

Best Evidence Summaries of Topics in Mental Healthcare

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

Question

“In adults with dementia, how effective is specialist staff training/education, compared to a lack of or no specialist staff training/education, in reducing BPSD (behavioural and psychological symptoms of dementia)?”

Clarification of question using PICO structure

Patients: Adults with dementia
Intervention: Specialist staff training/education
Comparator: Lack of specialist staff training/education
Outcome: Reducing BPSD (behavioural and psychological symptoms of dementia)

Clinical and research implications

No definite clinical implications can be made from the available evidence. The specific interventions and outcomes assessed are variable, as are the results. One systematic review with a low risk of bias reported no significant differences between an education intervention and usual care on BPSD in three out of four studies, but no interpretation of this result was provided. As suggested in the literature, there is an urgent need for more high quality research and evidence-based practice in BPSD.

What does the evidence say?

Number of included studies/reviews (number of participants)

Two systematic reviews (SRs) (Richter et al. 2012; Spector et al. 2013) and two cluster-RCTs (Leone et al. 2013; Verkaik et al. 2011) met the inclusion criteria for this BEST summary.

Main Findings

One systematic review evaluated the effectiveness of psychosocial interventions to reduce antipsychotic medication in care home residents (Richter et al. 2012). All studies included in this SR offered an educational programme as main component of a complex intervention. In three studies, the intervention comprised an educational programme for nursing staff, and in the fourth study, an educational programme for pharmacists was offered in addition to multidisciplinary team meetings. Three of the four included studies reported on BPSD as an outcome, all of which found no significant difference between the intervention and usual care.

A recent SR specifically aimed to evaluate staff training interventions to reduce the behavioural and psychological symptoms of dementia (Spector et al. 2013). This review included twenty studies, of which only one was also included in Richter et al. (2012). Of these studies, twelve (7 RCTs and 5 non-RCTs) demonstrated that staff training had a significant positive effect on BPSD, four (3 RCTs and 1 non-RCT) found positive trends, and another four (3 RCTs and 1 non-RCT) found no impact on symptoms.

A recent cluster-RCT evaluated the effectiveness of nursing home staff education for the management of apathy in older individuals with a diagnosis of dementia (Leone et al. 2013). The authors found that, within the three dimensions of apathy, only emotional blunting responded to the training programme.

Another cluster-RCT evaluated the introduction of a nursing guideline on depression in residents with dementia of psychogeriatric nursing home wards (Verkaik et al. 2011). The authors observed a significant reduction in depression in the intervention group when one scale was used (Minimum Data Set/Resident Assessment Instrument-Depression Rating Scale), but not when another scale was used (Cornell Scale for Depression in Dementia). No differences between groups were observed for the secondary outcome: mood.

Authors Conclusions

The authors of one SR (Richter et al. 2012) did not make any conclusions regarding the effectiveness of educational programmes on reducing BPSD. They only stated in their discussion that no study found significant changes in BPSD.

The authors of another SR (3 RCTs and 1 non-RCT) concluded that there was some evidence that staff training interventions can impact on BPSD, although the authors also stated that the poor

quality of the available evidence and inconsistency of the findings make it difficult to draw firm conclusions in agreement with previous reviews (Spector et al. 2013).

Leone et al. (2013) concluded that apathy is rarely identified as a problem in nursing homes, and that emotional blunting was the only dimension sensitive to change.

Verkaik et al. (2011) concluded that the introduction of a nursing guideline on psychogeriatric nursing home wards resulted in significant reductions in depression severity.

Reliability of conclusions/Strength of evidence

Richter et al. (2012) was a well-conducted review with a low risk of bias. Given the quality of the review, and the included studies, the results are likely to be reliable.

Spector et al. (2013) was well-conducted with the exception that no details were provided on the number of reviewers involved in the SR process, thus giving it an overall rating of high risk of bias. Regardless, the authors' cautious conclusions appear to reflect the evidence.

Due to the lack of reporting in Leone et al. (2013)), these studies had an unclear risk of bias, so that the reliability of their results is uncertain.

Verkaik et al. (2011) had a low risk of bias so that the results of this study are likely to be reliable.

What do guidelines say?

The following was found in NICE guidelines (CG42 2006, updated 2012 pp. 45-46);

“Does training of care staff in dementia-specific person-centred care lead to improvement in behaviour that challenges and reduced prescription of medication to control such behaviour in people with dementia requiring 24-hour care when compared with current practice?”

Why this is important

According to prescribing advice published by the Royal College of Psychiatrists, there is a history of inappropriate use of antipsychotic drugs in people with dementia. The proportion of people with dementia with behaviour that challenges tends to rise as the dementia progresses; therefore this issue is of particular importance for people requiring 24-hour care.”

Date question received: 01/07/2013
Date searches conducted: 03/07/2013
Date answer completed: 17/07/2013

References

SRs

Richter T, Meyer G, Möhler R, Köpke S. Psychosocial interventions for reducing antipsychotic medication in care home residents. *Cochrane Database of Systematic Reviews*. Issue 12.

Spector, A., Orrell, M. and Goyder, J. (2013) A systematic review of staff training interventions to reduce the behavioural and psychological symptoms of dementia. *Ageing Research Reviews* 12, pp. 354–364.

RCTs

Leone, E., Deudon, A., Bauchet, M., Laye, M., Bordone, N., Lee, J-H., Piano, J., Friedman, L., David, R., Delva, F., Brocker, P., Yesavage, J. and Robert, P.H. (2013) Management of apathy in nursing homes using a teaching program for care staff: the STIM-EHPAD study. *International Journal of Geriatric Psychiatry* 28. pp. 383-392.

Verkaik, R., Francke, A.L., Meijel, B.V., Spieeuwenberg, P.M.M., Ribbe, M.W. and Bensing, J.M. (2011) The effects of a nursing guideline on depression in psychogeriatric nursing home residents with dementia. *International Journal of Geriatric Psychiatry* 26, pp. 723-732.

Guidelines

National Institute for Health and Care Excellence (2006, updated 2012) *Dementia. Supporting people with dementia and their carers in health and social care. CG42*. London: National Institute for Health and Care Excellence. <http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf>

Results

Systematic Reviews

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Richter et al. (2012)	19/12/2011	<p>P: Male and female care home residents requiring long-term nursing care, irrespective of their cognitive status. Although the target group for antipsychotic medication predominantly consists of people with dementia and BPSD, in practice, such people are not easy to determine. Therefore, all residents were included, assuming that most of those who receive antipsychotic medication do so because of BPSD and only a minority as a treatment for psychosis.</p> <p>I: Psychosocial intervention aimed at reducing antipsychotic medication (interventions directly targeting residents, interventions targeting nursing and other healthcare staff, interventions targeting both groups).</p> <p>C: Treatment as usual.</p> <p>O: Primary outcomes; use of regularly prescribed antipsychotic medication measured at the unit of randomisation level (the resident or the care home). Secondary outcomes; type, dosage, number, and duration of regularly prescribed antipsychotic medication, antipsychotic medication administered 'as</p>	4 cluster RCTs	<p>One study was considered by of high-quality and the other three were considered to be of moderate quality.</p> <p>In three studies, the intervention comprised an educational programme for nursing staff. In two of these studies, an education programme for physicians was also offered. In the fourth study, an educational programme for pharmacists was offered in addition to multidisciplinary team meetings.</p> <p>The primary outcome evaluated in this SR was the use of regularly prescribed antipsychotic medication measured at the unit of randomisation level (the resident or the care home). As this was not relevant to this BEST summary, this data was not extracted.</p> <p>The SR authors evaluated BPSD (measured with a validated scale) as a secondary outcome, and three of the four studies evaluated this outcome. In one of the studies, no significant differences between</p>	Low

		needed', prescription of any regular psychotropic medication, adverse effects of the interventions employed (e.g. falls, injuries, hospitalisation, and death), residents' cognitive status, BPSD measured with a validated scale (e.g. Neuropsychiatric Inventory (NPI), Cohen-Mansfield-Agitation-Inventory (CMAI), Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD), physical restraints, costs.		groups were found for worsening of behavioural symptoms, as measured by FRED (Functionally Ranked Explanatory Designations) and residents' self-reported sleep disorders. Another study reported no significant differences in the level of agitation (measured by the Cohen-Mansfield Agitation Inventory) and aggression, assessed as "events during the last 12 months". A third study reported no increase in behavioural symptoms in the subgroup of residents with withdrawn antipsychotic medication.	
Spector, Orrell and Goyder (2013)	2011 (specific date not reported)	<p>P: Adults with dementia.</p> <p>I: Any Training interventions designed to help paid care staff manage BPSD in residents living in nursing or residential care homes.</p> <p>C: Treatment as usual.</p> <p>O: Improved behavioural and psychological symptoms of depression, various measured depending on individual trials.</p>	20 (13 RCTs and 7 non-randomised studies)	<p>Of the 13 RCTs, only two achieved Jadad scores of 4 and two achieved scores of 3. Out of the seven other studies, only one was rated as 'good'.</p> <p>Seven RCTs found that training interventions were effective for reducing BPSD, whilst three RCTs found positive trends despite a lack of significant findings. Three RCTs found no evidence for the benefits of staff training interventions on BPSD.</p> <p>Five non-randomised designs obtained positive findings, one found a positive trend which failed to reach significance and one found no impact of staff training on BPSD.</p> <p>Sixteen studies included a follow-up assessment and most found that the positive effects of the training intervention were</p>	High

				maintained at follow-up.	
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RCTs








Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Leone et al. (2013)	<p>P: France a diagnosis of dementia according to medical record information; a Mini mental state examination (MMSE)<24; and presence of apathy according to the proposed diagnostic criteria for apathy.</p> <p>I: The first intervention consisted of a 2-h training including a description of the study, a didactic session on AD and BPSD, it explained how staff could act to avoid or decrease the emergence of BPSDs especially in carrying out ADL. In the second stage of the intervention, NH staff received a weekly 4-h training for a month, consisting of suggested methods and practical advice on how to deal with apathy and depression, two hours was devoted to techniques for dealing with deficits in ADL. This aimed at teaching staff how to promote patients' autonomy and increase their sense of competence, 2 hr teaching staff how to structure these activities and to learn techniques and exercises.</p> <p>C: Treatment as usual.</p> <p>O: Nursing home staff completed the Katz ADL Scale (Katz, 1983) to assess functional</p>	N= 230 patients, N= 16 nursing homes.	<p>Based on the Neuropsychiatric Inventory–Nursing Home (NPI–NH), residents from the intervention group (IG) had significantly higher change from baseline scores compared to the usual treatment group for symptoms belonging to the affective subgroup (2.52 vs. -0.39, $p<0.01$) and to the psychotic subgroup at four weeks (0.99 vs. -0.89, $p<0.01$). The differences did not remain significant when comparing baseline and week 17 change scores. Comparing baseline and week 4 Katz ADL scores, residents from the IG had significantly lower scores for “dressing” (-0.07 vs. 0.04) and “transferring” items (-0.06 vs. 0.07) (both $p<0.05$), whereas residents from usual treatment group had significantly lower scores for the “continence” item (-0.09 vs. 0.12, $p<0.01$) and “go to the toilet” item (-0.04 vs. 0.15, $p<0.05$); the lower the score, the more self-sufficient residents are. There was no significant difference between the two groups in change in the “toileting” and “feeding” item scores. Comparing baseline and week 17 ADL change scores, residents from the IG group had lower scores for the “toileting” (-0.05 vs. 0.11) and “transferring” items (-0.05 vs. 0.07) (both $p<0.05$), and residents from the usual treatment group continued to have lower scores for the “continence” item (0.03 vs. 0.19, $p<0.05$). There was no significant difference between the two groups in change in the “dressing”, “go to the toilet” and “feeding” item scores (change from baseline to week 17 scores). Apathy assessment (AI–C) and observational scales (GOS and IOS) were also evaluated. The only significant</p>	Unclear

	<p>abilities and the 12 domains of the Neuropsychiatric Inventory–Nursing Home (NPI–NH) version (Sisco et al., 2000) to evaluate the residents’ neuropsychiatric symptoms. Research team psychologists completed the following: (1) The Apathy Inventory–Clinician version (AI–C) (Leone et al., 2008), designed to evaluate the three dimensions of apathy. Group Observation Scale (GOS) specifically developed for the study to assess behavioural disturbance through direct observation of residents of a given NH during normal mealtimes. An Individual Observation Scale (IOS) specifically developed for the study to assess behavioural disturbance in a one-on-one interview.</p>		<p>decrease was observed for the AI–C emotional blunting dimension in the IG (baseline to week 4: -0.32 vs. 0.11, $p < 0.01$ and baseline to week 17: -0.34 vs. 0.12, $p < 0.01$). For the GOS, the only significant change for the usual group was also observed for the emotional blunting dimension (BL–W17, -0.1 vs. 1.01, $p = 0.05$).</p> <p>Analysis of drug treatment prescriptions demonstrated no significant difference between the two groups in terms of number of residents having a prescription (presence or absence) of psychotropic drugs (IG: 71, Usual: 76), antidepressants (IG: 52; Usual: 48), anxiolytics (IG: 32, Usual: 43) or antipsychotics (IG: 25, Usual: 24).</p>	
Verkaik et al. (2011)	<p>P: Adults with a diagnosis of dementia (all types), severity of dementia from “age associated memory impairment” to “moderately severe dementia”, residents with severe dementia were excluded from the study because the intervention was aimed at residents who were still able to verbally communicate, diagnosed with depression in dementia according to the Provisional Diagnostic Criteria for depression of Alzheimer’s Disease. Exclusion for individual caregivers were not certified or registered, employed for less than 20 h per week.</p> <p>I: Introduction of the guideline; key</p>	N= 97	<p>There was a significant difference on depression using the MDS/RAI-DRS, such that depression severity in the intervention group was reduced from 4.56 (SE 0.35) to 3.91 (SE 0.35) at post-test to 3.79 (SE 0.38) at follow-up. In the control group depression severity at pre-test was 3.84 (SE 0.52), at post-test rises to 4.61 (SE 0.57) and then decreases to follow-up to 4.07 (SE 0.61). Pre-test to follow-up was significant at the $p \leq 0.05$ level. There was no significant difference between the groups when the Cornell Scale for Depression in Dementia (Dutch version) was used.</p> <p>No significant effect of the guideline introduction was found on observed mood. For both observations during morning care and observations during residence in the living room the mean mood scores remain stable in both the</p>	Low











	<p>elements were increasing individualized pleasant activities and decreasing unpleasant events.</p> <p>C: Treatment as usual.</p> <p>O: The primary outcome is depression severity. Instruments used to assess depression severity are the Cornell Scale for Depression in Dementia (Alexopoulos et al., 1988) (Dutch version) and the Depression Rating Scale (DRS) of the Minimum Data Set (MDS) of the Resident Assessment Instrument severity of depression, the variable "mood" is assessed. Observed mood concerns the emotional consequences of depression and is assessed with the instrument FACE.</p>		<p>experimental and control groups, from pre-test to follow-up.</p>	
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Risk of Bias:

SRs

Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Richter (2012)					
Spector (2013)					

Cluster-RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Leone (2013)			NA			
Verkaik (2011)			NA			

 Low Risk
  High Risk
  Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
NICE	Dementia	206	1
MEDLINE	<p>MEDLINE; DEMENTIA/; 35533 results.</p> <p>40. MEDLINE; dementia.ti,ab; 62772 results.</p> <p>41. MEDLINE; alzheimer*.ti,ab; 87081 results.</p> <p>42. MEDLINE; 39 OR 40 OR 41; 135863 results.</p> <p>43. MEDLINE; (challeng* adj3 behavio*).ti,ab; 1808 results.</p> <p>44. MEDLINE; BPSD.ti,ab; 451 results.</p> <p>45. MEDLINE; ((behavio* OR psychological).ti,ab; 840132 results.</p> <p>46. MEDLINE; (neuropsychiatric AND symptoms).ti,ab; 4593 results.</p> <p>47. MEDLINE; agitat*.ti,ab; 12588 results.</p> <p>48. MEDLINE; aggress*.ti,ab; 129215 results.</p> <p>49. MEDLINE; anxiety.ti,ab; 104817 results.</p> <p>50. MEDLINE; depression.ti,ab; 207498 results.</p> <p>51. MEDLINE; vocali*.ti,ab; 6718 results.</p> <p>52. MEDLINE; repetitive.ti,ab; 48519 results.</p> <p>53. MEDLINE; sundown*.ti,ab; 104 results.</p> <p>54. MEDLINE; 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR 51 OR 52 OR 53; 1201482 results.</p> <p>55. MEDLINE; train*.ti,ab; 309593 results.</p> <p>56. MEDLINE; educat*.ti,ab; 359945 results.</p> <p>57. MEDLINE; skills.ti,ab; 83140 results.</p> <p>58. MEDLINE; (teach* OR taught).ti,ab; 132568 results.</p> <p>59. MEDLINE; supervi*.ti,ab; 37623 results.</p> <p>60. MEDLINE; learn*.ti,ab; 216131 results.</p> <p>61. MEDLINE; 55 OR 56 OR 57 OR 58 OR 59 OR 60; 913011 results.</p>		

	<p>62. MEDLINE; "care home".ti,ab; 964 results.</p> <p>63. MEDLINE; "nursing home".ti,ab; 15265 results.</p> <p>64. MEDLINE; residential.ti,ab; 18310 results.</p> <p>65. MEDLINE; NURSING HOME/; 27604 results.</p> <p>66. MEDLINE; HOMES FOR THE AGED/ OR RESIDENTIAL FACILITIES/; 15154 results.</p> <p>67. MEDLINE; 62 OR 63 OR 64 OR 65 OR 66; 56749 results.</p> <p>68. MEDLINE; 42 AND 54 AND 61 AND 67; 406results.</p> <p>72. MEDLINE; 68 [Limit to: Publication Year 2011-Current]; 83 results.</p> <p>73. MEDLINE; "randomized controlled trial".pt; 367858 results.</p> <p>74. MEDLINE; "controlled clinical trial".pt; 87730 results.</p> <p>75. MEDLINE; randomi?ed.ab; 338688 results.</p> <p>76. MEDLINE; placebo.ab; 151391 results.</p> <p>78. MEDLINE; randomly.ab; 203202 results.</p> <p>79. MEDLINE; trial.ab; 293793 results.</p> <p>80. MEDLINE; groups.ab; 1299744 results.</p> <p>81. MEDLINE; 73 OR 74 OR 75 OR 76 OR 77 OR 78 OR 79 OR 80; 3258802 results.</p> <p>82. MEDLINE; 72 AND 81 [Limit to: Publication Year 2011-Current]; 36 results.</p>		
EMBASE	<p>6. EMBASE; DEMENTIA/; 70433 results.</p> <p>7. EMBASE; ALZHEIMER'S DISEASE/; 115102 results.</p> <p>8. EMBASE; dementia.ti,ab; 81727 results.</p> <p>9. EMBASE; alzheimer*.ti,ab; 108342 results.</p> <p>10. EMBASE; 6 OR 7 OR 8 OR 9; 197100 results.</p> <p>11. EMBASE; (challeng* adj3 behavio*).ti,ab; 2269 results.</p> <p>12. EMBASE; BPSD.ti,ab; 588 results.</p> <p>13. EMBASE; ((behavio* OR psychological)).ti,ab; 946068 results.</p> <p>14. EMBASE; (neuropsychiatric AND symptoms).ti,ab; 6383 results.</p> <p>15. EMBASE; agitat*.ti,ab; 17061 results.</p> <p>16. EMBASE; aggress*.ti,ab; 160042 results.</p> <p>17. EMBASE; anxiety.ti,ab; 134737 results.</p> <p>18. EMBASE; depression.ti,ab; 255126 results.</p>		

	<p>19. EMBASE; vocali*.ti,ab; 6878 results.</p> <p>20. EMBASE; repetitive.ti,ab; 54464 results.</p> <p>21. EMBASE; sundown*.ti,ab; 130 results.</p> <p>22. EMBASE; 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21; 1382325 results.</p> <p>23. EMBASE; train*.ti,ab; 363103 results.</p> <p>24. EMBASE; educat*.ti,ab; 416200 results.</p> <p>25. EMBASE; skills.ti,ab; 100380 results.</p> <p>26. EMBASE; (teach* OR taught).ti,ab; 152669 results.</p> <p>27. EMBASE; supervi*.ti,ab; 45106 results.</p> <p>28. EMBASE; learn*.ti,ab; 247376 results.</p> <p>29. EMBASE; 23 OR 24 OR 25 OR 26 OR 27 OR 28; 1056166 results.</p> <p>30. EMBASE; "care home".ti,ab; 1126 results.</p> <p>31. EMBASE; "nursing home".ti,ab; 17994 results.</p> <p>32. EMBASE; residential.ti,ab; 21569 results.</p> <p>33. EMBASE; NURSING HOME/; 36985 results.</p> <p>34. EMBASE; RESIDENTIAL CARE/; 9286 results.</p> <p>35. EMBASE; HOME FOR THE AGED/; 8305 results.</p> <p>36. EMBASE; 30 OR 31 OR 32 OR 33 OR 34 OR 35; 72044 results.</p> <p>37. EMBASE; 10 AND 22 AND 29 AND 36; 543 results.</p> <p>38. EMBASE; 37 [Limit to: Publication Year 2011-Current]; 142 results.</p> <p>39. EMBASE; random*.tw; 811287 results.</p> <p>40. EMBASE; factorial*.tw; 20887 results.</p> <p>41. EMBASE; placebo*.tw; 189880 results.</p> <p>42. EMBASE; (crossover* OR cross-over*).tw; 66004 results.</p> <p>43. EMBASE; (doubl* adj3 blind*).tw; 137363 results.</p> <p>44. EMBASE; (singl* adj3 blind*).tw; 15557 results.</p> <p>45. EMBASE; assign*.tw; 222915 results.</p> <p>46. EMBASE; allocat*.tw; 76037 results.</p> <p>47. EMBASE; volunteer*.tw; 168371 results.</p>		
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	<p>48. EMBASE; CROSSOVER PROCEDURE/; 37280 results.</p> <p>49. EMBASE; DOUBLE-BLIND PROCEDURE/; 115368 results.</p> <p>50. EMBASE; SINGLE-BLIND PROCEDURE/; 17562 results.</p> <p>51. EMBASE; RANDOMIZED CONTROLLED TRIAL/; 345100 results.</p> <p>52. EMBASE; 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR 51; 1319968 results.</p> <p>53. EMBASE; 38 AND 52 [Limit to: Publication Year 2011-Current]; 44 results.</p>		
PsychINFO???	<p>PsychINFO; DEMENTIA/; 22416 results.</p> <p>2. PsychINFO; ALZHEIMER'S DISEASE/; 29265 results.</p> <p>3. PsychINFO; dementia.ti,ab; 39741 results.</p> <p>4. PsychINFO; alzheimer*.ti,ab; 36479 results.</p> <p>5. PsychINFO; 1 OR 2 OR 3 OR 4; 61880 results.</p> <p>6. PsychINFO; "care home".ti,ab; 460 results.</p> <p>7. PsychINFO; "nursing home".ti,ab; 6380 results.</p> <p>8. PsychINFO; residential.ti,ab; 17902 results.</p> <p>9. PsychINFO; NURSING HOMES/; 6292 results.</p> <p>10. PsychINFO; RESIDENTIAL CARE INSTITUTIONS/; 8093 results.</p> <p>11. PsychINFO; 6 OR 7 OR 8 OR 9 OR 10; 28356 results.</p> <p>12. PsychINFO; train*.ti,ab; 221026 results.</p> <p>13. PsychINFO; educat*.ti,ab; 309173 results.</p> <p>14. PsychINFO; skills.ti,ab; 117402 results.</p> <p>15. PsychINFO; (teach* OR taught).ti,ab; 199961 results.</p> <p>16. PsychINFO; supervi*.ti,ab; 37862 results.</p> <p>17. PsychINFO; learn*.ti,ab; 305029 results.</p> <p>18. PsychINFO; 12 OR 13 OR 14 OR 15 OR 16 OR 17; 841800 results.</p> <p>19. PsychINFO; 5 AND 11 AND 18; 636 results.</p> <p>20. PsychINFO; 19 [Limit to: Publication Year 2011-Current]; 111 results.</p> <p>21. PsychINFO; CLINICAL TRIALS/; 6839 results.</p> <p>22. PsychINFO; random*.ti,ab; 119985 results.</p> <p>23. PsychINFO; groups*.ti,ab; 346879 results.</p>		

	<p>24. PsycINFO; (doubl* adj3 blind*).ti,ab; 17401 results.</p> <p>25. PsycINFO; (singl* adj3 blind*).ti,ab; 1503 results.</p> <p>26. PsycINFO; EXPERIMENTAL DESIGN/; 8682 results.</p> <p>27. PsycINFO; controlled.ti,ab; 74822 results.</p> <p>28. PsycINFO; (clinical adj3 study).ti,ab; 7392 results.</p> <p>29. PsycINFO; trial.ti,ab; 63185 results.</p> <p>30. PsycINFO; "treatment outcome clinical trial".md; 24262 results.</p> <p>31. PsycINFO; 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30; 534901 results.</p> <p>32. PsycINFO; 20 AND 31 [Limit to: Publication Year 2011-Current]; 29 results.</p>		
Central	<p>#1 dementiadementia 9107</p> <p>#2 Enter terms for search train*train* 31831</p> <p>#3 Enter terms for search educat*educat* 34957</p> <p>#4 Enter terms for search skillsskills 10185</p> <p>#5 Enter terms for search supervisionsupervision 1968</p> <p>#6 Enter terms for search teach* or taughtteach* or taught 11182</p> <p>#7 Enter terms for search {or #2-#6}{or #2-#6} 66652</p> <p>#8 Enter terms for search #1 and #7#1 and #7 1500</p> <p>#9 Enter terms for search "care home""care home" 244</p> <p>#10 Enter terms for search "nursing home""nursing home" 1732</p> <p>#11 Enter terms for search residentialresidential 1556</p> <p>#12 MeSH descriptor: [Nursing Homes] explode all trees 896</p> <p>#13 MeSH descriptor: [Residential Facilities] explode all trees 1181</p> <p>#14 Enter terms for search {or #9-#13} 3661</p> <p>#15Enter terms for search#8 and #1435817 with date limit.</p>		
Summary	NA	NA	

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