

Ergotherapie
voor het behoud van de functionaliteit en
de sociale participatie
van de thuiswonende fysiek kwetsbare oudere persoon

Deel 2: Methodologie



GDG:

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

Ergotherapie
voor het behoud van de functionaliteit en
de sociale participatie
van de thuiswonende fysiek kwetsbare oudere persoon

Deel 2: Methodologie

Versie aangepast aan de opmerkingen van de validatiecommissie van Cebam en
gevalideerd op 9/3/2023



GDG:

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



Deze richtlijn werd ontwikkeld binnen het Evikey netwerk met de financiële steun van de FOD Volksgezondheid. www.evikey.be

Table of Contents

3 Gedetailleerde methodiek richtlijnontwikkeling	5
3.1 Fases in het ontwikkelingsproces	5
3.2 Bespreking per fase	6
3.2.1 Bepalen de novo of ADAPTE	6
3.2.2 Tot stand komen klinische subvragen	7
3.2.3 Literatuursearch en -selectie en tabellen, kritische beoordeling literatuur	13
3.2.4 Formuleren aanbevelingen, voorleggen aan GDG en contextadaptatie (stakeholdersbevraging).....	31
3.2.5 Waarde-toekenning aanbevelingen.....	41
3.2.6 Documenteren aanbevelingen.....	46
4 Methodiek per klinische vraag	48
4.1 Klinische vraag 1.....	48
4.1.1 Concepten zoekstrategie	48
4.1.2 Geïdentificeerde resultaten	52
4.1.3 Literatuurmatrixen klinische vraag 1	53
4.1.4 Kritische beoordeling geïnccludeerde artikels	65
4.1.5 GRADE-toekenning	66
4.2 Klinische vraag 2.....	67
4.2.1 Concepten zoekstrategie	67
4.2.2 Geïdentificeerde resultaten	73
4.2.3 Literatuurmatrix vraag 2	74
4.2.4 Kritische beoordeling geïnccludeerde artikels	105
4.2.5 GRADE-toekenning	105
4.3 Klinische vraag 3.....	106
4.3.1 Concepten zoekstrategie	106
4.3.2 Geïdentificeerde resultaten	111
4.3.3 Literatuurmatrix klinische vraag 3	112
4.3.4 Kritische beoordeling geïnccludeerde artikels	120
4.3.5 GRADE-toekenning	120
4.4 Klinische vraag 4.....	121
4.4.1 Concepten zoekstrategie	121
4.4.2 Geïdentificeerde resultaten	131
4.4.3 Literatuurmatrix klinische vraag 4	132
4.4.4 Kritische beoordeling geïnccludeerde artikels	190

4.4.5 GRADE-toekenning	190
4.5 Klinische vraag 5.....	191
4.5.1 Concepten zoekstrategie	191
4.5.2 Geïdentificeerde resultaten	195
4.5.4 Kritische beoordeling geïncludeerde artikels	211
4.5.5 GRADE-toekenning	211
5 Bijlagen.....	212
Overzicht bijlages.....	212
5.1 Analyse klinische vragen aanverwante richtlijnen.....	213
5.2 Verslagen GDG	228
5.3 Verslagen adviescommissie	229
5.4 Critical appraisals geïncludeerde artikels.....	230
5.5 Verantwoording GRADE-toekenning.....	231
5.6 Conflict of interest.....	232

3 Gedetailleerde methodiek richtlijnontwikkeling

3.1 Fases in het ontwikkelingsproces



3.2 Bespreking per fase

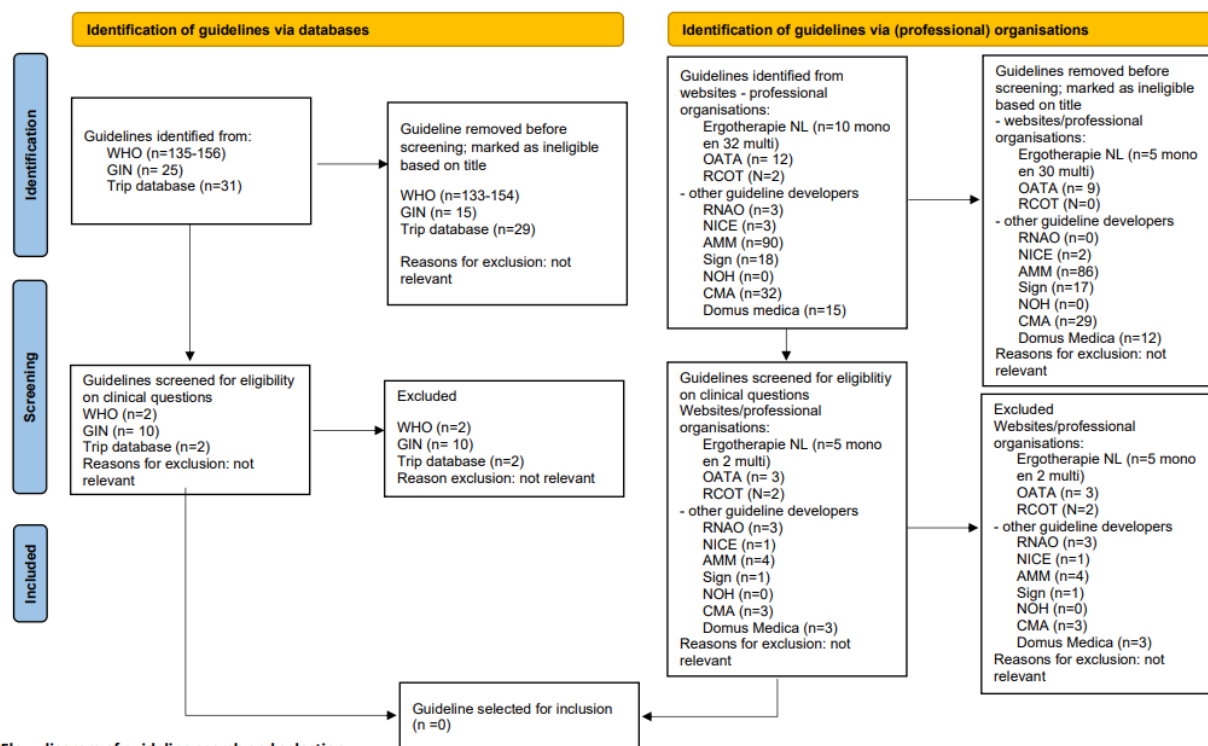
3.2.1 Bepalen de novo of ADAPTE

'Occupational therapy' and 'elderly' werden als zoektermen gebruik om relevante richtlijn te detecteren. Richtlijndatabanken (WHO, GIN, TRIP database), websites van beroepsorganisaties ergotherapie die richtlijnen ontwikkelen (Ergotherapie Nederland - NL, American Occupational Therapy Association - USA, Royal college of Occupational Therapy - GB) en websites van andere richtlijnontwikkelaars (RNAO - Canada, NICE - Engeland, AMM - Maleisië, SIGN – Schotland en NOH-Singapore) werden geraadpleegd. Ook werden de beroepsorganisaties ergotherapie waarvan via hun website niet af te leiden viel of ze richtlijnen ontwikkelden, aangeschreven. (Zie tabel 1)

Land	Naam beroepsvereniging
Australië	OTA
Canada	CAOT
Europe	COTEC
Engeland	RCOT
Finland	STI (syndicaal)
Frankrijk	ANFE
IJsland	ICOTA
Japan	JAOT
Maleisië	MOTA
Nieuw-Zeeland	OTNZ
Noorwegen	NET
Zweden	SAOT
Ierland	AOTI
Zwitserland	EVS

Tabel 1: Aangeschreven beroepsverenigingen ergotherapie

Geen van de aangeschreven beroepsverenigingen ontwikkelde een ergorichtlijn over frailty.



Flow diagram of guideline search and selection

Based on "PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources"

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: <http://www.prisma-statement.org/>

Figuur 1: Flow chart identificatie en selectie richtlijnen

Deze gedetailleerde zoektocht leidde niet tot een valabele (en gratis beschikbare) richtlijn die als bronrichtlijn bruikbaar is voor adaptatie. Daarom werd beslist om een de novo richtlijn te ontwikkelen.

3.2.2 Tot stand komen klinische subvragen

De centrale vraag van de richtlijn is:

Waarom moet een kwaliteitsvolle evidence-based ergotherapeutische interventie voldoen om impact te hebben op het behoud van de functionaliteit en de sociale participatie van de thuiswonende fysiek kwetsbare oudere persoon?

Om de richtlijn te structureren en de aanbevelingen voor de praktijk hanteerbaar te maken, werden topics bepaald waarrond klinische subvragen kunnen worden geformuleerd. Inspiratie werd gehaald door klinische subvragen van aanverwante richtlijnen – geïdentificeerd via bovenstaande search- te analyseren (bijlage 5.1). Om een eerste kader te schetsen werden relevante topics uit de geselecteerde richtlijnen geclusterd en per topic werden uit de analyse van de tabel analyse klinische vragen richtlijnen potentiële subvragen afgeleid. Dit leidde tot volgend resultaat:

Toeleiding (case finding) – indicatie

- Wat is de rol van de mantelzorger in het herkennen van een nood aan ergotherapie?
- Wanneer zouden thuiswonende fysiek kwetsbare ouderen moeten doorverwezen worden naar een ergotherapeut?
- Wat zijn indicaties voor doorverwijzing door ergotherapeuten van de thuiswonende fysiek kwetsbare oudere naar andere hulpbronnen en/of secundaire/tertiaire zorg?
- Wat zijn de voornaamste factoren die een ergotherapeutische aanpak vereisen bij de thuiswonende fysiek kwetsbare oudere?
- Wat is de beste methode om een nood aan een ergotherapeutische interventie te detecteren bij de thuiswonende fysiek kwetsbare oudere?
- Welke evidentie is er om ergotherapie aan te raden bij thuiswonende fysiek kwetsbare ouderen?
- Welke problemen, die samenhangen met fysiek kwetsbare oudere personen zijn van belang voor ergotherapeuten?
- Welke symptomen zijn het meest relevant voor een vroege herkenning van fysiek kwetsbare oudere personen?
- Welk risicoschattingsinstrument of risicoschattingsproces kan gebruikt worden om fysiek kwetsbare thuiswonenden ouder personen op te sporen
- Wat zijn de risicofactoren voor vallen bij fysiek kwetsbare oudere personen in de thuissituatie?

Assessment en doelen bepalen/plan van aanpak opstellen

- Welke multifactoriële evaluatie is aangewezen bij een ergotherapeutische interventie bij de thuiswonende fysiek kwetsbare oudere?
- Welke multifactoriële evaluatie is aangeraden als ergotherapeut bij de thuiswonende fysiek kwetsbare oudere (en zijn mantelzorger)?
- Zijn assessments om de noden in kaart te brengen, zinvol voor de mantelzorgers van de thuiswonende fysiek kwetsbare oudere?
- Hoe zouden de ADL en IADL mogelijkheden van de thuiswonende fysiek kwetsbare oudere in kaart moeten gebracht worden?
- Hoe bepaalt te ergotherapeut de functionele mogelijkheden van de thuiswonende fysiek kwetsbare oudere?
- Welke methoden en instrumenten zijn geschikt voor de vraaginventarisatie en analyse van participatie en het uitvoeren van betekenisvolle activiteiten bij fysiek kwetsbare oudere personen?
- Welke methode en principes van doelbepaling en interventieplanning zijn passend voor een ergotherapeutische behandeling bij fysiek kwetsbare ouder personen?
- Op welke wijze kan de ergotherapeut de (te verwachten) ervaren handelings- en participatieproblemen inventariseren en analyseren?
- Wat zijn aandachtspunten voor de ergotherapeut tijdens de inventarisatie van persoonlijke en externe factoren die het functioneren van de fysiek kwetsbare oudere persoon en diens naasten beïnvloeden?
- Welke ergotherapie middelen en methoden zijn valide en betrouwbaar om de mogelijkheden en beperkingen, wensen en behoeften in kaart te brengen ten aanzien van het dagelijks handelen van fysiek kwetsbare oudere personen en hun naastbetrokkenen?

- Hoe worden revalidatie-doelen en behandelplan met cliënten en naastbetrokkenen opgesteld waarbij uitgegaan wordt van hun ervaringen en perspectieven?
- Welke instrumenten voor probleeminventarisatie en -analyse zijn betrouwbaar en valide voor het in kaart brengen van participatie, welbevinden en problemen in de uitvoer van activiteiten m.b.t. wonen en zorgen, werken, en vrije tijd?
- Hoe kunnen de onderliggende capaciteiten op fysiek, cognitief en psychosociaal vlak en de sociale en fysieke omgeving in kaart worden gebracht?
- Welke aspecten zijn belangrijk bij het opstellen van doelen met de cliënt en zijn naastbetrokkenen? Hoe wordt bij het opstellen van een plan van aanpak uitgegaan van veranderen van het handelen van een cliënt passend bij diens veerkracht en mogelijkheden tot verandering? Hoe wordt zelfmanagement bevordert tijdens de fase van doelbepaling en het plan van aanpak?
- Hoe kan de ergotherapeutische diagnostiek bij fysiek kwetsbare oudere personen en hun mantelzorgers het beste worden vormgegeven?
- Welke (screenings)methode moet worden toegepast om problemen bij activiteiten en participatie bij fysiek kwetsbare oudere personen te herkennen?
- Welke (screenings)methoden zijn te adviseren voor het vaststellen van stoornissen bij fysiek kwetsbare oudere personen?
- Welk multifactoriële valrisicobeoordeling kan het beste worden verricht bij fysiek kwetsbare oudere personen met een verhoogd valrisico?

Interventie – aanpak/communicatie – follow-up

- Welke preventie en gezondheid bevorderende ergotherapeutische strategieën zijn aanbevolen bij thuiswonende fysiek kwetsbare oudere personen?
- Zijn informatieve activiteiten gunstig in de ergotherapeutische behandeling van de thuiswonende fysiek kwetsbare oudere en zijn mantelzorger?
- Wat zijn significante eigenschappen van een effectieve ergotherapeut bij de thuiswonende fysiek kwetsbare oudere persoon?
- Zijn ergotherapeutische interventies waarbij de oudere persoon en zijn eventuele mantelzorger worden betrokken in het ontwerp en de uitvoeren effectiever dan deze waarbij deze betrokkenheid er niet is?
- Wat zijn barrières en facilitatoren van een effectieve implementatie van ergotherapeutische thuisinterventies bij de thuiswonende fysiek kwetsbare oudere persoon?
- Wat zijn de centrale en perifere effecten van ergotherapie bij thuiswonende fysiek kwetsbare ouderen?
- Welke types van ergotherapeutische interventies zijn effectief bij thuiswonende fysiek kwetsbare ouderen ter verbetering van kwaliteit van leven/welbevinden, veilige thuisomgeving, valincidentie, IADL, BADL en belasting van de mantelzorger, functioneren op zelfzorg/productiviteit en ontspanning, zelf ingeschat vermogen om ADL te doen?
- Wat zijn de voorwaarden voor gerichte en effectieve ergotherapie voor de thuiswonende fysiek kwetsbare oudere (en zijn mantelzorger)?
- Welke multifactoriële interventies zijn aangeraden als ergotherapeut bij de thuiswonende fysiek kwetsbare oudere (en zijn mantelzorger)?
- Zijn deze ergotherapeutische interventies (advies en coaching mbt veilige omgeving, gewricht beschermende maatregelen, valpreventie, methodeverandering, ...) gunstig voor thuiswonende fysiek kwetsbare ouderen?

- Zijn de ergotherapeutische strategieën die de onafhankelijkheid van de thuiswonende fysiek kwetsbare oudere promoten, gunstig of schadelijk?
- Welke omgevingsaanpassingen zijn wenselijk voor de thuiswonende fysiek kwetsbare oudere?
- Wat zijn momenteel de beste praktijkvoeringen voor ergotherapeuten voor de thuiswonende fysiek kwetsbare oudere?
- Wat is het effect van een multifactoriële ergotherapeutische aanpak bij de thuiswonende fysiek kwetsbare oudere?
- Welke multifactoriële ergotherapeutische interventies zijn aangewezen bij de thuiswonende fysiek kwetsbare oudere?
- Zijn interventies voor de mantelzorgers van de thuiswonende fysiek kwetsbare oudere zinvol?
- Hoe kan de ergotherapeut omgaan met een gebrek aan autonomie bij de thuiswonende fysiek kwetsbare oudere?
- Hoe kan de ergotherapeut betere therapietrouw bekomen bij de thuiswonende fysiek kwetsbare oudere (en zijn mantelzorgers)?
- Hoe kan de ergotherapeut zorgen voor een betere therapietrouw bij de thuiswonende fysiek kwetsbare oudere?
- Welke evidence-based interventies gericht op fysiek kwetsbare oudere personen en passend bij de rol van de ergotherapie, versterken het veilig functioneren?
- Welke ergotherapeutische interventies kunnen (preventief) worden ingezet bij beperkingen of een verminderde functioneren bij fysiek kwetsbare oudere personen?
- Welke ergotherapeutische interventies kunnen worden ingezet bij handelings- en participatieproblemen van fysiek kwetsbare oudere personen binnen de domeinen 'communicatie', 'mobiliteit', 'zelfverzorging', 'huishouden', en 'dagbesteding (werk, vrije tijd)', en wat zijn hierbij de aandachtspunten?
- Welke ergotherapeutische interventies kunnen worden ingezet om naasten van fysiek kwetsbare oudere personen te adviseren en begeleiden?
- Welke ergotherapie interventies zijn effectief voor fysiek kwetsbare oudere personen en hun naastbetrokkenen?
- Welke interventies zijn effectief bij de ergotherapeutische behandeling van fysiek kwetsbare oudere personen in het verbeteren van participatie, zelfstandig functioneren (voor alle activiteiten gebieden)?
- Hoe kan de ergotherapeutische behandeling bij fysiek kwetsbare oudere personen en hun mantelzorgers het beste worden vormgegeven?
- Welke interventies kunnen worden aanbevolen voor het verbeteren van functioneren, stemming en welbevinden en verminderen van zorglast/stress bij mantelzorgers van fysiek kwetsbare oudere personen?
- Welke behandeling heeft de voorkeur en wanneer moet deze toegepast worden?
- Welke valrisico verlagende interventies zijn effectief bij fysiek kwetsbare thuiswonende oudere personen?
- Hoe kan de compliantie van fysiek kwetsbare oudere personen voor ergotherapeutische adviezen worden verbeterd?
- What is the evidence for the effect of occupation and activity-based interventions on the performance of selected instrumental activities of daily living (IADLs) for community-dwelling older adults?
- What is the evidence for the effectiveness of home modification and fall prevention programs on the performance of community-dwelling older adults?

- What is the evidence for the effect of occupation and activity-based health management and maintenance interventions on the performance of community-dwelling older adults?
- What is the evidence that participation in occupations and activities supports the health of community-dwelling older adults?

Multidisciplinaire samenwerking – doorverwijzing – organisatie GHZ

- Welke rol speelt de ergotherapeut in de opvolging van de communicatie met de andere hulpverleners met betrekking tot vooropgestelde doelstellingen en uitkomsten bij de thuiswonende fysiek kwetsbare oudere?
- Wanneer moet de ergotherapeut de thuiswonende fysiek kwetsbare oudere doorverwijzen?
- Welk organisatiebeleid en systeemondersteuning zijn nodig om effectieve ergotherapie bij thuiswonende fysiek kwetsbare ouderen aan te bieden?
- Welke kenmerken van de interventie en factoren van de cliënt en zorgcontext zijn van belang voor een succesvolle toepassing van ergotherapeutische interventies bij fysiek kwetsbare oudere personen?
- Welke aspecten zijn randvoorwaarden voor het verlenen van zorg aan fysiek kwetsbare oudere personen?
- What is the evidence for the effect for policy and community mobility programs (e.g., alternative transportation, walkable communities, education, driving cessation programs, pedestrian programs) on the performance and participation of older adults?
- What content and educational strategies are necessary to effectively educate health-care providers to prevent falls and injury from falls?
- What organizational policies and system-level supports are required to help prevent falls and injuries from falls among at-risk older adults?

Uit deze analyse werden volgende topics gefilterd en voorgelegd aan de GDG:



Aan deze topics werden volgende initiële klinische subvragen gekoppeld:

Topic 1: Toeleiding (case finding) – indicatie

- Hoe kan een thuiswonende fysieke kwetsbare oudere persoon worden gedetecteerd?

- Wanneer moet een thuiswonende fysiek kwetsbare oudere worden doorverwezen naar een ergotherapeut?

Topic 2: Communicatie en therapeutische grondhouding

- Waaraan voldoet een kwaliteitsvolle ergotherapeutische grondhouding en communicatie met de thuiswonende fysiek kwetsbare oudere persoon en zijn sociale context?

Topic 3: Ergotherapeutisch assessment en doel bepaling oudere persoon en/of sociale context

- Welke multifactoriële ergotherapeutische evaluatie is aangewezen om samen met de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context doelen te bepalen?

Topic 4: Plan van aanpak/ ergotherapeutische interventie oudere persoon en/of context en monitoring

- Welke multifactoriële ergotherapeutische interventie, preventief/curatief of behoudend van aard, is aangewezen bij de thuiswonende fysiek kwetsbare oudere en/of zijn context?
- Hoe kan de ergotherapeut de interventie bij de thuiswonende fysiek kwetsbare oudere en/of zijn context monitoren?

Topic 5: Ergotherapie in crisissituaties

- Wanneer en hoe is ergotherapie betekenisvol bij maatschappelijke en/of individuele crisissituaties voor de thuiswonende fysiek kwetsbare oudere en/of zijn sociale context?

Topic 6: Management, multidisciplinaire samenwerking en doorverwijzing

- Welke aanpak moet de ergotherapeut gebruiken om ergotherapie efficiënt aan te bieden bij de thuiswonende fysiek kwetsbare oudere en/of zijn context?
- Hoe geeft de ergotherapeut, die met de thuiswonende fysiek kwetsbare oudere en/of zijn sociale context werkt, mee vorm aan de multi- en disciplinaire samenwerking over de settings heen?

Topic 7: Vertaalslag praktijkaanbevelingen naar ergotherapeutisch onderwijs

- Welke kennis, vaardigheden en attitudes dienen aangeleerd te worden en op welke manier moeten deze aangebracht worden, aan studenten ergotherapie zodat ze effectieve ergotherapie kunnen aanbieden aan de thuiswonende fysiek kwetsbare oudere en/of zijn context?

Deze initiële klinische subvragen werden voorgelegd aan de GDG, de begeleidingscommissie van de FOD en de stakeholders.

Op voorstel van de GDG (verslag GDG 1 20200924) en de begeleidingscommissie van de FOD Volksgezondheid werden een aantal topics weggelaten (ergotherapie in crisissituaties en vertaalslag praktijkaanbevelingen naar ergotherapeutisch onderwijs) en subvragen samengevoegd. Bij de herwerking bracht het klinisch redeneerproces structuur in de formulering en volgorde van de klinische subvragen. Dit leidde tot de prefinale klinische subvragen. Deze werden goedgekeurd door de GDG (verslag GDG 20201210) en de begeleidingscommissie van de FOD Volksgezondheid.

De prefinale klinische subvragen werden vervolgens voor relevantie via een survey (vierpunt Likertschaal) voorgelegd aan de adviescommissie (stakeholders) waarbij de cutoffwaarde voor

consensus werd bepaald op 70%. De vijf klinische subvragen werden in consensus relevant bevonden. (verslag stakeholdersoverleg 20201019)

Na feedback van de leescommissie van de WOREL, werd de term ‘case finding’ toegevoegd bij het eerste deel van klinische subvraag 1, dit om het onderscheid met de component “assessment” van klinische subvraag 2 duidelijker te maken. De finale klinische subvragen luiden als volgt:

Subvraag 1:

Hoe kan de fysiek kwetsbare oudere persoon worden gedetecteerd (case finding)? Hoe kan de fysiek kwetsbare oudere persoon en/of zijn sociale context efficiënt en effectief worden doorverwezen naar een ergotherapeut?

Subvraag 2:

Welke multifactoriële ergotherapeutische evaluatie is aangewezen bij de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context?

Subvraag 3:

Welke methodiek is aangewezen om samen met de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context doelen te bepalen?

Subvraag 4:

Welke multifactoriële ergotherapeutische interventies zijn aangewezen bij de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context?

Subvraag 5:

Hoe kan de ergotherapeut, die met de thuiswonende fysiek kwetsbare oudere en/of zijn sociale context werkt, bijdragen aan een kwaliteitsvolle discipline, geïntegreerde en/of transmurale zorg?

3.2.3 Literatuursearch en -selectie en tabellen, kritische beoordeling literatuur

3.2.3.1 Operationeel maken PIPOH

Elk item van de PIPOH werd operationeel gemaakt door een omschrijving te geven van de term, en synoniemen, hyperoniemen en hyponiemen te formuleren. (Tabel 2) Dit operationeel maken van de PIPOH dient als tussenstap om de concepten te definiëren zoals weergegeven onder item 3.2.3.6 “Vorbereiding zoekstring gelinkt aan PIPOH”.

	Term	Synoniem	Hyperoniem	Hyponiem
P	Thuiswonende fysiek kwetsbare ouder persoon ouder dan 75 jaar	physically frail elderly, older person over 75 years, "Frail Elderly"[Mesh],	Elderly, "aged"[MeSH Major Topic], "Aged, 80 and over"[Mesh], "Frailty"[Mesh], ageing in place, community dwelling elderly	"Homebound Persons"[Mesh], "Environment"[Mesh], "Independent Living"[Mesh]

<p>en/of zijn sociale omgeving</p>	<p>"Social Environment"[Mesh],</p>	<p>"Social Support"[Mesh], "Social Networking"[Mesh], "Social Environment"[Mesh], "Family"[Mesh], "Social Capital"[Mesh]</p>	<p>"Spouses"[Mesh], "Caregivers"[Mesh], "Nuclear Family"[Mesh], informal care</p>
<p>Kwaliteitsvolle evidence-based ergotherapeutische interventie, al dan niet als onderdeel van een multidisciplinaire aanpak</p>	<p>"Occupational Therapy"[Mesh], "Patient Care Team"[Mesh], multidisciplinary approach</p>	<p>"Interdisciplinary Communication"[Mesh], "Case Management"[Mesh], "Therapeutics"[Mesh], "therapy" [Subheading], "Patient-Centered Care"[Mesh], "Intersectoral Collaboration"[Mesh], "Activities of Daily Living"[Mesh]</p>	<p>"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, "Primary Prevention"[Mesh], "Secondary Prevention"[Mesh], "Tertiary Prevention"[Mesh] 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, 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, "Mobile Applications"[Mesh], "Recreation Therapy"[Mesh], "Animal</p>

			Assisted Therapy"[Mesh], "Healthy Lifestyle"[Mesh], "Computer User Training"[Mesh], curation, "Rehabilitation"[Mesh], "rehabilitation" [Subheading], "Physical Conditioning, Human"[Mesh], "Pain Management"[Mesh], "Patient Positioning"[Mesh], transfer techniques, joint protection techniques, energy management,
P Ergotherapeuten en andere betrokken zorgverleners	"Occupational Therapy"[Mesh], "Physicians"[Mesh], "General Practitioners"[Mesh], "Physical Therapists"[Mesh], "Nurses, Community Health"[Mesh], "Licensed Practical Nurses"[Mesh], "Nurse Clinicians"[Mesh], "Geriatricians"[Mesh], "Community Health Nursing"[Mesh], "Home Health Nursing"[Mesh] "Geriatric Nursing"[Mesh], "Allied Health Personnel"[Mesh], "Family Nurse Practitioners"[Mesh], "Case Managers"[Mesh]	"Community Health Workers"[Mesh], "Patient Care Team"[Mesh], "Community Medicine"[Mesh], "Community Health Services"[Mesh], "Delivery of Health Care"[Mesh], "Family Nursing"[Mesh]	"Home Health Aides"[Mesh],
O Mate van functionaliteit en sociale participatie	Functionality, "Social Participation"[Mesh], "Social Integration"[Mesh]	"Human Activities"[Mesh], "Activities of Daily Living"[Mesh], "Exercise"[Mesh], "Social Capital"[Mesh], participation, "Sense of Coherence"[Mesh],	"Leisure Activities"[Mesh], "Community Integration"[Mesh], "Community Participation"[Mesh], "Social Support"[Mesh]

		"Quality of Life"[Mesh], "Quality-Adjusted Life Years"[Mesh]	
H	Eerstelijnsgezondheidszorg, met -in kader van samenwerking-uitbreiding naar acute diensten geriatrie, geriatrie revalidatiecentra, geriatrie dagcentra en geriatrisch dagziekenhuis	"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],

Tabel 2: overzicht PIPOH-termen, synoniemen, hyperoniemen en hyponiemen

Gebruik makend van de PIPOH werden per klinische vraag specifieke zoektermen bepaald. Daar de ergotherapeutische literatuur beperkt is, besloten we om een sensitieve search uit te voeren.

3.2.3.2 Databanken

Cochrane Database of Systematic Reviews (CDSR)

De CDSR van de Cochrane Library werd als databank geselecteerd omwille van het niveau van bewijsmateriaal. De gepubliceerde systematische reviews worden voorbereid en gesuperviseerd door een Cochrane review groep en zijn ontwikkeld in overeenstemming met het Cochrane Handbook for Systematische Reviews of Interventions.

Medline (via Pubmed)

De selectie van Medline is essentieel omwille van de hoeveelheid van referenties naar biomedische literatuur die aanwezig is (meer dan 30 miljoen). Alle onderzoekdesigns zijn aanwezig in de Medline.

Cinahl

Cinahl werd weerhouden als alternatief van het in Vlaanderen beperkt beschikbaar zijn van AMED. AMED is een databank die zich richt naar paramedici. Cinahl focuste initieel voornamelijk op de doelgroep verpleegkundigen en breidde hun doelpubliek uit met paramedici. Cinahl bevat meer dan 450.000 referenties naar artikels (alle designs) gepubliceerd in verpleegkundige, paramedische en biomedische tijdschriften en tijdschriften voor gezondheidsgebruikers. Cinahl werd geraadpleegd als CDSR en Medline onvoldoende resultaten gaven.

OTDBase

OTDBase is een databank die meer dan 8.000 abstracts omvat van meer dan 30 internationale ergotherapeutische tijdschriften. OTDBase is de meest volledige databank van ergotherapeutische

tijdschriften. Alle onderzoeksdesigns worden opgenomen in OTDBase. Er werd niet gekozen om de database OTSeeker te gebruiken, daar deze sinds 2017 niet meer wordt ge-updated.

3.2.3.3 Onderzoeksdesigns

In eerste instantie werden meta-analyses, systematische reviews en RCT's geselecteerd. Dit om evidentie van hoge methodologische kwaliteit na te streven.

Waar wenselijk werd uitgebreid naar onderzoekdesigns van een hiërarchisch onderliggende orde. Dit kan zijn omwille van het gebrek aan systematische reviews of RCT's op een bepaalde subvraag.

Finaal werd voor klinische vraag 4 de onderzoeksdesigns beperkt tot meta-analyses, systematische reviews en RCT's. Omwille van de aard van de subvragen 1, 2, 3 en 5, werden de geïncludeerde designs voor deze vragen uitgebreid met observationele en kwalitatieve studies.

De in- en exclusiecriteria, zoals weergegeven in de richtlijn, werden in het kader van selectie van de artikels uitgebreid met volgende methodologische in- en exclusiecriteria:

Methodologische inclusiecriteria:

- Meta-analyses, systematische review of RCT (alle klinische subvragen)
- Observationele studies en kwalitatief onderzoek (klinische subvragen 1,2,3 en 5)
- Critical appraisal van voldoende kwaliteit¹

Methodologische exclusiecriteria:

- Pilot-studies

3.2.3.4 Taal

Hoewel we ervan uitgaan dat de overgrote meerderheid van de artikels in het Engels gepubliceerd worden, includeren we ook artikels gepubliceerd in één van de officiële nationale landstalen. Dit is onder meer zinvol om eventuele aan de Belgische context-geadapteerde artikels te detecteren.

Artikels worden hieraan gevolg gevend geselecteerd indien gepubliceerd in het Engels, Nederlands, Frans of Duits.

3.2.3.5 Zoekperiode

Artikels die voldoen aan de inclusiecriteria en gepubliceerd tot en met eind juni 2022 worden geïncludeerd. Er werd geen restrictie ingesteld wat betreft begindatum.

Enkel voor klinische vraag 4 werd de zoekperiode beperkt tot de laatste 10 jaar, omwille noodzaak recente informatie omwille van de aard van de materie. Daarnaast is er voldoende literatuur beschikbaar om deze tijdslijm in te stellen.

¹ Als de studie een score 'unacceptable quality' kreeg bij een critical appraisal met de SIGN-tool, of indien de overall beoordeling zeer zwak bleek bij een critical appraisal met de JBI-tool werd het artikel geëxcludeerd.

3.2.3.6 Voorbereiding zoekstring gelinkt aan PIPOH

De uitwerking van de zoekstrings per klinische vraag wordt in consensus door twee leden van de GDG, namelijk de hoofdonderzoekers, bepaald en ter goedkeuring voorgelegd aan de volledige GDG.

Om zicht te krijgen op de inhoud van de geïnccludeerde termen, wordt ook de onderliggende boomstructuur in kaart gebracht. De concepten worden bij de uitvoering van de search waar relevant aangepast naargelang de structuur van de databank.

P(erson, population, problem)

Concept: Doelgroep kwetsbare oudere personen

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

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Doelgroep mantelzorger

“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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Doelgroep fysieke context

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

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Ergotherapie

“Occupational Therapy” [MeSH]

Volgende termen worden automatisch meegenomen bij ingeven van:

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

Concept: Therapeutische basishouding:

“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”

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Samenwerking

"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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Detectie en doorverwijzing

Concept detectie:

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

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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

Concept doorverwijzing:

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

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Assessment

"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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Acuties, Patient; Acuity, Patient; Patient Acuties
- 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: Doelen bepalen algemeen

"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"

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Doelen bepalen methode

"Methods"[Mesh]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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"

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Hulpmiddelen en aanpassingen

"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*"

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Online interventies

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

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Interventies mbt samenwerking

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

Volgende termen worden automatisch meegenomen bij ingeven van

- 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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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(rofessional)

Concept: Ergotherapeut

"Occupational Therapy"[Mesh]

Volgende termen worden automatisch meegenomen bij ingeven van

- Occupational Therapy: Therapy, Occupational; Occupational Therapies; Therapies, Occupational

Concept: Interprofessioneel team

"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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Doelgroep fysiek kwetsbare oudere persoon

"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"

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Uitbreiding doelgroep mantelzorger

"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"

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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: Uitbreiding fysieke context

"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]

Volgende termen worden automatisch meegenomen bij ingeven van:

- 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 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
- 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(health care setting)

Concept: Eerstelijnszorg

"Home Care Services"[MeSH] OR "Primary Health Care"[MeSH] OR "Independent Living"[MeSH] OR "Community Health Centers"[Mesh]

Concept: Gezondheids- en welzijnsinstellingen, en woonvormen relevant voor thuiszorg:

"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] OR "Geriatrics"[Mesh] OR "Housing for the Elderly" [Mesh] OR "Housing" [Mesh]

Volgende termen worden automatisch meegenomen bij ingeven van

- 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

Voor elke klinische subvraag werden deze concepten uitgewerkt volgens PICO-item. Deze concepten werden aangepast aan de interface van de databanken, gebruik makend van Polyglot Accelerator. De uitgewerkte concepten zijn per klinische vraag opgenomen onder het item 3 'staving methodiek per klinische vraag'.

3.2.3.7 Selectieprocedure

Basisprocedure selectie artikels op relevantie

Per klinische vraag worden in- en exclusiecriteria vastgelegd. Deze zijn gebaseerd op de vooraf ingestelde limieten (onderzoeksdesign, taal, zoekperiode) en op de content van de PICO. Deze kunnen variëren naargelang de vraag.

Zo betreft de P bij vragen 2 en 4 de fysiek kwetsbare oudere personen waarbij ouderdomsaandoeningen een invloed hebben op het functioneren. Wanneer een aandoening

waarbij een specifieke revalidatie wenselijk is, domineert, dan worden deze artikels niet geïnccludeerd. De richtlijn omvat namelijk geen aanbevelingen over de revalidatie van specifieke aandoeningen.

Eerste fase: selectie op basis van titel en abstract

Op basis van titel en abstract worden de weerhouden artikels dubbel onafhankelijk gescreend per klinische vraag, per databank.

Als bij een bepaalde klinische vraag één databank meer dan 200 resultaten opleverde, werd de dubbele onafhankelijke screening op basis van titel en abstract beperkt tot de eerste 200 resultaten. Na consensus op basis van de eerste 200 resultaten, werden de overige resultaten door één van de hoofdonderzoekers verder gescreend op relevantie. Bij twijfel wordt de tweede hoofdonderzoeker geconsulteerd.

Tweede fase: selectie op basis van full tekst

De weerhouden artikels op basis van titel en abstract worden full tekst gescreend en finaal weerhouden voor inclusie of geëxcludeerd.

De reden voor exclusie wordt weergegeven in een literatuurmatrijs. (Zie item 3 'Methodiek per klinische vraag')

Voor in- en exclusiecriteria, zie deel 1 van de richtlijn, item 1.3.2.

Bij onvoldoende antwoord op klinische vraag na tweede fase

Als er uit de initiële search in de vier databanken onvoldoende antwoord te filteren is uit de geselecteerde artikels, zal in eerste instantie worden uitgebreid wat betreft onderzoeksdesign.

Als deze uitbreiding nog onvoldoende resultaten geeft, wordt er sensitiever gezocht door bepaalde termen in de zoekstring te vervangen door hyperoniemen.

3.2.4 Formuleren aanbevelingen, voorleggen aan GDG en contextadaptatie (stakeholdersbevraging)

De initiële aanbevelingen werden opgesteld op basis van de literatuurstudie en voorgelegd aan de GDG ter goedkeuring of bijsturing.

Na bijsturing op basis van de feedback van de GDG werden de aanbevelingen voor contextadaptatie en om het draagvlak voor implementatie te verzekeren, voorgelegd aan de adviescommissie (stakeholders). Dit gebeurde tweeledig, nl via een online bevraging naar de items relevantie, haalbaarheid, ongewenste effecten en kostenrechtvaardiging, met de daaropvolgende week een discussieforum.

De vragen die per aanbeveling via de online bevraging werden voorgelegd aan de stakeholders waren:

- Is deze aanbeveling volgens jou relevant voor de Belgische context?
- Is deze aanbeveling volgens jou haalbaar om toe te passen in de Belgische context?
- Kunnen er zich volgens jou ongewenste effecten voordoen bij toepassing van deze aanbeveling?
- Zijn de kosten bij het toepassen van deze aanbeveling gerechtvaardigd?

De beoordeling van de voorgelegde items gebeurde per aanbeveling aan de hand van een vierpunt Likertschaal gaande van 'ja', over 'waarschijnlijk wel', 'waarschijnlijk niet' tot 'neen'. Bij een antwoord in de negatieve zone ('waarschijnlijk niet' en 'neen') werd gevraagd om deze keuze te verduidelijken en waar relevant aanpassingen voor te tellen. Bij een antwoord in de positieve zone ('ja' en 'waarschijnlijk wel' was men vrij om extra informatie te verschaffen. Vooraf werd door de GDG vastgesteld dat consensus werd bereikt bij 70% unanimititeit.

De antwoorden op de survey werden binnen de week verwerkt en in een presentatie gegoten die op de adviescommissie (discussieforum stakeholders) werd voorgesteld. Op het discussieforum werden de items waarvoor geen consensus was, besproken en waar wenselijk aangepast om tot consensus te komen. Er was de mogelijkheid om zelf ook te bespreken items aan te brengen.

Voor de meerderheid van de aanbevelingen was er meer dan 80% consensus. Op de vragen over relevantie, haalbaarheid en kostenverantwoording werd op een enkele aanbeveling na de cutoff-waarde van 70% behaald. De vraag over neveneffecten behaalde nooit de cutoff waarde van 70%. Bij bevraging gaven de stakeholders aan onvoldoende kennis te hebben over mogelijke neveneffecten om deze vraag te beantwoorden. Het niet bereiken van 70% had dus niet te maken met niet bereiken van consensus. Om dit hiaat in te vullen, werd in de geraadpleegde literatuur gezocht naar mogelijke neveneffecten. Er werden geen bijwerkingen teruggevonden.

Voor meer details over de resultaten van de online bevragingen verwijzen we naar de verslagen van de stakeholdersvergaderingen van 29/06/2021, 5/10/2021, 21/12/2021 en 25/01/2022 opgenomen in bijlage 5.3.

De finale aanbevelingen werden tot slot individueel voorgelegd aan de ervaringsdeskundige en mantelzorger die omwille van veranderende communicatievormen (online in plaats van overleg op locatie omwille van pandemie) niet konden deelnemen aan de reguliere GDG-vergaderingen.

Onderstaande tabel geeft een overzicht van de initiële aanbevelingen en de finale aanbevelingen (na verwerking feedback GDG, stakeholders en de ervaringsdeskundige en mantelzorger). (Tabel 3)

Initiële aanbeveling	Finale aanbeveling
Klinische vraag1	
We bevelen aan/we suggereren <ul style="list-style-type: none"> om frailty op te sporen bij oudere thuiswonende personen vanaf 75 jaar. dat de zorgverleners die hoog risicopersonen op frailty screenen een opleiding krijgen om de signalen en symptomen van kwetsbaarheid te leren herkennen. 	We suggereren om frailty op te sporen bij oudere thuiswonende personen vanaf 75 jaar. Verplaatst naar toelichting en randvoorwaarden: We suggereren dat de zorgverleners die hoog risicopersonen op frailty screenen een opleiding krijgen om de signalen en symptomen van kwetsbaarheid te leren herkennen.
We bevelen aan/we suggereren dat huisartsen en alle andere eerstelijnszorgverleners een hoog risico detectie op frailty uitvoeren tijdens hun reguliere huisbezoeken en dit jaarlijks of eerder als er zich veranderingen in het functioneren van de persoon voordoen.	We suggereren dat huisartsen en alle andere eerstelijnszorgverleners een hoog risico detectie op frailty uitvoeren tijdens hun reguliere huisbezoeken.
We bevelen niet aan/we suggereren niet om systematisch preventieve huisbezoeken op populatieniveau uit te voeren.	We suggereren niet om systematisch preventieve huisbezoeken op populatieniveau uit te voeren.

<p>We bevelen aan/we suggereren dat ergotherapeuten zich profileren als expert in het screenen van problemen in het functioneren in het dagelijks leven.</p>	<p>We bevelen aan dat ergotherapeuten zich profileren als expert in het screenen van problemen in het functioneren in het dagelijks leven.</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> om valide beoordelingsinstrumenten in de vorm van zelfrapportage, klinische observatie of een combinatie van beide te gebruiken voor het detecteren van frailty. dat de keuze van beoordelingsinstrument voor frailty wordt bepaald door het doel dat men voor ogen heeft en de context waarin het instrument zal gebruikt worden. <p>Valide instrumenten zijn onder meer de Clinical Frailty Scale, Timed Up and Go-test en InterRAI-screener.</p>	<p>We bevelen aan om valide beoordelingsinstrumenten in de vorm van zelfrapportage, klinische observatie of een combinatie van beide te gebruiken voor het detecteren van frailty.</p> <p>We bevelen aan dat de keuze van beoordelingsinstrument voor frailty wordt bepaald door het doel dat men voor ogen heeft en de context waarin het instrument zal worden gebruikt.</p>
<p>We bevelen aan/we suggereren:</p> <ul style="list-style-type: none"> dat eerstelijns-ergotherapeuten zich transparant profileren als expert in het functioneren in het dagelijks leven en de omgeving waarin dit functioneren plaats vindt. dat ergotherapeuten hun bereikbaarheid kenbaar maken zowel binnen een eerstelijnszone, als naar de diensten geriatrie van de tweede lijn in hun zorgregio om zo een gestroomlijnde doorverwijzing na te streven en geïntegreerde cliënt gecentreerde zorg te verlenen. 	<p>We bevelen aan dat eerstelijns-ergotherapeuten zich transparant profileren als expert in het functioneren in het dagelijks leven en de omgeving waarin dit functioneren plaats vindt.</p> <p>We bevelen aan dat ergotherapeuten hun bereikbaarheid kenbaar maken zowel binnen een eerstelijnszone, als naar de diensten geriatrie van de tweede lijn in hun zorgregio om zo een gestroomlijnde doorverwijzing na te streven en geïntegreerde cliënt gecentreerde zorg te verlenen.</p>
<p>We bevelen aan/we suggereren:</p> <ul style="list-style-type: none"> dat alle gezondheids- en welzijnswerkers die direct of indirect in contact komen met oudere personen, binnen hun eerstelijnszone getraind worden om kwetsbare oudere personen en hoog-risicopersonen op frailty op te sporen en door te verwijzen naar relevante zorgverleners, waaronder ergotherapeuten. dat ergotherapeuten kwetsbare oudere personen en hoog-risicopersonen op frailty opsporen en in het kader van interdisciplinaire aanpak ook doorverwijzen naar de relevante zorgverleners. 	<p>We bevelen aan dat alle gezondheids- en welzijnswerkers die direct of indirect in contact komen met oudere personen, binnen hun eerstelijnszone getraind worden om kwetsbare oudere personen en hoog-risicopersonen op frailty op te sporen en door te verwijzen naar relevante zorgverleners, waaronder ergotherapeuten.</p> <p>We bevelen aan dat ergotherapeuten kwetsbare oudere personen en hoog-risicopersonen op frailty opsporen en in het kader van interdisciplinaire aanpak ook doorverwijzen naar de relevante zorgverleners.</p>
<p>We bevelen aan/we suggereren:</p> <ul style="list-style-type: none"> om binnen een eerstelijnszone een procedure vast te leggen waarin is opgenomen hoe de detectie en doorverwijzing van hoog-risicopersonen aangaande kwetsbaarheid verloopt (door wie, hoe, wanneer en naar wie). om per eerstelijnszone een coördinator aan te duiden die dit proces monitort, concreet: opvolgt, periodisch evalueert en bijstuurt. dat alle gezondheids- en welzijnswerkers up-to-date zijn van de opsporings- en doorverwijzingsprocedure in hun eerstelijnszone. 	<p>We bevelen aan dat alle gezondheids- en welzijnswerkers die direct of indirect in contact komen met oudere personen, binnen hun eerstelijnszone getraind worden om kwetsbare oudere personen en hoog-risicopersonen op frailty op te sporen en door te verwijzen naar relevante zorgverleners, waaronder ergotherapeuten.</p> <p>We bevelen aan dat ergotherapeuten kwetsbare oudere personen en hoog-risicopersonen op frailty opsporen en in het kader van interdisciplinaire aanpak ook doorverwijzen naar de relevante zorgverleners.</p> <p>We suggereren om binnen een eerstelijnszone een procedure vast te leggen waarin is opgenomen hoe de detectie en doorverwijzing van hoog-risicopersonen aangaande kwetsbaarheid verloopt</p>

	<p>We suggereren om per eerstelijnszone een coördinator aan te duiden die dit proces monitort.</p> <p>We suggereren dat alle gezondheids- en welzijnswerkers up-to-date zijn van de opsporings- en doorverwijzingsprocedure in hun eerstelijnszone.</p>
Klinische vraag 2	
We bevelen aan/we suggereren om de tijd tussen de detectie van de hoog risicopersoon, het ergotherapeutisch assessment en de uitvoering van de aanbevelingen zo kort mogelijk te houden.	We bevelen aan om de tijd tussen de detectie van de hoog risicopersoon, het ergotherapeutisch assessment en de uitvoering van de aanbevelingen zo kort mogelijk te houden
We bevelen aan/we suggereren dat ergotherapeuten hun beoordeling van betekenisvol handelen uitvoeren in de vertrouwde omgeving van de oudere persoon, of in een omgeving die de vertrouwde omgeving zo goed mogelijk simuleert.	We bevelen aan dat ergotherapeuten hun beoordeling van betekenisvol handelen uitvoeren in de vertrouwde omgeving van de oudere persoon, of in een omgeving die de vertrouwde omgeving zo goed mogelijk simuleert.
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> dat ergotherapeuten zich bij beoordelingen richten op het in kaart brengen van de zowel de zwaktes, als de mogelijkheden binnen betekenisvol handelen. dat ergotherapeuten ook de interesses, behoeften, voorkeuren en doelen van de persoon op functioneel en participatie niveau bevragen. Ergotherapeuten doen dit binnen een holistische visie die zowel medische gezondheidsproblemen, als sociale situatie, subjectief ervaren gezondheid en welzijn, en de materiele situatie omvat. dat ergotherapeuten informeren naar de perceptie van de oudere persoon aangaande zijn handelen en naar wat hij vindt dat prioritair moet worden aangepakt. 	<p>We bevelen aan dat ergotherapeuten zich bij beoordelingen richten op het in kaart brengen van de zowel de zwaktes, als de mogelijkheden binnen betekenisvol handelen.</p> <p>We bevelen aan dat ergotherapeuten de interesses, behoeften, voorkeuren en de perceptie van de oudere persoon aangaande zijn handelen op functioneel en participatie niveau bevragen.</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> dat ergotherapeuten niet alleen bij intake, maar in alle fases van het therapeutisch proces (assessment en planning, interventie en opvolging) beoordelingsinstrumenten gebruiken voor zover dit relevant is. dat ergotherapeuten naast het inzetten van klinische expertise bij het beoordelen, zo veel mogelijk gestandaardiseerde meetinstrumenten te gebruiken. Dit om objectieve data te hebben, maar ook om een bijdrage te leveren aan de werktevredenheid van de ergotherapeuten. dat ergotherapeuten zich zowel baseren op geobserveerde, als op zelf-beoordeelde ADL-informatie. dat ergotherapeuten rekening houden met socio-demografische indicatoren bij interpretatie van zelfbeoordeling. <p>De beoordelingsinstrumenten kunnen zowel vragenlijsten, checklists, schalen, als observatie-instrumenten zijn en worden gebruikt volgens het protocol waarbinnen ze getest en genormeerd zijn.</p>	<p>We bevelen aan dat ergotherapeuten naast hun klinische expertise, indien relevant, in alle fases van het therapeutisch proces beoordelingsinstrumenten gebruiken.</p> <p>We bevelen aan dat de ergotherapeut bij het afnemen van de beoordeling aandacht besteedt aan de levensstijl en aan de balans in betekenisvol handelen van de oudere persoon en waar relevant zijn mantelzorger.</p>

<p>We bevelen aan/we suggereren om multidisciplinair samen te werken om een uitgebreide geriatrische beoordeling (Comprehensive Geriatric Assessment of CGA) uit te voeren bij de thuiswonende oudere persoon waarbij een taakverdeling moet worden bekeken in kader van expertise en kosteneffectiviteit.</p>	<p>We bevelen aan om multidisciplinair samen te werken om een uitgebreide geriatrische beoordeling (Comprehensive Geriatric Assessment of CGA) uit te voeren bij de thuiswonende oudere persoon waarbij een taakverdeling moet worden bekeken in kader van expertise en kosteneffectiviteit.</p>
<p>We bevelen aan/we suggereren om in kader van haalbaarheid naargelang de context te beslissen of een beoordeling bij ontslag wordt uitgevoerd door een ergotherapeut werkzaam in het ziekenhuis of in de thuiszorg.</p>	<p>We bevelen aan om in kader van haalbaarheid naargelang de context te beslissen of een beoordeling bij ontslag wordt uitgevoerd door een ergotherapeut werkzaam in het ziekenhuis of in de thuiszorg.</p>
<p>We bevelen/we suggereren aan dat ergotherapeuten een bijdrage leveren aan het interdisciplinaire team door te overwegen om gestandaardiseerde beoordelingsinstrumenten met voorspellende waarde naar nood aan thuiszorg af te nemen.</p>	<p>We bevelen aan dat ergotherapeuten een bijdrage leveren aan het interdisciplinaire team door te overwegen om gestandaardiseerde beoordelingsinstrumenten met voorspellende waarde naar nood aan thuiszorg af te nemen.</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut bij het afnemen van de beoordeling aandacht besteedt aan de levensstijl en aan de balans in betekenisvol handelen van de oudere persoon en waar relevant zijn mantelzorg.</p>	<p>We bevelen aan dat de ergotherapeut bij het afnemen van de beoordeling aandacht besteedt aan de levensstijl en aan de balans in betekenisvol handelen van de oudere persoon en waar relevant zijn mantelzorg.</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> • dat ergotherapeuten voldoende tijd voorzien om het handelen op vlak van ADL (BADL en IADL) in kaart te brengen met behulp van een gestandaardiseerd beoordelingsinstrument. • dat dit instrument zowel door de ergotherapeut kan worden ingevuld op basis van observatie of interview, als dat het een zelfbeoordelingsinstrument kan zijn dat wordt ingevuld door de oudere persoon of zijn mantelzorg. <p>De extra tijdsinvestering bij beoordeling wordt nadien gecompenseerd door efficiëntere diagnostiek en behandeling.</p>	<p>We bevelen aan dat ergotherapeuten voldoende tijd voorzien om het handelen op vlak van ADL (BADL en IADL) in kaart te brengen met behulp van een gestandaardiseerd beoordelingsinstrument (observatie, interview of zelfbeoordelingsinstrument door oudere persoon of mantelzorg).</p>
	<p>We bevelen aan dat de ergotherapeut de keuze van het instrument aanpast aan de persoon en zijn context, door onder meer rekening te houden met mogelijke vloer- en plafondeffecten².</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> • dat ergotherapeuten bij de keuze van het instrument voor meten van de BADL en IADL het protocol van het instrument nagaan om te weten of het instrument zowel kan worden afgenomen op basis van interview, directe observatie of zelfrapportage. • dat de ergotherapeut de keuze van het instrument aanpast aan de persoon en zijn context, door onder meer rekening te houden met mogelijke vloer- en plafondeffecten¹. • dat de ergotherapeut de testing over de tijd spreidt als dit wenselijk is. 	<p>We bevelen aan dat de ergotherapeut de keuze van het instrument aanpast aan de persoon en zijn context, door onder meer rekening te houden met mogelijke vloer- en plafondeffecten¹. (werd samengevoegd met vorige initiële aanbeveling)</p>
	<p>We bevelen aan dat de ergotherapeut de testing over de tijd spreidt als dit wenselijk is.</p>

² vb MMSE bij personen met sterk vermoeden van cognitief deficit en MOCA bij personen met vermoeden van intacte cognitieve functies

<ul style="list-style-type: none"> dat bij de interpretatie van de scores van BADL- en IADL-metingen niet enkel rekening wordt gehouden met de totaalscore, maar ook met de subscores. 	<p>We bevelen aan dat bij de interpretatie van de scores van BADL- en IADL-metingen niet enkel rekening wordt gehouden met de totaalscore, maar ook met de subscores.</p>
<p>We bevelen aan/we suggereren dat een zorgprofessional screent op valrisico en indien nodig doorverwijst naar een ergotherapeut en vice versa.</p>	<p>We bevelen aan dat een zorgprofessional screent op valrisico en indien nodig doorverwijst naar een ergotherapeut en vice versa.</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> dat de ergotherapeut bij het beoordelen van de woonomgeving een gevalideerd en betrouwbaar instrument gebruikt om de onveilige situaties in de woning en woonomgeving te detecteren. dat de ergotherapeut naast het beoordelen van de omgeving ook aandacht heeft voor de activiteiten en interactie van de persoon met de omgeving. 	<p>Opgenomen in ergo-richtlijn valpreventie (De Coninck et al., 2017)</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut de oudere persoon en of zijn mantelzorger een zelfbeoordelingsinstrument met duidelijke handleiding omtrent valrisicofactoren in de woonomgeving laat afnemen.</p>	<p>We bevelen aan dat de ergotherapeut de oudere persoon en of zijn mantelzorger een zelfbeoordelingsinstrument met duidelijke handleiding omtrent valrisicofactoren in de woonomgeving laat afnemen.</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut in het kader van valpreventie informeert naar potentiële beïnvloedende factoren wat betreft therapietrouw, waaronder het geloof in het nut van woningaanpassing, geloof in het effect van woningaanpassing op valpartijen en eerdere acties die werden ondernomen om woningen aan te passen.</p>	<p>Opgenomen in ergo-richtlijn valpreventie (De Coninck et al., 2017)</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> dat specifieke beoordelingsinstrumenten voor de risicofactor woonomgeving worden afgenomen door ergotherapeuten en dat deze worden aangevuld met relevante informatie omtrent valrisico's ingewonnen door alle betrokken zorgverleners. dat zorgverleners doorverwijzen naar ergotherapeuten wat betreft woningaanpassing in het kader van valpreventie. 	<p>Opgenomen in ergo-richtlijn valpreventie (De Coninck et al., 2017)</p> <p>We bevelen aan dat een zorgprofessional screent op valrisico en indien nodig doorverwijst naar een ergotherapeut en vice versa.</p>
<p>We bevelen aan/we suggereren dat ergotherapeuten in een betrouwbaar beoordelingsinstrument afnemen om de component 'gedrag', als risicofactor voor valpreventie in kaart te brengen.</p>	<p>We bevelen aan dat ergotherapeuten in een betrouwbaar beoordelingsinstrument afnemen om de component 'gedrag' als risicofactor voor valpreventie in kaart te brengen.</p>
<p>We bevelen aan/we suggereren</p> <ul style="list-style-type: none"> dat de ergotherapeut in zijn functie als rij-expert het beslissingsproces om al dan niet terug te rijden onderbouwt, de beoordeling van rijgeschiktheid meebepaalt en de persoon rijgeschiktheid meebepaalt en de persoon 	<p>We suggereren dat de ergotherapeut in zijn functie als rij-expert het beslissingsproces om al dan niet terug te rijden onderbouwt, de beoordeling van rijgeschiktheid meebepaalt en de persoon ondersteunt in het realistisch inschatten van de rijrisico's in zijn specifieke situatie.</p>

<p>ondersteunt in het realistisch inschatten van de rijrisico's in zijn specifieke situatie.</p> <ul style="list-style-type: none"> dat de ergotherapeut bij de beoordeling van de rijgeschiktheid volgende aspecten in kaart brengt: het gedrag van de chauffeur, de executieve functies (rijspecifiek en BADL/IADL) en de algemene cognitieve, en visuele en visuo-motorisch perceptuele vaardigheden. 	<p>We suggereren dat de ergotherapeut bij de beoordeling van de rijgeschiktheid volgende aspecten in kaart brengt: het gedrag van de chauffeur, de executieve functies (rijspecifiek en BADL/IADL) en de algemene cognitieve, en visuele en visuo-motorisch vaardigheden.</p>
<p>We bevelen aan/we suggereren om te overwegen al dan niet gebruik te maken van een rijsimulator in kader van voorspellen rijgeschiktheid.</p>	<p>We suggereren om te overwegen al dan niet gebruik te maken van een rijsimulator in kader van het voorspellen van de rijgeschiktheid.</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut de persoon, die niet rijgeschikt werd beoordeeld, begeleidt in het vinden en gebruiken van alternatieve transportmiddelen, en coacht bij andere gevolgen op vlak van participatie.</p>	<p>We bevelen aan dat de ergotherapeut de persoon, die niet rijgeschikt werd beoordeeld, begeleidt in het vinden en gebruiken van alternatieve transportmiddelen, en coacht bij andere gevolgen op vlak van participatie.</p>
<p>We bevelen aan/we suggereren om aangaande de wettelijke beslissing tot rijgeschiktheid door te verwijzen naar de nationale bevoegde instantie CARA.</p>	<p>We bevelen aan om aangaande de wettelijke beslissing tot rijgeschiktheid door te verwijzen naar de nationale bevoegde instantie CARA.</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut naast de reguliere cognitieve beoordelingsinstrumenten ook functionele testen gebruikt om cognitie in kaart te brengen.</p>	<p>We bevelen aan dat de ergotherapeut naast de reguliere cognitieve beoordelingsinstrumenten ook functionele testen gebruikt om cognitie in kaart te brengen.</p>
<p>We bevelen aan/we suggereren dat de ergotherapeut naast het beoordelen van BADL, IADL, mobiliteit en vrije tijd, ook de vaardigheden beoordeelt om technologie en eventuele applicaties te gebruiken.</p>	<p>We suggereren dat de ergotherapeut naast het beoordelen van BADL, IADL, mobiliteit en vrije tijd, ook de vaardigheden beoordeelt om technologie en eventuele applicaties te gebruiken.</p>
Klinische vraag 3	
<p>Het is aanbevolen/we suggereren om het opstellen van persoonlijke en haalbare doelen voor de oudere thuiswonende persoon op te nemen in het proces van cliëntgericht werken. De doelen worden opgesteld in samenwerking met de thuiswonende oudere persoon en/of een eventuele mantelzorger.</p>	<p>We bevelen aan om het opstellen van persoonlijke en haalbare doelen voor de oudere thuiswonende persoon op te nemen in het proces van cliëntgericht werken.</p>
<p>Het is aanbevolen/we suggereren dat vier fases in het doelen bepalen worden doorlopen namelijk (1) het onderhandelen over de doelen, (2) het opstellen en het prioriteren van de doelen, (3) het plannen van de doelen en (4) het evalueren van de doelen desgewenst opnieuw prioriteert en/of herformuleert.</p>	<p>We bevelen aan dat de vier fases in het doelen bepalen worden doorlopen.</p>
<p>Het is aanbevolen/we suggereren om de ergotherapie doelen mee te delen en te bespreken binnen het interprofessionele team en dit over verschillende settings heen (vb. ziekenhuis – thuis). Dit om de afstemming en de samenwerking te optimaliseren.</p>	<p>We suggereren om de ergotherapie doelen mee te delen en te bespreken binnen het interprofessionele team en dit over verschillende settings heen (vb. ziekenhuis – thuis).</p>
<p>Het is aanbevolen/we suggereren dat de ergotherapeut de thuiswonende oudere persoon stimuleert om zijn</p>	<p>We suggereren dat de ergotherapeut de thuiswonende oudere persoon stimuleert om zijn behandelingswensen</p>

behandelingswensen met zijn familie te bespreken anticiperend op een mogelijke toekomstige situatie waarin de persoon ondersteuning nodig heeft om behandelingsbeslissingen te nemen.	met zijn familie te bespreken anticiperend op een mogelijke toekomstige situatie waarin de persoon ondersteuning nodig heeft om behandelingsbeslissingen te nemen.
Klinische vraag 4	
Het is aanbevolen/We suggereren om: de ergotherapeutische interventies bij kwetsbare oudere personen uit te voeren vanuit een cliëntgerichte houding, samenwerkend partnerschap, het gedachtengoed van gedeelde besluitvorming en met aandacht voor empowerment. De ergotherapeut maakt hierbij gebruik van de principes van gezondheidsgeletterdheid en heeft aandacht voor betekenisvol handelen en het belang van dagstructuur voor de oudere persoon.	We bevelen aan om de ergotherapeutische interventies bij fysiek kwetsbare oudere personen uit te voeren vanuit een cliëntgerichte houding met aandacht voor empowerment.
	We bevelen aan om beslissingsondersteuning toe te passen om de keuze van de interventie te bepalen.
Het is aanbevolen/We suggereren om: om de interventies op maat van de kwetsbare oudere persoon aan te bieden als onderdeel van een multidisciplinaire aanpak.	We bevelen aan om de interventies op maat van de kwetsbare oudere persoon aan te bieden als onderdeel van een interprofessionele aanpak.
Het is niet aanbevolen/We suggereren niet om: een interdisciplinaire multicomponent interventie programma aan te bieden als er geen ergotherapeut betrokken is.	We suggereren niet om een interprofessioneel interventie programma in het kader van betekenisvol dagelijks handelen of sociale participatie aan te bieden als er geen ergotherapeut betrokken is.
Het is aanbevolen/We suggereren om in het kader van betekenisvol dagelijks handelen en sociale participatie individuele thuisinterventies uit te voeren die bestaan uit verhogen van gezondheidsgeletterdheid, aanleren van zelfmanagementstrategieën, aanleren van valpreventiestrategieën, advies over methodeverandering bij het uitvoeren van dagelijkse handelingen, oefenen van dagelijkse handelingen, advies over hulpmiddelen en oefenen in het gebruik ervan, advies over woningaanpassing met inbegrip van verlichting, advies over dienstverlening. We bevelen aan/suggereren om deze interventies te beperken in de tijd en af te sluiten met een follow up sessie	We bevelen aan om individuele thuisinterventies uit te voeren die bestaan uit een combinatie van: <ul style="list-style-type: none"> - verhogen van gezondheidsgeletterdheid, - advies over methodeverandering bij het uitvoeren van dagelijkse handelingen, - advies over hulpmiddelen en oefenen in het gebruik ervan, - advies over woningaanpassing met inbegrip van verlichting, - advies over ergonomie, - oefenen van dagelijkse handelingen, - aanleren van zelfmanagementstrategieën, - aanleren van valpreventiestrategieën, - advies over mogelijkheden dienstverlening.
	We bevelen aan om deze interventies te beperken over de tijd en af te sluiten met een follow up sessie.
Het is aanbevolen/We suggereren om interventies in het kader van gezondheidspromotie te verstrekken bij kwetsbare oudere personen om het fysieke, sociaal, cognitief en mentaal functioneren te verbeteren. Deze interventies maken bij voorkeur deel uit van een multifactoriële interdisciplinaire interventie waar aandacht is voor levensstijlaspecten waaronder voeding, medicatie, beweging en psychosociale ondersteuning en kunnen worden aangevuld met telefonische zelfzorg ondersteunende interventies.	We suggereren om in het kader van gezondheidspromotie interventies te verstrekken die het fysieke, sociaal, cognitief en mentaal functioneren verbeteren.
Het is aanbevolen/we suggereren om de veerkracht en het gevoel van coherentie van kwetsbare oudere personen te verhogen door op zelfzorg gebaseerde interventies aan te bieden die focussen op motivatie, op	Verplaatst naar toelichting aanbeveling 4.5

persoonlijke verantwoordelijkheid, op fysieke activiteiten, en op sociale en omgevingsimpact.	
Het is aanbevolen/We suggereren om groepsactiviteiten te organiseren om het dagelijks handelen en vaardigheden in gezondheids promotie te verbeteren en dit aanvullend op de individuele thuisinterventies. Groepsactiviteiten bevorderen naast fysieke vaardigheden ook de sociale participatie wat invloed heeft op de levenskwaliteit.	We suggereren om in het kader van gezondheids promotie aanvullend op thuisinterventies groepsinterventies te verstrekken om de sociale participatie te bevorderen.
Het is aanbevolen/We suggereren om bij kwetsbare oudere personen met depressieve symptomen levensstijlgerichte interventies aan te bieden die enerzijds ertoe aanzetten om meer activiteiten uit te voeren die leiden tot sociale contacten en anderzijds activiteiten faciliteren die een betekenis hebben voor de persoon.	We suggereren om in het bijzonder bij oudere personen met depressieve symptomen levensstijl gerichte interventies aan te bieden die enerzijds ertoe aanzetten om meer activiteiten uit te voeren die leiden tot sociale contacten, en anderzijds activiteiten faciliteren die een betekenis hebben voor de persoon.
Het is aanbevolen/We suggereren om in het kader van aanbevelingen over valpreventie de ergo richtlijn valpreventie te raadplegen.	Werd uit aanbevelingen gehaald en voorafgaand aan de aanbevelingen opgenomen.
Het is aanbevolen/ We suggereren om op maat uitgewerkte evidence-based fysieke oefeningen* aan te leren die aanzetten tot bewegen en die de kwetsbare oudere persoon kan integreren in het dagelijks functioneren en dit bijkomend op het uitvoeren van de reguliere dagelijkse activiteiten. Deze oefeningen worden op maat door onder andere ergotherapeuten geselecteerd en kunnen door opgeleide vrijwilligers aan de oudere persoon worden overgebracht en opgevolgd. Aandacht moet worden besteed aan planning, en aan samenwerking met en opleiden van de vrijwilligers. * bvb gebaseerd op LiFE, Stepping On of OTAGO-programma	We bevelen aan op maat uitgewerkte evidence-based fysieke oefeningen aan te leren die aanzetten tot bewegen en die kunnen worden geïntegreerd in het dagelijks functioneren en dit bijkomend op het uitvoeren van de reguliere dagelijkse activiteiten.
Het is aanbevolen/We suggereren om de kwetsbare oudere persoon ervaringen die betekenisvol zijn te laten opdoen door bijvoorbeeld: de zorg op te nemen voor iets, of en intergenerationele samenwerkingen te stimuleren om de bilaterale leereffecten te vergroten en de oudere persoon vanuit het gedachtegoed 'generativiteit' te laten ervaren. Wat betekenisvol is voor de oudere persoon kan onder meer worden nagegaan gebruik makend van 'the wheel of wellness*'. * "Wheel of Wellness", ook "life balans wheel" genoemd, beschrijft een manier van leven dat gericht is op optimale gezondheid en welzijn. ° verlangen om de jongere generaties te begeleiden en hen te helpen hun plek in de wereld te vinden.	We bevelen aan om de kwetsbare oudere persoon ervaringen die betekenisvol zijn te laten opdoen door onder meer de zorg op te nemen voor iets, of intergenerationele samenwerkingen te stimuleren.
Het is aanbevolen/We suggereren om als motiverende component aanvullend op oefenen speltechnologie of virtual reality technologie te schakelen.	We bevelen aan om een motiverende component en/of ondersteunende hulpmiddelen toe te voegen bij het trainen van het fysieke functioneren.
Het is aanbevolen/we suggereren om individuele cognitieve interventies al dan niet gerelateerd aan dagelijkse situaties te vertrekken die het werkgeheugen	We suggereren om individuele cognitieve interventies te verstrekken die het werkgeheugen en probleemoplossend vermogen trainen en al dan niet zijn gerelateerd aan

en probleemoplossend vermogen trainen, en een follow up sessie te voorzien om de transfer naar probleemoplossend vermogen in IADL te verhogen.	dagelijkse situaties. We suggereren om aanvullend een follow up sessie te voorzien om de transfer naar probleemoplossend vermogen in IADL te verhogen.
Het is aanbevolen/We suggereren om bij het aanbieden van fysieke oefeningen ondersteunende hulpmiddelen zoals weerstandsbanden of flexibele stokken te gebruiken.	We bevelen aan om een motiverende component en/of ondersteunende hulpmiddelen toe te voegen bij het trainen van het fysieke functioneren.
Het is aanbevolen/we suggereren om inter- en intrapersonlijke gedragsveranderingsstrategieën aan te leren aanvullend op het aanbieden van evidence based fysieke oefeningen.	We bevelen aan om gedragsveranderingsstrategieën aan te leren aanvullend op het aanbieden van evidence-based fysieke oefeningen.
Het is niet aanbevolen/We suggereren niet om robotica te gebruiken om mobiliteit of zelfzorg te ondersteunen.	We suggereren niet om robotica te gebruiken om mobiliteit of zelfzorg te ondersteunen
Het is aanbevolen/we suggereren om off-road vaardigheden te trainen en/of computer gebaseerde simulatietraining, waaronder verwerkingsnelheid, te verlenen in het kader van rijvaardigheid. Het is aanbevolen om bewustwording over de persoonlijke rijvaardigheden bij te brengen. Onderhandelende keuzes over toekomstige transportmiddelen en het trainen in gebruik van alternatieve transportmiddelen maken hier deel van uit.	We suggereren om off-road vaardigheden te trainen en/of computer gebaseerde simulatietraining, waaronder verwerkingsnelheid, te verstrekken in het kader van rijvaardigheid.
	We bevelen aan om bewustwording over de persoonlijke rijvaardigheden bij te brengen, onderhandelende keuzes over toekomstige transportmiddelen te stimuleren en gebruik van alternatieve transportmiddelen te trainen.
Het is aanbevolen/We suggereren om beslissingsondersteunende hulpmiddelen te gebruiken om de keuze van de interventie te bepalen. Deze beslissingsondersteunende hulpmiddelen verhogen de participatie van de kwetsbare oudere persoon in de keuze van de interventie, de kennis over gezondheidswinst en risico's van de interventie en doen mogelijk conflicten over besluitvorming afnemen.	We bevelen aan om beslissingsondersteuning toe te passen om de keuze van de interventie te bepalen.
	We bevelen aan om in kader van beslissingsondersteuning met de mantelzorg of familie van de kwetsbare oudere persoon te overleggen, als deze dit wenst.
Het is aanbevolen/We suggereren om met de mantelzorg van de kwetsbare oudere persoon te overleggen en een zorgplan voor de mantelzorg uit te werken om onder andere de stress te doen afnemen en de draagkracht te vergroten.	We bevelen aan om hierbij voldoende aandacht te hebben voor planning en voor communicatie, informatie en educatie van de oudere persoon en zijn mantelzorg.
Het is aanbevolen/We suggereren om de mantelzorgers te ondersteunen in empowerment door aanvullend op de reguliere ondersteuning korte psycho-educatieve telefonische, internet gebaseerde en/of technologie gebaseerde interventies in te schakelen.	We bevelen aan om de mantelzorgers te ondersteunen in empowerment door aanvullend op de reguliere ondersteuning korte psycho-educatieve telefonische, internet gebaseerde en/of technologie gebaseerde interventies in te schakelen.
Het is aanbevolen/we suggereren om de functionele noden van de kwetsbare oudere persoon die nog niet zijn ingestemd bij ontslag uit het ziekenhuis aan te pakken en in overleg tussen het ziekenhuis en de eerstelijnszorg vanuit de eerstelijnszorg cliëntgerichte, geïntegreerde thuisinterventies uit te voeren. Het is aanbevolen/ We suggereren om hierbij voldoende aandacht te hebben voor planning en voor communicatie, informatie en educatie van de oudere persoon en zijn mantelzorg.	We bevelen aan om de functionele noden van de kwetsbare oudere persoon die nog niet zijn ingestemd bij ontslag uit het ziekenhuis aan te pakken en in overleg tussen het ziekenhuis en de eerstelijnszorg vanuit de eerstelijnszorg cliëntgerichte, geïntegreerde thuisinterventies uit te voeren.

Klinische vraag 5	
We suggereren/bevelen aan om casemanagement te implementeren.	We bevelen aan om in complexe situaties een zorgcoördinator aan te stellen.
We suggereren/bevelen aan dat -indien casemanagement wordt toegepast- het casemanagement deel uitmaakt van een meer algemene integratiestructuur om te zorgen voor een structurele continuïteit op vlak van coördinatie zowel wat betreft gezondheidszorg, welzijn, als dienstverlening.	We bevelen aan dat bij zorgcoördinatie de zorgcoördinator deel uitmaakt van een meer algemene geïntegreerde structuur en dit in functie van continuïteit op vlak van zorgcoördinatie zowel wat betreft gezondheidszorg, welzijn, als dienstverlening.
We suggereren/bevelen aan dat -indien casemanagement wordt toegepast- de casemanager een lid is van het behandelend team van de oudere persoon.	We bevelen aan dat -indien zorgcoördinatie wordt toegepast- de zorgcoördinator een lid is van het behandelend team van de oudere persoon.
We suggereren/bevelen aan dat binnen het casemanagement naast de cliëntgerichte doelen voor de oudere persoon en de organisatorische verwachtingen, ook de noden van de mantelzorg over het optimaliseren van de zorg worden opgenomen en er op maat opleidingen met multidisciplinaire insteek worden voorzien (vb over voeding, ergonomie, ...)	We bevelen aan dat binnen de zorgcoördinatie naast de cliëntgerichte doelen voor de oudere persoon en de organisatorische verwachtingen, ook de noden van de mantelzorg over het optimaliseren van de zorg worden opgenomen en er op maat opleidingen met multidisciplinaire insteek worden voorzien (vb over voeding, ergonomie, ...).
We suggereren/bevelen aan dat er samenwerking is tussen het ziekenhuis en de eerstelijnszorg. We suggereren dat ziekenhuisergotherapeuten of het ontslagteam een eerstelijns ergotherapeut contacteert om bij ontslag thuisinterventies te laten uitvoeren en dit in het kader van volledigheid van ergotherapeutische adviezen. We suggereren niet/bevel niet aan om ziekenhuisergotherapeuten thuisinterventies te laten uitvoeren voor ontslag.	We bevelen aan dat er samenwerking is tussen het ziekenhuis en de eerstelijnszorg. We bevelen aan dat ziekenhuisergotherapeuten of het ontslagteam een eerstelijns ergotherapeut contacteert om bij ontslag thuisinterventies te laten uitvoeren en dit in het kader van volledigheid van ergotherapeutische adviezen. We bevelen niet aan om thuisinterventies voor ontslag door ziekenhuisergotherapeuten te laten uitvoeren.
We suggereren/bevelen aan dat over het delen van vertrouwelijke informatie afspraken schriftelijk worden vastgelegd.	We bevelen aan dat afspraken over het delen van vertrouwelijke informatie schriftelijk worden vastgelegd.
We suggereren/bevelen aan dat zorgverleners gebruik maken van HIT om onderling informatie uit te wisselen.	We bevelen aan dat zorgverleners gebruik maken van HIT om onderling informatie uit te wisselen.
We suggereren/bevelen aan dat bij het inschakelen van health Information Technology (HIT) (1) oudere personen en/of hun mantelzorgers worden betrokken bij de gezondheidsdoelen van de oudere persoon, (2) nagegaan wordt hoe ze de vertrouwelijkheid en veiligheid van de HIT waarnemen, (3) ervoor wordt gezorgd dat er geen technische storingen zijn en (4) dat de informatie betrouwbaar is.	We bevelen aan dat bij het inschakelen van health Information Technology (HIT) (1) oudere personen en/of hun mantelzorgers worden betrokken bij de gezondheidsdoelen van de oudere persoon, (2) nagegaan wordt hoe ze de vertrouwelijkheid en veiligheid van de HIT waarnemen, (3) ervoor wordt gezorgd dat er geen technische storingen zijn en (4) dat de informatie betrouwbaar is.

Tabel 3: Overzicht initiële en pre-finale aanbevelingen

3.2.5 Waarde-toekenning aanbevelingen

Om per aanbeveling een GRADE te bepalen werd in twee fases gewerkt, namelijk bepalen graad van bewijsmateriaal en bepalen sterkte van de aanbeveling.

Voor de kritische beoordeling van de geïnccludeerde artikels werden de critical appraisal tools van SIGN gebruikt aangevuld met deze van JBI wanneer er geen SIGN-appraisal tool beschikbaar is voor een bepaald onderzoeksdesign (observationale studies en kwalitatief onderzoek).

Als de studie een score 'unacceptable quality' kreeg bij een critical appraisal met de SIGN-tool, of indien de overall beoordeling zeer zwak bleek bij een critical appraisal met de JBI-tool werd het artikel geëxcludeerd.

3.2.5.1 Graad van bewijsmateriaal

Om de graad van bewijsmateriaal per aanbeveling te bepalen, werd gebruik gemaakt van de template die WOREL ter beschikking stelt. De ingevulde templates per aanbeveling zijn terug te vinden in bijlage onder het item 5.4 'Critical appraisals'.

Klinische vraag – Question clinique:			
Aanbeveling/ Recommandation			
Onderbouwing (referenties)/ Justification (références)			
Summary statistics			
Step 1: bepalen zekerheid van bewijs / Étape 1 : déterminer le degré de certitude des preuves			
Uitgangskwalificatie zekerheid van bewijs/ Qualification de base de la certitude de la preuve			
DALERS - GOUTES			
Beperkingen in design Limites de conception	Geen of niet-ernstig / Aucun ou non sérieux (0) Ernstig - Sérieux (-1) Zeer ernstig - Très sérieux (-2)		
			Toelichting besluit / L'explication de la décision
Inconsistentie Incohérence	Geen of niet-ernstig / Aucun ou non sérieux (0) Ernstig - Sérieux (-1)		
			Toelichting besluit / L'explication de la décision

	Zeer ernstig - Très sérieux (-2)		
Indirectheid Façon indirecte	Geen of niet- ernstig / Aucun ou non sérieux (0) Ernstig - Sérieux (-1) Zeer ernstig - Très sérieux (-2)		
			Toelichting besluit / L'explication de la décision
Onnauwkeurig heid Inexactitude	Geen of niet- ernstig / Aucun ou non sérieux (0) Ernstig - Sérieux (-1) Zeer ernstig - Très sérieux (-2)		
			Toelichting besluit / L'explication de la décision
Publicatiebias Bias de publication	Geen of niet- ernstig / Aucun ou non sérieux (0) Ernstig - Sérieux (-1) Zeer ernstig - Très sérieux (-2)		
			Toelichting besluit / L'explication de la décision
Kwalificatie na bestuderen van "dalers" / Qualification après l'étude des personnes « descendante s »	Hoog - Elevé (A) Matig - Modéré (B) Laag - Faible (C)		
STIJGERS (overslaan bij score A) - Contremarches (en sautant sur la partition A)			
<i>Deze stap geldt alleen voor observationele studies. Als er RCTs zijn met problemen in studieopzet kan men nadien niet opwaarderen. 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>			
Grootte effect Effet de taille	Niet groot - Pas grand (0) Groot - Grand (+1) Zeer groot - Très grand (+2)		
			Toelichting besluit / L'explication de la décision
Dosis-respons Réponse à la dose	Afwezig - Absent (0) Aanwezig - Présent (+1)		
			Toelichting besluit / L'explication de la décision
Confounding	Zou een aangetoond effect reduceren -Réduirait un effet démontré (+1)		
			Toelichting besluit / L'explication de la décision
Finale kwalificatie van zekerheid van bewijs / Qualification finale de la	Hoog - Elevé (A) Matig - Modéré (B) Laag - Faible (C)		

certitude de la preuve		
------------------------	--	--

Stap 2: bepalen van de sterkte van de aanbeveling - Étape 2 : déterminer la force de la recommandation			
Overwegingen - Considérations	Instructie – instruction	Conclusie - conclusion	Argumentatie - argumentation
Zekerheid van bewijs Certitude de la preuve	<i>Besluit stap 1 – conclusion étape 1</i>		
Balans voor- en nadelen Équilibrez le pour et le contre	<i>Duidelijk voordelen? - Avantages clairs? Voor- en nadelen in evenwicht - Avantages et inconvénients en équilibre Onzeker - Incertain</i>		
Is er onzekerheid over hoe mensen de belangrijkste uitkomsten beoordelen? Y a-t-il une incertitude quant à la façon dont les gens jugent les principaux résultats ?			
Kosten Coûter	<i>Wegen de voordelen van de aanbevolen interventie op tegen de kosten ervan? - Les avantages de l'intervention recommandée l'emportent-ils sur ses coûts ?</i>		
Is de behandeling aanvaardbaar voor de belangrijkste stakeholders? Le traitement est-il acceptable pour les principales parties prenantes ?			
Is de behandeling haalbaar om te implementeren? Le traitement est-il réalisable ?			
Grade of recommendation	Sterk – Fort (1) Zwak of voorwaardelijk - Faible ou conditionnel (2)		
Besluit GRADE – conclusion GRADE			

3.2.5.2 Sterkte van aanbeveling

Om de sterkte van de aanbeveling te bepalen werd in de eerste fase aan de stakeholders gevraagd om via een survey een waardeoordeel (4-punts likert-schaal) te formuleren op volgende items:

- Relevantie
- Haalbaarheid
- Ongewenste effecten
- Kosten-rechtvaardiging

Deze beoordelingen zijn terug te vinden in de verslagen van de stakeholderscommissie (29/06/2021, 05/10/21 en 21/12/2021).

Vervolgens werd op een adviescommissie aan de stakeholders gevraagd een oordeel te geven welke drie aanbevelingen volgens hen belangrijkste zijn en welke drie aanbevelingen volgens hen het minst belangrijk zijn. Bij het bepalen van de mate van belangrijkheid werden volgende criteria in acht genomen (Evidence to Decision):

- mate van prioriteit ,
- balans voor- en nadelen ,
- grootte effect ,
- mate van zekerheid bereiken effect ,
- mate van belangrijkheid te bereiken uitkomst ,
- kosten,
- beschikbaarheid middelen binnen redelijke termijn,
- mate van even waardigheid, voorkomen discriminatie binnen doelgroep,
- mate van aanvaardbaarheid (gericht naar patiënt en zijn context),
- mate van haalbaarheid (gericht naar zorgverlener, zorgstructuur en bredere context).

Deze resultaten werden vervolgens op de adviescommissie plenair besproken.

De bepaling van de sterkte van de aanbeveling werd bepaald op basis van de outcomes van zowel de survey en de Padlet. (Zie figuur 2 ‘Voorbeeld Padlet in kader van Evidence to Decision klinische vraag 4’)

Question 4: Intervention
Mark 2 or 3 recommendations which you label as 'important' with a like and 2 or 3 recommendations which you label 'less important' with a dislike.

<p>1 Algemeen/ Général</p> <p>Het is aanbevolen/We suggereren om: de ergotherapeutische interventies bij kwetsbare oudere personen uit te voeren vanuit een cliëntgerichte houding, samenwerkend partnerschap, het gedachtengoed van gedeelde besluitvorming en met aandacht voor empowerment. De ergotherapeut maakt hierbij gebruik van de principes van gezondheidsgeletterdheid en heeft aandacht voor betekenisvol handelen en het belang van dagstructuur voor de oudere persoon.</p> <p>Nous recommandons/suggérons de : effectuer les interventions ergothérapeutiques chez des personnes âgées qui sont physiquement vulnérables et adoptent un comportement axé sur les clients, un partenariat collaboratif, une pensée de codécision avec une attention particulière pour l'autonomisation.</p>	<p>2 Algemeen/ Général</p> <p>Het is aanbevolen/We suggereren om: om de interventies op maat van de kwetsbare oudere persoon aan te bieden als onderdeel van een multidisciplinaire aanpak.</p> <p>Nous recommandons/suggérons de : fournir les interventions adaptés à la personne âgée physiquement vulnérable comme faisant partie d'une approche multidisciplinaire.</p>	<p>3 Algemeen/ Général</p> <p>Het is niet aanbevolen/We suggereren niet om: een interdisciplinaire multicomponent interventie programma aan te bieden als er geen ergotherapeut betrokken is.</p> <p>Nous ne recommandons/ suggérons pas : d'utiliser un programme multidisciplinaire d'intervention si un ergothérapeute n'est pas impliqué.</p>	<p>4 Inhoud interventie, algemeen/ Contenu intervention, général</p> <p>Het is aanbevolen/We suggereren om: in het kader van betekenisvol dagelijks handelen en sociale participatie individuele thuisinterventies uit te voeren die bestaan uit verhogen van gezondheidsgeletterdheid, aanleren van zelfmanagementstrategieën, aanleren van valpreventiestrategieën, advies over methodeverandering bij het uitvoeren van dagelijkse handelingen, oefenen van dagelijkse handelingen, advies over hulpmiddelen en oefenen in het gebruik ervan, advies over woningaanpassing met inbegrip van verlichting, advies over dienstverlening. We bevelen aan/suggereren om deze interventies te beperken in de tijd en af te sluiten met een follow up sessie.</p> <p>Nous recommandons/suggérons :</p>	<p>5 Inhoud interventie, algemeen/ Contenu intervention, général</p> <p>Het is aanbevolen/We suggereren om: interventies gericht op versterking van persoonlijke capaciteiten en het maken van een netwerk van ondersteuning.</p> <p>Nous recommandons/suggérons :</p>
	<p>8 Inhoud interventie, gezondheidspromotie en preventie/ Contenu intervention, promotion de la santé et prévention</p> <p>Het is aanbevolen/We suggereren om: bij kwetsbare oudere personen met depressieve symptomen levensstijlgerichte interventies aan te bieden die enerzijds ertoe bijdragen om meer activiteiten uit te voeren en anderzijds de kwaliteit van leven te verbeteren.</p>	<p>9 Inhoud interventie, gezondheidspromotie en preventie/ Contenu intervention, promotion de la santé et prévention</p> <p>Het is aanbevolen/We suggereren om : in het kader van aanbevelingen over valpreventie de ergo-richtlijn valpreventie te raadplegen.</p> <p>Nous recommandons/suggérons :</p>		

Figuur 2: Voorbeeld Padlet in kader van Evidence to Decision klinische vraag 4

De analyse van de stakeholdersfeedback, aangevuld met de expertopinie van leden van de GDG werd gebruikt om sectie 2 van de stappen van GRADE-bepaling in te vullen (sterkte van de

aanbeveling). Voor elke aanbeveling is de ingevulde GRADE-template terug te vinden in bijlage '5.5 GRADE-toekenning'.

3.2.5.3 Toekenning waarde GPP

Een "good practice point" (GPP) kwam tot stand wanneer een aanbeveling werd gebaseerd op advies van de stakeholder-experten of experts binnen de GDG. Indien aanbevelingen die werden gebaseerd op literatuur die bij contextadaptatie in die mate werd aangepast dat de aanbeveling niet meer te linken is aan de initiële literatuur en als sterk werd beoordeeld, kreeg deze eveneens de waarde GPP. Dit is zo bij volgende aanbevelingen:

Aanbeveling 1.5A: We bevelen aan dat eerstelijns ergotherapeuten zich transparant profileren als expert in het functioneren in het dagelijks leven en de omgeving waarin dit functioneren plaats vindt. GPP

Aanbeveling 1.5B: We bevelen aan dat ergotherapeuten hun bereikbaarheid kenbaar maken zowel binnen een eerstelijnszone, als naar de diensten geriatrie van de tweede lijn in hun zorgregio om zo een gestroomlijnde doorverwijzing na te streven en geïntegreerde cliënt gecentreerde zorg te verlenen. GPP

Aanbeveling 2.18: We bevelen aan dat de ergotherapeut de persoon, die niet rijgeschikt werd beoordeeld, begeleidt in het vinden en gebruiken van alternatieve transportmiddelen, en coacht bij andere gevolgen op vlak van participatie. GPP

Aanbeveling 2.19: We bevelen aan om aangaande de wettelijke beslissing tot rijgeschiktheid door te verwijzen naar de nationale bevoegde instantie CARA. GPP

Aanbeveling 4.11B: We bevelen aan om bewustwording over de persoonlijke rijvaardigheden bij te brengen, onderhandelende keuzes over toekomstige transportmiddelen te stimuleren en gebruik van alternatieve transportmiddelen te trainen. GPP

Aanbeveling 5.5: We bevelen aan dat zorgverleners gebruik maken van HIT om onderling informatie uit te wisselen. GPP

3.2.6 Documenteren aanbevelingen

Het documenteren van de aanbeveling heeft tot doel de implementatie van de aanbeveling te faciliteren. Het betreft enerzijds het verstrekken van een toelichting die -waar relevant- de aanbeveling operationeel maakt, en anderzijds het toevoegen van implementatiemateriaal.

De toelichting is gebaseerd op literatuur, stakeholdersfeedback en expertopinie van leden van de GDG.

Het implementatiemateriaal betreft onder meer testmateriaal en didactisch materiaal. Waar mogelijk wordt een link naar onderliggend bewijsmateriaal toegevoegd, zoals sralab.org of meetinstrumentenzorg.nl voor klinimetriscie karakteristieken.

Het documenteren van de aanbevelingen was de laatste stap alvorens de richtlijn voor te leggen bij CEBAM.

3.2.7 Voorleggen richtlijn ter validatie bij CEBAM

Alvorens de richtlijn werd voorgelegd bij het nationale validatiecommissie CEBAM, werd ze door twee externe methodologisch experts van de leescommissie van CEBAM beoordeeld en op basis van hun feedback bijgestuurd.

Op 28 september werd de richtlijn op een hiervoor samengeroepen CEBAM-validatiecommissie beoordeeld met onderstaande feedback:

“De validatiecommissie wil de auteurs van deze richtlijn feliciteren voor de inspanningen die ze geleverd hebben om deze richtlijn te ontwikkelen.

Hieronder volgen de algemene indrukken van de validatiecommissie:

Methodologische aspecten:

De richtlijn is methodologisch sterk, met een gedetailleerde rapportage van alle stappen. Onze complimenten voor dit gedegen werk. Onze belangrijkste bemerkingen zijn:

- Er wordt regelmatig gebruik gemaakt van kwalitatief onderzoek, waaraan wordt gerefereerd als ‘dit onderzoek toont aan’. Kwalitatief onderzoek is vooral hypothese vormend en zou ook als dusdanig moeten worden gebruikt.*
- De GRADE gradering bevat enkele onjuistheden of onnauwkeurigheden (zie AGREE item 9).*
- Indien er een sterke aanbeveling wordt gemaakt op basis van bewijs van lage zekerheid, dan kunnen we onvoldoende terugvinden waarom dit is gedaan. De argumentatie hiervoor zou moeten worden gerapporteerd.*

Inhoudelijke aspecten:

Deze richtlijn is een uiting van een wetenschappelijk proces binnen de ergotherapie en een belangrijk document, ook beleidsmatig, voor het integreren van de ergotherapie binnen de eerste lijn. De richtlijn is zeer gebruiksvriendelijk, chronologisch opgesteld en alles is goed uitgelegd. Het is handig dat wordt verwezen naar verdere informatie of instrumenten. Een mogelijk knelpunt is de haalbaarheid voor deze populatie: in de richtlijn worden veel instrumenten voorgesteld. Vanuit communicatief oogpunt kan dit problematisch zijn voor de kwetsbare oudere. Het gebruik van een standaard vragenlijst kan onpersoonlijk overkomen, terwijl de mensen vaak nood hebben aan begrip en dus aandacht voor psychosociale factoren. Om de implementatie te bevorderen zou het goed zijn in de richtlijn uit te leggen hoe je dit best kan doen en wanneer je de informatie in een gesprek probeert te achterhalen.

Twee andere bemerkingen:

- Het zou goed zijn als de richtlijn richting geeft over welke instrument(en) beter zijn dan andere.*
- De richtlijn is heel goed, maar op dit moment is er geen terugbetaling voorzien. Dit is een majeure barrière voor implementatie (zie item 20).” (uit verslag Cebam-validatiecommissie 28 september 2022)*

Op basis van bovenstaande bedenkingen werd de richtlijn bijgestuurd. De richtlijn werd op 9 maart 2023 gevalideerd door Cebam.

4 Methodiek per klinische vraag

4.1 Klinische vraag 1

De klinische vraag luidt:

Hoe kan de fysiek kwetsbare oudere persoon worden gedetecteerd (case finding)? Hoe kan de fysiek kwetsbare oudere persoon en/of zijn sociale context efficiënt en effectief doorverwezen worden naar een ergotherapeut?

4.1.1 Concepten zoekstrategie

1a focus detectie

1b focus doorverwijzing

	Description	Pool of search terms
P	Thuiswonende fysiek kwetsbare oudere persoon ouder dan 75 jaar en/of zijn sociale omgeving	"Frail Elderly"[Mesh] OR "Aged, 80 and over"[Mesh] OR Frailty[Mesh]) AND "Primary Health Care"[Mesh]
I a	Detectie	"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	Doorverwijzen	("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	Efficiënt en effectief gedetecteerd en doorverwezen zijn naar ergotherapie in de eerste lijn	/

Geraadpleegde databases:

Cochrane database of systematic reviews, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Methodologische inclusiecriteria

- Design: Systematische reviews en meta-analyses, RCT's, observationele studies en kwalitatieve studies

- Methodologisch van voldoende kwaliteit gemeten met SIGN critical appraisal tool; Indien geen SIGN CA tool beschikbaar voor het betreffende design: JBI critical appraisal tool.
- Zoekperiode: begin databank tot 30 juni 2022

Inhoudelijke in- en exclusiecriteria:

Inclusie:

- de fysiek kwetsbare oudere persoon en/of de mantelzorger
- eerstelijnszorg of doorverwijzing naar de eerstelijnszorg
- detectie of doorverwijzing

Exclusie:

Volledig geriatrisch assessment (betreft vraag 2)

Search strings per database

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"+))

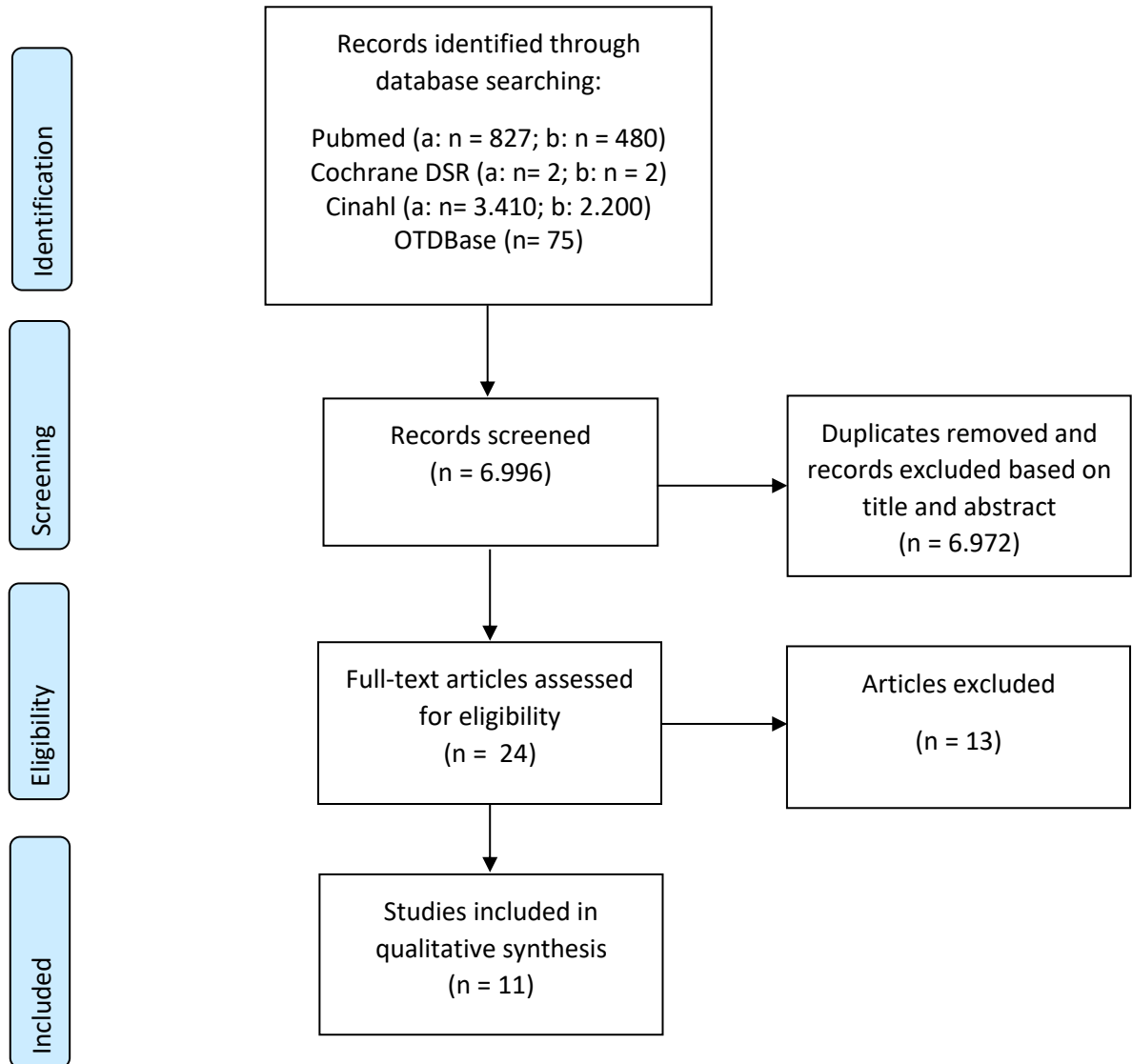
AND

(MH "Primary Health Care"+)

OTDBase

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

4.1.2 Geïdentificeerde resultaten



4.1.3 Literatuurmatrixen klinische vraag 1

Cochrane database of systematic review

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
Vraag 1a							
/							
Vraag 1b							
/							

Literature matrix excluded articles

referentie	design	reden exclusie
Vraag 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 13;7(7):CD000443. doi:	Sys rev	Andere populatie

10.1002/14651858.CD000443.pub4. PMID: 28703869; PMCID: PMC6483472.		
Vraag 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

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
McIntyre, Anne, et al. Engagement of General Practitioners in Falls Prevention and Referral to Occupational Therapists. The British Journal of Occupational Therapy, vol. 82, no. 2, 2018, pp. 71–79.	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 practices to occupational	Low level of evidence (JBI tool)

					74% of the GP's referred to occupational therapy Study in England	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'.	
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.	multiple case study design	a wide range of client populations: Older adults and individuals with complex chronic conditions are two prominent areas of occupational therapy focus.	Role of OT	to describe the emerging role of occupational therapy in Family Health Teams, a model of interprofessional primary care.	Understanding the impact of health conditions on daily function and enabling participation in activities are unique and important contributions of occupational therapy	When occupational therapy is situated in primary care, there is enhanced access to occupational therapy	Low level of evidence (JBI tool)

							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)

<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?” <i>Scandinavian Journal of Caring Sciences</i> , 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

referentie	design	reden exclusie
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

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
------------	-----------------------	-----------	-------------	--------------	-----------	---------------------------------	---------------

<p>McIntyre, Anne, et al. Engagement of General Practitioners in Falls Prevention and Referral to Occupational Therapists. The British Journal of Occupational Therapy, vol. 82, no. 2, 2018, pp. 71–79.</p>	<p>Descriptive study (survey)</p>	<p>People at risk of falls</p>	<p>Referral to OT</p>	<p>Frequency of referral to OT</p>	<p>90% identified occupational therapists as providing evidence-based falls prevention. 74% of the GP's referred to occupational therapy Study in England</p>	<p>There are gaps in general practitioners' falls prevention referral 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>Low level of evidence (JBI tool)</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

referentie	design	reden exclusie	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

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
------------	-----------------------	-----------	-------------	--------------	-----------	---------------------------------	---------------

Vraag 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>Vraag 1b</p>							
<p>/</p>							

Literature matrix excluded articles

referentie	design	reden exclusie
Vraag 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
Vraag 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 Kritische beoordeling geïnccludeerde artikels

See annex 5.4

4.1.5 GRADE-toekenning

See annex 5.5

4.2 Klinische vraag 2

De klinische vraag luidt:

Welke multifactoriële ergotherapeutische evaluatie is aangewezen bij de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context?

4.2.1 Concepten zoekstrategie

2a focus oudere persoon

2b focus sociale context/mantelzorger

2c focus fysieke context

	Description	Pool of search term
P a	Oudere persoon	"Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH]
P b	Sociale context/mantelzorger	"Social Environment"[MeSH] OR "Social Support"[MeSH] OR "Social Networking"[MeSH] OR "Friends"[MeSH] OR "Family"[MeSH] OR "Caregivers"[MeSH]
P c	Fysieke context	"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	Multifactoriële ergotherapeutische evaluatie	"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	Inventariseren barrières en mogelijkheden van de oudere persoon	"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	Inventariseren van barrières en mogelijkheden van de sociale context	"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	Inventariseren barrières en mogelijkheden van de fysieke context	"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]

Geraadpleegde databases:

Cochrane database of systematic reviews, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Methodologische inclusiecriteria

- Design: Systematische reviews en meta-analyses, RCT's, observationele studies en kwalitatieve studies
- Methodologisch van voldoende kwaliteit gemeten met SIGN critical appraisal tool; Indien geen SIGN CA tool beschikbaar voor het betreffende design: JBI critical appraisal tool.
- Zoekperiode: begin databank tot 30 juni 2022

Inhoudelijke in- en exclusiecriteria:

Inclusie:

- de fysiek kwetsbare oudere persoon en/of de mantelzorger
- ergotherapeutisch assessment of beoordeling van het functioneren/betekenisvol handelen of de sociale participatie in de eerstelijnszorg of in functie van terugkeer naar de eerstelijnszorg
- zowel assessment instrumenten, assessment batterijen, als assessment procedures
- beoordeling van de woonomgeving

Exclusie:

Assessment i.k.v. dementie of bij duidelijk verminderd cognitief functioneren

Searchstrings per database

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"+)

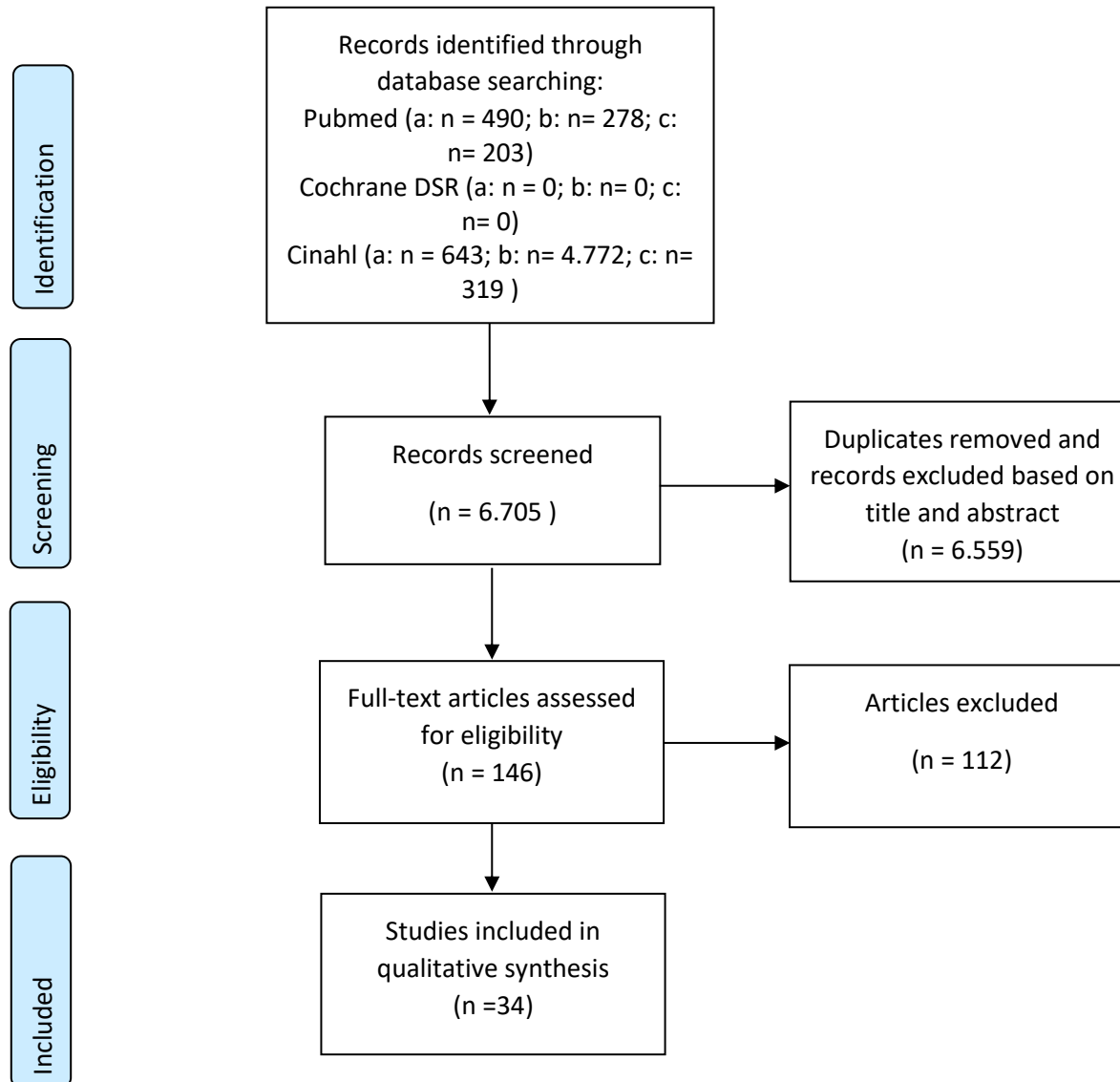
AND

((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 Geïdentificeerde resultaten



4.2.3 Literatuurmatrix vraag 2

Cochrane database of systematic review

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie
/		

Pubmed

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q- beoordeling

<p>119 a Dickerson AE, Meuel DB, Ridenour CD, Cooper K. Assessment tools predicting fitness to drive in older adults: a systematic review. <i>Am J Occup Ther.</i> 2014 Nov-Dec;68(6):670-80. doi: 10.5014/ajot.2014.011833. PMID: 25397762.</p>	<p>Sys rev</p>	<p>Older adults</p>	<p>Assessment fitness to drive</p>	<p>Valid ass instruments</p>	<p>Assess tool cognition, vision, perceptual, motor, simulation, screening batteries</p>	<p>Incl</p>	<p>Acceptable (SIGN)</p>
<p>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.</p>	<p>Descriptive study cross sectional</p>	<p>Occupational therapists</p>	<p>Assessment of methods to assess occupational performance in elderly clients living in special housing in community</p>	<p>use and perceptions of different methods to assess occupational performance for elderly clients living in special housing</p>	<p>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.</p>	<p>Incl</p>	<p>Acceptable quality (JBI)</p>
<p>139 Mallinson, Trudy, et al. “Development and Validation of the Activity Significance Personal Evaluation (ASPEN) Scale.” <i>Australian Occupational Therapy Journal</i>, vol. 61, no. 6, 2014, pp. 384–393.</p>	<p>Descriptive study – test development</p>	<p>Community dwelling older adults</p>	<p>Developing assessment Activity significant personal evaluation (ASPEN)</p>	<p>Meaning of older adult’s activity over time (contribution to health and wellness)</p>	<p>13-item scale forms a unidimensional hierarchy with good fit statistics and targeting. Person separation reliability (2.7) and internal consistency (.91)</p>	<p>Inclusion</p>	<p>Acceptable quality (JBI)</p>

					indicates the tool is appropriate for individual person 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 STEPassessment (Sandholzer et al., 2004) and each of the following additional tests: Barthel-Index (Mahoney & Barthel, 1965), Lambeth-disability screening	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)

		questionnaire (McDowell, Martini, & 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).				
--	--	---	--	--	--	--

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/.	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 offer an occupational focused lens.	COPM can be used by OT's in primary care to measure occupational performance.	acceptable quality (JBI)
Fischl, C., Blusi, M., Lindgren, H., & Nilsson, I. (2020). Tailoring to support digital technology-mediated occupational engagement for older adults—a multiple case study. Scandinavian Journal of Occupational Therapy, 27(8), 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. Aust Occup Ther J. 2019 Apr;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. American Journal of Occupational Therapy, 64, 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	develop and validate the Health Enhancement Lifestyle Profile (HELP),	The item hierarchy formed through logits provided an expected pattern of healthy lifestyle	HELP can assist in monitoring lifestyle risk factors and measuring the outcome of services	acceptable q

			dependency, and differential item functioning.		behaviors. Acceptable to good person separation and reliability 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.	aimed at promoting healthy lifestyles among older adults.	
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 processes and 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	Fear of falling	The intervention had no effect on fear of falling (P5.63). The occupational therapy group had significantly	Environmental assessment prescribed by an occupational therapist significantly reduced the number	acceptable quality (SIGN)

			greater risk of falls.		fewer falls than controls 12 months after the assessment (incidence rate ratio (IRR)50.54, 95% confidence interval (CI)50.36–0.83, P5.005).	of falls in high-risk individuals whereas that prescribed by a 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. Can J Occup Ther. 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. Am J Occup Ther. 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. Aust Occup Ther J. 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 sith clients 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. Occup Ther Health Care. 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. Occup Ther Health Care. 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) -

<p>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 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>	<p>RCT</p>	<p>Frail older adults</p>	<p>Assessment frail older people by OT and soc workers</p>	<p>Effectiveness of OT led or soc worker-led assessment</p>	<p>No difference in assessment Reasons are given</p>	<p>inclusion</p>	<p>Acceptable (SIGN)</p>
<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>	<p>Diagnostic study</p>	<p>Community residing older people (65-98 year) (N=678)</p>	<p>FAB (falls behaviour scale)</p>	<p>Validation and reliability, usefulness in clinical situations</p>	<p>29-item partial rating scale is valid, reliable and useful Short form useful alternate for evaluating effectiveness of fall reductioninterventions</p>	<p>Inclusion</p>	<p>Acceptable quality (JBI)</p>
<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>	<p>Longitudinal study</p>	<p>At least 65 years old and frail</p>	<p>(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</p>	<p>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</p>	<p>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</p>	<p>Incl interRAI HC</p>	<p>High quality (JBI)</p>

			(c) no home modifications or advice about assistive device		management and home modifications		
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)

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q- beoordeling
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	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)

					instrument can be administered in an interdisciplinary 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: <ul style="list-style-type: none"> • 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 	Acceptable (JBI)

						<ul style="list-style-type: none"> The HSSAT can be used with older adult populations where the occupational therapist is a consultant to a medical, nonmedical, or social service agency in a community setting to prevent falls 	
<p>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</p>	Diagnostic study	<p>37 older adults prior to discharge</p> <p>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</p>	Cooking task	<p>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.</p>	<p>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.</p> <p>A clinically meaningful difference (based on cut-off scores predicting need for assistance) was noted in 30% of the participants.</p> <p>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.</p>	<p>Advocacy to measure in the habitat of the older person</p>	Acceptable (JBI)

		activity; (d) consider 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	High quality (JBI)

						observation of the client's use of 3-4 of 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	Valid, reliable and would be useful in clinical situations when used as a prompt for discussion and in	Low quality (JBI)

<p>Disability and Rehabilitation, 30:7, 498-506, DOI: 10.1080/09638280701355546</p>					<p>2.36 and internal reliability of 0.85.</p>	<p>raising clients' 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>	
--	--	--	--	--	---	--	--

Literatuurmatrix excluded articles

referentie	onderzoeks-design	Reden exclusie
<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</p>	<p>Descriptive study; narrative review on health economics</p>	<p>Design and purpose (health economic outcomes)</p>

occupational therapy practice. Scand J Occup Ther. 2014 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

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)

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

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)

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)

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

improving activities of daily living performance and participation than a hospital-based discharge planning consultation for older adults in the acute hospital setting. Aust Occup Ther J. 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. Occup Ther Health Care. 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. Disabil Rehabil Assist Technol. 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? Aust Occup Ther J. 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. BMC Geriatr. 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. Aust Occup Ther J. 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

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

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)

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)

referentie	onderzoeks- design	Reden exclusie
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

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)

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)

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

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	Dataselectie klinische vraag	Q-beoordeling
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. <i>Scandinavian journal of occupational therapy</i>, 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)

		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

referentie	design	reden exclusie
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);

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

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q- beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie
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 Kritische beoordeling geïnccludeerde artikels

See annex 5.4

4.2.5 GRADE-toekenning

See annex 5.5

4.3 Klinische vraag 3

De klinische vraag luidt:

Welke methodiek is aangewezen om samen met de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context doelen te bepalen?

4.3.1 Concepten zoekstrategie

	Description	Pool of search terms
P	Oudere persoon en/of zijn sociale context	"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	Methode doelbepaling	"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]
I b	Attitude en vaardigheden bij doelbepaling	"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]

c	/	
O	Doelen die outcome bij oudere en/of sociale context	<p>"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"</p> <p>OR</p> <p>"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"</p>

Geraadpleegde databases:

Cochrane database of systematic reviews, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Methodologische inclusiecriteria

- Design: Systematische reviews en meta-analyses, RCT's, observationele studies en kwalitatieve studies
- Methodologisch van voldoende kwaliteit gemeten met SIGN Critical Appraisal tool; Indien geen SIGN CA tool beschikbaar voor het betreffende design: JBI critical appraisal tool.
- Zoekperiode: begin databank tot 30 juni 2022

Inhoudelijke in- en exclusiecriteria:

Inclusie:

- de fysiek kwetsbare oudere persoon en/of de mantelzorger
- doelbepaling

Exclusie:

/

Search strings per database

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

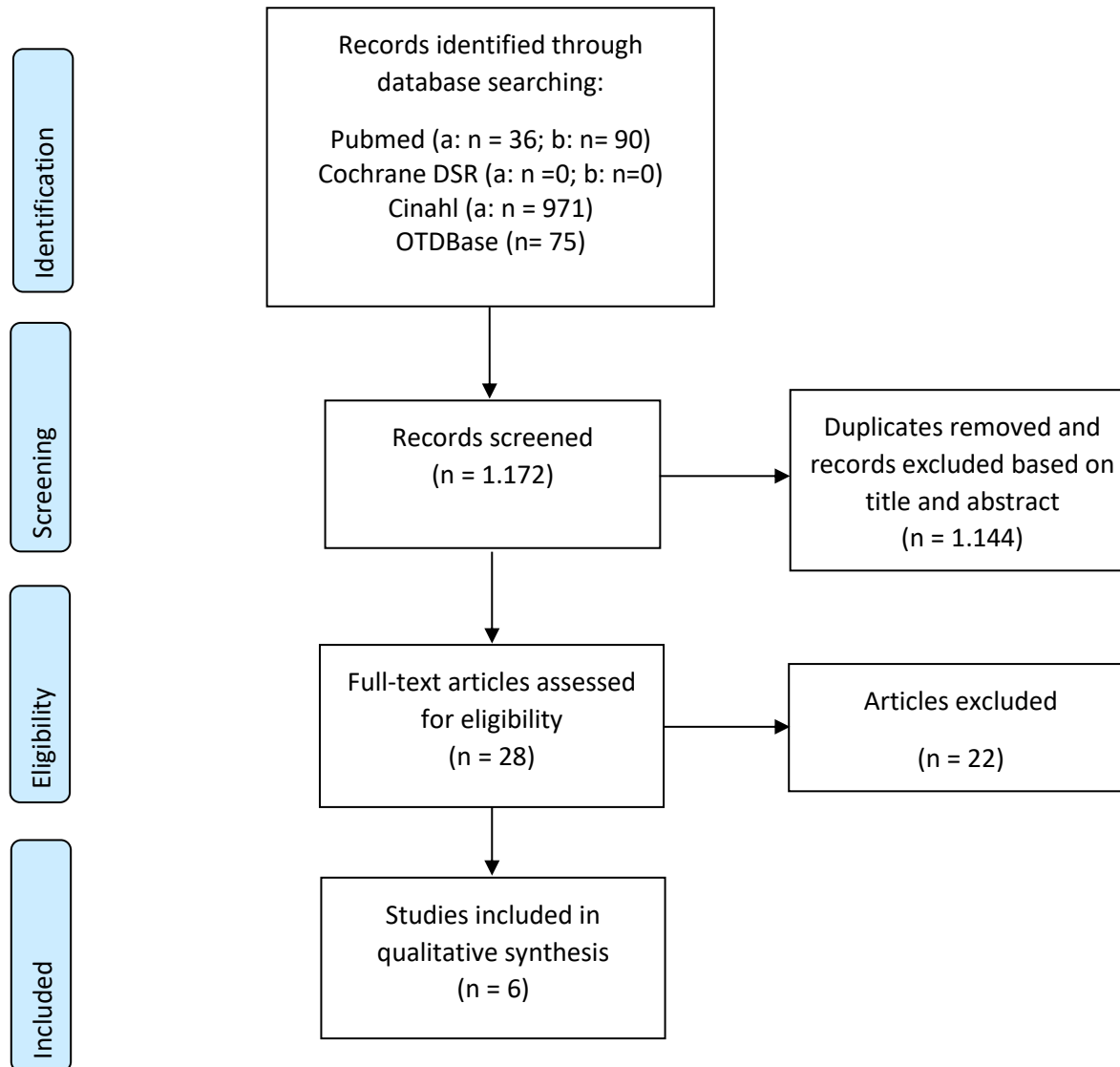
(MH "Activities of Daily Living"+) OR (MH Self-Management+) OR (MH "Physical Functional Performance"+) OR (MH "Community Integration"+) OR (MH "Community Participation"+) OR (MH "Social Integration"+) OR (MH "Human Activities"+) OR (MH "Healthy Lifestyle"+) OR (MH "Quality of Life"+) OR (MH "Sense of 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 Geïdentificeerde resultaten



4.3.3 Literatuurmatrix klinische vraag 3

Cochrane database of systematic review

Literature matrix included articles

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie
/		

Pubmed

Literature matrix included articles

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q beoordeling
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>

<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>

					<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>		
--	--	--	--	--	--	--	--

Literature matrix excluded articles

referentie	design	reden exclusie
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)

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

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
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

referentie	design	reden exclusie
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)
Murphy, A. D., Griffith, V. M., Mroz, T. M., & Jirikowic, T. L. (2017). Primary care for underserved populations: Navigating policy to	Case study, expert opinion	Content (OT in Federally qualified health centers)

incorporate occupational therapy into federally qualified health centers. American Journal of Occupational Therapy, 71(2).
<https://doi.org/10.5014/ajot.2017.712001>

Cinahl

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
Kelly, B., Rid, A., & Wendler, D. (2012, May). Systematic review: Individuals' goals for surrogate decision-making. Journal of the American Geriatrics Society. 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 groups. Only six articles surveyed a larger cross-section of a given population.</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)

Literature matrix excluded articles

referentie	design	reden exclusie
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>JBI 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 Kritische beoordeling geïnccludeerde artikels

See annex 5.4

4.3.5 GRADE-toekenning

See annex 5.5

4.4 Klinische vraag 4

De klinische vraag luidt:

Welke multifactoriële ergotherapeutische interventies zijn aangewezen bij de thuiswonende fysiek kwetsbare oudere persoon en/of zijn context?

4.4.1 Concepten zoekstrategie

- 4a focus preventie funct en soc part oudere persoon
- 4b focus curatie funct en soc part oudere persoon
- 4c focus behoud funct en soc part oudere persoon
- 4d focus balans draagkracht-draaglast sociale context
- 4e focus attitude en vaardigheden therapeut

	Description	Search terms
P a b c f	Oudere persoon	"Frail Elderly"[MeSH] OR "Aged, 80 and over"[MeSH] OR "Frailty"[MeSH]
P d	Sociale context/mantelzorg	"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	Ergotherapeutische interventie bij de oudere populatie (preventief, curatief en behoudend)	"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 OR "Distance Counseling"[Mesh] OR "Telerehabilitation"[Mesh] OR "Telemedicine"[Mesh] OR "Education, distance"[Mesh] OR "Internet-Based Intervention" [Mesh] OR "online therapy"

I d	Ergotherapeutische interventie sociale context focus balans draagkracht-draaglast	"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 – therapeutische vaardigheid - therapeutische basishouding	"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	Functioneren en sociaal participeren oudere persoon	"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	Draagkracht mantelzorger/sociale context	"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"

Geraadpleegde databases:

Cochrane database of systematic reviews, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Methodologische inclusiecriteria

- Design: Systematische reviews en meta-analyses, RCT's
- Methodologisch van voldoende kwaliteit gemeten met SIGN critical appraisal tool
- Zoekperiode: begin databank tot 30 juni 2022

Inhoudelijke in- en exclusiecriteria:

Inclusie:

- de fysiek kwetsbare oudere persoon en/of de mantelzorger
- eerstelijnszorg
- ergotherapeutische interventie of interventie omtrent functioneren/betekenisvol handelen of sociale participatie

Exclusie:

Interventies bij personen met dementie of ernstige cognitieve of psychische problemen

Searchstrings per database

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)))

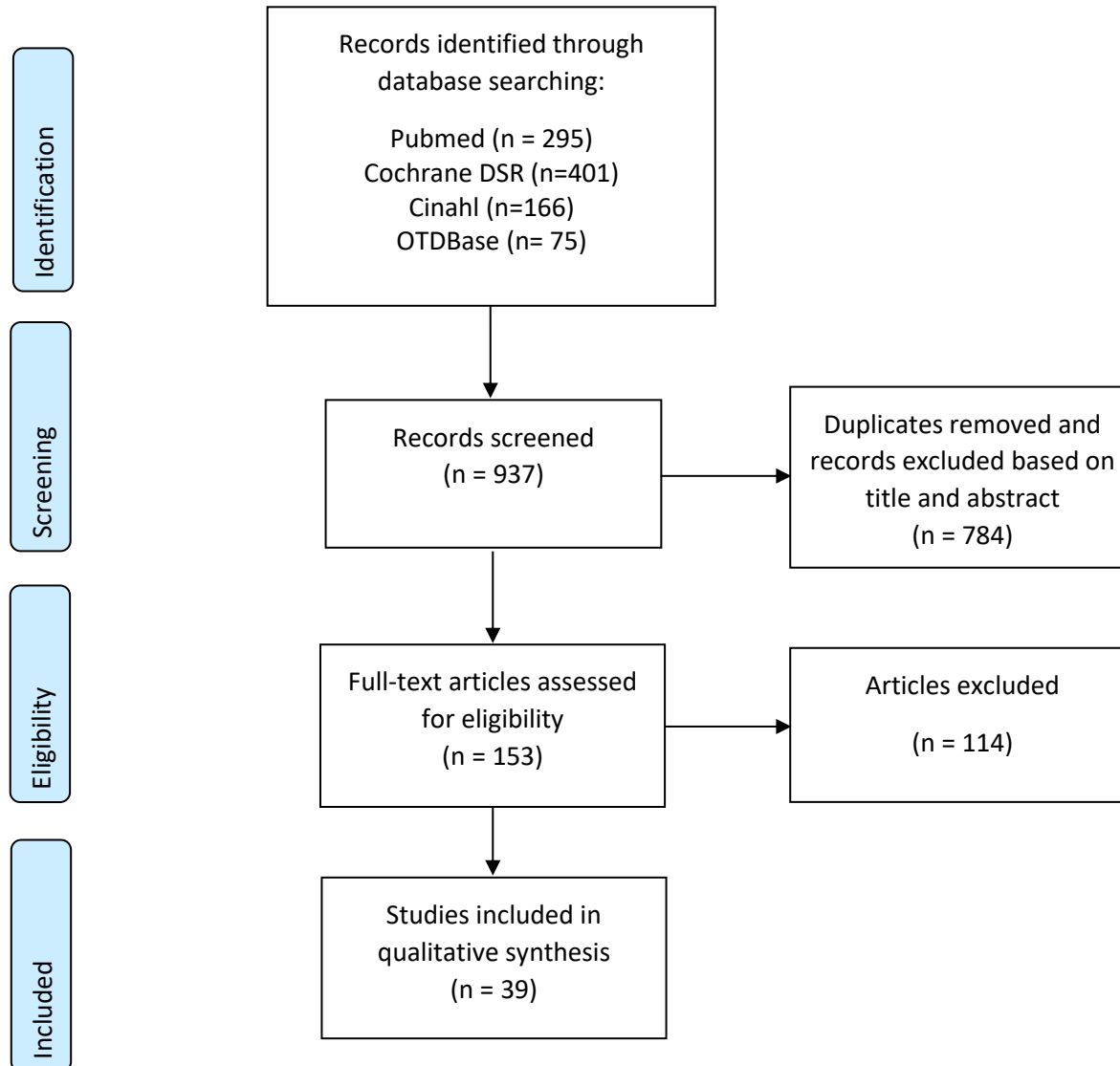
AND

((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 Geïdentificeerde resultaten



4.4.3 Literatuurmatrix klinische vraag 4

Cochrane database of systematic review

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
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	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 disease and	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; 95% CI 0.85 to 1.03; 1	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 people needing	Sign High quality (++)

		<p>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</p>	<p>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 uncertain about the</p>	<p>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>	
--	--	---	---	--	--

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

Literature matrix excluded articles

referentie	design	reden exclusie
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.		Physiotherapy

Cochrane Library, 2015(4), CD005381. https://doi.org/10.1002/14651858.CD005381.pub4		
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

Referentie	Onderzoeks-design	Populatie	Interventie	Uitkomstmaat	Resultaat	Dataselectie klinische vraag	Q-beoordeling
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 Controlled Trial. Int J Environ Res	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 based on gait and balance	At baseline, groups were equivalent for study outcomes. The comparison of pre- and post-intervention data revealed that subjects receiving CI reduced depressive symptomatology and	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 older adults from day	Sign acceptable (+)

<p>Public Health. 2019 Aug 28;16(17):3125. doi: 10.3390/ijerph16173125. PMID: 31466229; PMCID: PMC6747215.</p>					<p>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>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. Gerontologist. 2019 Jul 16;59(4): e268-e278. doi: 10.1093/geront/gnx195. PMID: 29329395.</p>	<p>Pragmatic and systematic review</p>	<p>Older 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>

					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 (-)

					<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>		
--	--	--	--	--	---	--	--

					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: Δ1.5, [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 (-)

<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>

<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>

			<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>	<p>RCT</p>	<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>	<p>Frailty and mobility</p>	<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>	<p>Sign Acceptable (+)</p>

					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 (++)

		<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>	
--	--	---	--	---	--

					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.		
<p>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.</p>	<p>Sys rev met meta ana of clinical trials</p>	<p>Independently living older adults over 60 years of age.</p>	<p>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.</p>	<p>Functional autonomy</p>	<p>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</p>	<p>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.</p>	<p>Sign Acceptable (+)</p>

					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 (++)

			<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>

		<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>

<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>	
--	--	---	--	---------------------------------------	---------------------------------------	--

			<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 (+)

					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 (-)

<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>	
---	--	---------------------------------	--	--	---	---	--

			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 (+)

					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 (+)

		<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 ($+0.15 \pm 0.16$ vs $+0.01 \pm 0.12$ m/s; $p = 0.007$), whereas the YMCA group's improvements were significantly greater than</p>	
--	--	---	--	--

				<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>		
--	--	--	--	--	--	--

					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 (+)

<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	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>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).</p> <p>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.</p> <p>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 (+)
---	-----	--	--	---	--	--	------------------------

					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 (+)

			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 (+)

					<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>

		<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>	
--	--	--	--	---	--

			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 (+)

<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>		
--	--	--	--	--	--	--

					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 (+)

					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.		
Tuntland H, Aaslund MK, Espehaug B, Førland O, Kjeklen I. Reablement in community-dwelling older adults: a randomised controlled trial. BMC Geriatr. 2015 Nov 4;15:145. doi: 10.1186/s12877-015-0142-9. PMID: 26537789; PMCID: PMC4634595.	Parallel-group randomised controlled trial	Home-dwelling older adults	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.	Daily activities, physical functioning, and health-related quality of life	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	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.	Sign High quality (++)

		<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>		
--	--	--	--	---	--	--

			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 (+)

					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 (++)

				<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>		
--	--	--	--	---	--	--

					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 (+)

			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 (+)

<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>

				<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.</p> <p>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.</p> <p>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>
--	--	--	--	---	--

					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 (++)

					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 (-)

					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

referentie	design	reden exclusie
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

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

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

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

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

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

Daily Functioning in Older People. <i>J Am Geriatr Soc.</i> 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. <i>BMC Geriatr.</i> 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. <i>Gerontologist.</i> 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. <i>Br J Gen Pract.</i> 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. <i>Accid Anal Prev.</i> 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. <i>Contemp Clin Trials.</i> 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. <i>J Safety Res.</i> 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. <i>Br J Nutr.</i> 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. <i>Patient Educ Couns.</i> 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. <i>Am J Phys Med</i>	Sys rev	Level not achieved

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

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

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

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

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	Eenmalige 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

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie
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 Kritische beoordeling geïncludeerde artikels

See annex 5.4

4.4.5 GRADE-toekenning

See annex 5.5

4.5 Klinische vraag 5

De klinische vraag luidt:

Hoe kan de ergotherapeut, die met de thuiswonende fysiek kwetsbare oudere persoon en/of zijn sociale context werkt, bijdragen aan een kwaliteitsvolle disciplinaire, geïntegreerde en/of transmurale zorg?

4.5.1 Concepten zoekstrategie

	Description	Search terms
P	Oudere persoon en sociale context /mantelzorger	("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	Vormen van samenwerking; personen en diensten waarmee wordt samengewerkt	("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	Informatieoverdracht	("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])

Geraadpleegde databases:

Cochrane database of systematic reviews, Medline (via Pubmed), Cinahl (via EBSCO), OTDbase

Methodologische inclusiecriteria

- Design: Systematische reviews en meta-analyses, RCT's, observationele studies en kwalitatieve studies
- Methodologisch van voldoende kwaliteit gemeten met critical appraisal tool
- Zoekperiode: begin databank tot 30 juni 2022

Inhoudelijke in- en exclusiecriteria:

Inclusie:

- de fysiek kwetsbare oudere persoon en/of de mantelzorger
- samenwerking binnen de eerste lijn zorg of tussen eerste en tweede lijn zorg

Exclusie:

/

Search string per database:**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

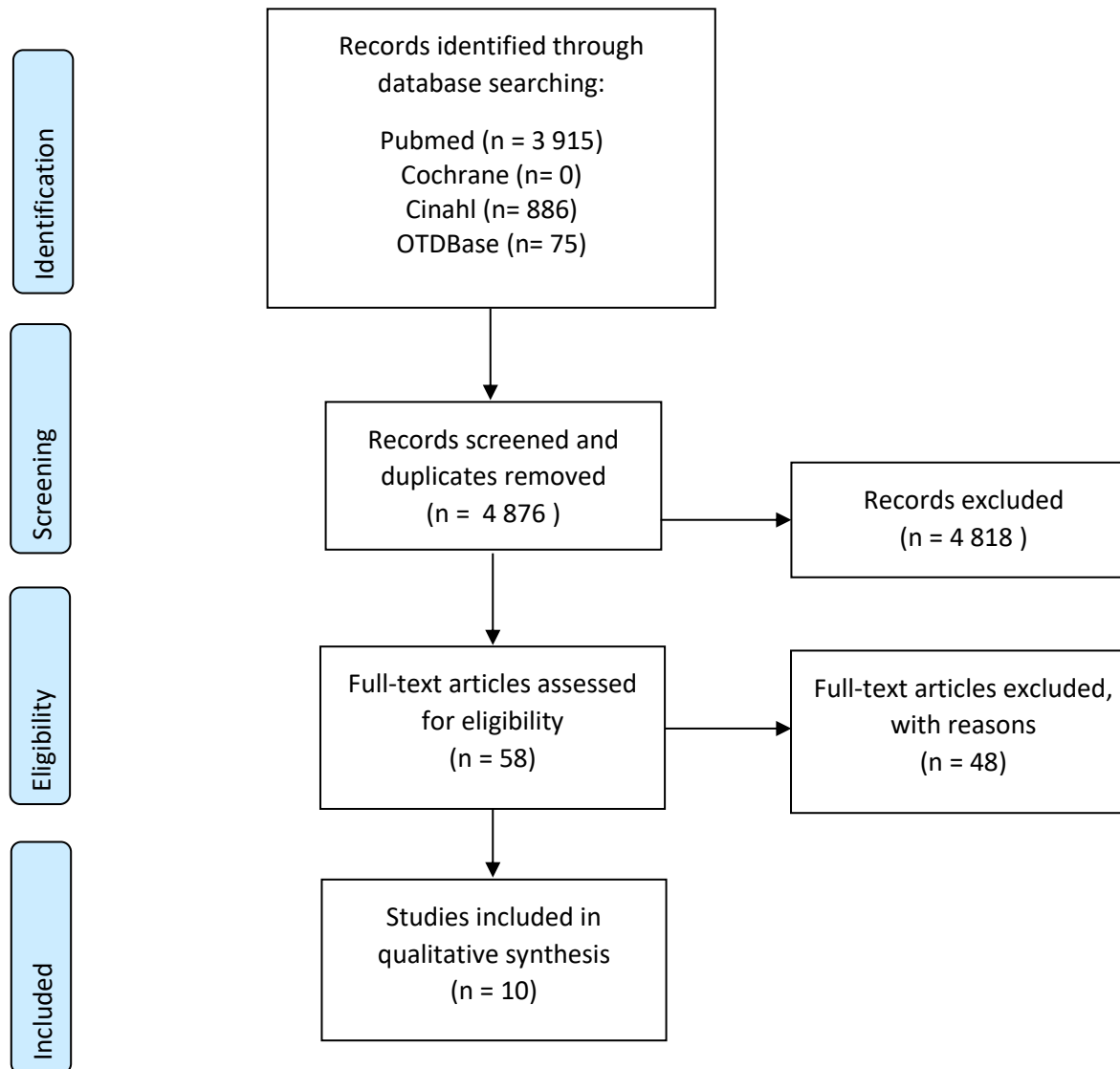
((MH "Occupational Therapy+") OR (MH Physicians+) OR (MH "General Practitioners+") OR (MH "Physical Therapists+") OR (MH "Nurses, Community Health+") OR (MH "Licensed Practical Nurses+") OR (MH "Nurse Clinicians+") OR (MH "Community Health Nursing+") OR (MH "Home Health Nursing+") OR (MH "Geriatric Nursing+") 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 Geïdentificeerde resultaten



4.5.3 Literatuurmatrix klinische vraag 5

Cochrane database of systematic review

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie	Achtergrond?
/			

Pubmed

Literature matrix included articles

referentie	onderzoeks- design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
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)

			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)

			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

referentie	design	reden exclusie
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

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
/							

Literature matrix excluded articles

referentie	design	reden exclusie
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 outcome 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

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 lt! 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

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

referentie	onderzoeks-design	populatie	interventie	uitkomstmaat	resultaat	dataselectie klinische vraag	Q-beoordeling
------------	-------------------	-----------	-------------	--------------	-----------	------------------------------	---------------

<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>

					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)

				<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>		
--	--	--	--	--	--	--

<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>

<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>

<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>
--	---------------------	-------------------------	----------------------------------	---	---	--	---------------------------------

					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		
--	--	--	--	--	---	--	--

Literature matrix excluded articles

referentie	design	reden exclusie
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 Gu�nette, France L�gare, Paul Morin, Thomas G Poder, Marie-�ve Poitras, Pasquale Roberge, Ruta Valaitis, Shirley Bighead, Cameron Campbell, Martine Couture, Breanna Davis, �laine Deschenes, Lynn Edwards, Sarah Gander, Gilles Gauthier, Patricia Gauthier, Richard J Gibson, Julie Godbout, Genevi�ve Landry, Christine Longjohn, Norma Rabbitskin, Denis A Roy, Judy Roy, V�ronique 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

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

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

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 Kritische beoordeling geïnccludeerde artikels

See annex 5.4

4.5.5 GRADE-toekenning

See annex 5.5

5 Bijlagen

Overzicht bijlages

5.1 Analyse klinische vragen aanverwante richtlijnen

5.2 Verslagen GDG

5.3 Verslagen adviescommissie

5.4 Critical appraisals geïnccludeerde artikels

5.5 Verantwoording GRADE-toekenning

5.6 Conflicts of interest

5.1 Analyse klinische vragen aanverwante richtlijnen

Search 09/2020	Search terms	Results	Number of selected guidelines	Research questions
Database/website				
GIN	Occupational therap* in 'guidelines'	3	1	1. What is the frequency and duration of an effective intervention? 2. What are the significant features of an effective intervener? 3. Are interventions that engage older people in their design and delivery more effective than those that do not? 4. Are interventions that engage immediate family members or carers more effective than those that do not? 5. Does the intervention lead to any adverse or unintended effects? 6. What are the barriers to and facilitators of effective implementation?
GIN	Elder* in 'guidelines'	22	9 Nt geselecteerd : tool om EB te werken (3); achter paswoord (2); in opbouw; in Portugees; niet gevonden; in Spaans (3); In Deens (2)	<p>Delier: geen vragen wel scope</p> <p>Diabetes type 1: scope</p> <p>Diabetes type 2: scope</p> <p>Hip fractures : goals and rationale</p> <p>Mictieklachten: geen vragen</p> <p>Abuse and neglect:</p> <p>1.What are the most effective ways for nurses (and other health-care providers) to identify and assess for abuse and neglect of older adults? 2. What are the most effective ways for nurses (and other health-care providers) to respond to the abuse and neglect of older adults? 3. What education do nurses (and other health-care providers) need to effectively address abuse and neglect of older adults? 4. What prevention and health promotion strategies are recommended regarding elder abuse and neglect? 5. What organizational policies and system level supports are required to effectively prevent and address abuse and neglect of older adults (living in facilities and community settings)?</p> <p>Kwetsbare ouderen:</p> <p>1.Wat zijn de huidige richtlijnen voor fysieke activiteit bij ouderen? 2. Wat zijn de centrale en perifere effecten van een beweginginterventie bij (kwetsbare) ouderen? 3. Welke typen beweginginterventies voor kwetsbare ouderen zijn effectief ter verbetering van spierkracht, uithoudingsvermogen, balans, gewrichtsmobiliteit, ADL-vaardigheden, functionele mobiliteit, kwaliteit van leven en valincidentie? 4. Welke factoren zijn van invloed op het beweeggedrag en het activiteitsniveau van (kwetsbare) ouderen?</p> <p>Dementie:</p> <p>What is the role of primary caregivers in recognising symptoms of suspected dementia?</p> <p>What are the specific tasks of the primary caregivers in the area of diagnostics when dementia is suspected?</p> <p>What are the specific tasks of the various primary caregivers with respect to interventions in people with dementia?</p> <p>Which support provided by primary caregivers is effective when dealing with people with dementia?</p>

				<p>What is the role of primary caregivers in monitoring and in communicating with other caregivers in relation to the defined goals and outcomes in people with dementia?</p> <p>What are the required conditions for targeted and effective care consultation?</p> <p>Valpreventie</p> <p>What are the main fall risk factors for elderly people living at home?</p> <p>What is the best method for establishing an increased fall risk for elderly people living at home?</p> <p>What is the effect of a multifactorial approach on the number of fall incidents experienced by elderly people living at home?</p> <p>What is the effect of a multifactorial approach on the number of fall injuries experienced by elderly people living at home?</p> <p>What kind of multifactorial evaluation is recommended in the case of increased fall risk in elderly people living at home?</p> <p>Which multifactorial interventions are recommended in the case of increased fall risk in elderly people living at home?</p> <p>How can professional care providers ensure better therapy compliance in elderly people with an increased fall risk living at home?</p> <p>Which professional care providers play an important role in the multifactorial management of fall prevention in elderly people living at home?</p>
WHO	"Guidelines" and "occupational therapy" and elder*	136-156 (aantal veranderingen afhankelijk van tijdstip opzoeken)	2 Voornaamste redens niet weerhouden: geen richtlijn en andere doelgroep	<p>WHO RL "Housing and health guidelines"</p> <p>Do residents with functional or cognitive impairments living in accessible/usable home environments have better health/social outcomes than residents with functional or cognitive impairments living in conventional or unmodified home environments?</p> <p>The systematic review focused on the following priority health outcomes, as ranked by the GDG:</p> <ul style="list-style-type: none"> • injury rates (especially falls) • well-being/quality of life • mental health/depression • dependency on external social or care services • social participation. <p>WHO RL "Integrated care for older people Guidelines on community-level interventions to manage declines in intrinsic capacity"</p> <p>Geen vragen geformuleerd, wel topics omtrent Indicatoren fysieke of cognitieve achteruitgang:</p> <ul style="list-style-type: none"> • mobiliteit, • malnutritie,

				<ul style="list-style-type: none"> • visuele en auditieve achteruitgang, • cognitieve achteruitgang,
NICE	Elder*	3	1	<p>RL “Home care: delivering personal care and practical support to older people living in their own homes”</p> <p>This guideline covers the planning and delivery of person-centred care for older people living in their own homes (known as home care or domiciliary care). It aims to promote older people's independence and to ensure safe and consistently high quality home care services.</p> <ul style="list-style-type: none"> • Ensuring care is person centred • Providing information about care and support options • Planning and reviewing home care and support • Delivering home care • Joint working between health and social care • Ensuring safety and safeguarding people using home care services • Recruiting, training and supporting home care workers <p>RL “Older people: independence and mental wellbeing”</p> <p>This guideline covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.</p> <p>1 Principles of good practice</p> <p>2 Group-based activities</p> <p>3 One-to-one activities</p> <p>4 Volunteering</p> <p>5 Identifying those most at risk of a decline in their independence and mental wellbeing</p>
SIGN	Older adults	18	1	<p>RL “Management of osteoporosis and the prevention of fragility fractures (SIGN 142)”</p> <p>(no questions, only topics)</p> <p>Modifiable risk factors: physical inactivity</p>
TRIP database	frailty	31	2	<p>RL “Frailty in Older Adults - Early Identification and Management”</p> <p>(no questions, only topics)</p> <p>Frailty suspected</p> <p>Frailty identified</p> <p>Frailty assessed</p> <p>RL “Clinical Practice Guidelines for Managing Frailty in Community Dwelling Korean Elderly Adults in Primary Care Settings”</p>

				(no questions, only topics) Diagnosis and assessment Intervention and monitoring
Databanken beroepsverenigingen ET (WFOT)				
Ergotherapie Nederland	Monodisciplinair	10	5 (valpreventie, ALS/PSMA/PLS, CVA, MS, Parkinson) Overige 5 andere doelgroep	<p>RL “Ergotherapierichtlijn Valpreventie Evidence-based ergotherapie bij volwassenen met een verhoogd valrisico”</p> <p>Welke methoden en instrumenten zijn geschikt voor de vraaginventarisatie en analyse van participatie en het uitvoeren van betekenisvolle activiteiten in relatie tot valproblematiek?</p> <p>Welke methode en principes van doelbepaling en interventieplanning zijn passend voor een ergotherapeutische behandeling bij mensen met een verhoogd valrisico?</p> <p>Welke evidence-based interventies gericht op valpreventie en passend bij de rol van de ergotherapie, versterken het veilig functioneren?</p> <p>Welke kenmerken van de interventie en factoren van de cliënt en zorgcontext zijn van belang voor een succesvolle toepassing van valpreventie-interventies?</p> <p>RL “Ergotherapie bij ALS, PSMA en PLS”</p> <p>Doel van de richtlijn is de uniformiteit en de kwaliteit van de begeleiding en de behandeling van patiënten met ALS, PSMA en PLS te verbeteren door het bieden van concrete praktische aanbevelingen.</p> <p>Op welke wijze kan de ergotherapeut de (te verwachten) ervaren handelings- en participatieproblemen inventariseren en analyseren?</p> <p>Wat zijn aandachtspunten voor de ergotherapeut tijdens de inventarisatie van persoonlijke en externe factoren die het functioneren van de patiënt met ALS en diens naasten beïnvloeden?</p> <p>Welke ergotherapeutische interventies kunnen (preventief) worden ingezet bij pijnklachten van patiënten met ALS?</p> <p>Welke ergotherapeutische interventies kunnen (preventief) worden ingezet bij vermoeidheidsklachten van patiënten met ALS?</p> <p>Welke ergotherapeutische interventies kunnen (preventief) worden ingezet bij beperkingen vanwege problemen met de lichaamshouding of een verminderde hoofdbalans van patiënten met ALS?</p> <p>Welke ergotherapeutische interventies kunnen (preventief) worden ingezet bij beperkingen door arm-handfunctieproblemen van patiënten met ALS?</p> <p>Welke ergotherapeutische interventies kunnen worden ingezet bij handelings- en participatieproblemen van patiënten met ALS, binnen de domeinen ‘communicatie’, ‘mobiliteit’, ‘zelfverzorging’, ‘huishouden’, en ‘dagbesteding (werk, vrije tijd)’, en wat zijn hierbij de aandachtspunten?</p> <p>Wat zijn aandachtspunten bij de ergotherapeutische training, begeleiding en advisering bij handelings- en participatieproblemen van patiënten met ALS met cognitieve stoornissen en/of gedragsproblemen/FTD?</p>

				<p>Welke ergotherapeutische interventies kunnen worden ingezet om naasten van patiënten met ALS te adviseren en begeleiden?</p> <p>RL “Ergotherapierichtlijn CVA”</p> <p>Welke ergotherapie middelen en methoden zijn valide en betrouwbaar om de mogelijkheden en beperkingen, wensen en behoeften in kaart te brengen ten aanzien van het dagelijks handelen van cliënten en hun naastbetrokkenen?</p> <p>Hoe worden revalidatiedoelen en behandelplan met cliënten en naastbetrokkenen opgesteld waarbij uitgegaan wordt van hun ervaringen en perspectieven?</p> <p>Welke ergotherapie interventies zijn effectief voor cliënten en hun naastbetrokkenen?</p> <p>RL “Ergotherapie richtlijn MS”</p> <p>Welke instrumenten voor probleeminventarisatie en -analyse zijn betrouwbaar en valide voor het in kaart brengen van participatie, welbevinden en problemen in de uitvoer van activiteiten m.b.t. wonen en zorgen, leren en werken, spelen en vrije tijd?</p> <p>Hoe kunnen de onderliggende capaciteiten op fysiek, cognitief en psychosociaal vlak en de sociale en fysieke omgeving in kaart worden gebracht?</p> <p>Welke aspecten zijn belangrijk bij het opstellen van doelen met de cliënt en zijn naastbetrokkenen? Hoe wordt bij het opstellen van een plan van aanpak uitgegaan van veranderen van het handelen van een cliënt passend bij diens veerkracht en mogelijkheden tot verandering? Hoe wordt zelfmanagement bevordert tijdens de fase van doelbepaling en het plan van aanpak?</p> <p>Welke interventies zijn effectief bij de ergotherapeutische behandeling van mensen met MS in het verbeteren van participatie, zelfstandig functioneren (voor alle activiteiten gebieden), mobiliteit, senso-motorische, cognitieve en psychosociale capaciteiten en het voorkomen van secundaire complicaties?</p> <p>RL “Ergotherapie bij de Ziekte van Parkinson”</p> <p>elke problemen, die samenhangen met de ziekte van Parkinson, zijn van belang voor ergotherapeuten?</p> <p>Wat is de rol van ergotherapie bij de behandeling en begeleiding van parkinsonpatiënten?</p> <p>Hoe kan de ergotherapeutische diagnostiek bij parkinsonpatiënten en hun mantelzorgers het beste worden vormgegeven?</p> <p>Hoe kan de ergotherapeutische behandeling bij parkinsonpatiënten en hun mantelzorgers het beste worden vormgegeven?</p>
Ergotherapie Nederland	Multidisciplinair	32	4 (CVA, pijn, MS, valpreventie)	<p>Mult RL “Herseneninfarct en hersenbloeding”</p> <p>Diagnostiek</p> <p>1 Welke behandelplanning bij een intracerebrale bloeding?</p>

		Overige 28 andere doelgroep	<p>3 Welke aanvullende diagnostiek moet worden verricht naar een atherosclerotische carotisstenose bij patiënten met een TIA of een niet-invaliderend herseninfarct?</p> <p>4 Hoe dient een cardiale emboliebron als oorzaak van een TIA of herseninfarct te worden gediagnosticeerd?</p> <p>Acute behandeling van hersenbloeding</p> <p>1 Moet een verhoogde bloeddruk bij patiënten met een hersenbloeding in de acute fase medicamenteus worden verlaagd? Zo ja: hoe en wanneer?</p> <p>2 Wat zijn de indicaties en contra-indicaties voor acute neurochirurgische behandeling van patiënten met een hersenbloeding?</p> <p>3 Wat zijn de indicaties en contra-indicaties voor liquordrainage bij patiënten met een acute hersenbloeding?</p> <p>Beeldvorming</p> <p>1 Welke beeldvormende techniek is het meest efficiënt bij patiënten met klinische verschijnselen van een herseninfarct om 1) een intracerebrale bloeding, of een andere oorzaak van de klinische verschijnselen, uit te sluiten, en 2) richting te geven aan de therapeutische strategie in de eerste uren?</p> <p>2 Welke aanvullende beeldvorming is aangewezen voor verdere diagnostiek en beha</p> <p>Reperfusetherapie voor het acute herseninfarct</p> <p>1 Onder welke (additionele) voorwaarden komt een patiënt met een acuut herseninfarct in aanmerking voor intraveneuze trombolysen als er tevens sprake is van recent gebruik van een DOAC?</p> <p>2 Welke patiënten met een acuut herseninfarct hebben baat bij intraveneuze trombolysen met alteplase?</p> <p>3 Vergroot endovasculaire behandeling de kans op een goed herstel bij patiënten met een herseninfarct en een occlusie van één van de proximale intracraniale arteriën?</p> <p>4 Doet chirurgische decompressie bij ruimte-innemende, supratentoriële herseninfarcten de kans op een slecht functioneel herstel en overlijden afnemen?</p> <p>Behandeling op de Stroke Unit</p> <p>1 Moeten patiënten met een herseninfarct of hersenbloeding op een stroke unit worden opgenomen en waar moet een stroke unit aan voldoen?</p> <p>2 Zijn monitoring en strikt reguleren (dat wil zeggen, binnen fysiologische grenzen houden) van parameters zoals serumglucose, zuurstofsaturatie en lichaamstemperatuur, zinvol bij patiënten met een acuut herseninfarct of hersenbloeding?</p> <p>3 Wat is de effectiviteit van maatregelen om verslik-pneumonie te voorkomen door systematisch monitoren van de slikfunctie en behandelen van dysfagie?</p> <p>4 Wat is de effectiviteit van maatregelen om diepe veneuze trombose te voorkomen?</p> <p>Indicaties voor carotisendarteriëctomie</p> <p>1 Wat zijn de indicaties voor een carotisendarteriëctomie?</p>
--	--	-----------------------------	---

2 Is er een indicatie voor carotisendarteriëctomie bij coronary artery bypass grafting (CABG) chirurgie ter voorkoming van een per- of postoperatieve beroerte?

3 Hoe snel na een herseninfarct of TIA dient operatieve behandeling van een symptomatische carotisstenose plaats te vinden?

4 Is er plaats voor een carotisendarteriëctomie bij een asymptomatische stenose?

5 Wat is de plaats van stenten van een carotisstenose (carotid artery stenting: CAS)?

Secundaire preventie na een TIA of herseninfarct

1 Wat is het risico op een nieuwe manifestatie van cardiovasculaire aandoeningen nadat patiënten een TIA of herseninfarct hebben doorgemaakt?

2.1 Hoe kan hypertensie het beste worden vastgesteld?

2.2 Welk antihypertensivum verdient de voorkeur na een herseninfarct?

2.3 Naar welke waarden dient bij de medicamenteuze behandeling van hypertensie bij patiënten met een TIA of herseninfarct te worden gestreefd?

2.4 Wanneer dient gestart te worden met bloeddrukverlagende therapie na een TIA of herseninfarct/-bloeding?

2.5 Wanneer is er een indicatie voor cholesterolverlagende medicatie na een TIA of herseninfarct?

2.6 Welke cholesterolverlagers kunnen worden voorgeschreven na een TIA of herseninfarct?

3 Met welke plaatjesaggregatieremmers moeten patiënten na een TIA of herseninfarct worden behandeld?

4 Wat is de beste antitrombotische therapie in het kader van secundaire preventie na TIA of herseninfarct bij patiënten met non-valvulair atriumfibrilleren?

Richtlijn Herseninfarct en hersenbloeding

1 Wat is het effect van intensiteit van oefentherapie op herstel van activiteiten van het dagelijks leven (ADL) na een herseninfarct of hersenbloeding?

1.1 *Hoe intensief dienen patiënten met een herseninfarct of hersenbloeding en een beperking in ADL zelfstandigheid (Barthel Index <19 punten) tijdens opname in een stroke unit in een ziekenhuis, revalidatiecentrum of verpleeghuis (met revalidatiefaciliteiten) minimaal dagelijks oefentherapie te ondergaan?*

1.2 *Wat is het effect van het continueren van het revalidatieprogramma in het weekend en tijdens opname op een stroke unit in een ziekenhuis, revalidatiecentrum of verpleeghuis met revalidatiefaciliteiten bij patiënten met een herseninfarct of hersenbloeding en een beperking in ADL-zelfstandigheid (BI <19)?*

1.3 *Wat is de effectiviteit van intensief oefenen met de paretische arm middels (modified) Constraint Induced Movement Therapy ((m)CIMT)?*

2 Wat is het effect van vroeg mobiliseren bij opname op een stroke unit in een ziekenhuis na een herseninfarct of hersenbloeding?

3 Wat is de doelmatigheid (effectiviteit en kosteneffectiviteit) van vervroegd ontslag uit een stroke unit in een ziekenhuis vergeleken met het reguliere zorgbeleid voor ADL-zelfstandigheid, stemming, ervaren zorglast bij partner, opnameduur en kosten bij patiënten met herseninfarct of hersenbloeding?

4 Welk diagnostisch instrument kan het beste worden aanbevolen voor het vaststellen van de aanwezigheid, de aard en de ernst van een afasie ten gevolge van een herseninfarct of hersenbloeding?

Behandeling van afasie ten gevolge van een herseninfarct of hersenbloeding

1 Is taaltherapie effectief voor het herstel van communicatie bij patiënten met afasie door een herseninfarct of hersenbloeding?

2 Wat is het optimale moment voor het starten met afasietherapie bij patiënten met afasie door een herseninfarct of hersenbloeding?

3 Wat is de optimale intensiteit van afasietherapie bij patiënten met afasie door een herseninfarct of hersenbloeding?

4 Welk screeningsinstrument heeft de beste psychometrische eigenschappen om de aanwezigheid en ernst van cognitieve problemen in de acute en subacute fase bij patiënten met een herseninfarct of hersenbloeding vast te stellen?

5 Wat is het beleid ten aanzien van cognitieve revalidatie bij patiënten met cognitieve stoornissen na een herseninfarct of hersenbloeding?

6 Wat is de plaats van farmacologische en gedragsmatige interventies voor het reduceren van depressie en/of angst na een herseninfarct of hersenbloeding?

7 Welke interventies kunnen worden aanbevolen voor het verbeteren van functioneren, stemming en welbevinden en verminderen van zorglast/stress bij mantelzorgers van patiënten met een herseninfarct of hersenbloeding?

RL “ Multiple Sclerose”

1. Hoe kan de diagnose MS zo vroeg mogelijk worden gesteld?

2. Welke symptomen zijn het meest relevant voor een vroege herkenning van MS?

3. Wanneer komt men in aanmerking voor immunomodulerende en immunosuppressieve therapie? Wat zijn de kenmerken van deze patiënten en op grond waarvan wordt de indicatie gesteld?

4. Welke (screenings)methode moet worden toegepast om problemen bij activiteiten en participatie bij mensen met MS te herkennen en in welke fase van de ziekte? Welke behandeling heeft de voorkeur en wanneer moet deze toegepast worden?

5. Welke (screenings)methoden zijn te adviseren voor het vaststellen van cognitieve stoornissen en in welke fase van de ziekte? Welke behandelmethode heeft de voorkeur en wanneer zou deze toegepast moeten worden?

6. Welke (screenings)methoden zijn te adviseren voor het vaststellen van vermoeidheid en/of conditieverlies en in welke fase van de ziekte? Welke

behandelmethode heeft de voorkeur en wanneer zou deze gebruikt moeten worden?

7. Welke (screenings)methoden zijn te adviseren voor het vaststellen van psychische en psychosociale problemen en in welke fase van de ziekte? Welke behandelmethode heeft de voorkeur en wanneer zou deze toegepast moeten worden?

8. Wat zijn de belangrijkste belemmerende en bevorderende factoren die van invloed zijn op de arbeidsmogelijkheden en arbeidsparticipatie van mensen met MS? Welke hiervan zijn essentieel voor de beoordeling van arbeidsgeschiktheid/belastbaarheid? Welke interventies kunnen de reïntegratie of participatie bevorderen?

9. Hoe ziet een zorgnetwerk eruit waarin de wensen van de mens met MS centraal staan?

Mult RL "Pijn bij ouderen"

Aanbeveling over pijnbeleving en gedrag

Aanbeveling over diagnostiek van pijn

Aanbevelingen over non-farmacologische behandeling van pijnbestrijding

Aanbevelingen over farmacologische behandeling van pijnbestrijding

Aanbevelingen over de organisatie van zorg bij pijnmanagement

Mult RL "Valpreventie"

1 Welk risicoschattingsinstrument of risicoschattingsproces kan gebruikt worden om thuiswonenden van 65 jaar en ouder met een verhoogd valrisico op te sporen?

2 Welk risicoschattingsinstrument of risicoschattingsproces kan gebruikt worden om patiënten met een verhoogd valrisico in het verpleeghuis op te sporen?

3 Welk risicoschattingsinstrument of risicoschattingsproces kan gebruikt worden om patiënten met een verhoogd valrisico in het ziekenhuis op te sporen?

4 Wat zijn de risicofactoren voor vallen bij ouderen? (in de thuissituatie, het verpleeg- of verzorgingshuis of het ziekenhuis)

5 Welk multifactoriële valrisicobeoordeling kan het beste worden verricht bij patiënten met een verhoogd valrisico die thuis wonen?

6 Welk multifactoriële valrisicobeoordeling kan het beste worden verricht bij patiënten met een verhoogd valrisico in het ziekenhuis?

7 Welk multifactoriële valrisicobeoordeling kan het beste worden verricht bij patiënten met een verhoogd valrisico in het verpleeghuis?

8 Welke testen van mobiliteit zijn voorspellend voor vallen?

9 Hoe beoordeel je welke door de patiënt gebruikte medicijnen het risico op vallen verhogen?

				<p>10 Welke ziekten van het hart- en vaatstelsel zijn geassocieerd met vallen en welk onderzoek moet worden verricht bij verdenking op een cardiovasculaire oorzaak van een val?</p> <p>11 Welke valrisico verlagende interventies zijn effectief bij thuiswonenden?</p> <p>12 Welke valrisico verlagende interventies zijn effectief in het ziekenhuis?</p> <p>13 Welke valrisico verlagende interventies zijn effectief in het verpleeghuis?</p> <p>14 Welke niet-medicamenteuze en medicamenteuze interventies zijn effectief ter preventie van vallen bij volwassenen van 65 jaar en ouder met orthostatische hypotensie?</p> <p>15 Hoe kan de compliantie van ouderen aan valpreventieprogramma's worden verbeterd?</p> <p>16 Welke aspecten zijn randvoorwaardelijk voor het verlenen van zorg aan patiënten met een verhoogd valrisico?</p>
AOTA	Onder 'Evidence-based Practice & Research' – 'Practice Guidelines'	12	3	<p>RL productive aging</p> <p>Productive Aging for Community-Dwelling Older Adults (99 dollar)</p> <p>Driving and Community Mobility for Older Adults (148 dollar)</p> <p>Home modification</p> <p>1 What is the evidence for the effect of occupation and activity-based interventions on the performance of selected instrumental activities of daily living (IADLs) for community-dwelling older adults?</p> <p>2 What is the evidence for the effectiveness of home modification and fall prevention programs on the performance of community-dwelling older adults?</p> <p>3 What is the evidence for the effect of occupation and activity-based health management and maintenance interventions on the performance of community-dwelling older adults?</p> <p>4 What is the evidence that participation in occupations and activities supports the health of community-dwelling older adults?</p> <p>RL Driving and community mobility for older adults</p> <p>What is the evidence supporting the use of clinical assessments (vision, cognition, physical function) and performance-based assessments (simulated and on-road) for determining driving safety and competence and the need for driving cessation of older adults?</p> <p>What is the evidence for the effect of interventions to address cognitive function, visual function, motor function, driving skills, self-regulation and self-awareness, and the role of passengers and family involvement in the driving ability, performance, and safety of older adults?</p> <p>What is the evidence for the effect of automobile-related modifications on driving ability, performance, and safety of older adults? Modifications include changes by the industry that enhance or hinder the driving ability, performance, and safety of older adults.</p> <p>What is the evidence for the effect for policy and community mobility programs (e.g., alternative transportation, walkable communities, education, driving cessation programs, pedestrian programs) on the performance and participation of older adults?</p> <p>RL Home modifications</p> <p>1 Home Modifications to Prevent Falls</p>

				2 Home Modifications to Improve Functional Performance 3 Caregiving
RCOT	Practice guidelines publications	2	2	RL Valpreventie: What evidence is there to support occupational therapy in the prevention and management of falls in adults? <ul style="list-style-type: none">• Omgevingsfactoren• Valangst• Therapietrouw• Community approach RL Heupprothese: What evidence is there to support occupational therapy intervention with adults over the age of 18 undergoing total hip replacement?
OTAustralia	Guideline	0 (achter de sleutel?)	0	Opgevraagd bij beroepsvereniging / geen resultaten
OT Canadian	Guideline	0	0	Opgevraagd bij beroepsvereniging / geen resultaten
Swedisch Association of OT	guideline	0	0	Opgevraagd bij beroepsvereniging / geen resultaten
Norsk Ergotherapie ut forbund	Enkel in Noors	0	0	Opgevraagd bij beroepsvereniging / geen resultaten
OT Malaysian	Guideline; in 'e-shop' en publications gezocht	0	0	Opgevraagd bij beroepsvereniging / geen resultaten
Andere: WFOT		0	0	Opgevraagd bij beroepsverenigingen Australië, Canada, Engeland, Finland, Frankrijk, IJsland, Japan, Maleisië, Nieuw- Zeeland, Noorwegen, Zweden, Ierland, Zwitserland
Databanken andere beroepsverenigingen				
Maleisië (LB) - CRC	guideline	0	0	
Maleisië - CRM	guideline	0	0	
Academy of Medicine of	guideline	90	4	Dementie 1.What are the groups of people who are at increased risk of developing dementia? 2. For people at risk of developing dementia, are there any non-

Maleisiä
(AMM)

pharmacological strategies to prevent or delay the onset of dementia? 3. Are there advantages/disadvantages to early identification of dementia? 4. Is a person with dementia capable of making decisions? 5. Is truth-telling beneficial for patients with dementia? 6. Are these interventions (artificial feeding and hydration, pain treatment, infection treatment, restraints, resuscitation) beneficial for patients with late/ severe dementia? 7. Are these interventions beneficial for patients with late/severe dementia? 8. What are the roles of memory clinic? 9. Are assessments of needs helpful to dementia caregivers? 10. Are interventions for caregivers beneficial? 11. Is routine cognitive screening for those 60 years and above at the primary care level useful to detect early dementia? 12. What are the tools suitable for screening people at risk of dementia at the primary care level? 13. When should patients with dementia be referred to a tertiary specialist service? 14. What are the brief cognitive tests that can help in the diagnosis of mild cognitive impairment or early dementia or dementia, at the secondary/tertiary care level? 15. How can one determine the progression of dementia? 16. What relevant investigations are needed to rule out treatable causes of dementia? o Routine blood investigation o Thyroid function tests o Tests for syphilis o Serum B1, B12 o Serum folate and Homocysteine level 125 17. Are there diagnostic classifications of dementia for different subtypes of dementia? o ICD10 o DSM-IV o NINDS- AIREN, ADDTC or HACHINSKI ISCHEMIC SCORE or Rosen o Modified Score o Lund- Manchester Criteria o MCI criteria 18. Are biomarkers useful in the diagnosis of dementia (AD, VAD, FTD, DLB/PDD)? 19. How should non-cognitive functions be assessed? 20. How do you determine the functional difficulties in patients with dementia 21. What is the role of CT and MRI brain in patient with dementia ? 22. What is the role of PET /SPECT in the diagnosis of dementia? 23. What is the role of EEG's in the diagnosis of Dementia? 24. For people with dementia do acetyl cholinesterase inhibitors/NMDA antagonist when compared to placebo cause improvement in cognitive function? 25. What are the other choices of drugs (other than acetylcholinesterase inhibitors/ memantine that produce benefit or harm compared with an appropriate comparator? 26. For people with vascular dementia do drugs (anti-dementia drugs and drugs that control vascular risk factors) when compared to placebo cause improvement or decline in cognitive function? 27. For people with dementia do drug treatment when compared to placebo cause improvement in non- cognitive function? 28. In healthy adults, is there any pharmaceutical product in the prevention of dementia? 29. In patient with dementia, are there any combination treatments for cognitive and non- cognitive symptoms of dementia which produce benefit or harm? 30. For patients with dementia are the strategies for promoting independence produce benefits/harm in the specified outcome? Appendix 2 (cont.) 126 31. For people with dementia does cognitive rehabilitation produce benefit or harm? 32. Do psychosocial/behavioural interventions (aromatherapy, reality orientation, validation therapy, reminiscence) for management of behaviour/psychological symptoms (BPSD) of dementia patient produce benefit or harm? 33. For people with dementia what environmental designs are appropriate compared to standard care? 34. Are educational interventions useful in the management of people with dementia and their caregivers?

Osteoporose

How do we identify patients at risk of osteoporosis? • What are the current best practices in the management of postmenopausal women with osteoporosis, male osteoporosis & glucocorticoid-induced osteoporosis? • What are the risks and benefits of osteoporosis treatments?

RA

			<p>1. Are the following investigations accurate in supporting the diagnosis of RA? • musculoskeletal ultrasound • MRI 2. What are the poor prognostic factors of RA? 3. What are the effective and safe non-pharmacological treatments of RA? • patient education • smoking cessation • physiotherapy • occupational therapy • podiatry • dietetics 4. Is rheumatology nurse-led care effective and safe in the treatment of RA? 5. What are the effective and safe pharmacological treatments of RA? • NSAIDs • corticosteroids • analgesics (paracetamol, opioids) • corticosteroids • DMARDs (synthetic, biologic) 6. Is TCM effective and safe in the treatment of RA? 7. What are the indications for referral to secondary/tertiary care?</p> <p>Diabetes type 2</p> <p>1. How best to diagnose diabetes and abnormal glucose tolerance? 2. How can patients with diabetes best managed? 3. How to treat the acute complications of diabetes? 4. How best to manage the chronic complications of diabetes? 5. How best to manage diabetes in special populations? 6. How to prevent diabetes? 7. How to address the issue of unproven therapies, traditional and complementary medicine in diabetes?</p>	
RNAO	Search in database	3	3	<p>RL “Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients”</p> <p>(1) Practice recommendations</p> <p>Multiple Self-Management Strategies</p> <p>Assess belief, behaviour and knowledge</p> <p>Advise: Provide specific information about health risks and benefits of change</p> <p>Agree: Collaboratively set goals based on client’s interest and confidence in their ability to change the behaviour</p> <p>Assist: Identify personal barriers, strategies, problem-solving techniques, and social/environmental support</p> <p>Arrange: Specify plan for follow-up</p> <p>Innovative delivery models</p> <p>(2) Educational recommendations</p> <p>(3) Management and policy recommendations</p> <p>RL “Preventing Falls and Reducing Injury from Falls”</p> <p>outline evidence-based approaches for preventing falls and reducing fall injuries for adults</p> <p>(1) What are the most effective ways to identify adults at risk for falls or for injury due to falls?</p> <p>(2) What interventions are effective in preventing falls and reducing the risk for falls or falls-related injury among at-risk adults?</p> <p>(3) What interventions or processes should occur immediately following a fall?</p> <p>(4) What content and educational strategies are necessary to effectively educate nurses and other health-care providers to prevent falls and injury from falls?</p>

				<p>(5) What organizational policies and system-level supports are required to help prevent falls and injuries from falls among at-risk adults?</p> <p>RL “Delirium, Dementia, and Depression in Older Adults: Assessment and Care”</p> <p>nurses and other members of the interprofessional health-care team to enhance the quality of their practice pertaining to delirium, dementia, and depression in older adult</p> <p>(1) Practice recommendations</p> <p>(2) Educational recommendations</p> <p>(3) Management and policy recommendations</p>
Domus Medica	In richtlijnen ‘ouderes’	15	3	<p>Valpreventie</p> <p>Wat zijn de voornaamste risicofactoren voor vallen bij thuiswonende ouderen? 2. Wat is het effect van een multifactoriële aanpak op het aantal valincidenten bij thuiswonende ouderen? 3. Wat is het effect van een multifactoriële aanpak op het aantal valletsels bij thuiswonende ouderen? 4. Wat is de beste methode om een verhoogd valrisico bij thuiswonende ouderen vast te stellen? 5. Welke multifactoriële evaluatie is aangewezen bij een verhoogd valrisico bij thuiswonende ouderen? 6. Welke multifactoriële interventies zijn aangewezen bij een verhoogd valrisico bij thuiswonende ouderen? 7. Hoe kunnen professionele zorgverleners zorgen voor een betere therapietrouw bij thuiswonende ouderen met een verhoogd valrisico? 8. Welke professionele zorgverleners spelen een belangrijke rol in de multifactoriële aanpak van valpreventie bij thuiswonende ouderen?</p> <p>Samenwerking dementie</p> <p>Detectiefase: Welke rol spelen eerstelijns hulpverleners in de herkenning van symptomen bij vermoeden van dementie? Ziekte diagnose fase: Wat zijn de specifieke taken inzake diagnostiek van de betrokken eerstelijns hulpverleners bij vermoeden van dementie? Zorgdiagnose fase: Wat zijn de specifieke taken van de verschillende eerstelijns hulpverleners m.b.t. interventies bij personen met dementie? Monitoring fase: · Welke ondersteuning is voor zorgverstrekkers in de eerstelijnszorg doeltreffend bij de aanpak van personen met dementie? · Welke rol spelen de eerstelijns hulpverleners in de opvolging en in de communicatie naar andere hulpverleners met betrekking tot vooropgestelde doelstellingen en uitkomsten bij personen met dementie? · Wat zijn noodzakelijke randvoorwaarden voor doelmatig en doeltreffend zorgoverleg?</p> <p>Ouderenmisbehandeling</p> <p>Detectie · Wanneer is er een hoog risico op ouderenmisbehandeling? · Wanneer moet de huisarts nog alert zijn voor ouderenmisbehandeling? · Kan de huisarts een formele diagnose stellen bij een vermoeden van misbehandeling? Inschatting · Op welke manier moet de huisarts een situatie van ouderenmisbehandeling beoordelen? · Hoe en met welke instrumenten kan het vermogen van de oudere om de situatie te melden en zijn beslissingsbekwaamheid ingeschat worden? · Wat kan de huisarts doen bij comorbiditeit (bijvoorbeeld dementie en depressie) bij het slachtoffer en/of de pleger? · Hoe kan de huisarts de urgentie, ernst, veiligheid en verdere verloop van de situatie inschatten? Aanpak · Wat kan de huisarts doen als hij ouderenmisbehandeling vaststelt? · Hoe kan de huisarts omgaan met ontkenning of minimalisering van de misbehandeling door de oudere? · Hoe</p>

				<p>kan de huisarts omgaan met gebrek aan autonomie bij de oudere? · Wanneer moet de oudere doorverwezen worden? · Hoe kan de huisarts omgaan met familierelaties? · Welke houding moet de huisarts aannemen tegenover de vermeende pleger van misbehandeling als het gaat om een zorgverlener? · Hoe kan de huisarts een verergering van misbehandeling of herhaling ervan voorkomen? Multidisciplinaire samenwerking · Op welke ondersteunende diensten kan de huisarts een beroep doen? · Welke hulp kunnen deze diensten bieden? · Hoe kan de huisarts samenwerken met deze diensten? Juridisch en deontologisch kader · Wanneer en op welke manier moet de huisarts gerecht en politiediensten betrekken om de veiligheid van de oudere te waarborgen? · Onder welke voorwaarden moet informatie worden meegedeeld aan de familie, de omgeving van de oudere, andere zorgverleners, politiediensten en justitie? · Wat is de rol van de huisarts in de aanstelling van een voorlopig bewindvoerder? Medisch dossier en certificaat · Welke gegevens worden opgenomen in het medisch dossier? · Welke gegevens worden vermeld in het medisch attest dat aan de oudere overhandigd wordt en wat zijn de voorwaarden hiervoor?</p>
Canadian Medical Association	Guideline elderly or old*	32	3	<p>RL “Frailty in Older Adults – Early Identification and Management”</p> <p>early identification and management of older adults with frailty or vulnerable to frailty. The guideline facilitates individualized assessment and provides a framework and tools to promote patient-centred strategies to manage frailty and prevent further functional decline. The primary focus of the guideline is the community-based primary care setting, although the tools and strategies included may be useful in other care contexts</p> <ul style="list-style-type: none"> • Identification of Patients with Frailty or Vulnerable to Frailty • Comprehensive Assessment of Patients with Frailty • Management • Medication Review • Advance Care Planning • Indications for Referral <p>RL “Recommendations on screening for cognitive impairment in older adults”</p> <p>recommends not screening community-dwelling asymptomatic older adults (≥ 65 yr) for cognitive impairment.</p> <p>RL “Screening for impaired vision in community dwelling adults aged 65 years and older in primary care settings”</p> <p>For community-dwelling adults aged 65 years and older, we recommend against screening for impaired vision in primary care settings</p>

Tabel: Analyse van klinische vragen nationale en internationale aanverwante richtlijnen

5.2 Verslagen GDG

Zie bijgevoegde map

5.3 Verslagen adviescommissie

Zie bijgevoegde map

5.4 Critical appraisals geïnccludeerde artikels

Zie bijgevoegde map

5.5 Verantwoording GRADE-toekenning

Zie bijgevoegde map

5.6 Conflict of interest

Zie bijgevoegde map