Evidence tables for review question: D.2a What are the best methods to deliver and coordinate rehabilitation services and social services for adults with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

Table 13: Quantitative evidence tables

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Browne, Allyson L., Appleton, Sally, Fong, Kim, Wood, Fiona, Coll, Fiona, de Munck, Sonja, Newnham, Elizabeth, Schug, Stephan A., A pilot randomized controlled trial of an early multidisciplinary model to prevent disability following traumatic injury, Disability and Rehabilitation, 35, 1149-63, 2013 **Ref Id** 1205181 **Country/ies where the study was carried out** Australia	**Sample size** N= 142 (randomised) • Multidisciplinary care intervention = 69 • Usual care = 73 N= 66 (analysed) • Multidisciplinary care intervention =31 • Usual care = 35 **Characteristics** Age in years [Mean (SD)]: • Multidisciplinary care intervention = 38.46 (13.32) • Usual care = 36.14 (14.61) Gender (M/F): 106/36 *NB. Only reported for whole study rather than by group.* Time since injury in years: not reported.	**Interventions** • *Intervention group: Multidisciplinary care intervention.* Invited to outpatient clinic at one and 3 months for 2 to 4 hours during which they were assessed by Rehab Medicine and Pain Medicine doctors, a physiotherapist, an occupational therapist and clinical psychologist for pain psychological function, and functional capacity; and 6 months post discharge for assessment and treatment. • *Control group: Usual care.* Invited for assessment and treatment at 6 months post discharge only. Attended outpatient for surgical reviews or allied health therapies depending on need, prior to discharge. Overall care was managed by GP.	**Results** *Return to work or education (measured using number of participants who had returned to work)* At 6 months: • Multidisciplinary care intervention: 16/31 (51.7%) • Usual care: 26/35 (74.3%) *Length of hospital stay (days) [Mean (SD)]* • Multidisciplinary care intervention: 13.87 (12.77) • Usual care: 12.67 (10.83)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y. " using random number assignments from a computer generated algorithm" (page 1151) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PY. "Patients in the MI group were invited by mail and by telephone call to attend an outpatient clinic at one and 3 months post discharge, and both the [control] and [intervention] groups were invited in writing and by telephone to attend for a 6 month review at which time patients in both groups were assessed and offered specialist treatment as required at this time" (page 1151). Trial authors appear to have carried out central allocation.

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** To examine the clinical utility of screening for reducing disability following traumatic injury. **Study dates** March – September 2008 **Source of funding** This received funding from Australian and New Zealand College of Anaesthetists and the State Health Research and Advisory Council of Western Australia.	Injury cause (Fall/MVA or MBA/assault/work related/sport related/other): • Multidisciplinary care intervention (n) = 5/52/4/3/3/2 • Usual care (n) = 7/52/6/3/5/0 **Inclusion criteria** Participants had to: • Be aged between 18–80 years • Be within four weeks post injury • Have been admitted for more than 24 h **Exclusion criteria** • Moderate to severe head injury defined as: ○ Post Traumatic Amnesia for more than 24 hours ○ Glasgow Coma Scale ≤ 8 at the scene ○ Glasgow Coma Scale <1 at admission • Being considered to be at high immediate suicide risk		*Changes in ADL (measured using FIM) [Mean (SD)]* Higher = better At 6 months: • Multidisciplinary care intervention (n=31): 122.73 (4.74) • Usual care (n=35): 123 (3.91) *Changes in ADL (measured using number of participants with impairment of ADL)* At 6 months: • Multidisciplinary care intervention = 16/31 (50%) • Usual care = 16/35 (45.2%)	1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N. "The intervention and control groups did not differ significantly on any of the socio-demographic, injury-related, and clinically defined risk factors at the time of screening … There was however, a non-significant trend for a higher proportion of trauma patients in the [intervention] group (59%) to have scored above the cut-off for risk of experiencing PTSD and Depression on the PAS compared with the [control] group (44%)" (page 1155). This was not considered a sufficient cause for concern. *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is unlikely to have been undertaken. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is unlikely to have been undertaken. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PY – Participants in intervention group

Study details	Participants	Interventions	Outcomes and Results	Comments
				attended extra clinics at 1 and 3 months, where they could be referred on for further treatment if needed. There is no reporting on what this extra treatment might entail or how many referrals were made. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group could be referred for extra rehabilitation sessions which likely could affect outcomes. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N – Outcome data only available for 46.5% of participants (31/69 in intervention and 35/73 in control). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N – No statistical or sensitivity analyses presented.

Study details	Participants	Interventions	Outcomes and Results	Comments
				3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN – Reasons for loss to follow-up and number of withdrawals from study similar across groups. *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate and validated methods 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Final outcome measurements using similar procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y – Outcome assessors unblinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Return to work – PN due to objective nature of outcome; Changes in ADL – PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of

Study details	Participants	Interventions	Outcomes and Results	Comments
				intervention received? Return to work – NA; Changes in ADL – PY. Assessments performed using standardised measurements but these were done by occupational therapist who appears to be involved in the study. *Risk-of-bias judgement:* Return to work – low risk; Changes in ADL – high risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN - Outcome data collected at 1 and 3 months were not reported but this appears to have been agreed on a priori. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Low risk <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** Length of hospital stay also reported but as baseline characteristics due to intervention starting after discharge. It

Study details	Participants	Interventions	Outcomes and Results	Comments
				is therefore not appropriate to extract as an outcome.
Full citation Chong, Tsung Wei, Chan, Gribson, Feng, Liang, Goh, Susie, Hew, Agnes, Ng, Tze Pin, Tan, Boon Yeow, Integrated care pathway for hip fractures in a subacute rehabilitation setting, Annals of the Academy of Medicine, Singapore, 42, 579-84, 2013 **Ref Id** 913615 **Country/ies where the study was carried out** Singapore **Study type** (Quasi-)RCT **Aim of the study** To assess if a hip fracture integrated care pathway at a sub-acute	**Sample size** N= 162 (randomised) • MDT care + structured assessments + checklists = 92 • MDT care only = 70 N = 122 (analysed) • MDT care + structured assessments and checklists = 66 • MDT care only = 56 **Characteristics** Age in years [Mean (SD)]: • MDT care + structured assessments and checklists = 77.1 (11.6) • MDT care only = 79.0 (9.6) Gender (M/F): • MDT care + structured assessments and checklists = 30/62 • MDT care only = 21/49 Time since injury in years [Mean (SD)]: Not reported	**Interventions** • *Intervention group: MDT care + structured assessments and checklists.* They had medical assessment on admission. This was followed by a protocol for early detection and management of complications involving weekly assessment of complications, psychological, nutritional status. 5 week physiotherapy and occupational therapy guidelines with recommended milestones were developed and applied by the therapists. Hip precaution advice was also given. • *Control group: MDT care only.* Usual care consisted of 2 half hourly therapy sessions per day, 5 days/week and medical ward rounds 3 times a week. Multidisciplinary rounds were conducted every 2 weeks	**Results** *Patient satisfaction (measured using a 5-point Likert scale) [Mean (SD)]* Higher = better. At discharge (149)*: • MDT care + structured assessments and checklists (n not reported): 61.4 (8.6) • MDT care only (n not reported): 60.2 (8.0) • No siginificant difference between groups (p=0.37, statistical test not reported) *N not reported, however, assumed based on numbers assessed for other subjective outcomes at the same time point *Length of hospital stay (days) [Median (range)]* • MDT care + structured assessments and checklists (n = 92): 35.0 (5 to 402) • MDT care only (n = 70): 48.0 (10 to 382)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? PN. Quasi-RCT. Quote: "Administrative staff allocated patients to either [intervention] or [control] according to the last digit of their National Registration Identity Card … numbers, odd numbers to the intervention group and even numbers to the control group" (page 580). 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? N. Quote: "Administrative staff allocated patients to either [intervention] or [control] […] Patients were enrolled by the principal investigators only after moving into their respective wards because of workflow limitations" (page 580). Comment: There is no indication as to whether allocation was concealed 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N. Although more participants in the intervention group were visually impaired, there is no indication that this led to bias. *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
rehabilitation facility would result in better functional outcomes, shorter length of stay and fewer institutionalisations **Study dates** September 2004 – June 2006 **Source of funding** Not reported	Injury cause (Traumatic/non-traumatic/not reported): not reported Type of hip fracture (Intertrochanteric/neck of femur/ subtrochanteric): • MDT care + structured assessments and checklists (n) = 46/43/3 • MDT care only (n) = 36/31/3 **Inclusion criteria** Participants had to: • Have been admitted for the purpose of rehabilitation after a new hip fracture **Exclusion criteria** • Pre-morbid non-ambulatory status • Nursing home residents • Palliative care patients • Patients previously enlisted for the trial		• Significantly shorter in intervention compared to control group (p=0.009, statistical test not reported) *Quality of life (measured using SF-12 physical component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months (149): • MDT care + structured assessments and checklists (n not reported): 39.0 (9.5) • MDT care only (n not reported): 38.3 (9.1) • No significant difference between groups (p=0.67, statistical test not reported) At 12 months (119): • MDT care + structured assessments and checklists (n not reported): 40.7 (9.9) • MDT care only (n not reported): 40.9 (9.7) • No significant difference between groups	<u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY. Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY. Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? N. There is no evidence of deviation from assignment 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all,

Study details	Participants	Interventions	Outcomes and Results	Comments
			(p=0.91, statistical test not reported) *Quality of life (measured using SF12 mental component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months (149): • MDT care + structured assessments and checklists (n not reported): 53.2 (9.3) • MDT care only (n not reported): 51.0 (9.2) • No significant difference between groups (p=0.18, statistical test not reported) At 12 months (119): • MDT care + structured assessments and checklists (n not reported): 52.0 (10.6) • MDT care only (n not reported): 53.4 (11.1) • No significant difference between groups (p=0.49, statistical test not reported)	participants randomized? For length of stay: Y. For patient satisfaction: NI; For SF-12 and Mondebello Rehab Score: Data were not available for 40/162 (24%) of the randomised participants at 12 months due to death and refusal of follow-up. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? Y. The reason for missingness was balanced across study groups. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. Outcome data were only available for 74% and 80% at 6-month and 12-month follow-up for the objective outcomes. There was insufficient information to assess with this was balanced between the study groups 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PY. Lack of study group information on number of study participants at different time points raises concerns. *Risk-of-bias judgement:* Length of hospital stay – low risk; Overall quality of life and changes in ADL – high risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. Measurements were carried out using appropriate and validated methods

Study details	Participants	Interventions	Outcomes and Results	Comments
			Changes in ADL (measured using Montebello Rehab Factor score) [Mean (SD)] Higher = better. At discharge (149): • MDT care + structured assessments and checklists (n not reported): 45.6 (30.5) • MDT care only (n not reported): 49.0 (34.0) • No significant difference between groups (p=0.51, statistical test not reported) At 6 months (129): • MDT care + structured assessments and checklists (n not reported): 67.2 (34.9) • MDT care only (n not reported): 61.2 (38.7) • No significant difference between groups (p=0.36, statistical test not reported) At 12 months (121): • MDT care + structured assessments and checklists (n not reported): 68.3 (37.5)	4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N. Quote: "...research baseline and outcome assessments were performed by trained research assistants, the latter being blinded with respect to the patient's allocation " (page 581) 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN.

Study details	Participants	Interventions	Outcomes and Results	Comments
			• MDT care only (n not reported): 70.2 (36.7) • No significant difference between groups (p=0.77, statistical test not reported) *Changes in ADL (measured using modified Barthel Index)* Scale 0-100, higher = better At baseline: • MDT care + structured assessments and checklists (n = 92): 48.0 (19.4) • MDT care only (n = 70): 50.3 (17.1) At discharge: • MDT care + structured assessments and checklists (n not reported): 22.2 (17.5) • MDT care only (n not reported): 23.9 (19.7) At 6 months: • MDT care + structured assessments and checklists (n not reported): 32.6 (21.3)	5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Low risk Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** Readmission to acute hospitals within 1 year also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).

Study details	Participants	Interventions	Outcomes and Results	Comments
			• MDT care only (n not reported): 27.7 (20.6) At 12 months: • MDT care + structured assessments and checklists (n not reported): 33.4 (22.9) • MDT care only (n not reported): 31.8 (19.5)	
Full citation Flikweert, E. R., Izaks, G. J., Knobben, B. A., Stevens, M., Wendt, K., The development of a comprehensive multidisciplinary care pathway for patients with a hip fracture: design and results of a clinical trial, BMC Musculoskeletal Disorders, 15, 188, 2014 **Ref Id** 1116015 **Country/ies where the study was carried out** The Netherlands	**Sample size** N = 401 (enrolled) • Multidisciplinary care pathway = 256 • Standard care = 145 N = 401 (analysed) • Multidisciplinary care pathway = 256 • Standard care = 145 **Characteristics** Age in years [Mean (SD)]: • Multidisciplinary care pathway = 78 (9) • Standard care = 80 (10) Gender (M/F): • Multidisciplinary care pathway (n) = 82/174 • Standard care (n) = 41/104	**Interventions** • *Intervention group: Multidisciplinary care pathway.* A 6 months MDT hip fracture pathway that spanned from admission to the emergency room to discharge from nursing home rehabilitation units. In A&E, an extensive nursing protocol was started which included using pressure relieving mattresses as soon as possible, as well as assessing the risk of post-operative delirium and anaesthetic complications. The anaesthesiologist also decided whether other specialists were required and coordinated the subsequent consultations if so. Surgery was scheduled for 8:00am the day after admission and followed a strict protocol with a dedicated operating team. All hip fracture patients were	**Results** *Length of hospital stay in days [Median (IQR)]* • Multidisciplinary care pathway (n=256): 7 (6-10) • Standard care (n=145): 11 (7-16) • Adjusted for admission time in days using log-transformation. • Significantly shorter in intervention group (p<0.001, statistical test unknown*) **The authors report in their tabulated results that they analysed these data with an independent t-test, which would be inappropriate for non-parametric data. However, the paper states*	**Limitations** **Quality assessment:** Risk of bias assessed using Risk Of Bias In Non-randomized Studies of Interventions (ROBINS-I) <u>Bias due to confounding</u> 1.1 Is there potential for confounding of the effect of intervention in this study? Y. 1.2. Was the analysis based on splitting participants' follow up time according to intervention received? N. 1.3. Were intervention discontinuations or switches likely to be related to factors that are prognostic for the outcome? NA. 1.4. Did the authors use an appropriate analysis method that controlled for all the important confounding domains? Y – Linear regression analysis controlling for intervention group, admission time, age, gender, if patient lived in nursing home and ASA classification. 1.5. If Y/PY to 1.4: Were confounding domains that were controlled for

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type Prospective and retrospective cohort study **Aim of the study** To evaluate the effectiveness of a new multidisciplinary care pathway for hip fracture patients over 60 years old. **Study dates** Retrospective group: January 2006 - January 2008; Prospective group: July 2009 - July 2011 **Source of funding** This study received funding from Biomet® and Trauma Center Northern Netherlands.	Time since injury in years: not reported but intervention starts in emergency room Injury cause: not reported Type of hip fracture (femoral neck/tronchanteric): • Multidisciplinary care pathway (n) = 142/114 • Standard care (n) = 83/62 **Inclusion criteria** Participants had to: • Be aged ≥ 60 years • Diagnosed with either a femoral neck hip fracture or pertrochanteric hip fracture • Be admitted to participating trauma centre within study dates **Exclusion criteria** • Serious abdominal or thoracic multi-trauma	admitted to a single nursing ward, ensuring nursing staff were knowledgeable and able to provide additional care such as early start for rehabilitation, nutritional monitoring and preventing pressure ulcers. While patients were inpatient, they were seen every day by a geriatrician. The pathway emphasised a strict discharge protocol, beginning upon admission to the medical centre when they were registered to 1 of 2 participating nursing homes. Both of these nursing homes had beds specifically reserved for hip fracture patients. After registration, the admission doctors at the nursing homes were able to view medical records of participants who would be discharged to them and track their progress prior to arrival. After discharge, patients had visits scheduled at a dedicated outpatient clinic (at 6 weeks, 3 months and 6 months after surgery), with an appointment at a fall prevention clinic if needed. • *Control group: Standard care.* As per the participating medical centres hip fracture protocol prior to the	*in the Analysis section that "For continuous variables, the intervention and control groups were compared with the independent sample t-test or, if appropriate, the Mann–Whitney U-test." (page 4). Due to this sentence and the majority of estimates being reported as means, we have assumed this is simply a reporting oversight on behalf of the authors.*	measured validly and reliably by the variables available in this study? PY – All extracted from electronic hospital records and no subjective variables mentioned. 1.6. Did the authors control for any post-intervention variables that could have been affected by the intervention? PN – No information but no post-intervention variables listed in the confounding domains adjusted for. 1.7. Did the authors use an appropriate analysis method that controlled for all the important confounding domains and for time-varying confounding? NA. 1.8. If Y/PY to 1.7: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? NA. *Risk of bias judgement:* Moderate risk. <u>Bias in selection of participants into the study</u> 2.1. Was selection of participants into the study (or into the analysis) based on participant characteristics observed after the start of intervention? N. 2.2. If Y/PY to 2.1: Were the post-intervention variables that influenced selection likely to be associated with intervention? NA. 2.3 If Y/PY to 2.2: Were the post-intervention variables that influenced selection likely to be influenced by the outcome or a cause of the outcome? NA.

Study details	Participants	Interventions	Outcomes and Results	Comments
		intervention. This meant that there was no MDT protocol, no communication between the hospital and nursing homes, and no structured discharge protocol.		2.4. Do start of follow-up and start of intervention coincide for most participants? Y – Both at admission to hospital. 2.5. If Y/PY to 2.2 and 2.3, or N/PN to 2.4: Were adjustment techniques used that are likely to correct for the presence of selection biases? NA. *Risk of bias judgement:* Low risk. <u>Bias in classification of interventions</u> 3.1 Were intervention groups clearly defined? Y – Dependent on time period of admission, with a buffer period between each group to minimise cross-over. 3.2 Was the information used to define intervention groups recorded at the start of the intervention? Y. 3.3 Could classification of intervention status have been affected by knowledge of the outcome or risk of the outcome? N. *Risk of bias judgement:* Low risk. <u>Bias due to deviations from intended interventions</u> 4.1. Were there deviations from the intended intervention beyond what would be expected in usual practice? NI – Intervention is multi-disciplinary and there is no information on how adherence to the intervention was standardised or measured. 4.2. If Y/PY to 4.1: Were these deviations from intended intervention unbalanced between groups and likely to have affected the outcome? NA. *Risk of bias judgement:* Moderate risk.

Study details	Participants	Interventions	Outcomes and Results	Comments
				Bias due to missing data 5.1 Were outcome data available for all, or nearly all, participants? Y – All participants identified from hospital records and included. 5.2 Were participants excluded due to missing data on intervention status? N. 5.3 Were participants excluded due to missing data on other variables needed for the analysis? NI – No mention of incomplete records or how these may have been considered. 5.4 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Are the proportion of participants and reasons for missing data similar across interventions? NA. 5.5 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Is there evidence that results were robust to the presence of missing data? NA. *Risk of bias judgement:* Low risk. Bias in measurement of outcomes 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? N – Length of hospital stay is on objective measurement. 6.2 Were outcome assessors aware of the intervention received by study participants? NI. 6.3 Were the methods of outcome assessment comparable across intervention groups? Y – Both extracted from electronic hospital records.

Study details	Participants	Interventions	Outcomes and Results	Comments
				6.4 Were any systematic errors in measurement of the outcome related to intervention received? PN. *Risk of bias judgement:* Low risk. Bias in selection of the reported result Is the reported effect estimate likely to be selected, on the basis of the results, from... 7.1. ... multiple outcome measurements within the outcome domain? N. 7.2 ... multiple analyses of the intervention-outcome relationship? PN. 7.3 ... different subgroups? N. *Risk of bias judgement:* Low risk. Overall risk of bias *Risk of bias judgement:* Moderate risk **Other information** Need for re-operation within 1 year also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).
Full citation Hall, Erin C., Tyrrell, Rebecca L., Doyle, Karen E., Scalea, Thomas M., Stein, Deborah M., Trauma transitional care coordination: A mature system at work, The journal of	**Sample size** N = 21,682 (enrolled) • Traumatic Clinical Care Coordination = 475 • No Traumatic Clinical Care Coordination = 21,207 N = 21,682 (analysed) • Traumatic Clinical Care Coordination = 475	**Interventions** • *Intervention group: Traumatic Clinical Care Coordination.* A full-time healthcare professional supervised and coordinated care during discharge. This included a phone call to patient (or their carer if appropriate) within 72 hours after discharge. The aim of	**Results** *Length of hospital stay in days [Mean (SD)]* At discharge: • Traumatic Clinical Care Coordination (n=475): 13 (13)	**Limitations** **Quality assessment:** Risk of bias assessed using Risk Of Bias In Non-randomized Studies of Interventions (ROBINS-I) Bias due to confounding 1.1 Is there potential for confounding of the effect of intervention in this study? Y – The inclusion criteria of enrolling patients in the intervention who are more likely to be readmitted

Study details	Participants	Interventions	Outcomes and Results	Comments
trauma and acute care surgery, 84, 711-717, 2018 **Ref Id** 1205590 **Country/ies where the study was carried out** USA **Study type** Retrospective cohort study **Aim of the study** To identify and characterise potential risk factors for re-admission in trauma patients, using these to identify patients that will benefit from Trauma Transitional Care Coordination. **Study dates** January 2013 - September 2016 **Source of funding** Not reported	• No Traumatic Clinical Care Coordination = 21,207 **Characteristics** Age in years [Mean (SD)]: • Traumatic Clinical Care Coordination = 43.3 (16) • No Traumatic Clinical Care Coordination = 50.0 (21) Gender (M/F): • Traumatic Clinical Care Coordination (n) = 344/131 • No Traumatic Clinical Care Coordination (n) = 13,793/7,414 Time since injury: not reported Injury cause: not reported but inclusion criteria states admission due to trauma Severity of injury (HSCRC level 1/2/3/4): • Traumatic Clinical Care Coordination (n) = 22/106/176/171 • No Traumatic Clinical Care Coordination (n) = 3,131/6,744/6,978/4,323 **Inclusion criteria** Participants had to:	this call was early identification of potential barriers for care, and to provide solutions for these. They also performed a full medication reconciliation and the coordination of follow-up appointments and home visits. No further details reported. • *Control group: No Traumatic Clinical Care Coordination.* No further details reported.	• No Traumatic Clinical Care Coordination (n=21,207): 6 (10) • Significantly longer in intervention group (p<0.001, statistical test not reported)	means potential for confounding is very high. 1.2. Was the analysis based on splitting participants' follow up time according to intervention received? N. 1.3. Were intervention discontinuations or switches likely to be related to factors that are prognostic for the outcome? NA. 1.4. Did the authors use an appropriate analysis method that controlled for all the important confounding domains? NI – No information presented on statistical analysis or adjustments. 1.5. If Y/PY to 1.4: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? NI – No information presented on statistical analysis or adjustments. 1.6. Did the authors control for any post-intervention variables that could have been affected by the intervention? NI – No information presented on statistical analysis or adjustments. 1.7. Did the authors use an appropriate analysis method that controlled for all the important confounding domains and for time-varying confounding? NA. 1.8. If Y/PY to 1.7: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? NA. *Risk of bias judgement:* Serious risk.

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Be involved in trauma • Be identified by Maryland Health Services Cost Review Commission database • Be eligible for readmission (no further details reported) **Exclusion criteria** Not reported.			<u>Bias in selection of participants into the study</u> 2.1. Was selection of participants into the study (or into the analysis) based on participant characteristics observed after the start of intervention? PN – Inclusion criteria includes eligibility for readmission, which include characteristics observed after admission. However, this intervention doesn't start until after discharge and there is no mention of characteristics observed after discharge. 2.2. If Y/PY to 2.1: Were the post-intervention variables that influenced selection likely to be associated with intervention? NA. 2.3 If Y/PY to 2.2: Were the post-intervention variables that influenced selection likely to be influenced by the outcome or a cause of the outcome? NA. 2.4. Do start of follow-up and start of intervention coincide for most participants? Y – Both 72 hours after discharge. 2.5. If Y/PY to 2.2 and 2.3, or N/PN to 2.4: Were adjustment techniques used that are likely to correct for the presence of selection biases? NA. *Risk of bias judgement:* Low risk. <u>Bias in classification of interventions</u> 3.1 Were intervention groups clearly defined? PN – Patients were enrolled to the Trauma Care Coordinator intervention based on risk factors that had been defined by a literature

Study details	Participants	Interventions	Outcomes and Results	Comments
				review and expert consensus. However, there is some interpretation possible within the criteria. 3.2 Was the information used to define intervention groups recorded at the start of the intervention? Y – Risk factors identified prior to discharge. 3.3 Could classification of intervention status have been affected by knowledge of the outcome or risk of the outcome? N. *Risk of bias judgement:* Moderate risk. <u>Bias due to deviations from intended interventions</u> 4.1. Were there deviations from the intended intervention beyond what would be expected in usual practice? NI – No information provided on how adherence to the intervention was standardised or measured. 4.2. If Y/PY to 4.1: Were these deviations from intended intervention unbalanced between groups and likely to have affected the outcome? NA. *Risk of bias judgement:* Moderate risk. <u>Bias due to missing data</u> 5.1 Were outcome data available for all, or nearly all, participants? Y – All participants identified from hospital records and included. 5.2 Were participants excluded due to missing data on intervention status? NI – Exclusion criteria not reported. 5.3 Were participants excluded due to missing data on other variables needed for the analysis? NI – No

Study details	Participants	Interventions	Outcomes and Results	Comments
				mention of incomplete records or how these may have been considered. 5.4 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Are the proportion of participants and reasons for missing data similar across interventions? NA. 5.5 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Is there evidence that results were robust to the presence of missing data? NA. *Risk of bias judgement:* Moderate risk. <u>Bias in measurement of outcomes</u> 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? N – Length of hospital stay is on objective measurement. 6.2 Were outcome assessors aware of the intervention received by study participants? NI. 6.3 Were the methods of outcome assessment comparable across intervention groups? Y – Both extracted from electronic hospital records. 6.4 Were any systematic errors in measurement of the outcome related to intervention received? PN. *Risk of bias judgement:* Low risk. <u>Bias in selection of the reported result</u> Is the reported effect estimate likely to be selected, on the basis of the results, from... 7.1. ... multiple outcome measurements within the outcome domain? N.

Study details	Participants	Interventions	Outcomes and Results	Comments
				7.2 ... multiple analyses of the intervention-outcome relationship? PN. 7.3 ... different subgroups? N. *Risk of bias judgement*: Low risk. Overall risk of bias *Risk of bias judgement:* Serious risk **Other information** None.
Full citation Huang, T. T., Liang, S. H., A randomized clinical trial of the effectiveness of a discharge planning intervention in hospitalized elders with hip fracture due to falling, J Clin Nurs, 14, 1193-201, 2005 **Ref Id** 1118076 **Country/ies where the study was carried out** Taiwan **Study type** RCT	**Sample size** N= 126 (randomised) • Discharge planning with gerontological nurse = 63 • Routine discharge planning = 63 N= 122 (analysed) • Discharge planning with gerontological nurse = 63 • Routine discharge planning = 59 **Characteristics** Age in years [Mean (SD)]: • Discharge planning with gerontological nurse = 75.9 (7.6) • Routine discharge planning = 78.1 (7.5) Gender (M/F):	**Interventions** • *Intervention group: Discharge planning with gerontological nurse.* Extended from hospital admission through three months after discharge + advice. Discharge in the hospital was provided by postgrad qualified gerontological nurse experienced in hospital and home care of older adults. Initial nurse visit within 48 house of hospital admission and at least every 48 hours during hospitalisation. Participants received one home visit 3 to 7 days after discharge and could call nurse 7days/week (8am to 8pm), phone contacts were initiated by nurse once a week. Individualised discharge plan were designed by nurse together with family caregivers and	**Results** *Length of hospital stay in days [Mean (SD)]* At 3 months: • Discharge planning with gerontological nurse (n=63): 8.17 (3.61) • Routine discharge planning (n=63): 10.06 (3.07) • Significantly shorter in intervention group compared to control group (p=0.002, student's t-test) *Quality of life (measured using SF-36) [Mean (SD)]* Scale: 0-100, higher = better At discharge:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. Quote: "According to a computer generated table, the researcher then randomly assigned patients to either the control group or the intervention group" (page 1195) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? Y. Baseline characteristics were balanced. *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended

Study details	Participants	Interventions	Outcomes and Results	Comments
Aim of the study To examine the effectiveness of a discharge plan in hospitalized elderly patients with hip fracture due to falling. **Study dates** January – December 2002 **Source of funding** This study received funding from National Science Council, Taiwan (NSC89-2314-B-182-138) and Chung Gung University (CMRP940).	• Discharge planning with gerontological nurse (63) = 23/40 • Routine discharge planning (63) = 16/47 Time since injury: not reported Injury cause: all traumatic Type of hip fracture (Intracapsular/extracapsular) • Discharge planning with gerontological nurse = 25/38 • Routine discharge planning = 30/33 (47.6%) **Inclusion criteria** Participants had to: • Be over 65 years with hip fractures due to falling • Have been discharged within the catchment areas of the medical centre **Exclusion criteria** • Cognitive impairment • Being too ill to participate • Unable to communicate • Admitted to the ICU	healthcare team members. One brochure on self-care for hip fracture and another for falls prevention, were provided. The nurse also provided direct care, advice, set up of home care services and the assessment of rehabilitation facility needs. Before discharge, hard copy summaries of plans, goals, progression and ongoing concerns were given to patients and carers. Through follow-up, the nurse addressed concerns of patients and caregivers, monitored patients' progress and collaborated with physicians to modify therapies and find needed services. • *Control group: Routine discharge planning.* Routine hospital discharge planning for adult patients, provided by non-postgrad qualified nurses. No information, discharge summary, home visit or telephone contact.	• Discharge planning with gerontological nurse (n=63): 42.24 (9.96) • Routine discharge planning (n=59): 36.22 (7.79) At 2 weeks post discharge: • Discharge planning with gerontological nurse (n=63): 46.04 (10.50) • Routine discharge planning (n=59): 38.58 (7.90) At 3 months* post discharge • Discharge planning with gerontological nurse (n=63): 60.77 (10.50) • Routine discharge planning (n=59): 51.3 (11.6) • Significantly higher (better) in intervention group compared to control group (p<0.001, repeated measures ANOVA test for time and group) *Changes in ADL (measured using Barthel Index) [Mean (SD)]*	<u>interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Hospital length of stay – Y. No loss to follow-up; Changes in ADL – Y. Outcome

Study details	Participants	Interventions	Outcomes and Results	Comments
			Scale: 0-100, higher = better. At baseline: • Discharge planning with gerontological nurse (n=63): 96.5 (7.6) • Routine discharge planning (n=63): 96.43 (7.1) At discharge: • Discharge planning with gerontological nurse (n=63): 47.62 (10.39) • Routine discharge planning (n=59): 37.54 (17.89) At 2 weeks after discharge: • Discharge planning with gerontological nurse (n=63): 73.41 (13.28) • Routine discharge planning (n=59): 58.73 (21.87) At 3 months* post discharge: • Discharge planning with gerontological nurse (n=63): 87.2 (11.6)	data available for 96.8% of participants (63/63 in intervention and 59/63 in control). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA. *Risk-of-bias judgement:* Low risk Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods and validated scales. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points (at discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Length of hospital stay – N – Outcome assessors blinded to group allocation; Changes in ADL – PY. Partially self-assessment and unlikely study participants were blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Routine discharge planning (n=59): 71.02 (26.1) • Significantly higher (better) in intervention group compared to control group (p<0.01, repeated measures ANOVA test for time and group) *Some confusion whether T3 reported in in table 4 and table 5 is 3 weeks post-discharge or 3 months post-discharge. 3 months post-discharge fits the narrative description and so this is what has been reported.*	influenced by knowledge of intervention received? Length of hospital stay – NA; Changes in ADL – Y. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Length of hospital stay – NA; Changes in ADL – PN. Standardised and validated measurement tool. *Risk-of-bias judgement:* Length of hospital stay – low risk; Changes in ADL – some concerns Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? PY - All outcomes stipulated in the methods section were reported. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN - All outcome data were reported as stated in the protocol. 5.3 ... multiple analyses of the data? PN - All outcome data were reported as stated in the protocol. *Risk-of-bias judgement:* Low risk Overall risk of bias

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement: Some concerns **Other information** Hospital readmissions within 3 months also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).
Full citation Lin, P. C., Wang, C. H., Chen, C. S., Liao, L. P., Kao, S. F., Wu, H. F., To evaluate the effectiveness of a discharge-planning programme for hip fracture patients, Journal of Clinical Nursing, 18, 1632-1639, 2009 **Ref Id** 1207043 **Country/ies where the study was carried out** Taiwan **Study type** RCT **Aim of the study**	**Sample size** N = 50 (randomised) • Comprehensive discharge planning = 26 • Routine discharge planning = 24 N = 50 (analysed) • Comprehensive discharge planning = 26 • Routine discharge planning = 24 **Characteristics** *NB. Characteristics only reported for whole study population rather than by study arm.* Age in years [Mean (SD)]: 78.75 (6.99) Gender (M/F): 32/18	**Interventions** • *Intervention group: Comprehensive discharge-planning.* Comprehensive discharge-planning service was devised with structured assessment of the discharge planning needs. Individualised nursing instruction was provided with monitoring services and two home visits after discharge. The need for discharge planning and the QOL prior to the fracture were assessed within 48 hours of admission. Patient self-care knowledge and degree of satisfaction regarding the discharge planning service were evaluated before discharge. The first home visit was conducted two weeks post discharge, performing a second evaluation of physical function and self-care knowledge. The second home visit was performed 3	**Results** *Patient satisfaction (measured using research designed questionnaire) [Mean (SD)]* Scale: 14-70 points, higher = better Time point not reported: • Comprehensive discharge planning (n=26): 52.73 (10.53) • Routine discharge planning (n=24): 50.00 (12.61) *Length of hospital stay in days [Mean (SD)]* At 3 months: • Comprehensive discharge planning (n=26): 6.04 (2.41)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? NI – Paper simply states randomised. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? NI – There is no indication that baseline characteristics were reported or compared across groups. *Risk-of-bias judgement:* Some concerns <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial?

Study details	Participants	Interventions	Outcomes and Results	Comments
To evaluate the effectiveness of a comprehensive discharge-planning service for hip fracture patients, including length of stay, functional status, self-care knowledge and quality of life **Study dates** November 2005 – December 2006 **Source of funding** This study received funding from the National Science Council, Taiwan (NSC94-2314-B-075- 072).	Time since injury: not reported Injury cause: not reported Type of hip fracture: not reported Inclusion criteria Participants had to: • Be aged 65 years or older • Have a hip fracture diagnosis • Be able to walk • Have a Barthel score of at least 70 points prior to hip fracture • Mentally alert and able to communicate • Living in the Taipei region **Exclusion criteria** • Cognitive impairment • Terrminal disease	months post-discharge and physical function and QOL at this point were evaluated again. • *Control group: Routine discharge planning.* Nurses who cared for patients provided the discharge service and gave non-structured discharge instructions according to their own professional judgement without following a standardised procedure.	• Routine discharge planning (n=24): 6.29 (2.17) *Changes in ADL (measured using Functional Status Subscale adapted from OARS Mutlidimensional Functional Assessment Questionnaire) [Mean (SD)]* Scale 0-18, higher = better At baseline (before fracture): • Comprehensive discharge planning (n=26): 17.53 (1.13) • Routine discharge plan (n=24): 17.62 (0.71) Before discharge: • Comprehensive discharge planning (n =26): 8.15 (2.49) • Routine discharge plan (n=24): 8.00 (1.88) 2 weeks post-discharge:	PY. Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y- Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – No reported drop out. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA.

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Comprehensive discharge planning (n=26): 12.50 (3.95) • Routine discharge plan (n=24): 11.38 (3.39) 3 months post-discharge: • Comprehensive discharge planning (n=26): 16.92 (1.41) • Routine discharge plan (n=24): 16.83 (1.71) • No significant difference between groups (p=0.409, repeated measures ANOVA)	3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA. *Risk-of-bias judgement:* Low risk Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods and validated scales for all objective and subjective outcomes 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points. "Evaluation of the control group was identical to that for the experimental group." (page 1634) 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y – Assessors were unblinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Length of hospital stay – PN. Due to the objective nature of the outcome; Patient satisfaction and changes in ADL – PY.

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Patient satisfaction: PY. Subjective measurement and satisfaction tool was not a validated one; Length of hospital stay – NA; Changes in ADL – PN. Assessors used structured and validated measurement tools. *Risk-of-bias judgement:* Patient satisfaction – high risk; Length of hospital stay – low risk; Changes in ADL – some concerns <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> Patient satisfaction – high risk; Length of hospital stay – some concerns; Changes in ADL – some concerns

Study details	Participants	Interventions	Outcomes and Results	Comments
				Other considerations Hospital readmissions within 3 months also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol). Quality of life using SF-36 was reported but only individually by domain rather than overall quality of life or mental/physical component scores which have been extracted previously.
Full citation Parsons, M., Parsons, J., Pillai, A., Rouse, P., Mathieson, S., Bregmen, R., Smith, C., Kenealy, T., Post-Acute Care for Older People Following Injury: A Randomized Controlled Trial, Journal of the American Medical Directors Association, 2019 **Ref Id** 1206192 **Country/ies where the study was carried out** New Zealand	**Sample size** N = 403 (randomised) • Supported discharge team care = 201 • Usual care = 202 N = 403 (analysed) • Supported discharge team care = 201 • Usual care = 202 **Characteristics** Age in years [Mean (SD)]: • Supported discharge team care = 81.1 (7.8) • Usual care = 80.5 (8.3) Gender (M/F): • Supported discharge team care = 45/156 • Usual care = 55/147	**Interventions** • *Intervention group: Supported discharge team care.* This was rehabilitation program delivered by a multidisciplinary team. It involved healthcare assistants, registered nurses, allied health professionals. Consultant geriatricians delivered weekly input through case conferencing, HCA provided up to 4 visits/day 7 days a week and used functional rehabilitation principles. The team worked collaboratively with the patient's primary care team as well as the specialist community and hospital services and continued to visit till the patient returned to independence or until stable. Patients were limited to 6 weeks attendance and	**Results** *Length of hospital stay in days [Mean (95% CI)]* • Supported discharge team care (n=201): 20.9 (17.7-24.1) • Usual care (n=202): 26.6 (23.5-29.6) • Significantly shorter in intervention group (p=0.002, ANOVA)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. Quote: "Participants were randomized using a computer-generated randomization sequence." (page 406) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N - "Demographics were similar across the 2 groups" (page 406). *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** To determine whether supported discharge team for older people admitted to hospital following a fracture enables earlier discharge from hospital and reduces readmissions and healthcare costs **Study dates** December 2013 – July 2015 **Source of funding** Not reported	Time since injury: not reported. Injury cause: not reported by inclusion criteria states trauma Type of injury (TBI/spinal fracture/soft tissue/wrist and forearm fracture/pelvic fracture/femur and knee fracture/tibia, fibula, ankle and foot fractures/clavicle, shoulder and humeral fracture/hip fracture/other fracture): • Supported discharge team care (n) = 3/12/8/4/12/7/10/15/4/12 6 • Usual care (n) = 6/13//7/3/23/84/13/17/109/3 **Inclusion criteria** Participants had to: • Have suffered an injury that required hospital admission and subsequent rehabilitation • Be 65 years of age • Be in hospital at time of referral • Not require ongoing acute hospital based treatment • Have consented to being treated at home	offered extension on case by case basis. The team discussed patient's progress weekly. Visits reduced as patients gained independence and on discharge, advance care planning was initiated and passed to the patient's primary care physician for completion. • *Control group: Usual care.* Discharge planning from the hospital and subsequent community-based services. Community-based services could include allied health, district nursing, and home care.		<u>interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – No attrition reported.

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Have agreed with the objectives set by the referring inter-disciplinary team. • Be considered to have potential for partial or complete recovery with suitable home rehabilitation within 6 weeks • Be able to stand and transfer with 1 person (with or without the help of a resident carer) • Have had a recent injury and was at a borderline level of function with an associated reduction in activities of daily living and/or instrumental ADL • Without input from the team, be considered likely to fail to recuperate full potential of functional recovery or be likely to fail to manage satisfactorily at home despite conventional community support and, therefore, be at risk of hospital re-admission or institutionalization. **Exclusion criteria** Not reported			3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods from electronic records. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points (discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PN – Due to objective nature of outcome. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? PN - Study protocol was registered during study after initial participants had completed intervention. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* Some concerns **Other information** Hospital readmissions within 1 year also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol). Changes in ADL also reported in paper. However, measures of variance were not reported so data pooling was not feasible. Paper noted that “no statistically significant differences were

Study details	Participants	Interventions	Outcomes and Results	Comments
				noted in the functional status over time between the 2 groups and both groups improved at the same rate" (page 407).
Full citation Ryan, T., Enderby, P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age, Clinical Rehabilitation, 20, 123-131, 2006 **Ref Id** 1184826 **Country/ies where the study was carried out** UK **Study type** RCT **Aim of the study** To compare intensive with non-intensive home based rehabilitation provision following	**Sample size** N= 81 (randomised) • More intensive MDT care = 37 • Less intensive MDT care = 34 N= 58 (analysed) • More intensive MDT care = 30 • Less intensive MDT care = 28 **Characteristics** Age in years [Mean (SD)]: • More intensive MDT care = 80.7 (7.4) • Less intensive MDT care = 80.9 (6.3) Gender (M/F): not reported Time since injury in years [Mean (SD)]: • More intensive MDT care = 40.6 (42.2) • Less intensive MDT care = 35 (24.6) Injury cause: not reported	**Interventions** • *Both groups:* The MDT comprised of physiotherapist, occupational therapist, speech and language therapist or therapy assistant. The maximum length of treatment time was 12 weeks. • *Intervention group: More intensive MDT care.* An augmented rehabilitation service providing 6 or more face-to-face contacts per week with a member of the MDT. • *Control group: Less intensive MDT care.* 3 or less face-to-face contacts per week with a member of the MDT.	**Results** *Quality of life (measured using EQ-5D) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.52 (0.26-0.69) • Less intensive MDT care (n=34): 0.62 (0.32-0.73) At 3 months: • More intensive MDT care (n=30): 0.62 (0.52-0.77) • Less intensive MDT care (n=28): 0.67 (0.59-0.79) • No significance difference between groups (p=0.3, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.3, Mann-Whitney U test;	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y – Using random number table in blocks of 10. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y - Opaque sealed envelopes. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Baseline characteristics are balanced between groups in whole study population, although there is no comparison purely for hip fracture patients. *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering the interventions aware of participants'

Study details	Participants	Interventions	Outcomes and Results	Comments
stroke or hip fracture in old age (65 years plus) **Study dates** July 2000 – June 2002 **Source of funding** This study received funding from NHS Executive Trent, United Kingdom.	Type of hip fracture: not reported **Inclusion criteria** Participants had to: • Be aged 65 or over • Recovering from stroke or hip fracture • Not be suffering from a concomitant disease (e.g. Parkinson's disease or dementia) • Be able to be contacted by the research team within five working days **Exclusion criteria** Not reported		adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 0.1 (0.23) vs. Less intensive MDT care = 0.1 (0.23) *Overall quality of life (measured using EQ-VAS) [Median (IQR)]* Scale 1-100, higher = better At baseline: • More intensive MDT care (n=37): 0.6 (0.51 - 0.71) • Less intensive MDT care (n=34): 0.63 (0.57-0.81) At 3 months: • More intensive MDT care (n=30): 0.71 (0.6-0.8) • Less intensive MDT care (n=28): 0.7 (0.5-0.82) • No significance difference between groups (p=0.98, Mann-Whitney U test; unadjusted)	assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Intervention group was meant to have a ratio of 2:1 MDT sessions compared to control. Mean (SD) sessions were reported as 24.4 (10.2) for intervention versus 17.9 (9.1) for control. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group did not achieve the forecast intensity of MDT sessions. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - Intention to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - Outcome data only available for 58/71 (82%) participants at 3 months (30/37 in

Study details	Participants	Interventions	Outcomes and Results	Comments
			• No significance difference between groups (p=0.98, Mann-Whitney U test; adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 0.03 (0.2) vs. Less intensive MDT care = -0.01 (0.1) *Change in ADL (measured using Barthel Index) [Median (IQR)]* Scale 0-100, higher=better At baseline: • More intensive MDT care (n=37): 17 (15-17) • Less intensive MDT care (n=34): 16 (14.75-17) At 3 months: • More intensive MDT care (n=30): 20 (19-20) • Less intensive MDT care (n=28): 20 (19-20) • No significance difference between groups (p=0.83, Mann-	intervention group and 28/34 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN – Reasons for and numbers of loss to follow up was roughly balanced across study groups. *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Outcomes were measured using validated instruments. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY – Blinding of researchers carrying out assessments were blind, but quality of life and acitivities of daily living have a subjective component to them and participants were unlikely to be blinded.

Study details	Participants	Interventions	Outcomes and Results	Comments
			Whitney U test; unadjusted) • No significance difference between groups (p=0.83, Mann-Whitney U test; adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 3.19 (1.7) vs. Less intensive MDT care = 3.36 (1.8) *Changes in ADL (measured using Frenchay Activities Index) [Median (IQR)]* Scale 0-45, higher=better At baseline: • More intensive MDT care (n=37): 28 (19.5-32) • Less intensive MDT care (n=34): 28 (22.75 - 31.25) 3 months: • More intensive MDT care (n=30): 19 (14-23) • Less intensive MDT care (n=28): 19 (14-24)	4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN – Researchers were blinded and using standardised and validated measurements. *Risk-of-bias judgement:* Some concerns. <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.

Study details	Participants	Interventions	Outcomes and Results	Comments
			• No significance difference between groups (p=0.81, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.46, Mann-Whitney U test; adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 7.06 (6) vs. Less intensive MDT care = 6.34 (5.1)	
Full citation Ryan, T., Enderby, P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age: results at 12-month followup, International journal on disability and human development, 5, 83-89, 2006	**Sample size** See Ryan 2006a **Characteristics** See Ryan 2006a **Inclusion criteria** See Ryan 2006a **Exclusion criteria** See Ryan 2006a	**Interventions** See Ryan 2006a	**Results** *Overall quality of life (measured using EQ-5D) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.52 (0.26-0.69) • Less intensive MDT care (n=34): 0.62 (0.32-0.73) At 12 months:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y – Using random number table in blocks of 10. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y - Opaque sealed envelopes. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Baseline characteristics are balanced between groups in whole study

Study details	Participants	Interventions	Outcomes and Results	Comments
Ref Id 1184825 **Country/ies where the study was carried out** UK **Study type** RCT **Aim of the study** See Ryan 2006a **Study dates** See Ryan 2006a **Source of funding** See Ryan 2006a			• More intensive MDT care (n=30): 0.7 (0.59-8) • Less intensive MDT care (n=28): 0.7 (0.62-0.74) • No significant difference between groups (p=0.67, Mann-Whitney U test) • Mean change (SD): More intensive MDT care = 0.16 vs. Less intensive MDT care = 0.08; 95% CI = -0.08-0.24 *Overall quality of life (measured using EQ-VAS) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.6 (0.51 - 0.71) • Less intensive MDT care (n=34): 0.63 (0.57-0.81) At 12 months: • More intensive MDT care (n=30): 0.7 (0.5-0.78)	population, although there is no comparison purely for hip fracture patients. *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Intervention group was meant to have a ratio of 2:1 MDT sessions compared to control. Mean (SD) sessions were reported as 24.4 (10.2) for intervention versus 17.9 (9.1) for control. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group did not achieve the forecast intensity of MDT sessions. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Less intensive MDT care (n=28): 0.65 (0.5-0.8) • No significant difference between groups (p=0.88, Mann-Whitney U test) • Mean change: More intensive MDT care = 0.04 vs. Less intensive MDT care = -0.05; 95% CI = -0.06 to 0.2 *Change in ADL (measured using Barthel Index) [Median (IQR)]* At baseline: • More intensive MDT care (n=37): 17 (15-17) • Less intensive MDT care (n=34): 16 (14.75-17) At 12 months: • More intensive MDT care (n=30): 20 (19-20) • Less intensive MDT care (n=28): 20 (19-20) • No significant difference between groups (p=0.18, Mann-Whitney U test) • Mean change: More intensive MDT care	intervention? Y - Intention to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. Domain 3: Missing outcome data 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - Outcome data only available for 58/71 (82%) participants at 12 months (30/37 in intervention group and 28/34 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN – Reasons for and numbers of loss to follow up was roughly balanced across study groups. *Risk-of-bias judgement:* Some concerns Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N - Outcomes were measured using validated instruments. 4.2 Could measurement or ascertainment of the outcome have

Study details	Participants	Interventions	Outcomes and Results	Comments
			= 3.36 vs. Less intensive MDT care = 3.47; 95% CI = -1.2-0.99 *Changes in ADL (measured using Frenchay Activities Index) [median (IQR)]* At baseline: • More intensive MDT care (n=37): 28 (19.5-32) • Less intensive MDT care (n=34): 28 (22.75 - 31.25) At 12 months: • More intensive MDT care (n=30): 22 (16.5-29.5) • Less intensive MDT care (n=28): 21 (13-26) • No significant difference between groups (p=0.27, Mann-Whitney U test) • Mean change: More intensive MDT care = -3.8 vs. Less intensive MDT care = -5.8; 95% CI = -2.4-6.5	differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY – Blinding of researchers carrying out assessments were blind, but quality of life and acitivities of daily living have a subjective component to them and participants were unlikely to be blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN – Researchers were blinded and using standardised and validated measurements. *Risk-of-bias judgement:* Some concerns. <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from...

Study details	Participants	Interventions	Outcomes and Results	Comments
				5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Stenvall, Michael, Olofsson, Birgitta, Nyberg, Lars, Lundstrom, Maria, Gustafson, Yngve, Improved performance in activities of daily living and mobility after a multidisciplinary postoperative rehabilitation in older people with femoral neck fracture: a randomized controlled trial with 1-year follow-up, Journal of rehabilitation medicine, 39, 232-8, 2007	**Sample size** N (randomised) = 199 • MDT post-operative rehabilitation = 102 • Conventional post-operative rehabilitation = 97 N (analysed) = 199 • MDT post-operative rehabilitation = 102 • Conventional post-operative rehabilitation = 97 **Characteristics** Age in years [Mean (SD)]: • MDT post-operative rehabilitation (N) = 82.3 (6.6)	**Interventions** • Targeted 8 separate areas of post-operative care: 1. Ward layout; 2. Staffing; 3. Staff education; 4. Teamwork; 5. Individual care planning; 6. Prevention and treatment of complications; 7. Nutrition; and 8. Rehabilitation. • *Intervention group: MDT post-operative rehabilitation.* Applied in a geriatric unit that specialised in geriatric orthopaedic patients. ○ Ward layout: 24-bed ward with single and double rooms, and extra beds when needed. ○ Staffing: 1.07 WTE nurses/aides per bed, plus 2 x 1 WTE physiotherapists, 2 x 1 WTE occupational	**Results** *Changes in ADL (measured using number of participants achieving independence in P-ADL at each time point)* Before fracture: • MDT post-operative rehabilitation: 47 • Conventional post-operative rehabilitation: 48 At 4 month post-operative follow-up: • MDT postoperative rehabilitation: 35/102 • Conventional postoperative rehabilitation: 23/97	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? NI – Simply states that participants were randomised. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y – Opaque, sequentially numbered envelopes that were only opened right before surgery. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Only 1 of the baseline characteristics were significantly different between groups (diagnosed depression). No other imbalances.

Study details	Participants	Interventions	Outcomes and Results	Comments
Ref Id 1279942 **Country/ies where the study was carried out** Sweden **Study type** RCT **Aim of the study** To evaluate both short- and long-term outcomes of a multidisciplinary post-operative rehabilitation package in patients after acute hip fracture. **Study dates** May 2000 – December 2002 **Source of funding** This study received funding from the Swedish Foundation for Health Care Sciences and Allergy Research, the Joint	• Conventional post-operative rehabilitation (N) = 82.0 (5.9) Gender (M/F): • MDT post-operative rehabilitation (n) = 28/74 • Conventional post-operative rehabilitation (n) = 23/74 Time since injury: not reported Injury cause: not reported but inclusion criteria states hip fracture following minimal trauma Type of fracture: not reported **Inclusion criteria** Participants had to: • Be aged 70 years or above • Have a femoral hip fracture • Be admitted to orthopaedic department at participating hospital between May 200 - December 2002 • Have underwent either internal fixation (undisplaced fracture) or hemi-arthroplasty (displaced fracture) **Exclusion criteria**	therapists and 0.2 WTE dietician. ○ Staff education: Included a 4-day course on post-operative rehabilitation, including information on possible complications, delirium and fall prevention. ○ Teamwork: The multi-disciplinary team included orthopaedic surgeons, geriatricians, Registered Nurses, Licensed Practical Nurses, physical therapists, occupational therapists, dieticians and geriatricians. ○ Individual care planning: Usually started within 24 hours, after assessment from all MDT members. The team updated a patient's rehabilitation process and goals twice a week. ○ Prevention and treatment of complications: Included an examination of why patient's fractured their hip and osteoporosis treatment if needed. Common post-operative complications were actively monitored, with prevention and treatment regimens where indicated. Oxygen enriched air was	• OR (95% CI): 2.51 (1.00–6.30) • Binary logistic regression adjusted for depression, dementia and independent walking ability at baseline. At 12 month post-operative follow-up • MDT postoperative rehabilitation: 33/102 • Conventional postoperative rehabilitation: 17/97 • OR (95% CI): 3.49 (1.31–9.23) • Binary logistic regression adjusted for depression, dementia and independent walking ability at baseline. *Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point)* A: Independent in all 6 functions (feeding, continence, transferring, going to toilet, dressing, and bathing).	*Risk-of-bias judgement:* Some concerns. Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? NI – Participants were recruited in the emergency department. No information presented on how much they were aware of the differences between the post-operative rehabilitation programmes, or if they knew which wards were used for which post-operative programmes. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? Y – Staff on intervention ward were aware of the intervention content. Staff on the control wards were aware that a new programme was being trial at the hospital on another ward. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Participants who were allocated to the control group were admitted to a general geriatric unit (rather than the control orthopaedic ward), which had staffing levels, teamwork and individual care planning similar to the intervention ward. Additionally, intervention was given until discharge rather than a specific time point. Therefore,

Study details	Participants	Interventions	Outcomes and Results	Comments
Committee of the Northern Health Region of Sweden, the JC Kempe Memorial Foundation, the Dementia Fund, the Foundation of the Medical Faculty, the Borgerskapet of Umeå Research Foundation, the Erik and Anne-Marie Detlof's Foundation, University of Umeå and the County Council of Västerbotten and the Swedish Research Council.	• Severe rheumatoid arthritis or hip osteoarthritis • Pathological hip fractures • Severe renal failure • People who were bedridden before trauma	given at least for post-operative day 1. Urinary tract infections were screened for, urinary catheters only left in for a maximum of 24 hours post-operatively and patient's had regular screening from urinary retention and constipation. If sleep was poor, possible causes were investigated and treated. ○ Nutrition: Food and liquid registration was routinely carried out, with patients receiving protein enriched meals until post-operative day 4 (and longer if indicated). Protein and nutritional drinks were administered daily. ○ Rehabilitation: Started with mobilisation within 24 hours post-operatively, including specific exercises with both physical therapists and occupational therapists and general acitivites for daily living with care staff. Functional re-training was administered with a specific focus on fall risk factors. A home visit was conducted by occupational therapists and/or physical therapists, who	B: Independent in any 5 out of 6 function. C: Dependent for bathing plus 1 other function, independent in other 4 functions. D: Dependent for bathing, dressing plus 1 other function, independent in other 3 functions. E: Dependent for bathing, dressing, going to the toilet plus 1 other function, independent in other 2 functions. F: Dependent for bathing, dressing, going to the toilet, transferring plus 1 other function, independent remaining function. G: Dependent in all six functions. At baseline: • Katz grade A ○ MDT post-operative rehabilitation: 50/101 ○ Conventional post-operative rehabilitation: 49/94 • Katz grade B ○ MDT post-operative rehabilitation: 15/101	participants staying longer will receive more of the intervention. 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? N. 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? Y. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intention-to-treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N. At 4 months data was available for 175/199 participants (92/102 in intervention group and 83/97 in control group). At 12 months data was available for 160/199 participants (84/102 in intervention group and 76/97 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? PN – No information reported on methods to correct for missing data bias (although P-ADL was corrected for baseline characteristics).

Study details	Participants	Interventions	Outcomes and Results	Comments
		communicated with counterparts in the community rehabilitation services to provide additional information post-discharge. Patients were offered additional rehabilitation as outpatients after discharge. A physical therapist or occupational therapist followed patients up via telephone 2 weeks after discharge, and with a home visit 4 months after discharge. This home visit included rehabilitation assessment, possible rehabilitation needs, environmental issues and nutritional problems. Another follow-up (also at 4 months after discharge) was carried out by a physician for a medication review and to detect possible complications. • *Control group: Conventional post-operative rehabilitation.* Primarily applied in a specialist orthopaedic unit that followed conventional post-operative routines. If a patient required longer rehabilitation, they were admitted to a general geriatric unit (although not	○ Conventional post-operative rehabilitation: 13/94 • Katz grade C ○ MDT post-operative rehabilitation: 11/101 ○ Conventional post-operative rehabilitation: 5/94 • Katz grade D ○ MDT post-operative rehabilitation: 1/101 ○ Conventional post-operative rehabilitation: 6/94 • Katz grade E ○ MDT post-operative rehabilitation: 10/101 ○ Conventional post-operative rehabilitation: 9/94 • Katz grade F ○ MDT post-operative rehabilitation: 9/101 ○ Conventional post-operative rehabilitation: 8/94 • Katz grade G ○ MDT post-operative rehabilitation: 3/101 ○ Conventional post-operative rehabilitation: 2/94 • Not classified	3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? Y. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? Y – Data missing due to death of patients which will have affected ADL measurements. *Risk-of-bias judgement:* High risk. <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points (at discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y – Assessors were unblinded to allocation. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Length of stay: N. ADL: PN – Validated instruments (Katz ADL and ADL Staircase) used for measurements, which involve little/no assessment judgement. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk.

Study details	Participants	Interventions	Outcomes and Results	Comments
		the same one as the intervention ward). ○ Ward layout: On the orthopaedic control ward, a 27-bed ward with single, double rooms and quadruple rooms, and extra beds when needed. On the geriatric control ward, layout was the same as the intervention group. ○ Staffing: On the orthopaedic control ward, 1.01 WTE nurses/aides per bed, plus 2 x 1 WTE physiotherapists, 1 x 0.5 WTE occupational therapists and no dietician. On the geriatric control ward, staffing was the same as the intervention group (10.7 WTE nurses/aides per bed). Staff education: No rehabilitation specific education given before or during the programme. ○ Teamwork: On the orthopaedic control ward, no specific teamwork was implemented. On the geriatric control ward, teamwork was the same as the intervention group. Individual care planning: On the orthopaedic control ward, individual care planning was used but not	○ MDT post-operative rehabilitation: 2/101 ○ Conventional post-operative rehabilitation: 2/94 • No difference between groups (p = 0.789, Mann-Whitney U test) At 12 months post-operative follow-up: • Katz grade A ○ MDT postoperative rehabilitation: 34/84 ○ Conventional postoperative rehabilitation: 17/76 • Katz grade B ○ MDT postoperative rehabilitation: 14/84 ○ Conventional postoperative rehabilitation: 21/76 • Katz grade C ○ MDT postoperative rehabilitation: 8/84 ○ Conventional postoperative rehabilitation: 3/76 • Katz grade D ○ MDT postoperative rehabilitation: 1/84 ○ Conventional postoperative rehabilitation: 2/76	Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI – No published protocol to check. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns. Overall risk of bias *Risk-of-bias judgement:* High risk. **Other information** Re-admissions are also reported but there is distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).

Study details	Participants	Interventions	Outcomes and Results	Comments
		routinely as per the intervention. On the geriatric control ward, a weekly individual care planning meeting was held. ○ Prevention and treatment of complications: On both control wards, there was no routine examination regarding the possible causes of fractures, there was no fall prevention assessment and no routine prescription of osteoporosis medication. Post-operative complications were assessed but not routinely. ○ Nutrition: On the orthopaedic control ward, no dietician was available. On both control wards, no nutrition registration or protein-enriched meals were available. ○ Rehabilitation: Mobilisation was within 24 hours of surgery by a physical therapist, and were visited every day. However, functional retraining for daily tasks was not always performed. On the orthopaedic control ward, occupational therapists only met patients for a consultation and there	• Katz grade E ○ MDT postoperative rehabilitation: 5/84 ○ Conventional postoperative rehabilitation: 4/76 • Katz grade F ○ MDT postoperative rehabilitation: 17/84 ○ Conventional postoperative rehabilitation: 17/76 • Katz grade G ○ MDT postoperative rehabilitation: 4/84 ○ Conventional postoperative rehabilitation: 11/76 • Not classified ○ MDT postoperative rehabilitation: 1/84 ○ Conventional postoperative rehabilitation: 1/76 • Significantly more participants achieving earlier grade (better) in intervention group compared to control group (p = 0.025, Mann-Whitney U test) *Changes in ADL (measured using number of participants returning to*	

Study details	Participants	Interventions	Outcomes and Results	Comments
		were no home visits. On the geriatric control ward, exercises were similar to the intervention group and were administered by both physical and occupational therapists. In both control groups, no follow-up interventions were scheduled.	*at least same Katz ADL level as before trauma)* At 4 months post-operative follow-up: • MDT postoperative rehabilitation: 56/92 • Conventional postoperative rehabilitation: 39/82 • No significant difference between groups (p = 0.078, Chi-squared test) At 12 months post-operative follow-up: • MDT postoperative rehabilitation: 49/84 • Conventional postoperative rehabilitation: 27/76 • Significantly higher (better) in intervention groups (p = 0.004, Chi-squared test)	
Full citation Vikane, E., Hellstrom, T., Roe, C., Bautz-Holter, E., Assmus, J., Skouen, J. S., Multidisciplinary outpatient treatment in patients with mild traumatic brain	**Sample size** N = 151 (randomised) • Multidisciplinary outpatient treatment = 81 • Usual care by GP = 70 N = 151 (analysed for return to work) • Multidisciplinary outpatient treatment = 81	**Interventions** • *Intervention group: Multidisciplinary outpatient treatment.* Individual contacts and a psycho-educational group intervention once a week over a consecutive 4-week period. Schedule for return to work and other activities were developed during the	**Results** *Return to work or education (measured using number of participants returned to work)* At 12 months post-injury:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. "For each hospital, the participants were randomised into two groups by simple randomisation with

Study details	Participants	Interventions	Outcomes and Results	Comments
injury: A randomised controlled intervention study, Brain Injury, 31, 475-484, 2017 **Ref Id** 1206647 **Country/ies where the study was carried out** Norway **Study type** RCT **Aim of the study** To evaluate the efficacy of a multidisciplinary outpatient follow-up programme compared to follow-up by a general practitioner for patients being at-risk or sick-listed with persistent post-concussion symptoms two months after a mild traumatic brain injury.	• Usual care by GP = 70 N = 126 (analysed for subjective outcomes) • Multidisciplinary outpatient treatment = 70 • Usual care by GP = 56 **Characteristics** Age in years [Median (range)]: • Multidisciplinary outpatient treatment = 31 (16-55) • Usual care by GP =35 (16-55) Gender (M/F): • Multidisciplinary outpatient treatment = 49/32 • Usual care by GP = 43/27 Time since injury: not reported but inclusion criteria states between 6-8 weeks. Injury cause (Traffic accident/fall/assault/sports injury and other) • Multidisciplinary outpatient treatment (n) = 23/30/16/12 • Usual care by GP (n) = 21/26/11/12	first consultation within two weeks after multidisciplinary examination. There were individualised additional follow-ups in the first year. A social worker, occupational therapist or nurse dealt with concerns of return to work; team led by rehabilitation medicine specialist assessed patients capabilities; a neuropsychologist assessed psychological issues; physician dealt with exacerbations and GP received a report for each follow-up. Patients received education and shared their experiences at group sessions • *Control group: Usual care by GP.* Follow-up by a GP after multidisciplinary examination. GP could refer to specialists or allied healthcare professionals.	• Multidisciplinary outpatient treatment = 49/81 (60%) • Usual care by GP = 50/70 (71%) *Change in ADL (measured using Glasgow Outcome Scale) [Median (range)]* Scale: 1-8, higher = better At 12 months post-injury: • Multidisciplinary outpatient treatment (n=69) = 7 (5-8) • Usual care by GP (n=56) = 7 (5-8)	1:1 allocation ratio according to a computer-generated list of random number assignment generated by an independent researcher" (page 477) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PY. "The allocation sequence was concealed from the multidisciplinary team, a person who did not participate in the study stored the lists and envelopes with group allocations from the lists were made". Although it was not mentioned whether the envelopes where opaque and sealed, the person in charge of the envelopes was not part of the study. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N. "As shown in Table I, there were no significant differences between the two groups at baseline two months after the injury" (page 479) *Risk-of-bias judgement:* Low risk Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? Y – Participants were unblinded to allocation. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial?

Study details	Participants	Interventions	Outcomes and Results	Comments
Study dates March 2009 – February 2012 **Source of funding** This study received funding from the Norwegian Extra Foundation for Health and Rehabilitation.	Severity of injury: not reported **Inclusion criteria** • Participants had to: • Be aged 16–55 years • Be diagnosed with TBI (ICD-10 code S06.0–S06.9) • Consecutively admitted to the Department of Neurosurgery with TBI • Have had sustained symptoms 6-8 weeks post-mild TBI (defined as ○ Glasgow Coma Scale 13–15 within 30 min or the lowest score during the first 24 hours ○ Unconsciousness less than 30 min ○ Post-traumatic amnesia less than 24 hours • Be hospitalised for five hours or longer • Provide written consent • Be either sick-listed or at-risk to be sick-listed with persistent post-concussion syndrome symptoms two months after the injury. **Exclusion criteria** • Major psychiatric diseases or other diseases (previous			Y – Participants were unblinded to allocation. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI - There is no indication of any deviations from the intended intervention. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Return to work – Y. No loss to follow up reported.; Changes in ADL – N. 126/151 (83%) of participants with data available (70/81 in intervention group and 56/70 in control group) 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data?

Study details	Participants	Interventions	Outcomes and Results	Comments
	head trauma) that impacted on working skills • Unemployed in the last 6 months • No Norwegian language skills • Diagnosed with substance abuse			Return to work – NA; Changes in ADL – N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? Return to work – NA; Changes in ADL – PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? Return to work – NA; Changes in ADL - PN. Attrition balanced across groups (although reasons not reported). *Risk-of-bias judgement:* Return to work – low risk; changes in ADL – some concerns Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N. Outcomes were measured appropriately using validated instruments 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Return to work - N. Sick leave data obtained from Norwegian Labour and Welfare Service through Statistics Norway which blinded data before sending it to the 1st author. Changes in ADL – PY. Researchers and participants were unblinded

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Return to work – NA; Changes in ADL – PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Changes in ADL – PN. Measured using validated and standardised measurements. *Risk-of-bias judgement:* Return to work – low risk; changes in ADL – some concerns <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? Y – Protocol registered with ClinicalTrials.gov (NCT00869154) prior to study start date. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? Y – Published protocol states outcome data to be collected at 6 and 12 months, however, only 12-month outcome data were reported. 5.3 ... multiple analyses of the data? NI.

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement: High risk Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** Hospital length of stay reported but only median (range) with no statistical analysis.
Full citation Wiechman, Shelley A., Carrougher, Gretchen J., Esselman, Peter C., Klein, Matthew B., Martinez, Erin M., Engrav, Loren H., Gibran, Nicole S., An expanded delivery model for outpatient burn rehabilitation, Journal of burn care & research : official publication of the American Burn Association, 36, 14-22, 2015 **Ref Id** 1111693 **Country/ies where the study was carried out**	**Sample size** N = 81 (randomised) • Extended care practitioner + telephone calls = 40 • Standard outpatient care = 41 N = 78 (analysed) • Extended care practitioner + telephone calls = 38 • Standard outpatient care = 40 **Characteristics** Age in years [Mean (SD)]: • Extended care practitioner + telephone calls = 43.23 (16.92) • Standard outpatient care = 43.68 (17.13) Gender (M/F): • Extended care practitioner + telephone calls = 25/15 • Standard outpatient care = 29/12	**Interventions** • *Intervention group: Extended care practitioner (ECC) + telephone calls.* The same standard outpatient care given to the control group as well as a reminder of upcoming telephone call schedule. They were contacted by ECC 24 to 48h post-discharge and at weeks 2, 4, 8, and 12, and months 5, 7, and 9. The calls were semi-structured to ensure that all domains were covered - first part of the interview reviewed medical or psychological issues and second part reviewed progress made on patient-set goals. Phone calls were recorded and supervised by the primary investigator. The ECC was a 'bachelor's level professional' (no further details provided) who was trained (on interviewing, burn pathophysiology and also observed treatment) an	**Results** *Patient satisfaction (measured using author patient satisfaction survey) [Mean (SD)]* Higher = better At 6 months: • Extended care practitioner + telephone calls (n=40): 8.9 (1.6) • Standard outpatient care (n=38): 8.4 (2.1) • No difference between groups (p = 0.0.0878, regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 8.4 (2.1)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? NI. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN - No formal statistical comparisons at baseline but participants' characteristics appear to be balanced across groups. *Risk-of-bias judgement:* Some concerns *Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)* 2.1. Were participants aware of their assigned intervention during the trial? NI – Study states it is a single-blind

Study details	Participants	Interventions	Outcomes and Results	Comments
USA (assumed based on authors' affiliation) **Study type** RCT **Aim of the study** To overcome the barriers to effective burn rehabilitation by utilizing an expanded care coordinator (ECC) to supplement the existing outpatient services. **Study dates** Not reported **Source of funding** Not reported	Time since injury: not reported. TBSA [Mean (SD)]: • Extended care practitioner + telephone calls (%) = 35.5 (42.91) • Standard outpatient care (%) = 38.0 (43.37) Inclusion criteria Participants had to: • Be aged ≥18 years old • Have burn size: ○ >15% TBSA ○ <15% TBSA that required surgery for wound closure ○ <15% TBSA located on the face, hand, or over the joint • Give informed consent **Exclusion criteria** Not reported	d supervised weekly by the PI. A team of surgeons, physicians, psychologists, nurses, therapists, vocational rehabilitation counsellor were available to assist the ECC with issues that had arisen during phone calls. ECC could encourage attendance at local support groups, assist with worker's compensation claim and facilitate participant's contact with employer. • *Control group: Standard outpatient care.* Advice before discharge and follow-up phone call 24h post-discharge, outpatient clinic visits every 2 weeks and 1-2 months after. Seen at outpatient clinic visits by multidisciplinary team that includes a nurse a surgeon, a physical and occupational therapist, vocational counsellor and a psychologist.	• Standard outpatient care (n=38): 7.5 (3.0) • No difference between groups (p = 0.0929 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Overall quality of life (measured using SF-12 Physical component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months: • Extended care practitioner + telephone calls (n=40): 48.8 (8.0) • Standard outpatient care (n=38): 44.1 (11.9) • No difference between groups (p = 0.4261 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 50.1 (11.8)	trial but no information given on who is blinded. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? NI – Study states it is a single-blind trial but no information given on who is blinded. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Only 33% of intervention group completed 7/8 phone calls and 23% completed 8/8 phone calls. The rest only completed ≤ 6 phone calls. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – Data available for 78/81 participants (40/41

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Standard outpatient care (n=38): 53.7 (15.3) • No difference between groups (p = 0.7162 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Overall quality of life (measured using SF-12 Mental component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months: • Extended care practitioner + telephone calls (n=40): 51.1 (8.6) • Standard outpatient care (n=38): 49.2 (11.5) • No difference between groups (p = 0.7353 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 51.2 (10.0)	in intervention group and 38/40 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA. *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? N - There is no indication that measurement differed between study groups 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI – Study states it is a single-blind trial but no information given on who is blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NI – Study states it is a single-blind trial but no information given on who is blinded. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Standard outpatient care (n=38): 46.8 (12.5) • No difference between groups (p = 0.7162 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Changes in ADL (measured using GAS) [Mean (SD)]* Higher = better At 6 months: • Extended care practitioner + telephone calls (n=40): 55.5 (13.5) • Standard outpatient care (n=38): 58.1 (14.8) • No difference between groups (p=0.1286 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 59.0 (14.2) • Standard outpatient care (n=38): 57.9 (13.6)	intervention received? Patient satisfaction – PY. Very subjective measurement with little information given on the tool used. Quality of life and changes in ADL – PN. Measurements conducted using a standardised and validated instrument. *Risk-of-bias judgement:* Patient satisfaction - high risk; Quality of life and changes in ADL – some concerns Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PY - There were other planned outcomes such as return to work which were collected but not reported beyond a sentence saying there was no difference in any outcome at any time point. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* High risk Overall risk of bias *Risk-of-bias judgement:* High risk **Other information**

Study details	Participants	Interventions	Outcomes and Results	Comments
			• No significant difference between groups (p=0.0902 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls)	Length of hospital stay also reported but before the start of intervention so not appropriate to extract.

ADL: Activities of daily living; ANOVA: Analysis of variance statistical test; ASA: American Society of Anesthesiologists; CI: Confidence interval; ECC: Extended care coordinator; EQ-5D; EuroQol, 5 domain; EQ-VAS; EuroQol, visual analogue scale; F: Female; FIM: Functional Independence Measure; GAS: Goal Attainment Scale; GP: General practitioner; ICD-10: International Statistical Classification of Diseases and Related Health Problems (10th revisiion); IQR: Interquartile range; ITT: Intention to treat; HCA: Healthcare assistant; M: Male; MBA: Motor bike accident; MDT: Multidisciplinary team; MVA: Motor vehicle accident; N: Number [or No if answering a risk of bias checklist question]; NA: Not applicable; NI: No information; OARS: Older Americans Resources and Services; OR: Odds ratio; P-ADL: Phyiscal activities of daily living; PN: Probably not; PY: Probably yes. RCT: Randomised controlled trial; SD: Standard deviation; SDT: Supported discharge team; SF-12; 12 item short form survey; SF-36: 36 item short-form survey; TBI: Traumatic brain injury; TBSA: Total burn surface area; Y: Yes

Table 14: Qualitative evidence tables

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist

Full citation
Barclay, Linda, Lalor, Aislinn, Migliorini, Christine, Robins, Lauren, A comparative examination of models of service delivery intended to support community integration in the immediate period following inpatient rehabilitation for spinal cord injury, Spinal Cord, 2019
 	
Ref Id
1181411
	Recruitment strategy
	Convenience sampling of spinal services in higher-income countries. Researchers identified 15 spinal services through personal contacts of 1st author or spinal service websites. These services then nominated the most appropriate person to interview about the methods used to facilitation community reintegration.
	
	Inclusion criteria
	Participants had to:
	• Be a spinal service in developed economy
	
	Exclusion criteria
	Not reported.
		Findings (including author's interpretation)
		
		• Author's theme: Models of service delivery
		  ○ Sub-theme: Peer mentors
		  - Example quote: *"Because they're in the building and you can refer to them pretty easily, often they'll identify somebody to be a peer mentor and to be their go-to if they have questions on the clients, and they'll often visit that person while in inpatients but sometimes in outpatients as well." (p6)*
			1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)
			Yes - To describe and compare service delivery approaches that aim to support re-integration into the community following SCI in-patient discharge.
			
			2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)
			Yes - Appropriate to explore the views and experiences of healthcare professionals regarding SCI rehabilitation service delivery.
			
			3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Country/ies where the study was carried out Australia **Study type** General qualitative inquiry **Study dates** July 2018 - January 2019	**Setting** Spinal services in high-income countries. **Participant characteristics** N = 10 spinal service centres • N = 12 healthcare professionals • Country (N): ○ Australia = 2 ○ Canada = 2 ○ New Zealand = 1 ○ Norway = 1 ○ Sweden = 1 ○ UK = 1 ○ USA = 2 No further details reported. **Data collection and analysis** 30-90 minute semi-structured interviews conducted via Zoom. Questions were designed to be open ended, asking participants to describe the models employed by their services to facilitate reintegration into the community. Interviews were audio recorded before being transcribed verbatim and checked by the researcher conducting the interview. Thematic analysis using the topic guide as initial framework. 1st author familiarised themselves with the	○ Sub-theme: facilitating community integration during inpatient rehabilitation - Example quote: *"They come back for ending the rehabilitation period, where they can say that okay you have been [home]—you have noticed that this and this and this is difficult when you come home, and we are going to have more focus on these things so you can manage when you come home." (p4)* • Author's theme: Services provided ○ Sub-theme: telehealth - Example quote: *"We have been working a lot with pressure ulcers the last years, so we now have a videoconferencing service for some of the patients that are living at home, where we have a videoconference to the patient's home, together with the nurses in the municipality, who are treating the pressure ulcers from day to day." (p6)* ○ Sub-theme: vocational services - Example quote: *"The return to work happens at inpatient, actually. They really like to start as early as they can, so the primary OT puts in a*	Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** No - SCI services were approached based on 1st author contacts on spinal service websites. Using 1st author contacts and personal communication for recruitment introduces a strong possibility of selection bias. No methods described to mitigate this. Additionally, no information given on how the websites were identified e.g. search engine. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Data collection method discussed and justified. No details given on how the topic guide was developed but it is published in the article and appears to be well balanced. Data saturation not discussed but not necessary for the aim of the study (comparison of services). **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - No details reported. Interviews were conducted by 1st and 2nd author. The 1st author is well known in the field of SCI rehabilitation and knew some of the participants personally.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	transcripts before independently coding and identifying potential themes. Constant comparison was then used to develop final themes and sub-themes.	*referral and the patient meets one-on-one with one of our community reintegration therapists - and they're typically OT by background - and what they do is they start speaking to the employer early on about what kind of adaptations and modifications they might need to return to work." (p6)*	**7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval granted by Monash University Human Research Ethics Committee. However, no mention of informed consent. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Adequate description of analysis process and how the themes were derived. Good presentation of data to support findings. 1st author independently coded transcripts , developed themes and finalised themes. The only discussion surrounding credibility is a brief mention of discussion of themes during regular team meetings. No mention about researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Brief discussion about credibility of findings. **10. How valuable is the research?** High value for current question - Aim specifically matches the aim of this question. Includes UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious concerns

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Source of funding This study received funding from the Transport Accident Commission. **Other information** None
Full citation Braaf, Sandra, Ameratunga, Shanthi, Nunn, Andrew, Christie, Nicola, Teague, Warwick, Judson, Rodney, Gabbe, Belinda J., Patient-identified information and communication needs in the context of major trauma, BMC health services research, 18, 163, 2018 **Ref Id** 1109524 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** July 2014 to July 2015	**Recruitment strategy** Purposive sampling from parent longitudinal study. Participants fitting inclusion/exclusion criteria at 3 years post-injury were contacted to complete a structured follow-up interview before being invited to complete a longer, more detailed telephone interview. *Inclusion criteria* Participants had to: • Be injured between 1st July 2011 - 30 June 2012 • Be ages 17 years old and over • Be registered with Victorian State Trauma Registry (i.e. death related to injury [either at scene or in-hospital]; ○ Admitted to ICU for more than 24 hours ○ Urgent surgery for intracranial/intrathoracic/intra-abdominal trauma ○ Urgent surgical fixation of pelvic or spinal fractures ○ Multiple traumatic injuries with an Injury Severity Score of over 12)	**Findings (including author's interpretation)** • Author's theme: Information needs: Inpatient discharge ○ Example quote: *"As I was leaving hospital, or before I was discharged, something could have been said about some kind of counselling or just some kind of number to contact." (p5)* • Author's theme: Information needs: Community care ○ Example quote: *"I came out of rehab on a very strong course of medication, and I really didn't know who I should be speaking to about that… I wasn't sure I needed it anymore but couldn't get a definitive answer anywhere on that." (p6)* • Author's theme: Accessing, using and understanding information: Consistency of information	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore major trauma patient's experiences of communication with healthcare professionals in the initial 3 years post-injury, in hospital, rehabilitation and community settings. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the long term experiences of trauma survivors in communication with healthcare providers. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Purposive sampling could introduce some selection bias but decreased by the inclusion/exclusion list. Additionally, a wide range of characteristics were sought.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Exclusion criteria • Patients with severe TBI or SCI who have been studied in another research study • Patients not able to converse in English **Setting** Victorian State Trauma System including 2 adult major trauma hospitals and 1 paediatric major trauma hospital **Participant characteristics** N = 65 adults with major trauma • Age [mean (SD)]: 50.7 (15.5) years • Gender (M/F): 42/23 • Length of hospital stay [median (IQR)]: 11 (5.4 - 26.5) days • Injury cause (N): ○ Traumatic: 65 - Motor vehicle: 22 - Fall: 12 - Motorcycle: 6 - Pedal cyclist: 6 - Other: 19 **Data collection and analysis**	○ Example quote: *"For me it would have been no good telling me anything at (hospital name). Perhaps if (hospital name) issued you ... a (written) summary of what your injuries were when you were brought in, what you were diagnosed with and resulting treatments that they performed. [Male,17–29yrs, road traffic injury #581]" (p8)* • Author's theme: Accessing, using and understanding information: Access to information ○ Example quote: *"Because once you get your discharge it's like you're on your own. You got to do it yourself... you feel sort of alienated.." (p7)* • Author's theme: Accessing, using and understanding information: Information coordination ○ Example quote: "I didn't have one particular person giving you all the information. It was just the medical staff as they came through. It was only at the end that I recall, that I got the information all put together." *(p7)* • Author's theme: Accessing, using and understanding information: Communication needs: a lack of patient engagement	However, there is a lack of information on how patients were initially contacted or recruited to RESTORE. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - 3 years later, which gives a fuller picture but relies on memory only. Author's acknowledge that this means that only the communications with the greatest impact are likely to be identified. Topic guide developed from trauma literature and published in the article for transparency. Data saturation not mentioned. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - No clear discussion, but researchers were not linked directly to any service provision. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study approved by The Monash University Human Research Ethics Committee and participating hospitals. Informed consent obtained prior to interviews. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Good description of analysis process and how the themes were derived.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Semi-structured telephone interviews (median 47 minutes each). Interviews took place between July 2014 - July 2015. Interviews were audio-recorded and transcribed. Thematic framework analysis. All interviews were read by 1st author, with a sample read by multiple other researchers. Initial coding was performed by 1st author, creating a list of emerging patterns. A framework of themes and sub-themes were then developed by 2 other authors. The other researchers who read a sample of the transcripts refined the framework and a final consensus was achieved through group discussion.	○ Example quote: "So it seems like you're going along, you're doing your rehab, you're attending, you're making progress and then all of a sudden they'll come to you and say okay, you'll be finishing up in a couple of weeks – that's it... it seems a lot like they don't engage the patient very well." (p9) • Author's theme: Accessing, using and understanding information: Clarity of information ○ Example quote: "I suppose just a bit more of an overall understanding of what was (surgically) happening. So a bit more information, just of a general nature rather than specific medical sort of speak, just, I suppose in layman's terms." (p6)	Adequate data presented to support findings. However, only 1st author initially coded the transcripts and developed themes in conjunction with another researcher (no mention of independence). Multiple investigators read a sample and provided input, but no mention of disagreements. Themes were finalised through consensus, although no mention of who was involved. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Brief discussion about credibility of findings. **10. How valuable is the research?** High value for the current question - Specifically looking at trauma patients experiences transferring back to the community. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the Australian Government's National Health and Medical Research Council. **Other information** None

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Full citation Christensen, Jan, Langberg, Henning, Doherty, Patrick, Egerod, Ingrid, Ambivalence in rehabilitation: thematic analysis of the experiences of lower limb amputated veterans, Disability and Rehabilitation, 40, 2553-2560, 2018 **Ref Id** 945375 **Country/ies where the study was carried out** Denmark **Study type** Phenomenological study **Study dates** November 2014 - February 2015	**Recruitment strategy** Purposive sampling of Danish veteran amputees, identified through a national register of wounded military veterans held by Copenhagen University Hospital (the hospital designated to receive wounded armed forces personnel). *Inclusion criteria* Participants had to: • Have unilateral transtibial or trans femoral lower limb amputation • Have completed inpatient rehabilitation or be part of outpatient rehabilitation programme *Exclusion criteria* Not reported. **Setting** In the community following discharge from Copenhagen University Hospital **Participant characteristics** N = 6 adults with lower-limb amputations • Age [median (range)]: 32 (25-46) years • Gender (M/F): 6/0	**Findings (including author's interpretation)** • Author's theme: Physical rehabilitation versus psychosocial reintegration ○ Example quote: *"It could have been nice with a kind of big brother to lean on in this chaotic period, one that had an impact and could speak up one one's behalf." (p2557)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the continuity of care between in-patient and outpatient rehabilitation services for Danish veterans with lower-limb amputees. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore in-depth views and experiences Danish veterans when undergoing amputation rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Purposive sampling used which can introduce some bias. However, justified by the small number of Danish amputee veterans. Inclusion criteria was applied in order to keep the sample homogenous, which is appropriate for such a specific population. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 2 forms of data collection were performed for different aspects of the data

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Time since amputation [median (range)]: 5.7 (2-17) years • Injury cause (N): ○ Traumatic: 6 ○ Explosion: 6 • Level of amputation (N): ○ Transtibial: 5 ○ Trans femoral: 1 **Data collection and analysis** 90-120 minute semi-structured individual interviews held in a quiet place of interviewee's choice. A topic guide was used to explore views on hospital physical rehabilitation and post-hospital physical rehabilitation. Observations were conducted over 4 rehabilitation sessions (2 hour sessions were taken by a hospital physiotherapist) which were available to any wounded veterans after initial rehabilitation had been completed. Observations were carried by the 1st author, who also actively participated in the sessions. Field notes were written directly after these sessions. Inductive latent thematic analysis. Field notes and interview transcripts were read 2 times before initial coding was performed and emerging themes were noted. These themes were applied to the whole data set, further developing the themes and sub-themes. These were defined following discussion with		(interviews for in-depth exploration of individual experiences and observation to view social context of rehabilitation and perform any follow up). Topic guide was described briefly but not mention of how it was developed. Field notes were written up directly after observation settings to reduce recall bias. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - Lack of information presented on researcher's bias and influence. Important due to the fact that 1st author actively participated in the rehabilitation sessions and performed the initial data coding. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study complied with Helsinki Declaration and was approved by Danish data protection agency. Informed consent obtained prior to interviews. Data protection and anonymity measures were described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Good description of analysis process and how the themes were derived. Adequate data presented to support findings. However, only 1st author initially coded the transcripts and developed themes. Emerging themes were then discussed, refined and finalised by the

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	all authors and any results that did not fit the current themes were re-analysed for potential additional themes.		whole team during regular team meetings. No mention about researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Limited value for current question - Very specific population, including military healthcare settings. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the Danish Defence Agreement. **Other information** None
Full citation Christiaens, Wendy, Van de Walle, Elke, Devresse, Sophie, Van Halewyck, Dries, Benahmed, Nadia, Paulus, Dominique, Van den Heede, Koen, The view of severely burned	**Recruitment strategy** Purposive sampling. *Adults with burn injuries* Care coordinators contacted eligible participants, who then contacted the research team to be enrolled and set up semi-structured interviews. No further details reported.	**Findings (including author's interpretation)** • Author's theme: Discharge protocol and procedures vary widely between burn centres ○ Example quote: *"The discharge from the burn centre is*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the rehabilitation and aftercare experiences of severe burn patients and the views of allied healthcare professionals.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
patients and healthcare professionals on the blind spots in the aftercare process: a qualitative study, BMC health services research, 15, 302, 2015 **Ref Id** 1109654 **Country/ies where the study was carried out** Belgium **Study type** General qualitative inquiry **Study dates** January - April 2013	*Healthcare professionals* The responsible physician at each of Belgium's 6 burn centres and 1 rehabilitation centre for severe burn injuries were invited to participate. No further details reported. No further details reported. *Allied healthcare professionals* Sampled using a sampling grid to ensure a balanced selection of each burn centre and key rehabilitation professions and invited to focus groups. No further details reported. *Inclusion criteria* Participants with burn injuries had to: • Have a burn injury 6-24 months' old • Satisfy the legal criteria for admission to a Belgium burn centre (out of 6 centres) Healthcare professionals: not reported. *Exclusion criteria* • Patients with Lyell syndrome (toxic epidermal necrolysis or Staphylococcal scalded skin syndrome) Healthcare professionals: not reported. **Setting** Home, following discharge from a burn centre	*considered as a crucial moment in the care process. Yet, most burn centres do not have a written discharge protocol." (p5)* • Author's theme: Initiatives to foster good practices in discharge planning are not widely implemented ○ Example quote: *"Sunday evening they asked me 'Did it go well?' then I said 'It went pretty well, … yes,… but, … I lived all the week-end in a pigsty, cooking was nearly impossible because I could not properly use my fingers, etc. Next week-end, same story, and on Tuesday or Wednesday they let me go home." (p5)* • Author's theme: Discharge towards step down units or rehabilitation units ○ Example quote: *"We try to transfer patients from the burn centre to a general hospital ward to learn to function more autonomously, and go home after that." (p6)* • Author's theme: Ambulatory care in the hospital after discharge ○ Example quote: *"We have difficulties with the way the follow-up by physicians is organized. It's always an assistant or junior doctor. You*	**2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the rehabilitation experiences of multiple participants. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Purposive sampling might have led to bias in 1. when care coordinators contacted eligible patients and 2. when patients contacted researchers to confirm interest. However, variation in age, gender, if they underwent surgery, visibility of scars and more, ensured a wide range of patients and experiences. Invitations were sent to responsible physicians and representatives to ensure a range of professions included in healthcare professionals sample (although lack of information on how these participants were selected for interview). **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 3 forms of data collection were performed for different aspects of the data (semi-structured interviews to explore issues freely with the guarentee of anonymity,

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Participant characteristics N = 57 individuals involved in burn injury rehabilitation • Burn patients and parents: 29 ○ Adult burn patients: 15 ○ Parents of children under 12 years: 8 ○ Parents of adolescents between 12-18 years: 3 ○ Adolescents between 12 and 18 years: 3 • Healthcare professionals working in burn rehabilitation: 24 ○ Physicians: 7 ○ Allied healthcare professionals :17 ○ Burn care patient organisations: 4 *Characteristics of people with burn injuries (and their parents)* • Age (N): ○ (Parents of) children <12 years: 8 ○ 12-18 years: 3 ○ (Parents of) children 12-18 years: 3 ○ 18-30 years: 3 ○ 31-40 years: 1 ○ 41-65 years: 8 ○ >65 years: 3 *Characteristics of healthcare professionals*	*just have to be Lucky with the one in front of you. You cannot build-up a trusting relationship. I remember a doctor coming in the room and he said: "Tell me, what happened?" I thought: "Are you serious? After all this time you want us to tell our story?" Isn't there something like a patient medical record? It does not give you the impression that this physician will be able to effectively evaluate whether the injuries evolve well" (p6)* • Author's theme: The crucial role of informal support after discharge ○ Example quote: *"Fortunately, we had a psychologist at the hospital, otherwise, I would dare to say we wouldn't be a couple anymore" (p7)* • Author's theme: Communication and information towards the patient ○ Example quote: *"It is perhaps a silly detail, but at the start it is very difficult to estimate. You get a certificate for a three to six months leave and you think: "I will have a hard time during six months, but then it will all be over." Over… now I know that with burn injuries it will never be over" (p8)*	focus groups to see how the groups dynamic affects decisions made in burn aftercare and obervations of meetings to see the discussions within professional context). Topic guides developed for semi-structured interviews, based on prior visits to burn centres and scoping literature review. The guide was piloted with 4 participants, resulting in changes. These changes were not mentioned but the pilot interviews were not included in analysis. Focus groups were led by a moderator and included a reported to take notes of discussion. Interviews and focus groups were audio recorded and transcribed verbatim. Data saturation was reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews/focus groups and ethical approval granted by all hospitals involved and the central ethical committee of the University Hospital Leuven. Methods of confidentiality described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Good description of analysis process and how the themes were derived.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Profession (N): ○ Care coordinators: 4 ○ Nurses: 4 ○ Physicians: 7 ○ Anaesthetist: 1 ○ Plastic surgeons: 5 ○ Rehabilitation medicine: 1 ○ Physiotherapist: 3 ○ Psychologists: 4 ○ Social workers: 2 **Data collection and analysis** 90-120 minute semi-structured interviews were held for patients, rehabilitation physicians and representatives for patient burn organisations. Separate topic guides were developed for each different participant groups (including parents of adolescents and parents of children) informed by the literature and from burn centre site visits. The guide was focused around the main transitions experiences during rehabilitation, including discharge, return to home and reintegration into daily life. 2 x 150-minute focus groups were held for allied health professionals. These groups were hosted by a moderator, and included both an observer (taking notes on non-verbal cues) and a reporter (taking notes on the verbal discourse). Both interviews and focus groups were audio-recorded and transcribed verbatim.	• Author's theme: What makes reintegration in social life difficult? ○ Example quote: *"Patients with severe burn injuries are isolated from social life for months, sometimes even years. They are pulled away from their usual activities, their home, their family and friends. After hospitalization, they need to gradually pick up their former life, but with new bodily conditions" (p8)*	Adequate data presented to support findings. Multiple, independent researchers initially coded a sample of transcripts (14.3%), before 1 researcher applied to the rest of the interviews. No mention of larger group discussions to develop themes. No discussion of researcher bias or credibility of findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current question. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/minor concerns **Source of funding** Not reported **Other information** None

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Constant comparative analysis. Transcripts were read before initial coding and identification of emerging themes. 14% of transcripts were coded independently by 2 researchers, and resulting node trees were integrated and compared. Discrepancies were discussed and a final node tree was agreed.		

Full citation
Glenny, Christine, Stolee, Paul, Sheiban, Linda, Jaglal, Susan, Communicating during care transitions for older hip fracture patients: family caregiver and health care provider's perspectives, International journal of integrated care, 13, e044, 2013
 	
Ref Id
1179484
 	
Country/ies where the study was carried out
Canada
 	
Study type
Ethnographic study
 	
Study dates
January - December 2010
	Recruitment strategy
	Purposive sampling of adults with hip fracture post-surgery in acute care. Once they were enrolled, members of the patient's care network (family members and healthcare professionals) were identified and recruited.
	
	Inclusion criteria
	Participants had to:
	• Have a hip fracture
	• Be over 65 years old
	• Be able to converse in English
	
	Exclusion criteria
	• Patients with moderate to severe cognitive impairment
	
	Setting
	Throughout hip fracture rehabilitation pathway (including acute care, inpatient rehabilitation, convalescent care, home with home care, home without home care and retirement homes).
		Findings (including author's interpretation)
		
		This study is included in Stolee 2019, a framework-based synthesis of 12 primary studies. To prevent double counting of the data, findings have only been extracted from this study if they do not appear in the findings of Stolee 2019.
		
		• Author's theme: Family caregivers and health care providers recognise caregivers' involvement is beneficial
		  ○ Example quote: *"The health care providers and family caregivers acknowledged that family caregivers have an essential role in transitional care for elderly patients" (p5)*
		• Author's theme: No clear organisation or process is used to guide information sharing
		  ○ Example quote: *"When [the patients] are discharged we*
			1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)
			Yes - To explore the communication experiences of caregivers and healthcare professionals during transitional care of elderly hip fracture patients from inpatient to community rehabilitation.
			
			2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)
			Yes - Appropriate to explore the experiences of caregivers and healthcare professionals.
			
			3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)
			Yes - Research design discussed and justified.
			
			4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)
			Yes - Healthcare professionals were recruited from eligible patients, with the aim of recruiting 2 per healthcare setting of projected care pathway. Lack of information

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Participant characteristics N = 35 individuals involved in hip fracture rehabilitation • Healthcare professionals working in hip fracture rehabilitation: 26 • Caregivers of individuals with hip fracture: 9 *Characteristics of healthcare professionals* • Profession (N): ○ General practitioner: 1 ○ Nurse care manager: 8 ○ Occupational therapist: 6 ○ Physiotherapist: 4 ○ Registered practical nurse: 6 ○ Retirement home care manager: 1 • Setting (N): ○ Acute care: 11 ○ Inpatient rehabilitation: 6 ○ Convalescent care: 2 ○ Home with home care: 3 ○ Home without home care: 2 ○ Retirement home: 2 **Data collection and analysis** Semi-structured interviews with 2 trained data collectors. 2 healthcare professionals from the discharge setting would be interviewed, 2 healthcare professionals from the admission setting	*have CCAC come in when they are involved, so we all everybody kind of talks to the family, like CCAC gets involved so it is just kind of like a whole team effort. . . I knew that it had been arranged already. I don't know by who but it had been arranged. (Inpatient rehabilitation, nurse)" (p8)*	on no-responders but good number and variation across settings. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Use of semi-structured interviews described and justified. Carried out by experienced qualitative researchers. Interviews were audio-recorded and transcribed verbatim. Data collectors recorded notes every 30 minutes throughout the interviews, as well as field notes from time in healthcare settings and interviews. Notes included verbal and non-verbal cues, environment of interviews and personal feelings of researchers. However, data saturation not mentioned. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes - Use of multiple researchers during interviews, and the comprehensive notes taken during the study. Notes were taken at 30 minute intervals during study process and contained verbal cues, non-verbal cues, environment in which interviews took place and researcher's feelings during interviews. Yes - Use of multiple researchers during interviews, and the comprehensive notes taken during the study. Notes were taken at 30 minute intervals during study process and contained verbal cues, non-verbal cues,

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	would be interviews and 1 family caregiver would be interviews for each patient care transition. Topic guides were used and developed from prior field work with healthcare professionals. Interviews were audio-recorded and transcribed verbatim. Data collectors recorded notes every 30 minutes throughout the interviews, as well as field notes from time in healthcare settings and interviews. Notes included verbal and non-verbal cues, environment of interviews and personal feelings of researchers. Content-based analysis. Interview transcripts were read through by 2 independent researchers, who highlighted any data on information exchange, before performing initial coding. Inter-coding agreement was established by cross-checking the coded transcripts and differences were resolved through discussion with both researchers. Final codes and themes were developed through consensus with all team members.		environment in which interviews took place and researcher's feelings during interviews. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study approved by the Office of Research Ethics (University of Waterloo), the Tri-Hospital Research Ethics Board and Community Care Access Centre. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Adequate description of analysis process and how themes were derived with adequate data presented to support findings. Initial coding was performed independently by 2 researchers, resolving differences via discussion. Final codes and themes were developed through consensus with all team members. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current question - Only focuses on transition experiences between healthcare professionals and caregivers, rather than patients themselves. Non-UK data.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Overall methodological limitations (No or minor/Minor/Moderate/Serious) No/minor concerns **Source of funding** This study received funding from and Emerging Team Grant from the Canadian Institutes of Health Research. **Other information** Carers also included in sample but outside of PCC for this review. Data has not been extracted where possible.
Full citation Graff, Heidi J., Christensen, Ulla, Poulsen, Ingrid, Egerod, Ingrid, Patient perspectives on navigating the field of traumatic brain injury rehabilitation: a qualitative thematic analysis, Disability and Rehabilitation, 40, 926-934, 2018 **Ref Id** 1182084 **Country/ies where the study was carried out** Denmark **Study type**	**Recruitment strategy** Purposive sampling of people with TBI admitted to Copenhagen University Hospital between January 2010 and December 2014. *Inclusion criteria* Participants had to: • Be admitted to trauma centre at Copenhagen University Hospital between January 2010 and December 2014 • Be aged 18-60 years old at the time of admission • Have a mild, moderate or severe TBI (defined at 3-15 on the Glasgow Coma Scale) • Admitted to either ICU, neuro-intensive care unit or step-down unit • Able to converse adequately in Danish	**Findings (including author's interpretation)** • Author's theme: Family involvement: family dependence ○ Example quote: *"After discharge, I was very exhausted and slept most of the day. We have two small children, so the doctor and I decided that it was for the best that I moved in with my parents to get some peace and quiet, which can be difficult to find in a home with small children. (Jack, male, 39, moderate TBI)" (p930)* • Author's theme: Family involvement: family influence ○ Example quote: *"My dad has since the day I was run down struggled with the municipality*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the rehabilitation experiences of adults with TBI up to 4 years post injury, including facilitators and barriers. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of TBI rehabilitation in adults. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. 1-4 years post hospital discharge might introduce recall bias but appropriate for study aim.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Phenomenological study **Study dates** December 2014 - May 2015	*Exclusion criteria* • People with concurrent SCIs • People with previous or concurrent neurological disorders **Setting** The community following discharge from a Trauma Centre. **Participant characteristics** N = 20 adults with TBI • Age (at recruitment) [median (range)]: 39 (25-63) years • Gender (M/F): 12/8 • Time since injury: not reported. • Injury cause: not reported. • Severity of TBI as measured with Glasgow Coma Scale (N): ○ Mild: 8 ○ Moderate: 7 ○ Severe: 5 **Data collection and analysis** 30-90 minute semi-structured interviews conducted either in-person or via telephone, concentrating on their experiences of TBI rehabilitation journey	*to get me to the proper rehabilitation. While I was in the program my dad helped me to get two months of rehabilitation. (Steven, male, 25, severe TBI)" (p930)* • Author's theme: Rehabilitation impediments: lack of transparency ○ Example quote: *"I have been missing some information and notice about what is going to happen and when. Because very often things happen simultaneously, and that is very frustrating when you have a traumatic brain injury. (Dorothy, female, 56, moderate TBI)" (p931)* • Author's theme: Rehabilitation impediments: lack of systemic follow-up ○ Example quote: *"I would have liked some sort of checkup. Or they could have given me some written information that told me not to panic. But no one could give me an exact answer. I didn't know whether I should call my general practitioner, the physiotherapist or the hospital myself or not to. For instance, can I go to work or should I take it easy? (Jason, male, 39, mild TBI)" (p931)*	**4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Purposive sampling may have led to potential bias but eligible participants were identified from retrospective hospital records, and a good range of participants contacted. Numbers and reasons of those who declined to participate are reported. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 1st author conducted the interviews was not very experienced in qualitative interviews but was supervised by experienced team. Topic guide used (although no mention of how it was developed). Issues with participants recalling acute phase of TBI but outside of scope for this question. Interviews audio recorded and transcribed verbatim. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - Lack of information presented on researcher's bias and influence. Important as interviews (and subsequent field notes) were conducted by 1st author. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	and transitions. These interviews were conducted by first author. Field notes were taken during the interviews and used in the data analysis. Due to the theory that different severity of TBI would have different rehabilitation journeys, TBI severity of participants determined when they were invited for interviews - mild TBI interviewed 1-2 years post-injury, moderate TBI interviewed 2-3 years. post-injury and severe TBI interviewed 3-4 years post-injury. Hermeneutical phenomenological thematic analysis. 1 research read the interview transcripts and field notes to familiarise themselves with the data, before agreeing on these codes with another member of the research team. Sub-themes and themes were discussed between the research team before defining them.	• Author's theme: Rehabilitation impediments: lack of age-appropriate rehabilitation ○ Example quote: *"They have offered me rehabilitation in a gym on an exercise bike, which can be great for some people, but not for a young person with a traumatic brain injury. I want a good life later and I have more cognitive problems than physical. Then it's not enough. (Steven, male, 25, severe TBI)" (p931)*	Yes - Informed consent given before interviews and ethical approval granted by the Danish Data Protection Agency Danish National Board of Health and Medicines Authority. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Good presentation of data to support findings. Rigour was ensured by 2 researchers agreeing initial codes (although only 1 performed the initial coding) and the entire team developing final themes. Results were compared with previous studies, supporting data from patient journals used to both personalise interviews and verify the clinical information given in the interview e.g. cause of accident. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Moderate value to the current question - Long term follow-up of trauma patients in the community. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			No/very minor concerns **Source of funding** This study received funding from by the Rigshospitalet Research Foundation and Helsefonden. **Other information** None
Full citation Isbel, Stephen T., Jamieson, Maggie I., Views from health professionals on accessing rehabilitation for people with dementia following a hip fracture, Dementia (London, England), 16, 1020-1031, 2017 **Ref Id** 1110315 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** Not reported.	**Recruitment strategy** 3 experts in the area of hip fracture and dementia were contacted to participate in the trial. They were then asked to identify any other healthcare professionals with experience in the area who would be willing to participate. *Inclusion criteria* Participants had to: • Be currently practicing in orthopaedics, rehabilitation or aged care • Have a large proportion of their patients consisting of elderly people with fractures *Exclusion criteria* Not reported **Setting** Range of rehabilitation hospitals i.e. urban and rural.	**Findings (including author's interpretation)** • Author's theme: What works well ○ Example quote: *"'Part of the other agenda is how you blend in the family into the rehabilitation. I think that's another area that could be worked on" (p1027)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the experiences and opinions of healthcare professionals regarding how dementia affects rehabilitation care after hip fracture. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore experiences and views of healthcare professionals. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** No - 3 experts were initially approached, with no explanation of how they were identified. They were then asked to volunteer other healthcare professionals in

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Participant characteristics N = 12 healthcare professionals working in hip fracture rehabilitation and dementia Occupation (N): • Clinical nurse specialist: 1 • Geriatrician: 5 • Nurse manager: 2 • Ortho-geriatrician: 2 • Physiotherapist: 1 • Rehabilitation physician: 1 **Data collection and analysis** 30 - 45 minute semi-structured interviews conducted via telephone, over a period of 4 weeks. Data analysis began after 6th interview was completed, using thematic analysis.		the area that might 'provide interesting insights and opinions'. Language is inherently biased. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Data collection method discussed and justified. Topic guide was used and published in write up but no mention of how it was developed. Data saturation reached after 9th interview. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received and reconfirmed before interviews and ethical approval granted by the Human Research Ethics Committee (University of Canberra). **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of the analysis process and how themes were derived, using multiple, independent researchers. Adequate data presented to support findings. No discussion of potential researcher bias.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			9**. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. No discussion of study credibility or limitations. **10. How valuable is the research?** Limited value for current question - Very specific population. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns. **Source of funding** This study received funding from the Dementia Collaborative Research Centre - Assessment and Better Care. **Other information** None
Full citation Jeyaraj, J. A., Clendenning, A., Bellemare-Lapierre, V., Iqbal, S., Lemoine, M. C., Edwards, D., Korner-Bitensky, N., Clinicians' perceptions of factors contributing to complexity and intensity of care of outpatients with traumatic	**Recruitment strategy** Convenience sampling and snowball sampling. Potential participants were identified through clinical research co-ordinators at organisations running an outpatient TBI programme, plus e-mail posters and short presentations. No further details reported. *Inclusion criteria*	**Findings (including author's interpretation)** • Author's theme: Additional patient-related factors linked to complexity ○ Example quote: *"A key point that surfaced throughout the discussions was that 'therapists working in TBI rehabilitation are*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore healthcare professionals views on which rehabilitation factors affect complexity TBI outpatient rehabilitation. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
brain injury, Brain Injury, 27, 1338-1347, 2013 **Ref Id** 1110342 **Country/ies where the study was carried out** Canada **Study type** General qualitative inquiry **Study dates** Not reported.	Not reported. *Exclusion criteria* Not reported. **Setting** TBI rehabilitation outpatient clinics **Participant characteristics** N = 12 healthcare professionals working in TBI rehabilitation No demographic information reported. **Data collection and analysis** 2 x 2-hour focus groups conducted in French (preferred language) plus 5 x 1 hour semi-structured interviews (4 in French, 1 in English). Before each, clinicians completed a brief questionnaire regarding socio-demographic information and their experiences treating TBIs patients as outpatients. During focus groups and interviews, participants were asked regarding typical patients, complex patients, barrier and facilitators to caring for people with complex TBI and possible changes to improve services. Focus groups were conducted by 2 moderators with 2 assistants writing notes and a 3rd assistant writing a summary of comments to be reviewed by the group for accuracy. Individual	*not only treating the body but the person as a whole', the implications of such a therapeutic approach can be difficult to understand at the administrative level.(p1341)* • Author's theme: Factors relating to the patient's environment ○ Example quote: *"return[ed] [. . .] to their usual environment often start again to take drugs and hang out with people who are of a bad influence" (p1342)* • Author's theme: Institutional barriers to optimal service provision ○ Example quote: *"..such as family doctors or professionals working in CLSCs (community healthcare services in Quebec), [who] don't know the issues related to TBI" (p1343)* • Author's theme: Factors facilitating the intervention process ○ Example quote: *"Another theme expressed by the clinicians focused on the impact that improved primary service provision has on the patients they see in out-patient care. Namely, they reported that the evolution of medicine, including the precision of medical tests, and the efficacy of post-TBI acute care delivery,*	Yes - Appropriate to explore experiences and views of healthcare professionals involved in TBI rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Convenience sampling and snowball sampling can both introduce bias and there is a lack of information presented on the recruitment methods to discern if it was mitigated in any way. No information presented on who were emailed, where was included in the presentations and who declined to participate. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Semi-structured interviews and focus groups both used in order to ensure maximum availability of clinicians. Researchers were all bilingual, so were able to translate the French into English, but there was no mention of which stage this occurred e.g. at the beginning or at the end. Also no mention of what happened to the notes assistants were taking during the groups and interviews. Audio recorded and transcribed. Data saturation reached.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	interviews were conducted 2-on-1, with a moderator carrying out the interview and an assistant to take notes. Content-based thematic analysis. The entire research group were involved in identifying emerging themes and key points each question. Themes were finalised by consensus, using iterative coding and grouping. Quotes representing themes were categorised with the topic areas and entered into the analysis. Specific quotes were selected to represent certain themes.	*greatly facilitates the management of cases referred for outpatient TBI rehabilitation" (p1343)*	**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Small amount of information presented on how collective analysis was used to validate findings but lack of information presented on researcher's bias and influence. Important during focus groups as it might have increased social acceptability bias. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - Article mentions that the study was approved by the Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal but no mention of ethical consideration specifically. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Brief description of analysis process and how the themes were derived. Poor presentation of data to support findings. All transcripts were sent to all participants before analysis stage for verification (although no mention of validation after analysis). The entire research group were involved in identifying emerging themes and key points, with themes finalised by consensus (although no mention of independent coding).

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			9. Is there a clear statement of findings? (Yes/Can't tell/No) Yes - Good description and discussion of findings, with relation back to the original research question. Discussion of study limitations and future research directions. **10. How valuable is the research?** Moderate value for current question - Specifically looking at how TBI complexity affects rehabilitation. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the School of Physical and Occupational Therapy, McGill University. **Other information** None
Full citation Jourdan, Claire, Bahrami, Stephane, Azouvi, Philippe, Tenovuo, Olli, Practitioners' opinions on traumatic brain injury care pathways in Finland and France: different organizations, common issues, Brain Injury, 33, 205-211, 2019	**Recruitment strategy** Participants were medical practitioners chosen to reflect the entirety of the TBI care pathway. No further details reported. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported.	**Findings (including author's interpretation)** • Author's theme: Availability of adequate services, from acute care to re-entry support ○ Example quote: *"Practitioners from both settings mentioned the insufficiency of dedicated beds in acute and post-acute care." (p208)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To compare TBI care pathways and explore the views of healthcare professionals on TBI care provision in Varsinais-Suomi, Finland and Ile-de-France, France. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Ref Id 1182358 **Country/ies where the study was carried out** France and Finland **Study type** Phenomenological study **Study dates** Not reported	**Setting** Across TBI rehabilitation care pathways in Ile-de-France (France) and Varsinais-Suomi (Finland). **Participant characteristics** N = 10 healthcare professions working in TBI rehabilitation • Working in Finland:6 • Working in France: 4 • Profession (N): ○ ICU practitioner:1 ○ Neuro-anaesthetist: 3 ○ Neurologist: 4 ○ Neurosurgeon: 2 • Department (N): ○ ICU: 4 ○ Neurological outpatient clinic: 1 ○ Neurosurgery: 2 ○ Physical medicine and rehabilitation: 1 ○ Rehabilitation and Brain Trauma Care: 1 • Experience working in TBI rehabilitation (range): 8 – 25 years **Data collection and analysis**	• Author's theme: Delays before comprehensive rehabilitation Example quote: *"Whether in an outpatient or inpatient setting, comprehensive rehabilitation did not appear to start early enough." (p209)* • Author's theme: Pathway-related decision-making ○ Example quote: *"Decision criteria for admission to IR were reportedly less clear-cut than for other acquired brain injuries such as stroke." (p209)*	Yes - Appropriate to explore the views of healthcare professionals on care provision. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Good justification of why a range of healthcare professionals were sought but lack of information presented on how participants were recruited. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - Data collection method discussed and justified. Topic guide used and published in the write-up. However, interviews were not audio recorded and instead were recorded using details field notes which involves a certain amount of translation before analysis begins. Data saturation not reached in data analysis but was in the individual interviews. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - No details reported and analysis relying solely on field notes taken by the researcher. Interviewer only had experience

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	45-60 minute semi-structured interviews conducted. The interviews covered details of TBI care received, finance, care transition and quality of care issues. Review questions were used to confirm interviewer's understanding of answers. Interviews were recorded using details field notes. Thematic analysis was used to code and organise data into themes.		of French TBI pathway, rather than both or neither. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - Study mentions that there was no legal need for ethical approval as patients were not contacted. No further details reported. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Adequate description of the analysis process and how themes were derived. Initial findings were verified by 1 participant from each area. Adequate data presented to support findings. No mention of multiple, independent assessors. No discussion of researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about limitations of study. **10. How valuable is the research?** Limited value for current question - Lack of data concerning transition home. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious concerns

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Source of funding This study received funding from Société Française de Médecine Physique et de Réadaptation. **Other information** None
Full citation Kennedy, Nicole, Barnes, Jessica, Rose, Anna, Veitch, Craig, Bowling, Cott Dahlberg Degeneffe Gage Higgins Keightley Majdan McCabe McColl O'Callaghan Patterson Patton Patton Schlossberg Sheppard Sinnakaruppan Smith Turner Turner Turner Turner Turner Voss, Clinicians' expectations and early experiences of a new comprehensive rehabilitation case management model in a specialist brain injury rehabilitation unit, Brain Impairment, 13, 62-71, 2012 **Ref Id** 1179875	**Recruitment strategy** No details reported after study dates and the inclusion/exclusion criteria. *Inclusion criteria* Participants had to: • Be aged between 18-65 years old • Still be in a post-traumatic amnesia state as defined by Westmead Post-traumatic Amnesia Protocol • Have an expected admission between 2-6 months *Exclusion criteria* • Patients in a minimally responsive state • Patients with non-TBI **Setting** Specialised TBI rehabilitation unit **Participant characteristics**	**Findings (including author's interpretation)** • Author's theme: Continuity of care ○ Example quote: *"Generally I think it is working really well. I think it has taken a lot of pressure off other therapists in relation to the contact person role. It is a lot smoother having one person do that coordination and transition into the community and linking services particularly rehabilitation for clients. (I4, inpatient therapist, T2)" (p68)* • Author's theme: Streamlining service delivery ○ Example quote: *"It really helps us to prioritise who needs to be picked up quickly versus those who are stable and may not need as much intervention straight away. (I2, community team, T2)" (p68)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the views of healthcare professionals on the design, implementation and acceptability of a new comprehensive rehabilitation case management (CRCM) model. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of healthcare professionals on the effects of a new case management model. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Country/ies where the study was carried out Australia **Study type** Qualitative case study **Study dates** May 2011 - September 2012	N = 32 healthcare professionals working in TBI rehabilitation • T1 = 15 healthcare professionals ○ Brain injury unit clinician: 12 ○ Rehabilitation case manager: 3 • T2 = 17 healthcare professionals ○ Brain injury unit clinician: 10 ○ External stakeholders: 3 ○ Rehabilitation case manager: 4 No further demographic information reported. **Data collection and analysis** 20-40 min semi-structured interviews (either in person or via telephone) conducted at 2 time points (May 2011 and September 2011). During initial interviews, participants were asked about the new model and what impact it might have for patients and their caregivers. The follow-up interview concerned views on how the model was working, what changes they might make to improve the model and what impact the new model had on their practice. Interviews were audio-recorded and transcribed. Transcripts were coded, with themes and key ideas identified. Any issues were discussed with the research team, in order to make sure the results reflect the new models implementation and practice.	• Author's theme: Driving discharge planning ○ Example quote: *"In the past, in case conferences, the same issues kept coming up. We were not moving anywhere and the process was so slow. I think having someone doing things and actually facilitating the process of discharge, things will flow on much better. So I can see the benefit. (I10, inpatient team, T1)" (p68)* • Author's theme: Transitions to external stakeholders ○ Example quote: *"It was really effective having the case manager Cc'ingme into those communications. I felt that I was really up to date. It has also been helpful because it has alerted me to some possible issues before the client came home, rather than finding them out as difficult surprises. (I15, external service provider, T2)" (p68)* • Author's theme: Potential challenges ○ Example quote: *"Our rehabilitation case managers have picked up a lot of work. They need to attend case conferences, which for me working part-time takes away their availability to us. So it does have a reciprocal effect*	Can't tell. No information reported after study dates and inclusion/exclusion criteria. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - Interviews were carried out on site, audio-recorded and transcribed. Interviews carried out at 2 time points in order to achieve a better evaluation, with 4 month time period described and justified. Brief description of interview content, although no mention of topic guide. Only 2 patients had been discharged at T2, meaning limited real world experiences and views of the discharge process. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval received from Human Research Ethics Committee and informed consent received from all participants **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Brief description of analysis process and how the themes were derived. Only 1 person coded the transcripts, although full evaluation team discussed and

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
		on the team. They may need increased hours to support that inpatient role. (I1, community team, T2)" (p69)	resolved any issues. Good presentation of data to support findings. No further mention of credibility or researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about limitations of study. **10. How valuable is the research?** High value for current question - Specifically evaluating case management intervention throughout the care pathway. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** Not reported. **Other information** None
Full citation Kornhaber, Rachel, Rickard, Greg, McLean, Loyola, Wiechula, Rick, Lopez, Violeta, Cleary, Michelle, Burn care and rehabilitation in Australia: health professionals' perspectives, Disability	**Recruitment strategy** Maximum variation sampling. Eligible participants were identified through professional registries and contacted with study details by the first author. *Inclusion criteria* Participants had to: • Be a healthcare professional	**Findings (including author's interpretation)** • Author's theme: Inter-professional collaboration ○ Example quote: *"So we actually didn't have a model of care or any … policies and procedures in place and we've kind of been*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore healthcare professional's experiences of acute care and rehabilitation in patients with burn injuries. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
and Rehabilitation, 41, 714-719, 2019 **Ref Id** 1182463 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** 2016	• Working in adult burn care and/or rehabilitation • Working at a facility within Australia *Exclusion criteria* Not reported. **Setting** Range of burn rehabilitation settings (acute, rehabilitation and community). **Participant characteristics** N = 22 healthcare professionals working in burns injuries • Occupation (N): ○ Doctor: 4 ○ Nurse: 9 ○ Occupational therapist: 3 ○ Physiotherapist: 4 ○ Psychologist: 1 ○ Social worker: 1 **Data collection and analysis** Semi-structured interviews were conducted in person and via telephone depending on participant preference. Questions focused on healthcare professional's experiences of providing rehabilitation care, their current care pathways and resource implications. Thematic analysis was used to code and organise data into findings.	*working them out on the fly as well go." (p716)* • Author's theme: Integrated community care ○ Example quote: *"the strength is all of us working together. We all want what's best for the patient … there was a lot of silo functioning before and … we're getting a lot better, working together as a team and being able to listen to each other and what the concerns are. (N) (P18)" (p715)* • Author's theme: Empowering patients to self-care ○ Example quote: *"Because their lives have changed so drastically. In many cases it's the family that actually needs a lot more support than the patient" (p717)*	Yes - Appropriate to explore the views of healthcare professionals involved in burn rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Maximum variation sampling used to recruit people from a variety of healthcare disciplines (although contacted by 1st author which might introduce response bias). Eligible participants were identified from professional registries but lack of information on which ones and how many. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Data collection method discussed and justified. Topic guide used was developed following literature review. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			7. Have ethical issues been taken into consideration? (Yes/Can't tell/No) Yes - Informed consent received and ethical approval granted by the Human Research Ethics Committee. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how themes were derived. Adequate data presented to support findings. Mentions that credibility, transferability, dependability and confirmability were used throughout the study (although lack of information on how this was achieved and no mention of multiple, independent researchers). **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current study - Wide range of perspectives sought across professions and settings. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/minor concerns **Source of funding**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Not reported. **Other information** None.
Full citation Lindahl, Marianne, Hvalsoe, Berit, Poulsen, Jeppe Rosengaard, Langberg, Henning, Quality in rehabilitation after a working age person has sustained a fracture: partnership contributes to continuity, Work (Reading, Mass.), 44, 177-89, 2013 **Ref Id** 1180086 **Country/ies where the study was carried out** Denmark **Study type** Qualitative case study **Study dates** January - March 2009	**Recruitment strategy** Adults with bone fractures were recruited through therapists in public hospitals and municipalities across the region. Unsuccessful attempts were made to contact private service users. *Inclusion criteria* • Aged 18-64 years old • Experienced short- or long- term rehabilitation • Were employed • Not retired before accident *Exclusion criteria* Not reported. **Setting** In the community, after discharge from rehabilitation. **Participant characteristics** N = 7 adults with bone fractures • Age [median (range)]: 51 (32-60) years • Gender (M/F) = 5/2	**Findings (including author's interpretation)** • Author's theme: Patient's perspective: management continuity ○ Example quote: *"Then they suggested that I had a toilet chair placed in the living room, and we were speechless. I couldn't sit and . . . you know, in here where we eat and so. Then we worked it through, but my wife had to say – well you can send him home, but I am not sure I'll be here. I really had to get rough on them. Then we got through and it was okay" (p181)* • Author's theme: Therapists' perspective: transition process from the hospital to the community ○ Example quote: *"When we know each other (employees across sectors) you get a larger framework of understanding for each other. You can easier agree that we want to solve this together. Instead, we use a lot of time on the phone and mail*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – To explore the experiences of orthopaedic trauma patients when transferring between acute hospital care and community settings. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes – Appropriate to explore the views and experiences of trauma patients when transferring between settings. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Maximum variation sampling used, ensuring a wide range of accessibility levels (all age groups, healthcare funding and degree of rurality).However, there is a lack of information presented on the how the initial survey was administered/delivered.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Time since injury (range): 2-24 months • Fracture type (N): ○ Upper extremity: 3 - Simple:2 - Multiple: 1 ○ Lower extremity: 6 - Simple: 5 - Multiple: 1 **Data collection and analysis** Individual semi-structured interviews were audio-taped and transcribed verbatim. These were analysed inductively according to a grounded theory approach, between two researchers.	*with people we do not know and maybe from day to day new therapists have to engage in new cases again [physiotherapist, hospital]" (p183)* • Author's theme: Therapists' perspective: continuity and return to work Example quote: *"I haven't heard anyone talk positively about the contact; they feel misunderstood by the system. They are sick and need time to recover" (p184)*	**5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Open interviews discussed and justified. The setting for interviews was chosen by the interviewee, with interviews audio-recorded and transcribed. Mentions that TBI might affect recall of events in the care continuum, which was mitigated by including significant others. No mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence although mentioned that interviews were carried out with minimal input from researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - There is discussion of consent, but a caveat that Danish national law doesn't require permission from an ethics board for this type of study. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes – Good description of analysis process and how themes were derived. Appears as though multiple researchers were used but no mention of independence. Good presentation of data to support findings. A summary of each interview was sent to

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			participants for validation of the content, with all agreed with. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – Good description of findings with relation back to original question. Mention of participant validation although no discussion of limitations. **10. How valuable is the research?** Limited value for current question - Focuses on engagement with rehabilitation rather than coordination and delivery. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor **Source of funding** Not reported. **Other information** None
Full citation O'Callaghan, Anna, McAllister, Lindy, Wilson, Linda, Insight vs readiness: factors affecting engagement in therapy from the perspectives of adults with TBI and their significant others, Brain Injury, 26, 1599-610, 2012	**Recruitment strategy** Maximum variation sampling using survey respondents from an earlier stage of the research. Characteristics used in the selection were degree of rurality, level and type of healthcare funding they were entitled to. *Inclusion criteria*	**Findings (including author's interpretation)** • Author's theme: Right service at the right time: things could have been different ○ Example quote: *"Even if they had have been able to give us a list of services, it may have*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the concept of engagement throughout the TBI rehabilitation care continuum and the factors that affect engagement. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Ref Id 1180418 **Country/ies where the study was carried out** Australia **Study type** Phenomenological study **Study dates** Not reported	Not reported. *Exclusion criteria* Not reported. **Setting** In the community, following discharge **Participant characteristics** N = 23 • Adults with moderate-severe TBI: 14 • Significant others of adults with moderate-severe TBI: 9 *Characteristics of adults with TBI* • Age in years (N): ○ 18-25 years: 2 ○ 26-35 years: 3 ○ 36-45 years: 3 ○ 46-55 years: 3 ○ 56-65 years: 3 • Gender (M/F): 8/6 • Time since injury: not reported. • Injury cause: not reported. **Data collection and analysis** 45-150 min open interviews with minimal input from the researcher, focusing on	*saved us a lot of drama and hassle and heartache. They need to make you aware of this may happen and if that happens, do this and give you a checklist or something" (p1607)*	Yes - Appropriate to explore perceptions of engagement throughout the TBI rehabilitation care pathway. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Maximum variation sampling used to ensure wide range of accessibility levels. However, no information presented on the initial survey that participants were sampled from. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence although mentioned that interviews were carried out with minimal input from researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	the patient's views and experiences of the TBI rehabilitation journey. Significant others were also included in the interview process if they came with the patient to the interview. The setting for interviews was chosen by the interviewee. Interviews were audio-recorded and transcribed. Thematic analysis. Researcher's first listened to the recordings of interviews, noting key idea and common themes. Recordings were transcribed and hand-coded, before being loaded into NVivo and re-coded. First level codes were condensed into overarching themes, with the process repeated for 2nd order and 3rd order themes. Interviews were re-checked to ensure consistency with codes and participants were sent a summary of their interview for validation.		Can't tell – No information given. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell – Adequate description of analysis but no mention of researcher influence. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – Good description of findings and mention of participant validation. **10. How valuable is the research?** Limited value for current question. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from Speech Pathology Australia Postgraduate Student Research Grant. **Other information** Significant others also included in sample but outside of PCC for this review. Data has not been extracted where possible.
Full citation Odumuyiwa, Tolu, Improving access to social care services following acquired brain injury: a needs analysis, Journal of	**Recruitment strategy** All participants were recruited through adverts on Twitter, Headway UK and brain injury rehabilitation organisations throughout the UK. No further details reported.	**Findings (including author's interpretation)** • Author's theme: Impact of ABI: Cognitive and behavioural effects of ABI	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To identify the long-term rehabilitation needs of patients with acquired brain injury and their families, and explore their

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Long-Term Care, 164-175, 2019 **Ref Id** 1182919 **Country/ies where the study was carried out** UK **Study type** General qualitative inquiry (within mixed methods study) **Study dates** Not reported	*Inclusion criteria* Participants had to: • Adults with ABI - have sustained an acquired brain injury (at any point) that led to a disability • Family members - be related to an ABI patient as described above • Healthcare professionals - have worked in ABI treatment for a minimum of 2 years *Exclusion criteria* Not reported. **Setting** Community ABI rehabilitation services. **Participant characteristics** <u>Stage 1</u> N = 76 • Adults with ABI: 19 • Family members of people with ABI: 26 • Healthcare professionals working in ABI rehabilitation: 32 *Characteristics of adults with ABI* • Age [mean (range)]: 44.6 (29-72) years • Gender (M/F): 10/9	○ Example quote: *"Poor understanding of implications of cognitive and behavioural changes, so poor capacity assessments/ care needs assessments" (p172)* • Author's theme: Types of services required ○ Example quote: *"You'd be a bit more in the system … you'd have a follow up appointment…and they would know why you needed help, like they would know they would have you on file." (p169)* • Author's theme: Poor access to support: Limited service provision ○ Example quote: *"There is not a specialist service operating in our area and therefore these clients are missing out on specialist rehab. [S31]" (p170)* • Author's theme: Poor access to support: Lack of professional knowledge ○ Example quote: *"Mental health services […] told a brain injured client that they have capacity to deal with their own finances despite the client telling them 'I will spend all my money if I was to have a large sum of money. MHS proceeded to tell the client that they could help the client have capacity to manage their money." (p170)*	experiences with accessing community services. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the experiences and views of rehabilitation patients in accessing services. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Wide variety of forums used to recruit participants. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Using different modes throughout the study i.e. free-text questions and interviews, was described and justified well. However, no mention of topic guide and how it was developed. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Characteristics of adults with ABI patients and family members • Injury cause (N): o Traumatic: 34 - Assault = 6 - Falls = 7 - Motor vehicle accident = 17 - Sports/work-related injuries = 4 o Non-traumatic: 11 • Time since injury (range): 1 – 41 years *Characteristics of healthcare professionals* • Age [mean (range)]: 35.3 (19-60) years • Gender (M/F/Not reported): 11/18/3 No further details reported. <u>Stage 2</u> N = 21 • Adults with ABI: 12 • Family members of adults with ABI: 5 • Healthcare professionals: 4 *Characteristics of adults with ABI* • Age [mean (range)]: 45 (36-72) years • Gender (M/F): 10/2	• Author's theme: Poor access to support: Organisational factors o Example quote: *"They're set out to manage people through…meetings, where people aren't actually in the meetings, so it's like a professionals meeting, which I think is ridiculous, urm or they don't actually go to the address, and they don't actually leave their offices – but their organisation just isn't set up for that frontline delivery." (p171)*	**7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes – Ethical approval granted by the University faculty ethics committee although informed consent poorly described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes – Good description of the analysis process and how themes were developed. Adequate data presented to support findings. While only 1 researcher involved in coding, results were validated by another member of the research team. No discussion of researcher's bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. No discussion on credibility of findings. **10. How valuable is the research?** High value for current question - Good description of needs when transferring back into the community using both patients and healthcare professionals. UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor concerns. **Source of funding**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	No further details reported. *Characteristics of healthcare professionals* • Age [mean (range)]: 42 (40-43) years • Gender (M/F): 1/3 No further details reported. **Data collection and analysis** Stage 1: Online questionnaire using platform SurveyMonkey, including free-text questions on the long-term needs following ABI. These questions were analysed using content analysis by 1 researcher, and checked by another member of the research team. Themes identified in this stage were used to inform a deductive framework for use in the analysis of stage 2. Stage 2: At the end of the questionnaire, participants were given the opportunity to complete follow-up semi-structured interviews on service needs and communication between healthcare and social care services. Interviews lasted 25-60 minutes, either in person (ABI patients) or via telephone (carers and healthcare professionals). Interviews were analysed using a mixture of inductive and deductive thematic analysis.		Not reported **Other information** Family carers also included in sample but outside of PCC for this review. Data has not been extracted where possible.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Full citation Sena Martins, Bruno, Fontes, Fernando, Hespanha, Pedro, Barnes, Barnes Davis Fontes Fontes Goffman Guion Hahn Henriques Hughes Klein Leder Martins Martins Oliver Oliver Oliver Santos Somers Stiker Stone Turner Wall, Spinal cord injury in Portugal: Institutional and personal challenges, Journal of Disability Policy Studies, 28, 119-128, 2017 **Ref Id** 1183258 **Country/ies where the study was carried out** Portugal **Study type** Qualitative case study (within mixed methods study) **Study dates** Not reported	**Recruitment strategy** Purposive sampling of SCI patients and healthcare professionals in 3 Portuguese SCI rehabilitation centres in Portugal that specialise in SCI rehabilitation. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** SCI rehabilitation centre **Participant characteristics** N = 93 • Individuals with SCI in initial rehabilitation: 28 (fieldwork I) • Healthcare professionals working in SCI rehabilitation centre: 22 (fieldwork I) • Individuals with SCI living in community: 29 (fieldwork II) • Family and institutional support organisations: 14 (fieldwork II) No demographic information reported. **Data collection and analysis**	**Findings (including author's interpretation)** • Author's theme: Returning home ○ Example quote: *"Even the homes . . . There isn't enough provision . . . There are also long-term care units but a patient has to have clinical criteria to be admitted, social reasons are not enough. And this places great restrictions on us and sometimes people are here a very long time before they are discharged. (Social worker)" (p124)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the experiences and views of patients undergoing SCI rehabilitation in Portugal. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the experiences and views of SCI rehabilitation patients. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. 2 stages used to cover the initial trauma recovery phase in hospital and then follow the challenges with reintegrating into the community after discharge. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Direct observation occurred in all 3 Portuguese rehabilitation centres specialising in SCI. Reasons given why 4th was not included. Purposive sampling was carried out for semi-structured interview phase. SCI patients were sampled to ensure heterogeneity. Healthcare professionals were sampled to ensure a wide variety of disciplines throughout inpatient rehabilitation.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Fieldwork II: Involves both qualitative and quantitative methods. 2 groups of participants - SCI individuals living in the community and community support networks (both family and institutional). Semi-structured interviews were conducted with SCI individuals, with 5 of these selected for further analysis. These 5 interviewees created a map of relevant community organisations and family support networks. These organisations underwent semi-structured interviews as well. Content analysis carried out for this data.		**5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Can't tell - Data collection used 2 methods (semi-structured interviews and direct observation) in order to validate results of each. discussed but no justification given. 10 days of direct observation Stage 1 involved 10 days of direct observation carried out in rehabilitation centres but no mention of how many rehabilitation centres involved or how the process was carried out. No mention of topic guide or how it was developed. No mention of data saturation, but this is not the aim of the study. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Small amount of information presented on how collective analysis and peer debriefing was used to validate findings. However, minimal information on how direct observation was carried out so unsure how this might impact the relationship between researcher and participants. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received and study complied with American Psychological Association ethical guidelines. Anonymity procedures described.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No) Yes – Adequate description of how data analysis was carried out and how themes were developed, including how data from interviews and observation were combined. Good presentation of data. Discussion of collective analysis and researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion on how credibility was increased. **10. How valuable is the research?** Moderate value for current question - Investigates a wide range of perspectives over the acute and chronic stages of SCI rehabilitation. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from Portuguese Foundation for Science and Technology. **Other information** This study has 2 parts – Fieldwork I and fieldwork II. Fieldwork I was aimed at investigating initial SCI rehabilitation,

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			recruiting newly injured SCI patients in initial rehabilitation and healthcare professionals working in rehabilitation centres. Fieldwork II was aimed at investigating the process of patients with SCI re-integration back into the community, recruiting people with SCI residing in the community and support organisations for SCI. Fieldwork I will be included for review question 4.1a and fieldwork II will be included in review question 4.2a.
Full citation Sims-Gould, Joanie, Byrne, Kerry, Hicks, Elisabeth, Khan, Karim, Stolee, Paul, Examining "success" in post-hip fracture care transitions: a strengths-based approach, Journal of Interprofessional Care, 26, 205-11, 2012 **Ref Id** 1180831 **Country/ies where the study was carried out** Canada **Study type** Ethnographic study **Study dates**	**Recruitment strategy** Convenience sampling. 2 emails were sent to community- and hospital-based healthcare professionals working with older hip fracture patients within the 2 healthcare regions included in the study. Subsequent participants were requested to encourage their colleagues to also participate. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** Across several healthcare settings Setting (N): • Community: 5 • Hospitals: 10	**Findings (including author's interpretation)** *This study is included in Stolee 2019, a framework-based synthesis of 12 primary studies. To prevent double counting of the data, findings have only been extracted from this study if they do not appear in the findings of Stolee 2019.* • Author's theme: Information gathering and communication ○ Example quote: *"in this case, a pre-discharge home visit, but providers on acute units acknowledged that although pre-discharge home visits are invaluable, they are rarely conducted" (p207)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the views of healthcare professionals on which factors are needed for a successful transition of care in patients after hip fracture. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of healthcare professionals on transition of care in hip fracture rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
March 2010 - July 2010	• Rehabilitation centres: 2 **Participant characteristics** N = 17 healthcare professionals working in hip fracture rehabilitation • Profession (N): ○ Nursing: 3 ○ Occupational therapy: 4 ○ Physiotherapy: 4 ○ Physician: 2 ○ Social work: 4 • Experience in current profession (range): 8 months - 36 years **Data collection and analysis** 45-90 minute semi-structured interviews. The research team requested that interviewees also bring along any documents that they use during care transition in hip fracture rehabilitation. Interviews were audio recorded and transcribed by an external agency. Thematic analysis. Conducted by the 3 researchers who conducted the interviews. Firstly, each of these read 2 interview transcripts to develop the initial coding framework. This was applied throughout all transcripts by 1 researcher. Key themes relating to successful transitions were discussed		Yes - Convenience sampling used, with recruited participants being asked to encourage colleagues to participate. However, this is appropriate method due to the specific population targeted and only 4 participants were recruited through colleague encouragement. Additionally, a wide range of settings were contacted (including long-term care, residential care, private homes, acute hospital wards, sub-acute hospital wards and rehabilitation wards). **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Semi-structured interviews described and justified, with 80 documents used in transition seen alongside. Topic guide described briefly, although no mention of how it was developed. Multiple researchers with qualitative research experience. 1st few interviews were pilots with all researchers to ensures similarity. Interviews audio-recorded and transcribed. No mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Small amount of information presented on how peer debriefing was used to validate findings but no information presented on whether relationship between

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	and developed between the research team.		researchers and participants was considered. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval granted by University of British Columbia ethics board and both participating healthcare regions in British Columbia. However, no mention of informed consent. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Rigour ensured by multiple methods of data collection with key themes developed between the research team. Additionally, final results were distributed to the healthcare professionals of 2 community settings and 2 hospital settings, and feedback on the data was sought. Adequate presentation of data to support findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Limited value for current question - Lack of information on transfer to outpatients. Non-UK data.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Overall methodological limitations (No or minor/Minor/Moderate/Serious) Minor concerns **Source of funding** This study received funding from Canadian Institutes of Health Research (CIHR) grant and a CIHR post-doctoral fellowship. **Other information** None
Full citation Singh, Gurkaran, MacGillivray, Megan, Mills, Patricia, Adams, Jared, Sawatzky, Bonita, Mortenson, W. Ben, Patients' Perspectives on the Usability of a Mobile App for Self-Management following Spinal Cord Injury, Journal of Medical Systems, 44, 26, 2019 **Ref Id** 1183310 **Country/ies where the study was carried out** Canada **Study type**	**Recruitment strategy** Consecutive sampling eligible participants who were admitted to the study rehabilitation centre with SCI. No further details reported. *Inclusion Criteria* Participants had to: • Be receiving inpatient SCI rehabilitation treatment • Be 18 years old or above • Have a ASIA Grade of A to D • Be able to communicate in English • Be able to provide informed consent *Exclusion criteria* • Co-morbid diagnosis of TBI or cognitive impairment. **Setting** SCI inpatient rehabilitation centre	**Findings (including author's interpretation)** • Author's theme: Being intuitive to navigate ○ Example quote: *"The calendar and appointments tracker do not give you notifications which is problematic because I [would] use it [if it had] reminders. There is no point to have [these tools] without notifications." (p26)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the acceptability of a novel mobile phone application designed to facilitate self-management skills in adults with SCI, and their experiences using the application in both inpatient to outpatient settings. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore views and acceptability of a self-management intervention in SCI rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
General qualitative inquiry (within wixed methods study) **Study dates** Spring 2015 - Winter 2016	**Participant characteristics** N = 20 adults with SCI • Age [mean (SD)]: 41 (18) years • Gender (M/F): 17/3 • Length of time since injury: not reported • Injury cause (N): o Traumatic: 15 o Non-traumatic: 5 • Level of injury (N): o AISA Score - A: 8 - B: 5 - C: 6 - D: 1 o Cervical: 15 o Thoracic: 4 o Lumbar: 1 **Data collection and analysis** Post-discharge exit questionnaire was administered including free-text questions regarding experiences using self-management mobile app for people with SCI. Researchers also had brief interactions with participants using the		**4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** No - Consecutive sampling is appropriate but no details reported on who decided to participate and who didn't. Additionally, there was a gift for completing the study (either study tablet computer or $100) and there is no mention on when participants were made aware of this and how this might impact recruitment. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - While free-text questionnaires appropriate for quantitative aspect, it is inherently limiting in the qualitative aspect. Especially as participants mention difficulties writing and using tablets, and the article makes no mention of how the questionnaire was administered. Poor information on what field notes included or how detailed they were. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. This is important considering the use of field notes as data collection but data was independently coded which decreases the possibility of bias.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	application at the rehabilitation centre, during which they took field notes of verbal and non-verbal cues. No further details reported on how questionnaire was administered or what format the meetings took. Thematic analysis of questionnaires and field notes using NVivo. Data was independently analysed by multiple researchers. No further details reported.		**7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received prior to data collection and ethical approval granted by Vancouver Costal Health Research Institute and University of British Columbia. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how themes were derived. Rigour ensured by using peer debriefing during regular meetings, independent coding of field notes by multiple researchers, and data triangulation using quantitative and qualitative methods and meetings/questionnaires. Adequate presentation of data to support findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Limited value for current question - Specific aim of evaluating a mobile application and it's use in SCI rehabilitation. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious concerns

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Source of funding This study received funding from the Rick Hansen Institute's 'Emerging Interventions & Innovative Technologies' grant. **Other information** None

Full citation
Slomic, M., Soberg, H. L., Sveen, U., Christiansen, B., Transitions of patients with traumatic brain injury and multiple trauma between specialized and municipal rehabilitation services-Professionals' perspectives, Cogent Medicine, 4, 1320849, 2017
 	
Ref Id
1183321
 	
Country/ies where the study was carried out
Norway
 	
Study type
Grounded theory
 	
Study dates
April 2014 - March 2016
	Recruitment strategy
	Purposive sampling. No further details reported.
	
	Inclusion criteria
	Not reported.
	
	Exclusion criteria
	Not reported.
	
	Setting
	2 specialised TBI rehabilitation units
	
	Participant characteristics
	N = 91
	• Healthcare professionals involved in 8 inter-professional meetings: 41
	  ○ 4 of these meetings involved patients as well but not further details reported
	• Semi-structured interviews: 16
	• Focus groups: 34
	
	Observations of inter-professional meetings: no details reported
		Findings (including author's interpretation)
		
		• Author's theme: Short-term individualised vs. long term service-orientated perspectives on service provision
		  ○ Example quote: *"Now the inpatient time is much shorter. They are back home so fast that one gets no time to establish a dialogue [with specialized rehabilitation services] before they are back home in the municipality. [Occupational therapist, focus group, municipal rehabilitation services]" (p6)*
		• Author's theme: Inter-professional vs. multi-professional teamwork
		  ○ Example quote: *We [a rehabilitation team at a specialized rehabilitation unit] have an outpatient clinic that could be used much more both before the patient arrives and before the first patient interview, but many more could*
			1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)
			Yes - To explore the experiences of rehabilitation healthcare professionals while transferring TBI and general major trauma patients between specialised and local rehabilitation services.
			
			2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)
			Yes - Appropriate to explore the experiences and views of healthcare professionals regarding transfer during TBI rehabilitation.
			
			3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)
			Yes - Research design discussed and justified.
			
			4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)
			Can't tell - No details reported beyond purposive sampling.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Professions involved in semi-structured interviews (N): • Doctor: 1 • Nurse: 2 • Occupational therapist: 3 • Physical therapist: 2 • Psychologist: 3 • Social worker: 2 • Speech therapist/special education professional: 1 • Team coordinator: 2 Professions involved in focus groups (N): • Auxiliary nurse: 2 • Cultural educator: 1 • Nurse: 11 • Occupational therapist: 8 • Physiotherapist: 8 • Social educator: 2 • Social worker: 2 No further details reported. **Data collection and analysis** Observations of 8 inter-professional meetings containing between 2-14 participants. A number of these observation sessions and interviews took place before the focus groups in order to inform subsequent focus groups. Observations focused on interactions, communication and	*also have the opportunity for follow-up after discharge. I think that this is an important issue. [Nurse, individual interview, specialized rehabilitation services]" (p7)* • Author's theme: A lack of knowledge exchange and feedback during patient transitions ○ Example quote: *"The hospital does not have a full overview of the available services in different municipalities, because, of course, it has more than one municipality to consider, so it is somewhat a puzzle. Therefore, one [i.e. specialized rehabilitation professionals] should not promise something on behalf of others, as this could create expectations that cannot be met. [Coordinating unit leader, focus group, municipal rehabilitation services]" (p8)* • Author's theme: Reduced direct contact between specialised and municipal rehabilitation services ○ Example quote: *"A physiotherapist worked there [at a specialized hospital] who I could just call and consult with when I was unsure. Then, she might come here and work with me on a treatment. I really got a lot out of it. However, this*	**5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 3 different types of data collection implemented, described and justified. This limits social acceptability bias introduced by focus groups. Collection occurred simultaneously, with results going to influence the questions/directions of future collections (although only a very brief discussion of how this occurred). Good range of professionals included in different settings. Data was audio recorded and transcribed verbatim, and was collected until saturation with reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. This is important considering the use of focus groups as a data source, with 1st author undertaking initial coding and no information on who conducted the groups/interviews. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Written informed consent received before observations/interviews and ethical approval granted by the Regional Committee for Medical and Health Research Ethics. Data protection methods described.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	decision-making between healthcare professionals. Notes were taken during these sessions. 8 vignette-based focus groups describing TBI and multiple trauma (containing 3-6 participants) each were conducted in south-eastern municipalities (rural and urban) in Norway. Groups included individuals working as case workers in coordination rehabilitation units and healthcare professionals working in TBI and multiple trauma rehabilitation. These were designed to view and compare the collaboration across municipalities. From this point, data was collected simultaneously and interchangeably, allowing emerging concepts and categories to be included as the study went on. Healthcare professionals identified during observations who were responsible for the patients being discussed or contributed extensively during the meetings were recruited for in-person semi-structured individual interviews. These lasted 20-45 minutes and used a topic guide to explore views and experiences of their rehabilitation processes. Grounded theory. Authors familiarised themselves with the transcripts before the research team developed initial codes together. First author then coded all transcripts using these codes, identifying emerging categories along the way. These were discussed within the research team using constant comparison.	*[collaboration] is now gone. [Physiotherapist, focus group, municipal rehabilitation services]" (p9)*	**8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Adequate description of analysis process and how the themes were derived. Adequate presentation of data to support findings. Multiple researchers used in coding but no mention of independence. No discussion of researcher bias or credibility of findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Very brief discussion about credibility of findings. **10. How valuable is the research?** High value for current question - Aims very similar to aim of this review. Range of healthcare professionals sampled. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the Research Council of Norway. **Other information** None

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Full citation Stolee, Paul, Elliott, Jacobi, Byrne, Kerry, Sims-Gould, Joanie, Tong, Catherine, Chesworth, Bert, Egan, Mary, Ceci, Christine, Forbes, Dorothy, A Framework for Supporting Post-acute Care Transitions of Older Patients With Hip Fracture, Journal of the American Medical Directors Association, 20, 414-419.e1, 2019 **Ref Id** 1111439 **Country/ies where the study was carried out** Canada **Study type** General qualitative inquiry **Study dates** 2010	**Recruitment strategy** Eligible hip fracture recruited while in acute care. A minimum of 2 healthcare professionals that had been/would be involved in each stage of projected care trajectory of each patient were recruited. *Inclusion criteria* Participants had to: • Have a hip fracture diagnosis • Be aged 65 years or older • Have no or very minimal cognitive impairment • Be able to read and communicate in English • Be an informal carer of eligible adults with hip fracture *Exclusion criteria* Not reported. **Setting** Range of rehabilitation settings (acute and sub-acute settings, inpatient and outpatient rehabilitation programmes, residential settings and home settings) **Participant characteristics** N = 134 • Adults with hip fracture: 23 • Carers of adults with hip fracture: 19	**Findings (including author's interpretation)** • Author's theme: System constraints ○ Example quote: *"I think one of the biggest problems right now that we're facing is that there is pressure to have people discharged quickly, and there may not always be services available for them when they go home. And a lot of the time we would like to keep people here longer than we do. (Occupational therapist)" (p416)* • Author's theme: Patient complexity ○ Example quote: *"If you're 85 and you have all these other problems, plus then you break your hip, you're not going to recover in 6 weeks, it's just not, it's not a realistic time frame and you're really not going to recover in the 10 days the hospital gives you to recover. It's just not possible." (p416)* • Author's theme: 6 potential points of intervention: family caregiver roles ○ Example quote: *"Sometimes they would like to know how can I help my mom or how can*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To identify factors to improve healthcare transitions in elderly adults with hip fracture and future healthcare transition interventions. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore views and experiences of transitioning between healthcare settings in hip fractures rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Limited but adequate description. Hip fracture patients recruited at the start of the rehabilitation journey, in acute care. 2 healthcare professionals recruited for each stages in the transition. No information given about who decided to take part and non-respondents. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Healthcare professionals working in hip fracture rehabilitation: 92 No further details reported. **Data collection and analysis** 20-90 minute in-person semi-structured interviews conducted with participants transitioning across the hip fracture rehabilitation care pathway (range 1-4 transitions). Separate topic guides were developed for each of the participants with hip fracture, family members and healthcare professionals (including physical/occupational therapists, nurses, doctors, social workers and case managers). Interviews were audio recorded and transcribed verbatim. Framework-based synthesis of 12 manuscripts based on the same study. 2 lead authors individually familiarised themselves with the 12 included articles before identifying a thematic framework across the data together. Each paper was then coded with these themes in NVivo before charting key messages and points of intersection. The whole research team was then involved in organising themes and mapping them onto a transition of care framework.	*I help my dad you know go up the stairs. . . . They're usually invited to observe a therapy session and that's when they learn and if they ask "OK, can I try to do that?" then by all means we spend time teaching them how to do things." (p417)* • Author's theme: 6 potential points of intervention: relationships ○ Example quote: *"To be honest, if there is something significant that they really want us to know right away they will call us. We do, we meet with the other site periodically for different practice events so we know who they are right and they feel comfortable calling. (Family physician)" (p417)* • Author's theme: 6 potential points of intervention: coordination of roles ○ Example quote: *"I don't work in acute care and I don't know what their workload's like and what their turnover is like and what they have access to." (p417)* • Author's theme: 6 potential points of intervention: documentation ○ Example quote: "Usually, 9 times out of 10 the information is there but it's not easy to find it always. It's not as obvious, it's not written necessarily	Yes - Semi-structured interviews justified. Different topic guides developed for each of the participants (although no mention of how it was developed). Interviews were audio recorded and transcribed verbatim. Data saturation not discussed but presumed to have been reached in a synthesis of 12 qualitative studies. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews and ethical approval granted by the University of Waterloo Human Research Ethics Committee, University of Alberta, and University of Laval. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Good description of analysis process and how the themes were derived. Adequate presentation of data to support findings. The 2 lead authors familiarised themselves with the transcripts individually but developed themes together so not independent. Themes were finalised and mapped onto framework by whole research team. Considering the amount of data (12 manuscripts), the number of researchers

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		where I would write it and the sheet that we get, the initial sheet has some tables and lines where things should be written but they're not always there. (Family physician)" (p417) • Author's theme: 6 potential points of intervention: information sharing ○ Example quote: *"I usually always try to have a discharge summary for wherever they're going. . . . I usually give it to the clerk to send with them in their stack of papers, [but] after that I don't know what happens to it. . . . I wouldn't have time to follow up and make sure they have it in their hand or anything like that, I just hope that they get it" (p417)*	involved in developing codes was minimal, and check is poorly described. No further mention of credibility of findings or researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with a diagram representing the proposed framework to support transition of care. There is a relation back to the original research question. Very brief discussion about limitations of findings. **10. How valuable is the research?** Moderate value for current question - Specific population of interest. Good description of transferring to outpatients. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor concerns **Source of funding** This study received funding via an Emerging Team Grant from the Canadian Institutes of Health Research. **Other information** This paper includes 2 primary studies that have been included in this review (Glenny 2013 and Sims-Gould 2012). Additionally, caregivers have also been included in

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			sample but outside of PCC for this review. Data has not been extracted where possible.
Full citation Turner, Benjamin James, Fleming, Jennifer, Ownsworth, Tamara, Cornwell, Petrea, Perceived service and support needs during transition from hospital to home following acquired brain injury, Disability and Rehabilitation, 33, 818-29, 2011 **Ref Id** 1111556 **Country/ies where the study was carried out** Australia **Study type** Phenomenological study **Study dates** Not reported (recruitment period is 5 months but dates not reported)	**Recruitment strategy** Consecutive eligible patients being discharged from inpatient ABI rehabilitation unit were recruited until saturation. Once enrolled, participants were asked to identify a family member to also participate. *Inclusion criteria* Participants had to: • Have a medical diagnosis of ABI • Be aged 16 years or above • Be expected to be discharged home after inpatient rehabilitation • Be able to communicate adequately in English during interview • Able to provide informed consent *Exclusion criteria* • Pre-morbid neurological or psychological condition. **Setting** At discharge from hospital, and then in the community. **Participant characteristics** N = 38 • Adults with ABI: 20 • Family carers: 18	**Findings (including author's interpretation)** • Author's theme: Balancing the service and support equation ○ Example quote: *"We've got meals on wheels coming so that takes a lot of stress off, we've got a house cleaner that comes so that takes a lot of stress off. In the first month it was hard because we didn't have anything prepared so the house was just getting messier, there wasn't meal organization but now that's all come into place (P13, 3)" (p823)* • Author's theme: Negotiating the rehabilitation maze ○ Example quote: *"In the beginning. . . . I hated it (therapy). . .. But Now I have [therapist] and she is fantastic. I have [therapist] all the time and she has a program. We set goals for me to achieve and I look forward to it (P13, 1)" (p826)* • Author's theme: Working with or against 'the system' ○ Example quote: *"A number of major disparities were also observed within 'the system' including between public and*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – To explore the service and support needs of adults with ABI (and their family carers), and identify factors that night affect these needs, when transitioning between the hospital and home. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore experiences of transitioning from the hospital to the community in TBI rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Consecutive patients being discharged from inpatient ABI. However, no information presented on who decided to participate and non-responders. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Use of semi-structured interviews discussed and justified. Topic guide was

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	Characteristics of adults with ABI • Age [mean (range)]: 40.2 (17-63) years • Gender (M/F): 15/5 • Length of stay in inpatient rehabilitation (N): ○ <3 months: 12 ○ 3–6 months: 7 ○ >6 months: 1 • Injury cause (N): ○ Traumatic: 16 - Motor vehicle accident: 7 - Motor bike accident: 1 - Assault: 1 - Fall: 4 - Other: 3 ○ Non traumatic: 4 **Data collection and analysis** 3 x semi-structured interviews per participants - 1 prior to discharge, 1 and 1-month post-discharge and the last a 3-months post-discharge. Average interview length was 33 minutes for participants with ABI and 36 minutes for family member participants. Pre-discharge interviews were carried out in person and approximately 1 week before discharge from the unit. Interviews conducted after discharge occurred in	*privately funded participants and those living in rural/regional areas compared with those in metropolitan locations" (p826)*	designed based on clinical experience of authors and ABI literature, along with the principles of conducting interviews with ABI patients. Versions were created for patients and family members. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes - Reflexivity used throughout the data analysis using all members of the research team. Example given of how this reflexivity led to the refinement of semi-structured interviews, in order to make them more direct for patients with ABI. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews and ethical approval granted by the relevant committee at recruitment site and (unnamed) University. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Methods included triangulation of data sources by using ABI participants and family members, consensus coding, interviews conducted at 3 different time point. Good presentation of data to support findings.

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	person (at the hospital or at home) or by telephone. An average of 34 days (range 27-46 days) passed between pre-discharge interview and 1st follow-up interview and 100 days (range 94-117 days) between those and 3-month post-discharge interviews. Grounded theory analysis. Interviews were audio-recorded and transcribed verbatim. Analysis started with open coding, noting initial themes and patterns found in the data. Axial coding was then undertaken, which included consensus coding of 2 transcripts (1 transcript from ABI patient and 1 from family member) by 2 independent researchers. The rest of the transcripts were coded with the revised codes. Finally, selective coding occurred using all members of the research team to identify overarching themes.		**9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Methods included triangulation of data sources by using ABI participants and family members, consensus coding, interviews conducted at 3 different time point. Good presentation of data to support findings. **10. How valuable is the research?** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/minor concerns **Source of funding** This study received funding from an Australian Post-Graduate Award. **Other information** Family carers also included in sample but outside of PCC for this review. Data has not been extracted where possible.

ABI: Acquired brain injury; ICU: Intensive care unit; IQR: Inter-quartile range; F: Female; M: Male; N: Number; p: Page; SCI: Spinal cord injury: SD: Standard deviation; TBI: Traumatic brain injury