

L'ergothérapie
pour le maintien de la fonctionnalité et
la participation sociale
de la personne âgée physiquement fragile vivant à domicile

Partie 2: Méthodologie



GDG:

***De Coninck L., Bouckaert L., Cordyn S., De Schutter F., Gielen E., Guisset ME.,
Kos D., Ledoux A., Aertgeerts B.***

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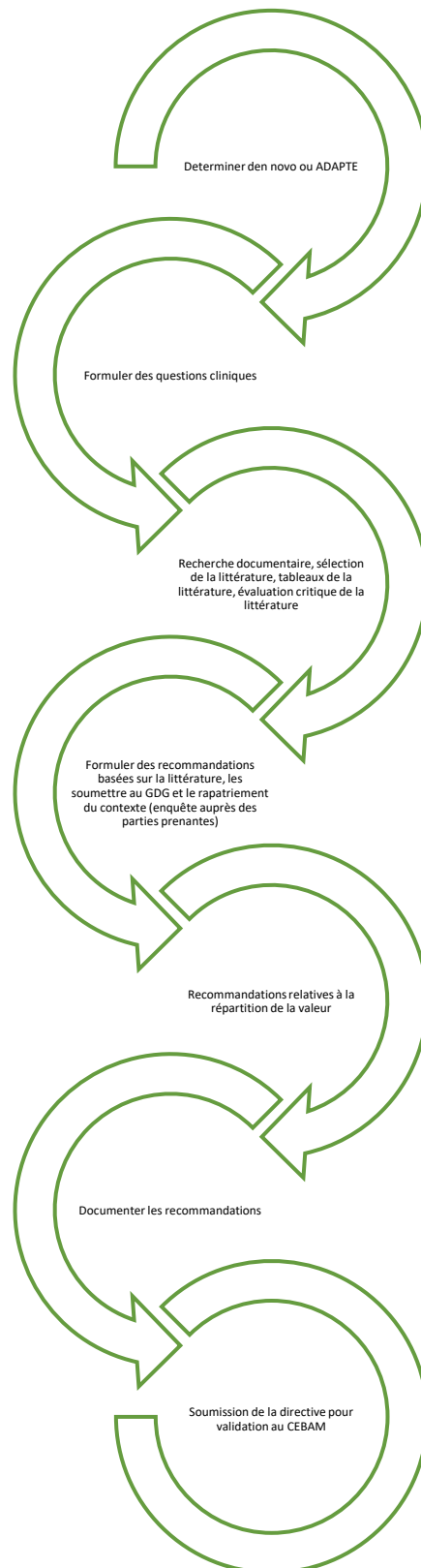
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3 Méthodologie détaillée de l'élaboration de guide clinique

3.1 Les étapes du processus de développement



3.2 Discussion par phase

3.2.1 Détermination de novo ou ADAPTE

Les termes "ergothérapie" et "personnes âgées" ont été utilisés comme termes de recherche pour détecter les guides cliniques pertinentes. Les bases de données de guides cliniques (WHO, GIN, base de données TRIP), les sites web des organisations professionnelles d'ergothérapie élaborant des guides cliniques (Ergotherapie Nederland - NL, American Occupational Therapy Association - USA, Royal college of Occupational Therapy - GB) et les sites web d'autres concepteurs de guides cliniques (RNAO - Canada, NICE - Angleterre, AMM - Malaisie, SIGN - Ecosse et NOH-Singapour) ont été consultés. Les organisations professionnelles d'ergothérapie dont les sites web ne nous permettaient pas de savoir si elles élaboraient des guides cliniques ont également été contactées par écrit. (Voir tableau 1)

| Pays | Nom de l'association professionnelle |
|------------------|--------------------------------------|
| Australie | OTA |
| Canada | CAOT |
| L'Europe | COTEC |
| Angleterre | RCOT |
| Finlande | STI (syndicat) |
| France | ANFE |
| Islande | ICOTA |
| Japon | JAOT |
| Malaisie | MOTA |
| Nouvelle-Zélande | OTNZ |
| Norvège | NET |
| Suède | SAOT |
| Irlande | AOTI |
| Suisse | SVE |

Tableau 1 : Associations professionnelles d'ergothérapeutes agréées

Aucune des associations professionnelles contactées n'a élaboré de guides cliniques professionnelles sur la fragilité.

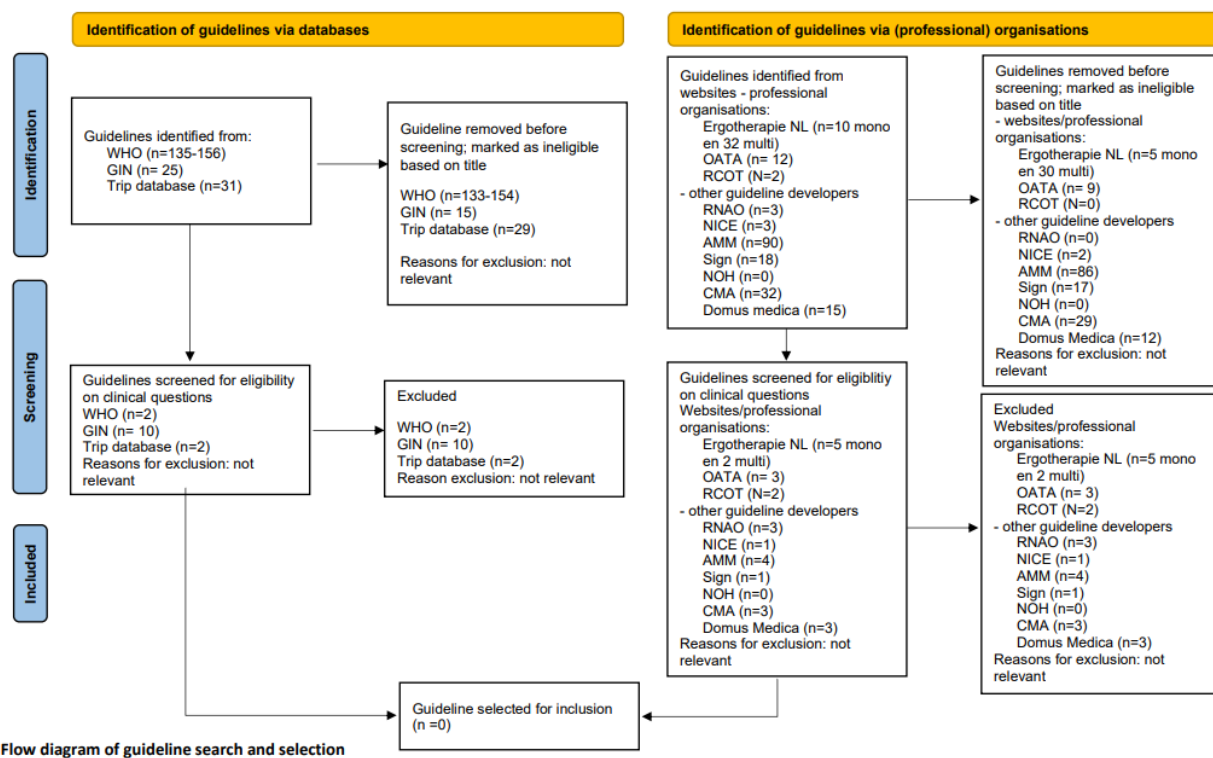


Figure 1 : Organigramme des guides cliniques en matière d'identification et de sélection

Cette recherche détaillée n'a pas permis de trouver une guide clinique valable (et disponible gratuitement) qui pourrait être utilisée comme guide clinique source pour l'adaptation. Il a donc été décidé d'élaborer une nouvelle guide clinique .

3.2.2 Établissement des question cliniques

La question centrale de la guide clinique est la suivante :

À quoi doit répondre une intervention ergothérapeutique de qualité fondée sur des données probantes pour avoir un impact sur le maintien de la fonctionnalité et de la participation sociale de la personne âgée physiquement fragile vivant à domicile ?

Pour structurer la guide clinique et rendre les recommandations gérables pour la pratique, des thèmes ont été déterminés autour desquels des questions cliniques pouvaient être formulées. L'inspiration a été trouvée en analysant les questions cliniques des guides cliniques apparentées - identifiées par la recherche ci-dessus - (annexe 5.1). Pour esquisser un cadre initial, les thèmes pertinents des guides cliniques sélectionnées ont été regroupés et, pour chaque thème, des questions cliniques potentielles ont été dérivées de l'analyse du tableau analysant les questions cliniques des lignes directrices. Cela a conduit au résultat suivant :

Renvoi (recherche de cas) - indication

- Quel est le rôle de l'aidant informel dans la reconnaissance d'un besoin d'ergothérapie ?
- Quand les personnes âgées physiquement fragiles vivant à domicile doivent-elles être orientées vers un ergothérapeute ?
- Quelles sont les indications pour que les ergothérapeutes orientent les personnes âgées physiquement fragiles vivant à domicile vers d'autres ressources et/ou des soins secondaires/tertiaires ?
- Quels sont les principaux facteurs qui nécessitent une approche ergothérapeutique chez les personnes âgées physiquement fragiles vivant à domicile ?
- Quelle est la meilleure méthode pour détecter la nécessité d'une intervention ergothérapeutique chez une personne âgée physiquement fragile vivant à domicile ?
- Quelles sont les preuves qui permettent de recommander l'ergothérapie pour les personnes âgées physiquement fragiles vivant à domicile ?
- Quels sont les problèmes associés aux personnes âgées physiquement fragiles qui intéressent les ergothérapeutes ?
- Quels sont les symptômes les plus pertinents pour le dépistage précoce des personnes âgées physiquement fragiles ?
- Quel outil d'évaluation des risques ou quel processus d'estimation des risques peut être utilisé pour identifier les personnes âgées vivant à domicile qui sont physiquement vulnérables ?
- Quels sont les facteurs de risque de chute chez les personnes âgées physiquement fragiles à domicile ?

Évaluation et fixation d'objectifs/plan d'activité

- Quelle évaluation multifactorielle est appropriée pour l'intervention de l'ergothérapeute auprès de la personne âgée physiquement fragile vivant à domicile ?
- Quelle évaluation multifactorielle est recommandée en tant qu'ergothérapeute chez la personne âgée physiquement fragile vivant à domicile (et chez son aidant informel) ?
- Les évaluations visant à identifier les besoins sont-elles utiles pour les aidants informels de la personne âgée physiquement fragile vivant à domicile ?
- Comment cartographier les capacités ADL et AIVJ de la personne âgée physiquement fragile vivant à domicile ?
- Comment l'ergothérapeute détermine-t-il les capacités fonctionnelles d'une personne âgée physiquement fragile vivant à domicile ?
- Quels sont les méthodes et les outils adaptés à l'évaluation de la demande et à l'analyse de la participation et de la réalisation d'activités significatives chez les personnes âgées physiquement fragiles ?
- Quelle méthode et quels principes de définition des objectifs et de planification des interventions sont appropriés pour le traitement ergothérapeutique des personnes âgées physiquement fragiles ?
- De quelle manière l'ergothérapeute peut-il identifier et analyser les problèmes d'activité et de participation (attendus) ?
- Quels sont les points essentiels pour l'ergothérapeute lors de l'inventaire des facteurs personnels et externes qui affectent le fonctionnement de la personne âgée physiquement fragile et de ses proches ?
- Quelles sont les ressources et les méthodes ergothérapeutiques valables et fiables pour identifier les capacités et les limitations, les souhaits et les besoins en matière de vie quotidienne des personnes âgées physiquement fragiles et de leurs soignants ?

- Comment les objectifs de réadaptation et le plan de traitement sont-ils élaborés avec les clients et leurs proches, en tenant compte de leurs expériences et de leurs points de vue ?
- Quels sont les outils d'inventaire et d'analyse des problèmes qui sont fiables et valables pour identifier la participation, le bien-être et les problèmes dans l'accomplissement des activités liées à la vie et aux soins, au travail et aux loisirs ?
- Comment identifier les capacités physiques, cognitives et psychosociales sous-jacentes et l'environnement social et physique ?
- Quels sont les aspects importants lors de la fixation d'objectifs avec le client et ses proches ? Comment l'élaboration d'un plan d'activité basé sur la modification des activités du client est-elle adaptée à sa résilience et à son potentiel de changement ? Comment l'autogestion est-elle encouragée pendant la phase de définition des objectifs et du plan d'activité ?
- Comment concevoir au mieux le diagnostic ergothérapeutique chez les personnes âgées physiquement fragiles et leurs aidants naturels ?
- Quelle méthode (de dépistage) faut-il utiliser pour reconnaître les problèmes d'activité et de participation chez les personnes âgées physiquement fragiles ?
- Quelles méthodes (de dépistage) peuvent être recommandées pour identifier les troubles chez les personnes âgées physiquement fragiles ?
- Quelle est l'évaluation multifactorielle du risque de chute la mieux adaptée aux personnes âgées physiquement fragiles et présentant un risque de chute accru ?

Intervention - approche/communication - suivi

- Quelles sont les stratégies de prévention et de promotion de la santé recommandées pour les personnes âgées physiquement fragiles vivant à domicile ?
- Les activités d'information sont-elles bénéfiques dans le traitement ergothérapeutique des personnes âgées physiquement fragiles vivant à domicile et de leurs aidants naturels ?
- Quelles sont les principales caractéristiques d'un ergothérapeute efficace auprès d'une personne âgée physiquement fragile vivant à domicile ?
- Les interventions ergothérapeutiques qui impliquent la personne âgée et son aidant informel, le cas échéant, dans la conception et la mise en œuvre sont-elles plus efficaces que celles qui n'impliquent pas cette personne ?
- Quels sont les obstacles et les facteurs facilitant une mise en œuvre efficace des interventions d'ergothérapie à domicile auprès des personnes âgées physiquement fragiles vivant à domicile ?
- Quels sont les effets centraux et périphériques de l'ergothérapie chez les personnes âgées physiquement fragiles vivant à domicile ?
- Quels types d'interventions ergothérapeutiques sont efficaces chez les personnes âgées physiquement fragiles vivant à domicile pour améliorer la qualité de vie/le bien-être, la sécurité de l'environnement domestique, l'incidence des chutes, les AIVJ, les BAVJ et la charge de travail des soignants, le fonctionnement des soins personnels/de la productivité et de la relaxation, la capacité auto-évaluée à effectuer les ADL ?
- Quelles sont les conditions préalables à une ergothérapie ciblée et efficace pour les personnes âgées physiquement fragiles (et leurs aidants naturels) vivant à domicile ?
- Quelles sont les interventions multifactorielles recommandées par les ergothérapeutes auprès des personnes âgées physiquement fragiles vivant à domicile (et de leurs aidants informels) ?
- Ces interventions ergothérapeutiques (conseils et coaching sur les environnements sûrs, les mesures de protection des articulations, la prévention des chutes, le changement de méthode, ...) sont-elles bénéfiques pour les personnes âgées physiquement fragiles vivant à domicile ?

- Les stratégies d'ergothérapie qui favorisent l'indépendance des personnes âgées physiquement fragiles vivant à domicile sont-elles bénéfiques ou néfastes ?
- Quelles adaptations environnementales sont souhaitables pour les personnes âgées physiquement fragiles vivant à domicile ?
- Quelles sont actuellement les meilleures pratiques des ergothérapeutes pour les personnes âgées physiquement fragiles vivant à domicile ?
- Quel est l'effet d'une approche multifactorielle de l'ergothérapie chez les personnes âgées physiquement fragiles vivant à domicile ?
- Quelles sont les interventions multifactorielles d'ergothérapie appropriées pour les personnes âgées physiquement fragiles vivant à domicile ?
- Les interventions destinées à l'aidant informel d'une personne âgée physiquement fragile vivant à domicile sont-elles utiles ?
- Comment l'ergothérapeute peut-il faire face au manque d'autonomie d'une personne âgée physiquement fragile vivant à domicile ?
- Comment l'ergothérapeute peut-il améliorer l'observance chez les personnes âgées physiquement fragiles (et leurs aidants naturels) vivant à domicile ?
- Comment l'ergothérapeute peut-il s'assurer que la personne âgée physiquement fragile vivant à domicile respecte mieux les règles ?
- Quelles sont les interventions fondées sur des données probantes qui ciblent les personnes âgées physiquement fragiles et qui sont adaptées au rôle de l'ergothérapie et qui améliorent le fonctionnement en toute sécurité ?
- Quelles interventions ergothérapeutiques peuvent être utilisées (à titre préventif) en cas de déficience ou d'altération du fonctionnement chez les personnes âgées physiquement fragiles ?
- Quelles interventions ergothérapeutiques peuvent être utilisées pour traiter les problèmes d'activité et de participation des personnes âgées physiquement fragiles dans les domaines de la "communication", de la "mobilité", des "soins personnels", de l'"entretien ménager" et des "activités de jour (travail, loisirs)", et quels sont les points centraux de ces interventions ?
- Quelles interventions ergothérapeutiques peuvent être utilisées pour conseiller et soutenir les proches des personnes âgées physiquement fragiles ?
- Quelles sont les interventions ergothérapeutiques efficaces pour les personnes âgées physiquement fragiles et leurs soignants ?
- Quelles interventions sont efficaces dans le traitement ergothérapeutique des personnes âgées physiquement fragiles pour améliorer la participation et le fonctionnement indépendant (pour tous les domaines d'activité) ?
- Comment concevoir au mieux le traitement ergothérapeutique des personnes âgées physiquement fragiles et de leurs soignants ?
- Quelles interventions peuvent être recommandées pour améliorer le fonctionnement, l'humeur et le bien-être et réduire la charge de travail et le stress des aidants informels de personnes âgées physiquement fragiles ?
- Quel est le traitement à privilégier et quand doit-il être appliqué ?
- Quelles interventions de réduction du risque de chute sont efficaces chez les personnes âgées physiquement fragiles vivant à domicile ?
- Comment améliorer l'adhésion des personnes âgées physiquement fragiles aux conseils de l'ergothérapeute ?

- Quelles sont les preuves de l'effet des interventions basées sur l'occupation et l'activité sur la réalisation de certaines activités instrumentales de la vie quotidienne (AIVQ) chez les personnes âgées vivant dans la communauté ?
- Quelles sont les preuves de l'efficacité des programmes d'aménagement du domicile et de prévention des chutes sur les performances des personnes âgées vivant dans la communauté ?
- Quelles sont les preuves de l'effet des interventions de gestion et de maintien de la santé fondées sur l'occupation et l'activité sur les performances des personnes âgées vivant dans la communauté ?
- Quelles sont les preuves que la participation à des occupations et à des activités contribue à la santé des personnes âgées vivant dans la communauté ?

Coopération multidisciplinaire - orientation - organisation de soins de santé

- Quel est le rôle de l'ergothérapeute dans le suivi de la communication avec les autres soignants concernant les objectifs et les résultats prédéfinis pour la personne âgée physiquement fragile vivant à domicile ?
- Quand l'ergothérapeute doit-il orienter une personne âgée physiquement fragile vivant à domicile ?
- Quelles sont les politiques organisationnelles et le soutien du système nécessaires pour fournir une ergothérapie efficace aux personnes âgées physiquement fragiles vivant à domicile ?
- Quelles sont les caractéristiques de l'intervention et les facteurs du client et du contexte de soins qui sont importants pour une application réussie des interventions d'ergothérapie chez les personnes âgées physiquement fragiles ?
- Quelles sont les conditions préalables à la fourniture de soins aux personnes âgées physiquement fragiles ?
- Quelles sont les preuves de l'effet des politiques et des programmes de mobilité communautaire (par exemple, transports alternatifs, communautés accessibles à pied, éducation, programmes d'arrêt de la conduite, programmes pour les piétons) sur les performances et la participation des personnes âgées ?
- Quels sont les contenus et les stratégies éducatives nécessaires pour former efficacement les prestataires de soins de santé à la prévention des chutes et des blessures dues aux chutes ?
- Quelles politiques organisationnelles et quels soutiens au niveau du système sont nécessaires pour aider à prévenir les chutes et les blessures dues aux chutes chez les personnes âgées à risque ?

À partir de cette analyse, les thèmes suivants ont été filtrés et soumis au GDG :



Les questions cliniques initiales suivantes ont été liées à ces thèmes :

Thème 1 : Renvoi (recherche de cas) - indication

- Comment détecter une personne âgée physiquement fragile vivant à domicile ?
- Quand une personne âgée physiquement fragile vivant à domicile doit-elle être orientée vers un ergothérapeute ?

Thème 2 : Communication et attitude basique thérapeutique

- Qu'est-ce qu'un ancrage ergothérapeutique de qualité et une communication avec la personne âgée physiquement fragile vivant à domicile et son contexte social ?

Thème 3 : Évaluation de l'ergothérapie et détermination des objectifs personne âgée et/ou contexte social

- Quelle évaluation multifactorielle de l'ergothérapie est appropriée pour fixer des objectifs à la personne âgée physiquement fragile vivant à domicile et/ou à son entourage ?

Thème 4 : Plan d'activité/ intervention ergothérapeutique personne âgée et/ou contexte et surveillance

- Quelle intervention multifactorielle d'ergothérapie, de nature préventive/curative ou conservatrice, est appropriée pour la personne âgée physiquement fragile vivant à domicile et/ou son contexte ?
- Comment l'ergothérapeute peut-il suivre l'intervention chez la personne âgée physiquement fragile vivant à domicile et/ou dans son contexte ?

Thème 5 : L'ergothérapie dans les situations de crise

- Quand et comment l'ergothérapie est-elle utile dans des situations de crise sociale et/ou individuelle pour la personne âgée physiquement fragile vivant à domicile et/ou dans son contexte social ?

Thème 6 : Prise en charge, collaboration multidisciplinaire et orientation des patients

- Quelle approche l'ergothérapeute doit-il utiliser pour proposer efficacement l'ergothérapie à la personne âgée physiquement fragile vivant à domicile et/ou à son entourage ?
- Comment l'ergothérapeute, qui travaille avec la personne âgée physiquement fragile vivant à domicile et/ou dans son contexte social, contribue-t-il à façonner une collaboration multidisciplinaire et interdisciplinaire ?

Thème 7 : Traduire les recommandations de pratique dans l'enseignement de l'ergothérapie

- Quelles connaissances, compétences et attitudes doivent être enseignées, et de quelle manière doivent-elles être appliquées, aux étudiants en ergothérapie afin qu'ils puissent fournir une ergothérapie efficace aux personnes âgées physiquement fragiles vivant à domicile et/ou dans leur contexte ?

Ces questions cliniques initiales ont été présentées au GDG, au comité d'orientation du SFP et aux parties prenantes.

A la suggestion du GDG (rapport GDG 1 20200924) et du comité d'orientation du SPF Santé publique, certains thèmes ont été omis (ergothérapie dans les situations de crise et traduction des recommandations de pratique dans l'enseignement de l'ergothérapie) et des questions cliniques ont été fusionnées. Lors du remaniement, le processus de raisonnement clinique a permis de structurer la formulation et l'ordre des questions cliniques. Cela a conduit aux questions cliniques préfinales. Celles-ci ont été approuvées par le GDG (rapport GDG 20201210) et le comité d'orientation du SPF Santé publique.

Les questions cliniques préfinales ont ensuite été soumises au comité consultatif (parties prenantes) pour vérifier leur pertinence au moyen d'une enquête (échelle de Likert en quatre points), la valeur limite du consensus étant fixée à 70 %. Les cinq questions cliniques ont été jugées pertinentes par consensus. (Rapport de consultation des parties prenantes 20201019)

Suite aux commentaires du comité de lecture de WOREL, le terme "case finding" a été ajouté à la première partie de la question clinique 1, ceci afin de rendre plus claire la distinction avec la composante "évaluation" de la question clinique 2. Les questions cliniques finales se lisent comme suit :

Question clinique 1 :

Comment détecter les personnes âgées physiquement fragiles (recherche de cas) ? Comment la personne âgée physiquement fragile et/ou son contexte social peuvent-ils être orientés de manière efficace et efficiente vers un ergothérapeute ?

Question clinique 2 :

Quelle évaluation multifactorielle de l'ergothérapie est appropriée pour la personne âgée physiquement fragile vivant à domicile et/ou son contexte ?

Question clinique 3 :

Quelle méthodologie est appropriée pour fixer des objectifs avec la personne âgée physiquement fragile vivant à domicile et/ou son entourage ?

Question clinique 4 :

Quelles sont les interventions multifactorielles d'ergothérapie appropriées pour la personne âgée physiquement fragile vivant à domicile et/ou son contexte ?

Question clinique 5 :

Comment l'ergothérapeute, travaillant avec la personne âgée physiquement fragile vivant à domicile et/ou son contexte social, peut-il contribuer à des soins disciplinaires, intégrés et/ou transmuraux de qualité ?

3.2.3 Recherche et sélection de la littérature et tableaux, évaluation critique de la littérature

3.2.3.1 Rendre le PIPOH opérationnel

Chaque élément du PIPOH a été rendu opérationnel en fournissant une description du terme et en formulant des synonymes, des hyperonymes et des hyponymes (tableau 2). (Cette opérationnalisation du PIPOH sert d'étape intermédiaire pour définir les concepts, comme indiqué au point 3.2.3.6 "Préparation de la chaîne de recherche liée au PIPOH".

| | Term | Synoniem | Hyperoniem | Hyponiem |
|---|--|---|---|--|
| P | Personne âgée physiquement fragile vivant à domicile et âgée de plus de 75 ans | physically frail elderly, older person over 75 years, "Frail Elderly"[Mesh], "Social Environment"[Mesh], | Elderly, "aged"[MeSH Major Topic], "Aged, 80 and over"[Mesh], "Frailty"[Mesh], ageing in place, community dwelling elderly "Social Support"[Mesh], "Social Networking"[Mesh], "Social Environment"[Mesh], "Family"[Mesh], "Social Capital"[Mesh] | "Homebound Persons"[Mesh], "Environment"[Mesh], "Independent Living"[Mesh] "Spouses"[Mesh], "Caregivers"[Mesh], "Nuclear Family"[Mesh], informal care |
| I | | "Occupational Therapy"[Mesh], "Patient Care Team"[Mesh], multidisciplinary approach | "Interdisciplinary Communication"[Mesh], "Case Management"[Mesh], "Therapeutics"[Mesh], "therapy" [Subheading], "Patient-Centered Care"[Mesh], "Intersectoral Collaboration"[Mesh], "Activities of Daily Living"[Mesh] | "Clinical Decision-Making"[Mesh], "Decision Making, Shared"[Mesh], "Disability Evaluation"[Mesh], "Treatment Outcome"[Mesh], "Geriatric Assessment"[Mesh], occupational therapy assessment, occupational therapy diagnosis, "Goals"[Mesh], set goal, |

| | | |
|--|--|---|
| | | <p>"Primary Prevention"[Mesh], "Secondary Prevention"[Mesh], "Tertiary Prevention"[Mesh]</p> <p>coaching, support, advice, "Teaching"[Mesh], "Psychosocial Support Systems"[Mesh], "Directive Counseling"[Mesh], "Counseling"[Mesh], "Distance Counseling"[Mesh], "Therapeutic Alliance"[Mesh], "Mentoring"[Mesh], "Social Learning"[Mesh], "Self-Management"[Mesh], support informal care,</p> <p>aids, "Sensory Aids"[Mesh], "Hearing Aids"[Mesh], "Communication Aids for Disabled"[Mesh], "Audiovisual Aids"[Mesh], eating aids, walking aids, washing aids, cooking aids, dressing aids, leisure aids, sitting aids, home modification, "Housing"[Mesh], home adaptation, falls prevention,</p> <p>"Mobile Applications"[Mesh], "Recreation Therapy"[Mesh], "Animal Assisted Therapy"[Mesh], "Healthy Lifestyle"[Mesh],</p> |
|--|--|---|

| | | | |
|---|---|--|--|
| | | | <p>"Computer User Training"[Mesh],</p> <p>curation,</p> <p>"Rehabilitation"[Mesh],</p> <p>"rehabilitation" [Subheading], "Physical Conditioning, Human"[Mesh],</p> <p>"Pain Management"[Mesh],</p> <p>"Patient Positioning"[Mesh],</p> <p>transfer techniques, joint protection techniques, energy management,</p> |
| P | <p>"Occupational Therapy"[Mesh],</p> <p>"Physicians"[Mesh],</p> <p>"General Practitioners"[Mesh],</p> <p>"Physical Therapists"[Mesh],</p> <p>"Nurses, Community Health"[Mesh],</p> <p>"Licensed Practical Nurses"[Mesh], "Nurse Clinicians"[Mesh],</p> <p>"Geriatricians"[Mesh],</p> <p>"Community Health Nursing"[Mesh], "Home Health Nursing"[Mesh]</p> <p>"Geriatric Nursing"[Mesh], "Allied Health Personnel"[Mesh], "Family Nurse Practitioners"[Mesh],</p> <p>"Case Managers"[Mesh]</p> | <p>"Community Health Workers"[Mesh],</p> <p>"Patient Care Team"[Mesh],</p> <p>"Community Medicine"[Mesh],</p> <p>"Community Health Services"[Mesh],</p> <p>"Delivery of Health Care"[Mesh], "Family Nursing"[Mesh]</p> | <p>"Home Health Aides"[Mesh],</p> |
| O | <p>Functionality, "Social Participation"[Mesh],</p> <p>"Social Integration"[Mesh]</p> | <p>"Human Activities"[Mesh],</p> <p>"Activities of Daily Living"[Mesh],</p> <p>"Exercise"[Mesh],</p> <p>"Social Capital"[Mesh],</p> <p>participation, "Sense of Coherence"[Mesh],</p> <p>"Quality of Life"[Mesh],</p> | <p>"Leisure Activities"[Mesh],</p> <p>"Community Integration"[Mesh],</p> <p>"Community Participation"[Mesh],</p> <p>"Social Support"[Mesh]</p> |

| | | | |
|---|---|---|---|
| | | "Quality-Adjusted Life Years"[Mesh] | |
| H | "Home Care Services"[Mesh], "Primary Health Care"[Mesh], "Ambulatory Care Facilities"[Mesh] | "Delivery of Health Care"[Mesh], "Health Care Sector"[Mesh], "Delivery of Health Care, Integrated"[Mesh], "Comprehensive Health Care"[Mesh] | "Home Care Services, Hospital-Based"[Mesh], "Foster Home Care"[Mesh], "Home Health Aides"[Mesh], "Home Nursing"[Mesh], "Physicians, Primary Care"[Mesh], "Hospitals, General"[Mesh], "Adult Day Care Centers"[Mesh], "Respite Care"[Mesh], "Hospitals, Community"[Mesh], "Community Health Centers"[Mesh], "Home Care Services, Hospital-Based"[Mesh], |

Tableau 2 : Aperçu des termes, synonymes, hyperonymes et hyponymes de PIPOH

À l'aide du PIPOH, des termes de recherche spécifiques ont été déterminés pour chaque question clinique. La littérature sur l'ergothérapie étant limitée, nous avons décidé d'effectuer une recherche sensible.

3.2.3.2 Bases de données

Base de données Cochrane des revues systématiques (CDSR)

Le CDSR de la Cochrane Library a été choisi comme base de données en raison du niveau de preuve. Les revues systématiques publiées sont préparées et supervisées par un groupe de révision Cochrane et sont élaborées conformément au Cochrane Handbook for Systematic Reviews of Interventions (Manuel Cochrane pour les revues systématiques d'interventions).

Medline (via Pubmed)

La sélection de Medline est essentielle en raison de la quantité de références à la littérature biomédicale présente (plus de 30 millions). Tous les modèles de recherche sont présents dans Medline.

Cinahl

Cinahl a été retenu comme alternative à la disponibilité limitée d'AMED en Flandre. AMED est une base de données destinée au personnel paramédical. Cinahl s'est d'abord concentré sur le groupe cible des infirmiers, puis a élargi son public cible aux paramédicaux. Cinahl contient plus de 450 000 références à des articles (toutes conceptions confondues) publiés dans des revues infirmières,

paramédicales, biomédicales et d'utilisateurs de la santé. Cinahl a été consulté lorsque le CDSR et Medline ne donnaient pas de résultats suffisants.

OTDBase

OTDBase est une base de données comprenant plus de 8 000 résumés de plus de 30 revues internationales d'ergothérapie. OTDBase est la base de données la plus complète des revues d'ergothérapie. Tous les modèles de recherche sont inclus dans l'OTDBase. Il n'a pas été choisi d'utiliser la base de données OTSeeker car elle n'a pas été mise à jour depuis 2017.

3.2.3.3 Modèles de recherche

Dans un premier temps, les méta-analyses, les revues systématiques et les essais contrôlés randomisés ont été sélectionnés. Il s'agissait de rechercher des preuves d'une grande qualité méthodologique.

Le cas échéant, des modèles de recherche d'un ordre hiérarchique sous-jacent ont été étendus. Cela peut être dû à l'absence de revues systématiques ou d'essais contrôlés randomisés sur une question clinique particulière.

Enfin, pour la question clinique 4, les modèles de recherche ont été limités aux méta-analyses, aux examens systématiques et aux essais contrôlés randomisés. En raison de la nature des questions cliniques 1, 2, 3 et 5, les modèles inclus pour ces questions ont été élargis pour inclure des études observationnelles et qualitatives.

Les critères d'inclusion et d'exclusion, tels que présentés dans la guide clinique, ont été élargis pour inclure les critères d'inclusion et d'exclusion méthodologiques suivants dans le contexte de la sélection des articles :

Critères d'inclusion méthodologiques :

- Méta-analyses, revue systématique ou RCT (toutes les questions cliniques)
- Études d'observation et recherche qualitative (questions cliniques 1, 2, 3 et 5)
- Évaluation critique d'une qualité suffisante¹

Critères d'exclusion méthodologique :

- Études pilotes

3.2.3.4 Langue

Bien que nous supposons que la grande majorité des articles sont publiés en anglais, nous incluons également les articles publiés dans l'une des langues nationales officielles. Cela permet, entre autres, de détecter les articles adaptés au contexte belge.

Les articles sont sélectionnés en fonction de leur publication en anglais, néerlandais, français ou allemand.

¹ Si l'étude a reçu un score de "qualité inacceptable" lors d'une évaluation critique à l'aide de l'outil SIGN, ou si l'évaluation globale a été jugée très faible lors d'une évaluation critique à l'aide de l'outil JBI, l'article a été exclu.

3.2.3.5 Période de recherche

Les articles répondant aux critères d'inclusion et publiés jusqu'à la fin du mois de juin 2022 ont été inclus. Aucune restriction n'a été imposée quant à la date de début.

La période de recherche n'a été limitée aux dix dernières années que pour la question clinique n° 4, en raison du besoin d'informations récentes dû à la nature du sujet. En outre, la littérature disponible est suffisante pour fixer cette limite temporelle.

3.2.3.6 Chaîne de recherche de préparation liée au PPOH

L'élaboration des critères de recherche pour chaque question clinique est déterminée par consensus par deux membres du GDG, à savoir les investigateurs principaux, et soumise à l'approbation de l'ensemble du GDG.

Pour mieux comprendre le contenu des termes inclus, la structure arborescente sous-jacente est également cartographiée. Le cas échéant, les concepts sont adaptés à la structure de la base de données lors de la recherche.

P(personne, population, problème)

Concept : cibler les personnes âgées vulnérables

"Aged"[MeSH] OR "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] OR "Homebound Persons"[MeSH]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- aged: Elderly
- frail elderly: Elderly, Frail; Frail Elders; Elder, Frail; Elders, Frail; Frail Elder; Functionally-Impaired Elderly; Elderly, Functionally-Impaired; Functionally Impaired Elderly; Frail Older Adults; Adult, Frail Older; Adults, Frail Older; Frail Older Adult; Older Adult, Frail; Older Adults, Frail
- aged, 80 and over: Oldest Old; Nonagenarians; Nonagenarian; Octogenarians; Octogenarian; Centenarians; Centenarian
- frailty: Frailties; Frailness; Frailty Syndrome; Debility; Debilities
- homebound persons: Living, Independent; Community Dwelling; Dwelling, Community; Dwellings, Community; Aging in Place

Concept : Groupe cible des aidants

"Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Social Capital"[MeSH] OR "Social Networking"[MeSH] OR "Friends"[MeSH] OR "Family"[MeSH] OR "Caregivers"[MeSH] OR "Patient Care"[MeSH] OR "Nuclear Family"[MeSH] OR "Spouses"[MeSH] OR "Home Nursing"[MeSH] OR "Foster Home Care"[MeSH]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- social environment: Environments, Social ; Social Environments ; Environment, Social ; Social Ecology; Ecologies, Social; Ecology, Social; Social Ecologies
- social support: Support, Social ; Online Social Support ; Online Social Supports ; Social Support, Online ; Social Supports, Online ; Support, Online Social
- social capital: capital, social
- social networking: Networking, Social; Social Networks; Network, Social; Social Network
- friends: Friend; Companions; Companion; Friendship; Friendships; Acquaintances

- family: Families; Family Life Cycles; Life Cycle, Family; Life Cycles, Family; Family Life Cycle; Family Members; Family Member; Stepfamily; Stepfamilies; Family, Reconstituted; Families, Reconstituted; Reconstituted Families; Reconstituted Family; Filiation; Kinship Networks; Kinship Network; Network, Kinship; Networks, Kinship; Relatives; Extended Family; Extended Families; Families, Extended; Family, Extended; Family Research; Research, Family
- caregivers: Caregiver; Carers; Carer; Care Givers; Care Giver; Spouse Caregivers; Caregiver, Spouse; Caregivers, Spouse; Spouse Caregiver; Family Caregivers; Caregiver, Family; Caregivers, Family; Family Caregiver
- patient care: Care, Patient; Informal care; Informal cares; care, Informal; cares, Informal
- nuclear family: Families, Nuclear; Family, Nuclear; Nuclear Families; Sons; Son; Daughters; Daughter
- spouses: Spouse; Married Persons; Married Person; Person, Married; Persons, Married; Husbands; Husband; Domestic Partners; Domestic Partner; Partner, Domestic; Partners, Domestic; Spousal Notification; Notification, Spousal; Wives; Wife
- home nursing: Home Care, Nonprofessional; Care, Nonprofessional Home; Nonprofessional Home Care; Home Care, Non-Professional; Care, Non-Professional Home; Home Care, Non Professional; Non-Professional Home Care; Nursing, Home
- Foster home care: Care, Foster Home; Fostering; Kinship Care; Care, Kinship; Adult Foster Care; Care, Adult Foster; Foster Care, Adult

Concept : groupe cible contexte physique

"Housing for the elderly" [Mesh] OR "Environment Design"[Mesh] OR "Built Environment"[Mesh] OR "Environment"[Mesh] OR "Environment, Controlled"[Mesh] OR "home" OR "house"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Housing for the elderly: Life Care Centers, Retirement; Continuing Care Retirement Center
- Environment Design: Design, Environment; Designs, Environment; Environment Designs; Healthy Places; Healthy Place
- Built Environment: Built Environments
- Environment: Environments; Impacts, Environmental; Environmental Impacts ; Impact, Environmental ; Environmental Impact
- Environment, Controlled: Controlled Environment ; Controlled Environments ; Environments, Controlled ; Clean Rooms; Clean Room; Room, Clean; Laminar Air-Flow Areas; Area, Laminar Air-Flow; Laminar Air Flow Areas; Laminar Air-Flow Area

I(ntervention)

Concept : ergothérapie

"Ergothérapie" [MeSH].

Les conditions suivantes sont automatiquement incluses lors de la participation :

- occupational therapy: Therapy, Occupational; Occupational Therapies; Therapies, Occupational

Concept : Posture thérapeutique de base :

"Patient-Centered Care"[Mesh] OR "Professional competence Mesh]" OR "Professional-patient relations"[Mesh] OR "Clinical Competence"[Mesh] OR "Social Skills"[Mesh] OR "Empathy"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Respect"[Mesh] OR "Codes of Ethics"[Mesh] OR Ethics, Professional OR "occupation based" OR "occupation-based" OR "context based" OR "context-based" OR "evidence based" OR "evidence-based" OR "technology based" OR "technology-based" OR "population based" OR "population-based" OR "professional competence" OR "use of self"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- patient-centered care: Care, Patient-Centered; Patient Centered Care; Nursing, Patient-Centered; Nursing, Patient Centered; Patient-Centered Nursing; Patient Centered Nursing; Patient-Focused Care; Care, Patient-Focused; Patient Focused Care; Medical Home; Home, Medical; Homes, Medical; Medical Homes
- professional competence: Professional-Patient Relations; Professional-Patient Relation ; Relation, Professional-Patient ; Relations, Professional-Patient ; Professional Patient Relationship ; Professional Patient Relationships ; Relationship, Professional Patient ; Relationships, Professional Patient; Pharmacist-Patient Relations ; Pharmacist Patient Relations ; Pharmacist-Patient Relation ; Relation, Pharmacist-Patient ; Relations, Pharmacist-Patient ; Contacting Clients ; Client, Contacting ; Clients, Contacting ; Contacting Client
- Professional-patient relations: Competence, Professional; Generalization of Expertise; Expertise Generalization; Technical Expertise; Expertise, Technical
- Clinical competence: Competency, Clinical; Competence, Clinical; Clinical Competency; Clinical Competencies; Competencies, Clinical; Clinical Skill; Skill, Clinical; Skills, Clinical; Clinical Skills
- Social Skills: Skill, Social; Skills, Social; Social Skill; Social Abilities; Abilities, Social; Ability, Social; Social Ability; Interpersonal Skills; Interpersonal Skill; Skill, Interpersonal; Skills, Interpersonal; Social Competence; Competence, Social
- Empathy: Caring; Compassion
- Attitude of Health Personnel: Health Personnel Attitude; Health Personnel Attitudes; Staff Attitude; Attitude, Staff; Attitudes, Staff; Staff Attitudes
- Respect: Personal Respect; Respect, Personal; Dignity
- Code of ethics: Ethics Code; Ethics Codes; Code of Ethics; Ethical Codes; Code, Ethical; Codes, Ethical; Ethical Code; Ethical Directives; Directive, Ethical; Directives, Ethical; Ethical Directive; Ethical Oaths; Ethical Oath; Oath, Ethical; Oaths, Ethical; Codes of Professional Ethics; Ethics Code, Professional; Ethics Codes, Professional; Professional Ethics Code; Professional Ethics Codes
- Ethics, professional: Ethic, Professional; Professional Ethic; Professional Ethics

Concept : Collaboration

“Interdisciplinary Communication”[Mesh] OR “Case Management”[Mesh] “Intersectoral Collaboration”[Mesh] OR “Decision Making, Shared”[Mesh] OR “Therapeutic Alliance”[Mesh] OR “Disease management”[Mesh] OR “Safety Management”[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- communication: Communication, Interdisciplinary; Communications, Interdisciplinary ; Interdisciplinary Communications ; Multidisciplinary Communication ; Communication, Multidisciplinary, ; Communications, Multidisciplinary ; Multidisciplinary Communications ; Cross-Disciplinary Communication ; Communication, Cross-Disciplinary ; Communications, Cross-Disciplinary ; Cross Disciplinary Communication ; Cross-Disciplinary Communications ; Communication Research ; Research, Communication
- Case management: Case management
- Intersectional collaboration: Collaboration, Intersectoral; Collaborations, Intersectoral; Intersectoral Collaborations; Intersectoral Cooperation; Cooperation, Intersectoral
- Decision making, shared: shared decision making
- Therapeutic alliance: Alliance, Therapeutic; Alliances, Therapeutic; Therapeutic Alliances
- Disease management: Disease Managements; Management, Disease; Managements, Disease
- Safety management: Management, Safety; Safety Culture; Culture, Safety; Cultures, Safety; Safety Cultures; Hazard Management; Management, Hazard; Hazard Control; Control, Hazard; Hazard Controls; Hazard Surveillance Program; Hazard Surveillance Programs; Program, Hazard Surveillance; Programs, Hazard Surveillance; Surveillance Program, Hazard; Surveillance Programs, Hazard

Concept : Détection et orientation

Détection de concepts :

"Diagnosis"[Mesh] OR "house calls"[Mesh] OR "screen*" OR "determin*" OR "detect*"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- diagnosis: Diagnoses; Diagnoses and Examinations; Examinations and Diagnoses; Postmortem Diagnosis; Diagnoses, Postmortem; Diagnosis, Postmortem; Postmortem Diagnoses; Antemortem Diagnosis; Antemortem Diagnoses; Diagnoses, Antemortem; Diagnosis, Antemortem-
- House Calls: Call, House; Calls, House; House Call; Home Visits; Home Visit; Visit, Home; Visits, Home

Projet de renvoi :

"Referral and Consultation"[Mesh] OR "Patient Handoff"[Mesh] OR "refer*" OR "handover" OR "transmission" OR "assignment" "Information Dissemination"[Mesh] OR "Health Information Exchange"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Referral and consultation: Consultation and Referral; Gatekeepers, Health Service; Health Service Gatekeepers; Gatekeeper, Health Service; Health Service Gatekeeper; Referral; Referrals; Second Opinion; Opinion, Second; Opinions, Second; Second Opinions; Consultation; Consultations; Hospital Referral; Referral, Hospital; Referrals, Hospital; Hospital Referrals
- Patient handoff: Handoff, Patient; Handoffs, Patient; Patient Handoffs; Patient Hand Over; Hand Over, Patient; Hand Overs, Patient; Patient Hand Overs; Patient Sign Out; Sign Out, Patient; Sign Outs, Patient; Patient Signout; Patient Signouts; Signout, Patient; Signouts, Patient; Patient Signover; Patient Signovers; Signover, Patient; Signovers, Patient; Patient Hand Off; Hand Off, Patient; Hand Offs, Patient; Patient Hand Offs; Patient Sign Outs; Patient Handover; Handover, Patient; Handovers, Patient; Patient Handovers; Nursing Handoff; Handoff, Nursing; Handoffs, Nursing; Nursing Handoffs; Nursing Hand Offs; Nursing Handover; Handover, Nursing; Handovers, Nursing; Nursing Handovers; Nursing Hand Overs; Nursing Hand Off; Hand Off, Nursing; Hand Offs, Nursing; Nursing Hand Over; Hand Over, Nursing; Hand Overs, Nursing; Clinical Handoffs; Clinical Handoff; Handoff, Clinical; Handoffs, Clinical; Clinical Handover; Clinical Handovers; Handover, Clinical; Handovers, Clinical
- Information Dissemination: Dissemination, Information; Information Distribution; Distribution, Information; Information Sharing; Information Sharings; Sharing, Information; Sharings, Information; Data Sharing; Data Sharings; Sharing, Data; Sharings, Data
- Health Information Exchange: Exchange, Health Information; Exchanges, Health Information; Health Information Exchanges; Information Exchange, Health; Information Exchanges, Health; Medical Information Exchange; Exchange, Medical Information; Exchanges, Medical Information; Information Exchange, Medical; Information Exchanges, Medical; Medical Information Exchanges

Concept : Évaluation

"Disability Evaluation"[Mesh] OR "Geriatric Assessment"[Mesh] OR "Clinical Decision-Making"[Mesh] OR "Diagnostic Self Evaluation"[Mesh] OR "Patient Health Questionnaire"[Mesh] OR "Needs assessment" "[Mesh] OR "Patient outcome assessment"[Mesh] OR "Self-Assessment"[Mesh] OR "Patient acuity"[Mesh] OR "Treatment Outcome"[Mesh] OR "House calls"[Mesh] OR "Physical Functional Performance"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Disability Evaluation: Disability Evaluations; Evaluation, Disability; Evaluations, Disability
- Geriatric Assessment: Assessment, Geriatric; Assessments, Geriatric; Geriatric Assessments
- Clinical Decision-Making: Clinical Decision Making; Decision-Making, Clinical; Medical Decision-Making; Decision-Making, Medical; Medical Decision Making
- Diagnostic Self Evaluation: Diagnostic Self Evaluations; Evaluations, Diagnostic Self; Self Evaluation, Diagnostic; Self Evaluations, Diagnostic; Subjective Health Complaint; Complaint, Subjective Health; Complaints, Subjective Health; Health Complaint, Subjective; Health Complaints, Subjective; Subjective Health Complaints; Subjective

Health; Health, Subjective; Subjective Healths; Self-Appraisal; Self Appraisal; Self-Appraisals; Self-Evaluation; Self Evaluation; Self-Evaluations

- Patient health questionnaire: PHQ Patient Health Questionnaire; Patient Health Questionnaire 9; PHQ-9; Generalized Anxiety Disorder Scale; GAD-7; Patient Health Questionnaire Anxiety and Depression Scale; PHQ-ADS; Primary Care Evaluation of Mental Disorders; PRIME-MD; Two-Item Generalised Anxiety Disorder Scale; GAD-2; Patient Health Questionnaire 2; PHQ-2
- Needs assessment: Needs Assessments; Educational Needs Assessment; Assessment, Educational Needs; Needs Assessment, Educational; Needs Assessments, Educational; Determination of Health Care Needs; Determination of Healthcare Needs; Assessment of Healthcare Needs; Needs Assessment, Healthcare; Needs Assessments, Healthcare; Assessment of Health Care Needs
- Patient outcome assessment: Assessments, Patient Outcome; Outcome Assessments, Patient; Patient Outcome Assessments; Patient-Centered Outcomes Research; Patient Centered Outcomes Research; Research, Patient-Centered Outcomes; Outcome Assessment, Patient; Outcomes Assessments, Patient; Assessment, Patient Outcome; Assessment, Patient Outcomes; Patient Outcomes Assessment
- Self-Assessment: Self-Assessments; Self Assessment; Self Assessment (Psychology); Assessment, Self (Psychology); Assessments, Self (Psychology); Self Assessments (Psychology); Assessment, Self; Assessments, Self; Self Assessments; Self-Criticism; Self Criticism; Self-Criticisms
- Patient acuity: Acuities, Patient; Acuity, Patient; Patient Acuities
- Treatment outcome: Outcome, Treatment; Patient-Relevant Outcome; Outcome, Patient-Relevant; Outcomes, Patient-Relevant; Patient Relevant Outcome; Patient-Relevant Outcomes; Clinical Effectiveness; Effectiveness, Clinical; Treatment Effectiveness; Effectiveness, Treatment; Rehabilitation Outcome; Outcome, Rehabilitation; Treatment Efficacy; Efficacy, Treatment; Clinical Efficacy; Efficacy, Clinical
- House Calls: Call, House; Calls, House; House Call; Home Visits; Home Visit; Visit, Home; Visits, Home
- Physical Functional therapy: functional Performance, Physical, Functional Performances, Physical; Performance, Physical Functional; Performances, Physical Functional; Physical Functional Performances; Functional Performance; Functional Performances; Performance, Functional; Performances, Functional; Physical Performance; Performance, Physical; Performances, Physical; Physical Performances

Concept : Fixation d'objectifs en général

"Goals"[Mesh] OR "Treatment Outcome"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Distance Counseling"[Mesh] OR "Patient Preference"[Mesh] OR "motivational interview*" OR "collaborative goal setting" OR "occupation-focused goal"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Goals: Goal
- Treatment Outcome: Outcome, Treatment; Patient-Relevant Outcome; Outcome, Patient-Relevant; Outcomes, Patient-Relevant; Patient Relevant Outcome; Patient-Relevant Outcomes; Clinical Effectiveness; Effectiveness, Clinical; Treatment Effectiveness; Effectiveness, Treatment; Rehabilitation Outcome; Outcome, Rehabilitation; Treatment Efficacy; Efficacy, Treatment; Clinical Efficacy; Efficacy, Clinical
- Directive Counseling: Counseling, Directive; Prescriptive Counseling; Counseling, Prescriptive
- Counseling: Counseling
- Distance Counseling: Counseling, Distance; E-Therapy; E Therapy; E-Therapies; E-Counseling; E Counseling
- Patient preference: Patient Preferences; Preference, Patient; Preferences, Patient

Concept : Méthode de fixation des objectifs

"Methods"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Methods: Method; Study, Methodological; Studies, Methodological; Methodological Studies; Methodological Study; Procedures; Procedure

Concept: Interventies, handelingen en methoden

“Occupational Therapy” [MeSH] OR “Therapeutics”[Mesh] OR “Activities of Daily living”[Mesh] OR “Exercise Therapy OR “Exercise”[Mesh] OR "Primary Prevention"[Mesh] OR "Secondary Prevention"[Mesh] OR "Tertiary Prevention"[Mesh] OR "Teaching"[Mesh] OR "Mentoring"[Mesh] OR "Social Learning"[Mesh] OR "Self-Management"[Mesh] OR "Rehabilitation"[Mesh] OR "Psychosocial Support Systems"[Mesh] OR "Recreation Therapy"[Mesh] OR "Animal Assisted Therapy"[Mesh] OR "Computer User Training"[Mesh] OR "Physical Conditioning, Human"[Mesh] OR "Pain Management"[Mesh] OR "Patient Positioning"[Mesh] OR “Ergonomics”[Mesh] OR “Community Integration”[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR “Education”[Mesh] OR “problem solving strateg*” OR “training” OR “guiding”

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Occupational Therapy: Therapy, Occupational; Occupational Therapies; Therapies, Occupational
- Therapeutics: Therapeutic; Therapy; Therapies; Treatment; Treatments
- Activities of Daily living: ADL; Activities, Daily Living; Activity, Daily Living; Daily Living Activities; Daily Living Activity; Living Activities, Daily; Living Activity, Daily; Limitation of Activity, Chronic; Chronic Limitation of Activity
- Exercise Therapy: Remedial Exercise; Exercise, Remedial; Exercises, Remedial; Remedial Exercises; Therapy, Exercise; Exercise Therapies; Therapies, Exercise; Rehabilitation Exercise; Exercise, Rehabilitation; Exercises, Rehabilitation; Rehabilitation Exercises
- Exercise: Exercises; Physical Activity; Activities, Physical; Activity, Physical; Physical Activities; Exercise, Physical; Exercises, Physical; Physical Exercise; Physical Exercises; Acute Exercise; Acute Exercises; Exercise, Acute; Exercises, Acute; Exercise, Isometric; Exercises, Isometric; Isometric Exercises; Isometric Exercise; Exercise, Aerobic; Aerobic Exercise; Aerobic Exercises; Exercises, Aerobic; Exercise Training; Exercise Trainings; Training, Exercise; Trainings, Exercise
- Primary Prevention: Disease Prevention, Primary; Disease Preventions, Primary; Primary Disease Prevention; Primary Disease Preventions; Prevention, Primary; Primordial Prevention; Preventions, Primordial; Primordial Preventions; Prevention, Primordial
- Secondary Prevention: Prevention, Secondary; Preventions, Secondary; Secondary Preventions; Secondary Disease Prevention; Disease Prevention, Secondary; Disease Preventions, Secondary; Prevention, Secondary Disease; Preventions, Secondary Disease; Secondary Disease Preventions; Relapse Prevention; Prevention, Relapse; Preventions, Relapse; Relapse Preventions; Early Therapy; Early Therapies; Therapies, Early; Therapy, Early
- Tertiary Prevention: Prevention, Tertiary; Preventions, Tertiary; Tertiary Preventions
- Teaching: Training Techniques; Technique, Training; Techniques, Training; Training Technique; Training Technics; Technic, Training; Technics, Training; Training Technic; Pedagogy; Pedagogies; Teaching Methods; Method, Teaching; Methods, Teaching; Teaching Method; Academic Training; Training, Academic; Training Activities; Activities, Training; Training Activity; Techniques, Educational; Technics, Educational; Educational Technics; Educational Technic; Technic, Educational; Educational Techniques; Educational Technique; Technique, Educational
- Mentoring: Coaching
- Social Learning: Learning, Social
- Self-Management: Self Management; Management, Self
- Rehabilitation: Habilitation
- Psychosocial Support Systems: Psychosocial Support System; Support System, Psychosocial; Support Systems, Psychosocial; Social Support System; Social Support Systems; Support System, Social; Support Systems, Social; System, Social Support; Systems, Social Support; Psychological Support System; Psychological Support Systems; Support System, Psychological; Support Systems, Psychological; System, Psychological Support; Systems, Psychological Support

- Recreation Therapy: Recreation Therapies; Therapies, Recreation; Therapy, Recreation; Recreational Therapy; Recreational Therapies; Therapies, Recreational; Therapy, Recreational
- Animal Assisted Therapy: Animal Assisted Therapies; Assisted Therapies, Animal; Assisted Therapy, Animal; Therapies, Animal Assisted; Therapy, Animal Assisted; Animal Facilitated Therapy; Animal Facilitated Therapies; Facilitated Therapies, Animal; Facilitated Therapy, Animal; Therapies, Animal Facilitated; Therapy, Animal Facilitated; Pet Therapy; Pet Therapies; Therapies, Pet; Therapy, Pet; Pet Facilitated Therapy; Facilitated Therapies, Pet; Facilitated Therapy, Pet; Pet Facilitated Therapies; Therapies, Pet Facilitated; Therapy, Pet Facilitated
- Computer User Training: Computer User Trainings; Training, Computer User; Trainings, Computer User; User Training, Computer; User Trainings, Computer
- Physical Conditioning, Human: Conditioning, Human Physical; Human Physical Conditioning; Physical Training, Human; Human Physical Training; Training, Human Physical
- Pain Management: Management, Pain; Managements, Pain; Pain Managements
- Patient Positioning: Patient Positionings; Positioning, Patient; Positionings, Patient
- Ergonomics: Ergonomic; Human Factors and Ergonomics; Human Engineering; Human Factors Engineering; Human Factors Engineerings; Cognitive Ergonomics; Cognitive Ergonomic; Ergonomic, Cognitive; Ergonomics, Cognitive; Visual Ergonomics; ; Ergonomic, Visual; Ergonomics, Visual; Visual Ergonomic; Organizational Ergonomics; Ergonomic, Organizational; Ergonomics, Organizational; Organizational Ergonomic; Physical Ergonomics; Ergonomic, Physical; Ergonomics, Physical; Physical Ergonomic; Engineering Psychology; Psychology, Engineering; Ergonomic Assessment; Ergonomic Assessments
- Community Integration: Community Integrations; Integration, Community; Integrations, Community
- Directive Counseling: Counseling, Directive; Prescriptive Counseling; Counseling, Prescriptive
- Counseling: Counseling
- Education: Workshops; Workshop; Training Programs; Program, Training; Programs, Training; Training Program; Educational Activities; Activities, Educational; Activity, Educational; Educational Activity; Literacy Programs; Literacy Program; Program, Literacy; Programs, Literacy

Concept : Outils et adaptations

"Sensory Aids"[Mesh] OR "Hearing Aids"[Mesh] OR "Communication Aids for Disabled"[Mesh] OR "Audiovisual Aids"[Mesh] OR "Housing for the elderly"[Mesh] OR "Mobile Applications"[Mesh] OR "Protective Devices"[Mesh] OR "Self-Help Devices"[Mesh] OR "eating aid*" OR "walking aid*" OR "washing aid*" OR "cooking aid*" OR "dressing aid*" OR "leisure aid*" OR "sitting aid*" OR "home modification*" OR "home adaptation*" OR "environmental adaptation*" OR "activity adaptation*"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Sensory Aids: Aid, Sensory; Aids, Sensory; Sensory Aid
- Hearing Aids: Aid, Hearing; Aids, Hearing; Hearing Aid; Ear Molds; Ear Mold; Mold, Ear; Molds, Ear
- Communication Aids for Disabled: Communication Aids for Handicapped; Text Telecommunication Devices; Telecommunication Device, Text; Telecommunication Devices, Text; Text Telecommunication Device; TTY Telephone; TTY Telephones; Text Telephone; Text Telephones; Telecommunications Devices for the Deaf; TDD; Communication Boards; Communication Board; Speech Synthesizers; Speech Synthesizer; Synthesizer, Speech; Synthesizers, Speech; Text Telecommunication; Telecommunication, Text; Telecommunications, Text; Text Telecommunications; Augmentative and Alternative Communications Systems;
- Audiovisual Aids: Aid, Audiovisual; Aids, Audiovisual; Audiovisual Aid; Audio-Visual Aids; Aid, Audio-Visual; Aids, Audio-Visual; Audio Visual Aids; Audio-Visual Aid; Visual Aids; Aid, Visual; Aids, Visual; Visual Aid
- Housing for the elderly: Life Care Centers, Retirement; Continuing Care Retirement Center

- Mobile Applications: Application, Mobile; Applications, Mobile; Mobile Application; Mobile Apps; App, Mobile; Apps, Mobile; Mobile App; Portable Electronic Apps; App, Portable Electronic; Apps, Portable Electronic; Electronic App, Portable; Electronic Apps, Portable; Portable Electronic App; Portable Electronic Applications; Application, Portable Electronic; Applications, Portable Electronic; Electronic Application, Portable; Electronic Applications, Portable; Portable Electronic Application; Portable Software Apps; App, Portable Software; Apps, Portable Software; Portable Software App; Software App, Portable; Software Apps, Portable; Portable Software Applications; Application, Portable Software; Applications, Portable Software; Portable Software Application; Software Application, Portable; Software Applications, Portable
- Protective Devices: Device, Protective; Devices, Protective ; Protective Device ; Safety Devices ; Device, Safety ; Devices, Safety; Safety Device
- Self-Help Devices: Device, Self-Help; Devices, Self-Help; Self Help Devices; Self-Help Device; Assistive Technology; Assistive Technologies; Technologies, Assistive; Technology, Assistive; Assistive Devices; Assistive Device ; Device, Assistive ; Devices, Assistive

Concept : Interventions en ligne

"Distance Counseling"[Mesh] OR "Telerehabilitation"[Mesh] OR "Telemedicine"[Mesh] OR "Education, distance"[Mesh] OR "Internet-Based Intervention" [Mesh] OR "online therapy

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Distance Counseling: Counseling, Distance; E-Therapy; E Therapy; E-Therapies; E-Counseling; E Counseling
- Telerehabilitation: Telerehabilitations; Tele-rehabilitation; Tele rehabilitation; Tele-rehabilitations; Remote Rehabilitation; Rehabilitation, Remote; Rehabilitations, Remote; Remote Rehabilitations; Virtual Rehabilitation; Rehabilitation, Virtual; Rehabilitations, Virtual; Virtual Rehabilitations
- Telemedicine: Mobile Health; Health, Mobile; mHealth; Telehealth; eHealth
- Education, Distance: Distance Education; Distance Learning; Learning, Distance; Online Learning; Learning, Online; Online Education; Education, Online; Online Educations; Correspondence Courses; Correspondence Course; Course, Correspondence
- Internet-Based Intervention: Internet Based Intervention; Internet-Based Interventions; Intervention, Internet-Based; Interventions, Internet-Based; Web-based Intervention; Intervention, Web-based; Interventions, Web-based; Web based Intervention; Web-based Interventions; Online Intervention; Intervention, Online; Interventions, Online; Online Interventions; Internet Intervention; Internet Interventions; Intervention, Internet; Interventions, Internet

Concept : Interventions de coopération

"Case management"[Mesh] OU "Database Management Systems"[Mesh] OU "Information Dissemination"[Mesh] OU "Information Storage and Retrieval"[Mesh] OU "Confidentiality"[Mesh] OU "Information Technology"[Mesh] OU "Learning Health System"[Mesh] OU "Software"[Mesh] OU "Health Information Exchange"[Mesh] OU "Health Information Systems"[Mesh] OU "Critical Pathways"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation

- Case management: Case management
- Database management system: Database Management System; Management Systems, Data Base; Data Base Management Systems; Management System, Data Base; System, Data Base Management; Systems, Data Base Management
- Information Dissemination: Dissemination, Information; Information Distribution; Distribution, Information; Information Sharing; Information Sharings; Sharing, Information; Sharings, Information; Data Sharing; Data Sharings; Sharing, Data; Sharings, Data

- Information Storage and Retrieval: Data Storage; Storage, Data; Information Storage; Information Extraction; Extraction, Information; Information Extractions; Machine-Readable Data Files; Data File, Machine-Readable; Data Files, Machine-Readable; Files, Machine-Readable Data; Machine Readable Data Files; MachineReadable Data File; Data Sources; Data Source; Data Linkage; Data Files; Data File; Data Storage and Retrieval; Data Retrieval; Retrieval, Data; Information Retrieval
- Confidentiality: Secrecy; Privileged Communication; Communication, Privileged; Communications, Privileged; Privileged Communications; Confidential Information; Information, Confidential; Privacy of Patient Data; Data Privacy, Patient; Patient Data Privacy; Privacy, Patient Data
- Information Technology: Information Technologies; Technology, Information
- Learning Health System: Health System, Learning; Learning Health Systems; System, Learning Health; Learning Healthcare System; Healthcare System, Learning; Healthcare Systems, Learning; Learning Healthcare Systems; System, Learning Healthcare; Systems, Learning Healthcare; Learning Health Community; Communities, Learning Health; Community, Learning Health; Health Community, Learning; Learning Health Communities
- Software: Computer Software; Software, Computer; Computer Programs; Computer Program; Program, Computer; Programs, Computer; Software Tools; Software Tool; Tool, Software; Tools, Software; Software Engineering; Engineering, Software; Computer Applications Software; Applications Software, Computer; Applications Softwares, Computer; Computer Applications Softwares; Software, Computer Applications; Softwares, Computer Applications; Computer Software Applications; Application, Computer Software; Applications, Computer Software; Computer Software Application; Software Application, Computer; Software Applications, Computer; Computer Programs and Programming
- Health Information Exchange: Exchange, Health Information; Exchanges, Health Information; Health Information Exchanges; Information Exchange, Health; Information Exchanges, Health; Medical Information Exchange; Exchange, Medical Information; Exchanges, Medical Information; Information Exchange, Medical; Information Exchanges, Medical; Medical Information Exchanges
- Health Information Systems: Health Information System; Information System, Health; Information Systems, Health; System, Health Information; Systems, Health Information
- Critical Pathways: Critical Pathway; Pathway, Critical; Pathways, Critical; Critical Paths; Critical Path; Path, Critical; Paths, Critical; Clinical Paths; Clinical Path; Path, Clinical; Paths, Clinical; Clinical Pathways; Clinical Pathway; Pathway, Clinical; Pathways, Clinical

Concept : Management

"Organization and Administration"[Mesh] OR "Critical Pathways"[Mesh] OR "Case management"[Mesh] OR "Evidence-Based Practice"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Organization and administration: Administration and Organization; Techniques, Administrative; Administrative Technique; Technique, Administrative; Administrative Techniques; Administrative Technics; Administrative Technic; Technic, Administrative; Technics, Administrative; Logistics; Supervision; Administration; Coordination, Administrative; Administrative Coordination
- Critical Pathways: Critical Pathway; Pathway, Critical; Pathways, Critical; Critical Paths; Critical Path; Path, Critical; Paths, Critical; Clinical Paths; Clinical Path; Path, Clinical; Paths, Clinical; Clinical Pathways; Clinical Pathway; Pathway, Clinical; Pathways, Clinical
- Case management: Case management
- Evidence-Based Practice: Evidence Based Practice; Evidence Based Management, Healthcare; Evidence Based Health Care Management; Evidence Based Healthcare Management; Evidence Based Management, Health Care; Evidence-Based Health Care; Evidence Based Health Care; Evidence-Based Health Cares; Health Care, Evidence-Based; Health Cares, Evidence-Based; Evidence-Based Healthcare; Evidence Based Healthcare; Evidence-Based Healthcares; Healthcare, Evidence-Based; Healthcares, Evidence-Based

P(rofessionnel)

Concept : ergothérapeute

"Occupational Therapy"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation

- Ergothérapie : Thérapie occupationnelle ; Thérapies occupationnelles ; Thérapies occupationnelles

Concept : Équipe interprofessionnelle

"Occupational Therapy"[Mesh] OR "Physicians"[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR "Geriatricians"[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Community Health Services"[Mesh] OR "Delivery of Health Care"[Mesh] OR "Home Health Aides"[Mesh] OR "Delivery of Health Care, Integrated"[Mesh] OR "Case Managers"[Mesh] OR "Disease management"[Mesh] OR "Social Workers"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Occupational Therapy: Therapy, Occupational; Occupational Therapies; Therapies, Occupational
 - Physicians: Physicians
- General Practitioners: General Practitioner; Practitioner, General; Practitioners, General; Physicians, General Practice; General Practice Physician; General Practice Physicians; Physician, General Practice; Practice Physicians, General
- Physical Therapists: Physical Therapist; Therapist, Physical; Therapists, Physical; Physiotherapists; Physiotherapist
- Nurses, Community Health: Community Health Nurse; Community Health Nurses; Nurse, Community Health; Visiting Nurses; Nurse, Visiting; Nurses, Visiting; Visiting Nurse; Home Health Nurses; Home Health Nurse; Nurse, Home Health; Nurses, Home Health; Home Nurses; Home Nurse; Nurse, Home; Nurses, Home; Health Visitors; Health Visitor
- Licensed Practical Nurses: Licensed Practical Nurse; Nurse, Licensed Practical; Nurses, Licensed Practical; Licensed Vocational Nurses; Licensed Vocational Nurse; Nurse, Licensed Vocational; Nurses, Licensed Vocational - Nurse Clinicians: Clinician, Nurse; Clinicians, Nurse; Nurse Clinician; Nurse Specialist, Clinical; Clinical Nurse Specialists; Specialist, Clinical Nurse; Specialists, Clinical Nurse; Clinical Nurse Specialist; Nurse Specialists, Clinical
 - Community Health Nursing: Community Health Nursing
 - Home Health Nursing: Nursing, Home Health; Home Health Care Nursing
 - Geriatric Nursing: Nursing, Geriatric; Geriatric Nursings; Nursings, Geriatric
- Family Nurse Practitioners: Family Nurse Practitioner; Nurse Practitioner, Family; Nurse Practitioners, Family
- Family Nursing: Family Nursings; Nursing, Family; Nursings, Family; Family-Centered Nursing; Family Centered Nursing; Family-Centered Nursings; Nursing, Family-Centered; Nursings, Family-Centered
 - Geriatricians: Geriatrician; Gerontologists; Gerontologist
- Allied Health Personnel: Health Personnel, Allied; Personnel, Allied Health; Allied Health Professional; Allied Health Professionals; Health Professional, Allied; Health Professionals, Allied; Professional, Allied Health; Professionals, Allied Health; Healthcare Assistants; Assistant, Healthcare; Assistants, Healthcare; Healthcare

Assistant; Healthcare Support Workers; Healthcare Support Worker; Support Worker, Healthcare; Support Workers, Healthcare; Worker, Healthcare Support; Workers, Healthcare Support; Paramedics; Paramedic; Paramedical Personnel; Personnel, Paramedical; Population Program Specialists; Population Program Specialist; Program Specialist, Population; Program Specialists, Population; Specialist, Population Program; Specialists, Population Program

- Community Health Workers: Community Health Worker; Health Worker, Community; Health Workers, Community; Worker, Community Health; Workers, Community Health; Community Health Aides; Aide, Community Health; Aides, Community Health; Community Health Aide; Health Aide, Community; Health Aides, Community; Family Planning Personnel; Personnel, Family Planning; Planning Personnel, Family; Village Health Workers; Health Worker, Village; Health Workers, Village; Worker, Village Health; Workers, Village Health; Village Health Worker; Barefoot Doctors; Barefoot Doctor; Doctor, Barefoot; Doctors, Barefoot; Family Planning Personnel Characteristics
- Patient Care Team: Care Team, Patient; Care Teams, Patient; Patient Care Teams; Team, Patient Care; Teams, Patient Care; Medical Care Team; Care Team, Medical; Care Teams, Medical; Medical Care Teams; Team, Medical Care; Teams, Medical Care; Interdisciplinary Health Team; Health Team, Interdisciplinary; Health Teams, Interdisciplinary; Interdisciplinary Health Teams; Team, Interdisciplinary Health; Teams, Interdisciplinary Health; Healthcare Team; Healthcare Teams; Team, Healthcare; Teams, Healthcare; Health Care Team; Care Team, Health; Care Teams, Health; Health Care Teams; Team, Health Care; Teams, Health Care
 - Community Medicine: Medicine, Community
- Community Health Services: Health Services, Community; Community Health Service; Health Service, Community; Service, Community Health; Services, Community Health; Community Health Care; Care, Community Health; Health Care, Community; Community Healthcare; Community Healthcares; Healthcare, Community; Healthcares, Community
 - Delivery of Health Care: Delivery of Healthcare; Healthcare Deliveries; Healthcare Delivery; Deliveries, Healthcare; Delivery, Healthcare; Health Care Delivery; Delivery, Health Care; Contraceptive Distribution; Contraceptive Distributions; Distribution, Contraceptive; Distributions, Contraceptive; Delivery of Dental Care; Dental Care Delivery; Delivery, Dental Care; Health Care; Care, Health; Healthcare; Health Care Systems; Health Care System; System, Health Care; Systems, Health Care; Healthcare Systems; Healthcare System; System, Healthcare; Systems, Healthcare; Nonclinical Distribution; Distributions, Nonclinical; Nonclinical Distributions; Distribution, Nonclinical; Distribution, Non-Clinical; Distribution, Non Clinical; Distributions, Non-Clinical; Non-Clinical Distributions; Non-Clinical Distribution; Non Clinical Distribution; Community-Based Distribution; Community Based Distribution; Community-Based Distributions; Distribution, Community-Based; Distributions, Community-Based; Distributional Activities; Activities, Distributional; Activity, Distributional; Distributional Activity
 - Home Health Aides: Aide, Home Health; Aides, Home Health; Health Aide, Home; Health Aides, Home; Home Health Aide; Homemaker-Home Health Aides; Aide, Homemaker-Home Health; Aides, Homemaker-Home Health; Health Aide, Homemaker-Home; Health Aides, Homemaker-Home; Homemaker Home Health Aides; Homemaker-Home Health Aide; Home Care Aides; Aide, Home Care; Aides, Home Care; Care Aide, Home; Care Aides, Home; Home Care Aide
 - Delivery of Health Care, Integrated: Integrated Health Care Systems; Integrated Delivery Systems; Delivery System, Integrated; Delivery Systems, Integrated; Integrated Delivery System; System, Integrated Delivery; Systems, Integrated Delivery;
 - Case Managers: Case Manager; Manager, Case; Managers, Case
 - Disease Management: Disease Managements; Management, Disease; Managements, Disease
 - Social Workers: Social Worker; Worker, Social; Workers, Social

O(utcome)

Concept : Groupe cible : personnes âgées physiquement vulnérables

"Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Activities of Daily Living: ADL; Activities, Daily Living; Activity, Daily Living; Daily Living Activities; Daily Living Activity; Living Activities, Daily; Living Activity, Daily; Limitation of Activity, Chronic; Chronic Limitation of Activity
- Healthy lifestyle: Lifestyle, Healthy; Lifestyles, Healthy; Healthy Life Styles; Healthy Lifestyles; Healthy Life Style; Life Style, Healthy; Life Styles, Healthy
- Accidental Falls: Falls; Falling; Falls, Accidental; Accidental Fall; Fall, Accidental; Slip and Fall; Fall and Slip
- Social Participation: Participation, Social
- Community Participation: Participation, Community; Community Involvement; Community Involvements; Involvement, Community; Involvements, Community; Consumer Participation; Participation, Consumer; Consumer Involvement; Consumer Involvements; Involvement, Consumer; Public Participation; Participation, Public; Community Action; Action, Community; Actions, Community; Community Actions
- Social Integration: Integration, Social
- Human Activities: Activities, Human; Activity, Human; Human Activity
- Quality of Life: Life Quality; Health-Related Quality Of Life; Health Related Quality Of Life; HRQOL
- Sense of Coherence: Coherence Sense; Salutogenesis; Salutogeneses
- Quality-Adjusted Life Years: Life Year, Quality-Adjusted; Life Years, Quality-Adjusted; Quality-Adjusted Life Year; Year, Quality-Adjusted Life; Years, Quality-Adjusted Life; Quality Adjusted Life Years; QALY; Healthy Years Equivalents; Equivalents, Healthy Years; Healthy Years Equivalent; Adjusted Life Years; Adjusted Life Year; Life Year, Adjusted; Life Years, Adjusted; Year, Adjusted Life; Years, Adjusted Life
- Global Burden of Disease: Disease Global Burden
- Leisure Activities: Activities, Leisure; Activity, Leisure; Leisure Activity; Leisure; Leisures
- Health literacy: Literacy, Health
- Patient Compliance: Compliance, Patient; Patient Adherence; Adherence, Patient ; Patient Cooperation; Cooperation, Patient; Patient Non-Compliance; Non-Compliance, Patient; Patient Non Compliance; Patient Nonadherence; Nonadherence, Patient; Patient Noncompliance; Noncompliance, Patient; Patient Non-Adherence; Non-Adherence, Patient; Patient Non Adherence; Treatment Compliance; Compliance, Treatment; Treatment Compliances; Therapeutic Compliance; Compliance, Therapeutic; Compliances, Therapeutic; Therapeutic Compliances
- Anxiety: Hypervigilance; Nervousness; Social Anxiety; Anxieties, Social; Anxiety, Social; Social Anxieties
- Sedentary behaviour: Behavior, Sedentary,; Sedentary Behaviors; Sedentary Lifestyle; Lifestyle, Sedentary; Physical Inactivity; Inactivity, Physical

Concept : Élargir le groupe cible des aidants

"Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge"

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Workload: Workloads; Work Load; Work Loads; Employee Workload; Employee Workloads; Workload, Employee; Workloads, Employee; Employee Work Load; Employee Work Loads; Work Load, Employee; Work Loads, Employee; Staff Workload; Staff Workloads; Workload, Staff; Workloads, Staff; Staff Work Load; Staff Work Loads; Work Load, Staff; Work Loads, Staff
- Psychological Burnout: Psychological Burnout; Burn-out Syndrome; Burn out Syndrome; Burnout; Burnout Syndrome; Burn-out; Burn out; Psychological Burn-out; Burn-out, Psychological; Psychological Burn out; Burnout, Student; School Burnout; Student Burnout; Burnout, School; Burnout, Caregiver; Caregiver Burnout; Caregiver Exhaustion; Exhaustion, Caregiver
- Social Support: Support, Social; Online Social Support; Online Social Supports; Social Support, Online; Social Supports, Online; Support, Online Social
- Social Capital: Capital, Social
- Respite Care: Care, Respite; Cares, Respite; Respite Cares
- Adaptation, Psychological: Adaptation, Psychologic; Psychologic Adaptation ; Psychological Adaptation ; Coping Behavior ; Behavior, Coping ; Behaviors, Coping; Coping Behaviors; Coping Skills; Coping Skill; Skill, Coping; Skills, Coping; Behavior, Adaptive; Adaptive Behavior; Adaptive Behaviors; Behaviors, Adaptive
- Stress, Psychological: Psychological Stress; Psychological Stresses; Stresses, Psychological; Life Stress; Life Stresses; Stress, Life; Stresses, Life; Stress, Psychologic; Psychologic Stress; Stressor, Psychological; Psychological Stressor; Psychological Stressors; Stressors, Psychological; Mental Suffering; Suffering, Mental; Suffering; Sufferings
- Sense of Coherence: Coherence Sense; Salutogenesis; Salutogeneses

Concept : Élargir le contexte physique

"Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "patient compliance"[Mesh] OR "occupational performance" OR "accidental falls" OR "Safety"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation :

- Activities of Daily Living: ADL; Activities, Daily Living; Activity, Daily Living; Daily Living Activities; Daily Living Activity; Living Activities, Daily; Living Activity, Daily; Limitation of Activity, Chronic; Chronic Limitation of Activity
- Healthy lifestyle: Lifestyle, Healthy; Lifestyles, Healthy; Healthy Life Styles; Healthy Lifestyles; Healthy Life Style; Life Style, Healthy; Life Styles, Healthy
- Accidental Falls: Falls; Falling; Falls, Accidental; Accidental Fall; Fall, Accidental; Slip and Fall; Fall and Slip
- Community Participation: Participation, Community; Community Involvement; Community Involvements; Involvement, Community; Involvements, Community; Consumer Participation; Participation, Consumer; Consumer Involvement; Consumer Involvements; Involvement, Consumer; Public Participation; Participation, Public; Community Action; Action, Community; Actions, Community; Community Actions
- Social Integration: Integration, Social
- Human Activities: Activities, Human; Activity, Human; Human Activity
- Quality of Life: Life Quality; Health-Related Quality Of Life; Health Related Quality Of Life; HRQOL
- Sense of Coherence: Coherence Sense; Salutogenesis; Salutogeneses
- Quality-Adjusted Life Years: Life Year, Quality-Adjusted; Life Years, Quality-Adjusted; Quality-Adjusted Life Year; Year, Quality-Adjusted Life; Years, Quality-Adjusted Life; Quality Adjusted Life Years; QALY; Healthy Years

Equivalent; Equivalent, Healthy Years; Healthy Years Equivalent; Adjusted Life Years; Adjusted Life Year; Life Year, Adjusted; Life Years, Adjusted; Year, Adjusted Life; Years, Adjusted Life

- Global Burden of Disease: Disease Global Burden
- Leisure Activities: Activities, Leisure; Activity, Leisure; Leisure Activity; Leisure; Leisures
- Patient Compliance: Compliance, Patient; Patient Adherence; Adherence, Patient ; Patient Cooperation; Cooperation, Patient; Patient Non-Compliance; Non-Compliance, Patient; Patient Non Compliance; Patient Nonadherence; Nonadherence, Patient; Patient Noncompliance; Noncompliance, Patient; Patient Non-Adherence; Non-Adherence, Patient; Patient Non Adherence; Treatment Compliance; Compliance, Treatment; Treatment Compliances; Therapeutic Compliance; Compliance, Therapeutic; Compliances, Therapeutic; Therapeutic Compliances
- Safety : safeties

H(cadre de soins de santé)

Concept : Soins primaires

"Home Care Services" [MeSH] OU "Primary Health Care" [MeSH] OU "Independent Living" [MeSH] OU "Community Health Centres" [Mesh].

Concept : Institutions de santé et d'aide sociale, et formes résidentielles liées aux soins à domicile:

"Ambulatory Care"[MeSH] OR "Ambulatory Care Facilities"[Mesh] OR "Home Care Services, Hospital-Based"[MeSH] OR "Home health nursing"[MeSH] OR "Home nursing"[MeSH] OR "Respite care"[MeSH] OR "Foster Home Care"[Mesh], "Adult Day Care Centres"[Mesh] OR "Hospitals, Community"[Mesh] OR "Health Services for the Aged"[Mesh] OR "Geriatrics"[Mesh] OR "Housing for the Elderly"[Mesh] OR "Housing"[Mesh]

Les conditions suivantes sont automatiquement incluses lors de la participation

- Home care services: Home Care Service; Service, Home Care; Care Services, Home; Domiciliary Care; Care, Domiciliary; Services, Home Care; Home Care; Care, Home
- Primary health care: Care, Primary Health; Health Care, Primary; Primary Healthcare; Healthcare, Primary; Primary Care; Care, Primary
- Ambulatory care: Care, Ambulatory; Outpatient Care; Care, Outpatient; Health Services, Outpatient; Health Service, Outpatient; Outpatient Health Service; Service, Outpatient Health; Outpatient Health Services; Outpatient Services; Outpatient Service; Service, Outpatient; Services, Outpatient; Services, Outpatient Health; Urgent Care; Care, Urgent; Cares, Urgent; Urgent Cares; Clinic Visits; Clinic Visit; Visit, Clinic; Visits, Clinic
- Ambulatory care facilities: Ambulatory Care Facility; Facilities, Ambulatory Care; Facility, Ambulatory Care; Outpatient Clinics; Outpatient Clinic; Clinic, Outpatient; Clinics, Outpatient; Clinic Activities; Activities, Clinic; Activity, Clinic; Clinic Activity; Urgent Care Centers; Care Center, Urgent; Care Centers, Urgent; Center, Urgent Care; Centers, Urgent Care; Urgent Care Center; Urgent Care Clinics; Care Clinic, Urgent; Care Clinics, Urgent; Clinic, Urgent Care; Clinics, Urgent Care; Urgent Care Clinic; Family Planning Centers; Center, Family Planning; Centers, Family Planning; Family Planning Center; Health Centers, Ambulatory; Ambulatory Health Center; Ambulatory Health Centers; Center, Ambulatory Health; Centers, Ambulatory Health; Health Center, Ambulatory; Abortion Centers; Abortion Center; Center, Abortion; Centers, Abortion; Abortion Clinics; Abortion Clinic; Clinic, Abortion; Clinics, Abortion; Clinics, Free-Standing; Clinic, Free-Standing; Clinics, Free Standing; Free-Standing Clinic; Free-Standing Clinics; Ambulatory Care Facilities, Non-Hospital; Ambulatory Care Facilities, Nonhospital; Ambulatory Care Facilities, Non Hospital
- Independent living: Living, Independent; Community Dwelling; Dwelling, Community; Dwellings, Community; Aging in Place
- Home care services: Home Care Service; Service, Home Care; Care Services, Home; Domiciliary Care; Care, Domiciliary; Services, Home Care; Home Care; Care, Home

- Home care services, hospital-based: Cares, Hospital-Based Home; Cares, Hospital Based Home; Home Care, Hospital-Based; Home Care, Hospital Based; Home Cares, Hospital-Based; Home Cares, Hospital Based; Hospital Home Care Services; Hospital-Based Home Care; Hospital Based Home Care; Home Care Services, Hospital Based; Hospital-Based Home Care Services; Hospital Based Home Care Services; Care, Hospital-Based Home; Care, Hospital Based Home; Hospital-Based Home Cares; Hospital Based Home Cares
- Home health nursing: Nursing, Home Health; home Health Care Nursing
- Home nursing: Home Care, Nonprofessional; Care, Nonprofessional Home; Nonprofessional Home Care; Home Care, Non-Professional; Care, Non-Professional Home; Home Care, Non Professional; Non-Professional Home Care; Nursing, Home
- Respite care: Care, Respite; Cares, Respite; Respite Cares
- Foster home care: Care, Foster Home; Fostering; Kinship Care; Care, Kinship; Adult Foster Care; Care, Adult Foster; Foster Care, Adult
- Adult day care centers: Day Care Center, Adult; Day Care Centers, Adult; Adult Day Care Center
- Community health centers: Center, Community Health; Centers, Community Health; Community Health Center; Health Center, Community; Health Centers, Community; Satellite Centers; Center, Satellite; Centers, Satellite; Satellite Center; Neighborhood Health Centers; Center, Neighborhood Health; Centers, Neighborhood Health; Health Center, Neighborhood; Health Centers, Neighborhood; Neighborhood Health Center
- Hospitals, community: Community Hospital; Community Hospitals; Hospital, Community
- Health services for the aged: Geriatric Health Services; Health Services for the Elderly; Health Services, Geriatric; Geriatric Health Service; Health Service, Geriatric; Service, Geriatric Health; Services, Geriatric Health; Health Services for Aged
- Geriatrics: gerontology
- Housing for the elderly: Life Care Centers, Retirement; Continuing Care Retirement Centers

Pour chaque question clinique, ces concepts ont été développés en fonction de l'item PICO. Ces concepts ont été adaptés à l'interface de la base de données à l'aide de l'Accélérateur Polyglotte. Les concepts élaborés ont été inclus par question clinique sous le point 3 "méthodologie de justification par question clinique".

3.2.3.7 Procédure de sélection

Procédure de base sélection des articles en fonction de leur pertinence

Des critères d'inclusion et d'exclusion sont définis pour chaque question clinique. Ils sont basés sur les limites prédéfinies (conception de l'étude, langue, période de recherche) et sur le contenu du PICO. Ils peuvent varier en fonction de la question.

Ainsi, le P pour les questions 2 et 4 concerne les personnes âgées physiquement fragiles pour lesquelles les conditions liées à l'âge affectent le fonctionnement. Lorsqu'une affection pour laquelle une rééducation spécifique est souhaitable domine, ces articles ne sont pas inclus. En effet, le guide ne contient pas de recommandations sur la réadaptation de conditions spécifiques.

Première étape : sélection sur la base du titre et du résumé

Sur la base du titre et du résumé, les articles retenus font l'objet d'une double vérification indépendante par question clinique et par base de données.

Pour une question clinique donnée, si une base de données fournissait plus de 200 résultats, la double sélection indépendante basée sur le titre et le résumé était limitée aux 200 premiers résultats. Après un consensus sur les 200 premiers résultats, les résultats restants ont fait l'objet d'une vérification supplémentaire de leur pertinence par l'un des chercheurs principaux. En cas de doute, le deuxième investigateur principal a été consulté.

Deuxième étape : sélection sur la base du texte intégral

Les articles retenus sur la base du titre et du résumé sont examinés en texte intégral et finalement retenus pour inclusion ou exclusion.

La raison de l'exclusion est indiquée dans une matrice bibliographique. (Voir point 3 "Méthodologie par question clinique")

Pour les critères d'inclusion et d'exclusion, voir la partie 1 de la guide clinique , point 1.3.2.

En cas de réponse insuffisante à la question clinique après la deuxième étape

Si la recherche initiale dans les quatre bases de données ne permet pas d'obtenir suffisamment de réponses à partir des articles sélectionnés, la première étape consistera à élargir la conception de la recherche.

Si cette extension ne donne toujours pas de résultats suffisants, une recherche plus sensible est effectuée en remplaçant certains termes de la chaîne de recherche par des hyperonymes.

3.2.4 Formuler des recommandations, les soumettre au GDG et les adapter au contexte (consultation des parties prenantes)

Les recommandations initiales ont été rédigées sur la base de l'analyse de la littérature et soumises au GDG pour approbation ou ajustement.

Après avoir été ajustées en fonction des réactivités du GDG, les recommandations visant à adapter le contexte et à garantir un soutien à la mise en œuvre ont été soumises au comité consultatif (parties prenantes). Cela s'est fait de deux manières, à savoir par le biais d'une enquête en ligne sur les points suivants : pertinence, faisabilité, effets indésirables et justification des coûts, et d'un forum de discussion la semaine suivante.

Les questions posées aux parties prenantes par le biais d'une recommandation dans l'enquête en ligne étaient les suivantes :

- Pensez-vous que cette recommandation soit pertinente dans le contexte belge ?
- Pensez-vous que cette recommandation puisse être appliquée dans le contexte belge ?
- Selon vous, l'application de cette recommandation pourrait-elle avoir des effets indésirables?
- Les coûts liés à l'application de cette recommandation sont-ils justifiés ?

L'évaluation des éléments présentés a été effectuée pour chaque recommandation à l'aide d'une échelle de Likert en quatre points allant de "oui", à "probablement oui", "probablement non" à "non". Une réponse dans la zone négative ("probablement pas" et "non") a été demandée pour clarifier ce choix et compter les ajustements le cas échéant. Pour une réponse dans la zone positive ("oui" et "probablement oui"), les personnes étaient libres de fournir des informations supplémentaires. Il a été établi à l'avance par le GDG que le consensus était atteint à 70 % d'unanimité.

Les réponses à l'enquête ont été traitées dans la semaine et ont fait l'objet d'une présentation au comité consultatif (forum de discussion des parties prenantes). Lors du forum de discussion, les points n'ayant pas fait l'objet d'un consensus ont été discutés et, le cas échéant, ajustés pour parvenir à un consensus. Les participants ont eu la possibilité d'ajouter eux-mêmes des points à discuter.

Pour la majorité des recommandations, le consensus était supérieur à 80 %. En ce qui concerne les questions relatives à la pertinence, à la faisabilité et à la justification des coûts, toutes les recommandations, sauf une, ont atteint la valeur seuil de 70 %. La question sur les effets secondaires n'a jamais atteint le seuil de 70 %. Lorsqu'elles ont été interrogées, les parties prenantes ont indiqué qu'elles ne connaissaient pas suffisamment les effets secondaires possibles pour répondre à cette question. Par conséquent, le fait de ne pas atteindre le seuil de 70 % n'était pas lié à l'absence de consensus. Pour combler cette lacune, la littérature consultée a été examinée à la recherche d'éventuels effets secondaires. Aucun effet secondaire n'a été trouvé.

Pour plus de détails sur les résultats des enquêtes en ligne, veuillez vous référer aux rapports des réunions des parties prenantes du 29/06/2021, 5/10/2021, 21/12/2021 et 25/01/2022 inclus dans l'annexe 5.3.

Enfin, les recommandations finales ont été présentées individuellement à l'expert par expérience et au soignant qui, en raison de l'évolution des formes de communication (consultations en ligne au lieu de consultations sur place en raison de la pandémie), n'ont pas été en mesure d'assister aux réunions régulières du GDG.

Le tableau ci-dessous résume les recommandations initiales et les recommandations finales (après avoir incorporé les commentaires du GDG, des parties prenantes et de l'expert en expérience et du soignant). (Tableau 3)

| Recommandation initiale | Recommandation finale |
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| Question clinique1 | |
| Nous recommandons/nous suggérons <ul style="list-style-type: none"> Détecter la fragilité chez les personnes âgées de 75 ans et plus vivant à domicile. Que les prestataires de soins de santé qui dépistent la fragilité chez les personnes à haut risque reçoivent une formation pour apprendre à reconnaître les signes et les symptômes de la fragilité. | Nous proposons de détecter la fragilité chez les personnes âgées de 75 ans et plus vivant à domicile. Déplacé vers l'explication et les conditions préalables : Nous suggérons que les prestataires de soins de santé qui dépistent la fragilité chez les personnes à haut risque reçoivent une formation pour apprendre à reconnaître les signes et les symptômes de la fragilité . |
| Nous recommandons/suggérons que les médecins généralistes et tous les autres prestataires de soins primaires procèdent à la détection des risques élevés de fragilité lors de leurs visites régulières à domicile et qu'ils le fassent une fois par an ou plus tôt en cas de changements dans le fonctionnement de la personne. | Nous suggérons que les médecins généralistes et tous les autres prestataires de soins primaires procèdent à la détection de la fragilité à haut risque lors de leurs visites régulières à domicile. |
| Nous ne recommandons pas/ne suggérons pas de visites préventives systématiques à domicile au niveau de la population. | Nous ne suggérons pas de visites préventives systématiques à domicile au niveau de la population. |

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| <p>Nous recommandons/suggérons que les ergothérapeutes se profilent comme des experts dans le dépistage des problèmes de fonctionnement dans la vie quotidienne.</p> | <p>Nous recommandons que les ergothérapeutes se profilent comme des experts dans le dépistage des problèmes de fonctionnement dans la vie quotidienne.</p> |
| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • Utiliser des outils d'évaluation valables sous forme d'auto-évaluation, d'observation clinique ou d'une combinaison des deux pour détecter la fragilité. • Le choix de l'outil d'évaluation de la fragilité est déterminé par l'objectif visé et le contexte dans lequel l'outil sera utilisé. <p>Les instruments valables sont l'échelle de fragilité clinique, le test Timed Up and Go et l'InterRAI screener.</p> | <p>Nous recommandons d'utiliser des outils d'évaluation valables sous forme d'auto-évaluation, d'observation clinique ou d'une combinaison des deux pour détecter la fragilité.</p> <p>Nous recommandons que le choix de l'outil d'évaluation de la fragilité soit déterminé par l'objectif visé et le contexte dans lequel l'outil sera utilisé.</p> |
| <p>Nous recommandons/nous suggérons :</p> <ul style="list-style-type: none"> • Que les thérapeutes énergétiques de première ligne se profilent de manière transparente comme des experts du fonctionnement dans la vie de tous les jours et de l'environnement dans lequel ce fonctionnement a lieu. • Que les ergothérapeutes fassent connaître leur accessibilité à la fois dans une zone de soins primaires et aux services gériatriques de deuxième ligne dans leur région de soins, afin de rationaliser l'orientation et de fournir des soins intégrés centrés sur le client. | <p>Nous recommandons que les thérapeutes énergétiques de première ligne se profilent de manière transparente comme des experts du fonctionnement dans la vie quotidienne et de l'environnement dans lequel ce fonctionnement se déroule.</p> <p>Nous recommandons que les ergothérapeutes fassent connaître leur accessibilité à la fois dans une zone de soins primaires et aux services gériatriques de deuxième ligne dans leur région de soins, afin de rationaliser l'orientation et de fournir des soins intégrés centrés sur le client.</p> |
| <p>Nous recommandons/nous suggérons :</p> <ul style="list-style-type: none"> • Tous les professionnels de la santé et de l'aide sociale qui sont en contact direct ou indirect avec des personnes âgées sont formés, dans leur zone de première ligne, à l'identification des personnes âgées vulnérables et des personnes à haut risque de fragilité et à leur orientation vers les prestataires de soins de santé compétents, y compris les ergothérapeutes. • Que les ergothérapeutes identifient les personnes âgées vulnérables et les personnes à haut risque de fragilité et qu'ils les orientent vers les prestataires de soins de santé concernés dans le cadre d'une approche interdisciplinaire. | <p>Nous recommandons que tous les professionnels de la santé et de l'aide sociale qui sont en contact direct ou indirect avec des personnes âgées soient formés, dans leur zone de première ligne, à identifier les personnes âgées fragiles et les personnes à haut risque de fragilité et à les orienter vers les prestataires de soins de santé compétents, y compris les ergothérapeutes.</p> <p>Nous recommandons aux ergothérapeutes d'identifier les personnes âgées vulnérables et les individus à haut risque de fragilité et de les orienter vers les prestataires de soins de santé concernés dans le cadre d'approches interdisciplinaires.</p> |
| <p>Nous recommandons/nous suggérons :</p> <ul style="list-style-type: none"> • établir une procédure au sein d'une zone de première ligne qui indique comment la détection et l'orientation des personnes à haut risque en matière de vulnérabilité sont effectuées (par qui, comment, quand et vers qui). • nommer un coordinateur pour chaque zone de front afin de contrôler, concrètement : suivre, évaluer périodiquement et ajuster ce processus. • Tous les professionnels de la santé et de l'aide sociale doivent être au courant de la procédure | <p>Nous recommandons que tous les professionnels de la santé et de l'aide sociale qui sont en contact direct ou indirect avec des personnes âgées soient formés, dans leur zone de première ligne, à identifier les personnes âgées fragiles et les personnes à haut risque de fragilité et à les orienter vers les prestataires de soins de santé compétents, y compris les ergothérapeutes.</p> <p>Nous recommandons aux ergothérapeutes d'identifier les personnes âgées vulnérables et les individus à haut risque de fragilité et de les orienter vers les prestataires de soins de santé concernés dans le cadre d'approches interdisciplinaires.</p> <p>Nous suggérons d'établir une procédure au sein d'une zone de première ligne qui inclut la manière de détecter</p> |

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| de détection et d'orientation dans leur zone de première ligne. | et d'orienter les personnes à haut risque en ce qui concerne la vulnérabilité. |
| | Nous suggérons de nommer un coordinateur pour chaque zone de première ligne afin de suivre ce processus. |
| | Nous suggérons que tous les professionnels de la santé et de l'aide sociale soient au courant de la procédure de détection et d'orientation dans leur secteur de première ligne. |
| Question clinique 2 | |
| Nous recommandons/nous suggérons de réduire au maximum le délai entre la détection de la personne à haut risque, l'évaluation par l'ergothérapeute et la mise en œuvre des recommandations. | Nous recommandons que le délai entre la détection de la personne à haut risque, l'évaluation ergothérapeutique et la mise en œuvre des recommandations soit le plus court possible |
| Nous recommandons/suggérons que les ergothérapeutes effectuent leur évaluation de l'activité significative dans l'environnement familial de la personne âgée, ou dans un environnement qui simule le plus fidèlement possible l'environnement familial. | Nous recommandons aux ergothérapeutes de procéder à l'évaluation de l'activité significative dans l'environnement familial de la personne âgée ou dans un environnement qui simule le plus fidèlement possible l'environnement familial. |
| Nous recommandons/nous suggérons <ul style="list-style-type: none"> • que les ergothérapeutes concentrent leurs évaluations sur l'identification des faiblesses et des opportunités dans le cadre d'une activité significative. • que les ergothérapeutes s'interrogent également sur les intérêts, les besoins, les préférences et les objectifs de la personne au niveau fonctionnel et au niveau de la participation. Les ergothérapeutes le font dans le cadre d'une vision holistique qui inclut les problèmes de santé médicaux, ainsi que la situation sociale, la santé et le bien-être subjectivement perçus, et la situation matérielle. • Que les ergothérapeutes s'enquière de la perception qu'a la personne âgée de ses activités et de ce qu'elle estime devoir être traité en priorité. | Nous recommandons aux ergothérapeutes d'axer leurs évaluations sur l'identification des faiblesses et des opportunités dans le cadre d'une activité significative. Nous recommandons aux ergothérapeutes de s'interroger sur les intérêts, les besoins, les préférences et la perception des activités de la personne âgée au niveau fonctionnel et au niveau de la participation. |
| Nous recommandons/nous suggérons <ul style="list-style-type: none"> • que les ergothérapeutes utilisent des outils d'évaluation non seulement à l'admission, mais aussi à toutes les phases du processus thérapeutique (évaluation et planification, intervention et suivi), dans la mesure où cela est pertinent. • Que les ergothérapeutes, en plus de leur expertise clinique en matière d'évaluation, | Nous recommandons aux ergothérapeutes d'utiliser des outils d'évaluation en plus de leur expertise clinique, le cas échéant, à tous les stades du processus thérapeutique. |

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| <p>utilisent autant que possible des instruments de mesure standardisés. Il s'agit de disposer de données objectives, mais aussi de contribuer à la satisfactivité professionnelle des ergothérapeutes.</p> <ul style="list-style-type: none"> • Les ergothérapeutes s'appuient à la fois sur les informations relatives aux AVQ observées et auto-évaluées. • Que les ergothérapeutes prennent en compte les indicateurs sociodémographiques dans l'interprétation de l'auto-évaluation. <p>Les instruments d'évaluation peuvent être des questionnaires, des listes de contrôle, des échelles ou des outils d'observation et sont utilisés conformément au protocole dans le cadre duquel ils sont testés et normalisés.</p> | <p>Nous recommandons que, lors de l'évaluation, l'ergothérapeute soit attentif au mode de vie et à l'équilibre des activités significatives de la personne âgée et, le cas échéant, de son aidant informel.</p> |
| <p>Nous recommandons/suggérons une collaboration multidisciplinaire pour réaliser une évaluation gériatrique complète (EGC) chez la personne âgée vivant à domicile, où une division du travail devrait être envisagée dans le contexte de l'expertise et du rapport coût-efficacité.</p> | <p>Nous recommandons une collaboration multidisciplinaire pour effectuer une évaluation gériatrique complète (EGC) chez la personne âgée vivant à domicile, où une division du travail devrait être envisagée dans le contexte de l'expertise et du rapport coût-efficacité.</p> |
| <p>Nous recommandons/nous suggérons que, dans le cadre de la faisabilité, en fonction du contexte, il soit décidé si une évaluation à la sortie est effectuée par un ergothérapeute travaillant à l'hôpital ou dans le cadre des soins à domicile.</p> | <p>Nous recommandons que, dans le cadre de la faisabilité, il soit décidé en fonction du contexte si une évaluation à la sortie est effectuée par un ergothérapeute travaillant à l'hôpital ou dans le cadre des soins à domicile.</p> |
| <p>Nous recommandons/suggérons que les ergothérapeutes contribuent à l'équipe interdisciplinaire en envisageant des instruments d'évaluation standardisés ayant une valeur prédictive quant au besoin de soins à domicile.</p> | <p>Nous recommandons que les ergothérapeutes contribuent à l'équipe interdisciplinaire en envisageant des instruments d'évaluation standardisés ayant une valeur prédictive quant au besoin de soins à domicile.</p> |
| <p>Nous recommandons/suggérons que, lors de l'évaluation, l'ergothérapeute soit attentif au mode de vie et à l'équilibre des activités significatives de la personne âgée et, le cas échéant, de son aidant informel.</p> | <p>Nous recommandons que, lors de l'évaluation, l'ergothérapeute soit attentif au mode de vie et à l'équilibre des activités significatives de la personne âgée et, le cas échéant, de son aidant informel.</p> |
| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • Les ergothérapeutes doivent disposer de suffisamment de temps pour évaluer les activités liées aux AVQ (AVB et AIVQ) à l'aide d'un outil d'évaluation standardisé. • que cet instrument peut être rempli par l'ergothérapeute sur la base d'une observation ou d'un entretien, ou qu'il peut s'agir d'un instrument d'auto-évaluation rempli par la personne âgée ou son aidant informel. <p>L'investissement en temps supplémentaire lors de l'évaluation est compensé par la suite par des diagnostics et des traitements plus efficaces.</p> | <p>Nous recommandons aux ergothérapeutes de prévoir suffisamment de temps pour évaluer les activités liées aux AVQ (AVB et AIVQ) à l'aide d'un instrument d'évaluation standardisé (observation, entretien ou instrument d'auto-évaluation par la personne âgée ou l'aidant informel).</p> <p>Nous recommandons à l'ergothérapeute d'adapter le choix de l'instrument à la personne et à son contexte, en tenant compte, entre autres, des effets de plancher et de plafond possibles².</p> |

² vb MMSE chez les personnes présentant une forte suspicion de déficit cognitif et MOCA chez les personnes présentant une suspicion de fonctions cognitives intactes

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| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • Les ergothérapeutes, lorsqu'ils choisissent l'instrument pour mesurer les AVB et les AIVQ, vérifient le protocole de l'instrument pour savoir s'il peut être administré sur la base d'un entretien, d'une observation directe ou d'une auto-évaluation. • que l'ergothérapeute adapte le choix de l'instrument à la personne et à son contexte, en tenant compte, entre autres, des éventuels effets de plancher et de plafond¹. • L'ergothérapeute étalera les tests dans le temps si cela est approprié. • Que l'interprétation des scores des mesures BAVJ et AIVJ prenne en compte non seulement le score total mais aussi les sous-scores. | <p>Nous recommandons à l'ergothérapeute d'adapter le choix de l'instrument à la personne et à son contexte, en tenant compte, entre autres, des éventuels effets de plancher et de plafond¹. (a été fusionné avec la recommandation initiale précédente)</p> <p>Nous recommandons à l'ergothérapeute d'étaler les tests dans le temps si cela est souhaitable.</p> <p>Nous recommandons que l'interprétation des scores des mesures BAVJ et AIVJ prenne en compte non seulement le score total mais aussi les sous-scores.</p> |
| <p>Nous recommandons/nous suggérons qu'un professionnel de la santé procède à un dépistage du risque de chute et oriente vers un ergothérapeute si nécessaire, et vice versa.</p> | <p>Nous recommandons qu'un professionnel de la santé examine le risque de chute et oriente vers un ergothérapeute si nécessaire, et vice versa.</p> |
| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • Lors de l'évaluation du cadre de vie, l'ergothérapeute utilise un outil validé et fiable pour détecter les situations dangereuses à la maison et dans le cadre de vie. • Ainsi, outre l'évaluation de l'environnement, l'ergothérapeute est également attentif aux activités de la personne et à son interactivité avec l'environnement. | <p>Incorporé dans la prévention ergo-guide clinique des chutes (De Coninck et al., 2017)</p> |
| <p>Nous recommandons/suggérons que l'ergothérapeute fasse remplir à la personne âgée et/ou à son aidant informel un instrument d'auto-évaluation avec des instructions claires concernant les facteurs de risque de chute dans l'environnement de vie.</p> | <p>Nous recommandons à l'ergothérapeute de faire remplir à la personne âgée ou à son aidant un instrument d'auto-évaluation avec des instructions claires concernant les facteurs de risque de chute dans l'environnement de vie.</p> |
| <p>Nous recommandons/suggérons que, dans le cadre de la prévention des chutes, l'ergothérapeute s'enquière des facteurs d'influence potentiels en termes d'observance, y compris la croyance en l'utilité de l'aménagement du domicile, la croyance en l'effet de l'aménagement du domicile sur les chutes et les activités antérieures entreprises pour aménager le domicile.</p> | <p>Incorporé dans la prévention ergo-guide clinique des chutes (De Coninck et al., 2017)</p> |
| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • que des instruments d'évaluation spécifiques pour l'environnement de vie à risque soient administrés par des ergothérapeutes et qu'ils soient complétés par des informations | <p>Incorporé dans la prévention ergo-guide clinique des chutes (De Coninck et al., 2017)</p> |

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| <p>pertinentes sur les risques de chute recueillies par tous les soignants concernés.</p> <ul style="list-style-type: none"> • Que les prestataires de soins de santé s'adressent à des ergothérapeutes pour l'aménagement du domicile dans le cadre de la prévention des chutes. | <p>Nous recommandons qu'un professionnel de la santé examine le risque de chute et oriente vers un ergothérapeute si nécessaire, et vice versa.</p> |
| <p>Nous recommandons/suggérons que les ergothérapeutes utilisent un instrument d'évaluation fiable pour identifier la composante "comportement" en tant que facteur de risque pour la prévention des chutes.</p> | <p>Nous recommandons aux ergothérapeutes d'utiliser un instrument d'évaluation fiable pour identifier la composante "comportement" en tant que facteur de risque pour la prévention des chutes.</p> |
| <p>Nous recommandons/nous suggérons</p> <ul style="list-style-type: none"> • que l'ergothérapeute, dans son rôle d'expert en conduite automobile, soutient le processus de décision de reprendre ou non le volant, aide à déterminer l'évaluation de l'aptitude à la conduite et aide la personne à évaluer de manière réaliste les risques liés à la conduite dans sa situation spécifique. • que lors de l'évaluation de l'aptitude à la conduite, l'ergothérapeute identifie les aspects suivants : le comportement du conducteur, les fonctions exécutives (spécifiques à la conduite et BAVJ/AIVJ) et les aptitudes cognitives générales, ainsi que les aptitudes perceptives visuelles et visuo-motrices. | <p>Nous suggérons que l'ergothérapeute, dans sa fonction d'expert en conduite automobile, soutienne le processus de décision de reprendre ou non le volant, codétermine l'évaluation de l'aptitude à la conduite et aide la personne à évaluer de manière réaliste les risques liés à la conduite dans sa situation spécifique.</p> <p>Nous suggérons que lors de l'évaluation de l'aptitude à la conduite, l'ergothérapeute identifie les aspects suivants : le comportement du conducteur, les fonctions exécutives (spécifiques à la conduite et BAVJ/AIVJ) et les compétences cognitives, visuelles et visuo-motrices générales.</p> |
| <p>Nous recommandons/nous suggérons de réfléchir à l'opportunité d'utiliser un simulateur de conduite dans le cadre de la prédiction de l'aptitude à la conduite.</p> | <p>Nous suggérons de réfléchir à l'opportunité d'utiliser un simulateur de conduite dans le contexte de la prédiction de l'aptitude à la conduite.</p> |
| <p>Nous recommandons/suggérons que l'ergothérapeute aide la personne, qui a été jugée inapte à conduire, à trouver et à utiliser d'autres moyens de transport, et qu'il l'accompagne dans d'autres implications en matière de participation.</p> | <p>Nous recommandons que l'ergothérapeute aide la personne, jugée inapte à conduire, à trouver et à utiliser d'autres moyens de transport, et qu'il l'accompagne dans d'autres conséquences de sa participation.</p> |
| <p>Nous recommandons/suggérons d'en référer à l'autorité nationale compétente CARA en ce qui concerne la décision juridique relative à l'aptitude à la conduite.</p> | <p>Nous vous recommandons de vous référer à l'autorité nationale compétente CARA en ce qui concerne la décision juridique relative à l'aptitude à la conduite.</p> |
| <p>Nous recommandons/nous suggérons que l'ergothérapeute utilise des tests fonctionnels pour évaluer la cognition en plus des outils d'évaluation cognitive habituels.</p> | <p>Nous recommandons à l'ergothérapeute d'utiliser des tests fonctionnels pour évaluer la cognition en plus des outils d'évaluation cognitive habituels.</p> |
| <p>Nous recommandons/nous suggérons qu'en plus d'évaluer les AVB, les AVCI, la mobilité et les loisirs, l'ergothérapeute évalue également les compétences en matière d'utilisation de la technologie et de ses applications.</p> | <p>Nous suggérons que l'ergothérapeute évalue non seulement les BAVJ, les AIVJ, la mobilité et les loisirs, mais aussi les compétences en matière d'utilisation de la technologie et de ses applications.</p> |
| Question clinique 3 | |
| <p>Il est recommandé/nous suggérons d'inclure la définition d'objectifs personnels et réalisables pour la personne âgée vivant à domicile dans le processus de travail centré sur le</p> | <p>Nous recommandons d'inclure la définition d'objectifs personnels et réalisables pour la personne âgée vivant à domicile dans le processus de travail centré sur le client.</p> |

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| client. Ces objectifs sont élaborés en collaboration avec la personne âgée vivant à domicile et/ou tout aidant informel. | |
| Il est recommandé/nous suggérons que quatre étapes soient franchies dans la définition des objectifs, à savoir (1) la négociation des objectifs, (2) la rédaction et la hiérarchisation des objectifs, (3) la planification des objectifs et (4) l'évaluation des objectifs, si nécessaire, la redéfinition des priorités et/ou la reformulation . | Nous vous recommandons de suivre les quatre étapes de la définition d'un objectif. |
| Il est recommandé/nous suggérons que les objectifs de l'ergothérapie soient partagés et discutés au sein de l'équipe interprofessionnelle et dans tous les contextes (par exemple, hôpital - domicile). Ceci afin d'optimiser l'alignement et la collaboration. | Nous suggérons de partager et de discuter des objectifs de l'ergothérapie au sein de l'équipe interprofessionnelle et de le faire dans tous les contextes (par exemple, hôpital - domicile). |
| Il est recommandé/nous suggérons que l'ergothérapeute encourage la personne âgée vivant à domicile à discuter de ses souhaits en matière de traitement avec sa famille en prévision d'une éventuelle situation future où la personne aura besoin d'aide pour prendre des décisions en matière de traitement. | Nous suggérons que l'ergothérapeute encourage la personne âgée vivant à domicile à discuter de ses souhaits en matière de traitement avec sa famille, en prévision d'une situation future où la personne aura besoin d'aide pour prendre des décisions en matière de traitement. |
| Question clinique 4 | |
| Il est recommandé/Nous suggérons de : mener des interventions ergothérapeutiques auprès de personnes âgées fragiles en adoptant une attitude centrée sur le client, un partenariat collaboratif, l'idée d'une prise de décision partagée et en prêtant attention à l'autonomisation. Ce faisant, l'ergothérapeute utilise les principes de la littératie en matière de santé et prête attention aux activités significatives et à l'importance de la structure de la journée pour la personne âgée. | Nous recommandons que les interventions ergothérapeutiques auprès des personnes âgées physiquement fragiles soient menées dans une optique centrée sur le client, en mettant l'accent sur l'autonomisation. |
| | Nous recommandons d'appliquer une aide à la décision pour déterminer le choix de l'intervention. |
| Il est recommandé/Nous suggérons de : proposer des interventions adaptées à la personne âgée vulnérable dans le cadre d'une approche pluridisciplinaire. | Nous recommandons que les interventions soient adaptées à la personne âgée vulnérable dans le cadre d'une approche interprofessionnelle. |
| Il n'est pas recommandé/Nous ne suggérons pas de le faire : Proposer un programme d'intervention interdisciplinaire à composantes multiples si un ergothérapeute n'est pas impliqué. | Nous ne suggérons pas de proposer un programme d'intervention interprofessionnel dans le domaine de la vie quotidienne ou de la participation sociale si un ergothérapeute n'est pas impliqué. |
| Il est recommandé/nous suggérons que, dans le contexte d'une vie quotidienne significative et d'une participation sociale, les interventions individuelles à domicile consistent à renforcer les connaissances en matière de santé, à enseigner des stratégies d'autogestion, à enseigner des stratégies de prévention des chutes, à donner des conseils sur le changement de méthode dans l'exécution des gestes quotidiens, à pratiquer les gestes quotidiens, à donner des conseils sur les appareils d'assistance et à pratiquer leur utilisation, à donner des conseils sur l'adaptation du domicile, y compris l'éclairage, et à donner des conseils sur la fourniture de services. Nous recommandons/suggérons que ces interventions | Nous recommandons des interventions individuelles à domicile consistant en une combinaison de.. : <ul style="list-style-type: none"> - Améliorer la connaissance de la santé, - des conseils sur le changement de méthode dans l'accomplissement des tâches quotidiennes, - des conseils sur les dispositifs d'assistance et s'entraîner à les utiliser, - des conseils sur l'aménagement du logement, y compris l'éclairage, - des conseils en matière d'ergonomie, - Pratiquer des activités quotidiennes, - Apprendre des stratégies d'autogestion, - Enseigner les stratégies de prévention des chutes, - Conseils sur les options de service. |

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| <p>soient limitées dans le temps et se terminent par une session de suivi.</p> | <p>Nous recommandons de limiter ces interventions dans le temps et de les conclure par une session de suivi.</p> |
| <p>Il est recommandé/Nous suggérons de proposer des interventions de promotion de la santé aux personnes âgées fragiles afin d'améliorer leur fonctionnement physique, social, cognitif et mental. Ces interventions s'inscrivent de préférence dans le cadre d'une intervention interdisciplinaire multifactorielle portant sur les aspects du mode de vie, notamment la nutrition, les médicaments, l'exercice physique et le soutien psychosocial, et peuvent être complétées par des interventions téléphoniques de soutien à l'autogestion de la santé.</p> | <p>Nous suggérons que la promotion de la santé devrait fournir des interventions qui améliorent le fonctionnement physique, social, cognitif et mental.</p> |
| <p>Il est recommandé/nous suggérons d'accroître la résilience et le sentiment de cohérence des personnes âgées vulnérables en proposant des interventions basées sur l'autogestion de la santé et axées sur la motivation, la responsabilité personnelle, les activités physiques et l'impact social et environnemental.</p> | <p>Il est proposé de prendre note de la recommandation 4.5</p> |
| <p>Il est recommandé/Nous suggérons d'organiser des activités de groupe pour améliorer les activités quotidiennes et les compétences en matière de promotion de la santé, en plus des interventions individuelles à domicile. Les activités de groupe favorisent la participation sociale en plus des compétences physiques, ce qui influe sur la qualité de vie.</p> | <p>Nous suggérons de proposer des interventions de groupe pour améliorer la participation sociale dans le contexte de la promotion de la santé, en plus des interventions à domicile.</p> |
| <p>Il est recommandé/Nous suggérons de proposer aux personnes âgées vulnérables présentant des symptômes dépressifs des interventions axées sur le mode de vie qui, d'une part, les encouragent à effectuer davantage d'activités conduisant à des contacts sociaux et, d'autre part, facilitent les activités qui ont un sens pour la personne.</p> | <p>Nous suggérons de proposer des interventions axées sur le mode de vie, en particulier chez les personnes âgées présentant des symptômes dépressifs, qui, d'une part, les encouragent à effectuer davantage d'activités conduisant à des contacts sociaux et, d'autre part, facilitent les activités qui ont un sens pour la personne.</p> |
| <p>Il est recommandé/Nous suggérons de consulter la guide clinique professionnelle sur la prévention des chutes dans le cadre des recommandations sur la prévention des chutes.</p> | <p>A été retiré des recommandations et inclus avant les recommandations.</p> |
| <p>Il est recommandé/ Nous suggérons d'enseigner des exercices physiques adaptés et fondés sur des données probantes* qui encouragent le mouvement et que la personne âgée fragile peut intégrer dans son fonctionnement quotidien et en plus de ses activités quotidiennes régulières. Ces exercices sont personnalisés et sélectionnés par des ergothérapeutes, entre autres, et peuvent être transmis à la personne âgée et suivis par des bénévoles formés. Il convient de prêter attention à la planification, à la coopération avec les bénévoles et à leur formation. * par exemple sur la base des programmes LiFE, Stepping On ou OTAGO</p> | <p>Nous recommandons des exercices physiques sur mesure, fondés sur des données probantes, qui encouragent l'exercice et peuvent être intégrés dans le fonctionnement quotidien, en plus des activités quotidiennes habituelles.</p> |

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| <p>Il est recommandé/nous suggérons de permettre à la personne âgée vulnérable de vivre des expériences significatives, par exemple en prenant soin de quelque chose ou en encourageant les collaborations intergénérationnelles afin d'accroître les effets d'apprentissage bilatéraux et de permettre à la personne âgée de faire l'expérience de la "générativité" à partir de l'état d'esprit. Ce qui est significatif pour la personne âgée peut être déterminé, entre autres, à l'aide de la "roue du bien-être*".</p> <p>* La "roue du bien-être", également appelée "roue de l'équilibre de vie", décrit un mode de vie visant à une santé et un bien-être optimaux.</p> <p>° envie d'encadrer les jeunes générations et de les aider à trouver leur place dans le monde.</p> | <p>Nous recommandons de permettre à la personne âgée vulnérable de vivre des expériences significatives, notamment en s'occupant de quelque chose, ou d'encourager les collaborations intergénérationnelles.</p> |
| <p>Il est recommandé/Nous suggérons d'utiliser la technologie des jeux ou de la réalité virtuelle comme élément de motivation en plus de l'exercice.</p> | <p>Nous recommandons d'ajouter une composante motivationnelle et/ou des outils de soutien lors de l'entraînement au fonctionnement physique.</p> |
| <p>Il est recommandé/nous suggérons de laisser des interventions cognitives individuelles, liées ou non à des situations quotidiennes, qui entraînent la mémoire de travail et la capacité de résolution de problèmes, et de prévoir une session de suivi pour augmenter le transfert vers la capacité de résolution de problèmes dans l'AIVQ.</p> | <p>Nous suggérons de proposer des interventions cognitives individuelles qui entraînent la mémoire de travail et la capacité de résolution de problèmes et qui peuvent être liées ou non à des situations de la vie quotidienne. Nous suggérons également d'organiser une session de suivi afin d'accroître le transfert vers la capacité de résolution de problèmes dans l'AIVQ.</p> |
| <p>Il est recommandé/Nous suggérons d'utiliser des supports tels que des bandes de résistance ou des bâtons flexibles lors de la réalisation d'exercices physiques.</p> | <p>Nous recommandons d'ajouter une composante motivationnelle et/ou des outils de soutien lors de l'entraînement au fonctionnement physique.</p> |
| <p>Il est recommandé/nous suggérons d'enseigner des stratégies de changement de comportement inter- et intrapersonnelles en plus de proposer des exercices physiques fondés sur des données probantes.</p> | <p>Nous recommandons d'enseigner des stratégies de changement de comportement en plus de proposer des exercices physiques fondés sur des données probantes.</p> |
| <p>Il n'est pas recommandé/Nous ne suggérons pas d'utiliser la robotique pour faciliter la mobilité ou les soins personnels.</p> | <p>Nous ne suggérons pas d'utiliser la robotique pour faciliter la mobilité ou les soins personnels.</p> |
| <p>Il est recommandé/nous suggérons d'offrir une formation aux compétences off-road et/ou une formation à la simulation sur ordinateur, y compris la vitesse de traitement, en matière de compétences de conduite. Il est recommandé d'instiller une prise de conscience des compétences de conduite personnelles. La négociation des choix concernant les futurs moyens de transport et la formation à l'utilisation de moyens de transport alternatifs en font partie.</p> | <p>Nous suggérons de proposer une formation aux compétences off-road et/ou une formation à la simulation sur ordinateur, y compris la vitesse de traitement, pour les compétences de conduite.</p> |
| | <p>Nous recommandons de sensibiliser aux compétences personnelles de conduite, d'encourager les choix négociés sur les futurs moyens de transport et de former à l'utilisation de moyens de transport alternatifs.</p> |
| <p>Il est recommandé/nous suggérons d'utiliser des outils d'aide à la décision pour déterminer le choix de l'intervention. Ces outils d'aide à la décision renforcent la participation de la personne âgée fragile au choix de</p> | <p>Nous recommandons d'appliquer une aide à la décision pour déterminer le choix de l'intervention.</p> |

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| l'intervention, la connaissance des bénéfiques et des risques de l'intervention pour la santé et réduit potentiellement les conflits liés à la prise de décision. | Nous recommandons de consulter l'aidant ou la famille de la personne âgée fragile dans le cadre de l'aide à la décision, s'ils le souhaitent. |
| Il est recommandé/Nous suggérons de consulter l'aidant informel de la personne âgée fragile et d'élaborer un plan de soins pour l'aidant informel afin, entre autres, de réduire le stress et d'augmenter la capacité de charge. | Nous recommandons d'accorder une attention suffisante à la planification et à la communication, à l'information et à l'éducation de la personne âgée et de son aidant. |
| Il est recommandé/Nous suggérons d'aider les aidants à se responsabiliser en mettant en place de brèves interventions psycho-éducatives par téléphone, sur Internet et/ou basées sur la technologie, en plus d'un soutien régulier. | Nous recommandons d'aider les aidants à se responsabiliser en utilisant de brèves interventions psycho-éducatives par téléphone, sur Internet et/ou basées sur la technologie, en plus d'un soutien régulier. |
| Il est recommandé/nous suggérons de répondre aux besoins fonctionnels de la personne âgée fragile qui n'ont pas encore été satisfaits à la sortie de l'hôpital et de mettre en œuvre des interventions à domicile intégrées et centrées sur le client, en consultation entre l'hôpital et les soins primaires. Il est recommandé/ Nous suggérons qu'une attention suffisante soit accordée à la planification et à la communication, à l'information et à l'éducation de la personne âgée et de son aidant informel dans le cadre de ce processus. | Nous recommandons de répondre aux besoins fonctionnels de la personne âgée fragile qui ne sont pas encore satisfaits à la sortie de l'hôpital et de mettre en œuvre des interventions à domicile intégrées et centrées sur le client, en consultation entre l'hôpital et les soins primaires. |
| Question clinique 5 | |
| Nous suggérons/recommandons la mise en place d'une gestion de cas. | Nous recommandons de désigner un coordinateur de soins dans les situations complexes. |
| Nous suggérons/recommandons que, si la gestion de cas est appliquée, elle fasse partie d'une structure d'intégration plus générale afin de garantir la continuité structurelle en termes de coordination des soins de santé, de l'aide sociale et des services. | Nous recommandons qu'en matière de coordination des soins, le coordinateur des soins fasse partie d'une structure intégrée plus générale et ce, en fonction de la continuité en termes de coordination des soins tant au niveau des soins de santé que de l'aide sociale et des services. |
| Nous suggérons/recommandons que, si la gestion de cas est utilisée, le gestionnaire de cas soit un membre de l'équipe de traitement de la personne âgée. | Nous recommandons que, si la coordination des soins est utilisée, le coordinateur des soins soit un membre de l'équipe de traitement de la personne âgée. |
| Nous suggérons/recommandons que dans le cadre de la gestion de cas, outre les objectifs centrés sur le client pour la personne âgée et les attentes organisationnelles, les besoins des aidants informels en matière d'optimisation des soins soient inclus et qu'une formation sur mesure avec une approche multidisciplinaire soit fournie (par exemple sur la nutrition, l'ergonomie, ...). | Nous recommandons que, dans le cadre de la coordination des soins, outre les objectifs centrés sur le client pour la personne âgée et les attentes organisationnelles, les besoins des aidants informels en matière d'optimisation des soins soient pris en compte et qu'une formation adaptée avec une approche multidisciplinaire soit fournie (par exemple, sur la nutrition, l'ergonomie, etc.). |
| Nous suggérons/recommandons une collaboration entre l'hôpital et les soins primaires. Nous suggérons que les ergothérapeutes de l'hôpital ou l'équipe de sortie contactent un ergothérapeute de soins primaires pour commander des interventions à domicile au moment de la | Nous recommandons une collaboration entre l'hôpital et les soins primaires. Nous recommandons que les ergothérapeutes de l'hôpital ou l'équipe de sortie contactent un ergothérapeute de soins primaires pour les interventions à domicile à la sortie, et ce dans le contexte de l'exhaustivité des conseils de l'ergothérapeute. |

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| sortie, et ce dans le contexte de l'exhaustivité des conseils de l'ergothérapeute. Nous ne suggérons/recommandons pas aux ergothérapeutes hospitaliers de mener des interventions à domicile avant la sortie de l'hôpital. | Nous ne recommandons pas aux thérapeutes énergétiques de l'hôpital d'intervenir à domicile avant la sortie de l'hôpital. |
| Nous suggérons/recommandons que les accords sur le partage d'informations confidentielles soient consignés par écrit. | Nous recommandons que les accords sur le partage d'informations confidentielles soient consignés par écrit. |
| Nous suggérons/recommandons aux prestataires de soins de santé d'utiliser les technologies de l'information pour échanger des informations entre eux. | Nous recommandons aux prestataires de soins de santé d'utiliser les technologies de l'information pour échanger des informations entre eux. |
| Nous suggérons/recommandons que lors de l'utilisation des technologies de l'information sur la santé (HIT), (1) les personnes âgées et/ou leurs aidants informels soient impliqués dans les objectifs de santé de la personne âgée, (2) la façon dont ils perçoivent la confidentialité et la sécurité des HIT soit évaluée, (3) il soit assuré qu'il n'y ait pas de problèmes techniques, et (4) l'information soit fiable. | Nous recommandons que, lors de l'utilisation des technologies de l'information en matière de santé (HIT), (1) les personnes âgées et/ou leurs aidants informels soient impliqués dans les objectifs de santé de la personne âgée, (2) la façon dont ils perçoivent la confidentialité et la sécurité des HIT soit évaluée, (3) il soit garanti qu'il n'y ait pas de défaillances techniques et (4) que l'information soit fiable. |

Tableau 3 : Aperçu des recommandations initiales et pre-finales

3.2.5 Recommandations à valeur ajoutée

Pour déterminer un GRADE pour chaque recommandation, deux étapes ont été utilisées, à savoir la détermination du degré de preuve et la détermination de la force de la recommandation.

Pour l'évaluation critique des articles inclus, les outils d'évaluation critique du SIGN ont été utilisés, complétés par ceux du JBI lorsqu'aucun outil d'évaluation du SIGN n'était disponible pour un modèle d'étude particulier (études d'observation et études qualitatives).

Si l'étude a reçu un score de "qualité inacceptable" lors d'une évaluation critique à l'aide de l'outil SIGN, ou si l'évaluation globale a été jugée très faible lors d'une évaluation critique à l'aide de l'outil JBI, l'article a été exclu.

3.2.5.1 Degré de preuve

Pour déterminer le degré de preuve par recommandation, le modèle fourni par WOREL a été utilisé. Les modèles complétés par recommandation se trouvent en annexe au point 5.4 "Évaluations critiques".

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| Question clinique - Clinical question : | |
| Recommandation | |

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| Justification (références)/ Justification (références) | | | |
| Statistiques sommaires | | | |
| Step 1 : determine certainty of proof / Étape 1 : déterminer le degré de certitude des preuves | | | |
| Qualification de la production certitude de la preuve/ Qualification de base de la certitude de la preuve | | | |
| DESCENDEURS - GOUTES | | | |
| Contraintes de conception Limites de conception | None or non-serious / Aucun ou non sérieux (0) Grave - Grave (-1) Very serious - Très sérieux (-2) | | |
| | | | Explanation of decision / L'explication de la décision |
| Incohérence Incohérence | None or non-serious / Aucun ou non sérieux (0) Grave - Grave (-1) Very serious - Très sérieux (-2) | | |
| | | | Explanation of decision / L'explication de la décision |
| Caractère indirect Façon indirecte | None or non-serious / Aucun ou non sérieux (0) Grave - Grave (-1) Very serious - Très sérieux (-2) | | |
| | | | Explanation of decision / L'explication de la décision |
| Imprécision Inexactitude | None or non-serious / Aucun ou non sérieux (0) Grave - Grave (-1) Very serious - Très sérieux (-2) | | |
| | | | Explanation of decision / L'explication de la décision |
| Biais de publication Biais de publication | None or non-serious / Aucun ou non sérieux (0) Grave - Grave (-1) Very serious - Très sérieux (-2) | | |
| | | | Explanation of decision / L'explication de la décision |

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| Qualification après l'étude des "downers" / Qualification après l'étude des personnes "descendantes" | Haut - Elevé (A) Modéré - Modéré (B) Faible - Faible (C) | | |
| STIJGERS (skip at score A) - Contremarches (en sautant sur la partition A) | | | |
| <i>Cette étape ne s'applique qu'aux études d'observation. S'il existe des essais contrôlés randomisés présentant des problèmes dans la conception de l'étude, il n'est pas possible de procéder à une mise à niveau par la suite.</i> | | | |
| <i>Cette étape ne s'applique qu'aux études d'observation. Si des ECR présentent des problèmes d'intention d'étude, ils ne peuvent pas être améliorés par la suite.</i> | | | |
| Effet de taille Effet de taille | Pas génial - Pas grand (0) Grand - Grand (+1) Très grand - Very large (+2) | | |
| | | | Explanation of decision / L'explication de la décision |
| Dose-réponse Réponse à la dose | Absent - Absent (0) Present - Présent (+1) | | |
| | | | Explanation of decision / L'explication de la décision |
| Confusion | Would reduce a demonstrated effect - Réduirait un effet démontré (+1) | | |
| | | | Explanation of decision / L'explication de la décision |
| Qualification finale de la certitude des preuves / Qualification finale de la certitude de la preuve | Haut - Elevé (A) Modéré - Modéré (B) Faible - Faible (C) | | |

| Step 2 : determining the strength of the recommendation - Étape 2 : déterminer la force de la recommandation | | | |
|--|---|-------------------|--------------------------------------|
| Considérations - Considerations | Instruction | Conclusion | Argumentation - argumentation |
| Certitude des preuves Certitude de la preuve | <i>Conclusion étape 1 - conclusion étape 1</i> | | |
| Bilan des avantages et des inconvénients Équilibrez le pour et le contre | <i>Obvious advantages ? -Avantages clairs ? Advantages and disadvantages in balance - Avantages et inconvénients en équilibre Incertain - Incertain</i> | | |
| Existe-t-il une incertitude quant à l'évaluation des principaux résultats ? Y a-t-il une incertitude quant à la façon dont les gens jugent les principaux résultats ? | | | |
| Coût Coûter | <i>Les avantages de l'intervention</i> | | |

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| | <i>recommandée sont-ils supérieurs à ses coûts ? - Les avantages de l'intervention recommandée l'emportent-ils sur ses coûts ?</i> | | |
| Le traitement est-il acceptable pour les principales parties prenantes ? Le traitement est-il acceptable pour les principales parties prenantes ? | | | |
| Le traitement est-il réalisable ? Le traitement est-il réalisable ? | | | |
| Grade de la recommandation | Strong - Fort (1) Faible ou conditionnel - Faible ou conditionnel (2) | | |
| GRADE de décision - GRADE de conclusion | | | |

3.2.5.2 Force de la recommandation

Pour déterminer la force de la recommandation, les parties prenantes ont été invitées, au cours de la première phase, à formuler un jugement de valeur (échelle de Likert en 4 points) sur les points suivants, par le biais d'une enquête :

- Pertinence
- Faisabilité
- Effets indésirables
- Justification des coûts

Ces évaluations figurent dans les rapports du comité des parties prenantes (29/06/2021, 05/10/21 et 21/12/2021).

Lors d'un comité consultatif, les parties prenantes ont ensuite été invitées à donner leur avis sur les trois recommandations qu'elles jugeaient les plus importantes et les trois recommandations qu'elles jugeaient les moins importantes. Pour déterminer le niveau d'importance, les critères suivants ont été pris en compte (de la preuve à la décision) :

- degré de priorité ,
- équilibrer les avantages et les inconvénients ,
- effet de taille ,
- degré de certitude de la réalisation de l'effet ,
- degré d'importance du résultat à atteindre ,
- coûts,
- la disponibilité des ressources dans un délai raisonnable,
- Degré d'égalité de dignité, prévention de la discrimination au sein du groupe cible,
- le degré d'acceptabilité (orienté vers le patient et son contexte),
- Niveau de faisabilité (orienté vers le prestataire de soins, la structure de soins et le contexte plus large).

Ces résultats ont ensuite été discutés lors de la séance plénière du comité consultatif.

La force de la recommandation a été déterminée sur la base des résultats de l'enquête et du Padlet. (Voir Figure 2 "Exemple de Padlet dans le contexte de la question clinique 4 "Des preuves à la décision"")



Figure 2 : Exemple de padlet dans le contexte de la question clinique 4 "Des preuves à la décision".

L'analyse des commentaires des parties prenantes, complétée par l'avis d'experts des membres du GDG, a été utilisée pour compléter la section 2 des étapes de la détermination GRADE (force de la recommandation). Pour chaque recommandation, le modèle GRADE complété se trouve dans l'annexe '5.5 Affectation GRADE'.

3.2.5.3 Attribution de la valeur des BPP

Un point de bonne pratique (GPP) a été attribué lorsqu'une recommandation était basée sur l'avis d'experts des parties prenantes ou d'experts au sein du GDG. Si les recommandations basées sur la littérature qui a été modifiée dans le cadre de l'adaptation du contexte au point que la recommandation ne pouvait plus être liée à la littérature initiale et qu'elle était jugée solide, la valeur GPP lui a également été attribuée. Il en va de même pour les recommandations suivantes :

Recommandation 1.5A : Nous recommandons que les ergothérapeutes de premier recours se présentent de manière transparente comme des experts du fonctionnement de la vie quotidienne et de l'environnement dans lequel ce fonctionnement s'inscrit. GPP

Recommandation 1.5B : Nous recommandons que les ergothérapeutes fassent connaître leur accessibilité à la fois dans une zone de soins primaires et aux services gériatriques de deuxième ligne

dans leur région de soins, afin de rationaliser l'orientation et de fournir des soins intégrés centrés sur le client. GPP

Recommandation 2.18 : Nous recommandons que l'ergothérapeute aide la personne jugée inapte à conduire à trouver et à utiliser d'autres moyens de transport, et qu'il l'accompagne dans ses autres implications en matière de participation. GPP

Recommandation 2.19 : Nous recommandons de s'adresser à l'autorité nationale compétente CARA en ce qui concerne la décision juridique relative à l'aptitude à la conduite. GPP

Recommandation 4.11B : Nous recommandons de sensibiliser aux compétences personnelles en matière de conduite, d'encourager les choix négociés concernant les futurs moyens de transport et de former à l'utilisation de moyens de transport alternatifs. GPP

Recommandation 5.5 : Nous recommandons aux prestataires de soins de santé d'utiliser les technologies de l'information pour échanger des informations entre eux. GPP

3.2.6 Documentation des recommandations

L'objectif de la documentation de la recommandation est de faciliter sa mise en œuvre. Il s'agit, d'une part, de fournir une explication qui, le cas échéant, rend la recommandation opérationnelle et, d'autre part, d'ajouter des éléments de mise en œuvre.

Le commentaire est basé sur la littérature, les commentaires des parties prenantes et l'avis d'experts des membres du GDG.

Le matériel de mise en œuvre comprend le matériel de test et le matériel didactique. Dans la mesure du possible, un lien vers les preuves sous-jacentes est ajouté, comme sralab.org ou measurementinstrumentszorg.nl pour les caractéristiques clinimétriques.

La documentation des recommandations a été la dernière étape avant la soumission de la guide clinique au CEBAM.

3.2.7 Soumettre la guide clinique pour la validation au CEBAM

Avant d'être soumis au comité national de validation du CEBAM, il a été revu par deux experts méthodologiques externes du comité de lecture du CEBAM et ajusté en fonction de leurs commentaires.

Le 28 septembre, la guide clinique a été examinée lors d'un comité de validation du CEBAM convoqué à cet effet, avec le retour d'information ci-dessous :

"Le comité de validation tient à féliciter les auteurs de ce guide pour les efforts qu'ils ont déployés pour l'élaborer.

Voici les impressions générales du comité de validation :

Aspects méthodologiques :

La guide clinique est solide sur le plan méthodologique, avec un rapport détaillé de toutes les étapes. Nous vous félicitons pour ce travail approfondi. Nos principales observations sont les suivantes :

- La recherche qualitative est fréquemment utilisée, sous l'appellation "cette recherche montre". La recherche qualitative est avant tout un outil de formulation d'hypothèses et doit être utilisée en tant que telle.

- La notation GRADE contient quelques inexactitudes ou imprécisions (voir le point 9 d'ACCORD).

- Si une recommandation forte est faite sur la base d'une preuve de faible certitude, nous ne pouvons pas trouver de preuves suffisantes pour expliquer pourquoi cela a été fait. Le raisonnement doit être rapporté.

Contenu :

Ce guide est l'expression d'un processus scientifique au sein de l'ergothérapie et un document important, également sur le plan politique, pour l'intégration de l'ergothérapie dans les soins primaires. La guide clinique est très conviviale, elle est rédigée de manière chronologique et tout est bien expliqué. Les références à d'autres informations ou outils sont utiles. Un goulot d'étranglement possible est la faisabilité pour cette population : de nombreux outils sont suggérés dans le guide. Du point de vue de la communication, cela peut être problématique pour les personnes âgées fragiles. L'utilisation d'un questionnaire standard peut sembler impersonnelle, alors que les personnes ont souvent besoin de compréhension et donc d'attention pour les facteurs psychosociaux. Pour améliorer la mise en œuvre, il serait bon d'expliquer dans le guide comment procéder au mieux et quand essayer de trouver l'information au cours d'une conversation.

Deux autres observations :

- Il serait bon que la guide clinique indique quel(s) outil(s) est (sont) préférable(s) à d'autres.

- La guide clinique est très bonne, mais aucun remboursement n'est actuellement prévu. Il s'agit d'un obstacle majeur à la mise en œuvre (voir point 20)." (extrait du rapport du comité de validation de la Cebam du 28 septembre 2022)

Sur la base de ces préoccupations, la guide clinique a été mise à jour. La guide clinique a été validée par Cebam le 9 March 2023.

4 Méthodologie par question clinique

4.1 Question clinique 1

La question clinique est la suivante :

Comment détecter les personnes âgées physiquement fragiles (recherche de cas) ? Comment la personne âgée physiquement fragile et/ou son contexte social peuvent-ils être orientés de manière efficace et efficiente vers un ergothérapeute ?

4.1.1 Stratégie de recherche de concepts

1a détection de la mise au point

1b focus referral

| | Description | Pool de termes de recherche |
|-----|---|---|
| P | Personne âgée physiquement fragile vivant à domicile et âgée de plus de 75 ans et/ou son environnement social | "Frail Elderly"[Mesh] OR "Aged, 80 and over"[Mesh] OR Frailty[Mesh] AND "Primary Health Care"[Mesh] |
| I a | Détection | "Diagnosis"[Mesh] OR "house calls"[Mesh] OR screen* OR determin* OR detect* AND ("Occupational Therapy"[Mesh] OR Physicians[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR Geriatricians[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[Mesh]) |
| I b | Renvoi | ("Referral and Consultation"[Mesh] OR "Patient Handoff"[Mesh] OR refer* OR handover OR transmission OR assignment OR "Information Dissemination"[Mesh] OR "Health Information Exchange"[Mesh]) AND ("Occupational Therapy"[Mesh] OR Physicians[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR Geriatricians[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[Mesh]) |
| C | / | / |
| O | Détection et orientation efficaces et efficientes vers l'ergothérapie dans le cadre des soins primaires | / |

Bases de données consultées :

Base de données Cochrane des revues systématiques, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Critères d'inclusion méthodologiques

- Conception : revues systématiques et méta-analyses, essais contrôlés randomisés, études d'observation et études qualitatives.
- Qualité méthodologique suffisante mesurée à l'aide de l'outil d'évaluation critique SIGN ; si aucun outil d'évaluation critique SIGN n'est disponible pour le modèle en question : outil d'évaluation critique JBI.
- Période de recherche : de la base de données au 30 juin 2022

Critères d'inclusion et d'exclusion du contenu :

Inclusion :

- la personne âgée physiquement fragile et/ou l'aidant informel
- soins primaires ou orientation vers des soins primaires
- la détection ou l'orientation

Exclusion :

Évaluation gériatrique complète (concerne la question 2)

Chaînes de recherche par base de données

Pubmed

String a

("Frail Elderly"[Mesh] OR "Aged, 80 and over"[Mesh] OR Frailty[Mesh])

AND

(Diagnosis[Mesh] OR screen* OR determin* OR detect*)

AND

("Occupational Therapy"[Mesh] OR Physicians[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR Geriatricians[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[Mesh])

AND

"Primary Health Care"[Mesh]

String b

("Frail Elderly"[Mesh] OR "Aged, 80 and over"[Mesh] OR Frailty[Mesh])

AND

("Referral and Consultation"[Mesh] OR "Patient Handoff"[Mesh] OR refer* OR handover OR transmission OR assignment OR "Information Dissemination"[Mesh] OR "Health Information Exchange"[Mesh])

AND

("Occupational Therapy"[Mesh] OR Physicians[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR Geriatricians[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[Mesh])

AND

"Primary Health Care"[Mesh]

Cochrane

String a

([mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty])

AND

([mh Diagnosis] OR screen* OR determin* OR detect*)

AND

([mh "Occupational Therapy"] OR [mh Physicians] OR [mh "General Practitioners"] OR [mh "Physical Therapists"] OR [mh "Nurses, Community Health"] OR [mh "Licensed Practical Nurses"] OR [mh "Nurse Clinicians"] OR [mh "Community Health Nursing"] OR [mh "Home Health Nursing"] OR [mh "Geriatric Nursing"] OR [mh "Family Nurse Practitioners"] OR [mh "Family Nursing"] OR [mh Geriatricians] OR [mh "Allied Health Personnel"] OR [mh "Community Health Workers"] OR [mh "Patient Care Team"] OR [mh "Community Medicine"] OR [mh "Social Workers"] OR [mh "Home Care Services"])

AND

[mh "Primary Health Care"]

String b

([mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty])

AND

([mh "Referral and Consultation"] OR [mh "Patient Handoff"] OR refer* OR handover OR transmission OR assignment OR [mh "Information Dissemination"] OR [mh "Health Information Exchange"])

AND

([mh "Occupational Therapy"] OR [mh Physicians] OR [mh "General Practitioners"] OR [mh "Physical Therapists"] OR [mh "Nurses, Community Health"] OR [mh "Licensed Practical Nurses"] OR [mh "Nurse Clinicians"] OR [mh "Community Health Nursing"] OR [mh "Home Health Nursing"] OR [mh "Geriatric Nursing"] OR [mh "Family Nurse Practitioners"] OR [mh "Family Nursing"] OR [mh Geriatricians] OR [mh "Allied Health Personnel"] OR [mh "Community Health Workers"] OR [mh "Patient Care Team"] OR [mh "Community Medicine"] OR [mh "Social Workers"] OR [mh "Home Care Services"])

AND

[mh "Primary Health Care"]

Cinahl (via Ebsco)**String a**

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+))

AND

((MH Diagnosis+) OR screen* OR determin* OR detect*)

AND

((MH "Occupational Therapy"+) OR (MH Physicians+) OR (MH "General Practitioners"+) OR (MH "Physical Therapists"+) OR (MH "Nurses, Community Health"+) OR (MH "Licensed Practical Nurses"+) OR (MH "Nurse Clinicians"+) OR (MH "Community Health Nursing"+) OR (MH "Home Health Nursing"+) OR (MH "Geriatric Nursing"+) OR (MH "Family Nurse Practitioners"+) OR (MH "Family Nursing"+) OR (MH Geriatricians+) OR (MH "Allied Health Personnel"+) OR (MH "Community Health Workers"+) OR (MH "Patient Care Team"+) OR (MH "Community Medicine"+) OR (MH "Social Workers"+) OR (MH "Home Care Services"+))

AND

(MH "Primary Health Care"+)

String b

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+))

AND

((MH "Referral and Consultation"+) OR (MH "Patient Handoff"+) OR refer* OR handover OR transmission OR assignment OR (MH "Information Dissemination"+) OR (MH "Health Information Exchange"+))

AND

((MH "Occupational Therapy"+) OR (MH Physicians+) OR (MH "General Practitioners"+) OR (MH "Physical Therapists"+) OR (MH "Nurses, Community Health"+) OR (MH "Licensed Practical Nurses"+) OR (MH "Nurse Clinicians"+) OR (MH "Community Health Nursing"+) OR (MH "Home Health Nursing"+) OR (MH "Geriatric Nursing"+) OR (MH "Family Nurse Practitioners"+) OR (MH "Family Nursing"+) OR (MH Geriatricians+) OR (MH "Allied Health Personnel"+) OR (MH "Community Health Workers"+) OR (MH "Patient Care Team"+) OR (MH "Community Medicine"+) OR (MH "Social Workers"+) OR (MH "Home Care Services"+))

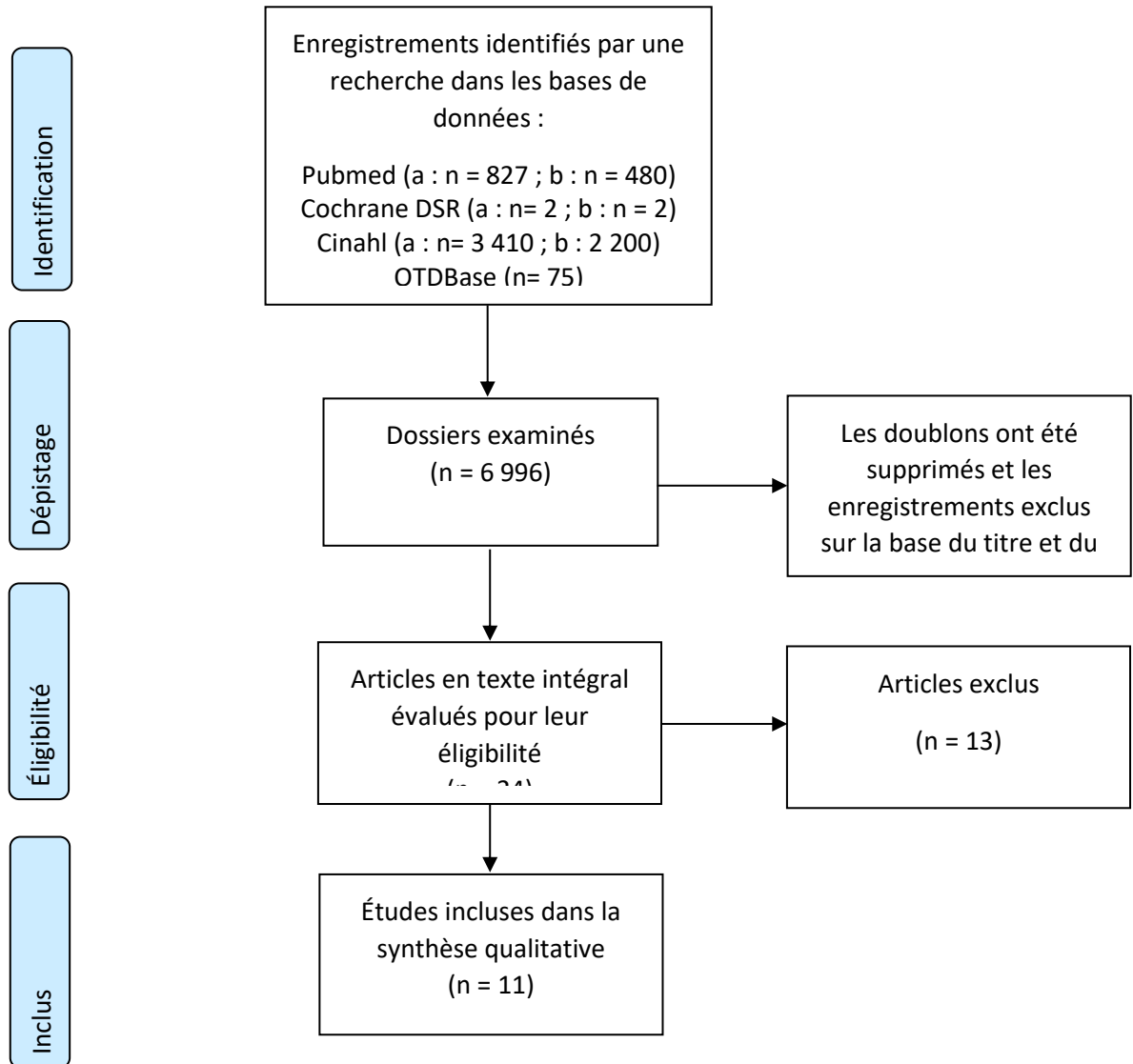
AND

(MH "Primary Health Care"+)

OTDBase

("frail elderly" AND "primary care") OR ("frailty" and "primary care")

4.1.2 Résultats identifiés



4.1.3 Matrices bibliographiques question clinique 1

Cochrane database of systematic review

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| Q 1a | | | | | | | |
| / | | | | | | | |
| Q 1b | | | | | | | |
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | Reason exclusion |
|---|---------|---------------------|
| Q 1a | | |
| Cochrane A, Furlong M, McGilloway S, Molloy DW, Stevenson M, Donnelly M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. Cochrane Database Syst Rev. 2016 Oct 11;10(10):CD010825. doi: 10.1002/14651858.CD010825.pub2. PMID: 27726122; PMCID: PMC6457975. | Sys rev | Geen bruikbare info |
| Langhorne P, Baylan S; Early Supported Discharge Trialists. Early supported discharge services for people with acute stroke. Cochrane Database Syst Rev. 2017 Jul | Sys rev | Andere populatie |

| | | |
|---|---------|---------------------|
| 13;7(7):CD000443. doi: 10.1002/14651858.CD000443.pub4. PMID: 28703869; PMCID: PMC6483472. | | |
| Q 1b | | |
| Cochrane A, Furlong M, McGilloway S, Molloy DW, Stevenson M, Donnelly M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. Cochrane Database Syst Rev. 2016 Oct 11;10(10):CD010825. doi: 10.1002/14651858.CD010825.pub2. PMID: 27726122; PMCID: PMC6457975. | Sys rev | Geen bruikbare info |
| Langhorne P, Baylan S; Early Supported Discharge Trialists. Early supported discharge services for people with acute stroke. Cochrane Database Syst Rev. 2017 Jul 13;7(7):CD000443. doi: 10.1002/14651858.CD000443.pub4. PMID: 28703869; PMCID: PMC6483472. | Sys rev | Andere populatie |

Pubmed

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|----------------------------|-------------------------|----------------|-----------------------------|--|--|----------------------------------|
| McIntyre, Anne, et al. Engagement of General Practitioners in Falls Prevention and Referral to Occupational Therapists. The British Journal of | Descriptive study (survey) | People at risk of falls | Referral to OT | Frequency of referral to OT | 90% identified occupational therapists as providing evidence-based falls prevention. | There are gaps in general practitioners' falls prevention referral | Low level of evidence (JBI tool) |

| | | | | | | | |
|--|-----------------------------------|--|-------------------|---|--|--|---|
| <p>Occupational Therapy, vol. 82, no. 2, 2018, pp. 71–79.</p> | | | | | <p>74% of the GP's referred to occupational therapy Study in England</p> | <p>practices to occupational therapists and allied health professionals. Better general practitioner pathways could enhance the quality of falls-prevention care for older people at risk. Once an older person is identified as being at risk of falling by a GP, it appears that in-depth assessments would be carried out 'in-house'.</p> | |
| <p>Donnelly, Catherine A, et al. The Emerging Role of Occupational Therapy in Primary Care. <i>Canadian Journal of Occupational Therapy</i>, vol. 81, no. 1, 2014, pp. 51–61.</p> | <p>multiple case study design</p> | <p>a wide range of client populations: Older adults and individuals with complex chronic conditions are two prominent areas of occupational therapy focus.</p> | <p>Role of OT</p> | <p>to describe the emerging role of occupational therapy in Family Health Teams, a model of interprofessional primary care.</p> | <p>Understanding the impact of health conditions on daily function and enabling participation in activities are unique and</p> | <p>When occupational therapy is situated in primary care, there is enhanced access to occupational</p> | <p>Low level of evidence (JBI tool)</p> |

| | | | | | | | | |
|---|------------------|---|--------------------------------------|--|--|---|--|---------------------------|
| | | | | | | important contributions of occupational therapy | therapy services, particularly for individuals who might not otherwise have had access. | |
| 5 Abbasi, Marjan, MD, et al. "Identification and Management of Frailty in the Primary Care Setting." <i>Canadian Medical Association Journal (CMAJ)</i> , vol. 190, no. 38, 2018, pp. E1134–E1140. | Narrative review | Frail elderly in primary care | Screening, management, interventions | | | We review the utility of validated instruments for case finding and identifying frailty components, as well as evidence for interventions to prevent or reverse frailty (Box 1) and consider the application of this evidence in the nonspecialist setting. | Identifying frailty at an earlier stage can be challenging and is best complemented with the use of valid, reliable tools that are also feasible in the busy primary care setting. | Low quality (Sign) |
| 12 Bouman, Ans, et al. (Nelemans)"Effects of Intensive Home Visiting Programs for Older People with Poor Health Status: A Systematic Review." <i>BMC Health Services Research</i> , vol. 8, no. 1, 2008, p. 74. | Review | older people (65 and over) with poor health within the health care setting of Western countries | Home visiting programs | improving the health and independent functioning of older people. Also, they intend to reduce hospital and nursing home admission and associated cost. | | had no effect on the health status or service use of older people with poor health. also no differences were found between the intervention and control | home visiting programs appear not to be beneficial | Acceptable quality (SIGN) |

| | | | | | | | |
|---|-------------------------------------|---|--|---|---|--|---------------------|
| | | | | | group in mortality. | | |
| 166 Bouman, Ans, et al. (Ambergen) "Effects of a Home Visiting Program for Older People with Poor Health Status: A Randomized, Clinical Trial in the Netherlands." <i>Journal of the American Geriatrics Society (JAGS)</i> , vol. 56, no. 3, 2008, pp. 397–404. | Randomized, clinical trial. | Community-dwelling citizens in the Netherlands. Three hundred thirty people aged 70 to 84 | : Eight home visits, lasting 1 hour or more, with telephone follow-up, over an 18-month period, conducted by experienced home nurses under supervision of a public health nurse; key elements of the (systematic) visits were assessment of health problems and risks, advice, and referral to professional and community services | Self-rated health, functional status, quality of life, and changes in self-reported problems. | No differences were found between the intervention and control group in these and other outcome measures at the end of the intervention period (18 months) | By nurse but relevant for OT | High quality (SIGN) |
| 167 Mason, Suzanne, et al. "Effectiveness of Paramedic Practitioners in Attending 999 Calls from Elderly People in the Community: Cluster Randomised Controlled Trial." <i>BMJ</i> , vol. 335, no. 7626, 2007, pp. 919–922. | Cluster randomised controlled trial | s 3018 patients aged over 60 who called the emergency services | Presenting complaint Falls Lacerations Epistaxis Minor burns Foreign body in ear, nose, or throat Practical skills Local anaesthetic techniques Wound care and suturing techniques Principles of dressings and splintage Special skills Joint examination Examination of neurological, cardiovascular, and respiratory system Examination of ear, nose, and throat Protocol led dispensing: simple analgesia, antibiotics, tetanus toxoid Assessment of mobility and social needs Additional options for referral and requesting investigations Requests for radiography Referral processes: emergency department, general practitioner, district nurse, community social services | Emergency department attendance or hospital admission between 0 and 28 days; interval from time of call to time of discharge; patients' satisfaction with the service received. | patients in the intervention group were less likely to attend an emergency department or require hospital admission within 28 days and experienced a shorter total episode time. Patients in the intervention group were more likely to report being highly satisfied with their healthcare episode | Screening when calling emergency and referral | High quality (SIGN) |
| 182 Metzelthin, Silke F, et al. "The Psychometric Properties of Three | cross-sectional study | 687 community-dwelling older people (≥ 70 years). | three frailty instruments and the disability measure; Groningen Frailty Indicator (GFI), the Tilburg Frailty Indicator (TFI) and the Sherbrooke Postal | psychometric properties | (1) prevalence estimates of frailty ranged between 40.2% | Inclusion although design because of study of assessment, Screening frailty in Netherlands | Low quality (JBI) |

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|--|--|---|--|---|--|---|----------------------------|
| <p>Self-Report Screening Instruments for Identifying Frail Older People in the Community.” BMC Public Health, vol. 10, no. 1, 2010, p. 176.</p> | | | <p>Questionnaire (SPQ). And Groningen Activity Restriction Scale (GARS)</p> | | <p>(TFI), 46.3% (GFI) and 59.1% (SPQ); (2) the agreement in identifying frailty between the GFI and the TFI was satisfactory (kappa = 0.74) and the agreements between the SPQ and the GFI and the TFI, respectively, were much lower; (3) both the GFI and the TFI had high internal consistency in contrast to the SPQ; (4) the GFI and the TFI had better construct validity in comparison with the SPQ</p> | | |
| <p>191 Christian Kronborg, et al. “Cost Effectiveness of Preventive Home Visits to the Elderly: Economic Evaluation Alongside Randomized Controlled Study.” The European Journal of Health Economics,</p> | <p>Economic evaluation alongside a randomized controlled study</p> | <p>In 21 municipalities all 75- and 80-year old home-dwelling citizens were invited</p> | <p>preventive home visits by health visitors that focused on early signs of disability while respecting individual variation, and encouraging interdisciplinary, coordinated follow-up in the local setting.</p> | <p>standard geriatric assessment tools were introduced, and the health visitors were taught to interpret unexplained tiredness in daily activities as an early sign of disability that should alert the visitor to search</p> | <p>y. The study did not provide conclusive evidence on the cost effectiveness of the programs under consideration</p> | <p>Screening on tiredness, brief GA</p> | <p>High quality (SIGN)</p> |

| | | | | | | | |
|---|------------------------------|--------------|-----|---|--|---------------------------------------|---------------------------|
| vol. 7, no. 4, 2006, pp. 238–246. | | | | for the reason for such tiredness in the health, mental, or social domains | | | |
| 206 Fagerström, Lisbeth, et al. "An Integrative Research Review of Preventive Home Visits among Older People – Is an Individual Health Resource Perspective a Vision or a Reality?" Scandinavian Journal of Caring Sciences, vol. 23, no. 3, 2009, pp. 558–568. | systematic literature search | Older people | PHV | (i) activities during home visits: screening, observation and evaluation, guidance, support, referral to care and other services, follow-up and individual aim; (ii) positive effects: reduced mortality, improved ability to function, improved life quality, improved subjective health, fewer admittances for care, older people's experiences of home visits and increased knowledge on health and (iii) unclear/negative effects: admittance to care, no effect on mortality, unaffected ability to function, unaffected general health and uninfluenced life quality. | current research results imply that this method has a positive affect on older people's health and well-being. This form of care must still be developed to include extensive screenings and interventions, as well as a health resource perspective where the starting point during every home visit is the older person's individual needs and wishes. | PHV as screening Naar klin vraag 2, 4 | acceptable quality (SIGN) |

Literature matrix excluded articles

| reference | design | reasonexclusion |
|--|----------------------------|---|
| Mackenzie L, Clemson L, Irving D. Fall prevention in primary care using chronic disease management plans: A process evaluation of provider and consumer perspectives. <i>Aust Occup Ther J.</i> 2020 Feb;67(1):22-30. doi: 10.1111/1440-1630.12618. Epub 2019 Nov 3. PMID: 31682030. | Descriptive study | Geen inhoudelijke info omtrent detectie of doorverwijzing |
| Provencher, Véronique, et al. "Cooking Task Assessment in Frail Older Adults: Who Performed Better at Home and in the Clinic?" <i>Scandinavian Journal of Occupational Therapy</i> , vol. 20, no. 5, 2013, pp. 374–383. | Descriptive clinical trial | Geen inhoudelijke info omtrent detectie of doorverwijzing |
| Wressle, Ewa, et al. "Evaluation of Occupational Therapy Interventions for Elderly Patients in Swedish Acute Care: A Pilot Study." <i>Scandinavian Journal of Occupational Therapy</i> , vol. 13, no. 4, 2006, pp. 203–210. | CCT pilot study | Betreft interventie |
| 101 Barrett DL, Secic M, Borowske D. The Gatekeeper Program: proactive identification and case management of at-risk older adults prevents nursing home placement, saving healthcare dollars program evaluation. <i>Home Healthc Nurse.</i> 2010 Mar;28(3):191-7. doi: 10.1097/01.NHH.0000369772.41656.4e. PMID: 20308813. | Observational study | Level not achieved |

OTDBase

Literature matrix included articles

| référéncé | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|----------------------------|-------------------------|----------------|-----------------------------|---|--|----------------------------------|
| McIntyre, Anne, et al. Engagement of General Practitioners in Falls Prevention and Referral to | Descriptive study (survey) | People at risk of falls | Referral to OT | Frequency of referral to OT | 90% identified occupational therapists as providing | There are gaps in general practitioners' falls prevention referral practices | Low level of evidence (JBI tool) |

| | | | | | | | |
|---|-----------------------------------|--|-------------------|---|--|--|---|
| <p>Occupational Therapists. The British Journal of Occupational Therapy, vol. 82, no. 2, 2018, pp. 71–79.</p> | | | | | <p>evidence-based falls prevention.</p> <p>74% of the GP's referred to occupational therapy</p> <p>Study in England</p> | <p>to occupational therapists and allied health professionals. Better general practitioner pathways could enhance the quality of falls-prevention care for older people at risk</p> <p>Once an older person is identified as being at risk of falling by a GP, it appears that in-depth assessments would be carried out 'in-house'.</p> | |
| <p>Donnelly, Catherine A, et al. The Emerging Role of Occupational Therapy in Primary Care. Canadian Journal of Occupational Therapy, vol. 81, no. 1, 2014, pp. 51–61.</p> | <p>multiple case study design</p> | <p>a wide range of client populations: Older adults and individuals with complex chronic conditions are two prominent areas of occupational therapy focus.</p> | <p>Role of OT</p> | <p>to describe the emerging role of occupational therapy in Family Health Teams, a model of interprofessional primary care.</p> | <p>Understanding the impact of health conditions on daily function and enabling participation in activities are unique and important contributions of occupational therapy</p> | <p>When occupational therapy is situated in primary care, there is enhanced access to occupational therapy services, particularly for individuals who might not otherwise have had access.</p> | <p>Low level of evidence (JBI tool)</p> |

Literature matrix excluded articles

| reference | design | reason exclusion | Achtergrond? |
|--|----------------------------|---|---|
| Mackenzie L, Clemson L, Irving D. Fall prevention in primary care using chronic disease management plans: A process evaluation of provider and consumer perspectives. <i>Aust Occup Ther J.</i> 2020 Feb;67(1):22-30. doi: 10.1111/1440-1630.12618. Epub 2019 Nov 3. PMID: 31682030. | Descriptive study | Geen inhoudelijke info omtrent detectie of doorverwijzing | Integrated processes and pathways to identify older people at risk of falls are needed to engage a whole of primary care approach to fall prevention. This will need to involve change in the current fall management practices of GPs and the up-skilling of AHPs in using evidence-based tools and interventions. |
| Provencher, Véronique, et al. "Cooking Task Assessment in Frail Older Adults: Who Performed Better at Home and in the Clinic?" <i>Scandinavian Journal of Occupational Therapy</i> , vol. 20, no. 5, 2013, pp. 374–383. | Descriptive clinical trial | Geen inhoudelijke info omtrent detectie of doorverwijzing | Not relevant |
| Wressle, Ewa, et al. "Evaluation of Occupational Therapy Interventions for Elderly Patients in Swedish Acute Care: A Pilot Study." <i>Scandinavian Journal of Occupational Therapy</i> , vol. 13, no. 4, 2006, pp. 203–210. | CCT pilot study | Betreft interventie | Wrong design |

Cinahl

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|

| Q 1a | | | | | | | |
|---|---|--|---|--|---|---|----------------------------|
| <p>12 Apóstolo J, Cooke R, Bobrowicz-Campos E, Santana S, Marcucci M, Cano A, Vollenbroek-Hutten M, Germini F, Holland C. Predicting risk and outcomes for frail older adults: an umbrella review of frailty screening tools. JBI Database System Rev Implement Rep. 2017 Apr;15(4):1154-1208. doi: 10.11124/JBISRIR-2016-003018. PMID: 28398987; PMCID: PMC5457829.</p> | <p>Umbrella review (quantitative systematic review)</p> | <p>Frail older people (community, hospital and long-term residential care)</p> | <p>Including sys rev on reliability, validity, diagnostic accuracy and predictive ability</p> | <p>Frailty screening tools</p> | <p>Frailty Index and a few other measures are valid, reliable and diagnostically accurate and have good predictive ability</p> | <p>Frailty index sufficiently accurate to predict increased risk of recurrent falls and recurrent fractures, decline in activities of daily living, changes in mental score, new disease and change in hospitalization and institutionalization at 12 months after evaluation and mortality at 12, 124 &ne 120 months after evaluation. FI also sufficient to predict increased risk of multiple negative outcomes Tilburg Frailty indicator statistically robust (P<0.001) for QoL, autonomy and resorting care.</p> | <p>High quality (SIGN)</p> |
| <p>van Kempen JA, Melis RJ, Perry M, Schers HJ, Rikkert MG. Diagnosis of frailty after a Comprehensive Geriatric Assessment: differences between family physicians and geriatricians. J Am Board Fam Med. 2015 Mar-Apr;28(2):240-8. doi:</p> | <p>explorative observational study</p> | <p>People 70 years and older</p> | <p>Detection of frailty</p> | <p>Compare outcomes of comprehensive geriatric assessment by family physicians and geriatricians</p> | <p>Geriatricians more often judge patients as frail compared with family physicians and seem to evaluate the available information differently. With increasing collaboration between primary</p> | <p>GP: EASY-Care Two-step Older persons Screening (EASY-Care-TOS13; Online Appendix Figure 1) is a 2-step method developed for use in primary care.</p> | <p>Acceptable (JBI)</p> |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| <p>10.3122/jabfm.2015.02.130081. PMID: 25748765.</p> | | | | | <p>and secondary care, understanding these differences becomes increasingly relevant</p> | <p>Geriatrician: This assessment consisted of an interview and medical examination by a hospital geriatrician and an interview with the geriatric nurse and additional tests for cognition, mental wellbeing, physical functioning, (I)ADL functioning, and mobility (Cumulative Illness Rating Scale for Geriatrics,16 Mini Mental State Examination,17 Katz-15 (I)ADL scale,18 Short Physical Performance Battery,19 Geriatric Depression Scale,20,21 and Hospital Anxiety and Depression Scale-A22)</p> | |
| <p>Q 1b</p> | | | | | | | |
| <p>/</p> | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusieon |
|--|---------------------------------|--|
| Q 1a | | |
| Rougé Bugat ME, Cestac P, Oustric S, Vellas B, Nourhashemi F. Detecting frailty in primary care: a major challenge for primary care physicians. J Am Med Dir Assoc. 2012 Oct;13(8):669-72. doi: 10.1016/j.jamda.2012.07.015. Epub 2012 Sep 7. PMID: 22959605. | Editorial | Editorial |
| van Kempen JA, Melis RJ, Perry M, Schers HJ, Rikkert MG. Diagnosis of frailty after a Comprehensive Geriatric Assessment: differences between family physicians and geriatricians. J Am Board Fam Med. 2015 Mar-Apr;28(2):240-8. doi: 10.3122/jabfm.2015.02.130081. PMID: 25748765. | explorative observational study | Geen inhoudelijk bruikbare informatie mbt detectie |
| Jaafar,MH; Mat S; Mackenzie L; Tan MP, Perceptions of Family Physicians About Fall Risk Screening, Fall Risk Assessment, and Referral Practices for Fall Prevention in Malaysia (2020) Topics in Geriatric Rehabilitation. 36(1) 38-43 | Cross sectional survey | Betreft specifieke situatie in Maleisië |
| Q 1b | | |
| Ringberg U, Fleten N, Deraas TS, Hasvold T, Førde O. High referral rates to secondary care by general practitioners in Norway are associated with GPs' gender and specialist qualifications in family medicine, a study of 4350 consultations. BMC Health Serv Res. 2013;13:147. Published 2013 Apr 23. doi:10.1186/1472-6963-13-147 | Observational study | Volwassen populatie; verwijzing naar tweede lijn |

4.1.4 Évaluation critique des articles retenus

Voir annexe 5.4

4.1.5 Attribution du GRADE

Voir annexe 5.5

4.2 Question clinique 2

La vague clinique se lit comme suit :

Quelle évaluation multifactorielle de l'ergothérapie est appropriée pour la personne âgée physiquement fragile vivant à domicile et/ou son contexte ?

4.2.1 Stratégie de recherche de concepts

2a focus personne âgée

2b focus contexte social/fournisseur de soins

2c focus contexte physique

| | Description | Pool de termes de recherche |
|------------|--|--|
| P a | Personne âgée | "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] |
| P b | Contexte social/soignant | "Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Social Networking"[MeSH] OR "Friends"[MeSH] OR "Family"[MeSH] OR "Caregivers"[MeSH] |
| P c | Contexte physique | "Housing for the elderly" [Mesh] OR "Environment Design"[Mesh] OR "Built Environment"[Mesh] OR "Environment"[Mesh] OR "Environment, Controlled"[Mesh] OR "home" OR "house" |
| I | Évaluation multifactorielle de l'ergothérapie | "Disability Evaluation"[Mesh] OR "Geriatric Assessment"[Mesh] OR "Clinical Decision-Making"[Mesh] OR "Diagnostic Self Evaluation"[Mesh] OR "Patient Health Questionnaire"[Mesh] OR "Needs assessment" [Mesh] OR "Patient outcome assessment"[Mesh] OR "Self-Assessment"[Mesh] OR "Patient acuity"[Mesh] OR "Treatment Outcome"[Mesh] OR "House calls"[Mesh] AND "Occupational Therapy"[Mesh] |
| C | / | |
| O a | Inventorier les obstacles et les capacités de la personne âgée | "Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR |

| | | |
|------------|--|--|
| | | "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling" |
| O b | Identifier les obstacles et les opportunités du contexte social | "Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "Physical Functional Performance"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge" |
| O c | Inventorier les obstacles et les opportunités du contexte physique | "Activities of Daily Living"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "patient compliance"[Mesh] OR "occupational performance" OR "accidental falls" OR "Safety"[Mesh] |

Bases de données consultées :

Base de données Cochrane des revues systématiques, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Critères d'inclusion méthodologiques

- Conception : revues systématiques et méta-analyses, essais contrôlés randomisés, études d'observation et études qualitatives.
- Qualité méthodologique suffisante mesurée à l'aide de l'outil d'évaluation critique SIGN ; si aucun outil d'évaluation critique SIGN n'est disponible pour le modèle en question : outil d'évaluation critique JBI.
- Période de recherche : de la base de données au 30 juin 2022

Critères d'inclusion et d'exclusion du contenu :

Inclusion :

- la personne âgée physiquement fragile et/ou l'aidant informel
- évaluation de l'ergothérapie ou évaluation du fonctionnement/de l'importance ou de la participation sociale dans le cadre des soins primaires ou en fonction du retour aux soins primaires
- les deux instruments d'évaluation, les batteries d'évaluation et les procédures d'évaluation
- évaluation du cadre de vie

Exclusion :

Évaluation dans le contexte d'une démence ou d'une altération manifeste des fonctions cognitives

Chaînes de recherche par base de données

Pubmed

String a

("Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH])

AND

("Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Caregivers"[MeSH])

AND

"Geriatric Assessment"[Mesh]

AND

("Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh])

String b

("Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH])

AND

("Housing for the elderly" [Mesh] OR "Environment Design"[Mesh] OR "Built Environment"[Mesh] OR "Environment"[Mesh] OR "Environment, Controlled"[Mesh] OR "home" OR "house")

AND

"Geriatric Assessment"[Mesh]

AND

("Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "Physical Functional Performance"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge")

String c

("Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH])

AND

("Disability Evaluation"[Mesh] OR "Geriatric Assessment"[Mesh] OR "Clinical Decision-Making"[Mesh] OR "Diagnostic Self Evaluation"[Mesh] OR "Patient Health Questionnaire"[Mesh] OR "Needs assessment" [Mesh] OR "Patient outcome assessment"[Mesh] OR "Self-Assessment"[Mesh] OR "Patient acuity"[Mesh] OR "Treatment Outcome"[Mesh] OR "House calls"[Mesh])

AND

"Occupational Therapy"[Mesh]

AND

("Activities of Daily Living"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "patient compliance"[Mesh] OR "occupational performance" OR "accidental falls" OR "Safety"[Mesh])

Cochrane

String a

([mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty])

AND

([mh "Social Environment"] OR [mh "Social Support"] OR [mh "Caregivers"])

AND

[mh "Geriatric Assessment"]

AND

([mh "Activities of Daily Living"] OR [mh Self-Management] OR [mh "Physical Functional Performance"] OR [mh "Social Participation"])

String b

([mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty])

AND

([mh "Housing for the elderly"] OR [mh "Environment Design"] OR [mh "Built Environment"] OR [mh Environment] OR [mh "Environment, Controlled"] OR home OR house)

AND

[mh "Geriatric Assessment"]

AND

([mh Workload] OR [mh "Psychological Burnout"] OR [mh "Social Support"] OR [mh "Social Capital"] OR [mh "Respite Care"] OR [mh "Stress, Psychological"] OR [mh "Adaptation, Psychological"] OR [mh "Sense of Coherence"] OR [mh "Physical Functional Performance"] OR "caregiver burden" OR "caregivers burden" OR overload OR overcharge)

String c

([mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty])

AND

([mh "Disability Evaluation"] OR [mh "Geriatric Assessment"] OR [mh "Clinical Decision-Making"] OR [mh "Diagnostic Self Evaluation"] OR [mh "Patient Health Questionnaire"] OR [mh "Needs assessment"] OR [mh "Patient outcome assessment"] OR [mh Self-Assessment] OR [mh "Patient acuity"] OR [mh "Treatment Outcome"] OR [mh "House calls"])

AND

[mh "Geriatric Assessment"]

AND

[mh "Occupational Therapy"]

AND

([mh "Activities of Daily Living"] OR [mh "Physical Functional Performance"] OR [mh "Community Integration"] OR [mh "Community Participation"] OR [mh "Social Integration"] OR [mh "Human Activities"] OR [mh "Healthy Lifestyle"] OR [mh "Quality of Life"] OR [mh "Sense of Coherence"] OR [mh "Quality-Adjusted Life Years"] OR [mh "Leisure Activities"] OR [mh "patient compliance"] OR "occupational performance" OR "accidental falls" OR [mh Safety])

Cinahl (via Ebsco)

String a

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+))

AND

((MH "Social Environment"+) OR (MH "'Social Support''"+) OR (MH "Caregivers''+))

AND

(MH "Geriatric Assessment"+)

AND

((MH "Activities of Daily Living"+) OR (MH Self-Management+) OR (MH "Physical Functional Performance"+) OR (MH "Social Participation"+))

String b

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+))

AND

((MH "Housing for the elderly"+) OR (MH "Environment Design"+) OR (MH "Built Environment"+) OR (MH Environment+) OR (MH "Environment, Controlled"+) OR home OR house)

AND

(MH "Geriatric Assessment"+)

AND

((MH Workload+) OR (MH "Psychological Burnout"+) OR (MH "Social Support"+) OR (MH "Social Capital"+) OR (MH "Respite Care"+) OR (MH "Stress, Psychological"+) OR (MH "Adaptation, Psychological"+) OR (MH "Sense of Coherence"+) OR (MH "Physical Functional Performance"+) OR "caregiver burden" OR "caregivers burden" OR overload OR overcharge)

String c

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+))

AND

((MH "Disability Evaluation"+) OR (MH "Geriatric Assessment"+) OR (MH "Clinical Decision-Making"+) OR (MH "Diagnostic Self Evaluation"+) OR (MH "Patient Health Questionnaire"+) OR (MH "Needs assessment"+) OR (MH "Patient outcome assessment"+) OR (MH Self-Assessment+) OR (MH "Patient acuity"+) OR (MH "Treatment Outcome"+) OR (MH "House calls"+))

AND

(MH "Occupational Therapy"+)

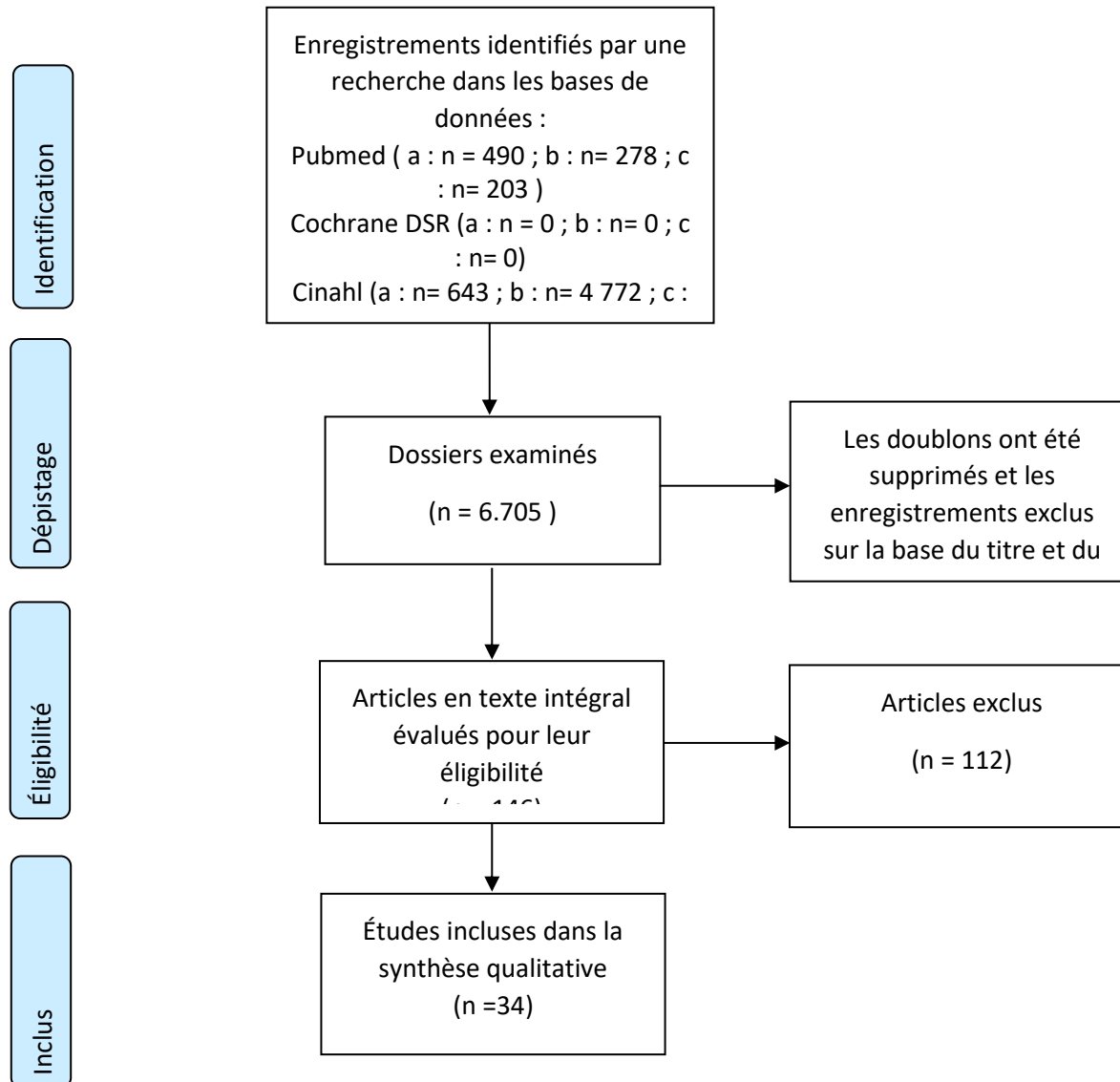
AND

((MH "Activities of Daily Living"+) OR (MH "Physical Functional Performance"+) OR (MH "Community Integration"+) OR (MH "Community Participation"+)
OR (MH "Social Integration"+) OR (MH "Human Activities"+) OR (MH "Healthy Lifestyle"+) OR (MH "Quality of Life"+) OR (MH "Sense of Coherence"+) OR
(MH "Quality-Adjusted Life Years"+) OR (MH "Leisure Activities"+) OR (MH "patient compliance"+) OR "occupational performance" OR "accidental falls" OR
(MH Safety+))

OTDBase

("frail elderly" AND "primary care") OR ("frailty" and "primary care")

4.2.2 Résultats identifiés



4.2.3 Question 2 de la matrice bibliographique

Cochrane database of systematic review

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|-----------|--------|------------------|
| / | | |

Pubmed

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|----------------------|--------------|-----------------------------|-----------------------|---|--|-------------------|
| 119 a Dickerson AE, Meuel DB, Ridenour CD, Cooper K. Assessment tools predicting fitness to drive in older adults: a systematic review. Am J Occup Ther. 2014 Nov- | Sys rev | Older adults | Assessment fitness to drive | Valid ass instruments | Assess tool cognition, vision, perceptual, motor, | Incl | Acceptable (SIGN) |

| | | | | | | | |
|--|--------------------------------------|---------------------------------|--|---|--|-----------|--------------------------|
| Dec;68(6):670-80. doi: 10.5014/ajot.2014.011833. PMID: 25397762. | | | | | simulation, screening batteries | | |
| 130 Andreassen M, Öhman A, Larsson Ranada Å. Assessing occupational performance in special housing in Sweden. Scand J Occup Ther. 2018 Nov;25(6):428-435. doi: 10.1080/11038128.2017.1367415. Epub 2017 Aug 23. PMID: 28830285. | Descriptive study cross sectional | Occupational therapists | Assessment of methods to assess occupational performance in elderly clients living in special housing in community | use and perceptions of different methods to assess occupational performance for elderly clients living in special housing | showed that OTs regularly assessed occupational performance but did not use standardized assessment instruments or structured methods to any great extent. In general, OTs reported that they were not pleased with their ability to assess their clients; however, OTs with higher education and with responsibility for fewer clients were more pleased with their assessments and stated that they had more knowledge about assessment methods. | Incl | Acceptable quality (JBI) |
| 139 Mallinson, Trudy, et al. "Development and Validation of the Activity Significance Personal Evaluation (ASPEn) Scale." Australian Occupational Therapy Journal, vol. 61, no. 6, 2014, pp. 384–393. | Descriptive study – test development | Community dwelling older adults | Developing assessment Activity significant personal evaluation (ASPEn) | Meaning of older adult's activity over time (contribution to health and wellness) | 13-item scale forms a unidimensional hierarchy with good fit statistics and targeting. Person separation reliability (2.7) and internal consistency (.91) indicates the tool is appropriate for individual person | Inclusion | Acceptable quality (JBI) |

| | | | | | | | |
|--|-------------------------------|---|---|--|--|---|---------------------|
| | | | | | measurement. Relative validity indicates equivalence between Rasch measures and total raw scores. | | |
| 143 Wales K, Clemson L, Lannin N, Cameron I. Functional Assessments Used by Occupational Therapists with Older Adults at Risk of Activity and Participation Limitations: A Systematic Review. PLoS One. 2016 Feb 9;11(2):e0147980. doi: 10.1371/journal.pone.0147980. PMID: 26859678; PMCID: PMC4747506. | Syst rev | Older adults at risk of activity and participation limitations | Assessment instruments | Risk of activity and participation limitations | SMAF and AMPS deems to be responsive to change. Use functional assessments that have been validated with their population and in their settings. | incl | Acceptable (SIGN) |
| 309 Frese, Thomas, et al. "In-Home Preventive Comprehensive Geriatric Assessment (CGA) Reduces Mortality—A Randomized Controlled Trial." Archives of Gerontology and Geriatrics, vol. 55, no. 3, 2012, pp. 639–644. | a randomized controlled trial | 1620 community-living persons aged 70 years and older (n = 630 intervention; 990 controls) from 20 general practitioner surgeries | preventive in-home CGA by trained medical students STEP assessment (Sandholzer et al., 2004) and each of the following additional tests: Barthel-Index (Mahoney & Barthel, 1965), Lambeth-disability screening questionnaire (McDowell, Martini, & | mortality and time able to stay in the community | evidence that a preventive in-home CGA is effective: mortality was reduced and older persons lived longer in their familiar environment | STEP tool as screening by OT? What is effective component? | High quality (Sign) |

| | | | | | | | |
|---|--------------|-------------------------|--|--|--|---|--------------------------|
| | | | <p>Waugh, 1978), Tinetti-gait score (Tinetti, 1986), Hamilton Depression Rating Scale (Hamilton, 1960), Hospital anxiety and depression scale (Zigmond & Snaith, 1983), Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975), Hierarchic Dementia Scale (Cole & Dastoor, 1996), clock drawing test (Sunderland et al., 1989; Watson, Arfken, & Birge, 1993) and COOP-Charts (Nelson et al., 1987).</p> | | | | |
| <p>Donnelly, C., O'Neill, C., Bauer, M., & Letts, L. (2017). Canadian Occupational Performance Measure (COPM) in primary care: A profile of practice. American Journal of Occupational Therapy, 71, 7106265010. https://doi.org/.</p> | Mixed method | clients in primary care | not applicable | frequency of goals mentioned at COPM, scores at COPM | The COPM is an valuable tool to guide initial assesments and | COPM can be used by OT's in primary care to measure | acceptable quality (JBI) |

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|---------------------------|
| | | | | | offer an occupational focused lens. | occupational performance. | |
| Fischl, C., Blusi, M., Lindgren, H., & Nilsson, I. (2020). Tailoring to support digital technology-mediated occupational engagement for older adults—a multiple case study. <i>Scandinavian Journal of Occupational Therapy, 27(8)</i>, 577–590. https://doi.org/10.1080/11038128.2020.1760347 | multiple case study methodology. | Older adults | Digital technology-mediated occupational therapy | Engagement in digital technology | The collaborative process followed a general structure – assessment and planning, intervention, and follow-up – to pursue participant-determined occupation-based goals involving DTs | | Acceptable quality (JBI) |
| Harper KJ, Llewellyn K, Jacques A, Ingram K, Pearson S, Barton A. Kettle test efficacy in predicting cognitive and functional outcomes in geriatric rehabilitation. <i>Aust Occup Ther J. 2019 Apr</i>;66(2):219-226. doi: 10.1111/1440-1630.12540. Epub 2018 Oct 9. PMID: 30298936. | cohort study | subacute rehabilitation setting - 97 patients | Mini-Mental State Examination (MMSE), Cognitive Functional Independence Measure (Cognitive FIM) and the Kettle Test | correlation between these three cognitive tests and efficacy of these tests in predicting functional outcomes via the motor subscale of the Functional Independence Measure (mFIM). | Correlation coefficients between the tests were statistically significant and moderately strong, with values ranging from 0.593 to -0.589. When adjusted for age and gender the MMSE and Cognitive FIM both explained the 47% of the variance at discharge. | de Kettle Test een valide assessmentinstrument is om te screenen op cognitieve en het functioneren bij oudere personen. | acceptable quality (SIGN) |
| Hwang, J. E. (2010). Promoting healthy lifestyles with aging: Development and validation of the Health Enhancement Lifestyle Profile (HELP) using the Rasch measurement model. <i>American Journal of Occupational Therapy, 64</i>, 786–795. doi: 10.5014/ajot.2010.09088. | test accuracy/development study | 253 community-dwelling older adults | analyses of principal components of residuals, fit statistics, local dependency, and differential | develop and validate the Health Enhancement Lifestyle Profile (HELP), | The item hierarchy formed through logits provided an expected pattern of healthy lifestyle behaviors. Acceptable to good person separation and reliability | HELP can assist in monitoring lifestyle risk factors and measuring the outcome of services aimed at promoting healthy lifestyles among older adults. | acceptable |

| | | | | | | | |
|---|----------------------|--|---|---|---|---|---------------------------|
| | | | item functioning. | | statistics supported the clinical applicability and consistency of the HELP scores. Finally, analysis of the rating scale structure confirmed the functioning of the 0- to 5-point rating scale used. | | |
| Mackenzie, Lynette & Clifford, Amanda. (2018). Perceptions of primary health staff about falls prevention in primary care settings in the west of Ireland. British Journal of Occupational Therapy. 81. 030802261876175. 10.1177/0308022618761759. | qualitative research | Three general practitioners, five occupational therapists and three physiotherapists from primary care teams | not applicable | perceptions of general practitioners, occupational therapists and physiotherapists working in the primary care setting about falls prevention in their practice | Two key themes emerged from the data: the level of primary care team integration and the nature of community fall prevention, linked by referral mechanisms | Providing comprehensive falls prevention services in the primary care context is complex. Integrated pathways in primary care teams are needed to identify older people at risk of falls and to engage a whole of primary care approach to fall prevention. | acceptable quality (JBI) |
| Pighills AC, Torgerson DJ, Sheldon TA, Drummond AE, Bland JM. Environmental assessment and modification to prevent falls in older people. J Am Geriatr Soc. 2011 Jan;59(1):26-33. doi: 10.1111/j.1532-5415.2010.03221.x. Erratum in: J Am Geriatr Soc. 2011 Apr;59(4):776. PMID: 21226674. | RCT | Two hundred thirty-eight community dwelling adults aged 70 and older with a history of falls in the previous year. | Assessment and modification of the home environment of people at greater risk of falls. | Fear of falling | The intervention had no effect on fear of falling (P5.63). The occupational therapy group had significantly fewer falls than controls 12 months after the assessment | Environmental assessment prescribed by an occupational therapist significantly reduced the number of falls in high-risk individuals whereas that prescribed by a | acceptable quality (SIGN) |

| | | | | | | | |
|--|--|---|---|--|---|---------------------------|--------------------------|
| | | | | | (incidence rate ratio (IRR)50.54, 95% confidence interval (CI)50.36–0.83, P5.005). | trained assessor did not. | |
| 209 Brown CL, Finlayson ML. Performance measures rather than self-report measures of functional status predict home care use in community-dwelling older adults. <i>Can J Occup Ther.</i> 2013 Dec;80(5):284-94. doi: 10.1177/0008417413501467. PMID: 24640643. | Diagnostic study retrospective data analysis | Elderly home based people (N=170) | Analysis of reports on self reported functional capacity, self reported functional use behaviour and PASS | Predictive ability to receive information about home care service requirements | Standardized performance measures are more predictive of formal HC us than self-reported measures | Incl | Acceptable (JBI) |
| 210 Tomita MR, Saharan S, Rajendran S, Nochajski SM, Schweitzer JA. Psychometrics of the Home Safety Self-Assessment Tool (HSSAT) to prevent falls in community-dwelling older adults. <i>Am J Occup Ther.</i> 2014 Nov-Dec;68(6):711-8. doi: 10.5014/ajot.2014.010801. PMID: 25397766. | Diagnostic test, mixed method | (N=26; 34; 104) community dwelling older adults | HSSAT Testing of all psychometric criteria | Predict falls | Instrument to detect fall risks Educational material leading to improvement home safety | Inclusion | Acceptable (JBI) |
| 228 Belchior P, Korner-Bitensky N, Holmes M, Robert A. Identification and assessment of functional performance in mild cognitive impairment: a survey of occupational therapy practices. <i>Aust Occup Ther J.</i> 2015 Jun;62(3):187-96. doi: 10.1111/1440-1630.12201. Epub 2015 May 7. PMID: 25950462. | Descriptive study (survey) | Older adults | OT's practice with potential MCI | Pointing the functional changes in people with MCI | No consensus | Excl due to other purpose | Acceptable (JBI) |
| 251 b Dickerson AE, Bédard M. Decision tool for clients with medical issues: a framework for identifying driving risk and potential to return to driving. <i>Occup Ther Health Care.</i> 2014 Apr;28(2):194-202. doi: 10.3109/07380577.2014.903357. PMID: 24754770. | Descriptive framework | Older adults | Clinical judgment tool | Identifying driving risk and potential to return to driving | Overview of the developed framework | Inclusion as background | Acceptable quality (JBI) |
| 269 c Dickerson AE. Screening and assessment tools for determining fitness to drive: a review of the literature for the pathways project. <i>Occup Ther Health Care.</i> 2014 Apr;28(2):82-121. doi: 10.3109/07380577.2014.904535. PMID: 24754758. | Literature review | Older adults | Screening fitness to drive | Fitness of risk to drive | Overview of assessment tools fitness to drive | inclusion | Low quality (SIGN) - |
| 276 Stewart S, Harvey I, Poland F, Lloyd-Smith W, Mugford M, Flood C. Are occupational therapists more effective than social workers when assessing frail older people? Results of | RCT | Frail older adults | Assessment frail older people by OT | Effectiveness of OT led or soc worker-led assessment | No difference in assessment Reasons are given | inclusion | Acceptable (SIGN) |

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| <p>CAMELOT, a randomised controlled trial. Age Ageing. 2005 Jan;34(1):41-6. doi: 10.1093/ageing/afh230. Epub 2004 Nov 3. PMID: 15525654.</p> | | | and soc workers | | | | |
| <p>280 Clemson L, Bundy AC, Cumming RG, Kay L, Lockett T. Validating the Falls Behavioural (FaB) scale for older people: a Rasch analysis. Disabil Rehabil. 2008;30(7):498-06. doi: 10.1080/09638280701355546. PMID: 17852314.</p> | Diagnostic study | Community residing older people (65-98 year) (N=678) | FAB (falls behaviour scale) | Validation and reliability, usefulness in clinical situations | 29-item partial rating scale is valid, reliable and useful Short form useful alternate for evaluating effectiveness of fall reduction interventions | Inclusion | Acceptable quality (JBI) |
| <p>30 Maggi P, de Almeida Mello J, Delye S, Cès S, Macq J, Gosset C, Declercq A. Fall determinants and home modifications by occupational therapists to prevent falls: Facteurs déterminants des chutes et modifications du domicile effectuées par les ergothérapeutes pour prévenir les chutes. Can J Occup Ther. 2018 Feb;85(1):79-87. doi: 10.1177/0008417417714284. PMID: 29506411.</p> | Longitudinal study | At least 65 years old and frail | (a) only occupational therapy at home based on home modifications and advice about assistive devices. (b) home modifications by an occupational therapist, advice about assistive devices, and coordination of care ensured by a case manager (c) no home modifications or advice about | Risk factors for falls of frail older persons living in the community who have not had a previous fall Impact on fall incidence of interventions offering home modifications and advice by occupational therapists with and without case management | The intervention of an occupational therapist to prevent falls seems to be efficient in the first 6 months after baseline with the use of a home modification process; older persons receiving home modifications provided by an occupational therapist had a lower chance of falling in the next 6 months (OR = 0.46) when compared to people in the control group; similar results for interventions combining case management and home modifications | Incl interRAI HC | High quality (JBI) |

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| | | | assistive device | | | | |
| 352 Unsworth CA. Using social judgment theory to study occupational therapists' use of information when making driver licensing recommendations for older and functionally impaired adults. Am J Occup Ther. 2007 Sep-Oct;61(5):493-502. doi: 10.5014/ajot.61.5.493. PMID: 17944286. | Descriptive (survey) | Older and functional impaired people | Social judgment theory framework | Informal cues OT's make when making driver licensing recommendations | 4 important cues: driving instructor interventions, driver behavior, cognitive and perceptual skills | Incl | Acceptable quality (JBI) |
| 466 Wyller TB, Sveen U, Bautz-Holter E. The Barthel ADL index one year after stroke: comparison between relatives' and occupational therapist's scores. Age Ageing. 1995 Sep;24(5):398-401. doi: 10.1093/ageing/24.5.398. PMID: 8669342. | Diagnostic study | Geriatric patients, stroke patients, patients with hip fracture | Barthel Index | Validity Barthel index different populations | Barthel ADL index to characterize geriatric patients and patients with hip fracture does not sufficiently take into account the complex factor structure of the index. | Incl | Low quality (JBI) - exclusive |
| 76 Giambelluca E, Panigazzi M, Saade A, Imbriani M. Assessment of functional status and rehabilitative strategies in occupational therapy: role of the Groningen Activity Restriction Questionnaire. G Ital Med Lav Ergon. 2019 Mar;41(1):52-57. PMID: 30946549. | Diagnostic study | Adult patients | GARS = instrument for measuring disability (IT) | effectiveness | GARS effective for measuring disability in ADL and IADL, can help clinicians to develop a customized plan of care in OT, improving patient's management and clinical outcome. | Incl | Acceptable (JBI) |
| 87 Bédard M, Dickerson AE; National Highway Traffic Safety Administration; American Occupational Therapy Association. Consensus statements for screening and assessment tools. Occup Ther Health Care. 2014 Apr;28(2):127-31. doi: 10.3109/07380577.2014.903017. PMID: 24754760. | Descriptive study (qualitative; vision) – text/opinion | | Fitness to drive | | | Statements might be helpful also to frame the recommendations | Acceptable (JBI) |

Literature matrix included articles (search string Cosmin)

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
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| 246 Dickerson AE, Reistetter T, Davis ES, Monahan M. Evaluating driving as a valued instrumental activity of daily living. Am J Occup Ther. 2011 Jan-Feb;65(1):64-75. doi: 10.5014/ajot.2011.09052. PMID: 21309373. | Cross sectional study | N= 61 (13 community living older adults; 22 neurological disorders, 5 cognitive issues) | Comparing performance of complex instrumental activities of daily living (IADLs) and a behind-the wheel driving (BTW) assessment | general practice occupational therapists have the skills and knowledge to address driving as a valued occupation using an algorithm based on the Occupational Therapy Practice Framework: Domain and Process | A significant relationship was found between the process skills from the performance assessment and whether the driver passed, failed, or needed restrictions as indicated by the behind-the-wheel assessment. T | occupational therapists using observational performance evaluation of IADLs can assist in determining who might be an at-risk driver. | Low quality (JBI) |
| 263 Enemark Larsen, Anette, and Carlsson, Gunilla. "Utility of the Canadian Occupational Performance Measure as an Admission and Outcome Measure in Interdisciplinary Community-Based Geriatric Rehabilitation." Scandinavian Journal of Occupational Therapy, vol. 19, no. 2, 2012, pp. 204–213. | Pre-post study | N= 195 Elderly citizen (PP 95) | OT rehabilitation | to evaluate the utility of the COPM as an admission and outcome measure in an interdisciplinary geriatric rehabilitation context in Denmark | the Danish version of the COPM may be useful as an admission and outcome measurement for the rehabilitation of elderly citizens of Copenhagen living at home. It can assist in uncovering client perceptions and expectations of their occupational performance, providing occupational therapists and physiotherapists with a better understanding of the participants' problems in their everyday lives and thereby a more focused rehabilitation. However, aspects of education and administration must be considered before the instrument can be administered in an interdisciplinary | COPM can assist in uncovering client perceptions and expectations of their occupational performance, providing occupational therapists and physiotherapists with a better understanding of the participants' problems in their everyday lives | High quality (JBI) |

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| | | | | | geriatric rehabilitation context. | | |
| 281 Tomita, Machiko R, et al. "Psychometrics of the Home Safety Self-Assessment Tool (HSSAT) to Prevent Falls in Community-Dwelling Older Adults." <i>The American Journal of Occupational Therapy</i> , vol. 68, no. 6, 2014, pp. 711–718. | Clinimetric study, mixed method | Test–Retest (n = 26) Construct Validity (n = 34) Responsiveness (n = 104) | To identify psychometric properties of the Home Safety Self-Assessment Tool (HSSAT) to prevent falls | tested psychometrics for the HSSAT for content validity, test–retest reliability, interrater reliability, construct validity, and responsiveness to change. | The content validity index was .98, the intraclass correlation coefficient for test–retest reliability was .97, and the interrater reliability was .89. The difference on identified risk factors between the use and nonuse of the HSSAT was significant (p < .005). Convergent validity with the Centers for Disease Control and Prevention Home Safety Checklist was high (r = .65), and discriminant validity with fear of falling was very low (r = .10). The responsiveness to change was moderate (standardized response mean = 0.57) | The results of this study have the following implications for occupational therapy practice: • Occupational therapists can use the HSSAT with confidence to assess home hazards to prevent falls. • Use of the HSSAT raises older adults' awareness of safety hazards in their home environment by returning locus of control to residents when identifying environmental hazards and plans for correction within their home and providing an opportunity to analyze the activity and environment interface for safe engagement in home-based occupations • The HSSAT can be used with older adult populations | Acceptable (JBI) |

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| | | | | | | where the occupational therapist is a consultant to a medical, nonmedical, or social service agency in a community setting to prevent falls | |
| 304 Véronique Provencher, Louise Demers, Isabelle Gélinas & Francine Giroux (2013) Cooking task assessment in frail older adults: who performed better at home and in the clinic?, Scandinavian Journal of Occupational Therapy, 20:5, 374-383, DOI: 10.3109/11038128.2012.743586 | Diagnostic study | 37 older adults prior to discharge Inclusion: (a) be 65 years or older; (b) have preserved cognitive functions based on clinical judgment; (c) meet three or more of the following five frailty criteria, as described by Fried and colleagues [(1), page 148]: 1 – unintentional weight loss; 2 – reduced grip strength, 3 – exhaustion, 4 – slow walking speed (based on a three-meter walk in our study (12)), and 5 – low physical activity; (d) consider | Cooking task | determine: (i) the proportion of frail older adults who demonstrate (a) statistically significant and (b) clinically meaningful differences between home and clinic cooking task performance; and (ii) factors associated with a better performance in each environment. | Thirty-three participants were retained for analysis. A statistically significant difference ($> \pm 2$ standard errors of measurement) between environments was found in 33% of the participants on the motor scale and the same proportion on the process scale. A clinically meaningful difference (based on cut-off scores predicting need for assistance) was noted in 30% of the participants. Better performance at home on the process scale was associated with a decrease in some executive functions, while better performance in the clinic on the motor scale was mostly related to a decline in grip strength. | Advocacy to measure in the habitat of the older person | Acceptable (JBI) |

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| | | cooking a relevant ADL; (e) have lived in their own home (house or apartment) and owned the main appliances (e.g. stove, refrigerator, toaster, kettle, can opener) for at least two months to ensure familiarity with their kitchen environment; and (f) have been discharged at least three months earlier (if recruited from inpatient services), which suggests a stable medical condition. | | | | | |
| 379 Camilla Malinowsky, Louise Nygård & Anders Kottorp (2011) Psychometric evaluation of a new assessment of the ability to manage technology in everyday life, Scandinavian Journal of Occupational Therapy, 18:1, 26-35, DOI: 10.3109/11038120903420606 | Clinimetric study | Older adults with and without cognitive impairment (n=116) | To validate a new observation-based assessment, the Management of Everyday Technology Assessment (META) | Psychometric evaluation | META demonstrates acceptable person response validity and technology goodness-of-fit. Additionally, the META can separate individuals with higher ability from individuals with lower ability to manage everyday technology. The META can be seen as a complement to existing ADL assessment techniques and is planned to be used in both research and practice. | The assessment starts with an interview, where the interviewer and the client reaches an agreement on technological objects and services that are relevant to the client but also somewhat challenging. Thereafter the assessment takes place through an observation of the client's use of 3-4 of | High quality (JBI) |

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| | | | | | | these somewhat challenging technologies, then followed by an interview to capture the person's own view on his/her performance skills. The assessment hence is a combination of observation and interview. | |
| 450 Kielhofner G, Mallinson T, Forsyth K, Lai JS. Psychometric properties of the second version of the Occupational Performance History Interview (OPHI-II). Am J Occup Ther. 2001 May-Jun;55(3):260-7. doi: 10.5014/ajot.55.3.260. PMID: 11723966. | Clinimetric study | Population with psychiatric or physical disorders | validity of the Occupational Identity, Occupational Competency, and Occupational Behavior Settings scales of OPHI-II. The study also asked whether the scales' items were targeted to and could effectively discriminate between persons at different levels of adaptation. | Occupational Competence Scale; Occupational Identity Scale; Occupational Behaviour Settings Scale | The items of each scale worked effectively to measure the underlying construct for which they were designed. All three scales validly measured more than 90% of the subjects, who varied by nationality, culture, age, and diagnostic status. More than 90% of the raters used the three scales validly and had approximately the same degree of severity or leniency. The scales were valid across subjects with physical dysfunction and psychiatric conditions as well as subjects with no active diagnosed condition. | The three scales of the OPHI-II are valid across age, diagnosis, culture, and language and effectively measure a wide range of persons. Raters can readily use the OPHI-II validly without formal training. | Acceptable quality (JBI) |
| 480 Lindy Clemson, Anita C. Bundy, Robert G. Cumming, Lynn Kay & Tim Lockett (2008) Validating the Falls Behavioural (FaB) scale for older people: A Rasch analysis, | Clinimetric study | Community-residing elderly people aged 65 – 98 years (n=678) | Establish the validity and robustness of the Falls Behavioural (FaB) Scale | | The latter produced item mean infit statistics of 1.00 (Z ¼ 0.0, SD ¼ 0.33) and mean outfit statistics of 1.03 (Z ¼ 0.0, SD ¼ 0.53), a person separation of 2.36 and internal reliability of 0.85. | Valid, reliable and would be useful in clinical situations when used as a prompt for discussion and in raising clients' | Low quality (JBI) |

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| <p>Disability and Rehabilitation, 30:7, 498-506, DOI: 10.1080/09638280701355546</p> | | | | | | <p>awareness of potential hazards; The short form is a useful alternate for evaluating the effectiveness of fall reduction interventions that aim to encourage protective strategies when negotiating the environment, mobilizing and doing activities of daily living.</p> | |
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Literatuurmatrix excluded articles

| reference | design | Reason exclusion |
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| <p>101 Chaves Gde F, Oliveira AM, Chaves JA, Forlenza OV, Aprahamian I, Nunes PV. Assessment of impairment in activities of daily living in mild cognitive impairment using an individualized scale. Arq Neuropsiquiatr. 2016 Jul;74(7):549-54. doi: 10.1590/0004-282X20160075. PMID: 27487375.</p> | <p>Descriptive study (Reliability and validation study)</p> | <p>Other population (MCI)</p> |
| <p>102 Classen S, Brooks J; National Highway Traffic Safety Administration; American Occupational Therapy Association. Driving simulators for occupational therapy screening, assessment, and intervention. Occup Ther Health Care. 2014 Apr;28(2):154-62. doi: 10.3109/07380577.2014.901590. PMID: 24754764.</p> | <p>Consensus statement</p> | <p>Other purpose (discussion driving simulator as test or as training tool)</p> |
| <p>103 Chiatti C, Iwarsson S. Evaluation of housing adaptation interventions: integrating the economic perspective into occupational therapy practice. Scand J Occup Ther. 2014</p> | <p>Descriptive study; narrative review on health economics</p> | <p>Design and purpose (health economic outcomes)</p> |

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| Sep;21(5):323-33. doi: 10.3109/11038128.2014.900109. Epub 2014 May 1. PMID: 24784725. | | |
| 107 Waldersen BW, Wolff JL, Roberts L, Bridges AE, Gitlin LN, Szanton SL. Functional Goals and Predictors of Their Attainment in Low-Income Community-Dwelling Older Adults. Arch Phys Med Rehabil. 2017 May;98(5):896-903. doi: 10.1016/j.apmr.2016.11.017. Epub 2016 Dec 19. PMID: 28007445; PMCID: PMC5403585. | Descriptive study | Linked to research question 1 |
| 109 Chen CC, Palmon O, Amini D. Responsiveness of the Manual Ability Measure-36 (MAM-36): changes in hand function using self-reported and clinician-rated assessments. Am J Occup Ther. 2014 Mar-Apr;68(2):187-93. doi: 10.5014/ajot.2014.009258. PMID: 24581405. | Pre-post test | Healthcare setting (admission to hospital) |
| 110 Fänge AM, Lindberg K, Iwarsson S. Housing adaptations from the perspectives of Swedish occupational therapists. Scand J Occup Ther. 2013 May;20(3):228-40. doi: 10.3109/11038128.2012.737368. Epub 2012 Oct 25. PMID: 23095046. | Survey, cross sectional study | Other purpose, no relevant information |
| 112 Stav WB, Hallenen T, Lane J, Arbesman M. Systematic review of occupational engagement and health outcomes among community-dwelling older adults. Am J Occup Ther. 2012 May-Jun;66(3):301-10. doi: 10.5014/ajot.2012.003707. PMID: 22549595. | Syst rev | Other purpose; no relevant information |
| 115 Norberg EB, Boman K, Löfgren B, Brännström M. Occupational performance and strategies for managing daily life among the elderly with heart failure. Scand J Occup Ther. 2014 Sep;21(5):392-9. doi: 10.3109/11038128.2014.911955. Epub 2014 May 30. PMID: 24878004. | Descriptive study (interview) | Other population; no relevant information |
| 125 Voigt-Radloff S, Ruf G, Vogel A, van Nes F, Hüll M. Occupational therapy for elderly. Evidence mapping of randomised controlled trials from 2004-2012. Z Gerontol Geriatr. 2015 Jan;48(1):52-72. doi: 10.1007/s00391-013-0540-6. PMID: 24127052. | Sys review (van protocols) | Review van protocols Other outcome |

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| Asimakopulos J, Boychuck Z, Sondergaard D, Poulin V, Ménard I, Korner-Bitensky N. Assessing executive function in relation to fitness to drive: a review of tools and their ability to predict safe driving. <i>Aust Occup Ther J.</i> 2012 Dec;59(6):402-27. doi: 10.1111/j.1440-1630.2011.00963.x. Epub 2011 Nov 13. PMID: 23174109. | review | Level not achieved |
| 127 Mayer J, Mooney V, Matheson L, Leggett S, Verna J, Balourdas G, DeFilippo G. Reliability and validity of a new computer-administered pictorial activity and task sort. <i>J Occup Rehabil.</i> 2005 Jun;15(2):203-13. doi: 10.1007/s10926-005-1219-7. PMID: 15844677. | Descriptive study | Population not described |
| 130 Andreassen M, Öhman A, Larsson Ranada Å. Assessing occupational performance in special housing in Sweden. <i>Scand J Occup Ther.</i> 2018 Nov;25(6):428-435. doi: 10.1080/11038128.2017.1367415. Epub 2017 Aug 23. PMID: 28830285. | Descriptive study cross sectional | Specific Swedish situation |
| 155 Dedding C, Cardol M, Eysen IC, Dekker J, Beelen A. Validity of the Canadian Occupational Performance Measure: a client-centred outcome measurement. <i>Clin Rehabil.</i> 2004 Sep;18(6):660-7. doi: 10.1191/0269215504cr746oa. PMID: 15473118. | Descriptive study | Population; Setting (hospital) |
| 156 Eysen IC, Beelen A, Dedding C, Cardol M, Dekker J. The reproducibility of the Canadian Occupational Performance Measure. <i>Clin Rehabil.</i> 2005 Dec;19(8):888-94. doi: 10.1191/0269215505cr883oa. PMID: 16323388. | Descriptive study | Population; setting (hospital) |
| 163 Lockwood KJ, Taylor NF, Harding KE. Pre-discharge home assessment visits in assisting patients' return to community living: A systematic review and meta-analysis. <i>J Rehabil Med.</i> 2015 Apr;47(4):289-99. doi: 10.2340/16501977-1942. PMID: 25782842. | Sys rev and meta-analysis | Population; setting (hospital) |
| 166 Wirtz, M. A., & Voigt-Radloff, S. (2008). The International Classification of Functioning, Disability and Health-orientated Occupational Therapy Assessment: a Rasch analysis of its | Descriptive study | Population (to broad); setting (residential) |

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| domains. <i>International Journal of Rehabilitation Research</i> , 31(1), 23–32. doi:10.1097/mrr.0b013e3282f4523c | | |
| 173 Hammell, Karen Whalley. "Self-Care, Productivity, and Leisure, or Dimensions of Occupational Experience? Rethinking Occupational 'Categories.'" <i>Canadian Journal of Occupational Therapy</i> (1939), vol. 76, no. 2, 2009, pp. 107–114. | Descriptive study | Other purpose |
| 181 Petty, Linda S, et al. "Clinical Report: Use of the Canadian Occupational Performance Measure in Vision Technology." <i>Canadian Journal of Occupational Therapy</i> (1939), vol. 72, no. 5, 2005, pp. 309–312. | Clinical report | Other purpose; no valuable data |
| 19 Thyer, Laura, et al. "The Validity of the Canadian Occupational Performance Measure (COPM) When Used in a Sub-Acute Rehabilitation Setting with Older Adults." <i>Occupational Therapy in Health Care</i> , vol. 32, no. 2, 2018, pp. 137–153. | quantitative single group pre-test and post-test design | Setting (acute rehabilitation) |
| 190 Merritt, Brenda K. "Validity of Using the Assessment of Motor and Process Skills to Determine the Need for Assistance." <i>The American Journal of Occupational Therapy</i> , vol. 65, no. 6, 2011, pp. 643–650. | Diagnostic study (retrospective data-analysis) | Population (to broad) |
| 228 Belchior P, Korner-Bitensky N, Holmes M, Robert A. Identification and assessment of functional performance in mild cognitive impairment: a survey of occupational therapy practices. <i>Aust Occup Ther J</i> . 2015 Jun;62(3):187-96. doi: 10.1111/1440-1630.12201. Epub 2015 May 7. PMID: 25950462. | Descriptive study (survey) | Other purpose; no valuable information |
| 268 Gage M, Noh S, Polatajko HJ, Kaspar V. Measuring perceived self-efficacy in occupational therapy. <i>Am J Occup Ther</i> . 1994 Sep;48(9):783-90. doi: 10.5014/ajot.48.9.783. PMID: 7977622. | Descriptive study | Population |
| 284 Doucet BM, Gutman SA. Quantifying function: the rest of the measurement story. <i>Am J Occup Ther</i> . 2013 Jan-Feb;67(1):7-9. doi: 10.5014/ajot.2013.007096. PMID: 23245777; PMCID: PMC3722663. | editorial | Exclusion Assessment in general To use for intro question 2 |
| 287 | Diagnostic study | Exclusion Population in general |

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| Kottorp A, Petersson I. Psychometric evaluation of an assessment of awareness using two different Rasch models. <i>Scand J Occup Ther.</i> 2011 Sep;18(3):219-30. doi: 10.3109/11038128.2010.521947. Epub 2010 Oct 18. PMID: 20950206. | | |
| 322 Watkins SL, Lounsbury PA, Fleming-Castaldy RP. The Self-Assessment of Role-Performance and Activities of Daily Living Abilities (SARA™): Development and Clinical Utility of a Client-Centered Screening Tool and Outcome Measure. <i>Occup Ther Health Care.</i> 2016;30(1):42-57. doi: 10.3109/07380577.2015.1050621. Epub 2015 Jun 26. PMID: 26115016. | diagnostic | Exclusion other population |
| 324 Martin E, Nugent C, Bond R, Martin S. Trainee Occupational Therapists Scoring the Barthel ADL. <i>J Med Syst.</i> 2015 Sep;39(9):93. doi: 10.1007/s10916-015-0293-4. Epub 2015 Aug 7. PMID: 26250757. | Diagnostic study | Population |
| 325 Klein S, Barlow I, Hollis V. Evaluating ADL measures from an occupational therapy perspective. <i>Can J Occup Ther.</i> 2008 Apr;75(2):69-81. doi: 10.1177/000841740807500203. PMID: 18510251. | Diagnostic, vision | Population (too broad) To be used as background |
| 326 Trombly C. Anticipating the future: assessment of occupational function | vision | Population (too broad) |
| 328 Dickerson AE, Reistetter T, Davis ES, Monahan M. Evaluating driving as a valued instrumental activity of daily living. <i>Am J Occup Ther.</i> 2011 Jan-Feb;65(1):64-75. doi: 10.5014/ajot.2011.09052. PMID: 21309373. | descriptive | Population; setting (residential older adults with different diagnosis) |
| Pellegrini M, Formisano D, Bucciarelli V, Schiavi M, Fugazzaro S, Costi S. Occupational Therapy in Complex Patients: A Pilot Randomized Controlled Trial. <i>Occup Ther Int.</i> 2018 Sep 3;2018:3081094. doi: 10.1155/2018/3081094. PMID: 30250407; PMCID: PMC6140010. | Pilot RCT | Setting (Complex patients undergoing rehabilitation in a hospital-home-based setting) |
| 331 Simmons DC, Crepeau EB, White BP. The predictive power of narrative data in occupational therapy evaluation. <i>Am J Occup</i> | Prospective design | Setting (hospital) |

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| Ther. 2000 Sep-Oct;54(5):471-6. doi: 10.5014/ajot.54.5.471. PMID: 11006806. | | |
| 333 Clemson L, Cumming RG, Roland M. Case-control study of hazards in the home and risk of falls and hip fractures. Age Ageing. 1996 Mar;25(2):97-101. doi: 10.1093/ageing/25.2.97. PMID: 8670535. | Case corntol | Population (pre-discharge) |
| 335 Law M, Polatajko H, Pollock N, McColl MA, Carswell A, Baptiste S. Pilot testing of the Canadian Occupational Performance Measure: clinical and measurement issues. Can J Occup Ther. 1994 Oct;61(4):191-7. doi: 10.1177/000841749406100403. PMID: 10137673. | Diagnostic study | Population (too broad) |
| 346 Darzins S, Imms C, Di Stefano M. Measurement properties of the Personal Care Participation Assessment and Resource Tool: a systematic review. Disabil Rehabil. 2013 Feb;35(4):265-81. doi: 10.3109/09638288.2012.690819. Epub 2012 Jun 22. PMID: 22725710. | Systematic review | Population (adults) |
| 355 Johansson K. Have they done what they should? Moral reasoning in the context of translating older persons' everyday problems into eligible needs for home modification services. Med Anthropol Q. 2013 Sep;27(3):414-33. doi: 10.1111/maq.12053. Epub 2013 Oct 4. PMID: 24123293. | Descriptive, qualitative study | Design |
| 365 Donnelly C, Carswell A. Individualized outcome measures: a review of the literature. Can J Occup Ther. 2002 Apr;69(2):84-94. doi: 10.1177/000841740206900204. PMID: 11977872. | Literature review | Population(too broad); design |
| Somerville E, Smallfield S, Stark S, Seibert C, Arbesman M, Lieberman D. Occupational Therapy Home Modification Assessment and Intervention. Am J Occup Ther. 2016 Sep-Oct;70(5):7005395010p1-3. doi: 10.5014/ajot.2016.705002. PMID: 27548872. | Case report | Population (MCI); no valuable information |
| 365 Hachisuka K, Ogata H, Ohkuma H, Tanaka S, Dozono K. Test-retest and inter-method reliability of the self-rating Barthel | Case series | Population (Stroke patients) |

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| Index. Clin Rehabil. 1997 Feb;11(1):28-35. doi: 10.1177/026921559701100105. PMID: 9065357. | | |
| 374 Rogers JC, Holm MB, Stone RG. Evaluation of daily living tasks: the home care advantage. Am J Occup Ther. 1997 Jun;51(6):410-22. doi: 10.5014/ajot.51.6.410. PMID: 9164607. | Descriptive; vision | Population (too broad) |
| 383 Malinowsky C, Lund ML. The association between perceived and observed ability to use everyday technology in people of working age with ABI. Scand J Occup Ther. 2014 Nov;21(6):465-72. doi: 10.3109/11038128.2014.919020. Epub 2014 Jun 2. PMID: 24889141. | Descriptive | Population (vocational) |
| 386 Currin ML, Comans TA, Heathcote K, Haines TP. Staying safe at home. Home environmental audit recommendations and uptake in an older population at high risk of falling. Australas J Ageing. 2012 Jun;31(2):90-5. doi: 10.1111/j.1741-6612.2011.00545.x. Epub 2011 Jul 5. PMID: 22676167. | Cohort nested in RCT | Other outcome |
| 395 Shaw L, Leyshon R, Liu M. Validating the potential of the International Classification of Functioning, Disability and Health to identify barriers to and facilitators of consumer participation. Can J Occup Ther. 2007;74 Spec No.:255-66. doi: 10.1177/00084174070740S306. PMID: 17844980. | Descriptive study | Population (Physical learning and mental health disabilities) |
| 403 Matheson LN. History, design characteristics, and uses of the pictorial activity and task sorts. J Occup Rehabil. 2004 Sep;14(3):175-95. doi: 10.1023/b:joor.0000022760.71820.91. PMID: 15156777. | Descriptive study | Population (too broad) |
| 415 Flinn NA, Stube JE. Post-stroke fatigue: qualitative study of three focus groups. Occup Ther Int. 2010 Jun;17(2):81-91. doi: 10.1002/oti.286. PMID: 19787634. | Qualitative study | Population (post stroke) |
| 421 Vickerman J. The role of the occupational therapist in continence care. Nurs Times. 2002 Apr 23-29;98(17):52. PMID: 12008266. | Descriptive study | Other purpose |
| 424 Swanton R, Britton L. An intensive occupational therapy discharge planning intervention was not more effective in | Multi centered RCT | No full text available |

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| improving activities of daily living performance and participation than a hospital-based discharge planning consultation for older adults in the acute hospital setting. <i>Aust Occup Ther J.</i> 2017 Jun;64(3):279-280. doi: 10.1111/1440-1630.12396. PMID: 28631365. | | |
| 426 Touchinsky S, Chew F, Davis ES. Gaps and Pathways Project: driving pathways by diagnosis sheets. <i>Occup Ther Health Care.</i> 2014 Apr;28(2):203-8. doi: 10.3109/07380577.2014.903450. PMID: 24754771. | Descriptive study | Design; other purpose |
| 442 Eek M, Wressle E. Everyday technology and 86-year-old individuals in Sweden. <i>Disabil Rehabil Assist Technol.</i> 2011;6(2):123-9. doi: 10.3109/17483107.2010.507858. Epub 2010 Jul 28. PMID: 20662743. | Cross sectional study (quant and qual) | Other purpose |
| 447 Arnold S, Mackenzie L, James C, Millington M. Why do occupational therapists' medico-legal opinions differ regarding the amount of domestic assistance a person requires? <i>Aust Occup Ther J.</i> 2017 Apr;64(2):194-197. doi: 10.1111/1440-1630.12278. Epub 2016 Jun 2. PMID: 27250666. | Descriptive study opinion | Design; other purpose |
| 449 Provencher V, Clemson L, Wales K, Cameron ID, Gitlin LN, Grenier A, Lannin NA. Supporting at-risk older adults transitioning from hospital to home: who benefits from an evidence-based patient-centered discharge planning intervention? Post-hoc analysis from a randomized trial. <i>BMC Geriatr.</i> 2020 Mar 2;20(1):84. doi: 10.1186/s12877-020-1494-3. PMID: 32122311; PMCID: PMC7053102. | Post hoc analyses of RCT | Population (Hospitalized older adults with cognitive impairment) |
| 473 Laver K, Wales K, Clemson L. Effectiveness of pre-discharge occupational therapy home visits has yet to be evaluated; a definitive trial is feasible and warranted. <i>Aust Occup Ther J.</i> 2013 Oct;60(5):374-5. doi: 10.1111/1440-1630.12086. PMID: 24089991. | RCT | Population (stroke survivors) |
| 477 Geriatrics impairment and disability: the cardiovascular health study | Longitudinal study | Other purpose |

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| 485 Kielhofner G. Functional assessment: toward a dialectical view of person-environment relations. Am J Occup Ther. 1993 Mar;47(3):248-51. doi: 10.5014/ajot.47.3.248. PMID: 8456925. | Descriptive vision | Other purpose |
| 499 Performance context and its role | Case report | Other purpose |
| 506 On-road driving evaluations | Mixed method (national survey, qualitative, survey driving schools) | Other purpose |
| 507 Descriptive analysis examining | Descriptive study | Population |
| 571 the development of the modified blaylock tool | Diagnostic study | Other setting |
| 582 Occupational therapists' capacity-building needs related to older driver screening | Descriptive study survey | Other purpose |
| 606 Reducing hazard related falls in people 75 years and older with significant visual impairment | Follow up RCT | Other purpose |
| 624 Using the exos handmaster to measure digital range of motion | Diagnostic study | Population |
| 634 Drive safe | Effect study | Not yet measured |
| 637 COPM in primary care: a profile of practice | Mixed method | Population (average age 56,7y) |
| 652 Determination of the minimal clinical important difference | Descriptive (survey) | Other purpose |
| 659 Driving assessment tools used by driver rehab specialists | Descriptive nonexperimental design with survey format | Population |
| 66 Portrait des pratiques évaluatives des ergothérapeutes | Cross sectional survey | Population |

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| 676 A randomized controlled trial to test the effectiveness of decision training on assessors' ability to determine optimal fitness-to-drive recommendations for older or disabled drivers | RCT | Other purpose |
| 687 Competent use of a motorized mobility scooter | Descriptive | Other purpose |
| 7 AM-PAC 6 clicks functional assessment scores predict acute care hospital discharge destination | Descriptive Retrospective and observational | Other population |
| 710 A Swedish survey of occupational therapists' involvement and performance in driving assessments | Descriptive study Survey | Other population |
| 716 A tool to enhance occupational reasoning from ICF perspective | Descriptive study | Other purpose |
| 73 Subjective memory complaints and difficulty performing activities of daily living among older women in Australia | Descriptive study (survey) | Population; other purpose |
| 755 Role of physical performance component evaluations in occupational therapy functional assessment | Descriptive vision | Other purpose; design |
| 787 The cross-cultural adaptation of the disability of arm, shoulder and hand (DASH) | Systematic review | Population (orthopedic) |
| 79 Test-retest reliability of a measure of independence | Diagnostic study | Population (Adults with traumatic brain injury) |
| 81 Feasibility trial of tailored home modifications | Proces evaluation within RCT | Other purpose |
| 814 The revised role checklist: improved utility, feasibility, and reliability | Diagnostic study | Other purpose; population (OT's and students) |
| 820 Guidetomeasure-OT: a mobile 3D application to improve the accuracy, consistency, and efficiency of clinician-led home-based falls-risk assessments | Effect study | Other purpose |
| 83 The construct validity of the dutch version of the activity card sort | Diagnostic study | Population (Parkinson disease) |

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| 833 Reliability of the performance and safety scores of the wheelchair skills test | Cohort study | Population (wheelchair users) |
| 86 Driving with parkinson's disease | Descriptive study | Population (Parkinson disease) |
| 90 Interpreting activity of daily living errors for treatment and discharge planning | Description study (survey, vision) | Other purpose |
| 91 Responsiveness of the Canadian occupational performance measure | Diagnostic study Descriptive study | Population (adults with specific disorders) |

Literature matrix excluded articles (search string COSMIN)

| reference | design | Reason exclusion |
|--|-----------------------------------|---|
| 229 Rotenberg-Shpigelman S, Rosen-Shilo L, Maeir A. Online awareness of functional tasks following ABI: the effect of task experience and associations with underlying mechanisms. NeuroRehabilitation. 2014;35(1):47-56. doi: 10.3233/NRE-141101. PMID: 24990012. | Klinimetric study | Acute brain injury (neurogenic and psychogenic factors) |
| 215 Anders Kottorp & Ingela Petersson (2011) Psychometric evaluation of an assessment of awareness using two different Rasch models, Scandinavian Journal of Occupational Therapy, 18:3, 219-230, DOI: 10.3109/11038128.2010.521947 Diagnostisch onderzoek | Clinimetric study | Other population (developmental disabilities, neurological disorders, stroke) |
| Gantschnig BE, Page J, Fisher AG. Cross-regional validity of the assessment of motor and process skills for use in middle Europe. J Rehabil Med. 2012 Feb;44(2):151-7. doi: 10.2340/16501977-0915. PMID: 22234673. | Clinimetric study | Other population (general population 3 till 103y) |
| 254 Gage M, Noh S, Polatajko HJ, Kaspar V. Measuring perceived self-efficacy in occupational therapy. Am J Occup Ther. 1994 Sep;48(9):783-90. doi: 10.5014/ajot.48.9.783. PMID: 7977622. | Descriptive and clinimetric study | Adults older than 21 years of age with chronic health problems such as stroke, heart disease, arthritis, and chronic pain |
| 258 Zur, Briana M, et al. "Examining the Construct Validity of the Cognitive Competency Test for Occupational Therapy Practice / Évaluer La | Clinimetric study | Inpatients and outpatients with cognitive impairment |

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|---|-------------------|--|
| Validité De Construit Du Cognitive Competency Test En Fonction De La Pratique De l'Ergothérapie." Canadian Journal of Occupational Therapy (1939), vol. 80, no. 3, 2013, pp. 171–180. | | |
| 263 Enemark Larsen, Anette, and Carlsson, Gunilla. "Utility of the Canadian Occupational Performance Measure as an Admission and Outcome Measure in Interdisciplinary Community-Based Geriatric Rehabilitation." Scandinavian Journal of Occupational Therapy, vol. 19, no. 2, 2012, pp. 204–213. | Clinimetric study | Other population |
| 264 Turner, Christopher, et al. "Interrater Reliability of the Personal Care Participation Assessment and Resource Tool (PC-PART) in a Rehabilitation Setting." Australian Occupational Therapy Journal, vol. 56, no. 2, 2009, pp. 132–139. | Clinimetric study | Inpatient elderly |
| 288 Ruchinkas, Robert. "Rehabilitation Therapists' Recognition of Cognitive and Mood Disorders in Geriatric Patients." Archives of Physical Medicine and Rehabilitation, vol. 83, no. 5, 2002, pp. 609–612. | Clinimetric study | Inpatient older adults Measuring mood and cognition |
| 296 Lenze, Eric J., MD, et al. "Enhanced Medical Rehabilitation Increases Therapy Intensity and Engagement and Improves Functional Outcomes in Postacute Rehabilitation of Older Adults: A Randomized-Controlled Trial." Journal of the American Medical Directors Association, vol. 13, no. 8, 2012, pp. 708–712. | RCT | Geriatric rehab patients |
| 305 Douglas, Alison M, et al. "Validity of Predischarge Measures for Predicting Time to Harm in Older Adults." Canadian Journal of Occupational Therapy, vol. 80, no. 1, 2013, pp. 19–27. | Clinimetric study | Older adults inpatient rehab unit |
| 346 Copolillo A, Teitelman JL. Acquisition and integration of low vision assistive devices: understanding the decision-making process of older adults with low vision. Am J Occup Ther. 2005 May-Jun;59(3):305-13. doi: 10.5014/ajot.59.3.305. PMID: 15969278. | Clinimetric study | Question 3 goals setting (shared-decision making) |
| 347 Nelson DL, Melville LL, Wilkerson JD, Magness RA, Grech JL, Rosenberg JA. Interrater reliability, concurrent validity, responsiveness, and predictive validity of the Melville-Nelson Self-Care Assessment. Am J Occup Ther. 2002 Jan-Feb;56(1):51-9. doi: 10.5014/ajot.56.1.51. PMID: 11833401. | Clinimetric study | Skilled nursing facilities older adults (rehab) |

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| 356 Pardessus V, Puisieux F, Di Pompeo C, Gaudefroy C, Thevenon A, Dewailly P. Benefits of home visits for falls and autonomy in the elderly: a randomized trial study. Am J Phys Med Rehabil. 2002 Apr;81(4):247-52. doi: 10.1097/00002060-200204000-00002. PMID: 11953541. | Clinimetric study | Question 4 and 1 Benefits of home-visits during hospitalization |
| 374 Tove Nilsen, Merete Hermann, Camilla S. Eriksen, Hanne Dagfinrud, Petter Mowinckel & Ingvild Kjeklen (2012) Grip force and pinch grip in an adult population: Reference values and factors associated with grip force, Scandinavian Journal of Occupational Therapy, 19:3, 288-296, DOI: 10.3109/11038128.2011.553687 | Cross sectional study | Other purpose (demographic data linked at grip force) |
| 386 Sarah L. Watkins, Peggy A. Lounsbury & Rita P. Fleming-Castaldy (2016) The Self-Assessment of Role-Performance and Activities of Daily Living Abilities (SARA™): Development and Clinical Utility of a Client-Centered Screening Tool and Outcome Measure, Occupational Therapy In Health Care, 30:1, 42-57, DOI: 10.3109/07380577.2015.1050621 | Clinimetric study | Other population (acute care hospital, nursing home, or subacute rehabilitation hospital) |
| 389 Deitz JC, Tovar VS, Thorn DW, Beeman C. The Test of Orientation for Rehabilitation Patients: interrater reliability. Am J Occup Ther. 1990 Sep;44(9):784-90. doi: 10.5014/ajot.44.9.784. PMID: 2220996. | Clinimetric study | other population (rehab – cognitive problems) |
| 410 Swenor BK, Yonge AV, Goldhammer V, Miller R, Gitlin LN, Ramulu P. Evaluation of the Home Environment Assessment for the Visually Impaired (HEAVI): an instrument designed to quantify fall-related hazards in the visually impaired. BMC Geriatr. 2016 Dec 9;16(1):214. doi: 10.1186/s12877-016-0391-2. PMID: 27938346; PMCID: PMC5148906. | Clinimetric study | Other population (vis impairment) |
| 437 Burger DK, McCluskey A. Australian norms for handwriting speed in healthy adults aged 60-99 years. Aust Occup Ther J. 2011 Oct;58(5):355-63. doi: 10.1111/j.1440-1630.2011.00955.x. PMID: 21957920. | Cohort study | Other purpose (norming handwriting speed in Australia) |

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| 451 Currin ML, Comans TA, Heathcote K, Haines TP. Staying safe at home. Home environmental audit recommendations and uptake in an older population at high risk of falling. <i>Australas J Ageing</i> . 2012 Jun;31(2):90-5. doi: 10.1111/j.1741-6612.2011.00545.x. Epub 2011 Jul 5. PMID: 22676167. | Cohort nested RCT | Other purpose Question 4 |
| 461 Wikström I, Arvidsson B, Nilsson K, Roos E, Jacobsson LT. Reliability, validity and responsiveness of a new leisure index: the Patient-Specific Leisure Scale (PSLS). <i>Musculoskeletal Care</i> . 2009 Sep;7(3):178-93. doi: 10.1002/msc.150. PMID: 19191254. | Clinimetric study | Other population: Adults with RA |

OTDBase

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|---|--|--|--|---|--|---------------------------|
| Avlund, Kirsten et al., 2002. Effects of Comprehensive Follow-up Home Visits after Hospitalization on Functional Ability and Readmissions among Old Patients. A Randomized Controlled Study. Scandinavian journal of occupational therapy, 9(1), pp.17–22. | Prospective randomized and controlled study | 149 patients who were discharged to their homes from geriatric and medical wards medical department consists of three wards with patients referred from primary care (1) mainly cardiological patients, mean length of stay 5.3 days, (2) mainly respiratory patients, mean length of stay 8.9 days, and (3) mainly endocrinological | Regular interdisciplinary comprehensive home visits after discharge from hospital IG: Visited by one of the geriatric team members on day of discharge from hospital, second day after discharge, and in second, fourth, and sixth week after discharge; geriatric assessment was performed focusing on the individual's specific health problems; Based on individual needs it was decided whether a home nurse, a home helper, a PT or an OT from the primary healthcare system should be present during the following | Effect on the functional ability (Barthel Index) of the patients and on readmissions; The study focuses on patients who are assumed to have benefits of this intervention: in need of treatment, rehabilitation and comprehensive home service after discharge; | Intervention had a beneficial effect on functional ability among patients who had been hospitalized at a medical ward. This was not the case among patients who had been hospitalized at a geriatric ward. In addition, there was a beneficial effect on functional ability among pulmonary patients and patients with fractures, but not among patients with cardiac failure. The results point at a need for the expertise of | Need for the expertise of the interdisciplinary geriatric team (including OT) in preparation of discharge among special groups of patients (e.g. home visit, contact to relevant persons in primary care, aids, etc.) and at a need for follow-up visits | Acceptable quality (SIGN) |

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| | | patients, mean length of stay 7.8 days Control: | visits from the geriatric team. CG: Existing norms for discharge planning, these included general coordination of discharges between the secondary and primary health services by the geriatric team; These services are offered to the patients from the geriatric ward if needed and to elderly patients with complicated discharges from other wards from the hospital. | assessed 3 months after hospital discharge | the interdisciplinary geriatric team in preparation of discharge among special groups of patients (e.g. home visit, contact to relevant persons in primary care, aids, etc.) and at a need for follow-up visits. | | |
| Jakobsson, Ulf & Karlsson, Staffan, 2011. Predicting Mortality With the ADL-Staircase in Frail Elderly. Physical & occupational therapy in geriatrics, 29(2), pp.136–147. | Cohorte | 626 65+ receiving long-term health care and service at home or in special accommodation (cfr nursing home) | Assessing functional ability Linked to data of the GAS study (demographic data, ...) | mortality | | ADL staircase as instrument to measure functionality (Swedish) | Acceptable quality (SIGN) |
| Provencher, Véronique et al., 2013. Cooking task assessment in frail older adults: who performed better at home and in the clinic? Scandinavian journal of occupational therapy, 20(5), pp.374–383. | Effect study Comparing results of assessment performed in two different contexts | Frail older adults (N=37) | Cooking task assessment | Relation between cognitive performance in home situation and hospital situation; idem motor skills | Relation between cognitive skills and habit | Prove that assessment must be performed at home to deliver the most reliable answers | High quality (JBI) |

Literature matrix excluded articles

| reference | design | reason exclusion |
|--|--|-------------------------------|
| Daniels, Ramon et al., 2008. Frailty in Older Age: Concepts and Relevance for Occupational and Physical Therapy. Physical & occupational therapy in geriatrics, 27(2), pp.81–95. | Descriptive study (an overview of the discussion about the concept of frailty, of intervention research, and instruments to identify frail elderly) | No content information |
| Donnelly, Catherine et al., 2017. Canadian Occupational Performance Measure (COPM) in Primary Care: A Profile of Practice. The American journal of occupational therapy, 71(6), pp.7106265010–p8. | Mixed method (implementation COPM followed by focus group discussion) | Other population |
| Hutchison, Alexander T & Clarke, Mark S. F, 2006. An Isometric Strength Testing Device for Use with the Elderly: Validation Compared with Isokinetic Measures. Physical & occupational therapy in geriatrics, 25(2), pp.1–12. | Prospective validation study | physiotherapy |
| Johansson, Maria M, Marcusson, Jan & Wressle, Ewa, 2016. Development of an instrument for measuring activities of daily living in persons with suspected cognitive impairment. Scandinavian journal of occupational therapy, 23(3), pp.230–239. | Development of test | Other population (cognition) |
| Kjellberg, Anette, Bolic, Vedrana & Haglund, Lena, 2011. Utilization of an ICF-based | Utility study | Other population (too broad); |

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| assessment from occupational therapists' perspectives. <i>Scandinavian journal of occupational therapy</i> , 19(3), pp.274–281. | | To other purpose (advice developing coresets) |
| Ridout, Alicia & Mayers, Christine, 2006. Evaluation of the Implementation of the Single Assessment Process and its Impact on Occupational Therapy Practice. <i>The British journal of occupational therapy</i> , 69(6), pp.271–280. | Qualitative research | Other purpose (profiling OT) |
| Wästberg, Birgitta A, Persson, Elisabeth B & Eklund, Mona, 2016. The Satisfaction with Daily Occupations (SDO-13) Scale: Psychometric Properties among Clients in Primary Care in Sweden. <i>Occupational therapy in health care</i> , 30(1), pp.29–41. | Diagnostic study | Other population (working age) |
| O'Toole, Lynn, Connolly, Deirdre & Smith, Susan, 2013. Impact of an occupation-based self-management programme on chronic disease management. <i>Australian occupational therapy journal</i> , 60(1), pp.30–38. | Pilot mixed method with quantitative per-post quasi experimental | Other purpose and other population (too broad) |
| Mann WC, Kimble C, Justiss MD, Casson E, Tomita M, Wu SS. Problems with dressing in the frail elderly. <i>Am J Occup Ther</i> . 2005 Jul- | Descriptive study | Content (assessments used in research) |

Aug;59(4):398-408. doi: 10.5014/ajot.59.4.398.
 PMID: 16124206.

Cinahl

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|--|-----------------|------------------------|
| Parker SG, McCue P, Phelps K, McCleod A, Arora S, Nockels K, Kennedy S, Roberts H, Conroy S. What is Comprehensive Geriatric Assessment (CGA)? An umbrella review. Age Ageing. 2018 Jan 1;47(1):149-155. doi: 10.1093/ageing/afx166. PMID: 29206906. | Umbrella review | Population (inpatient) |

4.2.4 Évaluation critique des articles retenus

Voir annexe 5.4

4.2.5 Attribution du GRADE

Voir annexe 5.5

4.3 Question clinique 3

La question clinique est la suivante :

Quelle méthodologie est appropriée pour fixer des objectifs avec la personne âgée physiquement fragile vivant à domicile et/ou son entourage ?

4.3.1 Stratégie de recherche de concepts

| | Description | Pool de termes de recherche |
|-----|--|--|
| P | La personne âgée et/ou son contexte social | "Aged"[MeSH] OR "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] OR "Homebound Persons"[MeSH] "Social Environment" [MeSH] OR "Social Support" [MeSH] OR "Caregivers" [MeSH]. |
| I a | Ciblage de la méthode | "Objectifs"[Mesh] OU "Résultat du traitement"[Mesh] OU "Conseil directif"[Mesh] OU "Conseil"[Mesh] OU "Conseil à distance"[Mesh] OU "entretien motivationnel*" OR "collaborative goal setting" OR "occupation-focused goal*" ET "Méthodes"[Mesh] ET "Ergothérapie"[Mesh] |
| I b | Attitude et compétences en matière de fixation d'objectifs | "Objectifs"[Mesh] OU "Résultat du traitement"[Mesh] OU "Conseil directif"[Mesh] OU "Conseil"[Mesh] OU "Conseil à distance"[Mesh] OU "entretien motivationnel*" OR "collaborative goal setting" OR "occupation-focused goal*" ET "Soins centrés sur le patient"[Mesh] OU "Compétence professionnelle Mesh]" OR "Professional-patient relations"[Mesh] OR "Clinical Competence"[Mesh] OR "Social Skills"[Mesh] OR "Empathy"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Respect"[Mesh] OR "Codes of Ethics"[Mesh] OR Ethics, Professionnel OU "basé sur la profession" OU "basé sur la profession" OU "basé sur le contexte" OU "basé sur le contexte" OU "basé sur les preuves" OU "basé sur les preuves" OU "basé sur la technologie" OU "basé sur la technologie" OU "basé sur la population" OU "basé sur la population" OU "compétence professionnelle" OU "utilisation de soi" ET "Ergothérapie"[Mesh] |

| | | |
|---|--|--|
| C | / | |
| O | Des objectifs qui s'inscrivent dans un contexte plus ancien et/ou social | <p>Activités de la vie quotidienne"[Mesh] OU "Autogestion"[Mesh] OU "Performance physique fonctionnelle"[Mesh] OU "Participation sociale"[Mesh] OU "Intégration communautaire"[Mesh] OU "Intégration sociale"[Mesh] OU "Capital social"[Mesh] OU "Activités humaines"[Mesh] OU "Mode de vie sain"[Mesh] OU "Qualité de vie"[Mesh] OU "Sentiment de cohérence"[Mesh] OU "Années de vie ajustées sur la qualité"[Mesh] OU "Activités de loisirs"[Mesh] OU "Connaissances en matière de santé"[Mesh] OU "Anxiété"[Mesh] OU "Observation du patient"[Mesh] OU "Sédentarité"[Mesh] OU "Anxiété"[Mesh] OU "Sédentarité"[Mesh].Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling"</p> <p>OU</p> <p>"Charge de travail" [Mesh] OU "épuisement psychologique" [Mesh] OU "soutien social" [Mesh] OU "capital social" [Mesh] OU "soins de répit" [Mesh] OU "stress psychologique" [Mesh] OU "adaptation psychologique" [Mesh] OU "sentiment de cohérence" [Mesh] OU "performance fonctionnelle physique" [Mesh] OU "fardeau de l'aidant" OU "fardeau de l'aidant" OU "surcharge" OU "surcharge".</p> |

Bases de données consultées :

Base de données Cochrane des revues systématiques, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Critères d'inclusion méthodologiques

- Conception : revues systématiques et méta-analyses, essais contrôlés randomisés, études d'observation et études qualitatives.
- Qualité méthodologique suffisante mesurée à l'aide de l'outil SIGN Critical Appraisal ; si aucun outil SIGN CA n'est disponible pour le modèle en question : outil d'évaluation critique JBI.
- Période de recherche : de la base de données au 30 juin 2022

Critères d'inclusion et d'exclusion du contenu :

Inclusion :

- la personne âgée physiquement fragile et/ou l'aidant informel
- ciblage

Exclusion :

/

Chaînes de recherche par base de données

Pubmed

String a

("Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] OR "Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Social Capital"[MeSH] OR "Social Networking"[MeSH] OR "Friends"[MeSH] OR "Family"[MeSH] OR "Caregivers"[MeSH] OR "Patient Care"[MeSH] OR "Nuclear Family"[MeSH] OR "Spouses"[MeSH] OR "Home Nursing"[MeSH] OR "Foster Home Care"[MeSH])

AND

"Goals"[Mesh] OR "Treatment Outcome"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Distance Counseling"[Mesh] OR "motivational interview*" OR "collaborative goal setting" OR "occupation-focused goal*")

AND

"Methods"[Mesh]

AND

"Occupational Therapy"[Mesh]

AND

("Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling" OR "Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "Physical Functional Performance"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge")

String b

("Aged"[MeSH] OR "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] OR "Homebound Persons"[MeSH])

OR

"Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Caregivers"[MeSH])

AND

"Goals"[Mesh] OR "Treatment Outcome"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Distance Counseling"[Mesh] OR "motivational interview*" OR "collaborative goal setting" OR "occupation-focused goal*")

AND

("Patient-Centered Care"[Mesh] OR "Professional competence Mesh]" OR "Professional-patient relations"[Mesh] OR "Clinical Competence"[Mesh] OR "Social Skills"[Mesh] OR "Empathy"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Respect"[Mesh] OR "Codes of Ethics"[Mesh] OR Ethics,

Professional OR "occupation based" OR "occupation-based" OR "context based" OR "context-based" OR "evidence based" OR "evidence-based" OR "technology based" OR "technology-based" OR "population based" OR "population-based" OR "professional competence" OR "use of self")

AND

"Occupational Therapy"[Mesh]

AND

("Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling"

OR

"Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "Physical Functional Performance"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge")

Cochrane

| ID | Search Hits | |
|----|---|-------|
| #1 | MeSH descriptor: [Activities of Daily Living] explode all trees | 10314 |
| #2 | MeSH descriptor: [Primary Health Care] explode all trees | 8427 |
| #3 | MeSH descriptor: [Occupational Therapy] explode all trees | 828 |
| #4 | #1 and #2 and #3 | 23 |
| #5 | MeSH descriptor: [Frailty] explode all trees | 306 |
| #6 | #4 and #5 | 1 |
| #7 | #3 and #5 | 2 |
| #8 | #1 and #5 | 51 |

Cinahl

((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+)

OR

(MH "Social Environment"+) OR (MH ""Social Support""+) OR (MH ""Social Capital""+) OR (MH ""Social Networking""+) OR (MH "Friends"+) OR (MH "Family"+) OR (MH "Caregivers"+) OR (MH "Patient Care"+) OR (MH ""Nuclear Family""+) OR (MH "Spouses"+) OR (MH "Home Nursing"+) OR (MH "Foster Home Care"+))

AND

(MH Goals+) OR (MH "Treatment Outcome"+) OR (MH "Directive Counseling"+) OR (MH Counseling+) OR (MH "Distance Counseling"+) OR "motivational interview*" OR "collaborative goal setting" OR "occupation-focused goal*"

AND

(MH Methods+)

AND

(MH "Occupational Therapy"+)

AND

((MH "Activities of Daily Living"+) OR (MH Self-Management+) OR (MH "Physical Functional Performance"+) OR (MH "Social Participation"+) OR (MH "Community Integration"+) OR (MH "Community Participation"+) OR (MH "Social Integration"+) OR (MH "Social Capital"+) OR (MH "Human Activities"+) OR (MH "Healthy Lifestyle"+) OR (MH "Quality of Life"+) OR (MH "Sense of Coherence"+) OR (MH "Quality-Adjusted Life Years"+) OR (MH "Leisure Activities"+) OR (MH "Health Literacy"+) OR (MH "patient compliance"+) OR (MH Anxiety+) OR (MH "Sedentary Behavior"+) OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling"

OR

(MH Workload+) OR (MH "Psychological Burnout"+) OR (MH "Social Support"+) OR (MH "Social Capital"+) OR (MH "Respite Care"+) OR (MH "Stress, Psychological"+) OR (MH "Adaptation, Psychological"+) OR (MH "Sense of Coherence"+) OR (MH "Physical Functional Performance"+) OR "caregiver burden" OR "caregivers burden" OR overload OR overcharge

OR

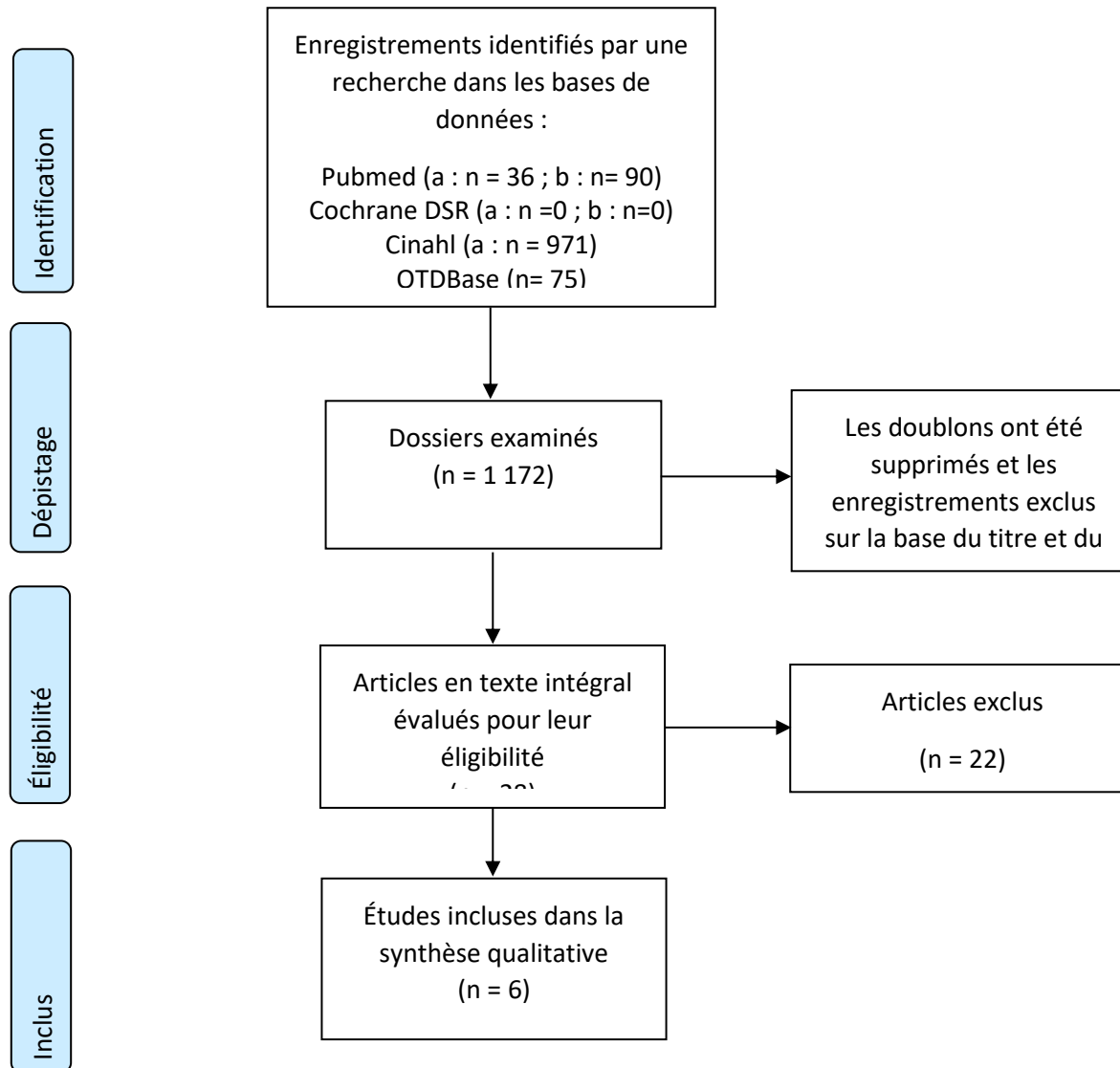
(MH "Activities of Daily Living"+) OR (MH Self-Management+) OR (MH "Physical Functional Performance"+) OR (MH "Community Integration"+) OR (MH "Community Participation"+) OR (MH "Social Integration"+) OR (MH "Human Activities"+) OR (MH "Healthy Lifestyle"+) OR (MH "Quality of Life"+) OR (MH "Sense of Coherence"+) OR (MH "Quality-Adjusted Life Years"+) OR (MH "Leisure Activities"+) OR (MH "patient compliance"+) OR "occupational performance" OR "accidental falls" OR (MH Safety+)

Limits: age 80 and over, English

OTDBase

("frail elderly" AND "primary care") OR ("frailty" and "primary care")

4.3.2 Résultats identifiés



4.3.3 Matrice bibliographique question clinique 3

Cochrane database of systematic review

Literature matrix included articles

| référéce | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|-----------|--------|------------------|
| / | | |

Pubmed

Literature matrix included articles

| référéce | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|---------------------------------|-------------------|---|---|--|--|-------------------|
| 3 Provencher, V., Clemson, L., Wales, K., Cameron, I. D., Gitlin, L. N., Grenier, A., & Lannin, N. A. (2020). Supporting at-risk older adults | Descriptive study from RCT data | 70 years or older | HOME (1) establishment of a hospital-based partnership with patient and family for goal setting and problem solving; 2) pre-discharge | Primary outcomes measures were independence in ADLs and participation in life roles, as well as number of | Goals as important topic in discharge planning | | Acceptable (SIGN) |

| | | | | | | | |
|---|------------|---------------------|---|--|--|--|----------------------------|
| <p>transitioning from hospital to home: Who benefits from an evidence-based patient-centered discharge planning intervention? Post-hoc analysis from a randomized trial. <i>BMC Geriatrics</i>, 20(1). https://doi.org/10.1186/s12877-020-1494-</p> | | | <p>home assessment to address safety issues and home modifications with patient and family; 3) postdischarge home assessment and in-home training to address unmet needs; and 4) follow-up telephone calls to provide ongoing support to increase independence for participants and families and ensure required services have been accessed.) or a structured in hospital consultation</p> | <p>unplanned re-hospitalizations and ED visits.</p> | | | |
| <p>Nielsen, T. L., Andersen, N. T., Petersen, K. S., Polatajko, H., & Nielsen, C. V. (2019). Intensive client-centred occupational therapy in the home improves older adults' occupational performance. Results from a Danish randomized controlled trial. <i>Scandinavian Journal of Occupational Therapy</i>, 26(5), 325–</p> | <p>RCT</p> | <p>Older adults</p> | <p>ICC-OT versus usual practice OT</p> | <p>The primary outcome was self-rated occupational performance assessed with the Canadian Occupational Performance Measure (COPM).</p> | <p>ICC-OT improved older adults' occupational performance more effectively than usual practice. This result may benefit older adults and support programmatic changes.</p> | <p>ICC-OT: client-centered OT, working collaboratively on goal-setting</p> | <p>High quality (SIGN)</p> |

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|---|---|--|---|---|---|--|----------------------------------|
| <p>342. https://doi.org/10.1080/11038128.2018.1424236</p> | | | | | | | |
| <p>Stevens A, Beurskens A, Köke A, van der Weijden T. The use of patient-specific measurement instruments in the process of goal-setting: a systematic review of available instruments and their feasibility. 2013</p> | <p>Systematic review</p> | <p>search in PubMed, EMBASE, CINAHL, PsychINFO and REHABDATA,</p> | <p>patient-specific instruments were included, structured in a goal-setting practice framework and subjected to a qualitative thematic analysis of feasibility.</p> | <p>25 patient-specific instruments were identified and 11 were included</p> | <p>there is no single good instrument that can be recommended specifically</p> | <p>Applying a combination of the strengths of the available instruments within a goal-setting framework can improve goal setting and tailor it to individual patients.</p> | <p>Acceptable quality (SIGN)</p> |
| <p>Yun D, Choi J. Person-centered rehabilitation care and outcomes: A systematic literature review. Int J Nurs Stud. 2019 May;93:74-83. doi: 10.1016/j.ijnurstu.2019.02.012. Epub 2019 Feb 26. PMID: 30870614.</p> | <p>Sys rev (17 experimentele studies)</p> | <p>Individuals aged 18 aged older who are in rehabilitation in acute care or community setting</p> | <p>rehabilitation intervention developed based on the person-centered care concept</p> | <p>1) to explore the current status of research about person-centered care for rehabilitation interventions, (2) to examine how person-centered care has been implemented in rehabilitation practice and empirically associated with outcomes, and (3) to investigate what attributes of the person-centered care concept were implemented specifically for rehabilitation practice</p> | <p>17 eligible studies were included. The selected studies were varied concerning the use of the term person-centered care, research design, target population, sample size, setting, intervention, and outcome measures. The most examined interventions in this review were focused on goal setting and shared-decision making processes based on the client-centered approach. The implementation of those interventions</p> | <p>For interventions to be successfully implemented, a systematic approach was used. - by establishing a collaborative partnership between the therapist and the client, identifying individual performance issues, and engaging clients in setting goals that were personally relevant - additional Strategies: the use of workbooks, systematic risk assessment, self-commitment to a written action plan, provision of resource packages or leaflets, and open communication. Attributes: holistic, individualized, respectful, and empowering</p> | <p>Sign Low quality (-)</p> |

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| | | | | | <p>varied considerably. Results showed mixed relationships between person-centered care and the outcomes examined in the studies although there was strong evidence regarding the positive effects of person-centered care on occupational performance and rehabilitation satisfaction.</p> <p>Significant outcomes: occupational performance and satisfaction, rehabilitation satisfaction, and client-centeredness</p> | | |
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Literature matrix excluded articles

| reference | design | reason exclusion |
|---|---------|------------------|
| To, L., & Editor, T. H. E. (2012). 1790 Letters To the Editor September 2012–Vol. 60, No. 9 Jags, 60(9), 2008–2009. | Opinion | Design (opinion) |

| | | |
|---|---|--|
| Graham, F. (2017, July 1). Occupational performance coaching: Client-centered and goal-directed practice; A commentary on collaborations with Sylvia Rodger. <i>Australian Occupational Therapy Journal</i> . Blackwell Publishing. https://doi.org/10.1111/1440-1630.12367 | Commentary | Design (opinion), population (children) |
| Yoshida, I., Hirao, K., & Kobayashi, R. (2018). Effect of adjusting the challenge-skill balance for occupational therapy: Study protocol for a randomised controlled trial. <i>BMJ Open</i> , 8(12). https://doi.org/10.1136/bmjopen-2018-022438 | Study protocol | Design |
| Doig, E., Prescott, S., Fleming, J., Cornwell, P., & Kuipers, P. (2015). Development and construct validation of the Client-Centredness of Goal Setting (C-COGS) scale. <i>Scandinavian Journal of Occupational Therapy</i> , 22(4), 302–310. https://doi.org/10.3109/11038128.2015.1017530 | construct validity study | Population (young, brain injury) |
| Donnelly, C., & Carswell, A. (2002). Individualized outcome measures: A review of the literature. <i>Canadian Journal of Occupational Therapy</i> . Canadian Association of Occupational Therapists. https://doi.org/10.1177/000841740206900204 | review | Level not achieved |
| Arthanat, S., Wilcox, J., & Macuch, M. (2019). Profiles and Predictors of Smart Home Technology Adoption by Older Adults. <i>OTJR Occupation, Participation and Health</i> , 39(4), 247–256. https://doi.org/10.1177/1539449218813906 | Descriptive study | Design, content (profiles and predictors of technology adoption) |
| Gagné, D. E., & Hoppes, S. (2003). The effects of collaborative goal-focused occupational therapy on self-care skills: A pilot study. <i>American Journal of Occupational Therapy</i> , 57(2), 215–219. https://doi.org/10.5014/ajot.57.2.215 | Pilot RCT | Population (inhospital) |
| Nagayama, H., Tomori, K., Ohno, K., Takahashi, K., Ogahara, K., Sawada, T., ... Yamauchi, K. (2016). Effectiveness and cost-effectiveness of occupation-based occupational therapy using the aid for decision making in occupation choice (ADOC) for older residents: Pilot cluster randomized controlled trial. <i>PLoS ONE</i> , 11(3). https://doi.org/10.1371/journal.pone.0150374 | single (assessor)-blind pilot cluster randomized controlled trial | Population (care home residents) |
| Comer, C. M., Johnson, M. I., Marchant, P. R., Redmond, A. C., Bird, H. A., & Conaghan, P. G. (2010). The Effectiveness of Walking Stick Use for Neurogenic Claudication: Results From a Randomized Trial and the Effects on Walking Tolerance and Posture. <i>Archives of Physical Medicine and Rehabilitation</i> , 91(1), 15–19. https://doi.org/10.1016/j.apmr.2009.08.149 | 2 phase stud, randomized trail | Population (neurogenic claudication), content (effectiveness of walking stick) |

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|--|------------------------|--|
| Daley, T., Cristian, A., & Fitzpatrick, M. (2006, May). The Role of Occupational Therapy in the Care of the Older Adult. <i>Clinics in Geriatric Medicine</i> . https://doi.org/10.1016/j.cger.2005.12.004 | Review-opinion | Level not achieved |
| Ponte-Allan, M., & Giles, G. M. (1999). Goal setting and functional outcomes in rehabilitation. <i>American Journal of Occupational Therapy</i> , 53(6), 646–649. https://doi.org/10.5014/ajot.53.6.646 | Descriptive study | Population (CVA), limited study information |
| Rowe, V. T., & Neville, M. (2018). Client perceptions of task-oriented training at home: “I forgot i was sick.” <i>OTJR Occupation, Participation and Health</i> , 38(3), 190–195. https://doi.org/10.1177/1539449218762729 | Descriptive study | Design, population (hemiparese) |
| Leone, D., Moja, E. A., & Vegni, E. (2013, July). Satisfaction for quality of life: A comparison of patient and occupational therapist perspectives. <i>Scandinavian Journal of Occupational Therapy</i> . https://doi.org/10.3109/11038128.2013.777939 | Descriptive study | Design, population (inpatient, pathology, age) |
| Liu, K. P. Y., Chan, C. C. H., & Chan, F. (2005). Would discussion on patients’ needs add value to the rehabilitation process? <i>International Journal of Rehabilitation Research</i> , 28(1), 1–7. https://doi.org/10.1097/00004356-200503000-00001 | comparative design | Design, population (in-patient, pathology) |
| Gitlin, L. N., Winter, L., Dennis, M. P., & Hauck, W. W. (2008). Variation in response to a home intervention to support daily function by age, race, sex, and education. <i>Journals of Gerontology - Series A Biological Sciences and Medical Sciences</i> , 63(7), 745–750. https://doi.org/10.1093/gerona/63.7.745 | RCT | Content (not about goals) |
| Gage, M., & Cook, J. V. (1997). Marie Gage, Joanne Valiant Cook, Karen Fryday-Field, 51(2), 96–103. | Qualitative study | Design, population (age), content (not about goals) |
| Pomeroy, V. M., Conroy, M. C., & Coleman, P. G. (1997). Setting handicap goals with elderly people: A pilot study of the Life Strengths Interview. <i>Clinical Rehabilitation</i> , 11(2), 156–161. https://doi.org/10.1177/026921559701100209 | Clinical case studies. | Design, population (inpatient), quality of article, terminology (handicap goals) |

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|-------------------------------|---|---|---|---|---|--------------------------|
| Winship, J. M., Ivey, C. K., & Etz, R. S. (2019). Opportunities for occupational therapy on a primary care team. <i>American Journal of Occupational Therapy</i> , 73(5). https://doi.org/10.5014/ajot.2019.030841 | qualitative descriptive study | Outpatient complex care clinic of an urban academic medical center. | Researchers attended 10 clinician team meetings and conducted 13 patient interviews and 10 clinician interviews | explore the need for and potential role of occupational therapy in a team-based primary care clinic | Our findings also show that patients' occupational needs go beyond chronic disease self-management and also include community mobility, ADLs, and IADLs | This study adds to the available literature examining patient needs and clinician challenges in a primary care clinic. Patients have occupational needs that are not being addressed in primary care, indicating a need for occupational therapy in this setting. | Acceptable quality (JBI) |

Literature matrix excluded articles

| reference | design | reason exclusion |
|---|--------------|-------------------------------------|
| Ridout, A., & Mayers, C. (2006). Evaluation of the implementation of the single assessment process and its impact on occupational therapy practice. <i>British Journal of Occupational Therapy</i> . British Journal of Occupational Therapy. https://doi.org/10.1177/030802260606900605 | Mixed method | Content (single assessment process) |

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| Murphy, A. D., Griffith, V. M., Mroz, T. M., & Jirikowic, T. L. (2017). Primary care for underserved populations: Navigating policy to incorporate occupational therapy into federally qualified health centers. <i>American Journal of Occupational Therapy</i> , 71(2). https://doi.org/10.5014/ajot.2017.712001 | Case study, expert opinion | Content (OT in Federally qualified health centers) |
|---|----------------------------|--|

Cinahl

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|------------------------------|--|---------------------|----------------------|---|--|---------------------|
| Kelly, B., Rid, A., & Wendler, D. (2012, May). Systematic review: Individuals' goals for surrogate decision-making. <i>Journal of the American Geriatrics Society</i>. https://doi.org/10.1111/j.1532-5415.2012.03937.x | Systematic literature review | <p>identify individuals' goals with respect to treatment decision-making during periods of incapacity.</p> <p>elderly individuals, typically aged 65 and older, nine reported the views of terminally or seriously ill patients. Ten articles focused on the views of particular patient or ethnic</p> | Literature reserach | Preferred leeway | Individuals have three primary goals with respect to making treatment decisions for them during periods of incapacity: involve their family, treat them consistently with their own treatment preferences, and reduce the burden on their family. | | High quality (SIGN) |

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|--|--|--|--|--|--|--|--|
| | | groups. Only six articles surveyed a larger cross-section of a given population. | | | | | |
|--|--|--|--|--|--|--|--|

Literature matrix excluded articles

| reference | design | reason exclusion |
|--|---|--|
| Clare, L., Kudlicka, A., Oyebode, J. R., Jones, R. W., Bayer, A., Leroi, I., ... Woods, B. (2019). Individual goal-oriented cognitive rehabilitation to improve everyday functioning for people with early-stage dementia: A multicentre randomised controlled trial (the GREAT trial). <i>International Journal of Geriatric Psychiatry</i> , 34(5), 709–721. https://doi.org/10.1002/gps.5076 | Parallel group multicentre single-blind randomised controlled trial (RCT) | Population (mild to moderate dementia) |
| Austin, C. A., Mohottige, D., Sudore, R. L., Smith, A. K., & Hanson, L. C. (2015, July 1). Tools to promote shared decision making in serious illness: A systematic review. <i>JAMA Internal Medicine</i> . American Medical Association. https://doi.org/10.1001/jamainternmed.2015.1679 | Review | Population (stable chronic diseases were excluded), content (advanced care planning) |
| Rueda Daz, L. J., & Monteiro da Cruz, D. L. (2014). The efficacy of telephone use to assist and improve the wellbeing of family caregivers of persons with chronic diseases: a systematic review. <i>JBIC Database of Systematic Reviews and Implementation Reports</i> , 12(12), 106–140. https://doi.org/10.11124/jbisrir-2014-1566 | Review | Content (telephone intervention) |

4.3.4 Évaluation critique des articles retenus

Voir annexe 5.4

4.3.5 Attribution du GRADE

Voir annexe 5.5

4.4 Question clinique 4

La question clinique est la suivante :

Quelles sont les interventions multifactorielles d'ergothérapie appropriées pour les personnes âgées physiquement fragiles vivant à domicile et/ou leur contexte ?

4.4.1 Stratégie de recherche de concepts

4a focus prévention funct et soc part personne âgée

4b focus curation funct and soc part older person

4c focus rétention funct and soc part older person

4d focus balance ability-to-carry contexte social

4ème axe attitude et compétences thérapeute

| | Description | Termes de recherche |
|------------------|--|--|
| P a b c f | Personne âgée | "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] |
| P d | Contexte social/soignant | "Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Social Capital"[MeSH] OR "Social Networking"[MeSH] OR "Friends"[MeSH] OR "Family"[MeSH] OR "Caregivers"[MeSH] OR "Patient Care"[MeSH] OR "Nuclear Family"[MeSH] OR "Spouses"[MeSH] OR "Home Nursing"[MeSH] OR "Foster Home Care"[MeSH] |
| I a b c | Intervention ergothérapeutique dans la population âgée (préventive, curative et conservatrice) | "Occupational Therapy" [MeSH] OR "Therapeutics"[Mesh] OR "Activities of Daily living"[Mesh] OR "Exercise Therapy"[MeSH] OR "Exercise"[Mesh] OR "Primary Prevention"[Mesh] OR "Secondary Prevention"[Mesh] OR "Tertiary Prevention"[Mesh] OR "Teaching"[Mesh] OR "Mentoring"[Mesh] OR "Social Learning"[Mesh] OR "Self-Management"[Mesh] OR "Rehabilitation"[Mesh] OR "Psychosocial Support Systems"[Mesh] OR "Recreation Therapy"[Mesh] OR "Animal Assisted Therapy"[Mesh] OR "Computer User Training"[Mesh] OR "Physical Conditioning, Human"[Mesh] OR "Pain Management"[Mesh] OR "Patient Positioning"[Mesh] OR "Ergonomics"[Mesh] OR "Community Integration"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Education"[Mesh] OR "problem solving strateg*" OR "training" OR "guiding" OR "Sensory Aids"[Mesh] OR "Hearing Aids"[Mesh] OR "Communication Aids for Disabled"[Mesh] OR "Audiovisual Aids"[Mesh] OR "Housing for the elderly"[Mesh] OR "Mobile Applications"[Mesh] OR "Protective Devices"[Mesh] OR "Self-Help Devices"[Mesh] OR "eating aid*" OR "walking aid*" OR "washing aid*" OR "cooking aid*" OR "dressing aid*" OR "leisure aid*" OR "sitting aid*" OR "home modification*" OR "home adaptation*" OR "environmental adaptation*" OR "activity adaptation*" OR |

| | | |
|--------------------|--|---|
| | | "Distance Counseling"[Mesh] OR "Telerehabilitation"[Mesh] OR "Telemedicine"[Mesh] OR "Education, distance"[Mesh] OR "Internet-Based Intervention" [Mesh] OR "online therapy" |
| I d | Intervention ergothérapeutique contexte social accent sur l'équilibre capacité de charge | "Occupational Therapy" [MeSH] OR "Teaching"[Mesh] OR "Mentoring"[Mesh] OR "Social Learning"[Mesh] OR "Self-Management"[Mesh] OR "Psychosocial Support Systems"[Mesh] OR "Computer User Training"[Mesh] OR "Physical Conditioning, Human"[Mesh] OR "Ergonomics"[Mesh] OR "Community Integration"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Education"[Mesh] OR "problem solving strateg*" OR "training" OR "guiding" OR "Distance Counseling"[Mesh] OR "Telerehabilitation"[Mesh] OR "Telemedicine"[Mesh] OR "Education, distance"[Mesh] OR "Internet-Based Intervention" [Mesh] OR "online therapy" |
| I e | Attitude - compétence thérapeutique - attitude thérapeutique de base | "Patient-Centered Care"[Mesh] OR "Professional competence"[Mesh] OR "Professional-patient relations"[Mesh] OR "Clinical Competence"[Mesh] OR "Social Skills"[Mesh] OR "Empathy"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Respect"[Mesh] OR "Codes of Ethics"[Mesh] OR "Ethics, Professional"[Mesh] OR "occupation based" OR "occupation-based" OR "context based" OR "context-based" OR "evidence based" OR "evidence-based" OR "technology based" OR "technology-based" OR "population based" OR "population-based" OR "professional competence" OR "use of self" |
| C | / | |
| O a b c e f | Fonctionnement et participation sociale des personnes âgées | "Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling" OR "Safety"[Mesh] |
| O d e | Capacité de l'aidant/contexte social | "Workload"[Mesh] OR "Psychological Burnout"[Mesh] OR "Social Support"[Mesh] OR "Social Capital"[Mesh] OR "Respite Care"[Mesh] OR "Stress, Psychological"[Mesh] OR "Adaptation, Psychological"[Mesh] OR "Sense of Coherence"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Self-Management"[Mesh] OR "caregiver burden" OR "caregivers burden" OR "overload" OR "overcharge" |

Bases de données consultées :

Base de données Cochrane des revues systématiques, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Critères d'inclusion méthodologiques

- Conception : revues systématiques et méta-analyses, essais contrôlés randomisés.
- Qualité méthodologique suffisante mesurée à l'aide de l'outil d'évaluation critique du SIGN
- Période de recherche : de la base de données au 30 juin 2022

Critères d'inclusion et d'exclusion du contenu :

Inclusion :

- la personne âgée physiquement fragile et/ou l'aidant informel
- soins primaires

- intervention d'ergothérapie ou intervention concernant le fonctionnement/la signification ou la participation sociale

Exclusion :

Interventions auprès de personnes atteintes de démence ou de graves problèmes cognitifs ou psychologiques

Chaînes de recherche par base de données

Pubmed

Primary care[MeSH Terms] AND (1000/1/1:2022/6/30[pdat]))

AND

((("Activities of Daily Living"[Mesh] OR "Self-Management"[Mesh] OR "Physical Functional Performance"[Mesh] OR "Social Participation"[Mesh] OR "Community Integration"[Mesh] OR "Community Participation"[Mesh] OR "Social Integration"[Mesh] OR "Social Capital"[Mesh] OR "Human Activities"[Mesh] OR "Healthy Lifestyle"[Mesh] OR "Quality of Life"[Mesh] OR "Sense of Coherence"[Mesh] OR "Quality-Adjusted Life Years"[Mesh] OR "Leisure Activities"[Mesh] OR "Health Literacy"[Mesh] OR "patient compliance"[Mesh] OR "Anxiety"[Mesh] OR "Sedentary Behavior"[Mesh] OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling" OR "Safety"[Mesh] AND (1000/1/1:2022/6/30[pdat]))

AND

("Occupational Therapy" [MeSH] OR "Therapeutics"[Mesh] OR "Activities of Daily living"[Mesh] OR "Exercise Therapy"[Mesh] OR "Exercise"[Mesh] OR "Primary Prevention"[Mesh] OR "Secondary Prevention"[Mesh] OR "Tertiary Prevention"[Mesh] OR "Teaching"[Mesh] OR "Mentoring"[Mesh] OR "Social Learning"[Mesh] OR "Self-Management"[Mesh] OR "Rehabilitation"[Mesh] OR "Psychosocial Support Systems"[Mesh] OR "Recreation Therapy"[Mesh] OR "Animal Assisted Therapy"[Mesh] OR "Computer User Training"[Mesh] OR "Physical Conditioning, Human"[Mesh] OR "Pain Management"[Mesh] OR "Patient Positioning"[Mesh] OR "Ergonomics"[Mesh] OR "Community Integration"[Mesh] OR "Directive Counseling"[Mesh] OR "Counseling"[Mesh] OR "Education"[Mesh] OR "problem solving strateg*" OR "training" OR "guiding" OR "Sensory Aids"[Mesh] OR "Hearing Aids"[Mesh] OR "Communication Aids for Disabled"[Mesh] OR "Audiovisual Aids"[Mesh] OR "Housing for the elderly"[Mesh] OR "Mobile Applications"[Mesh] OR "Protective Devices"[Mesh] OR "Self-Help Devices"[Mesh] OR "eating aid*" OR "walking aid*" OR "washing aid*" OR "cooking aid*" OR "dressing aid*" OR "leisure aid*" OR "sitting aid*" OR "home modification*" OR "home adaptation*" OR "environmental adaptation*" OR "activity adaptation*" OR "Distance Counseling"[Mesh] OR "Telerehabilitation"[Mesh] OR "Telemedicine"[Mesh] OR "Education, distance"[Mesh] OR "Internet-Based Intervention" [Mesh] OR "online therapy" AND (1000/1/1:2022/6/30[pdat]))

AND

("Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] AND (1000/1/1:2022/6/30[pdat])) AND (1000/1/1:2022/6/30[pdat]))

Filters: Meta-Analysis, Randomized Controlled Trial, Systematic Review, from 2012/1/1 - 2022/6/30

Cochrane

| ID | Search |
|-----|---|
| #1 | MeSH descriptor: [Aged] explode all trees |
| #2 | MeSH descriptor: [Frail Elderly] explode all trees |
| #3 | MeSH descriptor: [Aged, 80 and over] explode all trees |
| #4 | MeSH descriptor: [Frailty] explode all trees |
| #5 | MeSH descriptor: [Homebound Persons] explode all trees |
| #6 | #1 OR #2 OR #3 OR #4 OR #5 |
| #7 | MeSH descriptor: [Social Environment] explode all trees |
| #8 | MeSH descriptor: [Social Support] explode all trees |
| #9 | MeSH descriptor: [Social Capital] explode all trees |
| #10 | MeSH descriptor: [Social Networking] explode all trees |
| #11 | MeSH descriptor: [Friends] explode all trees |
| #12 | MeSH descriptor: [Family] explode all trees |
| #13 | MeSH descriptor: [Caregivers] explode all trees |
| #14 | MeSH descriptor: [Patient Care] explode all trees |
| #15 | MeSH descriptor: [Nuclear Family] explode all trees |
| #16 | MeSH descriptor: [Spouses] explode all trees |
| #17 | MeSH descriptor: [Home Nursing] explode all trees |
| #18 | MeSH descriptor: [Foster Home Care] explode all trees |
| #19 | #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 |
| #20 | #6 OR #19 |
| #21 | MeSH descriptor: [Housing for the Elderly] explode all trees |
| #22 | MeSH descriptor: [Environment Design] explode all trees |
| #23 | MeSH descriptor: [Built Environment] explode all trees |
| #24 | MeSH descriptor: [Environment] explode all trees |
| #25 | MeSH descriptor: [Environment, Controlled] explode all trees |
| #26 | home |
| #27 | house |
| #28 | #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 |
| #29 | #6 OR #19 OR #28 |
| #30 | MeSH descriptor: [Occupational Therapy] explode all trees |

#31 MeSH descriptor: [Disability Evaluation] explode all trees
 #32 MeSH descriptor: [Geriatric Assessment] explode all trees
 #33 MeSH descriptor: [Clinical Decision-Making] explode all trees
 #34 MeSH descriptor: [Diagnostic Self Evaluation] explode all trees
 #35 MeSH descriptor: [Patient Health Questionnaire] explode all trees
 #36 MeSH descriptor: [Needs Assessment] explode all trees
 #37 MeSH descriptor: [Patient Outcome Assessment] explode all trees
 #38 MeSH descriptor: [Self-Assessment] explode all trees
 #39 MeSH descriptor: [Patient Acuity] explode all trees
 #40 MeSH descriptor: [Treatment Outcome] explode all trees
 #41 MeSH descriptor: [House Calls] explode all trees
 #42 MeSH descriptor: [Physical Functional Performance] explode all trees
 #43 #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #'41OR #42
 #44 #30 AND #43
 #45 MeSH descriptor: [Activities of Daily Living] explode all trees
 #46 MeSH descriptor: [Self-Management] explode all trees
 #47 MeSH descriptor: [Social Participation] explode all trees
 #48 MeSH descriptor: [Community Integration] explode all trees
 #49 MeSH descriptor: [Community Participation] explode all trees
 #50 MeSH descriptor: [Social Integration] explode all trees
 #51 MeSH descriptor: [Social Capital] explode all trees
 #52 MeSH descriptor: [Human Activities] explode all trees
 #53 MeSH descriptor: [Healthy Lifestyle] explode all trees
 #54 MeSH descriptor: [Quality of Life] explode all trees
 #55 MeSH descriptor: [Sense of Coherence] explode all trees
 #56 MeSH descriptor: [Quality-Adjusted Life Years] explode all trees
 #57 MeSH descriptor: [Leisure Activities] explode all trees
 #58 MeSH descriptor: [Health Literacy] explode all trees
 #59 MeSH descriptor: [Patient Compliance] explode all trees
 #60 MeSH descriptor: [Anxiety] explode all trees
 #61 MeSH descriptor: [Sedentary Behavior] explode all trees
 #62 "occupational performance"
 #63 "occupational competence"
 #64 "accidental falls"
 #65 MeSH descriptor: [Accidental Falls] explode all trees
 #66 "fear of falling"
 #67 #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR # 51 OR #52 OR # 53 OR # 54 OR # 55 OR # 56 OR # 57 OR # 58 OR # 59 OR # 60 OR # 61 OR # 62 OR # 63 OR # 64 OR # 65
 #68 MeSH descriptor: [Workload] explode all trees
 #69 MeSH descriptor: [Burnout, Psychological] explode all trees
 #70 MeSH descriptor: [Social Support] explode all trees
 #71 MeSH descriptor: [Social Capital] explode all trees

#72 MeSH descriptor: [Respite Care] explode all trees
 #73 MeSH descriptor: [Stress, Psychological] explode all trees
 #74 MeSH descriptor: [Adaptation, Psychological] explode all trees
 #75 MeSH descriptor: [Sense of Coherence] explode all trees
 #76 "caregiver burden"
 #77 "caregivers burden"
 #78 "overload"
 #79 "overcharge"
 #80 #68 OR #69 OR #70 OR #71 OR #72 OR #73 OR #74 OR #75 OR #76 OR #77 OR #78 OR #79
 #81 MeSH descriptor: [Activities of Daily Living] explode all trees
 #82 MeSH descriptor: [Self-Management] explode all trees
 #83 MeSH descriptor: [Physical Functional Performance] explode all trees
 #84 MeSH descriptor: [Community Integration] explode all trees
 #85 MeSH descriptor: [Community Participation] explode all trees
 #86 MeSH descriptor: [Social Integration] explode all trees
 #87 MeSH descriptor: [Human Activities] explode all trees
 #88 MeSH descriptor: [Healthy Lifestyle] explode all trees
 #89 MeSH descriptor: [Quality of Life] explode all trees
 #90 MeSH descriptor: [Sense of Coherence] explode all trees
 #91 MeSH descriptor: [Quality-Adjusted Life Years] explode all trees
 #92 MeSH descriptor: [Leisure Activities] explode all trees
 #93 MeSH descriptor: [Patient Compliance] explode all trees
 #94 MeSH descriptor: [Safety] explode all trees
 #95 MeSH descriptor: [Accidental Falls] explode all trees
 #96 "occupational performance"
 #97 "occupational competence"
 #98 #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR # 88 OR #91 OR #92 OR #93 OR #94 OR #95 OR #96 OR #97
 #99 #66 AND #44 AND #67
 #100 #19 AND #44 AND #80
 #101 #28 AND #44 AND #98
 #102 #67 OR #80 OR #98
 #103 #29 AND #44 AND #102
 #104 MeSH descriptor: [Disability Evaluation] explode all trees
 #105 MeSH descriptor: [Geriatric Assessment] explode all trees
 #106 MeSH descriptor: [Clinical Decision-Making] explode all trees
 #107 MeSH descriptor: [Diagnostic Self Evaluation] explode all trees
 #108 MeSH descriptor: [Patient Health Questionnaire] explode all trees
 #109 MeSH descriptor: [Needs Assessment] explode all trees
 #110 MeSH descriptor: [Patient Outcome Assessment] explode all trees
 #111 MeSH descriptor: [Self-Assessment] explode all trees
 #112 MeSH descriptor: [Patient Acuity] explode all trees

#113 MeSH descriptor: [Treatment Outcome] explode all trees
 #114 MeSH descriptor: [House Calls] explode all trees
 #115 #104 OR #105 OR #106 OR #107 OR #108 OR #109 OR #110 OR #111 OR #112 OR # 115 OR # 116
 #116 MeSH descriptor: [Activities of Daily Living] explode all trees
 #117 MeSH descriptor: [Physical Functional Performance] explode all trees
 #118 MeSH descriptor: [Community Integration] explode all trees
 #119 MeSH descriptor: [Community Participation] explode all trees
 #120 MeSH descriptor: [Social Integration] explode all trees
 #121 MeSH descriptor: [Human Activities] explode all trees
 #122 MeSH descriptor: [Healthy Lifestyle] explode all trees
 #123 MeSH descriptor: [Quality of Life] explode all trees
 #124 MeSH descriptor: [Sense of Coherence] explode all trees
 #125 MeSH descriptor: [Quality-Adjusted Life Years] explode all trees
 #126 MeSH descriptor: [Leisure Activities] explode all trees
 #127 MeSH descriptor: [Patient Compliance] explode all trees
 #128 MeSH descriptor: [Safety] explode all trees
 #129 MeSH descriptor: [Accidental Falls] explode all trees
 #130 "occupational performance"
 #131 #116 OR #117 OR #118 OR #119 OR #120 OR #121 OR #122 OR #123 OR #124 OR #125 OR #126 OR #127 OR #128 OR #129 OR #130
 #132 MeSH descriptor: [Goals] explode all trees
 #133 MeSH descriptor: [Treatment Outcome] explode all trees
 #134 MeSH descriptor: [Directive Counseling] explode all trees
 #135 MeSH descriptor: [Counseling] explode all trees
 #136 MeSH descriptor: [Distance Counseling] explode all trees
 #137 "motivational interview"
 #138 "collaborative goal setting"
 #139 "occupation focused goal"
 #140 #132 OR #133 OR #134 OR #135 OR #138 OR #139
 #141 MeSH descriptor: [Methods] explode all trees
 #142 #140 AND #141 AND #30
 #143 MeSH descriptor: [Patient-Centered Care] explode all trees
 #144 MeSH descriptor: [Professional Competence] explode all trees
 #145 MeSH descriptor: [Professional-Patient Relations] explode all trees
 #146 MeSH descriptor: [Clinical Competence] explode all trees
 #147 MeSH descriptor: [Social Skills] explode all trees
 #148 MeSH descriptor: [Empathy] explode all trees
 #149 MeSH descriptor: [Attitude of Health Personnel] explode all trees
 #150 MeSH descriptor: [Respect] explode all trees
 #151 MeSH descriptor: [Codes of Ethics] explode all trees
 #152 MeSH descriptor: [Ethics, Professional] explode all trees
 #153 "occupation based"

#154 "context based"
 #155 "evidence based"
 #156 "technology based"
 #157 "population based"
 #158 "professional competence"
 #159 "use of self"
 #160 #143 OR #144 OR #145 OR #146 OR #147 OR #148 OR #149 OR #150 OR #151 OR #152 OR #153 OR #154 OR #155 OR #156 OR # 155 OR #158 OR #159
 #161 #40 AND #160 AND #30
 #162 MeSH descriptor: [Occupational Therapy] explode all trees
 #163 MeSH descriptor: [Therapeutics] explode all trees
 #164 MeSH descriptor: [Activities of Daily Living] explode all trees
 #165 MeSH descriptor: [Exercise Therapy] explode all trees
 #166 MeSH descriptor: [Exercise] explode all trees
 #167 MeSH descriptor: [Primary Prevention] explode all trees
 #168 MeSH descriptor: [Secondary Prevention] explode all trees
 #169 MeSH descriptor: [Tertiary Prevention] explode all trees
 #170 MeSH descriptor: [Teaching] explode all trees
 #171 MeSH descriptor: [Mentoring] explode all trees
 #172 MeSH descriptor: [Social Learning] explode all trees
 #173 MeSH descriptor: [Self-Management] explode all trees
 #174 MeSH descriptor: [Rehabilitation] explode all trees
 #175 MeSH descriptor: [Psychosocial Support Systems] explode all trees
 #176 MeSH descriptor: [Recreation Therapy] explode all trees
 #177 MeSH descriptor: [Animal Assisted Therapy] explode all trees
 #178 MeSH descriptor: [Computer User Training] explode all trees
 #179 MeSH descriptor: [Physical Conditioning, Human] explode all trees
 #180 MeSH descriptor: [Pain Management] explode all trees
 #181 MeSH descriptor: [Patient Positioning] explode all trees
 #182 MeSH descriptor: [Ergonomics] explode all trees
 #183 MeSH descriptor: [Community Integration] explode all trees
 #184 MeSH descriptor: [Directive Counseling] explode all trees
 #185 MeSH descriptor: [Counseling] explode all trees
 #186 MeSH descriptor: [Education] explode all trees
 #187 "problem solving strategy"
 #188 "problem solving strategies"
 #189 "training"
 #190 "guiding"
 #191 #162 OR #163 OR #164 OR #165 OR #166 OR #167 OR #168 OR # 166 OR #170 OR #171 OR #172 OR #173 OR #174 OR #175 OR #176 OR #177 OR #178 OR #179 OR #180 OR #181
 OR #182 OR #183 OR #184 OR #185 OR #186 OR #187 OR #188 OR #189 OR #190
 #192 MeSH descriptor: [Sensory Aids] explode all trees
 #193 MeSH descriptor: [Hearing Aids] explode all trees

#194 MeSH descriptor: [Communication Aids for Disabled] explode all trees
 #195 MeSH descriptor: [Audiovisual Aids] explode all trees
 #196 MeSH descriptor: [Housing for the Elderly] explode all trees
 #197 MeSH descriptor: [Mobile Applications] explode all trees
 #198 MeSH descriptor: [Protective Devices] explode all trees
 #199 MeSH descriptor: [Self-Help Devices] explode all trees
 #200 "eating aid" OR "eating aids"
 #201 "walking aid" OR "walking aids"
 #202 "washing aid" OR "washing aids"
 #203 "cooking aid" OR "cooking aids"
 #204 "dressing aid" OR "dressing aids"
 #205 "leisure aid" OR "leisure aids"
 #206 "sitting aid" OR "sitting aids"
 #207 "home modificiation" OR "home modifications"
 #208 "home adaptation" OR "home adaptations"
 #209 "environmental adaptation" OR "environmental adaptations"
 #210 "activity adaptation"
 #211 #192 OR #193 OR #194 OR #195 OR #196 OR #197 OR #198 OR #199 OR #200 OR #201 OR #202 OR #203 OR #204 OR #205 OR #206 OR #207 OR #208 OR #209 OR #210
 #212 MeSH descriptor: [Distance Counseling] explode all trees
 #213 MeSH descriptor: [Telerehabilitation] explode all trees
 #214 MeSH descriptor: [Telemedicine] explode all trees
 #215 MeSH descriptor: [Education, Distance] explode all trees
 #216 MeSH descriptor: [Internet-Based Intervention] explode all trees
 #217 "online therapy"
 #218 #212 OR #213 OR #214 OR #215 OR #216 OR #217
 #219 #191 OR #211 OR #218
 Final search: #6 AND #219 AND #67

Cinahl (limit aged 80 and over)

(MH "Primary care"+) AND ((MH 1000))

AND

(((((MH "Activities of Daily Living"+) OR (MH Self-Management+) OR (MH "Physical Functional Performance"+) OR (MH "Social Participation"+) OR (MH
 "Community Integration"+) OR (MH "Community Participation"+) OR (MH "Social Integration"+) OR (MH "Social Capital"+) OR (MH "Human Activities"+)
 OR (MH "Healthy Lifestyle"+) OR (MH "Quality of Life"+) OR (MH "Sense of Coherence"+) OR (MH "Quality-Adjusted Life Years"+) OR (MH "Leisure

Activities"+) OR (MH " Health Literacy"+) OR (MH "patient compliance"+) OR (MH Anxiety+) OR (MH "Sedentary Behavior"+) OR "occupational performance" OR "occupational competence" OR "accidental falls" OR "fear of falling" OR (MH Safety+) AND ((MH 1000)))

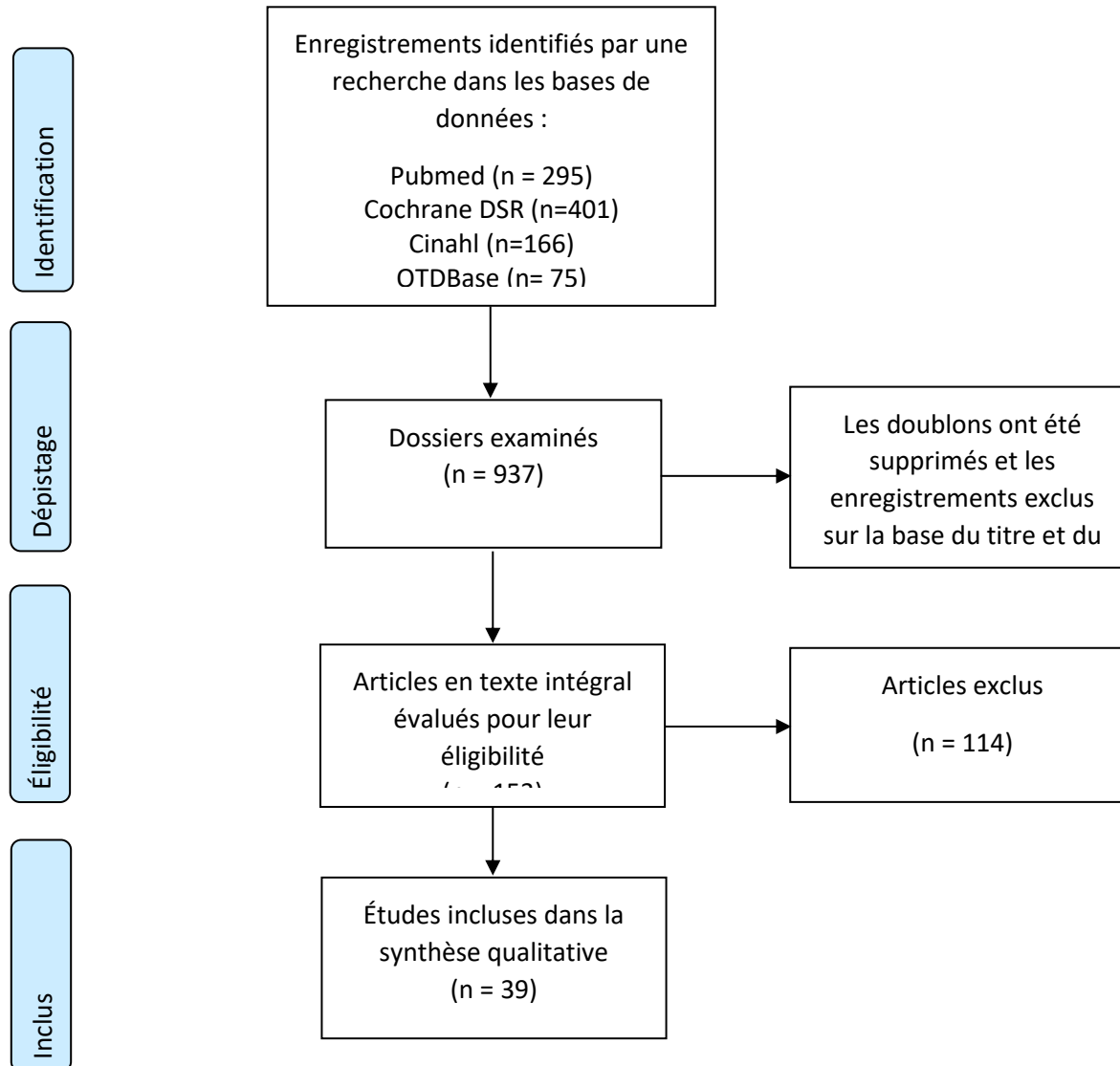
AND

((MH "Occupational Therapy"+) OR (MH Therapeutics+) OR (MH "Activities of Daily living"+) OR (MH "Exercise Therapy"+) OR (MH Exercise+) OR (MH "Primary Prevention"+) OR (MH "Secondary Prevention"+) OR (MH "Tertiary Prevention"+) OR (MH Teaching+) OR (MH Mentoring+) OR (MH "Social Learning"+) OR (MH Self-Management+) OR (MH Rehabilitation+) OR (MH "Psychosocial Support Systems"+) OR (MH "Recreation Therapy"+) OR (MH "Animal Assisted Therapy"+) OR (MH "Computer User Training"+) OR (MH "Physical Conditioning, Human"+) OR (MH "Pain Management"+) OR (MH "Patient Positioning"+) OR (MH Ergonomics+) OR (MH "Community Integration"+) OR (MH "Directive Counseling"+) OR (MH Counseling+) OR (MH Education+) OR "problem solving strateg*" OR training OR guiding OR (MH "Sensory Aids"+) OR (MH "Hearing Aids"+) OR (MH "Communication Aids for Disabled"+) OR (MH "Audiovisual Aids"+) OR (MH "Housing for the elderly"+) OR (MH "Mobile Applications"+) OR (MH "Protective Devices"+) OR (MH "Self-Help Devices"+) OR "eating aid*" OR "walking aid*" OR "washing aid*" OR "cooking aid*" OR "dressing aid*" OR "leisure aid*" OR "sitting aid*" OR "home modification*" OR "home adaptation*" OR "environmental adaptation*" OR "activity adaptation*" OR (MH "Distance Counseling"+) OR (MH Telerehabilitation+) OR (MH Telemedicine+) OR (MH "Education, distance"+) OR (MH "Internet-Based Intervention"+) OR "online therapy" AND ((MH 1000))) AND ((MH "Frail Elderly"+) OR (MH "Aged, 80 and over"+) OR (MH Frailty+) AND ((MH 1000))) AND ((MH 1000)))

OTDBase

("frail elderly" AND "primary care") OR ("frailty" and "primary care")

4.4.2 Résultats identifiés



4.4.3 Matrice bibliographique question clinique 4

Cochrane database of systematic review

Literature matrix included articles

| référéncé | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|--|----------------------|--------------------------------------|---|-------------------------|---|--|------------------------|
| Cochrane A, Furlong M, McGilloway S, Molloy DW, Stevenson M, Donnelly M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. <i>Cochrane Database Syst Rev.</i> 2016 Oct 11;10(10):CD010825. doi: 10.1002/14651858.CD010825.pub2. PMID: 27726122; PMCID: PMC6457975. | Sys rev | Older adults (aged 65 years or more) | Time-limited home-care reablement services (up to 12 weeks) Reablement: The reablement approach emphasises the active participation of an older person in working towards agreed goals that are designed to maximise independence and confidence. While reablement shares features with other interventions, it is distinguished by a re-orientation of home care away from treating | Functional independence | Functional status: very low quality evidence suggested that reablement may be slightly more elective than usual care in improving function at nine to 12 months (lower scores reflect greater independence; standardised mean difference (SMD) -0.30; 95% confidence interval (CI) -0.53 to -0.06; 2 studies with 249 participants). Adverse events: reablement may make little or no difference to mortality at 12 months' follow-up (RR 0.97; 95% CI 0.74 to 1.29; 2 studies with 811 participants) or rates of unplanned hospital admission at 24 months (RR 0.94; | Reablement may help some older adults to improve their abilities to engage in everyday activities (functional status) to a small degree, but may make little or no difference to death rates or admissions to hospital. The findings mean we are also uncertain whether reablement affects quality of life or living arrangements. Reablement may lead to a small decrease in numbers of | Sign High quality (++) |

| | | | | |
|--|--|--|--|---|
| | | <p>disease and creating dependency to maximising independence; it achieves this by offering intensive (i.e. multiple visits), time-limited (typically six to 12 weeks' duration), multidisciplinary, person centred and goal-directed home-care services (Ryburn 2009). It is important to note that reablement is not designed to resolve specific healthcare issues (e.g. Crotty 2010), but may help an older person to regain confidence and functional abilities are recovering from an illness or a period of hospitalisation. Therefore, a reablement programme typically includes</p> | <p>95% CI 0.85 to 1.03; 1 study with 750 participants). The very low quality evidence also means we are uncertain whether reablement may influence quality of life (SMD -0.23; 95% CI -0.48 to 0.02; 2 trials with 249 participants) or living arrangements (RR 0.92, 95% CI 0.62 to 1.34; 1 study with 750 participants) at time points up to 12 months. People receiving reablement may be slightly less likely to have been approved for a higher level of personal care than people receiving usual care over the 24 months' follow-up (RR 0.87; 95% CI 0.77 to 0.98; 1 trial, 750 participants). Similarly, although there may be a small reduction in total aggregated home and healthcare costs over the 24-month follow-up (reablement: AUD 19,888; usual care: AUD 22,757; 1 trial with 750 participants), we are</p> | <p>people needing higher levels of personal care, and may decrease care costs to a small degree, but neither study reported satisfaction of those using the reablement service. 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</p> |
|--|--|--|--|---|

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| | | | a range of targeted components designed to optimise functioning in the performance of activities of daily living (ADL). | | uncertain about the size and importance of these effects as the results were based on very low quality evidence. | | |
|--|--|--|---|--|--|--|--|

Literature matrix excluded articles

| reference | design | reason exclusion |
|--|---------|------------------|
| Gillespie, Gillespie, L. D., Robertson, M. C., Gillespie, W. J., Sherrington, C., Gates, S., Clemson, L., & Lamb, S. E. (2012). Interventions for preventing falls in older people living in the community. <i>Cochrane Library</i> , 2021(6), CD007146–CD007146. https://doi.org/10.1002/14651858.CD007146.pub3 | Sys rev | RL valpreventie |
| Hopewell, Adedire, O., Copsey, B. J., Boniface, G. J., Sherrington, C., Clemson, L., Close, J. C., Lamb, S. E., & Hopewell, S. (2018). Multifactorial and multiple component interventions for preventing falls in older people living in the community. <i>Cochrane Library</i> , 2018(7), CD012221–CD012221. https://doi.org/10.1002/14651858.CD012221.pub2 | Sys rev | RL valpreventie |
| Martin, Clare, L., Altgassen, A. M., Cameron, M. H., Zehnder, F., & Martin, M. (2011). Cognition-based interventions for healthy older people and people with mild cognitive impairment. <i>Cochrane Library</i> , 2011(1), CD006220–CD006220. https://doi.org/10.1002/14651858.CD006220.pub2 | Sys rev | Other outcome |
| Kumar, Delbaere, K., Zijlstra, G. A. R., Carpenter, H., Iliffe, S., Masud, T., Skelton, D., Morris, R., & Kenick, D. (2016). Exercise for reducing fear of falling in older people living in the community: Cochrane systematic review and meta-analysis. <i>Age and Ageing</i> , 45(3), 345–352. https://doi.org/10.1093/ageing/afw036 | Sys rev | RL val |
| Rankin, Cadogan, C. A., Patterson, S. M., Kerse, N., Cardwell, C. R., Bradley, M. C., Ryan, C., Hughes, C., & Hughes, C. (2018). Interventions to improve the appropriate use of polypharmacy for older people. <i>Cochrane Library</i> , 2018(9), CD008165–CD008165. https://doi.org/10.1002/14651858.CD008165.pub4 | Sys rev | Other purpose |

| | | |
|--|-------------------|---------------------------------|
| Young, Angevaren, M., Rusted, J., Tabet, N., & Young, J. (2015). Aerobic exercise to improve cognitive function in older people without known cognitive impairment. <i>Cochrane Library</i> , 2015(4), CD005381. https://doi.org/10.1002/14651858.CD005381.pub4 | | Physiotherapy |
| Richards, Hillsdon, M., Thorogood, M., Foster, C., & Foster, C. (2013). Face-to-face interventions for promoting physical activity. <i>Cochrane Library</i> , 2013(9), CD010392–CD010392. https://doi.org/10.1002/14651858.CD010392.pub2 | Research protocol | Other design |
| Cross, A. J., Elliott, R. A., Petrie, K., Kuruvilla, L., & George, J. (2020). Interventions for improving medication-taking ability and adherence in older adults prescribed multiple medications. <i>Cochrane Library</i> , 2020(5), CD012419–CD012419. https://doi.org/10.1002/14651858.CD012419.pub2 | Sys rev | Other purpose |
| Howe, T, Rochester, L., Neil, F., Skelton, D. A., Ballinger, C., & Howe, T. E. (2011). Exercise for improving balance in older people. <i>Cochrane Library</i> , 2012(5), CD004963–CD004963. https://doi.org/10.1002/14651858.CD004963.pub3 | Sys rev | Physiotherapy |
| Ferguson, Kitterick, P. T., Chong, L. Y., Edmondson-Jones, M., Barker, F., Hoare, D. J., & Ferguson, M. A. (2017). Hearing aids for mild to moderate hearing loss in adults. <i>Cochrane Library</i> , 2017(9), CD012023–CD012023. https://doi.org/10.1002/14651858.CD012023.pub2 | Sys rev | Other population |
| Santesso, Carrasco-Labra, A., Brignardello-Petersen, R., & Santesso, N. (2014). Hip protectors for preventing hip fractures in older people. <i>Cochrane Library</i> , 2014(3), CD001255–CD001255. https://doi.org/10.1002/14651858.CD001255.pub5 | Sys rev | Other population (nursing home) |

Pubmed

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|--|--|-----------------------|--|---|--|---|---------------------|
| Apóstolo J, Dixe MDA, Bobrowicz-Campos E, Areosa T, Santos-Rocha R, Braúna M, Ribeiro J, Marques I, Freitas J, Almeida ML, Couto F. Effectiveness of a Combined Intervention on Psychological and Physical Capacities of Frail Older Adults: A Cluster Randomized | Multicenter single-blinded two-arm cluster randomized controlled trial | 44 frail older adults | For 12 weeks, participants received two group sessions of physical exercise and one session of cognitive stimulation | Cognitive function, depressive symptomatology, gait speed, biomechanical parameters of gait, and risk of fall | At baseline, groups were equivalent for study outcomes. The comparison of pre- and post-intervention data revealed that subjects receiving CI reduced depressive | The present trial validates the effectiveness of the intervention composed of adapted and structured cognitive and physical exercise programs to promote psychological and physical capacities of frail | Sign acceptable (+) |

| | | | | | | | |
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| <p>Controlled Trial. <i>Int J Environ Res Public Health</i>. 2019 Aug 28;16(17):3125. doi: 10.3390/ijerph16173125. PMID: 31466229; PMCID: PMC6747215.</p> | | | | <p>based on gait and balance</p> | <p>symptomatology and risk of fall based on gait and balance, and improved gait speed. Simultaneously, in the CG a significant decline in activities of daily living was observed. Significant results were found among biomechanical parameters of gait (BPG). EG' effect size revealed to be small ($0.2 \leq r < 0.5$). CG' effect size was also small; but for activities of daily living there was an evident decrease.</p> | <p>older adults from day centers and nursing homes.</p> | |
| <p>Balis LE, Strayer T, Ramalingam N, Wilson M, Harden SM. Open-Access Physical Activity Programs for Older Adults: A Pragmatic and Systematic Review. <i>Gerontologist</i>. 2019 Jul 16;59(4): e268-e278. doi: 10.1093/geront/gnx195. PMID: 29329395.</p> | <p>Pragmatic and systematic review</p> | <p>Oder adults</p> | <p>Physical activities</p> | <p>Components of effective physical training</p> | <p>Sixteen peer-reviewed studies and 17 grey literature sources. Activities in the peer-reviewed literature were more likely to use a combination of physical activity components and be delivered by trained professionals. The results indicate notable differences between peer-reviewed literature and non-peer reviewed programs and present an opportunity for non-peer reviewed programs to more effectively use evidence-based program characteristics,</p> | <p>Physical Activity Programs for Older Adults must be based on evidence-based program characteristics, including behavioral theories and group dynamics, a combination of physical activity components, and educator/agent trained delivery agents.</p> | <p>Sign Low quality (-)</p> |

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| | | | | | including behavioral theories and group dynamics, a combination of physical activity components, and educator/agent trained delivery agents | | |
| Bedaf S, Gelderblom GJ, De Witte L. Overview and Categorization of Robots Supporting Independent Living of Elderly People: What Activities Do They Support and How Far Have They Developed. Assist Technol. 2015 Summer;27(2):88-100. doi: 10.1080/10400435.2014.978916. PMID: 26132353. | Sys rev | Older adults | robots | ADL: mobility, self-care, interpersonal interaction & relationships, and other activities. | Out of all robots found in this review, only six were known to be available on the market. None of these robots support mobility-related activities. For the Japanese communication robot Ifbot, developed by Business Design Laboratory (no. 1), no clear information in English could be found concerning its commercial availability and the exact activities it supports. When taking a closer look at the specific activities of the other five robots, it appears that this supports only a single activity: the Mealtime Partner (no. 2), My Spoon (no. 3), and Winsford Feeder (no. 6) all physically support the activity eating (d550). The Sanyo Bath Robot (no. 5) physically supports washing (d510), and the robot | No robots are proven to be cost-effective; No robots that support physical activities No robots relevant for this population | Sign Low quality (-) |

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| | | | | | <p>seal PARO is a robotic companion supporting interpersonal interaction & relationships (d7). In general, the need of a robot is questionable for activities which do not require physical movement and/or force exertion. Robots only providing non-physical support for mobility and self-care related activities (e.g., fall detection, medication reminders, medication monitoring) will most likely fail to cost-effectively prolong independent living of elderly people, as the problematic activities in these domains often require physical support (e.g., mobility transfers, dressing, showering, toileting). The step toward physical support is inevitable and needs to be taken. This brings with it many technical challenges, for example, robots being capable of handling and/or moving frail users. Nevertheless, these technical challenges need to be overcome in order to create successful robots. Additionally, the few</p> | | |
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| | | | | | robots that were commercially available for consumers only have the capability to support a single activity, while many of the robots under development claim to support many activities. | | |
| Behrndt EM, Straubmeier M, Seidl H, Vetter C, Luttenberger K, Graessel E. Brief telephone counselling is effective for caregivers who do not experience any major life events - caregiver-related outcomes of the German day-care study. BMC Health Serv Res. 2019 Jan 9;19(1):20. doi: 10.1186/s12913-018-3853-8. PMID: 30626439; PMCID: PMC6325874. | Two-arm cluster-randomised controlled intervention study | 359 informal caregivers) | Brief telephone intervention: The aim of the intervention was to “empower” the caregivers by improving their skills. The counsellors’ basic attitude was client-centred [22] and solution-oriented. The caregivers from the intervention group received three outreach telephone calls that were based on a manual designed specifically for | Effect on depressiveness and subjective burden | Sensitivity analyses for caregivers who did not experience any events that they felt were major (in a negative or positive sense) during the six months (n = 271) showed that group allocation (p < 0.05) was a significant predictor of positive change in both outcomes (BSFC-s: Δ -1.3, [- 2.4, - 0.3], Cohen’s d = 0.27; WHO-5: Δ 1.5, [0.4, 2.7], Cohen’s d = 0.26). Effect sizes were highest in the subgroup of caregivers of people with mild dementia (BSFC-s: Cohen’s d = 0.43; WHO-5: Cohen’s d = 0.42). | A “low-dose” psycho-educative telephone intervention designed to empower caregivers is effective, especially in an early stage, if the overlap between the effect of the intervention and the effect of events that are experienced as major events in the caregiver’s life is considered. | Sign Acceptable (+) |
| Berger S, Escher A, Mengle E, Sullivan N. Effectiveness of Health Promotion, Management, and Maintenance Interventions Within the Scope of Occupational Therapy for Community-Dwelling Older Adults: A Systematic Review. Am J Occup Ther. 2018 Jul/Aug;72(4):7204190010p1- | Sys rev | community-dwelling older adults mean age 65 | health promotion, management, and maintenance interventions within the scope of occupational therapy | effect of health promotion, management, and maintenance interventions within the scope of occupational therapy on the occupational | Strong evidence supports the use of group, individual, or a combination of group and individual interventions to improve occupational performance. Group interventions were also | Occupational therapy practitioners working with older adults in the community must understand the influence of aging and chronic illness on occupational performance, QOL, and health care | Sign Low quality (-) |

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| <p>7204190010p10. doi: 10.5014/ajot.2018.030346. PMID: 29953825.</p> | | | | <p>performance, QOL, and health care utilization of community dwelling older adults?</p> | <p>effective at improving QOL. The evidence was insufficient that any of these interventions decreased health care utilization.</p> | <p>utilization. Practitioners should consider</p> <ul style="list-style-type: none"> • Providing group or individual health promotion, management, and maintenance interventions to improve occupational performance; • Providing group health promotion, management, and maintenance interventions to improve QOL; and • Including individualized goal setting, coping strategies, problem-solving techniques, and skill-specific practice in health promotion, management, and maintenance interventions with older adults. Most important, occupational therapy practitioners must remember that older adults bring their unique background, strengths, and needs to the therapy session and that interventions must be tailored accordingly. | |
| <p>Berger S, McAteer J, Schreier K, Kaldenberg J. Occupational therapy interventions to improve leisure and social participation for older adults with low vision: a systematic review. <i>Am J Occup Ther.</i> 2013 May-Jun;67(3):303-11. doi:</p> | <p>Sys Rev 13 articles included (Nine of the 13 studies included in the review were</p> | <p>Older adults with low vision</p> | <p>Interventions within the scope of occupational therapy practice</p> | <p>To maintain, restore, and improve performance in leisure and social participation</p> | <p>The studies included in this review explored four themes in intervention that promote leisure and social participation among older adults with low vision: (1) using a</p> | <p>Problem-solving approach, using a combination of services and improving lighting to improve performance in leisure and social participation.</p> | <p>Sign Low quality (-)</p> |

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| <p>10.5014/ajot.2013.005447. PMID: 23597688.</p> | <p>Level I randomized controlled trials (RCTs) and thus provide robust evidence. One study had a Level II nonrandomized controlled design, and 3 provided Level III evidence.)</p> | | | | <p>problem-solving approach, (2) providing a combination of services, (3) teaching specific skills and strategies, and (4) performing home visits and environmental adaptations. Of these themes, the two most promising are incorporating a problem-solving approach and using a combination of services. In addition, one study demonstrated the benefits of improving lighting.</p> | | |
| <p>Borella E, Cantarella A, Carretti B, De Lucia A, De Beni R. Improving Everyday Functioning in the Old-Old with Working Memory Training. Am J Geriatr Psychiatry. 2019 Sep;27(9):975-983. doi: 10.1016/j.jagp.2019.01.210. Epub 2019 Jan 29. PMID: 30878190.</p> | <p>RCT</p> | <p>Thirty-two community-dwelling older adults (aged 75–85 years)</p> | <p>All participants attended six individual sessions lasting a similar amount of time: the first and fifth were for the pre- and post-tests, and the sixth was the 9-month follow-up. During the other three sessions the trained group was administered the WM training. Participants in the trained group were administered a modified version of the CWMS, in which lists of audio-recorded words were presented and participants were asked to recall target words, and also to tap with their hand on the table when they heard an animal noun. In the training sessions, the</p> | <p>1) abilities involved in everyday life using objective performance-based tasks (the Everyday Problem Test [EPT] and the Timed Instrumental Activities of Daily Living [TIADL] scale; 2) tasks demanding the comprehension and recall of spatial information and pairing names with faces; and 3) a measure of inhibitory control, that is, recall errors (intrusion errors).</p> | <p>The results confirm that there is room for cognitive improvement even in the so-called fourth age. Exploiting the efficacy and use of WM training could sustain a more active aging and an adequate everyday life functioning, also in terms of its potential for inducing changes in individual trajectories of cognitive decline. This might be particularly useful (although the matter remains to be explored) for individuals at risk of dementia, or</p> | <p>Only the trained group showed specific gains in the criterion task, and in the TIADL in the short term. At follow-up, the trained group maintained gains in the criterion task, and showed transfer effects to everyday problem-solving (in the EPT), and in constructing spatial representations of an environment. The trained group also improved in a cognitive inhibition measure (intrusion errors) at follow-up. No such improvements were seen in the active control group.</p> | <p>Sign Low quality (-)</p> |

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| | | | <p>maintenance demand (the number of words that successful participants needed to recall) and the processing requirement (tapping on the table when an animal noun occurred) were manipulated.</p> | | <p>with an impaired WM capacity.</p> | <p>WM training may be a valid way to help old-old adults preserve at least some abilities related to everyday functioning</p> | |
| <p>Cameron ID, Fairhall N, Langron C, Lockwood K, Monaghan N, Aggar C, Sherrington C, Lord SR, Kurrle SE. A multifactorial interdisciplinary intervention reduces frailty in older people: randomized trial. BMC Med. 2013 Mar 11;11:65. doi: 10.1186/1741-7015-11-65. PMID: 23497404; PMCID: PMC3751685.</p> | RCT | <p>216 participants mean age was 83.3 years (standard deviation, 5.9). 68% of participants were women and the</p> | <p>Participants of the intervention group will receive a multidisciplinary, multifactorial intervention for one year following discharge from hospital and community rehabilitation services. The interventions will be tailored to each participant, based on their frailty characteristics assessed at baseline. Case management and weekly case conferences will facilitate coordination of the multidisciplinary delivery of the intervention. The interventions were individually tailored to each participant based on their frailty characteristics as assessed at baseline, and additional problems as identified during a detailed assessment by the two experienced physiotherapists providing the intervention program. Geriatric evaluation and management principles underpinned both the assessment and intervention.</p> | Frailty and mobility | <p>In the intention-to-treat analysis, the between-group difference in frailty was 14.7% at 12 months (95% confidence interval: 2.4%, 27.0%; P = 0.02). The score on the Short Physical Performance Battery, in which higher scores indicate better physical status, was stable in the intervention group and had declined in the control group; with the mean difference between groups being 1.44 (95% confidence interval, 0.80, 2.07; P<0.001 op 12mnd. The intervention reduced frailty and improved mobility in older people who met the CHS frailty criteria. The improvement in these primary outcomes contrasts with the non-statistically significant changes in the secondary outcomes. The lack of changes in</p> | <p>Frailty and mobility disability can be successfully treated using an interdisciplinary multifaceted tailored made treatment program.</p> | Sign Acceptable (+) |

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| | | | | | secondary outcomes may relate to limited power to detect changes using these measures (see Table 5). However, the intervention resulted in a reduction in mobility-related disability [19]. The benefit of the intervention was not evident at 3-month follow-up and became apparent only at 12 months. This indicates that an intervention treating frailty needs to be prolonged. The analyses show participants who had higher levels of adherence to the intervention had much greater effects after adjusting for possible confounders. | | |
| Cochrane A, Furlong M, McGilloway S, Molloy DW, Stevenson M, Donnelly M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. <i>Cochrane Database Syst Rev.</i> 2016 Oct 11;10(10):CD010825. doi: 10.1002/14651858.CD010825.pub2. PMID: 27726122; PMCID: PMC6457975. | Sys rev | Older adults (aged 65 years or more) | Time-limited home-care reablement services (up to 12 weeks) Reablement: The reablement approach emphasises the active participation of an older person in working towards agreed goals that are designed to maximise independence and confidence. While reablement shares features with other | Functional independence | Functional status: very low quality evidence suggested that reablement may be slightly more effective than usual care in improving function at nine to 12 months (lower scores reflect greater independence; standardised mean difference (SMD) -0.30; 95% confidence interval | Reablement may help some older adults to improve their abilities to engage in everyday activities (functional status) to a small degree, but may make little or no difference to death rates or admissions to hospital. The findings mean we are also uncertain whether reablement affects quality of life or living | Sign High quality (++) |

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| | | <p>interventions, it is distinguished by a re-orientation of home care away from treating disease and creating dependency to maximising independence; it achieves this by offering intensive (i.e. multiple visits), time-limited (typically six to 12 weeks' duration), multidisciplinary, person centred and goal-directed home-care services (Ryburn 2009). It is important to note that reablement is not designed to resolve specific healthcare issues (e.g. Crotty 2010), but may help an older person to regain confidence and functional abilities are recovering from an illness or a period of hospitalisation. Therefore, a reablement programme typically includes a range of targeted components designed to optimise functioning in the performance of activities of daily living (ADL).</p> | <p>(CI) -0.53 to -0.06; 2 studies with 249 participants). Adverse events: reablement may make little or no difference to mortality at 12 months' follow-up (RR 0.97; 95% CI 0.74 to 1.29; 2 studies with 811 participants) or rates of unplanned hospital admission at 24 months (RR 0.94; 95% CI 0.85 to 1.03; 1 study with 750 participants). The very low quality evidence also means we are uncertain whether reablement may influence quality of life (SMD -0.23; 95% CI -0.48 to 0.02; 2 trials with 249 participants) or living arrangements (RR 0.92, 95% CI 0.62 to 1.34; 1 study with 750 participants) at time points up to 12 months. People receiving reablement may be slightly less likely to have been approved for a higher level of personal care than people receiving usual care over the 24 months' follow-up (RR 0.87; 95% CI 0.77 to 0.98; 1 trial, 750 participants). Similarly, although there may be a</p> | <p>arrangements. Reablement may lead to a small decrease in numbers of people needing higher levels of personal care, and may decrease care costs to a small degree, but neither study reported satisfaction of those using the reablement service. 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</p> | |
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| | | | | | small reduction in total aggregated home and healthcare costs over the 24-month follow-up (reablement: AUD 19,888; usual care: AUD 22,757; 1 trial with 750 participants), we are uncertain about the size and importance of these effects as the results were based on very low quality evidence. | | |
| Corregidor-Sánchez AI, Segura-Fragoso A, Criado-Álvarez JJ, Rodríguez-Hernández M, Mohedano-Moriano A, Polonio-López B. Effectiveness of Virtual Reality Systems to Improve the Activities of Daily Life in Older People. <i>Int J Environ Res Public Health</i> . 2020 Aug 28;17(17):6283. doi: 10.3390/ijerph17176283. PMID: 32872313; PMCID: PMC7504692. | Sys rev met meta ana of clinical trials | Independently living older adults over 60 years of age. | Treatments with virtual reality systems (VRSs) Intervention with VRS was the main technique. The use of VRSs was the main intervention technique. Seven studies used VRSs specifically designed for rehabilitation The rest of the studies used virtual reality active video games (Nintendo® Wii, Xbox®, Sony® PlayStation and Xavi Sport®). No study used head-mounted displays. The duration of the interventions was from 1 to 24 weeks, with sessions between 20 and 50 min. | Functional autonomy | A moderate, but clinically significant, effect was found for basic activities of daily living (BADLs), (Standard Medium Deviation, SMD 0.61; 95% CI: -0.15–1.37; P < 0.001). A small effect was found for instrumental ADLs (Instrumental Activities of daily living, IADLs) (SMD -0.34; 95% CI: -0.82–0.15; P < 0.001). Functional ambulation was the BADL which improved the most (SMD -0.63; 95% CI: -0.86, -0.40; P < 0.001). Due to the very low quality of the evidence for our main outcomes, the effects of a VRS on the BADLs and IADLs are uncertain. Clinical trials of a higher | The use of VRSs such as Wii or Nintendo is an innovative and feasible technique to support and improve the functional autonomy of community-dwelling older adults. | Sign Acceptable (+) |

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| | | | | | methodological quality are necessary to increase the level of knowledge of its actual effectiveness. | | |
| Dedeyne L, Deschodt M, Verschueren S, Tournoy J, Gielen E. Effects of multi-domain interventions in (pre)frail elderly on frailty, functional, and cognitive status: a systematic review. Clin Interv Aging. 2017 May 24;12:873-896. doi: 10.2147/CIA.S130794. PMID: 28579766; PMCID: PMC5448695. | Sys rev | (pre)frail elderly (>65 years) | multi-domain compared to mono-domain interventions. It included interventions targeting two or more domains (physical exercise, nutritional, pharmacological, psychological, or social interventions) | frailty status and score, cognition, muscle mass, strength and power, functional and social outcomes | Overall, multi-domain interventions tended to be more effective than mono-domain interventions on frailty status or score, muscle mass and strength, and physical functioning. Results were inconclusive for cognitive, functional, and social outcomes. Physical exercise seems to play an essential role in the multi-domain intervention, whereby additional interventions can lead to further improvement (eg, nutritional intervention). | Multi-domain interventions tended to be more effective than mono-domain interventions on frailty status or score, muscle mass and strength, and physical functioning. | Sign Acceptable (+) |
| De Coninck L, Bekkering GE, Bouckaert L, Declercq A, Graff MJL, Aertgeerts B. Home- and Community-Based Occupational Therapy Improves Functioning in Frail Older People: A Systematic Review. J Am Geriatr Soc. 2017 Aug;65(8):1863-1869. doi: 10.1111/jgs.14889. Epub 2017 Apr 3. PMID: 28369719. | Sys rev and meta-analyse of 9 studies | 3,163 comm dwelling older people suffering from chronic disabilities | Multidisciplinary interventions, OT among them of monodisciplinary OT; The frequency of interventions differed; OT interventions were individual interventions at home, whether or not supplemented with a group session. Individual OT interventions consisted of assessment, education and information, prevention | Mobility, functioning in ADL, and social participation; fear of falling and cognition | The pooled result for functioning in daily living activities was a standardized mean difference of -0.30 (95% CI -0.50 to -0.11; P = .002), for social participation -0.44 (95% CI -0.69, -0.19; P = .0007) and for mobility -0.45 (95% CI -0.78 to -0.12; P = .007). All secondary outcomes showed positive trends, with fear | All the OT interventions were individual interventions at home, whether or not supplemented with a group session. Individual OT interventions consisted of assessment, education and information, prevention strategies, exercises, use of assistive technology, home hazard modification, advice on aids and services, coaching, and/or follow up | Sign High quality (++) |

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| | | | <p>strategies, exercises, use of assistive technology, home hazard modification, advice on aids and services, coaching, and/or follow up session;</p> <p>The OT approach was characterized by client-centeredness, empowerment, education/information, embedding within meaningful activities, and collaboration.</p> | | <p>of falling being significant. No adverse effects of occupational therapy were found. Occupational therapists enable engagement in everyday living through occupation, which means they enable engagement in meaningful activities of everyday life. They empower the person and his environment. To achieve this, occupational therapists work in a client-centered way. Hence, occupational therapists are part of the group of professionals that contribute to achieving the main goal of older people, living independently.</p> | <p>session. The OT approach was characterized by client-centeredness, empowerment, education/information, embedding within meaningful activities, and collaboration.</p> | |
| <p>Eklund K, Wilhelmson K, Gustafsson H, Landahl S, Dahlin-Ivanoff S. One-year outcome of frailty indicators and activities of daily living following the randomised controlled trial: "Continuum of care for frail older people". BMC Geriatr. 2013 Jul 22;13:76. doi: 10.1186/1471-2318-13-76. PMID: 23875866; PMCID: PMC3750658.</p> | <p>Non blinded RCT</p> | <p>A total of 161 participated in the study, older people who sought care at the emergency department and who were discharged to their own homes; Inclusion criteria were age 80 and older, or 65 to 79, with at</p> | <p>Collaboration between a nurse with geriatric competence at the emergency department, the hospital wards and a multi-professional team for care and rehabilitation of the older people in the municipality with a case manager as the hub. The multi-professional team included professionals in nursing (the case manager), occupational therapy,</p> | <p>Functional ability</p> | <p>There were no significant differences between the groups with regards to change in frailty compared to baseline at any follow-up. At both the three- and twelve-month follow-ups the intervention group had doubled their odds for improved ADL independence compared to the control (OR 2.37, 95% CI; 1.20 – 4.68) and</p> | <p>The intervention 'Continuum of care for frail older people' showed that the integrated intervention improved independence in ADL up to twelve months and postponed dependence up to six months. Thus, the intervention has the means to support the frail older to age in place; a valuable benefit both to the individuals concerned and for society at large.</p> | <p>Sign Acceptable (+)</p> |

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| | | <p>least one chronic disease and dependent in at least one activity of daily living</p> <p>Exclusion: acute severe illness with immediate need of assessment and treatment by a physician (within ten minutes), dementia (or severe cognitive impairment, clinically assessed by the nurse with geriatric competence at the emergency department), and palliative care.</p> | <p>physiotherapy and social work.</p> | | <p>(2.04, 95% CI; 1.03 – 4.06) respectively. At six months the intervention group had halved their odds for decreased ADL independence (OR 0.52, 95% CI; 0.27 – 0.98) compared to the control group.</p> | | |
| <p>Gustafsson S, Wilhelmson K, Eklund K, Gosman-Hedström G, Zidén L, Kronlöf GH, Højgaard B, Slinde F, Rothenberg E, Landahl S, Dahlin-Ivanoff S. Health-promoting interventions for persons aged 80 and older are successful in the short term—results from the randomized and three-armed Elderly Persons in the Risk Zone study. <i>J Am Geriatr Soc.</i> 2012 Mar;60(3):447-54. doi:</p> | RCT | <p>459 older adult (> 80) is at risk of becoming frail: Four hundred fifty-nine communityliving adults aged 80 and older not dependent on the municipal home help service.</p> | <p>a health-promoting multiprofessional group intervention Preventive Home Visit from a specially trained professional in the intervention team: an occupational therapist (OT), a physiotherapist (PT), a registered nurse (RN), or a qualified social worker (SW). Information and advice about and, when appropriate,</p> | <p>To delay deterioration: frailty, self-rated health, and activities of daily living (ADLs)</p> | <p>Both interventions delayed deterioration of self-rated health (odds ratio (OR) = 1.99, 95% confidence interval (CI) = 1.12–3.54). Senior meetings were the most beneficial intervention for postponing dependence in ADLs (OR = 1.95, 95% CI = 1.14–3.33). No effect on</p> | <p>Health-promoting interventions made when older adults are at risk of becoming frail can delay deterioration in self-rated health and ADLs in the short term. A multiprofessional group intervention such as the senior meetings described seems to have a greater effect on delaying deterioration in ADLs than</p> | <p>Sign high quality (++)</p> |

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| <p>10.1111/j.1532-5415.2011.03861.x. PMID: 22409735.</p> | | <p>instructions in a basic home exercise program including balance exercises Assessment of the fall prevention checklist, information and advice on how to prevent identified fall risks and continue be active, and when requested a "safety walk" in the home Information and advice about technical aids and housing modifications and, if necessary, where and whom to turn to for purchase or application Information and advice about smoke alarms and, if necessary, an offer to check the smoke alarm Information about the range of help and support available in Gothenburg and in the municipality (e.g., volunteers, churches, mission fellow human, health centers), and where to turn to for help with health problems and illness, opening hours, telephone times, and telephone numbers Information on the possibility of an appointment with a pharmacist at the local pharmacy for review of and counselling on medicines Information and advice about incontinence Brochure with information on the Swedish legislation and possibilities for advice on and assessment</p> | | <p>frailty could be demonstrated.</p> | <p>a single preventive home visit</p> | |
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| | | | <p>of driving capacity by professionals Information and advice about what the municipality can provide in the form of local meeting places, activities run by local associations, physical training for seniors, walking groups for seniors, and possibility of receiving or providing volunteer interventions Offer to register for “tryout” activities, an additional group visit to local meeting places, a short introduction to computer sciences, petanque clubs for seniors, gyms for seniors, Nordic walking groups, and more Information about public transportation, including buses adapted for older adults, and mobility service for the disabled Information on the Social Services Act and on where and who.</p> | | | | |
| <p>Hu .C, Kung, S., Rummans, T. A., Clark, M. M., & Lapid, M. I. (2015). Reducing caregiver stress with internet-based interventions: a systematic review of open-label and randomized controlled trials. <i>Journal of the American Medical Informatics Association : JAMIA</i>, 22(e1), e194–e209. https://doi.org/10.1136/amiajnl-2014-002817</p> | Sys rev of RCT's | Caregivers of people with chronic conditions | Internet-based interventions | Caregiver stress | Moderate evidence of benefit: nine trials were positive (three open-label studies and six RCTs), nine were partially positive (four open-label studies and five RCTs), and six were negative (one open-label study and five RCTs). Despite inherent differences in assessing the risk of bias for | Internet-based interventions (e.g. online problem solving, internet based chat group) can reduce aspects of caregiver stress and improve their well-being. | Sign Acceptable (+) |

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| | | | | | internet behavioral trials versus the traditional medication-based double-blind RCT, the quality of the RCTs was acceptable given the nature of the interventions. | | |
| Huguet G L, Navarro González M, Kostov B, Ortega Carmona M, Colungo Francia C, Carpallo Nieto M, Hervás Docón A, Vilarrasa Sauquet R, García Prado R, Sisó-Almirall A. Pre Frail 80: Multifactorial Intervention to Prevent Progression of Pre-Frailty to Frailty in the Elderly. <i>J Nutr Health Aging</i> . 2018;22(10):1266-1274. doi: 10.1007/s12603-018-1089-2. PMID: 30498836. | RCT | 200 community-dwelling pre-frail individuals aged >80Y | intervention group received a 6-month interdisciplinary intervention based on physical exercise, Mediterranean diet advice, assessment of inadequate prescribing in polypharmacy patients and social assessment, while the control group received standard primary healthcare treatment | 173 pre-frail participants (86.5%) completed the study; mean age 84.5 years, 64.5% female. At twelve months, frailty was lower in the intervention group (RR 2.90; 95%CI 1.45 to 8.69). Reversion to robustness was greater in the intervention group (14.1% vs.1.1%, p <0.001). Functional and nutritional status, adherence to Mediterranean diet, quality of life, and functional mobility were improved in the intervention group (p ≤0.001). | A multifactorial, interdisciplinary primary healthcare intervention focused on physical exercise, nutrition, review of polypharmacy and social assessment prevented frailty in pre-frail elderly patients, and improved functional capacity, quality of life and adherence to the Mediterranean diet. | | Sign Acceptable (+) |
| Juang C, Knight BG, Carlson M, Schepens Niemiec SL, Vigen C, Clark F. Understanding the Mechanisms of Change in a Lifestyle | RCT | 460 multi-ethnic community-dwelling older | Lifestyle redesign intervention: Lifestyle Redesign is grounded in theories from | Depression: 1 Frequency of activity | The results demonstrated significant indirect effects from intervention receipt to | An occupational therapy-based lifestyle intervention reduced depressive symptoms by facilitating | Sign Low quality (-) |

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| <p>Intervention for Older Adults. Gerontologist. 2018 Mar 19;58(2):353-361. doi: 10.1093/geront/gnw152. PMID: 28329863; PMCID: PMC5946910.</p> | | <p>adults aged 60–95 years.</p> | <p>occupational therapy, emphasizing that participation in meaningful activities is a vital part of people’s lives. “Frequency” of performed activities—being active in a general sense—has been theorized to be an important determinant of positive aging outcomes (Lemon, Bengtson, & Peterson, 1972), an expectation commonly borne out in studies of the correlates of older adults’ well-being. In addition to activity frequency, positive perceptions of activity “significance” is considered as another active ingredient of Lifestyle Redesign. It is crucial to maintain a positive global perception of activity significance, or perceive activities to be important for personal health and wellness. However, in comparison to activity frequency, perceptions of activity significance have received less attention due to lack of appropriate measurement. Although not directly assessed, prior work highlights the value of engaging in activities that are perceived to be meaningful, suggesting that well-being</p> | <p>2 Global Perception of Activity Significance 3 Social communication Perceived control</p> | <p>decreased depressive symptoms via increased activity frequency and activity significance. Higher activity frequency was linked to fewer depressive symptoms via heightened social connections, whereas increased activity significance was associated with fewer depressive symptoms via enhanced perceived control.</p> | <p>activity frequency and promoting activity significance. There are two possible avenues in which activity frequency and activity significance may be beneficial. First, the intervention led to increased activity frequency, which predicted fewer depressive symptoms through increased social connections. Second, the intervention increased the perceived significance of activities, which in turn reduced depressive symptoms through the pathway of increased perceived control. Our findings not only provide evidence for the theoretical underpinnings of lifestyle-based interventions, but also suggest ways in which clinicians can optimize therapeutic changes.</p> | |
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| | | | can be dependent on the significance individuals place on the roles of activities in their daily life. | | | | |
| Ko HJ, Youn CH, Kim SH, Kim SY. Effect of Pet Insects on the Psychological Health of Community-Dwelling Elderly People: A Single-Blinded, Randomized, Controlled Trial. Gerontology. 2016;62(2):200-9. doi: 10.1159/000439129. Epub 2015 Sep 18. PMID: 26383099. | RCT | 109 community-dwelling elderly people. | Care for pet insects | psychological health | The insect-caring group had significantly lower GDS-15 scores at week 8 (3.20 vs. 4.90, $p = 0.004$) and, after adjustment for baseline values, a significantly greater change in GDS-15 scores relative to baseline (-1.12 vs. 0.20 , $p = 0.011$). They also had a significantly greater change in MMSE scores relative to baseline (1.13 vs. 0.31 , $p = 0.045$). The two groups did not differ in terms of other psychometric and laboratory tests. No serious risks or adverse events were reported. | Caring for has a positive outcome on the mental wellbeing of older people. | Sign Acceptable (+) |
| Lamore K, Montalescot L, Untas A. Treatment decision-making in chronic diseases: What are the family members' roles, needs and attitudes? A systematic review. Patient Educ Couns. 2017 Dec;100(12):2172-2181. doi: 10.1016/j.pec.2017.08.003. Epub 2017 Aug 14. PMID: 28838630. | Sys rev | adult patients without cognitive or psychiatric disorders affecting their ability to participate in decision-making | Decision-making in chronic diseases | roles of family members (FMs) in treatment decision-making for. | The examination of the included studies revealed five major themes: Theme 1: roles of the family Theme 2: types of family influence Theme 3: factors contributing to family involvement Theme 4: family needs and preferences Theme 5: decision-making patterns | FMs have an important role in the decision-making process. In fact, the final decision is often made by the patients after consulting their families. FMs can support both patients and medical teams, and thus facilitate the process. Practice implications: OT's should include FMs in treatment decision-making when the patients and their FMs wish to be included. | Sign Acceptable (+) |

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| | | | | | FMs have an important role in the decision-making process. In fact, the final decision is often made by the patients after consulting their families. | | |
| Manini TM, Beavers DP, Pahor M, Guralnik JM, Spring B, Church TS, King AC, Folta SC, Glynn NW, Marsh AP, Gill TM; LIFE study investigators. Effect of Physical Activity on Self-Reported Disability in Older Adults: Results from the LIFE Study. J Am Geriatr Soc. 2017 May;65(5):980-988. doi: 10.1111/jgs.14742. Epub 2017 Feb 7. PMID: 28168689; PMCID: PMC5435532. | Single blind RCT | 1635 sedentary men and women aged 70–89 years, | Lifestyle Interventions and Independence for Elders (LIFE); a long-term structured, moderate intensity physical activity (PA) program | Self-reported dependency and disability in basic activities of daily living (BADLs), disability in instrumental ADLs (IADL), and mobility disability | Over an average follow-up of 2.6 years, the cumulative incidence of BADL dependency was 15.2% among PA and 15.1% among HE participants (HR = 1.0, 95% CI = 0.78–0.1.3). Intervention groups had similar rates of incident BADL disability, IADL disability and reported mobility disability. Reporting severe mobility disability (HR = 0.78, 95% CI = 0.64–0.96) and ratings of difficulty on mobility tasks were reduced in the PA group. | A structured physical activity intervention reduces reported severe mobility disability and difficulty on mobility tasks, but not BADL and IADL disability in older adults with functional limitations. | Sign Acceptable (+) |
| Martel D, Lauzé M, Agnoux A, Fruteau de Lacroix L, Daoust R, Émond M, Sirois MJ, Aubertin-Leheudre M. Comparing the effects of a home-based exercise program using a gerontechnology to a community-based group exercise program on functional capacities in older adults after a minor injury. Exp Gerontol. 2018 Jul 15;108:41-47. doi: 10.1016/j.exger.2018.03.016. Epub 2018 Mar 22. PMID: 29577975. | Prospective interventional randomized controlled trial (RCT) | Patients aged 65 years old and over, consulting the ED to treat a minor injury | HEPtech and YMCA Program: two physical activity sessions per week for 12 consecutive weeks; Each exercise session lasted 55 min and included: 1) 10 min of low intensity warm-up exercises; 2) 20 min cardiovascular/aerobic exercises (2 sets of butt kicks, high knees, lateral launches, side steps); 3) 20 min of strengthening and balance | Physical functioning; Adherence and acceptability | Following the intervention, both groups showed a significant increase in Short physical Performance Battery (SPPB) total scores (HEPtech: +0.94/12 pt; p = 0.017; YMCA: +1/12 pt; p = 0.011), in MoCA scores (HEPtech: +0.93/30 pt; p = 0.030; YMCA: +1.31/30 pt; p = | Home-based interventions using remote feedbacks induce comparable effects as directly supervised training. | Sign Acceptable (+) |

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| | | | <p>exercises (8 exercises: weight transfer and squats; leg extension and balance; lateral shifting; balance; shoulder abduction/adduction; horizontal flexion and extension; core) and; 4) 5 min for cool down/ stretching.</p> <p>The YMCA group exercises were delivered by a trained kinesiologist. Groups included six to eight participants and no transportation facility was provided them. The HEPtech group used the Jintronix rehabilitation software to exercise at home on the days and times that best suited their schedule, with a mandatory minimum of one day off between sessions. No special intervention or monitoring was offered to the control group participants.</p> | <p>0.013) and a significant decrease in TUG time (HEPtech: -2.52 s; p = 0.001; YMCA: -1.68 s; p = 0.010). The HEPtech group also had a significantly faster walking speed (+0.15 m/s; p = 0.006), and better SPPB balance (+0.38/4 pt; p = 0.034), walking (+0.47/4; p = 0.020) and unipodal balance (+12.45 s; p = 0.011) performances following the intervention (Table 2). The YMCA group had a significantly better SPPB sit-to-stand score (+1.25/4 pt; p = 0.008) and lower number of comorbidities (-1.18; p = 0.017) following the intervention (Table 2). No change was observed in the CON group between baseline and post intervention (Table 2). The walking speed improvements of the HEPtech group were significantly greater than those of the YMCA group (+0.15 ± 0.16 vs +0.01 ± 0.12 m/s; p = 0.007), whereas the YMCA group's improvements were significantly greater than</p> | | |
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| | | | | <p>those of the HEPtech for the timed sit-to-stand test (-3.61 ± 3.71 vs -0.42 ± 2.45 s; $p = 0.009$) and the SPPB sit-to-stand score ($+0.75 \pm 0.86$ vs $+0.13 \pm 0.52$ /4; $p = 0.023$). In addition, the YMCA group showed greater improvements in the timed sit-to-stand test compared to the CON group (-3.61 ± 3.71 vs $+1.99 \pm 6.68$ s; $p = 0.004$).</p> <p>The HEPtech group completed an average of 23.4/24 sessions, resulting in an adherence rate of 97.6% whereas the YMCA group completed an average of 21.7/24 planned sessions, which resulted in an adherence rate of 90.4%. For the resistance and balance components of the exercise program, The HEPtech participants reached a compliance rate of 96.1% (IC: 87.5–99.6%) in quantity and 92% in quality range from 89% to 95%. This level of compliance was reached despite a constant increase in the level of difficulty</p> | | |
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| | | | | | throughout the 12 week intervention (difficulty level at T0:4.2/10 vs. T12: 6.6/10). | | |
| <p>McMahon SK, Lewis B, Oakes JM, Wyman JF, Guan W, Rothman AJ. Assessing the Effects of Interpersonal and Intrapersonal Behavior Change Strategies on Physical Activity in Older Adults: a Factorial Experiment. Ann Behav Med. 2017 Jun;51(3):376-390. doi: 10.1007/s12160-016-9863-z. PMID: 28188585; PMCID: PMC5634530.</p> | Randomized in a 2 × 2 factorial experiment | Community-dwelling older adults (N = 102, mean age = 79) | Interpersonal (e.g., social support, friendly social comparison; no, yes) and /or intrapersonal (e.g., goal setting, barriers management; no, yes) behavior change strategies, combined with an evidence-based, physical activity protocol (Otago exercise program) and a physical activity monitor (Fitbit One™). | Physical activity | Based on monitor data, participants who received interpersonal strategies, compared to those who did not, increased their average minutes of total physical activity (light, moderate, vigorous) per week, immediately (p = .006) and 6 months (p = .048) post-intervention. Similar, increases were observed on measures of functional strength and balance, immediately (p = .012) and 6 months (p = .003) post-intervention. The intrapersonal strategies did not elicit a significant increase in physical activity or functional strength and balance Findings suggest a set of interpersonally oriented behavior change strategies combined with an evidence-based physical activity protocol can elicit modest, but statistically and clinically significant, increases in older adults' physical activity and functional strength and balance | A set of interpersonally oriented behavior change strategies combined with an evidence-based physical activity protocol can elicit modest, but statistically and clinically significant, increases in older adults' physical activity and functional strength and balans. | Sign Acceptable (+) |

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| <p>Nielsen TL, Andersen NT, Petersen KS, Polatajko H, Nielsen CV. Intensive client-centred occupational therapy in the home improves older adults' occupational performance. Results from a Danish randomized controlled trial. <i>Scand J Occup Ther.</i> 2019 Jul;26(5):325-342. doi: 10.1080/11038128.2018.1424236. Epub 2018 Jan 12. PMID: 29325486.</p> | RCT | adults 60+ with chronic health issues, who received or applied for homecare services | 11 weeks of occupation-based intensive client-centred OT (ICCOT) in the homes of older adults compared to the usual practice | <p>Self-rated occupational performance Quality of occupational performance (motor abilities and process abilities) health-related quality of life would (physical components and mental components) Changes in these variables between the assessments at baseline and 3 months post baseline</p> | <p>All participants received practical and personal assistance and meal delivery as needed. In addition, they were randomized to receive either a maximum 22 sessions of occupation-based ICC-OT (N ¼ 59) or to receive usual practice with a maximum three sessions of occupational therapy (N ¼ 60). The primary outcome was self-rated occupational performance assessed with the Canadian Occupational Performance Measure (COPM). No important adverse events occurred. ICC-OT was accepted by 46 participants (88%), usual practice by 60 (100%). After 3 months, the ICC-OT-group had improved 1.86 points on COPM performance; the Usual-Practice group had improved 0.61 points. The between-group difference was statistically significant (95% confidence interval 0.50 to 2.02), t-test: p ¼ 0.001.</p> <p>The ICC-OT group improved their COPM</p> | <p>In-home ICC-OT, in which older adults with various chronic health issues intensively practised the activities they valued the most for up to 11 weeks, supplemented by free access to assistive devices and minor home modifications, effectively improved their self-rated occupational performance at 3 months and 6 months post baseline. The results of the present study are an important contribution to the emerging evidence base concerning intensive and client-centred OT for older adults with occupational performance problems. These results should therefore be taken into consideration when planning rehabilitative OT services and homecare reablement for home-dwelling older adults.</p> | Sign Acceptable (+) |
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| | | | | | performance from baseline to the 3- month assessment statistically significantly more than the Usual-Practice group: difference 1.26 points (95% CI 0.50 to 2.02), t-test: p ¼ 0.001. An exploratory multiple linear regression analysis adjusting for assessors at baseline and at the 3- month assessments, revealed a slightly smaller difference: 1.12 points (95% CI 0.35 to 1.89), p ¼ 0.005. | | |
| Provencher V, Clemson L, Wales K, Cameron ID, Gitlin LN, Grenier A, Lannin NA. Supporting at-risk older adults transitioning from hospital to home: who benefits from an evidence-based patient-centered discharge planning intervention? Post-hoc analysis from a randomized trial. BMC Geriatr. 2020 Mar 2;20(1):84. doi: 10.1186/s12877-020-1494-3. PMID: 32122311; PMCID: PMC7053102. | Post-hoc analysis of RCT | 400 older patients have trouble performing activities of daily living (ADL) following hospital discharge | Evidence-based discharge planning intervention (HOME intervention): 1) establishment of a hospital-based partnership with patient and family for goal setting and problem solving; 2) predischarge home assessment to address safety issues and home modifications with patient and family; 3) postdischarge home assessment and in-home training to address unmet needs; and 4) follow-up telephone calls to provide ongoing support to increase independence for participants and families and ensure required services have been accessed. Control: | (1) independence in ADL, (2) participation in life roles, (3) unplanned re-hospitalizations, and (4) ED presentations | Analyses revealed significant interaction effects for intervention by cognitive status for unplanned rehospitalization (p = 0.003) and ED presentations (p = 0.021) at 3 months. Within the at-risk subgroup of mild cognitively impaired, the HOME intervention significantly reduced unplanned hospitalizations (p = 0.027), but the effect did not reach significance in Emergency Department visits. While the effect of HOME differed | Fluid collaboration of OT between hospital and primary care supporting transition hospital to home leads to reduction of hospitalisations, and so cost saving in patients with family Predischarge home assessment to address safety issues and home modifications with patient and family; Postdischarge home assessment and in-home training to address unmet needs; and follow-up | Sign Acceptable (+) |

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| | | | standardized assessment and consultation by an occupational therapist for planning and supporting discharge to home, inclusive of equipment prescription where clinically warranted; no occupational therapy post-discharge support was provided to the group who received the in-hospital consultation. | | according to support received from family for participation in life roles ($p = 0.019$), the participation observed in HOME patients with no support was not significantly improved. Hospitalized older adults with mild cognitive impairment benefit from the HOME intervention, which involves preparation and post-discharge support in the environment, to reduce unplanned rehospitalizations. Improved discharge outcomes in this at-risk subgroup following an occupational therapist-led intervention may enable best care delivery as patients transition from hospital to home. | | |
| Ristolainen H, Kannasoja S, Tiilikainen E, Hakala M, Närhi K, Rissanen S. Effects of 'participatory group-based care management' on wellbeing of older people living alone: a randomized controlled trial. Arch Gerontol Geriatr. 2020 Jul-Aug;89:104095. doi: 10.1016/j.archger.2020.104095. Epub 2020 May 7. PMID: 32446172. | RCT | 329 community-dwelling older adults living alone | 'participatory group-based care management' conducted | QoL, loneliness and trust | In this article, baseline and 6-month follow-up surveys were used. QoL (WHOQOL-Bref instrument), loneliness (Revised UCLA Loneliness Scale; single-item question), and trust (two items of generalized trust and six items of institutional trust) were used as outcome | Based on some evidence of small positive effects, the intervention may be beneficial in alleviating loneliness and enhancing trust among older people living alone. | Sign Acceptable (+) |

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| | | | | | <p>measurements, and generalized estimating equations (GEE) modeling as the analysis method. Both per-protocol and intention-to-treat analyses were applied. Results: According to the per-protocol analysis, the intervention had no effects on QoL. Loneliness decreased among older people with poor QoL at the baseline. Additionally, the intervention enhanced trust in other people and some dimensions of institutional trust. The intention-to-treat analysis did not result in any significant effects on QoL or loneliness, but some small positive changes in institutional trust were found.</p> | | |
| <p>Ross LA, Edwards JD, O'Connor ML, Ball KK, Wadley VG, Vance DE. The Transfer of Cognitive Speed of Processing Training to Older Adults' Driving Mobility Across 5 Years. <i>J Gerontol B Psychol Sci Soc Sci</i>. 2016 Jan;71(1):87-97. doi: 10.1093/geronb/gbv022. Epub 2015 Apr 15. PMID: 25878053; PMCID: PMC4701127.</p> | RCT | <p>598 older adults who reported having driven within the last 12 months and those who indicated that they "would drive today" if they needed to do so.</p> | <p>Cognitive Speed of Processing Training (SPT) is a computerized, process-based, training program designed to increase the speed at which persons can process increasingly complex amounts of visual information. SPT transfers to distal (i.e., far transfer) real-world outcomes including health, well-being,</p> | <p>Driving frequency Driving exposure Driving space</p> | <p>No significant effects were found within the ITT analyses. However, number of SPT sessions did affect driving mobility outcomes. In the full sample (N = 1,806), higher cognitive speed of processing training doses were associated with maintained driving</p> | <p>These results reveal that greater amounts of SPT prolong some indices of driving mobility (e.g., driving frequency and driving exposure), mainly among at-risk older adult drivers with poor baseline processing speed. The intervention transferred to greater driving frequency</p> | <p>Sign High quality (++)</p> |

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| | | <p>performance of instrumental activities of daily living (IADL), and driving mobility.</p> <p>Initial training phase: The ACTIVE cognitive intervention conditions of memory, reasoning, and speed of processing training shared a number of key elements, including (1) focusing on strategies for solving problems, remembering, or responding quickly to information; (2) modeling and demonstrating of strategy usage by trainers; (3) practicing on exemplar problems; (4) individual and group exercises; (5) feedback on performance; (6) fostering of self-efficacy with regard to performance; (7) applying strategies to real-world tasks; (8) individualized training experiences; and (9) activities focusing on social interaction. In all three conditions, Sessions 1–5 focused on strategy instruction and exercises to practice the strategy. Sessions 6–10 provided additional practice exercises, but no new strategies were introduced. Content for each of the ten sessions was scripted in a trainer’s manual.</p> <p>Booster Training For each of the three intervention</p> | <p>frequency as compared with both control groups, but no effects were found for driving exposure or space. Subsample analyses (n = 315) revealed that persons at-risk for mobility declines (i.e., poor initial processing speed) who received additional booster SPT sessions reported greater maintenance of both driving frequency and exposure over time as compared with the no-contact and active control groups.</p> <p>The current study establishes that such transfer effects can still be detected 5 years after the initial intervention and are contingent upon the dose of training received.</p> | <p>(but not driving exposure or space) in the total sample and translated to greater driving frequency and exposure (but not driving space) in at-risk participants who received booster training. Given the importance of driving for older adults’ wellbeing and independence, these findings are noteworthy.</p> | |
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| | | | conditions, booster training was provided to a subset of participants approximately 11 months after the end of the primary training. | | | | |
| <p>Spoorenberg SLW, Wynia K, Uittenbroek RJ, Kremer HPH, Reijneveld SA. Effects of a population-based, person-centred and integrated care service on health, wellbeing and self-management of community-living older adults: A randomised controlled trial on Embrace. PLoS One. 2018 Jan 19;13(1):e0190751. doi: 10.1371/journal.pone.0190751. PMID: 29351295; PMCID: PMC5774687.</p> | RCT | 1456 older adults aged 75 and over living at home or in a home for the elderly | population-based, person-centred and integrated care service 'Embrace' care team consisting of GP, a nursing home physician and two case managers A multidisciplinary Elderly Care Team—consisting of the older adults' GP, a nursing home physician and two case managers (district nurse and social worker)—provides care and support to older adults | Self management and Health | 1456 older adults were randomized to Embrace (n(T0) = 747, n(T1) = 570, mean age 80.6 years (SD 4.5), 54.2% female) and CAU (n(T0) = 709, n (T1) = 561, mean age 80.8 years (SD 4.7), 55.6% female). Embrace participants showed a greater—but clinically irrelevant—improvement in self-management (PIH-OA Knowledge subscale effect size [ES] = 0.14), and a greater—but clinically relevant—deterioration in health (ADL ES = 0.10; physical ADL ES = 0.13) compared to CAU. No differences in change in wellbeing were observed. This picture was also found in the risk profiles. Complete case analyses showed comparable results. | This study found no clear benefits to receiving person-centred and integrated care delivered by a GP, Nursing home physician and case manager for twelve months for the domains of health, wellbeing and self-management in community-living older adults. NO OT | Sign Acceptable (+) |
| <p>Suksom D, Siripatt A, Lapo P, Patumraj S. Effects of two modes of exercise on physical fitness and endothelial function in the elderly: exercise with a flexible stick versus</p> | RCT | Community dwelling frail older adults | Exercise with a Flexible stick (EF): 83 postures assumed over a 40 minutes/session. | cardiovascular fitness Muscular strength. | Exercise with a Flexible stick (EF) was created for enhancing cardiovascular fitness while simultaneously | Promoting physical activities such as training with flexible stick or resistance bands. | Sign Acceptable (+) |

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| <p>Tai Chi. J Med Assoc Thai. 2011 Jan;94(1):123-32. PMID: 21425738.</p> | | | <p>24-form Tai Chi by following instructions provided by a qualified trainer</p> | <p>promoting muscular strength. To determine the beneficial effects of EF training for the elderly, the investigators measured health-related physical fitness and endothelial function of older women before and after 12 weeks of EF training and compared these with a group receiving TC training, a traditional Chinese conditioning exercise that includes slow, smooth and harmonic movement. In the present study, the older women participated in either EF or TC training for 40 minutes of continuous movement, 4 days/week for 12 weeks. The average oxygen costs for EF and TC were 14.50 ml/kg/min and 12.75 ml/kg/min, respectively, which were identified as moderate intensity exercise according to the five-level classification of physical activity based on exercise intensity. The results indicated that 12 weeks of EF training can improve health-related physical fitness by decreasing the</p> | | |
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| | | | | | percent body fat and increasing upper and lower muscular strength, flexibility and cardiorespiratory fitness, as well as improve endothelial function By contrast, participants in the TC training showed improvement only in lower muscular strength and flexibility. | | |
| Tessier A, Beaulieu MD, Mcginn CA, Latulippe R. Effectiveness of Reablement: A Systematic Review. Healthc Policy. 2016 May;11(4):49-59. PMID: 27232236; PMCID: PMC4872552. | Sys rev of 10 studies: Systematic reviews, meta-analyses, randomized controlled trials (RCTs) and quasi-experimental and qualitative studies | 14,742 participants, 65 years old, have functional limitations and be living at home | Reablement is defined as services for seniors with physical or mental disabilities that help them adapt to their condition by learning or re-learning the skills needed to function in everyday life. Intervention did not need to be called reablement or restorative care, but had to promote functional independence, be of short duration (6–12 weeks) and be provided by paid workers as part of homecare services; multidisciplinary | Functional status in activities of daily living (ADL) and instrumental activities of daily living (IADL), health-related quality of life (HRQoL) and healthcare service utilization | Positive impact of reablement, especially on health-related quality of life and service utilization. There is good evidence supporting the effectiveness of reablement, particularly regarding HRQoL and service utilization. The added value of recognizing the importance of patient participation in decision-making is well documented and is likely related to the observed improvement in HRQoL (Legare et al. 2014). Similarly, involving the patient in goal setting has been shown to lead to significant improvement in HRQoL, possibly via individualized activities (Parsons 2012). | The reablement has a positive impact on health-related quality of life and service utilization. | Sign Acceptable (+) |

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| | | | | | <p>Reablement has shown a positive effect on functional capacity, an effect which is comparable with that of usual homecare services. In the reviewed studies, most users required minimal-to-moderate assistance with their ADL prior to the intervention, and their functional status was assessed with tools that included few complex activities (the Barthel Index and the Nottingham Extended Activity of Daily Living). The small changes reported in functional capacity, which may be surprising considering the reported impact on HRQoL, are possibly due to the limited sensitivity of the assessment tools used.</p> | | |
| <p>Tuntland H, Aaslund MK, Espehaug B, Førland O, Kjekken I. Reablement in community-dwelling older adults: a randomised controlled trial. <i>BMC Geriatr.</i> 2015 Nov 4;15:145. doi: 10.1186/s12877-015-0142-9. PMID: 26537789; PMCID: PMC4634595.</p> | <p>Parallel-group randomised controlled trial</p> | <p>Home-dwelling older adults</p> | <p>Reablement: The occupational therapist and physical therapist used the COPM to identify activity limitations perceived as important by the participant. The therapists supervised the homecare personnel, some of whom had no formal education (assistants), in how to encourage and assist the person in the daily training.</p> | <p>Daily activities, physical functioning, and health-related quality of life</p> | <p>There were significant improvements in mean scores favouring reablement in COPM performance at 3 months with a score of 1.5 points ($p = 0.02$), at 9 months 1.4 points ($p = 0.03$) and overall treatment 1.5 points ($p = 0.01$), and for COPM satisfaction at 9 months 1.4 points ($p = 0.03$) and</p> | <p>A 10-week reablement program resulted in better activity performance and satisfaction with performance on a long-term basis, but not the other outcomes measured. OT's can supervise homecare personnel in encouraging and assisting participants to perform daily activities.</p> | <p>Sign High quality (++)</p> |

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| | | <p>The focus was on stimulating the participants to perform the daily activities themselves, rather than letting others do it for them. Among the individual features were training in daily activities, adaptations to the environment or the activity, and exercise programs. All health-care personnel attained training before the intervention was implemented, in particular in the ideology of self-management. The therapists took courses and were instructed in how to conduct the assessments. The therapists had weekly informal lunch meetings with the home-care staff in order to ensure good communication and follow-up of individual participants. Simpler physical exercises or skills training the assistants could provide, were illustrated and described in a booklet in the participant's home and also demonstrated during the informal meetings. New staff members were given extra attention in order to ensure adherence to the treatment.</p> <p>The control intervention Usual care. For most participants, usual care</p> | | <p>overall treatment 1.2 points ($p = 0.04$). No significant group differences were found concerning COPM satisfaction at 3 months, physical capacity or health-related quality of life.</p> | | |
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| | | | meant receiving the compensating help they applied for, in terms of personal or practical assistance, safety alarm, meals on wheels, or assistive technology. | | | | |
| Unsworth CA, Baker A. Driver rehabilitation: a systematic review of the types and effectiveness of interventions used by occupational therapists to improve on-road fitness-to-drive. <i>Accid Anal Prev.</i> 2014 Oct;71:106-14. doi: 10.1016/j.aap.2014.04.017. Epub 2014 Jun 2. PMID: 24906164. | Sys rev of 16 studies | Divers; of which 4 articles on individuals older than 55y (3 RCT's and 1 pre-post) | approaches are used by occupational therapists as part of driver rehabilitation programmes, | To identify what intervention approaches are used by occupational therapists as part of driver rehabilitation programmes, and to determine the effectiveness of these interventions with respect to on-road fitness-to-drive | The most common type of intervention approach used was computer-based driving simulator training (n = 8), followed by off-road skill-specific training (n = 4), and off-road education programmes (n = 3). Car adaptations/modifications were used in one of the included studies. There was significant variability between studies with regards to frequency, duration, and total number of intervention sessions, and the diagnoses of the participants. Of the four intervention approaches, there is evidence to support the effectiveness of off-road skill-specific training (with older clients), and computer-based driving simulator training (with both older clients and participants with | There is some evidence to suggest that off-road skill specific training may be of value with older clients, and computer-based driving simulator training may be effective with both older clients and those with acquired brain injury. | Sign Acceptable (+) |

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| | | | | | acquired brain injury). Three types of intervention approaches are commonly reported, however, there is limited evidence to determine to effectiveness of these in improving fitness-to-drive. | | |
| van Het Bolscher-Niehuis MJ, den Ouden ME, de Vocht HM, Francke AL. Effects of self-management support programmes on activities of daily living of older adults: A systematic review. Int J Nurs Stud. 2016 Sep;61:230-47. doi: 10.1016/j.ijnurstu.2016.06.014. Epub 2016 Jun 30. PMID: 27400029. | Sys rev of 12 studies with RCT profile | Older adults living at home | Self-management support programmes | Activities of daily living | <p>Three types of self-management support programmes were identified. There were intensive programmes with a short duration (<6 months) and weekly group sessions. Less intensive programmes (<1 session a month) using an individual approach. Programmes with an intermediate duration of 6 to 12 months (< 1 session a month-) and individual and/or group sessions.</p> <p>All studies used a self-management support programme with a multi-component structure. Core elements of the self-management support programmes were: health promotion and information about the disease, education</p> | There is a moderate level of evidence that self-management support programmes with a multi-component structure, containing disease-specific information, education of knowledge and skills and, in particular, individually tailored coaching, improve the activities of daily living of older adults | Sign High quality (++) |

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| | | | | <p>aimed at knowledge, skills and strategies to manage the consequences of the disease/disability, coaching of health behaviour changes using a personal plan or individual goals, social support through communication with peers or professionals and functional training/exercises.</p> <p>Most of the included studies presented a large number of findings, but this review only focussed on the effects of self-management support programmes on the activities of daily living of older adults. It turns out that the results of the studies (regardless their methodological quality and heterogeneity) nearly all point in the same direction. All studies (both with a low and high risk of bias), except for the study by Elzen et al. (2007), showed that the self-management support programme led to less disability in the</p> | | |
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| | | | | | activities of daily living of older adults. Although there was considerable variation in study population, intervention characteristics and measurement instruments used, most studies (n = 11) showed effects of self-management support programmes on the activities of daily living of older adults. | | |
| Valenzuela T, Okubo Y, Woodbury A, Lord SR, Delbaere K. Adherence to Technology-Based Exercise Programs in Older Adults: A Systematic Review. <i>J Geriatr Phys Ther.</i> 2018 Jan/Mar;41(1):49-61. doi: 10.1519/JPT.000000000000095. PMID: 27362526. | Sys rev of 22 studies (16 RCT's and 6 CT's) | Home based and residential older adults | technology-based exercise interventions; thirteen studies (59%) employed commercially available systems to prescribe the exercises: 4 (31%) used the Nintendo Wii console with Wii Fit/Sport games, 8 (62%) used the Wii Fit/Sports games coupled with the Wii balance board, and 1 (7%) used the Xbox Kinect. 17 The remaining 9 studies (41%) used customized technologies: 6 studies (67%) used stepping systems with pressure sensors, and the others used a balance rehabilitation program using virtual reality system, a computer feedback system with | To examine the literature regarding the use of technology-based exercise interventions to improve physical functioning in older adults, and explore older adults' acceptability and adherence to such programs. | This systematic review provides evidence that technology offers a well-accepted method to provide older adults with engaging exercise opportunities, and adherence rates remain high in both supervised and unsupervised settings at least throughout the first 12 weeks of intervention. The higher adherence rates to technology-based interventions can be largely explained by the high reported levels of enjoyment when using these programs. | This systematic review provides evidence that technology offers a safe and well-accepted method to provide older adults with engaging exercise opportunities that they find fun and motivating and provides a sustainable means of promoting physical activity and preventing falls in older people. It is important to consider that 9 of the 10 (90%) technology-based interventions and 8 of the 9 (89%) traditional exercise interventions provided supervision to participants. | Sign Acceptable (+) |

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| | | | infrared sensors, and a tablet-computer application. | | The included studies reported high adherence rates (median 91.25%, range 70.25%-100%) to technology-based exercise programs. | | |
| van Lieshout MRJ, Bleijenberg N, Schuurmans MJ, de Wit NJ. The Effectiveness of a PROactive Multicomponent Intervention Program on Disability in Independently Living Older People: A Randomized Controlled Trial. J Nutr Health Aging. 2018;22(9):1051-1059. doi: 10.1007/s12603-018-1101-x. PMID: 30379302. | RCT | 290 community-dwelling pre-frail older people aged 65 years and over | Interdisciplinary multicomponent intervention program to prevent disability; The intervention program consisted of four components: a medication review, physical fitness, social skills, and nutrition. | Activity of daily living (ADL); Quality of life (SF-12) and healthcare consumption | After the 12-month follow-up, the median Katz-6 score did not change significantly between the two groups; adjusted Odds Ratio (OR) = 0.96 (95% Confidence Interval (CI): 0.39-2.35, p-value 0.92). No statistically significant differences were observed between the groups for quality of life and healthcare consumption. Among the participants in the intervention group, the perception on IADL (Friedman's test p <=0.04, X2 =6.50), walking speed (Friedman's test p <0.001, X2 =19.09) and functional capacity (Friedman's test p <0.001, X2 =33.29) improved significantly after the one-year follow-up. | The intervention program did not significantly improve daily functioning, quality of life and healthcare consumption among (pre) frail community-dwelling older persons at the one-year follow-up. Participants in the intervention group experienced improvements in walking speed, functional capacity and instrumental activities of daily living. NO OT involved | Sign Acceptable (+) |
| van Weert JC, van Munster BC, Sanders R, Spijker R, Hooft L, Jansen J. Decision aids to help older people make health decisions: a | Sys revof meta-analysis of 22 RCT's and CCT's | Older adults 65y and older | "Interventions designed to help people make specific and deliberative choices among | Effectiveness of decision aids as compared to usual care and/or | Decision aids performed better than control resp. usual care interventions | Decision aids can be effective for older adults. The | Sign Acceptable (+) |

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| <p>systematic review and meta-analysis. <i>BMC Med Inform Decis Mak.</i> 2016 Apr 21;16:45. doi: 10.1186/s12911-016-0281-8. PMID: 27098100; PMCID: PMC4839148.</p> | | | <p>options (including the status quo) by making the decision explicit and by providing (at the minimum) information on the options and outcomes relevant to a person's health status" (decision aids)</p> | <p>alternative intervention(s) for older adults facing treatment, screening or care decisions, either for themselves or for an incapacitated significant other, on attributes of the decision and the decision process. Secondary outcomes are behavioral, health, and health system effects</p> | <p>by increasing knowledge and accurate risk perception in older people (decision attributes). Decision aids have the potential to increase older adults' risk perception, improve knowledge, decrease decisional conflict, and improve patient participation in decision making by decreasing practitioner-controlled decision making. With regard to decision process attributes, decision aids resulted in lower decisional conflict and more patient participation.</p> | <p>decision aids increased their knowledge and risk perception, decreased decisional conflict and seemed to enhance participation in decision making.</p> | |
| <p>Warner G, Packer TL, Kervin E, Sibbald K, Audulv Å. A systematic review examining whether community-based self-management programs for older adults with chronic conditions actively engage participants and teach them patient-oriented self-management strategies. <i>Patient Educ Couns.</i> 2019 Dec;102(12):2162-2182. doi: 10.1016/j.pec.2019.07.002. Epub 2019 Jul 2. PMID: 31301922.</p> | <p>Sys rev of 31 RCT and cluster RCT</p> | <p>Older adults with chronic conditions</p> | <p>Community-based self-management programs (SMP's)</p> | <p>Engagement in, or learning of individuals patient-oriented strategies Process Outcomes; Resource Outcomes; Health Behaviour and Disease Controlling Outcomes Emotional Outcomes Activities and Social Interaction Outcomes;</p> | <p>The 31 included studies demonstrated community-based SMP programs actively engaged participants and provided strategies to improve health behaviour or care of their condition. Only 16 percent of programs offered strategies to improve individuals' engagement in activities they valued. Although teaching goal-setting may help individuals set priorities that are</p> | <p>Health-care providers and community program planners delivering SMPs for older adults need to incorporate strategies that are patient-oriented and tailored to the needs of their clients. Teaching patient-oriented strategies aligns with the recommendations for improving primary healthcare practices and the need for health-care providers to actively engage their patients in self-managing their</p> | <p>Sign Acceptable (+)</p> |

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| | | | | <p>Global Self-Efficacy; Global Quality of Life Outcomes; Global Disease Outcomes</p> <p>personally meaningful, individuals may also need to learn strategies that help them attain goals.</p> <p>Few included strategies to help manage the impact of conditions on their everyday lives. Seventy-nine percent of studies reported significant differences; variations in sample sizes and outcomes made it difficult to conclude whether having these attributes led to significant differences.</p> <p>SMPs are not supporting older adults to use strategies to address the impact of conditions on their everyday lives, addressing the needs of older adults with multiple conditions, nor assessing outcomes that align with the strategies taught.</p> <p>Practice implications: Health-care providers delivering SMPs to older adults need to tailor programs to the needs of older adults and assess whether participants are using strategies being proposed.</p> | <p>conditions so they can fully participate in their everyday activities. Furthermore, SMPs need to ensure older adults are given strategies to help them successfully manage multiple conditions. The TEDSS Framework can assist health-care providers in understanding and identifying self-management issues that are relevant to older adults. Health-care teams could use the TEDSS Framework to assess, plan, and evaluate SMPs to ensure the program is meeting the needs of their patients.</p> |
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| | | | | | In conclusion, this review shows that the strategies SMPs provide for older adults have not evolved beyond fostering skills to improve problem solving, health behaviour, and disease management. They seem to reflect providers' rather than patients' perspectives of successful chronic condition self-management. | | |
| Whitehead PJ, Worthington EJ, Parry RH, Walker MF, Drummond AE. Interventions to reduce dependency in personal activities of daily living in community dwelling adults who use homecare services: a systematic review. Clin Rehabil. 2015 Nov;29(11):1064-76. doi: 10.1177/0269215514564894. Epub 2015 Jan 13. PMID: 25587088; PMCID: PMC4607918. | Sys rev of 13 studies (randomised controlled trials, non-randomised controlled trials and controlled before and after studies) | 4975 community dwelling adults who use homecare services | 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. Included: single component interventions (for example, mono-professional or one-off visits) or multiple components (for example a package provided by a multidisciplinary team). Comparator: routine homecare service in which assistance with personal ADL was provided but where there was no intention to improve individuals' performance in this. | content; effectiveness in improving ability to perform ADL; and whether delivery by qualified occupational therapists influences effectiveness | Interventions were categorised as those termed 're-ablement' or 'restorative homecare' (n=5/13); and those involving separate components which were not described using this terminology (n=8/13). Content of the intervention and level of health professional input varied within and between studies. Effectiveness on ADL: eight studies included an ADL outcome, five favoured the intervention group, only two with statistical significance, both these were controlled before and after studies judged | Homecare services incorporating interventions targeted at personal ADL can improve an individual's ability to carry out these activities independently. Re-ablement or restorative homecare interventions commonly involve more than one component. Content of interventions varies widely. There is some evidence that interventions aiming to improve ability to independently perform ADL are effective for a population of homecare service users, in comparison to standard homecare services in which | Sign High quality (++) |

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| | | | | | at high risk of bias. ADL outcome was reported using seven different measures. Occupational therapy: there was insufficient evidence to determine whether involvement of qualified occupational therapists influenced effectiveness. Conclusion: 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. | assistance is provided with personal care tasks. There is also evidence that these interventions can reduce the use of, and costs associated with, ongoing care services, particularly homecare. This finding is consistent with the wider literature. There is also some evidence that these interventions improve health related quality of life. | |
| Winzer E, Dorner TE, Grabovac I, Haider S, Kapan A, Lackinger C, Schindler K. Behavior changes by a buddy-style intervention including physical training, and nutritional and social support. <i>Geriatr Gerontol Int.</i> 2019 Apr;19(4):323-329. doi: 10.1111/ggi.13616. Epub 2019 Feb 5. PMID: 30724012; PMCID: PMC6849832. | RCT | 80 older persons | The buddies were encouraged to carry out the physical activity and nutritional intervention with the prefrail or frail persons at home twice a week. The main material of the intervention was a guidebook, which provided standardized physical activity exercises and nutritional recommendations, and encouraged goal setting to reinforce the self-efficacy. | Physical activity and nutritional behavior | The intervention group showed significant improvements in physical activity behavior, such as light sport activity ($\beta = 9.13$, 95% CI 0.90–17.37 min/day; $P = 0.030$), muscle strength exercise ($\beta = 68.18$, 95% CI 46.45– 89.91 min/week; $P < 0.001$) and overall activities ($\beta = 0.69$, 95% CI 0.21–1.18 h/day; $P = 0.006$), compared with the control group. Nutritional behavior improvements for the intervention group were observed in the consumption of | “Buddy-style” program in older adults living at home can produce effective physical activity changes and, to a lesser extent, changes in dietary behavior, and has the potential to be efficient and feasible. | Sign Low quality (-) |

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| | | | | | legumes/nuts ($\beta = 0.18$, 95% CI 0.00–0.35 portions/day; $P = 0.047$) and fluids ($\beta = 0.48$, 95% CI 0.01–0.98 portions/day; $P = 0.050$), relative to controls. | | |
| Zijlstra GA, van Haastregt JC, van Eijk JT, de Witte LP, Ambergen T, Kempen GI. Mediating effects of psychosocial factors on concerns about falling and daily activity in a multicomponent cognitive behavioral group intervention. <i>Aging Ment Health</i> . 2011 Jan;15(1):68-77. doi: 10.1080/13607863.2010.501054. PMID: 20924813. | Parallel-group randomized controlled trial | 540 community-dwelling adults aged 70 years or older, with concerns about falling and associated activity avoidance | Multicomponent cognitive behavioral group intervention | Psychosocial factors on concerns about falling and daily activity: Control beliefs, self-efficacy beliefs, outcome expectations, and social interactions, as potential mediators, and concerns about falling and daily activity. | Small to moderate statistically significant effects of the intervention on the potential mediators were found at nearly all follow-up assessments. Separate psychosocial factors showed modest mediating effects on the outcomes. When all mediators were taken into account simultaneously, 44–76% of the association between the intervention and the outcomes was explained. | This study showed that the multicomponent cognitive behavioral intervention improved control beliefs, self-efficacy, outcome expectations, and social interactions. These variables mediated the association between the intervention and concerns about falling or daily activity in community-dwelling older adults. This knowledge may facilitate further improvement and development of interventions to reduce concerns about falling and to increase daily activity. | Sign Acceptable (+) |

Literature matrix excluded articles

| reference | design | reason exclusion |
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| Arkkukangas M, Sundler AJ, Söderlund A, Eriksson S, Johansson AC. Older persons' experiences of a home-based exercise program with behavioral change support. <i>Physiother Theory Pract</i> . 2017 Dec;33(12):905-911. doi: 10.1080/09593985.2017.1359869. Epub 2017 Aug 16. PMID: 28812402. | Descriptive study | Wrong design |
| Arbesman M, Mosley LJ. Systematic review of occupation- and activity-based health management and maintenance interventions for community-dwelling | Sys rev of 28 articles (RCT, sys rev, meta-anal, pre-post and non rand) | Level not achieved |

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| older adults. Am J Occup Ther. 2012 May-Jun;66(3):277-83. doi: 10.5014/ajot.2012.003327. PMID: 22549592. | | |
| Baig MM, Afifi S, GholamHosseini H, Mirza F. A Systematic Review of Wearable Sensors and IoT-Based Monitoring Applications for Older Adults - a Focus on Ageing Population and Independent Living. J Med Syst. 2019 Jun 15;43(8):233. doi: 10.1007/s10916-019-1365-7. PMID: 31203472. | RCT | Seniors |
| Ballemans J, Kempen GI, Zijlstra GR. Orientation and mobility training for partially-sighted older adults using an identification cane: a systematic review. Clin Rehabil. 2011 Oct;25(10):880-91. doi: 10.1177/0269215511404931. Epub 2011 Jul 27. PMID: 21795405; PMCID: PMC3255517. | Sys rev | Geen primaire artikels geïnccludeerd |
| Balis LE, Strayer T, Ramalingam N, Wilson M, Harden SM. Open-Access Physical Activity Programs for Older Adults: A Pragmatic and Systematic Review. Gerontologist. 2019 Jul 16;59(4):e268-e278. doi: 10.1093/geront/gnx195. PMID: 29329395. | Pragmatic and systematic review | Focus ligt op vergelijk peer review en open acces programma's |
| Borges EGDS, Vale RGS, Pernambuco CS, Cader SA, Sá SPC, Pinto FM, Regazzi ICR, Knupp VMAO, Dantas EHM. Effects of dance on the postural balance, cognition and functional autonomy of older adults. Rev Bras Enferm. 2018;71(suppl 5):2302-2309. English, Portuguese. doi: 10.1590/0034-7167-2017-0253. PMID: 30365798. | RCT | People with dementia |
| Brosseau L, Wells GA, Kenny GP, Reid R, Maetzel A, Tugwell P, Huijbregts M, McCullough C, De Angelis G, Chen L. The implementation of a community-based aerobic walking program for mild to moderate knee osteoarthritis (OA): a knowledge translation (KT) randomized controlled trial (RCT): Part I: The Uptake of the Ottawa Panel clinical practice guidelines (CPGs). BMC Public Health. 2012 Oct 13;12:871. doi: 10.1186/1471-2458-12-871. PMID: 23061875; PMCID: PMC3491047. | Knowledge translation RCT | Adults with moderate osteo arthritis |
| Chi NC, Demiris G. A systematic review of telehealth tools and interventions to support family caregivers. J Telemed Telecare. 2015 Jan;21(1):37-44. doi: 10.1177/1357633X14562734. Epub 2014 Dec 4. PMID: 25475220; PMCID: PMC4486048. | Sys rev of experimental studies, non RCT evaluation studies and case study | Wrong population (family caregivers of children) |
| Dahlin-Ivanoff S, Eklund K, Wilhelmson K, Behm L, Häggblom-Kronlöf G, Zidén L, Landahl S, Gustafsson S. For whom is a health-promoting intervention effective? Predictive factors for performing activities of daily living independently. BMC Geriatr. 2016 Oct 6;16(1):171. doi: 10.1186/s12877-016-0345-8. PMID: 27716095; PMCID: PMC5052718. | secondary analysis of longitudinal data from the health promoting RCT EPRZ | Wrong design |
| Desapriya E, Harjee R, Brubacher J, Chan H, Hewapathirane DS, Subzwari S, Pike I. Vision screening of older drivers for preventing road traffic injuries and fatalities. Cochrane Database Syst Rev. 2014 Feb 21;(2):CD006252. doi: 10.1002/14651858.CD006252.pub4. PMID: 24563119. | Sys rev | No relevant information |

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| De Vriendt P, Peersman W, Florus A, Verbeke M, Van de Velde D. Improving Health Related Quality of Life and Independence in Community Dwelling Frail Older Adults through a Client-Centred and Activity-Oriented Program. A Pragmatic Randomized Controlled Trial. <i>J Nutr Health Aging</i> . 2016 Jan;20(1):35-40. doi: 10.1007/s12603-016-0673-6. PMID: 26728931. | Pragmatic RCT | Level not achieved |
| Duplaga, Grysztar, M., Rodzinka, M., & Kopec, A. (2016). Scoping review of health promotion and disease prevention interventions addressed to elderly people. <i>BMC Health Services Research</i> , 16(S5), 278–278. https://doi.org/10.1186/s12913-016-1521-4 | Scoping review | Wrong design |
| Feng Z, Lugtenberg M, Franse C, Fang X, Hu S, Jin C, et al. (2017) Risk factors and protective factors associated with incident or increase of frailty among community-dwelling older adults: A systematic review of longitudinal studies. <i>PLoS ONE</i> 12(6): e0178383. https://doi.org/10.1371/journal.pone.0178383 | Systematic review of longitudinal studies | Community dwelling older adults |
| Elias Filho J, Borel WP, Diz JBM, Barbosa AWC, Britto RR, Felício DC. Prevalence of falls and associated factors in community-dwelling older Brazilians: a systematic review and meta-analysis. <i>Cad Saude Publica</i> . 2019 Aug 29;35(8):e00115718. doi: 10.1590/0102-311X00115718. PMID: 31483046. | Sys rev and meta-anal | Prevalence of falls and associated factors |
| Figueiredo S, Morais JA, Mayo N. Managing mobility outcomes in vulnerable seniors (MMOVEs): a randomized controlled pilot study. <i>Clin Rehabil</i> . 2017 Dec;31(12):1604-1615. doi: 10.1177/0269215517705941. Epub 2017 May 1. PMID: 28459155. | RCT | Physiotherapy |
| Finnegan S, Bruce J, Skelton DA, Withers EJ, Lamb SE; PreFIT Study Group. Development and delivery of an exercise programme for falls prevention: the Prevention of Falls Injury Trial (PreFIT). <i>Physiotherapy</i> . 2018 Mar;104(1):72-79. doi: 10.1016/j.physio.2017.06.004. Epub 2017 Jun 27. PMID: 28801033; PMCID: PMC5840509. | descriptive | Development of program |
| Finnegan S, Bruce J, Seers K. What enables older people to continue with their falls prevention exercises? A qualitative systematic review. <i>BMJ Open</i> . 2019 Apr 15;9(4):e026074. doi: 10.1136/bmjopen-2018-026074. PMID: 30992291; PMCID: PMC6500202. | systematic literature review with thematic synthesis of qualitative studies | Community dwelling and at least 65 years |
| Martínez-Carbonell Guillamón E, Burgess L, Immins T, Martínez-Almagro Andreo A, Wainwright TW. Does aquatic exercise improve commonly reported predisposing risk factors to falls within the elderly? A systematic review. <i>BMC Geriatr</i> . 2019 Feb 22;19(1):52. doi: 10.1186/s12877-019-1065-7. PMID: 30795740; PMCID: PMC6387499. | , Sys rev of trias | No OT physio |

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| Gallo E, Stelmach M, Frigeri F, Ahn DH. Determining Whether a Dosage-Specific and Individualized Home Exercise Program With Consults Reduces Fall Risk and Falls in Community-Dwelling Older Adults With Difficulty Walking: A Randomized Control Trial. <i>J Geriatr Phys Ther.</i> 2018 Jul/Sep;41(3):161-172. doi: 10.1519/JPT.0000000000000114. PMID: 27893567. | RCT | Sixty-nine participants who were independent community dwellers, were 65 years or older, had difficulty walking or complaints of instability and had 1 or more risk of falls |
| Giesbrecht EM, Miller WC. Effect of an mHealth Wheelchair Skills Training Program for Older Adults: A Feasibility Randomized Controlled Trial. <i>Arch Phys Med Rehabil.</i> 2019 Nov;100(11):2159-2166. doi: 10.1016/j.apmr.2019.06.010. Epub 2019 Jul 20. PMID: 31336101. | Feasibility RCT | Wheelchair bound older adults |
| Gitlin LN, Marx K, Scerpella D, Dabelko-Schoeny H, Anderson KA, Huang J, Pizzi L, Jutkowitz E, Roth DL, Gaugler JE. Embedding caregiver support in community-based services for older adults: A multi-site randomized trial to test the Adult Day Service Plus Program (ADS Plus). <i>Contemp Clin Trials.</i> 2019 Aug;83:97-108. doi: 10.1016/j.cct.2019.06.010. Epub 2019 Jun 22. PMID: 31238172; PMCID: PMC7069225. | Multi-site randomized trial | Caregivers of people with dementia |
| Giuli, Papa, R., Lattanzio, F., & Postacchini, D. (2016). The Effects of Cognitive Training for Elderly: Results from My Mind Project. <i>Rejuvenation Research</i> , 19(6), 485–494. https://doi.org/10.1089/rej.2015.1791 , Prospective RCT | Prospective RCT | Other outcome (cognition) |
| Goodwin V, Jones-Hughes T, Thompson-Coon J, Boddy K, Stein K. Implementing the evidence for preventing falls among community-dwelling older people: a systematic review. <i>J Safety Res.</i> 2011 Dec;42(6):443-51. doi: 10.1016/j.jsr.2011.07.008. Epub 2011 Nov 10. PMID: 22152262. | Sys rev | Fall prevention Included in guideline fall prevention |
| Gruenewald TL, Tanner EK, Fried LP, Carlson MC, Xue QL, Parisi JM, Rebok GW, Yarnell LM, Seeman TE. The Baltimore Experience Corps Trial: Enhancing Generativity via Intergenerational Activity Engagement in Later Life. <i>J Gerontol B Psychol Sci Soc Sci.</i> 2016 Jul;71(4):661-70. doi: 10.1093/geronb/gbv005. Epub 2015 Feb 25. PMID: 25721053; PMCID: PMC4903034. | Effect study | Wrong design |
| Guse CE, Peterson DJ, Christiansen AL, Mahoney J, Laud P, Layde PM. Translating a Fall Prevention Intervention Into Practice: A Randomized Community Trial. <i>Am J Public Health.</i> 2015 Jul;105(7):1475-81. doi: 10.2105/AJPH.2014.302315. Epub 2015 Jan 20. PMID: 25602891; PMCID: PMC4463371. | RCT | Fall prevention Included in guideline fall prevention |
| Gustafsson S, Berglund H, Faronbi J, Barenfeld E, Ottenvall Hammar I. Minor positive effects of health-promoting senior meetings for older community-dwelling persons on loneliness, social network, and social support. <i>Clin Interv Aging.</i> 2017 Nov 7;12:1867-1877. doi: 10.2147/CIA.S143994. PMID: 29158669; PMCID: PMC5683788. | Secondary analysis of data was carried out from two randomized controlled studies | Wrong design |

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| Guirguis-Blake JM, Michael YL, Perdue LA, Coppola EL, Beil TL. Interventions to Prevent Falls in Older Adults: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. JAMA. 2018 Apr 24;319(16):1705-1716. doi: 10.1001/jama.2017.21962. PMID: 29710140. , Sys Rev of RCT | Sys rev of RCT | Fall prevention Included in guideline fall prevention |
| Harada K, Lee S, Lee S, Bae S, Harada K, Suzuki T, Shimada H. Objectively-measured outdoor time and physical and psychological function among older adults. Geriatr Gerontol Int. 2017 Oct;17(10):1455-1462. doi: 10.1111/ggi.12895. Epub 2016 Sep 16. PMID: 27633728. | RCT | No intervention; being outdoor |
| Hill KD, Hunter SW, Batchelor FA, Cavalheri V, Burton E. Individualized home-based exercise programs for older people to reduce falls and improve physical performance: A systematic review and meta-analysis. Maturitas. 2015 Sep;82(1):72-84. doi: 10.1016/j.maturitas.2015.04.005. Epub 2015 Apr 29. PMID: 25989701. , | Sys rev and meta anal of RCT or quasi experimental studies | Fall prevention Included in guideline fall prevention |
| Hirase T, Kataoka H, Nakano J, Inokuchi S, Sakamoto J, Okita M. Effects of a psychosocial intervention programme combined with exercise in community-dwelling older adults with chronic pain: A randomized controlled trial. Eur J Pain. 2018 Mar;22(3):592-600. doi: 10.1002/ejp.1149. Epub 2017 Nov 21. PMID: 29160597. | RCT | Other peurpose (pain management) |
| Jenkin CR, Eime RM, Westerbeek H, O'Sullivan G, van Uffelen JGZ. Sport and ageing: a systematic review of the determinants and trends of participation in sport for older adults. BMC Public Health. 2017 Dec 22;17(1):976. doi: 10.1186/s12889-017-4970-8. PMID: 29273036; PMCID: PMC5741887. | Sys rev | Aged 50 years and older) |
| Hirani SP, Beynon M, Cartwright M, Rixon L, Doll H, Henderson C, Bardsley M, Steventon A, Knapp M, Rogers A, Bower P, Sanders C, Fitzpatrick R, Hendy J, Newman SP. The effect of telecare on the quality of life and psychological well-being of elderly recipients of social care over a 12-month period: the Whole Systems Demonstrator cluster randomised trial. Age Ageing. 2014 May;43(3):334-41. doi: 10.1093/ageing/aft185. Epub 2013 Dec 12. PMID: 24333802. | Cluster RCT | Wrong population (>18y) |
| Jiang D, Warner LM, Chong AM, Li T, Wolff JK, Chou KL. Promoting Volunteering Among Older Adults in Hong Kong: A Randomized Controlled Trial. Gerontologist. 2020 Jul 15;60(5):968-977. doi: 10.1093/geront/gnz076. PMID: 31228197. | RCT | Other population: aged 50 years and older |
| Jimenez DE, Schulz R, Perdomo D, Lee CC, Czaja SJ. Implementation of a Psychosocial Intervention Program for Working Caregivers. J Appl Gerontol. 2019 Sep;38(9):1206-1227. doi: 10.1177/0733464817748777. Epub 2017 Dec 22. PMID: 29271282; PMCID: PMC6224315. | RCT (feasability) | Feasability studie |
| Johannesen M, LoGiudice D. Elder abuse: a systematic review of risk factors in community-dwelling elders. Age Ageing. 2013 May;42(3):292-8. doi: 10.1093/ageing/afs195. Epub 2013 Jan 22. PMID: 23343837. | Sys rev | Other purpose: detecting risk factors of abuse |

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| Lenouvel E, Novak L, Nef T, Klöppel S. Advances in Sensor Monitoring Effectiveness and Applicability: A Systematic Review and Update. <i>Gerontologist</i> . 2020 May 15;60(4):e299-e308. doi: 10.1093/geront/gnz049. PMID: 31102436. | Sys rev of 13 empirical studies (case studies and case controls) | Not relevant |
| Kampmeijer R, Pavlova M, Tambor M, Golinowska S, Groot W. The use of e-health and m-health tools in health promotion and primary prevention among older adults: a systematic literature review. <i>BMC Health Serv Res</i> . 2016 Sep 5;16 Suppl 5(Suppl 5):290. doi: 10.1186/s12913-016-1522-3. PMID: 27608677; PMCID: PMC5016733. | Sys rev | Ander doelgroep: Aged 50 and over |
| Kangovi S, Mitra N, Smith RA, Kulkarni R, Turr L, Huo H, Glanz K, Grande D, Long JA. Decision-making and goal-setting in chronic disease management: Baseline findings of a randomized controlled trial. <i>Patient Educ Couns</i> . 2017 Mar;100(3):449-455. doi: 10.1016/j.pec.2016.09.019. Epub 2016 Sep 25. PMID: 27717532; PMCID: PMC5437864. | RCT | No relevant outcome |
| Kapan A, Luger E, Haider S, Titze S, Schindler K, Lackinger C, Dorner TE. Fear of falling reduced by a lay led home-based program in frail community-dwelling older adults: A randomised controlled trial. <i>Arch Gerontol Geriatr</i> . 2017 Jan-Feb;68:25-32. doi: 10.1016/j.archger.2016.08.009. Epub 2016 Aug 28. PMID: 27588891. | RCT | Fall prevention, fear of falling Included in guideline fall prevention |
| Kumar A, Delbaere K, Zijlstra GA, Carpenter H, Iliffe S, Masud T, Skelton D, Morris R, Kendrick D. Exercise for reducing fear of falling in older people living in the community: Cochrane systematic review and meta-analysis. <i>Age Ageing</i> . 2016 May;45(3):345-52. doi: 10.1093/ageing/afw036. PMID: 27121683. | Sys rev en Meta anal (30 trials) | Fall prevention, fear of falling Included in guideline fall prevention |
| Kogan AC, Wilber K, Mosqueda L. Person-Centered Care for Older Adults with Chronic Conditions and Functional Impairment: A Systematic Literature Review. <i>J Am Geriatr Soc</i> . 2016 Jan;64(1):e1-7. doi: 10.1111/jgs.13873. Epub 2015 Dec 2. PMID: 26626408. | Sys rev | No relevant outcome (descriptive, no effect measurement) |
| Kojima G, Kendrick D, Skelton DA, Morris RW, Gawler S, Iliffe S. Frailty predicts short-term incidence of future falls among British community-dwelling older people: a prospective cohort study nested within a randomised controlled trial. <i>BMC Geriatr</i> . 2015 Dec 2;15:155. doi: 10.1186/s12877-015-0152-7. PMID: 26625940; PMCID: PMC4667521. | Prospective cohort nested in RCT | Community dwelling older people |
| Kossek EE, Thompson RJ, Lawson KM, Bodner T, Perrigino MB, Hammer LB, Buxton OM, Almeida DM, Moen P, Hurtado DA, Wipfli B, Berkman LF, Bray JW. Caring for the elderly at work and home: Can a randomized organizational intervention improve psychological health? <i>J Occup Health Psychol</i> . 2019 Feb;24(1):36-54. doi: 10.1037/ocp0000104. Epub 2017 Dec 7. PMID: 29215909; PMCID: PMC5991990. | RCT | No relevant data, more research necessary |
| Kulmala J, Ngandu T, Havulinna S, Levälähti E, Lehtisalo J, Solomon A, Antikainen R, Laatikainen T, Pippola P, Peltonen M, Rauramaa R, Soininen H, Strandberg T, Tuomilehto J, Kivipelto M. The Effect of Multidomain Lifestyle Intervention on | RCT | 60 to 77 years at the start of the study |

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| Daily Functioning in Older People. J Am Geriatr Soc. 2019 Jun;67(6):1138-1144. doi: 10.1111/jgs.15837. Epub 2019 Feb 26. PMID: 30809801. | | |
| Kidd T, Mold F, Jones C, Ream E, Grosvenor W, Sund-Levander M, Tingström P, Carey N. What are the most effective interventions to improve physical performance in pre-frail and frail adults? A systematic review of randomised control trials. BMC Geriatr. 2019 Jul 11;19(1):184. doi: 10.1186/s12877-019-1196-x. PMID: 31291884; PMCID: PMC6622112. | Sys rev of RCT | Physiotherapy |
| Kwak J, Montgomery RJ, Kosloski K, Lang J. The impact of TCARE® on service recommendation, use, and caregiver well-being. Gerontologist. 2011 Oct;51(5):704-13. doi: 10.1093/geront/gnr047. Epub 2011 May 17. PMID: 21593010; PMCID: PMC3218637. | Longitudinal RCT | Caregivers of people with cognitive impairment |
| MacNeill V, Sanders C, Fitzpatrick R, Hendy J, Barlow J, Knapp M, Rogers A, Bardsley M, Newman SP. Experiences of front-line health professionals in the delivery of telehealth: a qualitative study. Br J Gen Pract. 2014 Jul;64(624):e401-7. doi: 10.3399/bjgp14X680485. PMID: 24982492; PMCID: PMC4073725. | Qualitative study | Wrong design |
| Marino M, de Belvis A, Basso D, Avolio M, Pelone F, Tanzariello M, Ricciardi W. Interventions to evaluate fitness to drive among people with chronic conditions: Systematic review of literature. Accid Anal Prev. 2013 Jan;50:377-96. doi: 10.1016/j.aap.2012.05.010. Epub 2012 May 31. PMID: 22658463. | People with chronic conditions | Assessment |
| Matthias MS, Daggy J, Adams J, Menen T, McCalley S, Kukla M, McGuire AB, Ofner S, Pierce E, Kempf C, Heisler M, Bair MJ. Evaluation of a peer coach-led intervention to improve pain symptoms (ECLIPSE): Rationale, study design, methods, and sample characteristics. Contemp Clin Trials. 2019 Jun;81:71-79. doi: 10.1016/j.cct.2019.04.002. Epub 2019 Apr 2. PMID: 30951837. | 2-arm randomized controlled trial | Other population |
| Lovarini M, Clemson L, Dean C. Sustainability of community-based fall prevention programs: a systematic review. J Safety Res. 2013 Dec;47:9-17. doi: 10.1016/j.jsr.2013.08.004. Epub 2013 Aug 28. PMID: 24237865. | Systematic review | Fall prevention Included in other guideline |
| McHugh Power JE, Lee O, Aspell N, McCormack E, Loftus M, Connolly L, Lawlor B, Brennan S. RelAte: pilot study of the effects of a mealtime intervention on social cognitive factors and energy intake among older adults living alone. Br J Nutr. 2016 Nov;116(9):1573-1581. doi: 10.1017/S000711451600369X. Epub 2016 Oct 28. PMID: 27788696. Pilot study | Pilot study | Mealtime interventions with volunteers, no relevant data |
| Menichetti J, Graffigna G, Steinsbekk A. What are the contents of patient engagement interventions for older adults? A systematic review of randomized controlled trials. Patient Educ Couns. 2018 Jun;101(6):995-1005. doi: 10.1016/j.pec.2017.12.009. Epub 2017 Dec 12. PMID: 29246493. | Sys rev of RCT | Level not achieved |
| Mortenson WB, Demers L, Fuhrer MJ, Jutai JW, Lenker J, DeRuyter F. Effects of an assistive technology intervention on older adults with disabilities and their informal caregivers: an exploratory randomized controlled trial. Am J Phys Med | Sys rev | Level not achieved |

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| Rehabil. 2013 Apr;92(4):297-306. doi: 10.1097/PHM.0b013e31827d65bf. PMID: 23291602; PMCID: PMC5484629. | | |
| Montesinos L, Castaldo R, Pecchia L. Wearable Inertial Sensors for Fall Risk Assessment and Prediction in Older Adults: A Systematic Review and Meta-Analysis. IEEE Trans Neural Syst Rehabil Eng. 2018 Mar;26(3):573-582. doi: 10.1109/TNSRE.2017.2771383. PMID: 29522401. | Older adults | Wearables in research situation assessment |
| Moral RR, Torres LA, Ortega LP, Larumbe MC, Villalobos AR, García JA, Rejano JM; Collaborative Group ATEM-AP Study. Effectiveness of motivational interviewing to improve therapeutic adherence in patients over 65 years old with chronic diseases: A cluster randomized clinical trial in primary care. Patient Educ Couns. 2015 Aug;98(8):977-83. doi: 10.1016/j.pec.2015.03.008. Epub 2015 Mar 18. PMID: 25858633. | Cluster RCT | Tailored Caregiver Assessment and Referral® |
| Morat T, Mechling H. The functional movement circle for older adults: feasibility and effects on physical performance. Aging Clin Exp Res. 2014 Oct;26(5):529-37. doi: 10.1007/s40520-014-0201-7. Epub 2014 Feb 21. PMID: 24557812. | RCT | Physiotherapy |
| Morris ME, Adair B, Ozanne E, Kurowski W, Miller KJ, Pearce AJ, Santamaria N, Long M, Ventura C, Said CM. Smart technologies to enhance social connectedness in older people who live at home. Australas J Ageing. 2014 Sep;33(3):142-52. doi: 10.1111/ajag.12154. Epub 2014 Apr 15. PMID: 24730370. | Sys rev of | Aged 45 y and older |
| Morris RL, Hill KD, Ackerman IN, Ayton D, Arendts G, Brand C, Cameron P, Etherton-Ber CD, Flicker L, Hill AM, Hunter P, Lowthian JA, Morello R, Nyman SR, Redfern J, Smit V, Barker AL. A mixed methods process evaluation of a person-centred falls prevention program. BMC Health Serv Res. 2019 Nov 28;19(1):906. doi: 10.1186/s12913-019-4614-z. PMID: 31779624; PMCID: PMC6883679. | Mixed method | Process evaluation |
| Mountain G, Windle G, Hind D, Walters S, Keertharuth A, Chatters R, Sprange K, Craig C, Cook S, Lee E, Chater T, Woods R, Newbould L, Powell L, Shortland K, Roberts J. A preventative lifestyle intervention for older adults (lifestyle matters): a randomised controlled trial. Age Ageing. 2017 Jul 1;46(4):627-634. doi: 10.1093/ageing/afx021. PMID: 28338849; PMCID: PMC5860501. | RCT | Resistance training physiotherapy |
| Muller I, Kirby S, Yardley L. The therapeutic relationship in telephone-delivered support for people undertaking rehabilitation: a mixed-methods interaction analysis. Disabil Rehabil. 2015;37(12):1060-5. doi: 10.3109/09638288.2014.955134. Epub 2014 Aug 26. PMID: 25156569. | Mixed method | Other design |
| Nagai K, Miyamoto T, Okamae A, Tamaki A, Fujioka H, Wada Y, Uchiyama Y, Shinmura K, Domen K. Physical activity combined with resistance training reduces symptoms of frailty in older adults: A randomized controlled trial. Arch Gerontol Geriatr. 2018 May-Jun;76:41-47. doi: 10.1016/j.archger.2018.02.005. Epub 2018 Feb 13. PMID: 29455058. | RCT | Resistance training Physiotherapy |

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| Nielsen TL, Petersen KS, Nielsen CV, Strøm J, Ehlers MM, Bjerrum M. What are the short-term and long-term effects of occupation-focused and occupation-based occupational therapy in the home on older adults' occupational performance? A systematic review. <i>Scand J Occup Ther.</i> 2017 Jul;24(4):235-248. doi: 10.1080/11038128.2016.1245357. Epub 2016 Oct 21. PMID: 27769123. | Sys rev of peer reviewed quantitative papers | Level is not achieved |
| Ng TP, Ling LHA, Feng L, Nyunt MSZ, Feng L, Niti M, Tan BY, Chan G, Khoo SA, Chan SM, Yap P, Yap KB. Cognitive Effects of Multi-Domain Interventions Among Pre-Frail and Frail Community-Living Older Persons: Randomized Controlled Trial. <i>J Gerontol A Biol Sci Med Sci.</i> 2018 May 9;73(6):806-812. doi: 10.1093/gerona/glx207. PMID: 29069291. | RCT | Cognitive training |
| Piau A, Krams T, Voisin T, Lepage B, Nourhashemi F. Use of a robotic walking aid in rehabilitation to reduce fear of falling is feasible and acceptable from the end user's perspective: A randomised comparative study. <i>Maturitas.</i> 2019 Feb;120:40-46. doi: 10.1016/j.maturitas.2018.11.008. Epub 2018 Nov 17. PMID: 30583763. | RCT | Physiotherapy in academic setting |
| Pirauá ALT, Cavalcante BR, de Oliveira VMA, Beltrão NB, de Amorim Batista G, Pitangui ACR, Behm D, de Araújo RC. Effect of 24-week strength training on unstable surfaces on mobility, balance, and concern about falling in older adults. <i>Scand J Med Sci Sports.</i> 2019 Nov;29(11):1805-1812. doi: 10.1111/sms.13510. Epub 2019 Jul 26. PMID: 31273863. | 64 older adults | Strength training Physiotherapy |
| Purkale BA, Mold JW, Chen S. Encouraging Patient-Centered Care by Including Quality-of-Life Questions on Pre-Encounter Forms. <i>Ann Fam Med.</i> 2016 May;14(3):221-6. doi: 10.1370/afm.1905. PMID: 27184992; PMCID: PMC4868560. | RCT | Other population |
| Orellano E, Colón WI, Arbesman M. Effect of occupation- and activity-based interventions on instrumental activities of daily living performance among community-dwelling older adults: a systematic review. <i>Am J Occup Ther.</i> 2012 May-Jun;66(3):292-300. doi: 10.5014/ajot.2012.003053. PMID: 22549594; PMCID: PMC5553610. | Sys rev Of 12 studies | Level is not achieved |
| Reeder B, Meyer E, Lazar A, Chaudhuri S, Thompson HJ, Demiris G. Framing the evidence for health smart homes and home-based consumer health technologies as a public health intervention for independent aging: a systematic review. <i>Int J Med Inform.</i> 2013 Jul;82(7):565-79. doi: 10.1016/j.ijmedinf.2013.03.007. Epub 2013 Apr 30. PMID: 23639263; PMCID: PMC3740158. | Sys rev of 31 studies of different designs | Level not achieved |
| Reeder B, Meyer E, Lazar A, Chaudhuri S, Thompson HJ, Demiris G. Framing the evidence for health smart homes and home-based consumer health technologies as a public health intervention for independent aging: a systematic review. <i>Int J Med Inform.</i> 2013 Jul;82(7):565-79. doi: 10.1016/j.ijmedinf.2013.03.007. Epub 2013 Apr 30. PMID: 23639263; PMCID: PMC3740158. | Sys rev van 31 studies | More inventory of technologies; ne relevant data; 3 articles who indicated effect were on prognostic information Older adults in residential settings |

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| Richardson DL, Duncan MJ, Jimenez A, Juris PM, Clarke ND. Effects of movement velocity and training frequency of resistance exercise on functional performance in older adults: a randomised controlled trial. <i>Eur J Sport Sci.</i> 2019 Mar;19(2):234-246. doi: 10.1080/17461391.2018.1497709. Epub 2018 Jul 17. PMID: 30016185. | RCT | Other population (60-79y) Physiotherapy |
| Roets-Merken LM, Draskovic I, Zuidema SU, van Erp WS, Graff MJ, Kempen GI, Vernooij-Dassen MJ. Effectiveness of rehabilitation interventions in improving emotional and functional status in hearing or visually impaired older adults: a systematic review with meta-analyses. <i>Clin Rehabil.</i> 2015 Feb;29(2):107-19. doi: 10.1177/0269215514542639. Epub 2014 Jul 15. PMID: 25027446. | Sys rev | Visual and hearing impaired people (55y and older) recruited from specialized medical centers |
| Schnock KO, P Howard E, Dykes PC. Fall Prevention Self-Management Among Older Adults: A Systematic Review. <i>Am J Prev Med.</i> 2019 May;56(5):747-755. doi: 10.1016/j.amepre.2018.11.007. Epub 2019 Mar 16. PMID: 30885516. | Sys rev of 9 papers | No relevant data; description of characteristics |
| Slatyer S, Aoun SM, Hill KD, Walsh D, Whitty D, Toye C. Caregivers' experiences of a home support program after the hospital discharge of an older family member: a qualitative analysis. <i>BMC Health Serv Res.</i> 2019;19(1):220. Published 2019 Apr 11. doi:10.1186/s12913-019-4042-0 | Qualitative study | Other design |
| Smit LC, Schuurmans MJ, Blom JW, Fabbricotti IN, Jansen APD, Kempen GIJM, Koopmans R, Looman WM, Melis RJF, Metzelthin SF, Moll van Charante EP, Muntinga ME, Ruijckes FGH, Spoorenberg SLW, Suijker JJ, Wynia K, Gussekloo J, De Wit NJ, Bleijenberg N. Unravelling complex primary-care programs to maintain independent living in older people: a systematic overview. <i>J Clin Epidemiol.</i> 2018 Apr;96:110-119. doi: 10.1016/j.jclinepi.2017.12.013. Epub 2017 Dec 28. PMID: 29289764. | Sys overview | Other design; No relevant information (focus on nurse) |
| Skelton DA, Howe TE, Ballinger C, Neil F, Palmer S, Gray L. Environmental and behavioural interventions for reducing physical activity limitation in community-dwelling visually impaired older people. <i>Cochrane Database Syst Rev.</i> 2013 Jun 5;(6):CD009233. doi: 10.1002/14651858.CD009233.pub2. Update in: <i>Cochrane Database Syst Rev.</i> 2020 Sep 3;9:CD009233. PMID: 23740610. | Sys rev | No useful data in the article |
| Stav WB, Hallenen T, Lane J, Arbesman M. Systematic review of occupational engagement and health outcomes among community-dwelling older adults. <i>Am J Occup Ther.</i> 2012 May-Jun;66(3):301-10. doi: 10.5014/ajot.2012.003707. PMID: 22549595. | Sys rev | Level not achieved |
| Sundgren S, Stolt M, Suhonen R. Ethical issues related to the use of gerontechnology in older people care: A scoping review. <i>Nurs Ethics.</i> 2020 Feb;27(1):88-103. doi: 10.1177/0969733019845132. Epub 2019 May 21. PMID: 31113266. | Scoping review | Wrong design |

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| Sundstrup E, Jakobsen MD, Andersen LL, Andersen TR, Randers MB, Helge JW, Suetta C, Schmidt JF, Bangsbo J, Krstrup P, Aagaard P. Positive effects of 1-year football and strength training on mechanical muscle function and functional capacity in elderly men. <i>Eur J Appl Physiol</i> . 2016 Jun;116(6):1127-38. doi: 10.1007/s00421-016-3368-0. Epub 2016 Apr 11. PMID: 27068158. | RCT | Other population |
| Tan KK, Chan SW, Wang W, Vehviläinen-Julkunen K. A salutogenic program to enhance sense of coherence and quality of life for older people in the community: A feasibility randomized controlled trial and process evaluation. <i>Patient Educ Couns</i> . 2016 Jan;99(1):108-16. doi: 10.1016/j.pec.2015.08.003. Epub 2015 Aug 11. PMID: 26293542. | Feasibility randomized controlled trial and process evaluation | Wrong design (feasibility) |
| Tambor M, Pavlova M, Golinowska S, Arsenijevic J, Groot W. Financial incentives for a healthy life style and disease prevention among older people: a systematic literature review. <i>BMC Health Serv Res</i> . 2016 Sep 5;16 Suppl 5(Suppl 5):426. doi: 10.1186/s12913-016-1517-0. PMID: 27608973; PMCID: PMC5016732. | Sys rev of 15 studies | Financial incentives for lifestyle of older adults |
| Tang SK, Tse MMY, Leung SF, Fotis T. The effectiveness, suitability, and sustainability of non-pharmacological methods of managing pain in community-dwelling older adults: a systematic review. <i>BMC Public Health</i> . 2019 Nov 8;19(1):1488. doi: 10.1186/s12889-019-7831-9. PMID: 31703654; PMCID: PMC6842175. | Sys rev | Non OT-interventions |
| Taube E, Kristensson J, Midlöv P, Jakobsson U. The use of case management for community-dwelling older people: the effects on loneliness, symptoms of depression and life satisfaction in a randomised controlled trial. <i>Scand J Caring Sci</i> . 2018 Jun;32(2):889-901. doi: 10.1111/scs.12520. Epub 2017 Sep 12. PMID: 28895175. | RCT | No relevant info; no OT involved |
| Thomas S, Dalton J, Harden M, Eastwood A, Parker G. Updated meta-review of evidence on support for carers. Southampton (UK): NIHR Journals Library; 2017 Mar. PMID: 28358458. | Meta review | Wrong design |
| Elliott S, Leland NE. Occupational Therapy Fall Prevention Interventions for Community-Dwelling Older Adults: A Systematic Review. <i>Am J Occup Ther</i> . 2018 Jul/Aug;72(4):7204190040p1-7204190040p11. doi: 10.5014/ajot.2018.030494. PMID: 29953828; PMCID: PMC6023642. | Sys rev of 50 articles | Falls prevention |
| Tollár J, Nagy F, Moizs M, Tóth BE, Sanders LMJ, Hortobágyi T. Diverse Exercises Similarly Reduce Older Adults' Mobility Limitations. <i>Med Sci Sports Exerc</i> . 2019 Sep;51(9):1809-1816. doi: 10.1249/MSS.0000000000002001. PMID: 30973482. | RCT | high-intensity training Physiotherapy |
| Uittenbroek RJ, Kremer HPH, Spoorenberg SLW, Reijneveld SA, Wynia K. Integrated Care for Older Adults Improves Perceived Quality of Care: Results of a Randomized Controlled Trial of Embrace. <i>J Gen Intern Med</i> . 2017 May;32(5):516-523. doi: 10.1007/s11606-016-3742-y. Epub 2016 Jun 6. PMID: 27271728; PMCID: PMC5400746. | Single center RCT | Integrated care |

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| Wagner EH, LaCroix AZ, Grothaus L, Leveille SG, Hecht JA, Artz K, Odle K, Buchner DM. Preventing disability and falls in older adults: a population-based randomized trial. <i>Am J Public Health</i> . 1994 Nov;84(11):1800-6. doi: 10.2105/ajph.84.11.1800. PMID: 7977921; PMCID: PMC1615188. | Population based RCT | Enmalige verpleegkundige interventie |
| Wild B, Herzog W, Schellberg D, Böhlen F, Brenner H, Saum KU, Maatouk I. A short intervention targeting psychosomatic care in older adults with complex health care needs-results of a randomized controlled trial. <i>Int J Geriatr Psychiatry</i> . 2019 Feb;34(2):272-279. doi: 10.1002/gps.5017. Epub 2018 Nov 19. PMID: 30370681. | Elderly with complex psychosomatic care needs | Medical intervention |
| Williams HG, Ullmann G. Development of a community-based fall prevention program: Stay In Balance. <i>J Phys Act Health</i> . 2012 May;9(4):571-80. doi: 10.1123/jpah.9.4.571. Epub 2011 May 17. PMID: 21946291. | Mixed method | Development of a program |
| Wilson ML, Strayer TE, Davis R, Harden SM. Use of an Integrated Research-Practice Partnership to Improve Outcomes of a Community-Based Strength-Training Program for Older Adults: Reach and Effect of Lifelong Improvements through Fitness Together (LIFT). <i>Int J Environ Res Public Health</i> . 2018 Jan 31;15(2):237. doi: 10.3390/ijerph15020237. PMID: 29385024; PMCID: PMC5858306. | Pragmatic RC feasibility trial | LIFT: fitness program |
| Yoon DH, Lee JY, Song W. Effects of Resistance Exercise Training on Cognitive Function and Physical Performance in Cognitive Frailty: A Randomized Controlled Trial. <i>J Nutr Health Aging</i> . 2018;22(8):944-951. doi: 10.1007/s12603-018-1090-9. PMID: 30272098. | RCT | Cognitive frailty |
| van Beljouw IM, van Exel E, van de Ven PM, Joling KJ, Dhondt TD, Stek ML, van Marwijk HW. Does an outreaching stepped care program reduce depressive symptoms in community-dwelling older adults? A randomized implementation trial. <i>Am J Geriatr Psychiatry</i> . 2015 Aug;23(8):807-17. doi: 10.1016/j.jagp.2014.09.012. Epub 2014 Oct 5. PMID: 25499673. | RCT implementation | Depressive people Nurse led intervention |
| Wonggom P, Tongpeth J, Newman P, Du H, Clark R. Effectiveness of using avatar-based technology in patient education for the improvement of chronic disease knowledge and self-care behavior: a systematic review protocol. <i>JBISIRIR-2016-003083</i> . PMID: 27755311. | Protocol of sys rev | Wrong design |
| Zgibor JC, Schlenk EA, Vater L, Kola S, Vander Bilt J, Woody S, Jacob ME, Lo-Ciganic WH, Brenckle A, Brandenstein J, Kwok CK, Boudreau R, Albert S, Conroy M, Rodgers E, Newman AB. Partnership Building and Implementation of an Integrated Healthy-Aging Program. <i>Prog Community Health Partnersh</i> . 2016 Spring;10(1):123-32. doi: 10.1353/cpr.2016.0001. PMID: 27018361; PMCID: PMC5988248. | Descriptive study | Other design |
| Zhuang J, Huang L, Wu Y, Zhang Y. The effectiveness of a combined exercise intervention on physical fitness factors related to falls in community-dwelling | RCT | No frail older people (mean age 66) |

| | | |
|--|----------------|--------------------------|
| older adults. Clin Interv Aging. 2014;9:131-40. doi: 10.2147/CIA.S56682. Epub 2014 Jan 10. PMID: 24453483; PMCID: PMC3894141. | | |
| Manafó E, Wong S. Health literacy programs for older adults: a systematic literature review. Health Educ Res. 2012 Dec;27(6):947-60. doi: 10.1093/her/cys067. Epub 2012 Jun 29. PMID: 22752153. | Sys rev | Seniors |
| Richardson J, Loyola-Sanchez A, Sinclair S, Harris J, Letts L, MacIntyre NJ, Wilkins S, Burgos-Martinez G, Wishart L, McBay C, Martin Ginis K. Self-management interventions for chronic disease: a systematic scoping review. Clin Rehabil. 2014 Nov;28(11):1067-77. doi: 10.1177/0269215514532478. Epub 2014 Apr 30. PMID: 24784031. | Scoping review | Other design |
| Yu DS. Effects of a Health and Social Collaborative Case Management Model on Health Outcomes of Family Caregivers of Frail Older Adults: Preliminary Data from a Pilot Randomized Controlled Trial. J Am Geriatr Soc. 2016 Oct;64(10):2144-2148. doi: 10.1111/jgs.14259. Epub 2016 Aug 22. PMID: 27550619. | RCT | Other design (pilot RCT) |
| Sundgren S, Stolt M, Suhonen R. Ethical issues related to the use of gerontechnology in older people care: A scoping review. Nurs Ethics. 2020 Feb;27(1):88-103. doi: 10.1177/0969733019845132. Epub 2019 May 21. PMID: 31113266. | Scoping review | Other design |
| McSherry W. The principal components model: a model for advancing spirituality and spiritual care within nursing and health care practice. J Clin Nurs. 2006 Jul;15(7):905-17. doi: 10.1111/j.1365-2702.2006.01648.x. PMID: 16879383. | | Not full text available |

OTDBase

Literature included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|-----------------|---|--|
| 3 Mirza ea | Feasibility study comparing i-PROACTIF with complex care management using a two-group randomized controlled trial design with data gathered at baseline and during and after the 8-wk intervention. | Populatie sluit niet aan: Eighteen adult volunteers, ages ≥ 50 yr, with heart disease, arthritis, and uncontrolled diabetes |
| 29 Johansson ea | quasiexperimental Design +qual OZ | Design |
| 64 Avlund | prospective randomized | Too old |

4.4.4 Évaluation critique des articles retenus

Voir annexe 5.4

4.4.5 Attribution du GRADE

Voir annexe 5.5

4.5 Question clinique 5

La question clinique est la suivante :

Comment l'ergothérapeute, travaillant avec la personne âgée physiquement fragile vivant à domicile et/ou son contexte social, peut-il contribuer à des soins disciplinaires, intégrés et/ou transmuraux de qualité ?

4.5.1 Stratégie de recherche de concepts

| | Description | Termes de recherche |
|---|--|--|
| P | La personne âgée et le contexte social / l'aidant familial | ("Aged"[MeSH] OR "Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH] OR "Homebound Persons"[MeSH]) AND Primary Health Care"[MeSH] |
| I | Formes de coopération ; personnes et services avec lesquels coopérer | ("Occupational Therapy"[Mesh] OR "Physicians"[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR "Geriatricians"[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Community Health Services"[Mesh] OR "Delivery of Health Care"[Mesh] OR "Home Health Aides"[Mesh] OR "Delivery of Health Care, Integrated"[Mesh] OR "Case Managers"[Mesh] OR "Disease management"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[MeSH] OR "Community Health Centers"[Mesh] OR "Ambulatory Care"[MeSH] OR "Ambulatory Care Facilities"[Mesh] OR "Home Care Services, Hospital-Based"[MeSH] OR "Home health nursing"[MeSH] OR "Home nursing" [MeSH] OR "Respite care"[MeSH] OR "Foster Home Care"[Mesh], "Adult Day Care Centers"[Mesh] OR "Hospitals, Community"[Mesh] OR "Health Services for the Aged"[Mesh]) |
| C | / | |
| O | Transfert d'informations | ("Referral and Consultation"[Mesh] OR "Patient Handoff"[Mesh] OR refer* OR handover OR transmission OR assignment OR "Information Dissemination"[Mesh] OR "Health Information Exchange"[Mesh]) |

Bases de données consultées :

Base de données Cochrane des revues systématiques, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Critères d'inclusion méthodologiques

- Conception : revues systématiques et méta-analyses, essais contrôlés randomisés, études d'observation et études qualitatives.
- Qualité méthodologique suffisante mesurée à l'aide de l'outil d'évaluation critique
- Période de recherche : de la base de données au 30 juin 2022

Critères d'inclusion et d'exclusion du contenu :

Inclusion :

- la personne âgée physiquement fragile et/ou l'aidant informel
- la coopération au sein des soins primaires ou entre les soins primaires et secondaires

Exclusion :

/

Chaîne de recherche par base de données :**Medline (via Pubmed)**

(Aged[Mesh] OR "Frail Elderly"[Mesh] OR "Aged, 80 and over"[Mesh] OR Frailty[Mesh] OR "Homebound Persons"[Mesh])

AND

"Primary Health Care"[Mesh]

AND

("Referral and Consultation"[Mesh] OR "Patient Handoff"[Mesh] OR refer* OR handover OR transmission OR assignment OR "Information Dissemination"[Mesh] OR "Health Information Exchange"[Mesh])

AND

("Occupational Therapy"[Mesh] OR Physicians[Mesh] OR "General Practitioners"[Mesh] OR "Physical Therapists"[Mesh] OR "Nurses, Community Health"[Mesh] OR "Licensed Practical Nurses"[Mesh] OR "Nurse Clinicians"[Mesh] OR "Community Health Nursing"[Mesh] OR "Home Health Nursing"[Mesh] OR "Geriatric Nursing"[Mesh] OR "Family Nurse Practitioners"[Mesh] OR "Family Nursing"[Mesh] OR Geriatricians[Mesh] OR "Allied Health Personnel"[Mesh] OR "Community Health Workers"[Mesh] OR "Patient Care Team"[Mesh] OR "Community Medicine"[Mesh] OR "Community Health Services"[Mesh] OR "Delivery of Health Care"[Mesh] OR "Home Health Aides"[Mesh] OR "Delivery of Health Care, Integrated"[Mesh] OR "Case Managers"[Mesh] OR "Disease management"[Mesh] OR "Social Workers"[Mesh] OR "Home Care Services"[Mesh] OR "Community Health Centers"[Mesh] OR "Ambulatory Care"[Mesh] OR "Ambulatory Care Facilities"[Mesh] OR "Home Care Services, Hospital-Based"[Mesh] OR "Home health nursing"[Mesh])

OR "Home nursing"[Mesh] OR "Respite care"[Mesh] OR "Foster Home Care"[Mesh] OR "Hospitals, Community"[Mesh] OR "Health Services for the Aged"[Mesh])

Cochrane

([mh Aged] OR [mh "Frail Elderly"] OR [mh "Aged, 80 and over"] OR [mh Frailty] OR [mh "Homebound Persons"])

AND

[mh "Primary Health Care"]

AND

([mh "Referral and Consultation"] OR [mh "Patient Handoff"] OR refer* OR handover OR transmission OR assignment OR [mh "Information Dissemination"] OR [mh "Health Information Exchange"])

AND

([mh "Occupational Therapy"] OR [mh Physicians] OR [mh "General Practitioners"] OR [mh "Physical Therapists"] OR [mh "Nurses, Community Health"] OR [mh "Licensed Practical Nurses"] OR [mh "Nurse Clinicians"] OR [mh "Community Health Nursing"] OR [mh "Home Health Nursing"] OR [mh "Geriatric Nursing"] OR [mh "Family Nurse Practitioners"] OR [mh "Family Nursing"] OR [mh Geriatricians] OR [mh "Allied Health Personnel"] OR [mh "Community Health Workers"] OR [mh "Patient Care Team"] OR [mh "Community Medicine"] OR [mh "Community Health Services"] OR [mh "Delivery of Health Care"] OR [mh "Home Health Aides"] OR [mh "Delivery of Health Care, Integrated"] OR [mh "Case Managers"] OR [mh "Disease management"] OR [mh "Social Workers"] OR [mh "Home Care Services"] OR [mh "Community Health Centers"] OR [mh "Ambulatory Care"] OR [mh "Ambulatory Care Facilities"] OR [mh "Home Care Services, Hospital-Based"] OR [mh "Home health nursing"] OR [mh "Home nursing"] OR [mh "Respite care"] OR [mh "Foster Home Care"] OR [mh "Hospitals, Community"] OR [mh "Health Services for the Aged"])

Cinahl

((MH Aged+) OR (MH "Frail Elderly+") OR (MH "Aged, 80 and over+") OR (MH Frailty+) OR (MH "Homebound Persons+"))

AND

(MH "Primary Health Care+")

AND

((MH "Referral and Consultation+") OR (MH "Patient Handoff+") OR refer* OR handover OR transmission OR assignment OR (MH "Information Dissemination+") OR (MH "Health Information Exchange+"))

AND

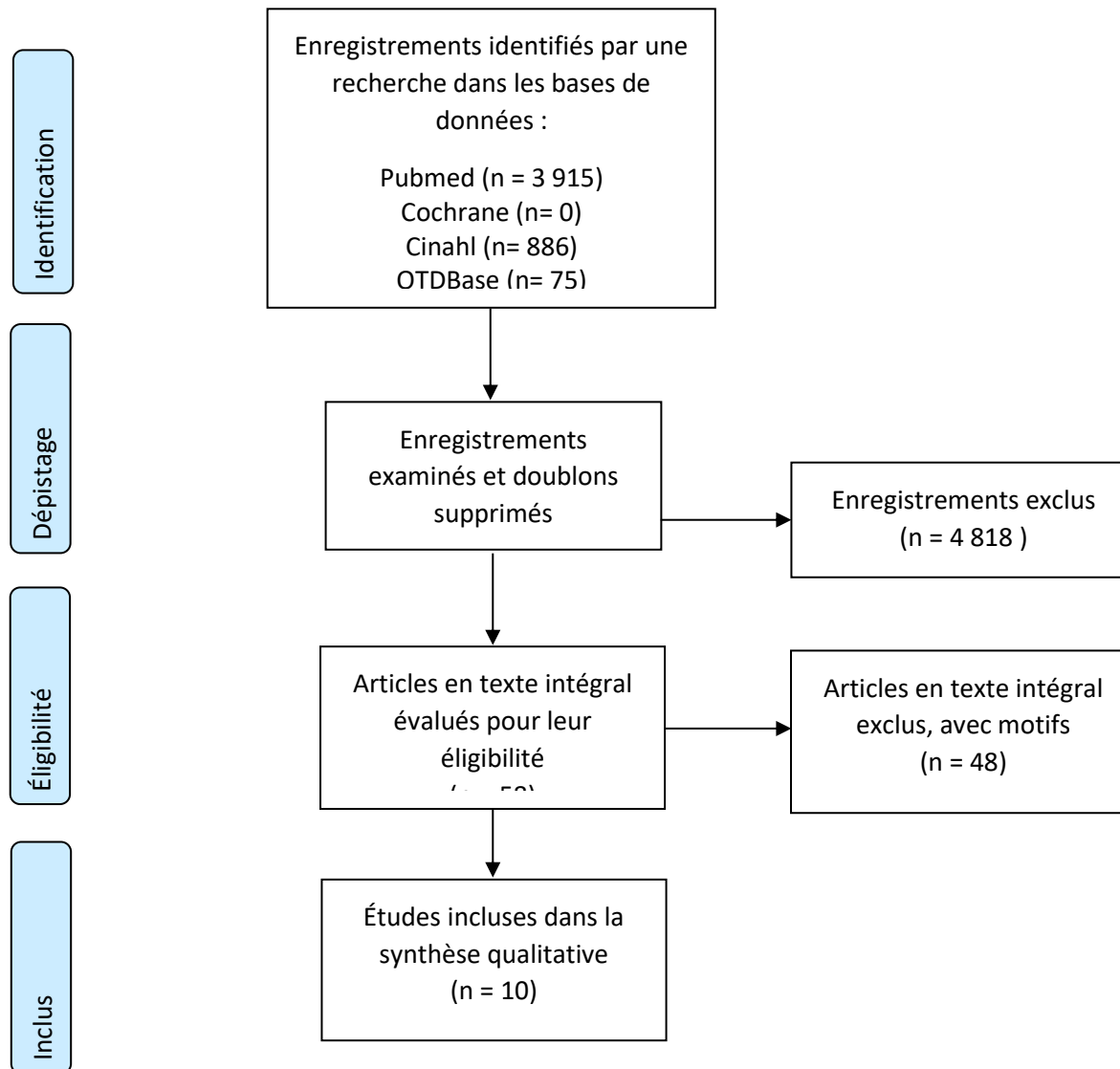
((MH "Occupational Therapy+") OR (MH Physicians+) OR (MH "General Practitioners+") OR (MH "Physical Therapists+") OR (MH "Nurses, Community Health+") OR (MH "Licensed Practical Nurses+") OR (MH "Nurse Clinicians+") OR (MH "Community Health Nursing+") OR (MH "Home Health Nursing+") OR (MH "Geriatric Nursing+") OR (MH "Family Nurse Practitioners+") OR (MH "Family Nursing+") OR (MH Geriatricians+) OR (MH "Allied Health Personnel+") OR (MH "Community Health Workers+") OR (MH "Patient Care

Team+") OR (MH "Community Medicine+") OR (MH "Community Health Services+") OR (MH "Delivery of Health Care+") OR (MH "Home Health Aides+") OR (MH "Delivery of Health Care, Integrated+") OR (MH "Case Managers+") OR (MH "Disease management+") OR (MH "Social Workers+") OR (MH "Home Care Services+") OR (MH "Community Health Centers+") OR (MH "Ambulatory Care+") OR (MH "Ambulatory Care Facilities+") OR (MH "Home Care Services, Hospital-Based+") OR (MH "Home health nursing+") OR (MH "Home nursing+") OR (MH "Respite care+") OR (MH "Foster Home Care+") OR (MH "Hospitals, Community+") OR (MH "Health Services for the Aged+"))

OTDBase

("frail elderly" AND "primary care") OR ("frailty" and "primary care")

4.5.2 Résultats identifiés



4.5.3 Matrice bibliographique question clinique 5

Cochrane database of systematic review

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|-----------|--------|------------------|
| / | | |

Pubmed

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|---|----------------------------------|--|---|--|---|---|---------------------------|
| 8 Lockwood, Kylee J, et al. "Pre-Discharge Home Assessment Visits in Assisting Patients' Return to Community Living: A Systematic Review and Meta-Analysis." <i>Journal of Rehabilitation Medicine</i> , vol. 47, no. 4, 2015, pp. 289–299. | Systematic rev and Meta Analysis | Hospitalized patients among which elderly patients | Home visit conducted by an occupational therapist for the purpose of assessment and discharge planning prior to the patient's discharge | to determine the effectiveness of pre-discharge home assessment visits by occupational therapists in assisting hospitalized patients from a range of | Pre-discharge home assessment visits reduced the risk of falling (risk ratio 0.68, 95% confidence interval (95% CI) 0.49–0.94) and increased participation levels (standardized mean difference 0.49; | The effect of home visits for discharge from the hospital performed by an occupational therapist from the hospital is low to moderate in terms of fall risk reduction, participation level and readmission. | Acceptable quality (SIGN) |

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| | | | from hospital. Therefore programmes providing therapeutic home visits in which multiple therapy sessions or training were conducted in the home as well as home visits conducted by other health professionals without the presence of an occupational therapist were excluded. | settings to return to community living. | 95% CI 0.01–0.98) in geriatric and mixed rehabilitation settings. The risk of readmission to hospital was also reduced (risk ratio 0.47, 95% CI 0.33–0.66), but not for patients following stroke. There was no effect on activity or quality of life. Patients and carers perceived that home assessment visits were beneficial and were satisfied with the process. Conclusion: There is low-to-moderate quality evidence that pre-discharge home assessment visits reduce patients' risk of falling and increase participation. The risk of readmission to hospital is also reduced, but not for patients following stroke. | | |
| 5 Clemson, Lindy, et al. "Occupational Therapy Predischarge Home Visits in Acute Hospital Care: A Randomized Trial." Journal of the American Geriatrics Society (JAGS), vol. 64, no. 10, 2016, pp. 2019–2026. | RCT | Individuals aged 70 and older (N = 400). | HOME and the in-hospital only consultation had manualized protocols and were conducted by OTs who were provided with two training sessions on the HOME intervention | Primary outcomes: activities daily living (ADLs; Nottingham Extended Activities of Daily Living) and participation in life roles and activities (Late Life Disability Index (LLDI)). | Occupational therapist recommendations differed significantly between groups (P < .001) (HOME n = 892 recommendations; control n = 329 recommendations). | Cooperation with the hospital to have primary care occupational therapists carry out the home adaptation in the context of completeness of OT-advice. HOME discharge planning, which had a strong emphasis on task | Acceptable quality (SIGN) |

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| | | | covering HOME aims, assessment of the person's functional ability, goal setting, and home assessment. | | There was no difference between groups in ADLs (Nottingham Extended Activities of Daily Living scale (NEADL): $b = -0.17$, 95% confidence interval (CI) = $-0.99-0.66$) or participation (LLDI—Frequency: $b = -0.23$, 95% CI = $-2.05-1.59$; LLDI—Limitation: $b = -0.14$, 95% CI = $-2.86-2.58$). Both groups maintained prehospital functional status at 90 days, and there was no difference between groups in the number of people with unplanned readmissions (HOME 23.5%, $n = 43$; control 21.9%, $n = 37$). When groups were combined, being male ($P = .03$) or having lower perceived participation because of physical problems ($P = .04$) resulted in higher risk of unplanned readmissions. | modification, well-being, and prevention strategies, implemented twice as many occupational therapy recommendations as the in-hospital only consultation, which had a greater emphasis on equipment provision, but HOME did not demonstrate greater benefit in global measures of ADLs or participation in life tasks than in-hospital consultation alone. It is not recommended that home visits be conducted routinely as part of discharge planning for acutely hospitalized medical patients | |
|--|--|--|---|--|--|--|--|

Literatuurmatrix excluded articles

| reference | design | reason exclusion |
|---|--------|------------------------------------|
| 5 Clemson, Lindy, et al. "Occupational Therapy Predischarge Home Visits in Acute Hospital Care: A Randomized Trial." Journal of the | RCT | No collaboration with community OT |

American Geriatrics Society (JAGS), vol. 64, no. 10, 2016, pp. 2019–2026.

OTDBase

Literatuurmatrix geïncludeerde artikels

| réfrence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
| / | | | | | | | |

Literature matrix excluded articles

| reference | design | reason exclusion |
|---|--|--|
| Avlund, Jepsen, E., Vass, M., & Lundemark, H. (2002). Effects of Comprehensive Follow-up Home Visits after Hospitalization on Functional Ability and Readmissions among Old Patients. A Randomized Controlled Study. <i>Scandinavian Journal of Occupational Therapy</i> , 9(1), 17–22. https://doi.org/10.1080/110381202753505827 | RCT | Sign RCT Level is not achieved |
| Ewa Wressle, Viveka Filipsson, Lena Andersson, Beatrice Jacobsson, Karin Martinsson & Kristina Engel (2006) Evaluation of occupational therapy interventions for elderly patients in Swedish acute care: A pilot study, <i>Scandinavian Journal of Occupational Therapy</i> , 13:4, 203-210, DOI: 10.1080/11038120600593049 | Pilot study | Wrong setting |
| Ridout, & Mayers, C. (2006). Evaluation of the Implementation of the Single Assessment Process and its Impact on Occupational Therapy Practice. <i>The British Journal of Occupational Therapy</i> , 69(6), 271–280. https://doi.org/10.1177/030802260606900605 | combination of methodological approaches | Exclusion due to otucome and design introduction |
| Söderback. (2008). Hospital discharge among frail elderly people: a pilot study in Sweden. <i>Occupational Therapy International</i> , 15(1), 18–31. https://doi.org/10.1002/oti.241 | Pilot study | Exclusion wrong outcome |
| Véronique Provencher, Louise Demers, Isabelle Gélinas & Francine Giroux (2013) Cooking task assessment in frail older adults: who performed better at home and in the clinic?, <i>Scandinavian Journal</i> | | Exclusion wrong outcome |

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| of Occupational Therapy, 20:5, 374-383, DOI: 10.3109/11038128.2012.743586 | | |
| Toole, Connolly, D., & Smith, S. (2013). Impact of an occupation-based self-management programme on chronic disease management. <i>Australian Occupational Therapy Journal</i> , 60(1), 30–38. https://doi.org/10.1111/1440-1630.12008 | | Wrong outcome |
| Tracy Chippendale (2014) Meeting the Mental Health Needs of Older Adults in All Practice Settings, <i>Physical & Occupational Therapy In Geriatrics</i> , 32:1, 1-9, DOI: 10.3109/02703181.2013.862331 | Opinion article | Wrong design (opinion) |
| Frenchman. (2014). The health promoting role of occupational therapy in primary health care: A reflection and emergent vision. <i>New Zealand Journal of Occupational Therapy</i> , 61(2), 64–69. | Opinion article | Wrong design (opinion) To use for intro |
| Donnelly, Brenchley, C. L., Crawford, C. N., & Letts, L. J. (2014). The emerging role of occupational therapy in primary care. <i>Canadian Journal of Occupational Therapy</i> (1939), 81(1), 51–61. https://doi.org/10.1177/0008417414520683 | Multiple case study | Other outcome |
| L'exercice coordonné en Maison de santé pluriprofessionnelle : enjeux organisationnels et dynamiques pluriprofessionnelles Coordinated practice in Multiprofessional Health Houses: Organizational issues and mu It! professional dynamics | | Not available |
| Donnelly, Leclair, L. L., Wener, P. F., Hand, C. L., & Letts, L. J. (2016). Occupational therapy in primary care: Results from a national survey. <i>Canadian Journal of Occupational Therapy</i> (1939), 83(3), 135–142. https://doi.org/10.1177/0008417416637186 | Survey | Other outcome |
| Catherine Killian, Gail Fisher & Sherry Muir (2015) Primary Care: A New Context for the Scholarship of Practice Model, <i>Occupational Therapy In Health Care</i> , 29:4, 383-396, DOI: 10.3109/07380577.2015.1050713 | Narrative review | Other outcome |
| Murphy, Griffith, V. M., Mroz, T. M., & Jirikowic, T. L. (2017). Primary care for underserved populations: Navigating policy to incorporate occupational therapy into federally qualified health centers. <i>The American Journal of Occupational Therapy</i> , 71(2), 7102090010p1–7102090010p5. https://doi.org/10.5014/ajot.2017.712001 | Policy perspective | Other outcome |
| Mackenzie, & Clifford, A. (2018). Perceptions of primary health staff about falls prevention in primary care settings in the west of Ireland. <i>The British Journal of Occupational Therapy</i> , 81(9), 525–534. https://doi.org/10.1177/0308022618761759 | Qualitative review | Other outcome intro |

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|---|-----------------------------|-------------------------------------|
| Trembath, F., Dahl-Popolizio, S., Vanwinkle, M., & Milligan, L. (2019). Retrospective Analysis: Most Common Diagnoses Seen in a Primary Care Clinic and Corresponding Occupational Therapy Interventions. <i>The Open Journal of Occupational Therapy</i> , 7(2). https://doi.org/10.15453/2168-6408.1539 | Analysis of patient records | Other outcome intro |
| Cathrine Arntzen, Unni Sveen, Cathrine Hagby, Tore Bonsaksen, Anne-Stine Dolva & Sissel Horghagen (2019) Community-based occupational therapy in Norway: Content, dilemmas, and priorities, <i>Scandinavian Journal of Occupational Therapy</i> , 26:5, 371-381, DOI: 10.1080/11038128.2018.1548647 | Qualitative research | Other outcome intro |
| McIntyre, Mackenzie, L., & Harvey, M. (2019). Engagement of general practitioners in falls prevention and referral to occupational therapists. <i>The British Journal of Occupational Therapy</i> , 82(2), 71–79. https://doi.org/10.1177/0308022618804752 | survey | Other outcome falls prevention |
| Tore Bonsaksen, Anne-Stine Dolva, Sissel Horghagen, Unni Sveen, Cathrine Hagby & Cathrine Arntzen (2020) Characteristics of community-based occupational therapy: Results of a norwegian survey, <i>Scandinavian Journal of Occupational Therapy</i> , 27:1, 39-46, DOI: 10.1080/11038128.2019.1609085 | Survey | Other outcome (situation in Norway) |
| Mackenzie, Clemson, L., & Irving, D. (2020). Fall prevention in primary care using chronic disease management plans: A process evaluation of provider and consumer perspectives. <i>Australian Occupational Therapy Journal</i> , 67(1), 22–30. https://doi.org/10.1111/1440-1630.12618 | | Other outcome Usefull for intro |
| Mirza, Gecht-Silver, M., Keating, E., Krischer, A., Kim, H., & Kottorp, A. (2020). Feasibility and preliminary efficacy of an occupational therapy intervention for older adults with chronic conditions in a primary care clinic. <i>The American Journal of Occupational Therapy</i> , 74(5), 7405205030–p13. https://doi.org/10.5014/ajot.2020.039842 | Feasibility studies | Other outcome |

Cinahl

Literature matrix included articles

| référence | recherche conception | population | intervention | mesure des résultats | résultat | sélection des données demande clinique | Évaluation Q |
|-----------|----------------------|------------|--------------|----------------------|----------|--|--------------|
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|--|--------------------------------|--|------------------------|--|---|--|---------------------------|
| <p>14 Alice Noblin, Barbara Hewitt, Murad Moqbel, Scott Sittig, Lakesha Kinnerson & Vera Rulon (2021) Can caregivers trust information technology in the care of their patients? A systematic review, Informatics for Health and Social Care, 46:1, 29-41, DOI: 10.1080/17538157.2020.1834399</p> | <p>Systematic review</p> | <p>Informal caregivers</p> | <p>Use of HIT</p> | <p>To identify prior research on trust of the primary IC using HIT to gain information about and/or care instructions for the patient. The researchers' goal was to examine the literature to provide a meticulous summary of the published literature on trust of IC who utilize HIT. Thus, the research question is: "How is trust a key factor for family or ICs when engaging and using HIT to help with their caregiving activities?"</p> | <p>While trust is a key factor for the use of HIT, the researchers only identified ten articles that met the research question thresholds. Four main topics of trust surfaced including perceived confidentiality, perceived security, technological malfunction, and trustworthiness of the information. Trust is a critical factor for informal caregivers when using HIT to assist in the care of their patient (child, loved one, parent, or acquaintance).</p> | <p>De HIT betroffen: persoonlijke gezondheidsdossier, telehomecare/EHR, draagbare technologie en mobile gezondheids app's Perceived confidentiality, perceived security, technological malfunction, and trustworthiness of the information zijn de kerntopics van vertrouwen in HIT.</p> | <p>Low quality (SIGN)</p> |
| <p>20 Balard, Frédéric, Dominique Somme, Marie-Christine Gély-Nargeot, Aline Corvol, and Olivier Saint-Jean. "Case Management for the Elderly with Complex Needs: Cross-linking the Views of Their Role Held by Elderly People, Their Informal Caregivers and the Case Managers." BMC Health Services Research, 2016, BMC Health Services Research, 2016.</p> | <p>Qualitative explorative</p> | <p>Individuals, over 60 years old living at home in situations deemed complex by professionals and their informal caregivers</p> | <p>Case management</p> | <p>To provide a thorough knowledge of the dispositive in order to reveal any initial failings and to ensure optimum conditions for the onset of full implementation.</p> | <p>Each group of people generated its own representations of the case manager's role, even though the three groups of informants shared the idea that the case manager is first and foremost a helper. The case managers insisted on their proximity to the old people and their role as coordinators. The informal caregivers saw the professional as a partner and potential provider of</p> | <p>De casemanager neemt ook een behandelende rol op bij de patiënt</p> | <p>High quality (JBI)</p> |

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| | | | | | assistance in accompanying old people. The old people focused on the personal connections established with the case manager. | | |
| 49 Marshall, Tina, and Phyllis Solomon. "Confidentiality Intervention: Effects on Provider-Consumer-Family Collaboration." <i>Research on Social Work Practice</i> 14, no. 1 (2004): 3-13. | Descriptive study | 59 providers and 68 families at baseline and 52 providers and 58 families upon termination of the study. | A form specifically designed for releasing information to families and/or significant others. | Improving provider-consumer-family collaboration | <p>Although it is commonly noted that unclear confidentiality policies pose a barrier to provider-consumer-family collaboration, this is the first study evaluating the effectiveness of an intervention to clarify confidentiality policies for the release of information to families.</p> <p>Although it is commonly noted that unclear confidentiality policies pose a barrier to provider-consumer-family collaboration, this is the first study evaluating the effectiveness of an intervention to clarify confidentiality policies for the release of information to families.</p> <p>Although the intervention was implemented only in part, the results indicated that families with relatives receiving treatment in the intervention agency were significantly</p> | Afspraken aangaande het doorgeven van vertrouwelijke informatie, vastgelegd in een template, bevordert de samenwerking tussen de patiënt, de mantelzorger/familie en de zorgverlener | Acceptable quality (JBI) |

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| | | | | <p>more likely to have had contact with providers during the course of the study than were families from the comparison agency. Furthermore, fidelity of the intervention by providers was significantly associated with all aspects of improved collaboration. These preliminary findings suggest that the model intervention, if faithfully implemented, may well enhance collaboration between providers, consumers, and families. The authors found that families with relatives receiving treatment from the intervention agency were significantly more likely to have had contact with providers during the course of the study than were families from the comparison agency. Families associated with providers who had higher fidelity to the intervention were also more likely to report more frequent provider contact, more information from providers, and more satisfaction with the amount of contact they had with providers</p> | | |
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| <p>65 Yu, Doris S. F. "Effects of a Health and Social Collaborative Case Management Model on Health Outcomes of Family Caregivers of Frail Older Adults: Preliminary Data from a Pilot Randomized Controlled Trial." <i>Journal of the American Geriatrics Society (JAGS)</i> 64, no. 10 (2016): 2144-148.</p> | <p>Preliminary data RCT</p> | <p>30 family caregivers of elderly people</p> | <p>comprehensive assessment to identify caregiver needs; a case management approach to provide integrated, coordinated, continued care; and multidisciplinary group-based education customized to caregiver individual needs</p> | <p>Case managers who conducted a comprehensive assessment of the care dyads to identify caregiver needs using a case management approach to optimize care coordination and continuity led the HSC-CM. These case managers served as liaisons for multidisciplinary efforts to provide group-based education according to caregiver needs.</p> | <p>Family caregivers who participated in the HSC-CM had significantly greater improvement on the Caregiver Burden Index ($p = .03$) and on the Medical Outcomes Study 36-item Short-Form Survey subscales, including vitality ($p = .049$), social functioning ($p = .047$), and general well-being ($p = .049$). This study provides preliminary evidence indicating that client-centered care, a case management approach, and multidisciplinary support are crucial to an effective caregiving support initiative</p> | <p>Casemanagement bestaande uit een uitgebreid assessment, van de noden van de mantelzorg aangaande optimaliseren van de zorg, Opleiding voor mantelzorgers met een multidisciplinaire insteek.</p> | <p>Low quality (SIGN)</p> |
| <p>67 You, Emily Chuanmei, David Dunt, Colleen Doyle, and Arthur Hsueh. "Effects of Case Management in Community Aged Care on Client and Carer Outcomes: A Systematic Review of Randomized Trials and Comparative Observational Studies." <i>BMC Health Services Research</i> 12, no. 1 (2012): 395.</p> | <p>Sys rev</p> | <p>Frail older people</p> | <p>Case management</p> | <p>To evaluate the effects of case management in community aged care on client and carer outcomes.</p> | <p>Available evidence showed that case management in community aged care can improve client psychological health or well-being and unmet service needs.</p> | <p>CM impact op welzijn en noden die nog niet ingevuld zijn</p> | <p>High quality (SIGN)</p> |
| <p>166 Carrier, Sébastien. "Service Coordination for Frail Elderly Individuals: An Analysis of Case Management Practices in</p> | <p>qualitative exploratory study</p> | <p>Frail older adult</p> | <p>Service coordination</p> | | <p>The informal and coercive basis of the coordination by means of an increased</p> | <p>Casemanagement moet deel uitmaken van een meer algemene integratiestructuur om te</p> | <p>Acceptable quality (JBI)</p> |

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| <p>Québec." <i>Journal of Gerontological Social Work</i>, vol. 55, no. 5, 2012, pp. 392–408.</p> | | | | | <p>systematization of coordination that is nevertheless opened to multidimensionality. To this end, case management must constitute a device that is part of a more general integrative structure to ensure a greater structural continuity in regard to coordination, with all the individuals from the local services network, including private institutions, community-based organizations, and the informal assistance network.</p> | <p>zorgen voor een grotere structurele continuïteit op het vlak van coördinatie, met alle personen uit het lokale dienstennetwerk, inclusief particuliere instellingen, maatschappelijke organisaties en het informele diensten netwerk.</p> | |
| <p>187 Duke C. The Frail Elderly Community-Based Case Management Project. <i>Geriatr Nurs.</i> 2005 Mar-Apr;26(2):122-7. doi: 10.1016/j.gerinurse.2005.03.003. PMID: 15824728.</p> | <p>Case series</p> | <p>aged 65 or older, resided in a private home or in 1 of 3 local assisted living communities in Pitt County, and received their health care at the BSOM Geriatric Clinic.</p> | <p>Depending on individual needs, interventions consisted of case management of medical and social conditions, telemedicine assessments for medically compromised patients, and utilization of hospice and promotion for acceptance of end-of-life decision making.</p> | <p>pre- and postenrollment cumulative outcomes, including emergency department visits, emergency department costs, hospital admissions, hospital admission costs, and total number of hospital days.</p> | <p>continued benefit in reducing hospital cost, length of stay, number of hospitalizations and trips for emergency care.</p> | <p>Een langdurig case management programma voor fraile personen ouder dan 65 jaar die een samenwerking tussen de eerstelijns en het ziekenhuis omvat, zorgt voor een vermindering van ziekenhuisopnames. De opbouw van een nauwe samenwerking, intensieve monitoring van de oudere personen en een vlotte informatiedeling zijn essentiële onderdelen van een dergelijk programma.</p> | <p>Low quality (JBI)</p> |

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| <p>205 Browne, Colette V, and Kathryn L Braun. "When a Case Management Program Closes: Impact as Perceived by Frail Elders and Their Family Caregivers." Journal of Applied Gerontology 20, no. 3 (2001): 338-55.</p> | <p>Mixed method</p> | <p>Older population</p> | <p>Geriatric case management</p> | <p>The perceived impact felt by clients and their families when this assistance is withdrawn. (technical and emotional support and linkages to services and financial assistance)</p> | <p>Attempts were made to contact all 205 former clients of a case management program in Honolulu 6 months after program closure. Of these, 118 were still living at home, 20 had entered nursing homes, 28 had died, and 39 were lost to follow-up. Compared to a previous 6-month period, the percentage who entered nursing homes was similar, whereas the percentage that died was higher. Half of responding caregivers reported a deterioration of their own health and increased emotional fatigue. Data suggest that the program was perceived by elders and their caregivers to be a critical component in providing support and maintaining the safety of frail elders in home settings</p> <p>families (primarily wives and daughters) provide the bulk of home care to older adults who are quite frail, disabled, or demented; (b) for these families, neither the provision nor withdrawal of formal</p> | <p>Stopzetten van case management resulteert in een toename van de GHD van de mantelzorger en toename van de emotionele vermoeidheid</p> | <p>Acceptable quality (JBI)</p> |
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| | | | | | services seems to result in their abandonment of frail elders; (c) for family caregivers who feel burdened by caregiving, help and encouragement from case managers appears to improve the quality of life for caregivers and elders alike; and (d) without such services, the safety of elders in home settings may be compromised | | |
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Literature matrix excluded articles

| reference | design | reason exclusion |
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| Lowenstein, A. (2000). A case management demonstration project for the frail elderly in israel. Care Management Journals : Journal of Case Management ; the Journal of Long Term Home Health Care, 2(1), 5-14. Retrieved from https://www-proquest-com.kuleuven.e-bronnen.be/scholarly-journals/case-management-demonstration-project-frail/docview/72285577/se-2?accountid=17215 | Project description | abstract |
| 24 Hudon, Catherine, Maud-Christine Chouinard, Kris Aubrey-Bassler, Frederick Burge, Shelley Doucet, Vivian R Ramsden, Magaly Brodeur, Paula L Bush, Yves Couturier, Marie-France Dubois, Line Guénette, France Légare, Paul Morin, Thomas G Poder, Marie-Ève Poitras, Pasquale Roberge, Ruta Valaitis, Shirley Bighead, Cameron Campbell, Martine Couture, Breanna Davis, Éline Deschenes, Lynn Edwards, Sarah Gander, Gilles Gauthier, Patricia Gauthier, Richard J Gibson, Julie Godbout, Geneviève Landry, Christine Longjohn, Norma Rabbitskin, Denis A Roy, Judy Roy, Véronique Sabourin, Tara Sampalli, Amanda Saulnier, Claude Spence, Jennifer Splane, Mike Warren, Joanne Young, and Pierre Pluye. "Case Management in Primary Care for Frequent Users of Healthcare Services with Chronic Diseases and Complex Care Needs: An Implementation and Realist Evaluation Protocol." BMJ Open 8, no. 11 (2018): E026433. | Protocol | Protocol implementation and realist evaluation |

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| 25 Dewing, K.C. "Case Management Information Needs. Effective Tools in the Management of Patient Care and Cost Containment." <i>Nursing Case Management</i> 2, no. 4 (1997): 168-72. | Narrative review | design |
| 28 Guttman, R. & (1999). Case Management of the Frail Elderly in the Community. <i>Clinical Nurse Specialist</i> , 13 (4), 174-178. | Part of textbook | design |
| 33 Ervin, Kaye, Sarah Finlayson, and Elaine Tan. "Case Management the Panacea for Aged Care?" <i>Australian Journal of Advanced Nursing</i> 30, no. 1 (2012): 5-11. | CCT | Nursing home |
| 200 Leung, Kevin, Drew Lu-McLean, Craig Kuziemsy, Richard G Booth, Sarah Collins Rossetti, Elizabeth Borycki, and Gillian Strudwick. "Using Patient and Family Engagement Strategies to Improve Outcomes of Health Information Technology Initiatives: Scoping Review." <i>Journal of Medical Internet Research</i> 21, no. 10 (2019): E14683. | Scoping review | No relevant info |
| Petrik ML, Billera M, Kaplan Y, Matarazzo B, Wortzel H. Balancing patient care and confidentiality: considerations in obtaining collateral information. <i>J Psychiatr Pract.</i> 2015 May;21(3):220-4. doi: 10.1097/PRA.000000000000072. PMID: 25955265. | Opinion article | Design |
| Noelker LS. Case management for caregivers. <i>Care Manag J.</i> 2002 Summer;3(4):199-204. doi: 10.1891/cmaj.3.4.199.57449. PMID: 12847937. | Narrative review | Article not available |
| Pyke J, Apa J. Evaluating a case management service: a family perspective. <i>J Case Manag.</i> 1994 Spring;3(1):21-6. PMID: 8000318. | Process evaluation | Content about method research |
| 110 Sheaff R, Boaden R, Sargent P, Pickard S, Gravelle H, Parker S, Roland M. Impacts of case management for frail elderly people: a qualitative study. <i>J Health Serv Res Policy.</i> 2009 Apr;14(2):88-95. doi: 10.1258/jhsrp.2008.007142. PMID: 19299262. | | Article not available |
| 120 Issues in the implementation of a community case management program for the frail elderly. Heller et al. <i>Care management</i> | | Article not available |
| 129 Ondeck, D. M. (2003). Individualizing Patient Care Through Case Management. <i>Home Health Care Management & Practice</i> , 15(3), 260–261. doi:10.1177/1084822302250700 | | Article not available |
| 130 Shendell-Falik N, Soriano KB. Managing patient care in a case management model: elements for success. <i>Semin Nurse Manag.</i> 1997 Mar;5(1):49-55. PMID: 9087114. | | Article not available |
| 134 "Medical Directors Are a Great Source of Support for Case Management: Teamwork Helped to Optimize Patient Care." <i>Case Management Advisor</i> , vol. 15, no. 3, 2004, p. 25. | | Article not available |
| 159 Program provides case management for ill, frail elderly who don't qualify for home care. | | Article not available |

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| 168 Noelker LS, Bass DM. Service use by caregivers of elderly receiving case management. <i>J Case Manag.</i> 1995 Winter;4(4):142-9. PMID: 8715176. | | Article not available |
| 180 Sarma, Sisira, et al. "The Association between Health Information Technology Adoption and Family Physicians' Practice Patterns in Canada: Evidence from 2007 and 2010 National Physician Surveys." <i>Healthcare Policy</i> , vol. 9, no. 1, 2013, pp. 97–117. | | Article not available |
| 76 Chiêm, Jean-Christophe, Thérèse Van Durme, Florence Vandendorpe, Olivier Schmitz, Niko Speybroeck, Sophie Cès, and Jean Macq. "Expert Knowledge Elicitation Using Computer Simulation: The Organization of Frail Elderly Case Management as an Illustration." <i>Journal of Evaluation in Clinical Practice</i> 20, no. 4 (2014): 534-43. | Descriptive study | Description of a method for rethinking and learning |
| 106 Gravelle, Hugh, Mark Dusheiko, Rod Sheaff, Penny Sargent, Ruth Boaden, Susan Pickard, Stuart Parker, and Martin Roland. "Impact of Case Management (Evercare) on Frail Elderly Patients: Controlled before and after Analysis of Quantitative Outcome Data." <i>BMJ: British Medical Journal</i> 334, no. 7583 (2007): 31-34. | | Article not available |
| 124 Fairman, Kathleen A, and Frederic R Curtiss. "Lessons Learned from Randomized Trials and Recent Experience with Health Information Technology: Promising Interventions Meet Real-world Patient Care." <i>Journal of Managed Care Pharmacy</i> 16, no. 9 (2010): 718-28. | Educational article | Not a research article |
| 125 Cleveland "Leveraging Information Technology to Manage Patient Care and Improve Outcomes." <i>Healthcare Informatics</i> , vol. 33, no. 4, 2016, p. 22. | Educational article | Not a research article |
| 135 Chambers, Mary G, et al. "Multimedia Software to Help Caregivers Cope." <i>Journal of the American Medical Informatics Association : JAMIA</i> , vol. 10, no. 5, 2003, pp. 504–511. | | Not a research article |
| 136 Wahlstedt, Patricia, and Wanda Blaser. "Nurse Case Management for the Frail Elderly: a Curriculum to Prepare Nurses for That Role." <i>Home Healthcare Nurse</i> , vol. 4, no. 2, 1986, pp. 30–35. | | Not a research article |
| 140 Essex, E. L., PhD., & Biegel, D. E., PhD. (2007). Older case management clients with younger family members in need of care: Interdependencies and well-being. <i>Care Management Journals</i> , 8(4), 162-70. doi:http://dx.doi.org.kuleuven.e-bronnen.be/10.1891/152109807782590655 | | Content not relevant |
| 181 Girard, Nancy. "The Case Management Model of Patient Care Delivery." <i>AORN Journal</i> 60, no. 3 (1994): 403,408,415-05,412,415. | | Not a research article |
| 182 Petryshen PR, Petryshen PM. The Case Management Model: an innovative approach to the delivery of patient care. <i>J Adv Nurs.</i> 1992 Oct;17(10):1188-94. doi: 10.1111/j.1365-2648.1992.tb01834.x. PMID: 1430620. | | Content not relevant |
| 184 Berthelsen, Connie Bøttcher, and Jimmie Kristensson. "The Content, Dissemination and Effects of Case Management Interventions for Informal | | Content not relevant |

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| Caregivers of Older Adults: A Systematic Review." International Journal of Nursing Studies 52, no. 5 (2015): 988-1002. | | |
| 191 Slack, Marion K, and Marylyn M McEwen. "The Impact of Interdisciplinary Case Management on Client Outcomes." Family & Community Health 22, no. 3 (1999): 30-48. | | Other population |

4.5.4 Évaluation critique des articles retenus

Voir annexe 5.4

4.5.5 Attribution du GRADE

Voir annexe 5.5

5 Annexes

Aperçu des pièces jointes

5.1 Analyse des questions cliniques liées aux lignes directrices

5.2 Rapports GDG

5.3 Rapports des comités consultatifs

5.4 Évaluations critiques des articles inclus

5.5 Comptabilisation de l'attribution du GRADE

5.6 Conflits d'intérêts

5.1 Analyse des questions cliniques liées aux lignes directrices

| Recherche 09/2020 | Termes de recherche | Résultats | Nombre de guides cliniques sélectionnés | Questions de recherche |
|--------------------------|--|-----------|---|--|
| Base de données/site web | | | | |
| GIN | L'ergothérapie* dans les "guides cliniques | 3 | 1 | 1. Quelles sont la fréquence et la durée d'une intervention efficace ? 2. Quelles sont les caractéristiques significatives d'un intervenant efficace ? 3. Les interventions qui impliquent les personnes âgées dans leur conception et leur mise en œuvre sont-elles plus efficaces que celles qui ne le sont pas ? 4. Les interventions qui impliquent les membres de la famille immédiate ou les soignants sont-elles plus efficaces que celles qui ne le sont pas ? 5. L'intervention a-t-elle des effets négatifs ou inattendus ? 6. Quels sont les obstacles et les facteurs facilitant une mise en œuvre efficace ? |
| GIN | Elder* dans "guides cliniques | 22 | 9 Non sélectionné : outil de travail EB (3) ; derrière le mot de passe (2) ; en construction ; en portugais ; non trouvé ; en espagnol (3) ; en danois (2) | Délire : pas de questions mais un champ d'application Diabète de type 1 : champ d'application Diabète de type 2 : champ d'application Fractures de la hanche : objectifs et justification Plaintes fictives : pas de questions Abus et négligence : 1. quels sont les moyens les plus efficaces pour les infirmières (et les autres prestataires de soins de santé) d'identifier et d'évaluer les cas de maltraitance et de négligence à l'égard des personnes âgées ? 2. Quels sont les moyens les plus efficaces pour les infirmières (et les autres prestataires de soins) de réagir à la maltraitance et à la négligence à l'égard des personnes âgées ? 3. De quelle formation les infirmières (et les autres prestataires de soins) ont-elles besoin pour lutter efficacement contre la maltraitance et la négligence à l'égard des personnes âgées ? 4. Quelles sont les stratégies de prévention et de promotion de la santé recommandées en ce qui concerne la maltraitance et la négligence envers les personnes âgées ? 5. Quelles politiques organisationnelles et quels soutiens au niveau du système sont nécessaires pour prévenir et traiter efficacement la maltraitance et la négligence à l'égard des personnes âgées (vivant dans des établissements et dans la communauté) ? Personnes âgées vulnérables : 1. quelles sont les recommandations actuelles en matière d'activité physique chez les personnes âgées ? 2. Quels sont les effets centraux et périphériques d'une intervention physique chez les personnes âgées (fragiles) ? 3. Quels types d'exercices destinés aux personnes âgées fragiles sont efficaces pour améliorer la force musculaire, l'endurance, l'équilibre, la mobilité des articulations, les aptitudes aux AVQ, la mobilité fonctionnelle, la qualité de vie et l'incidence des chutes ? 4. Quels sont les facteurs qui influencent le comportement en matière d'exercice et les niveaux d'activité des personnes âgées (fragiles) ? Démence : |

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| | | | | <p>Quel est le rôle des soignants primaires dans l'identification des symptômes d'une démence présumée ?</p> <p>Quelles sont les tâches spécifiques des soignants primaires dans le domaine du diagnostic en cas de suspicion de démence ?</p> <p>Quelles sont les tâches spécifiques des différents prestataires de soins primaires en ce qui concerne les interventions auprès des personnes atteintes de démence ?</p> <p>Quel est le soutien efficace apporté par les soignants primaires aux personnes atteintes de démence ?</p> <p>Quel est le rôle des principaux soignants dans le suivi et la communication avec les autres soignants en ce qui concerne les objectifs et les résultats définis pour les personnes atteintes de démence ?</p> <p>Quelles sont les conditions requises pour une consultation ciblée et efficace en matière de soins ?</p> <p>Prévention des chutes</p> <p>Quels sont les principaux facteurs de risque de chute chez les personnes âgées vivant à domicile ?</p> <p>Quelle est la meilleure méthode pour établir un risque accru de chute chez les personnes âgées vivant à domicile ?</p> <p>Quel est l'effet d'une approche multifactorielle sur le nombre de chutes subies par les personnes âgées vivant à domicile ?</p> <p>Quel est l'effet d'une approche multifactorielle sur le nombre de blessures dues à des chutes chez les personnes âgées vivant à domicile ?</p> <p>Quel type d'évaluation multifactorielle est recommandé en cas de risque accru de chute chez les personnes âgées vivant à domicile ?</p> <p>Quelles sont les interventions multifactorielles recommandées en cas de risque accru de chute chez les personnes âgées vivant à domicile ?</p> <p>Comment les professionnels de santé peuvent-ils garantir une meilleure observance thérapeutique chez les personnes âgées vivant à domicile et présentant un risque accru de chute ?</p> <p>Quels sont les professionnels qui jouent un rôle important dans la gestion multifactorielle de la prévention des chutes chez les personnes âgées vivant à domicile ?</p> |
| OMS (ORGANISATION MONDIALE DE LA SANTÉ) | Lignes directrices , "ergothérapie" et "aîné" . | 136-156 (le nombre varie en fonction de la durée de consultation) | 2 Principales raisons pour lesquelles le projet n'a pas été retenu : absence de guide clinique et groupe cible différent. | <p>OMS RL "Guide cliniques sur le logement et la santé"</p> <p>Les résidents atteints de déficiences fonctionnelles ou cognitives vivant dans des environnements domestiques accessibles/utilisables ont-ils de meilleurs résultats sanitaires/sociaux que les résidents atteints de déficiences fonctionnelles ou cognitives vivant dans des environnements domestiques conventionnels ou non modifiés ?</p> <p>L'examen systématique s'est concentré sur les résultats de santé prioritaires suivants, tels que classés par le GDG :</p> <ul style="list-style-type: none"> - les taux d'accidents (en particulier les chutes) - bien-être/qualité de vie - santé mentale/dépression |

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| | | | | <p>- la dépendance à l'égard de services sociaux ou de soins externes</p> <p>- la participation sociale.</p> <p>OMS RL "Soins intégrés pour les personnes âgées - Guides cliniques sur les interventions au niveau communautaire pour gérer le déclin des capacités intrinsèques".</p> <p>Pas de questions formulées, mais des sujets concernant les indicateurs de déclin physique ou cognitif :</p> <ul style="list-style-type: none"> • la mobilité, • la malnutrition, • détérioration visuelle et auditive, • le déclin cognitif, |
| NICE | Aîné* | 3 | 1 | <p>RL "Soins à domicile : fournir des soins personnels et une aide pratique aux personnes âgées vivant chez elles".</p> <p>Ce guide couvre la planification et la prestation de soins centrés sur la personne pour les personnes âgées vivant à leur domicile (appelés soins à domicile). Il vise à améliorer l'indépendance des personnes âgées et à garantir des services de soins à domicile sûrs et de qualité constante.</p> <ul style="list-style-type: none"> • Veiller à ce que les soins soient centrés sur la personne • Fournir des informations sur les options de soins et d'assistance • Planification et révision des soins et de l'aide à domicile • Fournir des soins à domicile • Travail conjoint entre les services de santé et les services sociaux • Garantir la sécurité et la protection des personnes utilisant les services de soins à domicile • Recruter, former et soutenir les travailleurs à domicile <p>RL "Personnes âgées : indépendance et bien-être mental"</p> <p>Ce guide couvre les interventions visant à maintenir et à améliorer le bien-être mental et l'indépendance des personnes âgées de 65 ans ou plus, ainsi que la manière d'identifier les personnes les plus exposées au risque de déclin.</p> <p>1 Principes de bonne pratique</p> <p>2 Activités de groupe</p> <p>3 Activités individuelles</p> <p>4 Le bénévolat</p> <p>5 Identifier les personnes les plus exposées au risque de perte d'autonomie et de bien-être mental</p> |

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| SIGNE | Personnes âgées | 18 | 1 | <p>RL "Prise en charge de l'ostéoporose et prévention des fractures de fragilité (SIGN 142)"</p> <p>(pas de questions, seulement des sujets)</p> <p>Facteurs de risque modifiables : inactivité physique</p> |
| Base de données TRIP | fragilité | 31 | 2 | <p>RL "La fragilité chez les personnes âgées - Identification et prise en charge précoces".</p> <p>(pas de questions, seulement des sujets)</p> <p>Fragilité suspectée</p> <p>Fragilité identifiée</p> <p>Évaluation de la fragilité</p> <p>RL "Guides cliniques de pratique clinique pour la prise en charge de la fragilité chez les personnes âgées coréennes vivant au sein de la communauté dans un contexte de soins primaires".</p> <p>(pas de questions, seulement des sujets)</p> <p>Diagnostic et évaluation</p> <p>Intervention et suivi</p> |
| Bases de données associations professionnelles ET (WFOT) | | | | |
| Ergothérapie Pays-Bas | Monodisciplinaire | 10 | 5 (prévention des chutes, SLA/PSMA/PLS, AVC, SEP, maladie de Parkinson) Autres 5 autres groupes cibles | <p>RL "Guide clinique sur l'ergothérapie - Prévention des chutes - Ergothérapie fondée sur des données probantes chez les adultes présentant un risque accru de chute".</p> <p>Quels sont les méthodes et les outils adaptés à l'évaluation de la demande et à l'analyse de la participation et de la réalisation d'activités significatives en relation avec les problèmes de chute ?</p> <p>Quelle méthode et quels principes de fixation des objectifs et de planification des interventions sont appropriés pour le traitement ergothérapeutique des personnes présentant un risque accru de chute ?</p> <p>Quelles sont les interventions fondées sur des données probantes qui visent à prévenir les chutes et qui sont adaptées au rôle de l'ergothérapie et qui améliorent le fonctionnement en toute sécurité ?</p> <p>Quelles sont les caractéristiques de l'intervention et les facteurs du client et du contexte de soins qui sont importants pour une mise en œuvre réussie des interventions de prévention des chutes ?</p> <p>RL "L'ergothérapie dans la SLA, la PSMA et la PLS".</p> <p>L'objectif de ce guide est d'améliorer l'uniformité et la qualité du conseil et du traitement des patients atteints de SLA, de PSMA et de PLS en fournissant des recommandations pratiques concrètes.</p> <p>De quelle manière l'ergothérapeute peut-il identifier et analyser les problèmes d'activité et de participation (attendus) ?</p> <p>Quels sont les points essentiels pour l'ergothérapeute lors de l'inventaire des facteurs personnels et externes qui affectent le fonctionnement du patient atteint de SLA et de ses proches ?</p> |

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| | | | <p>Quelles interventions ergothérapeutiques peuvent être utilisées (à titre préventif) pour les symptômes de la douleur chez les patients atteints de SLA ?</p> <p>Quelles interventions ergothérapeutiques peuvent être utilisées (à titre préventif) pour les symptômes de fatigue chez les patients atteints de SLA ?</p> <p>Quelles interventions ergothérapeutiques peuvent être utilisées (à titre préventif) pour les déficiences dues à des problèmes posturaux ou à des troubles de l'équilibre de la tête chez les patients atteints de SLA ?</p> <p>Quelles interventions ergothérapeutiques peuvent être utilisées (à titre préventif) pour les limitations dues à des problèmes de fonction bras-main chez les patients atteints de SLA ?</p> <p>Quelles interventions ergothérapeutiques peuvent être utilisées pour traiter les problèmes de manipulation et de participation des patients atteints de SLA, dans les domaines de la "communication", de la "mobilité", des "soins personnels", de l'"entretien ménager" et des "activités de jour (travail, loisirs)", et quels sont les points centraux de ces interventions ?</p> <p>Quelles sont les préoccupations en matière de formation, d'orientation et de conseil en ergothérapie concernant les problèmes de manipulation et de participation des patients atteints de SLA et présentant des troubles cognitifs et/ou des troubles du comportement/des TFT ?</p> <p>Quelles interventions ergothérapeutiques peuvent être utilisées pour conseiller et soutenir les proches des patients atteints de SLA ?</p> <p>RL "Guide d'ergothérapie pour l'AVC".</p> <p>Quelles ressources et méthodes ergothérapeutiques sont valables et fiables pour identifier les capacités et les limitations, les souhaits et les besoins des clients et de leurs proches en ce qui concerne les activités quotidiennes ?</p> <p>Comment les objectifs de réadaptation et le plan de traitement sont-ils élaborés avec les clients et leurs proches, en tenant compte de leurs expériences et de leurs points de vue ?</p> <p>Quelles sont les interventions ergothérapeutiques efficaces pour les clients et leurs soignants ?</p> <p>RL "Guides cliniques en matière d'ergothérapie MS".</p> <p>Quels sont les outils d'inventaire et d'analyse des problèmes qui sont fiables et valables pour identifier la participation, le bien-être et les problèmes dans la réalisation d'activités liées à la vie et aux soins, à l'apprentissage et au travail, au jeu et aux loisirs ?</p> <p>Comment identifier les capacités physiques, cognitives et psychosociales sous-jacentes et l'environnement social et physique ?</p> <p>Quels sont les aspects importants lors de la fixation d'objectifs avec le client et ses proches ? Comment l'élaboration d'un plan d'activité basé sur la modification des activités du client est-elle adaptée à sa résilience et à son potentiel de changement ? Comment l'autogestion est-elle encouragée pendant la phase de définition des objectifs et du plan d'activité ?</p> |
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| | | | | <p>Quelles interventions sont efficaces dans le traitement ergothérapeutique des personnes atteintes de SEP pour améliorer la participation, le fonctionnement indépendant (dans tous les domaines d'activité), la mobilité, les capacités sensori-motrices, cognitives et psychosociales et pour prévenir les complications secondaires ?</p> <p>RL "L'ergothérapie dans la maladie de Parkinson".</p> <p>Quels sont les problèmes associés à la maladie de Parkinson qui intéressent les ergothérapeutes ?</p> <p>Quel est le rôle de l'ergothérapie dans le traitement et la prise en charge des patients atteints de la maladie de Parkinson ?</p> <p>Comment concevoir au mieux le diagnostic ergothérapeutique chez les patients atteints de la maladie de Parkinson et leurs aidants naturels ?</p> <p>Comment concevoir au mieux le traitement ergothérapeutique des patients atteints de la maladie de Parkinson et de leurs aidants naturels ?</p> |
| Ergothérapie Pays-Bas | Multidisciplinaire | 32 | <p>4 (AVC, douleur, SEP, prévention des chutes)</p> <p>Autres 28 autres groupes cibles</p> | <p>Mult RL "Infarctus du cerveau et hémorragie cérébrale"</p> <p>Diagnostics</p> <p>1 Quelle planification du traitement en cas d'hémorragie intracérébrale ?</p> <p>3 Quels sont les diagnostics supplémentaires à effectuer pour détecter une sténose athéroscléreuse de la carotide chez les patients présentant un AIT ou un infarctus cérébral non invalidant ?</p> <p>4 Comment diagnostiquer une source embolique cardiaque comme cause d'un AIT ou d'un infarctus cérébral ?</p> <p>Traitement aigu de l'hémorragie cérébrale</p> <p>1 Faut-il réduire médicalement la pression artérielle élevée chez les patients souffrant d'hémorragie cérébrale à la phase aiguë ? Si oui : comment et quand ?</p> <p>2 Quelles sont les indications et les contre-indications du traitement neurochirurgical aigu des patients atteints d'hémorragie cérébrale ?</p> <p>3 Quelles sont les indications et les contre-indications du drainage de la liqueur chez les patients présentant une hémorragie cérébrale aiguë ?</p> <p>Image</p> <p>1 Quelle technique d'imagerie est la plus efficace chez les patients présentant des signes cliniques d'infarctus cérébral pour 1) éliminer une hémorragie intracérébrale, ou une autre cause des signes cliniques, et 2) guider la stratégie thérapeutique dans les premières heures ?</p> <p>2 Quelle imagerie supplémentaire est indiquée pour approfondir le diagnostic et le suivi ?</p> <p>Thérapie de reperfusion pour l'infarctus cérébral aigu</p> <p>1 Dans quelles conditions (supplémentaires) un patient souffrant d'un infarctus cérébral aigu peut-il bénéficier d'une thrombolyse intraveineuse s'il a également pris récemment un DOAC ?</p> |

2 Quels sont les patients souffrant d'un infarctus cérébral aigu qui bénéficient d'une thrombolyse intraveineuse à l'alteplase ?

3 Le traitement endovasculaire augmente-t-il les chances d'une bonne récupération chez les patients souffrant d'un infarctus cérébral et d'une occlusion de l'une des artères intracrâniennes proximales ?

4 La décompression chirurgicale des infarctus cérébraux supratentoriels occupant de l'espace réduit-elle le risque de mauvaise récupération fonctionnelle et de décès ?

Traitement à l'unité d'AVC

1 Les patients atteints d'infarctus cérébral ou d'hémorragie cérébrale doivent-ils être admis dans une unité d'aide aux victimes d'accidents vasculaires cérébraux (AVC) et quelles doivent être les caractéristiques d'une unité d'aide aux victimes d'AVC ?

2 La surveillance et la régulation stricte (c'est-à-dire le maintien dans les limites physiologiques) de paramètres tels que le glucose sérique, la saturation en oxygène et la température corporelle ont-elles un sens chez les patients souffrant d'un infarctus cérébral aigu ou d'une hémorragie cérébrale ?

3 Quelle est l'efficacité des mesures de prévention de la pneumonie d'étouffement par le contrôle systématique de la fonction de déglutition et le traitement de la dysphagie ?

4 Quelle est l'efficacité des mesures de prévention de la thrombose veineuse profonde ?

Indications pour l'artériectomie carotidienne

1 Quelles sont les indications de l'artériectomie carotidienne ?

2 Existe-t-il une indication pour une carotidectomie lors d'un pontage aorto-coronarien afin de prévenir les accidents vasculaires cérébraux per- ou postopératoires ?

3 Combien de temps après un infarctus cérébral ou un AIT le traitement chirurgical d'une sténose carotidienne symptomatique doit-il être effectué ?

4 L'artériectomie carotidienne a-t-elle sa place en cas de sténose asymptomatique ?

5 Quel est le site d'implantation de l'endoprothèse de l'artère carotide (CAS) ?

Prévention secondaire après un AIT ou un infarctus cérébral

1 Quel est le risque d'une nouvelle manifestation d'événements cardiovasculaires après un AIT ou un infarctus cérébral ?

2.1 Quelle est la meilleure façon de diagnostiquer l'hypertension ?

2.2 Quel antihypertenseur est préférable après un infarctus cérébral ?

2.3 Quelles valeurs faut-il viser dans le traitement médicamenteux de l'hypertension chez les patients victimes d'un AIT ou d'un infarctus cérébral ?

2.4 Quand faut-il commencer un traitement hypotenseur après un AIT ou un infarctus/saignement cérébral ?

2.5 Quand y a-t-il une indication pour un médicament hypocholestérolémiant après un AIT ou un infarctus cérébral ?

2.6 Quels médicaments hypocholestérolémiants peuvent être prescrits après un AIT ou un infarctus cérébral ?

3 Quels sont les antiplaquettaires à administrer aux patients après un AIT ou un infarctus cérébral ?

4 Quel est le meilleur traitement antithrombotique en prévention secondaire après un AIT ou un infarctus cérébral chez les patients atteints de fibrillation auriculaire non valvulaire ?

Guide clinique Infarctus du cerveau et hémorragie cérébrale

1 Quel est l'effet de l'intensité de la thérapie par l'exercice sur la récupération des activités de la vie quotidienne (AVQ) après un infarctus cérébral ou une hémorragie cérébrale ?

1.1 Lors de l'admission dans une unité d'AVC d'un hôpital, d'un centre de réadaptation ou d'une maison de repos (disposant d'installations de réadaptation), avec quelle intensité les patients présentant un infarctus cérébral ou une hémorragie cérébrale et une altération de l'autonomie dans les AVQ (indice de Barthel <19 points) doivent-ils suivre une thérapie par l'exercice au moins quotidienne ?

1.2 Quel est l'effet de la poursuite du programme de réadaptation pendant les week-ends et pendant l'admission dans une unité d'AVC dans un hôpital, un centre de réadaptation ou une maison de repos disposant d'installations de réadaptation chez les patients présentant un infarctus cérébral ou une hémorragie cérébrale et une altération de l'autonomie dans les AVQ (BI <19) ?

1.3 Quelle est l'efficacité de l'exercice intensif avec le bras parétique en utilisant la thérapie du mouvement induit par la contrainte (modifiée) ((m)CIMT) ?

2 Quel est l'effet d'une mobilisation précoce lors de l'admission dans une unité d'AVC dans un hôpital après un infarctus cérébral ou une hémorragie cérébrale ?

3 Quelle est l'efficacité (efficacité et coût-efficacité) d'une sortie précoce d'une unité d'AVC dans un hôpital par rapport à des politiques de soins régulières pour l'indépendance dans les AVQ, l'humeur, la charge de soins perçue par le partenaire, le temps d'admission et les coûts chez les patients souffrant d'infarctus cérébral ou d'hémorragie cérébrale ?

4 Quel outil de diagnostic est le plus recommandé pour déterminer la présence, la nature et la gravité de l'aphasie due à un infarctus cérébral ou à une hémorragie cérébrale ?

Traitement de l'aphasie due à un infarctus cérébral ou à une hémorragie cérébrale

1 La thérapie linguistique est-elle efficace pour restaurer la communication chez les patients atteints d'aphasie due à un infarctus cérébral ou à une hémorragie cérébrale ?

2 Quel est le moment optimal pour commencer le traitement de l'aphasie chez les patients atteints d'aphasie due à un infarctus cérébral ou à une hémorragie cérébrale ?

3 Quelle est l'intensité optimale du traitement de l'aphasie chez les patients atteints d'aphasie due à un infarctus cérébral ou à une hémorragie cérébrale ?

4 Quel instrument de dépistage présente les meilleures propriétés psychométriques pour déterminer la présence et la gravité des troubles

cognitifs en phase aiguë et subaiguë chez les patients souffrant d'infarctus cérébral ou d'hémorragie cérébrale ?

5 Quelle est la politique en matière de réadaptation cognitive chez les patients souffrant de troubles cognitifs après un infarctus cérébral ou une hémorragie cérébrale ?

6 Quelle est la place des interventions pharmacologiques et comportementales pour réduire la dépression et/ou l'anxiété après un infarctus cérébral ou une hémorragie cérébrale ?

7 Quelles sont les interventions recommandées pour améliorer le fonctionnement, l'humeur et le bien-être et réduire la charge de travail et le stress des aidants informels de patients atteints d'infarctus cérébral ou d'hémorragie cérébrale ?

RL " Sclérose en plaques"

1. Comment diagnostiquer la SEP le plus tôt possible ?

2. Quels sont les symptômes les plus importants pour le dépistage précoce de la SEP ?

3. Quand peut-on bénéficier d'une thérapie immunomodulatrice et immunosuppressive ? Quelles sont les caractéristiques de ces patients et sur quelle base l'indication est-elle posée ?

4. Quelle méthode (de dépistage) devrait être utilisée pour reconnaître les problèmes d'activités et de participation chez les personnes atteintes de SEP et à quel stade de la maladie ? Quel traitement est préférable et quand doit-il être appliqué ?

5. Quelles méthodes (de dépistage) peuvent être recommandées pour identifier les troubles cognitifs et à quel stade de la maladie ? Quelle méthode de traitement est préférable et quand doit-elle être appliquée ?

6. Quelles méthodes (de dépistage) peuvent être recommandées pour identifier la fatigue et/ou la perte de forme physique et à quel stade de la maladie ? Quelle méthode de traitement est préférable et quand doit-elle être utilisée ?

7. Quelles méthodes (de dépistage) peuvent être recommandées pour identifier les problèmes psychologiques et psychosociaux et à quel stade de la maladie ? Quelle méthode de traitement est préférable et quand doit-elle être appliquée ?

8. Quels sont les principaux facteurs limitants et favorisants qui affectent la capacité de travail et la participation au travail des personnes atteintes de SEP ? Lesquels sont essentiels pour évaluer l'aptitude au travail/la capacité de charge de travail ? Quelles interventions peuvent favoriser la réintégration ou la participation ?

9. À quoi ressemble un réseau de soins axé sur les souhaits de la personne atteinte de SEP ?

Mult RL "Douleur chez les personnes âgées"

Recommandation sur la perception de la douleur et le comportement

Recommandation sur le diagnostic de la douleur

Recommandations sur le traitement non pharmacologique de la douleur

Recommandations sur le traitement pharmacologique de la douleur

Recommandations sur l'organisation des soins dans la prise en charge de la douleur

Mult RL "Prévention des chutes"

1 Quel outil ou processus d'estimation des risques peut être utilisé pour identifier les personnes âgées de 65 ans et plus vivant à domicile et présentant un risque accru de chute ?

2 Quel outil d'évaluation des risques ou quel processus d'estimation des risques peut être utilisé pour identifier les patients présentant un risque accru de chute dans la maison de repos ?

3 Quel outil d'évaluation des risques ou quel processus d'estimation des risques peut être utilisé pour identifier les patients présentant un risque accru de chute à l'hôpital ?

4 Quels sont les facteurs de risque de chutes chez les personnes âgées ? (à domicile, en maison de repos ou de soins ou à l'hôpital)

5 Quelle évaluation multifactorielle du risque de chute est la plus appropriée chez les patients vivant à domicile et présentant un risque de chute accru ?

6 Quelle évaluation multifactorielle du risque de chute est la plus appropriée pour les patients présentant un risque accru de chute à l'hôpital ?

7 Quelle évaluation multifactorielle du risque de chute est la plus appropriée pour les patients présentant un risque accru de chute dans les maisons de retraite ?

8 Quels sont les tests de mobilité qui permettent de prédire les chutes ?

9 Comment évaluez-vous les médicaments utilisés par le patient qui augmentent le risque de chute ?

10 Quelles sont les maladies du système cardiovasculaire associées aux chutes et quels sont les examens à effectuer lorsqu'une cause cardiovasculaire est suspectée d'être à l'origine d'une chute ?

11 Quelles sont les interventions efficaces pour réduire les risques de chute chez les résidents ?

12 Quelles sont les interventions de réduction des risques de chute qui sont efficaces à l'hôpital ?

13 Quelles sont les interventions de réduction des risques de chute qui sont efficaces dans les maisons de retraite ?

14 Quelles interventions non médicamenteuses et médicamenteuses sont efficaces pour prévenir les chutes chez les adultes âgés de 65 ans et plus souffrant d'hypotension orthostatique ?

15 Comment améliorer l'adhésion des personnes âgées aux programmes de prévention des chutes ?

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| | | | | 16 Quelles sont les conditions préalables à la fourniture de soins aux patients présentant un risque accru de chute ? |
| AOTA | Sous "Pratique et recherche fondées sur des données probantes" - "Guides cliniques pour la pratique". | 12 | 3 Vieillessement productif pour les personnes âgées vivant dans la communauté (\$99) Conduite et mobilité communautaire pour les personnes âgées (148 \$) Modification du logement | <p>RL vieillissement productif</p> <p>1 Quelles sont les preuves de l'effet des interventions basées sur l'occupation et l'activité sur la réalisation de certaines activités instrumentales de la vie quotidienne (AIVQ) chez les personnes âgées vivant dans la communauté ?</p> <p>2 Quelles sont les preuves de l'efficacité des programmes d'aménagement du domicile et de prévention des chutes sur les performances des personnes âgées vivant dans la communauté ?</p> <p>3 Quelles sont les preuves de l'effet des interventions de gestion et de maintien de la santé fondées sur l'occupation et l'activité sur les performances des personnes âgées vivant dans la communauté ?</p> <p>4 Quelles sont les preuves que la participation à des occupations et à des activités contribue à la santé des personnes âgées vivant dans la communauté ?</p> <p>RL Conduite et mobilité communautaire des personnes âgées</p> <p>Quelles sont les preuves de l'utilisation d'évaluations cliniques (vision, cognition, fonction physique) et d'évaluations basées sur les performances (simulées et sur route) pour déterminer la sécurité et la compétence au volant et la nécessité d'arrêter de conduire chez les personnes âgées ?</p> <p>Quelles sont les preuves de l'effet des interventions portant sur les fonctions cognitives, les fonctions visuelles, les fonctions motrices, les compétences de conduite, l'autorégulation et la conscience de soi, et le rôle des passagers et de l'implication de la famille dans la capacité de conduite, les performances et la sécurité des personnes âgées ?</p> <p>Quelles sont les preuves de l'effet des modifications liées à l'automobile sur l'aptitude à la conduite, les performances et la sécurité des personnes âgées ? Les modifications comprennent les changements apportés par l'industrie qui améliorent ou entravent l'aptitude à la conduite, les performances et la sécurité des personnes âgées.</p> <p>Quelles sont les preuves de l'effet des politiques et des programmes de mobilité communautaire (par exemple, transports alternatifs, communautés accessibles à pied, éducation, programmes d'arrêt de la conduite, programmes pour les piétons) sur les performances et la participation des personnes âgées ?</p> <p>RL Modifications du logement</p> <p>1 Modifications du domicile pour prévenir les chutes</p> <p>2 Modifications du domicile pour améliorer les performances fonctionnelles</p> <p>3 Soins</p> |
| RCOT | Publications de guides cliniques pour la pratique | 2 | 2 | <p>RL Prévention des chutes :</p> <p>Quelles sont les preuves de l'utilité de l'ergothérapie dans la prévention et la gestion des chutes chez les adultes ?</p> <ul style="list-style-type: none"> • Facteurs environnementaux |

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| | | | | <ul style="list-style-type: none"> • Peur de tomber • Adhésion au traitement • Approche communautaire <p>RL Prothèse de hanche :</p> <p>Quelles sont les preuves qui soutiennent l'intervention de l'ergothérapie auprès des adultes de plus de 18 ans qui subissent une arthroplastie totale de la hanche ?</p> |
| OTAustralie | Guides cliniques | 0 (derrière la clé ?) | 0 | Récupéré de l'association professionnelle / aucun résultat |
| OT Canadien | Guides cliniques | 0 | 0 | Récupéré de l'association professionnelle / aucun résultat |
| Association suédoise d'ergothérapie | guide clinique | 0 | 0 | Récupéré de l'association professionnelle / aucun résultat |
| Norsk occupational therapist forbund (Fédération norvégienne des ergothérapeutes) | En norvégien uniquement | 0 | 0 | Récupéré de l'association professionnelle / aucun résultat |
| OT Malaisie | Guide clinique ; recherchée dans l'"e-shop" et les publications | 0 | 0 | Récupéré de l'association professionnelle / aucun résultat |
| Autre : WFOT | | 0 | 0 | Extrait des associations professionnelles d'Australie, du Canada et du Royaume-Uni, Finlande, France, Islande, Japon, Malaisie, Nouvelle-Zélande, Norvège, Suède, Irlande, Suisse |
| Bases de données d'autres associations professionnelles | | | | |
| Malaisie (LB) - CRC | guide clinique | 0 | 0 | |
| Malaisie - CRM | guide clinique | 0 | 0 | |
| Académie de médecine de Malaisie (AMM) | guide clinique | 90 | 4 | Démence 1. quels sont les groupes de personnes qui courent un risque accru de développer une démence ? 2. Pour les personnes à risque, existe-t-il des stratégies non pharmacologiques pour prévenir ou retarder l'apparition de la |

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| | | | <p>démence ? 3. L'identification précoce de la démence présente-t-elle des avantages/inconvénients ? 4. Une personne atteinte de démence est-elle capable de prendre des décisions ? 5. Le fait de dire la vérité est-il bénéfique pour les patients atteints de démence ? 6. Ces interventions (alimentation et hydratation artificielles, traitement de la douleur, traitement des infections, contention, réanimation) sont-elles bénéfiques pour les patients atteints de démence tardive/sévère ? 7. Ces interventions sont-elles bénéfiques pour les patients atteints de démence tardive/sévère ? 8. Quel est le rôle de la clinique de la mémoire ? 9. Les évaluations des besoins sont-elles utiles aux aidants des personnes atteintes de démence ? Les interventions auprès des aidants sont-elles bénéfiques ? Le dépistage cognitif systématique des personnes âgées de 60 ans et plus au niveau des soins primaires est-il utile pour détecter les démences précoces ? Quels sont les outils adaptés au dépistage des personnes présentant un risque de démence au niveau des soins primaires ? 13. quand les patients atteints de démence doivent-ils être orientés vers un service spécialisé tertiaire ? 14. Quels sont les tests cognitifs brefs qui peuvent aider à diagnostiquer une déficience cognitive légère ou une démence précoce ou une démence, au niveau des soins secondaires/tertiaires ? Comment peut-on déterminer la progression de la démence ? Quels examens pertinents sont nécessaires pour exclure les causes traitables de la démence ?</p> <ul style="list-style-type: none"> o Examens sanguins de routine o Tests de la fonction thyroïdienne o Tests de dépistage de la syphilis o Sérum B1, B12 o Sérum folate et taux d'homocystéine <p>15. Existe-t-il des classifications diagnostiques de la démence pour les différents sous-types de démence ?</p> <ul style="list-style-type: none"> o CIM10 o DSM-IV o NINDS- AIREN, ADDTC ou HACHINSKI o ISCHEMIC SCORE ou Rosen o Score modifié o Critères de Lund-Manchester o Critères MCI <p>18. Les biomarqueurs sont-ils utiles dans le diagnostic de la démence (MA, MAV, DFT, DLB/PDD) ? Comment les fonctions non cognitives doivent-elles être évaluées ? Quel est le rôle de la tomographie par émission de positons et de l'IRM cérébrale chez les patients atteints de démence ? 22. Quel est le rôle de la TEP/SPECT dans le diagnostic de la démence ? Quel est le rôle des EEG dans le diagnostic de la démence ? 24. Pour les personnes atteintes de démence, les inhibiteurs de l'acétylcholinestérase et les antagonistes de la NMDA entraînent-ils une amélioration des fonctions cognitives par rapport au placebo ? 25. quels sont les autres choix de médicaments (autres que les inhibiteurs de l'acétylcholinestérase et la mémantine) qui présentent un avantage ou un inconvénient par rapport à un comparateur approprié ? 26. Chez les personnes atteintes de démence vasculaire, les médicaments (médicaments contre la démence et médicaments contrôlant les facteurs de risque vasculaire), comparés à un placebo, entraînent-ils une amélioration ou un déclin des fonctions cognitives ? 27. Chez les personnes atteintes de démence, le traitement médicamenteux, comparé à un placebo, entraîne-t-il une amélioration des fonctions non cognitives ? 28. Chez les adultes en bonne santé, existe-t-il un produit pharmaceutique pour la prévention de la démence ? 29. Chez les patients atteints de démence, existe-t-il des traitements combinés des symptômes cognitifs et non cognitifs de la démence qui soient bénéfiques ou néfastes ? 30. Pour les patients atteints de démence, les stratégies de promotion de l'indépendance présentent-elles des avantages ou des inconvénients pour le résultat spécifié ? Annexe 2 (suite) 31. Pour les personnes atteintes de démence, la réadaptation cognitive présente-t-elle des avantages ou des inconvénients ? 32. Les interventions psychosociales/comportementales (aromathérapie, orientation vers la réalité, thérapie de validation, reminiscence) pour la gestion des symptômes comportementaux/psychologiques (SCPD) des patients atteints de démence présentent-elles des avantages ou des inconvénients ? 33. Pour les personnes atteintes de démence, quelles conceptions de l'environnement sont appropriées par rapport aux soins standard ? 34. Les interventions éducatives</p> |
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| | | | | <p>sont-elles utiles dans la prise en charge des personnes atteintes de démence et de leurs aidants ?</p> <p>Ostéoporose</p> <p>Comment identifier les patients à risque d'ostéoporose ? - Quelles sont les meilleures pratiques actuelles dans la prise en charge des femmes ménopausées atteintes d'ostéoporose, de l'ostéoporose masculine et de l'ostéoporose induite par les glucocorticoïdes ? - Quels sont les risques et les avantages des traitements de l'ostéoporose ?</p> <p>RA</p> <p>1. Les examens suivants permettent-ils de confirmer le diagnostic de PR ? - échographie musculo-squelettique - IRM 2. Quels sont les facteurs de mauvais pronostic de la PR ? 3. Quels sont les traitements non pharmacologiques efficaces et sûrs de la PR ? - éducation du patient - sevrage tabagique - physiothérapie - ergothérapie - podologie - diététique 4. Les soins infirmiers en rhumatologie sont-ils efficaces et sûrs dans le traitement de la PR ? 5. Quels sont les traitements pharmacologiques efficaces et sûrs de la PR ? - AINS - corticostéroïdes - analgésiques (paracétamol, opioïdes) - corticostéroïdes - DMARD (synthétiques, biologiques) 6. La MTC est-elle efficace et sûre dans le traitement de la PR ? 7. Quelles sont les indications pour l'orientation vers les soins secondaires/tertiaires ?</p> <p>Diabète de type 2</p> <p>1. Comment diagnostiquer au mieux un diabète et une tolérance anormale au glucose ? 2. Quelle est la meilleure façon de prendre en charge les patients atteints de diabète ? 3. Comment traiter les complications aiguës du diabète ? 4. Comment gérer au mieux les complications chroniques du diabète ? 5. Comment gérer au mieux le diabète dans des populations particulières ? 6. Comment prévenir le diabète ? 7. Comment aborder la question des thérapies non éprouvées, de la médecine traditionnelle et complémentaire dans le diabète ?</p> |
| ARNO | Recherche dans la base de données | 3 | 3 | <p>RL "Stratégies de soutien à l'autogestion des maladies chroniques : Collaboration avec les clients"</p> <p>(1) Recommandations pratiques</p> <p>Stratégies d'autogestion multiples</p> <p>Évaluer les croyances, les comportements et les connaissances</p> <p>Conseiller : fournir des informations spécifiques sur les risques et les avantages du changement pour la santé</p> <p>Accepter : fixer en collaboration des objectifs fondés sur l'intérêt du client et sa confiance dans sa capacité à changer de comportement.</p> <p>Assistance : Identifier les obstacles personnels, les stratégies, les techniques de résolution des problèmes et le soutien social/environnemental.</p> <p>Organiser : préciser le plan de suivi</p> <p>Modèles de distribution innovants</p> <p>(2) Recommandations en matière d'éducation</p> <p>(3) Recommandations en matière de gestion et de politique</p> |

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| | | | | <p>RL "Prévenir les chutes et réduire les blessures dues aux chutes".</p> <p>décrire les approches fondées sur des données probantes pour la prévention des chutes et la réduction des blessures dues aux chutes chez les adultes</p> <p>(1) Quels sont les moyens les plus efficaces pour identifier les adultes présentant un risque de chute ou de blessure due à une chute ?</p> <p>(2) Quelles sont les interventions efficaces pour prévenir les chutes et réduire le risque de chutes ou de blessures liées aux chutes chez les adultes à risque ?</p> <p>(3) Quelles sont les interventions ou les processus à mettre en œuvre immédiatement après une chute ?</p> <p>(4) Quels sont les contenus et les stratégies pédagogiques nécessaires pour former efficacement les infirmières et les autres prestataires de soins de santé à la prévention des chutes et des blessures dues aux chutes ?</p> <p>(5) Quelles politiques organisationnelles et quels soutiens au niveau du système sont nécessaires pour aider à prévenir les chutes et les blessures dues aux chutes chez les adultes à risque ?</p> <p>RL "Délire, démence et dépression chez les personnes âgées : évaluation et soins".</p> <p>les infirmières et les autres membres de l'équipe interprofessionnelle de soins de santé à améliorer la qualité de leur pratique en ce qui concerne le délire, la démence et la dépression chez les personnes âgées.</p> <p>(1) Recommandations pratiques</p> <p>(2) Recommandations en matière d'éducation</p> <p>(3) Recommandations en matière de gestion et de politique</p> |
| Domus Medica | Dans les guides cliniques "plus ancien | 15 | 3 | <p>Prévention des chutes</p> <p>Quels sont les principaux facteurs de risque de chute chez les personnes âgées vivant à domicile ? 2. Quel est l'effet d'une approche multifactorielle sur le nombre de chutes chez les personnes âgées vivant à domicile ? 3. Quel est l'effet d'une approche multifactorielle sur le nombre de blessures dues aux chutes chez les personnes âgées vivant à domicile ? 4. Quelle est la meilleure méthode pour identifier un risque accru de chute chez les personnes âgées vivant à domicile ? 5. Quelle évaluation multifactorielle est appropriée en cas de risque accru de chute chez les personnes âgées vivant à domicile ? 6. Quelles interventions multifactorielles sont appropriées en cas de risque accru de chute chez les personnes âgées vivant à domicile ? 7. Comment les aidants professionnels peuvent-ils assurer une meilleure observance chez les personnes âgées vivant à domicile et présentant un risque accru de chute ? 8. Quels aidants professionnels jouent un rôle important dans l'approche multifactorielle de la prévention des chutes chez les personnes âgées vivant à domicile ?</p> <p>Collaboration en matière de démence</p> <p>Phase de détection : quel est le rôle des prestataires de soins primaires dans l'identification des symptômes en cas de suspicion de démence ? Phase de diagnostic de la maladie : quelles sont les tâches diagnostiques spécifiques des prestataires de soins primaires concernés en cas de suspicion de démence ? Phase de diagnostic des soins : quelles sont les tâches spécifiques des différents prestataires de soins primaires en ce qui concerne les interventions</p> |

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| | | | | <p>auprès des personnes atteintes de démence ? Phase de suivi : - Quel soutien est efficace pour les prestataires de soins primaires dans la prise en charge des personnes atteintes de démence ? - Quel rôle les prestataires de soins primaires jouent-ils dans le suivi et la communication aux autres prestataires de soins des objectifs et résultats prédéfinis pour les personnes atteintes de démence ? - Quelles sont les conditions préalables à des consultations efficaces et efficientes en matière de soins ?</p> <p>Traitement de la maltraitance des personnes âgées</p> <p>Détection · Quand le risque de traitement de la maltraitance des personnes âgées est-il élevé ? · Quand le médecin généraliste doit-il rester attentif au traitement de la maltraitance des personnes âgées ? · Le médecin généraliste peut-il poser un diagnostic formel lorsqu'il soupçonne un mauvais traitement ? Évaluation · De quelle manière le médecin généraliste doit-il évaluer une situation de maltraitance ? · Comment et avec quels outils peut-on estimer la capacité de la personne âgée à rendre compte de la situation et sa capacité de décision ? · Que peut faire le médecin généraliste en cas de comorbidité (par exemple démence et dépression) chez la victime et/ou l'auteur de la maltraitance ? · Comment le médecin généraliste peut-il évaluer l'urgence, la gravité, la sécurité et l'évolution de la situation ? Approche · Que peut faire le médecin généraliste s'il identifie une maltraitance de personne âgée ? · Comment le médecin généraliste peut-il faire face au déni ou à la minimisation de la maltraitance des personnes âgées ? · Comment le médecin généraliste peut-il faire face au manque d'autonomie de la personne âgée ? · Quand la personne âgée doit-elle être orientée ? · Comment le médecin généraliste peut-il gérer les relations familiales ? · Quelle attitude le médecin généraliste doit-il adopter vis-à-vis de l'auteur présumé de la maltraitance lorsqu'il s'agit d'un aidant ? · Comment le médecin généraliste peut-il prévenir l'aggravation de la maltraitance ou sa récurrence ? Collaboration pluridisciplinaire · A quels services de soutien le médecin généraliste peut-il faire appel ? · Quelle aide ces services peuvent-ils apporter ? · Comment le médecin généraliste peut-il collaborer avec ces services ? Cadre juridique et déontologique · Quand et comment le médecin généraliste doit-il impliquer les services judiciaires et policiers pour assurer la sécurité de la personne âgée ? · Dans quelles conditions les informations doivent-elles être communiquées à la famille, à l'entourage de la personne âgée, aux autres soignants, aux services de police et à la justice ? · Quel est le rôle du médecin généraliste dans la désignation d'un administrateur provisoire ? Dossier médical et certificat · Quelles sont les données contenues dans le dossier médical ? · Quelles sont les données figurant dans le certificat médical remis à la personne âgée et quelles en sont les conditions ?</p> |
| Association médicale canadienne | Guide clinique aîné* ou ancien* | 32 | 3 | <p>RL "La fragilité chez les personnes âgées - Identification et prise en charge précoces".</p> <p>l'identification et la prise en charge précoces des personnes âgées fragiles ou vulnérables à la fragilité. Ce guide facilite l'évaluation individuelle et fournit un cadre et des outils pour améliorer des stratégies centrées sur le patient afin de gérer la fragilité et de prévenir un déclin fonctionnel plus important. Ce guide est principalement axé sur les soins primaires de proximité, bien que les outils et les stratégies proposés puissent être utiles dans d'autres contextes de soins.</p> <ul style="list-style-type: none"> - Identification des patients fragiles ou vulnérables à la fragilité - Évaluation complète des patients fragiles - Gestion |

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| | | | <ul style="list-style-type: none"> - Revue des médicaments - Planification préalable des soins - Indications pour le renvoi <p>RL "Recommandations sur le dépistage des troubles cognitifs chez les personnes âgées".</p> <p>recommande de ne pas dépister les troubles cognitifs chez les personnes âgées asymptomatiques (≥ 65 ans) vivant dans la communauté.</p> <p>RL "Dépistage des troubles de la vision chez les adultes âgés de 65 ans et plus vivant dans la communauté et recevant des soins primaires".</p> <p>Pour les adultes âgés de 65 ans et plus vivant dans la communauté, nous recommandons de ne pas dépister les troubles de la vision dans le cadre des soins primaires.</p> |
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Tableau : Analyse des questions cliniques, des guides cliniques nationales et internationales

5.2 Rapports GDG

Voir le dossier ci-joint

5.3 Rapports des comités consultatifs

Voir le dossier ci-joint

5.4 Évaluations critiques des articles inclus

Voir le dossier ci-joint

5.5 Comptabilisation de l'attribution du GRADE

Voir le dossier ci-joint

5.6 Conflit d'intérêts

Voir le dossier ci-joint