



# CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS

## **Stroke Systems of Care**

**7<sup>th</sup> Edition, Update 2026**

**Evidence Tables**

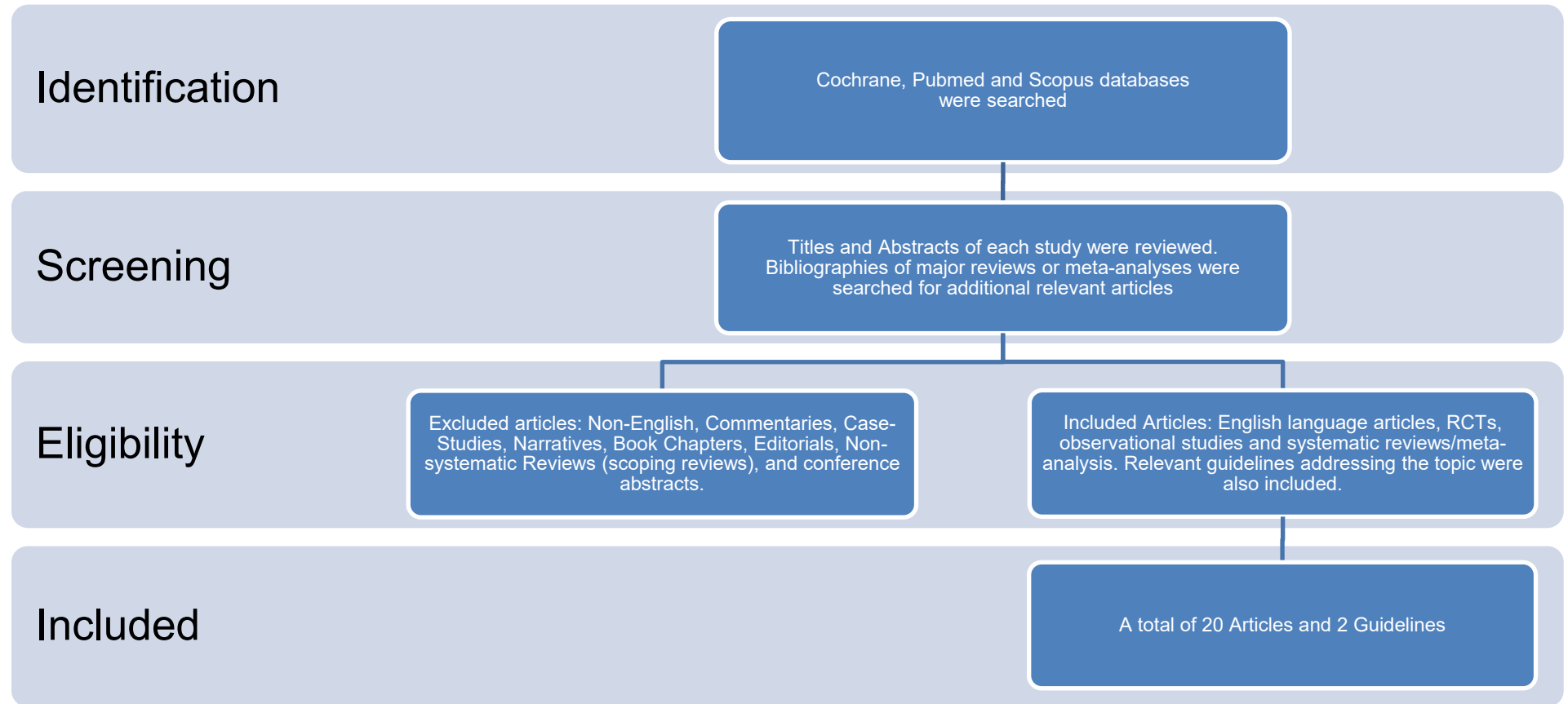
### ***Stroke Management in Long-term Care***

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Stroke Systems of Care Writing Group*

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## Search Strategy



Cochrane, PubMed, and Scopus databases were searched using terms such as (Stroke OR “cerebrovascular disease”) AND “long-term care” OR “nursing home” OR “senior’s home” AND “rehabilitation”). Titles and abstract of each article were reviewed for relevance. Bibliographies were reviewed to find additional relevant articles. Articles were excluded if they were: non-English, commentaries, case-studies, narrative, book chapters, editorials, non-systematic review, or conference abstracts. Additional searches for relevant best practice guidelines were completed and included in a separate section of the review. A total of 20 articles and 2 guidelines were included and were separated into separate categories designed to answer specific questions.

## Published Guidelines

Guideline	Recommendations
<p><b>National Clinical Guideline for Stroke for the UK and Ireland. London: Intercollegiate Stroke Working Party; 2023 May 4.</b></p> <p><b>Available at:</b> <a href="http://www.strokeguideline.org">www.strokeguideline.org</a>.</p>	<p><b>2.17 Recommendations</b></p> <p>A People with stroke living in care homes should be offered assessment and treatment from community stroke rehabilitation services to identify activities and adaptations that might improve quality of life.</p> <p>B Staff caring for people with stroke in care homes should have training in the physical, cognitive, communication, psychological and social effects of stroke and the management of common activity limitations.</p> <p>C People with stroke living in care homes with limited life expectancy, and their family where appropriate, should be offered advance care planning, with access to community palliative care services when needed.</p>
<p><b>Irish Heart Foundation: Council for Stroke: National Clinical Guidelines and Recommendations for the Care of People with Stroke and Transient Ischaemic Attack. Revised Version March 2010.</b></p>	<p>Rehabilitation in Extended Care Setting:</p> <p>All staff in nursing homes, care homes and residential homes should be familiar with the common clinical features of stroke and the optimal management of common impairments and activity limitations. ®</p> <p>Residents in extended care should have the same access to care as any community resident. (R)</p>

## Predictors of Transfer to Long-Term Care Facilities

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
<b>Saab et al. 2019</b> <b>Canada</b> <b>Retrospective study</b>	NA	227 patients with ischemic stroke discharged from a rehabilitation unit between January 1, 2005 and December 31, 2015. No patient demographics are provided.	Candidate variables considered to develop a predictive model of discharge destination (home vs. LTC) included age at onset of stroke, sex, FIM, and AlphaFIM scores prior to admission and FIM scores at admission and at discharge from rehabilitation and FIM change, residence (living at home versus chronic care facility), independent activities of daily living, right versus left versus both cerebral hemispheres, bladder and bladder incontinence, dysphagia, aphasia, Berg Balance Scale score on admission and at discharge and change, from admission to discharge, ability to transfer at discharge, MoCA score, hemianopsia, the presence of caregiver and having independent financial support for care and common comorbidities, such as diabetes etc.	<b>Primary outcome:</b> Independent predictors of discharge to LTC	Patients were more likely to be discharged to LTC if they were older (OR=1.15), living outside of the home before the stroke (OR=14.47), suffered from bowel incontinence (OR=10.6), and had no caregiver available (OR=22.1).
<b>Burton et al. 2018</b> <b>UK</b>	NA	18 studies (n=32,139) Including persons who were transferred directly to a long-term care (LTC) facility	Factors associated with transfer to LTC, were identified.	<b>Primary outcome:</b> Factors related to LTC admission	The median percentage of patients transferred to LTC was 17% (range 7%-39%). The median percentage of patients who died as inpatients was

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
<b>Systematic review</b>		following an acute hospitalization for stroke. Mean age of participants ranged from 58.9 to 88.9 years.			11% (range 3%- 29%)  Age and stroke severity were the strongest predictors of transfer to LTC. The greatest likelihood of LTC was reported for patients ≥ 80 years vs. <60 years (OR=28.5) and for persons with baseline NIHSS scores >16 vs. ≤5 (OR=38.2). Other significant predictors, included being single or divorced, poor social support, previous stroke, cardiac disease, dementia and other comorbidities.  None of the studies evaluated patient or family preferences, socioeconomic status, availability of social care, costs of care, insurance status, dysphagia, or continence.
<b>Pereira et al. 2014</b> <b>Canada</b> <b>Retrospective study</b>	NA	189 patients admitted to a stroke rehabilitation unit of a single hospital following a severe first-ever stroke (i.e FIM scores 12-38). Mean age was 69 years.	Phone interviews were used to establish post-discharge living arrangements	<b>Primary outcome:</b> Independent predictors of home discharge	Independent predictors of discharge home were younger age, higher admission FIM score and the availability of a caregiver.  65 patients (34%) were discharge to a nursing home.  Fewer patients with the availability of a caregiver were discharged home (45% vs. 99%, p<0.001).  The mean age of patients discharged to a nursing home was significantly higher compared with patients discharged home (78.5 vs. 63.8 years, p<0.001). Their mean admission FIM score for inpatient rehabilitation was significantly lower (47.5 vs. 50.4, p=0.012).
<b>Brody et al. 2010</b> <b>Australia</b> <b>Retrospective study</b>	NA	202 participants, <85 years without dementia who had suffered an ischemic stroke. Mean age was 72 years.  97 persons, recruited from the community, served as a control group. Mean age was 71 years	Participants were assessed at 3-7 days following stroke at 3-6 months and at 1, 3 and 5 years.  Model were developed to predict mortality and institutionalization. Candidate variables included age, development of	<b>Primary outcomes:</b> Mortality and rates of institutionalization at 10 years.	The survival rates for the stroke patients were: 100% at 1 month, 97.2% at 12 months, 92.0% at 2 years, 73.3% at 5 years and 17.5% at 10 years. The mean survival time for the stroke patients was significantly shorter compared with the controls.  Nursing home admission rates were 24% at 5 years and 32% at 10 years for patients and 0 for controls over 8.9 years follow-up.  Independent predictors of nursing home admission were advancing age (HR=1.08, 95% CI 1.01-1.12,

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			dementia, mild cognitive impairment, ability to perform ADL stroke severity (European Stroke Scale), marital status, depression (Geriatric Depression Scale), diabetes, education, and number of vascular risk factors		p=0.01) and lower performance on ADL (HR=0.81, 95% CI 0.74-0.88, p<0.001).
<b>Walsh et al. 2008</b> <b>Ireland</b> <b>Retrospective study</b>	NA	136 patients admitted to a stroke unit of a single hospital. Median age was 77 years. 98% of patients were living at home prior to stroke.	Patient data was obtained through a patient information system. Data collected included age, sex, stroke subtype, patients' residence pre-stroke and discharge medications	<b>Primary outcomes:</b> Mortality, rates of institutionalization and stroke recurrence at 4 years.	Mortality at 1 and 4 years was 16.3% and 39.5%, respectively.  Stroke recurrence at 1 and 4 years was 1.6% and 8.0%, respectively.  At 4 years, 40.3% of patients were institutionalized.
<b>Chuang et al. 2005</b> <b>Taiwan</b> <b>Prospective study</b>	NA	714 patients admitted to one of 6 hospitals following acute stroke. Mean age was 71 years. 59% of patients had experience their first stroke.	Data was collected in person during hospitalization and by telephone interviews at 1, 3 and 6 months following discharge. Data points collected included, age, sex, ability to perform ADL, discharge destination, mortality	<b>Primary outcomes:</b> Mortality and rates of institutionalization.	At 1 month after discharge, 22.1% of patients could perform ADL 4.5% of patients had died, 10.4% were admitted to a LTC facility.  At 3 months after discharge, 25.3% of patients could perform ADL 6.8% of patients had died, 11.2% were admitted to a LTC facility.  At 6 months after discharge, 29% of patients could perform ADL 10% of patients had died, 10.3% were admitted to a LTC facility.
<b>Portelli et al. 2005</b> <b>UK</b> <b>Retrospective study</b>	NA	2,778 patients randomly sampled from 79 hospitals, who had been admitted with acute stroke.	A 42-item questionnaire was used to collect data on admission and discharge details, prestroke status, stroke severity, resource utilization, and discharge disposition at 3- and 6-months post stroke.	<b>Primary outcomes:</b> Independent variables predicting institutionalization	349 patients (19%) were discharged from hospital to a nursing home. Of these, 242 (14%) patients lived at home, prior to stroke. 812 patients (29%) died in hospital.  At 3 months, 194 patients (74%) remained institutionalized. while 48 (18%) patients had died.  Age, Barthel Index at discharge and LOS were

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					significant predictors of institutionalization.

## Discharge Planning for Patients Entering Long-Term Care

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<b>Sackley &amp; Pound 2002</b> <b>UK</b> <b>Consensus panel</b>	NA	12 members from a multidisciplinary specialized stroke team participated in a panel to discuss priority items for discharge plans for stroke patients entering long term care.	Literature was reviewed and the evidence summarized. 22 discharge process items were identified and categorized into three areas: discharge process, physical care needs, and patient needs.  Panel members ranked the items in terms of priority, met to discuss importance of items, and provided a second ranking of items following this meeting.	<b>Primary outcome:</b> The development of an evidence-based discharge plan for persons moving from inpatient care to a nursing home facility following a stroke.	In addition to the identification of physical care needs (e.g., details of the methods the patient uses to transfer and mobilize) and care needs (e.g., details of current medications and pain management), priorities for discharge were identified and included: <ol style="list-style-type: none"> <li>1. Plans need to be coordinated by a single person</li> <li>2. A full assessment of needs for aids should be carried out and the findings given to the nursing home</li> <li>3. Patients should visit the nursing home before discharge</li> <li>4. Patient information should be recorded in written format</li> <li>5. Continuing rehabilitation plans should be included</li> <li>6. Staff at the nursing home should receive teaching on the patient's care before discharge</li> <li>7. Details of follow-up care should be included</li> <li>8. Hospital staff should carry out a follow-up visit to the nursing home</li> <li>9. The patient should be given an outpatient appointment after discharge</li> </ol> <p>Overall, there was good agreement on priority items</p>

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					between panel members (Kendall coefficient of concordance (W)=0.48-0.58).
<b>Sackley &amp; Pound. 2002</b> <b>UK</b> <b>Retrospective Study</b>	NA	38 stroke patients with Barthel Index scores of <11, three months post stroke who were discharged to a nursing home. Mean age of patients was 81 years.	A content analysis of case notes and discharge letters, completed by nurses and MDs was conducted to determine if the discharge letters contained information related to self-care ability, nursing needs, and risk assessment.	<b>Primary outcome:</b> Completeness and accuracy of discharge letters related to patient nursing needs	<p>Nursing care items that were most likely to have been recorded in the discharge letter were related to diet (82%), and self-care ability in bathing (71%) and transfer method (76%).</p> <p>Nursing care items that were least likely to have been recorded in the discharge letter were related to risk assessment (e.g., falls 18%) and depression and pressure care (37% each) and patient's level of communication (37%).</p> <p>Many items deemed to be priority for discharge communication were poorly recorded, and in several cases discharge letters contained inaccurate information regarding patients' abilities (i.e. mobility issues). In two cases, discharge letters were delivered to the nursing care facility months after the patient was discharge from inpatient care.</p> <p>The majority of discharge letters completed by MDs contained no information related to primary diagnosis, long-term care needs or social needs.</p>

### Outcomes for Patients Transferred to Long-Term Care

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
<b>Jantzi et al. 2014</b> <b>Canada</b> <b>Retrospective study</b>	NA	42,089 patients admitted to long-term care facilities in Ontario within 180 days. 7,226 patients (17.2%) had experienced a stroke	The association between various neurological conditions (dementia, seizure disorder, Huntington's disease, multiple sclerosis, Parkinson's disease, stroke, TBI and	<b>Primary outcome:</b> Independent predictors of fractures within 180 days of admission	<p>23,788 patients (55.5%) had one of the neurological conditions of interest.</p> <p>Of the entire cohort, 2.6% (1,094) sustained a fracture during the 180 days following admission to LTC.</p> <p>In the fully adjusted model, stroke, as a neurological condition was not an independent predictor of incident fracture (OR=1.12, 95% CI 0.92-1.37).</p> <p>Within the stroke sub group, independent predictors of incident fracture were: age &gt;64 Years (65-74 years: OR=4.64, 95% CI 1.07-20.2; 75-84 years: OR=5.21, 95% CI</p>

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			muscular dystrophy) and incident fractures (hip, spinal, forearm and pelvis) was explored		1.27-21.43 and >85 years: OR=7.06, 95% CI 1.73-28.86, compared with patients <65 years), female sex (OR=1.59, 95% CI 1.14-2.22), a score of 5-6 on the Cognitive Performance Scale (OR=2.23, 95% CI 1.15-4.3) a fall in the past 30 days (OR= 1.61, 95% CI 1.14-2.28) and an unsteady gait (OR=1.43, 95% CI 1.04-1.95).
<b>Brajkovic et al. 2009</b> <b>Croatia</b> <b>Cross-Sectional Survey</b>	NA	60 patients, living in a private nursing home (n=30) or their own homes (n=30), for at least the previous 9 months. Stroke onset was one year prior to the start of receipt of services.  Median age was 81 years for the nursing home group and 79 years for the home care group.	Participants living in the nursing home received 24-hour support including access to psychiatric and internist checkups (2 times per week), exercises with a physiotherapist (daily), massage (1 time per week).  Participants living in their home receive care from the same nursing facility but only received nurse, physical therapist and physician's assistance.  Questionnaires were administered to all participants with help from researchers.	<b>Primary outcomes:</b>  Quality of life (World Health Organization Quality of Life Questionnaire – short form WHOQOL-BREF), which includes four domains (physical, psychological, social relationships and environment)  <b>Secondary outcomes:</b> perception of quality of life, perception of health, and self-assessment of global quality of life.	<b>WHOQOL-BREF:</b>  Patients living in the nursing home had higher mean scores on the physical domain (28.5 vs. 17.2; p=0.001), psychological domain (22.3 vs. 16.3; P=0.001), social relationships (11.4 vs. 8.3; P=0.001) and environmental domain (32.8 vs. 24.0; P=0.001) compared to patients living in their homes.  <b>Perceived quality of life and health status:</b>  Patients living in the nursing home also had a higher perceived quality of life (78.7 vs. 59.3; p<0.001) and perceived health status (3.6 vs. 2.5; <0.001) compared to patients living in their home.
<b>Leeds et al. 2004</b> <b>UK</b> <b>Prospective study</b>	NA	Patients admitted to a stroke rehabilitation unit who had been discharged home (n=65) or to a nursing home (n=65) following stroke. Mean age for patients in both groups was 80 years.	Patients in each group were matched for age, sex, stroke severity, ADL performance, cognition, mood and HR QoL, and their outcomes compared at baseline and 6 months following	<b>Primary outcomes:</b>  CAMCOG, Barthel Index (BI), Geriatric Depression Scale (GDS), EQ-5D, number of drugs	Patients in both groups received low amounts of rehabilitation following discharge. A third of patients received none, while 1/5 attended a Day Hospital.  Mean baseline GDS score was significantly higher for patients discharged to a nursing home (6.1 vs. 3.4, p=0.003), but there were no significant differences between groups on any of the other measures.  At follow-up, patients who had been discharged home had significantly lower mean GDS score (4.2 vs. 5.9, p=0.002),

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			discharge from hospital		and significantly higher mean CAMCOG (81.4 vs. 75.4, p=0.03), BI scores (14.9 vs. 10.8, p=0.0001) and mean EQ-5D scores (0.60 vs. 0.35, p=0.001).  There was no significant difference in the mean number of drugs taken, between groups (5.9 vs. 5.1, p=0.07).
<b>Quilliam &amp; Lapane 2001</b> <b>U.S.</b> <b>Cross-Sectional Study</b>	NA	53, 829 patients in 5 states >65 years with stroke who were living in a long-term care facility following stroke.  21% of patients were 65-74 years, 43% were 75-84 years, and 36% were over 85.	Factors associated with the use of drugs for secondary prevention of stroke were assessed using an administrative database (SAGE).  Drugs that were classified as preventative agents included: aspirin, dipyridamole, ticlopidine and warfarin	<b>Primary outcomes:</b> independent predictors of anticoagulant or antiplatelet usage.	66% of patients were not receiving anticoagulant or antiplatelet therapy.  Among the 9042 patients who had been hospitalized within the previous 6 months, independent predictors of reduced likelihood of secondary prevention drug use were: older age (85+ years OR=0.80, 95% CI 0.72–0.89, female sex (OR= 0.92, 95% CI 0.85–0.99), physical dependency (OR= 0.62, 95% CI 0.52–0.74), moderate and severe cognitive impairment (OR= 0.85, 95% CI 0.77–0.93 and OR=0.61, 95% CI 0.55–0.68, respectively), Alzheimer’s disease (OR= 0.72, 95% CI 0.57–0.90) and a history of GI bleed (OR=0.51, 95% CI 0.43–0.61) or peptic ulcer (OR=0.58, 95% CI 0.48–0.69).  Independent predictors associated with increased likelihood of drug use were: atrial fibrillation (OR=1.67, 95% CI 1.54–1.81), HTN (OR= 1.16, 95% CI 1.08–1.25) and depression (OR= 1.16, 95% CI 1.03–1.30).

## Rehabilitation Provided in Long-Term Care

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
<p><b>Sackley et al. 2015</b></p> <p><b>UK</b></p> <p><b>Cluster RCT</b></p> <p><b>(OCTH trial)</b></p>	<p>CA: <input checked="" type="checkbox"/></p> <p>Blinding: <input type="checkbox"/></p> <p>Patient <input checked="" type="checkbox"/></p> <p>Assessor <input checked="" type="checkbox"/></p> <p>ITT: <input checked="" type="checkbox"/></p>	<p>1,042 care home residents from 228 facilities with a history of stroke or TIA. Mean age was 82.9 years, 36% were men. Mean BI score at baseline was 6.4. 47% of patients were severely disabled</p>	<p>Patients were randomized at the facility level to a 3-month program provided by occupational therapists (n=568) or usual care (n=474). Patients in the OT arm participated in individualized program with a focus on improvement or maintenance of functional capacity, adaptations to the environment and included an education component for the care home staff.</p> <p>The frequency and duration of therapy sessions varied based on goals of therapy.</p>	<p><b>Primary outcomes:</b></p> <p>Barthel Index (BI) 3 months post randomization</p> <p><b>Secondary outcomes:</b></p> <p>BI, at 6 and 12 months, Rivermead Mobility Index (RMI), Geriatric Depression Scale (GDS) and EQ-5D, assessed at 3, 6 and 12 months</p>	<p>The median length of stay between care home admission and trial randomization was 2.2 years.</p> <p>The mean number of OT visits was 5.1 per participant.</p> <p>At 12 months, 384 patients remained in the OT group and 303 in the control group.</p> <p>There was no significant difference in mean BI scores between groups at 3 months (5.47 vs. 5.29, adjusted mean difference=0.19, 95% CI -0.33 to 0.70, p=0.48), or at 6 or 12 months.</p> <p>There was no significant difference in mean RMI scores between groups at 3 months (2.74 vs. 2.73, adjusted mean difference=0.02, 95% CI -0.28 to 0.31, p=0.90) or at 6 or 12 months.</p> <p>There were no significant differences between groups in mean GDS or EQ-5D scores at 3, 6 or 12 months.</p> <p>There were no differences between groups in subgroup analysis of age, type of care home, baseline MMSE score or baseline BI score.</p> <p>There were no adverse events.</p> <p>The authors concluded there was no evidence of benefit of the program.</p>
<p><b>Fletcher-Smith et al. 2013</b></p> <p><b>UK</b></p> <p><b>Cochrane review</b></p>	<p>The included trial was at low risk of selection bias, detection bias, and attrition bias. The trial was at unclear risk of performance bias</p>	<p>1 phase II cluster RCT (OTCH trial, n=118) including patients with moderate to severe disability (BI 4-15) following stroke who were living in 12 care homes. Mean age was 87.5 years, 82% were men.</p>	<p>The single trial (Sackley et al. 2006) compared occupational therapy targeted towards improving independence in personal ADL and which included an education component for care home staff and carers vs. usual care</p>	<p><b>Primary outcome:</b></p> <p>ADL, death or poor outcome at the end of follow-up</p> <p><b>Secondary outcomes:</b></p> <p>ADL, or EADL at the end of intervention, death, global quality of life, mobility, mood, global cognition</p>	<p>At the end of scheduled follow-up there was no significant difference between groups in mean BI scores (10.2 vs. 8.1, SMD=0.39, 95% CI -0.11-0.90, p=0.13), or in the proportion of patients who were dead, or whose BI score had dropped (51.5% vs. 75.8%, OR=0.34, 95% CI 0.1-1.01, p=0.051).</p> <p>The odds of death at the end of scheduled follow-up were significantly lower for patients in the OT group (OR=0.29, 95% CI 0.09-0.98, p=0.047)</p> <p>At the end of the intervention, there was no significant difference between groups in the mean BI scores (10.8 vs. 8.2, SMD=0.48, 95% CI -0.03-0.99, p=0.064).</p>

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			(i.e. no OT intervention). The intervention was provided for 3 months. The frequency was based on patient goals.		There were no significant differences between groups in mean RMI scores (5.0 vs. 4.5, SMD=0.14, 95% CI -0.36, 0.64, p=0.58). Other outcomes were not estimable (i.e., not assessed). The authors stated there was <i>insufficient evidence to support or refute the efficacy of OT interventions for improving, restoring or maintaining independence in ADL for stroke survivors residing in care homes.</i>
<b>Crocker et al. 2013</b> <b>UK</b> <b>Systematic review &amp; meta-analysis</b>	No study had a low risk of bias across all the domains assessed	13 RCTs (n=2,379) including persons > 60 years, living in long-term care facilities. Mean age was 84 years, 21% were men. Mean baseline BI scores ranged from 10-14.  1 trial included persons with 100% stroke diagnosis (Sackley et al. 2006)	Trials compared any physical rehabilitation intervention vs. usual care, no intervention or an alternative intervention.  Rehabilitation therapies included group exercise classes with a focus on mobility, balance, flexibility, or ADL performance, which were delivered by rehab professionals or carers/ volunteers. 4 interventions were provided by OTs, PTs, or both. The intensity of therapies was judged to be high in 7 trials, low in 3, and unclear in 5 trials.	<b>Primary outcome:</b> ADL	Rehabilitation interventions were associated with a small benefit in improvement in ADL performance (WMD=0.24, 95% CI 0.11–0.38, p= 0.0005), equating to a mean improvement of 1.3 Barthel Index points.  Subgroup analyses based on the duration, delivery mode and intensity of interventions found no significant differences between groups in treatment effect.
<b>Sackley et al. 2009</b> <b>UK</b> <b>Cluster RCT</b>	CA: <input checked="" type="checkbox"/>  Blinding:	249 patients with mobility limitations and Barthel Index scores of 5-16, were recruited from 24 care homes. Mean age	Patients were randomized 1:1 at the facility level to a 3-month program provided by	<b>Primary outcomes:</b>	The mean number of PT visits was 6.4 per resident (mean contact time of 2.21 hours). The mean number of OT visits was 9.8 per resident (mean contact time of 3.6 hours).

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
	Patient <input checked="" type="checkbox"/> Assessor <input checked="" type="checkbox"/>  ITT: <input checked="" type="checkbox"/>	was 85 years, 26% were men. 22% of patients had a history of stroke	occupational and physical therapists (n=128) or standard care (n=121). The intervention program was aimed at improving mobility, strength, flexibility, balance, exercise tolerance and the ability to perform ADLs. Functional tasks (e.g., sit to stand) were also practiced	Barthel Index (BI) and Rivermead Mobility Index (RMI)	There were no adverse events.  The mean BI scores for patients in the intervention and control groups were: Baseline 11.1 vs. 12.5 3-months 10.6 vs. 11.8 6-months 10.7 vs. 11.9  There were no significant differences between groups at any assessment point.  The mean RMI scores for patients in the intervention and control groups were: Baseline 5.8 vs. 6.9 3-months 5.1 vs. 6.7 6-months 5.2 vs. 6.5  There were no significant differences between groups at any assessment point.  BI data at 3 and 6-month data were available for 214 and 187 patients, respectively.
<b>Baum et al. 2003</b> <b>USA</b> <b>RCT</b>	CA: <input checked="" type="checkbox"/> Blinding: Patient <input checked="" type="checkbox"/> Assessor <input checked="" type="checkbox"/> ITT: <input checked="" type="checkbox"/>	20 residents of a LTC facility aged 75 to 99 years. Mean age was 88 years, 25% were men.	Residents were randomized to receive group exercise (EX) or recreational therapy (C) for 6 months and then crossed over to the other group for an additional 6 months.  Residents in the EX group met for 1 hour 3x/week. Sessions included seated ROM exercises and strength and resistance training. Residents in the C	<b>Primary outcomes:</b>  Timed up-and-Go test (TUG), Berg Balance Scale (BBS), Physical Performance Test (PPT), and Mini-Mental State Exam (MMSE)	There was greater improvement in the EX group compared with the C group.  TUG: 18 seconds faster PPT: 1.3 points better BBS: 4.8 points better MMSE 3.1 points better  Two residents (one in each group) were non compliant.

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
			group also met 3x/week and participated in activities such as painting and other recreational activities.		
<b>Mulrow et al. 1994</b> <b>USA</b> <b>RCT</b>	CA: <input checked="" type="checkbox"/> Blinding: Patient <input checked="" type="checkbox"/> Assessor ? ITT: <input checked="" type="checkbox"/>	194 nursing home residents >60 years, dependent in ≥2 ADLs. Mean age was 80 years, 30% were men. 45% had a history of stroke.	Residents were randomized to receive individually tailored one-on-one PT sessions (ROM, strength, balance, transfer, and mobility exercises) or friendly visits (FVs) 3x/week for 4 months.	<b>Primary outcomes:</b> Physical Disability Index (PDI), Sickness Impact Profile (SIP), Katz ADL scale, Geriatric Depression Scale (GDS), MMSE assessed at baseline and post intervention	Drop-outs were 5% in the PT group and 9% in the FV group.  The cost for the 4-month PT program was \$1,220 per resident.  There were no significant differences between the groups for any of the outcomes. Residents in the PT group experienced a 3.7% greater improvement in PDI, compared with the FV group, a decrease of -4.2% in total SIP scores, a decrease of -0.4% in ADL and a decrease of -0.3% in GDS.

**Abbreviations**

ADL: Activity of Daily Living	CI: Confidence Interval
FIM: Functional Independence Measure	LTC: Long-term care
mRS: modified Rankin Scale	NA: Not assessed
NIHSS: National Institutes of Health Stroke Scale	OR: Odds Ratio

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