SYSTEMATIC REVIEWS

The effect of physical rehabilitation on activities of daily living in older residents of long-term care facilities: systematic review with meta-analysis

Tom Crocker1*, John Young2, Anne Forster2, Lesley Brown1, Seline Ozer1, Darren C. Greenwood3

1Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK
2Academic Unit of Elderly Care and Rehabilitation, Leeds Institute of Health Sciences, University of Leeds, Leeds, UK
3Centre for Epidemiology and Biostatistics, University of Leeds, Leeds, UK

*Address correspondence to: T. Crocker. Tel: +44 1274 383406; Fax: +44 1274 382766. Email: tom.crocker@bthft.nhs.uk; Temple Bank House, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ, UK

Abstract

**Background:** the worldwide population is ageing. One expected consequence of this is an increase in morbidity and an associated increased demand for long-term care. Physical rehabilitation is beneficial in older people, but relatively little is known about effects in residents of long-term care facilities.

**Objective:** to examine the effects of physical rehabilitation on activities of daily living (ADL) in elderly residents of long-term care facilities.

**Methods:** systematic review with meta-analysis of randomised controlled trials. We included studies that compared the effect of a physical rehabilitation intervention on independence in ADL with either no intervention or an alternative intervention in older people (over 60 years) living in long-term care facilities. We searched 19 databases including the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL, AMED, Web of Knowledge and Google Scholar. Two researchers independently screened papers and extracted data. Outcomes of included studies were combined in a standardised mean difference random-effects meta-analysis.

**Results:** thirteen of 14 studies identified were included in the meta-analysis. Independence in ADL was improved by 0.24 standard units (95% CI: 0.11–0.38; \( P = 0.0005 \)). This is equivalent to 1.3 points on the Barthel Index (0–20 scale). No significant differences in effect were found based on participant or intervention characteristics. Larger sample size and low attrition were associated with smaller estimates of effect. All studies were assessed to be at risk of bias.

**Conclusions:** physical rehabilitation may improve independence for elderly long-term care facility residents, but mean effects are small. It is unclear which interventions are most appropriate.

**Keywords:** senior citizen, nursing home, physical therapy, disability, functional independence, older people

Background

Changes in life expectancy and birth rates mean that by 2050 the proportion of the world’s population >60 is expected to double from 11 to 22% [1] and the number of residents in long-term care facilities is expected to increase significantly [2]. Elderly long-term care facility residents are some of the frailest members of our community. Residents identify mobility as central to their well-being [3] and many cannot independently perform basic activities of daily living (ADL) [4]. It is reported that residents currently spend much of their time physically inactive and with little social interaction [5, 6]. Inactivity can lead to acute illnesses [7] and is associated with all-cause mortality [8, 9]. For their health and well-being, and to reduce costs of care, interventions to improve independence in ADL should be sought and evaluated.

Physical rehabilitation is defined here as an intervention intended to maintain or improve the physical health or function...
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of people through their participation in physical action. Systematic reviews provide evidence that it is effective at improving certain physical outcomes in older long-term care populations [10–13]. However, the effect on ADL is ambiguous, with only one review [27 studies] reporting firm evidence of a positive effect [12]. In the recently updated Cochrane review, we evaluated the effects of physical rehabilitation in older residents of long-term care facilities (67 studies; 6,300 residents) on a range of outcomes including independence in ADL [13]. Several ADL outcome measures were reported and we summarised the results by calculating mean differences for each measure. However, this technique required separate meta-analyses for studies using the Barthel Index (seven studies; statistically significant improvement) and the Functional Independence Measure (FIM) (four studies; non-significant effect), and studies using other ADL measures were not included. Thus, the findings were difficult to interpret.

The systematic review reported here is based on the randomised controlled trials (RCTs) identified in the Cochrane review [13], but presents a new analysis using the standardised mean difference approach to combine the ADL outcome measures and therefore provides an improved estimate for the pooled results. Reasons for differences in effect estimates are also explored (Supplementary data are available in Age and Ageing online, Appendix, Methods).

Results

A total of 34,069 references were screened and 14 studies [17–30] described in 18 reports [17–30, 31–34] fulfilled the eligibility criteria and were included in this review (see Figure 1).

Eight of the studies were RCTs [17–19, 22, 23, 25, 29, 30]; the remaining six were cluster RCTs [20, 21, 24, 26–28]. Three cluster trials used an analysis that accounted for clustering [24, 27, 28]. Seven of the studies were conducted in Europe, six in North America and one in Japan.

Participants

The studies included 2,379 participants (median = 126) with a mean [standard deviation (SD)] age of 84 (8) years; 79% were female. With regard to physical function, four studies limited participation to residents with some degree of dependence in ADL. [22, 26–28], whereas four required some minimum level of physical function to participate (e.g. standing, walking) [17, 18, 25, 30].

At baseline, mean (SD) Barthel Index scores (0–20 scale) ranged from 10(5) [28] to 14(2) [29] in the seven studies that presented them.

Six studies presented mean Mini-Mental State Examination (MMSE) scores (0–30 scale; lower scores indicate greater cognitive impairment): one study had mean MMSE <10 [30]; two studies had mean MMSE between 10 and 20 [26, 29] and three studies had mean MMSE between 20 and 25 [17, 22, 24].

Figure 1. Flow chart for systematic review.

Interventions

The 14 studies examined 15 rehabilitation interventions, with one study comparing two rehabilitation groups with a control group [21]. The interventions were delivered for a median of 4 months, ranging between 10 weeks [17] and 12 months [24].

Seven of the interventions were group exercise classes [17–21, 25, 29]. These all included some form of resistance training, five included mobility training [18, 19, 21, 25, 29], four included balance training [17–19, 25], four included flexibility exercises [18, 19, 25, 29] and two included ball games [18, 29]. Five of these were delivered by rehabilitation professionals [17, 19, 20, 25, 29], whereas two were delivered by carers and volunteers [18, 21]. Three were delivered with music [20, 25, 29]. These were all delivered twice [20, 25] or three times weekly [17–19, 29] except for Morris et al. [21] where three resistance and three endurance sessions were delivered each week. Each session lasted between 45 and 75 min, although this was not reported for two studies [19, 21].

Two further interventions were group based [26, 30]. One involved mobility exercises selected for the individual based on functional ability [26]. This was delivered individually when the participant did not attend the session. Sessions lasted 45 min and occurred five times every fortnight. The other involved practice of ADL in a group setting [30]. Sessions lasted 2½ h and occurred five times a week.
Four interventions involved professional delivery of physiotherapy [22], occupational therapy [28] or both [23, 27]. These involved individual sessions that were tailored based on assessments. The repertoire of available therapies included ADL practice and mobility training. Mulrow et al. [22] also emphasised resistance and balance training to enable ADL practice. This intervention was delivered in 30–45 min sessions, three times weekly; the other three did not report typical frequency or duration of sessions. Two included training of care staff to promote independence [27, 28].

Two interventions involved encouraging a resident to take a more active part in routine activities such as transferring, bathing or dressing themselves, delivered by nurses and assistants following assessment and goal-setting [21, 24].

We judged the intensity of the interventions as high in seven cases [17, 18, 21, 22, 25, 26, 29], low in three [19, 20, 30] and unclear in five [21, 23, 24, 27, 28] (these were tailored to the participant).

Comparison conditions
Nine studies compared their intervention with usual care. It was typically unclear what, if any, rehabilitation was provided as part of usual care. Three studies compared their rehabilitative intervention with a social intervention [20, 22, 26], one study had both a usual care control group and a social control group [30], while one compared a high intensity exercise intervention with a seated range of motion intervention [18].

Outcome measures
The included studies reported five different measures of independence in ADL (details in Table 1): Barthel Index [17, 20, 24, 26–29], FIM [17–19, 23], Katz Index of Independence in ADL [22, 25, 29], Physical Self-Maintenance Scale [30] and a summary measure of eight items from the Minimum Data Set [21]. Two studies reported two of these scales: Dorner et al. [17] measured both Barthel Index and FIM, whereas Santana-Sosa et al. [29] reported both Barthel Index and Katz ADL scale.

In all studies outcome measures were taken at the end of the intervention. Three studies reported additional follow-up, 3 months after the end of the intervention [26–28].

Attrition
Missing outcome data ranged from 3 [19] to 45% [22]. In total, 469 allocated participants (21%) were not included in the final analysis.

Risk of bias
Overall, no study had a low risk of bias across all the domains assessed. For selection bias, four studies were judged to be at low risk [20, 26–28], nine studies had an unclear risk [17–19, 21, 22, 24, 25, 29, 30] and one study had a high risk [23]. For performance bias, the risk was judged unclear for five studies [18, 20–22, 26] and high for nine studies [17, 19, 23–25, 27–30]. For detection bias, risk was judged as low for 10 studies [18, 19, 21, 23–25, 27–30], unclear for 2 studies [17, 22] and high for 2 studies [20, 26]. Risk of attrition bias was judged as low for five studies [22, 24, 25, 27, 28], unclear for five studies [17, 19, 26, 29, 30] and high for four studies [18, 20, 21, 23]. Risk of reporting bias was judged as unclear for 12 studies [17–22, 24–26, 28–30] and high for 2 studies [23, 27]. No other risks of bias were identified. Because no study had a low risk of bias for blinding of participants and personnel or selective reporting, those studies with low risk of bias across all other domains were selected as a group (lower risk of bias, [27, 28]) for comparison with the other studies (higher risk of bias).

Effect of rehabilitation

Data handling. Przybylski et al. [23] did not present the numbers in each intervention group at follow-up, but did present total numbers, balanced numbers in each group at baseline and reported that attrition was similar. We therefore assumed equal drop-out in each group and similar numbers in each group at follow-up. For Santana-Sosa et al. [29], values were derived from the presented graphs. Sackley et al. [27] only presented an analysis adjusted for clustering at 3
months after the end of the intervention; therefore, we used these values.

Two of the cluster trials reported an intra-cluster correlation coefficient (ICC) of independence in ADL in long-term care institutions [27, 28], from which a pooled ICC was calculated as 0.38. This was used to adjust the estimate of effect in trials that did not account for clustering in their analysis [20, 21, 26].

Santana-Sosa et al. [29] has 16 participants in total and an effect estimate of 1.82, which is over twice the size of the second largest estimate (0.77, [18]). We therefore chose to exclude it from the main meta-analysis as an unreliable outlier that may represent publication bias (increased likelihood of small studies being published if they estimate large effects) or super-realisation bias (researchers managing delivery, attendance and other factors beyond what would occur in reality).

To convert the results of meta-analysis into a commonly used scale, we estimated the standard deviation of the Barthel Index (0–20 scale) in this population as 5.4, using baseline data from the two largest trials that reported the Barthel Index in this review [24, 27].

**Estimated effect.** On average, rehabilitation improved independence in ADL by 0.24 standard units (95% CI: 0.11–0.38; \( P = 0.0005 \)) in comparison with control conditions (Figure 2). This is equivalent to 1.3 points on the Barthel Index (0–20 scale). There was little between study heterogeneity (\( I^2 = 0\% ; \) Chi² = 12 on 12 degrees of freedom (df); \( P = 0.4 \)).

**Subgroup analyses.** Results of subgroup analyses are reported in Table 2. Subgroup analyses based on the age of the participant groups found no significant differences of effect. Subgroup analyses based on the duration, delivery mode and intensity of interventions found no significant differences in effect. There was evidence that studies with over 100 participants produced smaller estimates of effect than those with fewer (\( P = 0.005 \)). There was some evidence that studies with <20% of participants lost to follow-up produced smaller estimates of effect than those with more (\( P = 0.05 \)). No significant effect was found in analyses based on risk of bias, use of a cluster trial design or the particular measure of ADL independence used.

The sensitivity analysis that included Santana-Sosa et al. [29], estimated a larger effect size of 0.31 standard units and a wider confidence interval (95% CI: 0.14–0.48), equivalent to 1.7 points on the Barthel Index. It also introduced significant heterogeneity (\( I^2 = 29\% ; \) Chi² = 18 on 13 df; \( P = 0.1 \)).

Because of the apparent biases in effect estimates of smaller studies and those with high attrition, a post hoc sensitivity analysis limited to studies with over 100 participants and <20% attrition was conducted as a conservative estimate of effect. Among the five studies meeting this criteria [19, 21, 22, 25, 26] the pooled effect estimate was 0.10 standard units (95% CI: -0.08 to 0.27; \( P = 0.27 \)). This estimate is equivalent to a half point average increase in the Barthel Index (0–20 scale). There was very little statistical heterogeneity (\( I^2 = 0\% ; \) Chi² = 2 on 4 df; \( P = 0.7 \)).

**Discussion**

This systematic review and meta-analysis provides evidence that physical rehabilitation is associated with improvement in ADL independence in elderly residents of long-term care facilities. In contrast with other reviews [10–13], we have calculated a single estimate of the size of effect on ADL. The size of this mean effect (0.24 standard units) is conventionally interpreted as small [39], and is slightly smaller than estimates of minimal clinically important difference for the Barthel Index in chronic stroke survivors (1.45 or 1.85 points, compared with 1.3 points estimated here) [40]. However, this is a different patient population and it could be argued that independence in ADL is so important that even small improvements may be worthwhile and meaningful. Additionally, the effects of rehabilitation appear variable, with individual participants likely to benefit to a greater or lesser extent than the

**Figure 2.** Forest plot of standardised mean difference between rehabilitation and control groups (positive favours rehabilitation).
estimate, and suggesting some interventions may have a medium effect while others may be ineffective. Nonetheless, bias may have affected the estimate and the true effect may be smaller. It remains unclear which combinations of interventions and participants are associated with the greatest effect [13].

It is plausible that the small effect found is one of maintenance of function, rather than improvement, in a population that tends to become increasingly frail and dependent. Therefore, time to deterioration, or a dichotomous global outcome such as ‘improved or maintained independence’ compared with ‘deterioration or death’ [28, 41, 42], might be more appropriate measures of intervention effects as they would include all randomised patients, not just those still alive at follow-up. Also, it may be that studies with interventions of longer duration would identify a larger effect on independence in ADL. We recognise that physical rehabilitation is sometimes intended to improve other outcomes not considered here, such as mental health, social interaction, mood and well-being [13, 43, 44].

The cluster RCTs in this review had small effective sample sizes because the ICC of 0.38 is very high. A cluster design can be useful for preventing performance bias and intervention contamination between participants. However, the large ICC means very large samples will be needed in future trials, particularly where each cluster is large. The estimated ICC is derived from only two UK studies. It is plausible that different ICCs would be found in different settings and countries. Therefore, it is important that future cluster studies report adjusted results and an ICC.

The measurement properties of commonly used ADL scales are known to be problematic [45, 46], as they often lack unidimensionality and other requisite properties to allow valid summation. This review was constrained by the scales that have been used in the existing literature. Over the past 20 years, great advances have been made in the field of rehabilitation measurement through the introduction of item response theory [47]. This allows more meaningful scores to be developed, with increased sensitivity. Future studies should employ measures with the best psychometric properties, instead of relying on traditional scales.

This review has a number of limitations. Bias may have increased the estimate of effect on ADL. None of the studies included in the meta-analysis had a low risk of bias across all the domains assessed. One analysis suggested differences in assessed risk of bias were not associated with differences in effect size. However, other analyses linked studies with a large number of participants, and studies with low attrition, to small effect sizes, both of which are indicative of bias [15]. A post hoc sensitivity analysis that included only the five studies with a large sample and low attrition did not estimate a statistically significant mean effect of rehabilitation. Many

Table 2. Subgroup analyses

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Studies</th>
<th>Participants</th>
<th>Effect estimate (95% CI)</th>
<th>Test for subgroup differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Age</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1.1 Younger (mean age &lt; 85 years)</td>
<td>9</td>
<td>1,427</td>
<td>0.30 (0.11, 0.49)</td>
<td>P = 0.43</td>
</tr>
<tr>
<td>1.2 Older (mean age 85+ years)</td>
<td>4</td>
<td>467</td>
<td>0.18 (−0.07, 0.42)</td>
<td></td>
</tr>
<tr>
<td>2 Duration of intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Shorter (&lt;3 months)</td>
<td>3</td>
<td>327</td>
<td>0.10 (−0.12, 0.32)</td>
<td>P = 0.11</td>
</tr>
<tr>
<td>2.2 Longer (3+ months)</td>
<td>10</td>
<td>1,567</td>
<td>0.33 (0.16, 0.50)</td>
<td></td>
</tr>
<tr>
<td>3 Mode of delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Group</td>
<td>8</td>
<td>882</td>
<td>0.31 (0.13, 0.49)</td>
<td>P = 0.29</td>
</tr>
<tr>
<td>3.2 Individual</td>
<td>6</td>
<td>1,136</td>
<td>0.16 (−0.05, 0.36)</td>
<td></td>
</tr>
<tr>
<td>4 Intensity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 High</td>
<td>6</td>
<td>820</td>
<td>0.26 (0.01, 0.50)</td>
<td>P = 0.87</td>
</tr>
<tr>
<td>4.2 Low</td>
<td>3</td>
<td>249</td>
<td>0.30 (−0.13, 0.73)</td>
<td></td>
</tr>
<tr>
<td>5 Risk of bias</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Lower risk of bias</td>
<td>2</td>
<td>292</td>
<td>0.37 (−0.08, 0.82)</td>
<td>P = 0.62</td>
</tr>
<tr>
<td>5.2 Higher risk of bias</td>
<td>11</td>
<td>1,602</td>
<td>0.25 (0.09, 0.41)</td>
<td></td>
</tr>
<tr>
<td>6 Number of participants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 n &lt; 100</td>
<td>6</td>
<td>367</td>
<td>0.54 (0.29, 0.79)</td>
<td>P = 0.005</td>
</tr>
<tr>
<td>6.2 n ≥ 100</td>
<td>7</td>
<td>1,527</td>
<td>0.12 (−0.05, 0.28)</td>
<td></td>
</tr>
<tr>
<td>7 Attrition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7.1 &lt;20% lost to follow-up</td>
<td>7</td>
<td>1,118</td>
<td>0.15 (−0.01, 0.31)</td>
<td>P = 0.05</td>
</tr>
<tr>
<td>7.2 &gt;20% lost to follow-up</td>
<td>6</td>
<td>776</td>
<td>0.45 (0.20, 0.69)</td>
<td></td>
</tr>
<tr>
<td>8 Trial design</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1 RCT</td>
<td>7</td>
<td>663</td>
<td>0.28 (0.06, 0.50)</td>
<td>P = 0.90</td>
</tr>
<tr>
<td>8.2 Cluster RCT</td>
<td>6</td>
<td>1,231</td>
<td>0.30 (0.02, 0.58)</td>
<td></td>
</tr>
<tr>
<td>9 Outcome measure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.1 Barthel Index</td>
<td>6</td>
<td>869</td>
<td>0.33 (0.06, 0.60)</td>
<td>P = 0.51</td>
</tr>
<tr>
<td>9.2 FIM</td>
<td>4</td>
<td>303</td>
<td>0.32 (−0.02, 0.67)</td>
<td></td>
</tr>
<tr>
<td>9.3 Katz ADL</td>
<td>2</td>
<td>297</td>
<td>0.09 (−0.19, 0.37)</td>
<td></td>
</tr>
<tr>
<td>9.4 Minimum Data set</td>
<td>1</td>
<td>392</td>
<td>0.32 (−0.75, 1.40)</td>
<td></td>
</tr>
<tr>
<td>9.5 Physical Self-Maintenance Scale</td>
<td>1</td>
<td>66</td>
<td>0.60 (0.07, 1.14)</td>
<td></td>
</tr>
</tbody>
</table>
of the included trials are proof of concept studies that are likely to find a greater effect than would be achieved in routine practice, because of the enthusiasm and skill of those delivering the intervention and its fit with the local context. While underestimation could be a problem if contamination occurred, there was no evidence that these studies were so affected, either in the study reports or when comparing results of cluster trials to the RCTs in which contamination could occur. Underestimation of efficacy can be a problem when those unlikely to respond or those who do not participate in the intervention are included. However, this is unlikely to have been the case in these studies as all but one limited inclusion to a subset of participants, and when participants did drop out they were typically excluded from the analyses.

The generalisability of these results to residents of long-term care facilities is unclear. Only one-quarter of residents in participating facilities were recruited [13], as some studies restricted participation to those meeting some minimum level of functioning, while others were restricted to those with some degree of dependence in ADL. This highlights some of the diversity within the long-term care population and also in the aims and content of the interventions. However, we have reported characteristics of the included participants, which may assist in identifying those residents to which the results are most relevant. Despite this, the lack of information about the nature of the control conditions in many of the studies limits our understanding of the contexts in which the results would be applicable.

Conclusion

Physical rehabilitation appears to have a small effect on ADL in older people residing in long-term care facilities. However, this finding should be interpreted with caution as inferences are limited by study bias. Further well-designed, large-scale studies are still required.

Key points

- Many older residents of care homes (long-term care facilities) have limited physical function.
- Rehabilitation such as physiotherapy, occupational therapy and exercise classes has been trialed in geriatric institutions.
- Physical rehabilitation appears to have a small mean effect on ADL such as mobility and self-care.
- Bias appears to be a problem in much of the available primary evidence.
- Further well-designed, large-scale studies are still required.

Acknowledgements

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Conflicts of interest

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Supplementary data

Supplementary data mentioned in the text is available to subscribers in Age and Ageing online.

References

The very long list of references supporting this review has meant that only the most important are listed here and are represented by bold type throughout the text. The full list of references is available in Supplementary data in Age and Ageing online, Appendix 1.

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