

Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* **MH** *clinical question-answering service*

Question

For people with dementia how effective is a continuity of care model (particularly in terms of staff) compared to any other model of care in achieving improved clinical outcomes? Is there any evidence that this model is more effective in adults with dementia than the general older population?

Clarification of question using PICO structure

Patients: People with dementia

Intervention: Continuity of staff / care

Comparator: Any other model / treatment as usual

Outcome: Improved patient outcomes.

Clinical and research implications

One high quality Cochrane review, and a second poor quality systematic review provided the majority of the data to inform this evidence summary. Two randomised controlled trials (RCTs) and an analysis of data from an RCT published elsewhere provided some additional information. All of the primary studies were included in the second systematic review and all had important methodological weaknesses. The Cochrane review concluded that the available evidence on the effectiveness of a primary-care model compared with team nursing or usual care was unconvincing; this conclusion is likely to be reliable. By contrast, the conclusion of the second review, that the effectiveness of case management interventions is dependent upon their intensity and degree of integration with other aspects of care, is not adequately supported by the data presented. The results of the studies included in the second review were variable and not strongly supportive of the effectiveness of case management interventions.

No studies were identified which provided information on the effectiveness of continuity of care interventions in adults with dementia compared to their effectiveness in the general older population.

This summary suggests that the evidence base on continuity of care interventions in the elderly is currently weak. High quality randomised controlled trials are needed to provide reliable assessments of the effectiveness of continuity of care interventions on patient-relevant outcomes. Standardisation of interventions is also needed.

What does the evidence say?

Number of included studies/reviews (number of participants)

We identified two systematic reviews which were relevant to this evidence summary.^{1,2} The first systematic review, a Cochrane review, assessed the effectiveness of nursing models for improving patient and staff outcomes in long-term residential care and included two observational studies; the description of participant characteristics did not include dementia/cognitive status.¹ The second systematic review assessed the impact of case management interventions on clinical outcomes and resource utilisation in older people with dementia; this review included six randomised controlled trials (RCTs).² We also identified three potentially relevant primary studies, two RCTs,^{3,4} and one additional analysis of data from an RCT.⁵ All of these studies were included in the larger of the two systematic reviews.²

Main Findings

One of the studies included in the Cochrane review found no significant differences, between intervention (resident assignment to the same nurse; use and evaluation of nursing care plans, nursing histories, nursing goals and actions for each resident; resident-oriented and ward oriented tasks; resident-oriented or ward oriented nurse communication) and control (not described), in resident or family satisfaction with care, resident well-being, or assessment of resident well-being by a significant other.¹ The second study found a limited number of improvements associated with primary nursing (24-hour accountability and decision making by one nurse for several patients; case method of assignment; direct communication between caregivers; change in emphasis in the role of head nurse to facilitator) compared with standard team nursing.¹ Improvements were in Geriatric Residents' Goals scale scores (geriatric rehabilitation unit only) and Tranquillity-Agitation Scale scores (long-term care unit only).¹

Four of the six studies included in the second systematic review reported moderate effect sizes (defined as between 0.2 and 0.8), on the primary outcome measure, for case management interventions compared with a control group.² Reported primary outcome effect sizes, for patient clinical outcomes, were 0.24 for improvement in "intensity of behavioural problems," and 0.33 for reducing institutionalisation at one year (effect did not persist to year two and there was no significant effect on mortality).² The study which reported reduction in institutionalisation appeared to indicate that the case management program was more effective in patients with advanced dementia.^{2,5}

The results of the three primary studies identified^{3,4,5} did not differ substantially from those summarised in the systematic review by Somme et al.,² though some additional detail was reported. The study which was described in the Somme review as reporting moderate effects on "intensity of behavioural problems" reported improvements in patient Neuropsychiatric Inventory (NPI) scores, associated with the case management intervention, at 12 and 18 months (between group difference -5.6 (95% CI: -9.9 to -1.3) and -5.4 (95% CI: -9.9 to -1.2), respectively).³ There were no significant effects on patient depression, cognition, or activities of daily living (ADL).³ The study which reported reduction in institutionalisation reported that this finding applied to two separate elderly populations, one with dementia and one with delirium.⁵ The final primary study assessed factors associated with care giver mastery and relationship strain (data not included in the Somme review) and found that only home environment assessments of patient and care giver needs by the care manager were significantly associated with improvements in care giver mastery; there were no significant predictors of relationship strain.⁴

Authors Conclusions

The Cochrane review concluded that the available evidence on the effectiveness of a primary-care model compared with team nursing or usual care was unconvincing.¹ The second systematic review concluded that the degree of integration and intensity of the case management intervention seem to determine its effectiveness.² The primary studies, all of which were included in the second systematic review,² concluded that collaborative care of patients with Alzheimer's disease resulted in improvements in behaviour and psychological problems,³ home assessments for specific needs of caregivers and persons with dementia were associated with improvements in caregivers' sense of mastery,⁴ and a Nurse Care manager (NCM) intervention was effective in prolonging the community care of elderly people with cognitive impairment.⁵

Reliability of conclusions/Strength of evidence

One high quality Cochrane review,¹ and a second poor quality systematic review² provided the majority of the data to inform this evidence summary. Two RCTs^{3,5} and an analysis of data from an RCT published elsewhere⁴ provided some additional information. All of the primary studies were included in the second systematic review and all had important methodological weaknesses. Overall, the conclusion of the Cochrane review, that the available evidence on the effectiveness of a primary-care model compared with team nursing or usual care was unconvincing, is likely to be reliable.¹ The Conclusion of the second review is not adequately supported by the data presented and the findings of the included studies were variable and not strongly supportive of the effectiveness of case management interventions.²

What do guidelines say?

No UK guidelines relevant to this evidence summary were identified.

Date question received: 23/06/2013

Date searches conducted: 24/06/2013

Date answer completed: 15/07/2013

References

Systematic Reviews:

1. Hodgkinson B., Haesler, E.J., Nay, R., O'Donnell, M.H. and McAuliffe, L.P. (2011) Effectiveness of staffing models in residential, subacute, extended aged care settings on patient and staff outcomes. *Cochrane Database of Systematic Reviews*. Issue 6.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006563.pub2/pdf>

2. Somme,D., Trouve, H., Dram, M., Gagnon, D., Couturier, Y. and Saint-Jean, O. (2012) Analysis of case management programs for patients with dementia: A systematic review. *Alzheimer's & Dementia* (8) pp. 426–436.

RCT's

3. Callahan, C.M., Boustani, M.A., Unverzagt, F.W., Austrom, M.G., Damush, T.M., Perkins, A.J., Fultz, B.A., Hui, S.L., Counsell, S.R. and Hendrie, H.C. (2006) Effectiveness of Collaborative Care for Older Adults With Alzheimer Disease in Primary Care: A Randomized Controlled Trial. *JAMA* 295 (18) pp. 2148-2157

4. Connor,K.I., McNeese-Smith,D.K., Vickrey,B.G., van Servellen, G.M., Chang,B.L., Lee, M.L., Vassar, S.D. and Chodosh, J. (2008) Determining Care Management Activities Associated with Mastery and Relationship Strain for Dementia Caregivers. *JAGS* (56) pp. 891–897.

5. Eloniemi-Sulkava, U. (2002) Supporting community care of demented patients. *Kuopio University Publications D. Medical Sciences* (275)

Results

SRs

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Hodgkinson et al. (2011)	27/8/2007	<p><i>Participants</i> Staff of residential/subacute/extended aged-care settings (e.g. nursing homes, skilled nursing facilities). Also residents or patients of residential/subacute/extended aged-care settings aged 65 years or older. Studies which included participants ranging from 55 upwards were considered for inclusion if the standard deviation fell within one unit of 65.</p> <p><i>Intervention</i> Studies assessing the following interventions were eligible for inclusion in the review: organisational interventions (e.g. team/modular nursing, primary nursing, hierarchical nursing, care pairs or partner-in-care models) or regulatory interventions (e.g. staff patient/resident ratios).</p> <p><i>Comparator</i> No inclusion criteria were specified for comparators.</p> <p><i>Outcome</i> Primary outcomes for patients of</p>	The review included two observational studies. The total number of participants (residents/nurses) was unclear.	<p>The aim of this review was to determine which staff (nursing) models are associated with the best patient and staff outcomes in residential aged care.</p> <p>Two observational studies were included in the review.</p> <p>The first study was conducted in three residential nursing homes in the Netherlands; each home selected four wards (2 somatic and 2 psychogeriatric) for participation, with one ward of each type being assigned to the intervention and control conditions. Wards were selected based on comparability, provision of long-stay care and willingness to participate. Control and intervention wards were matched by number of beds, bed occupation, length of stay, and care load. The intervention had four components: resident assignment to the same nurse; use and evaluation of nursing care plans, nursing histories, nursing goals and actions for each resident; resident-oriented and ward oriented tasks; resident-oriented or ward oriented nurse communication. The control condition was not described.</p> <p>Residents had a mean age of 78 years and 70%</p>	<p>The article reported a clear research objective and appropriate inclusion criteria for the review were defined.</p> <p>Five bibliographic databases were searched to identify relevant publications. No language restrictions were applied. A Google search was conducted to try to identify grey literature sources.</p> <p>Measures to minimise error and bias (involvement of two reviewers</p>

		<p>residential/subacute/extended aged-care settings: incidence of pressure ulcers; incidence of falls; incidence of medication errors and adverse events; validated quality of life measurements. Primary outcomes for staff: days/hours lost to sick leave; days/hours lost to stress leave; staff turnover rates (as a percentage of staff total); staff burnout (as defined by the authors). Secondary outcomes for residents: tranquility-agitation; vitality; personal control; performance of activities of daily living. Secondary outcomes for staff: measurement of nursing activities (e.g. notes, entries in care plan); job satisfaction.</p> <p><i>Study design</i></p> <p>Randomised controlled trials (RCTs), controlled clinical trials (CCTs), interrupted time series and controlled before-and-after studies were eligible for inclusion.</p>		<p>were female; no further characteristics were reported. Nursing staff had a mean of >5 years ward experience.</p> <p>Outcomes assessed were extent of protocol implementation (nursing records and interviews with nurses and residents of somatic wards), resident well being (questions to participants, nurses and family members), and satisfaction with patient care (questions to residents and family members). Outcomes were measured before implementation of the intervention and at six and 16 months post-intervention.</p> <p>The second study was conducted in two units (one geriatric rehabilitation and one long-term care) of a Canadian university hospital. The intervention (primary nursing) had four components: 24-hour accountability and decision making by one nurse for several patients; case method of assignment; direct communication between caregivers; change in emphasis in the role of head nurse to facilitator. The control condition was team nursing, described as "a hierarchical system where patient care is supervised by a registered nurse, the team leader, and the actual provision of care is assigned to various skill levels of personnel according to the complexity of patient needs and care requirements." The study design comprised four time periods (not equal) with both units using team nursing, one unit using primary nursing and one unit using team nursing, crossover of intervention and control, both units using primary nursing.</p>	<p>with disagreements resolved by a third reviewer) were applied to all stages of the review process (study selection, data extraction and assessment of methodological quality).</p> <p>The methodological quality of included studies was assessed using appropriate Effective Practice and Organisation of Care (EPOC) group tools for observational studies.</p> <p>The use of a narrative synthesis to summarise included studies</p>
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				<p>The study included 53 staff (30 registered nurses, 17 registered nursing assistants, 6 nursing orderlies) and an un-specified number of residents who were cognitively intact war veterans with a mean age of 79 years.</p> <p>Outcomes assessed were measures of nursing practice (e.g. record keeping, consistency of patients assigned to caregivers, patients' knowledge of staff names), and measures of patient well-being (Tranquillity-Agitation Scale, Vitality Rating Scale, Personal Control rating Scale and Geriatric Residents Goals Scale). The study was conducted over two years, with patient well-being outcomes measured at 21 time points and nursing practice outcomes measured at 17-24 time points.</p> <p>Nursing practice/protocol implementation outcomes:</p> <p>The first study found that assignment of the same nurse to residents and use and evaluation of nursing care plans were significantly higher in the intervention wards. The level of resident-oriented tasks was also significantly higher (in the psychogeriatric intervention wards only), but there were no significant differences in ward-oriented tasks or communication. The second study found that continuous assignment of the same care giver was significantly improved with the primary nursing model (geriatric rehabilitation unit only).</p> <p>Consistency between daily and monthly nursing care signatures and between signature and actual provider of care was also significantly higher for primary nursing (both units). Patients' knowledge of</p>	<p>was appropriate.</p>
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				<p>staff names was significantly higher for the primary nursing model in the geriatric rehabilitation unit, but not in the long-term care unit. There were no significant differences in entries to the nursing notes or care plan between the two nursing models.</p> <p>Patient benefit outcomes: The first study found no significant differences, between intervention and control wards, in resident or family satisfaction with care, resident well-being, or assessment of resident well-being by a significant other. The second study found a limited number of improvements associated with primary nursing: The highest mean score on the Geriatric Residents' Goals scale was significantly higher for the primary nursing model (geriatric rehabilitation unit only) and there was a significant improvement in Tranquillity-Agitation Scale scores associated with the primary nursing model (long-term care unit only).</p> <p>The second study also reported no significant differences in staff morale measures of costs between the primary nursing and team nursing models.</p> <p>Neither study reported any comparison of effectiveness between older adults with dementia and older adults in the general population.</p>	
Somme et al. (2012)	04/2009	<i>Participants</i> Non-institutionalised patients with Alzheimer's disease and associated disorders (dementia).	The review included six RCTs. The total number of participants	This review aimed to impact of case management programs on clinical outcomes and the utilisation of resources in people with dementia.	The article reported a clear research objective and appropriate,

		<p><i>Intervention</i> Case management (care management, case management, or disease management involving at least the functions of assessment, individualised plan, and monitoring)</p> <p><i>Comparator</i> For included studies, the implementation of a case management program had to be the only difference between the intervention and control groups.</p> <p><i>Outcome</i> Included studies had to report the results of longitudinal follow-up (outcomes not specified).</p> <p><i>Study design</i> Randomised controlled trials (RCTs).</p>	<p>(patients/case managers) was unclear.</p>	<p>Five of the six included studies were conducted in the USA and one in Sweden. Settings varied and included primary care, memory care, and non-health care.</p> <p>The intervention was individual case management in all studies. The intensity of the case management intervention was defined using the 18-point Pacala scale and was classified as “high” in 2 studies, “mid” in 1 study and “low” in 3 studies. Integration of the case management program with other aspects of service delivery was classified as “mid” in 3 studies, “low” in 1 study and “none” in 2 studies.</p> <p>Where reported, the mean age of patients in the included studies ranged from 70 to 80 years, and between 43 and 74% were female. The proportion of ethnic minority participants ranged from 5-49% in four studies. Where reported, the care managers previous profession was either social work or nursing.</p> <p>Four of the six studies, including both of the “high” intensity studies and the “mid” intensity intervention study reported moderate effect sizes (defined as between 0.2 and 0.8) in their primary outcome measure. Detailed results were as follows: Study one assessed a “high” intensity intervention (disease management program) with 50 cases per manager and a study duration of 18 months. Case management had a moderate effect (effect size 0.54) on the primary endpoint of “following</p>	<p>broad inclusion criteria for the review were defined (outcome measures were not specified).</p> <p>Nine bibliographic databases were searched to identify relevant publications. The authors’ stated that they intended to restrict inclusion to articles with an English language abstract, but that no articles were excluded on this criterion.</p> <p>The review process did not include standard measures to minimise error and bias (the process was undertaken by a single reviewer).</p>
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				<p>recommendations in good practice guidelines,” a weak effect size (0.16) on patients’ quality of life and no significant effect on mortality or carers’ quality of life.</p> <p>Study two assessed a “high” intensity intervention (“collaborative care” model). The number of cases per manager was not reported and the study duration was 18 months. Case management had a moderate (0.24) effect size on the primary endpoint of “intensity of behavioural problems,” and a weak effect size (0.17) on “care giver stress.” There were no significant effects on rates of hospitalisation or institutionalisation.</p> <p>Study three assessed a “low” intensity intervention (the Medicare Alzheimer’s Disease Demonstration and Evaluation (MADDE) program) with between 40 and 100 cases per manager and a study duration of 36 months. The case management program had a moderate effect size (0.34) on the primary outcome of “patients’ access to services”, and very weak effect sizes (0.04 and 0.03) caregiver depression and feeling of burden.</p> <p>Study four assessed a “low” intensity intervention focusing on the empowerment of the person or family through the actions of a care consultant. The number of cases per manager and study duration were not reported. The effect sizes, for all reported measures of patient and care giver healthcare utilisation and satisfaction, were weak (<0.2).</p> <p>Study five assessed a “mid” intensity intervention</p>	<p>The methodological quality of included studies was assessed using the 25-item CONSORT checklist. However, it should be noted that CONSORT is a reporting guide for RCTs and not a tool designed to assess methodological quality.</p> <p>The use of Cohen’s effect size statistics to compare results across studies with varying interventions, outcome measures and assessment methods is of questionable value. This is compounded by the authors’</p>
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				with <50 cases per manager. The program had a moderate effect size (0.33) on reducing institutionalisation at one year, but this effect did not persist to year two and there was no significant effect on mortality. The program appeared to be more effective in patients with advanced dementia. Study six assessed a “low” intensity intervention with approximately 65 cases per manager and a study duration of six months. No significant effects of case management were found on health or social care utilisation by patients or care givers.	statement that they only calculated Cohen’s effect size for “results that were statistically significant in the original publication.”
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RCTs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Callaghan (2006)	<p><i>Participants</i> Older adults (65 years or older) with a diagnosis of Alzheimer’s and their carers, recruited from two primary care practices in Indianapolis. Exclusion criteria were residence in a nursing home, inability to understand English, no access to a telephone, or no caregiver willing to consent to participate in the study.</p> <p><i>Intervention</i> Collaborative care management, for a maximum of 12, months by a team led by the patient’s primary care physician and a geriatric nurse practitioner who served as the care manager. All intervention patients were recommended for treatment with</p>	n = 153 older adults with Alzheimer’s disease and their care givers	<p>This study was included in the Somme 2012 systematic review reported above (study two in Somme et al).</p> <p>The aim of the study was to assess the effectiveness of a collaborative care model on the quality of care for patients with Alzheimer disease.</p> <p>Information additional to that reported in the systematic review: There were no significant differences, in demographic characteristics, baseline Mini-Mental State examination (MMSE) score or number of medications, between patients in the intervention and control groups. Care giver characteristics were also equivalent, with the exception that there were significantly more female care givers in the</p>	Physicians were the unit of randomisation. Physicians were randomised in blocks of 2 stratified by teaching status (faculty or resident) and the clinic site. Randomisation used a random





	<p>cholinesterase inhibitors (or memantine) unless contraindicated. The minimum intervention that all intervention group caregivers and patients received included education on communication skills; caregiver coping skills; legal and financial advice; patient exercise guidelines with a guidebook and videotape; and a caregiver guide provided by the local chapter of the Alzheimer's Association.</p> <p><i>Comparator</i> Usual care appropriate as decided by physicians.</p> <p><i>Outcomes</i> Outcomes were assessed at 6, 12 and 18 months and included: Neuropsychiatric Inventory (NPI); Cornell Scale for Depression in Dementia (CSDD), cognition (measured by telephone interview); Alzheimer Disease Cooperative Study Group Activities of Daily Living (ADL); care giver NPI; Caregiver Patient Health Questionnaire-9.</p>		<p>control group.</p> <p>There were no significant effects at 6 months. Patient NPI scores were significantly lower in the intervention group at 12 and 18 months (between group difference -5.6 (95% CI: -9.9 to -1.3) and -5.4 (95% CI: -9.9 to -1.2), respectively). There were no significant effects on patient depression, cognition, or ADL.</p> <p>Care giver NPI scores were significantly lower in the intervention group at 12 months (between group difference -2.2 (95% CI: -4.2 to -0.2)), but this effect did not persist at 18 months. Care giver stress, as indicated by Caregiver Patient Health Questionnaire-9 was significantly improved in the intervention group at 18 months (between group difference -1.6 (95% CI: -3.0 to -0.2), but not at earlier time points.</p>	<p>numbers table.</p> <p>Physicians, nurse practitioners, patients and care givers were blinded to physician randomisation status until initial assessment was complete. However, the nature of the intervention precluded blinding during the study.</p> <p>Outcome assessment was conducted by independent assessors who were blind to treatment group.</p>
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				Full outcomes data appear to have been reported for all study participants.
Connor (2008)	<p><i>Participants</i> This study uses data from the Alzheimer's Disease Coordinated Care for San Diego Seniors (ACCESS) trial. Three healthcare organisations (including managed care and fee-for-service health plans) and three social service agencies in San Diego to implement and test a new dementia care management program participants had a previous diagnosis of dementia and had an informal caregiver.</p> <p><i>Intervention</i> A care management program of nurse and social work care managers who communicated about shared patient and caregiver needs, coordinated planned interventions, and provided follow-through for referrals across the participating healthcare organisations and social service agencies, thus providing continuity of care.</p> <p><i>Comparator</i> Usual care/treatment as usual.</p> <p><i>Outcomes</i> Caregiver's perception of caregiving mastery and relationship strain between</p>	n = 238 patients with dementia and their care givers	<p>This study was included in the Somme 2012 systematic review reported above (study one in Somme et al); two additional related publications of the same study were included I the Somme review.</p> <p>The aim of the study was to identify activities within a dementia care management intervention that are associated with 18-month change in caregiver mastery and relationship strain.</p> <p>Information additional to that reported in the systematic review: The mean age of patients was 80 years and 54% were female. The mean baseline dementia severity score was 5.7±3.4. Fifty-five percent of caregivers were spouses of the individuals with dementia. Fifty three percent of care givers reported at least one behavioural problem in the preceding year.</p> <p>Multivariable regression modelling indicated that home environment assessments of patient and care giver needs, by the care manager, was the only variable which was significantly associated with improvements in care giver mastery. Multivariable regression modelling found no</p>	Not applicable: This article reports additional analyses form an RCT published elsewhere.













	caregiver and care recipient, obtained from caregiver responses to the Margaret Blenkner Research Center Caregiver Strain Instrument.		significant predictors of relationship strain.	
Eloniemi-Sulkava (2001)	<p><i>Participants</i> Recruited from the register of the Social Insurance Institution living in the community, receiving primary support from an informal caregiver in eastern Finland. Participants in the dementia study were 65 years or older with a diagnosis of dementia without coexisting severe diseases (e.g. severe stroke or cancer). Participants in the delirium study were 65 years or older, admitted to hospital consecutively with a delirious state based on DSM-III-R criteria, otherwise healthy without predisposing disorders (e.g. cancer, hip fracture, moderate-severe dementia).</p> <p><i>Intervention</i> In both studies, patients with their caregivers were provided with a 2-year intervention by a nurse care manager (NCM).</p> <p><i>Comparator</i> Usual services provided for geriatric patients in community care from the municipal social and health care system or from the private sector.</p> <p><i>Outcomes</i> MMSE (Mini-Mental State Examination); used before and after the intervention to</p>	<p>Dementia study: n = 100 (n = 53 intervention arm, n = 47 control arm); n=106 caregivers.</p> <p>Delirium study: n = 102 (n=51 intervention arm, n=51 matched controls).</p>	<p>A different publication of one of the studies (Kuopio Dementia Study) in this report was included in the Somme 2012 systematic review reported above (study five in Somme et al). The systematic review incorrectly reported this study as conducted in Sweden; the study was conducted in Finland.</p> <p>The Kuopio Dementia Study and the Kuopio Delirium Study had three aims, of which only the first is relevant to this evidence summary: to assess the effects of a nurse care manager intervention on community care of elderly people with cognitive impairment.</p> <p>Information additional to that reported in the systematic review: Intervention and control groups were similar, with respect to age and gender, in both studies. In the dementia study, distribution of diagnoses (Alzheimer’s disease, vascular dementia, other) and baseline MMSE scores were similar in the intervention and control groups.</p> <p>Both the dementia and delirium studies reported that survival in the community, without institutionalisation, was significantly longer in the intervention than in the control group. Post-intervention MMSE data were not reported.</p>	<p>The dementia study was reported as “randomised”, randomisation was done by the patient or care giver drawing a non-transparent sealed envelope. The delirium study appears to have been a non-randomised study with age- and gender-matched controls.</p> <p>The nature of the intervention</p>


	<p>measure patients' cognitive symptoms. Other outcomes were not clearly pre-specified.</p>			<p>precluded blinding of study participants and personnel.</p> <p>Outcome assessment was done by the study physician.</p> <p>All study participants appear to have been included in the analyses, but outcomes were not fully pre-specified.</p>
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Risk of Bias: SRs


Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Hodgkinson et al. (2011)					
Somme et al. (2012)					

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Callaghan (2006)						
Connor (2008)	Not applicable: This article reports additional analyses form an RCT published elsewhere.					
Eloniemi-Sulkava (2001)						

 Low Risk

 High Risk

 Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
<i>SRs and Guidelines</i>			
DARE	1 MeSH DESCRIPTOR Alzheimer Disease EXPLODE ALL TREES 257 Delete 2 MeSH DESCRIPTOR dementia EXPLODE ALL TREES IN DARE,NHSEED 368 Delete 3 (dementia):TI 343 Delete 4 #1 OR #2 OR #3 560 Delete 5 MeSH DESCRIPTOR Continuity of Patient Care EXPLODE ALL TREES 102 Delete 6 ("continuity of care") 45 Delete 7 (continuity adj3 care) OR (continuity adj3 "patient care") 145 Delete 8 (staff adj3 continuity) 3 Delete 9 #5 OR #6 OR #7 OR #8 146	146	
CDSR	#1 MeSH descriptor: [Dementia] explode all trees 3399 #2 Enter terms for search dementiadementia 9106 #3 Enter terms for search #1 or #2#1 or #2 9847 #4 MeSH descriptor: [Continuity of Patient Care] explode all trees 462 #5 Enter terms for search "continuity of care" 239 #6 Enter terms for search "continuity of patient care" 499	131	

	<p>#7Enter terms for searccontinuity adj3 care83</p> <p>#8Enter terms for searccontinuous adj3 care1107</p> <p>#9Enter terms for searcstaff adj3 continuity51</p> <p>#10Enter terms for searc#4 or #5 or #6 or #7 or #8 or #91730</p> <p>#11Enter terms for searc#3 and #10 145</p> <p>CDSR only 131</p>		
Primary studies			
CENTRAL	<p>#1 MeSH descriptor: [Dementia] explode all trees 3399</p> <p>#2 Enter terms for search dementiadementia 9106</p> <p>#3 Enter terms for search #1 or #2#1 or #2 9847</p> <p>#4 MeSH descriptor: [Continuity of Patient Care] explode all trees 462</p> <p>#5 Enter terms for search "continuity of care" 239</p> <p>#6Enter terms for searc"continuity of patient care"499</p> <p>#7Enter terms for searccontinuity adj3 care83</p> <p>#8Enter terms for searccontinuous adj3 care1107</p> <p>#9Enter terms for searcstaff adj3 continuity51</p> <p>#10Enter terms for searc#4 or #5 or #6 or #7 or #8 or #91730</p> <p>#11Enter terms for searc#3 and #10 145</p> <p>Central only 6</p>		
PsycINFO	<p>1. PsycINFO; ALZHEIMER'S DISEASE/ OR exp DEMENTIA/; 48382 results.</p> <p>2. PsycINFO; dementia.ti,ab; 39636 results.</p>	41	

	<p>3. PsycINFO; 1 OR 2; 58239 results.</p> <p>4. PsycINFO; CONTINUUM OF CARE/; 917 results.</p> <p>5. PsycINFO; (continuity adj3 "patient care").ti,ab; 40 results.</p> <p>6. PsycINFO; "continuity of care".ti,ab; 1242 results.</p> <p>7. PsycINFO; (continuity adj3 care).ti,ab; 1429 results.</p> <p>8. PsycINFO; 4 OR 5 OR 6 OR 7; 1942 results.</p> <p>9. PsycINFO; 3 AND 8; 37 results.</p> <p>10. PsycINFO; "continuous care".ti,ab; 106 results.</p> <p>11. PsycINFO; (continuous adj3 care).ti,ab; 232 results.</p> <p>12. PsycINFO; 8 OR 10 OR 11; 2155 results.</p> <p>13. PsycINFO; 3 AND 12; 41 results.</p> <p>14. PsycINFO; "continuity of patient care".ti,ab; 35 results.</p> <p>15. PsycINFO; (staff adj3 continuity).ti,ab; 32 results.</p> <p>16. PsycINFO; 12 OR 14 OR 15; 2177 results.</p> <p>17. PsycINFO; 3 AND 16; 41 results.</p>		
Embase	31. EMBASE; ALZHEIMER'S DISEASE/ OR exp DEMENTIA/; 209679 results.	427	

<p>32. EMBASE; dementia.ti,ab; 81596 results.</p> <p>33. EMBASE; 31 OR 32; 220979 results.</p> <p>34. EMBASE; CONTINUUM OF CARE/; 0 results.</p> <p>35. EMBASE; (continuity adj3 "patient care").ti,ab; 239 results.</p> <p>36. EMBASE; "continuity of care".ti,ab; 4486 results.</p> <p>37. EMBASE; (continuity adj3 care).ti,ab; 5378 results.</p> <p>38. EMBASE; 34 OR 35 OR 36 OR 37; 5379 results.</p> <p>39. EMBASE; 33 AND 38; 48 results.</p> <p>40. EMBASE; "continuous care".ti,ab; 388 results.</p> <p>41. EMBASE; (continuous adj3 care).ti,ab; 1328 results.</p> <p>42. EMBASE; 38 OR 40 OR 41; 6654 results.</p> <p>43. EMBASE; 33 AND 42; 65 results.</p> <p>44. EMBASE; ALZHEIMER'S DISEASE/ OR exp DEMENTIA/; 209679 results.</p> <p>45. EMBASE; dementia.ti,ab; 81596 results.</p> <p>46. EMBASE; 44 OR 45; 220979 results.</p> <p>47. EMBASE; CONTINUUM OF CARE/; 0 results.</p> <p>48. EMBASE; (continuity adj3 "patient care").ti,ab; 239 results.</p> <p>49. EMBASE; "continuity of care".ti,ab; 4486 results.</p> <p>50. EMBASE; (continuity adj3 care).ti,ab; 5378 results.</p> <p>51. EMBASE; 47 OR 48 OR 49 OR 50; 5379 results.</p> <p>52. EMBASE; 46 AND 51; 48 results.</p> <p>53. EMBASE; "continuous care".ti,ab; 388 results.</p> <p>54. EMBASE; (continuous adj3 care).ti,ab; 1328 results.</p> <p>55. EMBASE; 51 OR 53 OR 54; 6654 results.</p> <p>56. EMBASE; 46 AND 55; 65 results.</p> <p>57. EMBASE; CONTINUITY OF PATIENT CARE/; 179673 results.</p>		
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	<p>58. EMBASE; 55 OR 57; 183289 results.</p> <p>59. EMBASE; 46 AND 58; 3607 results.</p> <p>60. EMBASE; 59 [Limit to: Exclude MEDLINE Journals]; 427 results.</p> <p>61. EMBASE; "staff continuity".ti,ab [Limit to: Exclude MEDLINE Journals]; 0 results.</p> <p>62. EMBASE; (staff adj3 continuity).ti,ab; 92 results.</p> <p>63. EMBASE; 58 OR 62; 183343 results.</p> <p>64. EMBASE; 46 AND 63; 3607 results.</p> <p>65. EMBASE; 64 [Limit to: Exclude MEDLINE Journals]; 427 results.</p>		
Medline	<p>14. MEDLINE; ALZHEIMER'S DISEASE/ OR exp DEMENTIA/; 115305 results.</p> <p>15. MEDLINE; dementia.ti,ab; 62656 results.</p> <p>16. MEDLINE; 14 OR 15; 134222 results.</p> <p>17. MEDLINE; CONTINUUM OF CARE/; 13899 results.</p> <p>18. MEDLINE; (continuity adj3 "patient care").ti,ab; 222 results.</p> <p>19. MEDLINE; "continuity of care".ti,ab; 3859 results.</p> <p>20. MEDLINE; (continuity adj3 care).ti,ab; 4623 results.</p> <p>21. MEDLINE; 17 OR 18 OR 19 OR 20; 16515 results.</p> <p>22. MEDLINE; 16 AND 21; 130 results.</p> <p>23. MEDLINE; "continuous care".ti,ab; 305 results.</p> <p>24. MEDLINE; (continuous adj3 care).ti,ab; 1018 results.</p> <p>25. MEDLINE; 21 OR 23 OR 24; 17408 results.</p> <p>26. MEDLINE; 16 AND 25; 143 results.</p> <p>28. MEDLINE; CONTINUITY OF PATIENT CARE/; 13899 results.</p> <p>29. MEDLINE; 25 OR 28; 17408 results.</p> <p>30. MEDLINE; 16 AND 29; 143 results.</p> <p>31. MEDLINE; (staff adj3 continuity).ti,ab; 80 results.</p> <p>32. MEDLINE; 29 OR 31; 17452 results.</p>	143	

	33. MEDLINE; 16 AND 32; 143 results.		
Summary	NA	NA	

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