

Appendix D: Clinical evidence tables

Study (subsidiary papers)	Circuit class therapy or seven-day therapy trial: English 2015 ²³ (Hillier 2011 ³¹)
Study type	RCT (Patient randomised; Parallel).
Number of studies (number of participants)	1 (n=283).
Countries and setting	Conducted in Australia, unknown, unknown multicentre; setting: participants were recruited from 1 of 5 stroke rehabilitation centres in 3 states within Australia.
Line of therapy	1st line.
Duration of study	Intervention + follow up: inpatient stay + 4 weeks after randomisation.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Overall.
Subgroup analysis within study	Not applicable.
Inclusion criteria	People with stroke admitted to inpatient rehabilitation facilities with moderate disability (FIM total score between 40 and 80 points or motor subscale score of between 38 and 62 points). Stroke survivors with moderate disability (defined by these FIM score ranges) show the greatest degree of functional recovery and are most likely to benefit from increasing the dose of activity-based therapy. Either participants provided informed consent themselves or proxy consent was obtained from an appropriate third party.
Exclusion criteria	People who are not able to walk independently before their stroke for any reason (prior use of a walking aid is acceptable).
Recruitment/selection of patients	Participants were recruited from 1 of 5 stroke rehabilitation centres in 3 states within Australia.
Age, gender and ethnicity	Age - Mean (SD): 69.9 (12.7). Gender (M:F): 3/2. Ethnicity: n/a.
Further population details	Elderly patients recovering from a stroke.
Indirectness of population	No indirectness.
Interventions	(n=96) Intervention 1: Presence of inpatient physiotherapists and/or occupational therapists - 7 day services. Seven-day week therapy: participants randomised to receive 7 day a week therapy received physiotherapy on both Saturday and Sunday for the duration of their inpatient stay, in addition to the usual 5 days of the working week. The duration of therapy sessions provided on the weekend was matched to that during the preceding week. Additional staffing was required to deliver the 7-day week therapy. Duration: as long as inpatient. Concurrent medication/care: usual care

	<p>therapy according to local site standard practice. For 3 of the 5 sites, this was individual sessions provided 5 days a week. At 2 of the recruitment sites usual care involved a combination of daily individual sessions augmented for some people by group physiotherapy provided between 1 and 4 times a week. In 2 of the 5 sites, usual care therapy included weekend therapy for some, but not all patients.</p> <p>Further details: 1. Therapists contact time: participants randomised to receive 7 day a week therapy received physiotherapy on both Saturday and Sunday for the duration of their inpatient stay, in addition to the usual 5 days of the working week.</p> <p>(n=94) Intervention 2: Presence of inpatient physiotherapists and/or occupational therapists - less than 7 day services (standard hours defined as 9am-5pm, Monday to Friday; anything above should be considered as enhanced). Usual care therapy: according to local site standard practice. For 3 of the 5 sites, this was individual sessions provided 5 days a week. at 2 of the recruitment sites usual care involved a combination of daily individual sessions augmented for some people by group physiotherapy provided between 1 and 4 times a week. In 2 of the 5 sites, usual care therapy included weekend therapy for some, but not all patients. Duration: as long as inpatient. Concurrent medication/care: n/a.</p> <p>Further details: 1. Therapists contact time: participants in the control group received therapy on the usual 5 days of the working week.</p> <p>Comments: usual care varied between sites. Some centres gave additional sessions with groups and some others provided some individuals with additional weekend therapy.</p>
Funding	Academic or government funding.
<p>RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: 7 DAY SERVICES versus LESS THAN 7 DAY SERVICES (STANDARD HOURS DEFINED AS 9AM-5PM, MONDAY TO FRIDAY; ANYTHING ABOVE SHOULD BE CONSIDERED AS ENHANCED).</p> <p>Protocol outcome 1: Quality of life. - Actual outcome for Stroke: Australian Quality of life at 4 weeks; Risk of bias: All domain - High, Selection - Low, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 8; Group 2 Number missing: 6</p> <p>Protocol outcome 2: Avoidable adverse events - Actual outcome for Stroke: all adverse events at discharge; Group 1: 16/96, Group 2: 12/94; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 0; Group 2 Number missing: 0</p> <p>Protocol outcome 3: Length of hospital stay. - Actual outcome for Stroke: length of stay in rehabilitation facility at discharge; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data</p>	

- Low, Outcome reporting - Low, Measurement - Low, Crossover - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 8; Group 2 Number missing: 6	
Protocol outcomes not reported by the study	Patient and/or carer satisfaction; Re-admission; Discharge to normal place; Time to mobilisation; Delayed transfers of care; Mortality.

Study	Said 2012 ⁵⁰
Study type	RCT (Patient randomised; Parallel).
Number of studies (number of participants)	1 (n=47).
Countries and setting	Conducted in Australia; setting: recruited from 2 aged care rehabilitation wards within a tertiary hospital. Most admissions to the wards were from an acute hospital.
Line of therapy	1st line.
Duration of study	Intervention + follow up: until discharge + 3 months follow-up.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Overall.
Subgroup analysis within study	Not applicable.
Inclusion criteria	Aged 60 years and over and had 'improve mobility/walking' as a goal at admission.
Exclusion criteria	If primary reason for admission was to await residential care placement, they did not require physiotherapy or if there were medical restrictions on mobilisation (for example, non-weight bearing).
Recruitment/selection of patients	Aged 60 years and over and had 'improve mobility/walking' as a goal at admission. Consent was obtained from the participant within 48 hours of admission.
Age, gender and ethnicity	Age - Mean (SD): control: 81.6 (6.5); intervention: 80.8 (4.6). Gender (M:F): 1/1. Ethnicity: n/a.
Further population details	1. Frail elderly: Age - Mean (SD): control: 81.6 (6.5); intervention: 80.8 (4.6).
Extra comments	As no funding for interpreters to assist with the trial was available, people who could not speak English could only be recruited if next of kin were available to assist with consent. If the participant was unable to provide consent due to cognitive impairment, consent was obtained from the 'person responsible'.
Indirectness of population	No indirectness.
Interventions	(n=25) Intervention 1: Presence of inpatient physiotherapists and/or occupational therapists - less than 7 day services (standard hours defined as 9am-5pm, Monday to Friday; anything above should be considered as enhanced). Usual care included therapy provided by a multidisciplinary team. All participants routinely received 1 to 2 sessions of physiotherapy from Monday to Friday. These sessions were either individual sessions supervised by a physiotherapist/physio assistant or group exercise classes designed to improve lower limb strength or balance, depending on participants' functional status and goals. Duration: until discharge + 3 month follow-up. Concurrent medication/care: n/a. Further details: 1. Therapists contact time: all participants routinely received 1 to 2 sessions of physiotherapy from Monday to Friday.

	<p>(n=22) Intervention 2: Presence of inpatient physiotherapists and/or occupational therapists - 7 day services. Intervention: additional programme of enhanced physical activity. This programme focused on increasing the time participants spent performing mobility activities in the late afternoons/evening and on weekends, as activity levels at these times have been shown to be low. The aim was to double the previously reported time spent performing standing and walking activities in the late afternoon and evening on weekdays. On weekends, the aim was to increase the time spent performing standing and walking activities so that activity levels were the same as activity levels on weekdays (with usual care). The intervention was individually tailored for each patient according to functional level, and delivered by a physio or physio assistant. Progress was monitored in each session and the intervention was modified as the patient's function improved. Duration: until discharge + 3 months follow-up. Concurrent medication/care: usual care included therapy provided by a multidisciplinary team. All participants routinely received 1 to 2 sessions of physiotherapy from Monday to Friday. These sessions were either individual sessions supervised by a physiotherapist/physio assistant or group exercise classes designed to improve lower limb strength or balance, depending on participants' functional status and goals.</p> <p>Further details: 1. Therapists contact time: all participants routinely received 1 to 2 sessions of physiotherapy from Monday to Friday; additional therapy in the evenings on weekdays, plus extra therapy on Saturdays.</p> <p>Comments: enhanced: additional therapy in the evenings on weekdays, plus extra therapy on Saturdays.</p>
Funding	Academic or government funding.
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: 7 DAY SERVICES versus LESS THAN 7 DAY SERVICES (STANDARD HOURS DEFINED AS 9AM-5PM, MONDAY TO FRIDAY; ANYTHING ABOVE SHOULD BE CONSIDERED AS ENHANCED).	
<p>Protocol outcome 1: Quality of life.</p> <p>- Actual outcome for Elderly: de Morton mobility index (DEMMI) at discharge; Group 1: mean 9.6 (SD 8.8); n=22, Group 2: mean 7.2 (SD 9.2); n=25; de Morton Mobility Index 0-100 Top=High is good outcome; Ri Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 0; Group 2 Number missing: 0</p>	
<p>Protocol outcome 2: Mortality</p> <p>- Actual outcome for Elderly: mortality at 3 month follow-up; Group 1: 3/22, Group 2: 4/25; Risk of bias: High; Indirectness of outcome: No indirectness.</p> <p>- Actual outcome for Elderly: mortality at during hospital stay; Group 1: 0/22, Group 2: 0/25; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness</p>	
<p>Protocol outcome 3: Avoidable adverse events</p> <p>- Actual outcome for Elderly: non-injurious fall at until discharge; Group 1: 1/22, Group 2: 1/25; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 0; Group 2 Number missing: 0</p>	

Protocol outcome 4: Re-admission

- Actual outcome for Elderly: readmission to acute hospital at during hospital (rehabilitation) stay; Group 1: 0/22, Group 2: 0/25; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness ; Group 1 Number missing: 0; Group 2 Number missing: 0

Protocol outcomes not reported by the study

Length of hospital stay; Discharge to normal place; Time to mobilisation; Delayed transfers of care; Patient and/or carer satisfaction.