STATENS BEREDNING FÖR MEDICINSK OCH SOCIAL UTVÄRDERING

Appendix to report:

Assessment and interventions in care and services for older adults

Tables of studies with low or moderate risk of bias

Table 1 Main characteristics of included systematic reviews with High or Moderate study quality

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
Abbott et al 2013 UK [1]	**Moderate** **SBU domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To determine the effectiveness of mealtime interventions for the elderly living in residential care, and where possible, determine which types of mealtime intervention were more effective.	**Inclusion criteria**: Studies of the following design were included: (cluster) randomized controlled trials (RCTs), non-RCTs, studies with before and after designs, including time-series studies, and case-control studies. Residents in residential nursing homes or care homes. Residents needed to be aged 65 years and older. Mealtime interventions were considered as those	**Number of studies**: 36 **Study design:** RCTs (n=10), crossover studies (n=6), pre-post or time series studies (n=13), non-RCTs (n=3), and case-control design (n=3). **Population**: Residents in residential nursing homes or care homes. **Number of participants**: 7 to 1726 participants	The need to improve the nutrition of the elderly living in long term care has long been recognized. Individual studies within this review have shown there are simple components of everyday practice within the care home setting that can be altered to improve nutritional care. Large scale multi-center pragmatic trials are however still required to establish the full efficacy of such interventions and cost implications.

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			which aimed to improve the mealtime routine, experience or environment. Interventions were included if they directly or indirectly provided: assistance and encouragement with eating, a more stimulating environment to eat, increased access to food, more choice of food or more appealing (visual, sensory) food. Nutrition education or train-ing interventions that were specific to mealtime care for residential elderly were also included. Studies had to report on at least one nutritional outcome. Nutritional out-comes were either those directly related to food intake (energy intake, macronutrient intake, percentage food intake) or those used in clinical practice to assess nutritional status: nutritional status assessment tool (e.g. Mini Nutritional Assessment [MNA) tool) weight, weight status (e.g. BMI), body compo-sition (e.g. mid-upper arm circumference,	**Country of origin:** USA 16, Sweden 5, Holland 5, Canada 4, UK 2, and 1 each from Finland, France and Taiwan. **Setting:** Residential care, i. e., nursing homes or care homes. **Interventions:** The interventions were varied in length, ranging from a couple of days through to one year and could be broadly categorised into five types: food improvement (n =4), food service (n =8), staff training (n = 6), feeding assistance (n = 4), a combination of food service and staff training (n = 2), combination of feeding assistance and food service (n = 2), and dining environment (n = 11) **Outcomes**: Food service Food improvement	Meta-analysis found inconsistent evidence of effects on body weight of changes to food service (0.5kg; 95% Cl: -1.1 to 2.2; p=0.51), food improvement interventions (0.4 kg; 95% Cl: -0.8 to 1.7; p = 0.50) or alterations to dining environment (1.5 kg; 95% Cl: -0.7 to 2.8; p = 0. 23). Findings from observational studies within these intervention types were mixed, but generally positive. Observational studies also found positive effects on food/ caloric intake across all intervention types, though meta-analyses of randomized studies showed little evidence of any effects on food/caloric intake in food improvement studies (-5kcal; 95% Cl: -36 to 26; p=0.74). There was some evidence of an effect on daily energy intakes within dining environment studies (181 kcal/day, 95% Cl: -5 to 367, p =0 .06).

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			Jean body mass), biochemical indices (e.g. serum haemoglobin, albumin), and func-tional status (e.g. hand-grip). Data on dietary satisfaction and quality of life, where measured, were also outcomes of interest. **Literature search**: 2012	Dining environment Staff training Feeding assistance **Follow-up time:** 2 days to 2 years	
Ayalon et al 2016 Israel [2]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt, både ordinärt och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To provide a systematic review and meta-analysis of the entire field of elder maltreatment interventions	**Inclusion criteria:** Intervention studies written in English **Literature search:** December 2014	**Number of studies:** 24 **Study design:** RCT, pre-post, quasi experimental **Population:** Older persons with dementia, staff, informal caregivers **Number of participants** 55 up to a couple of thousand older persons **Country of origin:** USA, Canada, Japan, Taiwan, Hongkong, Iran, UK, Germany, Netherlands, Norway, Sweden	The most effective place to intervene at the present time is by directly targeting physical restrain by long-term care paid carers. Specific areas that are still lacking evidence at the present time are interventions that target (i) elder neglect, (ii) public awareness, (iii) older adults who experience maltreatment, (iv) professionals responsible for preventing maltreatment,(v) family caregivers who abuse and (vi) carers who abuse.

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				Setting Nursing home, hospital, geriatric clinic, community **Interventions:** a) designed to improve the ability of professionals to detect or stop elder maltreatment *(n* = 2), b) interventions that target older adults who experience elder maltreatment *(n* = 3) and c) interventions that target caregivers who maltreat older adults **Outcomes:** Abuse, maltreatment, psychological outcome, elder speak, physical restraint **Follow-up time:** No information	
Baker et al 2016 Australia [3]	**High** **SBU Domain(s):** Insatser avseende våld (Interventions addressing abuse and neglect)	To assess the effectiveness of primary, secondary and tertiary intervention programs utilized to reduce or prevent, or both, elderly abuse in organisational, institutional and/or community settings (i.e.	**Inclusion criteria**: Studies: Randomised controlled studies (RCTs) comparing the use of strategies for the prevention and reduction of recurrent elder abuse with a minimum follow-up of 12 weeks in community	**Number of studies**: 7 **Study design:** RCT and non-randomized studies	There is inadequate trustworthy evidence to assess the effects of elder abuse interventions on occurrence or recurrence of abuse, although there is some evidence to suggest it may change the combined measure of

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	Quantitative	their own or someone else's home). We sought to identify and report on adverse consequences or effects of the intervention/s in the review. Second, to investigate whether the intervention's effects are modified by types of abuse, types of participants, setting of intervention, or cognitive status of the elderly.	dwelling and institutionally cared for elderly persons. **Intervention:** Education programs to reduce factors influencing elder abuse Specific policies on elder abuse Legislation on elder abuse Programs to increase detection rate for prevention of elder abuse Programs targeted to victims of elder abuse. Rehabilitation programs for perpetrators of elder abuse **Outcomes:** A primary outcome is any measure of rates of elder abuse in either communities or institutions. Secondary outcomes: Participant-related outcomes such as: • increase in awareness regarding elder abuse; • improvement in attitude towards elder abuse; • improvement in skills towards handling elder abuse • increase in detection • increase in elderly independent living.	**Population**: Residents, staff, family members **Number of participants**: 1924 elderly participants and 740 people (such as carers or nursing home staff) with whom they interact. **Country of origin**: USA, Taiwan, UK **Setting**: Home, community, institutions **Interventions:** Educational Interventions targeted at health professionals and/or carers Programs to reduce factors influencing elder abuse Programs to increase detection Programs targeted to victims **Outcomes**: changes in knowledge and attitudes, with very few measuring the	anxiety and depression of caregivers. There is a need for high quality trials, including from low- or middle-income countries, with adequate statistical power and appropriate study characteristics to determine whether specific intervention programs, and which components of these programs, are effective in preventing or reducing abuse episodes among the elderly. It is uncertain whether the use of educational interventions improves knowledge and attitude of caregivers, and whether such programs also reduce occurrence of abuse, thus future research is warranted. In addition, all future research should include a component of cost-effectiveness analysis, implementation assessment and equity considerations of the specific interventions under review.

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			Victim or perpetrator-related outcomes which include: • improvement in crisis management and relocation of the victims • improvement in conflict resolution and management of the perpetrators. We reported any adverse outcomes from interventions **Literature search:** March 2016	occurrence or reoccurrence of abuse. **Follow-up time:** 1 week to 24 months	
Bleakley et al 2015 UK [4]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To systematically review the evidence base and examine the physical and cognitive effects of physically based interactive computer games (ICG) in an older adult population. We also consider how it affects user's compliance, enjoyment, and safety during exercise.	**Inclusion criteria:** Studies must have used an ICG intervention on older adults (aged >65 years). ICG was defined as any kind of computer game or virtual reality technique where the participant could interact with virtual objects in a computer-based environment. The participants' interaction must have involved at least one of the following physical components: aerobic, strength, balance, or flexibility. Studies using ICG for specific rehabilitation after injury were excluded.	**Number of studies** 12 **Study design:** Observational (n=5) Controlled trial (n=2) RCT (n=5) **Population:** 65 years or older. In three studies participants were 80+ years. Gender not completely stated **Number of participants:** Sample sizes: 6–40.	There is preliminary evidence that ICG is a safe and effective exercise intervention for an older population and may be associated with a range of physical and cognitive benefits. Future ICG interventions should be tailored toward older people, and should aim to optimize motivation, enjoyment, and safety within this population. Study methodology should incorporate randomized, parallel group designs with lower risk of

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			We were primarily interested in outcomes relating to physical or cognitive functioning. Secondary outcomes were compliance, enjoyment, and adverse events. Case reports or small case series (n < 3) were excluded but there were no other restrictions placed on study design. **Literature search:** June 30, 2011.	**Country of origin:** Not stated, but one study was Swedish **Setting:** Community living mainly, but also residential settings **Interventions:** ICG: any kind of computer game or virtual reality technique where the participant could interact with virtual objects in a computer-based environment; the participants' interaction must involve at least one of the physical components: aerobic, strength, balance, or flexibility. **Outcomes:** Physical or cognitive functioning, secondary outcomes included adverse effects, compliance, and enjoyment. **Follow-up time:** 4-36 weeks	selection, detection, and attrition bias.

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Bøttcher Berthelsen et al 2015 Denmark & Sweden [5]	**Moderate** **SBU Domain(s):** Anhörigstöd och familjeorienterat arbete (Support to informal carers) **Quantitative**	To investigate and describe the content, dissemination and effects of case management interventions for informal caregivers of older adults, focusing on outcomes related to patients' activities of daily living, nutrition assessment, pain measurement, depression, length of stay and to caregivers' satisfaction and difficulties.	**Inclusion criteria:** Case management, Functional status, GRADE, Informal caregivers, Intervention Older adults, Satisfaction, Systematic review. **Literature search:** September 2013.	**Number of studies:** 7 studies (5 RCT). **Study design:** Quasiexperimental design. **Population:** Over 65 years old Caregivers to persons with dementia (n=5 489). I: n = 2 839, mean age: 63.3–64 years. C: n = 2 655, mean age: 62.5–64 years. 45 dyads of patients undergoing coronary artery graft surgery (mean age: 60.2 years) and their family members (mean age:54.2 years). I: n=22 dyads C: n=23 dyads. 100 persons with dementia living at home with primary support from informal caregiver and their primary informal caregiver I: n = 53, mean age: 64.8 years	Research of case management interventions for informal caregivers is very limited. This review identifies knowledge about case management as an intervention for what is already known about this topic. Active involvement of informal caregivers in the care and treatment of their older family members can provide an enhanced effect of treatment and well-being for the patient. Only a few studies include support and education for relatives through a family-oriented approach, even though relatives are needed in older patients' care trajectories. Case management interventions have been applied with success to patients in complex settings with significant effects on patients' quality of life, depression, mobility and length of stay. What this paper adds knowledge for clinical practice of the importance of involving informal caregivers

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				C: n = 47, mean age: 63.3 years. Dyads of patients with dementia, n=362 I: mean age 76.7–78 years C: mean age 76.3 years and their informal caregivers: I: mean age: 66.1–76 years C: mean age: 63.1 years I: n = 195 dyads; C: n = 167 dyads. Dyads of persons with early symptoms of dementia n=99, mean age 82.1years and their primary informal caregiver (mean age 63.6). I: n = 54 dyads C: n = 45 dyads. **Number of participants**: 6 956 **Country of origin:** USA (n=4), Finland (n=2), Netherlands (n=1).	through case management to improve patients' time to institutionalisation and municipal care costs. Importance of prioritising further research regarding specific case management interventions to informal caregivers to patients without dementia.

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				Setting: Community care-based settings in the participants' homes **Interventions:** -Case management. -Psycho-educational intervention of progressive Lowered Stress Threshold (PLST). -12 week family focused intervention programme by a research assistant for both patient and family member. -Nurse case management support programme during a maximum of 24 months by a dementia family care coordinator to both patient and informal caregiver. -12 months case management by district nurses to both patients and their informal caregivers. **Outcomes:** Outcomes related to patients' activities of daily living, nutrition assessment, pain measurement,	

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				depression, length of stay, and to caregivers' satisfaction and difficulties. **Follow-up time:** 3- 36 months. 3-4 days post-surgery and 2-12 weeks post discharge.	
Bradshaw et al 2012 UK [6]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats (Institutional care as an intervention) **Qualitative**	To produce a systematic review of qualitative studies that have examined residents' views of QoL. Specifically, it aims to identify and summarise the factors that positively influence care home life, and provide an evidence base of practical recommendations to improve QoL	**Inclusion criteria**: • English language studies of mixed methodology but including qualitative research methods as described below. •The views of residents in a care home. Care home refers to nursing and residential homes. Accommodation described as community villages, supported living or respite stays were excluded. • Studies had to examine factors that contribute to care home life. **Literature search**: Variations from April 2009 to January 2011.	**Number of studies**: 31 (29 about older adults). **Study design:** Qualitative synthesis from thematic analysis and meta-ethnographic rnethods. **Population**: Residents in care homes **Number of participants**: 1.223 participants aged from 20 to 100. **Country of origin:** Canada, USA, Taiwan, Hongkong, Netherlands, Iceland, UK. **Setting:** Care home	This is the first systematic thematic review consolidating the views of people in care homes. For good QoL in care homes, there needs to be an understanding of the residents' attitudes towards living there, and how factors within the care borne impact upon their attitude. This echoes quantitative research where psychological functioning and social support were most strongly correlated to resident satisfaction. Care homes need to make allowances to the care borne environment to more closely align with residents' personal preferences and meanings, e.g. match compatibility of roommates to promote

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				Interventions: Not applicable **Outcomes**: Four key themes were identified: (i) acceptance and adaptation, (ii) connectedness with others, (iii) a homelike environment, (iv) caring practices. **Follow-up time:** Not clear	meaningful engagement. Care staff providing both practical and emotional support can enhance residents' QoL. Organizational policies need to support this by maintaining continuity of care and less rigid time schedules and routines. Capabilities of residents must be promoted and valued, to redefine the care borne as one that promotes choice, not one that simply takes it away.
Brownie et al 2013 Australia [7]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser och arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To evaluate the impact of person-centered care approaches on residents and staff in residential aged-care facilities.	**Inclusion criteria**: Study design: experimental design studies, including pre-post-test design studies with or without a control group or randomized trials. **Intervention:** Person-centered approaches to residential aged care, including interventions focused on enhancing residents' autonomy, choice, sense of personal control, independence and interactions with residents and staff. Key phrases in studies that reflect the objectives of these	**Number of studies**: 7 **Study design:** Quasi-experimental research design (n=6), cluster-randomised, cluster randomized controlled trial (n=1) **Population**: Residents and staff **Number of participants**: 13-289 older adults + staff	The movement away from an institutional mode of care to one that accepts person-centered care as the guiding standard of practice is part of a culture change that is impacting the provision of aged-care services around the world. Forming accurate conclusions about the impact of person-centered interventions on residents and staffs hampered by the heterogeneity of the interventions and significant methodological

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			interventions included person centered care, patient-centered care, quality of life, quality of health care, individuality in old age, satisfaction with care, and organizational culture. Subjects and setting, ie, residents in a long-term aged-care facility (nursing home) and/or nursing staff. **Literature search**: October 2012	**Country of origin:** USA, Australia, Netherlands **Setting:** Long term care **Interventions:** - environmental enhancement (eg, plants and animals) - opportunities for social stimulation and fulfilling relationships - continuity of resident care by assigning residents to the same care staff changes in management and leadership approaches (often devolved), with the introduction of democratized approaches to decision-making that involve residents and staff - changes to staffing models focused on staff empowerment - individualized (rather than institutionalized) humanistic philosophy of care. **Outcomes**: Functional status, resident views of	differences between studies. Person-centered interventions are associated with positive influences on staff outcomes (satisfaction and capacity to provide individualized care); improvement in the psychological status of residents (lower rates of boredom and feelings of helplessness); and reduced levels of agitation in residents with dementia. It appears that some person-centered interventions might be associated with an increased risk of falls in aged-care residents.

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				satisfaction, QoL, organizational change etc. **Follow-up time:** Unclear	
Bunn et al 2015 UK [8]	**Moderate** **SBU Domain:** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To assess the effectiveness of interventions and environmental factors to increase fluid intake or hydration status in older people living in long-term care.	**Inclusion criteria** Intervention and observational studies involving older people (≥65 years) living in residential, long-term nursing care, or specialist dementia units (together called long-term care facilities), who could drink orally. Studies examined an association between the intervention, or modifiable exposure, and hydration status and/or fluid intake (primary outcomes). Secondary outcomes with a likely link to dehydration (such as constipation, falls, urinary and upper respiratory tract infections, or death) were noted where a primary outcome was described. **Literature search** September 30, 2013	**Number of studies:** 23 **Study design:** RCT, CCT, pre-post, cross sectional **Population:** Mean age 75-92,3 years **Number of participants:** 3-2128 **Country of origin:** United States 10, Canada 3, UK 2, Ireland, Germany, Japan and Taiwan 1 each. **Setting:** Long term care, nursing home **Interventions:** Multicomponent strategies on fluid intake or dehydration. Components included greater choice and availability of beverages, increased	Although this review has been unable to demonstrate the effectiveness of many strategies because of the high risk of bias, our findings indicate that further investigations into dehydration prevention should be undertaken at the resident, institutional, and national policy levels. Further investigations of promising interventions at the resident and institutional levels, using high-quality adequately powered RCTs with valid outcome measures, are required. We were particularly concerned about the lack of interventions to identify and target personal barriers to drinking, thus promoting person-centered care. Although blinding at the level of intervention delivery is challenging, improved study designs, perhaps

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				staff awareness, and increased staff assistance with drinking and toileting. Modifications to the dining environment, advice to residents, presentation of beverages, and mode of delivery (straw vs beaker; pre thickened drinks vs those thickened at the bedside). **Outcomes:** Dehydration status and fluid intake. Secondary outcomes with a likely link to dehydration (such as constipation, falls, urinary and upper respiratory tract infections, or death). **Follow-up time** Unclear	involving 3 arms ("usual care," intervention, and modified intervention) and more rigorous blinding of personnel at the different stages (random sequence generation, allocation, outcome assessment, and statistical analysis) may resolve some of the biases identified in this review. Further, robust cohort studies investigating the effects of national policies, home ownership, staffing levels, and training are required. Adequate research support has been recognized as a key challenge in developing high-quality research in nursing homes,37 but this is what is required to improve fluid intake and hydration status in older care home residents.
Carrion et al 2013 Spain [9]	**Moderate** **SBU Domain(s):** Effekten av vissa hjälpmedel inom kommunikation och kognitiv förmåga. (Effects from	To review existing scientific evidence on interventions included in the category of cognition-oriented approaches when treating people suffering from dementia. This category includes both reality orientation	**Inclusion criteria**: Articles that reported on intervention studies regarding cognition-oriented care approaches for dementia in older people diagnosed as having Alzheimer's disease or probable Alzheimer's	**Number of studies**: 17 **Study design:** RCTs **Population**: Older people diagnosed as having Alzheimer's	We conclude that stimulation of cognitive functions, especially by means of reality orientation, improve overall cognitive function (measured by the MMSE or ADAS-Cog) in patients suffering from

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	communication and cognitive devices) **Quantitative**	and skills training interventions.	disease. Only randomized controlled trials (RCTs) or controlled clinical trials were eligible. **Literature search**: April 2010	disease or probable Alzheimer's disease **Number of participants**: 11-201 **Country of origin:** USA, Great Britain, Italy, Germany **Setting:** Participants were recruited from day centers and residential homes **Interventions:** *Reality Orientation Interventions:* Presentation and repetition of orientation information with the purpose of providing the patients with a better understanding of their surroundings. (During the session, the therapist repeatedly presents basic personal and current information to each patient beginning with the patient's name, where he or she is and the date. When the patient	dementia. Although the reviewed papers included patients with Alzheimer's or probable Alzheimer's disease, stimulation of cognitive functions may apply to dementia in general. Higher-quality trials are warranted in order to confirm these findings. Multicenter and large-sample trials may improve evidence regarding the effects of cognitive interventions on patients suffering from dementia.

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				has relearned these basic facts, others are presented such as age, hometown and former occupation). *Skills training:* computer activities, mixture of activities, some of which were computer cognitive training activities, organizing stimulus items into meaningful categories, organizing ideas and details for remembering everyday text-based information, visualizing and associating items to be remembered, lists of words to be remembered, using an agenda and a calendar and training in daily living activities. **Outcomes**: Cognition, Memory, Visual memory, Verbal memory Fluency, Problem solving, ADL, language etc.	

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				Follow-up time: Not stated	
Chen et al 2016 Hong Kong & Switzerland [10]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande metoder och arbetssätt – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Qualitative and quantitative**	To explore the effects of Information Communication Technology (ICT) interventions, on reducing social isolation of the elderly	**Inclusion criteria:** (1) publications must be in English; (2) studies must empirically investigate the effects of ICTs on one or more attributes of social isolation among the elderly; and (3) study participants must be aged 55 years or older. **Literature search:** July 2015	**Number of studies:** 25 **Study design:** RCT (6 studies); another 6, were cohort studies (2 with a control group and 4 without, 4 were cross-sectional studies (surveys) and 14 were qualitative studies. **Number of participants:** 8-5203 **Characteristics of participants:** 55–99 years (average age ranged from 66 years (SD not given) to 83 years). In most studies, mostly females. **Setting:** regular living environments of the participants, including private housing (n=13), assisted and independent living communities (n=2), congregate housing sites (n=1), retirement villages (n=2), nursing	More well-designed studies that contain a minimum risk of research bias are needed to draw conclusions on the effectiveness of ICT interventions for elderly people in reducing their perceived social isolation as a multi-dimensional concept. The results of this review suggest that ICT could be an effective tool to tackle social isolation among the elderly. However, it is not suitable for every senior alike. Future research should identify who among elderly people can most benefit from ICT use in reducing social isolation. Research on other types of ICT (eg, mobile phone–based instant messaging apps) should be conducted to promote understanding and practice of ICT-based social-isolation interventions for elderly people.

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				homes (n=4), day care centers (n=1), and no specifics on where they resided (n=2). **Country of origin:** USA (n=9), Australia (n=2), Canada (n=1), Finland and Slovenia (n=1), Israel (n=2), The Netherlands (n=3), New Zealand (n=2), Norway (n=1), Sweden (n=1), Taiwan (n=2), United Kingdom (n=1) **Interventions:** ICT interventions (e.g., mobile phone–based instant messaging apps). **Outcomes:** Social isolation or did so by looking at its effect on 1 or more of the 7 single attributes of social isolation: loneliness, social support, social contact, number of confidants, social connectedness/social connectivity, social networks, and social well-being.	

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				Follow-up time Unclear	
Chin et al 2007 China [11]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser – särskilt boende och ordinärt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To examine the clinical effect of reminiscence therapy on the life satisfaction, happiness, depression, and self-esteem of older adults aged 50 or above	**Inclusion criteria:** All controlled trials, before 200I, investigating the effect of reminiscence therapy on life satisfaction, happiness, self-esteem and depression in older adults were included in this review. The trials are eligible: (I) if they were of pre-post-test design; (2) if there were at least two groups, one received reminiscence therapy whereas the other received no treatment (except baseline treat-ment, e.g. basic nursing care for nursing home subjects); and (3) if each comparison group consisted of at least five subjects in post-test. Participants are older adults of age 50 years or above. The types of reminiscence intervention were those aligned with the definition provided by Haight & Burnside (1993). The intervention should also have been conducted in the	**Number of studies:** 15 **Study design:** Randomized or controlled trials **Number of participants:** 424 (range 24-43) **Characteristics of participants:** Twelve studies >60% female subjects, Mean age 65.6 – 86.0 years. **Setting:** Residential care and community subject. **Country of origin:** Not stated. **Interventions:** 4-20 sessions, sometimes with audio, visual or real objects. **Outcomes:** Life satisfaction, happiness, depression and self-esteem. **Follow-up time:**	This review shows that reminiscence therapy has beneficial effects on the happiness and depression of older adults, but its effects on life-satisfaction and self-esteem are not significant. However, due to the limited number of included studies, the small sample size of the trials, the possible play of publication bias, language bias and Hawthorne effect, a convincing conclusion on the clinical effects of reminiscence therapy on life satisfaction, happiness, depression and self-esteem of older adults cannot be drawn at this stage. A more comprehensive search to identify eligible studies would surely contribute to future systematic reviews.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			format of discussion or interview. Outcomes were those relating to reminiscence therapy in terms of life satisfaction, happiness, self-esteem and depression. The outcomes should have been measured by validated assessment tools. **Literature search** 2001	Not stated	
Choi et al 2012 South Korea [12]	**Moderate** **SBU Domain(s)** Upprätthållande och stimulerande arbetssätt - både ordinärt och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To examine the effectiveness of computer and Internet interventions in reducing loneliness and depression among older adults, through a meta-analysis.	**Inclusion criteria:** Older adults living in either communities or facilities as the target population. An intervention that involved computer or Internet use, and measuring the psychosocial outcomes (i.e., levels of loneliness and depression) of interest. **Literature search:** July 2012	**Number of studies:** 6 **Study design:** 4 RCT, 2 quasi-experimental studies **Number of participants:** 373 **Characteristics of participants:** Mean age: 73 – 82,6 years **Setting:** Community or residential care	Computer and Internet interventions were effective in decreasing loneliness, but not depression. Cur-rently, many older adults have the opportunity to use various devices besides a personal computer, such as tablet PCs or smart-devices. In the near future, these devices may play a key role in providing older adults with social networks so that they stay connected with the wider world and obtain new information that has a beneficial effect on their psycho-social wellbeing.

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				Country of origin: Israel, Netherlands and USA **Interventions:** All interventions included both computer and Internet training, and 4 studies provided computers as well to the older adults, duration 3-36 months **Outcomes:** Depression Loneliness **Follow-up time:** Baseline and 3-36 months	Thus, web pages and applications for tablet PCs and smart-devices that older adults find more usable should be developed. In further studies, the effectiveness of these newly developed devices on psychosocial problems should be investigated.
Chuanmei You et al 2012 Australia [13]	**Moderate** **SBU Domain(s):** Integrerade insatser eller aktiviteter, samverkan och informations-överföring (Integrated measures or activities) **Quantitative**	To summarise the evidence for the effects of case management in community aged care on client and carer outcomes.	**Inclusion criteria**: No restriction on date; English language; only involving community-dwelling frail older people (suffering from age-related health problems, such as functional disabilities and dementia) and/or carers; case management interventions (excluding disease management programs that target older adults with specific chronic diseases, and specific preventive measures, such as in-home visit); care	**Number of studies**: 15 **Study design:** RCT (n=10), quasi-experimental study design (n=4), retrospective cohort (n=1) **Population**: Persons aged 65 or more; carers. **Number of participants**: 60 to 8095	Available evidence in this review showed that case management in community aged care interventions can improve client psychological health or well-being and unmet service needs. In contrast, the effects of the interventions on client mortality, functional status, medical conditions, behavioral problems and satisfaction with care services, as well as carer outcomes as

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			setting limited to community aged care (excluding the other community based care settings, such as primary care, community mental health, etc.); case management as an independent intervention (rather than as a small component of a multi-faceted intervention or an integrated care delivery system/model); published in refereed journals or publications of equivalent standard; RCTs or comparative observational studies; and evaluating client and/or carer outcomes. **Literature search**: 2011	**Country of origin:** USA, Hongkong, England, Finland, Italy and Israel. **Setting:** Community aged care. **Interventions:** Needs identification and assessment, care plan development, home visits, phone contacts, face-to-face contacts, periodic reassessment & care system coordination. **Outcomes**: Client outcomes included mortality/ survival days, physical or cognitive functioning, medical conditions, psychiatric symptoms and associated behavioral problems, unmet service needs, psychological health or well-being (related to self-perceived health status, such as depression, stress, anxiety, life satisfaction etc.), and satisfaction	noted by this review are less conclusive. Future studies should investigate what specific components of case management are crucial in achieving improved outcomes for the client and their carer. In addition, undertaking evaluation studies by employing rigorous study designs are warranted. This review provided largely consistent evidence that case management interventions improve older clients' psychological health or well-being and also deliver significant improvements in unmet service needs. Clear effects of the interventions on other client outcomes and carer outcomes are not so evident, with mixed evidence for the other outcome variables reviewed here. We found that studies reported inconsistent results regarding client physical

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				with care. Carer outcomes included stress or burden, psychological health or well-being, satisfaction with care, and social consequences (such as social support, and relationships with care clients—getting on well or not). **Follow-up time** Between 6-36 months, but not specified for all studies.	or cognitive functioning and carer stress or burden. There was also limited evidence supporting that case management in community aged care interventions improve client length of survival, health conditions, behavioral problems or satisfaction with care, as well as carer satisfaction with care, psychological health or well-being and social consequences.
Chuanmei You et al 2013 Australia [14]	**Moderate** **SBU Domain(s):** Integrerade insatser, samverkan och informationsöverföring. (Integrated measures or activities) **Quantitative**	To evaluate the effects of case management in community aged care (CMCAC) interventions on service use and costs.	**Inclusion criteria**: We included RCTs and observational comparative studies that examined the effects of CMCAC on service use and/or costs. Only studies in English language and also published in refereed journals or publications of equivalent standard were included. **Literature search**: July 2011	**Number of studies**: 21 **Study design:** RCT (n=16) and observational studies (n=5) **Population**: Participants in the studies reviewed were community dwelling frail elderly (people aged 65 and older who suffer from age-related health problems such as functional disabilities and cognitive problems	In the future, more research related to the use of case management services, informal care, and various other social and health care relevant to the frail elderly is warranted. Cost studies with a societal perspective are recommended, and where possible full economic evaluation can be explored to uncover robust economic impacts of CMCAC interventions. Based on available studies, we found that there is **Moderate**

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				Number of participants: 60 – 8 095. **Setting:** Community aged care. **Country of origin**: Fourteen studies were based in the United States, 2 in Finland, and 1, respectively, in Canada, China Hongkong, England, Israel, and Italy. **Interventions:** Independent case management interventions specifically applied in the community aged care setting. Studies involving more than one or multifaceted identifiable core case management functions, such as assessment, care planning, care coordination, monitoring, and so on were of particular interest. CMCAC Interventions were rnainly provided by nursing and/or social worker case managers.	evidence supporting the conclusion that CMCAC interventions can significantly improve clients' use of some community care services (greater likelihood, higher intensity, higher frequency, and earlier use). We also found moderate evidence in regard to improving the use of case management services, delaying nursing home placement, reducing nursing home admission, and shortening the length of nursing home stay due to CMCAC interventions. In contrast, we did not find evidence showing that CMCAC interventions can significantly influence clients' use of hospital care and other medical services. We did not find evidence indicating that CMCAC interventions could significantly change costs either.

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				Case man-agers' caseload size varied from 15 to more than 100. The intervention aims were generally divided into client goals (such as improving quality of life), organizational goals (such as controlling cost), and system goals (such as improving system integration). **Outcomes:** 1. Nursing home care use: nursing home admission, delay of nursing home placement, and length of nursing home stay; 2. Formal community care use: the timing, likelihood, frequency, and intensity of using case management services (also known as indirect community care that includes assessment, care planning, etc.), and various direct community care services, such as home nursing and personal care.	

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				3. Informal care use: the timing, likelihood, frequency, and intensity of receiving assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) from carers, such as family members, friends, and neighbors 4. Health care use: hospital admission and length of hospital stay, and the timing, likelihood, frequency, and intensity of using other medical services such as ED visits and physician services 5. Costs: service costs, start-up costs of CMCAC programs, intervention costs, and other related costs. **Follow-up time** Unclear	
Clegg et al 2015 UK [15]	**Moderate** **SBU Domain(s):** Behovsbedömning och uppföljning. (Needs assessment and follow-up: older persons).	To investigate the diagnostic test accuracy (DTA) of simple instruments for identifying frailty in community-dwelling older people.	**Inclusion criteria:** Prospective studies assessing the DTA of one or more simple instruments for identifying frailty in community-dwelling older people (index tests) against a reference standard were considered for inclusion.	**Number of studies:** 3 **Study design:** Prospective studies. **Number of participants:**	Slow gait speed, PRISMA 7 and TUGT all have high sensitivity but limited specificity as simple instruments for identifying frailty. This means that there are many false-positive test results which limit their

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	Quantitative		**Literature search:** January 1990 to October 2013	3261 (summarised in Supplementary data). **Characteristics of participants:** Community-dwelling older people, defined for this review as a mean age in the study population of 65 years and over. The reported mean age in study participants was 74.7 years (range: 70.0–78.6 years), 47.5% were male. **Setting:** Community-dwelling older people **Country of origin:** UK **Interventions:** 7 simple instruments for identifying frailty: Gait speed PRISMA 7 Timed-up-and-go test Self-rated health General Practitioner assessment Polypharmacy Groningen Frailty Indicator.	DTA. Use of these tools in older populations with higher baseline prevalence of frailty is likely to improve test accuracy. Use of a simple instrument with a high sensitivity followed by either a reference standard test or second simple instrument in a two-step approach to diagnosis would potentially improve accuracy but requires further investigation.

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				Outcomes: Identifying frailty (loss of resources in several domains of functioning (physical, psychological, social), increasing the risk of adverse outcomes. **Follow-up time:** Unclear	
Cochrane et al 2016 Ireland [16]	**High** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To assess the effects of time-limited home-care reablement services (up to 12 weeks) for maintaining and improving the functional independence of older adults (aged 65 years or more) when compared to usual home-care or wait-list control group.	**Inclusion criteria**: Randomised controlled trials (RCTs), cluster randomised or quasi-randomised trials of time-limited reablement services for older adults (aged 65 years or more) delivered in their home; and incorporated a usual home-care or wait-list control group. Reablement interventions compared with groups receiving usual home-care services or with a wait list control group. Studies were required to meet the following criteria: • participants must have had an identified need for formal care and support or be at risk of functional decline	**Number of studies**: 2 **Study design:** RCT **Population**: Older persons **Number of participants**: 811 **Country of origin:** Australia and Norway **Setting:** Community **Interventions:** The interventions were similar in the two studies and in both cases there was an emphasis on	There is considerable uncertainty regarding the effects of reablement as the evidence was of very low quality according to our GRADE ratings. Therefore, the effectiveness of reablement services cannot be supported or refuted until more robust evidence becomes available. There is an urgent need for high quality trials across different health and social care systems due to the increasingly high profile of reablement services in policy and practice in several countries. Reablement may slightly improve functional status

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			• the intervention must have been time-limited (up to 12 weeks) and intensive (e.g. multiple home visits) • the intervention must have been delivered in the older person's own home, and provided by an interdisciplinary team • the intervention must have been focused on maximising independence; and • the intervention must have been person-centred and goal directed **Literature search**: June 2015	encouraging participants to achieve individualized goals and to perform daily activities themselves rather than letting others do it for them. In addition, the intervention included exercises to improve mobility, adaptations to tasks and equipment, and strategies to promote social connectedness. Both interventions involved interdisciplinary teams including occupational therapists and physiotherapists, who conducted the initial assessments and developed the rehabilitation plan tailored to the aims and needs of each participant. **Outcomes**: - Functional status including measures of the skills and abilities to complete ADL. • Adverse events including mortality, hospital (re)admission.	but may have little or no effect on QoL of older adults, or mortality rates at nine to 12 months. Other outcomes were measured by one study), and an associated costs paper. The very low-quality evidence suggested there is uncertainty regarding the effects of reablement on living arrangements, unplanned hospital admissions or visits to an emergency department at both the 12-month follow-up and for the overall 24-month period, or for mortality at 24 months. There was very low-quality evidence from one study to indicate that the reablement intervention may reduce need for either ongoing home-care, or a new episode of personal care at 12-month follow-up, and may slightly reduce the likelihood of being assessed as needing a higher level of care (i.e. residential care or equivalent home care) at 24 months. Neither study

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				• Quality of life (QoL). • User satisfaction. • Service outcomes, including level of ongoing home-care service (e.g. care hours) or use of external health services (e.g. visits to emergency department). • Living arrangements (i.e. in own home or other setting). • Cost-effectiveness **Follow-up time** 3-12 months	measured user satisfaction, which is possibly an important factor in ensuring uptake and adherence related to such interventions
Coker et al 2014 Canada [17]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To examine the effect of intervention programs designed to enhance the ability of nurses and nursing assistants to improve oral hygiene outcomes in frail older adults residing in long-term care or having an extended hospital stay.	**Inclusion criteria**: Primary quantitative research studies were eligible if: (a) they evaluated an intervention aimed at nurses or nursing assistants (under a variety of job titles) who provide oral hygiene care to primarily older adults with functional or cognitive disabilities in an institutional care setting; (b) the outcome was directly related to patients' oral health status (e.g., a change in one or more oral health measures, or a change in	**Number of studies**: 8 **Study design:** RCT (n=1), controlled clinical trial (n=7) **Population**: Older people in long term care **Number of participants**: 113-343 **Country of origin:** United Kingdom, Canada, Switzerland, Belgium, Netherlands.	Although a link has been made between oral hygiene and systemic disease, poor oral hygiene occurs frequently among older adults in institutions who are dependent on others for care. A literature search for studies of interventions to improve oral hygiene delivered by nurses or nursing assistants yielded eight **Moderate** to strongly rated studies reporting in-service educational sessions, either alone or augmented in some way

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			risk for oral hygiene related sequelae); and (c) they were published in English. Finally, eligible studies were assessed for their inclusion of a comparison group. **Literature search**: July 2013	**Setting:** Long term care **Interventions:** (a) single in-service education sessions; (b) single in-service education sessions supplemented by a "train the-trainer" approach; and (c) education sessions supplemented with ongoing active involvement of a dental hygienist. **Outcomes**: Dental and denture hygiene, dental debris, denture debris, denture plaque, dental plaque, root caries, tooth mobility, fillings, oral flora, condition of oral mucosa, gingival health, glossitis, denture stomatitis, angular cheilitis, an inflamed lesion at the corner of the mouth. Professional knowledge. **Follow-up time:** 1-18 months	(i.e., single in-service education sessions, single in-service education sessions supplemented by a "train-the-trainer" approach, and educational sessions supplemented with ongoing active involvement of a dental hygienist). None of the approaches emerged as being more effective than the others but this was due in great part to poor intervention integrity in many of the studies. A well designed and executed educational program cannot have its effect measured if the caregivers for whom it is intended do not attend the session or do not subsequently care for the patients whose oral hygiene status is being measured. Further study of ways to enhance nurses' ability to deliver oral hygiene care to improve the oral health of patients is crucial. The newly exposed significance of oral hygiene and the role nurses can play in

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					optimizing the oral health of older adults promises to be an important area for practice and research.
Collet et al 2010 The Netherlands [18]	**Moderate** **SBU Domain(s):** Samverkan mellan olika instanser (myndigheter sjukvård inom socialtjänst) **Quantitative**	Which integrated interventions combining both psychiatric care and nursing home care in Double Care Demanding (DCD) nursing home residents are described in the research literature? Which effects of these integrated models combining both psychiatric care and nursing home care in DCD nursing home residents are reported in the literature?	**Inclusion criteria**: 1) a study population of nursing borne patients suffering from either somatic illness or dementia combined with psychiatric disorders or severe behavioral problems (2) studies using an inpatient intervention combining both psychiatric care and nursing home care (3) studies yielding quantitative data of a comprehensive intervention combining both psychiatric care and nursing borne care. **Literature search**: January 2008	**Number of studies**: 8 **Study design:** RCT (n=4), retrospective cohort (n=1), prospective case series (n=1), prospective cohort (n=1), retrospective cohort (n=1), **Population:** Nursing home residents 70.6 ± 6.1 to 82.9 ± 8.9 years of age. **Number of participants**: 15-64 **Country of origin:** USA, Canada, Australia, UK **Setting:** Nursing home **Interventions:** teams involved comprised at least four disciplines up to a maximum of six	Important elements of a successful treatment strategy for DCD nursing home patients include a thorough assessment of psychiatric, medical and environmental causes as well as programs for teaching behavioral management skills to nurses. DCD nursing home patients were found to benefit from short-term mental hospital admission. This review underlines the need for more rigorously designed studies to assess the effects of a comprehensive, integrated multidisciplinary approach towards DCD nursing home residents.

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				disciplines. Certified psychiatric nurses were part of the multi-disciplinary team in all of the eight selected studies. In six of the studies a psychiatrist and a psychologist (sometimes specializing in geriatrics) were part of the multidisciplinary team. A physician was part of the multi-disciplinary team in five studies. The physician involved could be a geriatrician, an internist or a general physician. The multi-disciplinary interventions included a comprehensive assessment of the psychiatric disorders or severe behavioral disorders in the DCD nursing home patients. **Outcomes:** Levels of general psychiatric symptoms (especially depression and agitation or aggression), global functioning (cognitive and functional status).	

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				Follow-up time: 7 days to 6 months	
Coll-Planas et al 2017 Spain [19]	**Moderate** **SBU domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – både ordinärt och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To assess the currently unclear health impact of social capital interventions targeting older adults.	**Inclusion criteria:** Publication period: Between January 1980 and July 2015 **Population:** Participants over 60 years old. Study design: Studies had to assess an intervention that promoted social capital or one of its components. In multicomponent trials, the inclusion was restricted to those studies in which social capital was the focus of the intervention. Comparison/control: The comparison group should not promote social capital. Other criteria: No language restrictions were applied. **Literature search:** July 2015	**Number of studies:** 36 studies in 73 papers. **Study design**: RCT (n=36) **Number of participants:** Ranging between less than 100 to more than 300. Only listed in this way. **Characteristics of participants:** Not stated. **Country of origin:** South Europe (n=1), Northern Europe (n=4), United Kingdom (n=4), Central Europe (n=5), North America (n=16), South America (n=1), Asia (n=3), Oceania (n=2) **Setting:** Community, nursing home, hospital, hospital and community **Interventions:** Group interventions (n=15)	Our review highlights the lack of evidence and the diversity among trials, while supporting the potential of social capital interventions to reach comprehensive health effects in older adults.

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				Individual interventions (n=14) Combined interventions (n=3) Setting approach (n=4) **Outcomes:** Intermediate social outcomes (increased social support, increased social participation, increased social network, increased trust and social cohesion). Intermediate health outcomes (physiological changes, psychological changes, behavioral changes, instrumental changes). Longer term health outcomes (increased general health, decreased morbidity, decreased functional decline and disability, decreased mortality). **Follow-up time:** 1.5 months to more than 1 year	
Comondore et al 2009 Canada [20]	**High** **SBU Domain(s):** Särskilda boendeformer som	To compare quality of care in for-profit and not-for-profit nursing homes.	**Inclusion criteria**: Patients: residing in nursing homes in any jurisdiction; Intervention: for-profit status of the institutions	**Number of studies**: 82 (spanning 1965 to 2003)	Most studies suggest a trend towards higher quality care in not-for-profit facilities than in for-profit homes, but a

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	insats (Institutional care as an intervention) **Quantitative**		Comparator: not-for-profit status. **Literature search**: April 2006	**Study design:** Comparative studies **Population**: Persons living in nursing homes, i.e. need 24 hours nursing care **Number of participants**: Not stated. (Number of public, for profit and not for profit units are presented) **Country of origin:** USA and Canada **Setting:** Nursing home/long term care **Interventions:** See setting **Outcomes**: Measures of quality of care in for-profit and not-for-profit nursing homes. The most frequently used quality measures were as follows: Number of staffs per resident or level of training of staff Physical restraints	large proportion of studies show no significant trend Although this review has fully assessed the data available comparing for-profit and not-for-profit nursing home care, additional work is needed to compare the costs between these types of facilities and to evaluate the consistency of these findings outside of the USA and Canada. Although we have extensively evaluated the literature comparing quality of care in for-profit, charitable organization owned, and government owned nursing homes, the available studies did not allow comparison of the possible impact of factors such as subcategory of for-profit ownership (for example, chain v non-chain, investor v small business ownership, municipality v federal government ownership). Nursing home management companies further complicate the

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				Pressure ulcers (regulatory (government survey) deficiencies. **Follow-up time:** Not applicable	relation between ownership and quality of care. These are all important areas that warrant further research.
Cooper et al 2012 UK [21]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt, både ordinärt och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To review the effectiveness of non-pharmacological interventions to focus on quality of life or well-being of people with dementia.	**Inclusion criteria**: Research in people with dementia evaluating non-pharmacological interventions in randomized controlled trials (RCTs), which included quality of life or well-being as a quantitative outcome. We restricted our search to studies published in English and excluded single case reports, dissertations, meeting abstracts, and studies that only used quality of life measure subscales, if we judged that these did not measure overall quality of life. **Literature search**: January 2011	**Number of studies**: 20 **Population**: Persons with dementia. **Number of participants**: 24-289 **Study design:** RCT **Country of origin:** Australia, USA, Peru, UK, Netherlands, Hongkong. **Setting:** Living at home or in institutional care. **Interventions:** Family carer interventions. Activity programs for people with dementia and family carer coping	There is a lack of definitive evidence for any intervention that increases quality of life or well-being of people with dementia. Nonetheless, lack of evidence of efficacy is not evidence of lack of efficacy. Coping strategy-based family carer interventions and tailored activities for the person with dementia and their family carers, and a system of care management, may improve quality of life of people with dementia living at home. In contrast the only high-quality evidence we found that improved quality of life among care home residents with dementia was a single study of group CST. Further research is needed, to develop and test interventions to increase quality of life among

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				strategy combined interventions Cognitive stimulation therapy in group Care management Discussion groups Individual cognitive rehabilitation Exercise Staff training and individualized resident care plans Other interventions **Outcomes**: Quality of life **Follow-up time:** Post intervention up to 18 months	people with dementia and to test their cost effectiveness.
Cowdell et al 2015 UK [22]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – ordinärt boende.	To locate, summarise and critically analyse current knowledge about skin hygiene practices for older people.	**Inclusion criteria:** Studies included were alternative bathing protocol or bathing product interventions (cleansing, hygiene, older people, skin, systematic review). Primary focus on general skin cleansing.	**Number of studies:** 7 **Study design:** RCT n=2 Quasi-experimental n=5 6 used purely quantitative research methods, and one mixed methods.	There is a significant lack of high-quality research studies to provide a framework for guiding evidence-based skin cleansing practice. Current guidance is based on clinical expertise rather than on robust trial evidence. A research

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	Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**		Original quantitative or qualitative research of any design. **Literature search:** To the last 5 years to ensure currency; however, due to the dearth of papers, the date range was expanded to 1990 onwards.	**Number of participants:** N=334 **Characteristics of participants:** Aged over 65 years. Gender reported in two studies, n=63) **Setting:** Residential care homes for older people n=5. This setting with the addition of some community-dwelling participants n=1. A combination of residents in long-term care hospital wards and community dwellers n=1. **Country of origin:** US n=5 Canada n=1 Sweden n=1 **Interventions:** Skin cleansing interventions using bathing protocols and/ or products. -The Skin Condition Data Form n=3.	agenda has been developed which may become the basis for developing evidence-based, best practice guidelines. Future research must move beyond descriptive studies to include more robust methods of investigation. The lack of intervention studies limits the practice-guiding implications that can be gained from the current body of research.

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				-Subjective measures including assessment of skin tears evaluation of erythema, rashes and open wounds n=3. This also recorded the number of preparations and medications given for skin conditions. In addition to focusing on skin condition, there were other identified foci in the literature. 1 study investigated patient and nurse perceptions of the 'Bag Bath' using a Residents Satisfaction Questionnaire and a Nursing Staff Satisfaction Questionnaire, and 1 study interviewed participants. **Outcomes:** Measures of skin health (for example, dryness, erythema, cracking and open wounds). Qualitative or quantitative feedback on the experience of the intervention from nurses or patients.	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Follow-up time Not stated	
Dawson et al 2015 UK [23]	**Moderate** **SBU Domain(s)** Stimulerande och upprätthållande arbetssätt och metoder –ordinärt boende. Maintaining and stimulating work methods - community settings) **Qualitative synthesis**	To synthesize research evidence about the effectiveness of services intended to support and sustain people with dementia to live at home, including supporting carers. (The review was commissioned to support an inspection regime and identifies the current state of scientific knowledge regarding appropriate and effective services in relation to a set of key outcomes derived from Scottish policy, inspection practice and standards.)	**Inclusion criteria:** Studies that examines research evidence about the effectiveness of services intended to support and sustain community-dwelling people with dementia and their carers. key outcomes: Prevention of unnecessary hospital and mission, prevention of delayed discharge from hospital, delivery of community nursing, management of medication at home, reducing lengths of hospital stay, effective discharge from hospital, consistency and quality of home care delivery (including staff training, staff support), carer support and self directed support. **Literature search:** November 2012	**Number of studies:** 131 **Study design:** Reviews and primary studies **Number of participants:** Not stated **Characteristics of participants:** Age unclear for specifics see included studies **Setting:** Ordinary housing **Country of origin:** Majority of studies from UK, US and from an International perspective. Other studies from Ireland, Japan, Australia, Taiwan, Canada, India, Sweden and Germany **Interventions:** Services intended to support and sustain people with dementia to live at home,	In many areas, policy and practice developments are proceeding on a limited evidence base. Key issues affecting substantial numbers of existing studies include: poorly designed and overly narrowly focused studies; variability and uncertainty in outcome measurement; lack of focus on the perspectives of people with dementia and supporters; and failure to understanding the complexities of living with dementia, and of the kinds of multifactorial interventions needed to provide holistic and effective support. Weaknesses in the evidence base present challenges both to practitioners looking for guidance on how best to design and deliver evidence-based services to support people living with dementia in the community and their carers and to those charged with the inspection of services.

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				including supporting carers. **Outcomes:** Of 131 publications evaluated, 56 were assessed to be of 'high-quality, 62 of 'medium' quality and 13 of 'low' quality. Evaluations identified weaknesses in many published accounts of research, including lack of methodological detail and failure to evidence conclusions. Thematic analysis revealed multiple gaps in the evidence base, including in relation to take-up and use of self-directed support by people with dementia, use of rapid response teams and other multidisciplinary approaches, use of technology to support community-dwelling people with dementia, and support for people without access to unpaid or informal support. **Follow-up time:**	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Unclear	
De Sâo José et al 2016 Portugal [24]	**Moderate** **SBU domain(s):** Hemtjänst som insats (Home help as an intervention) **Qualitative**	To identify, appraise, synthesize and discuss relevant research-based evidence of the experiences and perspectives of older persons receiving social care in the community.	**Inclusion criteria:** Publication period: Between 1990 and September 2014. **Population**: Older people (people aged 65 and over). **Study design:** • a focus on older people who were receiving social care at the moment of data collection (or who had stopped receiving it less than 1 year previously); • an account of the experiences and perspectives of these older people; • a base on qualitative research (data collection and analysis); • a focus on older people living in one of the countries of the European Union (27 countries). **Setting:** Living in the community (not in institutional settings). **Other criteria:** English or Portuguese	**Number of studies:** 30 **Study design:** Ethnographic (n=1), Qualitative (n=18), Biographical (n=1), Phenomenological (n=3), Psychosocial narrative (n=2), Multiple case study (n=4), Mixed method (n=1) **Number of participants:** Between (n=3) and (n=391) **Characteristics of participants:** Age between 50 and 98. Males between (n=0) and (n=15), Females between (n=3) and (n=23). Not all studies list gender. Informal caregivers between (n=0) and (n=37), Care managers between (n=0) and (n=28) **Country of origin:** United Kingdom (n=21), Sweden (n=8),	Both positive and negative experiences of receiving social care relate, mostly, to the relational dimension of care. Receiving social care per se does not automatically imply a negative or a positive experience. Rather, it is the concrete form of social care provision, primarily the attitudes and behaviour of the carers, which determine whether the care is experienced as positive or negative. This conclusion has implications for professional and non-professional practice and for social policy. We must not forget that 'good care practices' (professional and non-professional) can be effective and sustainable only if social and public policies ensure 'good conditions' – in terms of training/education, time for care, income/cash for care, security and protection – in order for

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			Literature search: Date not specified, but probably September 2014.	Netherlands (n=1), Denmark (n=1), Spain (n=1), France (n=1), Slovakia (n=1), Ireland (n=2), Finland (n=1). Some studies include more than one country. **Setting:** People living in the community **Interventions:** All type of social care to older people in the community. **Outcomes:** Qualitative data of older person's experiences and perspectives of receiving social care. **Follow-up time:** Receiving social care at the moment or stopped less than 1 year.	carers 'to do their job' with dignity.
Dickens et al 2011 UK [25]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – både ordinärt och särskilt boende (Maintaining	To determine the effectiveness of interventions designed to alleviate social isolation and/or loneliness in older people, we reviewed randomized controlled trials and quasi-experimental studies that	**Inclusion criteria**: Related in full/part to older people; • the intervention targeted people identified as socially isolated and/or lonely, and stated a clear and plausible aim to alleviate this;	**Number of studies**: 32 **Study design:** RCTs (n=16) and quasi-experimental studies (n=16) **Population**:	Our systematic review has identified a need for well conducted studies to improve the evidence base regarding the effectiveness of social interventions for alleviating social

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	and stimulating work methods – both community and institutional settings) **Quantitative**	assessed treatment effects of such interventions, in comparison with inactive controls. Second, to identify the potential health benefits of such interventions.	• recorded some form of participant-level outcome measure, and reported sufficient outcome data for treatment effects to be obtained; - used a randomized controlled trial (RCT), or quasi experimental (controlled trial or matched controlled trial) design • included an inactive (usual care, no intervention, attentional) control group • was published in English. **Literature search**: May 2009	Participants included caregivers, disease sufferers, housing residents, residents in institutional settings and community-dwelling older people **Number of participants**: 4061 participants contributed to the 32 studies, with between 23 and 741 participants per study. **Country of origin:** USA, Canada, Japan, Sweden, Finland, Netherlands. **Setting:** Institutional setting, community dwelling **Interventions:** Interventions were categorised as offering activities (social or physical programs), support (discussion, counselling, therapy or education), internet training, home visiting or service provision	isolation. However, it appeared that common characteristics of effective interventions may include having a theoretical basis and offering social activity and/ or support within a group format. Interventions in which older people are active participants also appeared more likely to be effective. Participatory interventions and those including social activity and support were also more likely to be beneficial. While the nature of the intervention provider appeared to be a factor on the basis of vote counting, this should be interpreted cautiously due to the large number of providers identified and the small number of studies relating to each one. There are indications that social isolation interventions may have wide-ranging benefits including structural social support, functional social support, loneliness, and

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				Outcomes: three outcome domains including social health (four sub-domains of: 'loneliness', 'social isolation', 'structural social support', 'functional social support'); mental health (two subdomains of: 'depression', mental/ psychological wellbeing') and physical health (e.g. perceived health status, blood pressure, daily medication intake). **Follow-up time:** Six weeks to 5 years	mental and physical health. This study advances the evidence base of previous reviews by including studies published since 2002 and by considering a wider range of outcomes reflecting the multi-dimensional definition of social isolation.
Easton et al 2017 Australia [26]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats. (Institutional care as an intervention) **Quantitative**	To provide a systematic and narrative summary of the existing literature of economic evaluations of residential aged care infrastructure.	**Inclusion criteria**: Eligible studies included full economic evaluations (e.g. cost- effectiveness analyses, cost-utility analyses, cost benefit analyses), partial economic evaluations (e.g. cost analyses, cost minimization analyses, cost consequences analyses), and randomized trials reporting more limited information, such as estimates of resource use	**Number of studies**: 14 (16 articles) **Study design:** RCT, cross-sectional, prospective cohort **Population**: participating facilities per study ranged from 1 to 3,492 (mean: 424; median: 150). Of the three studies that recruited resident participants, sample	This research highlights a gap in economic evidence, and this evidence is needed to inform future aged care sector facility design and development. Despite the high cost of providing care to older people in residential care facilities, there is a lack of robust economic evidence on the value of organisational and environmental design

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			or costs of interventions, pertaining to organizational and environmental characteristics aimed at improving the quality of care for older adults in a residential aged care setting. **Literature search**: 14 December 2015	sizes varied widely (44 - 2,405) **Number of participants**: 3492 **Country of origin:** Australia, USA, Switzerland, UK **Setting:** Residential aging care **Interventions:** Not applicable. **Outcomes**: Resource use, cost of interventions, clinical outcomes **Follow-up time:** Unclear	features. There is a shortage of research linking costs to outcomes. The quality of existing cost analyses and economic evidence is varied, and much of the existing research is outdated which limits the usefulness of the data. Key methodological issues for consideration in the design of economic evaluations of residential care infrastructure include robust study designs, valuing health and/or quality of life effects in a meaningful way and increasing the representativeness of data by ensuring the inclusion of residents with dementia. Future research should focus on identifying appropriate and meaningful outcome measures that can be used at a service planning level, as well as the broader health benefits and cost-saving potential of different organizational and environmental characteristics in residential care.

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Elias et al 2015 Australia & Malaysia [27]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser och arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	What is the effect of group reminiscence therapy on reducing feelings of loneliness, anxiety and depression, in older people diagnosed with symptoms of loneliness, anxiety and depression residing in long-term care settings?	**Inclusion criteria:** Experimental, non-experimental, observational and qualitative studies. Systematic reviews were excluded. The population of interest was people aged 60 years and over. LTC encompassed nursing homes, assisted living facilities and residential aged care facilities. The intervention was group reminiscence therapy. Studies that used individual reminiscence therapy were excluded. The outcomes of interest were loneliness, anxiety and depression. **Literature search** No information. Studies published in English and Malay languages between 2002 and 2014 and full text articles were considered for inclusion.	**Number of studies:** 8 **Study design:** Quasi experimental **Number of participants:** 24-92 participants **Characteristics of participants:** Two studies involved males only, one study involved females only and five studies involved both males and females. **Setting:** Nursing home and assisted living facilities **Country of origin:** United States of America, Taiwan, the United Kingdom and Iran **Interventions:** Group reminiscence therapy, duration 4-12 weeks **Outcomes:** Loneliness, depression, anxiety	The majority of group reminiscence therapy studies reviewed were quasi-experimental and included small participant samples, therefore there are no conclusive findings to be made. Notwithstanding the lack of empirical evidence, as there are no reported adverse events to reminiscence therapy, and it can be practically implemented in long-term care settings, it should certainly be considered a worthwhile treatment.

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				Follow-up time: Up to 6 months	
Fearing et al 2017 Canada [28]	**Moderate** **SBU Domain(s):** Anhörigstöd och familjeorienterat arbete (Support to informal carers) **Quantitative/qualitative**	To examine the quality of evidence for elder abuse and neglect interventions for community-dwelling older adults.	**Inclusion criteria:** Peer-reviewed quantitative studies available in English and focused on elder mistreatment interventions (e.g., physical, emotional, financial, or neglect) for the older adult or perpetrator living in noninstitutional settings where outcomes were reported. **Literature search:** January 2009 and December 2015.	**Number of studies:** 9 **Study design:** RCT n=2, pre–post experimental n=2, retrospective secondary data analysis n=1, quasi-experimental n=3, retrospective national e-survey, mixed method prospective evaluation n=1. **Number of participants:** *START or TAU*: Caregivers of a family member with dementia n=520, patients n=260. Male 28–42%, age 56–78 yrs *DBT*: Caregivers of older adults with dementia n=24, male 21%, aged 33–87 years. *Israeli multisystem model*: Elder abuse victims n=558, 15% male, average age 75.	There are limited high-quality studies on interventions for elder abuse and neglect. The lack of effective interventions holds serious implications for practice to identify evidence-based interventions that are effective in reducing elder abuse and neglect. Need to identify an ideal rating tool to assess the methodological quality of findings and thereby improve our ability to compare findings across review papers. The use of standardized tools, such as the D&B tool and PEDro scale, are promising for creating a common approach for assessing methodological rigor.

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				Social workers and professionals n=19. *Multidisciplinary approach and lone social worker:* 65 years or older investigated for abuse, n=1 200, 35.9% male, mean age 80.5. *Examine effectiveness of E-CARE in assisting suspected victims:* n=175, males 56, age 79.59. *Multidisciplinary team FC:* n=948, female 314, age 82.3 Elder mediation in preventing financial abuse, n=228 chief executive officers, n=214 service providers, n=113 older adults and relatives, age range 65 to 74 years. **Characteristics of participants:** Community-dwelling older adults. Age and sex, see above **Setting:** Noninstitutional settings.	

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				Country of origin: UK, USA, Israel, Australia. **Interventions:** Psychological interventions for dementia family caregivers (n=3). Multidisciplinary team interventions (n=2). Forensic center and conservatorship interventions (n=2). Elder abuse intervention programs for caregivers (n=2). **Outcomes:** The outcomes identified in the nine articles on community-based interventions for addressing elder abuse and neglect. 2 studies addressed financial abuse specifically, while the remaining addressed all types of mistreatment. **Follow-up time:** Not stated	
Flanagan et al 2014 UK	**Moderate** **SBU Domain(s):**	To provide a narrative summary of intervention studies identifying	**Inclusion criteria**: 1. Studies with residents/ participants aged 65 or	**Number of studies**: 42 intervention studies out of which 9 were	Managing incontinence and promoting continence in care homes

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
[29]	Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende (Maintaining and stimulating work methods - institutional settings) **Quantitative**	practices and associated factors for the management of incontinence and promotion of continence in care borne residents.	above or a majority with a mean age of 65 and over living in care homes (residential homes, nursing homes) or assisted living facilities. 2. Studies included were either descriptive/ observational or interventions. All of the studies focus on the management of incontinence, promotion and maintenance of continence in care home populations. Study designs include randomized controlled trials (RCT), quasi-randomized controlled trials, quasi-experimental studies, case--control studies, cohort studies, surveys, pre-test/ posttest studies, economic evaluation or empirical studies. 3. Continence status, management of incontinence or the promotion or maintenance of continence included as an outcome measure. 4. Type of condition - Urinary incontinence (UI) or dual incontinence (UI with faecal incontinence (FI))	related to associated factors with incontinence **Study design:** Interventional studies **Population**: Older persons living in long term care **Number of participants**: 24-164 **Country of origin:** USA and UK **Setting:** Residential care homes **Interventions:** Prompted voiding, toileting reinforcement, padding methods etc. **Outcomes**: Factors included economic data, skin care, exercise studies, staff quality and prompted voiding adherence and the promotion of continence by the management of	is complex, requiring time and cost-efficient management procedures to contain the problem and deliver quality, achievable care. When developing and designing systems of care in care homes, it is important to also recognize the impact of associated factors. As with any healthcare intervention program, resources are required to implement the protocols. Economic evaluation studies are limited, with further studies warranted alongside preventative studies to maintain long-term continence in these populations.

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			with or without definitions included. 5. Language - All published articles were in English. 6. Year of study publication **Literature search**: May 2010**.**	dehydration and incontinence. **Follow-up time:** Unclear	
Fleming et al 2014 Australia [30]	**Moderate** **SBU Domain(s):** Effekten av vissa hjälpmedel inom kommunikation och kognitiv förmåga. (Effects from communication and cognitive devices) **Quantitative**	To assess the empirical support for the use of assistive technology in the care of people with dementia as an intervention to improve independence, safety, communication, wellbeing and carer support.	**Inclusion criteria**: Studies published between 1995 and 2011, incorporated a control group, pre-test-post-test, cross sectional or survey design, evaluated an intervention utilizing an assistive technology and focused on the care of people with dementia over 50 years of age. **Literature search**: 2011	**Number of studies**: 41out of which 7 were considered as strong and 10 as **Moderate** validity and were described. **Study design:** Unclear **Population**: Persons with dementia or their caregivers **Number of participants**: 5-136 persons or caregivers **Country of origin:** Not stated **Setting:** Various to unclear: nursing home, chronic care facility, psychogeriatric ward	This review aimed to explore the ways in which technology has been applied to helping people with dementia carry out the tasks of daily living and how it may be making a contribution to the wellbeing of these people by reducing their behavioural problems and improving their emotional state. Research to date has been unable to establish a positive difference to the lives of people with dementia by the general use of the assistive technology reviewed here. The literature exploring the use of assistive technologies for increasing independence and compensating for memory problems illustrate the problems of moving from the laboratory to real life. The

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				Interventions: Telemedicine (cognitive intervention program using telemedicine (VC) vs a conventional face-to-face (FTF) method). Brigth light. Robot cat. Technology-aided pictorial cues alone or in combination with verbal instructions. Simulated presence therapy (SPT) – an audio tape on a personal stereo. Snoezelen room. Multi-sensory stimulation (MSS) or activity groups (playing card games, looking at photographs, etc.) **Outcomes**: The review is presented around the following topics: independence, prompts and reminders; safety and security; leisure and lifestyle, communication and telehealth; and therapeutic interventions. **Follow-up time:** Various to unclear	review has demonstrated that the research has been characterised by very small samples, high drop-out rates, very basic statistical analyses, lack of adjustment for multiple comparisons and poor performance of the technology itself. Regarding the use of assistive technologies for increasing independence, this review showed that once the evaluation moves from the laboratory significant practical and methodological problems emerge and the use of the technology reported to date makes little difference to practical outcomes. The evidence for the effective use of assistive technology to improve the safety and security of people with dementia is very weak. No methodologically strong evaluations of the use of assistive technology to improve the safety and/or security of people with dementia were found. The common

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					problems associated with lack of acceptance by the user, difficulties with use and technical reliability are evident. Overall there is a great need for better designed studies with larger samples.
Forsman et al 2011 Sweden & Finland [31]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To assess the effectiveness of psychosocial interventions in the primary prevention of depressive symptoms and unipolar depressive disorders in people aged 65 or above.	**Study design:** Prospective controlled studies. **Participants:** All participants aged 65 years or older, or an average participant age of 70 years or older. Should not meet the diagnostic criteria for a depressive disorder at the time of enrolment. Studies where the participants suffered from a psychiatric disorder (e.g., dementia) were excluded. **Setting:** All settings, i.e. institution or community. **Interventions:** Psychosocial interventions, i.e. emphasizing psychological or social factors, not biological factors. Excluding	**Number of studies**: In review: 30 studies In meta-analysis: 19 studies. **Study design:** RCT (n=23), non-randomized controlled trials (n=7) **Number of participants:** N=1697 in meta-analysis **Characteristics of participants:** Mean age: 77 years (for pooled data) Age range: Not stated Gender distribution: 71% women **Setting:** Regardless of setting, i.e. institution or community	Psychosocial interventions have a small but statistically significant effect in reducing depressive symptoms among older adults. The current evidence base for psychosocial interventions for primary prevention of depression in older people is weak, and further trials warranted especially for the most promising type of interventions evaluated, that is, social activities. More large-scale, high-quality controlled trials on psychosocial interventions are needed to detect important effects of primary prevention of depression in older people. The review suggests that attention should be paid

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			interventions with organization of care. **Outcomes:** Depressive symptoms or depression. **Literature search:** October 2009	**Country of origin:** Not stated **Interventions:** Physical exercise (n=7) Skill training (n=7) Group support (n=1), Reminiscence (n=6) Social activities (n=3) Multicomponential (n=6) **Outcomes:** Depression Secondary outcomes: functional ability, quality of life. **Follow-up time:** Not stated	not only to the duration of the interventions but also to the frequency of sessions so as to obtain the best effects. In addition, further research on cost effectiveness of psychosocial interventions is called for.
Franck et al 2016 Australia [32]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - ordinärt boende. Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende. (Maintaining and stimulating work methods – both	To systematically review studies reporting interventions for reducing social isolation and depression in older people receiving aged care services (community or residential)	**Study design**: Intervention studies, with no design exclusions **Participants**: Studies involving participants who were mostly aged 60 years and over **Setting:** Address social isolation and depression in aged care clients living in rural setting (though urban setting was also included)	**Number of studies:** n=6 **Study design:** All intervention studies (various) **Number of participants:** All studies had small sample sizes, ranging from 26 to 113 participants.	Only one intervention, group-based reminiscence therapy, was reported as successful in reducing both social isolation and depression in older people within an urban aged care setting. More research is needed to explore transferability of interventions across different aged care settings and into rural areas

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	community and institutional settings) **Quantitative**		**Interventions:** Any **Outcomes**: Outcomes of social isolation or loneliness, or the combination of depression with social isolation or loneliness were included **Literature search:** July 2014.	**Characteristics of participants:** Study participants were older adults ranging in age from 77 to 86 years **Setting:** All urban residential care **Country of origin:** Taiwan n=1, UK n=1, USA n=1, Hong Kong n=1, Australia n=1 **Interventions:** Reminiscence therapy n=1, Gender-based Social Clubs n=1, Playing Wii n=1, Indoor Gardening n=1, Radio Program n=1 **Outcomes:** Three of the five included intervention studies successfully reduced social isolation; one also successfully reduced depression **Follow-up time:** 3 month, 10 and 8 weeks, depending on outcome.	

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Gallione et al 2017 Italy [33]	**Moderate** **SBU Domain(s):** Insatser avseende våld. (Interventions addressing abuse and neglect) Behovsbedömning och uppföljning (Needs assessment and follow-up: older persons) **Quantitative**	To review the efficacy and accuracy of tools administered to older people, intended to detect and measure elder abuse	**Study design**: Prospective and retrospective observational cohort studies **Participants**: Aged 60 and older **Setting:** The article describes an intervention designed to be provided to individual subjects (abused persons or perpetrators), healthcare professionals or the community. **Interventions:** Detect/assess the risk of elder abuse (physical, psychological, financial, sexual or neglect) using a screening tool **Outcomes**: Elder abuse risk assessment/quantification, reduced exposure to violence **Literature search:** April to May 2015	**Number of studies:** n=11 **Study design:** Prospective and retrospective observational cohort studies **Number of participants:** H-S/EAST (115 abused, 28 non abused and 47 in comparison group), VASS (10421 women, EASI (663), CASE (139 caregivers), BASE (492 subjects), E-IOA (T0-n 108, T1-n 730, T2-n 1317 (T 3 –71 subjects in nursing homes), EAI (501 older adults and 484 patients, EPAS (88 males and 107 females), CPEABS (28 males and 64 females), OAPAM (unclear) and OAFEM (unclear) **Characteristics of participants:** Aged 60 and older **Setting:** The article describes an intervention designed to be provided to	The fundamental function of any assessment instrument is to guide through a standardised screening process and to ensure that signs of abuse are not missed. Several tools have been tested; some have demonstrated a **Moderate** to good internal consistency and some have been validated to allow an early identification. None have been evaluated against measurable violence or health outcomes.

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				individual subjects (abused persons or perpetrators), healthcare professionals or the community **Country of origin:** USA, Canada, Israel, Taiwan, Australia **Interventions:** Data summarised and not synthetized **Outcomes:** Eleven screening tools have been presented: H-S/EAST, VASS, EASI, CASE, BASE, E-IOA, EAI, EPAS, CPEABS, OAPAM and OAFEM, all aimed at healthcare professional or, in some cases, expected to be specifically used by nurse **Follow-up time:** Not stated	
Gardiner et al 2016 UK [34]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt	To conduct an integrative review to identify the range and scope of interventions that target social isolation and loneliness among older people, to gain insight	**Inclusion criteria:** Literature relating to interventions with a primary or secondary outcome of reducing or preventing social isolation and/or loneliness	**Number of studies:** 39 **Study design:** 6 randomised controlled trials (RCT), 21 other quantitative	A wide range of interventions have been developed to tackle social isolation and loneliness among older people. The majority of interventions reported some success in

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	och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative and qualitative**	into why interventions are successful and to determine the effectiveness of those interventions	Literature relating to older adults Empirical research articles reporting primary research, published in full, including all research methodologies (but excluding reviews) English language articles Published since 2003 **Literature search:** January 2016	designs, 10 were qualitative studies, 2 were mixed method studies. **Number of participants:** 8-5203 **Characteristics of participants:** 53 years or older. Frail persons. Age and gender distribution not always stated **Setting:** Community settings as friendship clubs, day centres, residential care **Country of origin:** Australia, USA, Japan, Hong Kong, Taiwan, Nya Zeeland, Iran, Israel, Finland, Slovenia, Netherlands, UK **Interventions:** Social facilitation interventions, psychological therapies, health and social care provision, animal interventions, befriending interventions and	reducing social isolation and loneliness, but there was significant heterogeneity between interventions. Common features of successful interventions include adaptability, community participation and activities involving productive engagement. However, it is important to note that our conclusions are based on combined evidence from studies using a range of methods and are not based on meta-analysis. Therefore, conclusions regarding effectiveness cannot be confirmed statistically. Further research is now required to enhance theoretical understandings of how successful interventions mediate social isolation and loneliness and provide more robust data on effectiveness. Research exploring the cost-effectiveness of different approaches is also urgently required in order to further support the development of interventions which

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				leisure/skill development. **Outcomes:** Social isolation, loneliness **Follow-up time:** Postintervention to 3 years, but follow-up time is not specified for each study.	address the growing issue of social isolation and loneliness in our expanding older populations.
Gjerlaug et al 2016 Norway [35]	**Moderate** **SBU Domain(s):** Behovsbedömning och uppföljning (Needs assessment and follow-up: older persons) **Quantitative**	To identify screening tools suitable for uncovering risk of malnutrition in elderly residents in long-term care facilities, and among users of home care services.	**Inclusion criteria:** Aged 65 an older Community-dwelling with home care services resident in long-term care facility with nursing personnel present, such as nursing home or assisted living facility studies performed to validate one or several screening tools **Literature search:** February 2014	**Number of studies:** 9 **Study design:** Validation and reliability studies **Number of participants:** 3599 (127-2603) **Characteristics of participants:** 65 years of age or older **Setting:** Assisted living, nursing home, community living **Country of origin:** Australia, Poland, Italy, Netherlands, France **Interventions:** Screening tool	This study shows that there is little research available assessing validity, reliability and applicability of screening tools to uncover risk of malnutrition in elderly in long-term care facilities and community-dwelling elderly receiving home care services. Available research shows that MNA-SF is a well-suited screening tool for this target group. SNAQ-BMI and MST can also be good screening tools in long-term care facilities, but seem to overdiagnose malnutrition. More research is needed, particularly with regard to reliability and applicability.

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				Outcomes: Risk of malnutrition **Follow-up time:** Not applicable	
Goris et al 2016 USA [36]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To evaluate the evidence concerning the effects of non-pharmacological interventions on reducing apathy in persons with dementia.	**Inclusion criteria:** (1) the design was preferably a RCT, but minimally included a separate control or comparison group or a randomized cross-over design; (2) a non-pharmacological intervention was tested; (3) focus was on apathy or passivity in dementia; (4) the population was limited to older adults; and (5) publication occurred in a peer-reviewed, English-language journal. **Literature search:** December 2014	**Number of studies:** 16 **Study design:** RCT and quasi experimental studies **Number of participants:** 18-146 **Characteristics of participants:** Mean age was over 80 years in a majority of studies. **Setting:** Residential care or nursing home facilities, specialized dementia care units or adult day care. Acute care intervention delivery settings such as inpatient geriatric psychiatric units or military sanatoriums were also used.	Findings from this quantitative systematic review hold several important implications for policy, practice, research and education. At the level of institutional policy and clinical practice, a continued need exists to support the appropriate assessment of the presence and severity of apathy among persons with dementia to identify persons in need of intervention. While this review provides some evidence to support the use of several non-pharmacologic interventions to reduce apathy, multiple high-quality studies point to a role for music therapy for apathy reduction in institutionalized persons with dementia. Findings suggest a need for

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				Country of origin: Australia, USA, Italy, Germany, France, Spain, Netherlands, China, Taiwan, Japan. **Interventions:** Music therapies including music alone, music therapy in addition to standard care or music therapy in combination with treatment and Education of Autistic and related Communication Handicapped Children (TEACCH)-based cognitive-behavioural and environmental interactions, a combination music, art, psychomotor activity and mime intervention, cognitive stimulation therapy, art therapy, multi-sensory stimulation techniques, snoezelen-based care, reminiscence group therapy. **Outcomes:** Apathy	appropriately trained staff to then support the implementation and evaluation of music therapy in this population.

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				Follow-up time: Post intervention in 12 studies. 4 studies had a follow-up from 1 week to 4 months.	
Grant et al 2014 UK [37]	**Moderate** **SBU Domain(s):** Insatser eller aktiviteter för att stödja kvarboende. (Interventions to support ageing in place) Upprätthållande och stödjande arbetssätt - ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To assess the effectiveness of preventive home visits for community-dwelling older adults (65+ years) without dementia and investigate factors that may **Moderate** effects through pre-specified subgroup analyses.	**Types of studies:** Randomised controlled trials, clustered RCTs. **Population:** 65 years or older living at home (alone or with partner), i.e. majority of sample 65 years or older. Excluded studies in which more than 50% of the participants had dementia. **Intervention:** Visits at home by health or social care professional. Eligible interventions: 'routine' health visiting practice; visits that included multidimensional geriatric assessment and resulted in specific recommendations to reduce, treat, or prevent problems; visits that focused on fall prevention; visits that included exercise components; follow-up home visits that were directly related to recent hospital discharge. Studies with control conditions that explicitly	**Number of studies**: In review: 64 studies (reported in 89 articles) + 2 included post-hoc In meta-analyses: 23-55 studies **Study design:** RCT (n=64); quasi-random methods (n=2) **Number of participants:** N= 28 642 **Characteristics of participants:** Mean age: 69-86 years Age range: Not stated Gender distribution: median of 69% women. **Setting:** Community/ordinary home **Country of origin:** United States (14), Great Britain (14), Canada (11), Australia (4), New Zealand (4) Denmark (2), Italy (1),	We were unable to identify reliable effects of home visits overall or in any subset of the studies in this review. It is possible that some home visiting programmes have beneficial effects for community-dwelling older adults, but poor reporting of how interventions and comparisons were implemented prevents more robust conclusions. While it is difficult to draw firm conclusions given these limitations, estimates of treatment effects are statistically precise, and further small studies of multi-component interventions compared with usual care would be unlikely to change the conclusions of this review. If researchers continue to evaluate these types of interventions, they should begin with a clear theory of change, clearly

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			involved home visits were also excluded. **Outcomes:** Primary: Mortality Secondary Institutionalisation, hospitalization, falls, injuries, physical functioning, cognitive functioning, quality of life, psychiatric illness **Literature search:** December 2012	Finland (1), Netherlands (5), Japan (3), Taiwan (2), Sweden (2), and Switzerland (1). **Interventions:** Preventive home visits including falls prevention (n=17), multi-dimensional geriatric assessment (n=25), both (n=16), alternative focus regarding health impairment prevention (n=6); sometimes also exercise component (n=26). **Outcomes:** Institutionalization Hospitalisation Other outcomes, including functioning and psychiatric illness. **Follow-up time:** 3-60 months	describe the programme theory of change and implementation, and report all outcomes measured.
Gravolin et al 2007 Australia [38]	**Moderate** **SBU Domain(s):** Stöd, råd och information (Support, advice and information)	To assess the effects of various decision-support interventions delivered by health or social care providers on the outcomes of older people facing the possibility of entering long-term residential care.	**Inclusion criteria:** Population: All older people (60 or older) facing the possibility of residential aged care, and their families or carers. Study design:	**Number of studies:** 0 **Study design:** Not relevant **Number of participants:** Not relevant	No studies met the review's inclusion criteria. Although the searches identified a number of studies, they were predominantly opinion pieces or qualitative in nature. While these studies are a potential

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	Quantitative		Randomised control trials, quasi-randomised control trials/quasi-experimental trials • Controlled before and after studies • Controlled prospective studies • Interrupted time series studies Settings: Living at home **Literature search:** March 2005	**Characteristics of participants:** Not relevant **Country of origin:** Not stated **Interventions:** Not applicable **Outcomes:** Not applicable **Follow-up time**: Not applicable	source of evidence about current practice or people's views, they were not suitable for drawing conclusions about the effects of interventions to support decision-making.
Gregory et al 2017 Australia [39]	**Moderate** **SBU Domain(s):** Hemtjänst som insats (Home help as an intervention) **Qualitatitve**	To synthesize the qualitative literature about perceived experiences of health care for older people who need support to live at home, from the perceptions of older people, carers and health providers.	**Inclusion criteria:** Publication period: 1995 to 2015 Population: Older people (aged 60 years or older) who needed support to live at home; carers; and health providers. Study design: Qualitative studies and mixed methods studies with qualitative data collection and analysis were included. Settings: The context was community-based settings,	**Number of studies:** 46 **Study design:** Generic qualitative (n = 27), phenomenological (n = 9), ethnographic (n = 3), grounded theory (n = 2), participatory action (n = 2), and interpretive descriptive (n = 1). **Number of participants:** 4319 participants **Characteristics of participants:** Not specified for all studies. Age ranging	Findings from this review provide new insights into how health care impacts on the older person's sense of autonomy, both in health care decision-making and everyday life. The autonomy of the older person living in their community is empowered by the person's own capacity, and by respectful conduct and communication by health providers. Engagement between older people, carers and health providers is a negotiated and shifting interaction, affected by multiple factors. Given

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			not residential facilities. Hospital-based studies were excluded if they reported about acute care only, with no relevance to care supporting older people to live at home. Other criteria: English **Literature search:** November 2015	between (n=61) and (n=98) for those where listed. **Country of origin:** Israel (n=1), England (n=13), USA (n=4), Norway (n=1), Sweden (n=4) Canada (n=5), Australia (n=9), Korea (n=1), Scotland (n=2), Finland (n=2), Estonia (n=1), France (n=1), Germany (n=1), The Netherlands (n=2), Spain (n=1), New Zealand (n=1), Denmark (n=2), United Kingdom (n=2), China (n=1). Note: some studies include more than one country which is why the numbers do not add up to the total number. **Setting:** Home care **Interventions:** Health care for older people who need support to live at home	the negotiated nature of engagement between older people and health providers, there are implications for policy, practice, education and research. To empower the older person's autonomy during interactions with health providers, skills of negotiation and collaboration are important enablers. Therefore, training in skills of negotiation and advocacy may be useful for some older people and carers. Attention is required on further developing the skills of health providers in respectful conduct, advanced communication and negotiation skills, and resolution of complex ethical dilemmas.

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				Outcomes: The phenomena of interest were perceived experiences of health care for older people who need support to live at home (from the older persons, carers and health providers' perspective). **Follow-up time**: Not stated.	
Haesler 2004 Australia [40]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To establish the best available evidence in relation to the promotion of sleep in older adults in the high-level aged care setting. Specifically, it addressed: 1. What are the most effective measures to assess and diagnose sleep disturbances in older adults residing in high-level care? 2. What are the most effective interventions for promotion of sleep in older adults residing in high-level aged care settings?	**Inclusion criteria**: Papers addressing sleep diagnosis, assessment and/or management in adults aged 65 or over who were residing in high-level aged care. Randomized controlled trials (RCTs) and, due to the limited number of RCTs available, non-RCTs, cohort and case control studies and qualitative research. Research was included if it addressed the assessment, diagnosis or management of sleep using outcome measure of improved nighttime sleep or daytime function, improvements in resident satisfaction with sleep or reduction in medication use associated with sleep.	**Number of studies**: 41 **Study design:** RCT (n=8), non-RCT (n=3), cohort studies (n=15), times series trial (n=5), case report (n=3), descriptive study (n=5), opinion paper (n=2) **Population**: Adults aged 65 or over who were residing in high-level aged care. **Number of participants**: 2-800 **Country of origin:** Not stated	Wrist actigraphy was found to be the most accurate objective sleep assessment tool for use in the population of interest, and issues surrounding its use are presented. Although no subjective sleep assessment tools were identified in this review, the evidence suggested that subjective reports of sleep quality are an important consideration in sleep assessment. Evidence suggested that behavioral observations may be an effective assessment strategy when conducted on a frequent basis. The review found no evidence

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			Literature search: 2003	**Setting:** Nursing homes, geriatric facility, LTC. **Interventions:** alternative therapies including massage, aromatherapy and medicinal herbs; behavioral or cognitive interventions; biochemical, environmental, pharmacological interventions, and related nocturnal interventions such as continence care. Instruments and strategies to diagnose and assess the sleep of older high-level care residents, including objective and subjective assessment tools **Outcomes**: indicators of improved sleep quality and quantity, including improvement in daytime functioning and improved night-time sleep; reduction in use of hypnotics and	on the effectiveness of any assessment tools for the diagnosis of specific sleep problems in older adults. The use of multidisciplinary strategies including reduction of environmental noise, reduction of nighttime nursing care that disrupts sleep and daytime activity is likely to be the most effective strategy for the promotion of sleep in older **High** -level care residents. The use of sedating medications did not appear to have a substantial effect in promoting sleep, and health practitioners in high-level aged care should consider their use cautiously.

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				sedatives; and increased satisfaction with sleep. **Follow-up time:** When applicable and reported, between 5 days and 18 months	
Haesler et al 2004 Australia [41]	**Moderate** **SBU Domain(s):** Anhörigstöd och familjeorienterat arbete (Support for informal carers) **Quantitative and qualitative**	To present the best available evidence on the strategies, practices and organisational characteristics that promote constructive staff-family relationships in the care of older adults in the health care setting. Specifically this review sought to investigate how staff and family members perceive their relationships with each other; staff characteristics that promote constructive relationships with the family; and interventions that support staff-family relationships.	**Inclusion criteria:** Publication period: 1990-2005. **Population:** Participants were residents and patients within acute, subacute, rehabilitation and residential settings, aged over 65 years, their family and health care staff. No restrictions were made in terms of the patient's condition (e.g. their cognitive state, seriousness/level of illness). **Study design:** This review considered quantitative (e.g. RCT, time series, crossover design, case series, crosssectional, cohort, prospective, case control, retrospective studies) and qualitative studies (e.g. case ACEBAC Constructive staff-family relationships in the care of older adults in the	**Number of studies:** 35 studies. **Study design:** RCT (n=1) Triangulated experiments (n=3) Qualitative research studies (n=28) Textual papers (n=3) **Number of participants:** Not calculated but listed for most included study. Residents ranging between (n=10) and (n=16), family members ranging between (n=7) and (n=349), staff ranging between (n=7) and (n=895) **Characteristics of participants:** Residents and patients within acute, subacute, rehabilitation and	Family members' perceptions of their relationships with staff showed that a strong focus was placed on opportunities for the family to be involved in the patient's care. Staff members also expressed a theoretical support for the collaborative process, however this belief often did not translate to the staff members' clinical practice. In the studies included in the review staff were frequently found to rely on traditional medical models of care in their clinical practice and maintaining control over the environment, rather than fully collaborating with families. Four factors were found to be essential to interventions designed to support a collaborative partnership

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			institutional setting reports, phenomenological studies, grounded theory, ethnographic studies, naturalistic studies) which reported on staff and family perceptions of staff-family relationships in the care of older people who are patients of acute, subacute, rehabilitation and long term care settings. Text which were derived from sources other than research (e.g. opinion papers, discussion papers, reviews, consensus guidelines) were also be considered. **Settings:** Acute, subacute, rehabilitation and residential settings. **Other criteria:** English **Literature search:** 2005	residential settings, aged over 65 years, their family and health care staff. **Country of origin:** The following are mentioned but country is not listed for all studies. United States, Australia, New Zealand, Canada, Sweden, Iceland, Finland, United Kingdom, **Setting:** Residential settings **Interventions:** Partners in Caregiving (PIC (n=1), Family Involvement in Care (FIC) (n=2), Family meeting intervention (n=1) **Outcomes:** Subjective and objective measure of staff-family relationship staff outcomes related to constructive staff-family relationship (e.g. decreased stress, increased job satisfaction, more inclusive practice,	between family members and health care staff: communication, information, education and administrative support. Based on the evidence analysed in this systematic review, staff and family education on relationship development, power and control issues, communication skills and negotiating techniques is essential to promoting constructive staff-family relationships. Managerial support, such as addressing workloads and staffing issues; introducing care models focused on collaboration with families; and providing practical support for staff education, is essential to gaining sustained benefits from interventions designed to promote constructive family-staff relationships.

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				improved retention of staff, increased satisfaction with relationship with resident/patient and family) family satisfaction with the relationship with staff resident satisfaction related to constructive staff-family relationships **Follow-up time**: Not stated.	
Hall et al 2011 UK [42]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To determine effectiveness of multi-component palliative care service delivery interventions for residents of care homes for older people. Second, to describe the range and quality of outcome measures.	**Inclusion criteria** 1 study: All residents in units at time of initial chart review. 1 study: Non reported - probably all residents. 1 study: Residents diagnosed with endstage dementia, identified by staff as usually unable to engage in group programmes for residents with dementia, at least 2 symptoms, advance directives requesting no cardiopulmonary resuscitation. **Literature search** All to February 2010	**Number of studies:** 3 **Study design:** RCT (n=277) CBA (n=458) **Number of participants:** 735 particpants. Intervention = 487 Control = 248 **Characteristics of participants:** Average age varied from 80.0 to 87.9 years. Female (75 to 81%), reflecting the higher proportion of women living in most care homes.	Clearly a need for effective palliative care interventions in care homes for older people, and the core principles and practices of palliative care, such as advance care planning and symptom management could benefit all residents, not just those at the end of life. The review found potentially promising results for 3 interventions: assessing residents' suitability for specialist palliative care and making recommendations to their physicians, developing palliative care expertise in care homes

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				Setting: 12 nursing homes (with own hospice services or arrangements with external hospice services) and 3 long-term care facilities. **Country of origin:** USA **Interventions:** Structured interview to identify residents suitable for palliative care and asked their physicians to refer them to specialist palliative care (n=107). Development of palliative care leadership teams, technical assistance meetings for team members, education in palliative care for all staff, feedback on performance (n=345). Residents transferred to special units in the homes, interdisciplinary teams to develop individualized care plans, holistic care, and staff education in palliative care (n=35).	and moving residents with end-stage dementia to special units in the care home. However, without further evaluation, we cannot recommend the use of the interventions in clinical practice. There is an absence of a shared understanding in the literature of what a palliative care intervention for residents should look like. Some features of the interventions evaluated in this review are likely to be important: relationships between care homes and specialist palliative care services who can provide specialist support for residents with complex needs. Specialist services can also provide training and advice to care home staff who could provide a general palliative approach to care which is appropriate for all residents, regardless of their diagnosis or prognosis. However, training is a necessary but not sufficient condition to

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				Outcomes: Six-month mortality Family rating of quality of care (N = 17) Resident in pain Behaviours associated with dementia Discomfort Physical complications **Follow-up time:** Study 1: Residents: for 6 months or until death. Bereaved relatives 2 months post-death. Study 2: 6 months post intervention. Study 3: 2 months post intervention	improve the care of residents. Other components, such as the development of multidisciplinary teams, are also likely to be important. Such teams were included in two of the interventions and are a key aspect of a palliative approach to care.
Hill et al 2017 Australia [43]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	Previous meta-analyses indicate that computerised cognitive training (CCT) is a safe and efficacious intervention for cognition in older adults. However, efficacy varies across populations and cognitive domains, and little is known about the efficacy of CCT in people with mild cognitive impairment or dementia.	**Inclusion criteria:** Randomized controlled trials of CCT in older adults with mild cognitive impairment or dementia. **Literature search:** From inception to July 1, 2016.	**Number of studies:** 25 **Study design:** RCT **Number of participants:** Mild cognitive impairment: n=686, CCT: N=351, control: N=335. Mean age 67 and 81 years old, and 51.88% of participants were female.	CCT is efficacious on global cognition, select cognitive domains, and psychosocial functioning in people with mild cognitive impairment. This intervention therefore warrants longer-term and larger-scale trials to examine effects on conversion to dementia. Conversely, evidence for efficacy in people with dementia is weak and limited to trials

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				Dementia: n=389, CCT: N=201, control: N=188. Mean age 66 and 81 years old, and 63.5% of participants were female. **Characteristics of participants:** Older adults with mild cognitive impairment or dementia. **Setting:** Supervised home-based. **Country of origin:** Not stated apart from Australia **Interventions:** At least 4 hours of drill and practice, with a clear cognitive rationale, videogames, or virtual reality, had to be completed. **Outcomes:** Global cognition, memory, working memory, and attention and helps improve psychosocial	of immersive technologies.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				functioning, including depressive symptoms. **Follow-up time** Is reported in a supplement.	
Hodgkinson et al 2007 Australia [44]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser och arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To establish the best available evidence for the effectiveness and safety of topical skin care interventions for residents of aged care facilities.	**Inclusion criteria:** Study designs of interest to this review were systematic reviews, randomized and non-randomized controlled trials. The review considered studies that included adults aged 65 years and over residing in an aged care facility. Studies with adults aged 65 years and over and in long-term care were also considered when aged care studies were not available when addressing specific skin conditions. Interventions of interest were any non-medical intervention or program designed to promote or improve the integrity of skin in older adults. Excluded were studies that evaluated pressure relieving techniques for the prevention of skin breakdown.	**Number of studies:** Ten studies and 1 review. **Study design:** RCT, CCT, case – control, retrospective, repeated measure **Number of participants:** 12-93 **Characteristics of participants:** Some information about frailty and continence status. **Setting:** Nursing home, long term care **Country of origin:** Not stated **Interventions:** Absorbent products, no-rinse cleansers, skin creams, emollient	Many of the studies showed trends favouring a specific treatment but were underpowered and therefore a statistically significant difference between two groups, if one truly existed, was unlikely to be identified. More research is warranted, specifically into the effectiveness of no-rinse cleansers on overall skin condition, topical skin care to prevent skin tears and dermatitis and topical skin care to reduce skin dryness.

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			Outcome measures included the incidence of adverse skin conditions such as rash, skin irritation, haematoma or tears during the study period. Patient satisfaction was also considered. **Literature search:** April 2003	soaps and structured skin cleansing regimes **Outcomes:** General skin condition, pressure sores, dry skin, skin tears, dermatitis, satisfaction **Follow-up time:** Not stated	
Huang et al 2015 Taiwan [45]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To investigate the immediate and long-term (6 -10 months) effects of reminiscence therapy on cognitive functions and depressive symptoms in elderly people with dementia.	**Inclusion criteria:** All RCTs of reminiscence therapy performed for elderly people with dementia. Outcome measures comprising cognitive functions and depressive symptoms were included. **Literature search:** December 2014	**Number of studies:** 12 **Study design:** RCT **Number of participants:** 9 to 268, in total, 1325 **Characteristics of participants:** Participants with various types of dementia, including those with Alzheimer dementia, vascular dementia, and dementia secondary to medical disorders. **Setting:** Institutional and community setting	This meta-analysis including more recent RCTs shows that reminiscence therapy yields a small-size effect on cognitive functions and a Moderate-size effect on depressive symptoms in elderly people with dementia. Long-term effects of reminiscence therapy on cognitive functions and depressive symptoms were not confirmed. Reminiscence therapy is more effective for depressive symptoms in institutionalized residents with dementia than for those in community-dwelling elderly adults. Because reminiscence therapy is an easy-to-perform and easily administered

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				Country of origin: Not clearly stated apart from China **Interventions:** Group or individual reminiscence therapy sessions, 5-12 weeks **Outcomes:** Cognitive function and depressive symptoms **Follow-up time:** 6-10 months when stated	intervention, health care providers should adopt it in multidimensional treatments to improve cognitive functions and depressive symptoms in elderly people with dementia, particularly in institutionalized residents with dementia. Because long-term effects of reminiscence therapy on cognitive functions and depressive symptoms in elderly people with dementia were not confirmed, additional well-designed RCTs should be conducted to clarify this.
Hutchinson et al 2010 Australia [46]	**Moderate** **SBU Domain(s):** Behovsbedömning och uppföljning. (Needs assessment and follow-up: older persons) **Quantitative**	To systematically examine published and grey research reports in order to assess the state of the science regarding the validity and reliability of the RAI-MDS 2.0 QI.	**Publications:** Literature in the English language Articles or reports of research published up to December 2008 **Primary purpose:** Examining reliability and/or validity of Resident Assessment Instrument (RAI)-Minimum Data Set 2.0 **Literature search:** Not stated; publications published up to December 2008 included	**Number of studies:** 14 articles **Study design:** 1) Comparison between RAI-MDS 2.0 data routinely collected by facility staff and that collected by trained research nurses (n=2); Comparison between data collected using the RAI-MDS 2.0 instrument and that collected using another method designed to measure the same	The findings indicate that the strength of the evidence with respect to the validity and reliability of RAI-MDS 2.0 QI is limited, and further research is warranted. While the QIs provide a useful tool for quality monitoring and with which to inform quality improvement programs, caution should be exercised when interpreting the QI results. Importantly, the results should be

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				resident characteristics (n=12). **Number of participants**: N=109-5758/study **Characteristics of participants:** Mean age: Not stated Age range: Not stated Gender distribution: Not stated **Setting:** Residential long-term care **Country of origin:** United States. **Intervention/assessment:** Resident Assessment Instrument (RAI)-Minimum Data Set 2.0 **Outcomes:** Validity and reliability of multiple indicators Validity and reliability of single indicators (falls, depression, depression without treatment, incontinence, urinary tract infection, weight	contextualized and interpreted in conjunction with other valid and reliable sources of information and evidence about care processes. Finally, this review indicates the need for further validation of the RAI-MDS 2.0 Qis.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				loss, bedfast, restraint, pressure ulcers, pain) **Follow-up time:** Not applicable	
Joseph et al 2016 USA & South Korea [47]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative and qualitative**	To provide an overview and synthesis of the most recent empirical evidence addressing the impact of the physical environment on residents and staff of residential health, care, and support facilities.	**Study design**: Randomized controlled, quasi-randomized controlled, controlled before-and-after, historically controlled and cohort studies, and cross-sectional studies. **Participants**: Older adults 55 years of age or older, health personnel such as medical staff, nurses, and physicians. **Setting:** Residential care facilities (i.e., assisted living facilities, group homes, homes for the aged, nursing homes such as residential health, care, and support facility (RHCSF). **Intervention**: Physical environment component that is being evaluated. **Outcomes:** Not clear, Resident quality of life, resident safety, and	**Number of studies:** 66 **Study design:** Randomized controlled, quasi-randomized controlled, controlled before-and-after, historically controlled and cohort studies, and cross-sectional studies. **Number of participants:** Not stated **Characteristics of participants:** Not stated specifically for each study. **Setting:** Majority of the studies in this sample were conducted in nursing home (NH) environment alone (32 studies). Eight studies were conducted in two different settings (3 studies in skilled nursing facility (SNFs)/	This review found 66 studies examining the relationship between the built environment and outcomes in three broad domains of resident quality of life, resident safety, and staff and organizational outcomes. The studies address a range of topics including the impact on elderly residents of the facility scale and size, outdoor environments, and environmental quality.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			staff and organizational outcomes. **Literature search:** January 2000 and October 2012	assisted living facility (ALF) and 2 studies in hospitals/unknown type of long-term care settings, 2 studies in hospitals/post-acute facilities, and 1 study in retirement communities/ single-family community dwellings). One study was conducted in three different settings simultaneously (i.e., ALF, NH, and care homes). Other than studies that focused solely on NH settings, a few studies focused on just one type of setting such as ALF (2 studies), care homes (3 studies), and retirement communities (3 studies). Seventeen studies indicated long-term care settings generally without specifying the type of RHCSF **Country of origin:** Not stated (not limiting to US). **Interventions and outcomes:**	

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				Resident quality of life including facility-level design factors, site optimization/outdoor environments, unit configuration and layout, small-scale facilities, public-private space gradient, support for wayfinding, unit density and design, room configuration, daylight and lighting, furniture fixtures and equipment, physical restraint, disguising doorways, multi-sensory environments, overall environmental quality, ambient environment. Resident safety -falls including facility-level design factors, furniture, fixtures, and equipment, interior materials, environmental / condition, Health care-associated infections including room configuration, environmental conditions Medication safety	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Room configuration, - environmental conditions (noise) Staff and organizational outcomes: facility-level design factors, unit type, furniture, fixtures, and equipment. **Follow-up time:** Not applicable or not stated specifically for each study	
Jutkowitz et al 2016 USA [48]	**Moderate** **SBU domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To evaluate the efficacy of nonpharmacological care-delivery interventions (staff training, care-delivery models, changes to the environment) to reduce and manage agitation and aggression in nursing home and assisted living residents.	**Inclusion criteria:** Population**:** Facility caregiving staff. Publication period: Studies published before August 2015. Study design: RCTs evaluating nonpharmacological interventions designed to reduce agitation or aggression in individuals with dementia. Setting: Nursing homes and assisted living facilities. Other criteria: English	**Number of studies:** 19 **Study design:** RCT (n=19) **Number of participants:** Not summarised but ranges between n=31 and n=659. **Characteristics of participants:** Not stated. **Country of origin:** Australia (n=1), Norway (n=1), Netherlands (n=4), United Kingdom (n=4), Germany (n=1), France (n=1), United States (n=6), Canada (n=1)	Evidence was insufficient regarding the efficacy of nonpharmacological care-delivery interventions to reduce agitation or aggression in nursing home and assisted living facility residents with dementia.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			Literature search: July 2015.	**Setting:** Nursing homes and assisted living facilities **Interventions:** 22 interventions of 19 studies: Dementia care mapping (n=3) Person-centred care (n=3) Clinical guidelines to reduce antipsychotic and other psychotropic drug use (n=3) Emotion-oriented care (n=2) Additional mutually distinct types of staff training and environmental changes (n=11) **Outcomes:** Resident well-being, agitation, aggression, general behavior antipsychotic and other psychotropic use) **Follow-up time:** 2 weeks to 20 months.	
Kelly et al 2014 Ireland [49]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande	To investigate the impact of cognitive training and general mental stimulation on the cognitive and everyday	**Study design:** Randomized controlled trials **Participants:**	**Number of studies:** n=31	The impact of cognitive training on everyday functioning is largely under investigated. More research is required to

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	arbetssätt och metoder - ordinärt boende (Maintaining and stimulating work methods - community settings) **Quantitative**	functioning of older adults without known cognitive impairment. Examine transfer and maintenance of intervention effects, and the impact of training in group versus individual settings	Older adults (>50) with no known existing cognitive impairment. **Setting:** Community dwelling **Intervention:** Cognitive training or general mental stimulation **Outcomes:** Cognitive function **Literature search:** 2012	**Study design:** All Randomized controlled trials **Number of participants:** 1806 participants in cognitive training groups and 386 in general mental stimulation groups. 1541 'no intervention' controls and 822 active controls. **Characteristics of participants:** Mean age not calculated. Inclusion starts from 50 years of age. Main part of the studies analyse participants older than 60 years of age (n=29). **Setting:** Community dwelling **Country of origin:** Not stated **Interventions:** The most common cognitive training intervention was memory-based training. Mental stimulation	determine if general mental stimulation can benefit cognitive and everyday functioning. Transfer and maintenance of intervention effects are most commonly reported when training is adaptive, with at least ten intervention sessions and a long-term follow-up. Memory and subjective cognitive performance might be improved by training in group versus individual settings.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				interventions were diverse and included activities such as playing piano, acting, and helping children with reading difficulties. The 'no intervention' controls received either no contact, minimum social support, or were placed on a waiting list. Active control groups included educational DVDs or lectures, health-promotion training, non-brain training computer games, or some form of unstructured learning. **Outcomes:** Meta-analysis results revealed that compared to active controls, cognitive training improved performance on measures of executive function (working memory, $p = 0.04$; processing speed, $p < 0.0001$) and composite measures of cognitive function ($p = 0.001$). Compared to no intervention, cognitive training improved performance on	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				measures of memory (face-name recall, p= 0.02; immediate recall, p =0.02; paired associates, p =0.001) and subjective cognitive function (p = 0.01) **Follow-up time:** Not stated per outcome. (Weeks to years)	
Kimber et al 2015 UK [50]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – både särskilt och ordinärt boende (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To synthesise evidence from nonrandomised studies aiming to improve nutritional intake in nutritionally vulnerable individuals and to describe their effects on cost, nutritional, clinical and patient centred outcomes	**Inclusion criteria**: Studies were eligible for inclusion if they were non-RCTs, before-and-after studies or were prospective studies providing either quantitative or qualitative data. Case studies (or those with insufficient detail to permit replication or quality appraisal) were excluded **Literature search**: Searching was undertaken three times: To the end of October 2011 (all databases); to 31 March 2013 (all databases); and to 3 May 2013 (Scopus only)	**Number of studies**: 41 **Study design:** Controlled trials (n=35) and observational studies (n=6) **Population**: Adults (Included studies aged 60 an over) who were malnourished, judged to be at nutritional risk or were considered to have the potential to benefit from improved nutritional care. Participants were identified as malnourished or at risk of malnutrition based on published clinical guidelines.	This systematic review describes a range of interventions that may be implemented in clinical practice. A limited range of outcomes are reported, and it is difficult to draw any meaningful conclusions on the effect of the different methods.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Setting: Eligible participants were either in a hospital or a residential care home (RCH) setting, or were receiving home care **Number of participants**: 3 751 **Country of origin:** Not stated **Interventions:** Changes to the organisation of nutritional care (n = 15), changes to the feeding environment (n = 11), modification to meals (n = 6), supplementation of meals (n = 7) and recipients of home delivered meals (n = 2). **Outcomes:** The primary outcomes were: Nutritional intake, health-related quality of life, patient satisfaction, patient and staff experience and morbidity/ complications. The	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				secondary outcomes were: Nutritional status, clinical and other functional measures, hospital admission and institutionalization, length of hospital stay, adverse effects, death from any cause and costs. **Follow-up time:** Per outcome or unclear	
Konno et al 2014 Japan [51]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt - särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To examine what interventions effectively manage or reduce the resistance-to care behaviours of nursing home residents with dementia.	**Inclusion criteria:** (1) Examined any non-pharmacological intervention to reduce the resistance-to-care behaviours of people with dementia over the age of 55, who were living in a residential-care setting. (2) Used outcome measures of resistance-to-care frequency and intensity during personal care; and (3) were randomized controlled trials (RCT), or quasi-experimental studies, published in English. **Literature search** December 2012	**Number of studies:** 19 **Study design:** Quasiexperimental (16 studies), RCT (3 studies) **Number of participants:** 7-127 **Characteristics of participants:** Mainly women with **Moderate**-to-severe dementia, with a mean age of 80–90 years. **Setting:** Nursing home	**Conclusion:** We reviewed the effects of non-pharmacological interventions on the resistance-to-care behaviours of residents with dementia in a personal-care context. Interventions were mostly targeted for mealtime care, bathing and morning care. The level of recommendation for the non-pharmacological interventions for resistance-to-care behaviours is low because of problems in study design, measurement of resistance to care and the evaluation of interventions, regardless

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Country of origin: USA (11), Canada (3), Taiwan (3), Belgium (1), Sweden (1) **Interventions:** *Interventions with environmental control:* mealtime music interventions (9 studies), bathing care (3 studies), music intervention for morning care (1 study). *Educational interventions for caregivers:* A person-centred educational programme for bathing (4 studies) An ability-focused educational intervention for daily care and morning care (five studies) **Outcomes:** Disruptive behaviour, problem behaviour, agitation, aggression and resistance-to-care.	of the type of care. However, most of the studies showed significant reductions in resistant-to-care behaviours. Providing culturally sensitive, person-centred care on the basis of individual preferences and abilities is a basic principle for personal care considering the alternative of non-personcentred care. Future research needs to overcome the problem of the measurement and evaluation of the effects of non-pharmacological interventions during personal care.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Follow-up time: Post-intervention periods are not specified	
Lai et al 2009 Hong Kong [52]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats. (Institutional care as an intervention) **Quantitative**	To evaluate the effect of special care units (SCUs) on behavioural problems, mood, use of restraints and psychotropic medication in patients with dementia.	**Inclusion criteria:** Types of studies: RCTs in which the outcomes were compared against traditional nursing units. No limit concerning the number of participants in the trials; double-blind assessment not required. Studies where participants received more than one intervention sequentially were excluded unless results obtained during the first treatment phase assessing the outcomes of SCU placement were clearly documented. Included had to comprise pre- and post-intervention testing with at least two-time measurement points. Clinical trials that investigated the effect of a certain dimension were excluded, as were case studies. Clinical trials that included dementia subjects who had no behavioural problems at baseline were included if onset of new agitated behaviour was an	**Number or studies:** In review: 8 studies In meta-analysis: 4 **Study design:** No RCTs identified; therefore, inclusion of non-RCTs with matched controls. Quasi-experimental study (n=1), prospective cohort study (n=4), prospective matched cohort study (n=2), prospective case controlled cohort study (n=1) **Number of participants:** 21-1423/study **Characteristics of participants:** Mean age: Not stated Age range: Not stated Gender distribution: 9-80%. **Setting:** Special care units for dementia.	There are no identified RCTs investigating the effects of SCUs on behavioural symptoms in dementia, and no strong evidence of benefit from the available non-RCTs. It is probably more important to implement best practice than to provide a specialized care environment. The routine collection of data on behaviour, restraint and psychotropic drug use across multiple nursing home settings offers the best modality for formal evaluation of the benefit or otherwise of SCUs.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			outcome measure of those trials. **Intervention group:** Patients with a confirmed diagnosis of dementia or Alzheimer's disease or related disorders (ADRD). **Control group:** People with dementia and/or ADRD who resided in long-term care settings that were not specifically designed. **Exclusion**: People with dementia and/or ADRD who live in psychiatric facilities. **Intervention:** Special care units for dementia **Outcomes:** Primary Outcomes: Agitated behaviours Secondary outcomes: use of physical restraints, psychotropic medications, mood, well-being, quality of life. **Literature search:** 6 September 2007	**Country of origin:** United States (n=3), Canada (n=1), Germany (n=1), Italy (n=1), multi-national (France, Italy, Sweden; n=1), No information (n=1). **Interventions:** SCU **Outcomes:** Agitated behaviours Use of physical restraints, psychotropic medications, mood, well-being, quality of life. **Follow-up time** 3-18 months	

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Fraser et al 2014 Australia [53]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative and qualitative**	To explore the value of using participatory arts activities (such as music, dance, singing and the visual arts) in residential care settings to enhance the health and well-being of older people.	**Inclusion criteria:** Interventions with people 65 or older. Interventions within residential care settings and/or for residents in care, taking account of cultural differences in the names used for such provision in other countries. Participatory arts activities such as playing music, singing, creating visual art, creating physical art such as clay modelling, performing arts such as acting or reciting poetry. Qualitative, quantitative, mixed and/or multimethod research. English language. **Literature search:** Articles published between 2000 and 2013.	**Number of studies:** 5 **Study design:** 2 used quantitative approaches 1 used mixed methods 2 used qualitative **Number of participants:** N=169 **Characteristics of participants** Alzheimer's/dementia/ mixture of conditions. Aged 65 years and over. (range 43–97) **Setting:** Residential care. **Country of origin:** Australia, England, France, Sweden, USA. **Interventions:** -Participative percussion accompaniment amongst Alzheimers resident to know songs or participative and collaborative recipe completion through a	Music therapy interventions are believed to have beneficial outcomes for people with dementia. Such benefits include "providing frameworks for meaningful activity and stimulation, the management of problematic behaviour such as agitation, improved activity participation, social interaction and emotional and cognitive skills." Participatory music interventions, seem to provide many similar benefits, and can be led by non-specialist caregivers and others within the community. Multi-centre studies need to be conducted using similar care settings and with residents who have similar characteristics. Need for longitudinal studies which explore impact over time, and which also use pre- and post-intervention measures. It seems particularly important to try and understand in

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				mixture of culinary tasks. -Visual arts activities. -Music participatory singing. - Music/dancing/singing/ listening participatory singing, playing and listening to music. **Outcomes:** Well-being, mood, engagement and memory, quality of life, meaningful activity and stimulation. Management of problematic behaviour such as agitation, activity participation, social interaction, emotional and cognitive skills. **Follow-up time:** Duration of interventions: 2-hours twice per week to 4 weeks, 6 weeks, 5 months, 9 months.	more detail the balance between the impact of the “arts” activities and the relevance of the “participation” element. The role of the caregiver in the triangle of relationships between artist–caregiver–older person needs more attention. Participatory arts-based activities have a role to play in improving the QoL amongst older people living in residential care settings.
Leah 2016 UK [54]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och	To evaluate the best ways of supporting people with dementia to eat.	**Inclusion criteria:** Dementia, hydration, nutrition, older people, systematic review. **Literature search:**	**Number of studies:** 22 **Study design:** CCT, cohort, RCT, interrupted time series,	The strongest evidence is shown in the more complex educational programmes for people with dementia. The evidence suggests that

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	metoder – ordinärt boende. Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. **(**Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**		January 2004 to July 2015	interrupted time series crossover. **Number of participants:** Educational: (n=1 283) I=609, C=623. Environmental or routine changes (n=436), I=141, C=137 (not stated for all studies). Assistance with eating (n=210). Mixed interventions (n=116). **Characteristics of participants:** People with dementia. People with mild/**Moderate** Alzheimer's. **Setting:** Living at home, long-term dementia specialist units, long-term care, rehabilitation unit, nursing homes, residential home. **Country of origin:** US (8), Taiwan (5), Sweden (1), Finland (1), Spain (2), Canada (2),	staff who support people with dementia to eat should undertake face-to-face education programmes and aim to give people enough time when helping them to eat. However, cultural change may be needed to ensure that individual assessments are carried out to identify those having difficulty eating, and to ensure they are afforded enough time to eat their meals. People living with dementia experience a range of difficulties with eating, because of the different areas of the brain that can be affected, as well as the individual's personality and life history. We can try to make changes to address these difficulties based on our understanding of damage to the brain and how the person sees and experiences the world. The eating difficulties experienced by people with dementia are unique

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				France (2), New Zealand (1). **Interventions:** Educational programmes (n=10), environmental or routine changes (n=8), assistance with eating (n=2), mixed interventions (n=2). **Outcomes:** Increases in the time people with dementia spent sitting, increased food/calorie consumption, positive response from caregivers in terms of reported improvement in knowledge among professional carers and attitudes towards people with dementia. (summarised) **Follow-up time:** 1 year (only stated in 1 study).	to each person; successful interventions will therefore need to be based on assessments of each individual's difficulties and what would be practical in their care environment.
Liu et al 2014 USA [55]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – särskilt boende. (Maintaining	To evaluate the effects of interventions on mealtime difficulties in older adults with dementia	**Inclusion criteria**: Any comparator, or none at all (e.g., placebo, no therapy, another active therapy, or no control therapy).	**Number of studies**: 22 **Study design:** RCT (n=9), CCT (n=5), cohort (n=2),	Mealtime difficulties in older adults with dementia still exist, and various types of effective interventions should be implemented to alleviate eating or feeding

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	and stimulating work methods - institutional settings) **Quantitative**		**Literature search**: September 2012	interrupted time series (n=6). **Population**: Older adults aged 65 years old or above, with dementia of any type and any stage. **Number of participants**: 2082 older adults and 95 nursing professionals. **Country of origin:** USA, Canada, Taiwan, Spain, France, Netherlands, Finland and New Zealand **Setting:** Long-term care, nursing home, day care **Interventions:** Any intervention on mealtime difficulties in which the study analyzes its effect on the outcome of interest. **Outcomes**: behavioral and functional outcomes (e.g., eating time,	difficulties and reduce adverse outcomes. By evaluating studies of almost the last decade, this systematic review provides updated evidence for clinical practice and points out priorities for nursing research. Such evidence was based on a body of research with **Moderate** quality and existing limitations, and more methodologically rigorous studies need to be conducted. ‘‘Nutritional supplements’’ showed **Moderate** evidence to increase food intake, body weight and BMI. ‘‘Training/education programs’’ demonstrated **Moderate** evidence to increase eating time and decrease feeding difficulty. Both ‘‘training/ education programs’’ and ‘‘feeding assistance’’ were insufficient to increase food intake. ‘‘Environment/ routine modification’’ indicated low evidence to increase food intake, and

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				feeding difficulties, eating ability, frequency and time of self-feeding, physical or verbal assistance/ prompts, level of dependence, agitation, cognitive and behavioral function and behavioral disturbance), nutritional outcomes (e.g., food intake, body weight, BMI, nutritional status, body composition, biochemical parameters), and other adverse e.g., occurrence of fractures, pressure ulcers and hospitalization). Caregiver outcomes included knowledge, attitude and behaviors in nursing assistants, staffing time and caregiver's burden. **Follow-up time:** Not clear	insufficient to decrease agitation. Evidence was sparse on nutritional status, eating ability, behavior disturbance, behavioral and cognitive function, or level of dependence.
Liu et al 2015 USA [56]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande	To summarise available interventions and evaluate their effectiveness on eating performance among	**Inclusion criteria:** Older adults (≥ 65 years old) with dementia who were involved in oral eating or feeding.	**Number of studies:** 11 **Study design:**	Effective interventions should be based on multilevel), multi-component individualized care

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	older adults with dementia in LTC settings.	Excluded if subjects were experiencing enteral nutrition or parenteral nutrition approaches. Any behavioral or environmental intervention on optimizing oral feeding or eating performance or behaviors, in which the study analyzes its effect on the outcome of interest. Excluded if interventions were only nutritional supplementation, nutritional education, or music. Any comparator, or none at all (e.g., placebo, no therapy, another active therapy, or no control therapy). Outcomes: self-feeding or eating performance (e.g., eating independence, eating frequency, eating task participation and assistance, self-feeding ability, feeding difficulty). Excluded if only any of the following outcomes are available: 1) nutritional	5 RCTs, 2 CCTs, 2 interrupted time series, 2 single group repeated measures. **Number of participants:** 530 (range 5-134). **Characteristics of participants:** Older adults with dementia, aged 65-96 years and 86 nursing caregivers (e.g., registered nurses, nursing assistants, certified assistant nurses, licensed practical nurses). **Setting:** 21 LTC facilities (e.g., assisted living, nursing home, geriatric centers, Alzheimer specialized center). **Country of origin:** Taiwan, USA, Canada **Interventions:** Training programs for residents or nursing assistants at intra- or interpersonal levels, mealtime assistance	approaches to achieve optimal eating performance among LTC residents with dementia. By evaluating studies within the last three decades, this review provides preliminary support for using training programs and mealtime assistance to optimize eating performance in this population.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			intake (e.g., food/liquid intake, dietary intake/ consumption, energy/ carbohydrate/protein/fat intake, calories consumption); 2) anthropometric parameters (e.g., weight, height, BMI, MNA, biceps, triceps and sub scapular skin fold, brachial and calf circumference, upper-arm circumference); 3) Serum biochemical parameters (e.g., albumin, transferrin, B12, haemoglobin, proteinogram, total serum proteins/cholesterol, pre-albumin, lympoocyte count, calcium, posphorus, acid, uric acid, folic acid, iron, zinc, vitamin A, B and E levels, and flavonids), 4) disruptive behaviors or behavioral disturbances (e.g., agitation, depression, aggression, wondering, leaving during mealtimes); and 5) other adverse events (e.g., cognitive deterioration, morbidity, mortality, hospitalization, number of infectious events and days in bed). RCTs, Con-trolled Clinical Trials [interrupted time	from nursing caregivers at interpersonal level, environment modification at environmental level, and multicomponent interventions at both personal (i.e., resident or nursing staff) and environmental levels. Duration up to 6 months. **Outcomes:** Self-feeding or eating performance (e.g., eating independence, eating frequency, eating task participation and assistance, self-feeding ability, feeding difficulty). **Follow-up time:** Not stated	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			series, single group repeated measures **Literature search:** June 2014		
Livingston et al 2014 UK [57]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	Which non-pharmacological interventions are clinically effective for reducing agitation in adults with dementia, considering the following: dementia severity; setting; whether the intervention is with the person with dementia, their carer, or both; and whether any beneficial effects are immediate or longer term?	**Inclusion criteria:** - Studies evaluating a psychological, behavioural, sensory or environmental intervention to manage agitation - Studies with a comparator group: separate groups or before/after comparisons - studies with agitation results reported as quantitative outcome - Studies in which all participants had dementia, or those with dementia were analysed separately - Studies in which no people with dementia in the sample were aged < 50 years. Interventions were excluded if every individual was given psychotropic drugs or some participants only had medication but no other intervention. **Literature search** 9 August 2011 and 12 June 2012	**Number of studies:** In review: 160 studies; 97 studies rated as high quality are described in the tables in meta-analysis: 3 studies **Study design:** RCTs, Within-subjects, Non-randomised crossover, Non-randomised case-matched controls, Quasi-experimental, Non-randomised within-subjects, Matched controls, Non-randomised-matched groups, Non-randomised matched controls **Number of participants:** N=4-387/study **Characteristics of participants:** Mean age: Not stated Age range: Not stated Gender distribution: Not stated	There is consistent evidence that teaching staff in care homes to communicate and consider the person with dementia's needs rather than focus on completing tasks with them was helpful for severe agitation, as were touch therapies. Activities and structured music therapy helped to decrease the level of agitation in care homes but was not specifically tested in severe agitation. We suggest using a manual with managers and staff of care homes to ensure the permanent and consistent implementation of effective interventions. Future studies should consider cost-effectiveness, and treatments for people in their own homes.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Setting: Any setting **Country of origin:** USA (n=77), Australia (n=13), the UK (n=13), Canada (n=10), Italy (n=7), Taiwan, Province of China (n=7), the Netherlands (n=6), Republic of Korea (n=6), Japan (n = 4), Sweden (n=4), China/Hong Kong (n=3), Germany (n=3), France (n=2), Islamic Republic of Iran (n=2), Iceland (n=1), Israel (n=1) Norway (n=1), Spain (n=1). **Interventions:** Intervention categories: psychological, behavioural, sensory or environmental. Subdivided into: Working with person with dementia: - activities - music therapy - sensory interventions - light therapy - aroma therapy - exercise - pet therapy	

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				- dementia specific therapy - home-like care Working through paid caregivers - person-centred care and communication skills - dementia care mapping (DCM) - behavioural management and communication skills - changing the environment - mixed interventions Working with family caregivers in the home of person with dementia - training in behavioural management - CBT **Outcomes:** Clinically significant agitation, decreasing mean agitation symptoms. **Secondary outcomes:** Functioning Quality of life	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
Low et al 2011 Australia [58]	**Moderate** **SBU Domain(s):** Integrerade insatser eller aktiviteter och informationsöverföring. (Integrated measures or activities) **Quantitative**	To evaluate the outcomes of case management, integrated care and consumer directed home and community care services for older persons, including those with dementia.	**Study design/methods:** Quantitative outcomes. **Population:** Community dwelling, with either a majority aged 65 years and over, or with a subsample of persons aged 65 and over for whom results were reported separately. Not samples with specific medical illness, except for dementia. **Intervention:** Case management Integrated care Consumer directed care **Language:** Written in English. **Literature search:** 2004 – May 2009	**Number or studies:** 35 articles **Study design:** RCTs (n=12), non-randomized trials (n=5), observational studies (n=13), randomized trial evaluated effects of computerised system (n=1). **Number of participants:** N=85-18143/study **Characteristics of participants:** Mean age: 67.7-83.3 years Age range: Not stated Gender distribution: 3.8-85.7% women **Setting:** Home and community services **Country of origin:** United States (n=17), Canada (n=3), United Kingdom (n=3), Finland (n=2), Italy (n=2), Australia (n=1), Spain (n=1), Europe (n=1), not specified (n=1)	This is the first systematic review comparing different models of non-medical home and community services for older persons. Each model impacts on different outcomes which relate to the focus of the model. Instead of asking which model is the best at improving outcomes, we should be asking how to combine the successful features of all three models to maximize outcomes.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Interventions: Case management (n=14) Integrated care: (n=11) Consumer directed care (n=6) **Outcomes:** Clinical outcomes: Function (ADLs, IADLs), Cognition, Medication management, Quality of Life, Physical health, Social interaction or support, Depression, psychological health, Risk of mortality, Caregiver burden/distress, Pain Satisfaction: Satisfaction with care, Caregiver satisfaction, Life satisfaction Service use: Risk of nursing home admission, Risk of hospital admissions, Risk of emergency admissions, Community service use, Length of hospital stay **Follow-up time:** 3 weeks to 3 years	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
Low et al 2015 Australia [59]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	1. To systematically identify and describe studies that have investigated the effects of interventions to change staff practice or care approaches in order to improve resident outcomes in nursing homes. 2. To identify interventions or intervention components which lead to successful staff practice or care approach change in nursing homes. 3. To identify potential barriers and enablers to staff practice or care approach change in nursing homes.	**Inclusion criteria:** Higher quality studies. Studies with 3 or more sites in each group. Clustered trials with at least two intervention sites and two control sites. At least 3 intervention and 3 control sites in order to reduce the possibility of site-specific confounding and increase generalizability. Nursing homes. Changing the care practices of staff for the benefit of the residents. **Literature search:** December, 2013	**Number of studies:** 63 **Study design:** Randomized controlled trials and quasi-experimental controlled trials **Number of participants:** Control: 117 233 (61 facilities, 9 665 cities) **Intervention**: 70 539 (37 facilities, 7 182 cities). **Characteristics of participants:** Residential care of older people. **Setting:** Facilities catering for permanent residential care of older people including providing housekeeping, personal care, meals, activities and nursing home. **Country of origin:** Australia, Sweden, USA, UK, Hong Kong, Belgium, Netherlands, Germany	Changing staff practice in nursing homes is possible but complex. Interventionists should consider barriers and feasibility of program components to impact on each intended outcome.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Interventions: Oral health, n=3 studies C: 562, I: 565 Hygiene and infection control, n=3 studies C: 1959, I: 3274 Nutrition, n=2 studies C: 1229, I: 601 Nursing home acquired pneumonia prevention and management, n=4 studies C: 549, I: 574 + 10 sites, Depression, n=2 studies C: 13, I: 46 + 33 sites Appropriate prescribing, n=7 studies C: 3 287, I: 2 952 Physical restraint, use n=3 studies C: 2 183, I: 2 477 Management of behavioral and psychological symptoms of dementia, n=6 studies C: 1 230, I: 1 122	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Falls reduction and prevention, n=11 C: 100 363 + 25 cites I: 38 592 + 23 cites Quality improvement, n=9 C: 1 724 + 61 facilities, 9 665 cites I: 2 787 + 57 facilities, 7 091 cites Philosophy of care and aspects of culture of care, n=10 studies C: 954, I: 1 196 Other studies, n=5 studies C: 3 127, I: 3 178 **Outcomes:** Change in staff behavior (not just attitudes or knowledge), change in other staff outcomes (e.g. staff turnover, absenteeism or stress) change in resident clinical outcomes (but not just satisfaction with care).	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Follow-up time: 16 weeks, 26 weeks, 52 weeks, 78 weeks, 100 weeks, 0-16 months	
Martin et al 2016 Australia [60]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To identify the effects of ACP interventions on nursing home residents.	**Inclusion criteria:** Studies examining an effect of advance care planning on nursing home residents. Nursing homes (defined as residential aged care facilities, long-term care units, and skilled nursing facilities or care homes). ACP (defined as any advance discussions or directives, including medical treatment orders, with effect on nursing home residents). Randomized controlled trials, controlled trials, pre/poststudy design trials, and prospective trials. **Literature search:** April 2015.	**Number of studies:** 13 **Study design:** (5 Systematic reviews) Controlled trial n=5 Prospective cohort n=5 Pre- postintervention n=2 RCT n=1 **Number of participants:** I: 4 465 C: 5 025 (numbers not reported in all studies) **Characteristics of participants:** Frail older people Age and gender not stated **Setting:** Nursing home population **(**residential aged care facilities, long-term care units, and skilled nursing facilities or care homes)	ACP has beneficial effects in the nursing home population. The types of ACP interventions vary, and it is difficult to identify superiority in effectiveness of one intervention over another. Outcome measures also vary considerably between studies although hospitalization, place of death, and actions being consistent with resident's wishes are by far the most common. Very few studies with high quality methodology have been undertaken in the area with a significant lack of randomized controlled trials. More robust studies, especially randomized controlled trials, are required to support the findings.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Country of origin: Australia, Canada, Hong Kong, USA (n=7), UK, The Netherlands, Singapore/Netherlands **Interventions:** The ACP interventions included (1) 5 studies evaluating educational programs; (2) 5 studies introducing or evaluating a new ACP form; (3) 2 studies introducing an ACP program with a palliative care initiative; and (4) 1 study observing the effect of do not resuscitate orders on medical treatments for respiratory infections. A range of effects of ACP was demonstrated in the study populations. Hospitalization was the most frequent outcome measure. Of note, in the 2 studies that included mortality, the decrease in hospitalization was not associated with increased mortality. Place of death is another important	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				effect of ACP. Medical treatments being consistent with ones' wishes were increased with ACP although not to 100% compliance. Two studies showed a decrease in overall health costs. One study found an increase in community palliative care use but not in-patient hospice referrals. **Outcomes:** Hospitalization and costs, place of death, mortality, QOL/ satisfaction, actions consistent with wishes, use of life-sustaining treatments, palliative care and hospice. **Follow-up time:** Not stated	
Mason et al 2007 UK [61]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats. (Institutional care as an intervention) **Quantitative**	To review the evidence for different models of community-based respite care for frail older people and their carers, where the participant group included older people with frailty, disability, cancer or dementia. Where data permitted,	**Inclusion criteria:** Effectiveness studies had to be well controlled, with uncontrolled studies included only in the absence of higher quality evidence. Economic evaluations had to compare 2 or more options and	**Number of studies:** 42 studies were included in the review: 20 systematic reviews, 22 effectiveness studies (10 RCTs, 7 quasi-experimental studies and 5 uncontrolled studies), and 5 economic evaluations.	The literature review provides some evidence that respite for carers of frail elderly people may have a small positive effect upon carers in terms of burden and mental or physical health. Carers were generally very satisfied with

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		subgroups of carers and care recipients, for whom respite care is particularly effective or cost-effective, were to be identified.	consider both costs and consequences. **Literature search:** March 2005. Ongoing and recently completed research databases were searched in July 2005.	**Study design:** Randomised trials n=10 Quasi-experimental studies n=7 Uncontrolled studies n=5. **Number of participants:** Recipients: n=3 205, dyads n=1 730. Male %: 13, 17, 20, 23, 26.3, 28, 33, 35.8, 40, 43, 45, 47.6, 50, 63.1, 96. Mean age: 66, 68.3, 74.5, 75.8, 76.2, 77.2, 78, 79.5, 80.4, 81.5. **Characteristics of participants:** Older people receiving respite care, including those with frailty, disability, dementia or cancer, and their carers care recipient: person being cared for (patient, older person) dyad: carer and care recipient frail: having one or more long-term health problems and/or difficulties in one or	respite. No reliable evidence was found that respite either benefits or adversely affects care recipients, or that it delays entry to residential care. Economic evidence suggests that day care is at least as costly as usual care. Pilot studies are needed to inform full-scale studies of respite in the UK.

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				more aspects of personal care (e.g. as assessed against the Activities of Daily Living Index), such that support to live independently is required. older: aged 65 years or above. **Setting:** Day care, host-family, in-home, institutional and video respite. Studies of respite care services in all settings apart from acute medical and/or surgical inpatient wards were eligible for inclusion in the review. Settings such as nursing and residential homes, hospices, community and GP-run hospital units, day centres and domiciliary settings were all eligible for inclusion. **Country of origin:** Australia n=2 Canada n=2 Germany n=1	

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				Spain n=1, UK n=5, USA n=11. **Interventions:** For the purposes of the review, 'respite care' is defined as care provided intermittently in the home, community or institution in order to provide temporary relief to the principal carer. Respite care includes, but is not limited to: ● day care ● in-home respite (day or overnight) ● host family respite ● institutional respite (overnight) ● programmes ● video respite. **Outcomes:** Data on the following categories of outcome measures (as reported for carers and care recipients separately, and by the care recipient, carer or clinician) were included: ● quality of life (carer/care recipient)	

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				● physical health (carer/care recipient) ● mental/psychological health (carer/care recipient) ● satisfaction (carer/care recipient) ● carer burden ● utilisation of any health and social services (carer/care recipient) ● utilisation of informal or voluntary support services (carer/care recipient) ● (time to) institutionalisation ● time spent on caring tasks ● activities of daily living (ADL). **Follow-up time:** 3 to 6 months	
Mignani et al 2017 Italy [62]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings)	To search and synthesize qualitative studies exploring the perspectives of older people living in long-term care facilities and of their family members about advance care planning (ACP) discussions.	**Inclusion criteria:** 1. Studies with a study population including older people age >65 years) living in long-term care facilities (including nursing homes and care homes) and/or their family members. 2. Qualitative studies or mixed method studies	**Number of studies:** 9 **Study design:** Qualitative (semi structured interviews, focus groups etc) **Number of participants:** 135 older persons, 133 family caregivers	**Conclusion:** Despite their willingness to be involved in a shared decision making process regarding EOL care, older residents of long-term care settings across the globe and their family members still know and have little experience with ACP.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	Qualitative		including a qualitative component. 3. Studies whose main aim included exploring participants' opinions and attitudes about ACP discussions. 4. Studies published in English. **Literature search:** November 2015	**Characteristics of participants:** 66-104 years **Setting:** Long-term care facilities (including nursing homes and care homes) but also participants from other settings as well (ie, community center, acute geriatric ward, medical oncology ward, palliative care unit, and home services for older people) **Country of origin:** Australia (I), Belgium (2), Norway (2), UK (2), USA (2). **Interventions:** Advance care planning discussion **Outcomes:** Four main themes: I) plans already made; 2) EOL care and decision-making; 3) opinions and attitudes toward ACP; and 4) how, when, about what, and with whom to carry out ACP.	Further, methodologically rigorous studies specifically addressing older people living in long-term care facilities in different cultural contexts are needed in order to explore and understand their perspectives and authentically provide person-centered EOL care.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Follow-up time: Not applicable	
Milne et al 2002 UK & Australia [63]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende och ordinärt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To examine trials for improvement in nutritional status and clinical outcomes when extra protein and energy were provided, usually as commercial 'sip-feeds'.	**Inclusion criteria:** Randomised and quasi-randomised controlled trials of oral protein and energy supplementation in older people, with the exception of groups recovering from cancer treatment or in critical care. **Literature search:** November 2007	**Number of studies:** 62 (meta analyses is based on up to 42 studies) **Study design:** Randomised and quasi-randomised controlled trials **Number of participants:** 10 87 participants. Range 10 - 4023 (42 trials had fewer than 100 participants). **Characteristics of participants:** Female: approximately 55% of participants. Forty studies (48% participants) included older people with no specified disease or condition. The mean age reported in studies varied from 65 to 88 years (not reported in seven studies). **Setting:** Hospitalised in-patients with acute conditions. Other participants were	Supplementation produces a small but consistent weight gain in older people. Mortality may be reduced in older people who are undernourished. There may also be a beneficial effect on complications which needs to be confirmed. However, this updated review found no evidence of improvement in functional benefit or reduction in length of hospital stay with supplements. Additional data from large-scale multi-centre trials are still required. Trials should also focus more on primary outcomes of relevance to patients such as improvement in function or quality of life measures.

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				either in long-stay / care of the elderly / continuing care wards or nursing homes (14%, 15 studies), or at home in the community (15%, 21 studies). **Country of origin:** Europe, USA, Canada, Australia and Hong Kong. The number of participants in trials varied greatly between **Interventions:** Interventions were aimed at improving the intake of protein and energy using only the normal oral route. Protein was provided together with non-protein energy sources such as carbohydrate and fat, and with or without added minerals and vitamins. Supplements in the form of: • commercial sip feeds • milk based supplements • via the fortification of normal food sources.	

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				Primary outcomes: • all cause mortality • morbidity • functional status. **Secondary outcomes:** • participants' perceived quality of life • length of hospital stay • number of primary care contacts • adverse effects of nutritional supplementation; • level of care and support required; • number of hospital / care home admissions / re admissions; • nutritional status (change in anthropometry, for example percentage weight change, percentage change arm muscle circumference); • percentage change in dietary intake • compliance with intervention • economic outcomes. **Follow-up time:** Range: one week to 18 months	

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Montgomery et al 2008 USA [64]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To assess the effectiveness of personal assistance for older adults with impairments, and the impacts of personal assistance on others, compared to other interventions	**Inclusion criteria:** Older adults (65+) living in the community who require assistance to perform tasks of daily living (e.g., bathing and eating) and participate in normal activities due to permanent impairments. Controlled studies of personal assistance in which participants were prospectively assigned to study groups and in which control group outcomes were measured concurrently with intervention group outcomes were included. **Literature search:** June 2005	**Number of studies:** 4 **Study design:** RCT (n=1), quasi-randomised Non-randomised (n=3) **Number of participants:** Total n=1 642 Study 1. Receiving personal assistance (n=49 adults) Nursing homes (n=49) Average 78 and 80 years. Mostly female (28 and 28). Study 2. 79% female, 59% white, 40% Hispanic. Study 3. 4 sites who continued to receive personal assistance (n=175), 7 sites with cluster care (n=229). Those receiving personal assistance were more likely to be black (62% versus 38%), less likely to be Hispanic (14% and 28%), and less likely to live with	Research in this field is limited. Personal assistance is expensive and difficult to organise, especially in places that do not already have services in place. When implementing new programmes, recipients could be randomly assigned to different forms of assistance. While advocates may support personal assistance for myriad reasons, this review demonstrates that further studies are required to determine which models of personal assistance are most effective and efficient.

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				someone (17% and 28%). Study 4. Intervention group (n=101), controls (n=101). Most participants and assistants were white. **Characteristics of participants:** Older adults (65+) living in the community who require assistance to perform tasks of daily living (bathing, eating, getting around, etc.) and to participate in normal activities due to permanent impairments. Older adults living outside their own homes (e.g., in nursing homes) were excluded. Studies in which the majority (51% or more) of participants had been diagnosed as suffering from dementia at baseline were excluded as their reasons for receiving assistance and goals might differ from other older adults.	

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				Setting: In the community, receiving personal assistance. Nursing homes. Users of the state's personal care benefit Living with family or friends. Cluster care. **Country of origin:** USA **Interventions:** Personal assistance compared to other forms of support or to 'no-intervention' (which may include unpaid care) in which participants were prospectively assigned to study groups and in which control group outcomes were measured concurrently with intervention group outcomes. Participants received a monthly allowance that could be used to hire caregivers. Intervention participants received approximately 19 hours of paid care per week	

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				compared to 16.6 hours of paid care per week in the control group. The intervention allowed people to hire relatives 'during a time when agency workers were in short supply'. Participants reported difficulty budgeting for the programme and completing paperwork; they were less likely than younger adult participants in a related trial to receive the intervention. Of those who received a payment in the 8th month of the study, 86% of participants used it to pay workers, using 81% for this purpose (data available for 267 participants). Of those who hired a worker in the first 9 months, 45% hired a worker who lived with the participant; 20% of participants tried to hire a worker but were unable to do so (data available for 402 participants)	

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				Participants in both groups received paid assistance. Those switched to cluster care received assistance that was organised in blocks of time and over which the users had less control. Intervention group lived with an assistant, 41% of whom spent more than 8 hours per day giving assistance in household tasks, activities of daily living and participating in activities. Assistants provided help with laundry (97%), personal shopping (83%), cleaning clients' rooms (80%), transportation to social activities (77%), handling money (65%), grooming (49%), bathing (37%), dressing (26%), and preparing special diets (21%). Most did not work outside the home; they typically earned $6,000 to $7,000 excluding program payments	

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				Outcomes: 1) Global quality of life, 2) User satisfaction. 3) Participation **Secondary outcomes** 1) Unmet needs, 2)Health outcomes, 3) Functional status 4) Outwardly directed 5) Psychological outcomes, 6) Impact on others, 7) Direct and indirect costs **Follow-up time:** 3 -16 months	
Morilla-Herrera et al 2016 Spain [65]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende och ordinärt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To determine the effectiveness of food-based fortification to prevent risk of malnutrition in elderly patients in community-dwelling, institutionalized, or hospitalized elderly patients, compared to other methods of nutritional support.	**Inclusion criteria**: Types of studies: The included studies were randomized controlled trials, quasi-experimental, and interrupted time series including a longitudinal analysis of the results with at least two observations, before and after the intervention. Types of participants: The Patients include older people aged over 65 years receiving hospital services for acute or chronic conditions or as outpatients for diverse health problems, in home care	**Number of studies**: 7 **Study design:** RCT **Population**: Elderly patients who are institutionalized, hospitalized or community-dwelling, with a minimum average age of 65 years. older people aged over 65 years receiving hospital services for acute or chronic conditions or as outpatients for diverse	Food-based fortification yielded positive results in the total amount of ingested calories and protein. Nevertheless, due to the small number of participants and the poor quality of some studies, further high quality studies are required to provide reliable evidence. *Implications for practice*: Despite the limited evidence, due to their simplicity, low cost, and positive results in protein and calories intake, simple dietary

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			programs, or in residential care in which food-based fortification was applied due to its condition of risk of malnutrition. Types of interventions and outcome measures: The selected studies compared food-based fortification with macronutrients against other alternatives and assessed their effectiveness on any nutritional parameter, such as weight gain, protein or calories intake, or non-nutritional outcomes such as food consumption, functional status or quality of life. Interventions that investigated the use of oral nutritional upplementation such as commercial sip feeds, or vitamin and mineral supplements were excluded **Literature search**: Not given	health problems, in home care programs, or in residential care in which food based fortification was applied due to its condition of risk of malnutrition. **Number of participants**: 588 **Country of origin:** Not stated **Setting:** Community or institutionalized elderly patients **Interventions:** Compared food-based fortification with macronutrients against other alternatives. Alternative interventions found in this review were: administration of informative brochures, to compare against the usual diet, inclusion of controls in social programs, different standardized diets, or	interventions based on the food-based fortification or densification with protein or energy of the standard diet could be considered in patients at risk of malnutrition. Despite the poor methodological quality of most studies analyzed due to their simplicity, low cost, and absence of contraindications, simple dietary interventions based on the food-based fortification or densification with protein or energy of the standard diet could be considered in patients at risk of malnutrition, because its effect on total amount of Kcal ingested and protein intake. Nevertheless, further studies to determine which modality of enrichment is more effective, and long-term follow-up are needed. Moreover, studies that include functional and quality of life outcomes, as well as cost effectiveness analyses are recommended.

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				diets provided by the hospital. **Outcomes:** Weight gain, protein or calories intake, or non-nutritional outcomes such as food consumption, functional status or quality of life. **Follow-up time:** Highly variable between studies. Probably between 3 days and 6 months	
Morris et al 2014 Australia [66]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser och arbetssätt – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To undertake a systematic literature review of studies that assessed the effectiveness of smart technologies in improving or maintaining the social connectedness of older people living at borne.	**Inclusion criteria:** • Assessed effectiveness of smart technologies on social connectedness (as defined by Thomas et al. [17]) using some form of intervention study • Published in English and available in full-text from peer review journals • Set in a home environment • Included participants aged 45 years or more **Literature search:** February 2013	**Number of studies:** 18 **Study design:** RCT (n=12); cohorts (n=6). **Number of participants:** Sample sizes: 12–309 **Characteristics of participants:** Mean age: 59–82 years. **Setting:** Ordinary housing	Despite the interest in the use of smart technologies, and the need to better cater for an ageing population, relatively few studies identified their effectiveness in improving social connectedness in older people living in the community. The multidimensionality of social connectedness and the use of a variety of outcome measures limited the direct compari-son of study outcomes. It is possible that smart technolo-gies,

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Country of origin: USA (n=11), The Netherlands (n=4), Canada (n=1), Norway (n=1), one undetermined. **Interventions:** The range of smart technologies under investigation included web based information, intervention and communication programs. • online education program that provided information related to the health condition of interest • email access to health professionals • In addition to online included access to peer-led, asynchronous discussion forums that were monitored or coordinated by a member of the research team. • provision of necessary equipment as well as training for computer, Internet and email use.	such as interactive computer programs with electronic access to clinicians and relevant websites, may help older people to better manage and understand various health conditions. An improved understanding of the condition could potentially result in subsequent improvements in factors that are correlated with social connectedness, such as depression. Further investigation is warranted to deter-mine the effectiveness of smart technologies to enhance positive aspects of social connectedness, such as participa-tion, engagement and social cohesion with friends and family.

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				• use of pre-recorded, interactive telephone messages • the Nintendo Wii • automated, online self-help program • visual and verbal contact between study participants **Outcomes:** Social connectedness as social support, participation, empowerment, engagernent, isolation and loneliness. **Follow-up time:** Not clearly stated for all studies	
Mottram et al 2002 UK [67]	**Moderate/High** **SBU Domain(s):** Hemtjänst som insats (Home help as an intervention) **Quantitative**	To assess the effects of institutional versus at-home care for functionally dependent older people on health outcomes, satisfaction (of functionally dependent older people, relatives and health care professionals), quality of care and costs.	**Inclusion criteria**: Randomized trials, controlled clinical trials, controlled before and after studies and interrupted time series studies where functionally dependent older people were assigned to either institutional or at-home care. **Literature search**: 1999	**Number of studies**: 1 **Study design:** RCT **Population**: older people who, due to chronic physical health problems, are unable to function without support and are assessed as needing institutional care.	There is insufficient evidence to estimate the likely benefits, harms and costs of institutional or at-home care for functionally dependent older people.

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				Number of participants: 112 **Country of origin:** Not stated **Setting:** Not applicable **Interventions:** - Home care in adapted or non-adapted residence - Day-care - Regular respite care - Foster care. **Outcomes:** Health outcomes, including mortality, morbidity measures and functional status. - Satisfaction of functionally dependent older people, family and health care professionals. - Quality of the professional practice. - Non-health outcomes such as functionally dependent older people’s freedom of choice of meals, bed hours, visits etc.	

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				- Resource utilization. **Follow-up time:** 3-12 months	
Möhler et al 2011 Germany [68]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	1. To evaluate the effectiveness of interventions for preventing and reducing the use of physical restraints in older people who require long-term nursing care (either in community nursing care or in residential care facilities). 2. To evaluate these complex interventions by retrieving detailed data on implementation. 3. To highlight the quality and quantity of research evidence available and to set an agenda for future research.	**Type of studies:** Individual or cluster-randomised controlled trials in which older adults or groups of older adults requiring long-term nursing care were allocated either to a restraint reduction programme or usual care (control group). Studies comparing two types of programmes were also included. **Population:** Older people of either gender requiring long-term nursing care irrespective of their cognitive status. **Intervention:** Restraint reduction or prevention programme: 1. Educational interventions 2. Organisational interventions 3. Interventions providing restraint alternatives 4. Other interventions: All other interventions, also interventions comprising a combination of these categories.	**Number of studies**: 5 **Study design:** Cluster RCTs. **Number of participants**: Not stated **Characteristics of participants**: Mean age: Not stated Age range: Not stated Gender distribution: Not stated **Setting:** Community nursing care or residential care facilities **Country of origin:** Norway (n=2), the Netherlands (n=1), Sweden (n=1), United States(n=1) **Interventions:** Educational programme. In addition, consultation or guidance for nursing	There is insufficient evidence to support the effectiveness of interventions for preventing or reducing the use of PR in geriatric long-term care. The review is based on a limited number of studies with various methodological shortcomings. The studies showed significant clinical heterogeneity in terms of the components of the interventions and the definitions of PR applied. Bedrails were not always counted as physical restraints. Only one study investigated group dwelling units for persons with dementia and no studies in the community setting could be identified. For both settings further studies are needed. Researchers in the field of PR reduction are urgently requested to put more

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			Interventions containing drug therapy were excluded **Outcomes:** Primary: Number or proportion of residents with at least one PR; Prevention of physical restraints (PR); Reduction of PR. Secondary: Type of PR; Duration of PR use; Prescription of psychotropic drugs; Residents' and caregivers' quality of life; Adverse effects of the interventions employed; Duration of effect of the interventions; Injuries and deaths during the study period **Literature search:** 7 September 2009	staff was offered in 4 studies. **Outcomes:** Primary: Physical strain use Secondary: Types of restraints, Multiple restraints, Restraint intensity; Psychotropic medications; Falls and fall-related injuries; Adverse outcomes **Follow-up time:** 6-12 months	weight on the careful development of their complex interventions including theory-based modelling of components and pilot testing of feasibility and acceptability. Evaluation studies should adhere to the best available methodological standards, especially in terms of placing more emphasis on well-designed cluster-randomised controlled trials with rigorous statistical methods adjusting for cluster design. Reporting of complex interventions should comply with existing reporting statements.
Osakwe et al 2017 USA [69]	**Moderate** **SBU Domain(s):** Behovsbedömning och uppföljning. (Needs assessment and follow-up: older persons) **Quantitative**	To describe and compare methods used to assess ADLs among older adult patients skilled nursing facilities and home health care	**Inclusion criteria:** Quantitative and qualitative primary research studies published in English. The following inclusion criteria were used to identify relevant studies: a) original research published in English, b) included patient's age 65 years or	**Number of studies:** 8 (five cross-sectional, one quasi experimental, one prospective cohort and one retrospective cohort study) **Study design:** 8 cross-sectional studies, one quasi experimental study,	This review adds to the growing body of evidence to evaluate ADL measures across PAC settings to ensure efficiency of healthcare expenditure and standardization of assessment. There is substantial variation in the ADL measures of self-care and mobility in SNF

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			older, c) used a standardized ADL instrument in either HHC or SNF. We only included studies of nursing homes with individuals who had a length of stay of 100 days or less and who had a hospitalization prior to their nursing home stay. Instruments that assessed ADLs in SNF and HHC **Literature search:** April 21, 2016.	one prospective cohort study, one retrospective cohort study. **Number of participants** 131 to 1 023 036. **Characteristics of participants:** Average age: 77.1 to 84.9 years. Females up to 77.2% where stated **Setting:** Skilled nursing facilities and home health care (4 studies each) **Country of origin:** Norway and USA **Interventions:** Five instruments: The Barthel Index and OASIS were used in HHC whereas the MDS 2.0, MDS 3.0, and FIMFRG were used in SNF settings. **Outcomes:** ADL ability levels **Follow-up time:** On the day or a prior period	and HHC. To address this, uniform ADL terminology and measures are needed, and standardized training is warranted for clinicians assessing ADLs. This is particularly important in HHC where registered nurses or physical therapist can conduct OASIS assessment. Additional research is needed particularly on the reliability and validity of ADL measures using OASIC-C1.

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Ostaszkiewicz et al 2005 Australia & UK [70]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser och arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To assessing the effectiveness of timed voiding for the management of urinary incontinence in adults. (a) timed voiding is more effective than no timed voiding. (b) timed voiding is more effective than other interventions. (c) timed voiding combined with another intervention is more effective than that other intervention alone. (d) timed voiding combined with another intervention is more effect-ive than timed voiding alone. (e) timed voiding combined with another intervention is more effective than usual care.	**Inclusion criteria:** Randomized or quasi-randomized controlled trials on timed voiding for the treatment of urinary incontinence in adults. that also described a behavioral intervention with an adjustment to the voiding schedule or toileting program that described a fixed interval of voiding or toileting that was delivered either alone or in combination with another intervention. Urinary incontinence was defined either by symptom classification or urodynamic diagnosis and included urge, stress and mixed incontinence. The main outcomes of interest were changes in the frequency or severity of urinary incontinence or changes in the number of individuals with incontinence. Secondary outcomes of interest included changes in (a) bladder volume; (b) health economic measures; (c) the incidence of urinary tract infection; (d) alterations to skin integrity; and (e) altered caregiver burden	**Number of studies:** 2 **Study design:** 1 RCT, 1 CCT **Number of participants:** 20-278 **Characteristics of participants:** Mean age 87,3 years predominantly cognitively and physically impaired older women **Setting:** Nursing home setting **Country of origin:** Not stated **Interventions:** Fixed interval of voiding as one component of the overall intervention **Outcomes:** Day- and nighttime urinary incontinence **Follow-up time** Not stated	This review was challenged by a lack of consensus in terminology for interventions that involve adjustment to voiding schedules. We believe that this reflects an incompletely theoretically informed construct of timed voiding. There is a need, therefore, to review the theory underpinning behavioral interventions for the management of urinary incontinence and the definitions used for the various systematic voiding programs. Despite a comprehensive search, only two trials met the inclusion criteria. These tested the hypothesis that timed voiding combined with another intervention is more effective than usual care. There was insufficient evidence for a quantitative estimate. Moreover, it is difficult to draw conclusions about the effects of time voiding from the limited evidence available as the trials were of variable quality. There is a need

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			and other quality of life considerations. **Literature search:** May 2002		for well-designed and larger trials that address these biases and evaluate different types of systematic voiding programs in a range of different populations and settings. This is important, as it would support the development of criteria that would enable clinicians and consumers to select appropriate and targeted interventions.
Park et al 2016 Korea & USA [71]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende och ordinärt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To screen the pressure ulcer risk by evaluating a predictive function of tools among older adults by use of a meta analysis methodology. Specific aims: (a) examining characteristics of studies which applied assessment tools for risk of pressure ulcers and their outcomes of prevalence of pressure ulcers in older adults through a systematic review. (b) summarising the evidence of overall predic-tive validities and	**Inclusion criteria:** Selection criteria for this study required the following: a) application of the indexed test (the Norton Pressure Sore Risk-Assessment Scale, Waterlow Pressure Ulcer Risk Assessment, and Braden Scale for Predicting Pressure Sore Risks). (b) inclusion of the predictive validity (sensitivity, specificity, and diagnostic odds ratio) of the indexed tests and outcomes of screening (positive, negative, or false) in the development of pressure ulcers.	**Number of studies:** 29 **Study design:** Prospective (n=23) **Number of participants:** 11 729 participants. 6 studies, n=≤100 persons; 10 studies >300 persons. **Characteristics of participants:** 7 studies had a male dominant sample, and 11 were female dominant. In 17 studies the mean age was ≥65 years.	The findings indicate that those tools in current use have I limitations in accurately predicting the accuracy in pressure ulcer risks in older adults, because high heterogeneity existed among studies. Strategies to reduce heterogeneity among studies using the Braden Scale should be developed. To provide optimal opportunity for prevention of pressure ulcers for older adults, efforts should be made to modify the current scales by augmenting the strength of the tools and

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		heterogeneity from selected studies by type of screening tools. (c) exploring heterogeneity among the studies by the subgroups of participants (age and gender), care facilities conducting the studies (acute hospital and long-term care), and reference standards.	(c) focus on age 60 years or above; and (d) articles published either on-line or in hard copies. Literature which did not provide a full text or an original study was excluded. **Literature search:** 2013	**Country of origin:** North America n=14 (United States and Canada), Asia (n=6), Europe (n=4), Latin America (n=3), Middle East (n=1,) Oceania (n=1). **Setting:** Acute care (hospital) admission units; long-term or home care agencies **Interventions:** Three pressure ulcer risk assessment tools: Braden, Norton, and Waterlow Scales **Outcomes:** Predictability **Follow-up time:** Not clear	reducing limitations. The development of more accurate assessment tools for the prediction of pressure ulcers is necessary to insure evidenced-based interventions are targeted where they can have the greatest impact. Overall, the findings indicate that the three scales show a similar predictability (**Moderate** level) regarding pressure ulcer development and existence of heterogeneity between studies.
Petriwskyj et al 2016 Australia [72]	**Moderate** **SBU domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings)	To identify and evaluate the existing evidence and knowledge regarding the use of subscription-based, person-centered culture change models. Although the broader review addressed a range of research questions, this article focuses on consumer outcomes and	**Inclusion criteria:** Population: Staff included those in any roles as employees of the services, and consumers included those receiving or accessing services, their carers, and immediate family.	**Number of studies:** 28 articles with 33 studies were included in the full review. However, the part covered by this article includes 19 articles with 27 studies. **Study design:**	Outcomes for these models are at best comparable with traditional care with limited suggestions that they result in poorer outcomes and sufficient potential for benefits to warrant further investigation. Although these models may have

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	Quantitative and qualitatitve	experience, including quality of care, clinical outcomes, and consumer experience of care.	Studies published: Up to and including 2015. Study design: The review considered both qualitative and quantitative studies, including but not limited to randomized controlled trials, nonrandomized controlled trials, quasi-experimental, before and after studies, prospective and retrospective cohort studies and cross sectional studies, and designs such as phenomenology, grounded theory, ethnography, action research, and feminist research. Other criteria: Studies were considered for the review if they reported on subscription-based, person-centered culture change models, including voluntary endorsement or badging systems or rating systems. Language: English **Literature search:** 2015	No number of each type of study is given. **Number of participants**: From 10 individuals to 16 000 facilities (facility-level data collection). **Characteristics of participants:** Not stated. **Country of origin:** United States, Canada, England, and Norway. No numbers given. **Setting:** Health and aged care services (staff, and consumers). **Interventions:** Many of the articles offered only limited detail regarding implementation of person-centered care, and the articles described the implementation of different models indicated considerable variation.	the potential to benefit residents, the implementation of person-centered principles may affect the outcomes.

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				The person-centered models: The Eden alternative (n=4), Green hose (n=2) EverCare (n=4), The Pioneer Network (n=1), VIPS Practice Model (n=2), Planetree (n=1) **Outcomes:** The included studies use a multitude of outcome measures. The most important are: Resident outcomes including quality of life, clinical outcome. Quality of care. Resident and family experience of care **Follow-up time:** Not stated.	
Pinto-Bruno et al 2017 Spain & UK [73]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt – bade ordinärt och särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings)	To assess the effects of ICT-based interventions evaluating their utility to promote 'active ageing' and 'social health' in people with dementia.	**Inclusion criteria:** Qualitative and quantitative research which analyses the effect of ICT-based interventions to facilitate social participation and social health among people living with dementia. (2) Studies whose participants are aged 55 years old or older with a	**Number of studies:** 6 **Study design:** Qualitative (4), mixed methods and one quantitative design. **Number of participants:** 79 (18-34)	**Conclusion:** Even though the concept of social health is relatively new in the dementia area, it is surprising the lack of papers assessing this fundamental aspect of psychosocial interventions. The scarce evidence gathered in this review shows promising

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	Qualitative/Quantitative		diagnosis of dementia (both, living in the community or in residential care facilities). (3) Publications written in English. **Literature search** May 2016	**Characteristics of participants:** Persons with dementia, mostly women **Setting:** Community living, residential care **Country of origin:** UK, Finland, Sweden, Netherlands **Interventions:** different technology hardware such as computers, laptops, mobile phones, monitoring devices and tablets. The aim of these technologies is to avoid the social isolation of people living with dementia encouraging their social participation and social contacts in the community through leisure and cognitive activities. **Outcomes:** social participation (social interaction, social inclusion)	results based in mostly qualitative studies. The two studies that provided quantitative results show that ICT-based interventions promote more social behaviours than the non-ICT-based interventions used in the control group traditional ones. Although technology has been included in several psychosocial interventions during the last decades, most of the ICT-based interventions focused in cognitive decline (ICT-based cognitive interventions) and daily life activities (assistive technologies). There is a need to develop specific outcome measures to assess all the aspects related to social health as a whole in psychosocial interventions with people with dementia. Further research is also needed in this area and there is also a need for medium- and long-term follow-ups to examine longer term intervention effects. Most importantly what we

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				Follow-up time: Not applicable	need are high quality randomised controlled trials.
Ploeg et al 2009 Canada [74]	**Moderate** **SBU Domain(s):** Insatser mot våld. (Interventions addressing abuse and neglect) **Quantitative**	To critically appraise the quality of existing studies in the elder abuse field and to summarise the current state of knowledge related to the effectiveness of interventions for elder abuse.	**Inclusion criteria:** (a) the article addresses abuse of persons aged 60 and older; (b) the article describes an intervention that addresses one or more of the following types of elder abuse: physical, psychological, financial, or neglect; (c) the article describes an intervention that is designed to be provided to individual clients (abused persons or perpetrators), professionals who care for older persons, or the community; (d) the article includes assessment of client, professional, and/or community outcomes; (e) the article is a primary study; (f) the study uses quantitative methods; (g) the study includes a comparison group (comparison with usual care or another intervention); and (h) the study is published in English. **Literature search:** February 2008	**Number of studies:** 8 **Study design:** RCT and nonequivalent comparison group studies **Number of participants:** Reported for each study **Characteristics of participants:** Older persons **Setting:** Community **Country of origin** All but one from USA **Interventions:** Psychoeducational support group, community based elder abuse case management programs, education related to elder abuse and home visits by a domestic violence counselor and police volunteer visitors who provided	While elder abuse is an increasingly important issue internationally, there is little high-quality research on the effectiveness of interventions. This review highlights the limited number and quality of empirical research studies in the field. Further, the review suggests that there may be both positive and negative consequences of elder abuse interventions. The need for high quality research in the field is critical not only to ensure health and quality of life for older adults but also to ensure wise use of scarce and costly health and social service resources.

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				assistance, support, and advocacy in the use of the criminal justice system and case management and other services including a law-oriented program and an advocacybased program. **Outcomes:** recurrence of abuse, case resolution, and relocation, professional outcomes **Follow-up time:** Not stated	
Pol et al 2013 The Netherlands [75]	**Moderate** **SBU domain(s):** Insatser eller aktiviteter för att stödja kvarboende (Interventions to support ageing in place) **Quantitative and qualitatitve**	To study sensor monitoring (use of a sensor network placed in the home environment to observe individuals' daily functioning (activities of daily living and instrumental activities of daily living)) as a method to measure and support daily functioning for older people living independently at home.	**Inclusion criteria:** Publication period: Between 2000 and October 2012. Population: Community-dwelling individuals aged 65 and older. Study design: All study designs. Setting: Participants' homes. Other criteria: English	**Number of studies:** 17 **Study design:** Case–control studies (n=3) Mixed methods studies (n=1) Longitudinal pilot studies (n=1) Single-group pre–post design studies (n=1) Multiple-case studies (n=3) Case studies (n=7) Experiment (n=1). **Number of participants:**	The use of sensor monitoring could provide promising opportunities in clinical practice by measuring and supporting daily functioning in older persons living independently, although clear evidence is still lacking. This systematic review also showed that the research has focused largely on the technical aspects of sensor monitoring and less on its application in everyday life and clinical practice. Future research should

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			Literature search: 18 October 2011, updated 9 January 2012 and 25 October 2012.	Varied between (n=1) to (n=52). **Characteristics of participants:** In seven studies, the mean age of the older participants was not specified. The weighted mean age of the participants in the remaining eight studies was 82.6. **Country of origin:** Not stated. **Setting:** Participants' home **Interventions:** Wireless sensor monitoring to measure or support daily functioning for independently living**.** **Outcomes:** Studies that focused on daily functioning in terms of ADL or IADL as the primary outcome measure. **Follow-up time:** Not all studies had a follow-up time. But for	focus on facilitating the use of sensor monitoring in everyday life and clinical practice. To encourage this, a roadmap for future research was proposed that includes the participation of the older people themselves.

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				those who had it ranged between 4 hours and 80 months.	
Reijnders et al 2013 The Netherlands [76]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To evaluate the effectiveness of cognitive interventions in healthy older adults and people with mild cognitive impairment, MCI, by taking into account the content and methodological quality of the intervention studies.	**Inclusion criteria**: (1) randomized controlled trial or clinical study, (2) study population consisting of healthy older adults or people with MCI, (3) any type of cognitive intervention, (4) use of objective and/or subjective outcome measures. Studies were excluded if the language was not English. **Literature search**: February 2012	**Number of studies**: 35 **Study design** 27 RCTs, 8 clinical trials **Population**: Consisting of healthy older adults or people with MCI. Mean age: 63.5 – 80.2 years. **Number of participants**: 13-242 **Country of origin:** Not stated **Setting:** Experimental settings **Interventions:** Most interventions aimed at improving memory performance by training memory strategies, accompanied with psychoeducation on memory, lifestyle, or practice of attentional skills, improving processing speed by	This systematic review, evaluating the effectiveness of cognitive interventions in healthy older adults and people with MCI, showed that cognitive interventions can be effective in improving various aspects of objective cognitive functioning memory performance, executive functioning, processing speed, attention, fluid intelligence, and subjective cognitive performance. The results show evidence that cogrnt1ve training can be effective in improving various aspects of objective cognitive functioning; memory performance, executive functioning, processing speed, attention, fluid intelligence, and subjective cognitive performance. A critical comparison between different intervention studies is difficult

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				using a computer-based cognitive training program. The duration of an intervention varied between 5 and 20 weeks. **Outcomes:** Objective cognitive functioning; memory performance, executive functioning, processing speed, attention, fluid intelligence, and subjective cognitive performance. **Follow-up time:** Post intervention up to 26 months.	because of the heterogeneity of the intervention programs and the chosen outcome measures. In addition to the heterogeneity of the included intervention studies, the methodological quality of the studies differed widely. The issue whether the effects of cognitive interventions generalize to improvement in everyday life activities is still unresolved and needs to be addressed more explicitly in future research. For future research, inclusion of a core set of outcome measures would be necessary to compare the effectiveness of different cognitive intervention programs. Both objective and subjective outcome measures for specific cognitive domains (e.g. memory, executive functioning) and ecological valid measures that show improvements in daily cognitive functioning should be part of this core set of outcome measures.

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					Besides this, the methodological quality of future intervention studies should be improved by specifically addressing the quality control items contained in the Consort criteria. In particular, the description of trial design and randomization should be reporting more accurately and follow-up assessments should be included.
Reuther et al 2012 Germany [77]	**Moderate** **SBU Domain(s):** Integrerade insatser eller aktiviteter och informationsöverföring. (Integrated measures or activities) **Quantitative**	To describe the effects of case conferences on people with dementia and challenging behavior and the staff in nursing homes. 1. What are the key elements of case conferences held on people with dementia and challenging behavior? 2. What impact do case conferences have on people with dementia living in nursing homes and their challenging behaviors?	**Inclusion criteria**: • Studies on the subject of case conferences published before the end of September 2011; • English or German language • Studies in nursing homes • Focus on challenging behavior in people with dementia attended by all those involved with caring for these residents. **Literature search**: October 2011	**Number of studies**: 7 **Study design:** 4 cluster-randomization, 2 quasi-experimental design, 1 pre-post design. **Population**: Residents and staff in nursing homes **Number of participants**: 10-165 residents and 11- 151 staff members **Country of origin:** Not stated.	Case conferences help a care team cope with recurring care problems and approach cases analytically within a team, and case conferences facilitate critical thinking. This is the basis for a sustainable improvement in caring for people with dementia who show challenging behavior. However, good preparation, introduction, and support appear to be essential for using case conferences as a successful intervention. The results of the studies reviewed here indicate that case conferences can reduce challenging

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		3. What influence do case conferences have on the subjective strain and the competence development of staff working with people with dementia?		**Setting**: Nursing home **Interventions:** Case conference/s from 2-18 months **Outcomes:** Challenging behavior, medication, quality of life. **Follow-up time:** Post intervention to 18 months	behavior of people with dementia. However, the validity of these results is limited by the insufficient quality of most studies included. Due to the methodological and content-related differences of the studies, it is not possible to determine a definite effect on the competence, strain, and stress experience of staff working in the nursing homes. The body of evidence regarding the effect of case conferences is weak, and high-quality studies with longer intervention periods are needed. It is necessary to apply similar outcome instruments in different studies.
Richards et al 2003 UK [78]	**Moderate** **SBU Domain(s):** Integrerade insatser eller aktiviteter och informationsöverföring. (Integrated measures or activities) **Quantitative**	To determine the effectiveness and costs of interventions intended to improve access to health and social care for older patients following discharge from acute hospitals.	**Inclusion criteria:** Publication period: Cinahl (1982 to June 2000); Embase (1980 to June 2000); Medline (1966 to June 2000); BIDs Social Science Index (1981 to March 2000); National Institute of Social Work Caredata (1995 to June	**Number of studies:** 23 studies after search. This later drops to 15 due to post-randomization exclusions. **Study design:** RCT (n=15)	The assessment of need may be insufficient in itself for the adequate provision of post-discharge care. Needs assessment should be combined with a service that facilitates the implementation of care plans.

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			2000, or 1975 onwards for British Journal of Social Work); Silver-platter Psychlit (1989 to March 2000); and Silverplatter Social Abstracts (1963 to March 2000). Population: Older people (aged 60 years or over) Study design: RCTs evaluating needs assessment methods and patient discharge coordinator roles. Economic evaluations conducted alongside RCTs were also selected. **Literature search:** June 2000**.**	**Number of participants:** Not stated. **Characteristics of participants:** Older people (aged 60 years or over) of any level of frailty, whose expected location upon discharge was the patient's home. **Country of origin:** USA (n=11), Canada (n=1), Italy (n=1), Germany (n=1), Australia (n=1) **Interventions:** Geriatric consultation teams (GCT) (n=3) Inpatient geriatric evaluation and management (GEM) (n=4) Outpatient geriatric evaluation and management (GEM) (n=3) Coordinator roles (n=5) **Outcomes:** Outcomes assessed included: referrals to or use of health and social care (n=15); mortality	

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				(n=13); patients' functional health status and disability (n=13); and patient perceptions of health (N=5), quality of life (n=3), cognitive functioning and psychological well-being (n=10), social support (n=2) and the adequacy of services (n=4). **Follow-up time:** Between 30 days and 3 years.	
SBU 2013 Sweden [79]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) Treatment not included **Quantitative**	Att granska det vetenskapliga underlaget för behandling av urininkontinens hos äldre och sköra äldre.	**Inclusion criteria:** Population: Personer med urinläckage och som är ≥65 år. Inklusive undergrupper som tillhör gruppen de sköra äldre/ mest sjuka äldre, vilka definieras som personer som är beroende av äldreomsorg och/eller samsjuklighet. Intervention: Behandling kan bestå av kirurgisk behandling, farmakologisk behandling, behandlingsprogram (toaletträning mm), alternativmedicin, bäckenbottenträning,	**Number of studies** 2 **Study design:** RCT **Number of participants:** 259 (112-147) **Characteristics of participants:** Frail elderly (mean age 85-88 years) **Setting:** Nursing home **Country of origin:** The Netherlands	Uppmärksamhetsträning och hjälp till toalettbesök (prompted voiding) i kombination med funktionell träning jämfört med sedvanlig vård minskar antal inkontinensepisoder hos sköra äldre. Det vetenskapliga underlaget är begränsat. Det saknas studier för om uppmärksamhetsträning och hjälp till toalettbesök i kombination med funktionell träning påverkar livskvaliteten hos äldre och sköra äldre. Vetenskapligt underlag saknas.

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			blåsträning, elstimulering, komplexa interventioner (vårdprogram mm), miljö (personal, lokal, utbildning) samt livsstilsinterventioner (dryck, träning mm). Jämförelsegruppen kan ha fått sedvanlig vård, annan definierad behandling, ingen aktiv behandling eller placebo. Endast studier med relevant jämförelsegrupp inkluderades. Undantag för kirurgistudier. Utfallsmått: För att en studie skulle inkluderas måste minst ett primärt utfallsmått rapporteras. Primära utfallsmått var patientens (eller via närstående) upplevelse, antal inkontinensepisoder per dag/vecka utvärderat med lista, symtomskattning (formulär), livskvalitet eller påverkan på det dagliga livet samt biverkningar. **Study design:** Randomiserad kontrollerad studie eller en kontrollerad observationsstudie **Literature search** October 2012	**Interventions:** Uppmärksamhets-träning och hjälp till toalettbesök (prompted voiding) i kombination med funktionell träning **Outcomes:** Urinary incontinence frequency (andel våta kontrollerade skydd) **Follow-up time:** 12-32 weeks.	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
Shaw et al 2009 UK [80]	**Moderate** **SBU Domain(s):** Anhörigstöd och familjeorienterat arbete (Support to informal carers) **Quantitative/qualitative**	To assess the effectiveness and cost-effectiveness of breaks in care in improving the well-being of informal carers of frail and disabled older people living in the community and to identify carer needs and barriers to uptake of respite services.	**Inclusion criteria:** • studies assessed an intervention designed to provide the carer with a break from caring, and they assessed carer outcomes • the care recipient population was aged 65 years or over (or included subsample analysis of participants over 65 years) • the respite intervention was compared with no respite or another intervention. All types of study design were included randomised and non-randomised controlled trials (RCTs), longitudinal before-and-after studies, and observational studies using cross-sectional or longitudinal methods]. Studies were not excluded on the basis of language or year of publication. Studies were included in the qualitative review if: - they employed qualitative methods (face-to-face semi structured/in-depth interviews; focus groups; open questions in	**Number of studies:** Quantitative: 104 (16 in meta analysis) Qualitative: 70. **Study design:** RCT (9), quasi experimental (17), before-after (14); observational (19), cross-sectional (45). **Number of participants:** Reported in appendix 4-9. **Characteristics of participants:** Frail elderly, over the age of 65 years in receipt of informal care from a relative or friend **Setting:** Respite care **Country of origin:** USA, Canada, Australia, New Zealand, Hongkong and Germany. Qualitative studies also from Japan, Iceland and Sweden.	There was some evidence to support respite having a positive effect on carers but the evidence was limited and weak. There was a lack of good-quality larger trials and respite interventions were varied, often with poor descriptions of the characteristics of interventions and limited provision and uptake. There was also a lack of economic analysis. There was no evidence of negative effects on care recipients.

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			questionnaires) they reported the views of carers and/or recipients - the care recipient population was aged 65 years or over, the mean age was 65 years or over, or analysis identified those over the age of 65 years when reporting findings and either: they reported views of resp i te care or reported respite as a theme in relation to other types of care, e.g. care aimed to change the state of the care recipient or: views of respite included respite care service provision/satisfaction with services impact of respite on the carer and/or care recipient unmet needs/perceived needs for respite care reasons for utilising or not utilising respite care. **Literature search:** April 2008	**Interventions:** Institutional, in-home, day care, mixed. **Outcomes:** Recipients: institutionalization Carers: quality of life, burden, anger, anxiety, depression. **Follow-up time:** Up to 15 months.	
Sheppard et al 2016 Canada [81]	**Moderate** **SBU Domain(s):**	To systematically assess the quality of the research examining the benefits of Montessori-	**Inclusion criteria**: All randomized and non-randomized studies examining the effect of	**Number of studies**: 14 **Study design:**	Overall, for persons with dementia, there was strong evidence for the benefits of Montessori-

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	Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	based activities for persons with dementia.	Montessori-based activities for persons with dementia were considered for this systematic review if they had been published in English in a peer-reviewed journal. **Literature search**: April 2015	RCT, within subjects, randomized cross-over, pre-post **Population**: Persons with dementia **Number of participants**: Unclear in the main text and dependent on outcome **Country of origin:** USA, Taiwan and Australia **Setting:** Nursing homes, day care etc. **Interventions:** Montessori-based activities adopt rehabilitation principles, which include task breakdown, guided repetition, and the use of self correcting, modifiable tasks with progressive difficulty such as moving from simple to complex, as well as from concrete to abstract	based activities on eating behaviors, but weak evidence for the benefits on cognition. The level of evidence for the benefits of Montessori-based activities on engagement and affect varied from strong to weak. The dose-response characteristics of the Montessori interventions, including duration, session frequency, and facilitation format varied highly across studies, suggesting that more research is needed to help standardize the approach and learn what minimum participation schedule is needed to provide clinically relevant outcomes. Similarly, future research is needed to examine the benefits of Montessori interventions long-term, both with and without ongoing participation in the activities.

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				Outcomes: Cognition, eating behaviors, affect, engagement. **Follow-up time:** Very various and depending on outcome	
Shier et al 2014 USA [82]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats (Institutional care as an intervention) **Quantitative/qualitative**	(a) What are the nature and scope of nursing home culture change interventions that have been studied? (b) How has culture change and the extent of adherence to interventions been measured? (c) How have culture change outcomes been measured? (d) What is the relationship between nursing home culture change interventions and outcomes?	**Inclusion criteria:** (a) the setting was nursing homes providing care to adults in United States, Canada, or United Kingdom. (b) the intervention focused on more than quality improvement, management interventions, health information technology, infection control, or medication prescribing (i.e., it had to additional reference resident direc-tion, home environment, close relationships, staff empowerment, or collaborative decision making); and if an outcome study, it. (c) employed a research design with a comparator group (randomized controlled trial, nonrandomized controlled	**Number of studies:** 36 (31 peer-reviewed articles reporting on 27 distinct studies and 9 gray literature publications). **Study design:** RCT, pre-post. **Number of participants:** 4-349 **Characteristics of participants:** Information about age range and gender is not stated. **Setting:** Nursing home **Country of origin:** USA , Canada and UK **Interventions:** Resident direction Home environment	Nursing home culture change has face validity in terms of its value, and there are potential policy opportunities to support the development of data to determine its effectiveness. For example, the survey and certification process could prioritize measures that are shown to be sensitive to change and have a clear causal relationship with culture change. Doing so would be an advantage, as culture change is growing in the absence of consistent evidence as to its efficacy. The variation in the way each domain of culture change is operationalized and each type of intervention outcome is measured makes it difficult to conclude whether a particular domain of

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			trial, cohort study, pre-post study with and without concurrent comparator, and case control study). (d) there was sufficient information to evaluate intervention effectiveness (e) the outcomes that could be classified into resident, quality of care or services, family, staff, and organizational **Literature search** July 2012	Relationships Staff empowerment Collaborative management Change Quality Improvement Processes **Outcomes:** Resident, family, staff, quality of care and services, and organisational outcomes **Follow-up time:** Not stated	culture change is associated with a par-ticular outcome. As a result, nursing homes wanting to import culture change are currently unable to use the published literature to identify the best tested approaches to be implemented now. This lack of clear association between culture change and outcomes is unfortunate because comprehensive culture change may require substantial buy-in from all nursing home leadership and staff and require considerable resources. This means that nursing homes would benefit from the ability to weigh these investments against the anticipated benefits. Providers need sufficient information for selecting interventions based on the expectation of improving measurable outcomes. Future studies should carefully measure the process of implementation and fidelity to the culture change intervention to

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					improve understanding of the extent to which changes in intervention outcomes can be attributed to change in nursing borne culture. Studies should also begin from a well conceptualized framework and measure, using validated tools, outcomes that are most likely related by a clear causal hypothesis to domains of culture change and are sensitive to change. Results from these types of studies would facilitate the interpretation of findings, and if positive, would provide evidence to guide providers implementing culture change, and help strengthen the argument for local, state, and federal policy changes to support adoption of culture change practices.
Shizheng et al 2015 China [83]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - ordinärt boende. (Maintaining	To examine the efficacy of Taichi exercise in promoting self-reported sleep quality in older adults	**Study design**: Randomized controlled studies. **Participants**: People aged 60 and over **Setting:**	**Number of studies:** n=5 **Study design:** All randomized controlled studies.	Weak evidence shows that Taichi exercise has a beneficial effect in improving self-rated sleep quality for older adults, suggesting that Taichi could be an effective alternative and

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
	and stimulating work methods - community settings) **Quantitative**		Not reported **Intervention:** Tai chi exercise **Outcomes:** Only those studies in which sleep quality was considered as primary outcomes: Pittsburgh Sleep Quality Index (PSQI) **Literature search:** December 2013.	**Number of participants:** n=460 (range 62 to 118) 243 participants were allocated in intervention groups and 227 in control groups **Characteristics of participants:** Mean ages ranging from 65.94 and 75.45 years old. The participants were predominantly the female elderly, with a proportion of 59.1 %. **Setting:** All in community settings. **Country of origin:** USA n=2, Iran n=1, China n=1, Germany n=1 **Interventions:** Tai chi **Outcomes:** All suffered from same methodological flaws. The results of this study showed that Taichi has beneficial effect on sleep quality in older	complementary approach to existing therapies for older people with sleep problems. More rigorous experimental studies are required.

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				people, as indicated by decreases in the global Pittsburgh Sleep Quality Index score [standardized mean difference = -0.87, 95% confidence intervals (95% confidence interval) (-1 .25, -0.49)], as well as i ts sub-domains of subjective sleep quality [standardized mean difference = -0.83, 95% confidence interval (-1.08, -0.57)], sleep latency [standardized mean difference = -0.75, 95% confidence interval (-1.42, -0.07)], sleep duration [standard-ized mean difference = -0.55, 95% confidence interval (-0.90, -0.21)], habitual sleep efficiency [standardized mean difference = -0.49, 95% confidence interval (-0.74, -0.23)], sleep disturbance [standardized mean difference = -0.44, 95% confidence interval (-0.69, -0.19)], and daytime dysfunction [standardized mean	

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				difference = -0.34, 95% confidence interval (-0.59, -0.09)]. Daytime sleepiness improvement was also observed. **Follow-up time:** 12 weeks to 6 months depending on outcome.	
Sjögren et al 2016 Sweden [84]	**Moderate** **SBU domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To compare the effect of intensified oral care interventions given by dental or nursing personnel on mortality from healthcare-associated pneumonia (HAP) in elderly adults in hospitals or nursing homes with the effect of usual oral care.	**Inclusion criteria:** Publication period: January 1, 1996 – August 18, 2015 Population: Elderly adults in hospitals or nursing homes (mean age ≥65). Study design: RCT covering one of three oral care interventions: given by dental personnel (dental hygienists or dentists) (I1), given by nursing personnel (I2), given by dental or nursing personnel (I3). Comparison was with usual oral care. Setting: Nursing homes or hospitals. Other criteria:	**Number of studies:** 5 **Study design**: RCT (n=5) **Number of participants:** 3 944 **Characteristics of participants:** Not stated. **Country of origin:** Japan (n=2), United States (n=2), France (n=1). **Setting:** Hospitals and nursing homes **Interventions:** Two RCTs compared the effect on mortality from pneumonia of	Oral care interventions given by dental personnel may reduce mortality from HAP (low certainty of evidence, Grading of Recommendations Assessment, Development and Evaluation (GRADE) whereas oral care interventions given by nursing personnel probably result in little or no difference from usual care (moderate certainty of evidence, GRADE in elderly adults in hospitals or nursing homes.

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			Language English, Danish, Norwegian and Swedish. **Literature search:** August 18th 2015	intensified oral care interventions provided by dental personnel (dentists or dental hygienists) with that of usual oral care in elderly adults in hospitals or nursing homes. Three RCTs compared the effect on mortality from HAP of intensified oral care interventions provided by nursing personnel with that of usual oral care in elderly adults in hospitals and nursing homes reported mortality from HAP ranged from 1.7% to 28.1% in the intervention groups and from 1.6% to 20.0% in the control groups. **Outcomes:** Mortality from healthcare-associated pneumonia (HAP). **Follow-up time:** 1,5 years to 2,5 years.	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
Soril et al 2014 Canada [85]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To determine the effectiveness of built environment interventions, in comparison to usual care or no intervention, on the frequency and/or severity of BPSD among residents in LTC.	**Inclusion criteria**: Behavioral and psychological symptoms of dementia (BPSD) or responsive behaviors in dementia. Long-term care (LTC) or unit or facility specialized in dementia care. Environmental interventions (e.g. architectural design, decorative change, relocation in physical space, etc.) Outcome measure related to BPSD (change in frequency and/or severity) Original Data - Randomized or Nonrandomized - Quasi-experimental Trials - Prospective Comparative Cohort Studies - English or French language **Literature search**: June 2013	**Number of studies**: 5 **Study design:** Non-randomized comparative cohort studies (n=5) **Population**: Residents in long term care. **Number of participants**: 32-185 **Country of origin:** Australia, Canada, USA, Scotland **Setting**: Long-term care (LTC) or unit or facility specialized in dementia care. **Interventions:** Environmental interventions (e.g. architectural design, decorative change, relocation in physical space, etc.) Three general categories of intervention were identified: a change or redesign of existing	The complex and multi-dimensional nature of BPSD requires a multifaceted management approach. Responsiveness to an intervention is likely to be highly individualized, with the degree of response to therapy based on an individual's background and the complexity of their symptoms. The interventions to the built environment examined within this present review serve as a reminder that one's physical and social surroundings have large influence over one's psychological well-being. However, there remains a dearth of high-quality evidence to conclusively guide the selection of any particular built environment intervention. Given the growing evidence concerning the effectiveness of other nonpharmacological approaches to managing BPSD, changes to the built environment likely serve as only one component of the arsenal

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				physical structures or spaces within the environment the addition of physical objects or spaces to the existing environment; and the relocation of the study population to a novel living environment. **Outcomes**: behavioral and psychological symptoms of dementia (BPSD). **Follow-up time:** Post intervention to 5 months	of therapies in managing BPSD among residents in LTC.
Stern et al 2009 Australia [86]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – ordinärt boende. Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende (Maintaining and stimulating work methods – both	To determine the best available evidence in relation to physical leisure activities in preventing dementia among older adults.	**Inclusion criteria:** Adults aged 60 years and older with or without a clinical diagnosis of dementia, living in the community or residential care setting. Types of intervention: Physical leisure activities that require active movement of the body including gardening, playing sports, exercises and any other activities. Type of outcomes:	**Number of studies:** 17 **Study design:** Two case-controls and 15 cohort. **Number of participants:** 180-551 **Characteristics of participants:** Age groups varied and same studies focused on specific populations	Results from 17 epidemiological studies showed that the evidence is conflicting and no solid conclusions could be drawn. Although the findings of the present review did not show a strong association between engagement and this particu-lar outcome, physical activity has been linked to many other physiological, psychological and social benefits.28 It is not related to any serious

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	community and institutional settings) **Quantitative**		The presence or absence of dementia as determined by cognitive function tests, mental examination scores, DSM classification (Diagnostic and Statistical Manual of Mental Disorders) and other valid dementia diagnostic tools. **Type of studies:** Randomised controlled trials and other experimental designs were considered for the review. In their absence, other study designs such as cohort, case-control and cross-sectional were included. Only articles published in the English language were included with no publication date restriction. **Literature search** October 2008	**Setting:** Community settings and combinations with clinical settings. **Country of origin:** Sweden, Japan, Finland, France, China, Australia, Canada, USA **Interventions** Physical activities such as eg. sports, walking, dancing, gardening. **Outcomes:** Dementia **Follow-up time:** 1-36 years	adverse effects and is relatively cheap and enjoyable to partake in, it would seem rational to continue to engage and promote physical activities; however, the current literature is equivocal as to whether this will prevent the development or onset of dementia
Stern et al 2011 Australia [87]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work	To synthesize the best available evidence on the effects of canine-assisted interventions on the health and social care of the older population residing in long-term care.	**Inclusion criteria**: Population: Older people who resided in long term care facilities and who received CAIs. Intervention: CAIs, grouped as either CAAs or CATs. For the purpose of this review CAAs were defined as „the	**Number of studies**: 8 **Study design:** RCT **Population**: Older people residing in long term care (range 51-101 years).	The current evidence base for the effects of canine-assisted interventions in long term care facilities is methodologically weak and is unable to be pooled. No solid recommendations can be made, however some

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	methods - institutional settings) **Quantitative**		utilization of canines that meet specific criteria to provide participants with opportunities for motivational, educational, and/or recreational benefits to enhance quality of life‟50 CATs were defined as a goal-directed intervention directed and/or delivered by a health/human service professional with specialized expertise, and within the scope of practice of his/her profession. Control: usual care, alternative therapeutic interventions or no intervention, on the proviso that descriptions of usual care and/or therapeutic interventions were provided. **Outcomes:** Physical, emotional, social functioning **Literature search**: 2009	**Number of participants**: 36-80 participants. **Country of origin:** USA **Setting:** Single long-term care facility or multiple facilities. **Interventions:** All interventions involved interaction between the participant and the dog in an unstructured fashion. The opportunity to let the participant touch, talk, brush and generally interact with the dog was at the discretion of the participant. **Outcomes**: Autistic Spectrum Disorder outcomes, medical outcomes, emotional well-being and observable behaviors. **Follow-up time:** Unclear	preliminary conclusions based on the results of single studies are provided. Caution is advised when interpreting these results. Implications for practice: Due to the poor quality of evidence located on this topic the use of canine-assisted interventions cannot currently be recommended nor refuted. If, however, a long-term care facility is considering implementing canine-assisted interventions for older residents they should be aware that canine-assisted activities may produce some short-term beneficial effects but they are similar to those seen from organizing visits from people or arranging interactions with animal-like inanimate objects. Implications for research: Due to the lack of well-designed trials further higher quality experimental studies that examine the effects of canine-assisted interventions on older long-term care residents

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					should be conducted. Trials need to be conducted following a standardized rigorous process.
Strout et al 2016 USA [88]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To systematically identify, appraise, and summarise research on the effects of behavioral interventions to prevent cognitive decline in community-dwelling older adults using a holistic wellness framework.	**Inclusion criteria:** Publication period: PubMed MEDLINE (1947-2014), EMBASE (1980-2014), CENTRAL (1966-2014), CINAHL (1937-2014), PsycINFO (1887-2014), ALOIS (1982-2014), and The (NYAM) Grey Literature Report (1999-2014). Population: Community-dwelling men or women aged 60 and older Study design: Must include at least one behavioral intervention from one or more dimension of wellness: Occupational, Social, Physical, Intellectual, Emotional, Spiritual. Measurement: Must include measurements from at least three of the following cognitive domains: executive function, attention, episodic	**Number of studies:** 18 **Study design:** RCT (n=18) **Number of participants:** n=6254 individuals. Ranging between (n=31) and (n=2832) **Characteristics of participants:** Mean age between (n=67 and (n=83) **Country of origin:** Not stated. **Setting:** Community **Interventions:** Intellectual exercises (n=12) Physical exercises (n=6) **Outcomes:** Cognitive measures such as memory (n=17), processing speed	Intellectual and physical interventions were most studied, with varied results. Future research is needed using more-consistent methods to measure cognition. Researchers should include the National Institutes of Health Toolbox Cognition Battery among measurement tools to facilitate effective data harmonization, pooling, and comparison.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			memory, language, processing speed, working memory. Setting: Community. **Literature search:** July 2014.	(n=13), excecutive function (n=12), attention (n=11) and language (n=5). **Follow-up time:** 3 weeks to 1 year.	
Sutton et al 2016 UK [89]	**Moderate** **SBU Domain(s):** Behovsbedömning och uppföljning. (Needs assessment and follow-up: older persons) **Quantitative**	To systematically and critically evaluate the available evidence concerning the reliability and validity of multi-component frailty assessment tools that were specifically developed to assess frailty in older adult populations; establishing the tool with the best evidence to support its use in both research and clinical settings.	**Inclusion criteria:** • Study participants were at least 60 years old. • The study described a multi-component tool (de-fined as a tool that assesses at least two indicators of frailty. Single-component tools were excluded due to the multifactorial and complex nature of the frailty syndrome). • The study described a tool that was specifically developed to assess frailty • The main purpose of the study was the development and/or evaluation of the reliability and validity of a multi-component tool to assess frailty. • The study applied the original version of a multi-component tool to assess frailty. • The study reported quantitative data (the study	**Number of studies:** 73 **Study design:** Assessment tools **Number of participants:** 24 – 31 115 **Characteristics of participants:** Overall mean age of the participants as calculated by pooling the mean ages from 55 studies was 77.0 years. Female 31.2 – 100%. **Setting:** Community, hospital and long term settings. **Country of origin:** Austria, UK, Canada, Poland, Italy, Belgium, Netherlands, Germany, USA, Australia, France,	This review provides an up-to-date comprehensive list of all multi-component frailty assessment tools for which there is published psychometric data. It identifies a large number of multi-component frailty assessment tools in existence; however, the breadth and quality of the psy-chometric properties of these tools is limited. Only the FI-CGA and TFI have both reliability and validity data within statistically significant parameters and of fair-excellent quality. However, this should be interpreted with caution as a score of fair' on the COSMIN checklist means that the evidence is only of questionable quality.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			must have reported inferential validation, studies reporting descriptive data alone were excluded). • Studies were available in English or were translated wherever possible. **Literature search:** 30 March 2015	Japan, Switzerland, Greece, Portugal, Spain, Sweden, Denmark, Israel. **Interventions:** 38 multicomponent frailty assessment tools **Outcomes:** Psychometric property and use in clinical and research settings **Follow-up time:** 1-348 months	At present, the TFI has the most robust evidence-base supporting its reliability and validity in assessing frailty. However, the psychometric properties of the TFI and all other multi-component frailty assess-ment tools require further in-depth evaluation before they can fulfil the criteria for a gold standard assessment tool, and before definitive conclusions regarding the best tool for use in research and clinical settings can be drawn.
Tam-Tham et al 2013 Canada [90]	**Moderate** **SBU Domain(s):** Integrerade insatser, samverkan eller informationsöverföring. (Integrated measures or activities) **Quantitative**	To evaluate the effectiveness of dementia case management compared with usual care on reducing long-term care placement, hospitalization, and emergency department visits for adult patients with dementia. Also, to evaluate the effectiveness of this intervention on delaying time to long-term care placement and hospitalization.	**Inclusion criteria:** The study design was an RCT, the study population included adults living in the community and diagnosed with dementia (regard-less of methods used to make the diagnosis) and their caregivers, the study compared standard practice or usual care as defined in the article to CM intervention involving at least one healthcare professional (e.g., nurse or social worker) and providing at least one key compo-nent of care (i.e.,	**Number of studies:** 17 **Study design:** RCT **Number of participants:** 5257 and 4909 caregiver-care recipient dyads, respectively. **Characteristics of participants:** Mean age varying between 70 and 81 years. 32-70% were women. The majority of	Our results suggest that dementia CM may have a short-term positive effect on reducing the risk of LTC placement among older people with demen-tia residing in the community. However, other sources of resource utilization (including hospitalization and emergency department visits) and longer-term effects of dementia CM on risk of LTC placement warrant further investigation.

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			assessment and planning, education, emotional support, service facilitation, or legal advice and financial counseling) for caregivers and people with dementia, and the study reported on at least one of the resource utilization measures, namely, LTC placements, hospitalizations, emergency department visits, time to LTC placement, or time to hospitalization. No language restrictions were applied; **Literature search:** October 2011	studies included participants with mild to Moderate levels of dementia severity at baseline. **Setting:** Community living persons and their caregivers **Country of origin:** USA, Canada, Australia, Finland, Italy, Netherlands, UK **Interventions:** Interventions involved a single case manager from a variety of professions (e.g., social worker or nurse), a partner (e.g. a psychologist working with an occupational ther-apist), or a multidisciplinary team-based model (e.g., a team consisting of a psychiatrist, dietitian, psychologist, occupational therapist, physical therapist, social worker, and/or nurse) with different types of professionals act-ing to fulfi.11 the	

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				demands of CM. The delivery of CM varied from home visits to telephone counseling or a combination of both. The duration of the intervention also ranged from a single visit lasting approximately 3 h to continued CM for the entire length of follow-up. Variation in the control groups was also observed. Control groups included usual care (e.g. educational materials and availability of a counselor), respite, and, to a lesser degree than the intervention group, access to a case manager and to community services. **Outcomes:** Risk of long-term care placement, time to placement and hospital and emergency **Follow-up time:** 6 months - 15.9 years	
Toles et al 2016 USA	**Moderate** **SBU Domain(s):**	To systematically review, studies of patients discharged from skilled	**Study design:** Randomized controlled trials, non-randomized	**Number of studies** n=6	Although the risk for bias was high across studies, the findings suggest that

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[91]	Integrerade insatser, samverkan eller informationsöverföring. (Integrated measures or activities) **Quantitative**	nursing facilities (SNFs) to home. Study findings were assessed (I) to identify whether transitional care interventions, as compared to usual care, improved clinical outcomes such as mortality, readmission rates, quality of life or functional status; and (2) to describe intervention characteristics, resources needed for implementation, and methodologic challenges	controlled trials, and non-randomized before and after studies that were published in English after January 1, 2000. **Participants:** Older adults not specified **Setting:** Skilled nursing facilities and home **Interventions** All interventions - Discharged from SNFs to home **Outcomes**: One clinical outcome such as mortality, hospital readmission rates, preparedness for discharge, and functional status **Literature search:** September 1, 2015	**Study design:** RCT n=2. Non-randomized controlled trials n=1, before and after study n=3 **Number of participants** N=619 (17 to 217) **Characteristics of participants** In 5 studies, participants had average age ranging from 77-80 years; female gender (61-74%); white non-Hispanic race (73-89%); and diverse medical conditions such as fractures, congestive heart failure and pneumonia. In one study, participants were 95% male, and in a second study, participants were treated exclusively for cardiac medical conditions. **Setting:** From SNF, veteran affairs hospital, home health agency, health maintenance organization	there is promising but limited evidence that transitional care improves clinical outcomes for SNF patients. Evidence in the review identifies needs for further study, such as the need for randomized studies of transitional care in SNFs, and methodological challenges to studying transitional care for SNF patients.

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				Country of origin: All from USA. **Interventions:** A nurse and social worker provided transitional care in the SNF and at home, Usual care & staff nurses provided exercise monitoring and training in cardiac self-management in the SNF/home care visits, usual care and pharmacist medication. Staff nurses provided transitional care in the SNF and visited/ called after discharge, Usual care & NPs provided transitional care in I post discharge clinic visit. **Outcomes:** Studies included diverse clinical outcomes; outcomes were classified as (a) Acute Care Use 30 or 60 Days after SNF Discharge and (b) Mortality and Other Outcomes, which included mortality,	

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				satisfaction with transitional care, function, and participation in clinical services after discharge **Follow-up time:** 30 or 60 days, others or not specified	
Trabal et al 2015 Spain [92]	**Moderate** **SBU Domain(s):** Upprätthållande stimulerande arbetssätt – både ordinärt och särskilt boende. (Integrated measures or activities) **Quantitative**	To determine whether dietary enrichment with conventional foods and/or powdered modules improves energy and nutrient intake, the present review was conducted; randomized and nonrandomized studies that assessed the effect of this type of intervention for improving energy and protein intake compared with a standard diet in older adults were evaluated	**Inclusion criteria**: Studies deemed eligible for review included experimental, quasi-experimental, or observational time series designs and were restricted to those published in English, Catalan, or Spanish. Case series and case studies were excluded. There were no restrictions on the sample size, length of follow-up, comparators, or date and publication status of the studies. Participants described as older adults (over 65 years of age) of any nutritional status (from malnourished to well-nourished) were considered. **Literature search**: 31 January 2014	**Number of studies**: 9 **Study design:** Cluster randomized (n=4), randomized crossover trial (n=3), non-randomized controlled trial (n=2) **Population**: Older adults over 65 years of age (mean age 67-91 years). **Number of participants**: 10-62 **Country of origin:** USA, Sweden, Germany, UK. **Setting:** Hospital, long-term care facilities (e.g., nursing homes), or a community setting.	The reviewed studies suggest that dietary enrichment based on low-volume and energy- and nutrient-dense foods is a valid intervention to improve energy intake in older adults and is probably most effective in those who are malnourished. This could likely be the case for protein intake as well, but in the absence of a higher number of studies of sufficient quality, it cannot be confirmed. It is not presently known whether dietary enrichment is a valid intervention to improve the nutritional status or other clinical and functional outcomes in older adults. The lack of conclusive results for most of the

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Interventions: Dietary enrichment with conventional foods and/or powdered modules **Outcomes**: Changes in energy intake, protein intake, nutritional status, body weight, functional status, and episodes of infection **Follow-up time:** Not clear	assessed outcomes justifies the need for largescale clinical trials with long-term interventions to clearly establish the effects and economic consequences of this treatment to address malnutrition in older adults.
Trivedi et al 2013 UK [93]	**Moderate** **SBU domain(s):** Integrerade insatser eller aktiviteter. (Integrated measures or activities) **Quantitative and qualitativve**	To investigate• What types of Inter-professional working (IPW) interventions are described in the literature? • How is IPW organised? • What are the outcomes of different models of IPW?	**Inclusion criteria:** Publication period: 1 January 1990– December 2010 Population: Older people aged 65 and over Study design: The study included randomised controlled trials (RCT) and qualitative studies linked to RCTs that described IPW care for community-dwelling older people aged 65 and over, with multiple long-term conditions.	**Number of studies:** 37 studies in 66 papers and 14 systematic reviews. **Study design**: RCT (n=37) **Number of participants:** Ranging between (n=260) and (n=624). Not listed for all studies. **Characteristics of participants:** Mean age ranging between 68.5 and 84.9	This review sought to differentiate between the effectiveness of interventions that relied on different models of IPW for the benefit of community based older people. Overall, the proportion of studies demonstrating improved outcomes is similar across the three main IPW models. More than half reported improved health/functional/clinical, and process outcomes, including patient/user satisfaction, with only a few studies reporting favourable caregiver

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			Setting: Community-dwelling Other criteria: English **Literature search:** December 2010	**Setting:** Community **Country of origin:** Canada (n=3), USA (n=18), Hong Kong (n=1), Switzerland (n=1), Norway (n=1), Australia (n=4), United Kingdom (n=3), Finland (n=1), Netherlands (n=1), Sweden (n=1), Germany (n=2), Italy (n=1). **Interventions:** Case management model (n=7) Collaboration model (n=11) Integrated team model (n=19) **Outcomes:** Physical and mental functioning such as Activities of daily living (ADL), Mortality, Quality of Life, Geriatric depression scale (GDS), Cognitive health, Caregiver burden, SF-36 and Service utilization (admissions to hospital, costs etc), patient/user satisfaction and experiences, Resource	outcomes. The evidence on service use and costs is mixed, which is not unusual for complex care practices and IPW.

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				use as well as Care processes (See study supplement 4-7) **Follow-up time:** Different time periods between 6 months and 3 years.	
Ueda et al 2013 Japan [94]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande insatser - ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To investigate the effects of music therapy on behavioral and psychological symptoms of dementia (BPSD), cognitive function, and activities of daily living in patients with dementia	**Inclusion criteria:** Study design: The study design had to be either an RCT a controlled clinical trial (CCT), a cohort study, or a CT (before-after studies without control groups and studies with an N of 1 by single-case study were excluded). (2) Intervention**:** The music types that were used for intervention had to be a single music-related experi-ence or a combination of music-related experiences such as singing, listening, performing, rhythmic exercising, and/or improvising. (3) Study population: The study population comprised older individuals who were formally diagnosed with any type of dementia occurring with Parkinson's	**Number of studies:** 20 **Study design:** RCT (10), CCT (1) and CT (9) **Number of participants:** 651 (12-61) **Characteristics of participants:** Age range: 75.4±7.9 - 89.5±4.5 Patients with senile dementia of Alzheimer's type, vascular type, Parkinson's type, and/or mild to severe mixed types. Information about gender not stated, **Setting:** Not stated	This systematic review and meta-analysis of RCTs, a CCT, and CTs showed that music therapy influenced BPSD in patients with dementia. The length of the intervention period was associated with the effects of the music therapy. In particular, interventions of >3-month durations strongly decreased anxiety. Furthermore, the effects of music therapy were greater than those of other non-pharmacological interventions. Even though the effects of music therapy were small compared with those of non-pharmacological interventions, music therapy is recommended for the management of BPSD, especially after considering the adverse

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			Disease or Alzheimer's Disease, vascular dementia, frontotemporal dementia, or other types included in the Diagnostic and Statistical Manual of Mental Disorders-lV (American Psychiatric Association, 1994), the International Classification of Diseases-10 (World Health and Organization, 1993), or other accepted diagnostic criteria. The primary outcomes were changes in depression, anxiety, and behavioral symptoms such as agitation, apathy, elation, and irritability. The secondary outcomes included changes in cognitive function and ADL. We extracted these outcomes, which were measured before and after the treatment period. **Literature search:** February 2011	**Country of origin:** four were from Europe, three were from USA, one was from Australia, and twelve were from Asia. **Interventions:** Almost all studies used a combination of methods such as singing, playing musical instruments, and/or listening to live performances. Many studies including this meta-analysis used pre-ferred or familiar music. Some studies used methods wherein the participants listened to recorded music through headphones and CD players. Three studies used the method of rhythmic exercising to music. One study used improvising with drums. The interventionists in these studies were music therapists, students studying music therapy, occupational therapists, nurses,	effects of pharmacological intervention on one's health. We expect that music therapy will make important contributions to management strategies designed for decreasing BPSD.

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				musicians, or care workers. **Outcomes:** Behavioral symptoms, ADL, anxiety, depression **Follow-up time:** 10 weeks- 11 months	
Vaismoradi et al 2016 Norway [95]	**Moderate** **SBU Domain(s):** Stimulerande och upprätthållande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Qualitative**	To integrate the current international findings and enhance our understanding of the experiences of older people of being cared for in nursing homes.	**Inclusion criteria:** 1) peer-reviewed empirical qualitative studies in caring sciences. (2) focused on the experiences of older people being cared for in nursing homes. (3) studies conducted with older people who had an intact or sufficiently intact cognitive status. (4) pub-lished in online scientific journals. **Literature search:** No information (The chosen studies had been published between 2007 and 2015).	**Number of studies:** 7 **Study design:** Qualitative studies using grounded theory, phenomenology, qualitative descriptive analysis **Number of participants:** 128 older people in 24 nursing homes. **Characteristics of participants:** Generally, the studies recruited older people over the age of 60 years, both male and female. **Setting:** Nursing homes	From the older people's perspectives, nursing homes were not always experienced as their own home. The balance between the older people's expectations of the living condition in nursing homes, and nurses' commitments and facilities in nursing homes helps them retain the meaning of being alive. The institutional character of the nursing home restricted the older people's decision making for their own life. The main challenge in nursing home care was to balance the tensions between individual needs and the holistic dimensions of care. The question is why the nursing home becomes institutionalized to the point that the

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				Country of origin: Sweden, Canada, Taiwan, Norway, Spain **Interventions:** The older people' s experiences were related to 'care and help in nursing homes', 'quality of care' 'nature of care' and 'nursing homes' organization and practice **Outcomes:** Confrontation of needs, participation in living, adjustment. **Follow-up time:** Not applicable	'home' aspect of the nursing home is forgotten, and the older people lose their meaning of life.
van Bokhorstede-van der Schueren et al 2014 The Netherlands [96]	**Moderate** **SBU Domain:** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To assess the criterion and predictive validity of malnutrition screening tools used in nursing homes	Articles were eligible for inclusion if they expressed criterion validity (how well can a tool assess nutritional status) or predictive validity (how well can a tool predict clinical outcome) of malnutrition screening tools in a nursing home population. Included were articles that had been published in the English, German, French, Dutch, Spanish, or Portuguese language.	**Number of studies**: 26 **Study design** Any study design. Articles were eligible for inclusion if they expressed criterion validity (how well can a tool assess nutritional status) or predictive validity (how well can a tool predict clinical outcome) of malnutrition screening tools	The use of existing screening tools for the nursing home population carries limitations, as none performs better than “fair” in assessing nutritional status or in predicting outcome. Also, no superior tool can be pointed out. This systematic review implies that further considerations regarding malnutrition screening among nursing home residents are required.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			Literature search: 30 jan 2013	**Population**: 55 years or more. **Number of participants**: 49-867 **Country of origin:** Not stated. **Setting:** Nursing home. **Outcomes**: Nutritional status. **Number of tools**: 20. Of 20 tools applied in the nursing home population, 4 were originally developed for use in this specific setting (CNS, MDS, SNAQ [US tool] and SNAQ-RC [without, and with BMI]), 8 were originally developed for use among elderly (DETERMINE, GNRI, MNA, MNA-SF [and its revised form], NRI, NUFFE, Rapid Screen), 5 for use among adult persons (MST, NRS, SGA, SNAQ (Dutch	The review shows that malnutrition screening in long term care facilities using existing tools has serious limitations. None of the nutrition screening or assessment tools included in the studies in this review performed consistently well in assessing the nutritional status of the residents, not even the tools that were originally designed for assessing the nutritional status of older persons. Existing screening tools, even those developed for the nursing home setting, are only fairly able of assessing the nutritional status of nursing home residents, or of predicting poor nutrition-related outcomes. The ideal tool for the nursing home population should perhaps contain more items referring to the multi-factorial back-ground of malnutrition in this specific population. The present tools could be used as a first step in identifying residents at

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				tool), NRS-2002), and 3 (MUST, and the Simple Screenings Tools #1 and #2) for use in both adult and older persons. **Follow-up time:** Unclear	risk of malnutrition, preferably in combination with a comprehensive geriatric assessment investigating possible causes of malnutrition.
Vandemeulebroucke et al 2018 Belgium [97]	**Moderate** **SBU Domain(s):** Effekten av vissa hjälpmedel inom kommunikation och kognitiv förmåga. (Effects from communication and cognitive devices) **Qualitative**	To gain a better understanding of how older adults experience, perceive, think, and feel about the use of socially assistive robots (SARs) in aged care settings	**Inclusion criteria:** reporting on primary, empirical research using a qualitative or mixed method approach. Older adults who were aged 60 years and older or participant groups that had a mean age of 65 years or above. Socially assisted robots studied had a certain degree of autonomy, or for which the illusion of an autonomous SAR was created. **Literature search:** 31 Jan 2016	**Number of studies:** 17 studies, 23 articles. **Study design:** 7 used a qualitative approach and 10 used a mixed-method approach. **Number of participants:** 3-123 **Characteristics of participants:** 50-95 years **Setting:** Aged care; institutional care and community care. **Country of origin** France, USA, UK, Canada, Japan, Sweden, New Zealand, Finland, Belgium, Netherlands, Singapore.	Older adults have clear positive and negative opinions about different aspects of SARs in aged care. Nonetheless, some opinions can be ambiguous and need more attention if SARs are to be considered for use in aged care. Understanding older adults' lived experiences with SARs creates the possibility of using an approach that embeds technological innovation into the care practice itself.

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				Interventions: Socially assisted robot. **Outcomes:** (1) roles of a SAR. (2) interaction between the older adult and the SAR, which could be further subdivided into (a) the technical aspect of the interaction and (b) the human aspect of the interaction; (3) appearance of the SAR; and (4) normative/ ethical issues regarding the use of SARs in aged care. **Follow-up time:** Not applicable.	
Van Malderen et al 2013 Belgium [98]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To review systematically the literature, focusing on the identification of interventions that attempt to enhance the QoL of residents of LTC-facilities.	**Inclusion criteria**: When screening for relevance, English articles were included when they reported an intervention study in the LTC, directed towards residents in general, with QoL as (one of the) outcome measure(s). Articles were excluded when these were not original articles presenting an intervention study, when the studies	**Number of studies**: 36 **Study design:** 18 RCT, 13 controlled trials without randomization, 4 Pretest–posttest trials **Population**: Persons 65 years or older living in LTC.	QoL is currently a much discussed topic in gerontology. Despite the omnipresence of the concept, our systematic review indicates that only few studies draw conclusions on evidence based practice to improve the QoL within the residential care. We identified studies for all the determinants of AA in LTC. 'Behavioral determinants' and

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			concerned were not directed at the residents of LTC-facilities or directed only at residents with specific conditions or diseases (e.g. dementia, CVA, epilepsy, deafness). Only papers published from 1990 onwards were included in order to avoid possible generation related biases. **Literature search**: Not stated	**Number of participants**: 3 910 **Country of origin:** Asia: n = 11; Australasia: n = 3; Europe: n = 14; North-America: n = 7 **Setting:** Long term care facilities **Interventions:** Active ageing determinants: Culture and gender Determinants related to health and social services. Behavioral determinants. Determinants related to personal factors. Determinants related to the physical environment. Determinants related to the social environment. Economic determinants. **Outcomes**: Quality of life **Follow-up time:** Unclear	'Psychological factors', were more studied than other determinants. Referring to Table 1, several aspects of the different AA-determinants were not addressed in any study. To give only one example, interventions on the behavioral determinant (and thus enhancing a healthy lifestyle) can be considered as broader than merely working on the physical activity level or on the oral health. This existing gap in insight on all aspects of the different AA-determinants indicates that a lot of work still remains to be done and there is a strong need for further research on interventions in LTC to promote residents' QoL. Furthermore, this review identified a significant lack of methodological quality in studies on QoL thus far and noted the vastly diverse ways of interpreting QoL. Intervention effects on QoL were present in some studies, but not in

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					other ones. This lack of systematic effect on QoL can probably be related to the fact that interventions are often only aimed at modifying one determinant, while QoL is a multidimensional concept and should preferably be enhanced across its different dimensions. Several studies examining the perspectives and the definitions for QoL of older people show that the different aspects/ dimensions of QoL of older people are interrelated and influence each other. QoL has to be seen from a holistic perspective and interventions may not be limited to one facet, as Kelley-Gillespie (2009) concludes when developing an integrated conceptual model of QoL for older adults. This review invites future research to make the following considerations: (1) more consensus is needed regarding the number of dimensions that QoL encompasses;

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					(2) the best way to measure or explore QoL should be determined; (3) multidimensional intervention studies are needed to give insight in the best evidence based practice to improve QoL in the LTC.
Van't Leven et al 2013 The Netherlands [99]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To study the effects of dyadic psychosocial interventions focused on community dwelling people with dementia and their family caregivers, and the relationship of the effects with intervention components of programs	**Inclusion criteria:** People with dementia 65 years old or more. People with dementia and their informal caregivers living in the community, not a nursing home. Effect study: randomized controlled trial. Intervention aimed at reducing or preventing the mental health decline of one or both members of the dyad, including the areas of cognition, activities, daily living skills, competence, and interpersonal relationships. Face-to-face contact between care professional and person with dementia, and between the same care professional and the caregiver. English, Dutch, German, and French. **Literature search:** January 2012	**Number of studies:** 20 dyadic psychosocial programs studied in 23 RCTs **Study design:** RCT, Meta-analysis **Number of participants:** Program = 9 713 Control = 5 337 Tot = 15 050 **Characteristics of participants:** People with dementia and caregivers **Setting:** Community dwelling people with dementia **Country of origin:** Not summarised for all studies	Dyadic psychosocial programs are effective, but the outcomes for the person with dementia and the caregiver vary. More attention is needed for matching the targeted functional domains, intervention components, and delivery characteristics of a program with the needs of the person with dementia and the family caregiver.

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				Interventions: -Dementia Family Care Program for home-residing persons with dementia. -Night-time Insomnia Treatment and Education in Alzheimer's Disease. -Early-Stage Memory Loss Support groups -Advanced Caregiver Training - Care of Persons with Dementia in their Environments -Tailored Activity Program -Community Occupational Therapy in Dementia -Partners in Caregiving: Psychoeducation Program -Environmental Skill-building Program -Environmental Skill-building Program -Reducing Disability in Alzheimer Disease -Minnesota Family Workshop -Case management -Multicomponent support program	

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				-Home Care Program Goa, India -Collaborative care for Older Adults with Alzheimer Disease -Reality Orientation with cholinesterase inhibitors -Early Home Care Program -Medicare Alzheimer's Disease Demonstration Evaluation -Integrative Reactivation and Rehabilitation Program -Supporting program -Training program **Outcomes:** Behavioral problem, mood, daily activities, quality of life, institutionalization **Follow-up time:** 2 months up to 8 years	
Vasse et al 2010 The Netherlands [100]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work	To appraise (1) the effectiveness of communication-enhancing interventions for the care staff and/or residents with dementia in institutional care settings, and	**Inclusion criteria**: Randomized or nonrandomized controlled trial with the full text obtainable in English or Dutch. **Literature search**: February 2007	**Number of studies**: 19 **Study design:** RCT (n=9), controlled trials (n=6), Quasi-experimental controlled trials (n=4)	This review indicates that care staff can improve their communication with residents with dementia when strategies are embedded in daily care activities or interventions are single-task sessions at set times. Staff training

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	methods - institutional settings) **Quantitative**	(2) the effects of these interventions on neuropsychiatric symptoms.		**Population**: People with dementia living in residential care homes or in nursing homes and/or professional caregivers working in long-term care facilities with people with dementia. The inclusion criteria for the trial required a diagnosis of dementia or screening for cognitive impairment of resident participants. If groups of residents were mixed with nonresidents, at least 80% of the participants had to be residents or else their separate results needed to be available. **Number of participants**: 22-194 **Country of origin:** Not stated. **Setting:** Residential care. **Interventions:** an intervention aimed at improving the	should include time for personal feedback, interactive learning and refresher sessions. These results offer the possibility of improving the quality of care, but not directly of reducing neuropsychiatric symptoms. More research is needed to study the effect of communication interventions on neuropsychiatric symptoms.

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				communication of participants. Multi-component interventions had to include a communicative component. Communication was defined as sharing information by speaking, writing, body movements, or other signaling behavior. **Outcomes**: at least one outcome measure was required to address the quantity and/or quality of communication performance or else no productive communication (e.g. apathy or noncompliance) of the participants. **Follow-up time:** Unclear	
Watkins et al 2016 UK [101]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining	To better understand factors that may contribute to malnutrition by examining the attitudes, perceptions and experiences of mealtimes	**Inclusion criteria**: All qualitative studies, or mixed-method studies with a qualitative component, which used a recognized method of data collection (e.g., focus groups, interviews) and analysis	**Number of studies**: 15 **Study design** Observational studies, interview, focus groups **Population**:	Four main themes were identified: (1) organizational and staff support, (2) resident agency, (3) mealtime culture, and (4) meal quality and enjoyment. Organizational and staff

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	and stimulating work methods - institutional settings) **Qualitative**	among care home residents and staff.	(e.g., thematic analysis, grounded theory, framework analysis), and explored the attitudes, perceptions and experiences of mealtimes in care homes for older adults were included. **Literature search**: November 2015.	Residents, staff. **Number of participants**: Ca 300 elderly and 250 staff etc. **Setting**: Residential aged care facilities (nursing homes, care homes etc.) **Country of origin**: Nine countries (USA, Canada, Australia, Guyana, Sweden, Denmark, UK, Spain, Netherlands) **Interventions:** Dining environment, restaurant-style meal provision, feeding assistance. **Outcomes**: Attitudes, perceptions and experiences of mealtimes among care home residents and staff. **Follow-up time:** Unclear	support was an over-arching theme, impacting all aspects of the mealtime experience. Mealtimes are a pivotal part of care home life, providing structure to the day and generating opportunities for conversation and companionship. Enhancing the mealtime experience for care home residents needs to take account of the complex needs of residents while also creating an environment in which individual care can be provided in a communal setting. Despite care home residents being the central focus of mealtime interventions, only eight studies included in this review sought the views and opinions of residents themselves. Gaining greater insight into the resident experience is essential to identifying ways of improving care provision and can highlight the potential

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					barriers and facilitators to the implementation of future interventions
Watson et al 2012 Australia [102]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To identify the efficacy of Complementary Therapies (CT) interventions in reducing the frequency and severity of agitated behavior among older people in RACF. Specific questions addressed include: - What types of CT are being implemented for the management of agitation for older people in RACFs? Which Complementary Therapies are identified as being effective in reducing the frequency and severity of agitation in older people in RACFs?.	**Inclusion criteria**: Randomized controlled trials of Complementary Therapies interventions that could be initiated by a nurse **Literature search**: September 2010	**Number of studies**: 10 **Study design:** Randomised controlled trials **Population**: Over the age of 65 years of age. **Number of participants**: 584 **Country of origin:** Japan, Canada, Taiwan, Netherlands, Canada, France, Iceland and Italy. **Setting:** Residential Aged Care Facilities (RACFs). **Interventions:** complementary therapies (CT) such as aromatherapy, exercise, massage, music therapy and therapeutic touch.	Positive findings of this review support the growing body of evidence that Complementary Therapies are effective in agitation management for older people in RACFs. CT appear to be successful in the management of physical non aggressive and verbal agitation in the areas of aromatherapy, exercise, massage, music therapy and therapeutic touch. RCTs on aromatherapy and music therapy interventions both showed success in managing physical aggressive agitation. The gentle nature and low side effects of CT supports these interventions being implemented in older people as a first line management for agitation. CT as a first line intervention for agitation management in RACFs has the potential to alleviate problematic side effects and health

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				Outcomes: frequency and/or severity of verbal, non-physical aggressive and physical aggressive agitation. **Follow-up time:** Not clear	deterioration associated with restraints currently used in the management of agitation. Present treatments for agitation in RACFs are detrimental to the older persons physical and emotional wellbeing. Restraints are implemented as a quick fix management strategy to agitation which is short sighted and fails to address the causative nature of the agitation. Restraint often increases frequency and severity of the agitation due to their invasive restrictive nature, adds to confusion in the older person and is often perceived as punishment. Escalations in agitation lead to high demands on staff time, workplace stress, decreased job satisfaction and unmet care needs among residents.1,22,86 RACF management must exhaust all possible avenues of agitation management before resorting to restraint. RCTs included in this review have shown innovative approaches to

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					the management of agitation with CT and acknowledge that current agitation management with restraint is not working. Agitation management currently places high fiscal cost on RACFs and older people, with high cost of pharmacology, equipment, adequate staffing and education necessary. Low et al estimate that dementia related costs in Australia would by 2022-2023 be 8.2 billion dollars. According to Access Economics79 these costs will encompass 3.3% of Australian Gross Domestic Profit (GDP) by 2051. CT are an alternative first line management for agitation that is in comparison relatively inexpensive. Intervention equipment found in this systematic review includes essential oils, oil burners, massage oil, tape recorders and music69.88Resources can be reused over a numerous number of

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					therapy sessions and may break monotony of routine institutional life for older people therefore increasing quality of life. Introducing CT into the management of agitation could ultimately change the way we care for our older population in RACFs. Nurse intervention of CT would ensure the timely administration of treatment by trained professionals who best know the residents care needs, enabling them to assess and rectify agitation effectively when necessary. Included RCTs show adherence to methodological quality that has previously not been present in previous studies as evidenced in the literature reviewed. However limitations of methodology of included trials in this review still do not meet the necessary evidence required for efficacy. There remains insufficient evidence that Complementary Therapies are effective in the agitation

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					management of older people in RACFs. While improvement in CT research is noted among the included RCTs, further research with strict adherence to quality methodology is required to deem CT effective.
Weening-Verbree et al 2013 The Netherlands [103]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Quantitative**	To review implementation strategies used to promote or improve oral health care for cider people in long term care facilities from the perspective of behavior change, to code strategy content at the level of determinants, and to explore their effectiveness.	**Inclusion criteria**: Studies had to include an outcome comparison with a randomized or non-randomized comparison group, or a comparison with baseline data in the case of a single group before-after design. Population: Health care personnel (e.g. nurses or nurse assistants) in nursing homes who were involved in the implementation and/or older people in nursing homes or residential care facilities. Outcomes: Oral health (plaque, gingivitis or candidoses), or knowledge and beliefs of health care personnel. **Literature search**: September 2011	**Number of studies**: 20 **Study design:** Uncontrolled before and after design (n=10), controlled before and after design (n=5), RCT (n=4), CCT (n=1). **Population**: Staff or residents in long term care. **Number of participants**: Ranged from 41 to almost 2000 in the included studies. **Country of origin:** USA, Canada, Australia, Europe. **Setting:** Long term care. **Interventions:**	Knowledge, self-efficacy and facilitation of behaviour are determinants that are often addressed in implementation strategies for successful improvement of oral health care in older patients. Strategies addressing increasing memory, feedback of clinical outcomes, and mobilizing social norm are promising and should be studied in the future. However, as the quality and heterogeneity of studies is a reason for concern, it is not possible to unequivocally recommend strategies or combinations of strategies for improving oral health in the older population. This calls for a more robust design of studies.

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				Knowledge was addressed in all studies. This was typically operationalized as the transfer of information in (interactive) lectures with slides and sometimes videos. Self-efficacy in combination with knowledge such as showing how to correctly brush the teeth of care dependent residents (modelling) and/or practice brushing teeth on manikin heads or modets (guided practice). Facilitating the behavior by offering toothbrushes (provide materials) or continuous professional support. In most studies the educational programme consisted of one session lasting 45-90 min. **Outcomes**: The most successful strategies for improving oral health were the ones addressing knowledge (providing general information), self-efficacy (modelling)	When choosing strategies to improve oral health care, care professionals should thoroughly examine the setting and target group, identify barriers to change and tailor their implementation strategies to these barriers for oral health care. This should lead to a reduction of unnecessary strategies, that aim to influence issues which are not causing the problem, and will contribute to the evidence base in this field while increasing quality of care.

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				and facilitation of behavior (providing materials to facilitate behavior). **Follow-up time:** Post intervention to 6 years	
Whear et al 2014 UK [104]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings) **Mixed**	What is the impact of gardens and outdoor spaces on the mental and physical well-being of people with dementia who are resident in care homes? What are the views of people with dementia, their carers, and care home staff on the value of gardens and outdoor spaces?	**Inclusion criteria**: All comparative, quantitative studies of the use of an outside space or garden in a care home for people with dementia reporting at least one of the following outcomes, agitation, number of falls, aggression, physical activity, cognitive functioning, or quality of life, were included. Qualitative studies that used a recognized method of data collection (eg, focus groups, interviews) and analysis (eg, thematic analysis, grounded theory, framework analysis), and explored the views of people with dementia who were resident in care homes, care home staff, carers and families on the use of gardens and outdoor spaces were included.	**Number of studies**: 17 (quantitative = 9, qualitative = 7, mixed = 1) **Study design:** 9 quantitative, 7 qualitative, 1 mixed methods **Population**: Persons with dementia **Number of participants**: 10-50 persons **Country of origin:** USA, China, Canada, Sweden, Finland, Austria, Scotland **Setting:** Specialized dementia care units, nursing home	This systematic review explores both quantitative and qualitative evidence on the impact of gardens for people with dementia in residential care. There is quantitative evidence, albeit from poor-quality studies, of decreased agitation associated with garden use. There was insufficient evidence from quantitative studies to allow generalizability of the findings on other aspects of physical and mental wellbeing. The evidence for Horticulture Therapy was also inconclusive. There are promising impacts on levels of agitation in care home residents with dementia to spend time in a garden, although the topic is currently

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			Literature search: February 2013	**Interventions:** Horticulture Therapy (sessions involved activities such as seeding, planting and flower arranging, singing, and making jam) or garden visit. **Outcomes**: Dementia related behaviors, physical outcomes, emotional outcomes, medication **Follow-up time:** 2 to 78 weeks	understudied and undervalued. Interpretation of the findings further suggest that gardens need to offer a range of ways of interacting, to suit different people's preferences and needs. Future research also would benefit from a focus on key outcomes measured in comparable ways with a separate focus on what lies behind limited accessibility to gardens within the residential care setting. Developing knowledge and understanding in these areas will help to further improve appropriate care experiences and inform policy more accurately.
Whear et al 2014 UK [105]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods - institutional settings)	To examine the effectiveness of mealtime interventions aimed at improving behavioral symptoms in elderly people living with dementia in residential care.	**Inclusion criteria:** All comparative studies were included. Music, group conversation, dining environment, and food service. **Literature search:** November 2012.	**Number of studies:** 11 **Study design:** Systematic review Included articles: Controlled trial (n=1), before-and-after studies (n=3), repeated measure time series studies (=7).	There is some evidence to suggest that mealtime interventions improve behavioral symptoms in elderly people with dementia living in residential care, although weak study designs limit the generalizability of the findings. Well designed, controlled trials are

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	Quantitative			**Number of participants:** Tot n=261 **Characteristics of participants:** Residents aged 65 years and older with dementia. Studies were small: sample sizes ranged from 5 to 41 participants. 3 studies had fewer than 20 participants. Residents' mean age ranged from 74.8 years to 87.0 years, with generally more women than men involved. **Setting:** Residential nursing homes (n=4), another facility (n=2), or standing independently (n=4). **Country of origin:** US n=6, Taiwan n=2, Canada n=1, Sweden n=1, Belgium n=1 **Interventions:** -Music interventions during the mealtime n=7.	needed to further understand the utility of mealtime interventions in this setting.

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				-Changes to the dining environment, such as lighting and table setting n=2. -Food service intervention n=1. Group conversation intervention n=1. Mealtime interventions were categorised into 4 types: music, changes to food service, dining environment alteration, and group conversation. Nutrition education or training interventions that were specific to mealtime care for residential elderly were also included. **Outcomes:** Behavioral and psychological symptoms of dementia were primarily of interest. Aggressive and agitated behaviors, communication, functional independence, and psychological outcomes. Improving the mealtime routine,	

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				experience, or environment. **Follow-up time:** Time series repeated measures 8 weeks, 4 weeks, 1 week, 7–10 days, 25 days.	
Whitehead et al 2015 UK [106]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt – ordinärt boende. (Maintaining and stimulating work methods - community settings) **Quantitative**	To identify interventions that aim to reduce dependency in activities of daily living (ADL) in homecare service users. To determine: content; effectiveness in improving ability to perform ADL; and whether delivery by qualified occupational therapists influences effectiveness.	**Inclusion criteria:** Randomised controlled trials (RCTs), non-randomised controlled trials, controlled before and after studies and interrupted time series were all eligible. Participants: individuals, aged 18 years or older, living at borne in the community (i.e. not in residential or nursing homes), and in receipt of homecare. Studies were eligible for inclusion if a mixture of assistance with personal (such as washing and dressing) and domestic (such as cleaning) ADL was provided but studies were excluded if all par-ticipants received help only with domestic ADL. Studies of participants receiving palliative care were excluded because of the likelihood of physi-cal	**Number of studies:** 13 **Study design:** Six RCTs and seven controlled before and after studies **Number of participants:** 4 975 participants were included. Sample size ranged from 74 to 1 382, mean 383. **Characteristics of participants:** 74-75. Gender not stated. **Setting:** Community care. **Country of origin:** USA, Canada, Australia, New Zealand, England, Sweden.	There is limited evidence that interventions targeted at personal ADL can reduce homecare service users' dependency with activities, the content of evaluated interventions varies greatly, further research is needed

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			deterioration and different outcomes. Any intervention delivered in or from the participant's home and designed to reduce dependency in personal ADL and to reduce the need for paid care. We included single component interventions (for example, mono-professional or one-off visits) or multiple components (for example a package provided by a multidisciplinary team). The comparator was defined as a routine homecare service in which assistance with personal ADL was provided but where there was no intention to improve individuals' performance in this. The main outcome of interest was performance in personal ADL. Other outcomes included: death; performance in extended ADL (for example, shopping, outdoor mobility); admission to hospital, residential or nursing care homes; falls; mood/morale; health or social care related quality of life; caregiver strain/burden; health	**Interventions:** Restorative homecare, Nurse-led health promotion/care coordination, Cluster care, Specialist inter-professional stroke care, Occupational therapy bathing intervention, goal setting, assistive technology **Outcomes:** Health Related Quality of Life Remaining at home, functional status, duration and intensity of home care episode. Ability to perform ADL **Follow-up time:** 1-16 months.	

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			economic outcomes; use of health and community services; participant and carer satisfaction with services; and healthcare provider satisfaction with the service. Outcomes were grouped into short term (<6 months), medium term (6 to 12 months) and long term (> 12 months). **Literature search:** November 2014		
Viués-Ortega et al 2012 Canada & Spain [107]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - ordinärt boende. Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To assess if animal-assisted therapy (AAT) may affect health via an increase in perceived social support and social interaction on selected populations with poor social functioning.	**Study design:** Matched or controlled trials incorporating pre- and post-test outcome measures and with at least five participants subjected to a multiple-day AAT intervention **Participants:** Elderly participants and those with depression and schizophrenia **Setting:** No limitations **Intervention:** Animal-assisted therapy **Outcomes:** Social functioning, depression, anxiety,	**Number of studies:** 21 **Study design:** 11 studies were controlled trials - of which 7 were RCTs. 10 were matched studies. **Number of participants** From 7 to 144 participants; social functioning n = 275; depression n =447; anxiety n =291; behavioural disturbances n = 367 **Characteristics of participants:** About 10 studies targeted cognitively unimpaired elderly	Effects on social functioning and depression were larger in individuals with psychiatric conditions while behavioral disturbances were reduced in patients with dementia. The inconsistent methodological characteristics of the studies meta-analysed suggest a conservative interpretation of these findings.

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			behavioural disturbances, loneliness, daily living skills and cognitive status **Literature search:** January 2009	populations, 5 studies targeted elderly individuals with dementia and 6 studies involved psychiatric patients. All but two studies involved both men and women. **Setting:** The interventions were based on natural or spontaneous human-animal interactions in 11 studies. Prompted or guided interactions in the remaining 10 studies. Most studies delivered AAT in a group format used dogs as therapy animals. All but four studies used periodic AAT sessions with a median intensity of 2 hours per week, while the others involved permanent animal adoptions. **Country of origin:** (USA n=11, Italy n=2, Japan n=3, Israel n=2, Hungary n=1, Honduras n=1, Australia n=1)	

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				Interventions: Animal-assisted therapy (dog, cat, rabbit, bird, ferret, dolphin, aquarium and robotic dog) **Number of studies:** outcomes: depression (n=9); anxiety (n=4); behavioural disturbances including bizarre vocalisations; disruptive, aggressive and self-injurious behaviour (n=7); loneliness (n=4); social functioning including basic (e.g., visual contact) and advanced (e.g., conversational skills) forms of social interaction either observed directly or measured through a rating scale (n=7); daily living skills (n=6); and cognitive ability (n=5). **Outcomes:** AAT improved social functioning (pooled effect size = 1.06, n = 275). Moderate effects were found for depression (-0.34, n =447), anxiety (-0.29, n	

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				=291) and behavioural disturbances (-0.32, n = 367). **Follow-up time:** The length of interventions ranged from 1 to 69 weeks, with a median AAT duration of 7 weeks. Depending on outcome.	
Wysocki et al 2012 USA [108]	**Moderate** **SBU Domain(s):** Särskilda boendeformer som insats. (Institutional care as an intervention) Hemtjänst som insats. (Home help as an intervention) **Quantitative**	To compare long-term care (LTC) for older adults delivered through Home and Community-Based Services (HCBS) with care provided in nursing homes (NHs) by evaluating (1) the characteristics of older adults served through HCBS and in NHs; (2) the impact of HCBS and NH care on outcome trajectories of older adults; and (3) the per person costs of HCBS and NH care, costs for other services such as acute care, and family burden.	**Inclusion criteria:** Randomized controlled trials (RCTs) and observational studies that directly compared LTC for older adults (age ≥60) served through HCBS and in NHs. Studies were limited by date (1995–March 2012), language (English), and geographical location (United States and other economically developed countries with well-established health and LTC systems). **Literature search:** March 2012	**Number of studies:** 42 **Study design:** Cross sectional and longitudinal studies. **Number of participants:** Not stated. **Characteristics of participants:** At least 60 years. **Setting:** Residential care and home-based care. **Country of origin:** United States, Canada, United Kingdom, Australia, and New Zealand, Norway, Sweden, and other European countries.	Determining whether and how the delivery of LTC through HCBS versus NHs affects outcome trajectories of older adults is difficult due to scant evidence and the methodological limitations of studies reviewed. More and better research is needed to draw robust conclusions about how the setting of care delivery influences the outcomes and costs of LTC for older adults.

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				Interventions: Residential care and home-based care. **Outcomes:** Physical function, mental health outcomes (e.g., depression and anxiety), quality of life, social function, satisfaction, outcomes related to family caregivers, death, place of death, use of acute care services (e.g., hospitals, emergency) and costs departments), and harms (e.g., accidents, injuries, pain, abuse, and neglect). **Follow-up time:** 6 months up to many years	
Xu et al 2017 China [109]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder – ordinärt boende. Upprätthållande och stimulerande	To determine whether there is an association between music intervention and cognitive dysfunction therapy in healthy older adults, and if so, whether music intervention can be used as firstline non-pharmacological treatment.	**Inclusion criteria:** Clinical trials were in any language and included older adults (aged 65 or over) experiencing cognitive dysfunction, regardless of study design. Studies that compared any form and intervention	**Number of studies:** 10 **Study design:** RCT and CCT. **Number of participants:** Intervention=470 Control=496	There was positive evidence to support the use of music intervention on treatment of cognitive function.

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	arbetssätt och metoder – särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings **Quantitative**		method of music intervention with no music care. **Literature search:** September 2016.	**Characteristics of participants:** Older adults, healthy older adults, older elderly, between 69–88 years, 3–46% men. **Setting:** Nursing home, nutrition sites, hospital, home. **Country of origin** USA, Italy, UK, Korea, Canada. **Interventions:** Interactive (singing): nutrition-focused song, n=1 study. Interactive (face-to-face training sessions); musical backgrounds, n=1 study. Interactive music from the 1920s, 1930s, 1940s, n=1 study. Interactive (playing of rhytm instruments), n=2 studies. Passive, a) secular song, b) religious song, n=1 study. Interactive (following the piano music), n=2 studies.	

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				Passive (2/4 rhythm), n=1 study. Interactive (individualized piano playing), n=1 study. **Outcomes:** Primary outcome was cognitive function. The secondary outcomes included disruptive behavior, depressive score, anxiety score and quality of life. 2 types of outcome measures were extracted from the older adults with dementia. **Follow-up time:** 3 months – 2 years	
Young et al 2017 UK [110]	**Moderate** **SBU Domain(s):** Insatser för att stödja kvarboende. (Interventions to support ageing in place) **Quantitative**	To assess the effects of long-term home or foster home care versus institutional care for functionally dependent older people, with a particular focus on mortality, physical function, quality of life, and caregiver outcomes.	**Inclusion criteria**: We included randomized and non-randomized trials, controlled before-after studies and interrupted time series studies complying with the EPOC study design criteria and comparing the effects of long-term home care versus institutional care for functionally dependent older people. **Literature search**:	**Number of studies**: 10 **Study design:** 1 randomised trial, 4 non-randomised trials, 4 observational cohort studies 1 nested case-control study **Population**: Persons aged 65 years or older with long term functional dependency who were considered	There are insufficient high-quality published data to support any particular model of care for functionally dependent older people. Community-based care was not consistently beneficial across all the included studies; there were some data suggesting that community-based care may be associated with improved quality of life and physical function

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			November 2015	as potentially requiring care home placement (from hospital or the community). We defined functional dependence as the need for assistance in one or more activities of daily living (ADLs). **Number of participants**: 16 377 **Country of origin:** USA, Taiwan, Sweden, the UK, and Canada. **Setting:** community-based care compared with institutional care (care homes). **Interventions:** Enhanced long-term home care services can include a number of different elements, such as formal personal care (including bathing, toileting, feeding, dressing, transfers, meal preparation, shopping), adapted environments	compared to institutional care. However, community alternatives to institutional care may be associated with increased risk of hospitalization. Future studies should assess healthcare utilization, perform economic analysis, and consider caregiver burden. It is uncertain whether long-term home care compared to nursing home care decreases mortality risk (2 studies, N = 314, very-low certainty evidence). Estimates ranged from a nearly three-fold increased risk of mortality in the homecare group (risk ratio (RR) 2.89, 95% confidence interval (CI) 1.57 to 5.32) to a 62% relative reduction (RR 0.38, 95% CI 0.17 to 0.61). We did not pool data due to the high degree of heterogeneity (I2 = 94%). It is uncertain whether the intervention has a beneficial effect on physical function, as the certainty of evidence is

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				(including within the older person's own home, or in a specifically adapted residence), day care (planned regular care given in day care centres to patients otherwise living at home), or respite care (care given primarily at home, but where patients receive planned regular respite within an institution). **Outcomes**: Primary outcomes: Mortality at the end of scheduled follow-up Physical function (activities of daily living scales) Quality of life measures Secondary outcomes: Participant outcomes • Satisfaction with care • Number of adverse health outcomes, including incidence of infection (chest and urinary) over the period of the study • Hospital admissions	very low (5 studies, N = 1295). Two studies reported that participants who received long-term home care had improved activities of daily living compared to those in a nursing home, whereas a third study reported that all participants performed equally on physical function. It is uncertain whether long-term home care improves happiness compared to nursing home care (RR 1.97, 95% CI 1.27 to 3.04) or general satisfaction because the certainty of evidence was very low (2 studies, N = 114). The extent to which long-term home care was associated to more or fewer adverse health outcomes than nursing home care was not reported. It is uncertain whether long-term home care compared to nursing home care decreases the risk of hospital admission (very low-certainty evidence, N = 14,853). RR estimates ranged from 2.75 (95% CI 2.59 to 2.92), showing an

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Informal caregivers of functionally dependent older people • Satisfaction with care (of the caregiver) • Perceived stress • Perceived burden **Follow-up time:** Unclear	increased risk for those receiving care at home, to 0.82 (95% CI 0.72 to 0.93), showing a slightly reduced risk for the same group. We did not pool data due to the high degree of heterogeneity (I2 = 99%).
Zhao et al 2016 China & USA [111]	**Moderate** **SBU Domain(s):** Upprätthållande och stimulerande arbetssätt och metoder - ordinärt boende. Upprätthållande och stimulerande arbetssätt och metoder - särskilt boende. (Maintaining and stimulating work methods – both community and institutional settings) **Quantitative**	To determine the efficacy of music therapy in the management of depression in the elderly.	**Study design**: Randomized controlled trials. **Participants**: Men and women aged 60 or older with clinical diagnosis of depression using any diagnostic criteria, such as JCD-10 or DSM-5 (American Psychiatric Association, 2013) research diagnostic criteria, or obvious depressive mood coupled with some disease, such as hypertension, cerebral apoplexy, Alzheimer's disease, sleep disorder, etc. Participants who scored above a cutoff score on a self-rating depression questionnaire. Included studies that used healthy people to detect the efficacy of music therapy in	**Number of studies:** n=19 **Study design:** Randomized controlled trials. **Number of participants:** Music therapy plus standard therapies versus standard therapies. 10 studies with 909 participants. (Sample sizes ranging from 30 to 268) **Characteristics of participants:** Age 60 or older. One study had two intervention groups that tested the efficacy of different types of music therapy. Five studies involved diagnoses of varying	This systematic review and meta-analysis suggest that music therapy has an effect on reducing depressive symptoms to some extent. However, high-quality trials evaluating the effects of music therapy on depression are required.

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
			reducing depressive symptoms **Setting:** Any (a bit unclear). **Intervention:** Any type of music therapies for example, individual or group therapy, active or re-ceptive-was included **Outcomes:** Change in depressive symptoms. The measurements included the Hamilton Rating Scales for Depression, Geriatric Depression Scale, Self-Rating Depression Scale, Hospital Anxiety and Depression Scale, Narcissism Personality Inventory, and Cornell Scale for Depression in Dementia **Literature search:** 13 September 2014	degrees of dementia, six studies involved diagnoses of depression. Two studies involved healthy volunteers. Ten studies used music therapy plus standard therapies (i.e., standard drug treatment, rehabilitation, and exercise) to make comparisons with a control group. **Setting:** Any -unclear. **Country of origin:** Australia (n = 1), Italy (n = 2), USA (n = 1), France (n= 1), Switzerland (n= 1), mainland China (n = 11), Hong Kong (n = 1), and Taiwan (n= 1). **Interventions:** Any type of music therapies **Outcomes:** The combined standardized mean difference (SMD) for the experimental and control groups was 1.02 (95% CI=0.87, 1.17)	

Author Year Country Reference	Study quality SBU Domain(s) Quantitative/ qualitative	Objectives of the systematic review	Inclusion criteria for the systematic review Literature search (date)	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author(s)
				Follow-up time: 4 weeks to one year depending on outcome	

Note: Follow-up time is sometimes difficult to record as multiple outcomes and timepoints have been assessed. Additionally, follow-up time was not always specifically mentioned.

Some data can be hard to find, and, in those cases, we marked it with unclear.

n = Number of participants, RCT = Randomised Controlled Trial, CCT=controlled clinical trial

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