfaction. activity performance is used in the meta analysis *Forblive i eget hjem (ændring af bopælsstatus) (LF)* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Not reported *Fald (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Partially reported ● **Notes**: Reported in text *Serious adverse events (EOT)* ● **Outcome type**: AdverseEvent ● **Reporting**: Partially reported ● **Notes**: Reprted in text no adverse events related to treatment occured during the data colection period
Identification	**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. **Country:** Norway **Setting:** Community **Comments:** The study have inclusion criteria that recruit persons if they are + 18 years of age and receive home care. We desided to include this study in the meta analysis as 95% of the persons in this study> 60 years of age (Table I) **Authors name:** Hanne Tuntland **Institution:** Department of Global Public Health and Primary Care, University of Bergen **Email:** Hanne.Kristin.Tuntland@hib.no **Address:** University of Bergen, Faculty of Medicine and Dentistry, P.O. Box 7804, 5018 Bergen, Norway
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 contamin- ation from the intervention arm of the study to the con- trol arm. Due to problems with recruitment in a sparsely inhabited municipality, the intervention was imple- mented 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 ex- perimental and control interventions, however to differ- ent participants. Also, the significantly higher amount of co-interventions in terms of outpatient physiotherapy re- ceived by participants in the control group during the first 3 months might have had an impact." Judgement Comment: No further comments

Footnotes

References to studies

Included studies

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Cichocki M.; Quehenberger V.; Zeiler M.; Adamcik T.; Manousek M.; Stamm T.; Krajic K.. Effectiveness of a low-threshold physical activity intervention in residential aged care - results of a randomized controlled trial. Clinical Interventions in Aging 2015;10(Web Page):885-895. [DOI:]

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Gronstedt 2013

Frandin,K.; Gronstedt,H.; Helbostad,J. L.; Bergland,A.; Andresen,M.; Puggaard,L.; Harms-Ringdahl,K.; Granbo,R.; Hellstrom,K.. Long-Term Effects of Individually Tailored Physical Training and Activity on Physical Function, Well-Being and Cognition in Scandinavian Nursing Home Residents: A Randomized Controlled Trial. Gerontology 2016;(Journal Article). [DOI: 000443611 [pii]]

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Parsons,J. G.; Sheridan,N.; Rouse,P.; Robinson,E.; Connolly,M.. A randomized controlled trial to determine the effect of a model of restorative home care on physical function and social support among older people. Archives of Physical Medicine and Rehabilitation 2013;94(6):1015-1022. [DOI: 10.1016/j.apmr.2013.02.003 [doi]]

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Peri,Kathryn; Kerse,Ngaire; Robinson,Elizabeth; Parsons,Matthew; Parsons,John; Latham,N.. Does functionally based activity make a difference to health status and mobility? A randomised controlled trial in residential care facilities (The Promoting Independent Living Study; PILS). Age and Ageing 2008;37(1):57-63. [DOI:]

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Resnick,Barbara; Gruber-Baldini,Ann; Zimmerman,Sheryl; Galik,Elizabeth; Pretzer-Aboff,Ingrid; Russ,Karin; Hebel,J. R.. Nursing home resident outcomes from the Res-Care intervention. Journal of the American Geriatrics Society 2009;57(7):1156-65. [DOI:]

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Data and analyses

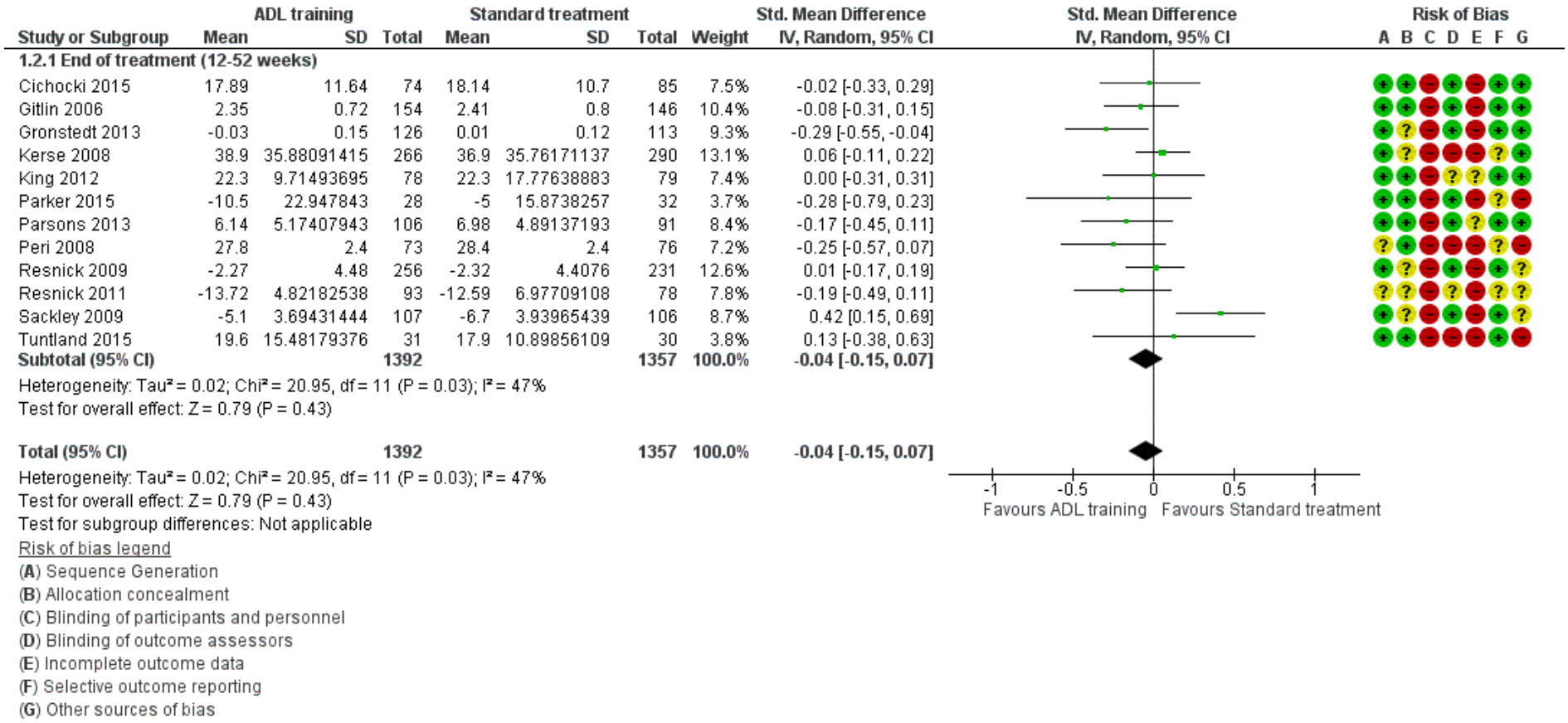
1 ADL training vs Standard treatment

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 (inklusiv 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 (Non-event) (IV, Fixed, 95% CI)	1.48 [0.85, 2.59]
1.7.1 Follow-up (time)	1	59	Risk Ratio (Non-event) (IV, Fixed, 95% CI)	1.48 [0.85, 2.59]
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]

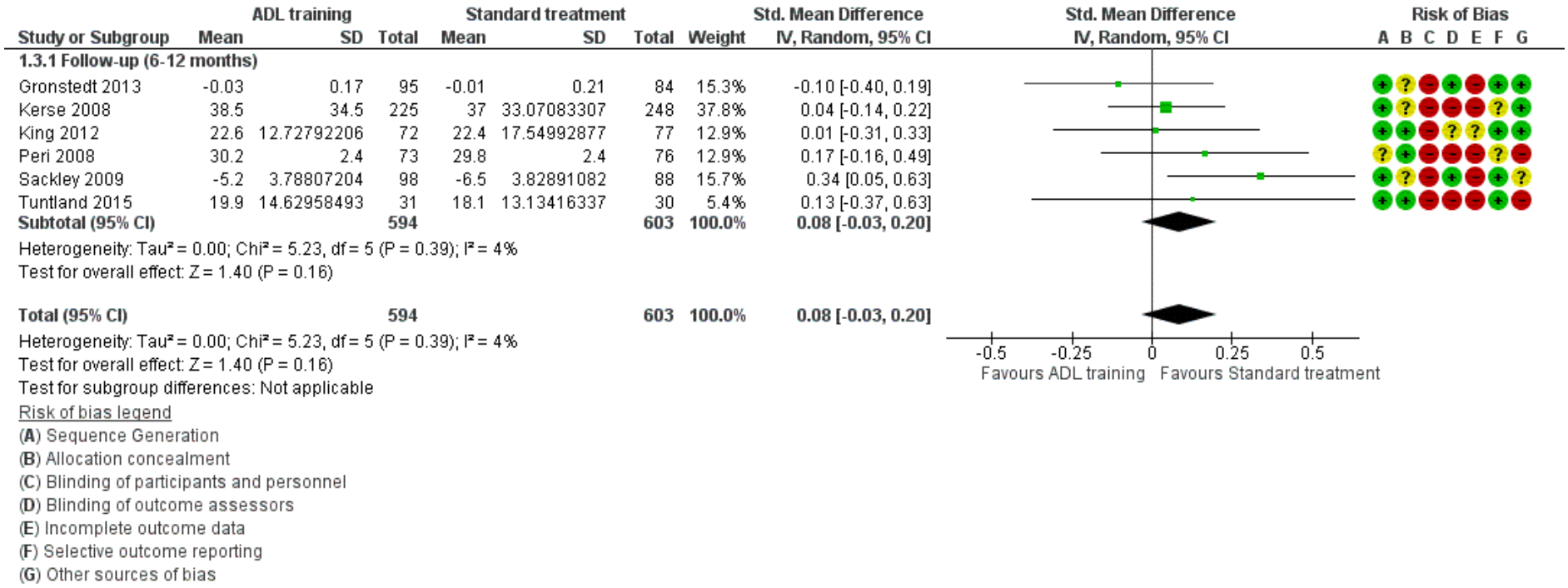
Figures

Figure 1 (Analysis 1.2)



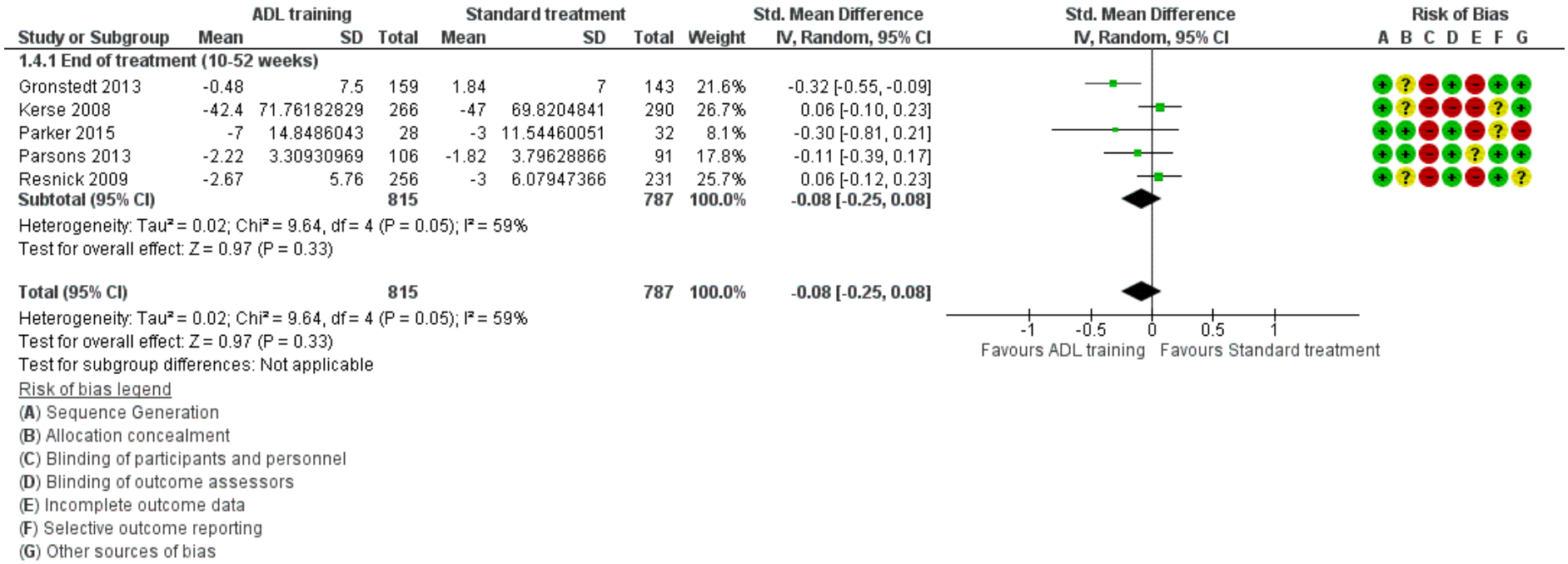
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.2 Mobilitet (Bevægelse og færden) (EOT).

Figure 2 (Analysis 1.3)



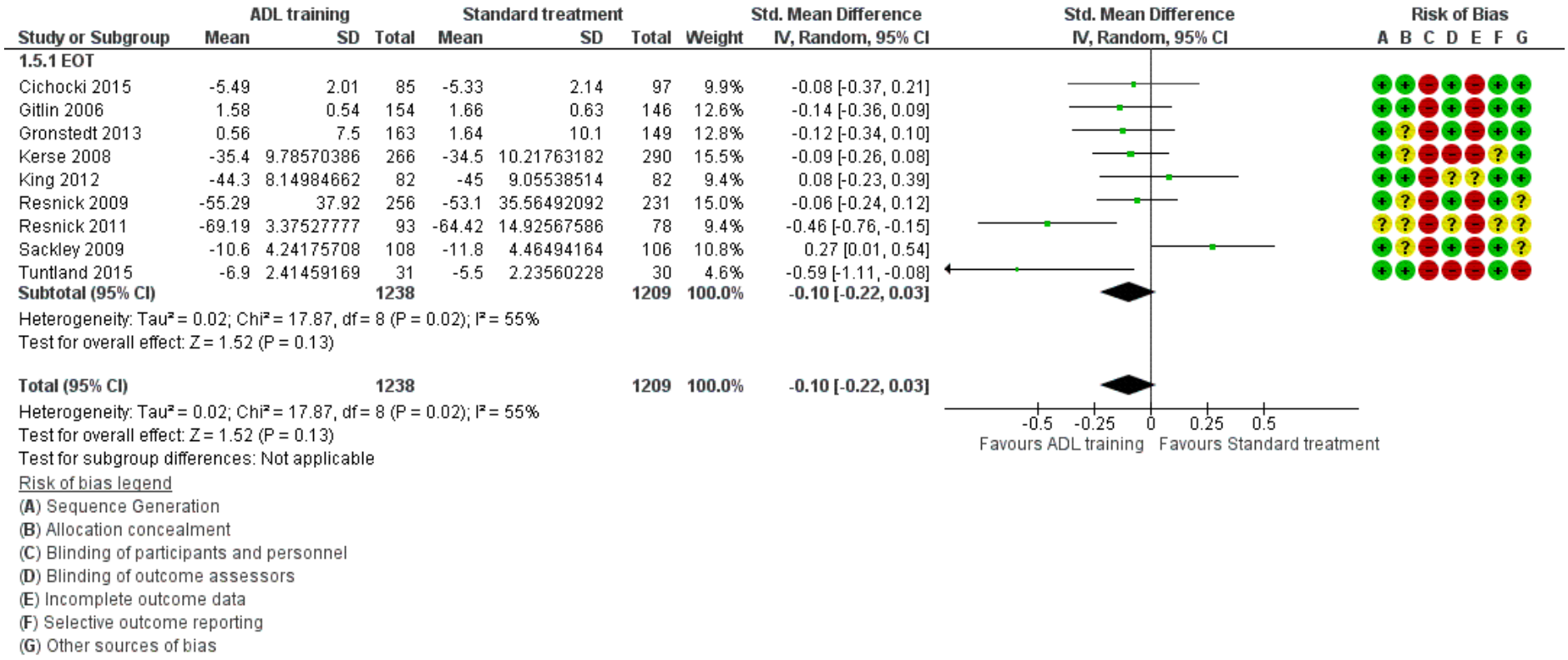
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.3 Mobilitet (Bevægelse og færden) (LF).

Figure 3 (Analysis 1.4)



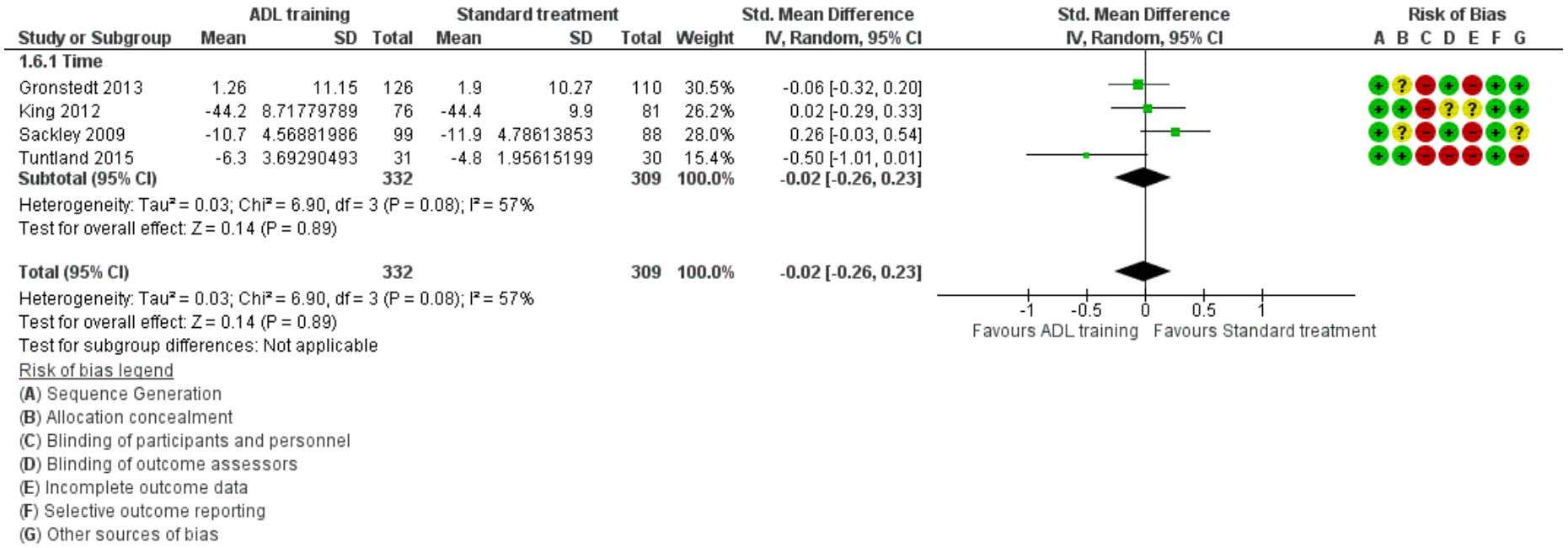
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.4 Balance (EOT).

Figure 4 (Analysis 1.5)



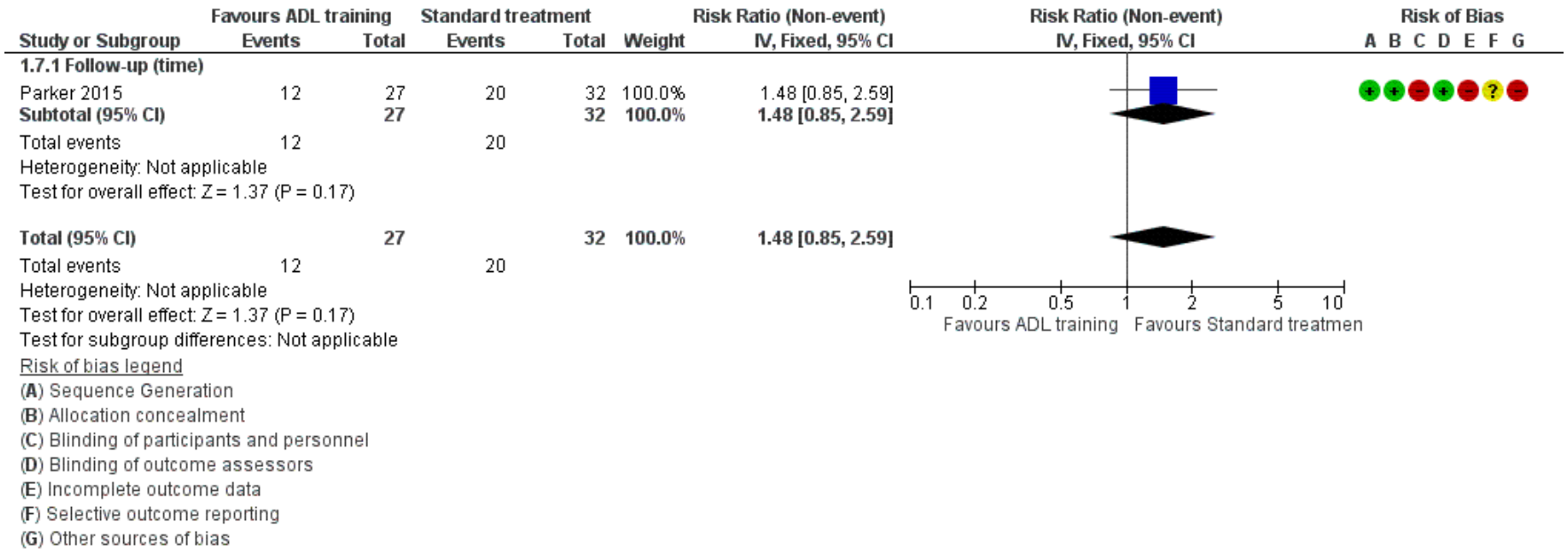
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.5 ADL (inkluderer både ADL og IADL) (EOT).

Figure 5 (Analysis 1.6)



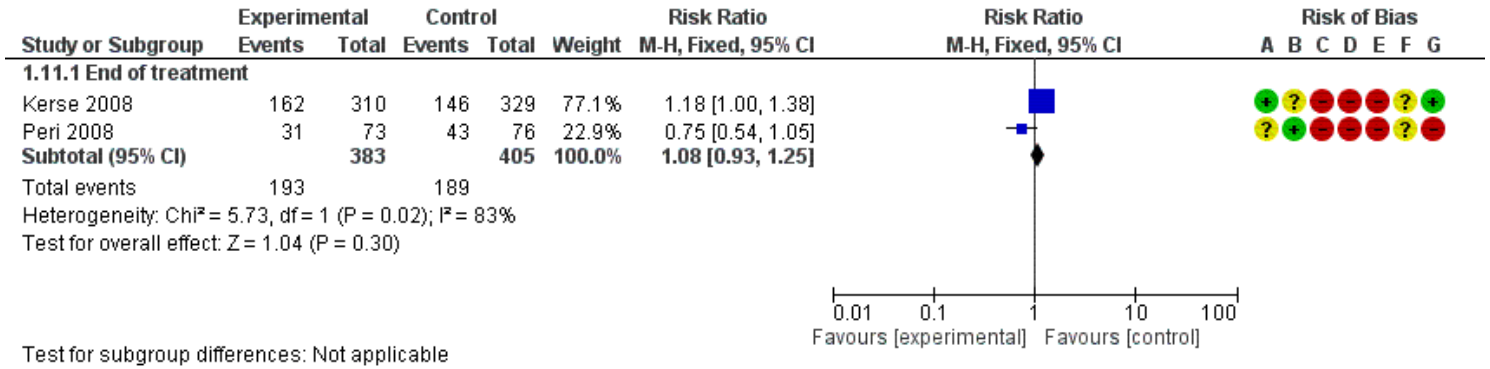
Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.6 ADL (inklusiv både ADL og IADL) (LF).

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)



Test for subgroup differences: Not applicable

Risk of bias legend

(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

Forest plot of comparison: 1 ADL training vs Standard treatment, outcome: 1.11 Fald (Falls).