National Institute for Health and Care Excellence

Draft for consultation

Rehabilitation after traumatic injury

D.2 Service coordination: Inpatient to outpatient settings for people with complex rehabilitation needs after traumatic injury

NICE guideline <number>

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Draft for consultation

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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Summary of review questions covered in this report

This evidence report contains information on 2 reviews:

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

D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

Service coordination: Inpatient to outpatient settings for people with complex rehabilitation needs after traumatic injury

Review question

This evidence report contains information on 2 reviews relating to service coordination when transferring from inpatient to outpatient settings:

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

D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

Introduction

The transition from inpatient to outpatient services can provoke many emotions for the patient and their families, from excitement and happiness to loneliness and anxiety. Typically, the patient moves from inpatient care where there is consistent daily rehabilitation support to less intensive or fragmented outpatient community-based services, with the addition of social care if required. There are many challenges in achieving a seamless transition, such as regional variation in how services are offered (if they exist at all), waiting times for services and the handover of good quality patient information. The patient and family can often feel isolated and frustrated that they are left to fend for themselves. Therefore, it is vital to strive to deliver an equitable and seamless pathway through both health and social care across this transition point to achieve a high quality rehabilitation journey.

The objective of this review is to determine the best methods to deliver and coordinate rehabilitation services and social services for people with complex rehabilitation needs following traumatic injury, when they are transferring from inpatient to outpatient rehabilitation services.

Summary of the protocol

This review was a mixed methods review. See Table 1 and Table 2 for a summary of the Population, Intervention, Comparison and Outcome (PICO; quantitative) and Population, Phenomenon of interest and Context (PPC; qualitative) characteristics characteristics of this review in the adult and children and young people populations, respectively

Table 1: Summary of the adult protocol (PICO/PPC table)

Population	**Quantitative**	• *For the coordination and delivery of rehabilitation services part of the question:* Rehabilitation services for adults (aged 18 years and above) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient • *For the coordination and delivery of rehabilitation services and social services part of the question:* Rehabilitation services and social services for adults (aged 18 years and above) with social

		service needs and complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient
	Qualitative	• Adults (aged 18 years and above) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient. For the social services aspect of this question, the population also have to have social services needs • Staff working at inpatient and outpatient rehabilitation services and/or social services for adults (aged 18 years and above) who have complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss and hearing loss.

Intervention/ Phenomenon of interest	**Quantitative**	• *For the coordination of rehabilitation services part of the question:* Rehabilitation services coordination method A (for example, neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method A (for example, community, group classes, intensive, multi-disciplinary, cohort clinic, specialist outpatients rehabilitation services, early supported discharge, self-management support, family support, outpatient [at hospital], individual, non-intensive, uni--disciplinary, non-cohort clinic, non-specialist) • *For the coordination of rehabilitation and social services part of the question:* Rehabilitation and social services coordination method A (for example, continuing healthcare assessor, housing occupational therapists, housing officers, community healthcare teams [e.g., district nurses], re-enablement specialists, specialist injury/disability voluntary organisations, non-specialist social care/disability/user-led organisations, speech and language therapists, neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method A (for example, hospital/discharge-led social care and rehabilitation coordination at discharge, ‘separate/disconnected’ NHS continuing health care and local authority social care assessments for discharge (including assessments for capital costs like aids and adaptations and care costs like costs of a daily carer), rehabilitation and social care services delivered via completely different funding set up between health and social care, liaison at discharge with relevant voluntary organisations, use of personal budgets at discharge, liaison at discharge with reablement services/intermediate care, liaison with housing occupational therapists and other housing liaison at discharge (for example, to establish whether disabled facilities grants may be available if adaptations are needed, community-led social care and rehabilitation coordination at discharge, ‘joined up/connected NHS continuing health care and local authority social care assessments for discharge, rehabilitation and social care services delivered via a pooled/coordinated budget method (health and social care)

	Qualitative	Methods to coordinate and deliver rehabilitation services (including in combination with social services) for adults when transferring from inpatient to outpatient rehabilitation services. Themes will be identified from the literature, but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker

Comparison	**Quantitative**	• *For the coordination of rehabilitation services part of the question:*
		  ○ Rehabilitation services coordination method B (for example, any of the above interventions)
		  ○ No coordination
		• *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method B (for example, any of the above interventions)
		• *For the coordination of rehabilitation and social services part of the question:*
		  ○ Rehabilitation and social services coordination method B (for example, any of the above interventions)
		  ○ No coordination
		• *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method B (for example, any of the above interventions)

	Qualitative	Not applicable.

Outcomes	**Quantitative**	• Critical
		  ○ Patient satisfaction
		  ○ Length of hospital stay
		  ○ Return to work or education
		• Important
		  ○ Overall quality of life (EURO-QoL 5D 3L, SF-36, SF-12, SF-6D, SFMA)
		  ○ Carer impact
		  ○ Unplanned readmission
		  ○ Changes in activity of daily living (Barthel ADL index, COPM, E-ADL-Test, FIMFAM, GAS, Katz, OARS, PAT, PSMS)

	Qualitative	Themes will be identified from the literature pertaining to methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for adults, when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective. Themes will be identified from the literature but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
Context	**Quantitative**	Rehabilitation and social care settings for patients with complex rehabilitation needs after traumatic injury

	Qualitative	Exclusion: • Accident and emergency departments • Critical care units • Prisons

ADL: Activities of daily living; COPM: Canadian occupational performance measure; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L; EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GP: General practitioner; MDT: Multi-disciplinary team; NHS: National Health Service; OARS: Older American resources and services scale; PAT: Performance ADL test; SFMA; Selective functional movement assessment ; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form

Table 2: Summary of the children and young people protocol (PICO/PPC table)

Population	**Quantitative**	• *For the coordination and delivery of rehabilitation services part of the question:* Rehabilitation services for children and young people (aged below 18 years) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient • *For the coordination and delivery of rehabilitation services and social services part of the question:* Rehabilitation services and social services for children and young people (aged below 18 years) with social service needs and complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient
	Qualitative	• Children and young people (aged below 18 years) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient. *For the social services aspect of this question, the population also have to have social services needs.* The views of the families/carers of the children and young people will also be sought. • Staff working at inpatient and outpatient rehabilitation services and/or social services for children and young people (aged below 18 years) who have complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss and hearing loss..

Intervention/ Phenomenon of interest	**Quantitative**	• *For the coordination of rehabilitation services part of the question:* Rehabilitation services coordination method A (for example, community paediatrician, education representatives [teachers, SENCO], neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method A (for example, community, group classes, intensive, multi-disciplinary, cohort clinic, specialist outpatients rehabilitation services, early supported discharge, self-management support, family support, outpatient [at hospital], individual, non-intensive, uni-disciplinary, non-cohort clinic, non-specialist) • *For the coordination of rehabilitation and social services part of the question:* Rehabilitation and social services coordination method A (for example, continuing healthcare assessor, housing occupational therapists, housing officers, community healthcare teams [for example, district nurses], re-enablement specialists, specialist injury/disability voluntary organisations, non-specialist social care/disability/user-led organisations, speech and language therapists, neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method A (for example, hospital/discharge-led social care and rehabilitation coordination at discharge, ‘separate/disconnected’ NHS continuing health care and local authority social care assessments for discharge (including assessments for capital costs like aids and adaptations and care costs like costs of a daily carer), rehabilitation and social care services delivered via completely different funding set up between health and social care, liaison at discharge with relevant voluntary organisations, use of personal budgets at discharge, liaison at discharge with reablement services/intermediate care, liaison with housing occupational therapists and other housing liaison at discharge (e.g. to establish whether disabled facilities grants may be available if adaptations are needed), community-led social care and rehabilitation coordination at discharge, ‘joined up/connected NHS continuing health care and local authority social care assessments for discharge, rehabilitation and social care services delivered via a pooled/coordinated budget method (health and social care))

	Qualitative	Methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for children and young people when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective. Themes will be identified from the literature but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
Comparison	**Quantitative**	• *For the coordination of rehabilitation services part of the question*: ○ Rehabilitation services coordination method B (for example, any of the above interventions) ○ No coordination • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method B (for example, any of the above interventions) • *For the coordination of rehabilitation and social services part of the question:* ○ Rehabilitation and social services coordination method B (for example, any of the above interventions) ○ No coordination • *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method B (for example, any of the above interventions)
	Qualitative	Not applicable.
Outcomes	**Quantitative**	• Critical ○ Patient satisfaction ○ Length of hospital stay ○ Return to nursery, education, training or work • Important ○ Overall quality of life including sleep (CHQ-CF80, CHQ-PF-50, EURO-QoL 5D 3L Y, PEDS-QL, SCIM, SF-36, SF-12, SF-6D, SFMA, TARN) ○ Carer impact ○ Unplanned readmission ○ Changes in activity of daily living (Barthel ADL index, COPM, E-ADL-Test, FIMFAM, GAS, Katz, OARS, PAT, PSMS)
	Qualitative	Themes will be identified from the literature but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
Context	**Quantitative**	Rehabilitation and social care settings for patients with complex rehabilitation needs after traumatic injury
	Qualitative	Exclusion: • Accident and emergency departments • Critical care units • Prisons

ADL: Activities of daily living; CHQ-CF80: Child Health Questionnaire self-report (adolescents aged 12-18 years); CHQ-PF-50: Child Health Questionnaire parent-report (children aged 5-18 years); COPM: Canadian occupational performance measure; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L; EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GP: General practitioner; MDT: Multi-disciplinary team; NHS: National Health Service; OARS: Older American resources and services scale; PAT: Performance ADL test; PEDS-QL: Pediatric Quality of Life Inventory; SENCO: Special Educational Needs Co-ordinator; SFMA; Selective functional movement assessment ; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form; TARN; Trauma Audit and Research Network

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and in the methods chapter (Supplement 1). This is a mixed methods review, using parallel synthesis. Quantitative and qualitative data were analysed and synthesised separately and integrated through the committee's interpretation of results, described in the committee's discussion of the evidence.

Declarations of interest were recorded according to NICE's 2018 conflicts of interest policy.

Clinical evidence: Adults

The included studies are summarised in Table 3 and Table 4.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Included quantitative studies

Eleven studies (reported in 12 papers) were included in the quantitative section of this review. Nine of these studies were randomised controlled trials (RCTs; Browne 2013, Chong 2013, Hall 2005, Lin 2009, Parson 2019, Ryan 2006, Stenvall 2007, Vikane 2017 and Wiechman 2015), with the remaining 2 being non-randomised cohort studies (Flikweert 2014 and Hall 2018).

One RCT compared the effectiveness of multidisciplinary team care with usual care in general trauma patients, and was conducted in Austrialia (Browne 2013). Another RCT compared the effectiveness of multidisciplinary team care plus structured assessments with multidisciplinary team care only in hip fracture patients, and was conducted in Singapore (Chong 2015). Two RCTs were conducted in Tawainese hip fracture patients: 1 compared the effectiveness of discharge planning by a gerontological nurse with routine discharge planning (Huang 2005) and the other compared comprehensive discharge planning with routine discharge planning (Lin 2009). Another RCT compared supported discharge team care with usual care in general trauma patients, and was conducted in New Zealand (Parsons 2019), while another RCT compared an intensive multidisciplinary intervention with a less intensive intervention in hip fracture patients and was conducted in the UK (Ryan 2006). Please note that this study reported 3-month and 12-month data in 2 separate publications. An RCT compared the effectiveness of multidisciplinary outpatient treatment with usual care by general practitioners in patients with traumatic brain injury (TBI), and was conducted in Norway (Vikane 2009), while another RCT compared the effectiveness of an extended care practitioner care plus telephone calls with standard outpatient care in burn injury patients, and was conducted in the USA (Wiechman 2015).

The final RCT compared the effectiveness of a multidisciplinary post-operative rehabilitation intervention with conventional post-operative rehabilitation, and was conducted in Sweden (Stenvall 2007). This intervention spanned rehabilitation coordination both while patients were in inpatient settings and when patients were transferring between inpatient and

outpatient settings. It therefore met the inclusion criteria for 2 of the coordination of rehabilitation reviews. Stenvall (2007) is therefore included in both reviews, with the outpatient outcomes reported in this review and the inpatient outcomes reported in the review focusing on coordination of inpatient rehabilitation services.

One cohort study compared the effectiveness of a multidisciplinary care pathway with standard care in hip fracture patients and was conducted in the Netherlands (Flikweert 2014), while the other cohort study compared the effectiveness of a traumatic clinical care coordination with no traumatic clinical care coordination and was conducted in the USA (Hall 2018).

Included qualitative studies

Nineteen primary studies were included in the qualitative section of this review. One of these studies was conducted in the UK (Odumuyiwa 2019), 7 were conducted in Australia (Barclay 2019, Braaf 2018, Isbel 2017, Kennedy 2012, Kornhaber 2019, O'Callaghan 2012 and Turner 2011), 4 in Canada (Glenny 2013, Jeyaraj 2013, Sims-Gould 2012 and Singh 2018) and 3 in Denmark (Christensen 2018, Graff 2018 and Lindahl 2013). One study each was carried out in Belgium (Christiaens 2015), Portugal (Sena Martins 2017) and Norway (Slomic 2017). The final study was a multinational study between France and Finland (Jourdan 2019).

One paper was a framework-based meta-synthesis of 12 primary studies, all conducted by the same research team in Canada (Stolee 2019). It is important to note that this paper included 2 of the above studies in their synthesis (Glenny 2013 and Sims-Gould 2012). In order to prevent double counting of data, findings have only been extracted from Glenny 2013 and Sims-Gould 2012 if they have not appeared in Stolee 2019.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 3 (quantitative studies) and Table 4 (qualitative studies).

Table 3: Summary of included quantitative studies

Study	Population	Intervention[a]	Control[a]	Outcomes
Browne 2013 RCT Australia	N = 142 General trauma Age in years [Mean (SD)]: • Multidisciplinary care = 38.46 (13.32) • Usual care = 36.14 (14.61) Gender (M/F): 106/36 *NB. Only reported for*	<u>Multidisciplinary care</u> Patients were invited to a MDT outpatient clinic at 1-month, 3-months post-discharge and 6-month post-discharge assessment. Visits lasted for 2-4 hours and included consultations with rehabilitation doctors, a physiotherapist,	<u>Usual care</u> Overseen by a GP, with patients attending outpatients for surgical reviews or allied health therapies depending on need, prior to discharge. Invited for assessment and treatment at 6-months post-discharge only.	• Critical ○ Length of hospital stay (at discharge) ○ Return to work or education (at 6 months) • Important ○ Changes in ADL (at 6 months)

Study	Population	Intervention[a]	Control[a]	Outcomes
	whole study rather than by group. Time since injury in years: not reported.	an occupational therapist and clinical psychologist.		
Chong 2013 RCT Singapore	N = 162 Hip fracture Age in years [Mean (SD)]: • MDT care + structured assessments + checklists = 77.1 (11.6) • Usual care = 79.0 (9.6) Gender (M/F): • MDT care + structured assessments + and checklists = 30/62 • Usual care = 21/49 Time since injury: not reported	<u>MDT care + structured assessments and checklists</u> Patients had medical assessment on admission, followed by a protocol for early detection and management of complications. 5-week physiotherapy and occupational therapy were applied by therapists, complete with recommended milestones. Hip precaution advice was also given.	<u>MDT care only</u> 2 x 30 minutes' therapy sessions per day, 5 x per week (10 sessions total per week). Medical ward rounds occureed 3 x per week, with an MDT round every 2 weeks.	• Critical ○ Patient satisfaction (at discharge) ○ Length of hospital stay (at discharge) • Important ○ Overall quality of life (at 6 months; 12 months) ○ Changes in ADL (at discharge; 6 months; 12 months)
Flikweert 2014 Prospective and retrospective cohort study The Netherlands	N = 401 Hip fracture Age in years [Mean (SD)]: • Multidisciplinary care pathway = 78 (9) • Standard care = 80 (10) Gender (M/F): • Multidisciplinary care pathway = 82/174	<u>Multidisciplinary care pathway</u> A 6 months MDT hip fracture pathway that spanned from admission to discharge from nursing home rehabilitation units. The pathway had a strict discharge protocol, beginning upon admission to the medical centre when they were registered to nursing homes	<u>Standard care</u> As per the participating medical centres hip fracture protocol prior to the intervention. No further details reported.	• Critical ○ Length of hospital stay (at discharge) • Important ○ None

Study	Population	Intervention[a]	Control[a]	Outcomes
	• Standard care = 41/104 Time since injury: not reported but intervention starts in emergency room	that had beds specifically reserved for hip fracture patients. Doctors at these nursing homes were able to view medical records of participants who would be discharged to them. Post-discharge, patients had 6-week, 3-months and 6-months visits outpatient clinics.		
Hall 2018 Retrospective cohort study USA	N = 21,682 General trauma Age in years [Mean (SD)]: • Traumatic Clinical Care Coordination = 43.3 (16) • No Traumatic Clinical Care Coordination = 50.0 (21) Gender (M/F): • Traumatic Clinical Care Coordination = 344/131 • No Traumatic Clinical Care Coordination = 13,793/7,414 Time since injury: not reported	<u>Traumatic clinical care coordination</u> A full-time healthcare professional supervised and coordinated care, including a phone call to patient within 72 hours after discharge.	<u>No traumatic clinical care coordination</u> No further details reported.	• Critical ○ Length of hospital stay (at discharge) • Important ○ None
Huang 2005 RCT Taiwan	N = 126 Hip fracture Age in years [Mean (SD)]: • Discharge planning with	<u>Discharge planning with gerontological nurse</u> Hospital discharge was provided by qualified gerontological	<u>Routine discharge planning</u> Routine discharge planning provided by nurses. No information, discharge summary, home visit or telephone	• Critical ○ Length of hospital stay (at 3 months) • Important ○ Overall quality of life (at discharge; 2-

Study	Population	Intervention[a]	Control[a]	Outcomes
	gerontological nurse = 75.9 (7.6) • Routine care = 78.1 (7.5) Gender (M/F): • Discharge planning with gerontological nurse = 23/40 • Routine care = 16/47 Time since injury: not reported	nurse and included hard copies of an individualised discharge plan, goals, progression and ongoing concerns. Pariticpants received a nurse visit within 48 hours of hospital admission (and at least every 2 days during their stay) with a home visit scheduled 3-7 days' post-discharge.	contact was given.	weeks post-discharge; 3-weeks post-discharge; 3-months post-discharge) ○ Changes in ADL (at discharge; 2-weeks post-discharge; 3-weeks post-discharge; 3-months post-discharge)
Lin 2009 RCT Taiwan	N = 50 Hip fracture *Characteristics only reported for whole study population rather than by arm.* Age in years [Mean (SD)]: 78.75 (6.99) Gender (M/F): 32/18 Time since injury: not reported	<u>Comprehensive discharge planning</u> Comprehensive discharge-planning was delivered by trained nurses using structured discharge instructions. 2 x home visits were also provided post-discharge, 1 at 2-weeks post-discharge and the other at 3-months post-dicharge.	<u>Routine discharge planning</u> Discharge service with non-structured discharge instructions.	• Critical ○ Patient satisfaction (ime point not reported) ○ Length of hospital stay (at 3 months) • Important ○ Changes in ADL (Before discharge; at 2-weeks post-discharge; 3-months post-discharge)
Parsons 2019 RCT New Zealand	N = 403 General trauma Age in years [Mean (SD)]: • Supported discharge team care = 81.1 (7.8) • Usual care = 80.5 (8.3)	<u>Supported discharge team care</u> Rehabilitation programme delivered by a MDT (including healthcare assistants, registered nurses, allied health professionals) for a maximum of 6 weeks. Consultant	<u>Usual care</u> Hospital-based discharge planning with subsequent community-based services (to include allied health, district nursing and home care).	• Critical ○ Length of hospital stay (at discharge) • Important ○ None

Study	Population	Intervention[a]	Control[a]	Outcomes
	Gender (M/F): • Supported discharge team care = 45/156 • Usual care = 55/147 Time since injury: not reported	geriatricians were consulted weekly via case conferencing, with healthcare assistance visiting ≤ 4 x visits per day, 7 x per week. The team discussed patient's progress weekly. On discharge, advance care planning was passed to the patient's GP.		
Ryan 2006a RCT UK	N = 71 Hip fracture Age in years [Mean (SD)]: • More intensive MDT care = 80.7 (7.4) • Less intensive MDT care = 80.9 (6.3) Gender (M/F): not reported for hip fracture group. Time since injury in years [Mean (SD)]: • More intensive MDT care = 40.6 (42.2) • Less intensive MDT care = 35 (24.6)	<u>More intensive MDT care</u> ≥6 x face-to-face contacts per week with a member of the rehabilitation MDT, for a maximum of 12 weeks.	<u>Less intensive MDT care</u> ≤ 3 x face-to-face contacts per week with a member of the rehabilitation MDT, for a maximum of 12 weeks.	• Critical ○ None • Important ○ Overall quality of life (at 3 months) ○ Changes in ADL (at 3 months)
Ryan 2006b RCT UK	See Ryan 2006a	Seen Ryan 2006a	See Ryan 2006a	• Critical ○ None • Important ○ Overall quality of life (at 12 months) ○ Changes in

Study	Population	Intervention[a]	Control[a]	Outcomes
				ADL (at 12 months)
Stenvall 2007 RCT Sweden	N = 199 Hip fracture Age in years [Mean (SD)]: • MDT post-operative rehabilitation = 82.3 (6.6) • Conventional post-operative rehabilitation = 82.0 (5.9) Gender (M/F): • MDT post-operative rehabilitation = 28/74 • Conventional post-operative rehabilitation = 23/74 Time since injury: not reported	<u>MDT post-operative rehabilitation</u> Implemented in a geriatric orthopaedic ward. Areas of the pathway that were related to coordination of rehabilitation were: • Staff education which included a 4-day course on post-operative rehabilitation. • MDT including orthopaedic surgeons, geriatricians, physical therapists and occupational therapists. • Individual care planning within 24 hours of surgery and included assessments from all MDT members. Rehabilitation plans and goals were updated twice a week. • Osteoporosis treatment if needed. • Mobilisation within 24 hours post-operatively, including specific exercises with both physical therapists and occupational therapists and general acitivites for daily living with care staff.	<u>Conventional post-operative rehabilitation</u> Implemented in general orthopaedic ward (or general geriatric unit if patient required longer rehabilitation). Differences included ward layout, staffing levels, no staff education, no specific team structure, and less individual care planning. Additionally, there was no routine examination for post-operative complications, no nutritionally enriched food. Regarding rehabilitation, functional retraining for daily tasks was not always performed and no follow-up was scheduled after discharge.	• Critical ○ None • Important ○ Changes in ADL (at 4 months; 12 months)

Study	Population	Intervention[a]	Control[a]	Outcomes
		• A home visit was conducted by occupational therapists and/or physical therapists, who communicated with counterparts in the community rehabilitation services. • Patients were offered extra outpatient rehabilitation. • Telephone follow-up at 2 weeks post-discharge and home visit follow-up at 4 months post-discharge by physical/occupational therapist.		
Vikane 2017 RCT Norway	N = 151 TBI Age in years [Median (range)]: • Multidisciplinary outpatient treatment = 31 (16-55) • Usual care by GP = 35 (16-55) Gender (M/F): • Multidisciplinary outpatient treatment = 49/32 • Usual care by GP = 43/27 Time since injury: not reported	<u>Multidisciplinary outpatient treatment</u> 1 x individual contact with a rehabilitation MDT and a psycho-educational group per week for 4-weeks. A schedule for return to work and other activities was developed, with individualised follow-ups in the first year. The MDT included a rehabilitation specialist, a neuropsychologist, a physician, a social worker, an occupational therapist and a nurse.	<u>Usual care by GP</u> Follow-up by a GP after multidisciplinary examination, who could refer patients to other rehabilitation professionals.	• Critical ○ Return to work or education (at 12 months post-injury) • Important ○ Changes in ADL (at 12 months post-injury)
Wiechman 2015 RCT	N = 81 Burn injury	<u>Extended care practitioner + telephone calls</u>	<u>Standard outpatient care</u> Consisted of pre-	• Critical ○ Patient satisfaction (at

Study	Population	Intervention[a]	Control[a]	Outcomes
USA	Age in years [Mean (SD)]: • Extended care practitioner + telephone calls = 43.23 (16.92) • Standard outpatient care = 43.68 (17.13) Gender (M/F): • Extended care practitioner + telephone calls = 25/15 • Standard outpatient care = 29/12 Time since injury: not reported	Standard care as per control group plus a reminder of telephone call schedule. Particpiants received semi-structure telephone calls from extended care coordinator at 24-48 hours post-discharge, as well as 2-, 4-, 8- and 12-weeks and 5-, 7- and 9-months post-discharge. The care coordinator assisted with local support groups, worker's compensation and return to work. MDT were available to assist care coordinator with any other medical issues.	discharge advice and a follow-up phone call 24h post-discharge. Participants attended outpatient clinic visits every 2 week by a MDT.	6 months; 12 months) • Important ○ Overall quality of life (at 6 months; 12 months) ○ Change in ADL (at 6 months; 12 months)

ADL: Activities of daily linving; F: Female; GP: General practitioner; M: Male; MDT: Multidisciplinary team; N/n: Number; RCT: Randomised controlled trials; SD: Standard deviation; TBI: Traumatic brain injury
(a) For full details about the intervention/comparison, please see the evidence tables in Appendix D

Table 4: Summary of included qualitative studies

Study and aim of study	Population	Methods	Themes
Barclay 2019 **Aim of study** To describe and compare service delivery approaches that aim to support re-integration into the community following SCI in-patient discharge.	N = 10 spinal service centres • N=12 healthcare professionals working in SCI rehabilitation Setting: spinal service centres Country (N): • Australia: 2 • Canada: 2 • New Zealand: 1 • Norway: 1 • Sweden: 1 • UK: 1 • USA: 2	**Recruitment period:** July 2018 – January 2019 **Data collection and analysis:** • Semi-structured interviews • Thematic analysis	• Integrating multiple services: Interdisciplinary consistency • Delivery: Peer support • Delivery: Technology • Timing: Gradual • Timing: Start early

Study and aim of study	Population	Methods	Themes
	No further details reported.		

Braaf 2018
 	
Aim of study
To explore major trauma patient's experiences of communication with healthcare professionals in the initial 3 years post-injury, in hospital, rehabilitation and community settings.
	N = 65 adults with major trauma
	
	Setting: Victorian State Trauma System
	
	Age [mean (SD)]: 50.7 (15.5) years
	
	Gender (M/F): 42/23
	
	Length of hospital stay [median (IQR)]: 11 (5.4 - 26.5) days
	
	Injury cause (N):
	• Traumatic: 65
	  ○ Motor vehicle: 22
	  ○ Fall: 12
	  ○ Motorcycle: 6
	  ○ Pedal cyclist: 6
	  ○ Other: 19
		Recruitment period: July 2014 – July 2015
		
		Data collection and analysis:
		• Semi-structured interviews
		• Thematic framework analysis
			• Integrating multiple services: Inter-service communication of information
			• Integrating multiple services: Case coordinator
			• Integrating multiple services: Interdisciplinary consistency
			• Delivery: Point of contact
			• Information: Inform about services and plan
			• Information: Prognosis
			• Information: Format
			• Timing: Start early
			• Timing: Gap in service

Christensen 2018 **Aim of study** To explore the continuity of care between in-patient and outpatient rehabilitation services for Danish veterans with lower-limb amputees.	N = 6 adults with lower-limb amputation Setting: in the community Age [median (range)]: 32 (25-46) years Gender (M/F): 6/0 Time since amputation [median (range)]: 5.7 (2-17) years Injury cause (N): • Traumatic: 6 ○ Explosion: 6	**Recruitment period:** November 2014 – February 2015 **Data collection and analysis:** • Semi-structured interviews and group observations • Thematic analysis	• Integrating multiple services: Inter-service communication of information • Delivery: Point of contact • Individual factors: Advocacy
Christiaens 2015 **Aim of study** To explore the rehabilitation and aftercare experiences	N = 57 • People with burn injuries (and their parents): 29 • Healthcare professionals	**Recruitment period:** January – April 2013 **Data collection and analysis:** • Semi-structured	• Service commissioning: Commission a full service • Integrating multiple services: Inter-

Study and aim of study	Population	Methods	Themes
of severe burn patients and the views of allied healthcare professionals.	working in burn rehabilitation: 24 Setting: In the home *Characteristics of individuals with burn injuries (and their parents)* Burn patients and parents (N): 29 • Adult burn patients: 15 • Parents of children under 12 years: 8 • Parents of adolescents between 12 and 18 years: 3 • Adolescents between 12-18 years: 3 Age (N) of adult patients: • 18-30 years: 3 • 31-40 years: 1 • 41-65 years: 8 • > 65 years: 3 Gender: not reported Time since injury: not reported Injury cause: not reported *Characteristics of healthcare professionals* Profession (N): • Care coordinators: 4 • Nurses: 4 • Physicians: 7 • Physiotherapists: 3 • Psychologists: 4 • Social workers: 2 Experience working in burn rehabilitation: not reported	interviews and focus groups • Constant comparative analysis	service communication of information • Integrating multiple services: Case coordinator • Delivery: Continuity of staff • Delivery: Include family • Information: Inform about services and plan • Information: Prognosis • Individual factors: Specialists • Timing: Gradual

Study and aim of study	Population	Methods	Themes
Glenny 2013 **Aim of study** To explore the communication experiences of caregivers and healthcare professionals during transitional care of elderly hip fracture patients from inpatient to community rehabilitation.	N = 35 • Caregivers of individuals with hip fracture: 9 • Healthcare professionals working in hip fracture rehabilitation: 26 Setting: Throughout hip fracture rehabilitation pathway *Characteristics of healthcare professionals only* Profession (N): • General practitioner: 1 • Nurse care manager: 8 • Occupational therapist: 6 • Physiotherapist: 4 • Registered practical nurse: 6 • Retirement home care manager: 1 Experience working in hip fracture rehabilitation: not reported	**Recruitment period:** January – December 2010 **Data collection and analysis:** • Semi-structured interviews • Content-based thematic analysis	• Delivery: Include family • Individual factors: Advocacy
Graff 2018 **Aim of study** To explore the rehabilitation experiences of adults with TBI up to 4 years post injury, including facilitators and barriers.	N = 20 adults with TBI Setting: In the community Age at recruitment [median (range)]: 39 (25-63) years Gender (M/F): 12/8 Time since injury: not reported. Injury cause: not reported.	**Recruitment period:** December 2014 – May 2015 **Data collection and analysis:** • Semi-structured interviews • Hermeneutical phenomenological thematic analysis	• Delivery: Point of contact • Information: Inform about services and plan • Individual factors: Personalisation • Individual factors: Admission criteria • Individual factors: Advocacy • Timing: Gradual
Isbel 2017	N = 12 healthcare	**Recruitment period:**	• Integrating multiple

Study and aim of study	Population	Methods	Themes
Aim of study To explore the experiences and opinions of healthcare professionals regarding how dementia affects rehabilitation care after hip fracture.	professionals working in hip fracture rehabilitation and dementia Setting: range of rehabilitation hospitals (urban and rural). Profession (N): • Clinical nurse specialist: 1 • Geriatrician: 5 • Nurse manager: 2 • Ortho-geriatrician: 2 • Physiotherapist: 1 • Rehabilitation physician: 1 Experience working in hip fracture rehabilitation: not reported.	Not reported. **Data collection and analysis methods:** • Semi structured interviews • Thematic analysis	services: Integrated multidisciplinary team approach • Delivery: Include family • Timing: Gap in service
Jeyaraj 2013 **Aim of study** To explore healthcare professionals views on which rehabilitation factors affect complexity TBI outpatient rehabilitation.	N = 12 healthcare professionals working in TBI rehabilitation Setting: TBI rehabilitation outpatient clinic No demographic information reported.	**Recruitment period:** Not reported. **Data collection and analysis:** • Semi-structured interviews and focus groups • Content-based thematic analysis	• Service commissioning: Commission a full service • Service commissioning: Community services and facilities • Integrating multiple services: Interdisciplinary consistency • Delivery: Include family • Delivery: Delivery at home • Individual factors: Personalisation • Individual factors: Specialists • Timing: Gap in service
Jourdan 2019 **Aim of study** To compare TBI care pathways and explore the views of healthcare professionals on TBI care provision in	N = 10 healthcare professionals working in TBI rehabilitation • Finland: 6 • France: 4 Setting: across TBI	**Recruitment period:** Not reported. **Data collection and analysis methods:** • Semi-structured interviews	• Service commissioning: Community services and facilities • Service commissioning: • Rural services

Study and aim of study	Population	Methods	Themes
Varsinais-Suomi, Finland and Ile-de-France, France.	rehabilitation care pathways in Ile-de-France and Varsinais-Suomi. Profession (N): • ICU practitioner: 1 • Neuro-anaesthetist: 3 • Neurologist: 4 • Neurosurgeon: 2 Experience working in TBI rehabilitation (range): 8-25 years	• Thematic analysis	• Timing: Gap in service
Kennedy 2012 **Aim of study** To explore the views of healthcare professionals on the design, implementation and acceptability of a new comprehensive rehabilitation case management (CRCM) model.	N = 32 healthcare professionals working in TBI rehabilitation Setting: Specialised TBI rehabilitation unit Profession (N): • Brain injury unit clinicians: 22 • External stakeholders: 3 • Rehabilitation case manager: 7 Experience working in TBI rehabilitation: not reported	**Recruitment period:** May 2011 – September 2012 **Data collection and analysis:** • Semi-structured interviews • Thematic analysis	• Service commissioning: Workload and demand • Integrating multiple services: Case coordinator • Delivery: Continuity of staff • Delivery: Point of contact • Timing: Start early
Kornhaber 2019 **Aim of study** To explore healthcare professional's experiences of acute care and rehabilitation in patients with burn injuries.	N = 22 healthcare professionals working in burn rehabilitation Setting: range of burn rehabilitation settings (acute, rehabilitation and community). Profession (N): • Doctor: 4 • Nurse: 9 • Occupational therapist: 3 • Physiotherapist: 4 • Psychologist: 1 • Social worker: 1	**Recruitment period:** 2016 **Data collection and analysis methods:** • Semi-structured interviews • Thematic analysis	• Service commissioning: Commission a full service • Service commissioning: Community services and facilities • Service commissioning: Rural services • Integrating multiple services: Integrated multidisciplinary team approach • Delivery: Include family • Delivery: Delivery at

Study and aim of study	Population	Methods	Themes
	Experience working in burn rehabilitation: not reported		home • Delivery: Technology • Information: Inform about services and plan • Individual factors: Personalisation • Individual factors: Specialists • Timing: Gradual • Timing: Start early
Lindahl 2013 **Aim of study** To explore the experiences of orthopaedic trauma patients when transferring between acute hospital care and community settings.	N = 7 adults with orthopaedic trauma Age [median (range)]: 51 (32-60) years Gender (M/F): 5/2 Time since injury (range): 2-24 months Injury cause: not reported	**Recruitment period:** January – March 2009 **Data collection and analysis:** • Semi-structured interviews • Grounded theory	• Service commissioning: Commission a full service • Integrating multiple services: Inter-service awareness and relationships • Integrating multiple services: Inter-service communication of information • Delivery: Continuity of staff • Individual factors: Personalisation • Individual factors: Home adjustments • Timing: Gap in service • Timing: Gradual
O'Callaghan 2012 **Aim of study** To explore the concept of engagement throughout the TBI rehabilitation care continuum and the factors that affect engagement.	N = 23 • Adults with TBI: 14 • Significant others: 9 Setting: In the community *Characteristics of adults with TBI only* Age (N): • 18-25 years: 2 • 26-35 years: 3 • 36-45 years: 3 • 46-55 years: 3 • 56-65 years: 3 Gender (M/F): 8/6 Time since injury: not	**Recruitment period:** Not reported. **Data collection and analysis:** • Open interviews • Thematic analysis	• Service commissioning: Rural services • Information: Inform about services and plan • Indidivual factors: Specialists • Timing: Gradual • Timing: Start early

Study and aim of study	Population	Methods	Themes
	reported Injury cause: not reported		
Odumuyiwa 2019 **Aim of study** To identify the long-term rehabilitation needs of patients with acquired brain injury and their families, and explore their experiences with accessing community services.	Setting: Community ABI rehabilitation services. <u>Stage 1</u> N = 76 • Adults with ABI: 19 • Family members: 26 • Healthcare professionals working in ABI rehabilitation: 32 *Characteristics of adults with ABI* Age [mean (range)]: 44.6 (29-72) years Gender (M/F): 10/9 *Combined characteristics of adults with ABI and family members* Injury cause (N): • Traumatic: 34 • Non-traumatic: 11 Time since injury (range): 1-41 years *Characteristics of healthcare professionals* Profession: not reported Experience working in rehabilitation: not reported <u>Stage 2</u> N = 21 • Adults with ABI: 12 • Family members: 5 • Healthcare professionals working in ABI	**Recruitment period:** Not reported. **Data collection and analysis methods:** • Free text questionnaires and semi-structured interviews • Inductive and deductive thematic analysis	• Service commissioning: Community services and facilities • Service commissioning: Rural services • Service commissioning: Workload and demand • Integrating multiple services: Integrated multidisciplinary team approach • Delivery: Include family • Information: Prognosis • Individual factors: Specialists

Study and aim of study	Population	Methods	Themes
	rehabilitation: 4 *Characteristics of adults with ABI* Age [mean (range)]: 45 (36-72) years Gender (M/F): 10/2 Time since injury: not reported Injury cause: not reported *Characteristics of healthcare professionals* Profession: not reported Experience working in rehabilitation: not reported		
Sena Martins 2017 **Aim of study** To explore the experiences and views of patients undergoing SCI rehabilitation in Portugal.	N = 93 • People with SCI in initial rehabilitation: 28 • Healthcare professionals working in SCI rehabilitation: 22 • People with SCI in the community: 29 • Family and institutional support organisations: 14 Setting: Multiple rehabilitation centres and in the community No demographic information reported.	**Recruitment period:** Not reported. **Data collection and analysis methods:** • Fieldwork and semi-structured interviews • Content analysis	• Service commissioning: Community services and facilities • Integrating multiple services: Integrated multidisciplinary team approach • Delivery: Include family • Individual factors: Personalisation
Sims-Gould 2012 **Aim of study** To explore the views of healthcare professionals on which factors are needed for a successful transition	N = 17 healthcare professionals working in hip fracture rehabilitation Setting: Multiple healthcare settings (community, hospitals	**Recruitment period:** March – July 2010 **Data collection and analysis:** • Semi-structured interviews	• Timing: Gradual

Study and aim of study	Population	Methods	Themes
of care in patients after hip fracture.	and rehabilitation centres) Profession (N): • Nursing: 3 • Occupational therapy: 4 • Physiotherapy: 4 • Physician: 2 • Social work: 4 Experience in current profession (range): 8 months - 36 years	• Thematic analysis	
Singh 2018 **Aim of study** To explore the acceptability of a novel mobile phone application designed to facilitate self-management skills in adults with SCI, and their experiences using the application in both inpatient to outpatient settings.	N = 20 adults with SCI Setting: SCI inpatient rehabilitation centre Age [mean (SD)]: 41 (18) years Gender (M/F): 17/3 Time since injury: not reported Injury cause (N): • Traumatic: 15 • Non-traumatic: 5	**Recruitment period:** Spring 2015 – Winter 2016 **Data collection and analysis:** • Post discharge exit questionnaire and interactions with patients • Thematic analysis	• Delivery: Technology
Slomic 2017 **Aim of study** To explore the experiences of rehabilitation healthcare professionals while transferring TBI and general major trauma patients between specialised and local rehabilitation services.	N = 85 healthcare professionals working in TBI rehabilitation • Focus groups: 34 • Observations of professional meetings: 41 • Semi-structured interviews: 10 Setting: 2 specialised TBI rehabilitation units NB. No demographic information reported for observations of professional meetings. Profession (N): • Auxiliary nurse: 2	**Recruitment period:** April 2014 – March 2016 **Data collection and analysis:** • Observations of inter-professional meetings, focus groups and semi-structured interviews • Grounded theory	• Service commissioning: Community services and facilities • Timing: Gradual • Integrating multiple services: Integrated multidisciplinary team approach • Integrating multiple services: Inter-service awareness and relationships • Inter-service communication of information

Study and aim of study	Population	Methods	Themes
	• Cultural educator: 1 • Doctor: 1 • Nurse: 13 • Occupational therapist: 11 • Physical therapist: 10 • Psychologist: 3 • Social educator: 2 • Social worker: 4 • Speech therapist: 1 • Team coordinator: 2 Experience in TBI rehabilitation: not reported		
Stolee 2019 **Aim of study** To identify factors to improve healthcare transitions in elderly adults with hip fracture and future healthcare transition interventions.	N = 134 • Adults with hip fracture: 23 • Carers: 19 • Healthcare professionals working in hip fracture rehabilitation: 92 Setting: Range of rehabilitation settings (acute, sub-acute, inpatient rehabilitation, outpatient rehabilitation, residential, home) No demographic information reported.	**Recruitment period:** 2010 **Data collection and analysis:** • Semi-structured interviews • Framework-based meta-synthesis	• Service commissioning: Commission a full service • Service commissioning: Workload and demand • Integrating multiple services: Inter-service awareness and relationships • Integrating multiple services: Inter-service communication of information • Delivery: Include family • Information: Inform about services and plan • Individual factors: Personalisation • Individual factors: Admission criteria
Turner 2011 **Aim of study** To explore the service and support needs of adults with ABI (and their family carers), and identify factors that night affect these needs, when transitioning between	N = 38 • Adults with ABI: 20 • Family carers: 18 Setting: Hospital discharge and in the community *Characteristics of adults with ABI only*	**Recruitment period:** Not reported **Data collection and analysis:** • Semi-structured interviews • Grounded theory analysis	• Service commissioning: Community services and facilities • Service commissioining: Rural services • Delivery: Continuity of staff • Delivery: Include

Study and aim of study	Population	Methods	Themes

the hospital and home.	Age [mean (range)]: 40.2 (17-63) years
	
	Gender (M/F): 15/5
	
	Length of stay in inpatient rehabilitation (N):
	• <3 months: 12
	• 3–6 months: 7
	• >6 months: 1
	
	Injury cause (N):
	• Traumatic: 16
	  ○ Motor vehicle accident: 7
	  ○ Motor bike accident: 1
	  ○ Assault: 1
	  ○ Fall: 4
	  ○ Other: 3
	• Non traumatic: 4
			family
			• Delivery: Point of contact
			• Information: Inform about services and plan
			• Individual factors: Admission criteria
			• Timing: Gap in service

ABI: Acquired brain injury; ICU: Intensive care unit; F: Female; M: Male; N: Number; SCI: Spinal cord injury: SD: Standard deviation; TBI: Traumatic brain injury

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Results and quality assessment of clinical outcomes included in the evidence review

The quality of the evidence was assessed using GRADE for the quantitative evidence and CERQual for the qualitative evidence. See the evidence profiles in appendix F.

Summary of the quantitative evidence

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

Of the pre-defined outcomes, evidence was found for:

- Patient satisfaction
- Length of hospital stay
- Return to work or education
- Overall quality of life
- Changes in activities of daily living

No evidence was found for outcomes relating to carer impact or unplanned readmission rates following discharge.

One RCT compared the effectiveness of an MDT care with usual care (Browne 2013). No statistically or clinically important difference was found in length of hospital stay between the

groups. Additionally, no statistically or clinically important difference was found between groups in return to work or education, number of participants with impairment of ADL or FIM scores at 6 months post-discharge. All of these effect estimates were judged to be of very low quality.

One RCT compared the effectiveness of an MDT care plus structured assessments with MDT care only (Chong 2015). No statistically or clinically important difference in patient satisfaction at discharge was found between the groups. The evidence was judged to be of very low quality. Median length of hospital stay was reported in the study and, based on statistical analyses by the authors, was found to be statistically importantly lower in the MDT plus structured assessment than the MDT only group. However, the authors did not report whether this difference was clinically important and the evidence was judged to be of very low quality. No statistically or clinically important differences in overall quality of life (measured using SF-12 physical component score and SF-12 mental component score) or changes in ADL (measured using modified Barthel Index and Montebello Rehabiliation Factor score) were found at either 6 or 12 months. Evidence ranged from very low to low quality for these outcomes.

One cohort study compared the effectiveness of multidisciplinary care pathway with standard care (Flikweert 2014). According to the statistical analyses performed by the author, the median hospital length of stay was statistically importantly shorter in the multidisciplinary care pathway group. However, the authors did not report whether this difference was clinically important. This was judged to be of moderate quality.

One cohort study compared the effectiveness of traumatic clinical care coordination with no traumatic clinical care coordination (Hall 2018). Length of hospital stay was both clinically and statistically importantly longer in the traumatic clinical care coordination group when compared to the control group. This evidence was judged to be of low quality.

One RCT compared the effectiveness of discharge planning by a gerontological nurse with routine discharge planning (Huang 2005). The length of hospital stay was statistically and clinically importantly shorter in the discharge planning by a gerontological nurse group. Overall quality of life (measured using SF-36) and changes in ADL (measured using the Bathel Index) were statistically and clinically importantly higher (better) at discharge, at 2 weeks post-discharge and at 3 months post-discharge in the discharge planning by a gerontological nurse group when compared to the routine discharge planning group. Evidence ranged from low to moderate quality.

One RCT compared comprehensive discharge planning with routine discharge planning (Lin 2009). Outcomes were reported for patient satisfaction, length of hospital stay and changes in ADL (measured using Functional Status Subscale) up to 3 months post-discharge. No statistically or clinically important differences were reported between the groups for any of these outcomes. Evidence was judged to be very low to low quality.

One RCT compared supported discharge team with usual care (Parsons 2019). Length of hospital stay was statistically signficantly shorter in the supported discharge group compared to the usual care group. As the authors did not report standard deviations, and there are no published MIDs, clinical significance could not be determined. Evidence was of moderate quality.

One RCT compared an more intensive MDT care intervention with a less intensive MDT care intervention (Ryan 2006). Outcomes were reported for overall quality of life (measured using EQ-5D and EQ-VAS) and changes in ADL (measured using Barthel Index and Franchay Activities Index) at 3 and 12 months. No statistically or clinically important difference was found between the groups at either time point, and evidence was all judged to be very low quality.

One RCT compared the effectiveness of a multidisciplinary post-operative rehabilitation intervention with conventional post-operative rehabilitation (Stenvall 2007). No statistically or clinically important differences were found between the groups in the proportion of participants achieving independence in P-ADL at the 4 or 12 months post-operative follow-up or in each of the Katz ADL grades at discharge. Additionally, there were no statistically or clinically important differences in the proportion of participants achieving each Katz ADL score at 12 months, apart from grade G, where a statistically and clinically importantly lower number of participants achieved Grade G in the multidisciplinary post-operative rehabilitation compared to conventional post-operative rehabilitation. There was a statisticcally and clinically important increase in the proportion of participants returning to at least the same Katz ADL levels as before trauma in the multidisciplinary post-operative rehabilitation group compared to the conventional post-operative rehabilitation group at 12 months (although this was not true at 4 months follow-up). The evidence was judged to be of very low quality for all outcomes.

One RCT compared the effectiveness of multidisciplinary outpatient treatment with usual care by general practitioners (Vikane 2009). There was no statistically or clinically important differences between the groups in the proportion of participants able to return to work or changes in ADL (measured using the Glasgow Outcome Scale) at 12 months post-injury. Evidence was judged to be of very low quality.

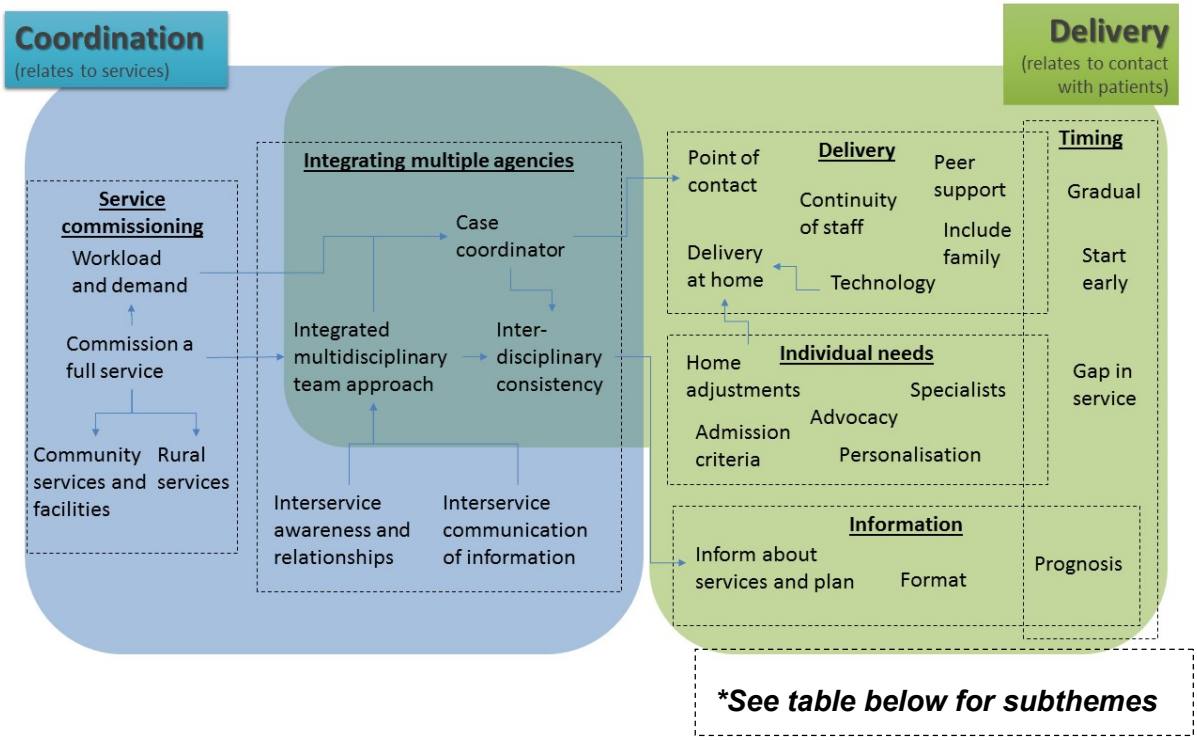
One RCT compared the effectiveness of an extended care practitioner care plus telephone calls with standard outpatient care (Wiechman 2015). No statistically or clinically important differences were found between groups in patient satisfaction, overall quality of life (measured using the mental component of SF-12) or changes in ADL (measured using Goal Attainment Score) at either 6 or 12 months. There was a statistically, but not clinically, importantly higher (better) SF-12 physical component score in the extended care practitioner care plus telephone calls group at 6 months. However, this had disappeared at 12 months when no statistical or clinical important difference in SF-12 physical component score was reported. Evidence was very low to low quality for outcomes.

Summary of qualitative evidence

The views of adults with complex rehabilitation needs after traumatic injury, as well as staff who work in rehabilitation services and/or social services, were thematically analysed to find what they believed to be important for coordinating and delivering rehabilitation services and social services across transfer from inpatient to outpatient rehabilitation services. ‘Coordination’ was considered to relate mostly to the ways services organise within themselves, and ‘delivery’ was considered to relate mostly to how these should operate in front-line contact with service users. Six overarching themes were identified that had a total of 26 sub-themes (see appendix F).

The theme ‘service commissioning’ related to service coordination, as did the theme ‘integrating multiple services’ although some parts also crossed into delivery. The themes ‘delivery’, ‘individual needs’, and ‘information’ were all a part of how services should be delivered, and these were intersected by the theme of ‘timing’ and the need for action and consideration before, during and after discharge to the community. Although all the sub-themes are relevant to the question, some relate very practically and conceptually to others and this is indicated by blue arrows.

Figure 1: Needs and preferences thematic map



1 **Table 5: Summary of themes and subthemes**

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
1 Service commissioning					
1.1	**Commission a full service** Services need to be funded and available for the entire journey of a service user - along with guidelines and a clear vision for how these services should co-ordinate, communicate and standardise in order to meet the needs of their local population	Moderate	5	Brain injury (1), Burns (2), Hip-fracture (1), Fractures (1)	Frail adults aged 65+ (1)
1.2	**Community services and facilities** The availability and accessibility of community and social services (for example, social care and housing services) is just as important for overall rehabilitation as medical services	High	7	Brain injury (4), Burns (1), Spinal cord injury (1), Brain injury and multiple trauma (1)	None

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	are. These services should be properly funded and promoted.				
1.3	**Workload and demand** Rehabiltation healthcare staff report being overworked and underfunded, leading to long waiting lists and poor healthcare provision.	High	3	Brain injury (2), Hip-fracture (1)	Frail adults aged 65+ (1)
1.4	**Rural services** People living in rural areas are often underserved. Additional effort will be needed to ensure that the rehabilitation needs after traumatic injuries of these people are met.	High	5	Brain injury (4), Burns (1)	None
2 Integrating multiple services					
2.1	**Integrated multidisciplinary team approach** A MDT approach to co-ordinating medical and social support needs is important when transferring from inpatient to outpatient services.	High	5	Brain injury (1), Burns (1), Hip-fracture (1), Spinal cord injury (1), Brain injury and multiple trauma (1)	Frail adults aged 65+ (1)
2.2	**Inter-service awareness and relationships** Healthcare staff find it easier for multiple agencies to work together if they know each other's roles and remits, and have the opportunity to build relationships.	High	3	Hip-fracture (1), Fractures (1), Brain injury and multiple trauma (1)	Frail adults aged 65+ (1)
2.3	**Inter-service communication of information** Adults with rehabilitation needs can find it distressing to repeat their injury	Moderate	6	Burns (1), Hip-fracture (1), Fractures (1), General trauma (1), Amputations (1), Brain injury and multiple trauma (1)	Frail adults aged 65+ (1)

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	and medical history to multiple people. Communication between rehabilitation services should be efficient and easy.				
2.4	**Case coordinator** A case coordinator helps to increase continuity and consistency when transferring between inpatient and outpatient settings.	High	3	Brain injury (1), Burns (1), General trauma (1)	None
2.5	**Interdisciplinary consistency** Medical information and instructions from different healthcare professionals should be compatible, complimentary and consistent to prevent confusion.	Moderate	3	Brain injury (1), Spinal cord injury (1), General trauma (1)	None
3 Delivery					
3.1	**Continuity of staff** Where possible, healthcare professionals and people with rehabilitation needs appreciate continuity of staff, This helps to build trust and rapport while changes in staff can be discouraging, costs time to share history and details, and cause mistakes.	High	4	Brain injury (2), Burns (1), Fractures (1)	None
3.2	**Include family** Family play a very significant role in coordination of rehabilitation care when returning to the community. If appropriate, family members should be included in discussions and planning of care, as	High	9	Brain injury (3), Burns (2), Hip-fracture (3), Spinal cord injury (1)	Frail adults aged 65+ (3)

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	well as any education needed to provide rehabilitation support.				
3.3	**Point of contact** A single, identifiable point of communication for information and support can increase coordination when transferring between inpatient and outpatient rehabilitation services.	High	5	Brain injury (3), General trauma (1), Amputations (1)	None
3.4	**Peer support** Peer mentors can encourage people in their ongoing rehabilitation, be a role-model and provide information on their own lived experiences with rehabilitation services in the area.	Very low	1	Spinal cord injury (1)	None
3.5	**Delivery at home** Healthcare staff report that delivery of rehabilitation at home is becoming more feasible, meaning people do not have to have such prolonged hospital stays.	Low	2	Brain injury (1), Burns (1)	None
3.6	**Technology** Videoconferencing and telemedicine can be useful to reach people who cannot attend in-person consultations for a variety of reasons. Apps can also be useful for alerts or reminders	Low	3	Burns (1), Spinal cord injury (2)	None
4 Information					
4.1	**Inform about services and plans** Adults with rehabilitation needs report co-ordination	High	7	Brain injury (3), Burns (2), Hip-fracture (1), General trauma (1)	Frail adults aged 65+ (1)

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	being increased when they receive more information on what to expect after discharge, what arrangements are in place and probable timelines.				
4.2	**Prognosis** Adults with rehabilitation needs want information about the likely long-term prognosis of their injuries and how this will affect their lives going forward.	High	3	Brain injury (1), Burns (1), General trauma (1)	None
4.3	**Format** Information should be given information in plain, accessible language. Written information may be helpful for retaining this information.	Very low	1	General trauma (1)	None
5 Individual factors					
5.1	**Personalisation** Rehabilitation should be delivered in an adaptable fashion, taking into account related to age, and symptoms or comorbidities which may limit mobility. Additional planning may be needed to provide flexible rehabilitation sessions, as well as social vulnerabilities (for example, such as housing and financial situation).	Low	6	Brain injury (2), Burns (1), Hip-fracture (1), Spinal cord injury (1), Fractures (1)	Frail adults aged 65+ (1)
5.2	**Admission criteria** Inflexible admission criteria may mean that rehabilitative support is not offered to certain adults (for example, if their	Low	3	Brain injury (2), Hip-fracture (1)	Frail adults aged 65+ (1)

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	difficulties are perceived as less severe). Financial factors or postcode may also limit rehabilitation access.				
5.3	**Specialists** Upon discharge from inpatient settings, adults with rehabilitation needs report that services become more generic and staff do not have knowledge about their particular conditions or disabilities. It is important for the delivery of an individual's rehabilitation ongoing care team to include some staff with specialist knowledge.	High	5	Brain injury (3), Burns (2)	None
5.4	**Home adjustments** Some adults with rehabilitation needs require physical aids and small adjustments in their home. These adjustments may be vital to the discharge process and progression with rehabilitation.	Low	1	Fractures (1)	None
5.5	**Advocacy** Some adults with rehabilitation needs may need support with researching options and initiating conversations. Some might need their family to take the lead healthcare staff about rehabilitation, or in some cases the adult may do it for themselves.	High	3	Brain injury (1), Hip-fracture (1), Amputations (1)	Frail adults aged 65+ (1)
6 Timing					
6.1	**Gradual**	High	8	Brain injury (2), Burns	Frail adults aged

Themes and subthemes		CERQual Quality	No. of studies	Populations covered	
				Contribution by injury type (number of studies)	Sub-groups as specified in the protocol (number of studies)
	Return to the community should be a gradual and incremental process (for example, using pre-discharge home visits). Abrupt endings or loss of support can be distressing.			(2), Hip-fracture (1), Spinal cord injury (1), Fractures (1), Brain injury and multiple trauma (1)	65+ (1)
6.2	**Start early** Conversations about discharge planning and any adjustments should start early on to avoid abruptness. Last-minute conversations about needs and rehabilitation close to the time discharge are distressing.	Low	5	Brain injury (2), Burns (1), Spinal cord injury (1), General trauma (1)	None
6.3	**Gap in service** Some adults with rehabilitation needs report experiencing gaps in service and long waiting times before starting community rehabilitation, which was confusing and distressing. Some of this distress can be lessened if people were given probably timelines.	Low	6	Brain injury (3), Hip-fracture (1), Fractures (1), General trauma (1)	Frail adults aged 65+ (1)

Summary of relevant qualitative and quantitative evidence

This is a mixed methods review, using parallel synthesis. Quantitative and qualitative data were analysed and synthesised separately and integrated through the committee's interpretation of results, described in the committee's discussion of the evidence.

Some of the qualitative evidence helped to explain or contextualise the quantitative findings and Table 6 shows where this was the case. Table 6 lists the sub themes from the qualitative evidence and matches it with the quantitative evidence from interventions targeting the identified area of coordination. It should be noted that not all aspects of a quantitative intervention will relate to a qualitative theme. Interventions often include features of more than 1 theme, and can therefore appear multiple times.

Table 6: Summary of relevant qualitative and quantitative evidence

Qualitative theme	Quantitative intervention and results	Study IDs

Qualitative theme	Quantitative intervention and results	Study IDs
1 Service commissioning		
Rehabilitation services should be developed to included the entire patient pathway, ensuring that there is a clear vision of how different areas should coordinate and communicate with each other. *(moderate quality)*	The multidisciplinary care pathway intervention was designed to span from admission at the emergency room to discharge from nursing home rehabilitation units. • Length of hospital stay ○ Multidisciplinary care pathway versus Standard care – Significantly shorter in multidisciplinary care pathway group* *(moderate quality)*	**Quantitative** • Flikweerk 2014 **Qualitative** • Christiaens 2015 • Jeyaraj 2013 • Kornhaber 2019 • Lindahl 2013 • Stolee 2019
If rehabilitation services are understaffed, healthcare workers can become overworked which affects the coordination of rehabilitatin services. This may cause long waiting lists, cases to be missed and less patient contact time. *(high quality)*	The MDT post-operative rehabilitation intervention included increasing staffing levels from 1.07 WTE nurses/aides per bed, plus 2 x 1 WTE physiotherapists, 2 x 1 WTE occupational therapists and 0.2 WTE dietician. • Changes in ADL ○ MDT post-operative rehabilitation versus Conventional post-operative rehabilitation - Number of participants achieving Independence in P-ADL at each time point at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Independence in P-ADL at each time point at 12 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade A at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade B at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade C at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade D at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade E at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade F at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade G at 12 month post-operative follow-up – Clinically importantly lower in MDT post-operative	**Quantitative** • Stenvall 2007 **Qualitative** • Kennedy 2012 • Stolee 2019 • Odumuyiwa 2019

Qualitative theme	Quantitative intervention and results	Study IDs
	rehabilitation group *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 12 months post-operative follow-up – Clinically importantly higher in MDT post-operative rehabilitation group *(very low quality)*	
2 Integrating multiple services		
Multidisciplinary team approach to medical and social support needs should be integrated and united at transfer from inpatient to outpatient rehabilitation services. *(high quality)*	The multidisciplinary team care, multidisciplinary care pathway, multidisciplinary outpatient treatment, multidisciplinary post-opertive rehabilitation and support discharge team care involved assessment and care from different professionals such as physiotherapist, psychologist nurses, healthcare assistants etc, depending on the needs of the patients until they were discharged into the community. • Return to work or education ○ Multidisciplinary intervention versus Usual care - Number of participants who had returned to work at 6 months post-discharge – No clinically important difference between groups *(very low quality)* ○ Multidisciplinary outpatient treatment versus Usual care by GP - Number of participants returning to work at 12 months post-injury – No clinically important difference between groups *(very low quality)* • Length of hospital stay ○ Multidisciplinary intervention versus Usual care – No clinically important difference between groups *(very low quality)* ○ Multidisciplinary care pathway versus Standard care – Significantly shorter in multidisciplinary care pathway group* *(moderate quality)* ○ Supported discharge team versus Usual care – Significantly shorter in Supported discharge team group* *(moderate quality)* • Changes in ADL ○ Multidisciplinary intervention versus Usual care - Number of participants with impairment of ADL at 6 months post-discharge – No clinically important difference between groups *(very low quality)* - FIM at 6 months post-discharge – No clinically important difference between groups *(very low quality)* ○ MDT post-operative rehabilitation versus Conventional post-operative rehabilitation - Number of participants achieving Independence in P-ADL at each time point at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Independence in P-ADL at each time point at 12 months post-operative follow-up – No clinically important difference between	**Quantitative** • Browne 2013 • Filkweert 2014 • Parsons 2019 • Stenvall 2007 • Vikane 2017 **Qualitative** • Isbel 2017 • Kornhaber 2019 • Odumuyiwa 2019 • Sena Martins 2017 • Slomic 2017

Qualitative theme	Quantitative intervention and results	Study IDs
	groups *(very low quality)* - Number of participants achieving Katz ADL Grade A at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade B at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade C at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade D at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade E at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade F at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade G at 12 month post-operative follow-up – Clinically importantly lower in MDT post-operative rehabilitation group *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 12 months post-operative follow-up –Clinically importantly higher in MDT post-operative rehabilitation group *(very low quality)* ○ Multidisciplinary outpatient treatment versus Usual care by GP - Glasgow Outcome Scale at 12 months post-injury – No clinically important difference between groups *(very low quality)*	
Better communication and information sharing between different services reduce the need for adults with rehabilitation to recount or recall their history or symptoms which may be distressing. *(moderate quality)*	Within the multidisciplinary care pathway and supported discharge team care, patient information was passed to rehabilitation homes and community primary care services respectively, prior to discharge. • Length of hospital stay ○ Multidisciplinary care pathway versus Standard care – Significantly shorter in multidisciplinary care pathway group* *(moderate quality)* ○ Supported discharge team versus Usual care – Significantly shorter in Supported discharge team group* *(moderate quality)*	**Quantitative** • Flikweerk 2014 • Parsons 2019 **Qualitative** • Braaf 2018 • Christensen 2018 • Christiaens 2015 • Lindahl 2013

Qualitative theme	Quantitative intervention and results	Study IDs
		• Slomic 2017 • Stolee 2019

Having a case manager or coordinator ensures continuity and provides a point of contact for patients' enquiries. *(high quality)*	The traumatic clinical care coordination and the extended care practitioner plus telephone calls included a healthcare professional that coordinated care during discharge as well as post-discharge follow-ups and home visits.
	• Patient satisfaction
	  ○ Extended care practitioner + telephone calls versus Standard outpatient care
	  - Patient satisfaction survey at 6 months – No clinically important difference between groups *(very low quality)*
	  - Patient satisfaction survey at 12 months – No clinically important difference between groups *(very low quality)*
	• Length of hospital stay
	  ○ Traumatic Clinical Care Coordination versus No Traumatic Clinical Care Coordination – Clinically importantly longer in Traumatic Clinical Care Coordination group *(low quality)*
	• Overall quality of life
	  ○ Extended care practitioner + telephone calls versus Standard outpatient care
	  - SF-12 physical component score at 6 months – No clinically important difference between groups *(very low quality)*
	  - SF-12 physical component score at 12 months – No clinically important difference between groups *(very low quality)*
	  - SF-12 mental component score at 6 months – No clinically important difference between groups *(very low quality)*
	  - SF-12 mental component score at 12 months – No clinically important difference between groups *(very low quality)*
	• Change in ADL
	  ○ Extended care practitioner + telephone calls versus Standard outpatient care
	  - GAS at 6 months – No clinically important difference between groups *(low quality)*
	  - GAS at 12 months – No clinically important difference between groups *(very low quality)*
		Quantitative
		• Hall 2018
		• Wiechman 2015
		Qualitative
		• Braaf 2018
		• Christiaens 2015
		• Kennedy 2012

Consistency in the information provided by the different parts of the multidisciplinary team can a build trust between the patients and the team. *(moderate quality)*	Within the extended care practioner plus telephone calls intervention, the extended care practitioner communication with the multidisciplinary team regulary about progress and concerns. The extended care practitioner then relayed this information to the patient, their families and carers.
	• Patient satisfaction
	  ○ Extended care practitioner + telephone calls versus Standard outpatient care
	  - Patient satisfaction survey at 6 months – No clinically important difference between groups *(very low quality)*
	  - Patient satisfaction survey at 12 months – No clinically important difference between groups *(very*
		Quantitative
		• Wiechman 2015
		Qualitative
		• Barclay 2019
		• Braaf 2018
		• Jeyaraj 2013

Qualitative theme	Quantitative intervention and results	Study IDs
	low quality) • Overall quality of life ○ Extended care practitioner + telephone calls versus Standard outpatient care - SF-12 physical component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 physical component score at 12 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 12 months – No clinically important difference between groups *(very low quality)* • Change in ADL ○ Extended care practitioner + telephone calls versus Standard outpatient care - GAS at 6 months – No clinically important difference between groups *(low quality)* - GAS at 12 months – No clinically important difference between groups *(very low quality)*	
3 Delivery		
A single point of contact for information, support, and for the coordination of plans is helpful for patients as they transfer from inpatient to outpatient rehabilitation settings. *(high quality)*	Traumatic Clinical Care Coordination, the discharge planning with a gerontological nurse intervention and extended care practitioner intervention all had a central healthcare professional for patients to contact and help coordinate rehabilitation. • Patient satisfaction ○ Extended care practitioner + telephone calls versus Standard outpatient care - Patient satisfaction survey at 6 months – No clinically important difference between groups *(very low quality)* - Patient satisfaction survey at 12 months – No clinically important difference between groups *(very low quality)* • Length of hospital stay ○ Traumatic Clinical Care Coordination versus No Traumatic Clinical Care Coordination – Clinically importantly longer in Traumatic Clinical Care Coordination group *(low quality)* ○ Discharge planning versus Routine care at 3 months – Clincally importantly shorter in discharge planning group *(low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group	**Quantitative** • Hall 2018 • Huang 2005 • Wiechman 2015 **Qualitative** • Braaf 2018 • Christensen 2018 • Graff 2018 • Kennedy 2012 • Turner 2011

Qualitative theme	Quantitative intervention and results	Study IDs
	(moderate quality) ○ Extended care practitioner + telephone calls versus Standard outpatient care - SF-12 physical component score at 6 months - No clinically important difference between groups *(very low quality)* - SF-12 physical component score at 12 months - No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 6 months - No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 12 months - No clinically important difference between groups *(very low quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* ○ Extended care practitioner + telephone calls versus Standard outpatient care - GAS at 6 months – No clinically important difference between groups (low quality) - GAS at 12 months – No clinically important difference between groups (very low quality)	
Peer mentors with lived experience in the delivery of rehabilitation services can support patients, offer encouragement and answer questions. *(very low quality)*	Patients involved in multidisciplinary outpatient treatment internvention shared their experiences at group sessions. • Return to work or education ○ Multidisciplinary outpatient treatment versus Usual care by GP - Number of participants returning to work at 12 months post-injury – No clinically important difference between groups *(very low quality)* • Changes in ADL ○ Multidisciplinary outpatient treatment versus Usual care by GP - Glasgow Outcome Scale at 12 months post-injury – No clinically important difference between groups *(very low quality)*	**Quantitative** • Vikane 2017 **Qualitative** • Barclay 2019
4 Information		
Transitions can be smoothed by increasing information available. Patients need to know about the arrangements that have been made for them and their ongoing treatment plan, or what	Both discharge planning interventions, extended care coordinator intervention, and the Traumatic Clinical Care Coordination intervention made sharing information with patients and family a key area to focus on. • Patient satisfaction ○ Comprehensive discharge planning versus Routine discharge planning - Patient satisfaction questionnaire – No clinically	**Quantitative** • Hall 2018 • Huang 2005 • Lin 2009 • Wiechman 2015 **Qualitative**

Qualitative theme	Quantitative intervention and results	Study IDs
they will need to arrange themselves. This information is empowering and improves treatment adherence. *(high quality)*	important difference between groups *(very low quality)* ○ Extended care practitioner + telephone calls versus Standard outpatient care - Patient satisfaction survey at 6 months – No clinically important difference between groups *(very low quality)* - Patient satisfaction survey at 12 months – No clinically important difference between groups *(very low quality)* • Length of hospital stay ○ Traumatic Clinical Care Coordination versus No Traumatic Clinical Care Coordination – Clinically importantly longer in Traumatic Clinical Care Coordination group *(low quality)* ○ Discharge planning versus Routine care at 3 months – Clinically importantly shorter in discharge planning group *(low quality)* ○ Comprehensive discharge planning versus Routine discharge planning - At 3 months – No clinically important difference between groups *(very low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* ○ Extended care practitioner + telephone calls versus Standard outpatient care - SF-12 physical component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 physical component score at 12 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 12 months – No clinically important difference between groups *(very low quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group	• Braaf 2018 • Christiaens 2015 • Graff 2018 • Kornhaber 2019 • O'Callaghan 2012 • Stolee 2019 • Turner 2011

Qualitative theme	Quantitative intervention and results	Study IDs
	(moderate quality) ○ Comprehensive discharge planning versus Routine discharge planning - Functional Status Subscale before discharge – No clinically important difference between groups *(very low quality)* - Functional Status Subscale at 2 weeks post-discharge – No clinically important difference between groups *(very low quality)* - Functional Status Subscale at 3 months post-discharge – No clinically important difference between groups *(very low quality)* ○ Extended care practitioner + telephone calls versus Standard outpatient care - GAS at 6 months – No clinically important difference between groups *(low quality)* - GAS at 12 months – No clinically important difference between groups *(very low quality)*	
Information should be presented in plain, accessible language. Written information can help rehabilitation patients to understand and retain information. *(very low quality)*	The discharge planning intervention included hard copies of rehabilitation plans, goals and any concerns given to patient and carers prior to discharge. • Length of hospital stay ○ Discharge planning versus Routine care at 3 months – Clinically importantly shorter in discharge planning group *(low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)*	**Quantitative** • Huang 2005 **Qualitative** • Braaf 2018
5 Individual factors		
Rehabilitation should be delivered in a way that is adaptable to the circumstances and needs of individuals. Rehabilitation should take into account needs related to age, working patterns, and	The multidisciplinary care pathway, tramatic clinical care coordination, discharge planning with a gerontological nurse, comprehensive discharge planning, supported discharge team care, multidisciplinary post-operative rehabilitation and multidisciplinary outpatient treatment interventions stressed the important of personalising the rehabilitation pathway for patients, rather than a standard 'one-size-fits-all' approach.	**Quantitative** • Flikweerk 2014 • Hall 2018 • Huang 2005 • Lin 2009 • Parsons

Qualitative theme	Quantitative intervention and results	Study IDs
symptoms or comorbidities such as chronic pain, or disabilities which may limit mobility. *(low quality)*	• Patient satisfaction ○ Comprehensive discharge planning versus Routine discharge planning - Patient satisfaction questionnaire – No clinically important difference between groups *(very low quality)* • Length of hospital stay ○ Multidisciplinary care pathway versus Standard care – Significantly shorter in multidisciplinary care pathway group* *(moderate quality)* ○ Traumatic Clinical Care Coordination versus No Traumatic Clinical Care Coordination – Clinically importantly longer in Traumatic Clinical Care Coordination group *(low quality)* ○ Discharge planning versus Routine care - At 3 months – Clinically importantly shorter in discharge planning group *(low quality)* ○ Comprehensive discharge planning versus Routine discharge planning - At 3 months – No clinically important difference between groups *(very low quality)* ○ Supported discharge team versus Usual care – Significantly shorter in Supported discharge team group* *(moderate quality)* • Return to work or education ○ Multidisciplinary outpatient treatment versus Usual care by GP - Number of participants returning to work at 12 months post-injury – No clinically important difference between groups *(very low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* ○ Comprehensive discharge planning versus Routine discharge planning - Functional Status Subscale before discharge – No clinically important difference between groups *(very*	2019 • Stenvall 2007 • Vikane 2017 **Qualitative** • Graff 2018 • Jeyaraj 2013 • Kornhaber 2019 • Lindahl 2013 • Sena Martins 2017 • Stolee 2019

Qualitative theme	Quantitative intervention and results	Study IDs
	low quality) - Functional Status Subscale at 2 weeks post-discharge – No clinically important difference between groups *(very low quality)* - Functional Status Subscale at 3 months post-discharge – No clinically important difference between groups *(very low quality)* ○ MDT post-operative rehabilitation versus Conventional post-operative rehabilitation - Number of participants achieving Independence in P-ADL at each time point at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Independence in P-ADL at each time point at 12 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade A at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade B at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade C at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade D at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade E at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade F at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade G at 12 month post-operative follow-up – Clinically importantly lower in MDT post-operative rehabilitation group *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 12 months post-operative follow-up – Clinically importantly higher in MDT post-operative rehabilitation group *(very low quality)* ○ Multidisciplinary outpatient treatment versus Usual care by GP - Glasgow Outcome Scale at 12 months post-injury –	

Qualitative theme	Quantitative intervention and results	Study IDs
	No clinically important difference between groups *(very low quality)*	
Some adults with rehabilitation needs require physical aids and small adjustments in their home to aid discharge process and rehabilitation progress. *(low quality)*	The discharge planning intervention and MDT post-operative rehabilitation both involved home visits, where minor home adjustments could be made. • Length of hospital stay ○ Discharge planning versus Routine care at 3 months – Clinically importantly shorter in discharge planning group *(low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* ○ MDT post-operative rehabilitation versus Conventional post-operative rehabilitation - Number of participants achieving Independence in P-ADL at each time point at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Independence in P-ADL at each time point at 12 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade A at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade B at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade C at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade D at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)*	**Quantitative** • Huang 2005 • Stenvall 2007 **Qualitative** • Lindahl 2013

Qualitative theme	Quantitative intervention and results	Study IDs
	- Number of participants achieving Katz ADL Grade E at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade F at 12 month post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants achieving Katz ADL Grade G at 12 month post-operative follow-up – Clinically importantly lower in MDT post-operative rehabilitation group *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 4 months post-operative follow-up – No clinically important difference between groups *(very low quality)* - Number of participants returning to at least same Katz ADL level as before trauma at 12 months post-operative follow-up – Clinically importantly higher in MDT post-operative rehabilitation group *(very low quality)*	
Some patients (and their families) may not be able to advocate for themselves as strongly as others. Healthcare workers should ensure that these vulnerable service users are properly advocated for in rehabilitation and social service situations. *(high quality)*	• The traumatic clinical care coordination and extended care practitioner interventions involved a central healthcare professional that help to coordinate medical rehabilitation services and social care services. • Patient satisfaction ○ Extended care practitioner + telephone calls versus Standard outpatient care - Patient satisfaction survey at 6 months – No clinically important difference between groups *(very low quality)* - Patient satisfaction survey at 12 months – No clinically important difference between groups *(very low quality)* • Length of hospital stay ○ Traumatic Clinical Care Coordination versus No Traumatic Clinical Care Coordination – Clinically importantly longer in Traumatic Clinical Care Coordination group *(low quality)* • Overall quality of life ○ Extended care practitioner + telephone calls versus Standard outpatient care - SF-12 physical component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 physical component score at 12 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 6 months – No clinically important difference between groups *(very low quality)* - SF-12 mental component score at 12 months – No clinically important difference between groups *(very low quality)* • Change in ADL ○ Extended care practitioner + telephone calls versus	**Quantitative** • Hall 2018 • Weichman 2015 **Qualitative** • Christensen 2018 • Glenny 2013 • Graff 2018

Qualitative theme	Quantitative intervention and results	Study IDs
	Standard outpatient care - GAS at 6 months – No clinically important difference between groups *(low quality)* - GAS at 12 months – No clinically important difference between groups *(very low quality)*	
6 Timing		
Conversations about rehabilitation and discharge planning should start early on, allowing needs and preferences to be integrated smoothly into recovery plans. Last-minute conversations and preparations can be distressing for patients. *(low quality)*	The multidisciplinary care pathway and discharge planning interventions ensured that conversations surrounding discharge were initiated early on. • Length of hospital stay ○ Multidisciplinary care pathway versus Standard care – Significantly shorter in multidisciplinary care pathway group* *(moderate quality)* ○ Discharge planning versus Routine care at 3 months – Clinically importantly shorter in discharge planning group *(low quality)* • Overall quality of life ○ Discharge planning versus Routine care - SF-36 at discharge – Clinically importantly higher in discharge planning group *(low quality)* - SF-36 at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - SF-36 at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* • Changes in ADL ○ Discharge planning versus Routine care - Barthel Index at discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 2 weeks post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)* - Barthel Index at 3 months post-discharge – Clinically importantly higher in discharge planning group *(moderate quality)*	**Quantitative** • Flikweerk 2014 • Huang 2005 **Qualitative** • Barclay 2019 • Braaf 2018 • Kennedy 2012 • Kornhaber 2019 • O'Callaghan 2012

ADL: Activities of daily living; EQ-5D; Euroqol 5-Domain; EQ-VAS; Euroqol Visual Analogue Scale; GP: General practitioner; P-ADL: Phyiscal actitivies of daily living; SF-12; 12 item short form survey; SF-36: 36 item short-form survey
**This outcome measure was reported as statistically significant according to the analysis performed by the authors. As only the median and interquartile ranges/no standard deviations were reported by the study authors, and no published minimally important difference were found, we were unable to determine clinical importance.*

The contents of Table 6 are restricted to the results of the quantitative evidence and the qualitative themes this evidence speaks to. The following themes did not appear in any of the identified quantitative studies: 1.2 Community services and facilities; 1.4 Rural services; 2.2 Inter-service awareness and relationships; 3.1 Continuity of staff; 3.2 Include family; 3.5 Delivery at home; 3.6 Technology; 4.2 Prognosis; 5.2 Admission criteria; 5.3 Specialists; 6.1 Gradual; and 6.3 Gap in service. Additionally, 2 of the quantitative interventions did not include any of the qualitative themes identified in this review. Chong 2013 compared MDT care plus structured assessments and checklists with MDT care only and Ryan 2006a compared more intensive MDT care with less intensive MDT care.

For details of all study results, see the adult Summary of the quantitative evidence and Summary of qualitative evidence sections above.

Clinical evidence: Children and young people

The included studies are summarised in Table 7 and Table 8.

See the literature search strategies in appendix B and study selection flow charts in appendix C.

Included quantitative studies

One study was included in this review, a RCT conducted in Brazil which compared a family-supported rehabilitation programme to a clinician-delivered rehabilitation programme in children with TBI (Braga 2005).

Included qualitative studies

One study was included for this review, a qualitative study conducted in healthcare professionals involved in acquired brain injury (ABI) rehabilitation in Canada (Rashid 2018).

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 7 and Table 4.

Table 7: Summary of included quantitative studies

Study	Population	Intervention[a]	Control[a]	Outcomes
Braga 2005 RCT Brazil	N=87 TBI Age in months [Mean (SD)]: • Family-supported rehabilitation = 97.66 (29.61) • Clinician-delivered rehabilitation = 96.95 (30.30) Gender (M/F): • Family-supported rehabilitation (n) = 20/18 • Clinician-delivered rehabilitation (n) = 19/15 Time since injury* [Mean (SD)]: • Family-supported	<u>Family-supported rehabilitation programme</u> An individualised rehabilitation programme was designed around simple activities that could be done at home. Parents received training and a manual containing illustrations of the exercises in their child's regimen. Bi-weekly appointments at the rehabilitation centre carried on throughout the 12-month intervention to monitor progress and discuss new rehabilitation objectives. Each child had 2 case managers assigned	<u>Clinician-delivered rehabilitation programme</u> 5 x 2 hour conventional rehabilitation sessions per week for 12 months, given directly by rehabilitation healthcare professionals. Clinicians followed conventional rehabilitation procedures and treated children without parental presence. Parents received no training about their child's rehabilitation but did attend information and support group sessions during the initial 2-week assessment period	• Critical ○ None • Important ○ Changes in ADL (at 12 months)

Study	Population	Intervention[a]	Control[a]	Outcomes
	rehabilitation = 15.66 (7.18) • Clinician-delivered rehabilitation = 13.41 (6.71) * Unit of time not specified in study but likely to be weeks.	throughout the programme to teach exercises to family members and coordinate care.	in order to help their coping of their child's	

ADL: Activities of daily living; N: Number; RCT: Randomised controlled trial; SD: Standard deviation; TBI: Traumatic brain injury
(a) For full details about the intervention/comparison, please see the evidence tables in Appendix D

Table 8: Summary of included qualitative studies

Study and aim of study	Population	Methods	Themes
Rashid 2018 Canada **Aim of study** To explore healthcare professional's experiences and views regarding the needs of families' rehabilitation needs for children with ABI.	N = 15 healthcare professionals working in ABI rehabilitation Setting: Brain injury clinic of large urban rehabilitation centre *No further details reported*	**Recruitment period:** Not reported **Data collection & analysis methods:** • Semi-structured focus groups • Thematic analysis	• Compatibility across healthcare disciplines: Setting common goals • Resources: Case managers • Resources: Importance of community support

ABI: Acquired brain injury; N: Number

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Results and quality assessment of clinical outcomes included in the evidence review

The quality of the evidence was assessed using GRADE for the quantitative evidence and CERQual for the qualitative evidence. See the evidence profiles in appendix F.

Summary of the quantitative evidence

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

Of the pre-defined outcomes, evidence was only found for changes in activity of ADL. No evidence was found for:

Patient satisfaction
Length of hospital stays
Return to nursey, education, training or work
Overall quality of life including sleep
Carer impact
Unplanned readmission

One RCT found that a family-supported rehabilitation programme was associated with a statistically significantly, but not clinically importantly, higher (better) motor development score (as measured by the SARAH scale of motor development) compared to a clinician-delivered rehabilitation programme in children with TBI (Braga 2005).

Summary of the qualitative evidence

The following sub-groups were specified in the protocol but no evidence was found.

Major trauma/non-major trauma

Children and young people who are currently receiving social care services/not receiving social care services

Children on at risk register/not on the register

Children from lower socioeconomic group/not from lower socioeconomic groups

Additionally, no evidence was found for the coordination of rehabilitation services and social services.

Please see **Error! Reference source not found.** for a summary of the extracted themes.

Table 9: Summary of themes

Themes and subthemes		Quality	No. of studies	Populations covered	
				Contribution by injury type (no. of studies)	Sub-groups as specified in the protocol (no. of studies)
Theme 1: Compatibility across healthcare disciplines					
1.1	**Setting common goals** In order to increase coordination between disciplines during discharge, healthcare professionals should endeavour to set goals that are common across healthcare settings. Progress should be monitored using standardised measurements, including quality of life.	Very low	1	TBI (1)	[none]
Theme 2: Resources					
2.1	**Case workers** A designated case worker can act as an additional resource for families during discharge, acting as a knowledgeable intermediary between healthcare staff and families.	Very low	1	TBI (1)	[none]

Themes and subthemes		Quality	No. of studies	Populations covered	
				Contribution by injury type (no. of studies)	Sub-groups as specified in the protocol (no. of studies)
2.2	**Importance of community support** Families who have a child with ABI can help support other families re-integrate into the community after discharge. Social media can facilitate this by building stronger connections between parents/carers or support groups.	Very low	1	TBI (1)	[none]

ABI: Acquired brain injury; TBI: Traumatic brain injury

Summary of relevant qualitative and quantitative evidence

The quantitative and qualitative results were extracted, analysed and summarised separately before being considered together in an overall synthesis of the evidence. Table 10 lists the sub-themes identified in the qualitative evidence that are also addressed by the identified quantitative evidence along with the results of the corresponding quantitative evidence. It should be noted that not all aspects of a quantitative intervention will relate to a qualitative theme. Interventions often include features of more than 1 theme, and will therefore appear multiple times.

Table 10: Synthesis of qualitative and quantitative evidence

Qualitative theme	Quantitative intervention and results	Study IDs
Resources		
A designated case worker can act as an additional resource for families during discharge, acting as a intermediary between rehabilitation MDT and families *(very low quality)*	Within the family-supported rehabilitation programme, each child was allocated 2 case workers (from different rehabilitation disciplines) to act as a central contact point after discharge. • Changes in ADL ○ Family-supported rehabilitation versus Clinician-delivered rehabilitation – No clinically important difference between groups *(very low quality)*	**Quantitative** • Braga 2005 **Qualitative** • Rashid 2018

ADL: Activities of daily living; MDT: Multidisciplinary team;

The contents of Table 10 are restricted to the results of the quantitative evidence and the qualitative themes this evidence speaks to. The following themes did not appear in the identified quantitative study: 1.1 Setting common goals and 2.2 Importance of community support. Peer support was a theme identified in the qualitative literature, and was a component of the family-supported rehabilitation intervention. However, this feature was also offered to the clinician-delivered rehabilitation control group and did not differ between groups. Due to this, it has not been included in the above synthesis.

For details of all study results, see the children and young people Summary of the quantitative evidence and Summary of qualitative evidence sections above.

Economic evidence: Adults and children and young people

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to these review questions.

See the literature search strategy in appendix B and study selection flow chart in appendix G.

Excluded studies

Economic studies not included in these reviews are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the economic evidence review

No economic evidence was identified which was applicable to this review question.

Economic model

Thes adult review question was identified as an economic priority, however, no economic modelling was undertaken because the committee could not identify a recommendation in this area that would benefit from supporting economic modelling. No economic modelling was undertaken for the children and young people review because the committee agreed that other topics were higher priorities for economic evaluation.

The committee's discussion of the evidence

The outcomes that matter most

Quantiative evidence

When selecting the critical and important quantitative outcomes to examine for adults, the committee prioritised outcomes that can be applied to the whole heterogeneous population of people with complex rehabilitation needs after traumatic injury, complement the anticipated qualitative themes in the literature, and apply to the services and settings covered in this review question. Patient satisfaction, length of hospital stay and return to work or education were selected as critical outcomes. Patient satisfaction was chosen as it is indicative of a person's trust and future engagement with rehabilitation and social services. Length of hospital stay was chosen due to its applicability to coordination of rehabilitation care, and preparation for discharge. The committee discussed an outcome that would encompass both rehabilitation and social services. Return to work or education requires co-ordination of multiple services (for example, healthcare professionals, social services, employment services) and was identified as a suitable outcome to measure this co-ordination. Return to nursery was added to this outcome for the children and young people review. The committee discussed that their interest in investigating co-ordination of care was ultimately to improve rehabilitation outcomes for people after traumatic injury. Therefore, although not direct indicators of care co-ordination, quality of life and changes in activities of daily living were selected as important outcomes. Sleep was added to the quality of life outcome for the children and young people review because especially in younger people it can be difficult to measure well-being, function and quality of life adequately, but if young children are not functioning well, this is often reflected in poor sleep. Traumatic injury also has a large effect on carers, who may have to take on a greater supportive or advocacy role. To encompass

this population, carer impact was selected as another important outcome. Finally, unplanned readmission can occur when rehabilitation needs after discharge have not been adequately addressed. Therefore, the committee also included this as an important outcome.

Qualitative evidence

This was a mixed-methods review so the committee were unable to specify in advance the qualitative data that would be located. Instead they identified the following example main themes to guide the review and were aware that additional themes may have been identified:

Rehabilitation prescription

Case managers

Rehabilitation specialist

Multidisciplinary team approach

Social worker

The quality of the evidence

Quantitative evidence

The overall quality of evidence was assessed using GRADE methodology.

For adults, the evidence was judged as being very low to moderate quality, with the majority being very low quality. Evidence was downgraded in 2 areas: concerns about the risk of bias in contributing studies (commonly due to lack of standardisation of intervention duration and dose for non-randomised studies, and a lack of blinding in RCTs) and imprecision in the effect estimates.

For children and young people, the evidence was judged as being very low quality. Evidence was downgraded in 2 areas: concerns about risk of bias (namely differences in intensity and duration of rehabilitation sessions for children carrying out their rehabilitation at home compared to children attending rehabilitation at the clinic) and imprecision in the effect estimate (probably due to a small number of study participants).

Qualitative evidence

The evidence was assessed using GRADE-CERQual methodology.

For adults, the evidence was found to range in quality from very low to high quality, with the majority being high quality. In some cases, the evidence was downgraded due to poor applicability (for example, where the themes were not based on any research from a UK context, and/or had only been identified in studies of populations with only one particular type of traumatic injury). Some downgrading for adequacy occurred when the richness or quantity of the data was low, or where there were few first-order quotes to back up the author's second-order findings. Other issues resulting in downgrading were in the event of methodological problems that may have had an impact on the findings, and/or for incoherence within the findings.

For children and young people, the evidence was judged to be very low quality. Evidence was downgraded due to concerns over the applicability of the rehabilitation population as no data came from UK settings and the population which can include traumatic and non-traumatic ABI. Adequacy of data was also a concern.

Benefits and harms

High quality qualitative evidence from the theme 'Prognosis' in the adult review showed that people with rehabilitation needs want information about their condition, probable long-term prognosis and how this could affect their lives in future. The committee agreed with this

finding, but added that this can often be difficult to correctly predict and that not everyone with traumatic injuries will want this information. Therefore, they added that prognoses should only be delivered after receiving the views and opinions of the entire MDT so that any considerations and limitations can be conveyed to patients. Additionally, healthcare staff might be delivering sensitive and distressing information which should be communicated in a private and thoughtful manner.

Moderate quality qualitative evidence from the theme 'Inter-service communication of information' in the adult review showed that people with rehabilitation needs and healthcare staff believe that relevant healthcare information should be communicated in a timely and simple manner. Particularly, a relevant history of the patient's events, injuries, treatments, and results (for example, x-rays) should be passed on to services in advance. This theme included evidence from a variety of traumatic injury populations, as well as moderate quality quantitative evidence from 2 quantitative studies reporting a significantly shorter length of hospital stay during interventions that included prompt information exchange prior to discharge. The committee discussed that one way of facilitating this simple transfer was to make sure that all the relevant information was collated into a rehabilitation plan, so it is all in one place when needed. The use of a rehabilitation plan will also help to increase consistency between members of the rehabilitation MDT. Moderate quality qualitative evidence from the theme 'Interdisciplinary consistency' in the adult review showed that people undergoing rehabilitation are confused when they receive different information and instructions from different healthcare professionals. This in turn decreases their trust in rehabilitation services which may cause decreased engagement in their rehabilitation programme. The committee recommended that the rehabilitation plan includes input from the whole MDT in order to increase consistency. Very low quality qualitative evidence from the theme 'Format' in the adult review reports that people with rehabilitation needs may find information easier to understand and retain if it is presented to them in plain, accessible language. The committee agreed if information is not written in an accessible format, it can lead to confusion, and therefore specified that the rehabilitation plan should be written in clear and easy-to-understand language.

The benefits of a shared rehabilitation plan between healthcare professionals and people undergoing rehabilitation after traumatic injury was supported by high quality qualitative evidence from the theme 'Inform about services and plans' in the adult review. This finding showed that people with rehabilitation needs after traumatic injury appreciate being offered information about rehabilitation, believing that it smoothes transitions between healthcare settings (particularly when being discharged into the community). This information should include information on what services are available to them, how to access them, what arrangements have been made by healthcare professionals and what they may need to arrange themselves. Educating people on these matters empowers them and increases engagement in rehabilitation. Three of the included quantitative studies investigated the effectiveness of using a central healthcare professional for people to contact, and to help co-ordinate rehabilitation. The committee discussed the conflicting quantitative evidence identified in the adult population. One study investigating a discharge planning intervention versus routine care reported evidence of a clinically importantly shorter hospital length of stay (low quality evidence), as well as clinically importantly higher quality of life (moderate quality evidence) and changes in activities of daily living up to 3 months post discharge (moderate quality evidence) in the group that received the discharge planning intervention. This was contradicted by results from another study using a trauma clinical care co-ordinator, which found a clinically importantly longer length of hospital stay in the group who received input from a trauma clinical care co-ordinator. However, this intervention intentionally increased the length of stay in people receiving the intervention and the committee therefore disregarded the evidence. The remaining study compared an extended care practitioner plus telephone calls intervention to standard outpatient care. This study reported no clinically important difference between groups in patient satisfaction, overall quality of life or changes in activities of daily living. Despite the conflicting evidence, the committee agreed that their experience and expertise support the beneficial effects of informing people about their

rehabilitation plans, and noted that the qualitative evidence also encompassed a variety of different trauma populations (general trauma, burns, hip fracture and brain injury), so was widely applicable. They noted that they have made several recommendations throughout the guideline regarding keeping people educated and informed of their rehabilitation options and support available. They used the above evidence to expand and strengthen recommendations on what the rehabilitation plan should include, which healthcare professionals it should be shared with, and how it should be shared with people undergoing rehabilitation.

Low quality evidence from the theme 'Personalisation' in the adult review showed that both healthcare staff and people with rehabilitation needs after traumatic injury feel that a rehabilitation plan should be tailored to each person (for example, their age, co-morbidities, physical function), and should be flexible around other commitments. It will also need to take into consideration particular vulnerabilities (for example, housing or risk of substance misuse). Seven of the included quantitative studies identified in the adult review stressed the importance of personalising the rehabilitation pathway for patients, rather than a standard 'one-size-fits-all' approach. Of the 5 that reported length of hospital stay, 3 reported a clinically significantly shorter stay in hospital for people receiving personalised rehabilitation care when compared to the standard rehabilitation care (judged to be moderate to low quality). Furthermore, 1 study investigating the effectiveness of a discharge planning intervention reported that is was associated with a clinically importantly higher quality of life (moderate quality) and changes in activities of daily living up to 3 months post discharge (moderate quality) compared to standard care. No clinically important difference was found for either patient satisfaction or return to work or education (very low quality, reported in 1 study each). The committee recommended including people in developing their rehabilitation plan, to ensure that it is personalised and focused on the most important goals to the person. The committee also applied this evidence to agree the importance of personalisation at all stages of the rehabilitation pathway, reporting that it promoted communication, as well as increasing trust and engagement with rehabilitation services. The committee used this evidence to strengthen several recommendations throughout the guideline that highlight the importance of a holistic and individualised rehabilitation programme.

High quality evidence from the theme 'Advocacy' in the adult review showed that adults with rehabilitative needs reported that they sometimes relied upon family members to research available rehabilitation services, support them with arranging appointments and completing administration, and starting conversations with healthcare professionals. However, advocacy services were not supported by the quantitative evidence (also in the adult population), with no difference reported for patient satisfaction, overall quality of life or changes in activities of daily living between groups receiving extra coordination of rehabilitation services when compared to those who did not. One study reported a higher length of hospital stay in people receiving advocacy as part of their intervention. However, the committee discussed that the intervention in question had specifically increased hospital stay in order to complete all aspects of the intervention, and decided to disregard this low quality evidence. The committee decided not to make recommendations in the area of advocacy, but did discuss the strength of the qualitative evidence and the positive testimonies of support received from healthcare professionals shared by the lay members. Therefore, the committee highlighted the legal entitlement of certain populations of people to professional advocacy services under the Mental Capacity Act 2005 and/or the Care Act 2014. Further information can also be found in the NICE guideline on decision making and mental capacity which can be used as a guide to ensure that people are supported to make decisions for themselves when they have the mental capacity to do so or, where they lack the mental capacity to make specific decisions, they remain at the centre of the decision-making process.

High quality qualitative evidence from the theme 'Continuity of staff' in the adult review showed that people with rehabilitation needs prefer to see the same healthcare professionals wherever possible. This is because patients and healthcare staff both invest time to build trust and rapport with each other, which can lead to more honest and open communication.

When healthcare staff are changed, service users lose that relationship and can become discouraged with continuing rehabilitation. Additionally, there is an increased resource impact of time taken to re-share history and personal details, as well as the possibility of mistakes when information is not passed on. Both the healthcare professionals and lay members of the committee agreed with this theme. While it was acknowledged that full continuity is not always possible, the committee highlighted the importance of considering this aspect of a patient's rehabilitation journey. The committee discussed periods of transfer when changes in rehabilitation teams are unavoidable (for example, when being discharged back into the community), and how this can be managed. In their experience, community teams meeting patients and families before the transfer of care, rather than a 'cold' transfer, is very important in making people feel more comfortable with the change. It allows introductions in a less formal setting, a detailed handover of care needs from the current clinical team, and time for any questions patients and family members might have. The committee were aware that time is often limited during scheduled rehabilitation appointments, and this extra meeting would decrease pressure for all parties in the subsequent appointments.

Low to moderate quality quantitative evidence in the adult review showed that interventions that focused on the early initiation of conversations about discharge led to a decreased length of hospital stay, increased overall quality of life and increased changes in activities of daily living. Moreover, these differences were sustained at 3 months after discharge. These results were supported by low quality qualitative evidence from the theme 'Start early' in the adult review, which shows that both healthcare staff and adults with rehabilitation needs believe that discussions about discharge planning should begin early, in order to allow for a gradual incorporation of necessary exercises and adjustments into rehabilitation plans. The committee used their experience and expertise to recommend that these discussions should be multidisciplinary, in order to capture the full range of exercises and adjustments that a person will need once discharged from inpatient services. However, the committee were also aware that not every rehabilitation setting will be adequately resourced to deliver this discharge planning. Similarly, it might not be appropriate to start discharge planning conversations early (for example, if people are still distress or confused, leading to a difficultly processing and retaining information). Therefore, the committee suggested that this format of discharge planning be considered, but not mandatory.

High quality qualitative evidence from the theme 'Include family' in the adult review reported that healthcare staff and adults with rehabilitation needs are aware of the significant support family members can offer, especially when discharged into the community. This was somewhat supported by quantitative evidence from the children and young people's population, where a family supported rehabilitation programme reported significantly (but not clinically) importantly improved activities of daily living when compared to a clinician-delivered rehabilitation programme. The committee discussed that this support is often invaluable, covering potential gaps in services and coordination of care during the transition process. Therefore, they recommended that family members be actively involved in the discharge planning process as well receiving any rehabilitation education they may need. However, they also are aware of a potential safeguarding aspect of a blanket recommendation to include family members in discharge planning (for example, if there are disagreements about what rehabilitation options should be taken). They therefore highlighted that this inclusion should only be done after consent has been given by patients and if families feel comfortable with it.

High quality qualitative evidence from the theme 'Gradual' in the adult review reported that healthcare staff and adults with rehabilitation needs believe that rehabilitation should include a gradual and incremental return to the community. The committee discussed that this softer discharge approach can reduce the distress of the sudden loss of inpatient-support. In their experience, using local step-down wards, pre-discharge weekend home visits and supported community accommodations are all good ways of providing a continued level of support for rehabilitation patients. However, the committee agreed that this strategy is not always needed by patients, and may even at times prolong time away from home which brings its

own disadvantages. Additionally, there is a corresponding increase in the level of planning healthcare professionals will need to undertake in order to organise these interventions. Therefore, the committee recommended that this approach is offered to rehabilitation patients with significant ongoing medical and therapy needs, where their experience suggests the most benefit will be had.

High quality qualitative evidence from the theme 'Integrated multidisciplinary team approach' in the adult review showed that healthcare professionals and people undergoing rehabilitation highlight the importance of a multidisciplinary team approach when delivering rehabilitation after traumatic injury. This is especially true when transferring from inpatient to outpatient care, to co-ordinate medical and social support needs. A multidisciplinary team was involved in 5 of the included quantitative studies identified in the adult review. Three of these studies reported length of hospital stay as an outcome measure, with 2 reporting moderate quality evidence showing a clinically importantly shorter length of stay in the groups that received multidisciplinary discharge coordination Three studies also reported changes in activities of daily living, all of which were very low quality. Of the 14 measures of activities of daily living reported, there were 2 clinically importantly better results in intervention groups that received multidisciplinary discharge coordination, with the remaining 12 reporting no clinically important difference between the groups. Very low quality evidence from 2 of these studies showed no clinically important difference between the groups in return to work or education either. The committee discussed how the quantitative results did not agree with their clinical experience. They noted that the included studies varied in the amount of post-discharge support provided by the multi-disciplinary team and the length of the interventions. Because of this and the quality of the quantitative evidence, the committee made their recommendations based on the above high quality evidence from the theme 'Integrated multidisciplinary team approach', supplemented by 3 additional themes identified for this review. High quality qualitative evidence from the theme 'Interservice awareness and relationships' in the adult review shows that healthcare staff find it helpful to work with other agencies if they have the opportunity to build a working relationship. The opportunity to meet in person may help to delivery better integrated and coordinated rehabilitation care. Moderate quality qualitative evidence from the theme 'Interdisciplinary consistency' (in the adult population) and very low quality evidence from the theme 'Setting common goals' (in the children and young people population) shows that people find it confusing when different professionals provide them with inconsistent information, advice or instructions. This in turn decreases their trust in rehabilitation services which may decrease their engagement in their rehabilitation programme. Arranging pre-discharge meetings or joint-handover sessions will allow professionals from different settings to directly communicate with each other, increase their opportunity to form working relationships and ensure that the same information is provided to all parties at the same time. Finally, low quality qualitative evidence from the theme 'Home adjustments' in the adult review showed that people may need home adjustments in order to increase their independence and aid rehabilitation progress. Arranging a pre-discharge planning meeting with community practitioners will not only increase communication between healthcare and social care professionals, it will also allow any home adjustments to be noted and implemented by the relevant community teams before people are discharged back home. However, the committee were also aware that not every rehabilitation setting will be able deliver this pre-discharge meeting, as finding a time for suitable for multiple agencies presents a challenge. Therefore, the committee suggested that this meeting be considered, but not mandatory.

High quality qualitative evidence from the theme 'Point of contact' in the adult review showed that adults appreciated a single point of contact to provide information, support and rehabilitation co-ordination as they transfer from inpatient to outpatient settings. This was supported by high quality qualitative evidence from the theme 'Case co-ordinator' (also in the adult review) showing that healthcare professionals and adults with rehabilitation needs appreciated being able to communicate with one source for all information regarding a person's rehabilitation plan. Additional very low quality evidence from the theme 'Case workers' in the children and young people population was consisted with this finding. Three

of the included quantitative studies investigated the effectiveness of using a central healthcare professional for people to contact, and to help co-ordinate rehabilitation. The committee discussed the conflicting quantitative evidence identified in the review population. One study investigating a discharge planning intervention versus routine care reported evidence of a clinically importantly shorter hospital length of stay (low quality evidence), as well as clinically importantly higher quality of life (moderate quality evidence) and changes in activities of daily living up to 3 months post discharge (moderate quality evidence). This was contradicted by results from another study using a trauma clinical care co-ordinator, which found that the length of hospital stay was clinically importantly longer in the group who received input from the trauma clinical care co-ordinator. However, this intervention intentionally increased the length of stay in people receiving the input from the trauma clinical care co-ordinator and the committee therefore disregarded the evidence. The remaining study compared an extended care practitioner plus telephone calls intervention with standard outpatient care. This study reported no clinically important difference between groups in patient satisfaction, overall quality of life or changes in activities of daily living. The committee acknowledged the conflicting quantitative evidence, but discussed the strong qualitative evidence presented in this review and in other co-ordination reviews showing that a central point of contact was very helpful in developing relationships with patients and their families. In their experience, this can cause a better rapport with and increased trust in rehabilitation services. The committee discussed concerns about patients assuming that they could contact a named healthcare professional at any time, regardless of shifts and annual leave. However, they agreed that a central point of contact will be particularly important when patients transfer from inpatient to outpatient settings, when care is being handed over to community healthcare teams. This contact can be a team or service within a hospital, which will give support to patients and flexibility in staffing. They recommended that the hospital point of contact be available to patients for a limited period of time after discharge in order to improve continuity of care during this period. The committee gave an example of 3 months which was designed to encompass the transition period while still providing a stimulus to ensure healthcare is properly transferred to the appropriate setting. The committee understood that this recommendation would not necessarily be appropriate for rehabilitation patients with long-term and/or complex conditions that require the cooperation of more than one agency. Here, a continuing relationship between professionals and service users is important to understand personal and medical history as fully as possible, in order to better help patients navigate complicated and interacting agencies. Therefore, the committee recommended that appointing a key worker should be considered for patients with complex or long term conditions and/or social care needs. This can be a healthcare or social care professional, depending on which is more appropriate for the person in question. For children and young people, the healthcare or social care professional should also have experience in education and training support, as this will form a portion of their social needs. The committee highlighted additional guidance on the role of a named worker for young people transitioning to adult services, which can be found in the NICE guideline on transferring from children's to adults' services for young people using health or social care services.

Moderate quality quantitative evidence from 1 large study in the adult population investigating a multi-disciplinary care pathway spanning from accident and emergency to eventual discharge from a rehabilitation unit showed a significantly shorter length of hospital stay in patients following the multi-disciplinary care pathway. Clinical importance could not be determined due to only median and IQRs being reported by the study authors, and no MIDs identified either in the literature or from the committee. This was supported by moderate quality evidence from the theme 'Commission a full service' in the adult review. This theme described the importance of commissioning and funding rehabilitation pathways covering the entire pathway of a service user, including how services within these pathways should communicate and coordinate. Commissioners should collaborate with other commissioning bodies to ensure that rehabilitation pathways include the full range of services people may need access to (for example, vocational and educational rehabilitation services). The committee discussed that the wider rehabilitation needs of young people who are transferring

from paediatric to adult services can be overlooked by commissioners, and therefore specifically mentioned this population. The committee discussed a central aspect of this theme, which described that criteria and rehabilitation milestones should be standardised within the pathway in order to facilitate easy transfer of care. In their experience, without this standardisation and clear direction of how services and healthcare professionals should interact with each other, delays are common from a variety of sources (for example, patients might be able to be discharged from one setting but not fulfil the admission criteria for another, or reduced funding of a downstream service might lead to less capacity and therefore longer waiting lists).

High quality qualitative evidence from the theme 'Community services and facilities' in the adult review showed that the availability of community and social services is just as important for overall rehabilitation as rehabilitative medical services are. These services are wide ranging and can include social care, housing, home-adaption, transport services, and sports/recreational facilities. The committee discussed that information on how to access these services should be given to service users prior to discharge, so patients and their families are aware of what is available in their local area.

High quality qualitative evidence from the theme 'Inter-service awareness and relationships' in the adult review reported that continuity of care is increased when staff from different areas of the rehabilitation pathway are aware of the other areas (for example, rehabilitation healthcare professionals knowing about social services available in their areas), and have an opportunity to network with these difference areas. The committee discussed how providing networking opportunities will increase staff knowledge of how to access these different facilities, increase the amount of opportunities professionals have to communicate with rehabilitation peers, and strengthen communication channels between organisations.

High quality evidence from the theme 'Rural services' in the adult review showed that rural areas are often underserved by specialist rehabilitation services. This is supported by evidence on the availability of specialist services in other co-ordination reviews. The committee discussed that it is not simply rural areas that are underserved, and that there is a wide spectrum of access to specialist rehabilitation professionals across healthcare settings in the UK (for example, some people are unable to leave their homes). This becomes particularly important when people are returning home from a hospital in-patient setting. The committee discussed this finding along with high quality qualitative evidence from the theme 'Specialists' in the adult review, which showed that it is important for rehabilitation outcomes that an individual's ongoing care team include some staff with specialist knowledge, in order to support more generalised healthcare areas. For example, GPs may not have specialist knowledge of a patient's disabilities and/or conditions following complex trauma but they act as gatekeepers to more specialist services. Therefore, they may not be aware of the appropriate referrals to make when confronted with patients undergoing rehabilitation. The committee discussed that this could be mitigated by ensuring patients have an ongoing rehabilitation team that contains staff with specialist knowledge. The committee were aware that it would not be feasible to recommend increasing the amount of specialist healthcare professionals in this area due to the large resource implications this would have. However, they discussed the feasibility of ensuring that more generalised services received some specialist support to cover rehabilitation populations (for example, psychologist trained in trauma). The committee agreed that, as support would not be needed full time, it could be delivered remotely, which would keep potential resource implications low. However, it would greatly increase the ability of generalised healthcare services to provide rehabilitation care. Low quality evidence from the theme 'Technology' in the adult review showed that healthcare professionals and people undergoing rehabilitation after traumatic injury report technology is a useful tool to increase access to rehabilitation specialists. Further low quality qualitative evidence from the theme 'Delivery at home' was found regarding the ability of healthcare services to provide rehabilitation at home earlier in the recovery process, which decreases length of length of hospital stay. Both use of technology and options for home rehabilitation have been identified in other co-ordination reviews, and the committee discussed how

technology can be used to deliver follow-up, support and rehabilitation sessions to people in the community if these services are not available in their area (for example, videoconferencing being used to deliver specialist rehabilitation sessions at community services or in a person's home). To support this recommendation, the committee also recommended that professionals in generalised medical settings should have access to individualised peer support and networking opportunities with specialised rehabilitation settings. However, the committee were aware that not every individual has accesss to the technology (for example, the internet) or the level of technological knowledge needed to deliver technology-enabled follow-up, support and rehabilitation sessions. Therefore, they recommended that this is only 1 way that can be considered in increase flexibility and accessability.

Very low quality qualitative evidence from the themes 'Peer support (in the adult population) and 'Importance of community support' (in the children and young people population) showed that healthcare professionals and people undergoing rehabilitation after traumatic injury reported the benefits of support from people with lived experience. Due to the quality of the evidence, the committee used this evidence to strengthen previous recommendations on peer support rather than create new recommednations in this area.

The committee discussed the 3 remaining themes found in the adult population, but decided not to use them to make recommendations. High quality qualitative evidence from the theme 'Workload and demand' showed that efficiency can be decreased when staff are overworked and waiting list times may be increased. There was very low quality quantitative evidence supporting this, with changes in activities of daily living being clinically importantly better in participants receiving a multi-disciplinary team post-operative rehabilitation intervention which included increased staffing levels of the wards allocated to this intervention. However, this was only seen in 2 measures of activities of daily living (number of participants achieving independence in activities of daily living at 12 months and number of participants achieving Katz Grade G at 12 months). The other 9 activities of daily living measures did not find a difference between the groups. With this in mind, the large number of settings any recommendations would apply to, and the large resource impact recommendations in this area would have, the committee decided not to use this evidence in any recommendations. Low quality qualitative evidence from the theme 'Admission criteria' showed that inflexible admission criteria (for example, income factors or postcodes) can limit the services available to some adults with rehabilitation needs. While the committee discussed the importance of every patient receiving equal treatment access, they have made several other recommendations regarding flexibility of appointments throughout the guideline. While they do not target admission criteria directly, the committee believe that these will lead to greater access for all. Low quality evidence from the theme 'Gap in service' showed that, when discharged back into the community, some adults with rehabilitation needs experienced long waiting times before community rehabilitation began. The committee agreed that it was difficult to make specific recommendations to reduce waiting times, but they were confident that the recommendations made from this evidence review (along with co-ordination reviews) will lead to reduced waiting time for rehabilitation services in the longer-term.

Despite the limited evidence identified for children and young people in this review, the committee decided not to make a research recommendation in this area. Within the UK there is a relatively small number of paediatric major trauma centres, making studies in this population difficult. This, combined with the large amount of evidence found for the adult population, meant that the committee decided that other areas of the guideline would benefit more from new research.

Cost effectiveness and resource use

There was no existing economic evidence for this review.

The committee explained that multidisciplinary team reviews happen anyway. If people ask for information about the likely long-term prognosis providing such information only after a multidisciplinary team review will not incur additional resources. In most cases, the long-term prognosis is discussed at multidisciplinary team meetings to plan for long term rehabilitation, i.e. it is not something new that the teams will need to discuss.

The committee discussed delays between acute and rehabilitation settings. The committee explained that trauma systems are efficient and are ready to discharge much quicker than rehabilitation services which by their very nature are of a slower stream with much longer length of stays. The committee discussed potential solutions, e.g. commissioner's/service managers focus on discharge to the community, making the system work as efficiently as possible, including early discharge conversations and early engagement with social services/ funders. The committee explained that the transfer recommendations might make the process more efficient and result in cost savings to services.

Additional professional time might be needed to cover early discharge planning, checking access to community rehabilitation services, and organising home visits. The recommendations imply more coordination between inpatient teams and other health and social care services, which will take more time. However, this additional time spent will result in patients feeling more supported, increasing their confidence in services and improving outcomes. Also, this would only be required for a small number of people with the most complex needs. The committee explained that these recommendations reinforce current practice in this subset of people with the most complex needs for most services. However, there may be resource implications for services that are providing sub-optimal care / are underperforming.

Similarly, the committee explained that if a person has significant ongoing and complex medical and therapy needs, offering a gradual and incremental return into the community, e.g., transfer to a local hospital, a stepdown bed or a pre-discharge visit to a home, is a standard practice. Also, a pre-discharge planning meeting with community practitioners involved in the person's rehabilitation, social care and support would be a standard practice in people with the most complex needs. These recommendations are not expected to result in a resource impact. However, there may be resource implications for services that are providing sub-optimal care / are underperforming.

The committee explained that in spite of the existence of major trauma networks there is still considerable variation in practice around planning, commissioning and coordination of many aspects of rehabilitation. The committee explained that organising services with whole care pathways in mind and collaboration between commissioners represent good practice principles and should be happening across services. Where this is not happening, there may be some resource implications because services will need to set up or extend existing frameworks for more integrated commissioning and collaborative rehabilitation planning. In practice, this may entail more communication, effective information sharing and more meetings between services/practitioners. However, it is also likely to create efficiencies by ensuring that services are joined up and providing integrated care, with a potential to improve access to services, reducing waiting times and improving transfer and discharge practices, and ultimately improve patient outcomes.

The recommendation about giving people and their families and carers information about community rehabilitation and social services and/or national support networks and how they can access these are only about signposting and will not incur additional resources. It might require more practitioner time. However, it is expected to be standard practice for most services.

Most professionals already have networking opportunities. However, the practice may need to change for some services where this is not the case (for example, rural areas). Overall this recommendation is not expected to result in a resource impact for services.

Staff working with complex rehabilitation needs should already have specialist skills, knowledge, expertise, and experience of their particular injuries. This recommendation is stating the principle of good practice and should not result in a resource impact.

The recommendation on making sure that community rehabilitation practitioners have access to training expertise, advice or peer support from specialist services may mean that specialist rehabilitation professionals might need to spend more time providing peer support/training to general services/non-specialists. This could be done in low-cost ways, e.g., virtual meetings, signposting to information sources. The committee noted that if non-specialist healthcare professionals are better supported, people's needs are more likely to be met locally and there will be less pressure on specialist services. The committee also discussed some benefits of such support to practitioners, e.g., individuals not feeling isolated, sharing experiences, empowerment, which ultimately lead to better care and improved patient outcomes. Overall, the committee expect that basic specialist/support for practitioners might be a cost-saving strategy, e.g. even though clinicians may spend time on initial support, local/community/generalist practitioners will provide care with minimal input from then on. This would also benefit people (e.g. care closer to home, less disruptive) and the health service (e.g. no need to cover travel costs, less reliance on ambulance transport).

The committee discussed recommendation around technology-enabled follow-up and explained that this is already standard practice in some services. The committee also discussed that an individual might have follow-up care/rehabilitation with their initial rehabilitation specialist with, e.g., videoconferencing. The committee member with an experience of trauma discussed that the use of technology might mean that rehabilitation is more accessible, e.g. not driving to appointments. Allows individualised support with the original team. The committee noted that this might result in a higher intervention cost, i.e. support/training local therapist would take half a day to a day versus continuous support by a consultant. However, overall this could be a cost-effective approach, i.e. any cost increase in staff costs could be offset by benefits/cost-savings due to less disruption to care (continuity), no need to train/support local community therapists who may not understand the complexity of a problem, and better patient outcomes.

The committee explained that handover, i.e. between the inpatient multidisciplinary team and community practitioners at the point of discharge, does happen and should not have a resource impact on services. Where this is not happening, more professional time will be required to attend these joint handover meetings. The committee explained that handover is crucial and, if not done appropriately, may adversely affect patient outcomes. For example, a committee member with an experience of trauma referred to a situation where a community therapist advised an individual to undertake weight-bearing, which conflicted with the advice by a specialist rehabilitation therapist. Such a joint handover appointment has the potential to avoid conflicting advice and ensure an individual is receiving appropriate care in the community. This may also reduce the number of people coming back to specialist services with unmet needs, which may require intensive rehabilitation further down the line.

The single patient document, such as a rehabilitation prescription, is standard good practice; however, it is variable. The recommendations on this might have resource implications for services that are providing sub-optimal care / are underperforming.

The committee also discussed a single point of contact (e.g. a clinical nurse specialist) at discharge from the hospital to provide people and their family/carers with information, help and advice. The committee explained that anyone could do this with a clinical background and that it doesn't have to be one particular person. However, this is currently happening inconsistently, and so this recommendation may represent a change in practice for some services. The committee discussed the benefits of having a single point of contact, including developing relationships with patients and their families, a better rapport with and increased trust in rehabilitation services, particularly when patients transfer from inpatient to outpatient settings, i.e. when care is being handed over to community healthcare teams. Having a

single point of contact will provide assurance to individuals and their family/carers, may potentially ensure continuity in care and also engagement with care. The committee was of a view that benefits would offset any additional costs to services where this is not happening, and having a single point of contact for a limited time would represent value for money.

The committee explained that all other recommendations reinforce standard practice and will not require additional resources.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.1, 1.2.1, 1.2.2, 1.4.1, 1.4.2, 1.5.7, 1.6.6, 1.7.1, 1.7.8, 1.8.1, 1.8.3, 1.8.7, 1.8.13, 1.8.14, 1.8.20, 1.8.21, 1.8.22, 1.8.23, 1.9.1, 1.9.2, 1.10.1, 1.10.2, 1.10.6, 1.10.8, 1.10.9, 1.10.10, 1.10.12 and 1.10.14 in the NICE guideline.

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Appendices

Appendix A – Review protocol

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

Table 11: Review protocol for coordination of inpatient and outpatient rehabilitation and social service for adults after traumatic injury

ID	Field	Content
0.	PROSPERO registration number	CRD42019154585
1.	Review title	Service coordination: Inpatient to outpatient settings for adults
2.	Review question	4.2a: What are the best methods to deliver and coordinate rehabilitation services and social services for adults with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?
3.	Objective	To determine the best methods to deliver and coordinate rehabilitation services and social services for adults with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?
4.	Searches	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • MEDLINE Searches will be restricted by: • Date: ○ Qualitative: The committee is of the opinion that 2010 is a reasonable cut-off date due to the practice changes in rehabilitation services introduced by the establishment of major trauma centres in 2012. Data about adults/CYPs' views of rehabilitation services which predate these changes would be less relevant to current practice and less useful to the committee as a basis for drafting recommendations ○ Quantitative: 2000 onwards as there has been significant change in practice in 2012 and the guideline committee wanted to capture the evidence that lead to that so imposed a date limit going back 12 years prior to the change in practice

		• Country:
		  ○ Qualitative: The committee wished to prioritise views about rehabilitation services which most closely reflect the UK practice context. They therefore agreed to include studies from high income European countries according to the World Bank (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519; i.e., Andorra, Austria, Belgium, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Greenland, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lichtenstein, Lithuania, Luxembourg, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and UK), Canada, Australia and New Zealand, which would be sufficiently transferable. Priority will be given to UK studies, however data from studies conducted in other high-income countries will be added if new themes arise that are not captured in the UK evidence.
		  ○ Quantitative: No country limit
		• Human studies
		The full search strategies for MEDLINE database will be published in the final review.

5.	Condition or domain being studied	Complex rehabilitation needs resulting from traumatic injury 'Complex rehab needs' refers to 'multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and could also include the following: • Vocational or educational social support for the person to return to their pervious functional level, including return to work, school or college • Emotional, psychological and psychosocial support • Equipment or adaptations • Ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in feature clinic) • Further surgery and readmissions to hospital Traumatic injury is defined as 'traumatic injury that requires admission to hospital at the time of injury.'
6	Population (quantitative)	• *For the coordination and delivery of rehabilitation services part of the question:* Rehabilitation services for adults (aged 18 years and above) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient • *For the coordination and delivery of rehabilitation services and social services part of the question:* Rehabilitation services and social services for adults (aged 18 years and above) with social service needs and complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient
	Population (qualitative)	• Adults (aged 18 years and above) with complex rehabilitation needs after traumatic injury, including

		those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient. For the social services aspect of this question, the population also have to have social services needs • Staff working at inpatient and outpatient rehabilitation services and/or social services for adults (aged 18 years and above) who have complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss and hearing loss.
7	Intervention (quantitative)	• *For the coordination of rehabilitation services part of the question:* Rehabilitation services coordination method A (e.g., neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method A (e.g., community, group classes, intensive, multi-disciplinary, cohort clinic, specialist outpatients rehabilitation services, early supported discharge, self-management support, family support, outpatient [i.e., at hospital], individual, non-intensive, uni--disciplinary, non-cohort clinic, non-specialist) • *For the coordination of rehabilitation and social services part of the question:* Rehabilitation and social services coordination method A (e.g., continuing healthcare assessor, housing occupational therapists, housing officers, community healthcare teams [e.g., district nurses], re-enablement specialists, specialist injury/disability voluntary organisations, non-specialist social care/disability/user-led organisations, speech and language therapists, neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method A (e.g., hospital/discharge-led social care and rehabilitation coordination at discharge, ‘separate/disconnected’ NHS continuing health care and local authority social care assessments for discharge (including assessments for capital costs like aids and adaptations and care costs like costs of a daily carer), rehabilitation and social care services delivered via completely different funding set up between health and social care, liaison at discharge with relevant voluntary organisations, use of personal budgets at discharge, liaison at discharge with reablement services/intermediate care, liaison with housing occupational therapists and other housing liaison at discharge (e.g. to establish whether disabled facilities grants may be available if adaptations are needed, community-led social care and rehabilitation coordination at discharge, ‘joined up/connected NHS continuing health care and local authority social care assessments for discharge, rehabilitation and social care services delivered via a pooled/coordinated budget method (health and social care)
	Phenomenon of interest (qualitative)	Methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for adults when transferring from inpatient to outpatient rehabilitation services,

		regarded by the population as optimal/not optimal or effective/non-effective Themes will be identified from the literature, but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker

8	Comparator (quantitative)	• *For the coordination of rehabilitation services part of the question:*
		  ○ Rehabilitation services coordination method B (e.g., any of the above interventions)
		  ○ No coordination
		• *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method B (e.g., any of the above interventions)
		• *For the coordination of rehabilitation and social services part of the question:*
		  ○ Rehabilitation and social services coordination method B (e.g., any of the above interventions)
		  ○ No coordination
		• *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method B (e.g., any of the above interventions)

9	Types of study to be included (quantitative)	• Systematic review of RCTs • Randomised controlled trial If no RCT data are available for an intervention, evidence from the followings will be considered in order • Cluster-randomised trial • Systematic review of non-randomised studies • Comparative prospective cohort studies with N≥100 per treatment arm • Comparative retrospective cohort studies with N≥100 per treatment arm
	Types of study to be included (qualitative)	• Systematic reviews of qualitative studies • Qualitative studies (for example, interviews, focus groups, observations)
10	Other exclusion criteria (quantitative)	Study design: • Cross-over design • Case-controls • Cross-sectional • Case series and case reports • Audits

		Language: • Non-English Publication status: • Abstract only
	Other exclusion criteria (qualitative)	Study design: • Purely quantitative studies (including surveys with only descriptive quantitative data) Language: • Non-English Publication status: • Abstract only
11	Context	Settings - Inclusion: • Rehabilitation and social care settings for patients with complex rehabilitation needs after traumatic injury Exclusion: • Accident and emergency departments • Critical care units • Prisons
12	Primary outcomes (critical outcomes; quantitative)	Critical: • Patient satisfaction • Length of hospital stay • Return to work or education Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
	Primary outcomes (critical outcomes; qualitative)	Themes will be identified from the literature pertaining to methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for adults, when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective

		These themes may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
13	Secondary outcomes (important outcomes; quantitative)	Important: • Overall quality of life [EURO-QoL 5D 3L, SF-36, SF-12, SF-6D, SFMA] • Carer impact • Unplanned readmission • Changes in activity of daily living (COPM, Barthel ADL index, Katz, PSMS, OARS, PAT, EADL-Test, GAS, FIMFAM) Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
	Secondary outcomes (important outcomes; qualitative)	Themes will be identified from the literature pertaining to methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for adults, when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective These themes may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
14	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. 5% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be retrieved and will be assessed in line with the criteria outlined above. A standardised form will be used to extract data from studies (see Developing NICE guidelines: the manual section 6.4.
15	Risk of bias (quality) Assessment (quantitative)	Risk of bias will be assessed using the Cochrane RoB tool 2.0 for RCTs, the Cochrane ROBINS-I for non-randomised studies, and ROBIS for systematic reviews.
	Risk of bias (quality) Assessment (qualitative)	Risk of bias will be assessed using the CASP qualitative checklist

16	Strategy for data synthesis (quantitative)	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. If pairwise meta-analyses are undertaken, they will be performed using Cochrane Review Manager (RevMan). 'GRADEpro' will be used to assess the quality of evidence for each outcome.
	Strategy for data synthesis (qualitative)	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. Studies will be reviewed chronologically from most recent first to oldest. Thematic analysis of the data will be conducted and findings presented. The quality of the evidence will be assessed using GRADE-CERQual for each theme.
17	Analysis of sub-groups	The following subgroups were specified for this question for stratification of the data: • Major trauma / non-major trauma • Homeless people / non-homeless people • People who are currently receiving social care services (e.g., people with learning disabilities) / not receiving social care services • Age below 65 years / age above 65 years • People from lower socioeconomic group / not from lower socioeconomic groups
18	Type and method of review	Mixed methods review: Quantitative (intervention) and qualitative
19	Language	English
20	Country	England
21	Anticipated or actual start date	01/04/2019
22	Anticipated completion date	31/10/2020
23	Stage of review at time of this submission	Review stage / Started / Completed Preliminary searches ☑ ☑ Piloting of the study selection process ☑ ☑ Formal screening of search results against eligibility criteria ☑ ☑ Data extraction ☑ ☑

		Risk of bias (quality) assessment	☑ ☑
		Data analysis	☑ ☑
24	Named contact	National Guideline Alliance	
25	Review team members	National Guideline Alliance	
26	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.	
27	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
28	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10105	
29	Other registration details	-	
30	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=154585	
31	Dissemination plans		
32	Keywords		
33	Details of existing review of same topic by same authors		
34	Current review status		
35	Additional information		
36	Details of final publication	www.nice.org.uk	

ADL: Activities of daily living; CASP: Critical appraisal skills programme; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; COPM: Canadian occupational performance measure; CYP: Children and young people; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L; EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GRADE: Grading of Recommendations Assessment, Development and Evaluation; MDT: Multi-disciplinary team; NGA: National Guideline Alliance; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; OARS: Older American resources and services scale; PAT: Performance ADL test; PROSPERO: International prospective register of systematic reviews; PSMS; Physical self-maintenance scale; RCT: Randomised controlled trial; RoB: Risk of bias; ROBINS-I: Risk of bias in non-randomized studies of

intervention; ROBIS: Risk of bias in systematic reviews; SD: Standard deviation; SFMA; Selective functional movement assessment ; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form

Review protocol for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

Table 12: Review protocol for coordination of inpatient and outpatient rehabilitation and social service for children and young people after traumatic injury

ID	Field	Content
0.	PROSPERO registration number	CRD42019154588
1.	Review title	Service coordination: Inpatient to outpatient settings for children and young people
2.	Review question	4.2b: What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?
3.	Objective	To determine the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?
4.	Searches	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • MEDLINE Searches will be restricted by: • Date: ○ Qualitative: The committee is of the opinion that 2010 is a reasonable cut-off date due to the practice changes in rehabilitation services introduced by the establishment of major trauma centres in 2012. Data about adults/CYPs' views of rehabilitation services which predate these changes would be less relevant to current practice and less useful to the committee as a basis for drafting recommendations. ○ Quantitative: 2000 onwards as there has been significant change in practice in 20102 and the guideline committee wanted to capture the evidence that lead to that so imposed a date limit going back 102 years prior to the change in practice

		• Country:
		  ○ Qualitative: The committee wished to prioritise views about rehabilitation services which most closely reflect the UK practice context. They therefore agreed to include studies from high income European countries according to the World Bank (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519; i.e., Andorra, Austria, Belgium, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Greenland, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lichtenstein, Lithuania, Luxembourg, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and UK), Canada, Australia and New Zealand, which would be sufficiently transferable. Priority will be given to UK studies, however data from studies conducted in other high-income countries will be added if new themes arise that are not captured in the UK evidence.
		  ○ Quantitative: No country limit
		• Human studies
		The full search strategies for MEDLINE database will be published in the final review.

5.	Condition or domain being studied	Complex rehabilitation needs resulting from traumatic injury 'Complex rehab needs' refers to 'multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and could also include the following: • Vocational or educational social support for the person to return to their pervious functional level, including return to work, school or college • Emotional, psychological and psychosocial support • Equipment or adaptations • Ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in feature clinic) • Further surgery and readmissions to hospital Traumatic injury is defined as 'traumatic injury that requires admission to hospital at the time of injury.'
6	Population (quantitative)	• *For the coordination and delivery of rehabilitation services part of the question*: Rehabilitation services for children and young people (aged below 18 years) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient

		• *For the coordination and delivery of rehabilitation services and social services part of the question*: Rehabilitation services and social services for children and young people (aged below 18 years) with social service needs and complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient
	Population (qualitative)	• Children and young people (aged below 18 years) with complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss, and hearing loss, when they transfer from being an inpatient to being an outpatient. *For the social services aspect of this question, the population also have to have social services needs.* The views of the families/carers of the children and young people will also be sought. • Staff working at inpatient and outpatient rehabilitation services and/or social services for children and young people (aged below 18 years) who have complex rehabilitation needs after traumatic injury, including those with traumatic brain injury, sight loss and hearing loss.
7	Intervention (quantitative)	• *For the coordination of rehabilitation services part of the question:* Rehabilitation services coordination method A (e.g., community paediatrician, education representatives [teachers, SENCO], neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational therapist) • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method A (e.g., community, group classes, intensive, multi-disciplinary, cohort clinic, specialist outpatients rehabilitation services, early supported discharge, self-management support, family support, outpatient [i.e., at hospital], individual, non-intensive, uni-disciplinary, non-cohort clinic, non-specialist) • *For the coordination of rehabilitation and social services part of the question:* Rehabilitation and social services coordination method A (e.g., continuing healthcare assessor, housing occupational therapists, housing officers, community healthcare teams [e.g., district nurses], re-enablement specialists, specialist injury/disability voluntary organisations, non-specialist social care/disability/user-led organisations, speech and language therapists, neuro-navigator, trauma nurse coordinators, rehabilitation consultant, rehabilitation coordinators, case managers, key workers, discharge coordinators, GP, social worker, early supported discharge [homefirst], specialist trauma multidisciplinary team/combined clinics, rehabilitation prescriptions, multi-disciplinary discharge planning meeting/consultation, follow up meeting [phone or face to face], interface teams or intermediate care, occupational

		therapist) • *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method A (e.g., hospital/discharge-led social care and rehabilitation coordination at discharge, 'separate/disconnected' NHS continuing health care and local authority social care assessments for discharge (including assessments for capital costs like aids and adaptations and care costs like costs of a daily carer), rehabilitation and social care services delivered via completely different funding set up between health and social care, liaison at discharge with relevant voluntary organisations, use of personal budgets at discharge, liaison at discharge with reablement services/intermediate care, liaison with housing occupational therapists and other housing liaison at discharge (e.g. to establish whether disabled facilities grants may be available if adaptations are needed), community-led social care and rehabilitation coordination at discharge, 'joined up/connected NHS continuing health care and local authority social care assessments for discharge, rehabilitation and social care services delivered via a pooled/coordinated budget method (health and social care))
	Phenomenon of interest (qualitative)	Methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for children and young people when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective Themes will be identified from the literature, but may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
8	Comparator (quantitative)	• *For the coordination of rehabilitation services part of the question*: ○ Rehabilitation services coordination method B (e.g., any of the above interventions) ○ No coordination • *For the delivery of rehabilitation services part of the question:* Rehabilitation services delivery method B (e.g.,any of the above interventions) • *For the coordination of rehabilitation and social services part of the question:* ○ Rehabilitation and social services coordination method B (e.g., any of the above interventions) ○ No coordination

		• *For the delivery of rehabilitation and social services part of the question:* Rehabilitation and social services delivery method B (e.g., any of the above interventions)
9	Types of study to be included (quantitative)	• Systematic review of RCTs • Randomised controlled trial If no RCT data are available for an intervention, evidence from the followings will be considered in order • Cluster-randomised trial • Systematic review of non-randomised studies • Comparative prospective cohort studies with N≥100 per treatment arm • Comparative retrospective cohort studies with N≥100 per treatment arm
	Types of study to be included (qualitative)	• Systematic reviews of qualitative studies • Qualitative studies (for example, interviews, focus groups, observations)
10	Other exclusion criteria (quantitative)	Study design: • Cross-over design • Case-controls • Cross-sectional • Case series and case reports • Audits Language: • Non-English Publication status: • Abstract only
	Other exclusion criteria (qualitative)	Study design: • Purely quantitative studies (including surveys with only descriptive quantitative data) Language: • Non-English Publication status:

		• Abstract only
11	Context	Settings - Inclusion: • Rehabilitation and social care settings for patients with complex rehabilitation needs after traumatic injury Exclusion: • Accident and emergency departments • Critical care units • Prisons
12	Primary outcomes (critical outcomes; quantitative)	Critical: • Patient satisfaction • Length of hospital stay • Return to nursery, education, training or work Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
	Primary outcomes (critical outcomes; qualitative)	Themes will be identified from the literature pertaining to methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for children and young people, when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective These themes may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
13	Secondary outcomes (important outcomes; quantitative)	Important: • Overall quality of life including sleep [CHQ-CF80, CHQ-PF-50, PEDS-QL, EURO-QoL 5D 3L Y, SF-36, SF-12, SF-6D, SFMA, TARN, SCIM] • Carer impact

		• Unplanned readmission • Changes in activity of daily living (COPM, Barthel ADL index, Katz, PSMS, OARS, PAT, EADL-Test, GAS, FIMFAM) Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
	Secondary outcomes (important outcomes; qualitative)	Themes will be identified from the literature pertaining to methods to coordinate and deliver rehabilitation services themselves and rehabilitation and social services in combination for children and young people, when transferring from inpatient to outpatient rehabilitation services, regarded by the population as optimal/not optimal or effective/non-effective These themes may include: • Rehabilitation prescription • Case managers • Rehabilitation specialist • MDT approach • Social worker
14	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. 5% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be retrieved and will be assessed in line with the criteria outlined above. A standardised form will be used to extract data from studies (see Developing NICE guidelines: the manual section 6.4).
15	Risk of bias (quality) Assessment (quantitative)	Risk of bias will be assessed using the Cochrane RoB tool 2.0 for RCTs, the Cochrane ROBINS-I for non-randomised studies, and ROBIS for systematic reviews.
	Risk of bias (quality) Assessment (qualitative)	Risk of bias will be assessed using the CASP qualitative checklist
16	Strategy for data synthesis (quantitative)	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. If pairwise meta-analyses are undertaken, they will be performed using Cochrane Review Manager (RevMan). 'GRADEpro' will be used to assess the quality of evidence for each outcome.

	Strategy for data synthesis (qualitative)	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. Studies will be reviewed chronologically from most recent first to oldest. Thematic analysis of the data will be conducted and findings presented. The quality of the evidence will be assessed using GRADE-CERQual for each theme.
17	Analysis of sub-groups	The following subgroups were specified for this question for stratification of the data: • Major trauma / non-major trauma • Children and young people who are currently receiving social care services / not receiving social care services • Children on at risk register / not on the register • Children from lower socioeconomic group / not from lower socioeconomic groups
18	Type and method of review	Mixed methods review: Quantitative (intervention) and qualitative
19	Language	English
20	Country	England
21	Anticipated or actual start date	01/03/2020
22	Anticipated completion date	30/05/2020
23	Stage of review at time of this submission	Review stage / Started / Completed Preliminary searches ☑ ☑ Piloting of the study selection process ☑ ☑ Formal screening of search results against eligibility criteria ☑ ☑ Data extraction ☑ ☑ Risk of bias (quality) assessment ☑ ☑ Data analysis ☑ ☑
24	Named contact	National Guideline Alliance

25	Review team members	National Guideline Alliance
26	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
27	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10105
29	Other registration details	-
30	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=154588
31	Dissemination plans	
32	Keywords	
33	Details of existing review of same topic by same authors	
34	Current review status	
35	Additional information	
36	Details of final publication	www.nice.org.uk

ADL: Activities of daily living; CASP: Critical appraisal skills programme; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CHQ-CF80: Child Health Questionnaire self-report (adolescents aged 12-18 years); CHQ-PF-50: Child Health Questionnaire parent-report (children aged 5-18 years); COPM: Canadian occupational performance measure; CYP: Children and young people; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L; EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GRADE: Grading of Recommendations Assessment, Development and Evaluation; MDT: Multi-disciplinary team; NGA: National Guideline Alliance; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; OARS: Older American resources and services scale; PAT: Performance ADL test; PEDS-QL: Pediatric Quality of Life Inventory; PROSPERO: International prospective register of systematic reviews; PSMS; Physical self-maintenance scale; RCT: Randomised controlled trial; RoB: Risk of bias; ROBINS-I: Risk of bias in non-randomized studies of intervention; ROBIS: Risk of bias in systematic reviews; SD: Standard deviation; SENCO: Special Educational Needs Co-ordinator; SFMA; Selective functional movement assessment ; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form; TARN; Trauma Audit and Research Network

Appendix B – Literature search strategies

Literature search strategies for review question:

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

D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

A combined search was conducted for both review questions.

Qualitative literature search strategies

Please note that this search was a combined search for the adult and children and young people evidence reviews covering this question AND the following evidence review questions: D.1 (What are the best methods to coordinate rehabilitation services for people with complex rehabilitation needs after traumatic injury whilst they are an inpatient, including when transferring between inpatient settings?), D.3 (What are the barriers and facilitators to accessing rehabilitation services, including follow-up, following discharge to the community for people with complex rehabilitation needs after traumatic injury?) and D.4 (What are the support needs and preferences of people who have complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient or community rehabilitation services?).

Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations

Date of last search: 17/01/2020

#	Searches
1	interview:.mp.
2	experience:.mp.
3	qualitative.tw.
4	or/1-3
5	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
6	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
7	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.

#	Searches
8	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
9	(patient? adj5 trauma$).ti,ab.
10	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
11	wound$ patient?.ti,ab.
12	injur$ patient?.ti,ab.
13	accident$ patient?.ti,ab.
14	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ti.
15	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ab. /freq=2
16	exp MULTIPLE TRAUMA/
17	TRAUMATOLOGY/
18	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
19	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
20	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
21	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
22	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
23	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
24	(polytrauma? or poly-trauma?).ti,ab.
25	traumatolog$.ti,ab.
26	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (exp *"WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/))
27	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
28	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
29	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
30	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
31	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
32	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
33	*SPINAL CORD INJURIES/ or *SPINAL CORD COMPRESSION/
34	exp *THORACIC INJURIES/ or *ACUTE LUNG INJURY/
35	*PERIPHERAL NERVE INJURIES/ or exp *CRANIAL NERVE INJURIES/
36	exp *AMPUTATION/ or *AMPUTATION, TRAUMATIC/ or *AMPUTEES/ or *AMPUTATION

#	Searches
	STUMPS/ or *LIMB SALVAGE/
37	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
38	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
39	((Flail$ or stove in) adj3 chest?).ti.
40	(rib? adj3 fractur$).ti.
41	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
42	(amputat$ or amputee?).ti.
43	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
44	*HEAD INJURIES, CLOSED/ or *HEAD INJURIES, PENETRATING/
45	(head adj3 injur$).ti.
46	exp *BRAIN INJURIES/
47	(brain adj3 injur$).ti.
48	or/5-47
49	MODELS, ORGANIZATIONAL/
50	"DELIVERY OF HEALTH CARE, INTEGRATED"/
51	INTERINSTITUTIONAL RELATIONS/
52	INTERSECTORAL COLLABORATION/
53	INTERDEPARTMENTAL RELATIONS/
54	INTERPROFESSIONAL RELATIONS/
55	INTERDISCIPLINARY COMMUNICATION/
56	(interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$).ti,ab.
57	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$)).ti,ab.
58	(interdisciplin$ or multidisciplin$ or jointdisciplin$).ti.
59	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
60	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti,ab.
61	((inter or multi or joint) adj3 disciplin$).ti.
62	((inter or multi or joint) adj3 disciplin$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
63	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti,ab.
64	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across)).ti,ab.
65	(rehab$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$)).ti,ab.
66	(service? adj5 deliver$).ti,ab.
67	((service? or care) adj3 (configurat$ or model?)).ti,ab.
68	SOCIAL WORK/
69	(social adj1 (service? or work$)).ti,ab.
70	or/49-69
71	"CONTINUITY OF PATIENT CARE"/
72	AFTERCARE/
73	*PATIENT DISCHARGE/
74	PATIENT HANDOFF/
75	PATIENT TRANSFER/
76	TRANSITION TO ADULT CARE/
77	TRANSITIONAL CARE/
78	((continuity or continuum) adj3 care).ti,ab.
79	aftercare.ti,ab.
80	(follow up adj3 (care or service? or outpatient? or communit$)).ti,ab.

#	Searches
81	(patient? adj5 (discharg$ or postdischarg$) adj5 follow$ up).ti,ab.
82	(follow up adj5 (post or after) adj5 discharg$).ti,ab.
83	(discharg$ adj3 plan$).ti,ab.
84	((patient? or clinical or nurs$) adj3 (handoff? or hand$ off? or handover? or hand$ over? or signout? or sign$ out? or signover? or sign$ over?)).ti,ab.
85	(patient? adj3 transfer$ adj3 (service? or setting? or department$ or ward? or hospital?)).ti,ab.
86	(care adj3 transfer$).ti,ab.
87	((inpatient or outpatient) adj3 transfer$).ti,ab.
88	(patient? adj5 transition$).ti,ab.
89	(care adj5 transition$).ti,ab.
90	((inpatient or outpatient) adj5 transition$).ti,ab.
91	or/71-90
92	HEALTH SERVICES ACCESSIBILITY/
93	HEALTHCARE DISPARITIES/
94	"FACILITIES AND SERVICES UTILIZATION"/
95	(access$ adj5 service?).ti,ab.
96	(access$ adj3 care).ti,ab.
97	((service? or care) adj3 (disparit$ or inequal$)).ti,ab.
98	((service? or care) adj3 (utiliz$ or utilis$)).ti,ab.
99	or/92-98
100	*SOCIAL SUPPORT/
101	*SELF CARE/
102	(social$ adj5 support$).ti.
103	(social$ adj3 support$).ab. /freq=2
104	((communit$ or outpatient?) adj5 support$).ti,ab.
105	((support or communit$ or outpatient?) adj3 need?).ti,ab.
106	(support$ adj3 rehab$).ti,ab.
107	COMMUNITY HEALTH SERVICES/
108	(communit$ adj3 service?).ti,ab.
109	((communit$ or outpatient?) adj3 rehab$).ti,ab.
110	((outpatient? or home$ or communit$) adj5 (information or communicat$)).ti,ab.
111	or/100-110
112	48 and 70
113	48 and 91
114	48 and 99
115	48 and 111
116	or/112-115
117	limit 116 to english language
118	limit 117 to yr="2000 -Current"
119	4 and 118

1 **Databases: Embase; and Embase Classic**

2 **Date of last search: 17/01/2020**

#	Searches
1	interview:.tw.
2	exp HEALTH CARE ORGANIZATION/
3	experiences.tw.
4	or/1-3
5	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and

#	Searches
	(HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
6	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
7	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
8	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
9	(patient? adj5 trauma$).ti,ab.
10	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
11	wound$ patient?.ti,ab.
12	injur$ patient?.ti,ab.
13	accident$ patient?.ti,ab.
14	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ti.
15	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ab. /freq=2
16	MULTIPLE TRAUMA/
17	TRAUMATOLOGY/
18	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
19	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
20	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
21	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
22	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
23	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
24	(polytrauma? or poly-trauma?).ti,ab.
25	traumatolog$.ti,ab.
26	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or

#	Searches
	STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/))
27	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
28	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
29	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
30	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
31	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
32	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
33	*SPINAL CORD INJURY/ or *SPINAL CORD COMPRESSION/
34	exp *THORAX INJURY/ or *ACUTE LUNG INJURY/ or exp *RIB FRACTURE/
35	exp *NERVE INJURY/
36	exp *AMPUTATION/ or *AMPUTEE/ or *LIMB SALVAGE/
37	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
38	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
39	((Flail$ or stove in) adj3 chest?).ti.
40	(rib? adj3 fractur$).ti.
41	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
42	(amputat$ or amputee?).ti.
43	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
44	*HEAD INJURY/
45	(head adj3 injur$).ti.
46	exp *BRAIN INJURY/
47	(brain adj3 injur$).ti.
48	or/5-47
49	NONBIOLOGICAL MODEL/
50	INTEGRATED HEALTH CARE SYSTEM/
51	PUBLIC RELATIONS/
52	INTERSECTORAL COLLABORATION/
53	INTERDISCIPLINARY COMMUNICATION/
54	MULTIDISCIPLINARY TEAM/
55	COLLABORATIVE CARE TEAM/
56	(interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$).ti,ab.
57	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$)).ti,ab.
58	(interdisciplin$ or multidisciplin$ or jointdisciplin$).ti.
59	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
60	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti,ab.
61	((inter or multi or joint) adj3 disciplin$).ti.
62	((inter or multi or joint) adj3 disciplin$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
63	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti,ab.

#	Searches
64	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across)).ti,ab.
65	(rehab$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$)).ti,ab.
66	(service? adj5 deliver$).ti,ab.
67	((service? or care) adj3 (configurat$ or model?)).ti,ab.
68	SOCIAL WORK/
69	(social adj1 (service? or work$)).ti,ab.
70	or/49-69
71	*PATIENT CARE/
72	AFTERCARE/
73	*HOSPITAL DISCHARGE/
74	CLINICAL HANDOVER/
75	TRANSITION TO ADULT CARE/
76	TRANSITIONAL CARE/
77	((continuity or continuum) adj3 care).ti,ab.
78	aftercare.ti,ab.
79	(follow up adj3 (care or service? or outpatient? or communit$)).ti,ab.
80	(patient? adj5 (discharg$ or postdischarg$) adj5 follow$ up).ti,ab.
81	(follow up adj5 (post or after) adj5 discharg$).ti,ab.
82	(discharg$ adj3 plan$).ti,ab.
83	((patient? or clinical or nurs$) adj3 (handoff? or hand$ off? or handover? or hand$ over? or signout? or sign$ out? or signover? or sign$ over?)).ti,ab.
84	(patient? adj3 transfer$ adj3 (service? or setting? or department$ or ward? or hospital?)).ti,ab.
85	(care adj3 transfer$).ti,ab.
86	((inpatient or outpatient) adj3 transfer$).ti,ab.
87	(patient? adj5 transition$).ti,ab.
88	(care adj5 transition$).ti,ab.
89	((inpatient or outpatient) adj5 transition$).ti,ab.
90	or/71-89
91	*HEALTH CARE DELIVERY/
92	*HEALTH CARE DISPARITY/
93	*HEALTH CARE UTILIZATION/
94	(access$ adj5 service?).ti,ab.
95	(access$ adj3 care).ti,ab.
96	((service? or care) adj3 (disparit$ or inequal$)).ti,ab.
97	((service? or care) adj3 (utiliz$ or utilis$)).ti,ab.
98	or/91-97
99	*SOCIAL SUPPORT/
100	*SELF CARE/
101	(social$ adj5 support$).ti.
102	(social$ adj3 support$).ab. /freq=2
103	((communit$ or outpatient?) adj5 support$).ti,ab.
104	((support or communit$ or outpatient?) adj3 need?).ti,ab.
105	(support$ adj3 rehab$).ti,ab.
106	*COMMUNITY CARE/
107	COMMUNITY BASED REHABILITATION/
108	(communit$ adj3 service?).ti,ab.
109	((communit$ or outpatient?) adj3 rehab$).ti,ab.
110	((outpatient? or home$ or communit$) adj5 (information or communicat$)).ti,ab.
111	or/99-110
112	48 and 70
113	48 and 90
114	48 and 98
115	48 and 111

#	Searches
116	or/112-115
117	limit 116 to english language
118	limit 117 to yr="2000 -Current"
119	4 and 118

1 **Database: PsycInfo**

2 **Date of last search: 17/01/2020**

#	Searches
1	experiences.tw.
2	interview:.tw.
3	qualitative.tw.
4	or/1-3
5	(exp INJURIES/ not BIRTH INJURIES/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED PATIENTS/ or HOSPITALS/ or exp INTENSIVE CARE/ or REHABILITATION CENTERS/)
6	(exp INJURIES/ not BIRTH INJURIES/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
7	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
8	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
9	(patient? adj5 trauma$).ti,ab.
10	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
11	wound$ patient?.ti,ab.
12	injur$ patient?.ti,ab.
13	accident$ patient?.ti,ab.
14	(exp INJURIES/ not BIRTH INJURIES/) and trauma$.ti,ab.
15	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
16	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
17	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
18	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
19	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
20	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
21	(polytrauma? or poly-trauma?).ti,ab.
22	traumatolog$.ti,ab.
23	exp ACCIDENTS/ and (exp INJURIES/ not BIRTH INJURIES/)
24	exp ACCIDENTS/ and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti,ab.
25	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
26	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
27	exp ACCIDENTS/ and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED PATIENTS/ or HOSPITALS/ or exp INTENSIVE CARE/ or REHABILITATION CENTERS/)
28	exp ACCIDENTS/ and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
29	SPINAL CORD INJURIES/
30	AMPUTATION/
31	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
32	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
33	((Flail$ or stove in) adj3 chest?).ti.
34	(rib? adj3 fractur$).ti.

#	Searches
35	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
36	(amputat$ or amputee?).ti.
37	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
38	HEAD INJURIES/
39	(head adj3 injur$).ti.
40	exp BRAIN INJURIES/
41	(brain adj3 injur$).ti.
42	or/5-41
43	INTEGRATED SERVICES/
44	INTERDISCIPLINARY TREATMENT APPROACH/
45	(interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$).ti,ab.
46	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$)).ti,ab.
47	(interdisciplin$ or multidisciplin$ or jointdisciplin$).ti.
48	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
49	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti,ab.
50	((inter or multi or joint) adj3 disciplin$).ti.
51	((inter or multi or joint) adj3 disciplin$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
52	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti,ab.
53	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across)).ti,ab.
54	(rehab$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$)).ti,ab.
55	(service? adj5 deliver$).ti,ab.
56	((service? or care) adj3 (configurat$ or model?)).ti,ab.
57	SOCIAL CASEWORK/
58	SOCIAL SERVICES/
59	(social adj1 (service? or work$)).ti,ab.
60	or/43-59
61	"CONTINUUM OF CARE"/
62	AFTERCARE/
63	FACILITY DISCHARGE/
64	HOSPITAL DISCHARGE/
65	DISCHARGE PLANNING/
66	CLIENT TRANSFER/
67	POSTTREATMENT FOLLOWUP/
68	OUTPATIENT TREATMENT/
69	((continuity or continuum) adj3 care).ti,ab.
70	aftercare.ti,ab.
71	(follow up adj3 (care or service? or outpatient? or communit$)).ti,ab.
72	(patient? adj5 (discharg$ or postdischarg$) adj5 follow$ up).ti,ab.
73	(follow up adj5 (post or after) adj5 discharg$).ti,ab.
74	(discharg$ adj3 plan$).ti,ab.
75	((patient? or clinical or nurs$) adj3 (handoff? or hand$ off? or handover? or hand$ over? or signout? or sign$ out? or signover? or sign$ over?)).ti,ab.
76	(patient? adj3 transfer$ adj3 (service? or setting? or department$ or ward? or hospital?)).ti,ab.
77	(care adj3 transfer$).ti,ab.
78	((inpatient or outpatient) adj3 transfer$).ti,ab.

#	Searches
79	(patient? adj5 transition$).ti,ab.
80	(care adj5 transition$).ti,ab.
81	((inpatient or outpatient) adj5 transition$).ti,ab.
82	or/61-81
83	HEALTH CARE ACCESS/
84	HEALTH DISPARITIES/
85	HEALTH CARE UTILIZATION/
86	(access$ adj5 service?).ti,ab.
87	(access$ adj3 care).ti,ab.
88	((service? or care) adj3 (disparit$ or inequal$)).ti,ab.
89	((service? or care) adj3 (utiliz$ or utilis$)).ti,ab.
90	or/83-89
91	SOCIAL SUPPORT/
92	SELF-CARE SKILLS/
93	(social$ adj5 support$).ti.
94	(social$ adj3 support$).ab. /freq=2
95	((communit$ or outpatient?) adj5 support$).ti,ab.
96	((support or communit$ or outpatient?) adj3 need?).ti,ab.
97	(support$ adj3 rehab$).ti,ab.
98	COMMUNITY SERVICES/
99	COMMUNITY HEALTH/
100	(communit$ adj3 service?).ti,ab.
101	((communit$ or outpatient?) adj3 rehab$).ti,ab.
102	((outpatient? or home$ or communit$) adj5 (information or communicat$)).ti,ab.
103	or/91-102
104	42 and 60
105	42 and 82
106	42 and 90
107	42 and 103
108	or/104-107
109	limit 108 to english language
110	limit 109 to yr="2000 -Current"
111	4 and 110
112	limit 111 to ("0100 journal" or "0110 peer-reviewed journal" or "0120 non-peer-reviewed journal")

1 **Database: Social Policy and Practice**

2 **Date of last search: 17/01/2020**

#	Searches
1	interview:.mp.
2	experience:.mp.
3	qualitative.tw.
4	or/1-3
5	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
6	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
7	(patient? adj5 trauma$).ti,ab.
8	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
9	wound$ patient?.ti,ab.
10	injur$ patient?.ti,ab.
11	accident$ patient?.ti,ab.
12	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
13	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.

#	Searches
14	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
15	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
16	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
17	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
18	(polytrauma? or poly-trauma?).ti,ab.
19	traumatolog$.ti,ab.
20	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
21	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
22	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
23	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
24	((Flail$ or stove in) adj3 chest?).ti.
25	(rib? adj3 fractur$).ti.
26	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
27	(amputat$ or amputee?).ti.
28	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
29	(head adj3 injur$).ti.
30	(brain adj3 injur$).ti.
31	or/5-30
32	(interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$).ti,ab.
33	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$)).ti,ab.
34	(interdisciplin$ or multidisciplin$ or jointdisciplin$).ti.
35	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
36	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti,ab.
37	((inter or multi or joint) adj3 disciplin$).ti.
38	((inter or multi or joint) adj3 disciplin$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$)).ti,ab.
39	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti,ab.
40	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across)).ti,ab.
41	(rehab$ adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$)).ti,ab.
42	(service? adj5 deliver$).ti,ab.
43	((service? or care) adj3 (configurat$ or model?)).ti,ab.
44	(social adj1 (service? or work$)).ti,ab.
45	or/32-44
46	((continuity or continuum) adj3 care).ti,ab.
47	aftercare.ti,ab.
48	(follow up adj3 (care or service? or outpatient? or communit$)).ti,ab.
49	(patient? adj5 (discharg$ or postdischarg$) adj5 follow$ up).ti,ab.
50	(follow up adj5 (post or after) adj5 discharg$).ti,ab.
51	(discharg$ adj3 plan$).ti,ab.
52	((patient? or clinical or nurs$) adj3 (handoff? or hand$ off? or handover? or hand$ over? or signout? or sign$ out? or signover? or sign$ over?)).ti,ab.
53	(patient? adj3 transfer$ adj3 (service? or setting? or department$ or ward? or hospital?)).ti,ab.
54	(care adj3 transfer$).ti,ab.
55	((inpatient or outpatient) adj3 transfer$).ti,ab.

#	Searches
56	(patient? adj5 transition$).ti,ab.
57	(care adj5 transition$).ti,ab.
58	((inpatient or outpatient) adj5 transition$).ti,ab.
59	or/46-58
60	(access$ adj5 service?).ti,ab.
61	(access$ adj3 care).ti,ab.
62	((service? or care) adj3 (disparit$ or inequal$)).ti,ab.
63	((service? or care) adj3 (utiliz$ or utilis$)).ti,ab.
64	or/60-63
65	(social$ adj5 support$).ti.
66	(social$ adj3 support$).ab. /freq=2
67	((communit$ or outpatient?) adj5 support$).ti,ab.
68	((support or communit$ or outpatient?) adj3 need?).ti,ab.
69	(support$ adj3 rehab$).ti,ab.
70	(communit$ adj3 service?).ti,ab.
71	((communit$ or outpatient?) adj3 rehab$).ti,ab.
72	((outpatient? or home$ or communit$) adj5 (information or communicat$)).ti,ab.
73	or/65-72
74	31 and 45
75	31 and 59
76	31 and 64
77	31 and 73
78	or/74-77
79	limit 78 to yr="2000 -Current"
80	4 and 79

Databases: Cochrane Central Register of Controlled Trials (CCTR); and Cochrane Database of Systematic Reviews (CDSR)

Date of last search: 17/01/2020

#	Searches
#1	interview*:ti,ab
#2	experience*:ti,ab
#3	qualitative:ti,ab
#4	#1 or #2 or #3
#5	([mh "WOUNDS AND INJURIES"] not ([mh ^ASPHYXIA] or [mh ^"BATTERED CHILD SYNDROME"] or [mh "BIRTH INJURIES"] or [mh "BITES AND STINGS"] or [mh DROWNING] or [mh ^"EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"] or [mh ^FROSTBITE] or [mh "HEAT STRESS DISORDERS"] or [mh "RADIATION INJURIES"] or [mh ^RETROPNEUMOPERITONEUM] or [mh ^"SURGICAL WOUND"]))
#6	([mh ^HOSPITALIZATION] or [mh ^"PATIENT ADMISSION"] or [mh ^"ADOLESCENT, HOSPITALIZED"] or [mh ^"CHILD, HOSPITALIZED"] or [mh HOSPITALS] or [mh "EMERGENCY SERVICE, HOSPITAL"] or [mh "INTENSIVE CARE UNITS"] or [mh ^"REHABILITATION CENTERS"])
#7	#5 and #6
#8	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#9	#5 and #8
#10	((hospitalised or hospitalized or hospitalistion* or hospitaliztion*) near/10 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#11	((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*) near/5 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#12	(patient* near/5 trauma*):ti,ab
#13	(patient* near/3 (burn* or burned or fractur*)):ti,ab

#	Searches
#14	"wound* patient*":ti,ab
#15	"injur* patient*":ti,ab
#16	"accident* patient*":ti,ab
#17	trauma*:ti,ab
#18	#5 and #17
#19	[mh "MULTIPLE TRAUMA"]
#20	[mh ^TRAUMATOLOGY]
#21	(trauma* near/5 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#22	((complex* or multiple or critical*) near/3 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#23	(trauma* near/3 (severe or severely or major or multiple)):ti,ab
#24	((injur* or wound* or burn* or burned or fractur*) near/2 (severe or severely or major or multiple)):ti,ab
#25	((physical* or body or bodily) near/3 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#26	(acute near/1 (injur* or trauma* or wound* or burn* or burned or fractur*)):ti,ab
#27	(polytrauma* or poly-trauma*):ti,ab
#28	traumatolog*:ti,ab
#29	([mh ^ACCIDENTS] or [mh ^"ACCIDENTAL FALLS"] or [mh ^"ACCIDENTS, HOME"] or [mh ^"ACCIDENTS, OCCUPATIONAL"] or [mh ^"ACCIDENTS, TRAFFIC"])
#30	#5 and #29
#31	(injur* or wound* or trauma* or burn* or burned or fractur*):ti,ab
#32	#29 and #31
#33	(accident* near/5 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#34	(accident* near/3 (serious* or severe or severely or major)):ti,ab
#35	#6 and #29
#36	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or intensive care or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#37	#29 and #36
#38	[mh ^"SPINAL CORD INJURIES"] or [mh ^"SPINAL CORD COMPRESSION"]
#39	[mh "THORACIC INJURIES"] or [mh ^"ACUTE LUNG INJURY"]
#40	[mh ^"PERIPHERAL NERVE INJURIES"] or [mh "CRANIAL NERVE INJURIES"]
#41	[mh AMPUTATION] or [mh ^"AMPUTATION, TRAUMATIC"] or [mh ^AMPUTEES] or [mh ^"AMPUTATION STUMPS"] or [mh ^"LIMB SALVAGE"]
#42	((spinal* or spine* or chest* or thoracic* or nerve*) near/3 injur*):ti
#43	((spinal* or spine*) near/3 cord* near/3 compress*):ti
#44	((Flail* or stove in) near/3 chest*):ti
#45	(rib* near/3 fractur*):ti
#46	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) near/3 plexus near/3 injur*):ti
#47	(amputat* or amputee*):ti
#48	(limb* near/3 (loss or losing or lost or salvag* or re-construct* or reconstruct*)):ti
#49	[mh ^"HEAD INJURIES, CLOSED"] or [mh ^"HEAD INJURIES, PENETRATING"]
#50	(head near/3 injur*):ti
#51	[mh "BRAIN INJURIES"]
#52	(brain near/3 injur*):ti
#53	#7 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #30 or #32 or #33 or #34 or #35 or #37 or #38 or #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 or #52
#54	[mh ^"MODELS, ORGANIZATIONAL"]
#55	[mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"]
#56	[mh ^"INTERINSTITUTIONAL RELATIONS"]
#57	[mh ^"INTERSECTORAL COLLABORATION"]
#58	[mh ^"INTERDEPARTMENTAL RELATIONS"]
#59	[mh ^"INTERPROFESSIONAL RELATIONS"]

#	Searches
#60	[mh ^"INTERDISCIPLINARY COMMUNICATION"]
#61	(interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession*):ti,ab
#62	((inter or multi or joint) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession*)):ti,ab
#63	(interdisciplin* or multidisciplin* or jointdisciplin*).ti.
#64	((interdisciplin* or multidisciplin* or jointdisciplin*) near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*)):ti,ab
#65	((interdisciplin* or multidisciplin* or jointdisciplin*) near/5 rehab*):ti,ab
#66	((inter or multi or joint) near/3 disciplin*).ti.
#67	((inter or multi or joint) near/3 disciplin* near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*)):ti,ab
#68	((inter or multi or joint) near/3 disciplin* near/5 rehab*):ti,ab
#69	((institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin* or care) near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partnership* or network* or across)):ti,ab
#70	(rehab* near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partnership* or network*)):ti,ab
#71	(service* near/5 deliver*):ti,ab
#72	((service* or care) near/3 (configurat* or model*)):ti,ab
#73	[mh ^"SOCIAL WORK"]
#74	(social near/1 (service* or work*)):ti,ab
#75	#54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68 or #69 or #70 or #71 or #72 or #73 or #74
#76	[mh ^"CONTINUITY OF PATIENT CARE"]
#77	[mh ^AFTERCARE]
#78	[mh ^"PATIENT DISCHARGE"]
#79	[mh ^"PATIENT HANDOFF"]
#80	[mh ^"PATIENT TRANSFER"]
#81	[mh ^"TRANSITION TO ADULT CARE"]
#82	[mh ^"TRANSITIONAL CARE"]
#83	((continuity or continuum) near/3 care):ti,ab
#84	aftercare:ti,ab
#85	(follow up near/3 (care or service* or outpatient* or communit*)):ti,ab
#86	(patient* near/5 (discharg* or postdischarg*) near/5 follow* up):ti,ab
#87	(follow up near/5 (post or after) near/5 discharg*):ti,ab
#88	(discharg* near/3 plan*):ti,ab
#89	((patient* or clinical or nurs*) near/3 (handoff* or "hand* off*" or handover* or "hand* over*" or signout* or "sign* out*" or signover* or "sign* over*")):ti,ab
#90	(patient* near/3 transfer* near/3 (service* or setting* or department* or ward* or hospital*)):ti,ab
#91	(care near/3 transfer*):ti,ab
#92	((inpatient or outpatient) near/3 transfer*):ti,ab
#93	(patient* near/5 transition*):ti,ab
#94	(care near/5 transition*):ti,ab
#95	((inpatient or outpatient) near/5 transition*):ti,ab
#96	#76 or #77 or #78 or #79 or #80 or #81 or #82 or #83 or #84 or #85 or #86 or #87 or #88 or #89 or #90 or #91 or #92 or #93 or #94 or #95
#97	[mh ^"HEALTH SERVICES ACCESSIBILITY"]
#98	[mh ^"HEALTHCARE DISPARITIES"]
#99	[mh ^"FACILITIES AND SERVICES UTILIZATION"]
#100	(access* near/5 service*):ti,ab
#101	(access* near/3 care):ti,ab

#	Searches
#102	((service* or care) near/3 (disparit* or inequal*)):ti,ab
#103	((service* or care) near/3 (utiliz* or utilis*)):ti,ab
#104	#97 or #98 or #99 or #100 or #101 or #102 or #103
#105	[mh ^"SOCIAL SUPPORT"]
#106	[mh ^"SELF CARE"]
#107	(social* near/5 support*).ti,ab.
#108	((communit* or outpatient*) near/5 support*):ti,ab
#109	((support or communit* or outpatient*) near/3 need*):ti,ab
#110	(support* near/3 rehab*):ti,ab
#111	[mh ^"COMMUNITY HEALTH SERVICES"]
#112	(communit* near/3 service*):ti,ab
#113	((communit* or outpatient*) near/3 rehab*):ti,ab
#114	((outpatient* or home* or communit*) near/5 (information or communicat*)):ti,ab
#115	#105 or #106 or #107 or #108 or #109 or #110 or #111 or #112 or #113 or #114
#116	#53 and #75
#117	#53 and #96
#118	#53 and #104
#119	#53 and #115
#120	#116 or #117 or #118 or #119
#121	#4 and #120
#122	#4 and #120 with Cochrane Library publication date Between Jan 2000 and Jan 2019, in Cochrane Reviews
#123	#4 and #120 with Publication Year from 2000 to 2019, in Trials

Database: Social Care Online

Date of last search: 17/01/2020

#	Searches
	AllFields: qualitative or interview or experience
	AND AllFields: rehabilitation
	AND AllFields: trauma or injury
	AND PublicationYear:'2000 2019'

Quantitative literature search strategies

Please note that this search was a combined search for the adult and children and young people evidence reviews covering this question AND evidence review D.1 (What are the best methods to coordinate rehabilitation services for people with complex rehabilitation needs after traumatic injury whilst they are an inpatient, including when transferring between inpatient settings?).

Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations

Date of last search: 03/03/2020

#	Searches
1	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
2	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp

#	Searches
	FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
3	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
4	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
5	(patient? adj5 trauma$).ti,ab.
6	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
7	wound$ patient?.ti,ab.
8	injur$ patient?.ti,ab.
9	accident$ patient?.ti,ab.
10	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ti.
11	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ab. /freq=2
12	exp MULTIPLE TRAUMA/
13	TRAUMATOLOGY/
14	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
15	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
16	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
17	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
18	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
19	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
20	(polytrauma? or poly-trauma?).ti,ab.
21	traumatolog$.ti,ab.
22	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (exp *"WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/))
23	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
24	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
25	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
26	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
27	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
28	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (hospitali?ed or hospitali?tion? or

#	Searches
	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
29	*SPINAL CORD INJURIES/ or *SPINAL CORD COMPRESSION/
30	exp *THORACIC INJURIES/ or *ACUTE LUNG INJURY/
31	*PERIPHERAL NERVE INJURIES/ or exp *CRANIAL NERVE INJURIES/
32	exp *AMPUTATION/ or *AMPUTATION, TRAUMATIC/ or *AMPUTEES/ or *AMPUTATION STUMPS/ or *LIMB SALVAGE/
33	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
34	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
35	((Flail$ or stove in) adj3 chest?).ti.
36	(rib? adj3 fractur$).ti.
37	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
38	(amputat$ or amputee?).ti.
39	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
40	*HEAD INJURIES, CLOSED/ or *HEAD INJURIES, PENETRATING/
41	(head adj3 injur$).ti.
42	exp *BRAIN INJURIES/
43	(brain adj3 injur$).ti.
44	or/1-43
45	exp REHABILITATION/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or *PATIENT CARE TEAM/)
46	rh.fs. and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/)
47	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$) adj10 rehab$).ti,ab.
48	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$) adj10 rehab$).ti,ab.
49	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti.
50	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti.
51	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
52	((inter or multi or joint) adj3 disciplin$ adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
53	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across) adj5 rehab$).ti,ab.
54	or/45-53
55	(INPATIENTS/ or OUTPATIENTS/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
56	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$)

#	Searches
	adj7 (inpatient? or outpatient?)).ti,ab.
57	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj7 (inpatient? or outpatient?)).ti,ab.
58	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj7 (inpatient? or outpatient?)).ti,ab.
59	or/55-58
60	("CONTINUITY OF PATIENT CARE"/ or AFTERCARE/ or TRANSITION TO ADULT CARE/ or TRANSITIONAL CARE/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or PATIENT CARE TEAM/)
61	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 transition$).ti,ab.
62	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 transition$).ti,ab.
63	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj10 transition$).ti,ab.
64	((continuity or continuum) adj3 care adj10 transition$).ti,ab.
65	((continuity or continuum) adj3 care adj10 rehab$).ti,ab.
66	(case manager? adj10 transition$).ti,ab.
67	or/60-66
68	(HEALTH SERVICES/ or CHILD HEALTH SERVICES/ or ADOLESCENT HEALTH SERVICES/ or COMMUNITY HEALTH SERVICES/ or HOME CARE SERVICES/ or HEALTH SERVICES FOR PEOPLE WITH DISABILITIES/ or MENTAL HEALTH SERVICES/ or NURSING SERVICES/ or exp HEALTH PERSONNEL/) and (exp SOCIAL WORK/ or SOCIAL WORK, PSYCHIATRIC/ or SOCIAL WORKERS/)
69	((health$ or NHS or clinical or clinician? or medical or medic? or physician? or consultant? or nurse? or general practitioner? or GP? or occupational therapist? or OT? or allied health professional? or AHP? or ((speech or language) adj3 therapist?) or SLT?) adj10 (social$ adj3 (work$ or care or service?)) adj10 (rehab$ or deliver$ or collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up or inpatient? or outpatient? or transition$ or discharg$ or assess$)).ti,ab.
70	or/68-69
71	*NURSE ADMINISTRATORS/
72	CASE MANAGERS/
73	exp REHABILITATION/ and (CONSULTANTS/ or PEDIATRICIANS/ or GENERAL PRACTITIONERS/ or SOCIAL WORKERS/ or OCCUPATIONAL THERAPISTS/ or SCHOOL TEACHERS/ or NURSES, COMMUNITY HEALTH/)
74	(neuronavigator? or neuro-navigator?).ti,ab.
75	(trauma nurse? adj3 (coordinator? or co-ordinator?)).ti,ab.
76	key worker?.ti,ab.
77	(discharge adj3 (coordinator? or co-ordinator?)).ti,ab.
78	community p?ediatrician?.ti,ab.
79	SENCO?.ti,ab.
80	health$ assessor?.ti,ab.
81	(housing adj3 (officer? or staff or team? or service? or liaison or occupational therapist? or OT or OTs)).ti,ab.
82	((re-enabl$ or enablement or reabl$ or re-abl$) adj3 (specialist? or team? or service?)).ti,ab.
83	(rehab$ adj10 (case manager? or consultant? or coordinator? or co-ordinator? or p?ediatrician? or general practitioner? or GP or GPs or social worker? or occupational therapist? or OT or OTs or teacher? or community nurse? or district nurse? or SLT or SLTs)).ti,ab.
84	(rehab$ adj10 (speech or language) adj3 (therapist? or pathologist?)).ti,ab.

#	Searches
85	or/71-84
86	PATIENT CARE TEAM/ and (COMMUNITY HEALTH SERVICES/ or COMMUNITY HEALTH NURSING/ or COMMUNITY MENTAL HEALTH SERVICES/ or COMMUNITY PHARMACY SERVICES/)
87	(MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/) and (COMMUNITY HEALTH SERVICES/ or COMMUNITY HEALTH NURSING/ or COMMUNITY MENTAL HEALTH SERVICES/ or COMMUNITY PHARMACY SERVICES/)
88	((specialist or non-specialist or trauma$) adj3 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
89	(rehab$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
90	combined clinic?.ti,ab.
91	cohort? clinic?.ti,ab.
92	(interfac$ adj3 team?).ti,ab.
93	(rehab$ adj10 intermediate care).ti,ab.
94	(rehab$ adj10 communit$ adj5 (team? or service?)).ti,ab.
95	(communit$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
96	or/86-95
97	PATIENT DISCHARGE/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
98	(support$ adj3 discharg$).ti,ab.
99	homefirst.ti,ab.
100	(discharg$ adj5 plan$ adj5 (service? or team? or meet$ or consult$)).ti,ab.
101	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 discharg$).ti,ab.
102	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 discharg$).ti,ab.
103	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 discharg$).ti,ab.
104	((continuity or continuum) adj3 care adj10 discharg$).ti,ab.
105	(case manager? adj10 discharg$).ti,ab.
106	or/97-105
107	SELF-MANAGEMENT/
108	SELF CARE/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
109	SELF CARE/ and SOCIAL SUPPORT/
110	(SOCIAL SUPPORT/ or CHARITIES/ or CONSUMER ORGANIZATIONS/ or ORGANIZATIONS, NONPROFIT/ or VOLUNTARY HEALTH AGENCIES/ or SELF-HELP GROUPS/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAMS/)
111	(self adj3 manag$ adj5 support$).ti,ab.
112	(rehab$ adj10 (family or families or caregiver? or carer?) adj5 support$).ti,ab.
113	volunt$ organi?ation?.ti,ab.
114	volunt$ sector?.ti,ab.

#	Searches
115	non-government$ organi?ation?.ti,ab.
116	(NGO or NGOs).ti,ab.
117	(charity or charities).ti,ab.
118	(user? adj3 led adj3 organi?ation?).ti,ab.
119	or/107-118
120	*BUDGETS/
121	personal$ budget$.ti,ab.
122	disabled facilities grant?.ti,ab.
123	((pooled or coordinat$ or co-ordinat$ or joint$ or shared) adj3 (budget$ or finance?)).ti,ab.
124	((budget$ or financ$) adj5 discharg$).ti,ab.
125	or/120-124
126	(special$ adj5 (inreach or in-reach or outreach or out-reach)).ti,ab.
127	(special$ adj3 outpatient?).ti,ab.
128	(rehab$ adj3 prescription?).ti,ab.
129	(follow$ up adj3 (meet$ or consultation?)).ti,ab.
130	(follow up adj3 (care or service?) adj10 rehab$).ti,ab.
131	(aftercare adj10 rehab$).ti,ab.
132	((communit$ or outpatient? or post discharg$ or postdischarg$) adj10 rehab$ adj3 (group? or cohort? or non-cohort? or individual$ or intensive$ or non-intensive$ or multi-disciplin$ or multidisciplin$ or MDT or MDTs or uni-disciplin$ or unidisciplin$ or speciali$ or non-speciali$)).ti,ab.
133	or/126-132
134	44 and 54
135	44 and 59
136	44 and 67
137	44 and 70
138	44 and 85
139	44 and 96
140	44 and 106
141	44 and 119
142	44 and 125
143	44 and 133
144	or/134-143
145	limit 144 to english language
146	limit 145 to yr="2000 -Current"
147	LETTER/
148	EDITORIAL/
149	NEWS/
150	exp HISTORICAL ARTICLE/
151	ANECDOTES AS TOPIC/
152	COMMENT/
153	CASE REPORT/
154	(letter or comment*).ti.
155	or/147-154
156	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
157	155 not 156
158	ANIMALS/ not HUMANS/
159	exp ANIMALS, LABORATORY/
160	exp ANIMAL EXPERIMENTATION/
161	exp MODELS, ANIMAL/
162	exp RODENTIA/
163	(rat or rats or mouse or mice).ti.
164	or/157-163
165	146 not 164

1 **Databases: Embase; and Embase Classic**

2 **Date of last search: 03/03/2020**

#	Searches
1	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
2	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
3	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
4	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
5	(patient? adj5 trauma$).ti,ab.
6	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
7	wound$ patient?.ti,ab.
8	injur$ patient?.ti,ab.
9	accident$ patient?.ti,ab.
10	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ti.
11	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ab. /freq=2
12	MULTIPLE TRAUMA/
13	TRAUMATOLOGY/
14	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
15	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
16	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
17	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
18	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.

#	Searches
19	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
20	(polytrauma? or poly-trauma?).ti,ab.
21	traumatolog$.ti,ab.
22	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/))
23	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
24	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
25	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
26	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
27	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
28	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
29	*SPINAL CORD INJURY/ or *SPINAL CORD COMPRESSION/
30	exp *THORAX INJURY/ or *ACUTE LUNG INJURY/ or exp *RIB FRACTURE/
31	exp *NERVE INJURY/
32	exp *AMPUTATION/ or *AMPUTEE/ or *LIMB SALVAGE/
33	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
34	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
35	((Flail$ or stove in) adj3 chest?).ti.
36	(rib? adj3 fractur$).ti.
37	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
38	(amputat$ or amputee?).ti.
39	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
40	*HEAD INJURY/
41	(head adj3 injur$).ti.
42	exp *BRAIN INJURY/
43	(brain adj3 injur$).ti.
44	or/1-43
45	exp REHABILITATION/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
46	rh.fs. and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
47	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$) adj10 rehab$).ti,ab.
48	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$) adj10 rehab$).ti,ab.

#	Searches
49	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti.
50	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti.
51	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
52	((inter or multi or joint) adj3 disciplin$ adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
53	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across) adj5 rehab$).ti,ab.
54	or/45-53
55	(*HOSPITAL PATIENT/ or OUTPATIENT/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
56	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (inpatient? or outpatient?)).ti,ab.
57	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj5 (inpatient? or outpatient?)).ti,ab.
58	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 (inpatient? or outpatient?)).ti,ab.
59	or/55-58
60	(AFTERCARE/ or TRANSITION TO ADULT CARE/ or TRANSITIONAL CARE/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
61	*PATIENT CARE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
62	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 transition$).ti,ab.
63	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 transition$).ti,ab.
64	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj10 transition$).ti,ab.
65	((continuity or continuum) adj3 care adj10 transition$).ti,ab.
66	((continuity or continuum) adj3 care adj10 rehab$).ti,ab.
67	(case manager? adj10 transition$).ti,ab.
68	or/60-67
69	(HEALTH SERVICE/ or CHILD HEALTH CARE/ or COMMUNITY CARE/ or HOME CARE/ or MENTAL HEALTH SERVICE/ or *NURSING/ or exp *HEALTH CARE PERSONNEL/) and (SOCIAL CARE/ or SOCIAL WORK/ or SOCIAL WORKER/)
70	((health$ or NHS or clinical or clinician? or medical or medic? or physician? or consultant? or nurse? or general practitioner? or GP? or occupational therapist? or OT? or allied health professional? or AHP? or ((speech or language) adj3 therapist?) or SLT?) adj7 (social$ adj3 (work$ or care or service?)) adj7 (rehab$ or deliver$ or collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up

#	Searches
	or inpatient? or outpatient? or transition$ or discharg$ or assess$)).ti,ab.
71	or/69-70
72	*NURSE ADMINISTRATOR/
73	CARE COORDINATOR/
74	exp REHABILITATION/ and (PEDIATRICIANS/ or *GENERAL PRACTITIONERS/ or *SOCIAL WORKERS/ or *OCCUPATIONAL THERAPISTS/ or SCHOOL TEACHERS/)
75	(neuronavigator? or neuro-navigator?).ti,ab.
76	(trauma nurse? adj3 (coordinator? or co-ordinator?)).ti,ab.
77	key worker?.ti,ab.
78	(discharge adj3 (coordinator? or co-ordinator?)).ti,ab.
79	community p?ediatrician?.ti,ab.
80	SENCO?.ti,ab.
81	health$ assessor?.ti,ab.
82	(housing adj3 (officer? or staff or team? or service? or liaison or occupational therapist? or OT or OTs)).ti,ab.
83	((re-enabl$ or enablement or reabl$ or re-abl$) adj3 (specialist? or team? or service?)).ti,ab.
84	(rehab$ adj7 (case manager? or consultant? or coordinator? or co-ordinator? or p?ediatrician? or general practitioner? or GP or GPs or social worker? or occupational therapist? or OT or OTs or teacher? or community nurse? or district nurse? or SLT or SLTs)).ti,ab.
85	(rehab$ adj7 (speech or language) adj3 (therapist? or pathologist?)).ti,ab.
86	or/72-85
87	(*PATIENT CARE/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/) and (COMMUNITY CARE/ or COMMUNITY BASED REHABILITATION/ or COMMUNITY HEALTH NURSING/)
88	(NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/) and (COMMUNITY CARE/ or COMMUNITY BASED REHABILITATION/ or COMMUNITY HEALTH NURSING/)
89	((specialist or non-specialist or trauma$) adj3 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
90	(rehab$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
91	combined clinic?.ti,ab.
92	cohort? clinic?.ti,ab.
93	(interfac$ adj3 team?).ti,ab.
94	(rehab$ adj10 intermediate care).ti,ab.
95	(rehab$ adj7 communit$ adj5 (team? or service?)).ti,ab.
96	(communit$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
97	or/87-96
98	HOSPITAL DISCHARGE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
99	*HOSPITAL DISCHARGE/ and *PATIENT CARE/
100	(support$ adj3 discharg$).ti,ab.
101	homefirst.ti,ab.
102	(discharg$ adj5 plan$ adj5 (service? or team? or meet$ or consult$)).ti,ab.
103	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj7 discharg$).ti,ab.
104	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj7 discharg$).ti,ab.
105	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 discharg$).ti,ab.

#	Searches
106	((continuity or continuum) adj3 care adj10 discharg$).ti,ab.
107	(case manager? adj10 discharg$).ti,ab.
108	or/98-107
109	SELF CARE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
110	SELF CARE/ and SOCIAL SUPPORT/
111	(SOCIAL SUPPORT/ or SOCIAL WELFARE/ or CONSUMER ORGANIZATION/ or NON PROFIT ORGANIZATION/ or SELF HELP/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
112	(self adj3 manag$ adj5 support$).ti,ab.
113	(rehab$ adj10 (family or families or caregiver? or carer?) adj5 support$).ti,ab.
114	volunt$ organi?ation?.ti,ab.
115	volunt$ sector?.ti,ab.
116	non-government$ organi?ation?.ti,ab.
117	(NGO or NGOs).ti,ab.
118	(charity or charities).ti,ab.
119	(user? adj3 led adj3 organi?ation?).ti,ab.
120	or/109-119
121	*BUDGET/
122	personal$ budget$.ti,ab.
123	disabled facilities grant?.ti,ab.
124	((pooled or coordinat$ or co-ordinat$ or joint$ or shared) adj3 (budget$ or finance?)).ti,ab.
125	((budget$ or financ$) adj5 discharg$).ti,ab.
126	or/121-125
127	(special$ adj5 (inreach or in-reach or outreach or out-reach)).ti,ab.
128	(special$ adj3 outpatient?).ti,ab.
129	(rehab$ adj3 prescription?).ti,ab.
130	(follow$ up adj3 (meet$ or consultation?)).ti,ab.
131	(follow up adj3 (care or service?) adj10 rehab$).ti,ab.
132	(aftercare adj10 rehab$).ti,ab.
133	((communit$ or outpatient? or post discharg$ or postdischarg$) adj10 rehab$ adj3 (group? or cohort? or non-cohort? or individual$ or intensive$ or non-intensive$ or multi-disciplin$ or multidisciplin$ or MDT or MDTs or uni-disciplin$ or unidisciplin$ or speciali$ or non-speciali$)).ti,ab.
134	or/127-133
135	44 and 54
136	44 and 59
137	44 and 68
138	44 and 71
139	44 and 86
140	44 and 97
141	44 and 108
142	44 and 120
143	44 and 126
144	44 and 134
145	or/135-144
146	limit 145 to english language
147	limit 146 to yr="2000 -Current"
148	letter.pt. or LETTER/
149	note.pt.
150	editorial.pt.
151	CASE REPORT/ or CASE STUDY/
152	(letter or comment*).ti.

#	Searches
153	or/148-152
154	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
155	153 not 154
156	ANIMAL/ not HUMAN/
157	NONHUMAN/
158	exp ANIMAL EXPERIMENT/
159	exp EXPERIMENTAL ANIMAL/
160	ANIMAL MODEL/
161	exp RODENT/
162	(rat or rats or mouse or mice).ti.
163	or/155-162
164	147 not 163

Databases: Cochrane Central Register of Controlled Trials (CCTR); and Cochrane Database of Systematic Reviews (CDSR)

Date of last search: 03/03/2020

#	Searches
#1	([mh "WOUNDS AND INJURIES"] not ([mh ^ASPHYXIA] or [mh ^"BATTERED CHILD SYNDROME"] or [mh "BIRTH INJURIES"] or [mh "BITES AND STINGS"] or [mh DROWNING] or [mh ^"EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"] or [mh ^FROSTBITE] or [mh "HEAT STRESS DISORDERS"] or [mh "RADIATION INJURIES"] or [mh ^RETROPNEUMOPERITONEUM] or [mh ^"SURGICAL WOUND"]))
#2	([mh ^HOSPITALIZATION] or [mh ^"PATIENT ADMISSION"] or [mh ^"ADOLESCENT, HOSPITALIZED"] or [mh ^"CHILD, HOSPITALIZED"] or [mh HOSPITALS] or [mh "EMERGENCY SERVICE, HOSPITAL"] or [mh "INTENSIVE CARE UNITS"] or [mh ^"REHABILITATION CENTERS"])
#3	#1 and #2
#4	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#5	#1 and #4
#6	((hospitalised or hospitalized or hospitalistion* or hospitaliztion*) near/10 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#7	((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*) near/5 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#8	(patient* near/5 trauma*):ti,ab
#9	(patient* near/3 (burn* or burned or fractur*)):ti,ab
#10	"wound* patient*":ti,ab
#11	"injur* patient*":ti,ab
#12	"accident* patient*":ti,ab
#13	trauma*:ti,ab
#14	#1 and #13
#15	[mh "MULTIPLE TRAUMA"]
#16	[mh ^TRAUMATOLOGY]
#17	(trauma* near/5 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#18	((complex* or multiple or critical*) near/3 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#19	(trauma* near/3 (severe or severely or major or multiple)):ti,ab
#20	((injur* or wound* or burn* or burned or fractur*) near/2 (severe or severely or major or multiple)):ti,ab
#21	((physical* or body or bodily) near/3 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#22	(acute near/1 (injur* or trauma* or wound* or burn* or burned or fractur*)):ti,ab
#23	(polytrauma* or poly-trauma*):ti,ab

#	Searches
#24	traumatolog*:ti,ab
#25	([mh ^ACCIDENTS] or [mh ^"ACCIDENTAL FALLS"] or [mh ^"ACCIDENTS, HOME"] or [mh ^"ACCIDENTS, OCCUPATIONAL"] or [mh ^"ACCIDENTS, TRAFFIC"])
#26	#1 and #25
#27	(injur* or wound* or trauma* or burn* or burned or fractur*):ti,ab
#28	#25 and #27
#29	(accident* near/5 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#30	(accident* near/3 (serious* or severe or severely or major)):ti,ab
#31	#2 and #25
#32	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or intensive care or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#33	#25 and #32
#34	[mh ^"SPINAL CORD INJURIES"] or [mh ^"SPINAL CORD COMPRESSION"]
#35	[mh "THORACIC INJURIES"] or [mh ^"ACUTE LUNG INJURY"]
#36	[mh ^"PERIPHERAL NERVE INJURIES"] or [mh "CRANIAL NERVE INJURIES"]
#37	[mh AMPUTATION] or [mh ^"AMPUTATION, TRAUMATIC"] or [mh ^AMPUTEES] or [mh ^"AMPUTATION STUMPS"] or [mh ^"LIMB SALVAGE"]
#38	((spinal* or spine* or chest* or thoracic* or nerve*) near/3 injur*):ti
#39	((spinal* or spine*) near/3 cord* near/3 compress*):ti
#40	((Flail* or stove in) near/3 chest*):ti
#41	(rib* near/3 fractur*):ti
#42	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) near/3 plexus near/3 injur*):ti
#43	(amputat* or amputee*):ti
#44	(limb* near/3 (loss or losing or lost or salvag* or re-construct* or reconstruct*)):ti
#45	[mh ^"HEAD INJURIES, CLOSED"] or [mh ^"HEAD INJURIES, PENETRATING"]
#46	(head near/3 injur*):ti
#47	[mh "BRAIN INJURIES"]
#48	(brain near/3 injur*):ti
#49	#3 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #26 or #28 or #29 or #30 or #31 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48
#50	[mh REHABILITATION] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#51	MeSH descriptor: [] explode all trees and with qualifier(s): [rehabilitation - RH]
#52	([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"])
#53	#51 and #52
#54	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession*) near/10 rehab*):ti,ab
#55	((inter or multi or joint) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession*) near/10 rehab*):ti,ab
#56	((interdisciplin* or multidisciplin* or jointdisciplin*) near/5 rehab*):ti
#57	((inter or multi or joint) near/3 disciplin* near/5 rehab*):ti
#58	((interdisciplin* or multidisciplin* or jointdisciplin*) near/10 (collaborat* or coordinat* or co-

#	Searches
	ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*) near/10 rehab*):ti,ab
#59	((inter or multi or joint) near/3 disciplin* near/10 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*) near/10 rehab*):ti,ab
#60	((institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin* or care) near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partnership* or network* or across) near/5 rehab*):ti,ab
#61	#50 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60
#62	([mh ^INPATIENTS] or [mh ^OUTPATIENTS]) and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#63	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/7 (inpatient* or outpatient*)):ti,ab
#64	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/7 (inpatient* or outpatient*)):ti,ab
#65	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/7 (inpatient* or outpatient*)):ti,ab
#66	#62 or #63 or #64 or #65
#67	[mh ^"CONTINUITY OF PATIENT CARE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"PATIENT CARE TEAM"])
#68	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/10 transition*):ti,ab
#69	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/10 transition*):ti,ab
#70	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/10 transition*):ti,ab
#71	((continuity or continuum) near/3 care near/10 transition*):ti,ab
#72	((continuity or continuum) near/3 care near/10 rehab*):ti,ab
#73	("case manager*" near/10 transition*):ti,ab
#74	#67 or #68 or #69 or #70 or #71 or #72 or #73
#75	([mh ^"HEALTH SERVICES"] or [mh ^"CHILD HEALTH SERVICES"] or [mh ^"ADOLESCENT HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"HOME CARE SERVICES"] or [mh ^"HEALTH SERVICES FOR PEOPLE WITH DISABILITIES"] or [mh ^"MENTAL HEALTH SERVICES"] or [mh ^"NURSING SERVICES"] or [mh "HEALTH PERSONNEL"]) and ([mh "SOCIAL WORK"] or [mh ^"SOCIAL WORK, PSYCHIATRIC"] or [mh ^"SOCIAL WORKERS"])
#76	((health* or NHS or clinical or clinician* or medical or medic* or physician* or consultant* or nurse* or "general practitioner*" or GP OR GPs or "occupational therapist*" or OT or OTs or "allied health professional*" or AHP* or ((speech or language) near/3 therapist*) or SLT*) near/10 (social* near/3 (work* or care or service*)) near/10 (rehab* or deliver* or collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or

#	Searches
	connect* or "join* up" or inpatient* or outpatient* or transition* or discharg* or assess*)):ti,ab
#77	#75 or #76
#78	[mh ^"NURSE ADMINISTRATORS"]
#79	[mh ^"CASE MANAGERS"]
#80	[mh REHABILITATION] and ([mh ^CONSULTANTS] or [mh ^PEDIATRICIANS] or [mh ^"GENERAL PRACTITIONERS"] or [mh ^"SOCIAL WORKERS"] or [mh ^"OCCUPATIONAL THERAPISTS"] or [mh ^"SCHOOL TEACHERS"] or [mh ^"NURSES, COMMUNITY HEALTH"])
#81	(neuronavigator* or neuro-navigator*):ti,ab
#82	("trauma nurse*" near/3 (coordinator* or co-ordinator*)):ti,ab
#83	"key worker*":ti,ab
#84	(discharge near/3 (coordinator* or co-ordinator*)):ti,ab
#85	("community paediatrician*" or "community pediatrician*"):ti,ab
#86	SENCO*:ti,ab
#87	"health* assessor*":ti,ab
#88	(housing near/3 (officer* or staff or team* or service* or liaison or "occupational therapist*" or OT or OTs)):ti,ab
#89	((re-enabl* or enablement or reabl* or re-abl*) near/3 (specialist* or team* or service*)):ti,ab
#90	(rehab* near/10 ("case manager*" or consultant* or coordinator* or co-ordinator* or p*ediatrician* or "general practitioner*" or GP or GPs or "social worker*" or "occupational therapist*" or OT or OTs or teacher* or "community nurse*" or "district nurse*" or SLT or SLTs)):ti,ab
#91	(rehab* near/10 (speech or language) near/3 (therapist* or pathologist*)):ti,ab
#92	#78 or #79 or #80 or #81 or #82 or #83 or #84 or #85 or #86 or #87 or #88 or #89 or #90 or #91
#93	[mh ^"PATIENT CARE TEAM"] and ([mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH NURSING"] or [mh ^"COMMUNITY MENTAL HEALTH SERVICES"] or [mh ^"COMMUNITY PHARMACY SERVICES"])
#94	([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"]) and ([mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH NURSING"] or [mh ^"COMMUNITY MENTAL HEALTH SERVICES"] or [mh ^"COMMUNITY PHARMACY SERVICES"])
#95	((specialist or non-specialist or trauma*) near/3 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#96	(rehab* near/10 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#97	"combined clinic*":ti,ab
#98	"cohort* clinic*":ti,ab
#99	(interfac* near/3 team*):ti,ab
#100	(rehab* near/10 "intermediate care"):ti,ab
#101	(rehab* near/10 communit* near/5 (team* or service*)):ti,ab
#102	(communit* near/10 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#103	#93 or #94 or #95 or #96 or #97 or #98 or #99 or #100 or #101 or #102
#104	[mh ^"PATIENT DISCHARGE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#105	(support* near/3 discharg*):ti,ab
#106	homefirst:ti,ab
#107	(discharg* near/5 plan* near/5 (service* or team* or meet* or consult*)):ti,ab
#108	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or

#	Searches
	jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/10 discharg*):ti,ab
#109	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/10 discharg*):ti,ab
#110	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/5 discharg*):ti,ab
#111	((continuity or continuum) near/3 care near/10 discharg*):ti,ab
#112	("case manager*" near/10 discharg*):ti,ab
#113	#104 or #105 or #106 or #107 or #108 or #109 or #110 or #111 or #112
#114	[mh ^"SELF-MANAGEMENT"]
#115	[mh ^"SELF CARE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#116	[mh ^"SELF CARE"] and [mh ^"SOCIAL SUPPORT"]
#117	([mh ^"SOCIAL SUPPORT"] or [mh ^CHARITIES] or [mh ^"CONSUMER ORGANIZATIONS"] or [mh ^"ORGANIZATIONS, NONPROFIT"] or [mh ^"VOLUNTARY HEALTH AGENCIES"] or [mh ^"SELF-HELP GROUPS"]) and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#118	(self near/3 manag* near/5 support*):ti,ab
#119	(rehab* near/10 (family or families or caregiver* or carer*) near/5 support*):ti,ab
#120	("volunt* organisation*" or "volunt* organization*"):ti,ab
#121	"volunt* sector*":ti,ab
#122	("non-government* organisation*" or "non-government* organization*"):ti,ab
#123	(NGO or NGOs):ti,ab
#124	(charity or charities):ti,ab
#125	(user* near/3 led near/3 (organisation* or organization*)):ti,ab
#126	#114 or #115 or #116 or #117 or #118 or #119 or #120 or #121 or #122 or #123 or #124 or #125
#127	[mh ^"BUDGETS"]
#128	"personal* budget*":ti,ab
#129	"disabled facilities grant*":ti,ab
#130	((pooled or coordinat* or co-ordinat* or joint* or shared) near/3 (budget* or finance*)):ti,ab
#131	((budget* or financ*) near/5 discharg*):ti,ab
#132	#127 or #128 or #129 or #130 or #131
#133	(special* near/5 (inreach or in-reach or outreach or out-reach)):ti,ab
#134	(special* near/3 outpatient*):ti,ab
#135	(rehab* near/3 prescription*):ti,ab
#136	("follow* up" near/3 (meet* or consultation*)):ti,ab
#137	("follow up" near/3 (care or service*) near/10 rehab*):ti,ab
#138	(aftercare near/10 rehab*):ti,ab
#139	((communit* or outpatient* or "post discharg*" or postdischarg*) near/10 rehab* near/3 (group* or cohort* or non-cohort* or individual* or intensive* or non-intensive* or "multi-disciplin*" or multidisciplin* or MDT or MDTs or uni-disciplin* or unidisciplin* or speciali* or non-speciali*)):ti,ab
#140	#133 or #134 or #135 or #136 or #137 or #138 or #139
#141	#49 and #61
#142	#49 and #66
#143	#49 and #74
#144	#49 and #77

#	Searches
#145	#49 and #92
#146	#49 and #103
#147	#49 and #113
#148	#49 and #126
#149	#49 and #132
#150	#49 and #140
#151	#141 or #142 or #143 or #144 or #145 or #146 or #147 or #148 or #149 or #150
#152	#141 or #142 or #143 or #144 or #145 or #146 or #147 or #148 or #149 or #150 with Cochrane Library publication date Between Jan 2000 and Mar 2020, in Cochrane Reviews
#153	#141 or #142 or #143 or #144 or #145 or #146 or #147 or #148 or #149 or #150 with Publication Year from 2000 to 2020, in Trials

1 Health economics literature search strategies

2 *Please note that this search was a combined search for the adult and children and young*
3 *people evidence reviews covering this question AND evidence review D.1 (What are the best*
4 *methods to coordinate rehabilitation services for people with complex rehabilitation needs*
5 *after traumatic injury whilst they are an inpatient, including when transferring between*
6 *inpatient settings?).*

7 Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process &
8 Other Non-Indexed Citations

9 **Date of last search: 18/03/2020**

#	Searches
1	ECONOMICS/
2	VALUE OF LIFE/
3	exp "COSTS AND COST ANALYSIS"/
4	exp ECONOMICS, HOSPITAL/
5	exp ECONOMICS, MEDICAL/
6	exp RESOURCE ALLOCATION/
7	ECONOMICS, NURSING/
8	ECONOMICS, PHARMACEUTICAL/
9	exp "FEES AND CHARGES"/
10	exp BUDGETS/
11	budget*.ti,ab.
12	cost*.ti,ab.
13	(economic* or pharmaco?economic*).ti,ab.
14	(price* or pricing*).ti,ab.
15	(financ* or fee or fees or expenditure* or saving*).ti,ab.
16	(value adj2 (money or monetary)).ti,ab.
17	resourc* allocat*.ti,ab.
18	(fund or funds or funding* or funded).ti,ab.
19	(ration or rations or rationing* or rationed).ti,ab.
20	ec.fs.
21	or/1-20
22	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
23	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp

#	Searches
	FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
24	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
25	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
26	(patient? adj5 trauma$).ti,ab.
27	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
28	wound$ patient?.ti,ab.
29	injur$ patient?.ti,ab.
30	accident$ patient?.ti,ab.
31	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ti.
32	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ab. /freq=2
33	exp MULTIPLE TRAUMA/
34	TRAUMATOLOGY/
35	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
36	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
37	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
38	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
39	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
40	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
41	(polytrauma? or poly-trauma?).ti,ab.
42	traumatolog$.ti,ab.
43	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (exp *"WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/))
44	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
45	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
46	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
47	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
48	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
49	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (hospitali?ed or hospitali?tion? or

#	Searches
	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
50	*SPINAL CORD INJURIES/ or *SPINAL CORD COMPRESSION/
51	exp *THORACIC INJURIES/ or *ACUTE LUNG INJURY/
52	*PERIPHERAL NERVE INJURIES/ or exp *CRANIAL NERVE INJURIES/
53	exp *AMPUTATION/ or *AMPUTATION, TRAUMATIC/ or *AMPUTEES/ or *AMPUTATION STUMPS/ or *LIMB SALVAGE/
54	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
55	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
56	((Flail$ or stove in) adj3 chest?).ti.
57	(rib? adj3 fractur$).ti.
58	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
59	(amputat$ or amputee?).ti.
60	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
61	*HEAD INJURIES, CLOSED/ or *HEAD INJURIES, PENETRATING/
62	(head adj3 injur$).ti.
63	exp *BRAIN INJURIES/
64	(brain adj3 injur$).ti.
65	or/22-64
66	exp REHABILITATION/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or *PATIENT CARE TEAM/)
67	rh.fs. and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/)
68	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$) adj10 rehab$).ti,ab.
69	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$) adj10 rehab$).ti,ab.
70	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti.
71	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti.
72	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
73	((inter or multi or joint) adj3 disciplin$ adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
74	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across) adj5 rehab$).ti,ab.
75	or/66-74
76	(INPATIENTS/ or OUTPATIENTS/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
77	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$)

#	Searches
	adj7 (inpatient? or outpatient?)).ti,ab.
78	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj7 (inpatient? or outpatient?)).ti,ab.
79	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj7 (inpatient? or outpatient?)).ti,ab.
80	or/76-79
81	("CONTINUITY OF PATIENT CARE"/ or AFTERCARE/ or TRANSITION TO ADULT CARE/ or TRANSITIONAL CARE/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or PATIENT CARE TEAM/)
82	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 transition$).ti,ab.
83	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 transition$).ti,ab.
84	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj10 transition$).ti,ab.
85	((continuity or continuum) adj3 care adj10 transition$).ti,ab.
86	((continuity or continuum) adj3 care adj10 rehab$).ti,ab.
87	(case manager? adj10 transition$).ti,ab.
88	or/81-87
89	(HEALTH SERVICES/ or CHILD HEALTH SERVICES/ or ADOLESCENT HEALTH SERVICES/ or COMMUNITY HEALTH SERVICES/ or HOME CARE SERVICES/ or HEALTH SERVICES FOR PEOPLE WITH DISABILITIES/ or MENTAL HEALTH SERVICES/ or NURSING SERVICES/ or exp HEALTH PERSONNEL/) and (exp SOCIAL WORK/ or SOCIAL WORK, PSYCHIATRIC/ or SOCIAL WORKERS/)
90	((health$ or NHS or clinical or clinician? or medical or medic? or physician? or consultant? or nurse? or general practitioner? or GP? or occupational therapist? or OT? or allied health professional? or AHP? or ((speech or language) adj3 therapist?) or SLT?) adj10 (social$ adj3 (work$ or care or service?)) adj10 (rehab$ or deliver$ or collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up or inpatient? or outpatient? or transition$ or discharg$ or assess$)).ti,ab.
91	or/89-90
92	*NURSE ADMINISTRATORS/
93	CASE MANAGERS/
94	exp REHABILITATION/ and (CONSULTANTS/ or PEDIATRICIANS/ or GENERAL PRACTITIONERS/ or SOCIAL WORKERS/ or OCCUPATIONAL THERAPISTS/ or SCHOOL TEACHERS/ or NURSES, COMMUNITY HEALTH/)
95	(neuronavigator? or neuro-navigator?).ti,ab.
96	(trauma nurse? adj3 (coordinator? or co-ordinator?)).ti,ab.
97	key worker?.ti,ab.
98	(discharge adj3 (coordinator? or co-ordinator?)).ti,ab.
99	community p?ediatrician?.ti,ab.
100	SENCO?.ti,ab.
101	health$ assessor?.ti,ab.
102	(housing adj3 (officer? or staff or team? or service? or liaison or occupational therapist? or OT or OTs)).ti,ab.
103	((re-enabl$ or enablement or reabl$ or re-abl$) adj3 (specialist? or team? or service?)).ti,ab.
104	(rehab$ adj10 (case manager? or consultant? or coordinator? or co-ordinator? or p?ediatrician? or general practitioner? or GP or GPs or social worker? or occupational therapist? or OT or OTs or teacher? or community nurse? or district nurse? or SLT or SLTs)).ti,ab.
105	(rehab$ adj10 (speech or language) adj3 (therapist? or pathologist?)).ti,ab.

#	Searches
106	or/92-105
107	PATIENT CARE TEAM/ and (COMMUNITY HEALTH SERVICES/ or COMMUNITY HEALTH NURSING/ or COMMUNITY MENTAL HEALTH SERVICES/ or COMMUNITY PHARMACY SERVICES/)
108	(MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/) and (COMMUNITY HEALTH SERVICES/ or COMMUNITY HEALTH NURSING/ or COMMUNITY MENTAL HEALTH SERVICES/ or COMMUNITY PHARMACY SERVICES/)
109	((specialist or non-specialist or trauma$) adj3 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
110	(rehab$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
111	combined clinic?.ti,ab.
112	cohort? clinic?.ti,ab.
113	(interfac$ adj3 team?).ti,ab.
114	(rehab$ adj10 intermediate care).ti,ab.
115	(rehab$ adj10 communit$ adj5 (team? or service?)).ti,ab.
116	(communit$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
117	or/107-116
118	PATIENT DISCHARGE/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
119	(support$ adj3 discharg$).ti,ab.
120	homefirst.ti,ab.
121	(discharg$ adj5 plan$ adj5 (service? or team? or meet$ or consult$)).ti,ab.
122	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 discharg$).ti,ab.
123	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 discharg$).ti,ab.
124	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 discharg$).ti,ab.
125	((continuity or continuum) adj3 care adj10 discharg$).ti,ab.
126	(case manager? adj10 discharg$).ti,ab.
127	or/118-126
128	SELF-MANAGEMENT/
129	SELF CARE/ and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAM/)
130	SELF CARE/ and SOCIAL SUPPORT/
131	(SOCIAL SUPPORT/ or CHARITIES/ or CONSUMER ORGANIZATIONS/ or ORGANIZATIONS, NONPROFIT/ or VOLUNTARY HEALTH AGENCIES/ or SELF-HELP GROUPS/) and (MODELS, ORGANIZATIONAL/ or "DELIVERY OF HEALTH CARE, INTEGRATED"/ or INTERINSTITUTIONAL RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDEPARTMENTAL RELATIONS/ or INTERPROFESSIONAL RELATIONS/ or INTERDISCIPLINARY COMMUNICATION/ or "CONTINUITY OF PATIENT CARE"/ or PATIENT CARE TEAMS/)
132	(self adj3 manag$ adj5 support$).ti,ab.
133	(rehab$ adj10 (family or families or caregiver? or carer?) adj5 support$).ti,ab.
134	volunt$ organi?ation?.ti,ab.
135	volunt$ sector?.ti,ab.

#	Searches
136	non-government$ organi?ation?.ti,ab.
137	(NGO or NGOs).ti,ab.
138	(charity or charities).ti,ab.
139	(user? adj3 led adj3 organi?ation?).ti,ab.
140	or/128-139
141	*BUDGETS/
142	personal$ budget$.ti,ab.
143	disabled facilities grant?.ti,ab.
144	((pooled or coordinat$ or co-ordinat$ or joint$ or shared) adj3 (budget$ or finance?)).ti,ab.
145	((budget$ or financ$) adj5 discharg$).ti,ab.
146	or/141-145
147	(special$ adj5 (inreach or in-reach or outreach or out-reach)).ti,ab.
148	(special$ adj3 outpatient?).ti,ab.
149	(rehab$ adj3 prescription?).ti,ab.
150	(follow$ up adj3 (meet$ or consultation?)).ti,ab.
151	(follow up adj3 (care or service?) adj10 rehab$).ti,ab.
152	(aftercare adj10 rehab$).ti,ab.
153	((communit$ or outpatient? or post discharg$ or postdischarg$) adj10 rehab$ adj3 (group? or cohort? or non-cohort? or individual$ or intensive$ or non-intensive$ or multi-disciplin$ or multidisciplin$ or MDT or MDTs or uni-disciplin$ or unidisciplin$ or speciali$ or non-speciali$)).ti,ab.
154	or/147-153
155	65 and 75
156	65 and 80
157	65 and 88
158	65 and 91
159	65 and 106
160	65 and 117
161	65 and 127
162	65 and 140
163	65 and 146
164	65 and 154
165	or/155-164
166	limit 165 to english language
167	limit 166 to yr="2000 -Current"
168	LETTER/
169	EDITORIAL/
170	NEWS/
171	exp HISTORICAL ARTICLE/
172	ANECDOTES AS TOPIC/
173	COMMENT/
174	CASE REPORT/
175	(letter or comment*).ti.
176	or/168-175
177	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
178	176 not 177
179	ANIMALS/ not HUMANS/
180	exp ANIMALS, LABORATORY/
181	exp ANIMAL EXPERIMENTATION/
182	exp MODELS, ANIMAL/
183	exp RODENTIA/
184	(rat or rats or mouse or mice).ti.
185	or/178-184
186	167 not 185
187	21 and 186

1 **Databases: Embase; and Embase Classic**

2 **Date of last search: 18/03/2020**

#	Searches
1	HEALTH ECONOMICS/
2	exp ECONOMIC EVALUATION/
3	exp HEALTH CARE COST/
4	exp FEE/
5	BUDGET/
6	FUNDING/
7	RESOURCE ALLOCATION/
8	budget*.ti,ab.
9	cost*.ti,ab.
10	(economic* or pharmaco?economic*).ti,ab.
11	(price* or pricing*).ti,ab.
12	(financ* or fee or fees or expenditure* or saving*).ti,ab.
13	(value adj2 (money or monetary)).ti,ab.
14	resourc* allocat*.ti,ab.
15	(fund or funds or funding* or funded).ti,ab.
16	(ration or rations or rationing* or rationed).ti,ab.
17	or/1-16
18	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
19	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
20	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
21	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
22	(patient? adj5 trauma$).ti,ab.
23	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
24	wound$ patient?.ti,ab.
25	injur$ patient?.ti,ab.
26	accident$ patient?.ti,ab.
27	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ti.
28	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH

#	Searches
	INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ab. /freq=2
29	MULTIPLE TRAUMA/
30	TRAUMATOLOGY/
31	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
32	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
33	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
34	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
35	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
36	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
37	(polytrauma? or poly-trauma?).ti,ab.
38	traumatolog$.ti,ab.
39	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/))
40	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
41	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
42	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
43	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
44	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
45	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
46	*SPINAL CORD INJURY/ or *SPINAL CORD COMPRESSION/
47	exp *THORAX INJURY/ or *ACUTE LUNG INJURY/ or exp *RIB FRACTURE/
48	exp *NERVE INJURY/
49	exp *AMPUTATION/ or *AMPUTEE/ or *LIMB SALVAGE/
50	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
51	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
52	((Flail$ or stove in) adj3 chest?).ti.
53	(rib? adj3 fractur$).ti.
54	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
55	(amputat$ or amputee?).ti.
56	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
57	*HEAD INJURY/

#	Searches
58	(head adj3 injur$).ti.
59	exp *BRAIN INJURY/
60	(brain adj3 injur$).ti.
61	or/18-60
62	exp REHABILITATION/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
63	rh.fs. and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
64	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$) adj10 rehab$).ti,ab.
65	((inter or multi or joint) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$) adj10 rehab$).ti,ab.
66	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 rehab$).ti.
67	((inter or multi or joint) adj3 disciplin$ adj5 rehab$).ti.
68	((interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
69	((inter or multi or joint) adj3 disciplin$ adj10 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or network$ or communicat$) adj10 rehab$).ti,ab.
70	((institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$ or care) adj5 (collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partnership? or network$ or across) adj5 rehab$).ti,ab.
71	or/62-70
72	(*HOSPITAL PATIENT/ or OUTPATIENT/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
73	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj5 (inpatient? or outpatient?)).ti,ab.
74	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj5 (inpatient? or outpatient?)).ti,ab.
75	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 (inpatient? or outpatient?)).ti,ab.
76	or/72-75
77	(AFTERCARE/ or TRANSITION TO ADULT CARE/ or TRANSITIONAL CARE/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
78	*PATIENT CARE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
79	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or

#	Searches
	multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj10 transition$).ti,ab.
80	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj10 transition$).ti,ab.
81	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj10 transition$).ti,ab.
82	((continuity or continuum) adj3 care adj10 transition$).ti,ab.
83	((continuity or continuum) adj3 care adj10 rehab$).ti,ab.
84	(case manager? adj10 transition$).ti,ab.
85	or/77-84
86	(HEALTH SERVICE/ or CHILD HEALTH CARE/ or COMMUNITY CARE/ or HOME CARE/ or MENTAL HEALTH SERVICE/ or *NURSING/ or exp *HEALTH CARE PERSONNEL/) and (SOCIAL CARE/ or SOCIAL WORK/ or SOCIAL WORKER/)
87	((health$ or NHS or clinical or clinician? or medical or medic? or physician? or consultant? or nurse? or general practitioner? or GP? or occupational therapist? or OT? or allied health professional? or AHP? or ((speech or language) adj3 therapist?) or SLT?) adj7 (social$ adj3 (work$ or care or service?)) adj7 (rehab$ or deliver$ or collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up or inpatient? or outpatient? or transition$ or discharg$ or assess$)).ti,ab.
88	or/86-87
89	*NURSE ADMINISTRATOR/
90	CARE COORDINATOR/
91	exp REHABILITATION/ and (PEDIATRICIANS/ or *GENERAL PRACTITIONERS/ or *SOCIAL WORKERS/ or *OCCUPATIONAL THERAPISTS/ or SCHOOL TEACHERS/)
92	(neuronavigator? or neuro-navigator?).ti,ab.
93	(trauma nurse? adj3 (coordinator? or co-ordinator?)).ti,ab.
94	key worker?.ti,ab.
95	(discharge adj3 (coordinator? or co-ordinator?)).ti,ab.
96	community p?ediatrician?.ti,ab.
97	SENCO?.ti,ab.
98	health$ assessor?.ti,ab.
99	(housing adj3 (officer? or staff or team? or service? or liaison or occupational therapist? or OT or OTs)).ti,ab.
100	((re-enabl$ or enablement or reabl$ or re-abl$) adj3 (specialist? or team? or service?)).ti,ab.
101	(rehab$ adj7 (case manager? or consultant? or coordinator? or co-ordinator? or p?ediatrician? or general practitioner? or GP or GPs or social worker? or occupational therapist? or OT or OTs or teacher? or community nurse? or district nurse? or SLT or SLTs)).ti,ab.
102	(rehab$ adj7 (speech or language) adj3 (therapist? or pathologist?)).ti,ab.
103	or/89-102
104	(*PATIENT CARE/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/) and (COMMUNITY CARE/ or COMMUNITY BASED REHABILITATION/ or COMMUNITY HEALTH NURSING/)
105	(NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/) and (COMMUNITY CARE/ or COMMUNITY BASED REHABILITATION/ or COMMUNITY HEALTH NURSING/)
106	((specialist or non-specialist or trauma$) adj3 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
107	(rehab$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
108	combined clinic?.ti,ab.
109	cohort? clinic?.ti,ab.
110	(interfac$ adj3 team?).ti,ab.
111	(rehab$ adj10 intermediate care).ti,ab.
112	(rehab$ adj7 communit$ adj5 (team? or service?)).ti,ab.
113	(communit$ adj10 (multi-disciplin$ team? or multidisciplin$ team? or MDT?)).ti,ab.
114	or/104-113

#	Searches
115	HOSPITAL DISCHARGE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/)
116	*HOSPITAL DISCHARGE/ and *PATIENT CARE/
117	(support$ adj3 discharg$).ti,ab.
118	homefirst.ti,ab.
119	(discharg$ adj5 plan$ adj5 (service? or team? or meet$ or consult$)).ti,ab.
120	((interinstitution$ or multiinstitution$ or jointinstitution$ or interorgani?ation$ or multiorgani?ation$ or jointorgani?ation$ or intersector$ or multisector$ or jointsector$ or interagenc$ or multiagenc$ or jointagenc$ or inter-service$ or multiservice$ or jointservice$ or interdepartment$ or multidepartment$ or jointdepartment$ or interprofession$ or multiprofession$ or jointprofession$ or interdisciplin$ or multidisciplin$ or jointdisciplin$) adj7 discharg$).ti,ab.
121	((inter$ or multi$ or joint$) adj3 (institution$ or organi?ation$ or sector$ or agenc$ or service? or department$ or profession$ or disciplin$) adj7 discharg$).ti,ab.
122	((collaborat$ or coordinat$ or co-ordinat$ or cooperat$ or co-operat$ or integrat$ or partner$ or liais$ or connect$ or join$ up) adj5 discharg$).ti,ab.
123	((continuity or continuum) adj3 care adj10 discharg$).ti,ab.
124	(case manager? adj10 discharg$).ti,ab.
125	or/115-124
126	SELF CARE/ and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
127	SELF CARE/ and SOCIAL SUPPORT/
128	(SOCIAL SUPPORT/ or SOCIAL WELFARE/ or CONSUMER ORGANIZATION/ or NON PROFIT ORGANIZATION/ or SELF HELP/) and (NONBIOLOGICAL MODEL/ or INTEGRATED HEALTH CARE SYSTEM/ or PUBLIC RELATIONS/ or INTERSECTORAL COLLABORATION/ or INTERDISCIPLINARY COMMUNICATION/ or MULTIDISCIPLINARY TEAM/ or COLLABORATIVE CARE TEAM/ or *PATIENT CARE/)
129	(self adj3 manag$ adj5 support$).ti,ab.
130	(rehab$ adj10 (family or families or caregiver? or carer?) adj5 support$).ti,ab.
131	volunt$ organi?ation?.ti,ab.
132	volunt$ sector?.ti,ab.
133	non-government$ organi?ation?.ti,ab.
134	(NGO or NGOs).ti,ab.
135	(charity or charities).ti,ab.
136	(user? adj3 led adj3 organi?ation?).ti,ab.
137	or/126-136
138	*BUDGET/
139	personal$ budget$.ti,ab.
140	disabled facilities grant?.ti,ab.
141	((pooled or coordinat$ or co-ordinat$ or joint$ or shared) adj3 (budget$ or finance?)).ti,ab.
142	((budget$ or financ$) adj5 discharg$).ti,ab.
143	or/138-142
144	(special$ adj5 (inreach or in-reach or outreach or out-reach)).ti,ab.
145	(special$ adj3 outpatient?).ti,ab.
146	(rehab$ adj3 prescription?).ti,ab.
147	(follow$ up adj3 (meet$ or consultation?)).ti,ab.
148	(follow up adj3 (care or service?) adj10 rehab$).ti,ab.
149	(aftercare adj10 rehab$).ti,ab.
150	((communit$ or outpatient? or post discharg$ or postdischarg$) adj10 rehab$ adj3 (group? or cohort? or non-cohort? or individual$ or intensive$ or non-intensive$ or multi-disciplin$ or multidisciplin$ or MDT or MDTs or uni-disciplin$ or unidisciplin$ or speciali$ or non-speciali$)).ti,ab.
151	or/144-150
152	61 and 71

#	Searches
153	61 and 76
154	61 and 85
155	61 and 88
156	61 and 103
157	61 and 114
158	61 and 125
159	61 and 137
160	61 and 143
161	61 and 151
162	or/152-161
163	limit 162 to english language
164	limit 163 to yr="2000 -Current"
165	letter.pt. or LETTER/
166	note.pt.
167	editorial.pt.
168	CASE REPORT/ or CASE STUDY/
169	(letter or comment*).ti.
170	or/165-169
171	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
172	170 not 171
173	ANIMAL/ not HUMAN/
174	NONHUMAN/
175	exp ANIMAL EXPERIMENT/
176	exp EXPERIMENTAL ANIMAL/
177	ANIMAL MODEL/
178	exp RODENT/
179	(rat or rats or mouse or mice).ti.
180	or/172-179
181	164 not 180
182	17 and 181

1 **Databases: Cochrane Central Register of Controlled Trials (CCTR)**

2 **Date of last search: 18/03/2020**

#	Searches
#1	MeSH descriptor: [Economics] this term only
#2	MeSH descriptor: [Value of Life] this term only
#3	MeSH descriptor: [Costs and Cost Analysis] explode all trees
#4	MeSH descriptor: [Economics, Hospital] explode all trees
#5	MeSH descriptor: [Economics, Medical] explode all trees
#6	MeSH descriptor: [Resource Allocation] explode all trees
#7	MeSH descriptor: [Economics, Nursing] this term only
#8	MeSH descriptor: [Economics, Pharmaceutical] this term only
#9	MeSH descriptor: [Fees and Charges] explode all trees
#10	MeSH descriptor: [Budgets] explode all trees
#11	budget*:ti,ab
#12	cost*:ti,ab
#13	(economic* or pharmaco?economic*):ti,ab
#14	(price* or pricing*):ti,ab
#15	(financ* or fee or fees or expenditure* or saving*):ti,ab
#16	(value near/2 (money or monetary)):ti,ab
#17	resourc* allocat*:ti,ab
#18	(fund or funds or funding* or funded):ti,ab
#19	(ration or rations or rationing* or rationed) .ti,ab.
#20	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
#21	([mh "WOUNDS AND INJURIES"] not ([mh ^ASPHYXIA] or [mh ^"BATTERED CHILD

#	Searches
	SYNDROME"] or [mh "BIRTH INJURIES"] or [mh "BITES AND STINGS"] or [mh DROWNING] or [mh ^"EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"] or [mh ^FROSTBITE] or [mh "HEAT STRESS DISORDERS"] or [mh "RADIATION INJURIES"] or [mh ^RETROPNEUMOPERITONEUM] or [mh ^"SURGICAL WOUND"]))
#22	([mh ^HOSPITALIZATION] or [mh ^"PATIENT ADMISSION"] or [mh ^"ADOLESCENT, HOSPITALIZED"] or [mh ^"CHILD, HOSPITALIZED"] or [mh HOSPITALS] or [mh "EMERGENCY SERVICE, HOSPITAL"] or [mh "INTENSIVE CARE UNITS"] or [mh ^"REHABILITATION CENTERS"])
#23	#21 and #22
#24	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#25	#21 and #24
#26	((hospitalised or hospitalized or hospitalistion* or hospitaliztion*) near/10 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#27	((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*) near/5 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#28	(patient* near/5 trauma*):ti,ab
#29	(patient* near/3 (burn* or burned or fractur*)):ti,ab
#30	"wound* patient*":ti,ab
#31	"injur* patient*":ti,ab
#32	"accident* patient*":ti,ab
#33	trauma*:ti,ab
#34	#21 and #33
#35	[mh "MULTIPLE TRAUMA"]
#36	[mh ^TRAUMATOLOGY]
#37	(trauma* near/5 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#38	((complex* or multiple or critical*) near/3 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#39	(trauma* near/3 (severe or severely or major or multiple)):ti,ab
#40	((injur* or wound* or burn* or burned or fractur*) near/2 (severe or severely or major or multiple)):ti,ab
#41	((physical* or body or bodily) near/3 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#42	(acute near/1 (injur* or trauma* or wound* or burn* or burned or fractur*)):ti,ab
#43	(polytrauma* or poly-trauma*):ti,ab
#44	traumatolog*:ti,ab
#45	([mh ^ACCIDENTS] or [mh ^"ACCIDENTAL FALLS"] or [mh ^"ACCIDENTS, HOME"] or [mh ^"ACCIDENTS, OCCUPATIONAL"] or [mh ^"ACCIDENTS, TRAFFIC"])
#46	#21 and #45
#47	(injur* or wound* or trauma* or burn* or burned or fractur*):ti,ab
#48	#45 and #47
#49	(accident* near/5 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#50	(accident* near/3 (serious* or severe or severely or major)):ti,ab
#51	#22 and #45
#52	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or intensive care or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#53	#45 and #52
#54	[mh ^"SPINAL CORD INJURIES"] or [mh ^"SPINAL CORD COMPRESSION"]
#55	[mh "THORACIC INJURIES"] or [mh ^"ACUTE LUNG INJURY"]
#56	[mh ^"PERIPHERAL NERVE INJURIES"] or [mh "CRANIAL NERVE INJURIES"]
#57	[mh AMPUTATION] or [mh ^"AMPUTATION, TRAUMATIC"] or [mh ^AMPUTEES] or [mh ^"AMPUTATION STUMPS"] or [mh ^"LIMB SALVAGE"]
#58	((spinal* or spine* or chest* or thoracic* or nerve*) near/3 injur*):ti
#59	((spinal* or spine*) near/3 cord* near/3 compress*):ti

#	Searches
#60	((Flail* or stove in) near/3 chest*):ti
#61	(rib* near/3 fractur*):ti
#62	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) near/3 plexus near/3 injur*):ti
#63	(amputat* or amputee*):ti
#64	(limb* near/3 (loss or losing or lost or salvag* or re-construct* or reconstruct*)):ti
#65	[mh ^"HEAD INJURIES, CLOSED"] or [mh ^"HEAD INJURIES, PENETRATING"]
#66	(head near/3 injur*):ti
#67	[mh "BRAIN INJURIES"]
#68	(brain near/3 injur*):ti
#69	#23 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #46 or #48 or #49 or #50 or #51 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68
#70	[mh REHABILITATION] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#71	MeSH descriptor: [] explode all trees and with qualifier(s): [rehabilitation - RH]
#72	([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"])
#73	#71 and #72
#74	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession*) near/10 rehab*):ti,ab
#75	((inter or multi or joint) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession*) near/10 rehab*):ti,ab
#76	((interdisciplin* or multidisciplin* or jointdisciplin*) near/5 rehab*):ti
#77	((inter or multi or joint) near/3 disciplin* near/5 rehab*):ti
#78	((interdisciplin* or multidisciplin* or jointdisciplin*) near/10 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*) near/10 rehab*):ti,ab
#79	((inter or multi or joint) near/3 disciplin* near/10 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or network* or communicat*) near/10 rehab*):ti,ab
#80	((institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin* or care) near/5 (collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partnership* or network* or across) near/5 rehab*):ti,ab
#81	#70 or #73 or #74 or #75 or #76 or #77 or #78 or #79 or #80
#82	([mh ^INPATIENTS] or [mh ^OUTPATIENTS]) and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#83	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or

#	Searches
	jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/7 (inpatient* or outpatient*)):ti,ab
#84	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/7 (inpatient* or outpatient*)):ti,ab
#85	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/7 (inpatient* or outpatient*)):ti,ab
#86	#82 or #83 or #84 or #85
#87	[mh ^"CONTINUITY OF PATIENT CARE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"PATIENT CARE TEAM"])
#88	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/10 transition*):ti,ab
#89	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/10 transition*):ti,ab
#90	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/10 transition*):ti,ab
#91	((continuity or continuum) near/3 care near/10 transition*):ti,ab
#92	((continuity or continuum) near/3 care near/10 rehab*):ti,ab
#93	("case manager*" near/10 transition*):ti,ab
#94	#87 or #88 or #89 or #90 or #91 or #92 or #93
#95	([mh ^"HEALTH SERVICES"] or [mh ^"CHILD HEALTH SERVICES"] or [mh ^"ADOLESCENT HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"HOME CARE SERVICES"] or [mh ^"HEALTH SERVICES FOR PEOPLE WITH DISABILITIES"] or [mh ^"MENTAL HEALTH SERVICES"] or [mh ^"NURSING SERVICES"] or [mh "HEALTH PERSONNEL"]) and ([mh "SOCIAL WORK"] or [mh ^"SOCIAL WORK, PSYCHIATRIC"] or [mh ^"SOCIAL WORKERS"])
#96	((health* or NHS or clinical or clinician* or medical or medic* or physician* or consultant* or nurse* or "general practitioner*" or GP OR GPs or "occupational therapist*" or OT or OTs or "allied health professional*" or AHP* or ((speech or language) near/3 therapist*) or SLT*) near/10 (social* near/3 (work* or care or service*)) near/10 (rehab* or deliver* or collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up" or inpatient* or outpatient* or transition* or discharg* or assess*)):ti,ab
#97	#95 or #96
#98	[mh ^"NURSE ADMINISTRATORS"]
#99	[mh ^"CASE MANAGERS"]
#100	[mh REHABILITATION] and ([mh ^CONSULTANTS] or [mh ^PEDIATRICIANS] or [mh ^"GENERAL PRACTITIONERS"] or [mh ^"SOCIAL WORKERS"] or [mh ^"OCCUPATIONAL THERAPISTS"] or [mh ^"SCHOOL TEACHERS"] or [mh ^"NURSES, COMMUNITY HEALTH"])
#101	(neuronavigator* or neuro-navigator*):ti,ab
#102	("trauma nurse*" near/3 (coordinator* or co-ordinator*)):ti,ab
#103	"key worker*":ti,ab
#104	(discharge near/3 (coordinator* or co-ordinator*)):ti,ab
#105	("community paediatrician*" or "community pediatrician*"):ti,ab
#106	SENCO*:ti,ab
#107	"health* assessor*":ti,ab
#108	(housing near/3 (officer* or staff or team* or service* or liaison or "occupational therapist*" or OT or OTs)):ti,ab
#109	((re-enabl* or enablement or reabl* or re-abl*) near/3 (specialist* or team* or service*)):ti,ab
#110	(rehab* near/10 ("case manager*" or consultant* or coordinator* or co-ordinator* or p*ediatrician* or "general practitioner*" or GP or GPs or "social worker*" or "occupational therapist*" or OT or OTs or teacher* or "community nurse*" or "district nurse*" or SLT or

#	Searches
	SLTs)):ti,ab
#111	(rehab* near/10 (speech or language) near/3 (therapist* or pathologist*)):ti,ab
#112	#98 or #99 or #100 or #101 or #102 or #103 or #104 or #105 or #106 or #107 or #108 or #109 or #110 or #111
#113	[mh ^"PATIENT CARE TEAM"] and ([mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH NURSING"] or [mh ^"COMMUNITY MENTAL HEALTH SERVICES"] or [mh ^"COMMUNITY PHARMACY SERVICES"])
#114	([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"]) and ([mh ^"COMMUNITY HEALTH SERVICES"] or [mh ^"COMMUNITY HEALTH NURSING"] or [mh ^"COMMUNITY MENTAL HEALTH SERVICES"] or [mh ^"COMMUNITY PHARMACY SERVICES"])
#115	((specialist or non-specialist or trauma*) near/3 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#116	(rehab* near/10 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#117	"combined clinic*":ti,ab
#118	"cohort* clinic*":ti,ab
#119	(interfac* near/3 team*):ti,ab
#120	(rehab* near/10 "intermediate care"):ti,ab
#121	(rehab* near/10 communit* near/5 (team* or service*)):ti,ab
#122	(communit* near/10 ("multi-disciplin* team*" or "multidisciplin* team*" or MDT or MDTs)):ti,ab
#123	#113 or #114 or #115 or #116 or #117 or #118 or #119 or #120 or #121 or #122
#124	[mh ^"PATIENT DISCHARGE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#125	(support* near/3 discharg*):ti,ab
#126	homefirst:ti,ab
#127	(discharg* near/5 plan* near/5 (service* or team* or meet* or consult*)):ti,ab
#128	((interinstitution* or multiinstitution* or jointinstitution* or interorganisation* or interorganization* or multiorganisation* or multiorganization* or jointorganisation* or jointorganization* or intersector* or multisector* or jointsector* or interagenc* or multiagenc* or jointagenc* or inter-service* or multiservice* or jointservice* or interdepartment* or multidepartment* or jointdepartment* or interprofession* or multiprofession* or jointprofession* or interdisciplin* or multidisciplin* or jointdisciplin*) near/10 discharg*):ti,ab
#129	((inter* or multi* or joint*) near/3 (institution* or organisation* or organization* or sector* or agenc* or service* or department* or profession* or disciplin*) near/10 discharg*):ti,ab
#130	((collaborat* or coordinat* or co-ordinat* or cooperat* or co-operat* or integrat* or partner* or liais* or connect* or "join* up") near/5 discharg*):ti,ab
#131	((continuity or continuum) near/3 care near/10 discharg*):ti,ab
#132	("case manager*" near/10 discharg*):ti,ab
#133	#124 or #125 or #126 or #127 or #128 or #129 or #130 or #131 or #132
#134	[mh ^"SELF-MANAGEMENT"]
#135	[mh ^"SELF CARE"] and ([mh ^"MODELS, ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#136	[mh ^"SELF CARE"] and [mh ^"SOCIAL SUPPORT"]
#137	([mh ^"SOCIAL SUPPORT"] or [mh ^CHARITIES] or [mh ^"CONSUMER ORGANIZATIONS"] or [mh ^"ORGANIZATIONS, NONPROFIT"] or [mh ^"VOLUNTARY HEALTH AGENCIES"] or [mh ^"SELF-HELP GROUPS"]) and ([mh ^"MODELS,

#	Searches
	ORGANIZATIONAL"] or [mh ^"DELIVERY OF HEALTH CARE, INTEGRATED"] or [mh ^"INTERINSTITUTIONAL RELATIONS"] or [mh ^"INTERSECTORAL COLLABORATION"] or [mh ^"INTERDEPARTMENTAL RELATIONS"] or [mh ^"INTERPROFESSIONAL RELATIONS"] or [mh ^"INTERDISCIPLINARY COMMUNICATION"] or [mh ^"CONTINUITY OF PATIENT CARE"] or [mh ^"PATIENT CARE TEAM"])
#138	(self near/3 manag* near/5 support*):ti,ab
#139	(rehab* near/10 (family or families or caregiver* or carer*) near/5 support*):ti,ab
#140	("volunt* organisation*" or "volunt* organization*"):ti,ab
#141	"volunt* sector*":ti,ab
#142	("non-government* organisation*" or "non-government* organization*"):ti,ab
#143	(NGO or NGOs):ti,ab
#144	(charity or charities):ti,ab
#145	(user* near/3 led near/3 (organisation* or organization*)):ti,ab
#146	#134 or #135 or #136 or #137 or #138 or #139 or #140 or #141 or #142 or #143 or #144 or #145
#147	[mh ^"BUDGETS"]
#148	"personal* budget*":ti,ab
#149	"disabled facilities grant*":ti,ab
#150	((pooled or coordinat* or co-ordinat* or joint* or shared) near/3 (budget* or finance*)):ti,ab
#151	((budget* or financ*) near/5 discharg*):ti,ab
#152	#147 or #148 or #149 or #150 or #151
#153	(special* near/5 (inreach or in-reach or outreach or out-reach)):ti,ab
#154	(special* near/3 outpatient*):ti,ab
#155	(rehab* near/3 prescription*):ti,ab
#156	("follow* up" near/3 (meet* or consultation*)):ti,ab
#157	("follow up" near/3 (care or service*) near/10 rehab*):ti,ab
#158	(aftercare near/10 rehab*):ti,ab
#159	((communit* or outpatient* or "post discharg*" or postdischarg*) near/10 rehab* near/3 (group* or cohort* or non-cohort* or individual* or intensive* or non-intensive* or "multi-disciplin*" or multidisciplin* or MDT or MDTs or uni-disciplin* or unidisciplin* or speciali* or non-speciali*)):ti,ab
#160	#153 or #154 or #155 or #156 or #157 or #158 or #159
#161	#69 and #81
#162	#69 and #86
#163	#69 and #94
#164	#69 and #97
#165	#69 and #112
#166	#69 and #123
#167	#69 and #133
#168	#69 and #146
#169	#69 and #152
#170	#69 and #160
#171	#161 or #162 or #163 or #164 or #165 or #166 or #167 or #168 or #169 or #170
#172	#161 or #162 or #163 or #164 or #165 or #166 or #167 or #168 or #169 or #170 with Publication Year from 2000 to 2020, in Trials
#173	#20 and #172

1

Appendix C – Clinical evidence study selection

Study selection for:

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

D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

A combined search was conducted for both review questions.

Figure 2: Quantitative study selection flow chart: Adults

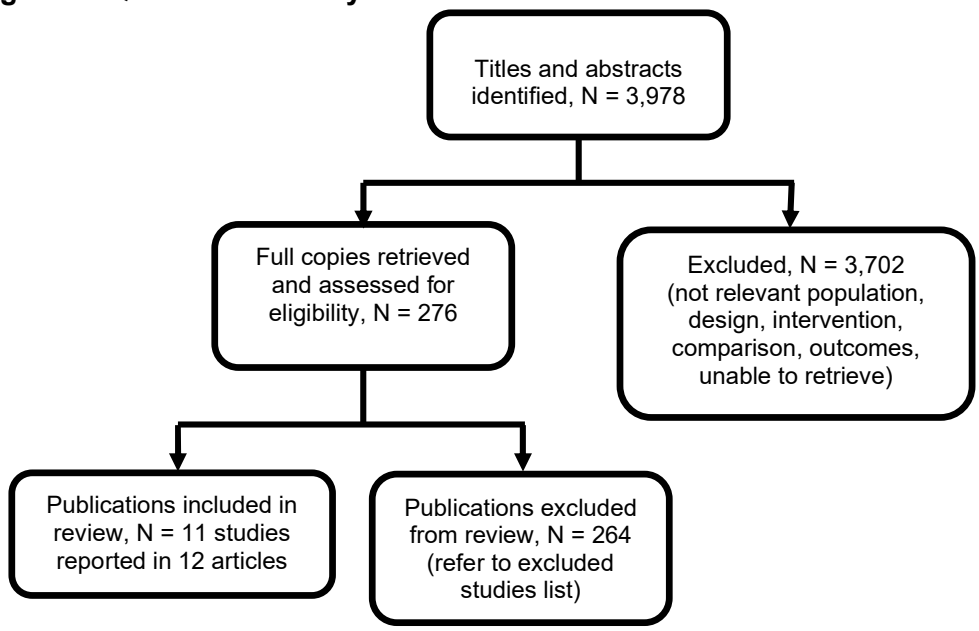


Figure 3: Qualitative study selection flow chart: Adults

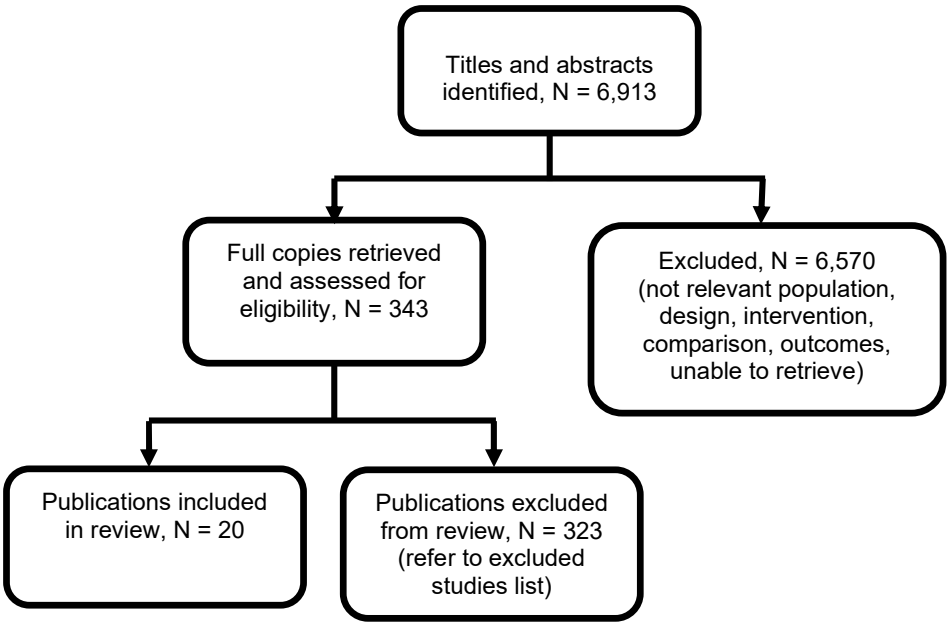


Figure 4: Quantitative study selection flow chart: Children and young people

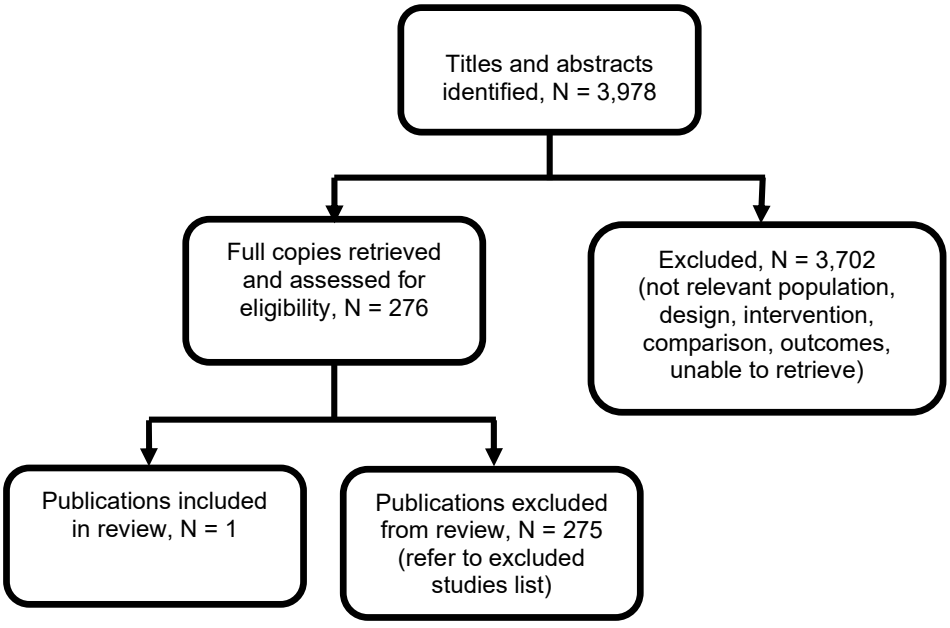
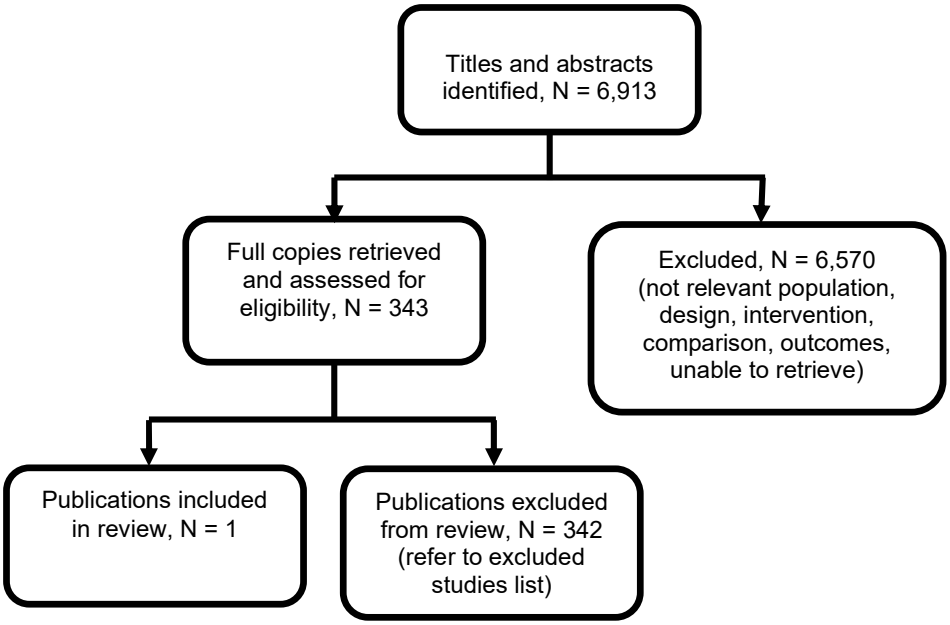


Figure 5: Qualitative study selection flow chart: Children and young people



Appendix D – Clinical evidence tables

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

Table 13: Quantitative evidence tables

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Browne, Allyson L., Appleton, Sally, Fong, Kim, Wood, Fiona, Coll, Fiona, de Munck, Sonja, Newnham, Elizabeth, Schug, Stephan A., A pilot randomized controlled trial of an early multidisciplinary model to prevent disability following traumatic injury, Disability and Rehabilitation, 35, 1149-63, 2013 **Ref Id** 1205181 **Country/ies where the study was carried out** Australia	**Sample size** N= 142 (randomised) • Multidisciplinary care intervention = 69 • Usual care = 73 N= 66 (analysed) • Multidisciplinary care intervention =31 • Usual care = 35 **Characteristics** Age in years [Mean (SD)]: • Multidisciplinary care intervention = 38.46 (13.32) • Usual care = 36.14 (14.61) Gender (M/F): 106/36 *NB. Only reported for whole study rather than by group.* Time since injury in years: not reported.	**Interventions** • *Intervention group: Multidisciplinary care intervention.* Invited to outpatient clinic at one and 3 months for 2 to 4 hours during which they were assessed by Rehab Medicine and Pain Medicine doctors, a physiotherapist, an occupational therapist and clinical psychologist for pain psychological function, and functional capacity; and 6 months post discharge for assessment and treatment. • *Control group: Usual care.* Invited for assessment and treatment at 6 months post discharge only. Attended outpatient for surgical reviews or allied health therapies depending on need, prior to discharge. Overall care was managed by GP.	**Results** *Return to work or education (measured using number of participants who had returned to work)* At 6 months: • Multidisciplinary care intervention: 16/31 (51.7%) • Usual care: 26/35 (74.3%) *Length of hospital stay (days) [Mean (SD)]* • Multidisciplinary care intervention: 13.87 (12.77) • Usual care: 12.67 (10.83) *Changes in ADL (measured using FIM)*	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. " using random number assignments from a computer generated algorithm" (page 1151) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PY. "Patients in the MI group were invited by mail and by telephone call to attend an outpatient clinic at one and 3 months post discharge, and both the [control] and [intervention] groups were invited in writing and by telephone to attend for a 6 month review at which time patients in both groups were assessed and offered specialist treatment as required at this time" (page 1151). Trial authors appear to have carried out central allocation. 1.3 Did baseline differences between

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

Study details	Participants	Interventions	Outcomes and Results	Comments
				months, where they could be referred on for further treatment if needed. There is no reporting on what this extra treatment might entail or how many referrals were made. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group could be referred for extra rehabilitation sessions which likely could affect outcomes. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N – Outcome data only available for 46.5% of participants (31/69 in intervention and 35/73 in control). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N – No statistical or sensitivity analyses presented. 3.3 If No/PN to 3.2: Could missingness

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

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

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

Study details	Participants	Interventions	Outcomes and Results	Comments
would result in better functional outcomes, shorter length of stay and fewer institutionalisations **Study dates** September 2004 – June 2006 **Source of funding** Not reported	Type of hip fracture (Intertrochanteric/neck of femur/ subtrochanteric): • MDT care + structured assessments and checklists (n) = 46/43/3 • MDT care only (n) = 36/31/3 **Inclusion criteria** Participants had to: • Have been admitted for the purpose of rehabilitation after a new hip fracture **Exclusion criteria** • Pre-morbid non-ambulatory status • Nursing home residents • Palliative care patients • Patients previously enlisted for the trial		• Significantly shorter in intervention compared to control group (p=0.009, statistical test not reported) *Quality of life (measured using SF-12 physical component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months (149): • MDT care + structured assessments and checklists (n not reported): 39.0 (9.5) • MDT care only (n not reported): 38.3 (9.1) • No significant difference between groups (p=0.67, statistical test not reported) At 12 months (119): • MDT care + structured assessments and checklists (n not reported): 40.7 (9.9) • MDT care only (n not reported): 40.9 (9.7) • No significant difference between groups (p=0.91, statistical test	<u>deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY. Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY. Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? N. There is no evidence of deviation from assignment 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? For length of

Study details	Participants	Interventions	Outcomes and Results	Comments
			not reported) *Quality of life (measured using SF12 mental component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months (149): • MDT care + structured assessments and checklists (n not reported): 53.2 (9.3) • MDT care only (n not reported): 51.0 (9.2) • No significant difference between groups (p=0.18, statistical test not reported) At 12 months (119): • MDT care + structured assessments and checklists (n not reported): 52.0 (10.6) • MDT care only (n not reported): 53.4 (11.1) • No significant difference between groups (p=0.49, statistical test not reported) *Changes in ADL (measured*	stay: Y. For patient satisfaction: NI; For SF-12 and Mondebello Rehab Score: Data were not available for 40/162 (24%) of the randomised participants at 12 months due to death and refusal of follow-up. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? Y. The reason for missingness was balanced across study groups. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. Outcome data were only available for 74% and 80% at 6-month and 12-month follow-up for the objective outcomes. There was insufficient information to assess with this was balanced between the study groups 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PY. Lack of study group information on number of study participants at different time points raises concerns. *Risk-of-bias judgement:* Length of hospital stay – low risk; Overall quality of life and changes in ADL – high risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. Measurements were carried out using appropriate and validated methods 4.2 Could measurement or ascertainment of the outcome have

Study details	Participants	Interventions	Outcomes and Results	Comments
			using Montebello Rehab Factor score) [Mean (SD)] Higher = better. At discharge (149): • MDT care + structured assessments and checklists (n not reported): 45.6 (30.5) • MDT care only (n not reported): 49.0 (34.0) • No significant difference between groups (p=0.51, statistical test not reported) At 6 months (129): • MDT care + structured assessments and checklists (n not reported): 67.2 (34.9) • MDT care only (n not reported): 61.2 (38.7) • No significant difference between groups (p=0.36, statistical test not reported) At 12 months (121): • MDT care + structured assessments and checklists (n not reported): 68.3 (37.5) • MDT care only (n not	differed between intervention groups? PN – Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N. Quote: "...research baseline and outcome assessments were performed by trained research assistants, the latter being blinded with respect to the patient's allocation " (page 581) 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN.

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

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

Study details	Participants	Interventions	Outcomes and Results	Comments
Prospective and retrospective cohort study **Aim of the study** To evaluate the effectiveness of a new multidisciplinary care pathway for hip fracture patients over 60 years old. **Study dates** Retrospective group: January 2006 - January 2008; Prospective group: July 2009 - July 2011 **Source of funding** This study received funding from Biomet® and Trauma Center Northern Netherlands.	Injury cause: not reported Type of hip fracture (femoral neck/tronchanteric): • Multidisciplinary care pathway (n) = 142/114 • Standard care (n) = 83/62 **Inclusion criteria** Participants had to: • Be aged ≥ 60 years • Diagnosed with either a femoral neck hip fracture or pertrochanteric hip fracture • Be admitted to participating trauma centre within study dates **Exclusion criteria** • Serious abdominal or thoracic multi-trauma	ward, ensuring nursing staff were knowledgeable and able to provide additional care such as early start for rehabilitation, nutritional monitoring and preventing pressure ulcers. While patients were inpatient, they were seen every day by a geriatrician. The pathway emphasised a strict discharge protocol, beginning upon admission to the medical centre when they were registered to 1 of 2 participating nursing homes. Both of these nursing homes had beds specifically reserved for hip fracture patients. After registration, the admission doctors at the nursing homes were able to view medical records of participants who would be discharged to them and track their progress prior to arrival. After discharge, patients had visits scheduled at a dedicated outpatient clinic (at 6 weeks, 3 months and 6 months after surgery), with an appointment at a fall prevention clinic if needed. • *Control group: Standard care.* As per the participating medical centres hip fracture protocol prior to the intervention. This meant that	*that "For continuous variables, the intervention and control groups were compared with the independent sample t-test or, if appropriate, the Mann–Whitney U-test." (page 4). Due to this sentence and the majority of estimates being reported as means, we have assumed this is simply a reporting oversight on behalf of the authors.*	variables available in this study? PY – All extracted from electronic hospital records and no subjective variables mentioned. 1.6. Did the authors control for any post-intervention variables that could have been affected by the intervention? PN – No information but no post-intervention variables listed in the confounding domains adjusted for. 1.7. Did the authors use an appropriate analysis method that controlled for all the important confounding domains and for time-varying confounding? NA. 1.8. If Y/PY to 1.7: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? NA. *Risk of bias judgement:* Moderate risk. <u>Bias in selection of participants into the study</u> 2.1. Was selection of participants into the study (or into the analysis) based on participant characteristics observed after the start of intervention? N. 2.2. If Y/PY to 2.1: Were the post-intervention variables that influenced selection likely to be associated with intervention? NA. 2.3 If Y/PY to 2.2: Were the post-intervention variables that influenced selection likely to be influenced by the outcome or a cause of the outcome? NA. 2.4. Do start of follow-up and start of intervention coincide for most

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

Study details	Participants	Interventions	Outcomes and Results	Comments
				5.1 Were outcome data available for all, or nearly all, participants? Y – All participants identified from hospital records and included. 5.2 Were participants excluded due to missing data on intervention status? N. 5.3 Were participants excluded due to missing data on other variables needed for the analysis? NI – No mention of incomplete records or how these may have been considered. 5.4 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Are the proportion of participants and reasons for missing data similar across interventions? NA. 5.5 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Is there evidence that results were robust to the presence of missing data? NA. *Risk of bias judgement:* Low risk. Bias in measurement of outcomes 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? N – Length of hospital stay is on objective measurement. 6.2 Were outcome assessors aware of the intervention received by study participants? NI. 6.3 Were the methods of outcome assessment comparable across intervention groups? Y – Both extracted from electronic hospital records. 6.4 Were any systematic errors in measurement of the outcome related

Study details	Participants	Interventions	Outcomes and Results	Comments
				to intervention received? PN. *Risk of bias judgement:* Low risk. Bias in selection of the reported result Is the reported effect estimate likely to be selected, on the basis of the results, from... 7.1. ... multiple outcome measurements within the outcome domain? N. 7.2 ... multiple analyses of the intervention-outcome relationship? PN. 7.3 ... different subgroups? N. *Risk of bias judgement:* Low risk. Overall risk of bias *Risk of bias judgement:* Moderate risk **Other information** Need for re-operation within 1 year also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).
Full citation Hall, Erin C., Tyrrell, Rebecca L., Doyle, Karen E., Scalea, Thomas M., Stein, Deborah M., Trauma transitional care coordination: A mature system at work, The journal of trauma and acute care surgery, 84,	**Sample size** N = 21,682 (enrolled) • Traumatic Clinical Care Coordination = 475 • No Traumatic Clinical Care Coordination = 21,207 N = 21,682 (analysed) • Traumatic Clinical Care Coordination = 475 • No Traumatic Clinical Care Coordination = 21,207	**Interventions** • *Intervention group: Traumatic Clinical Care Coordination.* A full-time healthcare professional supervised and coordinated care during discharge. This included a phone call to patient (or their carer if appropriate) within 72 hours after discharge. The aim of this call was early identification of potential	**Results** *Length of hospital stay in days [Mean (SD)]* At discharge: • Traumatic Clinical Care Coordination (n=475): 13 (13) • No Traumatic Clinical Care Coordination (n=21,207): 6 (10)	**Limitations** **Quality assessment:** Risk of bias assessed using Risk Of Bias In Non-randomized Studies of Interventions (ROBINS-I) Bias due to confounding 1.1 Is there potential for confounding of the effect of intervention in this study? Y – The inclusion criteria of enrolling patients in the intervention who are more likely to be readmitted means potential for confounding is very high.

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

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

Study details	Participants	Interventions	Outcomes and Results	Comments
				possible within the criteria. 3.2 Was the information used to define intervention groups recorded at the start of the intervention? Y – Risk factors identified prior to discharge. 3.3 Could classification of intervention status have been affected by knowledge of the outcome or risk of the outcome? N. *Risk of bias judgement:* Moderate risk. <u>Bias due to deviations from intended interventions</u> 4.1. Were there deviations from the intended intervention beyond what would be expected in usual practice? NI – No information provided on how adherence to the intervention was standardised or measured. 4.2. If Y/PY to 4.1: Were these deviations from intended intervention unbalanced between groups and likely to have affected the outcome? NA. *Risk of bias judgement:* Moderate risk. <u>Bias due to missing data</u> 5.1 Were outcome data available for all, or nearly all, participants? Y – All participants identified from hospital records and included. 5.2 Were participants excluded due to missing data on intervention status? NI – Exclusion criteria not reported. 5.3 Were participants excluded due to missing data on other variables needed for the analysis? NI – No mention of incomplete records or how these may have been considered. 5.4 If PN/N to 5.1, or Y/PY to 5.2 or

Study details	Participants	Interventions	Outcomes and Results	Comments
				5.3: Are the proportion of participants and reasons for missing data similar across interventions? NA. 5.5 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Is there evidence that results were robust to the presence of missing data? NA. *Risk of bias judgement:* Moderate risk. <u>Bias in measurement of outcomes</u> 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? N – Length of hospital stay is on objective measurement. 6.2 Were outcome assessors aware of the intervention received by study participants? NI. 6.3 Were the methods of outcome assessment comparable across intervention groups? Y – Both extracted from electronic hospital records. 6.4 Were any systematic errors in measurement of the outcome related to intervention received? PN. *Risk of bias judgement:* Low risk. <u>Bias in selection of the reported result</u> Is the reported effect estimate likely to be selected, on the basis of the results, from... 7.1. ... multiple outcome measurements within the outcome domain? N. 7.2 ... multiple analyses of the intervention-outcome relationship? PN.

Study details	Participants	Interventions	Outcomes and Results	Comments
				7.3 ... different subgroups? N. *Risk of bias judgement*: Low risk. Overall risk of bias *Risk of bias judgement:* Serious risk **Other information** None.
Full citation Huang, T. T., Liang, S. H., A randomized clinical trial of the effectiveness of a discharge planning intervention in hospitalized elders with hip fracture due to falling, J Clin Nurs, 14, 1193-201, 2005 **Ref Id** 1118076 **Country/ies where the study was carried out** Taiwan **Study type** RCT **Aim of the study** To examine the effectiveness of a	**Sample size** N= 126 (randomised) • Discharge planning with gerontological nurse = 63 • Routine discharge planning = 63 N= 122 (analysed) • Discharge planning with gerontological nurse = 63 • Routine discharge planning = 59 **Characteristics** Age in years [Mean (SD)]: • Discharge planning with gerontological nurse = 75.9 (7.6) • Routine discharge planning = 78.1 (7.5) Gender (M/F): • Discharge planning with gerontological nurse (63) = 23/40 • Routine discharge planning (63) = 16/47	**Interventions** • *Intervention group: Discharge planning with gerontological nurse.* Extended from hospital admission through three months after discharge + advice. Discharge in the hospital was provided by postgrad qualified gerontological nurse experienced in hospital and home care of older adults. Initial nurse visit within 48 house of hospital admission and at least every 48 hours during hospitalisation. Participants received one home visit 3 to 7 days after discharge and could call nurse 7days/week (8am to 8pm), phone contacts were initiated by nurse once a week. Individualised discharge plan were designed by nurse together with family caregivers and healthcare team members. One brochure on self-care for hip fracture and another	**Results** *Length of hospital stay in days [Mean (SD)]* At 3 months: • Discharge planning with gerontological nurse (n=63): 8.17 (3.61) • Routine discharge planning (n=63): 10.06 (3.07) • Significantly shorter in intervention group compared to control group (p=0.002, student's t-test) *Quality of life (measured using SF-36) [Mean (SD)]* Scale: 0-100, higher = better At discharge: • Discharge planning with gerontological nurse (n=63): 42.24 (9.96)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. Quote: "According to a computer generated table, the researcher then randomly assigned patients to either the control group or the intervention group" (page 1195) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? Y. Baseline characteristics were balanced. *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial?

Study details	Participants	Interventions	Outcomes and Results	Comments
discharge plan in hospitalized elderly patients with hip fracture due to falling. **Study dates** January – December 2002 **Source of funding** This study received funding from National Science Council, Taiwan (NSC89-2314-B-182-138) and Chung Gung University (CMRP940).	Time since injury: not reported Injury cause: all traumatic Type of hip fracture (Intracapsular/extracapsular) • Discharge planning with gerontological nurse = 25/38 • Routine discharge planning = 30/33 (47.6%) **Inclusion criteria** Participants had to: • Be over 65 years with hip fractures due to falling • Have been discharged within the catchment areas of the medical centre **Exclusion criteria** • Cognitive impairment • Being too ill to participate • Unable to communicate • Admitted to the ICU	for falls prevention, were provided. The nurse also provided direct care, advice, set up of home care services and the assessment of rehabilitation facility needs. Before discharge, hard copy summaries of plans, goals, progression and ongoing concerns were given to patients and carers. Through follow-up, the nurse addressed concerns of patients and caregivers, monitored patients' progress and collaborated with physicians to modify therapies and find needed services. • *Control group: Routine discharge planning.* Routine hospital discharge planning for adult patients, provided by non-postgrad qualified nurses. No information, discharge summary, home visit or telephone contact.	• Routine discharge planning (n=59): 36.22 (7.79) At 2 weeks post discharge: • Discharge planning with gerontological nurse (n=63): 46.04 (10.50) • Routine discharge planning (n=59): 38.58 (7.90) At 3 months* post discharge • Discharge planning with gerontological nurse (n=63): 60.77 (10.50) • Routine discharge planning (n=59): 51.3 (11.6) • Significantly higher (better) in intervention group compared to control group (p<0.001, repeated measures ANOVA test for time and group) *Changes in ADL (measured using Barthel Index) [Mean (SD)]* Scale: 0-100, higher = better.	PY - Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Hospital length of stay – Y. No loss to follow-up; Changes in ADL – Y. Outcome data available for 96.8% of participants (63/63 in intervention and 59/63 in control). 3.2 If No/PN/NI to 3.1: Is there

Study details	Participants	Interventions	Outcomes and Results	Comments
			At baseline: • Discharge planning with gerontological nurse (n=63): 96.5 (7.6) • Routine discharge planning (n=63): 96.43 (7.1) At discharge: • Discharge planning with gerontological nurse (n=63): 47.62 (10.39) • Routine discharge planning (n=59): 37.54 (17.89) At 2 weeks after discharge: • Discharge planning with gerontological nurse (n=63): 73.41 (13.28) • Routine discharge planning (n=59): 58.73 (21.87) At 3 months* post discharge: • Discharge planning with gerontological nurse (n=63): 87.2 (11.6) • Routine discharge planning (n=59): 71.02 (26.1) • Significantly higher (better) in intervention	evidence that the result was not biased by missing outcome data? NA. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA. *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods and validated scales. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points (at discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Length of hospital stay – N – Outcome assessors blinded to group allocation; Changes in ADL – PY. Partially self-assessment and unlikely study participants were blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Length of hospital stay – NA; Changes in ADL – Y.

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

Study details	Participants	Interventions	Outcomes and Results	Comments
				Hospital readmissions within 3 months also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).
Full citation Lin, P. C., Wang, C. H., Chen, C. S., Liao, L. P., Kao, S. F., Wu, H. F., To evaluate the effectiveness of a discharge-planning programme for hip fracture patients, Journal of Clinical Nursing, 18, 1632-1639, 2009 **Ref Id** 1207043 **Country/ies where the study was carried out** Taiwan **Study type** RCT **Aim of the study** To evaluate the effectiveness of a comprehensive discharge-planning service for hip	**Sample size** N = 50 (randomised) • Comprehensive discharge planning = 26 • Routine discharge planning = 24 N = 50 (analysed) • Comprehensive discharge planning = 26 • Routine discharge planning = 24 **Characteristics** *NB. Characteristics only reported for whole study population rather than by study arm.* Age in years [Mean (SD)]: 78.75 (6.99) Gender (M/F): 32/18 Time since injury: not reported Injury cause: not reported	**Interventions** • *Intervention group: Comprehensive discharge-planning.* Comprehensive discharge-planning service was devised with structured assessment of the discharge planning needs. Individualised nursing instruction was provided with monitoring services and two home visits after discharge. The need for discharge planning and the QOL prior to the fracture were assessed within 48 hours of admission. Patient self-care knowledge and degree of satisfaction regarding the discharge planning service were evaluated before discharge. The first home visit was conducted two weeks post discharge, performing a second evaluation of physical function and self-care knowledge. The second home visit was performed 3 months post-discharge and physical function and QOL at this point were evaluated again.	**Results** *Patient satisfaction (measured using research designed questionnaire) [Mean (SD)]* Scale: 14-70 points, higher = better Time point not reported: • Comprehensive discharge planning (n=26): 52.73 (10.53) • Routine discharge planning (n=24): 50.00 (12.61) *Length of hospital stay in days [Mean (SD)]* At 3 months: • Comprehensive discharge planning (n=26): 6.04 (2.41) • Routine discharge planning (n=24): 6.29 (2.17)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? NI – Paper simply states randomised. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? NI – There is no indication that baseline characteristics were reported or compared across groups. *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? PY. Due to the nature of the intervention, blinding is not feasible 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial?

Study details	Participants	Interventions	Outcomes and Results	Comments
fracture patients, including length of stay, functional status, self-care knowledge and quality of life **Study dates** November 2005 – December 2006 **Source of funding** This study received funding from the National Science Council, Taiwan (NSC94-2314-B-075- 072).	Type of hip fracture: not reported Inclusion criteria Participants had to: • Be aged 65 years or older • Have a hip fracture diagnosis • Be able to walk • Have a Barthel score of at least 70 points prior to hip fracture • Mentally alert and able to communicate • Living in the Taipei region **Exclusion criteria** • Cognitive impairment • Terrminal disease	• *Control group: Routine discharge planning.* Nurses who cared for patients provided the discharge service and gave non-structured discharge instructions according to their own professional judgement without following a standardised procedure.	*Changes in ADL (measured using Functional Status Subscale adapted from OARS Mutlidimensional Functional Assessment Questionnaire) [Mean (SD)]* Scale 0-18, higher = better At baseline (before fracture): • Comprehensive discharge planning (n=26): 17.53 (1.13) • Routine discharge plan (n=24): 17.62 (0.71) Before discharge: • Comprehensive discharge planning (n =26): 8.15 (2.49) • Routine discharge plan (n=24): 8.00 (1.88) 2 weeks post-discharge: • Comprehensive discharge planning (n=26): 12.50 (3.95) • Routine discharge plan (n=24): 11.38 (3.39) 3 months post-discharge:	PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y- Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – No reported drop out. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA.

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Comprehensive discharge planning (n=26): 16.92 (1.41) • Routine discharge plan (n=24): 16.83 (1.71) • No significant difference between groups (p=0.409, repeated measures ANOVA)	*Risk-of-bias judgement:* Low risk Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods and validated scales for all objective and subjective outcomes 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points. "Evaluation of the control group was identical to that for the experimental group." (page 1634) 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y – Assessors were unblinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Length of hospital stay – PN. Due to the objective nature of the outcome; Patient satisfaction and changes in ADL – PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Patient satisfaction: PY. Subjective measurement and satisfaction tool was not a validated one; Length of

Study details	Participants	Interventions	Outcomes and Results	Comments
				hospital stay – NA; Changes in ADL – PN. Assessors used structured and validated measurement tools. *Risk-of-bias judgement:* Patient satisfaction – high risk; Length of hospital stay – low risk; Changes in ADL – some concerns Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns Overall risk of bias Patient satisfaction – high risk; Length of hospital stay – some concerns; Changes in ADL – some concerns **Other considerations** Hospital readmissions within 3 months also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).

Study details	Participants	Interventions	Outcomes and Results	Comments
				Quality of life using SF-36 was reported but only individually by domain rather than overall quality of life or mental/physical component scores which have been extracted previously.
Full citation Parsons, M., Parsons, J., Pillai, A., Rouse, P., Mathieson, S., Bregmen, R., Smith, C., Kenealy, T., Post-Acute Care for Older People Following Injury: A Randomized Controlled Trial, Journal of the American Medical Directors Association, 2019 **Ref Id** 1206192 **Country/ies where the study was carried out** New Zealand **Study type** RCT **Aim of the study** To determine	**Sample size** N = 403 (randomised) • Supported discharge team care = 201 • Usual care = 202 N = 403 (analysed) • Supported discharge team care = 201 • Usual care = 202 **Characteristics** Age in years [Mean (SD)]: • Supported discharge team care = 81.1 (7.8) • Usual care = 80.5 (8.3) Gender (M/F): • Supported discharge team care = 45/156 • Usual care = 55/147 Time since injury: not reported. Injury cause: not reported by inclusion criteria states trauma	**Interventions** • *Intervention group: Supported discharge team care.* This was rehabilitation program delivered by a multidisciplinary team. It involved healthcare assistants, registered nurses, allied health professionals. Consultant geriatricians delivered weekly input through case conferencing, HCA provided up to 4 visits/day 7 days a week and used functional rehabilitation principles. The team worked collaboratively with the patient's primary care team as well as the specialist community and hospital services and continued to visit till the patient returned to independence or until stable. Patients were limited to 6 weeks attendance and offered extension on case by case basis. The team discussed patient's progress weekly. Visits reduced as patients gained independence and on	**Results** *Length of hospital stay in days [Mean (95% CI)]* • Supported discharge team care (n=201): 20.9 (17.7-24.1) • Usual care (n=202): 26.6 (23.5-29.6) • Significantly shorter in intervention group (p=0.002, ANOVA)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y. Quote: "Participants were randomized using a computer-generated randomization sequence." (page 406) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N - "Demographics were similar across the 2 groups" (page 406). *Risk-of-bias judgement:* Some concerns <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering

Study details	Participants	Interventions	Outcomes and Results	Comments
whether supported discharge team for older people admitted to hospital following a fracture enables earlier discharge from hospital and reduces readmissions and healthcare costs **Study dates** December 2013 – July 2015 **Source of funding** Not reported	Type of injury (TBI/spinal fracture/soft tissue/wrist and forearm fracture/pelvic fracture/femur and knee fracture/tibia, fibula, ankle and foot fractures/clavicle, shoulder and humeral fracture/hip fracture/other fracture): • Supported discharge team care (n) = 3/12/8/4/12/7/10/15/4/12 6 • Usual care (n) = 6/13//7/3/23/84/13/17/109/3 **Inclusion criteria** Participants had to: • Have suffered an injury that required hospital admission and subsequent rehabilitation • Be 65 years of age • Be in hospital at time of referral • Not require ongoing acute hospital based treatment • Have consented to being treated at home • Have agreed with the objectives set by the referring inter-disciplinary team. • Be considered to have potential for partial or	discharge, advance care planning was initiated and passed to the patient's primary care physician for completion. • *Control group: Usual care.* Discharge planning from the hospital and subsequent community-based services. Community-based services could include allied health, district nursing, and home care.		the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – No attrition reported. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that

Study details	Participants	Interventions	Outcomes and Results	Comments
	complete recovery with suitable home rehabilitation within 6 weeks • Be able to stand and transfer with 1 person (with or without the help of a resident carer) • Have had a recent injury and was at a borderline level of function with an associated reduction in activities of daily living and/or instrumental ADL • Without input from the team, be considered likely to fail to recuperate full potential of functional recovery or be likely to fail to manage satisfactorily at home despite conventional community support and, therefore, be at risk of hospital re-admission or institutionalization. **Exclusion criteria** Not reported			missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? N - Measurements were carried out using appropriate methods from electronic records. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points (discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PN – Due to objective nature of outcome. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? PN -

Study details	Participants	Interventions	Outcomes and Results	Comments
				Study protocol was registered during study after initial participants had completed intervention. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* Some concerns **Other information** Hospital readmissions within 1 year also reported but no distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol). Changes in ADL also reported in paper. However, measures of variance were not reported so data pooling was not feasible. Paper noted that "no statistically significant differences were noted in the functional status over time between the 2 groups and both groups improved at the same rate" (page 407).
Full citation Ryan, T., Enderby,	**Sample size** N= 81 (randomised)	**Interventions** • *Both groups:* The MDT	**Results**	**Limitations** **Quality assessment:** Risk of bias

Study details	Participants	Interventions	Outcomes and Results	Comments
P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age, Clinical Rehabilitation, 20, 123-131, 2006 **Ref Id** 1184826 **Country/ies where the study was carried out** UK **Study type** RCT **Aim of the study** To compare intensive with non-intensive home based rehabilitation provision following stroke or hip fracture in old age (65 years plus) **Study dates** July 2000 – June	• More intensive MDT care = 37 • Less intensive MDT care = 34 N= 58 (analysed) • More intensive MDT care = 30 • Less intensive MDT care = 28 **Characteristics** Age in years [Mean (SD)]: • More intensive MDT care = 80.7 (7.4) • Less intensive MDT care = 80.9 (6.3) Gender (M/F): not reported Time since injury in years [Mean (SD)]: • More intensive MDT care = 40.6 (42.2) • Less intensive MDT care = 35 (24.6) Injury cause: not reported Type of hip fracture: not reported **Inclusion criteria** Participants had to:	comprised of physiotherapist, occupational therapist, speech and language therapist or therapy assistant. The maximum length of treatment time was 12 weeks. • *Intervention group: More intensive MDT care.* An augmented rehabilitation service providing 6 or more face-to-face contacts per week with a member of the MDT. • *Control group: Less intensive MDT care.* 3 or less face-to-face contacts per week with a member of the MDT.	*Quality of life (measured using EQ-5D) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.52 (0.26-0.69) • Less intensive MDT care (n=34): 0.62 (0.32-0.73) At 3 months: • More intensive MDT care (n=30): 0.62 (0.52-0.77) • Less intensive MDT care (n=28): 0.67 (0.59-0.79) • No significance difference between groups (p=0.3, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.3, Mann-Whitney U test; adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 0.1 (0.23)	assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y – Using random number table in blocks of 10. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y - Opaque sealed envelopes. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Baseline characteristics are balanced between groups in whole study population, although there is no comparison purely for hip fracture patients. *Risk-of-bias judgement:* Low risk Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the

Study details	Participants	Interventions	Outcomes and Results	Comments
2002 **Source of funding** This study received funding from NHS Executive Trent, United Kingdom.	• Be aged 65 or over • Recovering from stroke or hip fracture • Not be suffering from a concomitant disease (e.g. Parkinson's disease or dementia) • Be able to be contacted by the research team within five working days **Exclusion criteria** Not reported		vs. Less intensive MDT care = 0.1 (0.23) *Overall quality of life (measured using EQ-VAS) [Median (IQR)]* Scale 1-100, higher = better At baseline: • More intensive MDT care (n=37): 0.6 (0.51 - 0.71) • Less intensive MDT care (n=34): 0.63 (0.57-0.81) At 3 months: • More intensive MDT care (n=30): 0.71 (0.6-0.8) • Less intensive MDT care (n=28): 0.7 (0.5-0.82) • No significance difference between groups (p=0.98, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.98, Mann-Whitney U test; adjusted using imputation for missing	experimental context? Y – Intervention group was meant to have a ratio of 2:1 MDT sessions compared to control. Mean (SD) sessions were reported as 24.4 (10.2) for intervention versus 17.9 (9.1) for control. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group did not achieve the forecast intensity of MDT sessions. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - Intention to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - Outcome data only available for 58/71 (82%) participants at 3 months (30/37 in intervention group and 28/34 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true

Study details	Participants	Interventions	Outcomes and Results	Comments
			data) • Mean change (SD): More intensive MDT care = 0.03 (0.2) vs. Less intensive MDT care = -0.01 (0.1) *Change in ADL (measured using Barthel Index) [Median (IQR)]* Scale 0-100, higher=better At baseline: • More intensive MDT care (n=37): 17 (15-17) • Less intensive MDT care (n=34): 16 (14.75-17) At 3 months: • More intensive MDT care (n=30): 20 (19-20) • Less intensive MDT care (n=28): 20 (19-20) • No significance difference between groups (p=0.83, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.83, Mann-Whitney U test; adjusted using	value? PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN – Reasons for and numbers of loss to follow up was roughly balanced across study groups. *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Outcomes were measured using validated instruments. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY – Blinding of researchers carrying out assessments were blind, but quality of life and acitivities of daily living have a subjective component to them and participants were unlikely to be blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN –

Study details	Participants	Interventions	Outcomes and Results	Comments
			imputation for missing data) • Mean change (SD): More intensive MDT care = 3.19 (1.7) vs. Less intensive MDT care = 3.36 (1.8) *Changes in ADL (measured using Frenchay Activities Index) [Median (IQR)]* Scale 0-45, higher=better At baseline: • More intensive MDT care (n=37): 28 (19.5-32) • Less intensive MDT care (n=34): 28 (22.75 - 31.25) 3 months: • More intensive MDT care (n=30): 19 (14-23) • Less intensive MDT care (n=28): 19 (14-24) • No significance difference between groups (p=0.81, Mann-Whitney U test; unadjusted) • No significance difference between groups (p=0.46, Mann-	Researchers were blinded and using standardised and validated measurements. *Risk-of-bias judgement:* Some concerns. <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.

Study details	Participants	Interventions	Outcomes and Results	Comments
			Whitney U test; adjusted using imputation for missing data) • Mean change (SD): More intensive MDT care = 7.06 (6) vs. Less intensive MDT care = 6.34 (5.1)	
Full citation Ryan, T., Enderby, P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age: results at 12-month followup, International journal on disability and human development, 5, 83-89, 2006 **Ref Id** 1184825 **Country/ies where the study was carried out** UK	**Sample size** See Ryan 2006a **Characteristics** See Ryan 2006a **Inclusion criteria** See Ryan 2006a **Exclusion criteria** See Ryan 2006a	**Interventions** See Ryan 2006a	**Results** *Overall quality of life (measured using EQ-5D) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.52 (0.26-0.69) • Less intensive MDT care (n=34): 0.62 (0.32-0.73) At 12 months: • More intensive MDT care (n=30): 0.7 (0.59-8) • Less intensive MDT care (n=28): 0.7 (0.62-0.74) • No significant difference between groups	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y – Using random number table in blocks of 10. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y - Opaque sealed envelopes. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Baseline characteristics are balanced between groups in whole study population, although there is no comparison purely for hip fracture patients. *Risk-of-bias judgement:* Low risk Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** See Ryan 2006a **Study dates** See Ryan 2006a **Source of funding** See Ryan 2006a			(p=0.67, Mann-Whitney U test) • Mean change (SD): More intensive MDT care = 0.16 vs. Less intensive MDT care = 0.08; 95% CI = -0.08-0.24 *Overall quality of life (measured using EQ-VAS) [Median (IQR)]* Higher = better At baseline: • More intensive MDT care (n=37): 0.6 (0.51 - 0.71) • Less intensive MDT care (n=34): 0.63 (0.57-0.81) At 12 months: • More intensive MDT care (n=30): 0.7 (0.5-0.78) • Less intensive MDT care (n=28): 0.65 (0.5-0.8) • No significant difference between groups (p=0.88, Mann-Whitney U test) • Mean change: More intensive MDT care	2.1. Were participants aware of their assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - Due to the nature of the intervention, blinding is not feasible 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Intervention group was meant to have a ratio of 2:1 MDT sessions compared to control. Mean (SD) sessions were reported as 24.4 (10.2) for intervention versus 17.9 (9.1) for control. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y – Intervention group did not achieve the forecast intensity of MDT sessions. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - Intention to treat analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. Domain 3: Missing outcome data

Study details	Participants	Interventions	Outcomes and Results	Comments
			= 0.04 vs. Less intensive MDT care = -0.05; 95% CI = -0.06 to 0.2 *Change in ADL (measured using Barthel Index) [Median (IQR)]* At baseline: • More intensive MDT care (n=37): 17 (15-17) • Less intensive MDT care (n=34): 16 (14.75-17) At 12 months: • More intensive MDT care (n=30): 20 (19-20) • Less intensive MDT care (n=28): 20 (19-20) • No significant difference between groups (p=0.18, Mann-Whitney U test) • Mean change: More intensive MDT care = 3.36 vs. Less intensive MDT care = 3.47; 95% CI = -1.2-0.99 *Changes in ADL (measured using Frenchay Activities Index) [median (IQR)]*	3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - Outcome data only available for 58/71 (82%) participants at 12 months (30/37 in intervention group and 28/34 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN – Reasons for and numbers of loss to follow up was roughly balanced across study groups. *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N - Outcomes were measured using validated instruments. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY – Blinding of researchers carrying out assessments were blind, but quality of life and

Study details	Participants	Interventions	Outcomes and Results	Comments
			At baseline: • More intensive MDT care (n=37): 28 (19.5-32) • Less intensive MDT care (n=34): 28 (22.75 - 31.25) At 12 months: • More intensive MDT care (n=30): 22 (16.5-29.5) • Less intensive MDT care (n=28): 21 (13-26) • No significant difference between groups (p=0.27, Mann-Whitney U test) • Mean change: More intensive MDT care = -3.8 vs. Less intensive MDT care = -5.8; 95% CI = -2.4-6.5	acitivities of daily living have a subjective component to them and participants were unlikely to be blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN – Researchers were blinded and using standardised and validated measurements. *Risk-of-bias judgement:* Some concerns. Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Other information None.
Full citation Stenvall, Michael, Olofsson, Birgitta, Nyberg, Lars, Lundstrom, Maria, Gustafson, Yngve, Improved performance in activities of daily living and mobility after a multidisciplinary postoperative rehabilitation in older people with femoral neck fracture: a randomized controlled trial with 1-year follow-up, Journal of rehabilitation medicine, 39, 232-8, 2007 **Ref Id** 1279942 **Country/ies where the study was carried out** Sweden	**Sample size** N (randomised) = 199 • MDT post-operative rehabilitation = 102 • Conventional post-operative rehabilitation = 97 N (analysed) = 199 • MDT post-operative rehabilitation = 102 • Conventional post-operative rehabilitation = 97 **Characteristics** Age in years [Mean (SD)]: • MDT post-operative rehabilitation (N) = 82.3 (6.6) • Conventional post-operative rehabilitation (N) = 82.0 (5.9) Gender (M/F): • MDT post-operative rehabilitation (n) = 28/74 • Conventional post-operative rehabilitation (n) = 23/74 Time since injury: not	**Interventions** • Targeted 8 separate areas of post-operative care: 1. Ward layout; 2. Staffing; 3. Staff education; 4. Teamwork; 5. Individual care planning; 6. Prevention and treatment of complications; 7. Nutrition; and 8. Rehabilitation. • *Intervention group: MDT post-operative rehabilitation.* Applied in a geriatric unit that specialised in geriatric orthopaedic patients. ○ Ward layout: 24-bed ward with single and double rooms, and extra beds when needed. ○ Staffing: 1.07 WTE nurses/aides per bed, plus 2 x 1 WTE physiotherapists, 2 x 1 WTE occupational therapists and 0.2 WTE dietician. ○ Staff education: Included a 4-day course on post-operative rehabilitation, including information on possible complications, delirium and fall prevention. ○ Teamwork: The multi-disciplinary team included	**Results** *Changes in ADL (measured using number of participants achieving independence in P-ADL at each time point)* Before fracture: • MDT post-operative rehabilitation: 47 • Conventional post-operative rehabilitation: 48 At 4 month post-operative follow-up: • MDT postoperative rehabilitation: 35/102 • Conventional postoperative rehabilitation: 23/97 • OR (95% CI): 2.51 (1.00–6.30) • Binary logistic regression adjusted for depression, dementia and independent walking ability at baseline. At 12 month post-	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? NI – Simply states that participants were randomised. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y – Opaque, sequentially numbered envelopes that were only opened right before surgery. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN – Only 1 of the baseline characteristics were significantly different between groups (diagnosed depression). No other imbalances. *Risk-of-bias judgement:* Some concerns. <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? NI – Participants were recruited in the emergency department. No information presented on how much they were aware of the differences

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** To evaluate both short- and long-term outcomes of a multidisciplinary post-operative rehabilitation package in patients after acute hip fracture. **Study dates** May 2000 – December 2002 **Source of funding** This study received funding from the Swedish Foundation for Health Care Sciences and Allergy Research, the Joint Committee of the Northern Health Region of Sweden, the JC Kempe Memorial Foundation, the Dementia Fund, the Foundation of the Medical Faculty, the Borgerskapet of	reported Injury cause: not reported but inclusion criteria states hip fracture following minimal trauma Type of fracture: not reported **Inclusion criteria** Participants had to: • Be aged 70 years or above • Have a femoral hip fracture • Be admitted to orthopaedic department at participating hospital between May 200 - December 2002 • Have underwent either internal fixation (undisplaced fracture) or hemi-arthroplasty (displaced fracture) **Exclusion criteria** • Severe rheumatoid arthritis or hip osteoarthritis • Pathological hip fractures • Severe renal failure • People who were bedridden before trauma	orthopaedic surgeons, geriatricians, Registered Nurses, Licensed Practical Nurses, physical therapists, occupational therapists, dieticians and geriatricians. ○ Individual care planning: Usually started within 24 hours, after assessment from all MDT members. The team updated a patient's rehabilitation process and goals twice a week. ○ Prevention and treatment of complications: Included an examination of why patient's fractured their hip and osteoporosis treatment if needed. Common post-operative complications were actively monitored, with prevention and treatment regimens where indicated. Oxygen enriched air was given at least for post-operative day 1. Urinary tract infections were screened for, urinary catheters only left in for a maximum of 24 hours post-operatively and patient's had regular screening from urinary retention and constipation. If sleep was poor, possible	operative follow-up • MDT postoperative rehabilitation: 33/102 • Conventional postoperative rehabilitation: 17/97 • OR (95% CI): 3.49 (1.31–9.23) • Binary logistic regression adjusted for depression, dementia and independent walking ability at baseline. *Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point)* A: Independent in all 6 functions (feeding, continence, transferring, going to toilet, dressing, and bathing). B: Independent in any 5 out of 6 function. C: Dependent for bathing plus 1 other function, independent in other 4 functions. D: Dependent for bathing, dressing plus 1 other function, independent in other 3 functions. E: Dependent for bathing,	between the post-operative rehabilitation programmes, or if they knew which wards were used for which post-operative programmes. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? Y – Staff on intervention ward were aware of the intervention content. Staff on the control wards were aware that a new programme was being trial at the hospital on another ward. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Participants who were allocated to the control group were admitted to a general geriatric unit (rather than the control orthopaedic ward), which had staffing levels, teamwork and individual care planning similar to the intervention ward. Additionally, intervention was given until discharge rather than a specific time point. Therefore, participants staying longer will receive more of the intervention. 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? N. 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? Y. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intention-to-treat analysis. 2.7 If No/PN/NI to 2.6: Was there

Study details	Participants	Interventions	Outcomes and Results	Comments
Umeå Research Foundation, the Erik and Anne-Marie Detlof's Foundation, University of Umeå and the County Council of Västerbotten and the Swedish Research Council.		causes were investigated and treated. ○ Nutrition: Food and liquid registration was routinely carried out, with patients receiving protein enriched meals until post-operative day 4 (and longer if indicated). Protein and nutritional drinks were administered daily. ○ Rehabilitation: Started with mobilisation within 24 hours post-operatively, including specific exercises with both physical therapists and occupational therapists and general acitivites for daily living with care staff. Functional re-training was administered with a specific focus on fall risk factors. A home visit was conducted by occupational therapists and/or physical therapists, who communicated with counterparts in the community rehabilitation services to provide additional information post-discharge. Patients were offered additional rehabilitation as outpatients after discharge. A physical therapist or occupational therapist	dressing, going to the toilet plus 1 other function, independent in other 2 functions. F: Dependent for bathing, dressing, going to the toilet, transferring plus 1 other function, independent remaining function. G: Dependent in all six functions. At baseline: • Katz grade A ○ MDT post-operative rehabilitation: 50/101 ○ Conventional post-operative rehabilitation: 49/94 • Katz grade B ○ MDT post-operative rehabilitation: 15/101 ○ Conventional post-operative rehabilitation: 13/94 • Katz grade C ○ MDT post-operative rehabilitation: 11/101 ○ Conventional post-operative rehabilitation: 5/94 • Katz grade D ○ MDT post-operative rehabilitation: 1/101 ○ Conventional post-	potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N. At 4 months data was available for 175/199 participants (92/102 in intervention group and 83/97 in control group). At 12 months data was available for 160/199 participants (84/102 in intervention group and 76/97 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? PN – No information reported on methods to correct for missing data bias (although P-ADL was corrected for baseline characteristics). 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? Y. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? Y – Data missing due to death of patients which will have affected ADL measurements. *Risk-of-bias judgement:* High risk. <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. 4.2 Could measurement or

Study details	Participants	Interventions	Outcomes and Results	Comments
		followed patients up via telephone 2 weeks after discharge, and with a home visit 4 months after discharge. This home visit included rehabilitation assessment, possible rehabilitation needs, environmental issues and nutritional problems. Another follow-up (also at 4 months after discharge) was carried out by a physician for a medication review and to detect possible complications. • *Control group: Conventional post-operative rehabilitation.* Primarily applied in a specialist orthopaedic unit that followed conventional post-operative routines. If a patient required longer rehabilitation, they were admitted to a general geriatric unit (although not the same one as the intervention ward). ○ Ward layout: On the orthopaedic control ward, a 27-bed ward with single, double rooms and quadruple rooms, and extra beds when needed. On the geriatric control ward, layout was the same as the intervention group. ○ Staffing: On the	operative rehabilitation: 6/94 • Katz grade E ○ MDT post-operative rehabilitation: 10/101 ○ Conventional post-operative rehabilitation: 9/94 • Katz grade F ○ MDT post-operative rehabilitation: 9/101 ○ Conventional post-operative rehabilitation: 8/94 • Katz grade G ○ MDT post-operative rehabilitation: 3/101 ○ Conventional post-operative rehabilitation: 2/94 • Not classified ○ MDT post-operative rehabilitation: 2/101 ○ Conventional post-operative rehabilitation: 2/94 • No difference between groups (p = 0.789, Mann-Whitney U test) At 12 months post-operative follow-up: • Katz grade A ○ MDT postoperative rehabilitation: 34/84	ascertainment of the outcome have differed between intervention groups? PN – Measured using same procedures at comparable time points (at discharge). 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y – Assessors were unblinded to allocation. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Length of stay: N. ADL: PN – Validated instruments (Katz ADL and ADL Staircase) used for measurements, which involve little/no assessment judgement. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk. <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI – No published protocol to check. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the

Study details	Participants	Interventions	Outcomes and Results	Comments
		orthopaedic control ward, 1.01 WTE nurses/aides per bed, plus 2 x 1 WTE physiotherapists, 1 x 0.5 WTE occupational therapists and no dietician. On the geriatric control ward, staffing was the same as the intervention group (10.7 WTE nurses/aides per bed). Staff education: No rehabilitation specific education given before or during the programme. ○ Teamwork: On the orthopaedic control ward, no specific teamwork was implemented. On the geriatric control ward, teamwork was the same as the intervention group. Individual care planning: On the orthopaedic control ward, individual care planning was used but not routinely as per the intervention. On the geriatric control ward, a weekly individual care planning meeting was held. ○ Prevention and treatment of complications: On both control wards, there was no routine examination regarding the possible causes of fractures, there	○ Conventional postoperative rehabilitation: 17/76 • Katz grade B ○ MDT postoperative rehabilitation: 14/84 ○ Conventional postoperative rehabilitation: 21/76 • Katz grade C ○ MDT postoperative rehabilitation: 8/84 ○ Conventional postoperative rehabilitation: 3/76 • Katz grade D ○ MDT postoperative rehabilitation: 1/84 ○ Conventional postoperative rehabilitation: 2/76 • Katz grade E ○ MDT postoperative rehabilitation: 5/84 ○ Conventional postoperative rehabilitation: 4/76 • Katz grade F ○ MDT postoperative rehabilitation: 17/84 ○ Conventional postoperative rehabilitation: 17/76 • Katz grade G ○ MDT postoperative	outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns. Overall risk of bias *Risk-of-bias judgement:* High risk. **Other information** Re-admissions are also reported but there is distinction between unplanned re-admissions (outcome as per protocol) and planned re-admissions (not in protocol).

Study details	Participants	Interventions	Outcomes and Results	Comments
		was no fall prevention assessment and no routine prescription of osteoporosis medication. Post-operative complications were assessed but not routinely. ○ Nutrition: On the orthopaedic control ward, no dietician was available. On both control wards, no nutrition registration or protein-enriched meals were available. ○ Rehabilitation: Mobilisation was within 24 hours of surgery by a physical therapist, and were visited every day. However, functional retraining for daily tasks was not always performed. On the orthopaedic control ward, occupational therapists only met patients for a consultation and there were no home visits. On the geriatric control ward, exercises were similar to the intervention group and were administered by both physical and occupational therapists. In both control groups, no follow-up interventions were scheduled.	rehabilitation: 4/84 ○ Conventional postoperative rehabilitation: 11/76 • Not classified ○ MDT postoperative rehabilitation: 1/84 ○ Conventional postoperative rehabilitation: 1/76 • Significantly more participants achieving earlier grade (better) in intervention group compared to control group (p = 0.025, Mann-Whitney U test) *Changes in ADL (measured using number of participants returning to at least same Katz ADL level as before trauma)* At 4 months post-operative follow-up: • MDT postoperative rehabilitation: 56/92 • Conventional postoperative rehabilitation: 39/82 • No significant difference between groups (p = 0.078, Chi-squared test) At 12 months post-	

Study details	Participants	Interventions	Outcomes and Results	Comments
			operative follow-up: • MDT postoperative rehabilitation: 49/84 • Conventional postoperative rehabilitation: 27/76 • Significantly higher (better) in intervention groups (p = 0.004, Chi-squared test)	
Full citation Vikane, E., Hellstrom, T., Roe, C., Bautz-Holter, E., Assmus, J., Skouen, J. S., Multidisciplinary outpatient treatment in patients with mild traumatic brain injury: A randomised controlled intervention study, Brain Injury, 31, 475-484, 2017 **Ref Id** 1206647 **Country/ies where the study was carried out** Norway	**Sample size** N = 151 (randomised) • Multidisciplinary outpatient treatment = 81 • Usual care by GP = 70 N = 151 (analysed for return to work) • Multidisciplinary outpatient treatment = 81 • Usual care by GP = 70 N = 126 (analysed for subjective outcomes) • Multidisciplinary outpatient treatment = 70 • Usual care by GP = 56 **Characteristics** Age in years [Median (range)]: • Multidisciplinary outpatient treatment = 31 (16-55) • Usual care by GP =35 (16-	**Interventions** • *Intervention group: Multidisciplinary outpatient treatment.* Individual contacts and a psycho-educational group intervention once a week over a consecutive 4-week period. Schedule for return to work and other activities were developed during the first consultation within two weeks after multidisciplinary examination. There were individualised additional follow-ups in the first year. A social worker, occupational therapist or nurse dealt with concerns of return to work; team led by rehabilitation medicine specialist assessed patients capabilities; a neuropsychologist assessed psychological issues; physician dealt with exacerbations and GP received a report for each	**Results** *Return to work or education (measured using number of participants returned to work)* At 12 months post-injury: • Multidisciplinary outpatient treatment = 49/81 (60%) • Usual care by GP = 50/70 (71%) *Change in ADL (measured using Glasgow Outcome Scale) [Median (range)]* Scale: 1-8, higher = better At 12 months post-injury: • Multidisciplinary outpatient treatment	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomization process 1.1 Was the allocation sequence random? Y. "For each hospital, the participants were randomised into two groups by simple randomisation with 1:1 allocation ratio according to a computer-generated list of random number assignment generated by an independent researcher" (page 477) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PY. "The allocation sequence was concealed from the multidisciplinary team, a person who did not participate in the study stored the lists and envelopes with group allocations from the lists were made". Although it was not mentioned whether the envelopes where opaque and sealed, the person in charge of the envelopes was not part of the

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** To evaluate the efficacy of a multidisciplinary outpatient follow-up programme compared to follow-up by a general practitioner for patients being at-risk or sick-listed with persistent post-concussion symptoms two months after a mild traumatic brain injury. **Study dates** March 2009 – February 2012 **Source of funding** This study received funding from the Norwegian Extra Foundation for Health and Rehabilitation.	55) Gender (M/F): • Multidisciplinary outpatient treatment = 49/32 • Usual care by GP = 43/27 Time since injury: not reported but inclusion criteria states between 6-8 weeks. Injury cause (Traffic accident/fall/assault/sports injury and other) • Multidisciplinary outpatient treatment (n) = 23/30/16/12 • Usual care by GP (n) = 21/26/11/12 Severity of injury: not reported **Inclusion criteria** • Participants had to: • Be aged 16–55 years • Be diagnosed with TBI (ICD-10 code S06.0–S06.9) • Consecutively admitted to the Department of Neurosurgery with TBI • Have had sustained symptoms 6-8 weeks post-mild TBI (defined as ○ Glasgow Coma Scale	follow-up. Patients received education and shared their experiences at group sessions • *Control group: Usual care by GP.* Follow-up by a GP after multidisciplinary examination. GP could refer to specialists or allied healthcare professionals.	(n=69) = 7 (5-8) • Usual care by GP (n=56) = 7 (5-8)	study. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N. "As shown in Table I, there were no significant differences between the two groups at baseline two months after the injury" (page 479) *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? Y – Participants were unblinded to allocation. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? Y – Participants were unblinded to allocation. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI - There is no indication of any deviations from the intended intervention. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? NA. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? NA. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat

Study details	Participants	Interventions	Outcomes and Results	Comments
	13–15 within 30 min or the lowest score during the first 24 hours ○ Unconsciousness less than 30 min ○ Post-traumatic amnesia less than 24 hours • Be hospitalised for five hours or longer • Provide written consent • Be either sick-listed or at-risk to be sick-listed with persistent post-concussion syndrome symptoms two months after the injury. **Exclusion criteria** • Major psychiatric diseases or other diseases (previous head trauma) that impacted on working skills • Unemployed in the last 6 months • No Norwegian language skills • Diagnosed with substance abuse			analysis. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Return to work – Y. No loss to follow up reported.; Changes in ADL – N. 126/151 (83%) of participants with data available (70/81 in intervention group and 56/70 in control group) 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? Return to work – NA; Changes in ADL – N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? Return to work – NA; Changes in ADL – PY. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? Return to work – NA; Changes in ADL - PN. Attrition balanced across groups (although reasons not reported). *Risk-of-bias judgement:* Return to work – low risk; changes in ADL – some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the

Study details	Participants	Interventions	Outcomes and Results	Comments
				outcome inappropriate? N. Outcomes were measured appropriately using validated instruments 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Measured using same procedures at comparable time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Return to work - N. Sick leave data obtained from Norwegian Labour and Welfare Service through Statistics Norway which blinded data before sending it to the 1st author. Changes in ADL – PY. Researchers and participants were unblinded 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Return to work – NA; Changes in ADL – PY. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Changes in ADL – PN. Measured using validated and standardised measurements. *Risk-of-bias judgement:* Return to work – low risk; changes in ADL – some concerns Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was

Study details	Participants	Interventions	Outcomes and Results	Comments
				finalized before unblinded outcome data were available for analysis? Y – Protocol registered with ClinicalTrials.gov (NCT00869154) prior to study start date. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? Y – Published protocol states outcome data to be collected at 6 and 12 months, however, only 12-month outcome data were reported. 5.3 ... multiple analyses of the data? NI. *Risk-of-bias judgement:* High risk <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** Hospital length of stay reported but only median (range) with no statistical analysis.
Full citation Wiechman, Shelley A., Carrougher, Gretchen J., Esselman, Peter C., Klein, Matthew B., Martinez, Erin M., Engrav, Loren H., Gibran, Nicole S., An expanded delivery model for	**Sample size** N = 81 (randomised) • Extended care practitioner + telephone calls = 40 • Standard outpatient care = 41 N = 78 (analysed) • Extended care practitioner + telephone calls = 38	**Interventions** • *Intervention group: Extended care practitioner (ECC) + telephone calls.* The same standard outpatient care given to the control group as well as a reminder of upcoming telephone call schedule. They were contacted by ECC 24 to 48h post-discharge and at weeks	**Results** *Patient satisfaction (measured using author patient satisfaction survey) [Mean (SD)]* Higher = better At 6 months:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? NI. 1.2 Was the allocation sequence concealed until participants were

Study details	Participants	Interventions	Outcomes and Results	Comments
outpatient burn rehabilitation, Journal of burn care & research : official publication of the American Burn Association, 36, 14-22, 2015 **Ref Id** 1111693 **Country/ies where the study was carried out** USA (assumed based on authors' affiliation) **Study type** RCT **Aim of the study** To overcome the barriers to effective burn rehabilitation by utilizing an expanded care coordinator (ECC) to supplement the existing outpatient services. **Study dates** Not reported	• Standard outpatient care = 40 **Characteristics** Age in years [Mean (SD)]: • Extended care practitioner + telephone calls = 43.23 (16.92) • Standard outpatient care = 43.68 (17.13) Gender (M/F): • Extended care practitioner + telephone calls = 25/15 • Standard outpatient care = 29/12 Time since injury: not reported. TBSA [Mean (SD)]: • Extended care practitioner + telephone calls (%) = 35.5 (42.91) • Standard outpatient care (%) = 38.0 (43.37) Inclusion criteria Participants had to: • Be aged ≥18 years old • Have burn size: ○ >15% TBSA ○ <15% TBSA that required surgery for wound	2, 4, 8, and 12, and months 5, 7, and 9. The calls were semi-structured to ensure that all domains were covered - first part of the interview reviewed medical or psychological issues and second part reviewed progress made on patient-set goals. Phone calls were recorded and supervised by the primary investigator. The ECC was a 'bachelor's level professional' (no further details provided) who was trained (on interviewing, burn pathophysiology and also observed treatment) an d supervised weekly by the PI. A team of surgeons, physicians, psychologists, nurses, therapists, vocational rehabilitation counsellor were available to assist the ECC with issues that had arisen during phone calls. ECC could encourage attendance at local support groups, assist with worker's compensation claim and facilitate participant's contact with employer. • *Control group: Standard outpatient care.* Advice before discharge and follow-up phone call 24h post-discharge, outpatient clinic visits every 2 weeks and 1-2	• Extended care practitioner + telephone calls (n=40): 8.9 (1.6) • Standard outpatient care (n=38): 8.4 (2.1) • No difference between groups (p = 0.0.0878, regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 8.4 (2.1) • Standard outpatient care (n=38): 7.5 (3.0) • No difference between groups (p = 0.0929 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Overall quality of life (measured using SF-12 Physical component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months:	enrolled and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN - No formal statistical comparisons at baseline but participants' characteristics appear to be balanced across groups. *Risk-of-bias judgement:* Some concerns *Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)* 2.1. Were participants aware of their assigned intervention during the trial? NI – Study states it is a single-blind trial but no information given on who is blinded. 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? NI – Study states it is a single-blind trial but no information given on who is blinded. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y – Only 33% of intervention group completed 7/8 phone calls and 23% completed 8/8 phone calls. The rest only completed ≤ 6 phone calls. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y.

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Not reported	closure ○ <15% TBSA located on the face, hand, or over the joint • Give informed consent **Exclusion criteria** Not reported	months after. Seen at outpatient clinic visits by multidisciplinary team that includes a nurse a surgeon, a physical and occupational therapist, vocational counsellor and a psychologist.	• Extended care practitioner + telephone calls (n=40): 48.8 (8.0) • Standard outpatient care (n=38): 44.1 (11.9) • No difference between groups (p = 0.4261 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 50.1 (11.8) • Standard outpatient care (n=38): 53.7 (15.3) • No difference between groups (p = 0.7162 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Overall quality of life (measured using SF-12 Mental component score) [Mean (SD)]* Scale 0-100, higher = better At 6 months:	2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y – Intent to treat. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? Y – Data available for 78/81 participants (40/41 in intervention group and 38/40 in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA. *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? N - There is no indication that

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Extended care practitioner + telephone calls (n=40): 51.1 (8.6) • Standard outpatient care (n=38): 49.2 (11.5) • No difference between groups (p = 0.7353 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 51.2 (10.0) • Standard outpatient care (n=38): 46.8 (12.5) • No difference between groups (p = 0.7162 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) *Changes in ADL (measured using GAS) [Mean (SD)]* Higher = better At 6 months: • Extended care practitioner + telephone	measurement differed between study groups 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI – Study states it is a single-blind trial but no information given on who is blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NI – Study states it is a single-blind trial but no information given on who is blinded. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? Patient satisfaction – PY. Very subjective measurement with little information given on the tool used. Quality of life and changes in ADL – PN. Measurements conducted using a standardised and validated instrument. *Risk-of-bias judgement:* Patient satisfaction - high risk; Quality of life and changes in ADL – some concerns <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from...

Study details	Participants	Interventions	Outcomes and Results	Comments
			calls (n=40): 55.5 (13.5) • Standard outpatient care (n=38): 58.1 (14.8) • No difference between groups (p=0.1286 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls) At 12 months: • Extended care practitioner + telephone calls (n=40): 59.0 (14.2) • Standard outpatient care (n=38): 57.9 (13.6) • No significant difference between groups (p=0.0902 regression analysis adjusting for sex, age at injury, ethnicity, TBSA, location and number of calls)	5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PY - There were other planned outcomes such as return to work which were collected but not reported beyond a sentence saying there was no difference in any outcome at any time point. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* High risk Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** Length of hospital stay also reported but before the start of intervention so not appropriate to extract.

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

Table 14: Qualitative evidence tables

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Full citation	**Recruitment strategy**	**Findings (including author's**	**1. Was there a clear statement of the**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Barclay, Linda, Lalor, Aislinn, Migliorini, Christine, Robins, Lauren, A comparative examination of models of service delivery intended to support community integration in the immediate period following inpatient rehabilitation for spinal cord injury, Spinal Cord, 2019 **Ref Id** 1181411 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** July 2018 - January 2019	Convenience sampling of spinal services in higher-income countries. Researchers identified 15 spinal services through personal contacts of 1st author or spinal service websites. These services then nominated the most appropriate person to interview about the methods used to facilitation community reintegration. *Inclusion criteria* Participants had to: • Be a spinal service in developed economy *Exclusion criteria* Not reported. **Setting** Spinal services in high-income countries. **Participant characteristics** N = 10 spinal service centres • N = 12 healthcare professionals • Country (N): ○ Australia = 2 ○ Canada = 2 ○ New Zealand = 1 ○ Norway = 1 ○ Sweden = 1 ○ UK = 1 ○ USA = 2	**interpretation)** • Author's theme: Models of service delivery ○ Sub-theme: Peer mentors - Example quote: *"Because they're in the building and you can refer to them pretty easily, often they'll identify somebody to be a peer mentor and to be their go-to if they have questions on the clients, and they'll often visit that person while in inpatients but sometimes in outpatients as well." (p6)* ○ Sub-theme: facilitating community integration during inpatient rehabilitation - Example quote: *"They come back for ending the rehabilitation period, where they can say that okay you have been [home]—you have noticed that this and this and this is difficult when you come home, and we are going to have more focus on these things so you can manage when you come home." (p4)* • Author's theme: Services provided ○ Sub-theme: telehealth - Example quote: *"We have been working a lot with*	**aims of the research? (Yes/Can't tell/No)** Yes - To describe and compare service delivery approaches that aim to support re-integration into the community following SCI in-patient discharge. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of healthcare professionals regarding SCI rehabilitation service delivery. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** No - SCI services were approached based on 1st author contacts on spinal service websites. Using 1st author contacts and personal communication for recruitment introduces a strong possibility of selection bias. No methods described to mitigate this. Additionally, no information given on how the websites were identified e.g. search engine. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	No further details reported. **Data collection and analysis** 30-90 minute semi-structured interviews conducted via Zoom. Questions were designed to be open ended, asking participants to describe the models employed by their services to facilitate reintegration into the community. Interviews were audio recorded before being transcribed verbatim and checked by the researcher conducting the interview. Thematic analysis using the topic guide as initial framework. 1st author familiarised themselves with the transcripts before independently coding and identifying potential themes. Constant comparison was then used to develop final themes and sub-themes.	*pressure ulcers the last years, so we now have a videoconferencing service for some of the patients that are living at home, where we have a videoconference to the patient's home, together with the nurses in the municipality, who are treating the pressure ulcers from day to day." (p6)* ○ Sub-theme: vocational services - Example quote: *"The return to work happens at inpatient, actually. They really like to start as early as they can, so the primary OT puts in a referral and the patient meets one-on-one with one of our community reintegration therapists - and they're typically OT by background - and what they do is they start speaking to the employer early on about what kind of adaptations and modifications they might need to return to work." (p6)*	Yes - Data collection method discussed and justified. No details given on how the topic guide was developed but it is published in the article and appears to be well balanced. Data saturation not discussed but not necessary for the aim of the study (comparison of services). **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - No details reported. Interviews were conducted by 1st and 2nd author. The 1st author is well known in the field of SCI rehabilitation and knew some of the participants personally. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval granted by Monash University Human Research Ethics Committee. However, no mention of informed consent. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Adequate description of analysis process and how the themes were derived. Good presentation of data to support findings. 1st author independently coded transcripts , developed themes and finalised themes. The only discussion surrounding credibility is a brief mention of discussion of themes during regular team meetings. No mention about researcher bias.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			9. Is there a clear statement of findings? (Yes/Can't tell/No) Yes - Good description and discussion of findings, with relation back to the original research question. Brief discussion about credibility of findings. **10. How valuable is the research?** High value for current question - Aim specifically matches the aim of this question. Includes UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious concerns **Source of funding** This study received funding from the Transport Accident Commission. **Other information** None
Full citation Braaf, Sandra, Ameratunga, Shanthi, Nunn, Andrew, Christie, Nicola, Teague, Warwick, Judson, Rodney, Gabbe, Belinda J., Patient-identified information and communication needs in the context of major trauma, BMC health	**Recruitment strategy** Purposive sampling from parent longitudinal study. Participants fitting inclusion/exclusion criteria at 3 years post-injury were contacted to complete a structured follow-up interview before being invited to complete a longer, more detailed telephone interview. *Inclusion criteria*	**Findings (including author's interpretation)** • Author's theme: Information needs: Inpatient discharge ○ Example quote: *"As I was leaving hospital, or before I was discharged, something could have been said about some kind of counselling or just*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore major trauma patient's experiences of communication with healthcare professionals in the initial 3 years post-injury, in hospital, rehabilitation and community settings. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
services research, 18, 163, 2018 **Ref Id** 1109524 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** July 2014 to July 2015	Participants had to: • Be injured between 1st July 2011 - 30 June 2012 • Be ages 17 years old and over • Be registered with Victorian State Trauma Registry (i.e. death related to injury [either at scene or in-hospital]; ○ Admitted to ICU for more than 24 hours ○ Urgent surgery for intracranial/intrathoracic/intra-abdominal trauma ○ Urgent surgical fixation of pelvic or spinal fractures ○ Multiple traumatic injuries with an Injury Severity Score of over 12) *Exclusion criteria* • Patients with severe TBI or SCI who have been studied in another research study • Patients not able to converse in English **Setting** Victorian State Trauma System including 2 adult major trauma hospitals and 1 paediatric major trauma hospital **Participant characteristics** N = 65 adults with major trauma • Age [mean (SD)]: 50.7 (15.5) years	*some kind of number to contact." (p5)* • Author's theme: Information needs: Community care ○ Example quote: *"I came out of rehab on a very strong course of medication, and I really didn't know who I should be speaking to about that… I wasn't sure I needed it anymore but couldn't get a definitive answer anywhere on that." (p6)* • Author's theme: Accessing, using and understanding information: Consistency of information ○ Example quote: *"For me it would have been no good telling me anything at (hospital name). Perhaps if (hospital name) issued you ... a (written) summary of what your injuries were when you were brought in, what you were diagnosed with and resulting treatments that they performed. [Male,17–29yrs, road traffic injury #581]" (p8)* • Author's theme: Accessing, using and understanding information: Access to information ○ Example quote: *"Because once you get your discharge it's like you're on your own. You got to do it yourself... you feel sort of*	Yes - Appropriate to explore the long term experiences of trauma survivors in communication with healthcare providers. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Purposive sampling could introduce some selection bias but decreased by the inclusion/exclusion list. Additionally, a wide range of characteristics were sought. However, there is a lack of information on how patients were initially contacted or recruited to RESTORE. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - 3 years later, which gives a fuller picture but relies on memory only. Author's acknowledge that this means that only the communications with the greatest impact are likely to be identified. Topic guide developed from trauma literature and published in the article for transparency. Data saturation not mentioned. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Gender (M/F): 42/23 • Length of hospital stay [median (IQR)]: 11 (5.4 - 26.5) days • Injury cause (N): ○ Traumatic: 65 - Motor vehicle: 22 - Fall: 12 - Motorcycle: 6 - Pedal cyclist: 6 - Other: 19 **Data collection and analysis** Semi-structured telephone interviews (median 47 minutes each). Interviews took place between July 2014 - July 2015. Interviews were audio-recorded and transcribed. Thematic framework analysis. All interviews were read by 1st author, with a sample read by multiple other researchers. Initial coding was performed by 1st author, creating a list of emerging patterns. A framework of themes and sub-themes were then developed by 2 other authors. The other researchers who read a sample of the transcripts refined the framework and a final consensus was achieved through group discussion.	*alienated.." (p7)* • Author's theme: Accessing, using and understanding information: Information coordination ○ Example quote: "I didn't have one particular person giving you all the information. It was just the medical staff as they came through. It was only at the end that I recall, that I got the information all put together." *(p7)* • Author's theme: Accessing, using and understanding information: Communication needs: a lack of patient engagement ○ Example quote: "So it seems like you're going along, you're doing your rehab, you're attending, you're making progress and then all of a sudden they'll come to you and say okay, you'll be finishing up in a couple of weeks – that's it... it seems a lot like they don't engage the patient very well." (p9) • Author's theme: Accessing, using and understanding information: Clarity of information ○ Example quote: "I suppose just a bit more of an overall understanding of what was (surgically) happening. So a bit more information, just of a general nature rather than	**tell/No)** Can't tell - No clear discussion, but researchers were not linked directly to any service provision. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study approved by The Monash University Human Research Ethics Committee and participating hospitals. Informed consent obtained prior to interviews. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Good description of analysis process and how the themes were derived. Adequate data presented to support findings. However, only 1st author initially coded the transcripts and developed themes in conjunction with another researcher (no mention of independence). Multiple investigators read a sample and provided input, but no mention of disagreements. Themes were finalised through consensus, although no mention of who was involved. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Brief discussion about credibility of findings. **10. How valuable is the research?**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
		specific medical sort of speak, just, I suppose in layman's terms." (p6)	High value for the current question - Specifically looking at trauma patients experiences transferring back to the community. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the Australian Government's National Health and Medical Research Council. **Other information** None
Full citation Christensen, Jan, Langberg, Henning, Doherty, Patrick, Egerod, Ingrid, Ambivalence in rehabilitation: thematic analysis of the experiences of lower limb amputated veterans, Disability and Rehabilitation, 40, 2553-2560, 2018 **Ref Id** 945375 **Country/ies where the**	**Recruitment strategy** Purposive sampling of Danish veteran amputees, identified through a national register of wounded military veterans held by Copenhagen University Hospital (the hospital designated to receive wounded armed forces personnel). *Inclusion criteria* Participants had to: • Have unilateral transtibial or trans femoral lower limb amputation • Have completed inpatient rehabilitation or be part of outpatient rehabilitation programme *Exclusion criteria*	**Findings (including author's interpretation)** • Author's theme: Physical rehabilitation versus psychosocial reintegration o Example quote: *"It could have been nice with a kind of big brother to lean on in this chaotic period, one that had an impact and could speak up one one's behalf." (p2557)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the continuity of care between in-patient and outpatient rehabilitation services for Danish veterans with lower-limb amputees. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore in-depth views and experiences Danish veterans when undergoing amputation rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
study was carried out Denmark **Study type** Phenomenological study **Study dates** November 2014 - February 2015	Not reported. **Setting** In the community following discharge from Copenhagen University Hospital **Participant characteristics** N = 6 adults with lower-limb amputations • Age [median (range)]: 32 (25-46) years • Gender (M/F): 6/0 • Time since amputation [median (range)]: 5.7 (2-17) years • Injury cause (N): ○ Traumatic: 6 ○ Explosion: 6 • Level of amputation (N): ○ Transtibial: 5 ○ Trans femoral: 1 **Data collection and analysis** 90-120 minute semi-structured individual interviews held in a quiet place of interviewee's choice. A topic guide was used to explore views on hospital physical rehabilitation and post-hospital physical rehabilitation. Observations		justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Purposive sampling used which can introduce some bias. However, justified by the small number of Danish amputee veterans. Inclusion criteria was applied in order to keep the sample homogenous, which is appropriate for such a specific population. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 2 forms of data collection were performed for different aspects of the data (interviews for in-depth exploration of individual experiences and observation to view social context of rehabilitation and perform any follow up). Topic guide was described briefly but not mention of how it was developed. Field notes were written up directly after observation settings to reduce recall bias. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - Lack of information presented on researcher's bias and influence. Important due to the fact that 1st author actively participated in the rehabilitation sessions and performed the initial data coding.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	were conducted over 4 rehabilitation sessions (2 hour sessions were taken by a hospital physiotherapist) which were available to any wounded veterans after initial rehabilitation had been completed. Observations were carried by the 1st author, who also actively participated in the sessions. Field notes were written directly after these sessions. Inductive latent thematic analysis. Field notes and interview transcripts were read 2 times before initial coding was performed and emerging themes were noted. These themes were applied to the whole data set, further developing the themes and sub-themes. These were defined following discussion with all authors and any results that did not fit the current themes were re-analysed for potential additional themes.		**7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study complied with Helsinki Declaration and was approved by Danish data protection agency. Informed consent obtained prior to interviews. Data protection and anonymity measures were described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Good description of analysis process and how the themes were derived. Adequate data presented to support findings. However, only 1st author initially coded the transcripts and developed themes. Emerging themes were then discussed, refined and finalised by the whole team during regular team meetings. No mention about researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Limited value for current question - Very specific population, including military healthcare settings. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Moderate concerns **Source of funding** This study received funding from the Danish Defence Agreement. **Other information** None

Full citation
Christiaens, Wendy, Van de Walle, Elke, Devresse, Sophie, Van Halewyck, Dries, Benahmed, Nadia, Paulus, Dominique, Van den Heede, Koen, The view of severely burned patients and healthcare professionals on the blind spots in the aftercare process: a qualitative study, BMC health services research, 15, 302, 2015
 	
Ref Id
1109654
 	
Country/ies where the study was carried out
Belgium
 	
Study type
General qualitative inquiry
	Recruitment strategy
	Purposive sampling.
	Adults with burn injuries Care coordinators contacted eligible participants, who then contacted the research team to be enrolled and set up semi-structured interviews. No further details reported.
	Healthcare professionals The responsible physician at each of Belgium's 6 burn centres and 1 rehabilitation centre for severe burn injuries were invited to participate. No further details reported. No further details reported.
	Allied healthcare professionals Sampled using a sampling grid to ensure a balanced selection of each burn centre and key rehabilitation professions and invited to focus groups. No further details reported.
	
	Inclusion criteria
	Participants with burn injuries had to:
	• Have a burn injury 6-24 months' old
		Findings (including author's interpretation)
		
		• Author's theme: Discharge protocol and procedures vary widely between burn centres
		  ○ Example quote: *"The discharge from the burn centre is considered as a crucial moment in the care process. Yet, most burn centres do not have a written discharge protocol." (p5)*
		• Author's theme: Initiatives to foster good practices in discharge planning are not widely implemented
		  ○ Example quote: *"Sunday evening they asked me 'Did it go well?' then I said 'It went pretty well, … yes,… but, … I lived all the week-end in a pigsty, cooking was nearly impossible because I could not properly use my fingers, etc. Next week-end, same story,*
			1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)
			Yes - To explore the rehabilitation and aftercare experiences of severe burn patients and the views of allied healthcare professionals.
			
			2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)
			Yes - Appropriate to explore the rehabilitation experiences of multiple participants.
			
			3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)
			Yes - Research design discussed and justified.
			
			4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)
			Yes - Purposive sampling might have led to bias in 1. when care coordinators contacted eligible patients and 2. when patients

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Study dates January - April 2013	• Satisfy the legal criteria for admission to a Belgium burn centre (out of 6 centres) Healthcare professionals: not reported. *Exclusion criteria* • Patients with Lyell syndrome (toxic epidermal necrolysis or Staphylococcal scalded skin syndrome) Healthcare professionals: not reported. **Setting** Home, following discharge from a burn centre **Participant characteristics** N = 57 individuals involved in burn injury rehabilitation • Burn patients and parents: 29 ○ Adult burn patients: 15 ○ Parents of children under 12 years: 8 ○ Parents of adolescents between 12-18 years: 3 ○ Adolescents between 12 and 18 years: 3 • Healthcare professionals working in burn rehabilitation: 24 ○ Physicians: 7 ○ Allied healthcare professionals :17	*and on Tuesday or Wednesday they let me go home." (p5)* • Author's theme: Discharge towards step down units or rehabilitation units ○ Example quote: *"We try to transfer patients from the burn centre to a general hospital ward to learn to function more autonomously, and go home after that." (p6)* • Author's theme: Ambulatory care in the hospital after discharge ○ Example quote: *"We have difficulties with the way the follow-up by physicians is organized. It's always an assistant or junior doctor. You just have to be Lucky with the one in front of you. You cannot build-up a trusting relationship. I remember a doctor coming in the room and he said: "Tell me, what happened?" I thought: "Are you serious? After all this time you want us to tell our story?" Isn't there something like a patient medical record? It does not give you the impression that this physician will be able to effectively evaluate whether the injuries evolve well" (p6)* • Author's theme: The crucial role of informal support after discharge	contacted researchers to confirm interest. However, variation in age, gender, if they underwent surgery, visibility of scars and more, ensured a wide range of patients and experiences. Invitations were sent to responsible physicians and representatives to ensure a range of professions included in healthcare professionals sample (although lack of information on how these participants were selected for interview). **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 3 forms of data collection were performed for different aspects of the data (semi-structured interviews to explore issues freely with the guarentee of anonymity, focus groups to see how the groups dynamic affects decisions made in burn aftercare and obervations of meetings to see the discussions within professional context). Topic guides developed for semi-structured interviews, based on prior visits to burn centres and scoping literature review. The guide was piloted with 4 participants, resulting in changes. These changes were not mentioned but the pilot interviews were not included in analysis. Focus groups were led by a moderator and included a reported to take notes of discussion. Interviews and focus groups were audio recorded and transcribed verbatim. Data saturation was reached. **6. Has the relationship between researcher and participants been**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	○ Burn care patient organisations: 4 *Characteristics of people with burn injuries (and their parents)* • Age (N): ○ (Parents of) children <12 years: 8 ○ 12-18 years: 3 ○ (Parents of) children 12-18 years: 3 ○ 18-30 years: 3 ○ 31-40 years: 1 ○ 41-65 years: 8 ○ >65 years: 3 *Characteristics of healthcare professionals* • Profession (N): ○ Care coordinators: 4 ○ Nurses: 4 ○ Physicians: 7 ○ Anaesthetist: 1 ○ Plastic surgeons: 5 ○ Rehabilitation medicine: 1 ○ Physiotherapist: 3 ○ Psychologists: 4 ○ Social workers: 2 **Data collection and analysis** 90-120 minute semi-structured interviews were held for patients, rehabilitation physicians and representatives for patient burn	○ Example quote: *"Fortunately, we had a psychologist at the hospital, otherwise, I would dare to say we wouldn't be a couple anymore" (p7)* • Author's theme: Communication and information towards the patient ○ Example quote: *"It is perhaps a silly detail, but at the start it is very difficult to estimate. You get a certificate for a three to six months leave and you think: "I will have a hard time during six months, but then it will all be over." Over… now I know that with burn injuries it will never be over" (p8)* • Author's theme: What makes reintegration in social life difficult? ○ Example quote: *"Patients with severe burn injuries are isolated from social life for months, sometimes even years. They are pulled away from their usual activities, their home, their family and friends. After hospitalization, they need to gradually pick up their former life, but with new bodily conditions" (p8)*	**adequately considered? (Yes/Can't tell/No)** Yes. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews/focus groups and ethical approval granted by all hospitals involved and the central ethical committee of the University Hospital Leuven. Methods of confidentiality described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Good description of analysis process and how the themes were derived. Adequate data presented to support findings. Multiple, independent researchers initially coded a sample of transcripts (14.3%), before 1 researcher applied to the rest of the interviews. No mention of larger group discussions to develop themes. No discussion of researcher bias or credibility of findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current question.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	organisations. Separate topic guides were developed for each different participant groups (including parents of adolescents and parents of children) informed by the literature and from burn centre site visits. The guide was focused around the main transitions experiences during rehabilitation, including discharge, return to home and reintegration into daily life. 2 x 150-minute focus groups were held for allied health professionals. These groups were hosted by a moderator, and included both an observer (taking notes on non-verbal cues) and a reporter (taking notes on the verbal discourse). Both interviews and focus groups were audio-recorded and transcribed verbatim. Constant comparative analysis. Transcripts were read before initial coding and identification of emerging themes. 14% of transcripts were coded independently by 2 researchers, and resulting node trees were integrated and compared. Discrepancies were discussed and a final node tree was agreed.		**Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/minor concerns **Source of funding** Not reported **Other information** None
Full citation Glenny, Christine, Stolee, Paul, Sheiban, Linda, Jaglal, Susan, Communicating during care transitions for older hip fracture patients: family caregiver and health care provider's perspectives,	**Recruitment strategy** Purposive sampling of adults with hip fracture post-surgery in acute care. Once they were enrolled, members of the patient's care network (family members and healthcare professionals) were identified and recruited.	**Findings (including author's interpretation)** *This study is included in Stolee 2019, a framework-based synthesis of 12 primary studies. To prevent double counting of the data, findings have only been extracted from this study if they do*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the communication experiences of caregivers and healthcare professionals during transitional care of elderly hip fracture patients from inpatient to community rehabilitation. **2. Is a qualitative methodology**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
International journal of integrated care, 13, e044, 2013 **Ref Id** 1179484 **Country/ies where the study was carried out** Canada **Study type** Ethnographic study **Study dates** January - December 2010	*Inclusion criteria* Participants had to: • Have a hip fracture • Be over 65 years old • Be able to converse in English *Exclusion criteria* • Patients with moderate to severe cognitive impairment **Setting** Throughout hip fracture rehabilitation pathway (including acute care, inpatient rehabilitation, convalescent care, home with home care, home without home care and retirement homes). **Participant characteristics** N = 35 individuals involved in hip fracture rehabilitation • Healthcare professionals working in hip fracture rehabilitation: 26 • Caregivers of individuals with hip fracture: 9 *Characteristics of healthcare professionals* • Profession (N): ○ General practitioner: 1 ○ Nurse care manager: 8 ○ Occupational therapist: 6 ○ Physiotherapist: 4	*not appear in the findings of Stolee 2019.* • Author's theme: Family caregivers and health care providers recognise caregivers' involvement is beneficial ○ Example quote: *"The health care providers and family caregivers acknowledged that family caregivers have an essential role in transitional care for elderly patients" (p5)* • Author's theme: No clear organisation or process is used to guide information sharing ○ Example quote: *"When [the patients] are discharged we have CCAC come in when they are involved, so we all everybody kind of talks to the family, like CCAC gets involved so it is just kind of like a whole team effort. . . I knew that it had been arranged already. I don't know by who but it had been arranged. (Inpatient rehabilitation, nurse)" (p8)*	**appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the experiences of caregivers and healthcare professionals. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Healthcare professionals were recruited from eligible patients, with the aim of recruiting 2 per healthcare setting of projected care pathway. Lack of information on no-responders but good number and variation across settings. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Use of semi-structured interviews described and justified. Carried out by experienced qualitative researchers. Interviews were audio-recorded and transcribed verbatim. Data collectors recorded notes every 30 minutes throughout the interviews, as well as field notes from time in healthcare settings and interviews. Notes included verbal and non-verbal cues, environment of interviews and personal feelings of researchers. However, data saturation not mentioned.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	○ Registered practical nurse: 6 ○ Retirement home care manager: 1 • Setting (N): ○ Acute care: 11 ○ Inpatient rehabilitation: 6 ○ Convalescent care: 2 ○ Home with home care: 3 ○ Home without home care: 2 ○ Retirement home: 2 **Data collection and analysis** Semi-structured interviews with 2 trained data collectors. 2 healthcare professionals from the discharge setting would be interviewed, 2 healthcare professionals from the admission setting would be interviews and 1 family caregiver would be interviews for each patient care transition. Topic guides were used and developed from prior field work with healthcare professionals. Interviews were audio-recorded and transcribed verbatim. Data collectors recorded notes every 30 minutes throughout the interviews, as well as field notes from time in healthcare settings and interviews. Notes included verbal and non-verbal cues, environment of interviews and personal feelings of researchers. Content-based analysis. Interview transcripts were read through by 2 independent researchers, who highlighted any data on information		**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes - Use of multiple researchers during interviews, and the comprehensive notes taken during the study. Notes were taken at 30 minute intervals during study process and contained verbal cues, non-verbal cues, environment in which interviews took place and researcher's feelings during interviews. Yes - Use of multiple researchers during interviews, and the comprehensive notes taken during the study. Notes were taken at 30 minute intervals during study process and contained verbal cues, non-verbal cues, environment in which interviews took place and researcher's feelings during interviews. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Study approved by the Office of Research Ethics (University of Waterloo), the Tri-Hospital Research Ethics Board and Community Care Access Centre. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Adequate description of analysis process and how themes were derived with adequate data presented to support findings. Initial coding was performed independently by 2 researchers, resolving differences via discussion. Final codes and themes were developed through consensus with all team members.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	exchange, before performing initial coding. Inter-coding agreement was established by cross-checking the coded transcripts and differences were resolved through discussion with both researchers. Final codes and themes were developed through consensus with all team members.		**9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Good discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current question - Only focuses on transition experiences between healthcare professionals and caregivers, rather than patients themselves. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/minor concerns **Source of funding** This study received funding from and Emerging Team Grant from the Canadian Institutes of Health Research. **Other information** Carers also included in sample but outside of PCC for this review. Data has not been extracted where possible.
Full citation Graff, Heidi J., Christensen, Ulla, Poulsen, Ingrid, Egerod, Ingrid, Patient perspectives on navigating the field of traumatic brain	**Recruitment strategy** Purposive sampling of people with TBI admitted to Copenhagen University Hospital between January 2010 and December 2014.	**Findings (including author's interpretation)** • Author's theme: Family involvement: family dependence ○ Example quote: *"After*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the rehabilitation experiences of adults with TBI up to 4 years post injury, including facilitators and barriers.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
injury rehabilitation: a qualitative thematic analysis, Disability and Rehabilitation, 40, 926-934, 2018 **Ref Id** 1182084 **Country/ies where the study was carried out** Denmark **Study type** Phenomenological study **Study dates** December 2014 - May 2015	*Inclusion criteria* Participants had to: • Be admitted to trauma centre at Copenhagen University Hospital between January 2010 and December 2014 • Be aged 18-60 years old at the time of admission • Have a mild, moderate or severe TBI (defined at 3-15 on the Glasgow Coma Scale) • Admitted to either ICU, neuro-intensive care unit or step-down unit • Able to converse adequately in Danish *Exclusion criteria* • People with concurrent SCIs • People with previous or concurrent neurological disorders **Setting** The community following discharge from a Trauma Centre. **Participant characteristics** N = 20 adults with TBI • Age (at recruitment) [median (range)]: 39 (25-63) years • Gender (M/F): 12/8	*discharge, I was very exhausted and slept most of the day. We have two small children, so the doctor and I decided that it was for the best that I moved in with my parents to get some peace and quiet, which can be difficult to find in a home with small children. (Jack, male, 39, moderate TBI)" (p930)* • Author's theme: Family involvement: family influence ○ Example quote: *"My dad has since the day I was run down struggled with the municipality to get me to the proper rehabilitation. While I was in the program my dad helped me to get two months of rehabilitation. (Steven, male, 25, severe TBI)" (p930)* • Author's theme: Rehabilitation impediments: lack of transparency ○ Example quote: *"I have been missing some information and notice about what is going to happen and when. Because very often things happen simultaneously, and that is very frustrating when you have a traumatic brain injury. (Dorothy, female, 56, moderate TBI)" (p931)* • Author's theme: Rehabilitation impediments: lack of systemic	**2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of TBI rehabilitation in adults. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. 1-4 years post hospital discharge might introduce recall bias but appropriate for study aim. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Purposive sampling may have led to potential bias but eligible participants were identified from retrospective hospital records, and a good range of participants contacted. Numbers and reasons of those who declined to participate are reported. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 1st author conducted the interviews was not very experienced in qualitative interviews but was supervised by experienced team. Topic guide used (although no mention of how it was developed). Issues with participants recalling acute phase of TBI but outside of scope for this question. Interviews audio recorded and transcribed verbatim. Data saturation reached.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Time since injury: not reported. • Injury cause: not reported. • Severity of TBI as measured with Glasgow Coma Scale (N): o Mild: 8 o Moderate: 7 o Severe: 5 **Data collection and analysis** 30-90 minute semi-structured interviews conducted either in-person or via telephone, concentrating on their experiences of TBI rehabilitation journey and transitions. These interviews were conducted by first author. Field notes were taken during the interviews and used in the data analysis. Due to the theory that different severity of TBI would have different rehabilitation journeys, TBI severity of participants determined when they were invited for interviews - mild TBI interviewed 1-2 years post-injury, moderate TBI interviewed 2-3 years. post-injury and severe TBI interviewed 3-4 years post-injury. Hermeneutical phenomenological thematic analysis. 1 research read the interview transcripts and field notes to familiarise themselves with the data, before agreeing on these codes with another member of the research team. Sub-themes and themes were discussed between the research team before	follow-up o Example quote: *"I would have liked some sort of checkup. Or they could have given me some written information that told me not to panic. But no one could give me an exact answer. I didn't know whether I should call my general practitioner, the physiotherapist or the hospital myself or not to. For instance, can I go to work or should I take it easy? (Jason, male, 39, mild TBI)" (p931)* • Author's theme: Rehabilitation impediments: lack of age-appropriate rehabilitation o Example quote: *"They have offered me rehabilitation in a gym on an exercise bike, which can be great for some people, but not for a young person with a traumatic brain injury. I want a good life later and I have more cognitive problems than physical. Then it's not enough. (Steven, male, 25, severe TBI)" (p931)*	**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - Lack of information presented on researcher's bias and influence. Important as interviews (and subsequent field notes) were conducted by 1st author. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent given before interviews and ethical approval granted by the Danish Data Protection Agency Danish National Board of Health and Medicines Authority. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Good presentation of data to support findings. Rigour was ensured by 2 researchers agreeing initial codes (although only 1 performed the initial coding) and the entire team developing final themes. Results were compared with previous studies, supporting data from patient journals used to both personalise interviews and verify the clinical information given in the interview e.g. cause of accident. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	defining them.		findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Moderate value to the current question - Long term follow-up of trauma patients in the community. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No/very minor concerns **Source of funding** This study received funding from by the Rigshospitalet Research Foundation and Helsefonden. **Other information** None
Full citation Isbel, Stephen T., Jamieson, Maggie I., Views from health professionals on accessing rehabilitation for people with dementia following a hip fracture, Dementia (London, England), 16, 1020-1031, 2017 **Ref Id**	**Recruitment strategy** 3 experts in the area of hip fracture and dementia were contacted to participate in the trial. They were then asked to identify any other healthcare professionals with experience in the area who would be willing to participate. *Inclusion criteria* Participants had to: • Be currently practicing in orthopaedics, rehabilitation or aged care • Have a large proportion of their	**Findings (including author's interpretation)** • Author's theme: What works well ○ Example quote: *"'Part of the other agenda is how you blend in the family into the rehabilitation. I think that's another area that could be worked on" (p1027)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the experiences and opinions of healthcare professionals regarding how dementia affects rehabilitation care after hip fracture. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore experiences and views of healthcare professionals. **3. Was the research design appropriate**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
1110315 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** Not reported.	patients consisting of elderly people with fractures *Exclusion criteria* Not reported **Setting** Range of rehabilitation hospitals i.e. urban and rural. **Participant characteristics** N = 12 healthcare professionals working in hip fracture rehabilitation and dementia Occupation (N): • Clinical nurse specialist: 1 • Geriatrician: 5 • Nurse manager: 2 • Ortho-geriatrician: 2 • Physiotherapist: 1 • Rehabilitation physician: 1 **Data collection and analysis** 30 - 45 minute semi-structured interviews conducted via telephone, over a period of 4 weeks. Data analysis began after 6th interview was completed, using thematic analysis.		**to address the aims of the research? (Yes/Can't tell/No)** Yes - Design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** No - 3 experts were initially approached, with no explanation of how they were identified. They were then asked to volunteer other healthcare professionals in the area that might 'provide interesting insights and opinions'. Language is inherently biased. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Data collection method discussed and justified. Topic guide was used and published in write up but no mention of how it was developed. Data saturation reached after 9th interview. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received and reconfirmed before interviews and ethical

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			approval granted by the Human Research Ethics Committee (University of Canberra). **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of the analysis process and how themes were derived, using multiple, independent researchers. Adequate data presented to support findings. No discussion of potential researcher bias. 9**. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. No discussion of study credibility or limitations. **10. How valuable is the research?** Limited value for current question - Very specific population. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns. **Source of funding** This study received funding from the Dementia Collaborative Research Centre - Assessment and Better Care. **Other information** None

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

Full citation
Jeyaraj, J. A., Clendenning, A., Bellemare-Lapierre, V., Iqbal, S., Lemoine, M. C., Edwards, D., Korner-Bitensky, N., Clinicians' perceptions of factors contributing to complexity and intensity of care of outpatients with traumatic brain injury, Brain Injury, 27, 1338-1347, 2013
 	
Ref Id
1110342
 	
Country/ies where the study was carried out
Canada
 	
Study type
General qualitative inquiry
 	
Study dates
Not reported.
	Recruitment strategy
	Convenience sampling and snowball sampling. Potential participants were identified through clinical research co-ordinators at organisations running an outpatient TBI programme, plus e-mail posters and short presentations. No further details reported.
	
	Inclusion criteria
	Not reported.
	
	Exclusion criteria
	Not reported.
	
	Setting
	TBI rehabilitation outpatient clinics
	
	Participant characteristics
	
	N = 12 healthcare professionals working in TBI rehabilitation
	
	No demographic information reported.
	
	Data collection and analysis
	2 x 2-hour focus groups conducted in French (preferred language) plus 5 x 1 hour semi-structured interviews (4 in French, 1 in English). Before each, clinicians completed a brief questionnaire regarding socio-demographic information and their
		Findings (including author's interpretation)
		
		• Author's theme: Additional patient-related factors linked to complexity
		  ○ Example quote: *"A key point that surfaced throughout the discussions was that 'therapists working in TBI rehabilitation are not only treating the body but the person as a whole', the implications of such a therapeutic approach can be difficult to understand at the administrative level.(p1341)*
		• Author's theme: Factors relating to the patient's environment
		  ○ Example quote: *"return[ed] [. . .] to their usual environment often start again to take drugs and hang out with people who are of a bad influence" (p1342)*
		• Author's theme: Institutional barriers to optimal service provision
		  ○ Example quote: *"..such as family doctors or professionals working in CLSCs (community healthcare services in Quebec), [who] don't know the issues related to TBI" (p1343)*
		• Author's theme: Factors facilitating the intervention process
			1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)
			Yes - To explore healthcare professionals views on which rehabilitation factors affect complexity TBI outpatient rehabilitation.
			
			2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)
			Yes - Appropriate to explore experiences and views of healthcare professionals involved in TBI rehabilitation.
			
			3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)
			Yes - Research design discussed and justified.
			
			4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)
			Can't tell - Convenience sampling and snowball sampling can both introduce bias and there is a lack of information presented on the recruitment methods to discern if it was mitigated in any way. No information presented on who were emailed, where was included in the presentations and who declined to participate.
			
			5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)
			Yes - Semi-structured interviews and focus

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	experiences treating TBIs patients as outpatients. During focus groups and interviews, participants were asked regarding typical patients, complex patients, barrier and facilitators to caring for people with complex TBI and possible changes to improve services. Focus groups were conducted by 2 moderators with 2 assistants writing notes and a 3rd assistant writing a summary of comments to be reviewed by the group for accuracy. Individual interviews were conducted 2-on-1, with a moderator carrying out the interview and an assistant to take notes. Content-based thematic analysis. The entire research group were involved in identifying emerging themes and key points each question. Themes were finalised by consensus, using iterative coding and grouping. Quotes representing themes were categorised with the topic areas and entered into the analysis. Specific quotes were selected to represent certain themes.	○ Example quote: *"Another theme expressed by the clinicians focused on the impact that improved primary service provision has on the patients they see in out-patient care. Namely, they reported that the evolution of medicine, including the precision of medical tests, and the efficacy of post-TBI acute care delivery, greatly facilitates the management of cases referred for outpatient TBI rehabilitation" (p1343)*	groups both used in order to ensure maximum availability of clinicians. Researchers were all bilingual, so were able to translate the French into English, but there was no mention of which stage this occurred e.g. at the beginning or at the end. Also no mention of what happened to the notes assistants were taking during the groups and interviews. Audio recorded and transcribed. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Small amount of information presented on how collective analysis was used to validate findings but lack of information presented on researcher's bias and influence. Important during focus groups as it might have increased social acceptability bias. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - Article mentions that the study was approved by the Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal but no mention of ethical consideration specifically. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Brief description of analysis process and how the themes were derived. Poor presentation of data to support findings. All

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			transcripts were sent to all participants before analysis stage for verification (although no mention of validation after analysis). The entire research group were involved in identifying emerging themes and key points, with themes finalised by consensus (although no mention of independent coding). **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion of study limitations and future research directions. **10. How valuable is the research?** Moderate value for current question - Specifically looking at how TBI complexity affects rehabilitation. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from the School of Physical and Occupational Therapy, McGill University. **Other information** None
Full citation Jourdan, Claire, Bahrami, Stephane, Azouvi,	**Recruitment strategy** Participants were medical practitioners chosen to reflect the entirety of the TBI	**Findings (including author's interpretation)**	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To compare TBI care pathways and

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Philippe, Tenovuo, Olli, Practitioners' opinions on traumatic brain injury care pathways in Finland and France: different organizations, common issues, Brain Injury, 33, 205-211, 2019 **Ref Id** 1182358 **Country/ies where the study was carried out** France and Finland **Study type** Phenomenological study **Study dates** Not reported	care pathway. No further details reported. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** Across TBI rehabilitation care pathways in Ile-de-France (France) and Varsinais-Suomi (Finland). **Participant characteristics** N = 10 healthcare professions working in TBI rehabilitation • Working in Finland:6 • Working in France: 4 • Profession (N): ○ ICU practitioner:1 ○ Neuro-anaesthetist: 3 ○ Neurologist: 4 ○ Neurosurgeon: 2 • Department (N): ○ ICU: 4 ○ Neurological outpatient clinic: 1 ○ Neurosurgery: 2 ○ Physical medicine and rehabilitation: 1	• Author's theme: Availability of adequate services, from acute care to re-entry support ○ Example quote: *"Practitioners from both settings mentioned the insufficiency of dedicated beds in acute and post-acute care." (p208)* • Author's theme: Delays before comprehensive rehabilitation Example quote: *"Whether in an outpatient or inpatient setting, comprehensive rehabilitation did not appear to start early enough." (p209)* • Author's theme: Pathway-related decision-making ○ Example quote: *"Decision criteria for admission to IR were reportedly less clear-cut than for other acquired brain injuries such as stroke." (p209)*	explore the views of healthcare professionals on TBI care provision in Varsinais-Suomi, Finland and Ile-de-France, France. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views of healthcare professionals on care provision. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Good justification of why a range of healthcare professionals were sought but lack of information presented on how participants were recruited. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - Data collection method discussed and justified. Topic guide used and published in the write-up. However, interviews were not audio recorded and instead were recorded using details field notes which involves a certain amount of translation before analysis begins. Data saturation not reached in data analysis but was in the individual interviews.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	○ Rehabilitation and Brain Trauma Care: 1 • Experience working in TBI rehabilitation (range): 8 – 25 years **Data collection and analysis** 45-60 minute semi-structured interviews conducted. The interviews covered details of TBI care received, finance, care transition and quality of care issues. Review questions were used to confirm interviewer's understanding of answers. Interviews were recorded using details field notes. Thematic analysis was used to code and organise data into themes.		**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - No details reported and analysis relying solely on field notes taken by the researcher. Interviewer only had experience of French TBI pathway, rather than both or neither. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - Study mentions that there was no legal need for ethical approval as patients were not contacted. No further details reported. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Adequate description of the analysis process and how themes were derived. Initial findings were verified by 1 participant from each area. Adequate data presented to support findings. No mention of multiple, independent assessors. No discussion of researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about limitations of study. **10. How valuable is the research?**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Limited value for current question - Lack of data concerning transition home. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious concerns **Source of funding** This study received funding from Société Française de Médecine Physique et de Réadaptation. **Other information** None
Full citation Kennedy, Nicole, Barnes, Jessica, Rose, Anna, Veitch, Craig, Bowling, Cott Dahlberg Degeneffe Gage Higgins Keightley Majdan McCabe McColl O'Callaghan Patterson Patton Patton Schlossberg Sheppard Sinnakaruppan Smith Turner Turner Turner Turner Turner Voss, Clinicians' expectations and early experiences of a new comprehensive rehabilitation case management model in a specialist brain injury	**Recruitment strategy** No details reported after study dates and the inclusion/exclusion criteria. *Inclusion criteria* Participants had to: • Be aged between 18-65 years old • Still be in a post-traumatic amnesia state as defined by Westmead Post-traumatic Amnesia Protocol • Have an expected admission between 2-6 months *Exclusion criteria* • Patients in a minimally responsive state • Patients with non-TBI	**Findings (including author's interpretation)** • Author's theme: Continuity of care ○ Example quote: *"Generally I think it is working really well. I think it has taken a lot of pressure off other therapists in relation to the contact person role. It is a lot smoother having one person do that coordination and transition into the community and linking services particularly rehabilitation for clients. (I4, inpatient therapist, T2)" (p68)* • Author's theme: Streamlining service delivery	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the views of healthcare professionals on the design, implementation and acceptability of a new comprehensive rehabilitation case management (CRCM) model. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views and experiences of healthcare professionals on the effects of a new case management model. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
rehabilitation unit, Brain Impairment, 13, 62-71, 2012 **Ref Id** 1179875 **Country/ies where the study was carried out** Australia **Study type** Qualitative case study **Study dates** May 2011 - September 2012	**Setting** Specialised TBI rehabilitation unit **Participant characteristics** N = 32 healthcare professionals working in TBI rehabilitation • T1 = 15 healthcare professionals o Brain injury unit clinician: 12 o Rehabilitation case manager: 3 • T2 = 17 healthcare professionals o Brain injury unit clinician: 10 o External stakeholders: 3 o Rehabilitation case manager: 4 No further demographic information reported. **Data collection and analysis** 20-40 min semi-structured interviews (either in person or via telephone) conducted at 2 time points (May 2011 and September 2011). During initial interviews, participants were asked about the new model and what impact it might have for patients and their caregivers. The follow-up interview concerned views on how the model was working, what changes they might make to improve the model and what impact the new model had on their practice. Interviews were audio-recorded and transcribed.	o Example quote: *"It really helps us to prioritise who needs to be picked up quickly versus those who are stable and may not need as much intervention straight away. (I2, community team, T2)" (p68)* • Author's theme: Driving discharge planning o Example quote: *"In the past, in case conferences, the same issues kept coming up. We were not moving anywhere and the process was so slow. I think having someone doing things and actually facilitating the process of discharge, things will flow on much better. So I can see the benefit. (I10, inpatient team, T1)" (p68)* • Author's theme: Transitions to external stakeholders o Example quote: *"It was really effective having the case manager Cc'ingme into those communications. I felt that I was really up to date. It has also been helpful because it has alerted me to some possible issues before the client came home, rather than finding them out as difficult surprises. (I15, external service provider, T2)" (p68)* • Author's theme: Potential challenges	Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell. No information reported after study dates and inclusion/exclusion criteria. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** No - Interviews were carried out on site, audio-recorded and transcribed. Interviews carried out at 2 time points in order to achieve a better evaluation, with 4 month time period described and justified. Brief description of interview content, although no mention of topic guide. Only 2 patients had been discharged at T2, meaning limited real world experiences and views of the discharge process. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval received from Human Research Ethics Committee and informed consent received from all participants

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Transcripts were coded, with themes and key ideas identified. Any issues were discussed with the research team, in order to make sure the results reflect the new models implementation and practice.	○ Example quote: *"Our rehabilitation case managers have picked up a lot of work. They need to attend case conferences, which for me working part-time takes away their availability to us. So it does have a reciprocal effect on the team. They may need increased hours to support that inpatient role. (I1, community team, T2)" (p69)*	**8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Brief description of analysis process and how the themes were derived. Only 1 person coded the transcripts, although full evaluation team discussed and resolved any issues. Good presentation of data to support findings. No further mention of credibility or researcher bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about limitations of study. **10. How valuable is the research?** High value for current question - Specifically evaluating case management intervention throughout the care pathway. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** Not reported. **Other information** None
Full citation Kornhaber, Rachel,	**Recruitment strategy** Maximum variation sampling. Eligible	**Findings (including author's interpretation)**	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Rickard, Greg, McLean, Loyola, Wiechula, Rick, Lopez, Violeta, Cleary, Michelle, Burn care and rehabilitation in Australia: health professionals' perspectives, Disability and Rehabilitation, 41, 714-719, 2019 **Ref Id** 1182463 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry **Study dates** 2016	participants were identified through professional registries and contacted with study details by the first author. *Inclusion criteria* Participants had to: • Be a healthcare professional • Working in adult burn care and/or rehabilitation • Working at a facility within Australia *Exclusion criteria* Not reported. **Setting** Range of burn rehabilitation settings (acute, rehabilitation and community). **Participant characteristics** N = 22 healthcare professionals working in burns injuries • Occupation (N): o Doctor: 4 o Nurse: 9 o Occupational therapist: 3 o Physiotherapist: 4 o Psychologist: 1 o Social worker: 1 **Data collection and analysis** Semi-structured interviews were	• Author's theme: Inter-professional collaboration o Example quote: *"So we actually didn't have a model of care or any … policies and procedures in place and we've kind of been working them out on the fly as well go." (p716)* • Author's theme: Integrated community care o Example quote: *"the strength is all of us working together. We all want what's best for the patient … there was a lot of silo functioning before and … we're getting a lot better, working together as a team and being able to listen to each other and what the concerns are. (N) (P18)" (p715)* • Author's theme: Empowering patients to self-care o Example quote: *"Because their lives have changed so drastically. In many cases it's the family that actually needs a lot more support than the patient" (p717)*	Yes - To explore healthcare professional's experiences of acute care and rehabilitation in patients with burn injuries. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the views of healthcare professionals involved in burn rehabilitation. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Maximum variation sampling used to recruit people from a variety of healthcare disciplines (although contacted by 1st author which might introduce response bias). Eligible participants were identified from professional registries but lack of information on which ones and how many. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Data collection method discussed and justified. Topic guide used was developed following literature review. Data saturation reached.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	conducted in person and via telephone depending on participant preference. Questions focused on healthcare professional's experiences of providing rehabilitation care, their current care pathways and resource implications. Thematic analysis was used to code and organise data into findings.		**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received and ethical approval granted by the Human Research Ethics Committee. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how themes were derived. Adequate data presented to support findings. Mentions that credibility, transferability, dependability and confirmability were used throughout the study (although lack of information on how this was achieved and no mention of multiple, independent researchers). **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings. **10. How valuable is the research?** Moderate value for current study - Wide range of perspectives sought across professions and settings. Non-UK data.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Overall methodological limitations (No or minor/Minor/Moderate/Serious) No/minor concerns **Source of funding** Not reported. **Other information** None.
Full citation Lindahl, Marianne, Hvalsoe, Berit, Poulsen, Jeppe Rosengaard, Langberg, Henning, Quality in rehabilitation after a working age person has sustained a fracture: partnership contributes to continuity, Work (Reading, Mass.), 44, 177-89, 2013 **Ref Id** 1180086 **Country/ies where the study was carried out** Denmark **Study type** Qualitative case study **Study dates**	**Recruitment strategy** Adults with bone fractures were recruited through therapists in public hospitals and municipalities across the region. Unsuccessful attempts were made to contact private service users. *Inclusion criteria* • Aged 18-64 years old • Experienced short- or long- term rehabilitation • Were employed • Not retired before accident *Exclusion criteria* Not reported. **Setting** In the community, after discharge from rehabilitation. **Participant characteristics**	**Findings (including author's interpretation)** • Author's theme: Patient's perspective: management continuity o Example quote: *"Then they suggested that I had a toilet chair placed in the living room, and we were speechless. I couldn't sit and . . . you know, in here where we eat and so. Then we worked it through, but my wife had to say – well you can send him home, but I am not sure I'll be here. I really had to get rough on them. Then we got through and it was okay" (p181)* • Author's theme: Therapists' perspective: transition process from the hospital to the community o Example quote: *"When we*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – To explore the experiences of orthopaedic trauma patients when transferring between acute hospital care and community settings. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes – Appropriate to explore the views and experiences of trauma patients when transferring between settings. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Maximum variation sampling used,

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
January - March 2009	N = 7 adults with bone fractures • Age [median (range)]: 51 (32-60) years • Gender (M/F) = 5/2 • Time since injury (range): 2-24 months • Fracture type (N): ○ Upper extremity: 3 - Simple:2 - Multiple: 1 ○ Lower extremity: 6 - Simple: 5 - Multiple: 1 **Data collection and analysis** Individual semi-structured interviews were audio-taped and transcribed verbatim. These were analysed inductively according to a grounded theory approach, between two researchers.	*know each other (employees across sectors) you get a larger framework of understanding for each other. You can easier agree that we want to solve this together. Instead, we use a lot of time on the phone and mail with people we do not know and maybe from day to day new therapists have to engage in new cases again [physiotherapist, hospital]" (p183)* • Author's theme: Therapists' perspective: continuity and return to work Example quote: *"I haven't heard anyone talk positively about the contact; they feel misunderstood by the system. They are sick and need time to recover" (p184)*	ensuring a wide range of accessibility levels (all age groups, healthcare funding and degree of rurality).However, there is a lack of information presented on the how the initial survey was administered/delivered. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Open interviews discussed and justified. The setting for interviews was chosen by the interviewee, with interviews audio-recorded and transcribed. Mentions that TBI might affect recall of events in the care continuum, which was mitigated by including significant others. No mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence although mentioned that interviews were carried out with minimal input from researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell - There is discussion of consent, but a caveat that Danish national law doesn't require permission from an ethics board for this type of study. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			Yes – Good description of analysis process and how themes were derived. Appears as though multiple researchers were used but no mention of independence. Good presentation of data to support findings. A summary of each interview was sent to participants for validation of the content, with all agreed with. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – Good description of findings with relation back to original question. Mention of participant validation although no discussion of limitations. **10. How valuable is the research?** Limited value for current question - Focuses on engagement with rehabilitation rather than coordination and delivery. Non-UK data. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor **Source of funding** Not reported. **Other information** None
Full citation O'Callaghan, Anna, McAllister, Lindy, Wilson, Linda, Insight vs	**Recruitment strategy** Maximum variation sampling using survey respondents from an earlier stage of the research. Characteristics	**Findings (including author's interpretation)**	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the concept of engagement throughout the TBI rehabilitation care

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
readiness: factors affecting engagement in therapy from the perspectives of adults with TBI and their significant others, Brain Injury, 26, 1599-610, 2012 **Ref Id** 1180418 **Country/ies where the study was carried out** Australia **Study type** Phenomenological study **Study dates** Not reported	used in the selection were degree of rurality, level and type of healthcare funding they were entitled to. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** In the community, following discharge **Participant characteristics** N = 23 • Adults with moderate-severe TBI: 14 • Significant others of adults with moderate-severe TBI: 9 *Characteristics of adults with TBI* • Age in years (N): ○ 18-25 years: 2 ○ 26-35 years: 3 ○ 36-45 years: 3 ○ 46-55 years: 3 ○ 56-65 years: 3 • Gender (M/F): 8/6 • Time since injury: not reported.	• Author's theme: Right service at the right time: things could have been different ○ Example quote: *"Even if they had have been able to give us a list of services, it may have saved us a lot of drama and hassle and heartache. They need to make you aware of this may happen and if that happens, do this and give you a checklist or something" (p1607)*	continuum and the factors that affect engagement. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore perceptions of engagement throughout the TBI rehabilitation care pathway. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Maximum variation sampling used to ensure wide range of accessibility levels. However, no information presented on the initial survey that participants were sampled from. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence although

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Injury cause: not reported. **Data collection and analysis** 45-150 min open interviews with minimal input from the researcher, focusing on the patient's views and experiences of the TBI rehabilitation journey. Significant others were also included in the interview process if they came with the patient to the interview. The setting for interviews was chosen by the interviewee. Interviews were audio-recorded and transcribed. Thematic analysis. Researcher's first listened to the recordings of interviews, noting key idea and common themes. Recordings were transcribed and hand-coded, before being loaded into NVivo and re-coded. First level codes were condensed into overarching themes, with the process repeated for 2nd order and 3rd order themes. Interviews were re-checked to ensure consistency with codes and participants were sent a summary of their interview for validation.		mentioned that interviews were carried out with minimal input from researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Can't tell – No information given. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell – Adequate description of analysis but no mention of researcher influence. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – Good description of findings and mention of participant validation. **10. How valuable is the research?** Limited value for current question. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns **Source of funding** This study received funding from Speech Pathology Australia Postgraduate Student Research Grant. **Other information** Significant others also included in sample but outside of PCC for this review. Data has not been extracted where possible.
Full citation	**Recruitment strategy**	**Findings (including author's**	**1. Was there a clear statement of the**

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

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Characteristics of adults with ABI • Age [mean (range)]: 44.6 (29-72) years • Gender (M/F): 10/9 *Characteristics of adults with ABI patients and family members* • Injury cause (N): o Traumatic: 34 - Assault = 6 - Falls = 7 - Motor vehicle accident = 17 - Sports/work-related injuries = 4 o Non-traumatic: 11 • Time since injury (range): 1 – 41 years *Characteristics of healthcare professionals* • Age [mean (range)]: 35.3 (19-60) years • Gender (M/F/Not reported): 11/18/3 No further details reported. <u>Stage 2</u> N = 21 • Adults with ABI: 12 • Family members of adults with ABI: 5 • Healthcare professionals: 4	*to have a large sum of money. MHS proceeded to tell the client that they could help the client have capacity to manage their money." (p170)* • Author's theme: Poor access to support: Organisational factors o Example quote: *"They're set out to manage people through…meetings, where people aren't actually in the meetings, so it's like a professionals meeting, which I think is ridiculous, urm or they don't actually go to the address, and they don't actually leave their offices – but their organisation just isn't set up for that frontline delivery." (p171)*	**adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes – Ethical approval granted by the University faculty ethics committee although informed consent poorly described. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes – Good description of the analysis process and how themes were developed. Adequate data presented to support findings. While only 1 researcher involved in coding, results were validated by another member of the research team. No discussion of researcher's bias. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. No discussion on credibility of findings. **10. How valuable is the research?** High value for current question - Good description of needs when transferring back into the community using both patients and healthcare professionals. UK data. **Overall methodological limitations (No or**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Characteristics of adults with ABI • Age [mean (range)]: 45 (36-72) years • Gender (M/F): 10/2 No further details reported. *Characteristics of healthcare professionals* • Age [mean (range)]: 42 (40-43) years • Gender (M/F): 1/3 No further details reported. **Data collection and analysis** Stage 1: Online questionnaire using platform SurveyMonkey, including free-text questions on the long-term needs following ABI. These questions were analysed using content analysis by 1 researcher, and checked by another member of the research team. Themes identified in this stage were used to inform a deductive framework for use in the analysis of stage 2. Stage 2: At the end of the questionnaire, participants were given the opportunity to complete follow-up semi-structured interviews on service needs and communication between healthcare and social care services. Interviews lasted		**minor/Minor/Moderate/Serious)** Minor concerns. **Source of funding** Not reported **Other information** Family carers also included in sample but outside of PCC for this review. Data has not been extracted where possible.

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	25-60 minutes, either in person (ABI patients) or via telephone (carers and healthcare professionals). Interviews were analysed using a mixture of inductive and deductive thematic analysis.		
Full citation Sena Martins, Bruno, Fontes, Fernando, Hespanha, Pedro, Barnes, Barnes Davis Fontes Fontes Goffman Guion Hahn Henriques Hughes Klein Leder Martins Martins Oliver Oliver Oliver Santos Somers Stiker Stone Turner Wall, Spinal cord injury in Portugal: Institutional and personal challenges, Journal of Disability Policy Studies, 28, 119-128, 2017 **Ref Id** 1183258 **Country/ies where the study was carried out** Portugal **Study type** Qualitative case study (within mixed methods study)	**Recruitment strategy** Purposive sampling of SCI patients and healthcare professionals in 3 Portuguese SCI rehabilitation centres in Portugal that specialise in SCI rehabilitation. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** SCI rehabilitation centre **Participant characteristics** N = 93 • Individuals with SCI in initial rehabilitation: 28 (fieldwork I) • Healthcare professionals working in SCI rehabilitation centre: 22 (fieldwork I) • Individuals with SCI living in community: 29 (fieldwork II) • Family and institutional support organisations: 14 (fieldwork II)	**Findings (including author's interpretation)** • Author's theme: Returning home ○ Example quote: *"Even the homes . . . There isn't enough provision . . . There are also long-term care units but a patient has to have clinical criteria to be admitted, social reasons are not enough. And this places great restrictions on us and sometimes people are here a very long time before they are discharged. (Social worker)" (p124)*	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore the experiences and views of patients undergoing SCI rehabilitation in Portugal. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore the experiences and views of SCI rehabilitation patients. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Research design discussed and justified. 2 stages used to cover the initial trauma recovery phase in hospital and then follow the challenges with reintegrating into the community after discharge. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Direct observation occurred in all 3 Portuguese rehabilitation centres specialising in SCI. Reasons given why 4th was not included. Purposive sampling was carried out for semi-structured interview

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

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

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

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Canada **Study type** Ethnographic study **Study dates** March 2010 - July 2010	Across several healthcare settings Setting (N): • Community: 5 • Hospitals: 10 • Rehabilitation centres: 2 **Participant characteristics** N = 17 healthcare professionals working in hip fracture rehabilitation • Profession (N): ○ Nursing: 3 ○ Occupational therapy: 4 ○ Physiotherapy: 4 ○ Physician: 2 ○ Social work: 4 • Experience in current profession (range): 8 months - 36 years **Data collection and analysis** 45-90 minute semi-structured interviews. The research team requested that interviewees also bring along any documents that they use during care transition in hip fracture rehabilitation. Interviews were audio recorded and transcribed by an external agency. Thematic analysis. Conducted by the 3 researchers who conducted the interviews. Firstly, each of these read 2 interview transcripts to develop the initial	*pre-discharge home visits are invaluable, they are rarely conducted" (p207)*	Yes - Research design discussed and justified. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - Convenience sampling used, with recruited participants being asked to encourage colleagues to participate. However, this is appropriate method due to the specific population targeted and only 4 participants were recruited through colleague encouragement. Additionally, a wide range of settings were contacted (including long-term care, residential care, private homes, acute hospital wards, sub-acute hospital wards and rehabilitation wards). **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Semi-structured interviews described and justified, with 80 documents used in transition seen alongside. Topic guide described briefly, although no mention of how it was developed. Multiple researchers with qualitative research experience. 1st few interviews were pilots with all researchers to ensures similarity. Interviews audio-recorded and transcribed. No mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	coding framework. This was applied throughout all transcripts by 1 researcher. Key themes relating to successful transitions were discussed and developed between the research team.		**tell/No)** Can't tell – Small amount of information presented on how peer debriefing was used to validate findings but no information presented on whether relationship between researchers and participants was considered. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Ethical approval granted by University of British Columbia ethics board and both participating healthcare regions in British Columbia. However, no mention of informed consent. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Rigour ensured by multiple methods of data collection with key themes developed between the research team. Additionally, final results were distributed to the healthcare professionals of 2 community settings and 2 hospital settings, and feedback on the data was sought. Adequate presentation of data to support findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes - Good description and discussion of findings, with relation back to the original research question. Discussion about credibility of findings.

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

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

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

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

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

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
April 2014 - March 2016	Observations of inter-professional meetings: no details reported Professions involved in semi-structured interviews (N): • Doctor: 1 • Nurse: 2 • Occupational therapist: 3 • Physical therapist: 2 • Psychologist: 3 • Social worker: 2 • Speech therapist/special education professional: 1 • Team coordinator: 2 Professions involved in focus groups (N): • Auxiliary nurse: 2 • Cultural educator: 1 • Nurse: 11 • Occupational therapist: 8 • Physiotherapist: 8 • Social educator: 2 • Social worker: 2 No further details reported. **Data collection and analysis** Observations of 8 inter-professional meetings containing between 2-14 participants. A number of these observation sessions and interviews took place before the focus groups in	*could be used much more both before the patient arrives and before the first patient interview, but many more could also have the opportunity for follow-up after discharge. I think that this is an important issue. [Nurse, individual interview, specialized rehabilitation services]" (p7)* • Author's theme: A lack of knowledge exchange and feedback during patient transitions ○ Example quote: *"The hospital does not have a full overview of the available services in different municipalities, because, of course, it has more than one municipality to consider, so it is somewhat a puzzle. Therefore, one [i.e. specialized rehabilitation professionals] should not promise something on behalf of others, as this could create expectations that cannot be met. [Coordinating unit leader, focus group, municipal rehabilitation services]" (p8)* • Author's theme: Reduced direct contact between specialised and municipal rehabilitation services ○ Example quote: *"A physiotherapist worked there [at a specialized hospital] who I could just call and consult with*	purposive sampling. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - 3 different types of data collection implemented, described and justified. This limits social acceptability bias introduced by focus groups. Collection occurred simultaneously, with results going to influence the questions/directions of future collections (although only a very brief discussion of how this occurred). Good range of professionals included in different settings. Data was audio recorded and transcribed verbatim, and was collected until saturation with reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - Lack of information presented on researcher's bias and influence. This is important considering the use of focus groups as a data source, with 1st author undertaking initial coding and no information on who conducted the groups/interviews. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Written informed consent received before observations/interviews and ethical approval granted by the Regional Committee for Medical and Health Research Ethics. Data protection methods described.

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

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

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	• Carers of adults with hip fracture: 19 • Healthcare professionals working in hip fracture rehabilitation: 92 No further details reported. **Data collection and analysis** 20-90 minute in-person semi-structured interviews conducted with participants transitioning across the hip fracture rehabilitation care pathway (range 1-4 transitions). Separate topic guides were developed for each of the participants with hip fracture, family members and healthcare professionals (including physical/occupational therapists, nurses, doctors, social workers and case managers). Interviews were audio recorded and transcribed verbatim. Framework-based synthesis of 12 manuscripts based on the same study. 2 lead authors individually familiarised themselves with the 12 included articles before identifying a thematic framework across the data together. Each paper was then coded with these themes in NVivo before charting key messages and points of intersection. The whole research team was then involved in organising themes and mapping them onto a transition of care framework.	*they would like to know how can I help my mom or how can I help my dad you know go up the stairs. . . . They're usually invited to observe a therapy session and that's when they learn and if they ask "OK, can I try to do that?" then by all means we spend time teaching them how to do things." (p417)* • Author's theme: 6 potential points of intervention: relationships ○ Example quote: *"To be honest, if there is something significant that they really want us to know right away they will call us. We do, we meet with the other site periodically for different practice events so we know who they are right and they feel comfortable calling. (Family physician)" (p417)* • Author's theme: 6 potential points of intervention: coordination of roles ○ Example quote: *"I don't work in acute care and I don't know what their workload's like and what their turnover is like and what they have access to." (p417)* • Author's theme: 6 potential points of intervention: documentation ○ Example quote: "Usually, 9 times out of 10 the information is there but it's not easy to find	**(Yes/Can't tell/No)** Yes - Semi-structured interviews justified. Different topic guides developed for each of the participants (although no mention of how it was developed). Interviews were audio recorded and transcribed verbatim. Data saturation not discussed but presumed to have been reached in a synthesis of 12 qualitative studies. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – Lack of information presented on researcher's bias and influence. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews and ethical approval granted by the University of Waterloo Human Research Ethics Committee, University of Alberta, and University of Laval. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** No - Good description of analysis process and how the themes were derived. Adequate presentation of data to support findings. The 2 lead authors familiarised themselves with the transcripts individually but developed themes together so not independent. Themes were finalised and mapped onto framework by whole research team. Considering the amount of data (12

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

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

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
	Characteristics of adults with ABI • Age [mean (range)]: 40.2 (17-63) years • Gender (M/F): 15/5 • Length of stay in inpatient rehabilitation (N): ○ <3 months: 12 ○ 3–6 months: 7 ○ >6 months: 1 • Injury cause (N): ○ Traumatic: 16 - Motor vehicle accident: 7 - Motor bike accident: 1 - Assault: 1 - Fall: 4 - Other: 3 ○ Non traumatic: 4 **Data collection and analysis** 3 x semi-structured interviews per participants - 1 prior to discharge, 1 and 1-month post-discharge and the last a 3-months post-discharge. Average interview length was 33 minutes for participants with ABI and 36 minutes for family member participants. Pre-discharge interviews were carried out in person and approximately 1 week before discharge from the unit. Interviews conducted after discharge occurred in	*privately funded participants and those living in rural/regional areas compared with those in metropolitan locations" (p826)*	designed based on clinical experience of authors and ABI literature, along with the principles of conducting interviews with ABI patients. Versions were created for patients and family members. Data saturation reached. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes - Reflexivity used throughout the data analysis using all members of the research team. Example given of how this reflexivity led to the refinement of semi-structured interviews, in order to make them more direct for patients with ABI. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received before interviews and ethical approval granted by the relevant committee at recruitment site and (unnamed) University. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - Good description of analysis process and how the themes were derived. Methods included triangulation of data sources by using ABI participants and family members, consensus coding, interviews conducted at 3 different time point. Good presentation of data to support findings. **9. Is there a clear statement of findings?**

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

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

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

Table 15: Quantitative evidence tables

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Braga, L. W., Da Paz, A. C., Ylvisaker, M., Direct clinician-delivered versus indirect family-supported rehabilitation of children with traumatic brain injury: a randomized controlled trial, Brain Injury, 19, 819-831, 2005 **Ref Id** 1206832 **Country/ies where the study was carried out** Brazil **Study type** RCT **Aim of the study** This study aimed to compare the effectiveness of primarily parent-	**Sample size** N=87 (randomised) • Family-supported rehabilitation=44 • Clinician-delivered rehabilitation=43 N=72 (analysed) • Family-supported rehabilitation=38 • Clinician-delivered rehabilitation=34 **Characteristics** Age in months [Mean (SD)]: • Family-supported rehabilitation = 97.66 (29.61) • Clinician-delivered rehabilitation = 96.95 (30.30) Gender (M/F): • Family-supported rehabilitation (n) = 20/18 • Clinician-delivered rehabilitation (n) =	**Interventions** • *Both groups:* 12 months of intensive, individualised rehabilitation programmes. • *Intervention group: Family-supported rehabilitation.* The intervention began with a 2-week assessment period, with scheduled hospital visits each morning. These visits consisted of multi-disciplinary assessments that identified areas needed for targeted rehabilitation (e.g. communication, activities of daily living). At least 1 parent attended each of these assessments, as well as daily support group meetings and training sessions. Information sessions included parental education on TBI, taught by trained members of the rehabilitation team. The support group and information sessions took place daily. Support meetings used a group therapy approach, encouraging parents to explore their feelings and concerns about their child's injury and rehabilitation, as well as share stories and coping	**Results** *Changes in ADL (measured using SARAH scale of motor development) [mean (SD)]* Higher=better. At baseline: • Family-supported rehabilitation: 2.5 (1.3) • Clinician-delivered rehabilitation: 2.4 (1.3) • No significant difference between groups At 12 months (post-intervention) • Family-supported rehabilitation: 3.1 (0.8) • Clinician-delivered rehabilitation: 2.6 (1.1) • Significantly higher (better) in the intervention group (p=0.018, Chi-squared test using proportions in each SARAH scale rating group)	**Limitations** **Quality assessment: Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2)** <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y - Computer-generated random number table. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI. 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N - None of the baseline characteristics were significantly different. *Risk-of-bias judgement:* Some concerns. <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? Y - Not possible to blind due to the nature of intervention. 2.2. Were carers and people

Study details	Participants	Interventions	Outcomes and Results	Comments
delivered rehabilitation exercises with specialist supervision to physician-delivered rehabilitation exercises with no family involvement. Secondary aims were to determine possible parental characteristics that might affect their ability to deliver the home rehabilitation exercises, and if children which most severe injuries responded better to the intervention. **Study dates** Not reported. **Source of funding** Not reported.	19/15 Time since injury* [Mean (SD)]: • Family-supported rehabilitation = 15.66 (7.18) • Clinician-delivered rehabilitation = 13.41 (6.71) * Unit of time not specified in study but likely to be weeks. Injury cause: not reported but inclusion criteria stated traumatic brain injury Severity of TBI (severe/moderate): • Family-supported rehabilitation (n) = 23/15 • Clinician-delivered rehabilitation (n) = 18/16 Glasgow Coma Scale score [Mean (SD)]: • Family-supported rehabilitation = 6.66 (3.30) • Clinician-delivered rehabilitation = 7.50 (3.80)	mechanisms with peers. Clinicians also performed home visits during this time, using these to inform a child's rehabilitation and increase integration of the programme into family routine. Each child had 2 case managers (ensuring at least 1 was available at all times) from rehabilitation specialities, relevant to a child's needs and goals, assigned to teach exercises to family members. Case managers also supported families, making home visits and school visits if needed. They organised referrals to other healthcare disciplines, and co-ordinated care. The assessment period informed the rehabilitation programme, rehabilitation goals and support programme. The rehabilitation programme was designed around simple activities that could be done at home using common household items. Tasks from different specialties were combined as appropriate, decreasing the number of different tasks children and parents had to carry out while targeting the same areas. To educate parents on the rehabilitation exercises, rehabilitation centre staff created a collection of over 200 illustrations designed to guide		delivering the interventions aware of participants' assigned intervention during the trial? Y - Not possible to blind due to the nature of intervention. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PY - Children in the intervention group could have received more intensive rehabilitation (more frequent or longer sessions than protocol) at home than children attending clinic for their sessions. 2.4 If Y/PY to 2.3: Were these deviations likely to have affected the outcome? Y. 2.5. If Y/PY/NI to 2.4: Were these deviations from intended intervention balanced between groups? N. 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - Intent to treat. 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA. *Risk-of-bias judgement:* High risk. <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all,

Study details	Participants	Interventions	Outcomes and Results	Comments
	*Unit of time not specified in study but likely to be weeks. **Inclusion criteria** Participants had to: • Be aged between 5-12 years old • Admitted to participating paediatric Rehabilitation centre • Diagnosed with moderate TBI (defined as Glasgow Coma Scale score 9-12 or >12 if accompanied by diffuse brain swelling/skull fracture/intracranial mass lesion) or severe TBI (defined as Glasgow Coma Scale ≤8) • Injury still in chronic stages (defined as sustained between 6-30 months before study commencement) • Chronic cognitive and/or physical impairment • Family consent for participation, as all	parents through the tasks, as well as help them modify everyday home routines to achieve rehabilitation objectives. It was decided to use illustrations rather than verbal instructions as many parents were illiterate or had difficulty with reading. For each child's rehabilitation programme, an individualised manual was created that included roughly 14 of these illustrations. Folders were updated regularly to include new tasks, in response to a child's progress and feedback. Parents began by watching professionals performed the rehabilitation exercises on their child but gradually assumed responsibility throughout the initial 2-week assessment period. This progression was based on parental competence and confidence in their skills, under the supervision of healthcare professionals. 2 families did not feel confident at the end of these 2 weeks, so received training for another week. After the assessment, parents took over the rehabilitation at home, attending bi-weekly (assuming 2 times a month but not stated) appointments at the paediatric rehabilitation centre. During these visits, progress was		participants randomized? N - 15/87 (17%) participants lost to follow-up (6 (13.6%) in intervention group, 9 (20.9%) in control group). 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? Y - Possible that participants with worse SARAH scores were unlikely to continue with treatment. 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - Although there is a difference in drop out rates between the 2 arms, the article reports that this is mainly due to the practical challenge of transporting children to and from the clinic. *Risk-of-bias judgement:* Some concerns. <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? N. 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN - Use of validated instrument (SARAH

Study details	Participants	Interventions	Outcomes and Results	Comments
	children were enrolled with either/both parents **Exclusion criteria** • Co-morbidities include: ○ Presence of significant vision or hearing loss ○ Severe psychiatric disorder ○ Frequent drug-resistant seizures • Child in a unresponsive state • Child not attending school • Family did not give consent for participation	evaluated, new goals were set, and any problems were discussed. Rehabilitation programmes were adjusted, and changes were made to manuals, with parents being fully trained in any new activities. • *Control group: Clinician-delivered rehabilitation.* 5 x 2 hour conventional rehabilitation sessions per week, given directly by rehabilitation healthcare professionals. Children attended an average of 91% sessions throughout the study period. Clinicians followed conventional rehabilitation procedures (dependent on their rehabilitation field), and treated children without parental presence. Clinicians were free to request consultations from other rehabilitation specialities and communicated with a child's school as needed (for information and instructions) but did not make any concerted effort to co-ordinate rehabilitation services. No home or school visits were carried out. Parents received no training about their child's rehabilitation but did attend information and support group sessions (as described in the intervention group) during the		scale), following similar procedures and at similar time points. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N - Assessors were blinded. 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA. 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA. *Risk-of-bias judgement:* Low risk. <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI. Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN. 5.3 ... multiple analyses of the data? PN. *Risk-of-bias judgement:* Some concerns.

Study details	Participants	Interventions	Outcomes and Results	Comments
		initial 2-week assessment period in order to help their coping of their child's trauma.		Overall risk of bias *Risk-of-bias judgement:* High risk. **Other information** None.

ADL: Activities of daily living; F: Female; M: Male; N: Number [or No if answering a risk of bias checklist question); NA: Not applicable; NI: No information; PN: Probably not; PY: Probably yes; SD: Standard deviation; TBI: Traumatic brain injury; Y: Yes

Table 16: Qualitative evidence tables

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Full citation Rashid, M., Caine, V., Newton, A. S., Goez, H. R., Healthcare professionals' perspective on the delivery of care to children with Acquired Brain Injury (ABI) and communication with their parents, Journal of Pediatric Rehabilitation Medicine, 11, 125-131, 2018 **Ref Id** 1183107 **Country/ies where the study was carried out** Canada	**Recruitment strategy** Invitations were sent by an intermediary to the entire multi-disciplinary team in brain injury clinic. Convenience sampling used to recruit healthcare professionals involved in long-term rehabilitation of children (and families) with ABI. *Inclusion criteria* Not reported. *Exclusion criteria* Not reported. **Setting** Brain injury clinic of large urban rehabilitation centre. **Participant characteristics** N = 15 healthcare professionals *(No further details reported.)*	**Findings (including author's interpretation)** • Author's theme: Reframing healthcare professional's roles and perceptions ○ Example quote: "for our complex cases with so many people involved there is the illusion that somebody will have their eyes on the child when discharged" (p. 128, Rashid 2018) • Author's theme: Practice rewards ○ Example quote: "When families become so strong and find the time to volunteer and give back to the community by assisting others, it is inspiring and rewarding and means that the system did well." (p. 128, Rashid 2018) • Author's theme: Finding ways	**1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - To explore healthcare professional's experiences and views regarding the needs of families' rehabilitation needs for children with ABI. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes - Appropriate to explore healthcare professional's experiences and views. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes - Appropriate to explore healthcare professional's experiences and views. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - Wide variety of professionals included in focus groups but convenience sampling introduces some bias. Additionally,

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
Study type General qualitative inquiry **Study dates** Not reported.	**Data collection and analysis** Semi-structured interview questions during 60-90-minute focus groups which took place in hospital. Interview scripts were designed to start initial conversations, with spontaneous conversation following as focus groups progressed. Thematic analysis conducted in 5 stages.	forward ○ Example quote: No quotes presented for this theme.	large urban rehabilitation centre may serve different ABI population than rural areas. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - Focus groups with semi-structured interview questions used and justified clearly. No mention of data saturation, but not necessary for aims of research. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell - No discussion surrounding relationship between researcher and participants. Important due to using focus group setting and semi-structured interviews. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - Informed consent received and ethical approval granted from Health Research Ethics Board (University of Alberta) and Alberta Health Services. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell - Discussion surrounding analytical rigour i.e. credibility and transferability. However, description of analysis does not include mention of multiple or independent researchers. Minimal raw data presented. **9. Is there a clear statement of findings?**

Study details	Methods and participants	Results	Risk of bias assessment using the CASP qualitative checklist
			(Yes/Can't tell/No) Yes - Discussion of evidence for and against findings, with reference back to original research question. **10. How valuable is the research?** Moderate value for current question – Good sections on how best to co-ordinate care using both healthcare and non-healthcare resources. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate concerns. **Source of funding** This study received funding from Alberta Centre for Child, Family and Community Research. **Other information** None

1 *ABI: Acquired brain injury; N: Number*

2

Appendix E – Forest plots

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

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

Forest plots for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

No meta-analyses were performed as only one study was identified.

Appendix F – GRADE and GRADE-CERQual tables

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

GRADE tables for quantitative evidence

Table 17: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Multidisciplinary care versus Usual care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary care	Usual care	Relative (95% CI)	Absolute		
Return to work or education (measured using number of participants who had returned to work) - At 6 months post-discharge												
1 (Browne 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	None	16/31 (51.6%)	26/35 (74.3%)	RR 0.69 (0.47 to 1.03)	230 fewer per 1000 (from 394 fewer to 22 more)	VERY LOW	CRITICAL
Length of hospital stay (days) (Better indicated by lower values)												
1 (Browne 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	None	31	35	-	MD 1.20 higher (4.55 lower to 6.95 higher)	VERY LOW	CRITICAL
Changes in ADL (measured using number of participants with impairment of ADL) - At 6 months post-discharge												
1 (Browne 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	None	16/31 (51.6%)	16/35 (45.7%)	RR 1.13 (0.69 to 1.85)	59 more per 1000 (from 142 fewer to 389 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using FIM; range between 18-126; better indicated by higher values) - At 6 months post-discharge												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary care	Usual care	Relative (95% CI)	Absolute		
1 (Browne 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	None	31	35	-	MD 0.27 lower (2.38 lower to 1.84 higher)	VERY LOW	IMPORTANT

ADL: Activities of daily living; CI: Confidence interval; FIM: Functional Independence Measure; MD: Mean difference RR: Risk ratio
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for number of participants returned to work 0.8 or 1.25; for hospital length of stay +/- 5.415; for FIM +/- 1.99)
3 95% CI crosses 2 MIDs (0.8 and 1.25)

Table 18: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: MDT care + structured assessment and checklist versus MDT care only

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT care + structured assessment + checklist	MDT care only	Relative (95% CI)	Absolute		
Patient satisfaction (measured using a 5-point Likert scale; range 15-75; better indicated by higher values) – At discharge												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	85	64	-	MD 1.20 higher (1.48 lower to 3.88 higher)	LOW	CRITICAL
Overall quality of life (measured using SF-12 physical component; range 0-100; better indicated by higher values) - At 6 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	85	64	-	MD 0.7 higher (2.31 lower to 3.71 higher)	LOW	IMPORTANT
Overall quality of life (measured using SF-12 physical component; range 0-100; better indicated by higher values) - At 12 months												
1 (Chong	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	70	59	-	MD 0.2 lower	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT care + structured assessment + checklist	MDT care only	Relative (95% CI)	Absolute		
2013)										(3.59 lower to 3.19 higher)		
Overall quality of life (measured using SF-12 mental component; range 0-100; better indicated by higher values) - At 6 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	85	64	-	MD 2.2 higher (0.8 lower to 5.2 higher)	VERY LOW	IMPORTANT
Overall quality of life (measured using SF-12 mental component; range 0-100; better indicated by higher values) - At 12 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	70	59	-	MD 1.4 lower (5.17 lower to 2.37 higher)	LOW	IMPORTANT
Changes in ADL (measured using MBI score; range 0-100; better indicated by higher values) - At discharge (exact time point not reported)												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	85	64	-	MD 1.7 lower (7.79 lower to 4.39 higher)	LOW	IMPORTANT
Changes in ADL (measured using MBI score; range 0-100; better indicated by higher values) - At 6 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	75	54	-	MD 4.9 higher (2.41 lower to 12.21 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using MBI score; range 0-100; better indicated by higher values) - At 12 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	71	50	-	MD 1.6 higher (5.99 lower to 9.19 higher)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT care + structured assessment + checklist	MDT care only	Relative (95% CI)	Absolute		
Changes in ADL (measured using Montebello Rehab Factor score; scale not reported; better indicated by higher values) - At discharge (exact time point not reported)												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	85	64	-	MD 3.4 lower (13.96 lower to 7.16 higher)	LOW	IMPORTANT
Changes in ADL (measured using Montebello Rehab Factor score; scale not reported; better indicated by higher values) - At 6 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	75	54	-	MD 6 higher (7 lower to 19 higher)	LOW	IMPORTANT
Changes in ADL (measured using Montebello Rehab Factor score; scale not reported; better indicated by higher values) - At 12 months												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	71	50	-	MD 1.9 lower (15.3 lower to 11.5 higher)	LOW	IMPORTANT

ADL: Activities of daily living; CI: Confidence interval; MDT: Multidisciplinary team; MBI: Modified Barthel Index; SF-12: 12-item short-form survey
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for SF-12 mental component at 6 months +/-4.6; for MBI score at 6 months +/-10.3)

Table 19: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: MDT care + structured assessment and checklist versus MDT care only

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT + structured assessment + checklist	MDT only	MDT care + structured assessment + checklist	MDT care only		
Length of hospital stay in days (Better indicated by lower values)												
1 (Chong 2013)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	92	70	Median (range): 35.0 (5-402)[3]	Median (range): 48.0 (10-	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT + structured assessment + checklist	MDT only	MDT care + structured assessment + checklist	MDT care only		
										382)[3]		

MDT: Multidisciplinary team
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using MIDs due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, the median difference was statistically significantly shorter in the intervention group (p=0.009, statistical test not reported). No mention was made of clinical importance.

Table 20: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Multidiscplinary care pathway versus Standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary care pathway	Standard care	Multidisciplinary care pathway	Standard care		
Length of hospital stay in days (Better indicated by lower values)												
1 (Flikweert 2014)	observational studies	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	256	145	Median (IQR): 7 (6-10)[2]	Median (IQR): 11 (7-16)[2]	MODERATE	CRITICAL

IQR: Interquartile range
1 Serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I
2 According to the statistical analyses performed by the author, the median difference was statistically significantly shorter in the intervention group (p<0.001, unsure of statistical test). No mention was made of clinical importance.*
**The authors report in their tabulated results that they analysed these data with an independent t-test, which would be inappropriate for non-parametric data. However, the paper states in the Analysis section that "For continuous variables, the intervention and control groups were compared with the independent sample t-test or, if appropriate, the Mann–Whitney U-test." (page 4). Due to this sentence and the majority of estimates being reported as means, we have assumed this is simply a reporting oversight on behalf of the authors.*

Table 21: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Traumatic Clinical Care Coordination (TCCC) versus No TCCC

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**TCCC**	**No TCCC**	**Relative (95% CI)**	**Absolute**		
Length of hospital stay in days (Better indicated by lower values)												
1 (Hall 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	475	21207	-	MD 7 higher (5.82 to 8.18 higher)	LOW	CRITICAL

CI: Confidence interval; MD: Mean difference; TCCC: Traumatic Clinical Care Coordination
1 Very serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I

Table 22: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Discharge planning with gerontological nurse versus Routine discharge planning

Quality assessment							**No of patients**		**Effect**		**Quality**	**Importance**
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Discharge planning with gerontological nurse**	**Routine discharge planning**	**Relative (95% CI)**	**Absolute**		
Length of hospital stay (days) - At 3 months (Better indicated by lower values)												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	63	-	MD 1.89 lower (3.06 to 0.72 lower)	LOW	CRITICAL
Overall quality of life (measured using SF-36; range 0-100; better indicated by higher values) - At discharge												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	59	-	MD 6 higher (2.85 to 9.15 higher)	LOW	IMPORTANT
Overall quality of life (measured using SF-36; range 0-100; better indicated by higher values) - At 2 weeks post-discharge												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	59	-	MD 7.46 higher (4.18 to 10.74 higher)	MODERATE	IMPORTANT
Overall quality of life (measured using SF-36; range 0-100; better indicated by higher values) - At 3 months post-discharge												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Discharge planning with gerontological nurse	Routine discharge planning	Relative (95% CI)	Absolute		
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	59	-	MD 9.52 higher (5.58 to 13.46 higher)	MODERATE	IMPORTANT
Changes in ADL (measured using Barthel Index; range 0-100; better indicated by higher values) - At discharge												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	59	-	MD 10.1 higher (4.86 to 15.34 higher)	MODERATE	IMPORTANT
Changes in ADL (measured using Barthel Index; range 0-100; better indicated by higher values) - At 2 weeks post-discharge												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	59	-	MD 14.68 higher (8.21 to 21.15 higher)	MODERATE	IMPORTANT
Changes in ADL (measured using Barthel Index; range 0-100; better indicated by higher values) - At 3 months post-discharge												
1 (Huang 2005)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	59	-	MD 16.2 higher (8.95 to 23.45 higher)	MODERATE	IMPORTANT

CI: Confidence interval; MD: Mean difference; SF-36: 36-item short-form survey
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for length of hospital stay +/-1.54; for SF-36 +/- 3.895)

Table 23: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Comprehensive discharge planning versus Routine discharge planning

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Comprehensive discharge planning	Routine discharge planning	Relative (95% CI)	Absolute		

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Comprehensive discharge planning	Routine discharge planning	Relative (95% CI)	Absolute		
Patient satisfaction (measured using research designed questionnaire; range 14-70; better indicated by higher values) - Time point not reported												
1 (Lin 2009)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	24	-	MD 2.73 higher (3.74 lower to 9.2 higher)	VERY LOW	CRITICAL
Length of hospital stay in days - At 3 months (Better indicated by lower values)												
1 (Lin 2009)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	26	24	-	MD 0.25 lower (1.52 lower to 1.02 higher)	LOW	CRITICAL
Changes in ADL (measured using Functional Status Subscale; range 0-18; better indicated by higher values) - Before discharge												
1 (Lin 2009)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	26	24	-	MD 0.15 higher (1.07 lower to 1.37 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using Functional Status Subscale; range 0-18; better indicated by higher values) - At 2 weeks post-discharge												
1 (Lin 2009)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	26	24	-	MD 1.12 higher (0.92 lower to 3.16 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using Functional Status Subscale; range 0-18; better indicated by higher values) - At 3 months post-discharge												
1 (Lin 2009)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	26	24	-	MD 0.09 higher (0.78 lower to 0.96 higher)	VERY LOW	IMPORTANT

1 *CI: Confidence interval; MD: Mean difference*
2 *1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2*
3 *2 95% CI crosses 1 MID (for patient satisfaction +/- 6.305; for length of hospital stay +/- 1.085)*
4 *3 Serious risk of bias in the evidence contributing to the outcomes as per RoB2*

4 95% CI crosses 2 MIDs (for Functional Status subscale +/- 0.355)

Table 24: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Supported discharge team care versus Usual care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supported discharge team care	Usual care	Relative (95% CI)	Absolute		
Length of hospital stay in days (Better indicated by lower values)												
1 (Parsons 2019)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	201	202	-	MD 5.7 lower (10.06 to 1.34 lower)	MODERATE	CRITICAL

CI: Confidence interval; MD: Mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 25: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: More intensive MDT care versus Less intensive MDT care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	More intensive MDT care	Less intensive MDT care	More intensive MDT care	Less intensive MDT care		
Overall quality of life (measured using EQ-5D; scale not reported; better indicated by higher values) - At 3 months												
1 (Ryan 2006a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 0.62 (0.52-0.77)[3]	Median (IQR): 0.67 (0.59-0.79)[3]	VERY LOW	IMPORTANT
Overall quality of life (measured using EQ-5D; scale not reported; better indicated by higher values) - At 12 months												
1 (Ryan 2006b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 0.7 (0.59-8)[3]	Median (IQR): 0.7 (0.62-0.74)[3]	VERY LOW	IMPORTANT
Overall quality of life (measured using EQ-VAS; range 1-100; better indicated by higher values) - At 3 months												
1 (Ryan	randomi	very	no serious	no serious	very serious[2]	none	30	28	Median	Median	VERY	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	More intensive MDT care	Less intensive MDT care	More intensive MDT care	Less intensive MDT care		
2006a)	sed trials	serious[1]	inconsistency	indirectness					(IQR): 0.71 (0.6-0.8)[3]	(IQR): 0.7 (0.5-0.82)[3]	LOW	
Overall quality of life (measured using EQ-VAS; range 1-100; better indicated by higher values) - At 12 months												
1 (Ryan 2006b)	randomi sed trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 0.7 (0.5-0.78)[3]	Median (IQR): 0.65 (0.5-0.8)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using Barthel Index; range 0-100; better indicated by higher values) - At 3 months												
1 (Ryan 2006a)	randomi sed trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 20 (19-20)[3]	Median (IQR): 20 (19-20)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using Barthel Index; range 0-100; better indicated by higher values) - At 12 months												
1 (Ryan 2006b)	randomi sed trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 20 (19-20)[3]	Median (IQR): 20 (19-20)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using FAI; range 0-45; better indicated by higher values) - At 3 months												
1 (Ryan 2006a)	randomi sed trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 19 (14-23)[3]	Median (IQR): 19 (14-24)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using FAI; range 0-45; better indicated by higher values) - At 12 months												
1 (Ryan 2006b)	randomi sed trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	28	Median (IQR): 22 (16.5-29.5)[3]	Median (IQR): 21 (13-26)[3]	VERY LOW	IMPORTANT

ADL: Activities of daily living; EQ-VAS: EuroQol Visual Analogue Scale; EQ-5D: EuroQol 5 dimensions; FAI: Frenchay Activities Index; IQR: Interquartile range; MDT: Multidisciplinary team

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB

2 Imprecision could not be assessed using MIDs due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.

3 According to the statistical analyses performed by the author, there was no significant difference between groups for any measure at any time point (for EQ-5D at 3 months p=0.3; for EQ-5D at 12 months p=0.67; for EQ-VAS at 3 months p=0.98; for EQ-VAS at 12 months p=0.88; for Barthel Index at 3 months p=0.83; for Barthel Index at 12 months p=0.18; for FAI at 3 months p=0.81 [unadjusted value]; for FAI at 12 months p=0.27, Mann-Whitney U test)

Table 26: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: MDT post-operative rehabilitation versus Conventional post-operative rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT post-operative rehabilitation	Conventional post-operative rehabilitation	Relative (95% CI)	Absolute		
Changes in ADL (measured using number of participants achieving Independence in P-ADL at each time point) - At 4 months post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	35/102 (34.3%)	23/97 (23.7%)	RR 1.45 (0.93 to 2.26)	107 more per 1000 (from 17 fewer to 299 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Independence in P-ADL at each time point) - At 12 months post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	33/102 (32.4%)	17/97 (17.5%)	RR 1.85 (1.1 to 3.09)	149 more per 1000 (from 18 more to 366 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade A at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	34/84 (40.5%)	17/76 (22.4%)	RR 1.46 (0.94 to 2.29)	103 more per 1000 (from 13 fewer to 289 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade B at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14/84 (16.7%)	21/76 (27.6%)	RR 0.6 (0.33 to 1.1)	111 fewer per 1000 (from 185 fewer to 28 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade C at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/84 (9.5%)	3/76 (3.9%)	RR 2.41 (0.66 to 8.77)	56 more per 1000 (from 13 fewer to 307 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade D at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/84 (1.2%)	2/76 (2.6%)	RR 0.45 (0.04 to 4.89)	14 fewer per 1000 (from 25	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MDT post-operative rehabilitation	Conventional post-operative rehabilitation	Relative (95% CI)	Absolute		
										fewer to 102 more)		
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade E at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/84 (6%)	4/76 (5.3%)	RR 1.13 (0.32 to 4.06)	7 more per 1000 (from 36 fewer to 161 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade F at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trial	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	17/84 (20.2%)	17/76 (22.4%)	RR 0.9 (0.5 to 1.64)	22 fewer per 1000 (from 112 fewer to 143 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants achieving Katz ADL scores at each time point) - Grade G at 12 month post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	4/84 (4.8%)	11/76 (14.5%)	RR 0.33 (0.11 to 0.99)	97 fewer per 1000 (from 1 fewer to 129 fewer)	VERY LOW	IMPORTANT
Changes in ADL (measured as the number of participants returning to at least same Katz ADL level as before trauma) - At 4 months post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	56/92 (60.9%)	39/82 (47.6%)	RR 1.28 (0.97 to 1.69)	133 more per 1000 (from 14 fewer to 328 more)	VERY LOW	IMPORTANT
Changes in ADL (measured as the number of participants returning to at least same Katz ADL level as before trauma) - At 12 months post-operative follow-up												
1 (Stenvall 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49/84 (58.3%)	27/76 (35.5%)	RR 1.64 (1.15 to 2.34)	227 more per 1000 (from 53 more to 476 more)	VERY LOW	IMPORTANT

1 *ADL: Activities of daily living; CI: Confidence interval; P-ADL: Personal activities of daily living; RR: Risk ratio*
2 *1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2*
3 *2 95% CI crosses 1 MID (0.8 or 1.25)*
4 *3 95% CI crosses 2 MIDs (0.8 and 1.25)*

Table 27: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Multidisciplinary outpatient treatment versus Usual care by GP (continuous variables)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary outpatient treatment	Usual care by GP	Multidisciplinary outpatient treatment	Usual care		
Changes in ADL (measured using Glasgow Outcome Scale; range 1-8; better indicated by higher values) - At 12 months post-injury												
1 (Vikane 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	69	56	Median (range): 7 (5-8)[3]	Median (range): 7 (5-8)[3]	VERY LOW	IMPORTANT

ADL: Activities of daily living
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using MIDs due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, there was no significant difference between groups (p=0.193, Mann-Whitney U test). No mention was made of clinical importance.

Table 28: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Multidisciplinary outpatient treatment versus Usual care by GP (categorical variables)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary outpatient treatment	Usual care by GP	Relative (95% CI)	Absolute		
Return to work or education (measured using number of participants returning to work) - At 12 months post-injury (follow-up 12 months)												
1 (Vikane 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49/81 (60.5%)	50/70 (71.4%)	RR 0.85 (0.67 to 1.07	107 fewer per 1000 (from 236 fewer to 50 more)	VERY LOW	CRITICAL

CI: Confidence interval; RR: Risk ratio
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (0.8 or1.25)

Table 29: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: Extended care practitioner + telephone calls versus Standard outpatient care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extended care practitioner + telephone calls	Standard outpatient care	Relative (95% CI)	Absolute		
Patient satisfaction (measured using author patient satisfaction survey; scale not reported; better indicated by higher values) - At 6 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 0.5 higher (0.33 lower to 1.33 higher)	VERY LOW	CRITICAL
Patient satisfaction (measured using author patient satisfaction survey; scale not reported; better indicated by higher values) - At 12 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 0.9 higher (0.25 lower to 2.05 higher)	VERY LOW	CRITICAL
Overall quality of life (measured using SF-12 physical component score; range 0-100; better indicated by higher values) - At 6 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 4.7 higher (0.18 to 9.22 higher)	VERY LOW	IMPORTANT
Overall quality of life (measured using SF-12 physical component score; range 0-100; better indicated by higher values) - At 12 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 3.6 lower (9.69 lower to 2.49 higher)	VERY LOW	IMPORTANT
Overall quality of life (measured using SF-12 mental component score; range 0-100; better indicated by higher values) - At 6 months												
1	randomis	very	no serious	no serious	serious[2]	none	40	38	-	MD 1.9	VERY	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extended care practitioner + telephone calls	Standard outpatient care	Relative (95% CI)	Absolute		
(Wiechman 2015)	ed trials	serious[1]	inconsistency	indirectness						higher (2.62 lower to 6.42 higher)	LOW	
Overall quality of life (measured using SF-12 mental component score; range 0-100; better indicated by higher values) - At 12 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 4.4 higher (0.64 lower to 9.44 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using GAS; scale not reported, better indicated by higher values) – At 6 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	38	-	MD 2.6 lower (8.9 lower to 3.7 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using GAS; scale not reported, better indicated by higher values) – At 12 months												
1 (Wiechman 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	40	38	-	MD 1.1 higher (5.07 lower to 7.27 higher)	LOW	IMPORTANT

1 *ADL: Activities of daily living; CI: Confidence interval; GAS: Goal Attainment Score; MD: Mean difference; SF-12: 12-item short-form survey*
2 *1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2*
3 *2 95% CI crosses 1 MID (for patient satisfaction +/-1.05; for SF-12 physical component +/- 5.95; for SF-12 mental component +/-5.75; for GAS +/- 7.4)*

4 GRADE-CERQual tables for qualitative evidence

5 Table 30: Summary of evidence (GRADE-CERQual): 1 Service commissioning

Study information	Description of Theme or Finding	CERQUAL Quality Assessment

Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
1.1 Commission a full service							
5[1]	Semi-structured interviews (3), semi-structured interviews and focus groups (2)	Staff believe that co-ordination of rehabilitation services during the transfer from inpatient to outpatient rehabilitation services needs to be led by service coordinators and commissioners. Services need to be funded and available for the entire journey of a service user - along with guidelines and a clear vision for how these services should co-ordinate, communicate and standardise in order to meet the needs of their local population. Guidelines and pathways are helpful but also need to allow for flexibility. *"So we actually didn't have a model of care or any … policies and procedures in place and we've kind of been working them out on the fly as well go. [OT] [P19]" (Kornhaber 2019, p716)*	No or very minor concerns	Moderate concerns[2]	Minor concerns[3]	No or very minor concerns	MODERATE
1.2 Community services and facilities							
7[4]	Semi-structured interviews (4), semi-structured interviews and focus groups (1), free-text questionnaire and semi-structured interviews (1), semi-structured interviews, focus groups and observations of inter-professional meetings (1)	Both staff and adults with rehabilitation needs feel that the availability and accessibility of community and social services is just as important for overall rehabilitation as rehabilitative medical services are. Such services include social care, housing, home-adaption, transport services, and sports/recreational facilities. Such services should be properly funded and promoted. Adults with rehabilitation needs may need to be directed to them as an integral part of their rehabilitation and their discharge planning. *"We've got meals on wheels coming so that takes a lot of stress off, we've got a house cleaner that comes so that takes a lot of stress off. In the first month it was hard because we didn't have anything prepared so the house was just getting messier, there wasn't meal organization but now that's all come into place [P13, 3]" (Turner 2011, p823)*	Minor concerns[5]	Minor concerns[6]	No or very minor concerns	No or very minor concerns	HIGH
1.3 Workload and demand							
3[7]	Semi-structured interviews (2), Free-text questionnaire and semi-structured	Some staff in rehabilitation services report being overworked and underfunded. This leads to long waiting lists and cases may be missed as a result. It may also mean caseworkers don't have time to see their service users properly. Caseloads should be	Minor concerns[8]	Minor concerns[6]	No or very minor concerns	No or very minor concerns	HIGH

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
	interviews (1)	considerate of demand plus increasing requirements to do paperwork and to network with other professionals. *"Our rehabilitation case managers have picked up a lot of work. They need to attend case conferences, which for me working part-time takes away their availability to us. So it does have a reciprocal effect on the team. They may need increased hours to support that inpatient role. (I1, community team, T2)" (Kennedy 2012, p69)*					
1.4 Rural services							
5[9]	Semi-structured interviews (3), open interviews (1), free-text questionnaire and semi-structured interviews (1)	Both staff and adults with rehabilitation needs report that those living in rural areas are often underserved. Extra effort is needed to coordinate the resources available in rural community, including utilising communication technology, and providing training for generalist services to meet specialist needs. *"There is not a specialist service operating in our area and therefore these clients are missing out on specialist rehab. [S31]" (Odumuyiwa 2019, p170)*	No or very minor concerns	No or very minor concerns	Minor concerns[10]	No or very minor concerns	HIGH

1 Christiaens 2015, Jeyaraj 2013, Kornhaber 2019, Lindahl 2013, Stolee 2019.
2 The evidence was downgraded for coherence of findings as the theme was a composite of several findings, not all fully related, but with an overall theme in common.
3 Evidence was downgraded for applicability as none of the evidence came from the UK, and this may be especially relevant to a finding about service coordination and commissioning.
4 Jeyaraj 2013, Jourdan 2019, Kornhaber 2019, Odumuyiwa 2019, Sena Martins 2017, Slomic 2017, Turner 2011
5 The methodological limitations of the studies ranged from very minor to serious as per the CASP qualitative study checklist, with most of the supporting data coming from studies that were vague in description in at least one key area such as describing recruitment, data collection, or potential risks of bias.
6 The evidence was downgraded for coherence of findings as the theme was amalgamated from a few varying but related service needs or issues.
7 Kennedy 2012, Stolee 2019, Odumuyiwa 2019.
8 The methodological limitations of the studies ranged from minor to moderate as per the CASP qualitative study checklist, with some analysis problems in one study and vague reporting of methods in the other, which may be masking issues that may have affected the findings.
9 Jourdan 2019, Kornhaber 2019, O'Callaghan 2012, Odumuyiwa 2019, Turner 2011.
10 Evidence was downgraded for applicability as the evidence was relating to adults with burns or with brain injury only, and it is unclear if this may generalise to other populations or be quite specific to these. Additionally, although the data were consistent, one study included views of family and friends which is not included in the review's population.

Table 31: Summary of evidence (GRADE-CERQual): 2 Integrating multiple services

Study information	Description of Theme or Finding	CERQUAL Quality Assessment

Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
2.1 Integrated multidisciplinary team approach							
5[1]	Semi-structured interviews (3), free-text questionnaire and semi-structured interviews (1), semi-structured interviews, focus groups and observations of inter-professional meetings (1)	Both staff and adults with rehabilitation needs feel that a multidisciplinary team approach to medical and social support needs is important upon transfer from inpatient to outpatient rehabilitation services. The overall delivery should feel integrated and united. *"the strength is all of us working together. We all want what's best for the patient … there was a lot of silo functioning before and … we're getting a lot better, working together as a team and being able to listen to each other and what the concerns are. (N) (P18)" (Kornhaber 2019, p715)*	Minor concerns[2]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
2.2 Inter-service awareness and relationships							
3[3]	Semi-structured interviews (2), semi-structured interviews, focus groups and observations of inter-professional meetings (1)	Staff suggest that it is easier for agencies to work together as a multidisciplinary team when they know a bit about what each other does, and have been able to network together as professionals. The opportunity to meet in person, or occasional video conferences, and build a working relationship may facilitate better overall service delivery for service users. *"When we know each other (employees across sectors) you get a larger framework of understanding for each other. You can easier agree that we want to solve this together. Instead, we use a lot of time on the phone and mail with people we do not know and maybe from day to day new therapists have to engage in new cases again [physiotherapist, hospital]" (Lindahl 2013, p183)*	Minor concerns[4]	No or very minor concerns	Minor concerns[5]	No or very minor concerns	HIGH
2.3 Inter-service communication of information							
6[6]	Semi-structured interviews (3), Semi-structured interviews and direct observation (1), Semi-structured interviews and focus groups (1), Semi-structured	Some adults with rehabilitation needs report finding it distressing if they have to repeat their history or recall their treatments and symptoms to multiple staff, or if there are delays with information. Both staff and adults with rehabilitation needs believe it is important that the services should communicate in a timely fashion and share relevant information easily with each other. It is expected that a relevant history of the patient's events, injuries, treatments, and	Minor concerns[2]	Minor concerns[7]	Minor concerns[5]	No or very minor concerns	MODERATE

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
	interviews, focus groups and observations of interprofessional meetings (1)	results (e.g. x-rays) should be passed on to services in advance. *"I remember a doctor coming in the room and he said: 'Tell me, what happened?' I thought: "Are you serious? After all this time you want us to tell our story?" Isn't there something like a patient medical record? It does not give you the impression that this physician will be able to effectively evaluate whether the injuries evolve well" (Christiaens 2015, p6)*					
2.4 Case coordinator							
3[8]	Semi-structured interviews (2), Semi-structured interviews and focus groups (1)	A case manager or coordinator was considered useful by other staff in the multidisciplinary team as it meant they could direct enquiries to one source. Adults with rehabilitation needs also appreciated the coordination and continuity a case coordinator offered. *"It was really effective having the case manager Cc'ingme into those communications. I felt that I was really up to date. It has also been helpful because it has alerted me to some possible issues before the client came home, rather than finding them out as difficult surprises. (I15, external service provider, T2)" (Kennedy 2012, p68)*	Minor concerns[2]	No or very minor concerns	Minor concerns[5]	No or very minor concerns	HIGH
2.5 Interdisciplinary consistency							
3[9]	Semi-structured interviews (2), semi-structured interviews and focus groups (1)	Information, actions and instructions from different parts of the multidisciplinary team should be compatible, complimentary and consistent. Otherwise its confusing to the patient and erodes trust. *"The discharge summaries, the one I got from (name of rehabilitation) and one I got from (name of hospital), are completely different in explaining what happened and what I can do now [Male, 17–29yrs. road traffic injury #860)" (Braaf 2018, p7)*	Moderate concerns[10]	No or very minor concerns	Minor concerns[5]	No or very minor concerns	MODERATE

1 *1 Isbel 2017, Kornhaber 2019, Odumuyiwa 2019, Sena Martins 2017, Slomic 2017.*
2 *2 The methodological limitations of the studies ranged from very minor to moderate as per the CASP qualitative study checklist, with most of the supporting data coming from*
3 *studies that were vague in description in at least one key area such as describing recruitment, data collection, or potential risks of bias.*
4 *3 Lindahl 2013, Slomic 2017, Stolee 2019.*

4 The methodological limitations of the studies ranged from very minor to moderate as per the CASP qualitative study checklist, with most of the supporting data coming from studies that were vague in description in at least one key area such as describing recruitment and potential risks of bias, or for analytical methodological approach taken.
5 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and this may be especially relevant to a finding about service coordination.
6 Braaf 2018, Christensen 2018, Christiaens 2015, Lindahl 2013, Slomic 2017, Stolee 2019.
7 The evidence was downgraded for coherence of findings as the theme was amalgamated from a few varying but related service needs.
8 Braaf 2018, Christiaens 2015, Kennedy 2012
9 Barclay 2019, Braaf 2018, Jeyaraj 2013
10 The methodological limitations of the studies ranged from moderate to serious as per the CASP qualitative study checklist, due to some serious concerns about risk of bias due to vague descriptions or unclear justifications for some of the methodological choices.

Table 32: Summary of evidence (GRADE-CERQual): 3 Delivery

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
3.1 Continuity of staff							
4[1]	Semi-structured interviews (3), semi-structured interviews and focus groups (1)	Both staff and adults with rehabilitation needs report that it is better when service users continue to see the same staff wherever possible, Trust and rapport is built over time with staff which is calming and motivating during rehabilitation. Changes in staff is discouraging, costs time to share history and details, and cause mistakes where information is not passed on. *"You cannot build-up a trusting relationship. I remember a doctor coming in the room and he said: 'Tell me, what happened?' I thought: "Are you serious? After all this time you want us to tell our story?" Isn't there something like a patient medical record? It does not give you the impression that this physician will be able to effectively evaluate whether the injuries evolve well" (Christiaens 2015, p6)*	No or very minor concerns	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH
3.2 Include family							
9[3]	Semi-structured interviews (6), semi-structured interviews and focus groups (2), free-text questionnaire and semi-structured interviews (1)	Both staff and adults with rehabilitation needs report that family can play a significant role in rehabilitation and care in general around the time of discharge to the community. Where it is appropriate and willingly provided, families should be included in plans, conversations and information sharing as this can promote smoother delivery of and adherence to rehabilitation. This central role means rehabilitative education and support may need to include family members. Laws and guidelines should be followed	No or very minor concerns	Minor concerns[4]	No or very minor concerns	No or very minor concerns	HIGH

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		for involving family. *"'Part of the other agenda is how you blend in the family into the rehabilitation. I think that's another area that could be worked on" (Isbel 2017, p1027)*					
3.3 Point of contact							
5[5]	Semi-structured interviews (5), semi-structured interviews and direct observation (1)	Adults with rehabilitation needs report wanting a single, identifiable point of communication for information, support, and for the coordination of plans as they transfer from inpatient to outpatient rehabilitation settings. *"I didn't have one particular person giving you all the information. It was just the medical staff as they came through. It was only at the end that I recall, that I got the information all put together." (Braaf 2018, p7)*	Minor concerns[6]	Minor concerns[4]	No or very minor concerns	No or very minor concerns	HIGH
3.4 Peer support							
1 (Barclay 2019)	Semi-structured interviews (1)	Staff report that it can be helpful to include peer mentors with lived experience in the delivery of rehabilitation services at this time, as they can encourage the patient, be a role-model and answer questions. *"Because they're in the building and you can refer to them pretty easily, often they'll identify somebody to be a peer mentor and to be their go-to if they have questions on the clients, and they'll often visit that person while in inpatients but sometimes in outpatients as well." (Barclay 2019, p6)*	Serious concerns[7]	No or very minor concerns	Moderate concerns[8]	Moderate concerns[9]	VERY LOW
3.5 Deliver at home							
2[10]	Semi-structured interviews (1), semi-structured interviews and focus groups (1)	Staff report that it is increasingly easy to deliver rehabilitation at home instead of keeping adults in hospital. Greater precision of medical tests and the efficacy of post-injury care means that adults with traumatic injuries do not to be hospitalised for such a long time, and videoconferencing and telehealth technology mean that delivery in homes may be easier. *"they reported that the evolution of medicine,*	Minor concerns[6]	Moderate concerns[4]	Minor concerns[11]	Minor concerns[12]	LOW

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		including the precision of medical tests, and the efficacy of post-TBI acute care delivery, greatly facilitates the management of cases referred for outpatient TBI rehabilitation" (Jeyaraj 2013, p1343)					
3.6 Technology							
3[13]	Semi-structured interviews (2), Free-text questionnaire (1)	Both staff and adults with rehabilitation needs report that technology can be useful for the delivery of rehabilitative support. Videoconferencing and telemedicine can be useful to reach people who find it hard to leave their homes, or who live rurally, or who need additional flexibility because they work etc. Apps can also be useful for alerts or reminders. *""We have been working a lot with pressure ulcers the last years, so we now have a videoconferencing service for some of the patients that are living at home, where we have a videoconference to the patient's home, together with the nurses in the municipality, who are treating the pressure ulcers from day to day" (Barclay 2019, p6)*	Minor concerns[14]	Moderate concerns[4]	Minor concerns[11]	No or very minor concerns	LOW

1 Christiaens 2015, Kennedy 2012, Lindahl 2013, Turner 2011.
2 The evidence was downgraded for adequacy as there were not many clear first-order quotes presented by the authors to support these second order findings.
3 Christiaens 2015, Glenny 2013, Isbel 2017, Jeyaraj 2013, Kornhaber 2019, Odumuyiwa 2019, Sena Martins 2017, Stolee 2019, Turner 2011.
4 The evidence was downgraded for coherence of findings as the theme was amalgamated from a few varying but related experiences.
5 Braaf 2018, Christensen 2018, Graff 2018, Kennedy 2012, Turner 2011
6 The methodological limitations of the studies ranged from very minor to moderate as per the CASP qualitative study checklist, with studies being flagged for a risk of bias related to the participants or the interviewers which could have influenced a theme asking about service received.
7 The methodological limitations of the study were rated as serious as per the CASP qualitative study checklist due to problems with the recruitment methods, problems with involvement of 1st author, and a lack of discussion on credibility
8 The finding was downgraded for applicability as the evidence only came from a population with spinal cord injury and in a non-UK setting, and may not generalise well to other conditions or a UK service/cultural context.
9 Evidence was downgraded for adequacy of data, as the statement was based on one study only with a moderate sample size and only moderate descriptive detail relating to this theme.
10 Jeyaraj 2013, Kornhaber 2019.
11 The finding was downgraded for applicability as the evidence only came from a non-UK setting, and may not generalise well to a UK service/cultural context.
12 Evidence was downgraded for adequacy of data, as the statement was based on two studies only with a moderate sample size and little descriptive detail relating to this theme.
13 Barclay 2019, Kornhaber 2019, Singh 2018.
14 The methodological limitations of the studies ranged from very minor to serious as per the CASP qualitative study checklist, with studies being flagged for a risk of bias related to the recruitment, participants and the interviewers, which could have influenced a theme that is asking about service experiences and preferences.

1 **Table 33: Summary of evidence (GRADE-CERQual): 4 Information**

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
4.1 Inform about services and plan							
7[1]	Semi-structured interviews (5), semi-structured interviews and focus groups (1), open interviews (1)	Some adults with rehabilitation needs report that transitions can be smoothed by increasing information available, but sometimes after discharge they don't know what will happen next and when. They need information about the services available to them, as well as how to access and use these services to meet their needs – including their GP. They also need to know about the arrangements that have been made for them and their ongoing treatment plan, or what they will need to arrange themselves. This information is empowering and improves treatment adherence. *"Even if they had have been able to give us a list of services, it may have saved us a lot of drama and hassle and heartache. They need to make you aware of this may happen and if that happens, do this and give you a checklist or something" (O'Callaghan 2012, p1607)*	No or very minor concerns	No or very minor concerns	Minor concerns[2]	No or very minor concerns	HIGH
4.2 Prognosis							
3[3]	Semi-structured interviews (1), semi-structured interviews and focus groups (1), free-text questionnaire and semi-structured interviews (1)	Adults with rehabilitation needs want information about their condition and the likely long-term prognosis as they leave inpatient services, and how this will affect their lives in future. *"It is perhaps a silly detail, but at the start it is very difficult to estimate. You get a certificate for a three to six months leave and you think: "I will have a hard time during six months, but then it will all be over." Over… now I know that with burn injuries it will never be over." (Christiaens 2015, p8)*	Minor concerns[4]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
4.3 Format							
1 (Braaf 2018)	Semi-structured interviews (1)	Adults with rehabilitation needs may find information more accessible if it is given to them in plain, accessible language. Providing written information can help them to understand and retain this information. *"For me it would have been no good telling me*	Moderate concerns[5]	No or very minor concerns	Moderate concerns[6]	Moderate concerns[7]	VERY LOW

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		anything at (hospital name). Perhaps if (hospital name) issued you ... a (written) summary of what your injuries were when you were brought in, what you were diagnosed with and resulting treatments that they performed. [Male,17–29yrs, road traffic injury #581]" (Braaf 2018, p8)					

1 Braaf 2018, Christiaens 2015, Graff 2018, Kornhaber 2019, O'Callaghan 2012, Stolee 2019, Turner 2011
2 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and there may be relevant difference about how information is disseminated in a UK service context.
3 Braaf 2018, Christiaens 2015, Odumuyiwa 2019
4 The methodological limitations of the studies ranged from very minor to moderate as per the CASP qualitative study checklist, with most of the supporting data coming from studies that were vague in description in at least one key area such as describing recruitment, data collection, or potential risks of bias.
5 The methodological limitations of the study were rated moderate as per the CASP qualitative study checklist, due to a high risk of recall bias (interviews were 3 years post-injury), and vague descriptions about recruitment methods and the relationships between researcher and participants which may be masking further risks of bias
6 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and was only identified in a study of people with brain injury – which may be more likely to have problems with memory than the traumatic injury population in general.
7 Evidence was downgraded for adequacy of data, as the statement was based on one study only with a moderate sample size only and only moderate descriptive detail relating to this theme.

Table 34: Summary of evidence (GRADE-CERQual): 5 Individual factors

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
5.1 Personalisation							
6[1]	Semi-structured interviews (5), semi-structured interviews and focus groups (1)	Both staff and adults with rehabilitation needs suggested that the rehabilitation should be delivered in a way that is adaptable to the circumstances and needs of individuals. Rehabilitation should take into account needs related to age, and symptoms or comorbidities such as chronic pain, or disabilities which may limit mobility. Some adults (e.g. with other responsibilities or who return to work) will need rehabilitation that is flexible to their availability. Rehabilitation planning will also need to take into account vulnerabilities such as housing and financial situation, risk of substance misuse and risk of coercion. *"I think they should focus on the best rehabilitation plan to optimize the patient's potential, this is my*	Minor concerns[2]	Moderate concerns[3]	Minor concerns[4]	No or very minor concerns	LOW

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		only complaint. They have offered me rehabilitation in a gym on an exercise bike, which can be great for some people, but not for a young person with a traumatic brain injury. I want a good life later and I have more cognitive problems than physical. Then it's not enough." (Graff 2018, p931)					
5.2 Admission criteria							
3[5]	Semi-structured interviews (3)	Inflexible admission criteria may mean that rehabilitative support is not offered to certain adults. Financial/income factors or postcode may limit rehabilitation access. In some cases adults also may not be offered necessary rehabilitation services because their difficulties are less severe, or are perceived as less severe, or may be less obvious (e.g. cognitive problems). *No quotes presented for this theme.*	No or very minor concerns	Moderate concerns[3]	Minor concerns[6]	Minor concerns[7]	LOW
5.3 Specialists							
5[8]	Semi-structured interviews (1), semi-structured interviews and focus groups (2), open interviews (1), free-text questionnaire and semi-structured interviews (1)	Upon discharge and de-escalation of specialized treatment it is reported that services and staff often become more generic, and the staff that are seen (including gatekeepers to services such as GPs) don't have specialist knowledge about particular disabilities or conditions. Both staff and adults with rehabilitation needs suggest it is important for the delivery of an individual's rehabilitation ongoing care team to include some staff with specialist knowledge. *"..such as family doctors or professionals working in CLSCs (community healthcare services in Quebec), [who] don't know the issues related to TBI" (Jeyaraj 2013, p1343)*	No or very minor concerns	Minor concerns[9]	No or very minor concerns	No or very minor concerns	HIGH
5.4 Home adjustments							
1 (Lindahl 2013)	Semi-structured interviews (1)	Some adults with rehabilitation needs require physical aids and small adjustments in their home. These adjustments may be vital to the discharge process and progression with rehabilitation. *"Then they suggested that I had a toilet chair placed in the living room, and we were speechless. I*	Minor concerns[10]	No or very minor concerns	Minor concerns[4]	Moderate concerns[11]	LOW

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		couldn't sit and . . . you know, in here where we eat and so. Then we worked it through, but my wife had to say – well you can send him home, but I am not sure I'll be here. I really had to get rough on them. Then we got through and it was okay" (Lindahl 2013, p181)					
5.5 Advocacy							
3[12]	Semi-structured interviews (2), semi-structured interviews and direct observation (1)	Some adults with rehabilitation needs report needing their family to take the lead in researching options and initiating conversations with staff about rehabilitation, or in some cases the adult may do it for themselves. Some individuals and/or their families may not be able to advocate for themselves as strongly as others. *"My dad has since the day I was run down struggled with the municipality to get me to the proper rehabilitation. While I was in the program my dad helped me to get two months of rehabilitation." (Graff 2018, p930)*	No or very minor concerns	No or very minor concerns	Minor concerns[4]	No or very minor concerns	HIGH

1 Graff 2018, Jeyaraj 2013, Kornhaber 2019, Lindahl 2013, Sena Martins 2017, Stolee 2019.

2 The methodological limitations of the studies ranged from very minor to moderate as per the CASP qualitative study checklist, with most downgrading due to vagueness around participant recruitment methods or analysis methods, which may have some impact on confidence in this finding.

3 The evidence was downgraded for coherence of findings as the theme was a composite of several findings, not all closely related, but with the headline theme in common.

4 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and there may be relevant difference about how to meet such individual needs within a UK social/support context.

5 Graff 2018, Stolee 2019, Turner 2011.

6 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and there may be relevant difference about how to meet such individual needs within a UK social/support context. Additionally, although the data were consistent, 1 study included views of family and friends which is not included in the review's population.

7 The evidence was downgraded for adequacy as there were not many clear first-order quotes presented by the authors to support their second order findings.

8 Christiaens 2015, Jeyaraj 2013, Kornhaber 2019, O'Callaghan 2012, Odumuyiwa 2019.

9 The evidence was downgraded for coherence of findings as the theme was amalgamated from a few varying but clearly related experiences.

10 The methodological limitations of the study were rated minor as per the CASP qualitative study checklist, with downgrading due to a lack of information on recruitment, or risks of researcher's bias and influence, or ethical considerations.

11 Evidence was downgraded for adequacy of data, as the statement was based on one study only with a moderate sample size only and only moderate descriptive detail relating to this theme.

12 Christensen 2018, Glenny 2013, Graff 2018.

Table 35: Summary of evidence (GRADE-CERQual): 6 Rehabilitation journey

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
6.1 Gradual							
8[1]	Semi-structured interviews (5), semi-structured interviews and focus groups (1), open interviews (1), Semi-structured interviews, focus groups and observations of interprofessional meetings (1)	Both staff and adults with rehabilitation needs state that rehabilitation and the return to the community should be a gradual and incremental process. There may need to be several rehabilitative stages to the return to community including pre-visits to home, moving from more to less intensive wards, time in supported community accommodation. This also includes follow-up visits or contact upon return home as abrupt endings or the sudden loss of support can be distressing and lead to further problems. *"We try to transfer patients from the burn centre to a general hospital ward to learn to function more autonomously, and go home after that" (Christiaens 2015, p6)*	No or very minor concerns	Minor concerns[2]	Minor concerns[3]	No or very minor concerns	HIGH
6.2 Start early							
5[4]	Semi-structured interviews (4), open interviews (1)	Both staff and adults with rehabilitation needs believe that conversations about rehabilitation and discharge planning should start early. Last-minute conversations about needs and rehabilitation close to the time discharge are distressing. Discussions about needs, plans and ideas for life after discharge can be incorporated into recovery from early on to avoid abruptness. *"The return to work happens at inpatient, actually. They really like to start as early as they can, so the primary OT puts in a referral and the patient meets one-on-one with one of our community reintegration therapists - and they're typically OT by background - and what they do is they start speaking to the employer early on about what kind of adaptations and modifications they might need to return to work." (Barclay 2019, p6)*	Moderate concerns[5]	Minor concerns[2]	Minor concerns[3]	Minor concerns[6]	LOW
6.3 Gap in service							
6[7]	Semi-structured interviews (5), semi-structured	Some adults with rehabilitation needs report that after returning to the community they experienced gaps and long waiting times before their	Moderate concerns[5]	Minor concerns[2]	Minor concerns[3]	No or very minor concerns	LOW

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
	interviews and focus groups (1)	rehabilitation commenced. These gaps and waiting times can be confusing and distressing, and in some cases being sedentary could also be detrimental to longer-term recovery. Some of the distress of service gaps can was eased if they had been given some approximate dates and warning and to expect a gap. In the intervening time some contact from professionals was appreciated. *"I came out of rehab on a very strong course of medication, and I really didn't know who I should be speaking to about that… I wasn't sure I needed it anymore but couldn't get a definitive answer anywhere on that." (Braaf 2018, p6)*					

1 Barclay 2019, Christiaens 2015, Graff 2018, Kornhaber 2019, Lindahl 2013, O'Callaghan 2012, Sims-Gould 2012, Slomic 2017
2 The evidence was downgraded for coherence of findings as the finding was an amalgamation of a some varying but related experiences.
3 Evidence was downgraded for applicability as none of the evidence came from the UK service context, and there may be relevant difference about how timings are organised or experienced in a UK context.
4 Barclay 2019, Braaf 2018, Kennedy 2012, Kornhaber 2019, O'Callaghan 2012
5 The methodological limitations of the studies ranged from very minor to serious as per the CASP qualitative study checklist, with some downgrading occurring due to the an introduction of bias from the relationship between reseaercher and participant, and recall bias as participants were being asked to recall past events from a traumatic time.
6 The evidence was downgraded for adequacy as there were not many clear first-order quotes presented by the authors to support these second order findings.
7 Braaf 2018, Isbel 2017, Jeyaraj 2013, Jourdan 2019, Lindahl 2013, Turner 2011

GRADE and GRADE-CERQual tables for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

GRADE tables for quantitative evidence

Table 36: Clinical evidence profile for coordination of rehabilitation and social services when transferring from inpatient to outpatient services: family-supported rehabilitation versus clinician-delivered rehabilitation in TBI

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family-supported rehabilitation	Clinician-delivered rehabilitation	Relative (95% CI)	Absolute		

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family-supported rehabilitation	Clinician-delivered rehabilitation	Relative (95% CI)	Absolute		
Changes in ADL (measured using SARAH scale; scale note reported; better indicated by higher values) - At 12 months (post-intervention)												
1 (Braga 2005)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	38	34	-	MD 0.5 higher (0.05 to 0.95 higher)	VERY LOW	IMPORTANT

1 *ADL: Activities of daily living; CI: Confidence interval; MD: Mean difference*
2 *1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2*
3 *2 95% CI crosses 1 MID (for SARAH scale +/- 0.65)*

4 **GRADE-CERQual tables for qualitative evidence**

5 **Table 37: GRADE-CERQual evidence profile for theme 1: Compatibility of healthcare disciplines**

Study information		Description of Theme or Finding	GRADE-CERQual Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
1.1 Setting common goals							
1 (Rashid 2018)	Semi-structured focus groups (1)	While MDTs are crucial to successful rehabilitation, information is not always shared between team members. In order to increase coordination between disciplines during discharge, healthcare professionals should endeavour to set goals that are common across healthcare settings. To do this successfully, they should understand the full medical history and rehabilitation needs of each patient. Progress should be monitored using standardised measurements,	Moderate concerns[1]	No/very minor concerns	Moderate concerns[2]	Serious concerns[3]	VERY LOW

Study information		Description of Theme or Finding	GRADE-CERQual Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
		including quality of life. *No quotes presented for this theme.*					

MDT: Multidisciplinary team
1 Evidence was downgraded due to moderate concerns regarding risk of bias in study designs as assessed using CASP Qualitative checklist
2 Evidence was downgraded for applicability as no data came from UK settings and the population being investigated was children with acquired brain injury (which can include traumatic and non-traumatic aetiology)
3 Evidence was downgraded for adequacy of data, as the findings were based on one study only with poor presentation of supporting first-order quotes

Table 38: GRADE-CERQual evidence profile for theme 2: Resources

Study information		Description of Theme or Finding	GRADE-CERQual Quality Assessment				
Number of studies	Design (Number of studies)		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
2.1 Case workers							
1 (Rashid 2018)	Semi-structured focus-groups	MDTs may not be suitable for families that have poor advocacy skills and family-centred care is not always practiced by all healthcare professionals involved in rehabilitation. A designated case worker can act as an additional resource for families during discharge, acting as a knowledgeable intermediary between healthcare staff and families. *'for our complex cases with so many people involved there is the illusion that somebody will have their eyes on the child when*	Moderate concerns[1]	No/very minor concerns	Moderate concerns[2]	Serious concerns[3]	VERY LOW

Study information		Description of Theme or Finding	GRADE-CERQual Quality Assessment				
Number of studies	**Design (Number of studies)**		**Methodological Limitations**	**Coherence of findings**	**Applicability of evidence**	**Adequacy of Data**	**Overall Confidence**
		discharged' (p. 128, Rashid 2018)					
2.2 Importance of community support							
1 (Rashid 2018)	Semi-structured focus groups	Families who have a child with ABI can help support other families re-integrate into the community after discharge. Social media can facilitate this by building stronger connections between parents/carers or support groups. *'When families become so strong and find the time to volunteer and give back to the community by assisting others, it is inspiring and rewarding and means that the system did well.' (p. 128, Rashid 2018)*	Moderate concerns[1]	No/very minor concerns	Moderate concerns[2]	Serious concerns[3]	VERY LOW

ABI: Acquired brain injury; MDT: Multidisciplinary team; p: Page

1 Evidence was downgraded due to moderate concerns regarding risk of bias in study designs as assessed using CASP Qualitative checklist

2 Evidence was downgraded for applicability as no data came from UK settings and the population being investigated was children with acquired brain injury (which can include traumatic and non-traumatic aetiology)

3 Evidence was downgraded for adequacy of data, as the findings were based on one study only with poor presentation of supporting first-order quotes

Appendix G – Economic evidence study selection

Economic evidence study selection for review question:

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

D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

A combined search was conducted for both review questions.

Figure 6: Economic evidence study selection flow chart: Adults

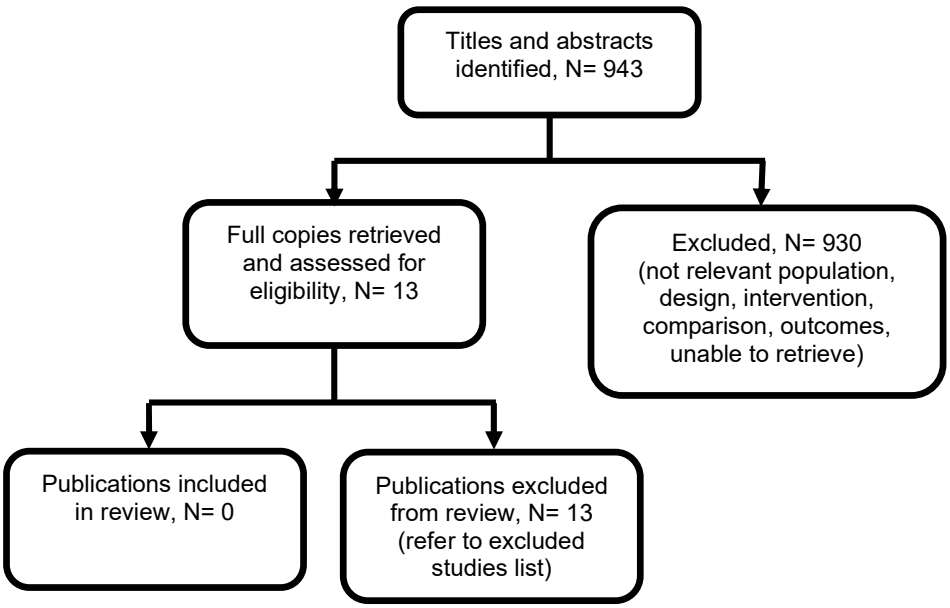
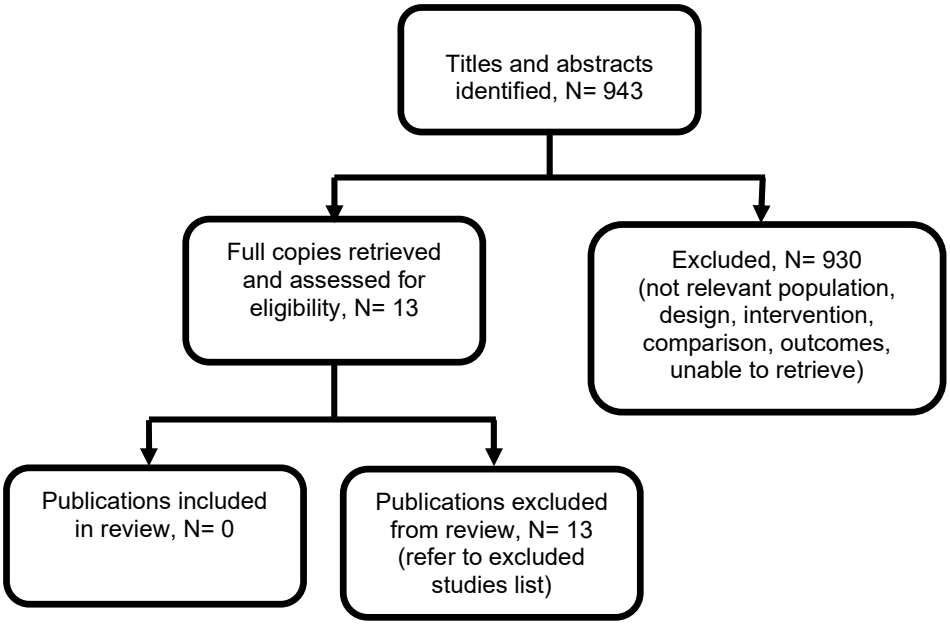


Figure 7: Economic evidence study selection flow chart: Children and young people



Appendix H – Economic evidence tables

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

No economic studies were identified which were applicable to this review question.

Economic evidence tables for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

No economic studies were identified which were applicable to this review question.

Appendix I – Economic evidence profiles

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

No economic evidence was identified which was applicable to this review question.

Economic evidence profiles for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

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

No economic analysis was undertaken for this review question.

Economic evidence analysis for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

No economic analysis was undertaken for this review question.

Appendix K – Excluded studies

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

Quantitative clinical studies

Table 39: Excluded quantitative studies and reasons for their exclusion

Study	Reason for Exclusion
Adams, Annette L., Schiff, Melissa A., Koepsell, Thomas D., Rivara, Frederick P., Leroux, Brian G., Becker, Thomas M., Hedges, Jerris R., Physician consultation, multidisciplinary care, and 1-year mortality in Medicare recipients hospitalized with hip and lower extremity injuries, Journal of the American Geriatrics Society, 58, 1835-42, 2010	Outcome not in PICO: Mortality
Aitken, Mary E., Korehbandi, Patricia, Parnell, Donna, Parker, James G., Stefans, Vikki, Tompkins, Esther, Schulz, Eldon G., Experiences from the development of a comprehensive family support program for pediatric trauma and rehabilitation patients, Archives of Physical Medicine and Rehabilitation, 86, 175-9, 2005	Study design not in PICO: Non-comparative study
Albert, Steven M., Im, Ashley, Brenner, Lynda, Smith, Michael, Waxman, Richard, Effect of a social work liaison program on family caregivers to people with brain injury, The Journal of Head Trauma Rehabilitation, 17, 175-89, 2002	Study design not in PICO: Non-randomised study with less than N=100 in each arm (n=27 in intervention, n=29 in control)
Anderson, J., Mason, C., Reverse culture - How intensive care coordination eases military transitions for returning soldiers with traumatic brain injuries, Brain Injury, Conference, 2010	Published as abstract only
Anderson, J., Mason, C., Reverse culture shock - Military transitions for returning soldiers with traumatic brain injury, Journal of Head Trauma Rehabilitation, Conference, 2008	Published as abstract only
Andersson, E. E., Emanuelson, I., Björklund, R., StaËšlhammar, D., Mild traumatic brain injuries: the impact of early intervention on late sequelae. A randomized controlled trial, Brain Injury, 26, 520-521, 2012	Published as abstract only
Anonymous,, Trauma center boosts patient outcomes, Hospital case management : the monthly update on hospital-based care planning and critical paths, 9, 115-6, 2001	Narrative review
Asplin, G., Carlsson, G., Zidén, L., Kjellby-Wendt, G., Early coordinated rehabilitation in acute phase after hip fracture - a model for increased patient participation, BMC Geriatrics, 17, 240, 2017	Study design not in PICO: Non-randomised study with less than N=100 in each arm (n=63 in intervention, n=63 in control)
Atwal, Anita, Caldwell, Kay, Do multidisciplinary integrated care pathways improve interprofessional collaboration?, Scandinavian journal of caring sciences, 16, 360-7, 2002	Study design not in PICO: Qualitative study and audit performed before 2000
Avlund, K., Jepsen, E., Vass, M., Lundemark, H., Effects of comprehensive follow-up home visits after hospitalization on functional ability and readmissions among old patients. A randomized controlled study, Scandinavian Journal of Occupational Therapy, 9, 17-22, 2002	Study dates not in PICO: 1996-1997
Ayvazian, J., Lucente, J., Dudley-Brown, S., Clinical management of veterans with traumatic brain injury within the	Published as abstract only

Study	Reason for Exclusion
context of polytrauma, Journal of Head Trauma Rehabilitation, Conference, 2012	
Bandyopadhyay, S., Wilkinson, I., Giokarinin-Royal, T., How incorporating 'lean' approach led to improved delivery of care and reduction in length of hospital stay, Age and Ageing, 48, 2019	Published as abstract only
Baron, Justine S., Sullivan, Katrina J., Swaine, Jillian M., Aspinall, Arlene, Jaglal, Susan, Presseau, Justin, White, Barry, Wolfe, Dalton, Grimshaw, Jeremy M., Self-management interventions for skin care in people with a spinal cord injury: part 1-a systematic review of intervention content and effectiveness, Spinal Cord, 56, 823-836, 2018	Systematic review: Included studies checked for relevance.
Baron, Justine S., Sullivan, Katrina J., Swaine, Jillian M., Aspinall, Arlene, Jaglal, Susan, Presseau, Justin, Wolfe, Dalton, Grimshaw, Jeremy M., Self-management interventions for skin care in people with a spinal cord injury: part 2-a systematic review of use of theory and quality of intervention reporting, Spinal Cord, 56, 837-846, 2018	Systematic review: Included studies checked for relevance.
Baron, Justine, Swaine, Jillian, Presseau, J., Aspinall, Arlene, Jaglal, Susan, White, Barry, Wolfe, Dalton, Grimshaw, Jeremy, Self-management interventions to improve skin care for pressure ulcer prevention in people with spinal cord injuries: a systematic review protocol, Systematic reviews, 5, 150, 2016	Published protocol for a systematic review
Bayley, M. T., Lamontagne, M. E., Kua, A., Marshall, S., Marier-Deschenes, P., Allaire, A. S., Kagan, C., Truchon, C., Janzen, S., Teasell, R., Swaine, B., Unique features of the INESSS-Onf rehabilitation guidelines for moderate to severe traumatic brain injury: Responding to users' needs, Journal of Head Trauma Rehabilitation, 33, 296-305, 2018	Results not in PICO: Guideline recommendations for moderate/severe TBI. No raw data presented. Systematic review performed as part of methodology but results and references not presented to check.
Beadle, E., Watter, K., Murray, A., Kennedy, A., The integration of telehealth into a community-based interdisciplinary brain injury service, Brain Impairment, 20, 345, 2019	Published as abstract only
Berggren, M., Karlsson, Å, Lindelöf, N., Englund, U., Olofsson, B., Nordström, P., Gustafson, Y., Stenvall, M., Effects of geriatric interdisciplinary home rehabilitation on complications and readmissions after hip fracture: a randomized controlled trial, Clinical Rehabilitation, 33, 64-73, 2019	Study design not in PICO: Non-randomised study with less than N=100 in each arm (n=106 in intervention, n=93 in control)
Bhattacharyya, R., Agrawal, Y., Elphick, H., Blundell, C., The impact of a new model of hip fracture care at a teaching hospital, Osteoporosis International, 23, S566-S567, 2012	Published as abstract only
Bhattacharyya, Rahul, Agrawal, Yuvraj, Elphick, Heather, Blundell, Chris, A unique orthogeriatric model: a step forward in improving the quality of care for hip fracture patients, International journal of surgery (London, England), 11, 1083-6, 2013	Unclear comparator: Only described as "patients remain primarily under the care of the orthopaedic teams" (p. 1084)
Bloemen-Vrencken, J. H. A., de Witte, L. P., Engels, J. P. G. M., van den Heuvel, W. J. A., Post, M. W. M., Transmural care in the rehabilitation sector: implementation experiences with a transmural care model for people with spinal cord injury, International journal of integrated care, 5, e02, 2005	Study design not in PICO: No comparison group
Bloemen-Vrencken, J. H. A., de Witte, L. P., Post, M. W. M., Follow-up care for persons with spinal cord injury living in the community: a systematic review of interventions and their evaluation, Spinal cord, 43, 462-75, 2005	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
Bogie, Kath M., Ho, Chester H., Multidisciplinary approaches to the pressure ulcer problem, Ostomy/wound management, 53, 26-32, 2007	Narrative review
Bolster, M. B., Cevallos, S., Beyer, L., Kronenberg, H. M., Leder, B., A model for improved management of fragility fractures: Navigating the fracture liaison service, Arthritis and Rheumatology, 69, 2017	Published as abstract only
Braga, L. W., Da Paz, A. C., Ylvisaker, M., Direct clinician-delivered versus indirect family-supported rehabilitation of children with traumatic brain injury: a randomized controlled trial, Brain Injury, 19, 819-831, 2005	Population not in PICO: ≤ 18 years old.
Brasure, Michelle, Lamberty, Greg J., Sayer, Nina A., Nelson, Nathaniel W., Macdonald, Roderick, Ouellette, Jeannine, Wilt, Timothy J., Participation after multidisciplinary rehabilitation for moderate to severe traumatic brain injury in adults: a systematic review, Archives of physical medicine and rehabilitation, 94, 1398-420, 2013	Systematic review: Included studies checked for relevance.
Buccellato, K. H., Nordstrom, M., Murphy, J. M., Burdea, G. C., Polistico, K., House, G., Kim, N., Grampurohit, N., Sorensen, J., Isaacson, B. M., et al.,, A Randomized Feasibility Trial of a Novel, Integrative, and Intensive Virtual Rehabilitation Program for Service Members Post-Acquired Brain Injury, Military Medicine, 2019	Comparison not in PICO: Immediate (weeks 0-6) versus delayed (weeks 3-9) outpatient cognitive rehabilitation program. However, immediate versus delayed does not appear to relate to the time of discharge for the patients; same study as Buccellato 2020
Buccellato, Kiara H., Nordstrom, Michelle, Murphy, Justin M., Burdea, Grigore C., Polistico, Kevin, House, Gregory, Kim, Nam, Grampurohit, Namrata, Sorensen, Jeff, Isaacson, Brad M., Pasquina, Paul F., A Randomized Feasibility Trial of a Novel, Integrative, and Intensive Virtual Rehabilitation Program for Service Members Post-Acquired Brain Injury, Military Medicine, 185, e203-e211, 2020	Comparison not in PICO: Immediate (weeks 0-6) versus delayed (weeks 3-9) outpatient cognitive rehabilitation program. However, immediate versus delayed does not appear to relate to the time of discharge for the patients; same study as Buccellato 2019
Burch, D., Bernert, S., Fraser, J. F., Increased physician and physical therapist communication is associated with earlier mobility and decreased length of stay in the cerebrovascular and trauma neuroscience population, NeuroRehabilitation, 43, 195-199, 2018	Study design not in PICO: Non-randomised study with mixed population and less than N=100 in each group of population
Burch, D., Bernert, S., Fraser, J. F., Increased physician and physical therapist communication is associated with earlier mobility and decreased length of stay in the cerebrovascular and trauma neuroscience population, Stroke, 47, 2016	Published as abstract only
Burgo-Black, L., Hunt, S. C., Implementing a system of integrated post deployment care for returning combat veterans, Journal of General Internal Medicine, Conference, 2012	Published as abstract only
Burns, A., Aarabi, B., Anderson, P., Arnold, P., Brodke, D., Chiba, K., Dettori, J., Furlan, J., Harrop, J., Holly, L., Howley, S., Jeji, T., Kalsi-Ryan, S., Kotter, M., Kurpad, S., Kwon, B., Marino, R., Martin, A., Massicotte, E., Merli, G., Middleton, J., Nakashima, H., Nagoshi, N., Palmieri, K., Shamji, M., Singh, A., Skelly, A., Tetreault, L., Wilson, J., Yee, A., Fehlings, M., A clinical practice guideline for the management of patients with acute spinal cord injury: Recommendations on the type and timing of rehabilitation, Global Spine Journal, 7, 358S-359S, 2017	Published as abstract only

Study	Reason for Exclusion
Calleja, Pauline, Aitken, Leanne M., Cooke, Marie L., Information transfer for multi-trauma patients on discharge from the emergency department: mixed-method narrative review, Journal of Advanced Nursing, 67, 4-18, 2011	Semi-systematic review emphasising qualitative research/analysis methods. Additionally, it focuses on trauma care and does not mention rehabilitation.
Callender, Librada, Brown, Rachel, Driver, Simon, Dahdah, Marie, Collinsworth, Ashley, Shafi, Shahid, Process for developing rehabilitation practice recommendations for individuals with traumatic brain injury, BMC neurology, 17, 54, 2017	Technical paper about how to develop an evidence-based guideline; contains no primary or secondary data.
Cameron, I. D., Handoll, H. H. G., Finnegan, T. P., Langhorne, P., Multidisciplinary rehabilitation for older people with hip fractures, Cochrane Database of Systematic Reviews, CD007125, 2008	Earlier version of Handoll 2009
Cameron, I. D., Handoll, H. H., Finnegan, T. P., Madhok, R., Langhorne, P., Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures, The Cochrane database of systematic reviews, CD000106, 2001	Earlier version of Cameron 2009
Cameron, Ian D., Coordinated multidisciplinary rehabilitation after hip fracture, Disability and rehabilitation, 27, 1081-90, 2005	Narrative review
Cameron, Ian D., Handoll, Helen Hg, Finnegan, Terence P., Madhok, Rajan, Langhorne, Peter, WITHDRAWN: Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures, The Cochrane database of systematic reviews, CD000106, 2009	Withdrawn from the Cochrane library as it has been incorporated into another review with an expended scope (Handoll 2009)
Campbell, C. V., Cooper, J., Shabir, F., Wills, E., Ong, T., An enhanced therapy service for patients with fractured neck of femur - Service evaluation of a pilot project, Age and Ageing, 46, 2017	Published as abstract only
Canadillas Rueda, R., Domingo Montesinos, N., Natividad Pedreno, M., Comprehensive treatment and secondary prevention of fragility fractures in the elderly in an orthogeriatric unit. Multidisciplinary management of osteoporotic patients pre and post surgery. Advantages and results, Osteoporosis International, 27, S539, 2016	Published as abstract only
Careau, Emmanuelle, Dussault, Julie, Vincent, Claude, Development of interprofessional care plans for spinal cord injury clients through videoconferencing, Journal of interprofessional care, 24, 115-8, 2010	Study design not in PICO: No comparison group
Carney, Nancy A., Petroni, Gustavo J., Lujan, Silvia B., Ballarini, Nicolas M., Faguaga, Gabriela A., du Coudray, Hugo E. M., Huddleston, Amy E., Baggio, Gloria M., Becerra, Juan M., Busso, Leonardo O., Dikmen, Sureyya S., Falcone, Roberto, Garcia, Mirta E., Gonzalez Carrillo, Osvaldo R., Medici, Paula L., Quaglino, Marta B., Randisi, Carina A., Saenz, Silvia S., Temkin, Nancy R., Vanella, Elida E., Postdischarge Care of Pediatric Traumatic Brain Injury in Argentina: A Multicenter Randomized Controlled Trial, Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies, 17, 658-66, 2016	Intervention not in PICO: Discharge support related to medical care. Study does not report on patients receiving rehabilitation or social care
Carroll, V., The Adult Patient Assessment Tool and care plan, Australian nursing journal (July 1993), 14, 29-32, 2007	Outcomes and population not in PICO: Description of the development of an assessment tool by a multi-disciplinary working group

Study	Reason for Exclusion
Castillo, Renan C., Wegener, Stephen T., Newell, Mary Zadnik, Carlini, Anthony R., Bradford, Anna N., Heins, Sara E., Wysocki, Elizabeth, Pollak, Andrew N., Teter, Harry, Mackenzie, Ellen J., Improving outcomes at Level I trauma centers: an early evaluation of the Trauma Survivors Network, The journal of trauma and acute care surgery, 74, 1534-40, 2013	Intervention and comparison not in PICO: Trauma survivor network program consisting of self-management course, peer support, information access and provider training standard care versus standard care
Chang, C. B., Yang, R. S., Huang, W. J., Chan, D. C., Fracture type on the outcome of patients managed within the fracture liaison and osteoporosis medication management services, Osteoporosis International, 30, S92, 2019	Published as abstract only
Chudyk, Anna M., Jutai, Jeffrey W., Petrella, Robert J., Speechley, Mark, Systematic review of hip fracture rehabilitation practices in the elderly, Archives of physical medicine and rehabilitation, 90, 246-62, 2009	Systematic review: Included studies checked for relevance.
Clark, J., Gill, C., Sprott, A., Joined up thinking: A model for long-term abi rehabilitation after return home, Brain Injury, 26, 432-433, 2012	Published as abstract only
Closa, Conxita, Mas, Miquel A., Santaeugenia, Sebastia J., Inzitari, Marco, Ribera, Aida, Gallofre, Miquel, Hospital-at-home Integrated Care Program for Older Patients With Orthopedic Processes: An Efficient Alternative to Usual Hospital-Based Care, Journal of the American Medical Directors Association, 18, 780-784, 2017	Study design not in PICO: Non-randomised study with less than N=100 in at least 1 intervention group
Coetzer, Rudi, Holistic neuro-rehabilitation in the community: is identity a key issue?, Neuropsychological rehabilitation, 18, 766-83, 2008	Narrative review
Collins, Nina, Miller, Richard, Kapu, April, Martin, Rita, Morton, Melissa, Forrester, Mary, Atkinson, Shelley, Evans, Bethany, Wilkinson, Linda, Outcomes of adding acute care nurse practitioners to a Level I trauma service with the goal of decreased length of stay and improved physician and nursing satisfaction, The journal of trauma and acute care surgery, 76, 353-7, 2014	Intervention not in PICO: Acute care nurse practitioner (ACNP) who coordinated acute/ clinical care with a very brief mention of rehabilitation was "The ACNP attended the daily "discharge huddle"™ a team meeting that encompasses T2 [step-down care from ICU] and T3 [trauma nurse practitioner satellite service] NPs [nurse practitioner], case managers, social worker, liaisons to rehabilitation and nursing home facilities, and home health agency staff to facilitate communication and the discharge process." (p. 354). Only outcome reported is length of stay.
Cooper, M., Ganda, K., Palmer, A., Seibel, M. J., Cost effectiveness of a targeted intervention to reduce refracture rates: Analysis of a four year prospective controlled study, Journal of Bone and Mineral Research, 26, 2011	Published as abstract only
Cooper, M., Palmer, A., Ganda, K., Seibel, M. J., Cost-effectiveness of a targeted intervention to reduce the rate of refracture: Results ofa 4-year prospective controlled study, Osteoporosis International, 22, S651-S652, 2011	Published as abstract only
Cordasco, K. M., Saifu, H., Rubenstein, L. V., Khafaf, M., Doyle, B., Hsiao, J., Orshansky, G., Ganz, D., The ED-PACT tool:	Published as abstract only

Study	Reason for Exclusion
Communicating veterans' care needs after emergency department visits via electronic messages, Journal of General Internal Medicine, 32, S800, 2017	
Corser, William D., Postdischarge outcome rates influenced by comorbidity and interdisciplinary collaboration, Outcomes management, 8, 45-51, 2004	Study design and population not in PICO: Non-randomised study with less than N=100 in each arm (total N=189). Unclear exactly why population admitted, but n=67 were admitted from medical cardiac services.
Crotty, M., Rowett, D., Spurling, L., Giles, L. C., Phillips, P. A., Does the addition of a pharmacist transition coordinator improve evidence-based medication management and health outcomes in older adults moving from the hospital to a long-term care facility? Results of a randomized, controlled trial, American Journal Geriatric Pharmacotherapy, 2, 257-264, 2004	Unclear population: Older people being transferred from hospital to long term care facility with no further details.
Crotty, M., Whitehead, C. H., Gray, S., Finucane, P. M., Early discharge and home rehabilitation after hip fracture achieves functional improvements: A randomized controlled trial, Clinical Rehabilitation, 16, 406-413, 2002	Study dates not in PICO: 1998-1999
Crouch, D., Taking spinal care into the community, Nursing times, 100, 24-25, 2004	Narrative review
Cuthbert, J., Anderson, J., Mason, C., Block, S., Martin, K., Dettmer, J., Weintraub, A., Harrison-Felix, C., Evaluating case management needs and impact for adults with chronic TBI, Brain Injury, 28, 706, 2014	Published as abstract only
Davies Urizar, B., Malanga Ferrari, A., Garcia Fernandez, J. A., Martin De Francisco Murga, E., Alonso Bouzon, C., Rodriguez-Manas, L., Benefits of an orthogeriatric unit, European Geriatric Medicine, 2, S138, 2011	Published as abstract only
De Goumoens, V., Rio, L. M., Jaques, C., Ramelet, A. S., Family-oriented interventions for adults with acquired brain injury and their families: A scoping review, JBI Database of Systematic Reviews and Implementation Reports, 16, 2330-2367, 2018	Systematic review: Included studies checked for relevance.
Dibardino, D., Cohen, E. R., Didwania, A., Meta-analysis: Multidisciplinary fall prevention strategies in the acute care inpatient population, Journal of Hospital Medicine, 7, 497-503, 2012	Systematic review: Included studies checked for relevance.
Doloresco, L., CARF: symbol of rehabilitation excellence, SCI nursing : a publication of the American Association of Spinal Cord Injury Nurses, 18, 165-172, 2001	Article not available
Donohue, Kathleen, Hoevenaars, Richelle, McEachern, Jocelyn, Zeman, Erica, Mehta, Saurabh, Home-Based Multidisciplinary Rehabilitation following Hip Fracture Surgery: What Is the Evidence?, Rehabilitation research and practice, 2013, 875968, 2013	Systematic review: Included studies checked for relevance.
Dorsey, Julie, Bradshaw, Michelle, Effectiveness of Occupational Therapy Interventions for Lower-Extremity Musculoskeletal Disorders: A Systematic Review, The American journal of occupational therapy : official publication of the American Occupational Therapy Association, 71, 7101180030p1-7101180030p11, 2017	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Drago, K., Bernstein, J., Graven, P., Dobbertin, K., Eckstrom, E., Higher quality, lower cost with a geriatrics consult service, Journal of the American Geriatrics Society, 65, S36, 2017	Published as abstract only

Study	Reason for Exclusion
Driessen, Julia, Bellon, Johanna E., Stevans, Joel, Forsythe, Raquel M., Reynolds, Benjamin R., James, A. Everette, 3rd, Perceived performance and impact of a non-physician-led interprofessional team in a trauma clinic setting, Journal of interprofessional care, 31, 112-114, 2017	Outcomes not in PICO: Team survey responses, consults given and new therapy referrals initiated.
Dunn, A. M., Boylston, M., Establishing a consultation service through multidisciplinary rounds, PM and R, 7, S151-S152, 2015	Published as abstract only
Dutton, Richard P., Cooper, Carnell, Jones, Alan, Leone, Susan, Kramer, Mary E., Scalea, Thomas M., Daily multidisciplinary rounds shorten length of stay for trauma patients, The Journal of trauma, 55, 913-9, 2003	Intervention not in PICO: Daily multidisciplinary rounds focused on medical care, not coordination or delivery of rehabilitation or social care.
Eicher, Vicki, Murphy, Mary Pat, Murphy, Thomas F., Malec, James F., Progress assessed with the Mayo-Portland Adaptability Inventory in 604 participants in 4 types of post-inpatient rehabilitation brain injury programs, Archives of Physical Medicine and Rehabilitation, 93, 100-7, 2012	Interventions not in PICO: 4 different rehabilitation programmes with different content, not coordination or delivery of rehabilitation or social care.
Espinoza, L., Scudder, B., Rosario, E., Patient navigation for traumatic brain injury, Journal of Head Trauma Rehabilitation, Conference, 2013	Published as abstract only
Farba, L., Cypin, I., Spesivtcev, I., The first assessment of the principles of "Co-managed care in elderly patients" in Moscow City hospital #13, Osteoporosis International, 27, S131, 2016	Published as abstract only
Faux, S., Wu, J., Harris, I., Poulos, C., Klein, L., Murray, G., Wilson, S., John, E., Early rehabilitation after hospital admission for road-trauma via an in-reach mobile team; a randomised controlled trial, Archives of Physical Medicine and Rehabilitation, 97, e15-e16, 2016	Published as abstract only
Featherall, J., Brigati, D. P., Faour, M., Messner, W., Higuera, C. A., Implementation of a Total Hip Arthroplasty Care Pathway at a High-Volume Health System: Effect on Length of Stay, Discharge Disposition, and 90-Day Complications, Journal of Arthroplasty, 33, 1675-1680, 2018	Intervention not in PICO: Hip arthroplasty care pathway, including pre-operative, peri-operative and post-operative interventions. Mention of clinical care coordinator in the post-operative section but not able to quantify what is due to care coordinator and what is attributable to other interventions.
Fernandez, M. A., Griffin, X. L., Costa, M. L., Management of hip fracture, British medical bulletin, 115, 165-72, 2015	Narrative review
Fernandez-Moyano, A., Fernandez-Ojeda, R., Ruiz-Romero, V., Garcia-Benitez, B., Palmero-Palmero, C., Aparicio-Santos, R., Comprehensive care program for elderly patients over 65 years with hip fracture, Revista clinica espanola, 214, 17-23, 2014	Length of stay and readmission data does not have enough details reported to compare results of pre-implementation group and post-implementation group (no mean or standard deviation for the before group and no statistical analysis presented). Barthel Index is only compared between those who survived and those who died during the study period.
Fiona, N., Lucinda, M., Margot, P., Gabor, M., Suzanne, M., Bernard, W., Erica, E., Sanjay, G., Implementation of re-fracture prevention of >65 year old inpatient fractured neck of femur prior	Published as abstract only

Study	Reason for Exclusion
to discharge, Internal Medicine Journal, 46, 10, 2016	
Fitzsimmons, R. D., Brain injury case management: The potential and limitations of late-stage intervention - A pilot study, Brain Injury, 17, 947-971, 2003	Study design not in PICO: Non-randomised study with less than N=100 in each arm (total N=22)
Flinn, N. A., Kelley, T., Foo, S., Medical home for persons with disabilities: A target for the triple aim, Archives of Physical Medicine and Rehabilitation, 94, e55-e56, 2013	Published as abstract only
Fojas Ma, C. M., Ing, S. W., Phieffer, L., Stephens, J., Southerland, L., Evolution of a fracture prevention program : A review of our experience at the Ohio state university, Endocrine Reviews, 37, 2016	Published as abstract only
Forni, Silvia, Pieralli, Francesca, Sergi, Alessandro, Lorini, Chiara, Bonaccorsi, Guglielmo, Vannucci, Andrea, Mortality after hip fracture in the elderly: The role of a multidisciplinary approach and time to surgery in a retrospective observational study on 23,973 patients, Archives of Gerontology and Geriatrics, 66, 13-7, 2016	Intervention not in PICO: Multi-disciplinary team designed to acutely treat hip fracture patients in order to decrease time from admission to surgery, rather than multi-disciplinary team for rehabilitation care
Franz, Shiney, Muser, Jurgen, Thielhorn, Ulrike, Wallesch, Claus W., Behrens, Johann, Inter-professional communication and interaction in the neurological rehabilitation team: a literature review, Disability and Rehabilitation, 1-9, 2018	Systematic review: Included studies checked for relevance.
Fukuda, Haruhisa, Shimizu, Sayuri, Ishizaki, Tatsuro, Has the Reform of the Japanese Healthcare Provision System Improved the Value in Healthcare? A Cost-Consequence Analysis of Organized Care for Hip Fracture Patients, PLoS ONE, 10, e0133694, 2015	Comparison not in PICO: Hip fracture care in hospitals autonomously providing integrated care across specialties versus in acute care hospitals and rehabilitative care hospitals providing organized care across separate facilities (the organisation of the care is not further described).
Furlan, Andrea D., Irvin, Emma, Munhall, Claire, Giraldo-Prieto, Mario, Fullerton, Laura, McMaster, Robert, Danak, Shivang, Costante, Alicia, Pitzul, Kristen, Bhide, Rohit P., Marchenko, Stanislav, Mahood, Quenby, David, Judy A., Flannery, John F., Bayley, Mark, Rehabilitation service models for people with physical and/or mental disability living in low- and middle-income countries: A systematic review, Journal of Rehabilitation Medicine, 50, 487-498, 2018	Systematic review: Included studies checked for relevance.
Gailey, Robert, Gaunaurd, Ignacio, Raya, Michele, Kirk-Sanchez, Neva, Prieto-Sanchez, Luz M., Roach, Kathryn, Effectiveness of an Evidence-Based Amputee Rehabilitation (EBAR) Program: A Pilot Randomized Controlled Trial, Physical therapy, 2020	Intervention not in PICO: Rehabilitation programme designed to occur after participants had completed physical therapy and prosthetic training.
Gjerberg, Elisabeth, Flottorp, Signe, Holte, Hilde H., 2008	Article not available
Grabljevec, Klemen, Singh, Rajiv, Denes, Zoltan, Angerova, Yvona, Nunes, Renato, Boldrini, Paolo, Delargy, Mark, Laxe, Sara, Kiekens, Carlotte, Varela Donoso, Enrique, Christodoulou, Nicolas, Evidence-based position paper on Physical and Rehabilitation Medicine professional practice for Adults with Acquired Brain Injury. The European PRM position (UEMS PRM Section), European journal of physical and rehabilitation medicine, 54, 971-979, 2018	Systematic review: Included studies checked for relevance.
Gregersen, Merete, Morch, Marianne Metz, Hougaard, Kjeld, Damsgaard, Else Marie, Geriatric intervention in elderly patients	Intervention not in PICO: Multi-disciplinary team designed to

Study	Reason for Exclusion
with hip fracture in an orthopedic ward, Journal of injury & violence research, 4, 45-51, 2012	acutely treat hip fracture patients in order to decrease time from admission to surgery, rather than multi-disciplinary team for rehabilitation care
Grigoryan, K., Javedan, H., Rudolph, J., Ortho-geriatric models and optimal outcomes: A systematic review and meta-analysis, Journal of the American Geriatrics Society, 61, S8-S9, 2013	Published as abstract only
Grigoryan, Konstantin V., Javedan, Houman, Rudolph, James L., Orthogeriatric care models and outcomes in hip fracture patients: a systematic review and meta-analysis, Journal of Orthopaedic Trauma, 28, e49-55, 2014	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Grill, E., Ewert, T., Lipp, B., Mansmann, U., Stucki, G., Effectiveness of a community-based 3-year advisory program after acquired brain injury, European Journal of Neurology, 14, 1256-65, 2007	Mixed population: Only 310/1181 were in PICO (traumatic brain injury) but results are not presented separately for target population.
Grobe, K. F., Lin, S. J., Ababneh, A. F., Orozco, E. M., Maxey, K., Smarda, M. J., Lopez, A. R., The feasibility and effectiveness of an internet-based exercise program in individuals with spinal cord injury, Cardiopulmonary Physical Therapy Journal, 31, e16-e17, 2020	Published as abstract only
Gupta, A., The effectiveness of geriatrician-led comprehensive hip fracture collaborative care in a new acute hip unit based in a general hospital setting in the UK, The journal of the Royal College of Physicians of Edinburgh, 44, 20-6, 2014	Intervention not in PICO: Multi-disciplinary team designed to acutely care for hip fracture patients pre- and post-operatively, rather than multi-disciplinary team for coordination of rehabilitation.
Guy, S., Kras-Dupuis, A., Wolfe, D., Hsieh, J., Walia, S., Askes, H., Spinal cord injury best practice implementation for pressure ulcer prevention: Initial implementation results, Archives of Physical Medicine and Rehabilitation, 94, e25, 2013	Published as abstract only
Haan, James M., Dutton, Richard P., Willis, Michelle, Leone, Susan, Kramer, Mary E., Scalea, Thomas M., Discharge rounds in the 80-hour workweek: importance of the trauma nurse practitioner, The Journal of trauma, 63, 339-43, 2007	Intervention not in PICO: Daily multidisciplinary rounds focused on medical care, not coordination or delivery of rehabilitation or social care.
Halbert, J., Crotty, M., Whitehead, C., Cameron, I., Kurrle, S., Graham, S., Handoll, H., Finnegan, T., Jones, T., Foley, A., Shanahan, M., Multi-disciplinary rehabilitation after hip fracture is associated with improved outcome: A systematic review, Journal of Rehabilitation Medicine, 39, 507-512, 2007	Systematic review: Included studies checked for relevance.
Hall, Erin C., Tyrrell, Rebecca, Scalea, Thomas M., Stein, Deborah M., Trauma Transitional Care Coordination: protecting the most vulnerable trauma patients from hospital readmission, Trauma surgery & acute care open, 3, e000149, 2018	No information presented for comparison group, including number of participants.
Hammond, Flora M., Gassaway, Julie, Abeyta, Nichola, Freeman, Erma S., Primack, Donna, Kreider, Scott E. D., Whiteneck, Gale, Outcomes of social work and case management services during inpatient spinal cord injury rehabilitation: the SCIRehab project, The journal of spinal cord medicine, 35, 611-23, 2012	Study design not in PICO: No intervention.
Handoll, H. H. G., Cameron, I. D., Mak, J. C. S., Finnegan, T. P., Multidisciplinary rehabilitation for older people with hip fractures,	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
Cochrane Database of Systematic Reviews, CD007125, 2009	
Hart, Tessa, Brockway, Jo Ann, Maiuro, Roland D., Vaccaro, Monica, Fann, Jesse R., Mellick, David, Harrison-Felix, Cindy, Barber, Jason, Temkin, Nancy, Anger Self-Management Training for Chronic Moderate to Severe Traumatic Brain Injury: Results of a Randomized Controlled Trial, The Journal of head trauma rehabilitation, 32, 319-331, 2017	Intervention not in PICO: Treatment protocol for anger self-management training. No mention of co-ordination or delivery of rehabilitation.
Hart, Tessa, Driver, Simon, Sander, Angelle, Pappadis, Monique, Dams-O'Connor, Kristen, Bocage, Claire, Hinkens, Emma, Dahdah, Marie N., Cai, Xinsheng, Traumatic brain injury education for adult patients and families: a scoping review, Brain Injury, 32, 1295-1306, 2018	Systematic review: Included studies checked for relevance.
Hartwell, J., Albanese, K., Retterer, A., Martin, S., O'Mara, M. S., A trauma patient advocate is a valuable addition to the multidisciplinary trauma team: A process improvement project, American Surgeon, 82, S183-S185, 2016	No study results presented in paper
He, J., Wei, Q., Effect observation of community rehabilitation model on generic set of ICF for patients with TBI, Neurorehabilitation and Neural Repair, 32, 323-324, 2018	Published as abstract only
Heinemann, A. W., Corrigan, J. D., Moore, D., Case Management for Traumatic Brain Injury Survivors with Alcohol Problems, Rehabilitation Psychology, 49, 156-166, 2004	Intervention not in PICO: Comprehensive case management for people with traumatic brain injury and post-injury substance abuse
Heppenstall, C. P., Hanger, H. C., Wilkinson, T. J., The canterbury community rehabilitation, enablement and support team (CREST) service: A novel service to support wellbeing and independence in the community, Age and Ageing, 48, 2019	Published as abstract only
Herrera-Espiñeira, C., Rodríguez del Águila Mdel, M., Navarro Espigares, J. L., Godoy Montijano, A., García Priego, A., Rodríguez, J. G., Sánchez, I. R., Effect of a telephone care program after hospital discharge from a trauma surgery unit, Gaceta sanitaria, 25, 133-138, 2011	Article in Spanish
Heyman, Noemi, Etzion, Isaac, Ben Natan, Merav, A coordination project for improvement of osteoporosis medication use among patients who sustained an osteoporotic fracture: The Israeli experience, Osteoporosis and Sarcopenia, 4, 134-139, 2018	Outcomes not in PICO: Osteoporosis medication use
Ho, W. S., Chan, H. H., Ying, S. Y., Cheng, H. S., Wong, C. S., Skin care in burn patients: A team approach, Burns, 27, 489-491, 2001	Study dates not in PICO: 1992-January 2000. Results not presented separately for the 1 month that was in PICO (January 2000)
Holliday, Anna, Samanta, Damayanti, Budinger, Julie, Hardway, Jessica, Bethea, Audis, An Outcome Analysis of Nurse Practitioners in Acute Care Trauma Services, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 24, 365-370, 2017	Intervention not in PICO: Nurse practitioners facilitated transfer throughout acute trauma services (including intensive care, floor, and post-acute clinic). Apart from placing the order for a rehabilitation consultation, there is no further mention of coordination of rehabilitation services.
Holstege, M. S., Bakkers, E., van Balen, R., Gussekloo, J., Achterberg, W. P., Caljouw, M. A., Structured scoring of supporting nursing tasks to enhance early discharge in geriatric rehabilitation: The BACK-HOME quasi-experimental study,	Population not in PICO: Only 31% (reference) and 34% (intervention) were admitted for traumatic injury. Results not

Study	Reason for Exclusion
International journal of nursing studies, 64, 13-18, 2016	presented separately for cause of admission.
Holstege, M. S., Caljouw, M. A. A., Van Balen, R., Gussekloo, J., Achterberg, W. P., Effectiveness of innovations in geriatric rehabilitation. The SINGER Study, European Geriatric Medicine, 4, S109-S110, 2013	Published as abstract only
Hossain, M. S., Harvey, L. A., Rahman, M. A., Bowden, J. L., Islam, M. S., Taylor, V., Muldoon, S., Herbert, R. D., A pilot randomised trial of community-based care following discharge from hospital with a recent spinal cord injury in Bangladesh, Clinical Rehabilitation, 31, 781-789, 2017	Unclear population: Inclusion criteria states participants with both traumatic and non-traumatic spinal cord injury. No further information about what proportions were traumatic, and results not presented separately for target population.
Houlihan, B., Brody, M., Skeels, S., Pernigotti, D., Zazula, J., Burnett, S., Green, C., Seetharama, S., Hasiotis, S., Belliveau, T., Rosenblum, D., Jette, A., RCT of peer-led phone-based empowerment intervention for persons with chronic spinal cord injury improves health self-management, Archives of Physical Medicine and Rehabilitation, 98, e152, 2017	Published as abstract only
Houlihan, Bethlyn Vergo, Brody, Miriam, Everhart-Skeels, Sarah, Pernigotti, Diana, Burnett, Sam, Zazula, Judi, Green, Christa, Hasiotis, Stathis, Belliveau, Timothy, Seetharama, Subramani, Rosenblum, David, Jette, Alan, Randomized Trial of a Peer-Led, Telephone-Based Empowerment Intervention for Persons With Chronic Spinal Cord Injury Improves Health Self-Management, Archives of Physical Medicine and Rehabilitation, 98, 1067-1076.e1, 2017	Intervention not in PICO: 'My Care My Call' designed for people with SCI already in the community. No mention of coordination or delivery of rehabilitation or social care during transfer.
Hums, Wendy, Williams, Julianne, Dedicated trauma care unit: an outcome-based model, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 12, 21-6, 2005	Narrative review
Jaber, Ala'a F., Hartwell, Julie, Radel, Jeff D., Interventions to Address the Needs of Adults With Postconcussion Syndrome: A Systematic Review, The American journal of occupational therapy : official publication of the American Occupational Therapy Association, 73, 7301205020p1-7301205020p12, 2019	Article not available
Johansen, Inger, Lindbaek, Morten, Stanghelle, Johan K., Brekke, Mette, Structured community-based inpatient rehabilitation of older patients is better than standard primary health care rehabilitation: an open comparative study, Disability and Rehabilitation, 34, 2039-46, 2012	Study design not in PICO: Non-randomised study. Although N=100 in one of the comparison groups, patients had mixed aetiologies (for example, 16/100 had stroke)
Johnson, M. K., Yanko, J. R., Collaborative practice: a successful model, SCI nursing : a publication of the American Association of Spinal Cord Injury Nurses, 18, 7-10, 2001	Article not available
Jones, Taryn M., Dean, Catherine M., Hush, Julia M., Dear, Blake F., Titov, Nickolai, A systematic review of the efficacy of self-management programs for increasing physical activity in community-dwelling adults with acquired brain injury (ABI), Systematic reviews, 4, 51, 2015	Systematic review: Included studies checked for relevance.
Jonsson, A., Gustafson, Y., Scholl, M., Hansen, F. R., Saarela, M., Nygaard, H., Laake, K., Jonsson, P. V., Valvanne, J., Dehlin, O., Geriatric rehabilitation as an integral part of geriatric medicine in the Nordic countries, Danish Medical Bulletin, 50, 439-445, 2003	Narrative review
Kammerlander, C., Gosch, M., Blauth, M., Lechleitner, M., Luger, T. J., Roth, T., The Tyrolean Geriatric Fracture Center: an	Study design not in PICO: No

Study	Reason for Exclusion
orthogeriatric co-management model, Zeitschrift fur Gerontologie und Geriatrie, 44, 363-7, 2011	comparison group.
Kapu, A., Jones, P., Financial impact of adding acute care nurse practitioners (ACNPs) to inpatient models of care, Critical Care Medicine, 40, 27, 2012	Published as abstract only
Karlsson, A., Berggren, M., Gustafson, Y., B, Olofsson, Lindelöf, N., Stenvall, M., Effects of geriatric interdisciplinary home rehabilitation on walking ability and length of hospital stay after hip fracture: a randomized controlled trial, Journal of the American Medical Directors Association, 17, 464.e9-e464.e15, 2016	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard inpatient rehabilitation but the intervention group received Geriatric Interdisciplinary Home Rehabilitation after discharge which included a High-Intensity Functional Exercise programme and medical care.
Karlsson, A., Lindelof, N., Olofsson, B., Berggren, M., Gustafson, Y., Nordstrom, P., Stenvall, M., Effects of Geriatric Interdisciplinary Home Rehabilitation on Independence in Activities of Daily Living in Older People With Hip Fracture: A Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 2020	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard inpatient rehabilitation but the intervention group received Geriatric Interdisciplinary Home Rehabilitation after discharge which included a High-Intensity Functional Exercise programme and medical care.
Kennedy, K., Establishing an orthopaedic physiotherapy practitioner role on the wards of an acute trauma hospital, Physiotherapy (United Kingdom), 97, eS1529, 2011	Published as abstract only
Khan, F., Amatya, B., Hoffman, K., Systematic review of multidisciplinary rehabilitation in patients with multiple trauma, The British journal of surgery, 99 Suppl 1, 88-96, 2012	Systematic review: Included studies checked for relevance.
Khan, S. K., Shirley, M. D., Glennie, C., Fearon, P. V., Deehan, D. J., Achieving best practice tariff may not reflect improved survival after hip fracture treatment, Clinical Interventions in Aging, 9, 2097-2102, 2014	Intervention not in PICO: Best practice tariffs for achieving targets, but no information presented on how these were achieved so no information on coordination and delivery of rehabilitation or social care.
Khan, S. K., Weusten, A., Bonczek, S., Tate, A., Port, A., The Best Practice Tariff helps improve management of neck of femur fractures: A completed audit loop, British Journal of Hospital Medicine, 74, 644-647, 2013	Population not in PICO: Inclusion criteria includes pathological hip fractures. Results not presented separately for target population.
Kiel, S., Zimak, C., Chenot, J. F., Schmidt, C. O., Evaluation of an ambulatory geriatric rehabilitation program - results of a matched cohort study based on claims data, BMC geriatrics, 20, 30, 2020	Study design not in PICO: Case-control design
Kind, A., Polnaszek, B., Hovanes, M., Smith, M., Designation of a clinician for post-hospital follow-up care and 30-day rehospitalizations in patients discharged to nursing homes and rehabilitation facilities, Journal of the American Geriatrics	Published as abstract only

Study	Reason for Exclusion
Society, 61, S16, 2013	
Koo, W. W. H., Hip care clinic: Improving osteoporosis treatment after a hip fracture, Osteoporosis International, 25, 609, 2014	Published as abstract only
Kooijmans, H., Post, M. W. M., Stam, H. J., van der Woude, L. H. V., Spijkerman, D. C. M., Snoek, G. J., Bongers-Janssen, H. M. H., van Koppenhagen, C. F., Twisk, J. W., Bussmann, J. B. J., Effectiveness of a Self-Management Intervention to Promote an Active Lifestyle in Persons With Long-Term Spinal Cord Injury: The HABITS Randomized Clinical Trial, Neurorehabilitation and Neural Repair, 31, 991-1004, 2017	Intervention not in PICO: Self-management intervention designed to increase physical activity in chronic SCI. No mention of coordination or delivery of rehabilitation or social care.
Krulova, A., Vackova, J., Svestkova, O., Community-based rehabilitation system for people with acquired brain injury in the Czech Republic (from the point of view of occupational therapist), Brain Injury, 31, 852-853, 2017	Published as abstract only
Kurowski, Brad G., Taylor, H. Gerry, McNally, Kelly A., Kirkwood, Michael W., Cassedy, Amy, Horn, Paul S., Stancin, Terry, Wade, Shari L., Online Family Problem-Solving Therapy (F-PST) for Executive and Behavioral Dysfunction After Traumatic Brain Injury in Adolescents: A Randomized, Multicenter, Comparative Effectiveness Clinical Trial, The Journal of head trauma rehabilitation, 2019	Outcomes not in PICO: Behaviour Rating Inventory of Executive Function, Global Executive Composite, Behaviour Regulation Index, Metacognition Index and Strengths and Difficulties Questionnaire
Kusen, J. Q., Schafroth, B., Poblete, B., van der Vet, P. C. R., Link, B. C., Wijdicks, F. J. G., Babst, R. H., Beeres, F. J. P., The implementation of a Geriatric Fracture Centre for hip fractures to reduce mortality and morbidity: an observational study, Archives of Orthopaedic and Trauma Surgery, 139, 1705-1712, 2019	Intervention not in PICO: Not concerned with the coordination of rehabilitation and social care for trauma patients while they are transferring between inpatients and outpatients. inpatients. Included in the review for coordination while inpatients.
Lamb, Laura C., Montgomery, Stephanie C., Wong Won, Brian, Harder, Siobhan, Meter, Jeffrey, Feeney, James M., A multidisciplinary approach to improve the quality of care for patients with fragility fractures, Journal of orthopaedics, 14, 247-251, 2017	Intervention not in PICO: Not concerned with the coordination of rehabilitation and social care for trauma patients while they are transferring between inpatients and outpatients. inpatients. Included in the review for coordination while inpatients.
Lannin, Natasha, Carr, Belinda, Allaous, Jeanine, Mackenzie, Bronwyn, Falcon, Alex, Tate, Robyn, A randomized controlled trial of the effectiveness of handheld computers for improving everyday memory functioning in patients with memory impairments after acquired brain injury, Clinical Rehabilitation, 28, 470-81, 2014	Comparison not in PICO: Electronic vs non-electronic memory aid after discharge
Lathbury, K., The road ahead--managing a spinal cord injury, The Case manager, 11, 55-7, 2000	Narrative review
Latz, David, Bergermann, Anja, Jungnitsch, Jeannie, Grassmann, Jan Peter, Schiffner, Erik, Gahr, Britta, Tank, Anne, Windolf, Joachim, Ritz-Timme, Stefanie, Gras, Lilly, Jungbluth, Pascal, Characterisation of Victims Of Violence in the A & E Department and Analysis of the Acceptance of a Medico-Legal Expertise Centre After its Implementation vs. Multi-Year Consolidation, Charakterisierung unfallchirurgischer Gewaltopfer und Erfassung der Inanspruchnahme nach Implementierung und mehrjahriger Etablierung einer rechtsmedizinischen	Population not in PICO: People presenting to A&E without admission

Study	Reason for Exclusion
Gewaltopferambulanz., 157, 426-433, 2019	
Lau, T. W., Leung, F., Siu, D., Wong, G., Luk, K. D. K., Geriatric hip fracture clinical pathway: The Hong Kong experience, Osteoporosis International, 21, S627-S636, 2010	No information presented on historical comparison group, including number of participants
Laver, Kate, Lannin, Natasha A., Bragge, Peter, Hunter, Peter, Holland, Anne E., Tavender, Emma, O'Connor, Denise, Khan, Fary, Teasell, Robert, Gruen, Russell, Organising health care services for people with an acquired brain injury: an overview of systematic reviews and randomised controlled trials, BMC health services research, 14, 397, 2014	Systematic review: Included studies checked for relevance.
Leal, J., Gray, A. M., Hawley, S., Prieto-Alhambra, D., Delmestri, A., Arden, N. K., Cooper, C., Javaid, M. K., Judge, A., Cost-Effectiveness of Orthogeriatric and Fracture Liaison Service Models of Care for Hip Fracture Patients: A Population-Based Study, Journal of Bone and Mineral Research, 32, 203-211, 2017	Outcomes not in PICO: 30 day mortality, 1 year mortality, risk of 2nd fracture and assorted intervention cost measures
Leclercq, M. M., For the return at home: Mobil teams brain-injury, Annals of Physical and Rehabilitation Medicine, 57, e411, 2014	Published as abstract only
Lee, John C., Horst, Michael, Rogers, Amelia, Rogers, Frederick B., Wu, Daniel, Evans, Tracy, Edavettal, Mathew, Checklist-styled daily sign-out rounds improve hospital throughput in a major trauma center, The American surgeon, 80, 434-40, 2014	Intervention not in PICO: Checklist designed to coordinate medical care of trauma patients rather than coordination or delivery of rehabilitation or social care
Lee, S. Y., Amatya, B., Judson, R., Truesdale, M., Reinhardt, J. D., Uddin, T., Xiong, X. H., Khan, F., Clinical practice guidelines for rehabilitation in traumatic brain injury: a critical appraisal, Brain Injury, 33, 1263-1271, 2019	Review of guidelines. References checked for possible included studies - none were identified.
Lems, W. F., Dreinhofer, K. E., Bischoff-Ferrari, H., Blauth, M., Czerwinski, E., Da Silva, J., Herrera, A., Hoffmeyer, P., Kvien, T., Maalouf, G., Marsh, D., Puget, J., Puhl, W., Poor, G., Rasch, L., Roux, C., Schuler, S., Seriolo, B., Tarantino, U., Van Geel, T., Woolf, A., Wyers, C., Geusens, P., EULAR/EFORT recommendations for management of patients older than 50 years with a fragility fracture and prevention of subsequent fractures, Annals of the Rheumatic Diseases, 76, 802-810, 2017	Systematic review: Included studies checked for relevance.
Leung, Andraay Hon-Chi, Lam, Tsz-Ping, Cheung, Wing-Hoi, Chan, Tan, Sze, Pan-Ching, Lau, Thomas, Leung, Kwok-Sui, An orthogeriatric collaborative intervention program for fragility fractures: a retrospective cohort study, The Journal of trauma, 71, 1390-4, 2011	Intervention not in PICO: Orthogeriatric Collaborative Programme consisting of geriatric reviews. Aim was to optimise patient condition for surgery and to address previously undiagnosed medical problems.
Li, L., Dai, J. X., Xu, L., Huang, Z. X., Pan, Q., Zhang, X., Jiang, M. Y., Chen, Z. H., The effect of a rehabilitation nursing intervention model on improving the comprehensive health status of patients with hand burns, Burns, 43, 877-885, 2017	Intervention not in PICO: Nursing intervention involving elements of occupational therapy and psychological treatment rather than interventions comparing the coordination and/or delivery of rehabilitation or social services
Lin, Francis O. Y., Luk, James K. H., Chan, T. C., Mok, Winnie W. Y., Chan, Felix H. W., Effectiveness of a discharge planning and community support programme in preventing readmission of high-risk older patients, Hong Kong medical journal = Xianggang yi xue za zhi, 21, 208-16, 2015	Population not in PICO: Home-dwelling older patients aged >60 years admitted to the general medical wards. Only 10% admitted through falls, results not presented separately

Study	Reason for Exclusion
	for target population.
Lin, L., Wade, C., Comprehensive prevention and management of pressure ulcers in an acute inpatient rehabilitation facility: An evidence ebased assessment, PM and R, 8, S182-S183, 2016	Published as abstract only
Linden, M., Hawley, C., Blackwood, B., Evans, J., Anderson, V., O'Rourke, C., Technological aids for the rehabilitation of memory and executive functioning in children and adolescents with acquired brain injury, Cochrane Database of Systematic Reviews, 2016	Systematic review: Included studies checked for relevance.
Ling, Shi-Neng James, Kleimeyer, Christopher, Lynch, Genni, Burmeister, Elizabeth, Kennedy, Diana, Bell, Kate, Watkins, Leith, Cooke, Cameron, Can geriatric hip fractures be managed effectively within a level 1 trauma center?, Journal of Orthopaedic Trauma, 29, 160-4, 2015	Intervention not in PICO: Coordination of acute management of hip fracture, rather than rehabilitation.
Lisk, R., Krasuski, M., Watters, H., Parsons, C., Yeong, K., 12 months impact of an orthopaedic early supportive discharge (OSD) team in our hip fracture service, European Geriatric Medicine, 6, S150, 2015	Published as abstract only
Liu, Vincent X., Rosas, Efren, Hwang, Judith, Cain, Eric, Foss-Durant, Anne, Clopp, Molly, Huang, Mengfei, Lee, Derrick C., Mustille, Alex, Kipnis, Patricia, Parodi, Stephen, Enhanced Recovery After Surgery Program Implementation in 2 Surgical Populations in an Integrated Health Care Delivery System, JAMA Surgery, 152, e171032, 2017	Intervention not in PICO: Enhanced recovery after surgery programme designed to impact peri-operative management and does not include rehabilitation or social care.
Lloyd-James, Lucy, Facing reality: discharge challenges after neuro-rehabilitation, Paediatric nursing, 18, 28, 2006	Narrative review
Lohse, Grant R., Leopold, Seth S., Theiler, Susan, Sayre, Cindy, Cizik, Amy, Lee, Michael J., Systems-based safety intervention: reducing falls with injury and total falls on an orthopaedic ward, The Journal of bone and joint surgery. American volume, 94, 1217-22, 2012	Population not in PICO: Mixture of traumatic and non-traumatic with results not reported separately for target population
Losh, Joseph, Duncan, Thomas K., Diaz, Graal, Lee, HyeSun, Romero, Javier, Multidisciplinary Patient Management Improves Mortality in Geriatric Trauma Patients, The American surgeon, 85, 230-233, 2019	Intervention not in PICO: Multidisciplinary medical trauma care, not rehabilitation
Lumba-Brown, A., Yeates, K. O., Sarmiento, K., Breiding, M. J., Haegerich, T. M., Gioia, G. A., Turner, M., Benzel, E. C., Suskauer, S. J., Giza, C. C., Joseph, M., Broomand, C., Weissman, B., Gordon, W., Wright, D. W., Moser, R. S., McAvoy, K., Ewing-Cobbs, L., Duhaime, A. C., Putukian, M., Holshouser, B., Paulk, D., Wade, S. L., Herring, S. A., Halstead, M., Keenan, H. T., Choe, M., Christian, C. W., Guskiewicz, K., Raksin, P. B., Gregory, A., Mucha, A., Taylor, H. G., Callahan, J. M., Dewitt, J., Collins, M. W., Kirkwood, M. W., Ragheb, J., Ellenbogen, R. G., Spinks, T. J., Ganiats, T. G., Sabelhaus, L. J., Altenhofen, K., Hoffman, R., Getchius, T., Gronseth, G., Donnell, Z., O'Connor, R. E., Timmons, S. D., Diagnosis and Management of Mild Traumatic Brain Injury in Children: A Systematic Review, JAMA Pediatrics, 172, 2018	Systematic review: Included studies checked for relevance..
Mackey, Patricia A., Rosenthal, Laura D., Mi, Lanyu, Whitaker, Michael D., Subsequent Fracture Prevention in Patients 50 Years and Older With Fragility Fractures: A Quality Improvement Initiative, Journal for healthcare quality : official publication of the National Association for Healthcare Quality, 41, 17-22, 2019	Intervention not in PICO: Osteoporosis education, screening and treatment.
Malec, J. F., Eicher, V., Murphy, M. P., Murphy, T. F., Progress assessed with the mayo-portland adaptability inventory through	Published as abstract only

Study	Reason for Exclusion
the client outcome system for 604 participants in four types of postacute brain injury rehabilitation programs, Brain Impairment, 12, 68, 2011	
Malec, J., Eicher, V., Murphy, M. P., Murphy, T., Progress in four postacute brain rehabilitation program types compared through the MPAI-4 outcome info system, Archives of Physical Medicine and Rehabilitation, 92, 1698, 2011	Published as abstract only
Mallick, Emad, Gulihar, Abhinav, Taylor, Grahame, Furlong, Andrew, Pandey, Radhakant, Impact of organisational changes on fracture neck of femur management, Annals of the Royal College of Surgeons of England, 93, 61-6, 2011	Intervention not in PICO: Project group aimed at changing surgical and medical management of hip fracture. No mention of rehabilitation.
Man, D. W., Soong, W. Y., Tam, S. F., Hui-Chan, C. W., Self-efficacy outcomes of people with brain injury in cognitive skill training using different types of trainer-trainee interaction, Brain Injury, 20, 959-970, 2006	Population not in PICO: Only 16/103 patients within PICO with results not reported separately for the target population.
Mangram, Alicia J., Shifflette, Vanessa K., Mitchell, Christopher D., Johnson, Van A., Lorenzo, Manuel, Truitt, Micheal S., Goel, Anuj, Lyons, Mark, Dunn, Ernest L., The creation of a geriatric trauma unit "G-60", The American surgeon, 77, 1144-6, 2011	Study design not in PICO: Non-randomised study with less than N=100 in 1 arm (n=150 in intervention group, n=78 in control group)
Massey, T., Smith, S., Bezzina, C., Ball, A., Specialist rehabilitation in a major trauma centre: It's not just about saving lives, Brain Injury, 28, 655, 2014	Published as abstract only
Mayo-Wilson, Evan, Grant, Sean, Burton, Jennifer, Parsons, Amanda, Underhill, Kristen, Montgomery, Paul, Preventive home visits for mortality, morbidity, and institutionalization in older adults: a systematic review and meta-analysis, PLoS ONE, 9, e89257, 2014	Systematic review: Included studies checked for relevance.
McMartin, K., Discharge planning in chronic conditions: An evidence-based analysis, Ontario Health Technology Assessment Series, 13, 1-72, 2013	Systematic review: Included studies checked for relevance.
Meaney, Mark, Divided loyalties in a brain injury case, The Case manager, 14, 30-72, 2003	Case report
Miller, Megan W., Emeny, Rebecca T., Freed, Gary L., Reduction of Hospital-acquired Pressure Injuries Using a Multidisciplinary Team Approach: A Descriptive Study, Wounds : a compendium of clinical research and practice, 31, 108-113, 2019	Population not in PICO: Hospital-wide implementation, with no separation of trauma and non-trauma patients
Mittal, Chikul, Lee, Hsien Chieh Daniel, Goh, Kiat Sern, Lau, Cheng Kiang Adrian, Tay, Leeanna, Siau, Chuin, Loh, Yik Hin, Goh, Teck Kheng Edward, Sandi, Chit Lwin, Lee, Chien Earn, ValuedCare program: a population health model for the delivery of evidence-based care across care continuum for hip fracture patients in Eastern Singapore, Journal of orthopaedic surgery and research, 13, 129, 2018	Intervention not in PICO: ValuedCare involved delivery of pre- and post-operative hip fracture care. No mention of delivery or coordination of rehabilitation or social care
Momosaki, Ryo, Kakuda, Wataru, Yamada, Naoki, Abo, Masahiro, Impact of board-certificated physiatrists on rehabilitation outcomes in elderly patients after hip fracture: An observational study using the Japan Rehabilitation Database, Geriatrics & gerontology international, 16, 963-8, 2016	Intervention not in PICO: Not concerned with the coordination of rehabilitation and social care for trauma patients while they are transferring between inpatients and outpatients. inpatients. Included in the review for coordination while inpatients.

Study	Reason for Exclusion
Morris, D. S., Reilly, P., Rohrbach, J., Telford, G., Kim, P., Sims, C. A., The influence of unit-based nurse practitioners on hospital outcomes and readmission rates for patients with trauma, Journal of Trauma and Acute Care Surgery, 73, 474-478, 2012	Intervention not in PICO: Unit-based nurse practitioners are involved in delivering acute trauma care, not delivery and coordination of rehabilitation or social care
Murphy, R. P., Reddin, C., Murphy, E. P., Waters, R., Murphy, C. G., Canavan, M., Key Service Improvements After the Introduction of an Integrated Orthogeriatric Service, Geriatric Orthopaedic Surgery and Rehabilitation, 10, 2019	Intervention not in PICO: Integrated orthogeriatric service designed to streamline pre- and post-operative care for hip fracture. No mention of delivery or coordination of rehabilitation or social care
Naeem, F., Rodriguez, S., MacRae, A., Implementation of an analgesia and bowels protocol to improve patient care after hip fracture, Age and Ageing, 48, 2019	Published as abstract only
Naglie, Gary, Tansey, Catherine, Kirkland, James L., Ogilvie-Harris, Darryl J., Detsky, Allan S., Etchells, Edward, Tomlinson, George, O'Rourke, Keith, Goldlist, Barry, Interdisciplinary inpatient care for elderly people with hip fracture: a randomized controlled trial, CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 167, 25-32, 2002	Study years not in PICO: 1993-1997
Nakase-Richardson, Risa, Stevens, Lillian Flores, Tang, Xinyu, Lamberty, Greg J., Sherer, Mark, Walker, William C., Pugh, Mary Jo, Eapen, Blessen C., Finn, Jacob A., Saylors, Mimi, Dillahunt-Aspillaga, Christina, Adams, Rachel Sayko, Garofano, Jeffrey S., Comparison of the VA and NIDILRR TBI Model System Cohorts, The Journal of Head Trauma Rehabilitation, 32, 221-233, 2017	Comparison not in PICO: Comparison between population characteristics of 2 databases contributing to Traumatic Brain Injury Model System
Niemeijer, Gerard C., Flikweert, Elvira, Trip, Albert, Does, Ronald J. M. M., Ahaus, Kees T. B., Boot, Anja F., Wendt, Klaus W., The usefulness of lean six sigma to the development of a clinical pathway for hip fractures, Journal of Evaluation in Clinical Practice, 19, 909-14, 2013	Intervention not in PICO: Lean Six Sigma aimed at decreasing the length of stay in hospital rather than coordinating or delivering rehabilitation
Nizamoglu, Metin, O'Connor, Edmund Fitzgerald, Bache, Sarah, Theodorakopoulou, Evgenia, Sen, Sankhya, Sherren, Peter, Barnes, David, Dziewulski, Peter, The impact of major trauma network triage systems on patients with major burns, Burns : journal of the International Society for Burn Injuries, 42, 1662-1670, 2016	Study design not in PICO: Non-RCT with less than 100 per arm
Noticewala, M. S., Swart, E., Shah, R. P., Macaulay, W., Geller, J. A., First Place Award Multidisciplinary care of the hip fracture patient: A case control analysis of differing treatment protocols, Current Orthopaedic Practice, 27, 346-350, 2016	Intervention not in PICO: Multi-disciplinary team delivering acute inpatient hip fracture care, with no mention of delivery or coordination of rehabilitation or social care
O'Keefe, Sophie, Stanley, Mandy, Adam, Kerry, Lannin, Natasha A., A Systematic Scoping Review of Work Interventions for Hospitalised Adults with an Acquired Neurological Impairment, Journal of Occupational Rehabilitation, 29, 569-584, 2019	Systematic review: Included studies checked for relevance.
Olenginski, T. P., Maloney-Saxon, G., Matzko, C. K., Mackiewicz, K., Kirchner, H. L., Bengier, A., Newman, E. D., High-risk osteoporosis clinic (HiROC): improving osteoporosis and postfracture care with an organized, programmatic approach, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 26, 801-10, 2015	Study design not in PICO: No comparison group.

Study	Reason for Exclusion
O'Malley, Natasha T., Blauth, Michael, Suhm, Norbert, Kates, Stephen L., Hip fracture management, before and beyond surgery and medication: a synthesis of the evidence, Archives of orthopaedic and trauma surgery, 131, 1519-27, 2011	Systematic review: Included studies checked for relevance.
O'Mara, Michael Shaymus, Ramaniuk, Aliaksandr, Graymire, Vickie, Rozzell, Monica, Martin, Stacey, Lean methodology for performance improvement in the trauma discharge process, The journal of trauma and acute care surgery, 77, 137-142, 2014	Comparison not in PICO: Trauma vs non-trauma wards
O'Neil, Jennifer, van Ierssel, Jacquie, Sveistrup, Heidi, Remote supervision of rehabilitation interventions for survivors of moderate or severe traumatic brain injury: A scoping review, Journal of telemedicine and telecare, 1357633X19845466, 2019	Systematic review: Included studies checked for relevance.
Parsons, Matthew, Parsons, John, Pillai, Avinesh, Rouse, Paul, Mathieson, Sean, Bregmen, Rochelle, Smith, Christine, Kenealy, Tim, Post-Acute Care for Older People Following Injury: A Randomized Controlled Trial, Journal of the American Medical Directors Association, 21, 404-409.e1, 2020	Duplicate
Patrick, P. D., Allaire, J. H., Hostler, S. L., A pediatric brain injury program: Families are catalysts for change, SAGGI - Child Development and Disabilities, 29, 31-39, 2003	Article not available
Perez Santamaria, M., Dominguez Arevalo, M. J., Manso Perez Cossio, J., Peraza Sanchez, M., Outcomes of a multidisciplinary approach for the management of hip fractures in older patients. Experience in a regional hospital, Osteoporosis International, 27, S419, 2016	Published as abstract only
Pfeifer, M., Dionyssiotis, Y., Musculoskeletal Rehabilitation after Hip Fracture: A Review, Osteologie, 28, 183-191, 2019	Systematic review: Included studies checked for relevance.
Pfeifer, M., Minne, H. W., Musculoskeletal rehabilitation after hip fracture: A review, Archives of Osteoporosis, 5, 49-59, 2010	Systematic review: Included studies checked for relevance.
Phillips, V. L., Vesmarovich, S., Hauber, R., Wiggers, E., Egner, A., Telehealth: reaching out to newly injured spinal cord patients, Public health reports (Washington, D.C. : 1974), 116 Suppl 1, 94-102, 2001	Study dates not in PICO: 1998-August/September 2000. Results not presented separately for the period in PICO (January-August/September 2000)
Pils, K., Vavrovsky, G., Meisner, W., Schreiber, W., Bohmer, F., Improvement of rehabilitation outcomes of hip fractures: discharge assessment by patient care team, case management and wound healing]. [German, Wiener klinische wochenschrift, 112, 413-419, 2000	Article in German
Pioli, G., Pellicciotti, F., Davoli, M. L., Pignedoli, P., Sabetta, E., Ferrari, A., Hip fracture management and outcomes in Italy, European Geriatric Medicine, 1, 104-107, 2010	Narrative description of hip fracture care model. No presentation of data
Pope, Sue, Vickerstaff, A. L., Wareham, A. P., Lessons learned from early rehabilitation of complex trauma at the Royal Centre for Defence Medicine, Journal of the Royal Army Medical Corps, 163, 124-131, 2017	Narrative description of Royal Centre for Defence Medicine rehabilitation model. No presentation of study data.
Powell, J., Heslin, J., Greenwood, R., Community based rehabilitation after severe traumatic brain injury: a randomised controlled trial, Journal of neurology, neurosurgery, and psychiatry, 72, 193-202, 2002	Study dates not in PICO: Pre-2000
Powell, Janet M., Fraser, Robert, Brockway, Jo Ann, Temkin, Nancy, Bell, Kathleen R., A Telehealth Approach to Caregiver Self-Management Following Traumatic Brain Injury: A Randomized Controlled Trial, The Journal of head trauma rehabilitation, 31, 180-90, 2016	Intervention not in PICO: Education for caregivers of people with traumatic brain injury

Study	Reason for Exclusion
Prestmo, A., Sletvold, O., Thingstad, P., Taraldsen, K., Johnsen, L. G., Helbostad, J., Saltvedt, I., Outcomes of activities of daily living, cognition and mobility in the Trondheim Hip Fracture Trial. A randomized controlled trial, European Geriatric Medicine, 3, S56, 2012	Published as abstract only
Proudfoot, Suzanne, Bennett, Brandon, Duff, Simon, Palmer, Julie, Implementation and effects of Enhanced Recovery After Surgery for hip and knee replacements and fractured neck of femur in New Zealand orthopaedic services, The New Zealand medical journal, 130, 77-90, 2017	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Multi-component intervention with only 1 of 5 sections focused on discharge planning. Other areas targeted by the intervention was within the ambulance, pre-operative care, peri-operative care and post-operative care.
Prvu Bettger, Janet A., Stineman, Margaret G., Effectiveness of multidisciplinary rehabilitation services in postacute care: state-of-the-science. A review, Archives of physical medicine and rehabilitation, 88, 1526-34, 2007	Systematic review: Included studies checked for relevance.
Rae-Grant, Alex D., Turner, Aaron P., Sloan, Alicia, Miller, Deborah, Hunziker, James, Haselkorn, Jodie K., Self-management in neurological disorders: systematic review of the literature and potential interventions in multiple sclerosis care, Journal of rehabilitation research and development, 48, 1087-100, 2011	Systematic review: Included studies checked for relevance.
Rapidi, C. A., Tederko, P., Moslavac, S., Popa, D., Branco, C. A., Kiekens, C., Varela Donoso, E., Christodoulou, N., Evidence-based position paper on Physical and Rehabilitation Medicine (PRM) professional practice for persons with spinal cord injury. The European PRM position (UEMS PRM Section), European Journal of Physical and Rehabilitation Medicine, 54, 797-807, 2018	Systematic review: Included studies checked for relevance.
Reguant, F., Arnau, A., Lorente, J. V., Maestro, L., Bosch, J., Efficacy of a multidisciplinary approach on postoperative morbidity and mortality of elderly patients with hip fracture, Journal of Clinical Anesthesia, 53, 11-19, 2019	Intervention not in PICO: MDT intervention designed to optimise patient health before hip fracture surgery, rather than rehabilitation.
Reinhardt, J., Chen, S., Gosney, J., Hu, X., Li, J., Liu, S., Zhang, X., Effectiveness of a comprehensive rehabilitation services program on long-term physical functioning in injured survivors of the 2008 sichuan earthquake, PM and R, 4, S300, 2012	Published as abstract only
Rezaei, Mojtaba, Sharifi, Amirsina, Vaccaro, Alexander Richard, Rahimi-Movaghar, Vafa, Home-Based Rehabilitation Programs: Promising Field to Maximize Function of Patients with Traumatic Spinal Cord Injury, Asian journal of neurosurgery, 14, 634-640, 2019	Systematic review: Included studies checked for relevance.
Robalino, S., Nyakang'o, S. B., Beyer, F., Fox, C., Allan, L. M., Effectiveness of interventions aimed at improving physical and psychological outcomes of fall-related injuries in people with dementia a systematic review, Age and Ageing, 47, 2018	Published as abstract only
Robles, L., Slogoff, M., Ladwig-Scott, E., Zank, D., Larson, M. K., Aranha, G., Shoup, M., The addition of a nurse practitioner to an inpatient surgical team results in improved use of resources, Surgery, 150, 711-717, 2011	Population not in PICO: Surgical and colorectal patients with no distinction between trauma and non-trauma surgical

Study	Reason for Exclusion
	patients.
Roels, E. H., Aertgeerts, B., Ramaekers, D., Peers, K., Hospital- and community-based interventions enhancing (re)employment for people with spinal cord injury: a systematic review, Spinal cord, 54, 2-7, 2016	Systematic review: Included studies checked for relevance.
Rosario, Emily R., Espinoza, Laura, Kaplan, Stephanie, Khonsari, Sepehr, Thurndyke, Earl, Bustos, Melissa, Vickers, Kayla, Navarro, Brittney, Scudder, Bonnie, Patient navigation for traumatic brain injury promotes community re-integration and reduces re-hospitalizations, Brain Injury, 31, 1340-1347, 2017	Study design not in PICO: Non-RCT with less than 100 per arm.
Rothman, E. F., Cohort study: Violent reinjury and mortality highlights the need for a comprehensive care approach to youth presenting for assault-related injury, Evidence-Based Medicine, 20, 112, 2015	Setting not in PICO: Emergency department
Ruggiero, C., Zampi, E., Baroni, M., Mecocci, P., Rinonapoli, G., Caraffa, A., Conti, F., Brandi, M. L., The fracture unit to bridge the osteoporosis care gap in Italy, Osteoporosis International, 25, S365, 2014	Published as abstract only
Rypkema, G., Adang, E., Dicke, H., Naber, T., De Swart, B., Disselhorst, L., Goluke-Willemse, G., Rikkert, M. O., Cost-effectiveness of an interdisciplinary intervention in geriatric inpatients to prevent malnutrition, Journal of Nutrition, Health and Aging, 8, 122-127, 2004	Unclear population: All non-terminally ill geriatric patients admitted for more than 2 days. Study does not report reason for admission.
Rytter, H. M., Westenbaek, K., Henriksen, H., Christiansen, P., Humle, F., Specialized interdisciplinary rehabilitation reduces persistent post-concussive symptoms: a randomized clinical trial, Brain Injury, 33, 266-281, 2019	Population not in PICO: People in the general population with post-concussive syndrome. Attended A&E but not admitted.
Saha, Sumit, DiRusso, Stephen M., Welle, Scott, Lieberman, Benjamin, Sender, Joel, Shabsigh, Ridwan, Baltazar, Gerard A., Integration of Geriatrician Consultation for Trauma Admissions May Benefit Patient Outcomes, Gerontology & geriatric medicine, 5, 2333721419858735, 2019	Intervention not in PICO: Geriatrician consultation for trauma patients upon admission to trauma centre if above 65 years old. No mention of coordination or delivery of rehabilitation.
Saltvedt, Ingvild, Prestmo, Anders, Einarsen, Elin, Johnsen, Lars Gunnar, Helbostad, Jorunn L., Sletvold, Olav, Development and delivery of patient treatment in the Trondheim Hip Fracture Trial. A new geriatric in-hospital pathway for elderly patients with hip fracture, BMC research notes, 5, 355, 2012	No study results presented in paper
Sander, Beate, Elliot-Gibson, Victoria, Beaton, Dorcas E., Bogoch, Earl R., Maetzel, Andreas, A coordinator program in post-fracture osteoporosis management improves outcomes and saves costs, The Journal of bone and joint surgery. American volume, 90, 1197-205, 2008	Intervention not in PICO: Coordination of osteoporosis treatment after fragility fracture
Savage, R., Camejo, M., Kramer, S., Jeanne Lozada, A., McAllister, T., Mensah, N., Romanelli, L., Sanchez, L., Schneider, L., Donohue, P., Does multidisciplinary and intense rehabilitation in a post-acute brain injury school produce positive outcomes?, Journal of Head Trauma Rehabilitation, 32, E87, 2017	Published as abstract only
Sayer, J., Quality improvement-fracture liaison service development, Osteoporosis International, 27, S557, 2016	Published as abstract only
Schneider, Kathryn J., Leddy, John J., Guskiewicz, Kevin M., Seifert, Tad, McCrea, Michael, Silverberg, Noah D., Feddermann-Demont, Nina, Iverson, Grant L., Hayden, Alix, Makdissi, Michael, Rest and treatment/rehabilitation following	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
sport-related concussion: a systematic review, British journal of sports medicine, 51, 930-934, 2017	
Semerano, Luca, Guillot, Xavier, Rossini, Maurizio, Avice, Evelyne, Begue, Thierry, Wargon, Mathias, Boissier, Marie-Christophe, Saidenberg-Kermanac'h, Nathalie, What predicts initiation of osteoporosis treatment after fractures: education organisation or patients' characteristics?, Clinical and Experimental Rheumatology, 29, 89-92, 2011	Intervention not in PICO: Patient osteoporosis education and organisation of osteoporosis care
Sen, A., Xiao, Y., Lee, S. A., Dutton, R., Scalea, T., Multidisciplinary discharge rounds may reduce ED overcrowding by facilitating hospital throughput, Academic Emergency Medicine, 17, S98-S99, 2010	Published as abstract only
Serghiou, Michael A., Holmes, Christina L., McCauley, Robert L., A survey of current rehabilitation trends for burn injuries to the head and neck, The Journal of burn care & rehabilitation, 25, 514-8, 2004	Study design not in PICO: Survey of burn rehabilitation providers (N=100)
Shahrokhi, Akram, Azimian, Jalil, Amouzegar, Atousa, Oveisi, Sonia, Effect of Telenursing on Outcomes of Provided Care by Caregivers of Patients With Head Trauma After Discharge, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 25, 21-25, 2018	Intervention not in PICO: Weekly telephone calls to caregivers of people with head injury to discuss health status and possible issues. No mention of rehabilitation.
Shahrokhi, Akram, Azimian, Jalil, Amouzegar, Atousa, Oveisi, Sonia, The Effect of Telenursing on Referral Rates of Patients With Head Trauma and Their Family's Satisfaction After Discharge, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 25, 248-253, 2018	Intervention not in PICO: Checklist teleheath intervention with no questions about rehabilitation
Shaw, W., Hong, Q. N., Pransky, G., Loisel, P., A literature review describing the role of return-to-work coordinators in trial programs and interventions designed to prevent workplace disability, Journal of Occupational Rehabilitation, 18, 2-15, 2008	Systematic review: Included studies checked for relevance.
Shepperd, S., Lannin, N. A., Clemson, L. M., McCluskey, A., Cameron, I. D., Barras, S. L., Discharge planning from hospital to home, Cochrane Database of Systematic Reviews, 2013, CD000313, 2013	Systematic review: Included studies checked for relevance.
Shingleton, S. K., Salinas, R. D., Aden, J. K., Berry, P. A., Palmer, C. R., Russe, C. S., Trichel, R. M., Melvin, J. J., King, B. T., Wound care team effectiveness on patient care efficiency and quality, Journal of Burn Care and Research, 37, S74, 2016	Published as abstract only
Shyu, Y. I. L., Liang, J., Wu, C. C., Su, J. Y., Cheng, H. S., Chou, S. W., Chen, M. C., Yang, C. T., Interdisciplinary intervention for hip fracture in older Taiwanese: Benefits last for 1 year, Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 63, 92-97, 2008	Follow-up data from Shyu 2005 study, which is excluded
Shyu, Y. I., Liang, J., Wu, C. C., Su, J. Y., Cheng, H. S., Chou, S. W., Yang, C. T., A pilot investigation of the short-term effects of an interdisciplinary intervention program on elderly patients with hip fracture in Taiwan, Journal of the American Geriatrics Society, 53, 811-818, 2005	Intervention/comparison not in PICO: Multidisciplinary rehabilitation program consisting of systemic interdisciplinary involvement, geriatric assessment, in-patient and in-home rehabilitation and discharge planning versus standard care that differed on most of these components, not just the coordination/delivery components

Study	Reason for Exclusion
Siefferman, J., Ambrose, A. F., Lin, E., Improving patient handoff for acute rehabilitation admission, PM and R, 3, S320, 2011	Published as abstract only
Singh, Nalin A., Quine, Susan, Clemson, Lindy M., Williams, Elodie J., Williamson, Dominique A., Stavrinos, Theodora M., Grady, Jodie N., Perry, Tania J., Lloyd, Bradley D., Smith, Emma U. R., Singh, Maria A. Fiatarone, Effects of high-intensity progressive resistance training and targeted multidisciplinary treatment of frailty on mortality and nursing home admissions after hip fracture: a randomized controlled trial, Journal of the American Medical Directors Association, 13, 24-30, 2012	Intervention not in PICO: High intensity progressive resistance training
Singler, K., Biber, R., Wicklein, S., Heppner, H. J., Sieber, C. C., Bail, H. J., "N-active": A new comanaged, orthogeriatric ward: Observations and prospects, Zeitschrift fur Gerontologie und Geriatrie, 44, 2011	Narrative description of implementation of orthogeriatric ward. Only data presented is non-comparative.
Spiliotopoulou, Georgia, Atwal, Anita, Is occupational therapy practice for older adults with lower limb amputations evidence-based? A systematic review, Prosthetics and orthotics international, 36, 7-14, 2012	Systematic review: Included studies checked for relevance.
Stubbs, Kendra E., Sikes, Lindsay, Interdisciplinary Approach to Fall Prevention in a High-Risk Inpatient Pediatric Population: Quality Improvement Project, Physical therapy, 97, 97-104, 2017	Outcome not in PICO - Fall rates
Talevski, Jason, Sanders, Kerrie M., Duque, Gustavo, Connaughton, Catherine, Beauchamp, Alison, Green, Darci, Millar, Lynne, Brennan-Olsen, Sharon L., Effect of Clinical Care Pathways on Quality of Life and Physical Function After Fragility Fracture: A Meta-analysis, Journal of the American Medical Directors Association, 20, 926.e1-926.e11, 2019	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Tan, T., Molina, J. D., Lim, Y., Dharmawan, A., Teo, A., Soon, M., Frailty ready inpatient care-interim findings from an integrated, comprehensive geriatric programme, Journal of the American Geriatrics Society, 67, S92-S93, 2019	Published as abstract only
Taraldsen, K., Sletvold, O., Thingstad, P., Saltvedt, I., Granat, M. H., Lydersen, S., Helbostad, J. L., Physical behavior and function early after hip fracture surgery in patients receiving comprehensive geriatric care or orthopedic care--a randomized controlled trial, Journals of gerontology. Series A, Biological sciences and medical sciences, 69, 338-345, 2014	Intervention not in PICO: Comprehensive geriatric care with an element of discharge planning and early mobilisation but focus appears to be on short-term post-operative outcomes with treatment of co-morbidities and acute care rather than delivery or coordination of rehabilitation or social care.
Torres, Audrey, Kunishige, Nalani, Morimoto, Denise, Hanzawa, Tracie, Ebesu, Mike, Fernandez, John, Nohara, Lynne, SanAgustin, Eliseo, Borg, Stephanie, Shared governance: a way to improve the care in an inpatient rehabilitation facility, Rehabilitation nursing : the official journal of the Association of Rehabilitation Nurses, 40, 69-73, 2015	Outcomes not in PICO: Mentions improved patient outcomes but no presentation of data
Tran, V., Lam, M. K., Amon, K. L., Brunner, M., Hines, M., Penman, M., Lowe, R., Togher, L., Interdisciplinary eHealth for the care of people living with traumatic brain injury: A systematic review, Brain Injury, 31, 1701-1710, 2017	Systematic review: Included studies checked for relevance.
Tricco, Andrea C., Thomas, Sonia M., Veroniki, Areti Angeliki, Hamid, Jemila S., Cogo, Elise, Strifler, Lisa, Khan, Paul A., Robson, Reid, Sibley, Kathryn M., MacDonald, Heather, Riva, John J., Thavorn, Kednapa, Wilson, Charlotte, Holroyd-Leduc, Jayna, Kerr, Gillian D., Feldman, Fabio, Majumdar, Sumit R.,	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
Jaglal, Susan B., Hui, Wing, Straus, Sharon E., Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis, JAMA, 318, 1687-1699, 2017	
Truchon, C., Moore, L., Belcaid, A., Clement, J., Trudelle, N., Ulysse, M. A., Grolleau, B., Clusiau, J., Levesque, D., De Guise, M., Shaping quality through vision, structure, and monitoring of performance and quality indicators: Impact story from the Quebec trauma network, International Journal of Technology Assessment in Health Care, 33, 415-419, 2017	Narrative description of Quebec Trauma Network and its set-up. No data presented apart from brief mention of mortality data.
Tseng, M. Y., Liang, J., Wang, J. S., Yang, C. T., Wu, C. C., Cheng, H. S., Chen, C. Y., Lin, Y. E., Wang, W. S., Shyu, Y. I. L., Effects of a diabetes-specific care model for hip fractured older patients with diabetes: A randomized controlled trial, Experimental Gerontology, 126, 110689, 2019	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard rehabilitation while inpatients but the intervention group also received in-home rehabilitation for 4 months after hospital discharge and diabetes-specific education and rehabilitation for up to 12 months after hospital discharge.
Tung, James Y., Stead, Brent, Mann, William, Ba'Pham,, Popovic, Milos R., Assistive technologies for self-managed pressure ulcer prevention in spinal cord injury: a scoping review, Journal of Rehabilitation Research and Development, 52, 131-46, 2015	Scoping review: Included studies checked for relevance.
Turner, Benjamin J., Fleming, Jennifer M., Ownsworth, Tamara L., Cornwell, Petrea L., The transition from hospital to home for individuals with acquired brain injury: A literature review and research recommendations, Disability and rehabilitation, 30, 1153-1176, 2008	Systematic review: Included studies checked for relevance.
Turner-Stokes, L., Disler, P. B., Nair, A., Wade, D. T., Multi-disciplinary rehabilitation for acquired brain injury in adults of working age, The Cochrane database of systematic reviews, CD004170, 2005	Systematic review: Included studies checked for relevance.
Turner-Stokes, Lynne, Evidence for the effectiveness of multi-disciplinary rehabilitation following acquired brain injury: a synthesis of two systematic approaches, Journal of rehabilitation medicine, 40, 691-701, 2008	Systematic review: Included studies checked for relevance.
Turner-Stokes, Lynne, Pick, Anton, Nair, Ajoy, Disler, Peter B., Wade, Derick T., Multi-disciplinary rehabilitation for acquired brain injury in adults of working age, The Cochrane database of systematic reviews, CD004170, 2015	Systematic review: Included studies checked for relevance.
Vaughn, S. L., King, A., A survey of state programs to finance rehabilitation and community services for individuals with brain injury, The Journal of head trauma rehabilitation, 16, 20-33, 2001	Study design not in PICO: Survey of state-funded programs for persons with traumatic brain injury.
Vidan, Maite, Serra, Jose A., Moreno, Concepcion, Riquelme, Gerardo, Ortiz, Javier, Efficacy of a comprehensive geriatric intervention in older patients hospitalized for hip fracture: a randomized, controlled trial, Journal of the American Geriatrics Society, 53, 1476-82, 2005	Study dates not in PICO: 1997
Vikane, E., Hellstrom, T., Roe, C., Bautz-Holter, E., Assmus, J., Skouen, J. S., Efficacy of a multidisciplinary outpatient treatment for patients with mild traumatic brain injury: A randomized	Published as abstract only

Study	Reason for Exclusion
controlled intervention trial, Brain Injury, 30, 617, 2016	
Ward, D., Drahota, A., Gal, D., Severs, M., Dean, T. P., Care home versus hospital and own home environments for rehabilitation of older people, Cochrane Database of Systematic Reviews, 2008	Systematic review: Included studies checked for relevance.
Webster, J., Kim, J. H., Hawley, C., Barbir, L., Barton, S., Young, C., Development, implementation, and outcomes of a residential vocational rehabilitation program for injured Service members and Veterans, Journal of Vocational Rehabilitation, 48, 111-126, 2018	Study design not in PICO: No comparison group
Wegener, Stephen T., Mackenzie, Ellen J., Ephraim, Patti, Ehde, Dawn, Williams, Rhonda, Self-management improves outcomes in persons with limb loss, Archives of Physical Medicine and Rehabilitation, 90, 373-80, 2009	Population not in PICO: Mixed population with <40% in PICO and results not reported separately for target population
Westgard, T., Ottenvall Hammar, I., Holmgren, E., Ehrenberg, A., Wisten, A., Ekdahl, A. W., Dahlin-Ivanoff, S., Wilhelmson, K., Comprehensive geriatric assessment pilot of a randomized control study in a Swedish acute hospital: A feasibility study, Pilot and Feasibility Studies, 4, 41, 2018	Unclear population: Frail adults over 75 years who required an acute hospital admission. No information presented on traumatic or non-trauma causes.
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Angere, D., Klein, M. B., Gibran, N. S., A randomized controlled trial to test an expanded delivery model for patients with burn injuries, Journal of burn care & research, 35, S79-, 2014	Published as abstract only
Winograd, A., Squirrell, T., Winters, B., The promise of progress: Co-ordinating interdisciplinary neuro-restorative care transitions, Brain Injury, 28, 775-776, 2014	Published as abstract only
Wu, Jane, Faux, Steven G., Harris, Ian, Poulos, Christopher J., Integration of trauma and rehabilitation services is the answer to more cost-effective care, ANZ journal of surgery, 86, 900-904, 2016	Comparison not in PICO: Delivery of rehabilitation in the trauma admission hospital versus rehabilitation in an external rehabilitation service. No details reported about what rehabilitation the patients received in either facility (and no data on any coordination or delivery aspects of the rehabilitation).
Young, T., Andreas, N., Howard-Brown, C., Enhancing early engagement for transitions to community, Brain Impairment, 20, 374-375, 2019	Published as abstract only
Zatzick, D. F., Roy-Byrne, P., Russo, J. E., Rivara, F. P., Koike, A., Jurkovich, G. J., Katon, W., Collaborative interventions for physically injured trauma survivors: a pilot randomized effectiveness trial, General Hospital Psychiatry, 23, 114-23, 2001	Intervention and comparison not in PICO: Collaborative care intervention consisting of counselling, consultation with surgical and primary care providers and attempted post-discharge coordination versus standard care that differed on all these components, not just the coordination/delivery components. Unclear if study period (years) within PICO
Zatzick, D., Russo, J., Thomas, P., Darnell, D., Teter, H., Ingraham, L., Whiteside, L. K., Wang, J., Guiney, R., Parker, L., Sandgren, K., Hedrick, M. K., Van Eaton, E. G., Jurkovich, G., Patient-Centered Care Transitions After Injury Hospitalization: A	Population not in PICO: Patients had to be admitted to an inpatient surgical ward or emergency department for at

Study	Reason for Exclusion
Comparative Effectiveness Trial, Psychiatry (New York), 81, 141-157, 2018	least 24 hours i.e. not all admitted to hospital. Results are not presented separately.
Zhang, Ming, Effect of HBM Rehabilitation Exercises on Depression, Anxiety and Health Belief in Elderly Patients with Osteoporotic Fracture, Psychiatria Danubina, 29, 466-472, 2017	Outcomes not in PICO : Anxiety, depression, osteoporosis knowledge, and osteoporosis health belief
Zhang, Xia, Reinhardt, Jan D., Gosney, James E., Li, Jianan, The NHV rehabilitation services program improves long-term physical functioning in survivors of the 2008 Sichuan earthquake: a longitudinal quasi experiment, PLoS ONE, 8, e53995, 2013	Intervention and comparison not in PICO: NHV is a complete rehabilitation programme (consisting of NGOs, health department and volunteers) implemented after the Sichuan earthquake. Comparisons are early-NHV, late-NHV, no NHV.
Zhao, Y. R., Liang, X., Yang, T. Y., Liu, Y., Prospective case-control study on comprehensive treatment for elderly hip fractures, Zhongguo gu shang [China journal of orthopaedics and traumatology], 27, 570-574, 2014	Article in Chinese
Zidén, L., Frändin, K., Kreuter, M., Home rehabilitation after hip fracture. A randomized controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008	Intervention and comparison not in PICO: Multidisciplinary geriatric rehabilitation home program focused on supported discharge, independence in daily activities, and enhancing physical activity versus standard care with no structured rehabilitation after discharge. Interventions differed on most of these components, not just the coordination/delivery components
Ziden, Lena, Frandin, Kerstin, Kreuter, Margareta, Home rehabilitation after hip fracture. A randomized controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008	Duplicate

1 Qualitative clinical studies

2 Table 40: Excluded qualitative studies and reasons for their exclusion

Study	Reason for Exclusion
Abrahamson, Vanessa, Jensen, Jan, Springett, Kate, Sakel, Mohamed, Experiences of patients with traumatic brain injury and their carers during transition from in-patient rehabilitation to the community: a qualitative study, Disability and rehabilitation, 39, 1683-1694, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences reviews.
Adams, Deana, Dahdah, Marie, Coping and adaptive strategies of traumatic brain injury survivors and primary caregivers, NeuroRehabilitation, 39, 223-37, 2016	Study not conducted in one of the countries included in the review protocol.
Adams, R. D. F., Cole, E., Brundage, S. I., Morrison, Z., Jansen, J. O., Beliefs and expectations of rural hospital practitioners towards a developing trauma system: A qualitative case study,	No themes examining coordination of rehabilitation and social care while

Study	Reason for Exclusion
Injury, 49, 1070-1078, 2018	transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Aitken, Leanne M., Chaboyer, Wendy, Jeffrey, Carol, Martin, Bronte, Whitty, Jennifer A., Schuetz, Michael, Richmond, Therese S., Indicators of injury recovery identified by patients, family members and clinicians, Injury, 47, 2655-2663, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Albrecht, Jennifer S., O'Hara, Lyndsay M., Moser, Kara A., Mullins, C. Daniel, Rao, Vani, Perception of Barriers to the Diagnosis and Receipt of Treatment for Neuropsychiatric Disturbances After Traumatic Brain Injury, Archives of Physical Medicine and Rehabilitation, 98, 2548-2552, 2017	Study not conducted in one of the countries included in the review protocol.
Alston, Margaret, Jones, Jennifer, Curtin, Michael, Alston, Bartky Blais Bourdieu Bourdieu Brookshire Butler Callaway Connell Cunningham Curtin Degeneffe Fine Foucault Graham Gwyn Howes Jones Kirkness Lupton Mukherjee O'Rance Ponsford Rees Reichard Reidpath Shildrick Slewa-Younan, Women and traumatic brain injury: "It's not visible damage", Australian Social Work, 65, 39-53, 2012	No qualitative data on phenomena of interest.
Ammons, L. L., Harraghy, R. L., Medlin, H. J., Faku, C. T., Shupp, J. W., Flanagan, K. E., Jeng, J. C., Fidler, P., Sava, J. A., Jordan, M. H., Assessing the utility of nurse-driven post-discharge telephone calls, Journal of Burn Care and Research, 32, S153, 2011	Conference abstract
Andersson, Kerstin, Bellon, Michelle, Walker, Ruth, Parents' experiences of their child's return to school following acquired brain injury (ABI): A systematic review of qualitative studies, Brain Injury, 30, 829-38, 2016	No findings or themes related to phenomena of interest. Included studies were checked for relevance.
Angel, Sanne, Kirkevold, Marit, Pedersen, Birthe D., Rehabilitation after spinal cord injury and the influence of the professional's support (or lack thereof), Journal of Clinical Nursing, 20, 1713-22, 2011	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehab following discharge.
Arbour-Nicitopoulos, K. P., Lamontagne, M. E., Tomasone, J., Pila, E., Cumming, I., Latimer-Cheung, A. E., Routhier, F., Why do I stick to the program? a qualitative analysis of the determinants of adherence to community-based physical activity support programs by persons with SCI and contrast with general population with disabilities, Journal of Spinal Cord Medicine, 37, 626, 2014	Conference abstract.
Armstrong, E., Missing voices: Aboriginal stories of stroke and traumatic brain injury, International Journal of Stroke, 12, 14, 2017	Conference abstract.
Armstrong, Elizabeth, Coffin, Juli, Hersh, Deborah, Katzenellenbogen, Judith M., Thompson, Sandra C., Ciccone, Natalie, Flicker, Leon, Woods, Deborah, Hayward, Colleen, Dowell, Catelyn, McAllister, Meaghan, "You felt like a prisoner in your own self, trapped": the experiences of Aboriginal people with acquired communication disorders, Disability and Rehabilitation, 1-14, 2019	The majority of participants had not experienced traumatic injury and the results not reported separately for the target population.
Armstrong, Elizabeth, Coffin, Juli, McAllister, Meaghan, Hersh, Deborah, Katzenellenbogen, Judith M., Thompson, Sandra C., Ciccone, Natalie, Flicker, Leon, Cross, Natasha, Arabi, Linda, Woods, Deborah, Hayward, Colleen, Alway, Armstrong Armstrong Baxter Blackmer Bohanna Bronfenbrenner Chase	No qualitative data on phenomena of interest.

Study	Reason for Exclusion
Coffin Creswell Elder Feigin Foster Gauld Gauthier Hines Jamieson Katzenellenbogen Katzenellenbogen Katzenellenbogen Keightley Kelly Kelly Lakhani Lewis Linton McDonald McKenna O'Reilly Olver Ponsford Rutland-Brown Salas Sandelowski Taylor Togher, 'I've got to row the boat on my own, more or less': Aboriginal Australian experiences of traumatic brain injury, Brain Impairment, 20, 120-136, 2019	
Arshad, Sira N., Gaskell, Sarah L., Baker, Charlotte, Ellis, Nicola, Potts, Jennie, Coucill, Theresa, Ryan, Lynn, Smith, Jan, Nixon, Anna, Greaves, Kate, Monk, Rebecca, Shelmerdine, Teresa, Leach, Alison, Shah, Mamta, Measuring the impact of a burns school reintegration programme on the time taken to return to school: A multi-disciplinary team intervention for children returning to school after a significant burn injury, Burns : journal of the International Society for Burn Injuries, 41, 727-34, 2015	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Ayer, Lynsay, Farris, Coreen, Farmer, Carrie M., Geyer, Lily, Barnes-Proby, Dionne, Ryan, Gery W., Skrabala, Lauren, Scharf, Deborah M., Care Transitions to and from the National Intrepid Center of Excellence (NICoE) for Service Members with Traumatic Brain Injury, Rand health quarterly, 5, 12, 2015	Study not conducted in one of the countries included in the review protocol.
Badger, Karen, Royse, David, Adult burn survivors' views of peer support: a qualitative study, Social Work in Health Care, 49, 299-313, 2010	Study not conducted in one of the countries included in the review protocol.
Balcazar, Fabricio E., Kelly, Erin Hayes, Keys, Christopher B., Balfanz-Vertiz, Kristin, Albrecht, Alston Balcazar Balcazar Block Boschen Burnett Cressy Devlieger Devlieger Dijkers Dijkers Engstrom Gill Groce Haskell Hayes Hernandez Hernandez Hibbard Jackson Kroll Ljungberg McDonald McKinley Ostrander Richards Rovinsky Sable Servan Sherman Veith Waters Waters Waters Whiteneck Wilson Wilson, Using peer mentoring to support the rehabilitation of individuals with violently acquired spinal cord injuries, Journal of Applied Rehabilitation Counseling, 42, 3-11, 2011	Study not conducted in one of the countries included in the review protocol.
Barclay, Linda, McDonald, Rachael, Lentin, Primrose, Social and community participation following spinal cord injury: a critical review, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 38, 1-19, 2015	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Barclay, Linda, McDonald, Rachael, Lentin, Primrose, Bourke-Taylor, Helen, Facilitators and barriers to social and community participation following spinal cord injury, Australian occupational therapy journal, 63, 19-28, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Beaton, Angela, O'Leary, Katrina, Thorburn, Julie, Campbell, Alaina, Christey, Grant, Improving patient experience and outcomes following serious injury, The New Zealand medical journal, 132, 15-25, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Beckett, K., Earthy, S., Sleney, J., Barnes, J., Kellezi, B., Barker, M., Clarkson, J., Coffey, F., Elder, G., Kendrick, D., Providing effective trauma care: The potential for service provider views to enhance the quality of care (qualitative study nested within a multicentre longitudinal quantitative study), BMJ Open, 4, e005668, 2014	No qualitative data on phenomena of interest.
Bergmark, Lisa, Westgren, Ninni, Asaba, Eric, Returning to work after spinal cord injury: exploring young adults' early expectations and experience, Disability and Rehabilitation, 33,	Study did not examine rehabilitation while an inpatient, when transferring to community,

Study	Reason for Exclusion
2553-8, 2011	or seeking to access rehabilitation following discharge.
Bernet, Madeleine, Sommerhalder, Kathrin, Mischke, Claudia, Hahn, Sabine, Wyss, Adrian, "Theory Does Not Get You From Bed to Wheelchair": A Qualitative Study on Patients' Views of an Education Program in Spinal Cord Injury Rehabilitation, Rehabilitation nursing : the official journal of the Association of Rehabilitation Nurses, 44, 247-253, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Bernhoff, K., Bjorck, M., Larsson, J., Jangland, E., Patient Experiences of Life Years After Severe Civilian Lower Extremity Trauma With Vascular Injury, European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery, 52, 690-695, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Biester, Rosette C., Krych, Dave, Schmidt, M. J., Parrott, Devan, Katz, Douglas I., Abate, Melissa, Hirshson, Chari I., Individuals With Traumatic Brain Injury and Their Significant Others' Perceptions of Information Given About the Nature and Possible Consequences of Brain Injury: Analysis of a National Survey, Professional case management, 21, 22-4, 2016	Study not conducted in one of the countries included in the review protocol.
Body, Richard, Muskett, Tom, Perkins, Mick, Parker, Mark, Your injury, my accident: talking at cross-purposes in rehabilitation after traumatic brain injury, Brain Injury, 27, 1356-63, 2013	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Boschen, K., Gerber, G., Gargaro, J., Comparison of outcomes and costs of 2 publicly-funded community-based models of acquired brain injury services, Archives of Physical Medicine and Rehabilitation, 91, e59, 2010	Conference abstract.
Bourge, C., Body Image (BI) of acquired spinal cord injury (SCI) persons. Which patient care in an internal unit of physical and neurological rehabilitation. Experience of the patient care in an internal and neurological unit of PMR of the University Hospital of Liege, Annals of Physical and Rehabilitation Medicine, 59 (Supplement), e128, 2016	No qualitative data on phenomena of interest.
Bourke, John A., Nunnerley, Joanne L., Sullivan, Martin, Derrett, Sarah, Relationships and the transition from spinal units to community for people with a first spinal cord injury: A New Zealand qualitative study, Disability and health journal, 12, 257-262, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not reported separately for the target population.
Braaf, Sandra C., Lennox, Alyse, Nunn, Andrew, Gabbe, Belinda J., Experiences of hospital readmission and receiving formal carer services following spinal cord injury: a qualitative study to identify needs, Disability and Rehabilitation, 40, 1893-1899, 2018	Study did not examine phenomena of interest.
Brauer, Jennifer, Hay, Catherine Cooper, Francisco, Gerard, A retrospective investigation of occupational therapy services received following a traumatic brain injury, Occupational Therapy in Health Care, 25, 119-30, 2011	Study not conducted in one of the countries included in the review protocol.
Brimicombe, L., Ling, J., De Sousa De Abreu, I., Hoffman, K., Salisbury, C., Jefferson, R., Makela, P., Early integration of a self-management support package into usual care following traumatic brain injury (TBI): A feasibility study, British Journal of	Conference abstract.

Study	Reason for Exclusion
Neurosurgery, 31, 501, 2017	
Brito, Sara, White, Jennifer, Thomacos, Nikos, Hill, Bridget, The lived experience following free functioning muscle transfer for management of pan-brachial plexus injury: reflections from a long-term follow-up study, Disability and Rehabilitation, 1-9, 2019	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Brockway, J. A., St De Lore, J., Fann, J. R., Hart, T., Hurst, S., Fey-Hinckley, S., Savage, J., Warren, M., Bell, K. R., Telephone-delivered problem-solving training after mild traumatic brain injury: qualitative analysis of service members' perceptions, Rehabilitation Psychology, 61, 221â 230, 2016	Study not conducted in one of the countries included in the review protocol.
Brown, F., Sofronoff, K., Whittingham, K., Boyd, R., McKinlay, L., Parenting a child with a traumatic brain injury: A focus group study, Developmental Medicine and Child Neurology, 54, 24-25, 2012	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Brown, Jessica, Hux, Karen, Hey, Morgan, Murphy, Madeline, Ackerman, Aldrich Anderson Arciniegas Bach Beigel Bogdan Brandt Brown Brown Catroppa Cicerone Cicerone Creswell Creswell Cushman de Joode de Joode DePompei Donders Dowds Doyle Edwards Ewing-Cobbs Fortuny Gillette Gillette Gioia Glang Gordon Gordon Grajzel Harper Hart Hawley Helm-Estabrooks Hendricks Hux Kelley Kennedy Kennedy Kertesz Krause Leopold Lincoln Martella Martinez McAllister McCrory Merriam Moustakas Ownsworth Patel Perna Reitan Rumrill Scherer Scherer Scherer Scherer Scherer Scherer Shanahan Sherer Sherer Sohlberg Spreen Starks Tate Todis Togher Vu Wallace Ylvisaker Ylvisaker, Exploring cognitive support use and preference by college students with TBI: A mixed-methods study, NeuroRehabilitation, 41, 483-499, 2017	Study not conducted in one of the countries included in the review protocol.
Browne, C., Living with traumatic brain injury: Views of survivors and family members, Brain Injury, 26, 400, 2012	Conference abstract.
Bruner-Canhoto, Laney, Savageau, Judith, Croucher, Deborah, Bradley, Kathryn, Lessons From a Care Management Pilot Program for People With Acquired Brain Injury, Journal for healthcare quality : official publication of the National Association for Healthcare Quality, 38, 255-263, 2016	Study not conducted in one of the countries included in the review protocol.
Buck, P., Kirzner, R., Sagrati, J., Laster, R., The challenge of mTBI work: An exploratory study of rehabilitation professionals, Brain Injury, 26, 583-584, 2012	Conference abstract.
Buck, Page Walker, Sagrati, Jocelyn Spencer, Kirzner, Rachel Shapiro, Belson, Bloom Brenner Briggs Brody Buck Chrisman Gaboda Klein Marchione Padgett Patton Schwartz Strauss Thompson, Mild traumatic brain injury: A place for social work, Social Work in Health Care, 52, 741-751, 2013	Study not conducted in one of the countries included in the review protocol.
Buddai, S., Di Taranti, L. J., Adenwala, A. Y., Aepli, S., Choudhary, M., George, D. L., Koilor, C. B., Linehan, M., Peifer, H., Rub, D., Kaplan, L., Johnson, N., Lane-Fall, M. B., Characterizing intensive care unit patient and family experiences of recovery after traumatic injury, American Journal of Respiratory and Critical Care Medicine. Conference: American Thoracic Society International Conference, ATS, 195, 2017	Conference abstract.
Buscemi, Valentina, Cassidy, Elizabeth, Kilbride, Cherry, Reynolds, Frances Ann, A qualitative exploration of living with chronic neuropathic pain after spinal cord injury: an Italian	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to

Study	Reason for Exclusion
perspective, Disability and Rehabilitation, 40, 577-586, 2018	access rehabilitation following discharge.
Bushnik, T., Smith, M., Long, C., Supporting factors for follow-up care in TBI patients post-inpatient discharge, Brain Injury, 31 (6-7), 974, 2017	Conference abstract.
Byrnes, Michelle, Beilby, Janet, Ray, Patricia, McLennan, Renee, Ker, John, Schug, Stephan, Patient-focused goal planning process and outcome after spinal cord injury rehabilitation: quantitative and qualitative audit, Clinical Rehabilitation, 26, 1141-9, 2012	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Cahow, C., Gassaway, J., Rider, C., Joyce, J. P., Bogenshutz, A., Edens, K., Kreider, S. E. D., Whiteneck, G., Relationship of therapeutic recreation inpatient rehabilitation interventions and patient characteristics to outcomes following spinal cord injury: The SCIRehab project, Journal of Spinal Cord Medicine, 35, 547-564, 2012	Study not conducted in one of the countries included in the review protocol.
Calder, Allyson, Nunnerley, Jo, Mulligan, Hilda, Ahmad Ali, Nordawama, Kensington, Gemma, McVicar, Tim, van Schaik, Olivia, Experiences of persons with spinal cord injury undertaking a physical activity programme as part of the SCIPA 'Full-On' randomized controlled trial, Disability and Health Journal, 11, 267-273, 2018	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Calleja, Pauline, Aitken, Leanne, Cooke, Marie, Staff perceptions of best practice for information transfer about multitrauma patients on discharge from the emergency department: a focus group study, Journal of Clinical Nursing, 25, 2863-73, 2016	Setting not in PICO: Emergency department.
Canto, Angela I., Chesire, David J., Buckley, Valerie A., Andrews, Terrie W., Roehrig, Alysia D., Arroyos-Jurado, Ball Bradley-Klug Brantlinger Braun Chesire Conoley Cook Davies Elliot Ewing-Cobbs Farmer Gioia Glang Glang Glang Gopinath Guba Guskiewicz Havey Hooper Hux Jantz Johnson Lewandowski Meehan Mellard Rosenthal Rutland-Brown Savage Sharp Shaw Shaw Shih Yeates Yeates Ylvisaker, Barriers to meeting the needs of students with traumatic brain injury, Educational Psychology in Practice, 30, 88-103, 2014	Study not conducted in one of the countries included in the review protocol.
Carron, R. M. C., 'nobody prepared me for this!' parents' experiences of seeking help and support with post-brain injury symptoms and changes in children and adolescents with acquired brain injury, Journal of Neurology, Neurosurgery and Psychiatry, 90, A9, 2019	Conference abstract.
Caspari, Synnove, Aasgaard, Trygve, Lohne, Vibeke, Slettebo, Ashild, Naden, Dagfinn, Perspectives of health personnel on how to preserve and promote the patients' dignity in a rehabilitation context, Journal of Clinical Nursing, 22, 2318-26, 2013	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for the target population.
Chapple, L. A., Chapman, M., Shalit, N., Udy, A., Deane, A., Williams, L., Barriers to Nutrition Intervention for Patients With a Traumatic Brain Injury: Views and Attitudes of Medical and Nursing Practitioners in the Acute Care Setting, Journal of Parenteral and Enteral Nutrition, 42, 318-326, 2018	Study did not examine phenomena of interest.
Chapple, Lee-Anne, Chapman, Marianne, Shalit, Natalie, Udy, Andrew, Deane, Adam, Williams, Lauren, Barriers to Nutrition Intervention for Patients With a Traumatic Brain Injury, JPEN. Journal of parenteral and enteral nutrition, 148607116687498,	Duplicate.

Study	Reason for Exclusion
2017	
Chondronikola, M., Weller, S., Rosenberg, L., Rosenberg, M., Meyer, W. J., Herndon, D. N., Sidossis, L., Variation among clinical specialties in perceptions of pediatric burn patient needs, Journal of Burn Care and Research, 37, S244, 2016	Conference abstract.
Christie, Nicola, Beckett, Kate, Earthy, Sarah, Kellezi, Blerina, Sleney, Jude, Barnes, Jo, Jones, Trevor, Kendrick, Denise, Seeking support after hospitalisation for injury: a nested qualitative study of the role of primary care, The British journal of general practice : the journal of the Royal College of General Practitioners, 66, e24-31, 2016	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Christie, Nicola, Braaf, Sandra, Ameratunga, Shanthi, Nunn, Andrew, Jowett, Helen, Gabbe, Belinda, Barclay, Barnes Berkman Boniface Braun Cameron Carpenter Cass Charlson Christie Christie Cox Gabbe Gabbe Kellezi Larsen Levasseur Lyons Marottoli McInnes Pointer Prang Smith Syed Urry Wilson, The role of social networks in supporting the travel needs of people after serious traumatic injury: A nested qualitative study, Journal of Transport & Health, 6, 84-92, 2017	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Cichon, S., Danford, E. K., Schladen, M. M., Bruner, D., Libin, A., Scholten, J., Integrating opportunities for family involvement into a manualized goal self-management intervention for veterans with mTBI, Archives of Physical Medicine and Rehabilitation, 96, e77, 2015	Conference abstract.
Cocks, Errol, Bulsara, Caroline, O'Callaghan, Annalise, Netto, Julie, Boaden, Ross, Exploring the experiences of people with the dual diagnosis of acquired brain injury and mental illness, Brain Injury, 28, 414-21, 2014	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Coffey, Nathan T., Weinstein, Ali A., Cai, Cindy, Cassese, Jimmy, Jones, Rebecca, Shaewitz, Dahlia, Garfinkel, Steven, Identifying and Understanding the Health Information Experiences and Preferences of Individuals With TBI, SCI, and Burn Injuries, Journal of patient experience, 3, 88-95, 2016	Study not conducted in one of the countries included in the review protocol.
Cogan, A., Treatment model of occupational therapy intervention for service members with chronic symptoms following MTBI, Archives of Physical Medicine and Rehabilitation, 98, e132, 2017	Conference abstract.
Conneeley, A. L., Transitions and brain injury: A qualitative study exploring the journey of people with traumatic brain injury, Brain Impairment, 13, 72-84, 2012	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Conneeley, Anne Louise, Exploring vocation following brain injury: a qualitative enquiry, Social Care and Neurodisability, 4, 6-16, 2013	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Copley, Anna, McAllister, Lindy, Wilson, Linda, Attitride-Stirling, Barnes Brooks Carr-Hill Fagen Foster Frattali Grbich Harradine Harris Honey Humphreys Johnstone Kelly LeFebvre Marsh Minichiello Morse Murphy Muus Nabors Newberry O'Callaghan O'Callaghan O'Callaghan O'Callaghan O'Callaghan Patton Sample Sample Schofield Schwandt Turner-Stokes Whitehead	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing

Study	Reason for Exclusion
Ylvisaker Youse, We finally learnt to demand: Consumers' access to rehabilitation following traumatic brain injury, Brain Impairment, 14, 436-449, 2013	rehabilitation services review.
Curtis, Kate, Foster, Kim, Mitchell, Rebecca, Van, Connie, How is care provided for patients with paediatric trauma and their families in Australia? A mixed-method study, Journal of Paediatrics and Child Health, 52, 832-6, 2016	Study did not examine the phenomena of interest.
Cuthbert, J., Anderson, J., Mason, C., Block, S., Dettmer, J., Weintraub, A., Harrison-Felix, C., Case management of individuals with chronic TBI: A research-based approach, Journal of Head Trauma Rehabilitation, 28, E49, 2013	Conference abstract.
Daggett, Virginia S., Bakas, Tamilyn, Buelow, Janice, Habermann, Barbara, Murray, Laura L., Needs and concerns of male combat Veterans with mild traumatic brain injury, Journal of Rehabilitation Research and Development, 50, 327-40, 2013	Study not conducted in one of the countries included in the review protocol.
Dahl, O., Wickman, M., Wengstrom, Y., Adapting to life after burn injury-reflections on care, Journal of Burn Care and Research, 33, 595-605, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Dalmaso, Kym, Weber, Sarah, Eley, Rob, Spencer, Lyndall, Cabilan, C. J., Nurses' perceived benefits of trauma nursing rounds (TNR) on clinical practice in an Australian emergency department: a mixed methods study, Australasian emergency nursing journal : AENJ, 18, 42-8, 2015	Setting not in PICO: Emergency department.
Dams-O'Connor, K., Landau, A., De Lore, J. S., Hoffman, J., Access, barriers, and health care quality after brain injury: Insiders' perspectives, Archives of Physical Medicine and Rehabilitation, 97, e129, 2016	Conference abstract.
Dams-O'Connor, Kristen, Landau, Alexandra, Hoffman, Jeanne, St De Lore, Jef, Patient perspectives on quality and access to healthcare after brain injury, Brain Injury, 32, 431-441, 2018	Study not conducted in one of the countries included in the review protocol.
Darnell, Doyanne A., Parker, Lea E., Wagner, Amy W., Dunn, Christopher W., Atkins, David C., Dorsey, Shannon, Zatzick, Douglas F., Task-shifting to improve the reach of mental health interventions for trauma patients: findings from a pilot study of trauma nurse training in patient-centered activity scheduling for PTSD and depression, Cognitive behaviour therapy, 48, 482-496, 2019	Study not conducted in one of the countries included in the review protocol.
D'Cruz, K., Howie, L., Lentin, P., Client-centred practice: Perspectives of persons with a traumatic brain injury, Scandinavian Journal of Occupational Therapy, 23, 30-38, 2016	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Dickson, Adele, Ward, Richard, O'Brien, Grainne, Allan, David, O'Carroll, Ronan, Difficulties adjusting to post-discharge life following a spinal cord injury: an interpretative phenomenological analysis, Psychology, health & medicine, 16, 463-74, 2011	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Diener, M., Kirby, A., Canary, H., Sumison, F., Green, M., Community reintegration following pediatric acquired brain injury: Perspectives of providers and families, Journal of Head Trauma Rehabilitation, 33 (3), E97, 2018	Conference abstract.
Dillahunt-Aspillaga, C., Bradley, S., Ramaiah, P., Radwan, C., Ottomanelli, L., Coalition Building: A Tool To Implement Evidenced-Based Resource Facilitation in The VHA: Pilot	Conference abstract.

Study	Reason for Exclusion
Results, Archives of Physical Medicine and Rehabilitation, 100, e164, 2019	
Dismann, Patrick D., Maignan, Maxime, Cloves, Paul D., Gutierrez Parres, Blanca, Dickerson, Sara, Eberhardt, Alice, A Review of the Burden of Trauma Pain in Emergency Settings in Europe, Pain and therapy, 7, 179-192, 2018	Setting not in PICO: Emergency settings.
Divanoglou, A., Georgiou, M., Perceived effectiveness and mechanisms of community peer-based programmes for Spinal Cord Injuries-a systematic review of qualitative findings, Spinal cord, 55, 225-234, 2017	Study did not report any findings related to the phenomena of interest.
Doig, E., Fleming, J., Kuipers, P., Cornwell, P., The relationship between goal attainment and the development of self-awareness in traumatic brain injury (TBI) rehabilitation: Descriptive and qualitative case analyses, Brain Impairment, 14, 159-160, 2013	Conference abstract.
Doig, Emmah, Fleming, Jennifer, Cornwell, Petrea, Kuipers, Pim, Comparing the experience of outpatient therapy in home and day hospital settings after traumatic brain injury: patient, significant other and therapist perspectives, Disability and Rehabilitation, 33, 1203-14, 2011	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Donnell, Zoe, Hoffman, Roseanne, Myers, Gaya, Sarmiento, Kelly, Seeking to improve care for young patients: Development of tools to support the implementation of the CDC Pediatric mTBI Guideline, Journal of Safety Research, 67, 203-209, 2018	Study not conducted in one of the countries included in the review protocol.
Donnelly, Kyla Z., Goldberg, Shari, Fournier, Debra, A qualitative study of LoveYourBrain Yoga: a group-based yoga with psychoeducation intervention to facilitate community integration for people with traumatic brain injury and their caregivers, Disability and Rehabilitation, 1-10, 2019	Study not conducted in one of the countries included in the review protocol.
Douglas, J., 'Nobody wants to know you'. Understanding the experience of friendship following severe traumatic brain injury, Brain Injury, 30, 515, 2016	Conference abstract.
Drew, S., Judge, A., Cooper, C., Javaid, M. K., Farmer, A., Gooberman-Hill, R., Secondary prevention of fractures after hip fracture: a qualitative study of effective service delivery, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 27, 1719-27, 2016	Study did not examine rehabilitation.
Drew, S., Judge, A., Javaid, M. K., Cooper, C., Farmer, A., Goobermen-Hill, R., Secondary prevention of fractures after hip fracture: A qualitative study of effective service delive, Osteoporosis International, 25, S308, 2014	Conference abstract.
Dwyer, Aoife, Heary, Caroline, Ward, Marcia, MacNeela, Padraig, Adding insult to brain injury: young adults' experiences of residing in nursing homes following acquired brain injury, Disability and Rehabilitation, 41, 33-43, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Dyke, J., Krupa, J., Vova, J., Medical symptoms, service gaps and barriers to care using the medical home model in adolescents with acquired brain injury, Journal of Head Trauma Rehabilitation, 27 (5), E18-E19, 2012	Conference abstract.
Edworthy Ann, Donne Hannah, The availability and intelligibility of information for carers of children with a brain injury, Social Care and Neurodisability, 1, 32-40, 2010	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to

Study	Reason for Exclusion
	access rehabilitation following discharge.
Eliacin, Johanne, Fortney, Sarah, Rattray, Nicholas A., Kean, Jacob, Access to health services for moderate to severe TBI in Indiana: patient and caregiver perspectives, Brain Injury, 32, 1510-1517, 2018	Study not conducted in one of the countries included in the review protocol.
Fitts, M., Fleming, J., Bird, K., Condon, T., Gilroy, J., Clough, A., Maruff, P., Esterman, A., Bohanna, I., Sentinel events during hospital admission for indigenous people following traumatic brain injury, Brain Impairment, 19, 336, 2018	Conference abstract.
Fitts, Michelle S., Bird, Katrina, Gilroy, John, Fleming, Jennifer, Clough, Alan R., Esterman, Adrian, Maruff, Paul, Fatima, Yaqoot, Bohanna, India, Abrahamson, Alfandre Amery Bell Blackmer Bohanna Bohanna Bohanna Braun Burnett Choi Claiborne Coronado D'Cruz Dillon Dudley Durey Durey Einsiedel Englander Feigin Foley Franks Gentilello Gilroy Gilroy Harrison Hunt Hyder Jamieson Jayaraj Juillard Katzenellenbogen Katzenellenbogen Lakhani Lee Levack Levack Liossi Marrone Martin Moreton-Robinson Nakata Nalder Nalder Nalder Niemeier Ownsworth Paradies Rutland-Brown Shahid Tuhiwai-Smith Turner Turner Willis Zeiler, A qualitative study on the transition support needs of indigenous Australians following traumatic brain injury, Brain Impairment, 20, 137-159, 2019	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Fleming, Jennifer, Sampson, Jennifer, Cornwell, Petrea, Turner, Ben, Griffin, Janell, Brain injury rehabilitation: The lived experience of inpatients and their family caregivers, Scandinavian journal of occupational therapy, 19, 184-193, 2012	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Ford, James H., 2nd, Wise, Meg, Krahn, Dean, Oliver, Karen Anderson, Hall, Carmen, Sayer, Nina, Family care map: Sustaining family-centered care in Polytrauma Rehabilitation Centers, Journal of Rehabilitation Research and Development, 51, 1311-24, 2014	Study not conducted in one of the countries included in the review protocol.
Foster, Kim, Mitchell, Rebecca, Van, Connie, Young, Alexandra, McCloughen, Andrea, Curtis, Kate, Resilient, recovering, distressed: A longitudinal qualitative study of parent psychosocial trajectories following child critical injury, Injury, 50, 1605-1611, 2019	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Foster, Kim, Mitchell, Rebecca, Young, Alexandra, Van, Connie, Curtis, Kate, Parent experiences and psychosocial support needs 6 months following paediatric critical injury: A qualitative study, Injury, 50, 1082-1088, 2019	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences reviews.
Foster, Kim, Young, Alexandra, Mitchell, Rebecca, Van, Connie, Curtis, Kate, Experiences and needs of parents of critically injured children during the acute hospital phase: A qualitative investigation, Injury, 48, 114-120, 2017	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Fournier, D., Goldberg, S., Figucia, C., Kennedy, P., Krauss, K., Smith, C., Springmann, J., An interdisciplinary traumatic brain injury clinic: Understanding the patient experience, Journal of	Conference abstract.

Study	Reason for Exclusion
Head Trauma Rehabilitation, 32, E97-E98, 2017	
Francis, A., Ziviani, J., Fleming, J., Rae, M., McKinlay, L., Transitioning to adulthood: Needs of young people with an acquired brain injury and those of their families, Neurorehabilitation and Neural Repair, 26, 780-781, 2012	Conference abstract.
Franz, Shiney, Muser, Jurgen, Thielhorn, Ulrike, Wallesch, Claus W., Behrens, Johann, Inter-professional communication and interaction in the neurological rehabilitation team: a literature review, Disability and Rehabilitation, 1-9, 2018	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Fraser, M. A., Lind, J. D., Powell-Cope, G., Gavin-Dreschnack, D., Addressing non-direct care, psychosocial concerns of veterans with spinal cord injuries, Journal of Spinal Cord Medicine, 36, 546-547, 2013	Conference abstract.
Freeman, Claire, Cassidy, Bernadette, Hay-Smith, E. Jean C., Beauregard, Beisecker Chan Craig DeSanto-Madeya Dickson Dixon Ell Esmail Esmail Fisher Fronek Gilad Kendall Kennedy Kidd Kreuter Leino-Kilpi Lemonidou New Parrott Racher Rembis Schuster Sinnott Smith Smith Steinglass Taylor Vocaturo, Couple's experiences of relationship maintenance and intimacy in acute spinal cord injury rehabilitation: An interpretative phenomenological analysis, Sexuality and Disability, 35, 433-444, 2017	Study did not examine phenomena of interest.
Fry, J. C., Price, P., Meeting the re-integration needs of individuals with spinal cord injury: Effectiveness of community-based occupational therapy, Archives of Physical Medicine and Rehabilitation, 94, e8, 2013	Conference abstract.
Gabbe, Belinda J., Sleney, Jude S., Gosling, Cameron M., Wilson, Krystle, Hart, Melissa J., Sutherland, Ann M., Christie, Nicola, Patient perspectives of care in a regionalised trauma system: lessons from the Victorian State Trauma System, The Medical journal of Australia, 198, 149-52, 2013	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Gagliardi, Anna R., Nathens, Avery B., Exploring the characteristics of high-performing hospitals that influence trauma triage and transfer, The journal of trauma and acute care surgery, 78, 300-5, 2015	Study did not examine rehabilitation.
Gagnon, I., Friedman, D., Management of mild traumatic brain injury or concussion in children: Is there a role for the physical therapist?, Physiotherapy (United Kingdom), 1), eS1487-eS1488, 2011	Conference abstract.
Garrino, Lorenza, Curto, Natascia, Decorte, Rita, Felisi, Nadia, Matta, Ebe, Gregorino, Silvano, Actis, M. Vittoria, Marchisio, Cecilia, Carone, Roberto, Towards personalized care for persons with spinal cord injury: a study on patients' perceptions, The journal of spinal cord medicine, 34, 67-75, 2011	Study did not examine phenomena of interest.
Gawel, Marcie, Emerson, Beth, Giuliano, John S., Jr., Rosenberg, Alana, Minges, Karl E., Feder, Shelli, Violano, Pina, Morrell, Patricia, Petersen, Judy, Christison-Lagay, Emily, Auerbach, Marc, A Qualitative Study of Multidisciplinary Providers' Experiences With the Transfer Process for Injured Children and Ideas for Improvement, Pediatric Emergency Care, 34, 125-131, 2018	Study not conducted in one of the countries included in the review protocol.
Gemmel, Paul, van Steenis, Thomas, Meijboom, Bert, Bensabat, Bohmer Broekhuis Burke Chase Chase Chase Eisenhardt Fredendall Frei Gronroos Hanne Johnston Lamontagne	Not specific to rehabilitation, or to traumatic injury and results not presented separately for

Study	Reason for Exclusion
Lamontagne Larsson Meredith Metters Metters Miles Ouwens Patricio Swanborn Vander Laane Voss Westert Yin Young Zomerdijk, Front-office/back-office configurations and operational performance in complex health services, Brain Injury, 28, 347-356, 2014	target population.
Gill, Carol J., Sander, Angelle M., Robins, Nina, Mazzei, Diana, Struchen, Margaret A., Allen, Aloni Aloni Anderson Anderson-Parente Bergland Brooks Ergh Garden Gillen Gosling Harrick Hibbard Hoofien Jeon Kersel Kravetz Kravetz Kreuter Kreutzer Kreutzer Kreutzer Lippert Marsh Oddy Olver Panting Patton Perlesz Peters Ponsford Porter Resnick Rosenbaum Sandel Siebert Snow Tate Tate Thomsen Vanderploeg Wallace Webster Wells Wood Wood, Exploring experiences of intimacy from the viewpoint of individuals with traumatic brain injury and their partners, The Journal of Head Trauma Rehabilitation, 26, 56-68, 2011	Study not conducted in one of the countries included in the review protocol.
Gill, Ian J., Wall, Gemma, Simpson, Jane, Clients' perspectives of rehabilitation in one acquired brain injury residential rehabilitation unit: a thematic analysis, Brain Injury, 26, 909-20, 2012	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Glintborg, C., Hansen, T., De La Mata Benites, M., Supporting transitions in neurorehabilitation. A pathway to improved psychosocial outcomes, Brain Injury, 30, 565-566, 2016	Conference abstract.
Glintborg, Chalotte, Hansen, Tia G. B., Bech, Bech Braun Brenner Creswell Ellervik Engel Ghaziani Glintborg Glintborg Glintborg Glintborg Hackett Haggerty Hald Hall Holm Jorge Jorge Keith Kennedy Miles Morton Norholm Pallant Rivera Schlossberg Teasdale Teasdale Turner, Bio-psycho-social effects of a coordinated neurorehabilitation programme: A naturalistic mixed methods study, NeuroRehabilitation, 38, 99-113, 2016	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Goel, R., Fruth, S., Geigle, P., Santurri, L., Abzug, J., Telerehabilitation for Individuals With Spinal Cord Injury: Is it Feasible?, Archives of Physical Medicine and Rehabilitation, 100, e203-e204, 2019	Conference abstract.
Goldsmith, Helen, McCloughen, Andrea, Curtis, Kate, Using the trauma patient experience and evaluation of hospital discharge practices to inform practice change: A mixed methods study, Journal of Clinical Nursing, 27, 1589-1598, 2018	Study did not examine rehabilitation.
Goldsmith, Helen, McCloughen, Andrea, Curtis, Kate, The experience and understanding of pain management in recently discharged adult trauma patients: A qualitative study, Injury, 49, 110-116, 2018	No qualitative data on phenomena of interest.
Goodridge, Donna, Rogers, Marla, Klassen, Laura, Jeffery, Bonnie, Knox, Katherine, Rohatinsky, Noelle, Linassi, Gary, Access to health and support services: perspectives of people living with a long-term traumatic spinal cord injury in rural and urban areas, Disability and Rehabilitation, 37, 1401-10, 2015	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Gotlib Conn, Lesley, Zwaiman, Ashley, DasGupta, Tracey, Hales, Brigette, Watamaniuk, Aaron, Nathens, Avery B., Trauma patient discharge and care transition experiences: Identifying opportunities for quality improvement in trauma centres, Injury, 49, 97-103, 2018	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.

Study	Reason for Exclusion
Gourdeau, Jenna, Fingold, Alissa, Colantonio, Angela, Mansfield, Elizabeth, Stergiou-Kita, Mary, Workplace accommodations following work-related mild traumatic brain injury: what works?, Disability and Rehabilitation, 1-10, 2018	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Gravell, R., Brumfit, S., Body, R., Hope and engagement following acquired brain injury: A qualitative study, Brain Injury, 31, 721-722, 2017	Conference abstract.
Guilcher, S., Everall, A., Wodchis, W., Joanna, deGraaf-Dunlop, Bar-Ziv, S., Kuluski, K., Understanding Transitions of Care in Older Adults With Hip Fractures: A Multiple-Case Study in Ontario, Archives of Physical Medicine and Rehabilitation, 100, e138, 2019	Conference abstract.
Gullick, Janice G., Taggart, Susan B., Johnston, Rae A., Ko, Natalie, The trauma bubble: patient and family experience of serious burn injury, Journal of burn care & research : official publication of the American Burn Association, 35, e413-27, 2014	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Guptill, C. A., The lived experience of professional musicians with playing-related injuries: A phenomenological inquiry, Medical Problems of Performing Artists, 26, 84-95, 2011	No qualitative data on phenomena of interest.
Haarbauer-Krupa, J., Vova, J., Follow-up of preschool children with acquired brain injury, Brain Injury, 26, 424-425, 2012	Conference abstract.
Haas, B. M., Price, L., Freeman, J. A., Qualitative evaluation of a community peer support service for people with spinal cord injury, Spinal Cord, 51, 295-9, 2013	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Harrington, Rosamund, Foster, Michele, Fleming, Jennifer, Experiences of pathways, outcomes and choice after severe traumatic brain injury under no-fault versus fault-based motor accident insurance, Brain Injury, 29, 1561-71, 2015	No qualitative data on phenomena of interest.
Harris, M. B., Rafeedie, S., McArthur, D., Babikian, T., Snyder, A., Polster, D., Giza, C. C., Addition of Occupational Therapy to an Interdisciplinary Concussion Clinic Improves Identification of Functional Impairments, Journal of Head Trauma Rehabilitation, 34, 425-432, 2019	Study not conducted in one of the countries included in the review protocol.
Harrison, Anne L., Hunter, Elizabeth G., Thomas, Heather, Bordy, Paige, Stokes, Erin, Kitzman, Patrick, Living with traumatic brain injury in a rural setting: supports and barriers across the continuum of care, Disability and Rehabilitation, 39, 2071-2080, 2017	Study not conducted in one of the countries included in the review protocol.
Hartley, Naomi A., Spinal cord injury (SCI) rehabilitation: systematic analysis of communication from the biopsychosocial perspective, Disability and rehabilitation, 1-10, 2015	Study not conducted in one of the countries included in the review protocol.
Hawkins, Brent L., Crowe, Brandi M., Contextual Facilitators and Barriers of Community Reintegration Among Injured Female Military Veterans: A Qualitative Study, Archives of Physical Medicine and Rehabilitation, 99, S65-S71, 2018	Study not conducted in one of the countries included in the review protocol.
Haywood, C., Perceptions of recovery among adolescents and young adults with acquired spinal cord injuries, Archives of Physical Medicine and Rehabilitation, 97, e76, 2016	Conference abstract.
Haywood, Carol, Pyatak, Elizabeth, Leland, Natalie, Henwood, Benjamin, Lawlor, Mary C., A Qualitative Study of Caregiving for Adolescents and Young Adults With Spinal Cord Injuries: Lessons From Lived Experiences, Topics in Spinal Cord Injury Rehabilitation, 25, 281-289, 2019	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Hellem, I., Forland, G., Eide, K., Ytrehus, S., Addressing uncertainty and stigma in social relations related to hidden dysfunctions following acquired brain injury, Scandinavian Journal of Disability Research, 20, 152-161, 2018	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Herrera-Escobar, J. P., Columbus, A., Castillo-Angeles, M., Rios-Diaz, A. J., Weed, C. N., Kasotakis, G., Velmahos, G. C., Salim, A., Haider, A. H., Kaafara, H. M., Discontinuity of patient-provider communication throughout the phases of care: Time to be more patient-centered in trauma?, Journal of the American College of Surgeons, 225 (4 Supplement 2), e176, 2017	Conference abstract.
Hill, Jennifer N., Smith, Bridget M., Weaver, Frances M., Nazi, Kim M., Thomas, Florian P., Goldstein, Barry, Hogan, Timothy P., Potential of personal health record portals in the care of individuals with spinal cord injuries and disorders: Provider perspectives, The journal of spinal cord medicine, 41, 298-308, 2018	Study not conducted in one of the countries included in the review protocol.
Hines, M., Brunner, M., Poon, S., Lam, M., Tran, V., Yu, D., Togher, L., Shaw, T., Power, E., Exploring ehealth 'tribes and tribulations' in interdisciplinary rehabilitation for people with a traumatic brain injury (TBI), Brain Impairment, 19, 292-293, 2018	Conference abstract.
Hines, M., Brunner, M., Poon, S., Lam, M., Tran, V., Yu, D., Togher, L., Shaw, T., Power, E., Tribes and tribulations: interdisciplinary eHealth in providing services for people with a traumatic brain injury (TBI), BMC health services research, 17, 757, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Hirsch, M. A., Grafton, L., Guerrier, T. P., Niemeier, J. P., Newman, M., Runyon, M. S., Unmet concussion care needs from the perspective of individuals with mild traumatic brain injury, Archives of Physical Medicine and Rehabilitation, 96, e33, 2015	Conference abstract.
Hitzig, S., Bain, P., Haycock, S., Hebert, D. A., Evaluation of a spinal cord injury community reintegration outpatient program (CROP) service, Archives of Physical Medicine and Rehabilitation, 95, e83, 2014	Conference abstract.
Hollick, R., Reid, D., Black, A., McKee, L., What matters to patients: Working together to improve the quality of osteoporosis services, Osteoporosis International, 27, S678, 2016	Conference abstract.
Holloway, Mark, Motivational interviewing and acquired brain injury, Social Care and Neurodisability, 3, 122-130, 2012	Narrative review.
Hoogerdijk, Barbara, Runge, Ulla, Haugboelle, Jette, The adaptation process after traumatic brain injury an individual and ongoing occupational struggle to gain a new identity, Scandinavian Journal of Occupational Therapy, 18, 122-32, 2011	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Hoonakker, Peter Leonard Titus, Wooldridge, Abigail Rayburn, Hose, Bat-Zion, Carayon, Pascale, Eithun, Ben, Brazelton, Thomas Berry, 3rd, Kohler, Jonathan Emerson, Ross, Joshua Chud, Rusy, Deborah Ann, Dean, Shannon Mason, Kelly, Michelle Merwood, Gurses, Ayse Pinar, Information flow during pediatric trauma care transitions: things falling through the cracks, Internal and emergency medicine, 14, 797-805, 2019	Study not conducted in one of the countries included in the review protocol.
Hosking, J. E., Ameratunga, S. N., Bramley, D. M., Crengle, S. M., Reducing ethnic disparities in the quality of trauma care: An important research gap, Annals of Surgery, 253, 233-237, 2011	Study did not examine rehabilitation.

Study	Reason for Exclusion
Hull, K., Ribariach, J., Panton, V., De Jonge, J., Bulsara, C., Developing independence and empowerment through medications self management amongst persons with acquired brain injury, Neurorehabilitation and Neural Repair, 26, 775-776, 2012	Conference abstract.
Hunt, Anne W., Laupacis, Dylan, Kawaguchi, Emily, Greenspoon, Dayna, Reed, Nick, Key ingredients to an active rehabilitation programme post-concussion: perspectives of youth and parents, Brain Injury, 32, 1534-1540, 2018	It was not clear that the participants had been hospitalised (study states that the intervention/ interviews were undertaken in a hospital but many of the participants were drawn from the community).
Hyatt, Kyong, Davis, Linda L., Barroso, Julie, Chasing the care: soldiers experience following combat-related mild traumatic brain injury, Military Medicine, 179, 849-55, 2014	Study not conducted in one of the countries included in the review protocol.
Irgens, Eirik Lind, Henriksen, Nils, Moe, Siri, Communicating information and professional knowledge in acquired brain injury rehabilitation trajectories - a qualitative study of physiotherapy practice, Disability and Rehabilitation, 1-8, 2018	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Jacoby, Sara F., Rich, John A., Webster, Jessica L., Richmond, Therese S., 'Sharing things with people that I don't even know': help-seeking for psychological symptoms in injured Black men in Philadelphia, Ethnicity & health, 1-19, 2018	Study not conducted in one of the countries included in the review protocol.
Jannings, Wendy, Pryor, Julie, The experiences and needs of persons with spinal cord injury who can walk, Disability and Rehabilitation, 34, 1820-6, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Janssen, Renske M. J., Satink, Ton, Ijspeert, Jos, van Alfen, Nens, Groothuis, Jan T., Packer, Tanya L., Cup, Edith H. C., Reflections of patients and therapists on a multidisciplinary rehabilitation programme for persons with brachial plexus injuries, Disability and Rehabilitation, 41, 1427-1434, 2019	Population not in PICO: Participants had not experienced traumatic injury.
Jellema, Sandra, van Erp, Sabine, Nijhuis-van der Sanden, Maria W. G., van der Sande, Rob, Steultjens, Esther M. J., Activity resumption after acquired brain injury: the influence of the social network as described by social workers, Disability and Rehabilitation, 1-8, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jeyathevan, Gaya, Cameron, Jill I., Craven, B. Catharine, Jaglal, Susan B., Identifying Required Skills to Enhance Family Caregiver Competency in Caring for Individuals With Spinal Cord Injury Living in the Community, Topics in Spinal Cord Injury Rehabilitation, 25, 290-302, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jeyathevan, Gaya, Catharine Craven, B., Cameron, Jill I., Jaglal, Susan B., Facilitators and barriers to supporting individuals with spinal cord injury in the community: experiences of family caregivers and care recipients, Disability and Rehabilitation, 1-11, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jiang, T., Webster, J. L., Robinson, A., Kassam-Adams, N., Richmond, T. S., Emotional responses to unintentional and intentional traumatic injuries among urban black men: A qualitative study, Injury, 49, 983-989, 2018	Study not conducted in one of the countries included in the review protocol.
Johnson, Rae A., Taggart, Susan B., Gullick, Janice G., Emerging from the trauma bubble: Redefining 'normal' after burn injury, Burns : journal of the International Society for Burn	No themes examining coordination of rehabilitation and social care while

Study	Reason for Exclusion
Injuries, 42, 1223-32, 2016	transferring between inpatient and outpatient services. Included in support needs and preferences review.
Jourdan, C., Azouvi, P., Pradat-Diehl, P., Ruet, A., Tenovuo, O., Traumatic Brain Injury (TBI) care pathways in Finland and in France: Organization and issues, Annals of Physical and Rehabilitation Medicine, 57, e397, 2014	Conference abstract.
Jurrius, K., After care for people with acquired brain injury in the chronic phase-New equilibrium in the aftercare of people with acquired brain injury and their next of kin, Brain Injury, 30, 567, 2016	Conference abstract.
Keck, Casey S., Creaghead, Nancy A., Turkstra, Lyn S., Vaughn, Lisa M., Kelchner, Lisa N., Pragmatic skills after childhood traumatic brain injury: Parents' perspectives, Journal of communication disorders, 69, 106-118, 2017	Study not conducted in one of the countries included in the review protocol.
Keenan, Alanna, Joseph, Lynn, The needs of family members of severe traumatic brain injured patients during critical and acute care: a qualitative study, Canadian journal of neuroscience nursing, 32, 25-35, 2010	Mixed setting and population, results not presented separately for the target settings and population.
Keightley, Michelle, Kendall, Victoria, Jang, Shu-Hyun, Parker, Cindy, Agnihotri, Sabrina, Colantonio, Angela, Minore, Bruce, Katt, Mae, Cameron, Anita, White, Randy, Longboat-White, Claudine, Bellavance, Alice, From health care to home community: an Aboriginal community-based ABI transition strategy, Brain Injury, 25, 142-52, 2011	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Kellezi, Blerina, Beckett, Kate, Earthy, Sarah, Barnes, Jo, Sleney, Jude, Clarkson, Julie, Regel, Stephen, Jones, Trevor, Kendrick, Denise, Understanding and meeting information needs following unintentional injury: comparing the accounts of patients, carers and service providers, Injury, 46, 564-71, 2015	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Kennedy, P., Sherlock, O., McClelland, M., Short, D., Royle, J., Wilson, C., A multi-centre study of the community needs of people with spinal cord injuries: the first 18 months, Spinal Cord, 48, 15-20, 2010	No qualitative data on phenomena of interest.
Kersten, Paula, Cummins, Christine, Kayes, Nicola, Babbage, Duncan, Elder, Hinemoa, Foster, Allison, Weatherall, Mark, Siegert, Richard John, Smith, Greta, McPherson, Kathryn, Making sense of recovery after traumatic brain injury through a peer mentoring intervention: a qualitative exploration, BMJ Open, 8, e020672, 2018	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Kiekens, C., Christiaens, W., Van Den Heede, K., Organization of aftercare for patients with severe burn injuries in Belgium, Annals of Physical and Rehabilitation Medicine, 57, e212-e213, 2014	Conference abstract.
Kimmel, Lara A., Holland, Anne E., Hart, Melissa J., Edwards, Elton R., Page, Richard S., Hau, Raphael, Bucknill, Andrew, Gabbe, Belinda J., Discharge from the acute hospital: trauma patients' perceptions of care, Australian health review : a publication of the Australian Hospital Association, 40, 625-632, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Kimmel, Lara A., Holland, Anne E., Lannin, Natasha, Edwards, Elton R., Page, Richard S., Bucknill, Andrew, Hau, Raphael, Gabbe, Belinda J., Clinicians' perceptions of decision making	No themes examining coordination of rehabilitation and social care while

Study	Reason for Exclusion
regarding discharge from public hospitals to in-patient rehabilitation following trauma, Australian health review : a publication of the Australian Hospital Association, 41, 192-200, 2017	transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Kingston, Gail A., Judd, Jenni, Gray, Marion A., The experience of medical and rehabilitation intervention for traumatic hand injuries in rural and remote North Queensland: a qualitative study, Disability and Rehabilitation, 37, 423-9, 2015	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Kingston, Gail A., Judd, Dr Jenni, Gray, Marion A., The experience of living with a traumatic hand injury in a rural and remote location: an interpretive phenomenological study, Rural and remote health, 14, 2764, 2014	No qualitative data on phenomena of interest.
Kirk, S., Fallon, D., Fraser, C., Robinson, G., Vassallo, G., Supporting parents following childhood traumatic brain injury: a qualitative study to examine information and emotional support needs across key care transitions, Child: care, health and development, 41, 303-313, 2015	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Kivunja, Stephen, River, Jo, Gullick, Janice, Experiences of giving and receiving care in traumatic brain injury: An integrative review, Journal of clinical nursing, 27, 1304-1328, 2018	Systematic review, included studies checked for relevance.
Kjaersgaard, A., Kristensen, H. K., Brain injury and severe eating difficulties at admission-patient perspective nine to fifteen months after discharge: A pilot study, Brain Sciences, 7, 96, 2017	Unclear how many participants had experienced traumatic injury, the results not presented separately for target population.
Knox, L., Douglas, J., Bigby, C., Exploring tensions associated with supported decision making in adults with severe traumatic brain injury, Brain Injury, 26, 477, 2012	Conference abstract.
Koehmstedt, Christine, Lydick, Susan E., Patel, Drasti, Cai, Xinsheng, Garfinkel, Steven, Weinstein, Ali A., Health status, difficulties, and desired health information and services for veterans with traumatic brain injuries and their caregivers: A qualitative investigation, PLoS ONE, 13, e0203804, 2018	Study not conducted in one of the countries included in the review protocol.
Koizia, L., Kings, R., Koizia, A., Peck, G., Wilson, M., Hettiaratchy, S., Fertleman, M. B., Major trauma in the elderly: Frailty decline and patient experience after injury, Trauma (United Kingdom), 21, 21-26, 2019	Not a qualitative study.
Koller, Kathryn, Woods, Lindsay, Engel, Lisa, Bottari, Carolina, Dawson, Deirdre R., Nalder, Emily, Bandura, Bottari Braun Chen Colantonio Creswell Dreer Engel Fleming Fox Gaudette Hall Hoskin Kelley Kershaw Kim Knight Kreutzer Langlois Levack Malee Marson Martin McCabe McHugh Patton Poncer Weiner, Loss of financial management independence after brain injury: Survivors' experiences, American Journal of Occupational Therapy, 70, No-Specified, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Kontos, P., Miller, K. L., Colantonio, A., Cott, C., Therapeutic landscape theory: Identifying health detracting and health enhancing aspects of neurorehabilitation, Brain Injury, 28, 535, 2014	Conference abstract.
Kornhaber, R., Wilson, A., Abu-Qamar, M., McLean, L., Vandervord, J., Inpatient peer support for adult burn survivors-a valuable resource: a phenomenological analysis of the Australian experience, Burns : journal of the International Society for Burn	Study did not examine phenomena of interest.

Study	Reason for Exclusion
Injuries, 41, 110-7, 2015	
Kozlowski-Moreau, O., Danze, F., Pollez, B., Brooks, N., Johnson, C., Line, M. C., Rousseaux, M., Croisiaux, C., Lanthier, A., Long-term management of severe TBI in Europe-The value of a network, Brain Injury, 30, 650, 2016	Conference abstract.
Kuipers, Pim, Kendall, Melissa B., Amsters, Delena, Pershouse, Kiley, Schuurs, Sarita, Descriptions of community by people with spinal cord injuries: concepts to inform community integration and community rehabilitation, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 34, 167-74, 2011	No qualitative data on phenomena of interest.
Lafebvre, H., Levert, M. J., Gelinas, I., Croteau, C., Le Dorze, G., Bottari, C., McKerrall, M., Personalized accompaniment for community integration for people with a traumatic brain injury in postrehabilitation, Archives of Physical Medicine and Rehabilitation, 91, e7, 2010	Conference abstract.
Lamontagne, M. E., Swaine, B. R., Lavoie, A., Careau, E., Analysis of the strengths, weaknesses, opportunities and threats of the network form of organization of traumatic brain injury service delivery systems, Brain Injury, 25, 1188-1197, 2011	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Lange, R., French, L., Bailie, J., Lippa, S., Gartner, R., Driscoll, A., Wright, M., Smith, J., Dilay, A., Pizzano, B., Johnson, L., Nora, D., Mahatan, H., Sullivan, J., Thompson, D., Snelling, A., Brickell, T., Caring for U.S. military service members following mild-moderate traumatic brain injury: Examination of access to services, service needs, and barriers to care, Journal of Head Trauma Rehabilitation, 32, E71, 2017	Conference abstract.
Lannin, N., Roberts, K., D'Cruz, K., Morarty, J., Unsworth, C., Who holds the 'Power' during goal-setting? A qualitative study exploring patient perceptions, International Journal of Stroke, 10, 68, 2015	Conference abstract.
Lapierre, Alexandra, Lefebvre, Helene, Gauvin-Lepage, Jerome, Factors Affecting Interprofessional Teamwork in Emergency Department Care of Polytrauma Patients: Results of an Exploratory Study, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 26, 312-322, 2019	Setting not in PICO: Emergency department.
Lee, Tracy, Norton, Andrea, Hayes, Sue, Adamson, Keith, Schwellnus, Heidi, Evans, Cathy, Exploring Parents' Perceptions and How Physiotherapy Supports Transition from Rehabilitation to School for Youth with an ABI, Physical & occupational therapy in pediatrics, 37, 444-455, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Lefebvre, Helene, Levert, Marie Josee, The needs experienced by individuals and their loved ones following a traumatic brain injury, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 19, 197-207, 2012	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient and accessing rehabilitation services reviews.
Letts, L., Martin Ginis, K. A., Faulkner, G., Colquhoun, H., Levac, D., Gorczynski, P., Preferred Methods and Messengers for	It was unclear if the focus was specific to participants who had

Study	Reason for Exclusion
Delivering Physical Activity Information to People With Spinal Cord Injury: A Focus Group Study, Rehabilitation Psychology, 56, 128-137, 2011	experienced traumatic injury and the results not presented separately for target population.
Lexell, E. M., Alkhed, A. K., Olsson, K., The group rehabilitation helped me adjust to a new life: Experiences shared by persons with an acquired brain injury, Brain Injury, 27, 529-537, 2013	No qualitative data on phenomena of interest.
Lind, J. D., Fraser, M. A., Powell-Cope, G., Gavin-Dreschnack, D., Enhancing patient dignity in va spinal cord injury units, Journal of Spinal Cord Medicine, 36, 555, 2013	Study not conducted in one of the countries included in the review protocol.
Lindahl, Marianne, Teljigovic, Sanel, Heegaard Jensen, Lars, Hvalsoe, Berit, Juneja, Hemant, Barth, Clay Cooper Cott Del Bano-Aledo Donabedian Donabedian Fitinghoff Griffiths Harris Hours Hush Jensen Kidd Lempp Lindahl Martins McLean Mead Mussener Partridge Pinto Polinder Rindflesch Sanders Strauss Walton Willamson, Importance of a patient-centred approach in ensuring quality of post-fracture rehabilitation for working aged people: A qualitative study of therapists' and patients' perspectives, Work: Journal of Prevention, Assessment & Rehabilitation, 55, 831-839, 2016	Mixed population, cannot separate or confirm which patients were hospitalised and match the population of interest.
Lindberg, J., Kreuter, M., Taft, C., Person, L. O., Patient participation in care and rehabilitation from the perspective of patients with spinal cord injury, Spinal Cord, 51, 834-7, 2013	Study did not examine phenomena of interest.
Linnarsson, J. R., Bubini, J., Perseius, K. I., A meta-synthesis of qualitative research into needs and experiences of significant others to critically ill or injured patients, Journal of Clinical Nursing, 19, 3102-11, 2010	Systematic review, included studies outside of date limits (1997-2007).
Littooij, E., Leget, C. J. W., Stolwijk-Swuste, J. M., Doodeman, S., Widdershoven, G. A. M., Dekker, J., The importance of 'global meaning' for people rehabilitating from spinal cord injury, Spinal Cord, 54, 1047-1052, 2016	Study did not examine phenomena of interest.
Lundine, J. P., Utz, M., Jacob, V., Ciccia, A. H., Putting the person in person-centered care: Stakeholder experiences in pediatric traumatic brain injury, Journal of Pediatric Rehabilitation Medicine, 12, 21-35, 2019	Study not conducted in one of the countries included in the review protocol.
Maddick, Rosie, Norton, Ali Amir Andrews Baker Batavia Batt-Rawden Bernstein Braun Bright Bright Bruscia De Carvalho Deegan Dijkers Dorsett Dorsett Dorsett Fook Fook Galvin Golden Humphries James Larsson Lee Lefevre Lethborg Manns Montague Nielson North O'Callaghan O'Callaghan O'Neil Riessman Riessman Scheiby Slivka Stover Tamplin Whittemore Zedjlik, 'Naming the unnameable and communicating the unknowable': Reflections on a combined music therapy/social work program, The Arts in Psychotherapy, 38, 130-137, 2011	Study did not examine phenomena of interest.
Makela, P., Jones, F., de Sousa de Abreu, M. I., Hollinshead, L., Ling, J., Supporting self-management after traumatic brain injury: Codesign and evaluation of a new intervention across a trauma pathway, Health expectations : an international journal of public participation in health care and health policy, 22, 632-642, 2019	Study did not examine phenomena of interest.
Manning, Joseph C., Hemingway, Pippa, Redsell, Sarah A., Survived so what? Identifying priorities for research with children and families post-paediatric intensive care unit, Nursing in critical care, 23, 68-74, 2018	Study did not examine rehabilitation.
Martin, Laurie T., Farris, Coreen, Parker, Andrew M., Epley, Caroline, The Defense and Veterans Brain Injury Center Care Coordination Program: Assessment of Program Structure, Activities, and Implementation, Rand health quarterly, 3, 4, 2013	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Martin, Suzanne, Armstrong, Elaine, Thomson, Eileen, Vargiu, Eloisa, Sola, Marc, Dauwalder, Stefan, Miralles, Felip, Daly Lynn, Jean, A qualitative study adopting a user-centered approach to design and validate a brain computer interface for cognitive rehabilitation for people with brain injury, Assistive technology : the official journal of RESNA, 30, 233-241, 2018	Study did not examine phenomena of interest.
Materne, M., Lundqvist, L. O., Strandberg, T., Opportunities and barriers for successful return to work after acquired brain injury: A patient perspective, Work (Reading, Mass.), 56, 125-134, 2017	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
McBain, Sacha A., Sexton, Kevin W., Palmer, Brooke E., Landes, Sara J., Barriers to and facilitators of a screening procedure for PTSD risk in a level I trauma center, Trauma surgery & acute care open, 4, e000345, 2019	Study not conducted in one of the countries included in the review protocol.
McDermott, Garret L., McDonnell, Anne Marie, Acquired brain injury services in the Republic of Ireland: experiences and perceptions of families and professionals, Brain Injury, 28, 81-91, 2014	The focus was not specific to care of people who have experienced traumatic injury and the results not presented separately for target population.
McGarry, Sarah, Elliott, Catherine, McDonald, Ann, Valentine, Jane, Wood, Fiona, Girdler, Sonya, "This is not just a little accident": a qualitative understanding of paediatric burns from the perspective of parents, Disability and Rehabilitation, 37, 41-50, 2015	Study did not examine phenomena of interest.
McIntyre, Michelle, Ehrlich, Carolyn, Kendall, Elizabeth, Informal care management after traumatic brain injury: perspectives on informal carer workload and capacity, Disability and Rehabilitation, 1-9, 2018	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
McKelvey, M., Bush, E., Screening and identification of individuals with brain injury (BI) seeking services through the area agency on ageing in rural Nebraska, Brain Injury, 28, 712, 2014	Conference abstract.
McPherson, K., Fadyl, J., Theadom, A., Channon, A., Levack, W., Starkey, N., Wilkinson-Meyers, L., Kayes, N., Feigin, V., Barker-Collo, S., Harwood, M., Mudge, S., Christie, G., Jenkins, S., Living Life after Traumatic Brain Injury: Phase 1 of a Longitudinal Qualitative Study, Journal of Head Trauma Rehabilitation, 33, E44-E52, 2018	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences reviews.
McPherson, K., Theadom, A., Wilkinson-Meyers, L., The experience of recovery-a qualitative study, Brain Injury, 26, 493-494, 2012	Conference abstract.
McRae, Philippa, Hallab, Lisa, Simpson, Grahame, Anstey, Braun Brooks Ellingsen Frost Gilworth Gilworth Gracey Harradine Kreutzer Macaden Medin Menon Nightingale Olver Oppermann Petrella Ponsford Rubenson Sabatello Simpson Tate Teasdale van Velzen van Velzen, Navigating employment pathways and supports following brain injury in Australia: Client perspectives, Australian Journal of Rehabilitation Counselling, 22, 76-92, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Meade, M., Carr, L., Ellenbogen, P., Barrett, K., Perceptions of provider education and attitude by individuals with spinal cord injury: Implications for health care disparities, Topics in Spinal Cord Injury Rehabilitation, 17, 25-37, 2011	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Medina-Mirapeix, F., Del Bano-Aledo, M. E., Oliveira-Sousa, S. L., Escolar-Reina, P., Collins, S. M., How the rehabilitation environment influences patient perception of service quality: A qualitative study, Archives of Physical Medicine and Rehabilitation, 94, 1112-1117, 2013	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Mehta, Swati, Hadjistavropoulos, Heather D., Earis, Danielle, Titov, Nick, Dear, Blake F., Patient perspectives of Internet-delivered cognitive behavior therapy for psychosocial issues post spinal cord injury, Rehabilitation Psychology, 2019	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services review.
Meixner, Cara, O'Donoghue, Cynthia R., Witt, Michelle, Accessing crisis intervention services after brain injury: a mixed methods study, Rehabilitation psychology, 58, 377-85, 2013	Study not conducted in one of the countries included in the review protocol.
Messinger, Seth, Bozorghadad, Sayeh, Pasquina, Paul, Social relationships in rehabilitation and their impact on positive outcomes among amputees with lower limb loss at Walter Reed National Military Medical Center, Journal of rehabilitation medicine, 50, 86-93, 2018	Study not conducted in one of the countries included in the review protocol.
Milte, R., Ratcliffe, J., Miller, M., Whitehead, C., Cameron, I. D., Crotty, M., What are frail older people prepared to endure to achieve improved mobility following hip fracture? A Discrete Choice Experiment, Journal of rehabilitation medicine : official journal of the UEMS European Board of Physical and Rehabilitation Medicine, 45, 81-86, 2013	Not a qualitative study.
Minney, M. J., Roberts, R. M., Mathias, J. L., Raftos, J., Kochar, A., Service and support needs following pediatric brain injury: perspectives of children with mild traumatic brain injury and their parents, Brain Injury, 33, 168-182, 2019	Study did not examine rehabilitation.
Mitchell, Rebecca, Fajardo Pulido, Diana, Ryder, Tayhla, Norton, Grace, Brodaty, Henry, Draper, Brian, Close, Jacqueline, Rapport, Frances, Lystad, Reidar, Harris, Ian, Harvey, Lara, Sherrington, Cathie, Cameron, Ian D., Braithwaite, Jeffrey, Access to rehabilitation services for older adults living with dementia or in a residential aged care facility following a hip fracture: healthcare professionals' views, Disability and Rehabilitation, 1-12, 2019	Study did not examine phenomena of interest.
Mitsch, Virginia, Curtin, Michael, Badge, Helen, The provision of brain injury rehabilitation services for people living in rural and remote New South Wales, Australia, Brain Injury, 28, 1504-13, 2014	The majority of participants had not experienced traumatic injury and the results not presented separately for target population .
Moore, M., Robinson, G., Mink, R., Hudson, K., Dotolo, D., Gooding, T., Ramirez, A., Zatzick, D., Vavilala, M., Acute care after pediatric traumatic brain injury: A qualitative study of the family perspective, Journal of Neurotrauma, 31, A59, 2014	Conference abstract.
Moore, Megan, Robinson, Gabrielle, Mink, Richard, Hudson, Kimberly, Dotolo, Danae, Gooding, Tracy, Ramirez, Alma, Zatzick, Douglas, Giordano, Jessica, Crawley, Deborah, Vavilala, Monica S., Developing a Family-Centered Care Model for Critical Care After Pediatric Traumatic Brain Injury, Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies, 16, 758-65, 2015	Study not conducted in one of the countries included in the review protocol.
Morriss, Elissa, Wright, Suzanne, Smith, Sharon, Roser, Judy, Kendall, Melissa, Ackerson, Ackerson Bassett Bassett	The majority of participants had not experienced traumatic injury

Study	Reason for Exclusion
Baulderstone Baxter Bisogni Butera-Prinzi Charles Cicerone Clark Cowling Craig Degeneffe Devany-Serio Evenson Flanagan Fletcher Gan Jacob Jones Kaatz Kirshbaum Kosciulek Lancaster Leinonen Lezak Llewellyn Maitz Nicholson Olson Pessar Qu Sander Smith Stake Strauss Urbach Uysal Visser-Meily Wade, Parenting challenges and needs for fathers following acquired brain injury (ABI) in Queensland, Australia: A preliminary model, Special Issue: Family support and adjustment following acquired brain injury: An international perspective., 19, 119-134, 2013	and the results not presented separately for target population.
Mumbower, R., Heaton, K., Dreer, L., Novack, T., Childs, G., Vance, D., Sleep experiences following traumatic brain injury: A qualitative descriptive study, Archives of Physical Medicine and Rehabilitation, 98, e155, 2017	Conference abstract.
Munce, Sarah E. P., Webster, Fiona, Fehlings, Michael G., Straus, Sharon E., Jang, Eunice, Jaglal, Susan B., Meaning of self-management from the perspective of individuals with traumatic spinal cord injury, their caregivers, and acute care and rehabilitation managers: an opportunity for improved care delivery, BMC Neurology, 16, 11, 2016	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Munce, Sarah E. P., Webster, Fiona, Fehlings, Michael G., Straus, Sharon E., Jang, Eunice, Jaglal, Susan B., Perceived facilitators and barriers to self-management in individuals with traumatic spinal cord injury: a qualitative descriptive study, BMC Neurology, 14, 48, 2014	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Murphy, Margaret, McCloughen, Andrea, Curtis, Kate, Using theories of behaviour change to transition multidisciplinary trauma team training from the training environment to clinical practice, Implementation science : IS, 14, 43, 2019	Study did not examine rehabilitation.
Murphy, Margaret, McCloughen, Andrea, Curtis, Kate, The impact of simulated multidisciplinary Trauma Team Training on team performance: A qualitative study, Australasian emergency care, 22, 1-7, 2019	Study did not examine rehabilitation.
Murray, A., Watter, K., Nielsen, M., Kennedy, A., A scoping study examining vocational rehabilitation in early acquired brain injury rehabilitation, Brain Impairment, 19, 306-307, 2018	Conference abstract.
Nalder, E., Fleming, J., Cornwell, P., Foster, M., Identity and the life course: Lived experiences of individuals with traumatic brain injury during the period of transition from hospital to home, Brain Impairment, 14, 159, 2013	Conference abstract.
Nalder, E., Fleming, J., Cornwell, P., Foster, M., Worrall, L., Ownsworth, T., Haines, T., Kendall, M., Chenoweth, L., What constitutes transition success? An investigation into factors influencing the perceptions of individuals with a TBI regarding the transition from hospital to home, Brain Injury, 24 (3), 189-190, 2010	Conference abstract.
Nalder, Emily J., Zabjek, Karl, Dawson, Deirdre R., Bottari, Carolina L., Gagnon, Isabelle, McFadyen, Bradford J., Hunt, Anne W., McKenna, Suzanne, Ouellet, Marie-Christine, Giroux, Sylvain, Cullen, Nora, Niechwiej-Szwedo, Ewa, Onf-Repar Abi Team, Research Priorities for Optimizing Long-term Community Integration after Brain Injury, The Canadian journal of neurological sciences. Le journal canadien des sciences neurologiques, 45, 643-651, 2018	Data was not collected using an appropriate qualitative methodology (the authors have analysed their own field notes taken at a 2-day conference for practitioners)
Nalder, Emily, Fleming, Jennifer, Cornwell, Petrea, Shields, Cassandra, Foster, Michele, Reflections on life: experiences of individuals with brain injury during the transition from hospital to home, Brain Injury, 27, 1294-303, 2013	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following

Study	Reason for Exclusion
	discharge.
Nasrabadi, A. N., Mohammadi, N., Davatgaran, K., Yekaninejad, M., Javidan, A. N., Shabany, M., Designing a client and family empowerment model to promote constructive life recovery among persons with spinal cord injury: A qualitative study, Archives of Neuroscience, 6, e87867, 2019	Study not conducted in one of the countries included in the review protocol.
Nilsson, Charlotte, Bartfai, Aniko, Lofgren, Monika, Bartfai, Ben-Yishai Brooks Carlsson Charmaz Christensen Cicerone Cicerone Cicerone Comper Creswell Cullen Dahlgren Ferguson Fleming Gard Ho Kielhofner Lincoln Miller Ohman Phipps Ponsford Prigatano Rice-Oxley Roding Roxendahl Rudolfsson Ruff Stalnacke Svendsen Tiersky Wilson, Holistic group rehabilitation-A short cut to adaptation to the new life after mild acquired brain injury, Disability and Rehabilitation: An International, Multidisciplinary Journal, 33, 969-978, 2011	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Norrbrink, Cecilia, Lofgren, Monika, Needs and requests--patients and physicians voices about improving the management of spinal cord injury neuropathic pain, Disability and Rehabilitation, 38, 151-8, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient and support needs and preferences reviews.
Nunnerley, J. L., Hay-Smith, E. J., Dean, S. G., Leaving a spinal unit and returning to the wider community: an interpretative phenomenological analysis, Disability and Rehabilitation, 35, 1164-1173, 2013	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
O'Callaghan, A., McNamara, B., Cocks, E., 'What am I supposed to do? Cartwheels down the passageway?' Perspectives on the rehabilitation journey from people with ABI, Brain Injury, 28, 577-578, 2014	Conference abstract.
O'Callaghan, Anna, McAllister, Lindy, Wilson, Linda, Blight, Brookshire Brown Cicerone Denzin Fleming Foster Gentleman Goranson Grbich Hickson Hughes Humphreys Humphreys Josselson Katz Keleher LeFebvre Mackay MacPhail Malec McNaughton Minichiello Morse Morton Muus O'Callaghan O'Callaghan O'Callaghan O'Callaghan Penchansky Rankin Sandelowski Schmidt Schwandt Seale Sherer Stringer Tuel Turner-Stokes Youse, Healthcare consumers' need for brain-injury services: The critical importance of timing in planning future services, Brain Impairment, 13, 316-332, 2012	Analysis methods not appropriate (data reduced into case vignettes)
Ogilvie, Rebekah, Foster, Kim, McCloughen, Andrea, Curtis, Kate, The injury trajectory for young people 16-24 years in the six months following injury: A mixed methods study, Injury, 47, 1966-74, 2016	Study did not examine phenomena of interest.
Ogilvie, Rebekah, Foster, Kim, McCloughen, Andrea, Curtis, Kate, Young peoples' experience and self-management in the six months following major injury: A qualitative study, Injury, 46, 1841-7, 2015	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Oster, Caisa, Kildal, Morten, Ekselius, Lisa, Return to work after burn injury: burn-injured individuals' perception of barriers and facilitators, Journal of burn care & research : official publication of the American Burn Association, 31, 540-50, 2010	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following

Study	Reason for Exclusion
	discharge.
Oyesanya, Tolu O., Bowers, Barbara J., Royer, Heather R., Turkstra, Lyn S., Nurses' concerns about caring for patients with acute and chronic traumatic brain injury, Journal of Clinical Nursing, 27, 1408-1419, 2018	Study not conducted in one of the countries included in the review protocol.
Palimaru, Alina, Cunningham, William E., Dillistone, Marcus, Vargas-Bustamante, Arturo, Liu, Honghu, Hays, Ron D., A comparison of perceptions of quality of life among adults with spinal cord injury in the United States versus the United Kingdom, Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation, 26, 3143-3155, 2017	Study did not examine phenomena of interest.
Pallesen, H., Buhl, I., Interdisciplinary facilitation of the minimal participation of patients with severe brain injury in early rehabilitation, European Journal of Physiotherapy, 19, 13-23, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Patterson, F., Fleming, J., Doig, E., Patient experiences of occupational therapy groups in traumatic brain injury rehabilitation, Brain Impairment, 19, 281, 2018	Conference abstract.
Patton, Desmond, Sodhi, Aparna, Affinati, Steven, Lee, Jooyoung, Crandall, Marie, Post-Discharge Needs of Victims of Gun Violence in Chicago: A Qualitative Study, Journal of interpersonal violence, 34, 135-155, 2019	Study not conducted in one of the countries included in the review protocol.
Pekmezaris, Renee, Kozikowski, Andrzej, Pascarelli, Briana, Handrakis, John P., Chory, Ashley, Griffin, Doug, Bloom, Ona, Participant-reported priorities and preferences for developing a home-based physical activity telemonitoring program for persons with tetraplegia: a qualitative analysis, Spinal cord series and cases, 5, 48, 2019	Study not conducted in one of the countries included in the review protocol.
Phillips, J., Holmes, J., Auton, M., Radford, K., What are the most important outcomes of traumatic brain injury vocational rehabilitation? People with TBI, service provider and employer perspectives, Brain Injury, 30, 494-495, 2016	Conference abstract.
Piccenna, Loretta, Lannin, Natasha A., Gruen, Russell, Pattuwage, Loyal, Bragge, Peter, The experience of discharge for patients with an acquired brain injury from the inpatient to the community setting: A qualitative review, Brain Injury, 30, 241-51, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Plant, Sarah E., Tyson, Sarah F., Kirk, Susan, Parsons, John, What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis, Clinical rehabilitation, 30, 921-30, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Pol, M., Peek, S., Van Nes, F., Van Hartingsveldt, M., Buurman, B., Krose, B., Everyday life after a hip fracture: What community-living older adults perceive as most beneficial for their recovery, Age and Ageing, 48, 440-447, 2019	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences review.
Poncet, F., Pradat-Diehl, P., Lamontagne, M. E., Alifax, A., Barette, M., Fradelizi, P., Swaine, B., A mixed-methods approach	Conference abstract.

Study	Reason for Exclusion
to evaluate participants' and service providers' perceptions of an outpatient rehabilitation programme for persons with acquired brain injury, Brain Injury, 31, 816, 2017	
Poncet, F., Pradat-Diehl, P., Lamontagne, M. E., Alifax, A., Fradelizi, P., Barette, M., Swaine, B., Participant and service provider perceptions of an outpatient rehabilitation program for people with acquired brain injury, Annals of Physical and Rehabilitation Medicine, 60, 334-340, 2017	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Popejoy, Lori L., Dorman Marek, Karen, Scott-Cawiezell, Jill, Patterns and problems associated with transitions after hip fracture in older adults, Journal of gerontological nursing, 39, 43-52, 2013	Study not conducted in one of the countries included in the review protocol.
Porto, A., Anderson, L., Vogel, L., Zebracki, K., Barriers in accessing adult healthcare for transitioning youth with spinal cord injury, Developmental Medicine and Child Neurology, 60, 116, 2018	Conference abstract.
Poulin, V., Lamontagne, M. E., Ouellet, M. C., Pellerin, M. A., Jean, A., Implementing best practices in cognitive rehabilitation: What are rehabilitation teams' priorities and why?, Archives of Physical Medicine and Rehabilitation, 98, e157, 2017	Conference abstract.
Prescott, Sarah, Fleming, Jennifer, Doig, Emmah, Refining a clinical practice framework to engage clients with brain injury in goal setting, Australian Occupational Therapy Journal, 66, 313-325, 2019	Study did not examine phenomena of interest.
Ramakrishnan, Kumaran, Johnston, Deborah, Garth, Belinda, Murphy, Gregory, Middleton, James, Cameron, Ian, Early Access to Vocational Rehabilitation for Inpatients with Spinal Cord Injury: A Qualitative Study of Patients' Perceptions, Topics in Spinal Cord Injury Rehabilitation, 22, 183-191, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Rashid, M., Caine, V., Newton, A. S., Goez, H. R., Healthcare professionals' perspective on the delivery of care to children with Acquired Brain Injury (ABI) and communication with their parents, Journal of Pediatric Rehabilitation Medicine, 11, 125-131, 2018	Population is under 18s. Included in corresponding paediatric review.
Roberts, J. L., Pritchard, A. W., Williams, M., Totton, N., Morrison, V., D. In N.U, Williams, N. H., Mixed methods process evaluation of an enhanced community-based rehabilitation intervention for elderly patients with hip fracture, BMJ Open, 8 (8) (no pagination), 2018	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Roberts, Jessica Louise, Din, Nafees Ud, Williams, Michelle, Hawkes, Claire A., Charles, Joanna M., Hoare, Zoe, Morrison, Val, Alexander, Swapna, Lemmey, Andrew, Sackley, Catherine, Logan, Phillipa, Wilkinson, Clare, Rycroft-Malone, Jo, Williams, Nefyn H., Development of an evidence-based complex intervention for community rehabilitation of patients with hip fracture using realist review, survey and focus groups, BMJ Open, 7, e014362, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences review.
Rongen, A., Bakx, W., Nijhuis, F., Follow-up study of patients with an acquired Brain Injury after early focus on return to work during post-acute rehabilitation, Brain Injury, 24, 450-451, 2010	Conference abstract.
Roscigno, Cecelia I., Parent Perceptions of How Nurse Encounters Can Provide Caring Support for the Family in Early Acute Care After Children's Severe Traumatic Brain Injury,	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Journal of Neuroscience Nursing, 48, E2-E15, 2016	
Roth, Karin, Mueller, Gabi, Wyss, Adrian, Experiences of peer counselling during inpatient rehabilitation of patients with spinal cord injuries, Spinal cord series and cases, 5, 1, 2019	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Rothlisberger, Fabian, Boes, Stefan, Rubinelli, Sara, Schmitt, Klaus, Scheel-Sailer, Anke, Challenges and potential improvements in the admission process of patients with spinal cord injury in a specialized rehabilitation clinic - an interview based qualitative study of an interdisciplinary team, BMC health services research, 17, 443, 2017	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Ryerson Espino, S., Kelly, E., Riordan, A., Zebracki, K., Vogel, L., Personal and family experiences of caregivers of children with SCI, Developmental Medicine and Child Neurology, 58, 107-108, 2016	Conference abstract.
Ryerson Espino, Susan L., Kelly, Erin H., Rivelli, Anne, Zebracki, Kathy, Vogel, Lawrence C., It is a marathon rather than a sprint: an initial exploration of unmet needs and support preferences of caregivers of children with SCI, Spinal Cord, 56, 284-294, 2018	Study not conducted in one of the countries included in the review protocol.
Sale, J. E. M., Bogoch, E., Hawker, G., Gignac, M., Beaton, D., Jaglal, S., Frankel, L., Patient perceptions of provider barriers to post-fracture secondary prevention, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 25, 2581-9, 2014	No qualitative data on phenomena of interest.
Salsbury, Stacie A., Vining, Robert D., Gosselin, Donna, Goertz, Christine M., Be good, communicate, and collaborate: a qualitative analysis of stakeholder perspectives on adding a chiropractor to the multidisciplinary rehabilitation team, Chiropractic & manual therapies, 26, 29, 2018	Study not conducted in one of the countries included in the review protocol.
Samoborec, Stella, Ayton, Darshini, Ruseckaite, Rasa, Winbolt, Gary, Evans, Sue M., System complexities affecting recovery after a minor transport-related injury: The need for a person-centred approach, Journal of Rehabilitation Medicine, 51, 120-126, 2019	Population described as people that sustained predominantly minor injuries; study does not report any results separately for target population.
Sandstrom, Linda, Engstrom, Asa, Nilsson, Carina, Juuso, Paivi, Experiences of suffering multiple trauma: A qualitative study, Intensive & critical care nursing, 2019	Setting not in PICO: Intensive care unit
Sashika, Hironobu, Takada, Kaoruko, Kikuchi, Naohisa, Rehabilitation needs and participation restriction in patients with cognitive disorder in the chronic phase of traumatic brain injury, Medicine, 96, e5968, 2017	Study not conducted in one of the countries included in the review protocol.
Schiller, Claire, Franke, Thea, Belle, Jessica, Sims-Gould, Joanie, Sale, Joanna, Ashe, Maureen C., Words of wisdom - patient perspectives to guide recovery for older adults after hip fracture: a qualitative study, Patient preference and adherence, 9, 57-64, 2015	Study did not examine rehabilitation.
Segevall, Cecilia, Soderberg, Siv, Bjorkman Randstrom, Kerstin, The Journey Toward Taking the Day for Granted Again: The Experiences of Rural Older People's Recovery From Hip Fracture Surgery, Orthopedic nursing, 38, 359-366, 2019	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Self, Megan, Driver, Simon, Stevens, Laurel, Warren, Ann Marie, Physical activity experiences of individuals living with a traumatic brain injury: a qualitative research exploration, Adapted physical activity quarterly : APAQ, 30, 20-39, 2013	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Sena Martins, Bruno, Fontes, Fernando, Hespanha, Pedro, Barnes, Barnes Davis Fontes Fontes Goffman Guion Hahn Henriques Hughes Klein Leder Martins Martins Oliver Oliver Oliver Santos Somers Stiker Stone Turner Wall, Spinal cord injury in Portugal: Institutional and personal challenges, Journal of Disability Policy Studies, 28, 119-128, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Sharp, K., Richards, S., Client's perspectives of smartphone technology in acquired brain injury rehabilitation, Brain Impairment, 14, 167, 2013	Conference abstract.
Silver, Jeremy, Ljungberg, Inger, Libin, Alexander, Groah, Suzanne, Barriers for individuals with spinal cord injury returning to the community: a preliminary classification, Disability and Health Journal, 5, 190-6, 2012	Study not conducted in one of the countries included in the review protocol.
Silver, Samuel A., Saragosa, Marianne, Adhikari, Neill K., Bell, Chaim M., Harel, Ziv, Harvey, Andrea, Kitchlu, Abhijat, Neyra, Javier A., Wald, Ron, Jeffs, Lianne, What insights do patients and caregivers have on acute kidney injury and posthospitalisation care? A single-centre qualitative study from Toronto, Canada, BMJ Open, 8, e021418, 2018	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Singh, Gurkaran, MacGillivray, Megan, Mills, Patricia, Adams, Jared, Sawatzky, Bonita, Mortenson, W. Ben, Patients' Perspectives on the Usability of a Mobile App for Self-Management following Spinal Cord Injury, Journal of Medical Systems, 44, 26, 2019	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in accessing rehabilitation services and support needs and preferences reviews.
Slomic, M., Christiansen, B., Sveen, U., Soberg, H. L., Users' experiential knowledge as a base for evidence-based practice in inter-professional rehabilitation, Brain Injury, 30, 580-581, 2016	Conference abstract.
Slomic, Mirela, Christiansen, Bjorg, Soberg, Helene L., Sveen, Unni, User involvement and experiential knowledge in interprofessional rehabilitation: a grounded theory study, BMC health services research, 16, 547, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Smith, Bridget M., Martinez, Rachael N., Evans, Charlesnika T., Saban, Karen L., Balbale, Salva, Proescher, Eric J., Stroupe, Kevin, Hogan, Timothy P., Barriers and strategies for coordinating care among veterans with traumatic brain injury: a mixed methods study of VA polytrauma care team members, Brain Injury, 32, 755-762, 2018	Study not conducted in one of the countries included in the review protocol.
Smith, E. M., Boucher, N., Miller, W. C., Caregiving services in spinal cord injury: A systematic review of the literature, Spinal Cord, 54, 562-569, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Smith, M., Hada, E., Long, C., Bushnik, T., Examining language preference and acculturation and implications for the continuum of care of patients with traumatic brain injury (TBI), Journal of Head Trauma Rehabilitation, 30, E107, 2015	Conference abstract.
Snell, Deborah L., Martin, Rachelle, Surgenor, Lois J., Siegert, Richard J., Hay-Smith, E. Jean C., What's wrong with me? seeking a coherent understanding of recovery after mild	Population not in PICO: Study did not mention that the patients were transferred to outpatient or

Study	Reason for Exclusion
traumatic brain injury, Disability and Rehabilitation, 39, 1968-1975, 2017	community services following discharge.
Soong, Christine, Kurabi, Bochra, Exconde, Kathleen, Tajammal, Faiqa, Bell, Chaim M., Design of an orthopaedic-specific discharge summary, BMC Health Services Research, 16, 545, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Sorli, H., Bach, B., Haarberg, D., Hjort-Larsen, G., Anette Hansen, S., Kristiansen, G., Hansen, H., Telerehabilitation in Norway, Brain Injury, 24, 284-285, 2010	Conference abstract.
Speck, Rebecca M., Jones, Gabrielle, Barg, Frances K., McCunn, Maureen, Team composition and perceived roles of team members in the trauma bay, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 19, 133-8, 2012	Study not conducted in one of the countries included in the review protocol.
Starnes, C. L., Bailey, E. A., Calvert, C. T., Gusler, J., Cairns, B. A., Development of a pediatric educational tool: Helping burns heal-an adventure for kids with burns, Journal of Burn Care and Research, 37, S172, 2016	Conference abstract.
Stergiou-Kita, M., Bottari, C., Dawson, D., Hebert, D., Grigorovich, A., Inter-professional approaches to vocational evaluation following traumatic brain injury, Brain Injury, 28, 774-775, 2014	Conference abstract.
Stott-Eveneshen, Sarah, Sims-Gould, Joanie, McAllister, Megan M., Fleig, Lena, Hanson, Heather M., Cook, Wendy L., Ashe, Maureen C., Reflections on Hip Fracture Recovery From Older Adults Enrolled in a Clinical Trial, Gerontology & geriatric medicine, 3, 2333721417697663, 2017	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Strandberg, T., Materne, M., Returning to working life after acquired brain injury-The rehabilitation-process, possibilities and hindrance for participation, Brain Injury, 28, 754, 2014	Conference abstract.
Sullivan, Martin, Paul, Charlotte E., Herbison, G. Peter, Tamou, Peina, Derrett, Sarah, Crawford, Maureen, A longitudinal study of the life histories of people with spinal cord injury, Injury prevention : journal of the International Society for Child and Adolescent Injury Prevention, 16, e3, 2010	A study protocol only. No data presented.
Sveen, Unni, Ostensjo, Sigrid, Laxe, Sara, Soberg, Helene L., Problems in functioning after a mild traumatic brain injury within the ICF framework: the patient perspective using focus groups, Disability and Rehabilitation, 35, 749-57, 2013	No qualitative data on phenomena of interest.
Swaine, B., Cullen, N., Bayley, M., Lavoie, A., Marshall, S., Turgeon, A., Sirois, M. J., Messier, F., Trempe, C., Who goes where and why? An environmental scan of rehab referral, admission and discharge of persons with brain injury in two canadian provinces, Brain Injury, 24, 362, 2010	Conference abstract.
Takada, Kaoruko, Sashika, Hironobu, Wakabayashi, Hidetaka, Hirayasu, Yoshio, Social participation and quality-of-life of patients with traumatic brain injury living in the community: A mixed methods study, Brain Injury, 30, 1590-1598, 2016	Study not conducted in one of the countries included in the review protocol.
Talbot, Lise R., Levesque, Annie, Trottier, Josee, Process of implementing collaborative care and its impacts on the provision of care and rehabilitation services to patients with a moderate or severe traumatic brain injury, Journal of multidisciplinary healthcare, 7, 313-20, 2014	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while

Study	Reason for Exclusion
	inpatient review.
Thrussell, Helen, Coggrave, Maureen, Graham, Allison, Gall, Angela, Donald, Michelle, Kulshrestha, Richa, Geddis, Tracey, Women's experiences of sexuality after spinal cord injury: a UK perspective, Spinal Cord, 56, 1084-1094, 2018	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Todis, Bonnie, McCart, Melissa, Glang, Ann, Hospital to school transition following traumatic brain injury: A qualitative longitudinal study, NeuroRehabilitation, 42, 269-276, 2018	Study not conducted in one of the countries included in the review protocol.
Torjussen, I., In sickness and in health? The effect of ABI on couples' relationships, Brain Impairment, 13, 160-161, 2012	Conference abstract.
Toscan, Justine, Manderson, Brooke, Santi, Selena M., Stolee, Paul, "Just another fish in the pond": the transitional care experience of a hip fracture patient, International journal of integrated care, 13, e023, 2013	Case report.
Turner, B., Fleming, J., Ownsworth, T., Cornwell, P., From hospital to home: A new conceptual framework for transition-based service delivery following acquired brain injury, Neurorehabilitation and Neural Repair, 26, 686, 2012	Conference abstract.
Turner, Benjamin, Fleming, Jennifer, Ownsworth, Tamara, Cornwell, Petrea, Perceptions of recovery during the early transition phase from hospital to home following acquired brain injury: a journey of discovery, Neuropsychological rehabilitation, 21, 64-91, 2011	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Turner, Benjamin James, Fleming, Jennifer, Ownsworth, Tamara, Cornwell, Petrea, Perceived service and support needs during transition from hospital to home following acquired brain injury, Disability and Rehabilitation, 33, 818-29, 2011	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Tverdal, Cathrine Buaas, Howe, Emilie Isager, Roe, Cecilie, Helseth, Eirik, Lu, Juan, Tenovuo, Olli, Andelic, Nada, Traumatic brain injury: Patient experience and satisfaction with discharge from trauma hospital, Journal of Rehabilitation Medicine, 50, 505-513, 2018	Not a qualitative study.
Tyerman, Emma, Eccles, Fiona J. R., Gray, Victoria, The experiences of parenting a child with an acquired brain injury: A meta-synthesis of the qualitative literature, Brain Injury, 31, 1553-1563, 2017	Study did not examine rehabilitation.
Tyerman, Emma, Eccles, Fiona J. R., Gray, Victoria, Murray, Craig D., Siblings' experiences of their relationship with a brother or sister with a pediatric acquired brain injury, Disability and Rehabilitation, 41, 2940-2948, 2019	The majority of participants' siblings had not experienced traumatic injury and results not presented separately for target population.
Umeasiegbu, Veronica I., Waletich, Brittany, Whitten, Laura A., Bishop, Malachy, Abreu, Bartlett Berg Bishop Corrigan Cott Creswell Degeneffe Degeneffe deGuise Elbogen Gontkovsky Heinemann Jennekens Kreutzer Lefebvre Lehan Man Murphy O'Callaghan O'Callaghan Pickelsimer Ponsford Rotondi Sinnakaruppan Spearman Turner Vaughn, Community-based rehabilitation needs: Perceptions of individuals with brain injury and their families in the Midwestern United States, Special Issue: Family support and adjustment following acquired brain injury: An international perspective., 19, 155-163, 2013	Study not conducted in one of the countries included in the review protocol.
Unger, Janelle, Singh, Hardeep, Mansfield, Avril, Hitzig, Sander	The focus was not specific to

Study	Reason for Exclusion
L., Lenton, Erica, Musselman, Kristin E., The experiences of physical rehabilitation in individuals with spinal cord injuries: a qualitative thematic synthesis, Disability and Rehabilitation, 41, 1367-1383, 2019	participants who had experienced traumatic injury and the results not presented separately for target population.
Valizadeh, Sousan, Dadkhah, Behrouz, Mohammadi, Eissa, Hassankhani, Hadi, The perception of trauma patients from social support in adjustment to lower-limb amputation: a qualitative study, Indian journal of palliative care, 20, 229-38, 2014	Study not conducted in one of the countries included in the review protocol.
Van de Velde, Dominique, Bracke, Piet, Van Hove, Geert, Josephsson, Staffan, Devisch, Ignaas, Vanderstraeten, Guy, The illusion and the paradox of being autonomous, experiences from persons with spinal cord injury in their transition period from hospital to home, Disability and Rehabilitation, 34, 491-502, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Van de Veldea, Dominique, Bracke, Piet, Van Hove, Geert, Josephsson, Staffan, Vanderstraeten, Guy, Perceived participation, experiences from persons with spinal cord injury in their transition period from hospital to home, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 33, 346-55, 2010	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Vassallo, G., Robinson, G., Fraser, C., Fallon, D., Kirk, S., A qualitative study to investigate families' information and support needs following severe traumatic brain injury in childhood, Developmental Medicine and Child Neurology, 1), 34, 2014	Conference abstract.
Wade, S. L., Moscato, E. L., Raj, S. P., Narad, M. E., Clinician perspectives delivering telehealth interventions to children/families impacted by pediatric traumatic brain injury, Rehabilitation Psychology, 64, 298-306, 2019	Study not conducted in one of the countries included in the review protocol.
Waring, Justin, Marshall, Fiona, Bishop, Simon, Understanding the occupational and organizational boundaries to safe hospital discharge, Journal of health services research & policy, 20, 35-44, 2015	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Weatherhead, S., Calvert, P., Newby, G., Three models of group therapy in community brain injury rehabilitation, Brain Injury, 26, 430-431, 2012	Conference abstract.
Weir, N., Prescott, S., Fleming, J., Doig, E., Exploration of structured communication during client-centred goal setting with people with acquired brain injury, Brain Impairment, 19, 347-348, 2018	Conference abstract.
Wharewera-Mika, Julie, Cooper, Erana, Kool, Bridget, Pereira, Susana, Kelly, Patrick, Caregivers' voices: The experiences of caregivers of children who sustained serious accidental and non-accidental head injury in early childhood, Clinical child psychology and psychiatry, 21, 268-86, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in support needs and preferences review.
Wheatley, Alison, Bamford, Claire, Shaw, Caroline, Flynn, Elizabeth, Smith, Amy, Beyer, Fiona, Fox, Chris, Barber, Robert, Parry, Steve W., Howel, Denise, Homer, Tara, Robinson, Louise, Allan, Louise M., Developing an Intervention for Fall-Related Injuries in Dementia (DIFRID): an integrated, mixed-methods approach, BMC Geriatrics, 19, 57, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Whiteneck, G., Gassaway, J., Dijkers, M., Balance of spinal cord injury rehabilitation services provided in inpatient and postdischarge settings, Archives of Physical Medicine and	Conference abstract.

Study	Reason for Exclusion
Rehabilitation, 91, e19, 2010	
Whiteneck, G., Gassaway, J., Dijkers, M., Lammertse, D., Hammond, F., Heinemann, A., Backus, D., Charlifue, S., Ballard, P., Zanca, J., Inpatient and post-discharge rehabilitation services provided in the first year after spinal cord injury: Findings from the SCI rehab study, Topics in Spinal Cord Injury Rehabilitation, 16, 28-29, 2011	Conference abstract.
Whiteneck, Gale G., Gassaway, Julie, Dijkers, Marcel P., Lammertse, Daniel P., Hammond, Flora, Heinemann, Allen W., Backus, Deborah, Charlifue, Susan, Ballard, Pamela H., Zanca, Jeanne M., Inpatient and postdischarge rehabilitation services provided in the first year after spinal cord injury: findings from the SCIRehab Study, Archives of Physical Medicine and Rehabilitation, 92, 361-8, 2011	Study not conducted in one of the countries included in the review protocol.
Wilbanks, Susan R., Ivankova, Nataliya V., Exploring factors facilitating adults with spinal cord injury rejoining the workforce: a pilot study, Disability and Rehabilitation, 37, 739-49, 2015	Study not conducted in one of the countries included in the review protocol.
Williams, L. M., Douglas, J. M., It takes 2 to tango: The therapeutic alliance in community brain injury rehabilitation, Brain Impairment, 18, 362, 2017	Conference abstract.
Wong, A., Papadimitriou, C., Whiteneck, G., Deutsch, A., Heinemann, A., Goldsmith, A., Christopher, K., Focht, C., Lenze, E., Patient engagement in spinal cord injury rehabilitation: Patient and provider perspectives, Archives of Physical Medicine and Rehabilitation, 97, e71, 2016	Conference abstract.
Wright, Courtney J., Zeeman, Heidi, Biezaitis, Valda, Holistic Practice in Traumatic Brain Injury Rehabilitation: Perspectives of Health Practitioners, PLoS ONE, 11, e0156826, 2016	No themes examining coordination of rehabilitation and social care while transferring between inpatient and outpatient services. Included in coordination while inpatient review.
Yenikomshian, Haig A., Lerew, Tara L., Tam, Melvin, Mandell, Sam P., Honari, Shari E., Pham, Tam N., Evaluation of Burn Rounds Using Telemedicine: Perspectives from Patients, Families, and Burn Center Staff, Telemedicine journal and e-health : the official journal of the American Telemedicine Association, 25, 25-30, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Yoshida, Karen K., Self, Hazel M., Renwick, Rebecca M., Forma, Laura L., King, Audrey J., Fell, Leslie A., A value-based practice model of rehabilitation: consumers' recommendations in action, Disability and Rehabilitation, 37, 1825-33, 2015	No qualitative data on phenomena of interest.

1 **Economic studies**

2 **Table 41: Excluded economic studies and reasons for their exclusion**

Study	Reason for Exclusion
Bandyopadhyay, S., Wilkinson, I., Giokarinin-Royal, T., How incorporating 'lean' approach led to improved delivery of care and reduction in length of hospital stay, Age and Ageing, 48, 2019	Conference abstract.
Bhowaneedin, A., Smith, H., Deeley, H., Reyes Payeras, C., Keating, O., Smallbone, T., Wright, I., Sharples, P. M., What evidence is available to support the development of a regional specialist neurorehabilitation outreach service, Archives of Disease in Childhood, 104, A26-A27, 2019	Conference abstract.

Study	Reason for Exclusion
Cheung, W. H., Shen, W. Y., Dai, D. L. K., Lee, K. B., Zhu, T. Y., Wong, R. M. Y., Leung, K. S., Evaluation of a multidisciplinary rehabilitation programme for elderly patients with hip fracture: A prospective cohort study, Journal of Rehabilitation Medicine, 50, 285-291, 2018	Intervention not in PICO: Intervention group included geriatrician care in an acute hospital and a multidisciplinary rehabilitation programme after discharge from the convalescence hospital (rehabilitation service coordination was not in an inpatient setting).
Closa, Conxita, Mas, Miquel A., Santaeugenia, Sebastia J., Inzitari, Marco, Ribera, Aida, Gallofre, Miquel, Hospital-at-home Integrated Care Program for Older Patients With Orthopedic Processes: An Efficient Alternative to Usual Hospital-Based Care, Journal of the American Medical Directors Association, 18, 780-784, 2017	Comparison not in PICO: Control group are in-patients and the experimental group are out-patients.
Collins, Nina, Miller, Richard, Kapu, April, Martin, Rita, Morton, Melissa, Forrester, Mary, Atkinson, Shelley, Evans, Bethany, Wilkinson, Linda, Outcomes of adding acute care nurse practitioners to a Level I trauma service with the goal of decreased length of stay and improved physician and nursing satisfaction, The journal of trauma and acute care surgery, 76, 353-7, 2014	Intervention not in PICO: Acute care nurse practitioner (ACPN) who coordinated acute/ clinical care; only mention of "rehabilitation" was "The ACNP attended the daily discharge huddle, a team meeting that encompasses T2 [step-down care from ICU] and T3 [trauma nurse practitioner satellite service] NPs [nurse practitioner], case managers, social worker, liaisons to rehabilitation and nursing home facilities, and home health agency staff to facilitate communication and the discharge process." Only outcome reported is length of stay.
Cooper, M., Ganda, K., Palmer, A., Seibel, M. J., Cost effectiveness of a targeted intervention to reduce refracture rates: Analysis of a four year prospective controlled study, Journal of Bone and Mineral Research, 26, 2011	Conference abstract.
Farquhar, M., Lannin, N. A., Morarty, J., Functional outcomes from a specialised acquired brain injury community rehabilitation service - Evaluating a new model of care, Brain Impairment, 18, 344, 2017	Conference abstract.
Fukuda, Haruhisa, Shimizu, Sayuri, Ishizaki, Tatsuro, Has the Reform of the Japanese Healthcare Provision System Improved the Value in Healthcare? A Cost-Consequence Analysis of Organized Care for Hip Fracture Patients, PLoS ONE, 10, e0133694, 2015	Comparison not in PICO: Hip fracture care in hospitals autonomously providing integrated care across specialties versus in acute care hospitals and rehabilitative care hospitals providing organized care across separate facilities (the organisation of the care not further described).
Kapu, A., Jones, P., Financial impact of adding acute care nurse practitioners (ACNPs) to inpatient models of care, Critical Care Medicine, 40, 27, 2012	Conference abstract.
Leung, C. K., Mok, H. W., Shen, W. Y., Cheung, W. H., Leung, K. S., Evaluation of cost-effectiveness of a multidisciplinary hip	Conference abstract.

Study	Reason for Exclusion
fracture management program in Hong Kong, Osteoporosis International, 24, S597-S598, 2013	
Ling, Shi-Neng James, Kleimeyer, Christopher, Lynch, Genni, Burmeister, Elizabeth, Kennedy, Diana, Bell, Kate, Watkins, Leith, Cooke, Cameron, Can geriatric hip fractures be managed effectively within a level 1 trauma center?, Journal of Orthopaedic Trauma, 29, 160-4, 2015	Intervention not in PICO: Acute hip fracture care and not coordination of rehabilitation.
Pogoda, Terri K., Levy, Charles E., Helmick, Katherine, Pugh, Mary Jo, Health services and rehabilitation for active duty service members and veterans with mild TBI, Brain Injury, 31, 1220-1234, 2017	Narrative overview including cost considerations; not an economic evaluation.
Soong, C., Cram, P., Chezar, K., Tajammal, F., Exconde, K., Matelski, J., Sinha, S.K., Abrams, H.B., Fan-Lun, C., Fabbruzzo-Cota, C. and Backstein, D., Impact of an integrated hip fracture inpatient program on length of stay and costs, Journal of orthopaedic trauma, 30, 647-652, 2016	Inpatient setting.

Excluded studies for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

Quantitative clinical studies

Table 42: Excluded quantitative studies and reasons for their exclusion

Study	Reason for Exclusion
Adams, Annette L., Schiff, Melissa A., Koepsell, Thomas D., Rivara, Frederick P., Leroux, Brian G., Becker, Thomas M., Hedges, Jerris R., Physician consultation, multidisciplinary care, and 1-year mortality in Medicare recipients hospitalized with hip and lower extremity injuries, Journal of the American Geriatrics Society, 58, 1835-42, 2010	Outcome not in PICO: Mortality
Aitken, Mary E., Korehbandi, Patricia, Parnell, Donna, Parker, James G., Stefans, Vikki, Tompkins, Esther, Schulz, Eldon G., Experiences from the development of a comprehensive family support program for pediatric trauma and rehabilitation patients, Archives of Physical Medicine and Rehabilitation, 86, 175-9, 2005	Study design not in PICO: Non-comparative study
Albert, Steven M., Im, Ashley, Brenner, Lynda, Smith, Michael, Waxman, Richard, Effect of a social work liaison program on family caregivers to people with brain injury, The Journal of Head Trauma Rehabilitation, 17, 175-89, 2002	Study design not in PICO: Non-randomised study with less than N=100 in each arm (n=27 in intervention, n=29 in control)
Anderson, J., Mason, C., Reverse culture - How intensive care coordination eases military transitions for returning soldiers with traumatic brain injuries, Brain Injury, Conference, 2010	Published as abstract only
Anderson, J., Mason, C., Reverse culture shock - Military transitions for returning soldiers with traumatic brain injury, Journal of Head Trauma Rehabilitation, Conference, 2008	Published as abstract only
Anderson, Mary E., McDevitt, Kelly, Cumbler, Ethan, Bennett, Heather, Robison, Zachary, Gomez, Bryan, Stoneback, Jason W., Geriatric Hip Fracture Care: Fixing a Fragmented System, The Permanente journal, 21, 16-104, 2017	Population not in PICO: Patients ≥ 18 years old
Andersson, E. E., Emanuelson, I., Björklund, R., StaËšlhammar, D., Mild traumatic brain injuries: the impact of	Published as abstract only

Study	Reason for Exclusion
early intervention on late sequelae. A randomized controlled trial, Brain Injury, 26, 520-521, 2012	
Anonymous,, Trauma center boosts patient outcomes, Hospital case management : the monthly update on hospital-based care planning and critical paths, 9, 115-6, 2001	Narrative review
Asplin, G., Carlsson, G., Zidén, L., Kjellby-Wendt, G., Early coordinated rehabilitation in acute phase after hip fracture - a model for increased patient participation, BMC Geriatrics, 17, 240, 2017	Study design not in PICO: Non-randomised study with less than N=100 in each arm (n=63 in intervention, n=63 in control)
Atwal, Anita, Caldwell, Kay, Do multidisciplinary integrated care pathways improve interprofessional collaboration?, Scandinavian journal of caring sciences, 16, 360-7, 2002	Study design not in PICO: Qualitative study and audit performed before 2000
Avlund, K., Jepsen, E., Vass, M., Lundemark, H., Effects of comprehensive follow-up home visits after hospitalization on functional ability and readmissions among old patients. A randomized controlled study, Scandinavian Journal of Occupational Therapy, 9, 17-22, 2002	Study dates not in PICO: 1996-1997
Ayvazian, J., Lucente, J., Dudley-Brown, S., Clinical management of veterans with traumatic brain injury within the context of polytrauma, Journal of Head Trauma Rehabilitation, Conference, 2012	Published as abstract only
Bandyopadhyay, S., Wilkinson, I., Giokarinin-Royal, T., How incorporating 'lean' approach led to improved delivery of care and reduction in length of hospital stay, Age and Ageing, 48, 2019	Published as abstract only
Baron, Justine S., Sullivan, Katrina J., Swaine, Jillian M., Aspinall, Arlene, Jaglal, Susan, Presseau, Justin, White, Barry, Wolfe, Dalton, Grimshaw, Jeremy M., Self-management interventions for skin care in people with a spinal cord injury: part 1-a systematic review of intervention content and effectiveness, Spinal Cord, 56, 823-836, 2018	Systematic review: Included studies checked for relevance.
Baron, Justine S., Sullivan, Katrina J., Swaine, Jillian M., Aspinall, Arlene, Jaglal, Susan, Presseau, Justin, Wolfe, Dalton, Grimshaw, Jeremy M., Self-management interventions for skin care in people with a spinal cord injury: part 2-a systematic review of use of theory and quality of intervention reporting, Spinal Cord, 56, 837-846, 2018	Systematic review: Included studies checked for relevance.
Baron, Justine, Swaine, Jillian, Presseau, J., Aspinall, Arlene, Jaglal, Susan, White, Barry, Wolfe, Dalton, Grimshaw, Jeremy, Self-management interventions to improve skin care for pressure ulcer prevention in people with spinal cord injuries: a systematic review protocol, Systematic reviews, 5, 150, 2016	Published protocol for a systematic review
Bayley, M. T., Lamontagne, M. E., Kua, A., Marshall, S., Marier-Deschenes, P., Allaire, A. S., Kagan, C., Truchon, C., Janzen, S., Teasell, R., Swaine, B., Unique features of the INESSS-Onf rehabilitation guidelines for moderate to severe traumatic brain injury: Responding to users' needs, Journal of Head Trauma Rehabilitation, 33, 296-305, 2018	Results not in PICO: Guideline recommendations for moderate/severe TBI. No raw data presented. Systematic review performed as part of methodology but results and references not presented to check.
Beadle, E., Watter, K., Murray, A., Kennedy, A., The integration of telehealth into a community-based interdisciplinary brain injury service, Brain Impairment, 20, 345, 2019	Published as abstract only
Berggren, M., Karlsson, Å, Lindelöf, N., Englund, U., Olofsson, B., Nordström, P., Gustafson, Y., Stenvall, M.,	Study design not in PICO: Non-randomised study with less than

Study	Reason for Exclusion
Effects of geriatric interdisciplinary home rehabilitation on complications and readmissions after hip fracture: a randomized controlled trial, Clinical Rehabilitation, 33, 64-73, 2019	N=100 in each arm (n=106 in intervention, n=93 in control)
Bhattacharyya, R., Agrawal, Y., Elphick, H., Blundell, C., The impact of a new model of hip fracture care at a teaching hospital, Osteoporosis International, 23, S566-S567, 2012	Published as abstract only
Bhattacharyya, Rahul, Agrawal, Yuvraj, Elphick, Heather, Blundell, Chris, A unique orthogeriatric model: a step forward in improving the quality of care for hip fracture patients, International journal of surgery (London, England), 11, 1083-6, 2013	Unclear comparator: Only described as "patients remain primarily under the care of the orthopaedic teams" (p. 1084)
Bloemen-Vrencken, J. H. A., de Witte, L. P., Engels, J. P. G. M., van den Heuvel, W. J. A., Post, M. W. M., Transmural care in the rehabilitation sector: implementation experiences with a transmural care model for people with spinal cord injury, International journal of integrated care, 5, e02, 2005	Study design not in PICO: No comparison group
Bloemen-Vrencken, J. H. A., de Witte, L. P., Post, M. W. M., Follow-up care for persons with spinal cord injury living in the community: a systematic review of interventions and their evaluation, Spinal cord, 43, 462-75, 2005	Systematic review: Included studies checked for relevance.
Bogie, Kath M., Ho, Chester H., Multidisciplinary approaches to the pressure ulcer problem, Ostomy/wound management, 53, 26-32, 2007	Narrative review
Bolster, M. B., Cevallos, S., Beyer, L., Kronenberg, H. M., Leder, B., A model for improved management of fragility fractures: Navigating the fracture liaison service, Arthritis and Rheumatology, 69, 2017	Published as abstract only
Brasure, Michelle, Lamberty, Greg J., Sayer, Nina A., Nelson, Nathaniel W., Macdonald, Roderick, Ouellette, Jeannine, Wilt, Timothy J., Participation after multidisciplinary rehabilitation for moderate to severe traumatic brain injury in adults: a systematic review, Archives of physical medicine and rehabilitation, 94, 1398-420, 2013	Systematic review: Included studies checked for relevance.
Browne, Allyson L., Appleton, Sally, Fong, Kim, Wood, Fiona, Coll, Fiona, de Munck, Sonja, Newnham, Elizabeth, Schug, Stephan A., A pilot randomized controlled trial of an early multidisciplinary model to prevent disability following traumatic injury, Disability and Rehabilitation, 35, 1149-63, 2013	Population not in PICO: Patients ≥ 18 years old
Buccellato, K. H., Nordstrom, M., Murphy, J. M., Burdea, G. C., Polistico, K., House, G., Kim, N., Grampurohit, N., Sorensen, J., Isaacson, B. M., et al.,, A Randomized Feasibility Trial of a Novel, Integrative, and Intensive Virtual Rehabilitation Program for Service Members Post-Acquired Brain Injury, Military Medicine, 2019	Comparison not in PICO: Immediate (weeks 0-6) versus delayed (weeks 3-9) outpatient cognitive rehabilitation program. However, immediate versus delayed does not appear to relate to the time of discharge for the patients; same study as Buccellato 2020
Buccellato, Kiara H., Nordstrom, Michelle, Murphy, Justin M., Burdea, Grigore C., Polistico, Kevin, House, Gregory, Kim, Nam, Grampurohit, Namrata, Sorensen, Jeff, Isaacson, Brad M., Pasquina, Paul F., A Randomized Feasibility Trial of a Novel, Integrative, and Intensive Virtual Rehabilitation Program for Service Members Post-Acquired Brain Injury, Military Medicine, 185, e203-e211, 2020	Comparison not in PICO: Immediate (weeks 0-6) versus delayed (weeks 3-9) outpatient cognitive rehabilitation program. However, immediate versus delayed does not appear to relate to the time of discharge for the patients; same study as Buccellato

Study	Reason for Exclusion
	2019
Burch, D., Bernert, S., Fraser, J. F., Increased physician and physical therapist communication is associated with earlier mobility and decreased length of stay in the cerebrovascular and trauma neuroscience population, NeuroRehabilitation, 43, 195-199, 2018	Study design not in PICO: Non-randomised study with mixed population and less than N=100 in each group of population
Burch, D., Bernert, S., Fraser, J. F., Increased physician and physical therapist communication is associated with earlier mobility and decreased length of stay in the cerebrovascular and trauma neuroscience population, Stroke, 47, 2016	Published as abstract only
Burgo-Black, L., Hunt, S. C., Implementing a system of integrated post deployment care for returning combat veterans, Journal of General Internal Medicine, Conference, 2012	Published as abstract only
Burns, A., Aarabi, B., Anderson, P., Arnold, P., Brodke, D., Chiba, K., Dettori, J., Furlan, J., Harrop, J., Holly, L., Howley, S., Jeji, T., Kalsi-Ryan, S., Kotter, M., Kurpad, S., Kwon, B., Marino, R., Martin, A., Massicotte, E., Merli, G., Middleton, J., Nakashima, H., Nagoshi, N., Palmieri, K., Shamji, M., Singh, A., Skelly, A., Tetreault, L., Wilson, J., Yee, A., Fehlings, M., A clinical practice guideline for the management of patients with acute spinal cord injury: Recommendations on the type and timing of rehabilitation, Global Spine Journal, 7, 358S-359S, 2017	Published as abstract only
Calleja, Pauline, Aitken, Leanne M., Cooke, Marie L., Information transfer for multi-trauma patients on discharge from the emergency department: mixed-method narrative review, Journal of Advanced Nursing, 67, 4-18, 2011	Semi-systematic review emphasising qualitative research/analysis methods. Additionally, it focuses on trauma care and does not mention rehabilitation.
Callender, Librada, Brown, Rachel, Driver, Simon, Dahdah, Marie, Collinsworth, Ashley, Shafi, Shahid, Process for developing rehabilitation practice recommendations for individuals with traumatic brain injury, BMC neurology, 17, 54, 2017	Technical paper about how to develop an evidence-based guideline; contains no primary or secondary data.
Cameron, I. D., Handoll, H. H. G., Finnegan, T. P., Langhorne, P., Multidisciplinary rehabilitation for older people with hip fractures, Cochrane Database of Systematic Reviews, CD007125, 2008	Earlier version of Handoll 2009
Cameron, I. D., Handoll, H. H., Finnegan, T. P., Madhok, R., Langhorne, P., Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures, The Cochrane database of systematic reviews, CD000106, 2001	Earlier version of Cameron 2009
Cameron, Ian D., Coordinated multidisciplinary rehabilitation after hip fracture, Disability and rehabilitation, 27, 1081-90, 2005	Narrative review
Cameron, Ian D., Handoll, Helen Hg, Finnegan, Terence P., Madhok, Rajan, Langhorne, Peter, WITHDRAWN: Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures, The Cochrane database of systematic reviews, CD000106, 2009	Withdrawn from the Cochrane library as it has been incorporated into another review with an expended scope (Handoll 2009)
Campbell, C. V., Cooper, J., Shabir, F., Wills, E., Ong, T., An enhanced therapy service for patients with fractured neck of femur - Service evaluation of a pilot project, Age and Ageing,	Published as abstract only

Study	Reason for Exclusion
46, 2017	
Canadillas Rueda, R., Domingo Montesinos, N., Natividad Pedreno, M., Comprehensive treatment and secondary prevention of fragility fractures in the elderly in an orthogeriatric unit. Multidisciplinary management of osteoporotic patients pre and post surgery. Advantages and results, Osteoporosis International, 27, S539, 2016	Published as abstract only
Careau, Emmanuelle, Dussault, Julie, Vincent, Claude, Development of interprofessional care plans for spinal cord injury clients through videoconferencing, Journal of interprofessional care, 24, 115-8, 2010	Study design not in PICO: No comparison group
Carney, Nancy A., Petroni, Gustavo J., Lujan, Silvia B., Ballarini, Nicolas M., Faguaga, Gabriela A., du Coudray, Hugo E. M., Huddleston, Amy E., Baggio, Gloria M., Becerra, Juan M., Busso, Leonardo O., Dikmen, Sureyya S., Falcone, Roberto, Garcia, Mirta E., Gonzalez Carrillo, Osvaldo R., Medici, Paula L., Quaglino, Marta B., Randisi, Carina A., Saenz, Silvia S., Temkin, Nancy R., Vanella, Elida E., Postdischarge Care of Pediatric Traumatic Brain Injury in Argentina: A Multicenter Randomized Controlled Trial, Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies, 17, 658-66, 2016	Intervention not in PICO: Discharge support related to medical care. Study does not report on patients receiving rehabilitation or social care
Carroll, V., The Adult Patient Assessment Tool and care plan, Australian nursing journal (July 1993), 14, 29-32, 2007	Outcomes and population not in PICO: Description of the development of an assessment tool by a multi-disciplinary working group
Castillo, Renan C., Wegener, Stephen T., Newell, Mary Zadnik, Carlini, Anthony R., Bradford, Anna N., Heins, Sara E., Wysocki, Elizabeth, Pollak, Andrew N., Teter, Harry, Mackenzie, Ellen J., Improving outcomes at Level I trauma centers: an early evaluation of the Trauma Survivors Network, The journal of trauma and acute care surgery, 74, 1534-40, 2013	Intervention and comparison not in PICO: Trauma survivor network program consisting of self-management course, peer support, information access and provider training standard care versus standard care
Chang, C. B., Yang, R. S., Huang, W. J., Chan, D. C., Fracture type on the outcome of patients managed within the fracture liaison and osteoporosis medication management services, Osteoporosis International, 30, S92, 2019	Published as abstract only
Chong, Tsung Wei, Chan, Gribson, Feng, Liang, Goh, Susie, Hew, Agnes, Ng, Tze Pin, Tan, Boon Yeow, Integrated care pathway for hip fractures in a subacute rehabilitation setting, Annals of the Academy of Medicine, Singapore, 42, 579-84, 2013	Population not in PICO: Patients ≥ 18 years old
Chudyk, Anna M., Jutai, Jeffrey W., Petrella, Robert J., Speechley, Mark, Systematic review of hip fracture rehabilitation practices in the elderly, Archives of physical medicine and rehabilitation, 90, 246-62, 2009	Systematic review: Included studies checked for relevance.
Clark, J., Gill, C., Sprott, A., Joined up thinking: A model for long-term abi rehabilitation after return home, Brain Injury, 26, 432-433, 2012	Published as abstract only
Closa, Conxita, Mas, Miquel A., Santaeugenia, Sebastia J., Inzitari, Marco, Ribera, Aida, Gallofre, Miquel, Hospital-at-home Integrated Care Program for Older Patients With Orthopedic Processes: An Efficient Alternative to Usual Hospital-Based Care, Journal of the American Medical Directors Association, 18, 780-784, 2017	Study design not in PICO: Non-randomised study with less than N=100 in at least 1 intervention group

Study	Reason for Exclusion
Coetzer, Rudi, Holistic neuro-rehabilitation in the community: is identity a key issue?, Neuropsychological rehabilitation, 18, 766-83, 2008	Narrative review
Collins, Nina, Miller, Richard, Kapu, April, Martin, Rita, Morton, Melissa, Forrester, Mary, Atkinson, Shelley, Evans, Bethany, Wilkinson, Linda, Outcomes of adding acute care nurse practitioners to a Level I trauma service with the goal of decreased length of stay and improved physician and nursing satisfaction, The journal of trauma and acute care surgery, 76, 353-7, 2014	Intervention not in PICO: Acute care nurse practitioner (ACNP) who coordinated acute/ clinical care with a very brief mention of rehabilitation was "The ACNP attended the daily "discharge huddle"™ a team meeting that encompasses T2 [step-down care from ICU] and T3 [trauma nurse practitioner satellite service] NPs [nurse practitioner], case managers, social worker, liaisons to rehabilitation and nursing home facilities, and home health agency staff to facilitate communication and the discharge process." (p. 354). Only outcome reported is length of stay.
Cooper, M., Ganda, K., Palmer, A., Seibel, M. J., Cost effectiveness of a targeted intervention to reduce refracture rates: Analysis of a four year prospective controlled study, Journal of Bone and Mineral Research, 26, 2011	Published as abstract only
Cooper, M., Palmer, A., Ganda, K., Seibel, M. J., Cost-effectiveness of a targeted intervention to reduce the rate of refracture: Results ofa 4-year prospective controlled study, Osteoporosis International, 22, S651-S652, 2011	Published as abstract only
Cordasco, K. M., Saifu, H., Rubenstein, L. V., Khafaf, M., Doyle, B., Hsiao, J., Orshansky, G., Ganz, D., The ED-PACT tool: Communicating veterans' care needs after emergency department visits via electronic messages, Journal of General Internal Medicine, 32, S800, 2017	Published as abstract only
Corser, William D., Postdischarge outcome rates influenced by comorbidity and interdisciplinary collaboration, Outcomes management, 8, 45-51, 2004	Study design and population not in PICO: Non-randomised study with less than N=100 in each arm (total N=189). Unclear exactly why population admitted, but n=67 were admitted from medical cardiac services.
Crotty, M., Rowett, D., Spurling, L., Giles, L. C., Phillips, P. A., Does the addition of a pharmacist transition coordinator improve evidence-based medication management and health outcomes in older adults moving from the hospital to a long-term care facility? Results of a randomized, controlled trial, American Journal Geriatric Pharmacotherapy, 2, 257-264, 2004	Unclear population: Older people being transferred from hospital to long term care facility with no further details.
Crotty, M., Whitehead, C. H., Gray, S., Finucane, P. M., Early discharge and home rehabilitation after hip fracture achieves functional improvements: A randomized controlled trial, Clinical Rehabilitation, 16, 406-413, 2002	Study dates not in PICO: 1998-1999
Crouch, D., Taking spinal care into the community, Nursing times, 100, 24-25, 2004	Narrative review
Cuthbert, J., Anderson, J., Mason, C., Block, S., Martin, K., Dettmer, J., Weintraub, A., Harrison-Felix, C., Evaluating case management needs and impact for adults with chronic TBI, Brain Injury, 28, 706, 2014	Published as abstract only

Study	Reason for Exclusion
Davies Urizar, B., Malanga Ferrari, A., Garcia Fernandez, J. A., Martin De Francisco Murga, E., Alonso Bouzon, C., Rodriguez-Manas, L., Benefits of an orthogeriatric unit, European Geriatric Medicine, 2, S138, 2011	Published as abstract only
De Goumoens, V., Rio, L. M., Jaques, C., Ramelet, A. S., Family-oriented interventions for adults with acquired brain injury and their families: A scoping review, JBI Database of Systematic Reviews and Implementation Reports, 16, 2330-2367, 2018	Systematic review: Included studies checked for relevance.
Dibardino, D., Cohen, E. R., Didwania, A., Meta-analysis: Multidisciplinary fall prevention strategies in the acute care inpatient population, Journal of Hospital Medicine, 7, 497-503, 2012	Systematic review: Included studies checked for relevance.
Doloresco, L., CARF: symbol of rehabilitation excellence, SCI nursing : a publication of the American Association of Spinal Cord Injury Nurses, 18, 165-172, 2001	Article not available
Donohue, Kathleen, Hoevenaars, Richelle, McEachern, Jocelyn, Zeman, Erica, Mehta, Saurabh, Home-Based Multidisciplinary Rehabilitation following Hip Fracture Surgery: What Is the Evidence?, Rehabilitation research and practice, 2013, 875968, 2013	Systematic review: Included studies checked for relevance.
Dorsey, Julie, Bradshaw, Michelle, Effectiveness of Occupational Therapy Interventions for Lower-Extremity Musculoskeletal Disorders: A Systematic Review, The American journal of occupational therapy : official publication of the American Occupational Therapy Association, 71, 7101180030p1-7101180030p11, 2017	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Drago, K., Bernstein, J., Graven, P., Dobbertin, K., Eckstrom, E., Higher quality, lower cost with a geriatrics consult service, Journal of the American Geriatrics Society, 65, S36, 2017	Published as abstract only
Driessen, Julia, Bellon, Johanna E., Stevans, Joel, Forsythe, Raquel M., Reynolds, Benjamin R., James, A. Everette, 3rd, Perceived performance and impact of a non-physician-led interprofessional team in a trauma clinic setting, Journal of interprofessional care, 31, 112-114, 2017	Outcomes not in PICO: Team survey responses, consults given and new therapy referrals initiated.
Dunn, A. M., Boylston, M., Establishing a consultation service through multidisciplinary rounds, PM and R, 7, S151-S152, 2015	Published as abstract only
Dutton, Richard P., Cooper, Carnell, Jones, Alan, Leone, Susan, Kramer, Mary E., Scalea, Thomas M., Daily multidisciplinary rounds shorten length of stay for trauma patients, The Journal of trauma, 55, 913-9, 2003	Intervention not in PICO: Daily multidisciplinary rounds focused on medical care, not coordination or delivery of rehabilitation or social care.
Eicher, Vicki, Murphy, Mary Pat, Murphy, Thomas F., Malec, James F., Progress assessed with the Mayo-Portland Adaptability Inventory in 604 participants in 4 types of post-inpatient rehabilitation brain injury programs, Archives of Physical Medicine and Rehabilitation, 93, 100-7, 2012	Interventions not in PICO: 4 different rehabilitation programmes with different content, not coordination or delivery of rehabilitation or social care.
Espinoza, L., Scudder, B., Rosario, E., Patient navigation for traumatic brain injury, Journal of Head Trauma Rehabilitation, Conference, 2013	Published as abstract only
Farba, L., Cypin, I., Spesivtcev, I., The first assessment of the principles of "Co-managed care in elderly patients" in Moscow City hospital #13, Osteoporosis International, 27, S131, 2016	Published as abstract only
Faux, S., Wu, J., Harris, I., Poulos, C., Klein, L., Murray, G.,	Published as abstract only

Study	Reason for Exclusion
Wilson, S., John, E., Early rehabilitation after hospital admission for road-trauma via an in-reach mobile team; a randomised controlled trial, Archives of Physical Medicine and Rehabilitation, 97, e15-e16, 2016	
Featherall, J., Brigati, D. P., Faour, M., Messner, W., Higuera, C. A., Implementation of a Total Hip Arthroplasty Care Pathway at a High-Volume Health System: Effect on Length of Stay, Discharge Disposition, and 90-Day Complications, Journal of Arthroplasty, 33, 1675-1680, 2018	Intervention not in PICO: Hip arthroplasty care pathway, including pre-operative, peri-operative and post-operative interventions. Mention of clinical care coordinator in the post-operative section but not able to quantify what is due to care coordinator and what is attributable to other interventions.
Fernandez, M. A., Griffin, X. L., Costa, M. L., Management of hip fracture, British medical bulletin, 115, 165-72, 2015	Narrative review
Fernandez-Moyano, A., Fernandez-Ojeda, R., Ruiz-Romero, V., Garcia-Benitez, B., Palmero-Palmero, C., Aparicio-Santos, R., Comprehensive care program for elderly patients over 65 years with hip fracture, Revista clinica espanola, 214, 17-23, 2014	Length of stay and readmission data does not have enough details reported to compare results of pre-implementation group and post-implementation group (no mean or standard deviation for the before group and no statistical analysis presented). Barthel Index is only compared between those who survived and those who died during the study period.
Fiona, N., Lucinda, M., Margot, P., Gabor, M., Suzanne, M., Bernard, W., Erica, E., Sanjay, G., Implementation of re-fracture prevention of >65 year old inpatient fractured neck of femur prior to discharge, Internal Medicine Journal, 46, 10, 2016	Published as abstract only
Fitzsimmons, R. D., Brain injury case management: The potential and limitations of late-stage intervention - A pilot study, Brain Injury, 17, 947-971, 2003	Study design not in PICO: Non-randomised study with less than N=100 in each arm (total N=22)
Flikweert, E. R., Izaks, G. J., Knobben, B. A., Stevens, M., Wendt, K., The development of a comprehensive multidisciplinary care pathway for patients with a hip fracture: design and results of a clinical trial, BMC Musculoskeletal Disorders, 15, 188, 2014	Population not in PICO: Patients ≥ 18 years old
Flinn, N. A., Kelley, T., Foo, S., Medical home for persons with disabilities: A target for the triple aim, Archives of Physical Medicine and Rehabilitation, 94, e55-e56, 2013	Published as abstract only
Fojas Ma, C. M., Ing, S. W., Phieffer, L., Stephens, J., Southerland, L., Evolution of a fracture prevention program : A review of our experience at the Ohio state university, Endocrine Reviews, 37, 2016	Published as abstract only
Forni, Silvia, Pieralli, Francesca, Sergi, Alessandro, Lorini, Chiara, Bonaccorsi, Guglielmo, Vannucci, Andrea, Mortality after hip fracture in the elderly: The role of a multidisciplinary approach and time to surgery in a retrospective observational study on 23,973 patients, Archives of Gerontology and Geriatrics, 66, 13-7, 2016	Intervention not in PICO: Multi-disciplinary team designed to acutely treat hip fracture patients in order to decrease time from admission to surgery, rather than multi-disciplinary team for rehabilitation care
Franz, Shiney, Muser, Jurgen, Thielhorn, Ulrike, Wallesch, Claus W., Behrens, Johann, Inter-professional communication and interaction in the neurological	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
rehabilitation team: a literature review, Disability and Rehabilitation, 1-9, 2018	
Fukuda, Haruhisa, Shimizu, Sayuri, Ishizaki, Tatsuro, Has the Reform of the Japanese Healthcare Provision System Improved the Value in Healthcare? A Cost-Consequence Analysis of Organized Care for Hip Fracture Patients, PLoS ONE, 10, e0133694, 2015	Comparison not in PICO: Hip fracture care in hospitals autonomously providing integrated care across specialties versus in acute care hospitals and rehabilitative care hospitals providing organized care across separate facilities (the organisation of the care is not further described).
Furlan, Andrea D., Irvin, Emma, Munhall, Claire, Giraldo-Prieto, Mario, Fullerton, Laura, McMaster, Robert, Danak, Shivang, Costante, Alicia, Pitzul, Kristen, Bhide, Rohit P., Marchenko, Stanislav, Mahood, Quenby, David, Judy A., Flannery, John F., Bayley, Mark, Rehabilitation service models for people with physical and/or mental disability living in low- and middle-income countries: A systematic review, Journal of Rehabilitation Medicine, 50, 487-498, 2018	Systematic review: Included studies checked for relevance.
Gailey, Robert, Gaunaurd, Ignacio, Raya, Michele, Kirk-Sanchez, Neva, Prieto-Sanchez, Luz M., Roach, Kathryn, Effectiveness of an Evidence-Based Amputee Rehabilitation (EBAR) Program: A Pilot Randomized Controlled Trial, Physical therapy, 2020	Intervention not in PICO: Rehabilitation programme designed to occur after participants had completed physical therapy and prosthetic training.
Gjerberg, Elisabeth, Flottorp, Signe, Holte, Hilde H., 2008	Article not available
Grabljevec, Klemen, Singh, Rajiv, Denes, Zoltan, Angerova, Yvona, Nunes, Renato, Boldrini, Paolo, Delargy, Mark, Laxe, Sara, Kiekens, Carlotte, Varela Donoso, Enrique, Christodoulou, Nicolas, Evidence-based position paper on Physical and Rehabilitation Medicine professional practice for Adults with Acquired Brain Injury. The European PRM position (UEMS PRM Section), European journal of physical and rehabilitation medicine, 54, 971-979, 2018	Systematic review: Included studies checked for relevance.
Gregersen, Merete, Morch, Marianne Metz, Hougaard, Kjeld, Damsgaard, Else Marie, Geriatric intervention in elderly patients with hip fracture in an orthopedic ward, Journal of injury & violence research, 4, 45-51, 2012	Intervention not in PICO: Multi-disciplinary team designed to acutely treat hip fracture patients in order to decrease time from admission to surgery, rather than multi-disciplinary team for rehabilitation care
Grigoryan, K., Javedan, H., Rudolph, J., Ortho-geriatric models and optimal outcomes: A systematic review and meta-analysis, Journal of the American Geriatrics Society, 61, S8-S9, 2013	Published as abstract only
Grigoryan, Konstantin V., Javedan, Houman, Rudolph, James L., Orthogeriatric care models and outcomes in hip fracture patients: a systematic review and meta-analysis, Journal of Orthopaedic Trauma, 28, e49-55, 2014	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Grill, E., Ewert, T., Lipp, B., Mansmann, U., Stucki, G., Effectiveness of a community-based 3-year advisory program after acquired brain injury, European Journal of Neurology, 14, 1256-65, 2007	Mixed population: Only 310/1181 were in PICO (traumatic brain injury) but results are not presented separately for target population.
Grobe, K. F., Lin, S. J., Ababneh, A. F., Orozco, E. M., Maxey, K., Smarda, M. J., Lopez, A. R., The feasibility and effectiveness of an internet-based exercise program in individuals with spinal cord injury, Cardiopulmonary Physical Therapy Journal, 31, e16-e17, 2020	Published as abstract only

Study	Reason for Exclusion
Gupta, A., The effectiveness of geriatrician-led comprehensive hip fracture collaborative care in a new acute hip unit based in a general hospital setting in the UK, The journal of the Royal College of Physicians of Edinburgh, 44, 20-6, 2014	Intervention not in PICO: Multi-disciplinary team designed to acutely care for hip fracture patients pre- and post-operatively, rather than multi-disciplinary team for coordination of rehabilitation.
Guy, S., Kras-Dupuis, A., Wolfe, D., Hsieh, J., Walia, S., Askes, H., Spinal cord injury best practice implementation for pressure ulcer prevention: Initial implementation results, Archives of Physical Medicine and Rehabilitation, 94, e25, 2013	Published as abstract only
Haan, James M., Dutton, Richard P., Willis, Michelle, Leone, Susan, Kramer, Mary E., Scalea, Thomas M., Discharge rounds in the 80-hour workweek: importance of the trauma nurse practitioner, The Journal of trauma, 63, 339-43, 2007	Intervention not in PICO: Daily multidisciplinary rounds focused on medical care, not coordination or delivery of rehabilitation or social care.
Halbert, J., Crotty, M., Whitehead, C., Cameron, I., Kurrle, S., Graham, S., Handoll, H., Finnegan, T., Jones, T., Foley, A., Shanahan, M., Multi-disciplinary rehabilitation after hip fracture is associated with improved outcome: A systematic review, Journal of Rehabilitation Medicine, 39, 507-512, 2007	Systematic review: Included studies checked for relevance.
Hall, Erin C., Tyrrell, Rebecca L., Doyle, Karen E., Scalea, Thomas M., Stein, Deborah M., Trauma transitional care coordination: A mature system at work, The journal of trauma and acute care surgery, 84, 711-717, 2018	Population not in PICO: Patients ≥ 18 years old
Hall, Erin C., Tyrrell, Rebecca, Scalea, Thomas M., Stein, Deborah M., Trauma Transitional Care Coordination: protecting the most vulnerable trauma patients from hospital readmission, Trauma surgery & acute care open, 3, e000149, 2018	No information presented for comparison group, including number of participants.
Hammond, Flora M., Gassaway, Julie, Abeyta, Nichola, Freeman, Erma S., Primack, Donna, Kreider, Scott E. D., Whiteneck, Gale, Outcomes of social work and case management services during inpatient spinal cord injury rehabilitation: the SCIRehab project, The journal of spinal cord medicine, 35, 611-23, 2012	Study design not in PICO: No intervention.
Handoll, H. H. G., Cameron, I. D., Mak, J. C. S., Finnegan, T. P., Multidisciplinary rehabilitation for older people with hip fractures, Cochrane Database of Systematic Reviews, CD007125, 2009	Systematic review: Included studies checked for relevance.
Hart, Tessa, Brockway, Jo Ann, Maiuro, Roland D., Vaccaro, Monica, Fann, Jesse R., Mellick, David, Harrison-Felix, Cindy, Barber, Jason, Temkin, Nancy, Anger Self-Management Training for Chronic Moderate to Severe Traumatic Brain Injury: Results of a Randomized Controlled Trial, The Journal of head trauma rehabilitation, 32, 319-331, 2017	Intervention not in PICO: Treatment protocol for anger self-management training. No mention of co-ordination or delivery of rehabilitation.
Hart, Tessa, Driver, Simon, Sander, Angelle, Pappadis, Monique, Dams-O'Connor, Kristen, Bocage, Claire, Hinkens, Emma, Dahdah, Marie N., Cai, Xinsheng, Traumatic brain injury education for adult patients and families: a scoping review, Brain Injury, 32, 1295-1306, 2018	Systematic review: Included studies checked for relevance.
Hartwell, J., Albanese, K., Retterer, A., Martin, S., O'Mara, M. S., A trauma patient advocate is a valuable addition to the multidisciplinary trauma team: A process improvement project, American Surgeon, 82, S183-S185, 2016	No study results presented in paper

Study	Reason for Exclusion
He, J., Wei, Q., Effect observation of community rehabilitation model on generic set of ICF for patients with TBI, Neurorehabilitation and Neural Repair, 32, 323-324, 2018	Published as abstract only
Heinemann, A. W., Corrigan, J. D., Moore, D., Case Management for Traumatic Brain Injury Survivors with Alcohol Problems, Rehabilitation Psychology, 49, 156-166, 2004	Intervention not in PICO: Comprehensive case management for people with traumatic brain injury and post-injury substance abuse
Heppenstall, C. P., Hanger, H. C., Wilkinson, T. J., The canterbury community rehabilitation, enablement and support team (CREST) service: A novel service to support wellbeing and independence in the community, Age and Ageing, 48, 2019	Published as abstract only
Herrera-Espiñeira, C., Rodríguez del Águila Mdel, M., Navarro Espigares, J. L., Godoy Montijano, A., García Priego, A., Rodríguez, J. G., Sánchez, I. R., Effect of a telephone care program after hospital discharge from a trauma surgery unit, Gaceta sanitaria, 25, 133-138, 2011	Article in Spanish
Heyman, Noemi, Etzion, Isaac, Ben Natan, Merav, A coordination project for improvement of osteoporosis medication use among patients who sustained an osteoporotic fracture: The Israeli experience, Osteoporosis and Sarcopenia, 4, 134-139, 2018	Outcomes not in PICO: Osteoporosis medication use
Ho, W. S., Chan, H. H., Ying, S. Y., Cheng, H. S., Wong, C. S., Skin care in burn patients: A team approach, Burns, 27, 489-491, 2001	Study dates not in PICO: 1992-January 2000. Results not presented separately for the 1 month that was in PICO (January 2000)
Holliday, Anna, Samanta, Damayanti, Budinger, Julie, Hardway, Jessica, Bethea, Audis, An Outcome Analysis of Nurse Practitioners in Acute Care Trauma Services, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 24, 365-370, 2017	Intervention not in PICO: Nurse practitioners facilitated transfer throughout acute trauma services (including intensive care, floor, and post-acute clinic). Apart from placing the order for a rehabilitation consultation, there is no further mention of coordination of rehabilitation services.
Holstege, M. S., Bakkers, E., van Balen, R., Gussekloo, J., Achterberg, W. P., Caljouw, M. A., Structured scoring of supporting nursing tasks to enhance early discharge in geriatric rehabilitation: The BACK-HOME quasi-experimental study, International journal of nursing studies, 64, 13-18, 2016	Population not in PICO: Only 31% (reference) and 34% (intervention) were admitted for traumatic injury. Results not presented separately for cause of admission.
Holstege, M. S., Caljouw, M. A. A., Van Balen, R., Gussekloo, J., Achterberg, W. P., Effectiveness of innovations in geriatric rehabilitation. The SINGER Study, European Geriatric Medicine, 4, S109-S110, 2013	Published as abstract only
Hossain, M. S., Harvey, L. A., Rahman, M. A., Bowden, J. L., Islam, M. S., Taylor, V., Muldoon, S., Herbert, R. D., A pilot randomised trial of community-based care following discharge from hospital with a recent spinal cord injury in Bangladesh, Clinical Rehabilitation, 31, 781-789, 2017	Unclear population: Inclusion criteria states participants with both traumatic and non-traumatic spinal cord injury. No further information about what proportions were traumatic, and results not presented separately for target population.
Houlihan, B., Brody, M., Skeels, S., Pernigotti, D., Zazula, J., Burnett, S., Green, C., Seetharama, S., Hasiotis, S.,	Published as abstract only

Study	Reason for Exclusion
Belliveau, T., Rosenblum, D., Jette, A., RCT of peer-led phone-based empowerment intervention for persons with chronic spinal cord injury improves health self-management, Archives of Physical Medicine and Rehabilitation, 98, e152, 2017	
Houlihan, Bethlyn Vergo, Brody, Miriam, Everhart-Skeels, Sarah, Pernigotti, Diana, Burnett, Sam, Zazula, Judi, Green, Christa, Hasiotis, Stathis, Belliveau, Timothy, Seetharama, Subramani, Rosenblum, David, Jette, Alan, Randomized Trial of a Peer-Led, Telephone-Based Empowerment Intervention for Persons With Chronic Spinal Cord Injury Improves Health Self-Management, Archives of Physical Medicine and Rehabilitation, 98, 1067-1076.e1, 2017	Intervention not in PICO: 'My Care My Call' designed for people with SCI already in the community. No mention of coordination or delivery of rehabilitation or social care during transfer.
Huang, T. T., Liang, S. H., A randomized clinical trial of the effectiveness of a discharge planning intervention in hospitalized elders with hip fracture due to falling, J Clin Nurs, 14, 1193-201, 2005	Population not in PICO: Patients ≥ 18 years old
Hums, Wendy, Williams, Julianne, Dedicated trauma care unit: an outcome-based model, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 12, 21-6, 2005	Narrative review
Jaber, Ala'a F., Hartwell, Julie, Radel, Jeff D., Interventions to Address the Needs of Adults With Postconcussion Syndrome: A Systematic Review, The American journal of occupational therapy : official publication of the American Occupational Therapy Association, 73, 7301205020p1-7301205020p12, 2019	Article not available
Johansen, Inger, Lindbaek, Morten, Stanghelle, Johan K., Brekke, Mette, Structured community-based inpatient rehabilitation of older patients is better than standard primary health care rehabilitation: an open comparative study, Disability and Rehabilitation, 34, 2039-46, 2012	Study design not in PICO: Non-randomised study. Although N=100 in one of the comparison groups, patients had mixed aetiologies (for example, 16/100 had stroke)
Johnson, M. K., Yanko, J. R., Collaborative practice: a successful model, SCI nursing : a publication of the American Association of Spinal Cord Injury Nurses, 18, 7-10, 2001	Article not available
Jones, Taryn M., Dean, Catherine M., Hush, Julia M., Dear, Blake F., Titov, Nickolai, A systematic review of the efficacy of self-management programs for increasing physical activity in community-dwelling adults with acquired brain injury (ABI), Systematic reviews, 4, 51, 2015	Systematic review: Included studies checked for relevance.
Jonsson, A., Gustafson, Y., Scholl, M., Hansen, F. R., Saarela, M., Nygaard, H., Laake, K., Jonsson, P. V., Valvanne, J., Dehlin, O., Geriatric rehabilitation as an integral part of geriatric medicine in the Nordic countries, Danish Medical Bulletin, 50, 439-445, 2003	Narrative review
Kammerlander, C., Gosch, M., Blauth, M., Lechleitner, M., Luger, T. J., Roth, T., The Tyrolean Geriatric Fracture Center: an orthogeriatric co-management model, Zeitschrift fur Gerontologie und Geriatrie, 44, 363-7, 2011	Study design not in PICO: No comparison group.
Kapu, A., Jones, P., Financial impact of adding acute care nurse practitioners (ACNPs) to inpatient models of care, Critical Care Medicine, 40, 27, 2012	Published as abstract only
Karlsson, A., Berggren, M., Gustafson, Y., B, Olofsson, Lindelöf, N., Stenvall, M., Effects of geriatric interdisciplinary home rehabilitation on walking ability and length of hospital stay after hip fracture: a randomized controlled trial, Journal of the American Medical Directors Association, 17, 464.e9-	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard

Study	Reason for Exclusion
e464.e15, 2016	inpatient rehabilitation but the intervention group received Geriatric Interdisciplinary Home Rehabilitation after discharge which included a High-Intensity Functional Exercise programme and medical care.
Karlsson, A., Lindelof, N., Olofsson, B., Berggren, M., Gustafson, Y., Nordstrom, P., Stenvall, M., Effects of Geriatric Interdisciplinary Home Rehabilitation on Independence in Activities of Daily Living in Older People With Hip Fracture: A Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 2020	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard inpatient rehabilitation but the intervention group received Geriatric Interdisciplinary Home Rehabilitation after discharge which included a High-Intensity Functional Exercise programme and medical care.
Kennedy, K., Establishing an orthopaedic physiotherapy practitioner role on the wards of an acute trauma hospital, Physiotherapy (United Kingdom), 97, eS1529, 2011	Published as abstract only
Khan, F., Amatya, B., Hoffman, K., Systematic review of multidisciplinary rehabilitation in patients with multiple trauma, The British journal of surgery, 99 Suppl 1, 88-96, 2012	Systematic review: Included studies checked for relevance.
Khan, S. K., Shirley, M. D., Glennie, C., Fearon, P. V., Deehan, D. J., Achieving best practice tariff may not reflect improved survival after hip fracture treatment, Clinical Interventions in Aging, 9, 2097-2102, 2014	Intervention not in PICO: Best practice tariffs for achieving targets, but no information presented on how these were achieved so no information on coordination and delivery of rehabilitation or social care.
Khan, S. K., Weusten, A., Bonczek, S., Tate, A., Port, A., The Best Practice Tariff helps improve management of neck of femur fractures: A completed audit loop, British Journal of Hospital Medicine, 74, 644-647, 2013	Population not in PICO: Inclusion criteria includes pathological hip fractures. Results not presented separately for target population.
Kiel, S., Zimak, C., Chenot, J. F., Schmidt, C. O., Evaluation of an ambulatory geriatric rehabilitation program - results of a matched cohort study based on claims data, BMC geriatrics, 20, 30, 2020	Study design not in PICO: Case-control design
Kind, A., Polnaszek, B., Hovanes, M., Smith, M., Designation of a clinician for post-hospital follow-up care and 30-day rehospitalizations in patients discharged to nursing homes and rehabilitation facilities, Journal of the American Geriatrics Society, 61, S16, 2013	Published as abstract only
Koo, W. W. H., Hip care clinic: Improving osteoporosis treatment after a hip fracture, Osteoporosis International, 25, 609, 2014	Published as abstract only
Kooijmans, H., Post, M. W. M., Stam, H. J., van der Woude, L. H. V., Spijkerman, D. C. M., Snoek, G. J., Bongers-Janssen, H. M. H., van Koppenhagen, C. F., Twisk, J. W., Bussmann, J. B. J., Effectiveness of a Self-Management Intervention to Promote an Active Lifestyle in Persons With Long-Term Spinal Cord Injury: The HABITS Randomized Clinical Trial, Neurorehabilitation and Neural Repair, 31, 991-1004, 2017	Intervention not in PICO: Self-management intervention designed to increase physical activity in chronic SCI. No mention of coordination or delivery of rehabilitation or social care.

Study	Reason for Exclusion
Krulova, A., Vackova, J., Svestkova, O., Community-based rehabilitation system for people with acquired brain injury in the Czech Republic (from the point of view of occupational therapist), Brain Injury, 31, 852-853, 2017	Published as abstract only
Kurowski, Brad G., Taylor, H. Gerry, McNally, Kelly A., Kirkwood, Michael W., Cassedy, Amy, Horn, Paul S., Stancin, Terry, Wade, Shari L., Online Family Problem-Solving Therapy (F-PST) for Executive and Behavioral Dysfunction After Traumatic Brain Injury in Adolescents: A Randomized, Multicenter, Comparative Effectiveness Clinical Trial, The Journal of head trauma rehabilitation, 2019	Outcomes not in PICO: Behaviour Rating Inventory of Executive Function, Global Executive Composite, Behaviour Regulation Index, Metacognition Index and Strengths and Difficulties Questionnaire
Kusen, J. Q., Schafroth, B., Poblete, B., van der Vet, P. C. R., Link, B. C., Wijdicks, F. J. G., Babst, R. H., Beeres, F. J. P., The implementation of a Geriatric Fracture Centre for hip fractures to reduce mortality and morbidity: an observational study, Archives of Orthopaedic and Trauma Surgery, 139, 1705-1712, 2019	Intervention not in PICO: Not concerned with the coordination of rehabilitation services for trauma patients between inpatient and outpatient services. Included in review concerning coordination for inpatient services.
Lamb, Laura C., Montgomery, Stephanie C., Wong Won, Brian, Harder, Siobhan, Meter, Jeffrey, Feeney, James M., A multidisciplinary approach to improve the quality of care for patients with fragility fractures, Journal of orthopaedics, 14, 247-251, 2017	Intervention not in PICO: Not concerned with the coordination of rehabilitation services for trauma patients between inpatient and outpatient services. Included in review concerning coordination for inpatient services.
Lannin, Natasha, Carr, Belinda, Allaous, Jeanine, Mackenzie, Bronwyn, Falcon, Alex, Tate, Robyn, A randomized controlled trial of the effectiveness of handheld computers for improving everyday memory functioning in patients with memory impairments after acquired brain injury, Clinical Rehabilitation, 28, 470-81, 2014	Comparison not in PICO: Electronic vs non-electronic memory aid after discharge
Lathbury, K., The road ahead--managing a spinal cord injury, The Case manager, 11, 55-7, 2000	Narrative review
Latz, David, Bergermann, Anja, Jungnitsch, Jeannie, Grassmann, Jan Peter, Schiffner, Erik, Gahr, Britta, Tank, Anne, Windolf, Joachim, Ritz-Timme, Stefanie, Gras, Lilly, Jungbluth, Pascal, Characterisation of Victims Of Violence in the A & E Department and Analysis of the Acceptance of a Medico-Legal Expertise Centre After its Implementation vs. Multi-Year Consolidation, Charakterisierung unfallchirurgischer Gewaltopfer und Erfassung der Inanspruchnahme nach Implementierung und mehrjahriger Etablierung einer rechtsmedizinischen Gewaltopferambulanz., 157, 426-433, 2019	Population not in PICO: People presenting to A&E without admission
Lau, T. W., Leung, F., Siu, D., Wong, G., Luk, K. D. K., Geriatric hip fracture clinical pathway: The Hong Kong experience, Osteoporosis International, 21, S627-S636, 2010	No information presented on historical comparison group, including number of participants
Laver, Kate, Lannin, Natasha A., Bragge, Peter, Hunter, Peter, Holland, Anne E., Tavender, Emma, O'Connor, Denise, Khan, Fary, Teasell, Robert, Gruen, Russell, Organising health care services for people with an acquired brain injury: an overview of systematic reviews and randomised controlled trials, BMC health services research, 14, 397, 2014	Systematic review: Included studies checked for relevance.
Leal, J., Gray, A. M., Hawley, S., Prieto-Alhambra, D., Delmestri, A., Arden, N. K., Cooper, C., Javaid, M. K., Judge, A., Cost-Effectiveness of Orthogeriatric and Fracture Liaison	Outcomes not in PICO: 30 day mortality, 1 year mortality, risk of 2nd fracture and assorted

Study	Reason for Exclusion
Service Models of Care for Hip Fracture Patients: A Population-Based Study, Journal of Bone and Mineral Research, 32, 203-211, 2017	intervention cost measures
Leclercq, M. M., For the return at home: Mobil teams brain-injury, Annals of Physical and Rehabilitation Medicine, 57, e411, 2014	Published as abstract only
Lee, John C., Horst, Michael, Rogers, Amelia, Rogers, Frederick B., Wu, Daniel, Evans, Tracy, Edavettal, Mathew, Checklist-styled daily sign-out rounds improve hospital throughput in a major trauma center, The American surgeon, 80, 434-40, 2014	Intervention not in PICO: Checklist designed to coordinate medical care of trauma patients rather than coordination or delivery of rehabilitation or social care
Lee, S. Y., Amatya, B., Judson, R., Truesdale, M., Reinhardt, J. D., Uddin, T., Xiong, X. H., Khan, F., Clinical practice guidelines for rehabilitation in traumatic brain injury: a critical appraisal, Brain Injury, 33, 1263-1271, 2019	Review of guidelines. References checked for possible included studies - none were identified.
Lems, W. F., Dreinhofer, K. E., Bischoff-Ferrari, H., Blauth, M., Czerwinski, E., Da Silva, J., Herrera, A., Hoffmeyer, P., Kvien, T., Maalouf, G., Marsh, D., Puget, J., Puhl, W., Poor, G., Rasch, L., Roux, C., Schuler, S., Seriolo, B., Tarantino, U., Van Geel, T., Woolf, A., Wyers, C., Geusens, P., EULAR/EFORT recommendations for management of patients older than 50 years with a fragility fracture and prevention of subsequent fractures, Annals of the Rheumatic Diseases, 76, 802-810, 2017	Systematic review: Included studies checked for relevance.
Leung, Andraay Hon-Chi, Lam, Tsz-Ping, Cheung, Wing-Hoi, Chan, Tan, Sze, Pan-Ching, Lau, Thomas, Leung, Kwok-Sui, An orthogeriatric collaborative intervention program for fragility fractures: a retrospective cohort study, The Journal of trauma, 71, 1390-4, 2011	Intervention not in PICO: Orthogeriatric Collaborative Programme consisting of geriatric reviews. Aim was to optimise patient condition for surgery and to address previously undiagnosed medical problems.
Li, L., Dai, J. X., Xu, L., Huang, Z. X., Pan, Q., Zhang, X., Jiang, M. Y., Chen, Z. H., The effect of a rehabilitation nursing intervention model on improving the comprehensive health status of patients with hand burns, Burns, 43, 877-885, 2017	Intervention not in PICO: Nursing intervention involving elements of occupational therapy and psychological treatment rather than interventions comparing the coordination and/or delivery of rehabilitation or social services
Lin, Francis O. Y., Luk, James K. H., Chan, T. C., Mok, Winnie W. Y., Chan, Felix H. W., Effectiveness of a discharge planning and community support programme in preventing readmission of high-risk older patients, Hong Kong medical journal = Xianggang yi xue za zhi, 21, 208-16, 2015	Population not in PICO: Home-dwelling older patients aged >60 years admitted to the general medical wards. Only 10% admitted through falls, results not presented separately for target population.
Lin, L., Wade, C., Comprehensive prevention and management of pressure ulcers in an acute inpatient rehabilitation facility: An evidence ebased assessment, PM and R, 8, S182-S183, 2016	Published as abstract only
Lin, P. C., Wang, C. H., Chen, C. S., Liao, L. P., Kao, S. F., Wu, H. F., To evaluate the effectiveness of a discharge-planning programme for hip fracture patients, Journal of Clinical Nursing, 18, 1632-1639, 2009	Population not in PICO: Patients ≥ 18 years old
Linden, M., Hawley, C., Blackwood, B., Evans, J., Anderson, V., O'Rourke, C., Technological aids for the rehabilitation of memory and executive functioning in children and adolescents with acquired brain injury, Cochrane Database of Systematic Reviews, 2016	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
Ling, Shi-Neng James, Kleimeyer, Christopher, Lynch, Genni, Burmeister, Elizabeth, Kennedy, Diana, Bell, Kate, Watkins, Leith, Cooke, Cameron, Can geriatric hip fractures be managed effectively within a level 1 trauma center?, Journal of Orthopaedic Trauma, 29, 160-4, 2015	Intervention not in PICO: Coordination of acute management of hip fracture, rather than rehabilitation.
Lisk, R., Krasuski, M., Watters, H., Parsons, C., Yeong, K., 12 months impact of an orthopaedic early supportive discharge (OSD) team in our hip fracture service, European Geriatric Medicine, 6, S150, 2015	Published as abstract only
Liu, Vincent X., Rosas, Efren, Hwang, Judith, Cain, Eric, Foss-Durant, Anne, Clopp, Molly, Huang, Mengfei, Lee, Derrick C., Mustille, Alex, Kipnis, Patricia, Parodi, Stephen, Enhanced Recovery After Surgery Program Implementation in 2 Surgical Populations in an Integrated Health Care Delivery System, JAMA Surgery, 152, e171032, 2017	Intervention not in PICO: Enhanced recovery after surgery programme designed to impact peri-operative management and does not include rehabilitation or social care.
Lloyd-James, Lucy, Facing reality: discharge challenges after neuro-rehabilitation, Paediatric nursing, 18, 28, 2006	Narrative review
Lohse, Grant R., Leopold, Seth S., Theiler, Susan, Sayre, Cindy, Cizik, Amy, Lee, Michael J., Systems-based safety intervention: reducing falls with injury and total falls on an orthopaedic ward, The Journal of bone and joint surgery. American volume, 94, 1217-22, 2012	Population not in PICO: Mixture of traumatic and non-traumatic with results not reported separately for target population
Losh, Joseph, Duncan, Thomas K., Diaz, Graal, Lee, HyeSun, Romero, Javier, Multidisciplinary Patient Management Improves Mortality in Geriatric Trauma Patients, The American surgeon, 85, 230-233, 2019	Intervention not in PICO: Multidisciplinary medical trauma care, not rehabilitation
Lumba-Brown, A., Yeates, K. O., Sarmiento, K., Breiding, M. J., Haegerich, T. M., Gioia, G. A., Turner, M., Benzel, E. C., Suskauer, S. J., Giza, C. C., Joseph, M., Broomand, C., Weissman, B., Gordon, W., Wright, D. W., Moser, R. S., McAvoy, K., Ewing-Cobbs, L., Duhaime, A. C., Putukian, M., Holshouser, B., Paulk, D., Wade, S. L., Herring, S. A., Halstead, M., Keenan, H. T., Choe, M., Christian, C. W., Guskiewicz, K., Raksin, P. B., Gregory, A., Mucha, A., Taylor, H. G., Callahan, J. M., Dewitt, J., Collins, M. W., Kirkwood, M. W., Ragheb, J., Ellenbogen, R. G., Spinks, T. J., Ganiats, T. G., Sabelhaus, L. J., Altenhofen, K., Hoffman, R., Getchius, T., Gronseth, G., Donnell, Z., O'Connor, R. E., Timmons, S. D., Diagnosis and Management of Mild Traumatic Brain Injury in Children: A Systematic Review, JAMA Pediatrics, 172, 2018	Systematic review: Included studies checked for relevance..
Mackey, Patricia A., Rosenthal, Laura D., Mi, Lanyu, Whitaker, Michael D., Subsequent Fracture Prevention in Patients 50 Years and Older With Fragility Fractures: A Quality Improvement Initiative, Journal for healthcare quality : official publication of the National Association for Healthcare Quality, 41, 17-22, 2019	Intervention not in PICO: Osteoporosis education, screening and treatment.
Malec, J. F., Eicher, V., Murphy, M. P., Murphy, T. F., Progress assessed with the mayo-portland adaptability inventory through the client outcome system for 604 participants in four types of postacute brain injury rehabilitation programs, Brain Impairment, 12, 68, 2011	Published as abstract only
Malec, J., Eicher, V., Murphy, M. P., Murphy, T., Progress in four postacute brain rehabilitation program types compared through the MPAI-4 outcome info system, Archives of Physical Medicine and Rehabilitation, 92, 1698, 2011	Published as abstract only
Mallick, Emad, Gulihar, Abhinav, Taylor, Grahame, Furlong,	Intervention not in PICO: Project

Study	Reason for Exclusion
Andrew, Pandey, Radhakant, Impact of organisational changes on fracture neck of femur management, Annals of the Royal College of Surgeons of England, 93, 61-6, 2011	group aimed at changing surgical and medical management of hip fracture. No mention of rehabilitation.
Man, D. W., Soong, W. Y., Tam, S. F., Hui-Chan, C. W., Self-efficacy outcomes of people with brain injury in cognitive skill training using different types of trainer-trainee interaction, Brain Injury, 20, 959-970, 2006	Population not in PICO: Only 16/103 patients within PICO with results not reported separately for the target population.
Mangram, Alicia J., Shifflette, Vanessa K., Mitchell, Christopher D., Johnson, Van A., Lorenzo, Manuel, Truitt, Micheal S., Goel, Anuj, Lyons, Mark, Dunn, Ernest L., The creation of a geriatric trauma unit "G-60", The American surgeon, 77, 1144-6, 2011	Study design not in PICO: Non-randomised study with less than N=100 in 1 arm (n=150 in intervention group, n=78 in control group)
Massey, T., Smith, S., Bezzina, C., Ball, A., Specialist rehabilitation in a major trauma centre: It's not just about saving lives, Brain Injury, 28, 655, 2014	Published as abstract only
Mayo-Wilson, Evan, Grant, Sean, Burton, Jennifer, Parsons, Amanda, Underhill, Kristen, Montgomery, Paul, Preventive home visits for mortality, morbidity, and institutionalization in older adults: a systematic review and meta-analysis, PLoS ONE, 9, e89257, 2014	Systematic review: Included studies checked for relevance.
McMartin, K., Discharge planning in chronic conditions: An evidence-based analysis, Ontario Health Technology Assessment Series, 13, 1-72, 2013	Systematic review: Included studies checked for relevance.
Meaney, Mark, Divided loyalties in a brain injury case, The Case manager, 14, 30-72, 2003	Case report
Miller, Megan W., Emeny, Rebecca T., Freed, Gary L., Reduction of Hospital-acquired Pressure Injuries Using a Multidisciplinary Team Approach: A Descriptive Study, Wounds : a compendium of clinical research and practice, 31, 108-113, 2019	Population not in PICO: Hospital-wide implementation, with no separation of trauma and non-trauma patients
Mittal, Chikul, Lee, Hsien Chieh Daniel, Goh, Kiat Sern, Lau, Cheng Kiang Adrian, Tay, Leeanna, Siau, Chuin, Loh, Yik Hin, Goh, Teck Kheng Edward, Sandi, Chit Lwin, Lee, Chien Earn, ValuedCare program: a population health model for the delivery of evidence-based care across care continuum for hip fracture patients in Eastern Singapore, Journal of orthopaedic surgery and research, 13, 129, 2018	Intervention not in PICO: ValuedCare involved delivery of pre- and post-operative hip fracture care. No mention of delivery or coordination of rehabilitation or social care
Momosaki, Ryo, Kakuda, Wataru, Yamada, Naoki, Abo, Masahiro, Impact of board-certificated physiatrists on rehabilitation outcomes in elderly patients after hip fracture: An observational study using the Japan Rehabilitation Database, Geriatrics & gerontology international, 16, 963-8, 2016	Intervention not in PICO: Not concerned with the coordination of rehabilitation services for trauma patients between inpatient and outpatient services. Included in review concerning coordination for inpatient services.
Morris, D. S., Reilly, P., Rohrbach, J., Telford, G., Kim, P., Sims, C. A., The influence of unit-based nurse practitioners on hospital outcomes and readmission rates for patients with trauma, Journal of Trauma and Acute Care Surgery, 73, 474-478, 2012	Intervention not in PICO: Unit-based nurse practitioners are involved in delivering acute trauma care, not delivery and coordination of rehabilitation or social care
Murphy, R. P., Reddin, C., Murphy, E. P., Waters, R., Murphy, C. G., Canavan, M., Key Service Improvements After the Introduction of an Integrated Orthogeriatric Service, Geriatric Orthopaedic Surgery and Rehabilitation, 10, 2019	Intervention not in PICO: Integrated orthogeriatric service designed to streamline pre- and post-operative care for hip fracture. No mention of delivery or coordination of rehabilitation or social care

Study	Reason for Exclusion
Naeem, F., Rodriguez, S., MacRae, A., Implementation of an analgesia and bowels protocol to improve patient care after hip fracture, Age and Ageing, 48, 2019	Published as abstract only
Naglie, Gary, Tansey, Catherine, Kirkland, James L., Ogilvie-Harris, Darryl J., Detsky, Allan S., Etchells, Edward, Tomlinson, George, O'Rourke, Keith, Goldlist, Barry, Interdisciplinary inpatient care for elderly people with hip fracture: a randomized controlled trial, CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 167, 25-32, 2002	Study years not in PICO: 1993-1997
Nakase-Richardson, Risa, Stevens, Lillian Flores, Tang, Xinyu, Lamberty, Greg J., Sherer, Mark, Walker, William C., Pugh, Mary Jo, Eapen, Blessen C., Finn, Jacob A., Saylors, Mimi, Dillahunt-Aspillaga, Christina, Adams, Rachel Sayko, Garofano, Jeffrey S., Comparison of the VA and NIDILRR TBI Model System Cohorts, The Journal of Head Trauma Rehabilitation, 32, 221-233, 2017	Comparison not in PICO: Comparison between population characteristics of 2 databases contributing to Traumatic Brain Injury Model System
Niemeijer, Gerard C., Flikweert, Elvira, Trip, Albert, Does, Ronald J. M. M., Ahaus, Kees T. B., Boot, Anja F., Wendt, Klaus W., The usefulness of lean six sigma to the development of a clinical pathway for hip fractures, Journal of Evaluation in Clinical Practice, 19, 909-14, 2013	Intervention not in PICO: Lean Six Sigma aimed at decreasing the length of stay in hospital rather than coordinating or delivering rehabilitation
Nizamoglu, Metin, O'Connor, Edmund Fitzgerald, Bache, Sarah, Theodorakopoulou, Evgenia, Sen, Sankhya, Sherren, Peter, Barnes, David, Dziewulski, Peter, The impact of major trauma network triage systems on patients with major burns, Burns : journal of the International Society for Burn Injuries, 42, 1662-1670, 2016	Study design not in PICO: Non-RCT with less than 100 per arm
Noticewala, M. S., Swart, E., Shah, R. P., Macaulay, W., Geller, J. A., First Place Award Multidisciplinary care of the hip fracture patient: A case control analysis of differing treatment protocols, Current Orthopaedic Practice, 27, 346-350, 2016	Intervention not in PICO: Multi-disciplinary team delivering acute inpatient hip fracture care, with no mention of delivery or coordination of rehabilitation or social care
O'Keefe, Sophie, Stanley, Mandy, Adam, Kerry, Lannin, Natasha A., A Systematic Scoping Review of Work Interventions for Hospitalised Adults with an Acquired Neurological Impairment, Journal of Occupational Rehabilitation, 29, 569-584, 2019	Systematic review: Included studies checked for relevance.
Olenginski, T. P., Maloney-Saxon, G., Matzko, C. K., Mackiewicz, K., Kirchner, H. L., Bengier, A., Newman, E. D., High-risk osteoporosis clinic (HiROC): improving osteoporosis and postfracture care with an organized, programmatic approach, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 26, 801-10, 2015	Study design not in PICO: No comparison group.
O'Malley, Natasha T., Blauth, Michael, Suhm, Norbert, Kates, Stephen L., Hip fracture management, before and beyond surgery and medication: a synthesis of the evidence, Archives of orthopaedic and trauma surgery, 131, 1519-27, 2011	Systematic review: Included studies checked for relevance.
O'Mara, Michael Shaymus, Ramaniuk, Aliaksandr, Graymire, Vickie, Rozzell, Monica, Martin, Stacey, Lean methodology for performance improvement in the trauma discharge process, The journal of trauma and acute care surgery, 77, 137-142, 2014	Comparison not in PICO: Trauma vs non-trauma wards
O'Neil, Jennifer, van Ierssel, Jacquie, Sveistrup, Heidi,	Systematic review: Included studies

Study	Reason for Exclusion
Remote supervision of rehabilitation interventions for survivors of moderate or severe traumatic brain injury: A scoping review, Journal of telemedicine and telecare, 1357633X19845466, 2019	checked for relevance.
Parsons, M., Parsons, J., Pillai, A., Rouse, P., Mathieson, S., Bregmen, R., Smith, C., Kenealy, T., Post-Acute Care for Older People Following Injury: A Randomized Controlled Trial, Journal of the American Medical Directors Association, 2019	Population not in PICO: Patients ≥ 18 years old
Parsons, Matthew, Parsons, John, Pillai, Avinesh, Rouse, Paul, Mathieson, Sean, Bregmen, Rochelle, Smith, Christine, Kenealy, Tim, Post-Acute Care for Older People Following Injury: A Randomized Controlled Trial, Journal of the American Medical Directors Association, 21, 404-409.e1, 2020	Duplicate
Patrick, P. D., Allaire, J. H., Hostler, S. L., A pediatric brain injury program: Families are catalysts for change, SAGGI - Child Development and Disabilities, 29, 31-39, 2003	Article not available
Perez Santamaria, M., Dominguez Arevalo, M. J., Manso Perez Cossio, J., Peraza Sanchez, M., Outcomes of a multidisciplinary approach for the management of hip fractures in older patients. Experience in a regional hospital, Osteoporosis International, 27, S419, 2016	Published as abstract only
Pfeifer, M., Dionyssiotis, Y., Musculoskeletal Rehabilitation after Hip Fracture: A Review, Osteologie, 28, 183-191, 2019	Systematic review: Included studies checked for relevance.
Pfeifer, M., Minne, H. W., Musculoskeletal rehabilitation after hip fracture: A review, Archives of Osteoporosis, 5, 49-59, 2010	Systematic review: Included studies checked for relevance.
Phillips, V. L., Vesmarovich, S., Hauber, R., Wiggers, E., Egner, A., Telehealth: reaching out to newly injured spinal cord patients, Public health reports (Washington, D.C. : 1974), 116 Suppl 1, 94-102, 2001	Study dates not in PICO: 1998-August/September 2000. Results not presented separately for the period in PICO (January-August/September 2000)
Pils, K., Vavrovsky, G., Meisner, W., Schreiber, W., Bohmer, F., Improvement of rehabilitation outcomes of hip fractures: discharge assessment by patient care team, case management and wound healing]. [German, Wiener klinische wochenschrift, 112, 413-419, 2000	Article in German
Pioli, G., Pellicciotti, F., Davoli, M. L., Pignedoli, P., Sabetta, E., Ferrari, A., Hip fracture management and outcomes in Italy, European Geriatric Medicine, 1, 104-107, 2010	Narrative description of hip fracture care model. No presentation of data
Pope, Sue, Vickerstaff, A. L., Wareham, A. P., Lessons learned from early rehabilitation of complex trauma at the Royal Centre for Defence Medicine, Journal of the Royal Army Medical Corps, 163, 124-131, 2017	Narrative description of Royal Centre for Defence Medicine rehabilitation model. No presentation of study data.
Powell, J., Heslin, J., Greenwood, R., Community based rehabilitation after severe traumatic brain injury: a randomised controlled trial, Journal of neurology, neurosurgery, and psychiatry, 72, 193-202, 2002	Study dates not in PICO: Pre-2000
Powell, Janet M., Fraser, Robert, Brockway, Jo Ann, Temkin, Nancy, Bell, Kathleen R., A Telehealth Approach to Caregiver Self-Management Following Traumatic Brain Injury: A Randomized Controlled Trial, The Journal of head trauma rehabilitation, 31, 180-90, 2016	Intervention not in PICO: Education for caregivers of people with traumatic brain injury
Prestmo, A., Sletvold, O., Thingstad, P., Taraldsen, K., Johnsen, L. G., Helbostad, J., Saltvedt, I., Outcomes of	Published as abstract only

Study	Reason for Exclusion
activities of daily living, cognition and mobility in the Trondheim Hip Fracture Trial. A randomized controlled trial, European Geriatric Medicine, 3, S56, 2012	
Proudfoot, Suzanne, Bennett, Brandon, Duff, Simon, Palmer, Julie, Implementation and effects of Enhanced Recovery After Surgery for hip and knee replacements and fractured neck of femur in New Zealand orthopaedic services, The New Zealand medical journal, 130, 77-90, 2017	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Multi-component intervention with only 1 of 5 sections focused on discharge planning. Other areas targeted by the intervention was within the ambulance, pre-operative care, peri-operative care and post-operative care.
Prvu Bettger, Janet A., Stineman, Margaret G., Effectiveness of multidisciplinary rehabilitation services in postacute care: state-of-the-science. A review, Archives of physical medicine and rehabilitation, 88, 1526-34, 2007	Systematic review: Included studies checked for relevance.
Rae-Grant, Alex D., Turner, Aaron P., Sloan, Alicia, Miller, Deborah, Hunziker, James, Haselkorn, Jodie K., Self-management in neurological disorders: systematic review of the literature and potential interventions in multiple sclerosis care, Journal of rehabilitation research and development, 48, 1087-100, 2011	Systematic review: Included studies checked for relevance.
Rapidi, C. A., Tederko, P., Moslavac, S., Popa, D., Branco, C. A., Kiekens, C., Varela Donoso, E., Christodoulou, N., Evidence-based position paper on Physical and Rehabilitation Medicine (PRM) professional practice for persons with spinal cord injury. The European PRM position (UEMS PRM Section), European Journal of Physical and Rehabilitation Medicine, 54, 797-807, 2018	Systematic review: Included studies checked for relevance.
Reguant, F., Arnau, A., Lorente, J. V., Maestro, L., Bosch, J., Efficacy of a multidisciplinary approach on postoperative morbidity and mortality of elderly patients with hip fracture, Journal of Clinical Anesthesia, 53, 11-19, 2019	Intervention not in PICO: MDT intervention designed to optimise patient health before hip fracture surgery, rather than rehabilitation.
Reinhardt, J., Chen, S., Gosney, J., Hu, X., Li, J., Liu, S., Zhang, X., Effectiveness of a comprehensive rehabilitation services program on long-term physical functioning in injured survivors of the 2008 sichuan earthquake, PM and R, 4, S300, 2012	Published as abstract only
Rezaei, Mojtaba, Sharifi, Amirsina, Vaccaro, Alexander Richard, Rahimi-Movaghar, Vafa, Home-Based Rehabilitation Programs: Promising Field to Maximize Function of Patients with Traumatic Spinal Cord Injury, Asian journal of neurosurgery, 14, 634-640, 2019	Systematic review: Included studies checked for relevance.
Robalino, S., Nyakang'o, S. B., Beyer, F., Fox, C., Allan, L. M., Effectiveness of interventions aimed at improving physical and psychological outcomes of fall-related injuries in people with dementia a systematic review, Age and Ageing, 47, 2018	Published as abstract only
Robles, L., Slogoff, M., Ladwig-Scott, E., Zank, D., Larson, M. K., Aranha, G., Shoup, M., The addition of a nurse practitioner to an inpatient surgical team results in improved use of resources, Surgery, 150, 711-717, 2011	Population not in PICO: Surgical and colorectal patients with no distinction between trauma and non-trauma surgical patients.
Roels, E. H., Aertgeerts, B., Ramaekers, D., Peers, K., Hospital- and community-based interventions enhancing (re)employment for people with spinal cord injury: a	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
systematic review, Spinal cord, 54, 2-7, 2016	
Rosario, Emily R., Espinoza, Laura, Kaplan, Stephanie, Khonsari, Sepehr, Thurndyke, Earl, Bustos, Melissa, Vickers, Kayla, Navarro, Brittney, Scudder, Bonnie, Patient navigation for traumatic brain injury promotes community re-integration and reduces re-hospitalizations, Brain Injury, 31, 1340-1347, 2017	Study design not in PICO: Non-RCT with less than 100 per arm.
Rothman, E. F., Cohort study: Violent reinjury and mortality highlights the need for a comprehensive care approach to youth presenting for assault-related injury, Evidence-Based Medicine, 20, 112, 2015	Setting not in PICO: Emergency department
Ruggiero, C., Zampi, E., Baroni, M., Mecocci, P., Rinonapoli, G., Caraffa, A., Conti, F., Brandi, M. L., The fracture unit to bridge the osteoporosis care gap in Italy, Osteoporosis International, 25, S365, 2014	Published as abstract only
Ryan, T., Enderby, P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age, Clinical Rehabilitation, 20, 123-131, 2006	Population not in PICO: Patients ≥ 18 years old
Ryan, T., Enderby, P., Rigby, A. S., A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age: results at 12-month followup, International journal on disability and human development, 5, 83-89, 2006	Population not in PICO: Patients ≥ 18 years old
Rypkema, G., Adang, E., Dicke, H., Naber, T., De Swart, B., Disselhorst, L., Goluke-Willemse, G., Rikkert, M. O., Cost-effectiveness of an interdisciplinary intervention in geriatric inpatients to prevent malnutrition, Journal of Nutrition, Health and Aging, 8, 122-127, 2004	Unclear population: All non-terminally ill geriatric patients admitted for more than 2 days. Study does not report reason for admission.
Rytter, H. M., Westenbaek, K., Henriksen, H., Christiansen, P., Humle, F., Specialized interdisciplinary rehabilitation reduces persistent post-concussive symptoms: a randomized clinical trial, Brain Injury, 33, 266-281, 2019	Population not in PICO: People in the general population with post-concussive syndrome. Attended A&E but not admitted.
Saha, Sumit, DiRusso, Stephen M., Welle, Scott, Lieberman, Benjamin, Sender, Joel, Shabsigh, Ridwan, Baltazar, Gerard A., Integration of Geriatrician Consultation for Trauma Admissions May Benefit Patient Outcomes, Gerontology & geriatric medicine, 5, 2333721419858735, 2019	Intervention not in PICO: Geriatrician consultation for trauma patients upon admission to trauma centre if above 65 years old. No mention of coordination or delivery of rehabilitation.
Saltvedt, Ingvild, Prestmo, Anders, Einarsen, Elin, Johnsen, Lars Gunnar, Helbostad, Jorunn L., Sletvold, Olav, Development and delivery of patient treatment in the Trondheim Hip Fracture Trial. A new geriatric in-hospital pathway for elderly patients with hip fracture, BMC research notes, 5, 355, 2012	No study results presented in paper
Sander, Beate, Elliot-Gibson, Victoria, Beaton, Dorcas E., Bogoch, Earl R., Maetzel, Andreas, A coordinator program in post-fracture osteoporosis management improves outcomes and saves costs, The Journal of bone and joint surgery. American volume, 90, 1197-205, 2008	Intervention not in PICO: Coordination of osteoporosis treatment after fragility fracture
Savage, R., Camejo, M., Kramer, S., Jeanne Lozada, A., McAllister, T., Mensah, N., Romanelli, L., Sanchez, L., Schneider, L., Donohue, P., Does multidisciplinary and intense rehabilitation in a post-acute brain injury school produce positive outcomes?, Journal of Head Trauma Rehabilitation, 32, E87, 2017	Published as abstract only

Study	Reason for Exclusion
Sayer, J., Quality improvement-fracture liaison service development, Osteoporosis International, 27, S557, 2016	Published as abstract only
Schneider, Kathryn J., Leddy, John J., Guskiewicz, Kevin M., Seifert, Tad, McCrea, Michael, Silverberg, Noah D., Feddermann-Demont, Nina, Iverson, Grant L., Hayden, Alix, Makdissi, Michael, Rest and treatment/rehabilitation following sport-related concussion: a systematic review, British journal of sports medicine, 51, 930-934, 2017	Systematic review: Included studies checked for relevance.
Semerano, Luca, Guillot, Xavier, Rossini, Maurizio, Avice, Evelyne, Begue, Thierry, Wargon, Mathias, Boissier, Marie-Christophe, Saidenberg-Kermanac'h, Nathalie, What predicts initiation of osteoporosis treatment after fractures: education organisation or patients' characteristics?, Clinical and Experimental Rheumatology, 29, 89-92, 2011	Intervention not in PICO: Patient osteoporosis education and organisation of osteoporosis care
Sen, A., Xiao, Y., Lee, S. A., Dutton, R., Scalea, T., Multidisciplinary discharge rounds may reduce ED overcrowding by facilitating hospital throughput, Academic Emergency Medicine, 17, S98-S99, 2010	Published as abstract only
Serghiou, Michael A., Holmes, Christina L., McCauley, Robert L., A survey of current rehabilitation trends for burn injuries to the head and neck, The Journal of burn care & rehabilitation, 25, 514-8, 2004	Study design not in PICO: Survey of burn rehabilitation providers (N=100)
Shahrokhi, Akram, Azimian, Jalil, Amouzegar, Atousa, Oveisi, Sonia, Effect of Telenursing on Outcomes of Provided Care by Caregivers of Patients With Head Trauma After Discharge, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 25, 21-25, 2018	Intervention not in PICO: Weekly telephone calls to caregivers of people with head injury to discuss health status and possible issues. No mention of rehabilitation.
Shahrokhi, Akram, Azimian, Jalil, Amouzegar, Atousa, Oveisi, Sonia, The Effect of Telenursing on Referral Rates of Patients With Head Trauma and Their Family's Satisfaction After Discharge, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 25, 248-253, 2018	Intervention not in PICO: Checklist teleheath intervention with no questions about rehabilitation
Shaw, W., Hong, Q. N., Pransky, G., Loisel, P., A literature review describing the role of return-to-work coordinators in trial programs and interventions designed to prevent workplace disability, Journal of Occupational Rehabilitation, 18, 2-15, 2008	Systematic review: Included studies checked for relevance.
Shepperd, S., Lannin, N. A., Clemson, L. M., McCluskey, A., Cameron, I. D., Barras, S. L., Discharge planning from hospital to home, Cochrane Database of Systematic Reviews, 2013, CD000313, 2013	Systematic review: Included studies checked for relevance.
Shingleton, S. K., Salinas, R. D., Aden, J. K., Berry, P. A., Palmer, C. R., Russe, C. S., Trichel, R. M., Melvin, J. J., King, B. T., Wound care team effectiveness on patient care efficiency and quality, Journal of Burn Care and Research, 37, S74, 2016	Published as abstract only
Shyu, Y. I. L., Liang, J., Wu, C. C., Su, J. Y., Cheng, H. S., Chou, S. W., Chen, M. C., Yang, C. T., Interdisciplinary intervention for hip fracture in older Taiwanese: Benefits last for 1 year, Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 63, 92-97, 2008	Follow-up data from Shyu 2005 study, which is excluded
Shyu, Y. I., Liang, J., Wu, C. C., Su, J. Y., Cheng, H. S., Chou, S. W., Yang, C. T., A pilot investigation of the short-term effects of an interdisciplinary intervention program on elderly patients with hip fracture in Taiwan, Journal of the American Geriatrics Society, 53, 811-818, 2005	Intervention/comparison not in PICO: Multidisciplinary rehabilitation program consisting of systemic interdisciplinary involvement, geriatric assessment,

Study	Reason for Exclusion
	in-patient and in-home rehabilitation and discharge planning versus standard care that differed on most of these components, not just the coordination/delivery components
Siefferman, J., Ambrose, A. F., Lin, E., Improving patient handoff for acute rehabilitation admission, PM and R, 3, S320, 2011	Published as abstract only
Singh, Nalin A., Quine, Susan, Clemson, Lindy M., Williams, Elodie J., Williamson, Dominique A., Stavrinos, Theodora M., Grady, Jodie N., Perry, Tania J., Lloyd, Bradley D., Smith, Emma U. R., Singh, Maria A. Fiatarone, Effects of high-intensity progressive resistance training and targeted multidisciplinary treatment of frailty on mortality and nursing home admissions after hip fracture: a randomized controlled trial, Journal of the American Medical Directors Association, 13, 24-30, 2012	Intervention not in PICO: High intensity progressive resistance training
Singler, K., Biber, R., Wicklein, S., Heppner, H. J., Sieber, C. C., Bail, H. J., "N-active": A new comanaged, orthogeriatric ward: Observations and prospects, Zeitschrift fur Gerontologie und Geriatrie, 44, 2011	Narrative description of implementation of orthogeriatric ward. Only data presented is non-comparative.
Soong, Christine, Cram, Peter, Chezar, Ksenia, Tajammal, Faiqa, Exconde, Kathleen, Matelski, John, Sinha, Samir K., Abrams, Howard B., Fan-Lun, Christopher, Fabbruzzo-Cota, Christina, Backstein, David, Bell, Chaim M., Impact of an Integrated Hip Fracture Inpatient Program on Length of Stay and Costs, Journal of Orthopaedic Trauma, 30, 647-652, 2016	Population not in PICO: Patients ≥ 18 years old
Spiliotopoulou, Georgia, Atwal, Anita, Is occupational therapy practice for older adults with lower limb amputations evidence-based? A systematic review, Prosthetics and orthotics international, 36, 7-14, 2012	Systematic review: Included studies checked for relevance.
Stenvall, Michael, Olofsson, Birgitta, Nyberg, Lars, Lundstrom, Maria, Gustafson, Yngve, Improved performance in activities of daily living and mobility after a multidisciplinary postoperative rehabilitation in older people with femoral neck fracture: a randomized controlled trial with 1-year follow-up, Journal of rehabilitation medicine, 39, 232-8, 2007	Population not in PICO: Patients ≥ 18 years old
Stubbs, Kendra E., Sikes, Lindsay, Interdisciplinary Approach to Fall Prevention in a High-Risk Inpatient Pediatric Population: Quality Improvement Project, Physical therapy, 97, 97-104, 2017	Outcome not in PICO - Fall rates
Talevski, Jason, Sanders, Kerrie M., Duque, Gustavo, Connaughton, Catherine, Beauchamp, Alison, Green, Darci, Millar, Lynne, Brennan-Olsen, Sharon L., Effect of Clinical Care Pathways on Quality of Life and Physical Function After Fragility Fracture: A Meta-analysis, Journal of the American Medical Directors Association, 20, 926.e1-926.e11, 2019	Systematic review. Included studies checked for relevance. Stenvall 2007 was identified as a relevant study and has been included.
Tan, T., Molina, J. D., Lim, Y., Dharmawan, A., Teo, A., Soon, M., Frailty ready inpatient care-interim findings from an integrated, comprehensive geriatric programme, Journal of the American Geriatrics Society, 67, S92-S93, 2019	Published as abstract only
Taraldsen, K., Sletvold, O., Thingstad, P., Saltvedt, I., Granat, M. H., Lydersen, S., Helbostad, J. L., Physical behavior and function early after hip fracture surgery in patients receiving comprehensive geriatric care or orthopedic care--a randomized controlled trial, Journals of gerontology.	Intervention not in PICO: Comprehensive geriatric care with an element of discharge planning and early mobilisation but focus appears to be on short-term post-

Study	Reason for Exclusion
Series A, Biological sciences and medical sciences, 69, 338-345, 2014	operative outcomes with treatment of co-morbidities and acute care rather than delivery or coordination of rehabilitation or social care.
Torres, Audrey, Kunishige, Nalani, Morimoto, Denise, Hanzawa, Tracie, Ebesu, Mike, Fernandez, John, Nohara, Lynne, SanAgustin, Eliseo, Borg, Stephanie, Shared governance: a way to improve the care in an inpatient rehabilitation facility, Rehabilitation nursing : the official journal of the Association of Rehabilitation Nurses, 40, 69-73, 2015	Outcomes not in PICO: Mentions improved patient outcomes but no presentation of data
Tran, V., Lam, M. K., Amon, K. L., Brunner, M., Hines, M., Penman, M., Lowe, R., Togher, L., Interdisciplinary eHealth for the care of people living with traumatic brain injury: A systematic review, Brain Injury, 31, 1701-1710, 2017	Systematic review: Included studies checked for relevance.
Tricco, Andrea C., Thomas, Sonia M., Veroniki, Areti Angeliki, Hamid, Jemila S., Cogo, Elise, Strifler, Lisa, Khan, Paul A., Robson, Reid, Sibley, Kathryn M., MacDonald, Heather, Riva, John J., Thavorn, Kednapa, Wilson, Charlotte, Holroyd-Leduc, Jayna, Kerr, Gillian D., Feldman, Fabio, Majumdar, Sumit R., Jaglal, Susan B., Hui, Wing, Straus, Sharon E., Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis, JAMA, 318, 1687-1699, 2017	Systematic review: Included studies checked for relevance.
Truchon, C., Moore, L., Belcaid, A., Clement, J., Trudelle, N., Ulysse, M. A., Grolleau, B., Clusiau, J., Levesque, D., De Guise, M., Shaping quality through vision, structure, and monitoring of performance and quality indicators: Impact story from the Quebec trauma network, International Journal of Technology Assessment in Health Care, 33, 415-419, 2017	Narrative description of Quebec Trauma Network and its set-up. No data presented apart from brief mention of mortality data.
Tseng, M. Y., Liang, J., Wang, J. S., Yang, C. T., Wu, C. C., Cheng, H. S., Chen, C. Y., Lin, Y. E., Wang, W. S., Shyu, Y. I. L., Effects of a diabetes-specific care model for hip fractured older patients with diabetes: A randomized controlled trial, Experimental Gerontology, 126, 110689, 2019	Comparison not in PICO: Groups received different treatment rather than same rehabilitation delivered or coordinated in different ways. Both groups received standard rehabilitation while inpatients but the intervention group also received in-home rehabilitation for 4 months after hospital discharge and diabetes-specific education and rehabilitation for up to 12 months after hospital discharge.
Tung, James Y., Stead, Brent, Mann, William, Ba'Pham,, Popovic, Milos R., Assistive technologies for self-managed pressure ulcer prevention in spinal cord injury: a scoping review, Journal of Rehabilitation Research and Development, 52, 131-46, 2015	Scoping review: Included studies checked for relevance.
Turner, Benjamin J., Fleming, Jennifer M., Ownsworth, Tamara L., Cornwell, Petrea L., The transition from hospital to home for individuals with acquired brain injury: A literature review and research recommendations, Disability and rehabilitation, 30, 1153-1176, 2008	Systematic review: Included studies checked for relevance.
Turner-Stokes, L., Disler, P. B., Nair, A., Wade, D. T., Multi-disciplinary rehabilitation for acquired brain injury in adults of working age, The Cochrane database of systematic reviews, CD004170, 2005	Systematic review: Included studies checked for relevance.

Study	Reason for Exclusion
Turner-Stokes, Lynne, Evidence for the effectiveness of multi-disciplinary rehabilitation following acquired brain injury: a synthesis of two systematic approaches, Journal of rehabilitation medicine, 40, 691-701, 2008	Systematic review: Included studies checked for relevance.
Turner-Stokes, Lynne, Pick, Anton, Nair, Ajoy, Disler, Peter B., Wade, Derick T., Multi-disciplinary rehabilitation for acquired brain injury in adults of working age, The Cochrane database of systematic reviews, CD004170, 2015	Systematic review: Included studies checked for relevance.
Vaughn, S. L., King, A., A survey of state programs to finance rehabilitation and community services for individuals with brain injury, The Journal of head trauma rehabilitation, 16, 20-33, 2001	Study design not in PICO: Survey of state-funded programs for persons with traumatic brain injury.
Vidan, Maite, Serra, Jose A., Moreno, Concepcion, Riquelme, Gerardo, Ortiz, Javier, Efficacy of a comprehensive geriatric intervention in older patients hospitalized for hip fracture: a randomized, controlled trial, Journal of the American Geriatrics Society, 53, 1476-82, 2005	Study dates not in PICO: 1997
Vikane, E., Hellstrom, T., Roe, C., Bautz-Holter, E., Assmus, J., Skouen, J. S., Efficacy of a multidisciplinary outpatient treatment for patients with mild traumatic brain injury: A randomized controlled intervention trial, Brain Injury, 30, 617, 2016	Published as abstract only
Vikane, E., Hellstrom, T., Roe, C., Bautz-Holter, E., Assmus, J., Skouen, J. S., Multidisciplinary outpatient treatment in patients with mild traumatic brain injury: A randomised controlled intervention study, Brain Injury, 31, 475-484, 2017	Population not in PICO: Patients ≥ 18 years old
Ward, D., Drahota, A., Gal, D., Severs, M., Dean, T. P., Care home versus hospital and own home environments for rehabilitation of older people, Cochrane Database of Systematic Reviews, 2008	Systematic review: Included studies checked for relevance.
Webster, J., Kim, J. H., Hawley, C., Barbir, L., Barton, S., Young, C., Development, implementation, and outcomes of a residential vocational rehabilitation program for injured Service members and Veterans, Journal of Vocational Rehabilitation, 48, 111-126, 2018	Study design not in PICO: No comparison group
Wegener, Stephen T., Mackenzie, Ellen J., Ephraim, Patti, Ehde, Dawn, Williams, Rhonda, Self-management improves outcomes in persons with limb loss, Archives of Physical Medicine and Rehabilitation, 90, 373-80, 2009	Population not in PICO: Mixed population with <40% in PICO and results not reported separately for target population
Wiechman, Shelley A., Carrougher, Gretchen J., Esselman, Peter C., Klein, Matthew B., Martinez, Erin M., Engrav, Loren H., Gibran, Nicole S., An expanded delivery model for outpatient burn rehabilitation, Journal of burn care & research : official publication of the American Burn Association, 36, 14-22, 2015	Population not in PICO: Patients ≥ 18 years old
Westgard, T., Ottenvall Hammar, I., Holmgren, E., Ehrenberg, A., Wisten, A., Ekdahl, A. W., Dahlin-Ivanoff, S., Wilhelmson, K., Comprehensive geriatric assessment pilot of a randomized control study in a Swedish acute hospital: A feasibility study, Pilot and Feasibility Studies, 4, 41, 2018	Unclear population: Frail adults over 75 years who required an acute hospital admission. No information presented on traumatic or non-trauma causes.
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Angere, D., Klein, M. B., Gibran, N. S., A randomized controlled trial to test an expanded delivery model for patients with burn injuries, Journal of burn care & research, 35, S79-, 2014	Published as abstract only

Study	Reason for Exclusion
Winograd, A., Squirrell, T., Winters, B., The promise of progress: Co-ordinating interdisciplinary neuro-restorative care transitions, Brain Injury, 28, 775-776, 2014	Published as abstract only
Wu, Jane, Faux, Steven G., Harris, Ian, Poulos, Christopher J., Integration of trauma and rehabilitation services is the answer to more cost-effective care, ANZ journal of surgery, 86, 900-904, 2016	Comparison not in PICO: Delivery of rehabilitation in the trauma admission hospital versus rehabilitation in an external rehabilitation service. No details reported about what rehabilitation the patients received in either facility (and no data on any coordination or delivery aspects of the rehabilitation).
Young, T., Andreas, N., Howard-Brown, C., Enhancing early engagement for transitions to community, Brain Impairment, 20, 374-375, 2019	Published as abstract only
Zatzick, D. F., Roy-Byrne, P., Russo, J. E., Rivara, F. P., Koike, A., Jurkovich, G. J., Katon, W., Collaborative interventions for physically injured trauma survivors: a pilot randomized effectiveness trial, General Hospital Psychiatry, 23, 114-23, 2001	Intervention and comparison not in PICO: Collaborative care intervention consisting of counselling, consultation with surgical and primary care providers and attempted post-discharge coordination versus standard care that differed on all these components, not just the coordination/delivery components. Unclear if study period (years) within PICO
Zatzick, D., Russo, J., Thomas, P., Darnell, D., Teter, H., Ingraham, L., Whiteside, L. K., Wang, J., Guiney, R., Parker, L., Sandgren, K., Hedrick, M. K., Van Eaton, E. G., Jurkovich, G., Patient-Centered Care Transitions After Injury Hospitalization: A Comparative Effectiveness Trial, Psychiatry (New York), 81, 141-157, 2018	Population not in PICO: Patients had to be admitted to an inpatient surgical ward or emergency department for at least 24 hours i.e. not all admitted to hospital. Results are not presented separately.
Zhang, Ming, Effect of HBM Rehabilitation Exercises on Depression, Anxiety and Health Belief in Elderly Patients with Osteoporotic Fracture, Psychiatria Danubina, 29, 466-472, 2017	Outcomes not in PICO : Anxiety, depression, osteoporosis knowledge, and osteoporosis health belief
Zhang, Xia, Reinhardt, Jan D., Gosney, James E., Li, Jianan, The NHV rehabilitation services program improves long-term physical functioning in survivors of the 2008 Sichuan earthquake: a longitudinal quasi experiment, PLoS ONE, 8, e53995, 2013	Intervention and comparison not in PICO: NHV is a complete rehabilitation programme (consisting of NGOs, health department and volunteers) implemented after the Sichuan earthquake. Comparisons are early-NHV, late-NHV, no NHV.
Zhao, Y. R., Liang, X., Yang, T. Y., Liu, Y., Prospective case-control study on comprehensive treatment for elderly hip fractures, Zhongguo gu shang [China journal of orthopaedics and traumatology], 27, 570-574, 2014	Article in Chinese
Zidén, L., Frändin, K., Kreuter, M., Home rehabilitation after hip fracture. A randomized controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008	Intervention and comparison not in PICO: Multidisciplinary geriatric rehabilitation home program focused on supported discharge, independence in daily activities, and enhancing physical activity versus standard care with no

Study	Reason for Exclusion
	structured rehabilitation after discharge. Interventions differed on most of these components, not just the coordination/delivery components
Ziden, Lena, Frandin, Kerstin, Kreuter, Margareta, Home rehabilitation after hip fracture. A randomized controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008	Duplicate

1 Qualitative clinical studies

2 Table 43: Excluded qualitative studies and reasons for their exclusion

Study	Reason for Exclusion
Abrahamson, Vanessa, Jensen, Jan, Springett, Kate, Sakel, Mohamed, Experiences of patients with traumatic brain injury and their carers during transition from in-patient rehabilitation to the community: a qualitative study, Disability and rehabilitation, 39, 1683-1694, 2017	No qualitative data on phenomena of interest.
Adams, Deana, Dahdah, Marie, Coping and adaptive strategies of traumatic brain injury survivors and primary caregivers, NeuroRehabilitation, 39, 223-37, 2016	Study not conducted in one of the countries included in the review protocol.
Adams, R. D. F., Cole, E., Brundage, S. I., Morrison, Z., Jansen, J. O., Beliefs and expectations of rural hospital practitioners towards a developing trauma system: A qualitative case study, Injury, 49, 1070-1078, 2018	No qualitative data on phenomena of interest.
Aitken, Leanne M., Chaboyer, Wendy, Jeffrey, Carol, Martin, Bronte, Whitty, Jennifer A., Schuetz, Michael, Richmond, Therese S., Indicators of injury recovery identified by patients, family members and clinicians, Injury, 47, 2655-2663, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Albrecht, Jennifer S., O'Hara, Lyndsay M., Moser, Kara A., Mullins, C. Daniel, Rao, Vani, Perception of Barriers to the Diagnosis and Receipt of Treatment for Neuropsychiatric Disturbances After Traumatic Brain Injury, Archives of Physical Medicine and Rehabilitation, 98, 2548-2552, 2017	Study not conducted in one of the countries included in the review protocol.
Alston, Margaret, Jones, Jennifer, Curtin, Michael, Alston, Bartky Blais Bourdieu Bourdieu Brookshire Butler Callaway Connell Cunningham Curtin Degeneffe Fine Foucault Graham Gwyn Howes Jones Kirkness Lupton Mukherjee O'Rance Ponsford Rees Reichard Reidpath Shildrick Slewa-Younan, Women and traumatic brain injury: "It's not visible damage", Australian Social Work, 65, 39-53, 2012	No qualitative data on phenomena of interest.
Ammons, L. L., Harraghy, R. L., Medlin, H. J., Faku, C. T., Shupp, J. W., Flanagan, K. E., Jeng, J. C., Fidler, P., Sava, J. A., Jordan, M. H., Assessing the utility of nurse-driven post-discharge telephone calls, Journal of Burn Care and Research, 32, S153, 2011	Conference abstract
Andersson, Kerstin, Bellon, Michelle, Walker, Ruth, Parents' experiences of their child's return to school following acquired brain injury (ABI): A systematic review of qualitative studies, Brain Injury, 30, 829-38, 2016	No findings or themes related to phenomena of interest. Included studies were checked for relevance.
Angel, Sanne, Kirkevold, Marit, Pedersen, Birthe D., Rehabilitation after spinal cord injury and the influence of the professional's support (or lack thereof), Journal of Clinical Nursing, 20, 1713-22, 2011	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehab

Study	Reason for Exclusion
	following discharge.
Arbour-Nicitopoulos, K. P., Lamontagne, M. E., Tomasone, J., Pila, E., Cumming, I., Latimer-Cheung, A. E., Routhier, F., Why do I stick to the program? a qualitative analysis of the determinants of adherence to community-based physical activity support programs by persons with SCI and contrast with general population with disabilities, Journal of Spinal Cord Medicine, 37, 626, 2014	Conference abstract.
Armstrong, E., Missing voices: Aboriginal stories of stroke and traumatic brain injury, International Journal of Stroke, 12, 14, 2017	Conference abstract.
Armstrong, Elizabeth, Coffin, Juli, Hersh, Deborah, Katzenellenbogen, Judith M., Thompson, Sandra C., Ciccone, Natalie, Flicker, Leon, Woods, Deborah, Hayward, Colleen, Dowell, Catelyn, McAllister, Meaghan, "You felt like a prisoner in your own self, trapped": the experiences of Aboriginal people with acquired communication disorders, Disability and Rehabilitation, 1-14, 2019	The majority of participants had not experienced traumatic injury and the results not reported separately for the target population.
Armstrong, Elizabeth, Coffin, Juli, McAllister, Meaghan, Hersh, Deborah, Katzenellenbogen, Judith M., Thompson, Sandra C., Ciccone, Natalie, Flicker, Leon, Cross, Natasha, Arabi, Linda, Woods, Deborah, Hayward, Colleen, Alway, Armstrong Armstrong Baxter Blackmer Bohanna Bronfenbrenner Chase Coffin Creswell Elder Feigin Foster Gauld Gauthier Hines Jamieson Katzenellenbogen Katzenellenbogen Katzenellenbogen Keightley Kelly Kelly Lakhani Lewis Linton McDonald McKenna O'Reilly Olver Ponsford Rutland-Brown Salas Sandelowski Taylor Togher, 'I've got to row the boat on my own, more or less': Aboriginal Australian experiences of traumatic brain injury, Brain Impairment, 20, 120-136, 2019	No qualitative data on phenomena of interest.
Arshad, Sira N., Gaskell, Sarah L., Baker, Charlotte, Ellis, Nicola, Potts, Jennie, Coucill, Theresa, Ryan, Lynn, Smith, Jan, Nixon, Anna, Greaves, Kate, Monk, Rebecca, Shelmerdine, Teresa, Leach, Alison, Shah, Mamta, Measuring the impact of a burns school reintegration programme on the time taken to return to school: A multi-disciplinary team intervention for children returning to school after a significant burn injury, Burns : journal of the International Society for Burn Injuries, 41, 727-34, 2015	No qualitative data on phenomena of interest.
Ayer, Lynsay, Farris, Coreen, Farmer, Carrie M., Geyer, Lily, Barnes-Proby, Dionne, Ryan, Gery W., Skrabala, Lauren, Scharf, Deborah M., Care Transitions to and from the National Intrepid Center of Excellence (NICoE) for Service Members with Traumatic Brain Injury, Rand health quarterly, 5, 12, 2015	Study not conducted in one of the countries included in the review protocol.
Badger, Karen, Royse, David, Adult burn survivors' views of peer support: a qualitative study, Social Work in Health Care, 49, 299-313, 2010	Study not conducted in one of the countries included in the review protocol.
Balcazar, Fabricio E., Kelly, Erin Hayes, Keys, Christopher B., Balfanz-Vertiz, Kristin, Albrecht, Alston Balcazar Balcazar Block Boschen Burnett Cressy Devlieger Devlieger Dijkers Dijkers Engstrom Gill Groce Haskell Hayes Hernandez Hernandez Hibbard Jackson Kroll Ljungberg McDonald McKinley Ostrander Richards Rovinsky Sable Servan Sherman Veith Waters Waters Waters Whiteneck Wilson Wilson, Using peer mentoring to support the rehabilitation of individuals with violently acquired spinal cord injuries, Journal of Applied Rehabilitation Counseling, 42, 3-11, 2011	Study not conducted in one of the countries included in the review protocol.
Barclay, Linda, Lalor, Aislinn, Migliorini, Christine, Robins, Lauren, A comparative examination of models of service delivery intended to support community integration in the immediate period following	Population not in PICO: People >18 years old.

Study	Reason for Exclusion
inpatient rehabilitation for spinal cord injury, Spinal Cord, 2019	
Barclay, Linda, McDonald, Rachael, Lentin, Primrose, Social and community participation following spinal cord injury: a critical review, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 38, 1-19, 2015	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Barclay, Linda, McDonald, Rachael, Lentin, Primrose, Bourke-Taylor, Helen, Facilitators and barriers to social and community participation following spinal cord injury, Australian occupational therapy journal, 63, 19-28, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Beaton, Angela, O'Leary, Katrina, Thorburn, Julie, Campbell, Alaina, Christey, Grant, Improving patient experience and outcomes following serious injury, The New Zealand medical journal, 132, 15-25, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Beckett, K., Earthy, S., Sleney, J., Barnes, J., Kellezi, B., Barker, M., Clarkson, J., Coffey, F., Elder, G., Kendrick, D., Providing effective trauma care: The potential for service provider views to enhance the quality of care (qualitative study nested within a multicentre longitudinal quantitative study), BMJ Open, 4, e005668, 2014	No qualitative data on phenomena of interest.
Bergmark, Lisa, Westgren, Ninni, Asaba, Eric, Returning to work after spinal cord injury: exploring young adults' early expectations and experience, Disability and Rehabilitation, 33, 2553-8, 2011	Study did not examine rehabilitation while an inpatient, when transferring to community, or seeking to access rehabilitation following discharge.
Bernet, Madeleine, Sommerhalder, Kathrin, Mischke, Claudia, Hahn, Sabine, Wyss, Adrian, "Theory Does Not Get You From Bed to Wheelchair": A Qualitative Study on Patients' Views of an Education Program in Spinal Cord Injury Rehabilitation, Rehabilitation nursing : the official journal of the Association of Rehabilitation Nurses, 44, 247-253, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Bernhoff, K., Bjorck, M., Larsson, J., Jangland, E., Patient Experiences of Life Years After Severe Civilian Lower Extremity Trauma With Vascular Injury, European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery, 52, 690-695, 2016	No qualitative data on phenomena of interest.
Biester, Rosette C., Krych, Dave, Schmidt, M. J., Parrott, Devan, Katz, Douglas I., Abate, Melissa, Hirshson, Chari I., Individuals With Traumatic Brain Injury and Their Significant Others' Perceptions of Information Given About the Nature and Possible Consequences of Brain Injury: Analysis of a National Survey, Professional case management, 21, 22-4, 2016	Study not conducted in one of the countries included in the review protocol.
Body, Richard, Muskett, Tom, Perkins, Mick, Parker, Mark, Your injury, my accident: talking at cross-purposes in rehabilitation after traumatic brain injury, Brain Injury, 27, 1356-63, 2013	No qualitative data on phenomena of interest.
Boschen, K., Gerber, G., Gargaro, J., Comparison of outcomes and costs of 2 publicly-funded community-based models of acquired brain injury services, Archives of Physical Medicine and Rehabilitation, 91, e59, 2010	Conference abstract.
Bourge, C., Body Image (BI) of acquired spinal cord injury (SCI) persons. Which patient care in an internal unit of physical and neurological rehabilitation. Experience of the patient care in an internal and neurological unit of PMR of the University Hospital of	No qualitative data on phenomena of interest.

Study	Reason for Exclusion
Liege, Annals of Physical and Rehabilitation Medicine, 59 (Supplement), e128, 2016	
Bourke, John A., Nunnerley, Joanne L., Sullivan, Martin, Derrett, Sarah, Relationships and the transition from spinal units to community for people with a first spinal cord injury: A New Zealand qualitative study, Disability and health journal, 12, 257-262, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not reported separately for the target population.
Braaf, Sandra, Ameratunga, Shanthi, Nunn, Andrew, Christie, Nicola, Teague, Warwick, Judson, Rodney, Gabbe, Belinda J., Patient-identified information and communication needs in the context of major trauma, BMC health services research, 18, 163, 2018	Population not in PICO: People >18 years old.
Braaf, Sandra C., Lennox, Alyse, Nunn, Andrew, Gabbe, Belinda J., Experiences of hospital readmission and receiving formal carer services following spinal cord injury: a qualitative study to identify needs, Disability and Rehabilitation, 40, 1893-1899, 2018	Study did not examine phenomena of interest.
Brauer, Jennifer, Hay, Catherine Cooper, Francisco, Gerard, A retrospective investigation of occupational therapy services received following a traumatic brain injury, Occupational Therapy in Health Care, 25, 119-30, 2011	Study not conducted in one of the countries included in the review protocol.
Brimicombe, L., Ling, J., De Sousa De Abreu, I., Hoffman, K., Salisbury, C., Jefferson, R., Makela, P., Early integration of a self-management support package into usual care following traumatic brain injury (TBI): A feasibility study, British Journal of Neurosurgery, 31, 501, 2017	Conference abstract.
Brito, Sara, White, Jennifer, Thomacos, Nikos, Hill, Bridget, The lived experience following free functioning muscle transfer for management of pan-brachial plexus injury: reflections from a long-term follow-up study, Disability and Rehabilitation, 1-9, 2019	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Brockway, J. A., St De Lore, J., Fann, J. R., Hart, T., Hurst, S., Fey-Hinckley, S., Savage, J., Warren, M., Bell, K. R., Telephone-delivered problem-solving training after mild traumatic brain injury: qualitative analysis of service members' perceptions, Rehabilitation Psychology, 61, 221â 230, 2016	Study not conducted in one of the countries included in the review protocol.
Brown, F., Sofronoff, K., Whittingham, K., Boyd, R., McKinlay, L., Parenting a child with a traumatic brain injury: A focus group study, Developmental Medicine and Child Neurology, 54, 24-25, 2012	No qualitative data on phenomena of interest.
Brown, Jessica, Hux, Karen, Hey, Morgan, Murphy, Madeline, Ackerman, Aldrich Anderson Arciniegas Bach Beigel Bogdan Brandt Brown Brown Catroppa Cicerone Cicerone Creswell Creswell Cushman de Joode de Joode DePompei Donders Dowds Doyle Edwards Ewing-Cobbs Fortuny Gillette Gillette Gioia Glang Gordon Gordon Grajzel Harper Hart Hawley Helm-Estabrooks Hendricks Hux Kelley Kennedy Kennedy Kertesz Krause Leopold Lincoln Martella Martinez McAllister McCrory Merriam Moustakas Ownsworth Patel Perna Reitan Rumrill Scherer Scherer Scherer Scherer Scherer Scherer Shanahan Sherer Sherer Sohlberg Spreen Starks Tate Todis Togher Vu Wallace Ylvisaker Ylvisaker, Exploring cognitive support use and preference by college students with TBI: A mixed-methods study, NeuroRehabilitation, 41, 483-499, 2017	Study not conducted in one of the countries included in the review protocol.
Browne, C., Living with traumatic brain injury: Views of survivors and family members, Brain Injury, 26, 400, 2012	Conference abstract.

Study	Reason for Exclusion
Bruner-Canhoto, Laney, Savageau, Judith, Croucher, Deborah, Bradley, Kathryn, Lessons From a Care Management Pilot Program for People With Acquired Brain Injury, Journal for healthcare quality : official publication of the National Association for Healthcare Quality, 38, 255-263, 2016	Study not conducted in one of the countries included in the review protocol.
Buck, P., Kirzner, R., Sagrati, J., Laster, R., The challenge of mTBI work: An exploratory study of rehabilitation professionals, Brain Injury, 26, 583-584, 2012	Conference abstract.
Buck, Page Walker, Sagrati, Jocelyn Spencer, Kirzner, Rachel Shapiro, Belson, Bloom Brenner Briggs Brody Buck Chrisman Gaboda Klein Marchione Padgett Patton Schwartz Strauss Thompson, Mild traumatic brain injury: A place for social work, Social Work in Health Care, 52, 741-751, 2013	Study not conducted in one of the countries included in the review protocol.
Buddai, S., Di Taranti, L. J., Adenwala, A. Y., Aepli, S., Choudhary, M., George, D. L., Koilor, C. B., Linehan, M., Peifer, H., Rub, D., Kaplan, L., Johnson, N., Lane-Fall, M. B., Characterizing intensive care unit patient and family experiences of recovery after traumatic injury, American Journal of Respiratory and Critical Care Medicine. Conference: American Thoracic Society International Conference, ATS, 195, 2017	Conference abstract.
Buscemi, Valentina, Cassidy, Elizabeth, Kilbride, Cherry, Reynolds, Frances Ann, A qualitative exploration of living with chronic neuropathic pain after spinal cord injury: an Italian perspective, Disability and Rehabilitation, 40, 577-586, 2018	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Bushnik, T., Smith, M., Long, C., Supporting factors for follow-up care in TBI patients post-inpatient discharge, Brain Injury, 31 (6-7), 974, 2017	Conference abstract.
Byrnes, Michelle, Beilby, Janet, Ray, Patricia, McLennan, Renee, Ker, John, Schug, Stephan, Patient-focused goal planning process and outcome after spinal cord injury rehabilitation: quantitative and qualitative audit, Clinical Rehabilitation, 26, 1141-9, 2012	No qualitative data on phenomena of interest.
Cahow, C., Gassaway, J., Rider, C., Joyce, J. P., Bogenshutz, A., Edens, K., Kreider, S. E. D., Whiteneck, G., Relationship of therapeutic recreation inpatient rehabilitation interventions and patient characteristics to outcomes following spinal cord injury: The SCIRehab project, Journal of Spinal Cord Medicine, 35, 547-564, 2012	Study not conducted in one of the countries included in the review protocol.
Calder, Allyson, Nunnerley, Jo, Mulligan, Hilda, Ahmad Ali, Nordawama, Kensington, Gemma, McVicar, Tim, van Schaik, Olivia, Experiences of persons with spinal cord injury undertaking a physical activity programme as part of the SCIPA 'Full-On' randomized controlled trial, Disability and Health Journal, 11, 267-273, 2018	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Calleja, Pauline, Aitken, Leanne, Cooke, Marie, Staff perceptions of best practice for information transfer about multitrauma patients on discharge from the emergency department: a focus group study, Journal of Clinical Nursing, 25, 2863-73, 2016	Setting not in PICO: Emergency department.
Canto, Angela I., Chesire, David J., Buckley, Valerie A., Andrews, Terrie W., Roehrig, Alysia D., Arroyos-Jurado, Ball Bradley-Klug Brantlinger Braun Chesire Conoley Cook Davies Elliot Ewing-Cobbs Farmer Gioia Glang Glang Glang Gopinath Guba Guskiewicz Havey Hooper Hux Jantz Johnson Lewandowski Meehan Mellard Rosenthal Rutland-Brown Savage Sharp Shaw Shaw Shih Yeates Yeates Ylvisaker, Barriers to meeting the	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
needs of students with traumatic brain injury, Educational Psychology in Practice, 30, 88-103, 2014	
Carron, R. M. C., 'nobody prepared me for this!' parents' experiences of seeking help and support with post-brain injury symptoms and changes in children and adolescents with acquired brain injury, Journal of Neurology, Neurosurgery and Psychiatry, 90, A9, 2019	Conference abstract.
Caspari, Synnove, Aasgaard, Trygve, Lohne, Vibeke, Slettebo, Ashild, Naden, Dagfinn, Perspectives of health personnel on how to preserve and promote the patients' dignity in a rehabilitation context, Journal of Clinical Nursing, 22, 2318-26, 2013	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for the target population.
Chapple, L. A., Chapman, M., Shalit, N., Udy, A., Deane, A., Williams, L., Barriers to Nutrition Intervention for Patients With a Traumatic Brain Injury: Views and Attitudes of Medical and Nursing Practitioners in the Acute Care Setting, Journal of Parenteral and Enteral Nutrition, 42, 318-326, 2018	Study did not examine phenomena of interest.
Chapple, Lee-Anne, Chapman, Marianne, Shalit, Natalie, Udy, Andrew, Deane, Adam, Williams, Lauren, Barriers to Nutrition Intervention for Patients With a Traumatic Brain Injury, JPEN. Journal of parenteral and enteral nutrition, 148607116687498, 2017	Duplicate.
Chondronikola, M., Weller, S., Rosenberg, L., Rosenberg, M., Meyer, W. J., Herndon, D. N., Sidossis, L., Variation among clinical specialties in perceptions of pediatric burn patient needs, Journal of Burn Care and Research, 37, S244, 2016	Conference abstract.
Christensen, Jan, Langberg, Henning, Doherty, Patrick, Egerod, Ingrid, Ambivalence in rehabilitation: thematic analysis of the experiences of lower limb amputated veterans, Disability and Rehabilitation, 40, 2553-2560, 2018	Population not in PICO: People >18 years old.
Christie, Nicola, Beckett, Kate, Earthy, Sarah, Kellezi, Blerina, Sleney, Jude, Barnes, Jo, Jones, Trevor, Kendrick, Denise, Seeking support after hospitalisation for injury: a nested qualitative study of the role of primary care, The British journal of general practice : the journal of the Royal College of General Practitioners, 66, e24-31, 2016	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Christiaens, Wendy, Van de Walle, Elke, Devresse, Sophie, Van Halewyck, Dries, Benahmed, Nadia, Paulus, Dominique, Van den Heede, Koen, The view of severely burned patients and healthcare professionals on the blind spots in the aftercare process: a qualitative study, BMC health services research, 15, 302, 2015	Population not in PICO: People >18 years old.
Christie, Nicola, Braaf, Sandra, Ameratunga, Shanthi, Nunn, Andrew, Jowett, Helen, Gabbe, Belinda, Barclay, Barnes Berkman Boniface Braun Cameron Carpenter Cass Charlson Christie Christie Cox Gabbe Gabbe Kellezi Larsen Levasseur Lyons Marottoli McInnes Pointer Prang Smith Syed Urry Wilson, The role of social networks in supporting the travel needs of people after serious traumatic injury: A nested qualitative study, Journal of Transport & Health, 6, 84-92, 2017	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Cichon, S., Danford, E. K., Schladen, M. M., Bruner, D., Libin, A., Scholten, J., Integrating opportunities for family involvement into a manualized goal self-management intervention for veterans with mTBI, Archives of Physical Medicine and Rehabilitation, 96, e77, 2015	Conference abstract.
Cocks, Errol, Bulsara, Caroline, O'Callaghan, Annalise, Netto,	Study did not examine

Study	Reason for Exclusion
Julie, Boaden, Ross, Exploring the experiences of people with the dual diagnosis of acquired brain injury and mental illness, Brain Injury, 28, 414-21, 2014	rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Coffey, Nathan T., Weinstein, Ali A., Cai, Cindy, Cassese, Jimmy, Jones, Rebecca, Shaewitz, Dahlia, Garfinkel, Steven, Identifying and Understanding the Health Information Experiences and Preferences of Individuals With TBI, SCI, and Burn Injuries, Journal of patient experience, 3, 88-95, 2016	Study not conducted in one of the countries included in the review protocol.
Cogan, A., Treatment model of occupational therapy intervention for service members with chronic symptoms following MTBI, Archives of Physical Medicine and Rehabilitation, 98, e132, 2017	Conference abstract.
Conneeley, A. L., Transitions and brain injury: A qualitative study exploring the journey of people with traumatic brain injury, Brain Impairment, 13, 72-84, 2012	No qualitative data on phenomena of interest.
Conneeley, Anne Louise, Exploring vocation following brain injury: a qualitative enquiry, Social Care and Neurodisability, 4, 6-16, 2013	No qualitative data on phenomena of interest.
Copley, Anna, McAllister, Lindy, Wilson, Linda, Attitride-Stirling, Barnes Brooks Carr-Hill Fagen Foster Frattali Grbich Harradine Harris Honey Humphreys Johnstone Kelly LeFebvre Marsh Minichiello Morse Murphy Muus Nabors Newberry O'Callaghan O'Callaghan O'Callaghan O'Callaghan O'Callaghan Patton Sample Sample Schofield Schwandt Turner-Stokes Whitehead Ylvisaker Youse, We finally learnt to demand: Consumers' access to rehabilitation following traumatic brain injury, Brain Impairment, 14, 436-449, 2013	No qualitative data on phenomena of interest.
Curtis, Kate, Foster, Kim, Mitchell, Rebecca, Van, Connie, How is care provided for patients with paediatric trauma and their families in Australia? A mixed-method study, Journal of Paediatrics and Child Health, 52, 832-6, 2016	Study did not examine the phenomena of interest.
Cuthbert, J., Anderson, J., Mason, C., Block, S., Dettmer, J., Weintraub, A., Harrison-Felix, C., Case management of individuals with chronic TBI: A research-based approach, Journal of Head Trauma Rehabilitation, 28, E49, 2013	Conference abstract.
Daggett, Virginia S., Bakas, Tamilyn, Buelow, Janice, Habermann, Barbara, Murray, Laura L., Needs and concerns of male combat Veterans with mild traumatic brain injury, Journal of Rehabilitation Research and Development, 50, 327-40, 2013	Study not conducted in one of the countries included in the review protocol.
Dahl, O., Wickman, M., Wengstrom, Y., Adapting to life after burn injury-reflections on care, Journal of Burn Care and Research, 33, 595-605, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Dalmaso, Kym, Weber, Sarah, Eley, Rob, Spencer, Lyndall, Cabilan, C. J., Nurses' perceived benefits of trauma nursing rounds (TNR) on clinical practice in an Australian emergency department: a mixed methods study, Australasian emergency nursing journal : AENJ, 18, 42-8, 2015	Setting not in PICO: Emergency department.
Dams-O'Connor, K., Landau, A., De Lore, J. S., Hoffman, J., Access, barriers, and health care quality after brain injury: Insiders' perspectives, Archives of Physical Medicine and Rehabilitation, 97, e129, 2016	Conference abstract.
Dams-O'Connor, Kristen, Landau, Alexandra, Hoffman, Jeanne, St De Lore, Jef, Patient perspectives on quality and access to	Study not conducted in one of the countries included in the

Study	Reason for Exclusion
healthcare after brain injury, Brain Injury, 32, 431-441, 2018	review protocol.
Darnell, Doyanne A., Parker, Lea E., Wagner, Amy W., Dunn, Christopher W., Atkins, David C., Dorsey, Shannon, Zatzick, Douglas F., Task-shifting to improve the reach of mental health interventions for trauma patients: findings from a pilot study of trauma nurse training in patient-centered activity scheduling for PTSD and depression, Cognitive behaviour therapy, 48, 482-496, 2019	Study not conducted in one of the countries included in the review protocol.
D'Cruz, K., Howie, L., Lentin, P., Client-centred practice: Perspectives of persons with a traumatic brain injury, Scandinavian Journal of Occupational Therapy, 23, 30-38, 2016	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Dickson, Adele, Ward, Richard, O'Brien, Grainne, Allan, David, O'Carroll, Ronan, Difficulties adjusting to post-discharge life following a spinal cord injury: an interpretative phenomenological analysis, Psychology, health & medicine, 16, 463-74, 2011	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Diener, M., Kirby, A., Canary, H., Sumison, F., Green, M., Community reintegration following pediatric acquired brain injury: Perspectives of providers and families, Journal of Head Trauma Rehabilitation, 33 (3), E97, 2018	Conference abstract.
Dillahunt-Aspillaga, C., Bradley, S., Ramaiah, P., Radwan, C., Ottomanelli, L., Coalition Building: A Tool To Implement Evidenced-Based Resource Facilitation in The VHA: Pilot Results, Archives of Physical Medicine and Rehabilitation, 100, e164, 2019	Conference abstract.
Dismann, Patrick D., Maignan, Maxime, Cloves, Paul D., Gutierrez Parres, Blanca, Dickerson, Sara, Eberhardt, Alice, A Review of the Burden of Trauma Pain in Emergency Settings in Europe, Pain and therapy, 7, 179-192, 2018	Setting not in PICO: Emergency settings.
Divanoglou, A., Georgiou, M., Perceived effectiveness and mechanisms of community peer-based programmes for Spinal Cord Injuries-a systematic review of qualitative findings, Spinal cord, 55, 225-234, 2017	Study did not report any findings related to the phenomena of interest.
Doig, E., Fleming, J., Kuipers, P., Cornwell, P., The relationship between goal attainment and the development of self-awareness in traumatic brain injury (TBI) rehabilitation: Descriptive and qualitative case analyses, Brain Impairment, 14, 159-160, 2013	Conference abstract.
Doig, Emmah, Fleming, Jennifer, Cornwell, Petrea, Kuipers, Pim, Comparing the experience of outpatient therapy in home and day hospital settings after traumatic brain injury: patient, significant other and therapist perspectives, Disability and Rehabilitation, 33, 1203-14, 2011	No qualitative data on phenomena of interest.
Donnell, Zoe, Hoffman, Roseanne, Myers, Gaya, Sarmiento, Kelly, Seeking to improve care for young patients: Development of tools to support the implementation of the CDC Pediatric mTBI Guideline, Journal of Safety Research, 67, 203-209, 2018	Study not conducted in one of the countries included in the review protocol.
Donnelly, Kyla Z., Goldberg, Shari, Fournier, Debra, A qualitative study of LoveYourBrain Yoga: a group-based yoga with psychoeducation intervention to facilitate community integration for people with traumatic brain injury and their caregivers, Disability and Rehabilitation, 1-10, 2019	Study not conducted in one of the countries included in the review protocol.
Douglas, J., 'Nobody wants to know you'. Understanding the experience of friendship following severe traumatic brain injury, Brain Injury, 30, 515, 2016	Conference abstract.

Study	Reason for Exclusion
Drew, S., Judge, A., Cooper, C., Javaid, M. K., Farmer, A., Gooberman-Hill, R., Secondary prevention of fractures after hip fracture: a qualitative study of effective service delivery, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 27, 1719-27, 2016	Study did not examine rehabilitation.
Drew, S., Judge, A., Javaid, M. K., Cooper, C., Farmer, A., Goobermen-Hill, R., Secondary prevention of fractures after hip fracture: A qualitative study of effective service delive, Osteoporosis International, 25, S308, 2014	Conference abstract.
Dwyer, Aoife, Heary, Caroline, Ward, Marcia, MacNeela, Padraig, Adding insult to brain injury: young adults' experiences of residing in nursing homes following acquired brain injury, Disability and Rehabilitation, 41, 33-43, 2019	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Dyke, J., Krupa, J., Vova, J., Medical symptoms, service gaps and barriers to care using the medical home model in adolescents with acquired brain injury, Journal of Head Trauma Rehabilitation, 27 (5), E18-E19, 2012	Conference abstract.
Edworthy Ann, Donne Hannah, The availability and intelligibility of information for carers of children with a brain injury, Social Care and Neurodisability, 1, 32-40, 2010	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Eliacin, Johanne, Fortney, Sarah, Rattray, Nicholas A., Kean, Jacob, Access to health services for moderate to severe TBI in Indiana: patient and caregiver perspectives, Brain Injury, 32, 1510-1517, 2018	Study not conducted in one of the countries included in the review protocol.
Fitts, M., Fleming, J., Bird, K., Condon, T., Gilroy, J., Clough, A., Maruff, P., Esterman, A., Bohanna, I., Sentinel events during hospital admission for indigenous people following traumatic brain injury, Brain Impairment, 19, 336, 2018	Conference abstract.
Fitts, Michelle S., Bird, Katrina, Gilroy, John, Fleming, Jennifer, Clough, Alan R., Esterman, Adrian, Maruff, Paul, Fatima, Yaqoot, Bohanna, India, Abrahamson, Alfandre Amery Bell Blackmer Bohanna Bohanna Bohanna Braun Burnett Choi Claiborne Coronado D'Cruz Dillon Dudley Durey Durey Einsiedel Englander Feigin Foley Franks Gentilello Gilroy Gilroy Harrison Hunt Hyder Jamieson Jayaraj Juillard Katzenellenbogen Katzenellenbogen Lakhani Lee Levack Levack Liossi Marrone Martin Moreton-Robinson Nakata Nalder Nalder Nalder Niemeier Ownsworth Paradies Rutland-Brown Shahid Tuhiwai-Smith Turner Turner Willis Zeiler, A qualitative study on the transition support needs of indigenous Australians following traumatic brain injury, Brain Impairment, 20, 137-159, 2019	No qualitative data on phenomena of interest.
Fleming, Jennifer, Sampson, Jennifer, Cornwell, Petrea, Turner, Ben, Griffin, Janell, Brain injury rehabilitation: The lived experience of inpatients and their family caregivers, Scandinavian journal of occupational therapy, 19, 184-193, 2012	No qualitative data on phenomena of interest.
Ford, James H., 2nd, Wise, Meg, Krahn, Dean, Oliver, Karen Anderson, Hall, Carmen, Sayer, Nina, Family care map: Sustaining family-centered care in Polytrauma Rehabilitation Centers, Journal of Rehabilitation Research and Development, 51, 1311-24, 2014	Study not conducted in one of the countries included in the review protocol.
Foster, Kim, Mitchell, Rebecca, Van, Connie, Young, Alexandra,	Study did not examine

Study	Reason for Exclusion
McCloughen, Andrea, Curtis, Kate, Resilient, recovering, distressed: A longitudinal qualitative study of parent psychosocial trajectories following child critical injury, Injury, 50, 1605-1611, 2019	rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Foster, Kim, Mitchell, Rebecca, Young, Alexandra, Van, Connie, Curtis, Kate, Parent experiences and psychosocial support needs 6 months following paediatric critical injury: A qualitative study, Injury, 50, 1082-1088, 2019	No qualitative data on phenomena of interest.
Foster, Kim, Young, Alexandra, Mitchell, Rebecca, Van, Connie, Curtis, Kate, Experiences and needs of parents of critically injured children during the acute hospital phase: A qualitative investigation, Injury, 48, 114-120, 2017	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Fournier, D., Goldberg, S., Figucia, C., Kennedy, P., Krauss, K., Smith, C., Springmann, J., An interdisciplinary traumatic brain injury clinic: Understanding the patient experience, Journal of Head Trauma Rehabilitation, 32, E97-E98, 2017	Conference abstract.
Francis, A., Ziviani, J., Fleming, J., Rae, M., McKinlay, L., Transitioning to adulthood: Needs of young people with an acquired brain injury and those of their families, Neurorehabilitation and Neural Repair, 26, 780-781, 2012	Conference abstract.
Franz, Shiney, Muser, Jurgen, Thielhorn, Ulrike, Wallesch, Claus W., Behrens, Johann, Inter-professional communication and interaction in the neurological rehabilitation team: a literature review, Disability and Rehabilitation, 1-9, 2018	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Fraser, M. A., Lind, J. D., Powell-Cope, G., Gavin-Dreschnack, D., Addressing non-direct care, psychosocial concerns of veterans with spinal cord injuries, Journal of Spinal Cord Medicine, 36, 546-547, 2013	Conference abstract.
Freeman, Claire, Cassidy, Bernadette, Hay-Smith, E. Jean C., Beauregard, Beisecker Chan Craig DeSanto-Madeya Dickson Dixon Ell Esmail Esmail Fisher Fronek Gilad Kendall Kennedy Kidd Kreuter Leino-Kilpi Lemonidou New Parrott Racher Rembis Schuster Sinnott Smith Smith Steinglass Taylor Vocaturo, Couple's experiences of relationship maintenance and intimacy in acute spinal cord injury rehabilitation: An interpretative phenomenological analysis, Sexuality and Disability, 35, 433-444, 2017	Study did not examine phenomena of interest.
Fry, J. C., Price, P., Meeting the re-integration needs of individuals with spinal cord injury: Effectiveness of community-based occupational therapy, Archives of Physical Medicine and Rehabilitation, 94, e8, 2013	Conference abstract.
Gabbe, Belinda J., Sleney, Jude S., Gosling, Cameron M., Wilson, Krystle, Hart, Melissa J., Sutherland, Ann M., Christie, Nicola, Patient perspectives of care in a regionalised trauma system: lessons from the Victorian State Trauma System, The Medical journal of Australia, 198, 149-52, 2013	No qualitative data on phenomena of interest.
Gagliardi, Anna R., Nathens, Avery B., Exploring the characteristics of high-performing hospitals that influence trauma triage and transfer, The journal of trauma and acute care surgery, 78, 300-5, 2015	Study did not examine rehabilitation.
Gagnon, I., Friedman, D., Management of mild traumatic brain injury or concussion in children: Is there a role for the physical therapist?, Physiotherapy (United Kingdom), 1), eS1487-eS1488,	Conference abstract.

Study	Reason for Exclusion
2011	
Garrino, Lorenza, Curto, Natascia, Decorte, Rita, Felisi, Nadia, Matta, Ebe, Gregorino, Silvano, Actis, M. Vittoria, Marchisio, Cecilia, Carone, Roberto, Towards personalized care for persons with spinal cord injury: a study on patients' perceptions, The journal of spinal cord medicine, 34, 67-75, 2011	Study did not examine phenomena of interest.
Gawel, Marcie, Emerson, Beth, Giuliano, John S., Jr., Rosenberg, Alana, Minges, Karl E., Feder, Shelli, Violano, Pina, Morrell, Patricia, Petersen, Judy, Christison-Lagay, Emily, Auerbach, Marc, A Qualitative Study of Multidisciplinary Providers' Experiences With the Transfer Process for Injured Children and Ideas for Improvement, Pediatric Emergency Care, 34, 125-131, 2018	Study not conducted in one of the countries included in the review protocol.
Gemmel, Paul, van Steenis, Thomas, Meijboom, Bert, Bensabat, Bohmer Broekhuis Burke Chase Chase Chase Eisenhardt Fredendall Frei Gronroos Hanne Johnston Lamontagne Lamontagne Larsson Meredith Metters Metters Miles Ouwens Patricio Swanborn Vander Laane Voss Westert Yin Young Zomerdijk, Front-office/back-office configurations and operational performance in complex health services, Brain Injury, 28, 347-356, 2014	Not specific to rehabilitation, or to traumatic injury and results not presented separately for target population.
Gill, Carol J., Sander, Angelle M., Robins, Nina, Mazzei, Diana, Struchen, Margaret A., Allen, Aloni Aloni Anderson Anderson-Parente Bergland Brooks Ergh Garden Gillen Gosling Harrick Hibbard Hoofien Jeon Kersel Kravetz Kravetz Kreuter Kreutzer Kreutzer Kreutzer Lippert Marsh Oddy Olver Panting Patton Perlesz Peters Ponsford Porter Resnick Rosenbaum Sandel Siebert Snow Tate Tate Thomsen Vanderploeg Wallace Webster Wells Wood Wood, Exploring experiences of intimacy from the viewpoint of individuals with traumatic brain injury and their partners, The Journal of Head Trauma Rehabilitation, 26, 56-68, 2011	Study not conducted in one of the countries included in the review protocol.
Gill, Ian J., Wall, Gemma, Simpson, Jane, Clients' perspectives of rehabilitation in one acquired brain injury residential rehabilitation unit: a thematic analysis, Brain Injury, 26, 909-20, 2012	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Glenny, Christine, Stolee, Paul, Sheiban, Linda, Jaglal, Susan, Communicating during care transitions for older hip fracture patients: family caregiver and health care provider's perspectives, International journal of integrated care, 13, e044, 2013	Population not in PICO: People >18 years old.
Glintborg, C., Hansen, T., De La Mata Benites, M., Supporting transitions in neurorehabilitation. A pathway to improved psychosocial outcomes, Brain Injury, 30, 565-566, 2016	Conference abstract.
Glintborg, Chalotte, Hansen, Tia G. B., Bech, Bech Braun Brenner Creswell Ellervik Engel Ghaziani Glintborg Glintborg Glintborg Glintborg Hackett Haggerty Hald Hall Holm Jorge Jorge Keith Kennedy Miles Morton Norholm Pallant Rivera Schlossberg Teasdale Teasdale Turner, Bio-psycho-social effects of a coordinated neurorehabilitation programme: A naturalistic mixed methods study, NeuroRehabilitation, 38, 99-113, 2016	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Goel, R., Fruth, S., Geigle, P., Santurri, L., Abzug, J., Telerehabilitation for Individuals With Spinal Cord Injury: Is it Feasible?, Archives of Physical Medicine and Rehabilitation, 100, e203-e204, 2019	Conference abstract.
Goldsmith, Helen, McCloughen, Andrea, Curtis, Kate, Using the trauma patient experience and evaluation of hospital discharge	Study did not examine rehabilitation.

Study	Reason for Exclusion
practices to inform practice change: A mixed methods study, Journal of Clinical Nursing, 27, 1589-1598, 2018	
Goldsmith, Helen, McCloughen, Andrea, Curtis, Kate, The experience and understanding of pain management in recently discharged adult trauma patients: A qualitative study, Injury, 49, 110-116, 2018	No qualitative data on phenomena of interest.
Goodridge, Donna, Rogers, Marla, Klassen, Laura, Jeffery, Bonnie, Knox, Katherine, Rohatinsky, Noelle, Linassi, Gary, Access to health and support services: perspectives of people living with a long-term traumatic spinal cord injury in rural and urban areas, Disability and Rehabilitation, 37, 1401-10, 2015	No qualitative data on phenomena of interest.
Gotlib Conn, Lesley, Zwaiman, Ashley, DasGupta, Tracey, Hales, Brigette, Watamaniuk, Aaron, Nathens, Avery B., Trauma patient discharge and care transition experiences: Identifying opportunities for quality improvement in trauma centres, Injury, 49, 97-103, 2018	No qualitative data on phenomena of interest.
Gourdeau, Jenna, Fingold, Alissa, Colantonio, Angela, Mansfield, Elizabeth, Stergiou-Kita, Mary, Workplace accommodations following work-related mild traumatic brain injury: what works?, Disability and Rehabilitation, 1-10, 2018	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Graff, Heidi J., Christensen, Ulla, Poulsen, Ingrid, Egerod, Ingrid, Patient perspectives on navigating the field of traumatic brain injury rehabilitation: a qualitative thematic analysis, Disability and Rehabilitation, 40, 926-934, 2018	Population not in PICO: People >18 years old.
Gravell, R., Brumfit, S., Body, R., Hope and engagement following acquired brain injury: A qualitative study, Brain Injury, 31, 721-722, 2017	Conference abstract.
Guilcher, S., Everall, A., Wodchis, W., Joanna, deGraaf-Dunlop, Bar-Ziv, S., Kuluski, K., Understanding Transitions of Care in Older Adults With Hip Fractures: A Multiple-Case Study in Ontario, Archives of Physical Medicine and Rehabilitation, 100, e138, 2019	Conference abstract.
Gullick, Janice G., Taggart, Susan B., Johnston, Rae A., Ko, Natalie, The trauma bubble: patient and family experience of serious burn injury, Journal of burn care & research : official publication of the American Burn Association, 35, e413-27, 2014	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Guptill, C. A., The lived experience of professional musicians with playing-related injuries: A phenomenological inquiry, Medical Problems of Performing Artists, 26, 84-95, 2011	No qualitative data on phenomena of interest.
Haarbauer-Krupa, J., Vova, J., Follow-up of preschool children with acquired brain injury, Brain Injury, 26, 424-425, 2012	Conference abstract.
Haas, B. M., Price, L., Freeman, J. A., Qualitative evaluation of a community peer support service for people with spinal cord injury, Spinal Cord, 51, 295-9, 2013	The majority of participants had not experienced traumatic injury and results not presented separately for target population.
Harrington, Rosamund, Foster, Michele, Fleming, Jennifer, Experiences of pathways, outcomes and choice after severe traumatic brain injury under no-fault versus fault-based motor accident insurance, Brain Injury, 29, 1561-71, 2015	No qualitative data on phenomena of interest.
Harris, M. B., Rafeedie, S., McArthur, D., Babikian, T., Snyder, A., Polster, D., Giza, C. C., Addition of Occupational Therapy to an Interdisciplinary Concussion Clinic Improves Identification of	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Functional Impairments, Journal of Head Trauma Rehabilitation, 34, 425-432, 2019	
Harrison, Anne L., Hunter, Elizabeth G., Thomas, Heather, Bordy, Paige, Stokes, Erin, Kitzman, Patrick, Living with traumatic brain injury in a rural setting: supports and barriers across the continuum of care, Disability and Rehabilitation, 39, 2071-2080, 2017	Study not conducted in one of the countries included in the review protocol.
Hartley, Naomi A., Spinal cord injury (SCI) rehabilitation: systematic analysis of communication from the biopsychosocial perspective, Disability and rehabilitation, 1-10, 2015	Study not conducted in one of the countries included in the review protocol.
Hawkins, Brent L., Crowe, Brandi M., Contextual Facilitators and Barriers of Community Reintegration Among Injured Female Military Veterans: A Qualitative Study, Archives of Physical Medicine and Rehabilitation, 99, S65-S71, 2018	Study not conducted in one of the countries included in the review protocol.
Haywood, C., Perceptions of recovery among adolescents and young adults with acquired spinal cord injuries, Archives of Physical Medicine and Rehabilitation, 97, e76, 2016	Conference abstract.
Haywood, Carol, Pyatak, Elizabeth, Leland, Natalie, Henwood, Benjamin, Lawlor, Mary C., A Qualitative Study of Caregiving for Adolescents and Young Adults With Spinal Cord Injuries: Lessons From Lived Experiences, Topics in Spinal Cord Injury Rehabilitation, 25, 281-289, 2019	Study not conducted in one of the countries included in the review protocol.
Hellem, I., Forland, G., Eide, K., Ytrehus, S., Addressing uncertainty and stigma in social relations related to hidden dysfunctions following acquired brain injury, Scandinavian Journal of Disability Research, 20, 152-161, 2018	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Herrera-Escobar, J. P., Columbus, A., Castillo-Angeles, M., Rios-Diaz, A. J., Weed, C. N., Kasotakis, G., Velmahos, G. C., Salim, A., Haider, A. H., Kaafara, H. M., Discontinuity of patient-provider communication throughout the phases of care: Time to be more patient-centered in trauma?, Journal of the American College of Surgeons, 225 (4 Supplement 2), e176, 2017	Conference abstract.
Hill, Jennifer N., Smith, Bridget M., Weaver, Frances M., Nazi, Kim M., Thomas, Florian P., Goldstein, Barry, Hogan, Timothy P., Potential of personal health record portals in the care of individuals with spinal cord injuries and disorders: Provider perspectives, The journal of spinal cord medicine, 41, 298-308, 2018	Study not conducted in one of the countries included in the review protocol.
Hines, M., Brunner, M., Poon, S., Lam, M., Tran, V., Yu, D., Togher, L., Shaw, T., Power, E., Exploring ehealth 'tribes and tribulations' in interdisciplinary rehabilitation for people with a traumatic brain injury (TBI), Brain Impairment, 19, 292-293, 2018	Conference abstract.
Hines, M., Brunner, M., Poon, S., Lam, M., Tran, V., Yu, D., Togher, L., Shaw, T., Power, E., Tribes and tribulations: interdisciplinary eHealth in providing services for people with a traumatic brain injury (TBI), BMC health services research, 17, 757, 2017	No qualitative data on phenomena of interest.
Hirsch, M. A., Grafton, L., Guerrier, T. P., Niemeier, J. P., Newman, M., Runyon, M. S., Unmet concussion care needs from the perspective of individuals with mild traumatic brain injury, Archives of Physical Medicine and Rehabilitation, 96, e33, 2015	Conference abstract.
Hitzig, S., Bain, P., Haycock, S., Hebert, D. A., Evaluation of a spinal cord injury community reintegration outpatient program (CROP) service, Archives of Physical Medicine and Rehabilitation, 95, e83, 2014	Conference abstract.

Study	Reason for Exclusion
Hollick, R., Reid, D., Black, A., McKee, L., What matters to patients: Working together to improve the quality of osteoporosis services, Osteoporosis International, 27, S678, 2016	Conference abstract.
Holloway, Mark, Motivational interviewing and acquired brain injury, Social Care and Neurodisability, 3, 122-130, 2012	Narrative review.
Hoogerdijk, Barbara, Runge, Ulla, Haugboelle, Jette, The adaptation process after traumatic brain injury an individual and ongoing occupational struggle to gain a new identity, Scandinavian Journal of Occupational Therapy, 18, 122-32, 2011	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Hoonakker, Peter Leonard Titus, Wooldridge, Abigail Rayburn, Hose, Bat-Zion, Carayon, Pascale, Eithun, Ben, Brazelton, Thomas Berry, 3rd, Kohler, Jonathan Emerson, Ross, Joshua Chud, Rusy, Deborah Ann, Dean, Shannon Mason, Kelly, Michelle Merwood, Gurses, Ayse Pinar, Information flow during pediatric trauma care transitions: things falling through the cracks, Internal and emergency medicine, 14, 797-805, 2019	Study not conducted in one of the countries included in the review protocol.
Hosking, J. E., Ameratunga, S. N., Bramley, D. M., Crengle, S. M., Reducing ethnic disparities in the quality of trauma care: An important research gap, Annals of Surgery, 253, 233-237, 2011	Study did not examine rehabilitation.
Hull, K., Ribariach, J., Panton, V., De Jonge, J., Bulsara, C., Developing independence and empowerment through medications self management amongst persons with acquired brain injury, Neurorehabilitation and Neural Repair, 26, 775-776, 2012	Conference abstract.
Hunt, Anne W., Laupacis, Dylan, Kawaguchi, Emily, Greenspoon, Dayna, Reed, Nick, Key ingredients to an active rehabilitation programme post-concussion: perspectives of youth and parents, Brain Injury, 32, 1534-1540, 2018	It was not clear that the participants had been hospitalised (study states that the intervention/ interviews were undertaken in a hospital but many of the participants were drawn from the community).
Hyatt, Kyong, Davis, Linda L., Barroso, Julie, Chasing the care: soldiers experience following combat-related mild traumatic brain injury, Military Medicine, 179, 849-55, 2014	Study not conducted in one of the countries included in the review protocol.
Irgens, Eirik Lind, Henriksen, Nils, Moe, Siri, Communicating information and professional knowledge in acquired brain injury rehabilitation trajectories - a qualitative study of physiotherapy practice, Disability and Rehabilitation, 1-8, 2018	The focus was not specific to participants who had experienced traumatic injury and results not presented separately for target population.
Isbel, Stephen T., Jamieson, Maggie I., Views from health professionals on accessing rehabilitation for people with dementia following a hip fracture, Dementia (London, England), 16, 1020-1031, 2017	Population not in PICO: People >18 years old.
Jacoby, Sara F., Rich, John A., Webster, Jessica L., Richmond, Therese S., 'Sharing things with people that I don't even know': help-seeking for psychological symptoms in injured Black men in Philadelphia, Ethnicity & health, 1-19, 2018	Study not conducted in one of the countries included in the review protocol.
Jannings, Wendy, Pryor, Julie, The experiences and needs of persons with spinal cord injury who can walk, Disability and Rehabilitation, 34, 1820-6, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.

Study	Reason for Exclusion
Janssen, Renske M. J., Satink, Ton, Ijspeert, Jos, van Alfen, Nens, Groothuis, Jan T., Packer, Tanya L., Cup, Edith H. C., Reflections of patients and therapists on a multidisciplinary rehabilitation programme for persons with brachial plexus injuries, Disability and Rehabilitation, 41, 1427-1434, 2019	Population not in PICO: Participants had not experienced traumatic injury.
Jellema, Sandra, van Erp, Sabine, Nijhuis-van der Sanden, Maria W. G., van der Sande, Rob, Steultjens, Esther M. J., Activity resumption after acquired brain injury: the influence of the social network as described by social workers, Disability and Rehabilitation, 1-8, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jeyathevan, Gaya, Cameron, Jill I., Craven, B. Catharine, Jaglal, Susan B., Identifying Required Skills to Enhance Family Caregiver Competency in Caring for Individuals With Spinal Cord Injury Living in the Community, Topics in Spinal Cord Injury Rehabilitation, 25, 290-302, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jeyaraj, J. A., Clendenning, A., Bellemare-Lapierre, V., Iqbal, S., Lemoine, M. C., Edwards, D., Korner-Bitensky, N., Clinicians' perceptions of factors contributing to complexity and intensity of care of outpatients with traumatic brain injury, Brain Injury, 27, 1338-1347, 2013	Population not in PICO: People >18 years old.
Jeyathevan, Gaya, Catharine Craven, B., Cameron, Jill I., Jaglal, Susan B., Facilitators and barriers to supporting individuals with spinal cord injury in the community: experiences of family caregivers and care recipients, Disability and Rehabilitation, 1-11, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Jiang, T., Webster, J. L., Robinson, A., Kassam-Adams, N., Richmond, T. S., Emotional responses to unintentional and intentional traumatic injuries among urban black men: A qualitative study, Injury, 49, 983-989, 2018	Study not conducted in one of the countries included in the review protocol.
Johnson, Rae A., Taggart, Susan B., Gullick, Janice G., Emerging from the trauma bubble: Redefining 'normal' after burn injury, Burns : journal of the International Society for Burn Injuries, 42, 1223-32, 2016	No qualitative data on phenomena of interest.
Jourdan, C., Azouvi, P., Pradat-Diehl, P., Ruet, A., Tenovuo, O., Traumatic Brain Injury (TBI) care pathways in Finland and in France: Organization and issues, Annals of Physical and Rehabilitation Medicine, 57, e397, 2014	Conference abstract.
Jourdan, Claire, Bahrami, Stephane, Azouvi, Philippe, Tenovuo, Olli, Practitioners' opinions on traumatic brain injury care pathways in Finland and France: different organizations, common issues, Brain Injury, 33, 205-211, 2019	Population not in PICO: People >18 years old.
Jurrius, K., After care for people with acquired brain injury in the chronic phase-New equilibrium in the aftercare of people with acquired brain injury and their next of kin, Brain Injury, 30, 567, 2016	Conference abstract.
Keck, Casey S., Creaghead, Nancy A., Turkstra, Lyn S., Vaughn, Lisa M., Kelchner, Lisa N., Pragmatic skills after childhood traumatic brain injury: Parents' perspectives, Journal of communication disorders, 69, 106-118, 2017	Study not conducted in one of the countries included in the review protocol.
Keenan, Alanna, Joseph, Lynn, The needs of family members of severe traumatic brain injured patients during critical and acute care: a qualitative study, Canadian journal of neuroscience nursing, 32, 25-35, 2010	Mixed setting and population, results not presented separately for the target settings and population.

Study	Reason for Exclusion
Keightley, Michelle, Kendall, Victoria, Jang, Shu-Hyun, Parker, Cindy, Agnihotri, Sabrina, Colantonio, Angela, Minore, Bruce, Katt, Mae, Cameron, Anita, White, Randy, Longboat-White, Claudine, Bellavance, Alice, From health care to home community: an Aboriginal community-based ABI transition strategy, Brain Injury, 25, 142-52, 2011	No qualitative data on phenomena of interest.
Kellezi, Blerina, Beckett, Kate, Earthy, Sarah, Barnes, Jo, Sleney, Jude, Clarkson, Julie, Regel, Stephen, Jones, Trevor, Kendrick, Denise, Understanding and meeting information needs following unintentional injury: comparing the accounts of patients, carers and service providers, Injury, 46, 564-71, 2015	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Kennedy, Nicole, Barnes, Jessica, Rose, Anna, Veitch, Craig, Bowling, Cott Dahlberg Degeneffe Gage Higgins Keightley Majdan McCabe McColl O'Callaghan Patterson Patton Patton Schlossberg Sheppard Sinnakaruppan Smith Turner Turner Turner Turner Turner Voss, Clinicians' expectations and early experiences of a new comprehensive rehabilitation case management model in a specialist brain injury rehabilitation unit, Brain Impairment, 13, 62-71, 2012	Population not in PICO: People >18 years old.
Kennedy, P., Sherlock, O., McClelland, M., Short, D., Royle, J., Wilson, C., A multi-centre study of the community needs of people with spinal cord injuries: the first 18 months, Spinal Cord, 48, 15-20, 2010	No qualitative data on phenomena of interest.
Kersten, Paula, Cummins, Christine, Kayes, Nicola, Babbage, Duncan, Elder, Hinemoa, Foster, Allison, Weatherall, Mark, Siegert, Richard John, Smith, Greta, McPherson, Kathryn, Making sense of recovery after traumatic brain injury through a peer mentoring intervention: a qualitative exploration, BMJ Open, 8, e020672, 2018	No qualitative data on phenomena of interest.
Kiekens, C., Christiaens, W., Van Den Heede, K., Organization of aftercare for patients with severe burn injuries in Belgium, Annals of Physical and Rehabilitation Medicine, 57, e212-e213, 2014	Conference abstract.
Kimmel, Lara A., Holland, Anne E., Hart, Melissa J., Edwards, Elton R., Page, Richard S., Hau, Raphael, Bucknill, Andrew, Gabbe, Belinda J., Discharge from the acute hospital: trauma patients' perceptions of care, Australian health review : a publication of the Australian Hospital Association, 40, 625-632, 2016	No qualitative data on phenomena of interest.
Kimmel, Lara A., Holland, Anne E., Lannin, Natasha, Edwards, Elton R., Page, Richard S., Bucknill, Andrew, Hau, Raphael, Gabbe, Belinda J., Clinicians' perceptions of decision making regarding discharge from public hospitals to in-patient rehabilitation following trauma, Australian health review : a publication of the Australian Hospital Association, 41, 192-200, 2017	No qualitative data on phenomena of interest.
Kingston, Gail A., Judd, Jenni, Gray, Marion A., The experience of medical and rehabilitation intervention for traumatic hand injuries in rural and remote North Queensland: a qualitative study, Disability and Rehabilitation, 37, 423-9, 2015	No qualitative data on phenomena of interest.
Kingston, Gail A., Judd, Dr Jenni, Gray, Marion A., The experience of living with a traumatic hand injury in a rural and remote location: an interpretive phenomenological study, Rural and remote health, 14, 2764, 2014	No qualitative data on phenomena of interest.
Kirk, S., Fallon, D., Fraser, C., Robinson, G., Vassallo, G., Supporting parents following childhood traumatic brain injury: a qualitative study to examine information and emotional support needs across key care transitions, Child: care, health and	No qualitative data on phenomena of interest.

Study	Reason for Exclusion
development, 41, 303-313, 2015	
Kivunja, Stephen, River, Jo, Gullick, Janice, Experiences of giving and receiving care in traumatic brain injury: An integrative review, Journal of clinical nursing, 27, 1304-1328, 2018	Systematic review, included studies checked for relevance.
Kjaersgaard, A., Kristensen, H. K., Brain injury and severe eating difficulties at admission-patient perspective nine to fifteen months after discharge: A pilot study, Brain Sciences, 7, 96, 2017	Unclear how many participants had experienced traumatic injury, the results not presented separately for target population.
Knox, L., Douglas, J., Bigby, C., Exploring tensions associated with supported decision making in adults with severe traumatic brain injury, Brain Injury, 26, 477, 2012	Conference abstract.
Koehmstedt, Christine, Lydick, Susan E., Patel, Drasti, Cai, Xinsheng, Garfinkel, Steven, Weinstein, Ali A., Health status, difficulties, and desired health information and services for veterans with traumatic brain injuries and their caregivers: A qualitative investigation, PLoS ONE, 13, e0203804, 2018	Study not conducted in one of the countries included in the review protocol.
Koizia, L., Kings, R., Koizia, A., Peck, G., Wilson, M., Hettiaratchy, S., Fertleman, M. B., Major trauma in the elderly: Frailty decline and patient experience after injury, Trauma (United Kingdom), 21, 21-26, 2019	Not a qualitative study.
Koller, Kathryn, Woods, Lindsay, Engel, Lisa, Bottari, Carolina, Dawson, Deirdre R., Nalder, Emily, Bandura, Bottari Braun Chen Colantonio Creswell Dreer Engel Fleming Fox Gaudette Hall Hoskin Kelley Kershaw Kim Knight Kreutzer Langlois Levack Malee Marson Martin McCabe McHugh Patton Poncer Weiner, Loss of financial management independence after brain injury: Survivors' experiences, American Journal of Occupational Therapy, 70, No-Specified, 2016	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Kontos, P., Miller, K. L., Colantonio, A., Cott, C., Therapeutic landscape theory: Identifying health detracting and health enhancing aspects of neurorehabilitation, Brain Injury, 28, 535, 2014	Conference abstract.
Kornhaber, R., Wilson, A., Abu-Qamar, M., McLean, L., Vandervord, J., Inpatient peer support for adult burn survivors-a valuable resource: a phenomenological analysis of the Australian experience, Burns : journal of the International Society for Burn Injuries, 41, 110-7, 2015	Study did not examine phenomena of interest.
Kornhaber, Rachel, Rickard, Greg, McLean, Loyola, Wiechula, Rick, Lopez, Violeta, Cleary, Michelle, Burn care and rehabilitation in Australia: health professionals' perspectives, Disability and Rehabilitation, 41, 714-719, 2019	Population not in PICO: People >18 years old.
Kozlowski-Moreau, O., Danze, F., Pollez, B., Brooks, N., Johnson, C., Line, M. C., Rousseaux, M., Croisiaux, C., Lanthier, A., Long-term management of severe TBI in Europe-The value of a network, Brain Injury, 30, 650, 2016	Conference abstract.
Kuipers, Pim, Kendall, Melissa B., Amsters, Delena, Pershouse, Kiley, Schuurs, Sarita, Descriptions of community by people with spinal cord injuries: concepts to inform community integration and community rehabilitation, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 34, 167-74, 2011	No qualitative data on phenomena of interest.
Lafebvre, H., Levert, M. J., Gelinas, I., Croteau, C., Le Dorze, G., Bottari, C., McKerrall, M., Personalized accompaniment for community integration for people with a traumatic brain injury in	Conference abstract.

Study	Reason for Exclusion
postrehabilitation, Archives of Physical Medicine and Rehabilitation, 91, e7, 2010	
Lamontagne, M. E., Swaine, B. R., Lavoie, A., Careau, E., Analysis of the strengths, weaknesses, opportunities and threats of the network form of organization of traumatic brain injury service delivery systems, Brain Injury, 25, 1188-1197, 2011	No qualitative data on phenomena of interest.
Lange, R., French, L., Bailie, J., Lippa, S., Gartner, R., Driscoll, A., Wright, M., Smith, J., Dilay, A., Pizzano, B., Johnson, L., Nora, D., Mahatan, H., Sullivan, J., Thompson, D., Snelling, A., Brickell, T., Caring for U.S. military service members following mild-moderate traumatic brain injury: Examination of access to services, service needs, and barriers to care, Journal of Head Trauma Rehabilitation, 32, E71, 2017	Conference abstract.
Lannin, N., Roberts, K., D'Cruz, K., Morarty, J., Unsworth, C., Who holds the 'Power' during goal-setting? A qualitative study exploring patient perceptions, International Journal of Stroke, 10, 68, 2015	Conference abstract.
Lapierre, Alexandra, Lefebvre, Helene, Gauvin-Lepage, Jerome, Factors Affecting Interprofessional Teamwork in Emergency Department Care of Polytrauma Patients: Results of an Exploratory Study, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 26, 312-322, 2019	Setting not in PICO: Emergency department.
Lee, Tracy, Norton, Andrea, Hayes, Sue, Adamson, Keith, Schwellnus, Heidi, Evans, Cathy, Exploring Parents' Perceptions and How Physiotherapy Supports Transition from Rehabilitation to School for Youth with an ABI, Physical & occupational therapy in pediatrics, 37, 444-455, 2017	No qualitative data on phenomena of interest.
Lefebvre, Helene, Levert, Marie Josee, The needs experienced by individuals and their loved ones following a traumatic brain injury, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 19, 197-207, 2012	No qualitative data on phenomena of interest.
Letts, L., Martin Ginis, K. A., Faulkner, G., Colquhoun, H., Levac, D., Gorczynski, P., Preferred Methods and Messengers for Delivering Physical Activity Information to People With Spinal Cord Injury: A Focus Group Study, Rehabilitation Psychology, 56, 128-137, 2011	It was unclear if the focus was specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Lexell, E. M., Alkhed, A. K., Olsson, K., The group rehabilitation helped me adjust to a new life: Experiences shared by persons with an acquired brain injury, Brain Injury, 27, 529-537, 2013	No qualitative data on phenomena of interest.
Lind, J. D., Fraser, M. A., Powell-Cope, G., Gavin-Dreschnack, D., Enhancing patient dignity in va spinal cord injury units, Journal of Spinal Cord Medicine, 36, 555, 2013	Study not conducted in one of the countries included in the review protocol.
Lindahl, Marianne, Hvalsoe, Berit, Poulsen, Jeppe Rosengaard, Langberg, Henning, Quality in rehabilitation after a working age person has sustained a fracture: partnership contributes to continuity, Work (Reading, Mass.), 44, 177-89, 2013	Population not in PICO: People >18 years old.
Lindahl, Marianne, Teljigovic, Sanel, Heegaard Jensen, Lars, Hvalsoe, Berit, Juneja, Hemant, Barth, Clay Cooper Cott Del Bano-Aledo Donabedian Donabedian Fitinghoff Griffiths Harris Hours Hush Jensen Kidd Lempp Lindahl Martins McLean Mead Mussener Partridge Pinto Polinder Rindflesch Sanders Strauss Walton Willamson, Importance of a patient-centred approach in ensuring quality of post-fracture rehabilitation for working aged people: A qualitative study of therapists' and patients' perspectives, Work: Journal of Prevention, Assessment &	Mixed population, cannot separate or confirm which patients were hospitalised and match the population of interest.

Study	Reason for Exclusion
Rehabilitation, 55, 831-839, 2016	
Lindberg, J., Kreuter, M., Taft, C., Person, L. O., Patient participation in care and rehabilitation from the perspective of patients with spinal cord injury, Spinal Cord, 51, 834-7, 2013	Study did not examine phenomena of interest.
Linnarsson, J. R., Bubini, J., Perseius, K. I., A meta-synthesis of qualitative research into needs and experiences of significant others to critically ill or injured patients, Journal of Clinical Nursing, 19, 3102-11, 2010	Systematic review, included studies outside of date limits (1997-2007).
Littooij, E., Leget, C. J. W., Stolwijk-Swuste, J. M., Doodeman, S., Widdershoven, G. A. M., Dekker, J., The importance of 'global meaning' for people rehabilitating from spinal cord injury, Spinal Cord, 54, 1047-1052, 2016	Study did not examine phenomena of interest.
Lundine, J. P., Utz, M., Jacob, V., Ciccia, A. H., Putting the person in person-centered care: Stakeholder experiences in pediatric traumatic brain injury, Journal of Pediatric Rehabilitation Medicine, 12, 21-35, 2019	Study not conducted in one of the countries included in the review protocol.
Maddick, Rosie, Norton, Ali Amir Andrews Baker Batavia Batt-Rawden Bernstein Braun Bright Bright Bruscia De Carvalho Deegan Dijkers Dorsett Dorsett Dorsett Fook Fook Galvin Golden Humphries James Larsson Lee Lefevre Lethborg Manns Montague Nielson North O'Callaghan O'Callaghan O'Neil Riessman Riessman Scheiby Slivka Stover Tamplin Whittemore Zedjlik, 'Naming the unnameable and communicating the unknowable': Reflections on a combined music therapy/social work program, The Arts in Psychotherapy, 38, 130-137, 2011	Study did not examine phenomena of interest.
Makela, P., Jones, F., de Sousa de Abreu, M. I., Hollinshead, L., Ling, J., Supporting self-management after traumatic brain injury: Codesign and evaluation of a new intervention across a trauma pathway, Health expectations : an international journal of public participation in health care and health policy, 22, 632-642, 2019	Study did not examine phenomena of interest.
Manning, Joseph C., Hemingway, Pippa, Redsell, Sarah A., Survived so what? Identifying priorities for research with children and families post-paediatric intensive care unit, Nursing in critical care, 23, 68-74, 2018	Study did not examine rehabilitation.
Martin, Laurie T., Farris, Coreen, Parker, Andrew M., Epley, Caroline, The Defense and Veterans Brain Injury Center Care Coordination Program: Assessment of Program Structure, Activities, and Implementation, Rand health quarterly, 3, 4, 2013	Study not conducted in one of the countries included in the review protocol.
Martin, Suzanne, Armstrong, Elaine, Thomson, Eileen, Vargiu, Eloisa, Sola, Marc, Dauwalder, Stefan, Miralles, Felip, Daly Lynn, Jean, A qualitative study adopting a user-centered approach to design and validate a brain computer interface for cognitive rehabilitation for people with brain injury, Assistive technology : the official journal of RESNA, 30, 233-241, 2018	Study did not examine phenomena of interest.
Materne, M., Lundqvist, L. O., Strandberg, T., Opportunities and barriers for successful return to work after acquired brain injury: A patient perspective, Work (Reading, Mass.), 56, 125-134, 2017	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
McBain, Sacha A., Sexton, Kevin W., Palmer, Brooke E., Landes, Sara J., Barriers to and facilitators of a screening procedure for PTSD risk in a level I trauma center, Trauma surgery & acute care open, 4, e000345, 2019	Study not conducted in one of the countries included in the review protocol.
McDermott, Garret L., McDonnell, Anne Marie, Acquired brain injury services in the Republic of Ireland: experiences and perceptions of families and professionals, Brain Injury, 28, 81-91,	The focus was not specific to care of people who have experienced traumatic injury

Study	Reason for Exclusion
2014	and the results not presented separately for target population.
McGarry, Sarah, Elliott, Catherine, McDonald, Ann, Valentine, Jane, Wood, Fiona, Girdler, Sonya, "This is not just a little accident": a qualitative understanding of paediatric burns from the perspective of parents, Disability and Rehabilitation, 37, 41-50, 2015	Study did not examine phenomena of interest.
McIntyre, Michelle, Ehrlich, Carolyn, Kendall, Elizabeth, Informal care management after traumatic brain injury: perspectives on informal carer workload and capacity, Disability and Rehabilitation, 1-9, 2018	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
McKelvey, M., Bush, E., Screening and identification of individuals with brain injury (BI) seeking services through the area agency on ageing in rural Nebraska, Brain Injury, 28, 712, 2014	Conference abstract.
McPherson, K., Fadyl, J., Theadom, A., Channon, A., Levack, W., Starkey, N., Wilkinson-Meyers, L., Kayes, N., Feigin, V., Barker-Collo, S., Harwood, M., Mudge, S., Christie, G., Jenkins, S., Living Life after Traumatic Brain Injury: Phase 1 of a Longitudinal Qualitative Study, Journal of Head Trauma Rehabilitation, 33, E44-E52, 2018	No qualitative data on phenomena of interest.
McPherson, K., Theadom, A., Wilkinson-Meyers, L., The experience of recovery-a qualitative study, Brain Injury, 26, 493-494, 2012	Conference abstract.
McRae, Philippa, Hallab, Lisa, Simpson, Grahame, Anstey, Braun Brooks Ellingsen Frost Gilworth Gilworth Gracey Harradine Kreutzer Macaden Medin Menon Nightingale Olver Oppermann Petrella Ponsford Rubenson Sabatello Simpson Tate Teasdale van Velzen van Velzen, Navigating employment pathways and supports following brain injury in Australia: Client perspectives, Australian Journal of Rehabilitation Counselling, 22, 76-92, 2016	No qualitative data on phenomena of interest.
Meade, M., Carr, L., Ellenbogen, P., Barrett, K., Perceptions of provider education and attitude by individuals with spinal cord injury: Implications for health care disparities, Topics in Spinal Cord Injury Rehabilitation, 17, 25-37, 2011	Study not conducted in one of the countries included in the review protocol.
Medina-Mirapeix, F., Del Bano-Aledo, M. E., Oliveira-Sousa, S. L., Escolar-Reina, P., Collins, S. M., How the rehabilitation environment influences patient perception of service quality: A qualitative study, Archives of Physical Medicine and Rehabilitation, 94, 1112-1117, 2013	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Mehta, Swati, Hadjistavropoulos, Heather D., Earis, Danielle, Titov, Nick, Dear, Blake F., Patient perspectives of Internet-delivered cognitive behavior therapy for psychosocial issues post spinal cord injury, Rehabilitation Psychology, 2019	No qualitative data on phenomena of interest.
Meixner, Cara, O'Donoghue, Cynthia R., Witt, Michelle, Accessing crisis intervention services after brain injury: a mixed methods study, Rehabilitation psychology, 58, 377-85, 2013	Study not conducted in one of the countries included in the review protocol.
Messinger, Seth, Bozorghadad, Sayeh, Pasquina, Paul, Social relationships in rehabilitation and their impact on positive outcomes among amputees with lower limb loss at Walter Reed National Military Medical Center, Journal of rehabilitation medicine, 50, 86-93, 2018	Study not conducted in one of the countries included in the review protocol.
Milte, R., Ratcliffe, J., Miller, M., Whitehead, C., Cameron, I. D., Crotty, M., What are frail older people prepared to endure to	Not a qualitative study.

Study	Reason for Exclusion
achieve improved mobility following hip fracture? A Discrete Choice Experiment, Journal of rehabilitation medicine : official journal of the UEMS European Board of Physical and Rehabilitation Medicine, 45, 81-86, 2013	
Minney, M. J., Roberts, R. M., Mathias, J. L., Raftos, J., Kochar, A., Service and support needs following pediatric brain injury: perspectives of children with mild traumatic brain injury and their parents, Brain Injury, 33, 168-182, 2019	Study did not examine rehabilitation.
Mitchell, Rebecca, Fajardo Pulido, Diana, Ryder, Tayhla, Norton, Grace, Brodaty, Henry, Draper, Brian, Close, Jacqueline, Rapport, Frances, Lystad, Reidar, Harris, Ian, Harvey, Lara, Sherrington, Cathie, Cameron, Ian D., Braithwaite, Jeffrey, Access to rehabilitation services for older adults living with dementia or in a residential aged care facility following a hip fracture: healthcare professionals' views, Disability and Rehabilitation, 1-12, 2019	Study did not examine phenomena of interest.
Mitsch, Virginia, Curtin, Michael, Badge, Helen, The provision of brain injury rehabilitation services for people living in rural and remote New South Wales, Australia, Brain Injury, 28, 1504-13, 2014	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Moore, M., Robinson, G., Mink, R., Hudson, K., Dotolo, D., Gooding, T., Ramirez, A., Zatzick, D., Vavilala, M., Acute care after pediatric traumatic brain injury: A qualitative study of the family perspective, Journal of Neurotrauma, 31, A59, 2014	Conference abstract.
Moore, Megan, Robinson, Gabrielle, Mink, Richard, Hudson, Kimberly, Dotolo, Danae, Gooding, Tracy, Ramirez, Alma, Zatzick, Douglas, Giordano, Jessica, Crawley, Deborah, Vavilala, Monica S., Developing a Family-Centered Care Model for Critical Care After Pediatric Traumatic Brain Injury, Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies, 16, 758-65, 2015	Study not conducted in one of the countries included in the review protocol.
Morriss, Elissa, Wright, Suzanne, Smith, Sharon, Roser, Judy, Kendall, Melissa, Ackerson, Ackerson Bassett Bassett Baulderstone Baxter Bisogni Butera-Prinzi Charles Cicerone Clark Cowling Craig Degeneffe Devany-Serio Evenson Flanagan Fletcher Gan Jacob Jones Kaatz Kirshbaum Kosciulek Lancaster Leinonen Lezak Llewellyn Maitz Nicholson Olson Pessar Qu Sander Smith Stake Strauss Urbach Uysal Visser-Meily Wade, Parenting challenges and needs for fathers following acquired brain injury (ABI) in Queensland, Australia: A preliminary model, Special Issue: Family support and adjustment following acquired brain injury: An international perspective., 19, 119-134, 2013	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Mumbower, R., Heaton, K., Dreer, L., Novack, T., Childs, G., Vance, D., Sleep experiences following traumatic brain injury: A qualitative descriptive study, Archives of Physical Medicine and Rehabilitation, 98, e155, 2017	Conference abstract.
Munce, Sarah E. P., Webster, Fiona, Fehlings, Michael G., Straus, Sharon E., Jang, Eunice, Jaglal, Susan B., Meaning of self-management from the perspective of individuals with traumatic spinal cord injury, their caregivers, and acute care and rehabilitation managers: an opportunity for improved care delivery, BMC Neurology, 16, 11, 2016	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Munce, Sarah E. P., Webster, Fiona, Fehlings, Michael G., Straus, Sharon E., Jang, Eunice, Jaglal, Susan B., Perceived facilitators and barriers to self-management in individuals with traumatic spinal cord injury: a qualitative descriptive study, BMC	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access

Study	Reason for Exclusion
Neurology, 14, 48, 2014	rehabilitation following discharge.
Murphy, Margaret, McCloughen, Andrea, Curtis, Kate, Using theories of behaviour change to transition multidisciplinary trauma team training from the training environment to clinical practice, Implementation science : IS, 14, 43, 2019	Study did not examine rehabilitation.
Murphy, Margaret, McCloughen, Andrea, Curtis, Kate, The impact of simulated multidisciplinary Trauma Team Training on team performance: A qualitative study, Australasian emergency care, 22, 1-7, 2019	Study did not examine rehabilitation.
Murray, A., Watter, K., Nielsen, M., Kennedy, A., A scoping study examining vocational rehabilitation in early acquired brain injury rehabilitation, Brain Impairment, 19, 306-307, 2018	Conference abstract.
Nalder, E., Fleming, J., Cornwell, P., Foster, M., Identity and the life course: Lived experiences of individuals with traumatic brain injury during the period of transition from hospital to home, Brain Impairment, 14, 159, 2013	Conference abstract.
Nalder, E., Fleming, J., Cornwell, P., Foster, M., Worrall, L., Ownsworth, T., Haines, T., Kendall, M., Chenoweth, L., What constitutes transition success? An investigation into factors influencing the perceptions of individuals with a TBI regarding the transition from hospital to home, Brain Injury, 24 (3), 189-190, 2010	Conference abstract.
Nalder, Emily J., Zabjek, Karl, Dawson, Deirdre R., Bottari, Carolina L., Gagnon, Isabelle, McFadyen, Bradford J., Hunt, Anne W., McKenna, Suzanne, Ouellet, Marie-Christine, Giroux, Sylvain, Cullen, Nora, Niechwiej-Szwedo, Ewa, Onf-Repar Abi Team, Research Priorities for Optimizing Long-term Community Integration after Brain Injury, The Canadian journal of neurological sciences. Le journal canadien des sciences neurologiques, 45, 643-651, 2018	Data was not collected using an appropriate qualitative methodology (the authors have analysed their own field notes taken at a 2-day conference for practitioners)
Nalder, Emily, Fleming, Jennifer, Cornwell, Petrea, Shields, Cassandra, Foster, Michele, Reflections on life: experiences of individuals with brain injury during the transition from hospital to home, Brain Injury, 27, 1294-303, 2013	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Nasrabadi, A. N., Mohammadi, N., Davatgaran, K., Yekaninejad, M., Javidan, A. N., Shabany, M., Designing a client and family empowerment model to promote constructive life recovery among persons with spinal cord injury: A qualitative study, Archives of Neuroscience, 6, e87867, 2019	Study not conducted in one of the countries included in the review protocol.
Nilsson, Charlotte, Bartfai, Aniko, Lofgren, Monika, Bartfai, Ben-Yishai Brooks Carlsson Charmaz Christensen Cicerone Cicerone Cicerone Comper Creswell Cullen Dahlgren Ferguson Fleming Gard Ho Kielhofner Lincoln Miller Ohman Phipps Ponsford Prigatano Rice-Oxley Roding Roxendahl Rudolfsson Ruff Stalnacke Svendsen Tiersky Wilson, Holistic group rehabilitation-A short cut to adaptation to the new life after mild acquired brain injury, Disability and Rehabilitation: An International, Multidisciplinary Journal, 33, 969-978, 2011	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Norrbrink, Cecilia, Lofgren, Monika, Needs and requests--patients and physicians voices about improving the management of spinal cord injury neuropathic pain, Disability and Rehabilitation, 38, 151-8, 2016	No qualitative data on phenomena of interest.
Nunnerley, J. L., Hay-Smith, E. J., Dean, S. G., Leaving a spinal unit and returning to the wider community: an interpretative phenomenological analysis, Disability and Rehabilitation, 35,	Population not in PICO: Study did not mention that the patients were transferred to

Study	Reason for Exclusion
1164-1173, 2013	outpatient or community services following discharge.
O'Callaghan, A., McNamara, B., Cocks, E., 'What am I supposed to do? Cartwheels down the passageway?' Perspectives on the rehabilitation journey from people with ABI, Brain Injury, 28, 577-578, 2014	Conference abstract.
O'Callaghan, Anna, McAllister, Lindy, Wilson, Linda, Insight vs readiness: factors affecting engagement in therapy from the perspectives of adults with TBI and their significant others, Brain Injury, 26, 1599-610, 2012	Population not in PICO: People over 18 years old.
O'Callaghan, Anna, McAllister, Lindy, Wilson, Linda, Blight, Brookshire Brown Cicerone Denzin Fleming Foster Gentleman Goranson Grbich Hickson Hughes Humphreys Humphreys Josselson Katz Keleher LeFebvre Mackay MacPhail Malec McNaughton Minichiello Morse Morton Muus O'Callaghan O'Callaghan O'Callaghan O'Callaghan Penchansky Rankin Sandelowski Schmidt Schwandt Seale Sherer Stringer Tuel Turner-Stokes Youse, Healthcare consumers' need for brain-injury services: The critical importance of timing in planning future services, Brain Impairment, 13, 316-332, 2012	Analysis methods not appropriate (data reduced into case vignettes)
Odumuyiwa, Tolu, Improving access to social care services following acquired brain injury: a needs analysis, Journal of Long-Term Care, 164-175, 2019	Population not in PICO: People over 18 years old.
Ogilvie, Rebekah, Foster, Kim, McCloughen, Andrea, Curtis, Kate, The injury trajectory for young people 16-24 years in the six months following injury: A mixed methods study, Injury, 47, 1966-74, 2016	Study did not examine phenomena of interest.
Ogilvie, Rebekah, Foster, Kim, McCloughen, Andrea, Curtis, Kate, Young peoples' experience and self-management in the six months following major injury: A qualitative study, Injury, 46, 1841-7, 2015	No qualitative data on phenomena of interest.
Oster, Caisa, Kildal, Morten, Ekselius, Lisa, Return to work after burn injury: burn-injured individuals' perception of barriers and facilitators, Journal of burn care & research : official publication of the American Burn Association, 31, 540-50, 2010	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Oyesanya, Tolu O., Bowers, Barbara J., Royer, Heather R., Turkstra, Lyn S., Nurses' concerns about caring for patients with acute and chronic traumatic brain injury, Journal of Clinical Nursing, 27, 1408-1419, 2018	Study not conducted in one of the countries included in the review protocol.
Palimaru, Alina, Cunningham, William E., Dillistone, Marcus, Vargas-Bustamante, Arturo, Liu, Honghu, Hays, Ron D., A comparison of perceptions of quality of life among adults with spinal cord injury in the United States versus the United Kingdom, Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation, 26, 3143-3155, 2017	Study did not examine phenomena of interest.
Pallesen, H., Buhl, I., Interdisciplinary facilitation of the minimal participation of patients with severe brain injury in early rehabilitation, European Journal of Physiotherapy, 19, 13-23, 2017	Study includes 5 participants with acquired brain injury but only 2 (40%) are from trauma
Patterson, F., Fleming, J., Doig, E., Patient experiences of occupational therapy groups in traumatic brain injury rehabilitation, Brain Impairment, 19, 281, 2018	Conference abstract.
Patton, Desmond, Sodhi, Aparna, Affinati, Steven, Lee, Jooyoung, Crandall, Marie, Post-Discharge Needs of Victims of Gun Violence in Chicago: A Qualitative Study, Journal of interpersonal violence,	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
34, 135-155, 2019	
Pekmezaris, Renee, Kozikowski, Andrzej, Pascarelli, Briana, Handrakis, John P., Chory, Ashley, Griffin, Doug, Bloom, Ona, Participant-reported priorities and preferences for developing a home-based physical activity telemonitoring program for persons with tetraplegia: a qualitative analysis, Spinal cord series and cases, 5, 48, 2019	Study not conducted in one of the countries included in the review protocol.
Phillips, J., Holmes, J., Auton, M., Radford, K., What are the most important outcomes of traumatic brain injury vocational rehabilitation? People with TBI, service provider and employer perspectives, Brain Injury, 30, 494-495, 2016	Conference abstract.
Piccenna, Loretta, Lannin, Natasha A., Gruen, Russell, Pattuwage, Loyal, Bragge, Peter, The experience of discharge for patients with an acquired brain injury from the inpatient to the community setting: A qualitative review, Brain Injury, 30, 241-51, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Plant, Sarah E., Tyson, Sarah F., Kirk, Susan, Parsons, John, What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis, Clinical rehabilitation, 30, 921-30, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Pol, M., Peek, S., Van Nes, F., Van Hartingsveldt, M., Buurman, B., Krose, B., Everyday life after a hip fracture: What community-living older adults perceive as most beneficial for their recovery, Age and Ageing, 48, 440-447, 2019	No qualitative data on phenomena of interest.
Poncet, F., Pradat-Diehl, P., Lamontagne, M. E., Alifax, A., Barette, M., Fradelizi, P., Swaine, B., A mixed-methods approach to evaluate participants' and service providers' perceptions of an outpatient rehabilitation programme for persons with acquired brain injury, Brain Injury, 31, 816, 2017	Conference abstract.
Poncet, F., Pradat-Diehl, P., Lamontagne, M. E., Alifax, A., Fradelizi, P., Barette, M., Swaine, B., Participant and service provider perceptions of an outpatient rehabilitation program for people with acquired brain injury, Annals of Physical and Rehabilitation Medicine, 60, 334-340, 2017	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Popejoy, Lori L., Dorman Marek, Karen, Scott-Cawiezell, Jill, Patterns and problems associated with transitions after hip fracture in older adults, Journal of gerontological nursing, 39, 43-52, 2013	Study not conducted in one of the countries included in the review protocol.
Porto, A., Anderson, L., Vogel, L., Zebracki, K., Barriers in accessing adult healthcare for transitioning youth with spinal cord injury, Developmental Medicine and Child Neurology, 60, 116, 2018	Conference abstract.
Poulin, V., Lamontagne, M. E., Ouellet, M. C., Pellerin, M. A., Jean, A., Implementing best practices in cognitive rehabilitation: What are rehabilitation teams' priorities and why?, Archives of Physical Medicine and Rehabilitation, 98, e157, 2017	Conference abstract.
Prescott, Sarah, Fleming, Jennifer, Doig, Emmah, Refining a clinical practice framework to engage clients with brain injury in goal setting, Australian Occupational Therapy Journal, 66, 313-325, 2019	Study did not examine phenomena of interest.
Ramakrishnan, Kumaran, Johnston, Deborah, Garth, Belinda, Murphy, Gregory, Middleton, James, Cameron, Ian, Early Access to Vocational Rehabilitation for Inpatients with Spinal Cord Injury:	The focus was not specific to participants who had experienced traumatic injury

Study	Reason for Exclusion
A Qualitative Study of Patients' Perceptions, Topics in Spinal Cord Injury Rehabilitation, 22, 183-191, 2016	and the results not presented separately for target population.
Rashid, M., Caine, V., Newton, A. S., Goez, H. R., Healthcare professionals' perspective on the delivery of care to children with Acquired Brain Injury (ABI) and communication with their parents, Journal of Pediatric Rehabilitation Medicine, 11, 125-131, 2018	No qualitative data on phenomena of interest.
Roberts, J. L., Pritchard, A. W., Williams, M., Totton, N., Morrison, V., D. In N.U, Williams, N. H., Mixed methods process evaluation of an enhanced community-based rehabilitation intervention for elderly patients with hip fracture, BMJ Open, 8 (8) (no pagination), 2018	No qualitative data on phenomena of interest.
Roberts, Jessica Louise, Din, Nafees Ud, Williams, Michelle, Hawkes, Claire A., Charles, Joanna M., Hoare, Zoe, Morrison, Val, Alexander, Swapna, Lemmey, Andrew, Sackley, Catherine, Logan, Phillipa, Wilkinson, Clare, Rycroft-Malone, Jo, Williams, Nefyn H., Development of an evidence-based complex intervention for community rehabilitation of patients with hip fracture using realist review, survey and focus groups, BMJ Open, 7, e014362, 2017	No qualitative data on phenomena of interest.
Rongen, A., Bakx, W., Nijhuis, F., Follow-up study of patients with an acquired Brain Injury after early focus on return to work during post-acute rehabilitation, Brain Injury, 24, 450-451, 2010	Conference abstract.
Roscigno, Cecelia I., Parent Perceptions of How Nurse Encounters Can Provide Caring Support for the Family in Early Acute Care After Children's Severe Traumatic Brain Injury, Journal of Neuroscience Nursing, 48, E2-E15, 2016	Study not conducted in one of the countries included in the review protocol.
Roth, Karin, Mueller, Gabi, Wyss, Adrian, Experiences of peer counselling during inpatient rehabilitation of patients with spinal cord injuries, Spinal cord series and cases, 5, 1, 2019	The majority of participants had not experienced traumatic injury and the results not presented separately for target population.
Rothlisberger, Fabian, Boes, Stefan, Rubinelli, Sara, Schmitt, Klaus, Scheel-Sailer, Anke, Challenges and potential improvements in the admission process of patients with spinal cord injury in a specialized rehabilitation clinic - an interview based qualitative study of an interdisciplinary team, BMC health services research, 17, 443, 2017	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Ryerson Espino, S., Kelly, E., Riordan, A., Zebracki, K., Vogel, L., Personal and family experiences of caregivers of children with SCI, Developmental Medicine and Child Neurology, 58, 107-108, 2016	Conference abstract.
Ryerson Espino, Susan L., Kelly, Erin H., Rivelli, Anne, Zebracki, Kathy, Vogel, Lawrence C., It is a marathon rather than a sprint: an initial exploration of unmet needs and support preferences of caregivers of children with SCI, Spinal Cord, 56, 284-294, 2018	Study not conducted in one of the countries included in the review protocol.
Sale, J. E. M., Bogoch, E., Hawker, G., Gignac, M., Beaton, D., Jaglal, S., Frankel, L., Patient perceptions of provider barriers to post-fracture secondary prevention, Osteoporosis international : a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA, 25, 2581-9, 2014	No qualitative data on phenomena of interest.
Salsbury, Stacie A., Vining, Robert D., Gosselin, Donna, Goertz, Christine M., Be good, communicate, and collaborate: a qualitative analysis of stakeholder perspectives on adding a chiropractor to the multidisciplinary rehabilitation team,	Study not conducted in one of the countries included in the review protocol.

Study	Reason for Exclusion
Chiropractic & manual therapies, 26, 29, 2018	
Samoborec, Stella, Ayton, Darshini, Ruseckaite, Rasa, Winbolt, Gary, Evans, Sue M., System complexities affecting recovery after a minor transport-related injury: The need for a person-centred approach, Journal of Rehabilitation Medicine, 51, 120-126, 2019	Population described as people that sustained predominantly minor injuries; study does not report any results separately for target population.
Sandstrom, Linda, Engstrom, Asa, Nilsson, Carina, Juuso, Paivi, Experiences of suffering multiple trauma: A qualitative study, Intensive & critical care nursing, 2019	Setting not in PICO: Intensive care unit
Sashika, Hironobu, Takada, Kaoruko, Kikuchi, Naohisa, Rehabilitation needs and participation restriction in patients with cognitive disorder in the chronic phase of traumatic brain injury, Medicine, 96, e5968, 2017	Study not conducted in one of the countries included in the review protocol.
Schiller, Claire, Franke, Thea, Belle, Jessica, Sims-Gould, Joanie, Sale, Joanna, Ashe, Maureen C., Words of wisdom - patient perspectives to guide recovery for older adults after hip fracture: a qualitative study, Patient preference and adherence, 9, 57-64, 2015	Study did not examine rehabilitation.
Segevall, Cecilia, Soderberg, Siv, Bjorkman Randstrom, Kerstin, The Journey Toward Taking the Day for Granted Again: The Experiences of Rural Older People's Recovery From Hip Fracture Surgery, Orthopedic nursing, 38, 359-366, 2019	Study did not examine rehabilitation while an inpatient, when transferring, or seeking to access rehabilitation following discharge.
Self, Megan, Driver, Simon, Stevens, Laurel, Warren, Ann Marie, Physical activity experiences of individuals living with a traumatic brain injury: a qualitative research exploration, Adapted physical activity quarterly : APAQ, 30, 20-39, 2013	Study not conducted in one of the countries included in the review protocol.
Sena Martins, Bruno, Fontes, Fernando, Hespanha, Pedro, Barnes, Barnes Davis Fontes Fontes Goffman Guion Hahn Henriques Hughes Klein Leder Martins Martins Oliver Oliver Oliver Santos Somers Stiker Stone Turner Wall, Spinal cord injury in Portugal: Institutional and personal challenges, Journal of Disability Policy Studies, 28, 119-128, 2017	No qualitative data on phenomena of interest.
Sharp, K., Richards, S., Client's perspectives of smartphone technology in acquired brain injury rehabilitation, Brain Impairment, 14, 167, 2013	Conference abstract.
Silver, Jeremy, Ljungberg, Inger, Libin, Alexander, Groah, Suzanne, Barriers for individuals with spinal cord injury returning to the community: a preliminary classification, Disability and Health Journal, 5, 190-6, 2012	Study not conducted in one of the countries included in the review protocol.
Silver, Samuel A., Saragosa, Marianne, Adhikari, Neill K., Bell, Chaim M., Harel, Ziv, Harvey, Andrea, Kitchlu, Abhijat, Neyra, Javier A., Wald, Ron, Jeffs, Lianne, What insights do patients and caregivers have on acute kidney injury and posthospitalisation care? A single-centre qualitative study from Toronto, Canada, BMJ Open, 8, e021418, 2018	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Sims-Gould, Joanie, Byrne, Kerry, Hicks, Elisabeth, Khan, Karim, Stolee, Paul, Examining "success" in post-hip fracture care transitions: a strengths-based approach, Journal of Interprofessional Care, 26, 205-11, 2012	Population not in PICO: People over 18 years old.
Singh, Gurkaran, MacGillivray, Megan, Mills, Patricia, Adams, Jared, Sawatzky, Bonita, Mortenson, W. Ben, Patients' Perspectives on the Usability of a Mobile App for Self-Management following Spinal Cord Injury, Journal of Medical	No qualitative data on phenomena of interest.

Study	Reason for Exclusion
Systems, 44, 26, 2019	
Singh, Hardeep, Shah, Meeral, Flett, Heather M., Craven, B. Catherine, Verrier, Mary C., Musselman, Kristin E., Perspectives of individuals with sub-acute spinal cord injury after personalized adapted locomotor training, Disability and Rehabilitation, 40, 820-828, 2018	Population not in PICO: People over 18 years old.
Slomic, M., Christiansen, B., Sveen, U., Soberg, H. L., Users' experiential knowledge as a base for evidence-based practice in inter-professional rehabilitation, Brain Injury, 30, 580-581, 2016	Conference abstract.
Slomic, M., Soberg, H. L., Sveen, U., Christiansen, B., Transitions of patients with traumatic brain injury and multiple trauma between specialized and municipal rehabilitation services-Professionals' perspectives, Cogent Medicine, 4, 1320849, 2017	Population not in PICO: People over 18 years old.
Slomic, Mirela, Christiansen, Bjorg, Soberg, Helene L., Sveen, Unni, User involvement and experiential knowledge in interprofessional rehabilitation: a grounded theory study, BMC health services research, 16, 547, 2016	No qualitative data on phenomena of interest.
Smith, Bridget M., Martinez, Rachael N., Evans, Charlesnika T., Saban, Karen L., Balbale, Salva, Proescher, Eric J., Stroupe, Kevin, Hogan, Timothy P., Barriers and strategies for coordinating care among veterans with traumatic brain injury: a mixed methods study of VA polytrauma care team members, Brain Injury, 32, 755-762, 2018	Study not conducted in one of the countries included in the review protocol.
Smith, E. M., Boucher, N., Miller, W. C., Caregiving services in spinal cord injury: A systematic review of the literature, Spinal Cord, 54, 562-569, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Smith, M., Hada, E., Long, C., Bushnik, T., Examining language preference and acculturation and implications for the continuum of care of patients with traumatic brain injury (TBI), Journal of Head Trauma Rehabilitation, 30, E107, 2015	Conference abstract.
Snell, Deborah L., Martin, Rachelle, Surgenor, Lois J., Siegert, Richard J., Hay-Smith, E. Jean C., What's wrong with me? seeking a coherent understanding of recovery after mild traumatic brain injury, Disability and Rehabilitation, 39, 1968-1975, 2017	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Soong, Christine, Kurabi, Bochra, Exconde, Kathleen, Tajammal, Faiqa, Bell, Chaim M., Design of an orthopaedic-specific discharge summary, BMC Health Services Research, 16, 545, 2016	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Sorli, H., Bach, B., Haarberg, D., Hjort-Larsen, G., Anette Hansen, S., Kristiansen, G., Hansen, H., Telerehabilitation in Norway, Brain Injury, 24, 284-285, 2010	Conference abstract.
Speck, Rebecca M., Jones, Gabrielle, Barg, Frances K., McCunn, Maureen, Team composition and perceived roles of team members in the trauma bay, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 19, 133-8, 2012	Study not conducted in one of the countries included in the review protocol.
Starnes, C. L., Bailey, E. A., Calvert, C. T., Gusler, J., Cairns, B. A., Development of a pediatric educational tool: Helping burns heal-an adventure for kids with burns, Journal of Burn Care and Research, 37, S172, 2016	Conference abstract.
Stergiou-Kita, M., Bottari, C., Dawson, D., Hebert, D., Grigorovich,	Conference abstract.

Study	Reason for Exclusion
A., Inter-professional approaches to vocational evaluation following traumatic brain injury, Brain Injury, 28, 774-775, 2014	
Stolee, Paul, Elliott, Jacobi, Byrne, Kerry, Sims-Gould, Joanie, Tong, Catherine, Chesworth, Bert, Egan, Mary, Ceci, Christine, Forbes, Dorothy, A Framework for Supporting Post-acute Care Transitions of Older Patients With Hip Fracture, Journal of the American Medical Directors Association, 20, 414-419.e1, 2019	Population not in PICO: People over 18 years old.
Stott-Eveneshen, Sarah, Sims-Gould, Joanie, McAllister, Megan M., Fleig, Lena, Hanson, Heather M., Cook, Wendy L., Ashe, Maureen C., Reflections on Hip Fracture Recovery From Older Adults Enrolled in a Clinical Trial, Gerontology & geriatric medicine, 3, 2333721417697663, 2017	No qualitative data on phenomena of interest.
Strandberg, T., Materne, M., Returning to working life after acquired brain injury-The rehabilitation-process, possibilities and hindrance for participation, Brain Injury, 28, 754, 2014	Conference abstract.
Sullivan, Martin, Paul, Charlotte E., Herbison, G. Peter, Tamou, Peina, Derrett, Sarah, Crawford, Maureen, A longitudinal study of the life histories of people with spinal cord injury, Injury prevention : journal of the International Society for Child and Adolescent Injury Prevention, 16, e3, 2010	A study protocol only. No data presented.
Sveen, Unni, Ostensjo, Sigrid, Laxe, Sara, Soberg, Helene L., Problems in functioning after a mild traumatic brain injury within the ICF framework: the patient perspective using focus groups, Disability and Rehabilitation, 35, 749-57, 2013	No qualitative data on phenomena of interest.
Swaine, B., Cullen, N., Bayley, M., Lavoie, A., Marshall, S., Turgeon, A., Sirois, M. J., Messier, F., Trempe, C., Who goes where and why? An environmental scan of rehab referral, admission and discharge of persons with brain injury in two canadian provinces, Brain Injury, 24, 362, 2010	Conference abstract.
Takada, Kaoruko, Sashika, Hironobu, Wakabayashi, Hidetaka, Hirayasu, Yoshio, Social participation and quality-of-life of patients with traumatic brain injury living in the community: A mixed methods study, Brain Injury, 30, 1590-1598, 2016	Study not conducted in one of the countries included in the review protocol.
Talbot, Lise R., Levesque, Annie, Trottier, Josee, Process of implementing collaborative care and its impacts on the provision of care and rehabilitation services to patients with a moderate or severe traumatic brain injury, Journal of multidisciplinary healthcare, 7, 313-20, 2014	No qualitative data on phenomena of interest.
Thrussell, Helen, Coggrave, Maureen, Graham, Allison, Gall, Angela, Donald, Michelle, Kulshrestha, Richa, Geddis, Tracey, Women's experiences of sexuality after spinal cord injury: a UK perspective, Spinal Cord, 56, 1084-1094, 2018	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Todis, Bonnie, McCart, Melissa, Glang, Ann, Hospital to school transition following traumatic brain injury: A qualitative longitudinal study, NeuroRehabilitation, 42, 269-276, 2018	Study not conducted in one of the countries included in the review protocol.
Torjussen, I., In sickness and in health? The effect of ABI on couples' relationships, Brain Impairment, 13, 160-161, 2012	Conference abstract.
Toscan, Justine, Manderson, Brooke, Santi, Selena M., Stolee, Paul, "Just another fish in the pond": the transitional care experience of a hip fracture patient, International journal of integrated care, 13, e023, 2013	Case report.
Turner, B., Fleming, J., Ownsworth, T., Cornwell, P., From hospital to home: A new conceptual framework for transition-based service delivery following acquired brain injury, Neurorehabilitation and Neural Repair, 26, 686, 2012	Conference abstract.

Study	Reason for Exclusion
Turner, Benjamin, Fleming, Jennifer, Ownsworth, Tamara, Cornwell, Petrea, Perceptions of recovery during the early transition phase from hospital to home following acquired brain injury: a journey of discovery, Neuropsychological rehabilitation, 21, 64-91, 2011	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Turner, Benjamin James, Fleming, Jennifer, Ownsworth, Tamara, Cornwell, Petrea, Perceived service and support needs during transition from hospital to home following acquired brain injury, Disability and Rehabilitation, 33, 818-29, 2011	No qualitative data on phenomena of interest.
Tverdal, Cathrine Buaas, Howe, Emilie Isager, Roe, Cecilie, Helseth, Eirik, Lu, Juan, Tenovuo, Olli, Andelic, Nada, Traumatic brain injury: Patient experience and satisfaction with discharge from trauma hospital, Journal of Rehabilitation Medicine, 50, 505-513, 2018	Not a qualitative study.
Tyerman, Emma, Eccles, Fiona J. R., Gray, Victoria, The experiences of parenting a child with an acquired brain injury: A meta-synthesis of the qualitative literature, Brain Injury, 31, 1553-1563, 2017	Study did not examine rehabilitation.
Tyerman, Emma, Eccles, Fiona J. R., Gray, Victoria, Murray, Craig D., Siblings' experiences of their relationship with a brother or sister with a pediatric acquired brain injury, Disability and Rehabilitation, 41, 2940-2948, 2019	The majority of participants' siblings had not experienced traumatic injury and results not presented separately for target population.
Umeasiegbu, Veronica I., Waletich, Brittany, Whitten, Laura A., Bishop, Malachy, Abreu, Bartlett Berg Bishop Corrigan Cott Creswell Degeneffe Degeneffe deGuise Elbogen Gontkovsky Heinemann Jennekens Kreutzer Lefebvre Lehan Man Murphy O'Callaghan O'Callaghan Pickelsimer Ponsford Rotondi Sinnakaruppan Spearman Turner Vaughn, Community-based rehabilitation needs: Perceptions of individuals with brain injury and their families in the Midwestern United States, Special Issue: Family support and adjustment following acquired brain injury: An international perspective., 19, 155-163, 2013	Study not conducted in one of the countries included in the review protocol.
Unger, Janelle, Singh, Hardeep, Mansfield, Avril, Hitzig, Sander L., Lenton, Erica, Musselman, Kristin E., The experiences of physical rehabilitation in individuals with spinal cord injuries: a qualitative thematic synthesis, Disability and Rehabilitation, 41, 1367-1383, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Valizadeh, Sousan, Dadkhah, Behrouz, Mohammadi, Eissa, Hassankhani, Hadi, The perception of trauma patients from social support in adjustment to lower-limb amputation: a qualitative study, Indian journal of palliative care, 20, 229-38, 2014	Study not conducted in one of the countries included in the review protocol.
Van de Velde, Dominique, Bracke, Piet, Van Hove, Geert, Josephsson, Staffan, Devisch, Ignaas, Vanderstraeten, Guy, The illusion and the paradox of being autonomous, experiences from persons with spinal cord injury in their transition period from hospital to home, Disability and Rehabilitation, 34, 491-502, 2012	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Van de Veldea, Dominique, Bracke, Piet, Van Hove, Geert, Josephsson, Staffan, Vanderstraeten, Guy, Perceived participation, experiences from persons with spinal cord injury in their transition period from hospital to home, International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation, 33, 346-55, 2010	Population not in PICO: Study did not mention that the patients were transferred to outpatient or community services following discharge.
Vassallo, G., Robinson, G., Fraser, C., Fallon, D., Kirk, S., A qualitative study to investigate families' information and support	Conference abstract.

Study	Reason for Exclusion
needs following severe traumatic brain injury in childhood, Developmental Medicine and Child Neurology, 1), 34, 2014	
Wade, S. L., Moscato, E. L., Raj, S. P., Narad, M. E., Clinician perspectives delivering telehealth interventions to children/families impacted by pediatric traumatic brain injury, Rehabilitation Psychology, 64, 298-306, 2019	Study not conducted in one of the countries included in the review protocol.
Waring, Justin, Marshall, Fiona, Bishop, Simon, Understanding the occupational and organizational boundaries to safe hospital discharge, Journal of health services research & policy, 20, 35-44, 2015	It was not clear how many participants had experienced a traumatic injury; results not presented separately for target population.
Weatherhead, S., Calvert, P., Newby, G., Three models of group therapy in community brain injury rehabilitation, Brain Injury, 26, 430-431, 2012	Conference abstract.
Weir, N., Prescott, S., Fleming, J., Doig, E., Exploration of structured communication during client-centred goal setting with people with acquired brain injury, Brain Impairment, 19, 347-348, 2018	Conference abstract.
Wharewera-Mika, Julie, Cooper, Erana, Kool, Bridget, Pereira, Susana, Kelly, Patrick, Caregivers' voices: The experiences of caregivers of children who sustained serious accidental and non-accidental head injury in early childhood, Clinical child psychology and psychiatry, 21, 268-86, 2016	No qualitative data on phenomena of interest.
Wheatley, Alison, Bamford, Claire, Shaw, Caroline, Flynn, Elizabeth, Smith, Amy, Beyer, Fiona, Fox, Chris, Barber, Robert, Parry, Steve W., Howel, Denise, Homer, Tara, Robinson, Louise, Allan, Louise M., Developing an Intervention for Fall-Related Injuries in Dementia (DIFRID): an integrated, mixed-methods approach, BMC Geriatrics, 19, 57, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Whiteneck, G., Gassaway, J., Dijkers, M., Balance of spinal cord injury rehabilitation services provided in inpatient and postdischarge settings, Archives of Physical Medicine and Rehabilitation, 91, e19, 2010	Conference abstract.
Whiteneck, G., Gassaway, J., Dijkers, M., Lammertse, D., Hammond, F., Heinemann, A., Backus, D., Charlifue, S., Ballard, P., Zanca, J., Inpatient and post-discharge rehabilitation services provided in the first year after spinal cord injury: Findings from the SCI rehab study, Topics in Spinal Cord Injury Rehabilitation, 16, 28-29, 2011	Conference abstract.
Whiteneck, Gale G., Gassaway, Julie, Dijkers, Marcel P., Lammertse, Daniel P., Hammond, Flora, Heinemann, Allen W., Backus, Deborah, Charlifue, Susan, Ballard, Pamela H., Zanca, Jeanne M., Inpatient and postdischarge rehabilitation services provided in the first year after spinal cord injury: findings from the SCIRehab Study, Archives of Physical Medicine and Rehabilitation, 92, 361-8, 2011	Study not conducted in one of the countries included in the review protocol.
Wilbanks, Susan R., Ivankova, Nataliya V., Exploring factors facilitating adults with spinal cord injury rejoining the workforce: a pilot study, Disability and Rehabilitation, 37, 739-49, 2015	Study not conducted in one of the countries included in the review protocol.
Williams, L. M., Douglas, J. M., It takes 2 to tango: The therapeutic alliance in community brain injury rehabilitation, Brain Impairment, 18, 362, 2017	Conference abstract.
Wong, A., Papadimitriou, C., Whiteneck, G., Deutsch, A., Heinemann, A., Goldsmith, A., Christopher, K., Focht, C., Lenze, E., Patient engagement in spinal cord injury rehabilitation: Patient and provider perspectives, Archives of Physical Medicine and	Conference abstract.

Study	Reason for Exclusion
Rehabilitation, 97, e71, 2016	
Wright, Courtney J., Zeeman, Heidi, Biezaitis, Valda, Holistic Practice in Traumatic Brain Injury Rehabilitation: Perspectives of Health Practitioners, PLoS ONE, 11, e0156826, 2016	No qualitative data on phenomena of interest.
Yenikomshian, Haig A., Lerew, Tara L., Tam, Melvin, Mandell, Sam P., Honari, Shari E., Pham, Tam N., Evaluation of Burn Rounds Using Telemedicine: Perspectives from Patients, Families, and Burn Center Staff, Telemedicine journal and e-health : the official journal of the American Telemedicine Association, 25, 25-30, 2019	The focus was not specific to participants who had experienced traumatic injury and the results not presented separately for target population.
Yoshida, Karen K., Self, Hazel M., Renwick, Rebecca M., Forma, Laura L., King, Audrey J., Fell, Leslie A., A value-based practice model of rehabilitation: consumers' recommendations in action, Disability and Rehabilitation, 37, 1825-33, 2015	No qualitative data on phenomena of interest.

1 Economic studies

2 Table 44: Excluded economic studies and reasons for their exclusion

Study	Reason for Exclusion
Bandyopadhyay, S., Wilkinson, I., Giokarinin-Royal, T., How incorporating 'lean' approach led to improved delivery of care and reduction in length of hospital stay, Age and Ageing, 48, 2019	Conference abstract.
Bhowaneedin, A., Smith, H., Deeley, H., Reyes Payeras, C., Keating, O., Smallbone, T., Wright, I., Sharples, P. M., What evidence is available to support the development of a regional specialist neurorehabilitation outreach service, Archives of Disease in Childhood, 104, A26-A27, 2019	Conference abstract.
Cheung, W. H., Shen, W. Y., Dai, D. L. K., Lee, K. B., Zhu, T. Y., Wong, R. M. Y., Leung, K. S., Evaluation of a multidisciplinary rehabilitation programme for elderly patients with hip fracture: A prospective cohort study, Journal of Rehabilitation Medicine, 50, 285-291, 2018	Intervention not in PICO: Intervention group included geriatrician care in an acute hospital and a multidisciplinary rehabilitation programme after discharge from the convalescence hospital (rehabilitation service coordination was not in an inpatient setting).
Closa, Conxita, Mas, Miquel A., Santaeugenia, Sebastia J., Inzitari, Marco, Ribera, Aida, Gallofre, Miquel, Hospital-at-home Integrated Care Program for Older Patients With Orthopedic Processes: An Efficient Alternative to Usual Hospital-Based Care, Journal of the American Medical Directors Association, 18, 780-784, 2017	Comparison not in PICO: Control group are in-patients and the experimental group are out-patients.
Collins, Nina, Miller, Richard, Kapu, April, Martin, Rita, Morton, Melissa, Forrester, Mary, Atkinson, Shelley, Evans, Bethany, Wilkinson, Linda, Outcomes of adding acute care nurse practitioners to a Level I trauma service with the goal of decreased length of stay and improved physician and nursing satisfaction, The journal of trauma and acute care surgery, 76, 353-7, 2014	Intervention not in PICO: Acute care nurse practitioner (ACPN) who coordinated acute/ clinical care; only mention of "rehabilitation" was "The ACNP attended the daily discharge huddle, a team meeting that encompasses T2 [step-down care from ICU] and T3 [trauma nurse practitioner satellite service] NPs [nurse practitioner], case managers, social worker,

Study	Reason for Exclusion
	liaisons to rehabilitation and nursing home facilities, and home health agency staff to facilitate communication and the discharge process." Only outcome reported is length of stay.
Cooper, M., Ganda, K., Palmer, A., Seibel, M. J., Cost effectiveness of a targeted intervention to reduce refracture rates: Analysis of a four year prospective controlled study, Journal of Bone and Mineral Research, 26, 2011	Conference abstract.
Farquhar, M., Lannin, N. A., Morarty, J., Functional outcomes from a specialised acquired brain injury community rehabilitation service - Evaluating a new model of care, Brain Impairment, 18, 344, 2017	Conference abstract.
Fukuda, Haruhisa, Shimizu, Sayuri, Ishizaki, Tatsuro, Has the Reform of the Japanese Healthcare Provision System Improved the Value in Healthcare? A Cost-Consequence Analysis of Organized Care for Hip Fracture Patients, PLoS ONE, 10, e0133694, 2015	Comparison not in PICO: Hip fracture care in hospitals autonomously providing integrated care across specialties versus in acute care hospitals and rehabilitative care hospitals providing organized care across separate facilities (the organisation of the care not further described).
Kapu, A., Jones, P., Financial impact of adding acute care nurse practitioners (ACNPs) to inpatient models of care, Critical Care Medicine, 40, 27, 2012	Conference abstract.
Leung, C. K., Mok, H. W., Shen, W. Y., Cheung, W. H., Leung, K. S., Evaluation of cost-effectiveness of a multidisciplinary hip fracture management program in Hong Kong, Osteoporosis International, 24, S597-S598, 2013	Conference abstract.
Ling, Shi-Neng James, Kleimeyer, Christopher, Lynch, Genni, Burmeister, Elizabeth, Kennedy, Diana, Bell, Kate, Watkins, Leith, Cooke, Cameron, Can geriatric hip fractures be managed effectively within a level 1 trauma center?, Journal of Orthopaedic Trauma, 29, 160-4, 2015	Intervention not in PICO: Acute hip fracture care and not coordination of rehabilitation.
Pogoda, Terri K., Levy, Charles E., Helmick, Katherine, Pugh, Mary Jo, Health services and rehabilitation for active duty service members and veterans with mild TBI, Brain Injury, 31, 1220-1234, 2017	Narrative overview including cost considerations; not an economic evaluation.
Soong, C., Cram, P., Chezar, K., Tajammal, F., Exconde, K., Matelski, J., Sinha, S.K., Abrams, H.B., Fan-Lun, C., Fabbruzzo-Cota, C. and Backstein, D., Impact of an integrated hip fracture inpatient program on length of stay and costs, Journal of orthopaedic trauma, 30, 647-652, 2016	Population not in PICO: Hip fracture in adults.

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Appendix L – Research recommendations

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

No research recommendations were made for this review question.

Research recommendations for review question: D.2b What are the best methods to deliver and coordinate rehabilitation services and social services for children and young people with complex rehabilitation needs after traumatic injury when they transfer from inpatient to outpatient rehabilitation services?

No research recommendations were made for this review question.