Supplementary Material 3. Review 2 TIDieR checklist

First author, date; intervention title	Recipient	Why (rationale, theory or goals)	What (materials)	What (procedure)	Who provided	How (mode of delivery; individual/ group)	Where	When and how much	Tailoring	Modification of intervention throughout the study	Strategies to improve or maintain intervention fidelity	Extent of intervention fidelity
Horner, 2013;{Horner, 2013 #52} Novel staff education to improve care of confused older inpatients	Clinical staff	Researchers and hospital staff remain uncertain about how best to train people in the recognition and management of acute confusion on acute medical wards. The aim of the study was to determine the feasibility of a proposed educational intervention in acute hospital wards.	Self-directed learning modules, with access to an education resource officer to reinforce learning in real time	*Engagement phase*: ward meeting to introduce the project *Formal education delivery*: an education package that aims to equip staff with the knowledge and skills to deliver evidence based care for medical inpatients with confusion. *Reinforcement phase*: de-briefing following training; support to staff in real time on the ward	*Engagement phase*: ward staff development nurse *Formal education delivery*: self-directed by staff *Reinforcement phase*: education resource office who was an experienced nurse educator	*Engagement phase:* group *Formal education delivery*: individual (self-directed study with on-on-one support from an education officer on the ward) *Reinforcement phase*: Individual (with one-on-one support from an education officer)	Two geriatric medicine wards in a tertiary teaching hospital	2 week engagement phase 4 week formal education delivery 2 week reinforcement phase During the formal education delivery phase, the education officer attended the wards for a total of 38.5 hours	Students had the option of completing the education online or in hardcopy format	NR	NR	NR
Naughton, 2018;{Naughton, 2018 #69} VERA (validation, emotion, reassurance, activity)	Student nurses	People living with dementia have complex communication needs, especially during acute hospital admissions. The VERA framework was designed to promote person centred communication between student	VERA Dementia communication training	2.5-hour face to face dementia training based on the VERA framework;	Mentors, link lecturers, clinical tutors	Training group Follow-up reflective discussions individual	Training – at one university Follow-up reflective discussions – on OAUs (7 acute care teaching hospitals; 2 intervention, 5 control)	VERA training provided at the beginning of placement on an Older Adult Unit (OAU). Follow-up short reflective discussions occurred during OAU placement. Placements ranged from 4 to 12 weeks	The aim is for student nurses to respond according to each individual's needs; VERA provides guidelines to orientate students to common issues	Activities and resources were scarce and therefore students had to create their own if they were to occur	NR	NR

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		nurses and people living with dementia										
Schindel Martin, 2016;{Schindel Martin, 2016 #80} Gentle Persuasive Approaches	Staff employed in 12 clinical	Within the model of person-centred care, behavioural and psychological symptoms of dementia are understood to be triggered by unmet needs. Through training staff can respond to need driven behaviour by meeting patient needs rather than by medicating or restraining patients	4 modules: 1. principles of PCC, 2. brain changes common in dementia and delirium, 3. communication and interpersonal strategies 4. staff-specific self-protective skills and team/patient/family debriefing and reassurance techniques	Staff training Staff teaching partners supported the implementation and sustainability of GPA in their respective practice units during clinical interactions departmental managers were invited to participate in information sessions	GPA coaches	Initial day of training to groups of 18-20 Ongoing individual support from staff during implementation Information provided to departmental managers as a group	12 clinical areas at two separate sites at a multisite acute care hospital	Full day training (7.5 hours) to groups of 18-20 at start of intervention Ongoing support on wards during implementation 8-weeks intervention duration	GPA meant to be tailored to individual patient unmet need	NR	Staff teaching partners were recruited to provide on-ward support; training was standardised across teams Departmental managers were invited to information meetings in order to secure fidelity because they scheduled staff participant in GPA sessions	NR
Smythe, 2014;{Smythe, 2014 #83} brief psychosocial training intervention (BPTI)	Hospital staff	Studies have shown lack of quality of care in acute care for PwD; conventional, didactic training is inadequate plus staff do not have time for training away from the wards so the training was developed to be implemented on the ward	*Standard training approach*: focused on physical health needs. *BPTI*: addressed attitudes, emotional competence, empathy and a non-judgemental approach. Training aimed to enable staff to make connections with people with dementia.	*Standard training approach:* delivery was didactic *BPTI*: Each session started with a conversation outlining training objectives and delivering important messages, followed by working alongside the staff member, feedback and reflection	Trainers were a mental health nurse/researcher with teaching experience and two general nurses.	Standard training: group based BPTI: intended to be administered to groups of 5 staff together to encourage peer learning	Standard training: classroom BPTI: on three acute wards	Standard training approach: Six week, classroom-based rolling programme. BPTI delivered 1 hour a week over 5 weeks.	Focus groups were held to probe staff needs before planning the training to foster ownership of the study and to meet needs	Rather than in groups, BPTI was delivered individually, increasing the time needed to deliver the intervention while also reducing time for modelling and preventing peer learning The environment prevented patient group activities and engagement There was evidence of resistance;	A manual was written and used to ensure implementation fidelity	The authors found it was difficult to ensure fidelity, and that time, organisational and environmental factors need to be taken into consideration

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										sometimes trainers were asked to reschedule without notice A trainer was required to backfill for staff		
Wilkinson, 2016;{Wilkinson, 2016 #92} Junior Doctor Dementia champions	Junior doctors	Junior doctors often conduct screening for dementia on admission; therefore developing skill in junior doctors in the area of dementia will support better care	'forget-me-not' scheme on all wards in the hospital. information leaflets for relatives, a car parking permit, a hospital passport, patient identifying stickers for the ward patient lists and an '8 things about me' form for completion in conjunction with patients and relatives	Initially, junior doctors collected data about the CQUIN achievement and then, over the year, set up structures to improve care,	Junior doctors with a consultant and registrar formed the dementia and delirium team	Junior doctors volunteered and chose how to implement the intervention with the support of a consultant and registrar	Two hospitals	forget-me-not scheme set up on the wards in which junior doctors spent their initial four months, and then as they moved job roles within the trust (every four months), the scheme was handed over to a new 'dementia champion' on the original ward and the junior doctor went on to set up the scheme with their new team	The "8 things about me" initiative was meant to support PCC	Led by participants so they were not modifying the intervention so much as designing it themselves over the course of the study	Peer leadership design Senior support	Authors conclude that there was a snowballing effect of the team 'coming together' that led to enthusiasm and success; attribute this to peer leadership Junior doctors felt empowered by senior staff involvement
Daykin, 2017;{Daykin, 2017 #36} Participatory music making	PIwD	Plwd may find the experience of being in hospital frightening and confusing and may experience boredom and anxiety, as well as pain or discomfort or stress from	Participatory music including listening to live music, singing, playing instruments, reminiscence, song writing and composing, conducting music	Each session began with a brief performance of a classical piece on the viola by the musician, this was followed by participatory activities	A professional orchestral musician trained to work with people with dementia	In groups of between five and eight participants (patients, their care staff and visitors)	54-bed acute care service for older people in a UK hospital; Sessions were held in an activity room close to the ward	Ten week period of weekly participatory music sessions that lasted up to 2 hours Because some patients were discharged during the study, each participant received	The professional musician adapted the music/activities to the needs of the recipients during the session	Sessions were interrupted by clinical schedules; staff began to put a 'do not disturb' sign on the door to prevent this	NR	Authors emphasised the importance of the music professionals' ability to read and respond appropriately to the moods of PIwD

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		environmental challenges. Music can help to reduce anxiety, agitation and behavioural problems	Tea and biscuits served					on average 2 to 3 music sessions				
McDonnell, 2014;{McDonnell, 2014 #65} On-ward volunteer service	Volunteers	Hospitals are particularly challenging environments for PlwD. The Royal Voluntary Service (RVS) on-ward volunteer service was launched at Sheffield Teaching Hospitals NHS Foundation Trust in November 2011 in order to improve the experience of patients with dementia	On-ward volunteer service to interact with PwD It was envisaged that the volunteers would provide befriending, diversional therapy, companionship and help with eating and drinking, as well as supporting family carers and providing respite time	Volunteers were trained then worked on the ward to complement the care provided by staff Recruitment of volunteers was the responsibility of the RVS, who also provided and funded a training programme and managed the volunteers.	Dementia nurse specialist employed by the Trust	The Royal Volunteer Service recruited the volunteers and trained them. Volunteers worked one-on-one with PlwD with the oversight of a dementia nurse specialist	Sheffield Teaching Hospitals NHS Trust; based on an orthopaedic ward that had a high proportion of patients with dementia who were recovering from surgery.	12-month pilot project Over the 12-month period, 28 volunteers worked on the ward; the mean number of volunteers was 12 each month (Range: 9-19); mean number of hours volunteers spent on the ward was 64.5 per month (range: 27-105 hours)	The trust appointed a dementia nurse specialist whose role was to direct the volunteers to work with patients and families in the most appropriate way.	Initially the volunteers were not always welcomed by staff; a rota/sign-in sheet was developed Over time, as staff became more familiar with the volunteers, they came to appreciate them because they provided care there was not time for nurses to give	Authors conclude that adequate training and; making sure volunteers felt wanted, felt useful and felt supported by staff was important	Authors found that the dementia nurse specialist was crucial because of her expertise with dementia and her role in supporting the volunteers Support at senior and strategic levels was important, as was good leadership and commitment on the ward
Wong Shee, 2014;{Wong Shee, 2014 #93} Volunteer-mediated diversional therapy program	Volunteers	The aim of this study was to evaluate the feasibility and acceptability for the patients and their families/carers, volunteers and staff, of a volunteer diversional therapy program for older patients with	Volunteer education Hospital induction session Diversional therapy program session Supervised patient sessions *Diversional therapy provided:*	A diversional therapy assessment was completed by a clinical consultant diversional therapist The volunteers visited one or more patients on a patient list. Volunteers provided orientation and	Volunteer education: Researcher Cognition nurse clinical consultant Diversional therapist Diversional therapy: Volunteers	The volunteers worked on a one-to-one basis with patient participants.	30-bed inpatient rehabilitation unit in a large regional health service in Australia	6 months period from March to September 2011, where volunteers spent 465 hours working on the ward. Each patient received an average of 9.93 visits during the program Volunteer education	A diversional therapy assessment was used to provide a personal profile of the patient participant to assist the volunteer's understanding of the participant and enable person-centered care	Volunteers were not always allowed by staff to access patient records, preventing them from using diversional therapy assessments. Although training for volunteers included health service confidentiality and	Review of implementation process - Feedback on education process - Review of volunteer roles - Assess staff perception of uptake by patients - Identify obstacles to implementation of the diversional therapy program Ideas for improvement	Authors conclude that attention paid to staff engagement, including providing information about volunteer training, was needed

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		cognitive impairment	Conversation (298 visits; 30 patients) Games (43 visits, 11 patients) Cards, memory (30 visits, 13 patients) Jigsaws (54 visits, 14 patients) Music (9 visits, 7 patients)	diversional therapy activities according to the diversional therapy assessment				Hospital induction session: 4 hours Diversional therapy program session: 2 hours Supervised patients session: 2x 1 hour sessions		privacy training, staff were not made aware of this.	- Logistics of volunteers working on ward - Maximizing use of volunteers - Resources - Strategies to improve uptake of diversional therapy program - Education - Goal setting	
Durepos, 2017;{Durepos, 2017 #41} Psychoeducation program for carers of PwD at end of life	Carers	This study explored perceived benefits and challenges of a unique psychoeducation program provided at end of life jointly attended by current and bereaved carers. Authors provide a logic model. Program aims for carers were to improve emotional well-being, increase knowledge and increase peer support.	Weekly content alternated between share/support sessions, social activities and educational presentations from hospital professionals or community service providers on topics such as decision-making at end of life, medications and brain behaviour.	The Leaders facilitated the weekly meeting based on a method of social group work, which focuses on the affirmation of group members' strengths and capacity to aid others and integrated educational content.	Program Leaders holding qualifications including Master's degree in Social Work, experience teaching for the Alzheimer's Society of Canada, facilitation of multiple past psychoeducation programs, and employment in the Specialised Care Unit for 20 years or more.	Group sessions	Hospital Specialised Care Unit (in-patient ward for PwD with challenging behaviour) in Ontario, Canada Units are characterized by specialty trained staff, a modified physical environment (e.g. wandering path, secure exits), therapeutic programming, and family involvement	Weekly 1.5 hour sessions; had been running for 18 months before the study was conducted About 15 current and bereaved carers had attended the program since its inception, and 10 persons regularly attended at the time of the study	NR	Adapted the intervention to allow bereaved carers to continue to attend	NR	NR
St John, 2017;{St John, 2017 #86} Namaste Care	Plwd at the end of life	This study aimed to evaluate the use of Namaste Care, commonly provided in care	A sensory room for group sessions Education/training for staff about the Namaste approach	Namaste Care integrates meaningful activity and multisensory	Activity coordinators	Group (no more than 6 patients) or one-on-one, depending on patients' level of need	3 Health and Aging Units (HAU) of an inner-city teaching Hospital	Group sessions usually lasted 1 hour, with single sessions lasting between 20 and 30 minutes.	Content of the session varied depending on individual patients' likes, wants and ability.	Normally formal family meetings were held that include discussion about the patient's current health	Instead, ward staff were encouraged to liaise with families to inform and educate them about Namaste care,	NR

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		homes, in an acute hospital Setting.	During the session the room is dimly lit, scented with lavender and relaxing music appropriate and appreciated by the patient group is played.	stimulation (such as massage and aromatherapy, touch, music, color, tastes and scents), with nursing care, person-centred care and reminiscence and provides carers with education and family/loved ones with support.			In either a sensory room or at the patients' bedside	No set structure, but usually 3x per week		status, likely disease trajectory and future care priorities, however as the hospital service was led by activity coordinators not health professionals, this aspect could not be included.	including the request of personal items for reminiscence therapy.	
Woods, 2014;{Woods, 2014 #94} Alzheimer's Society support service for carers	Carers	The current service evaluation aimed to evaluate staff perceptions of the effectiveness of the service, and carer experience and satisfaction following their meeting with the Alzheimer's Society.	Two weekly sessions Session 1: Resources are provided that explain what dementia is, how it progresses, what a diagnosis can mean for an individual and their family, and the support available from the Alzheimer's Society services in the community. Session 2: A patient and/or their family who are looking for support are met individually to discuss their circumstances in more detail. Factsheets are	Session 1: The service aims to bring support to service users and get information to those who need it in an appropriate setting. Session 2: The session introduces the Alzheimer's Society and the ongoing support it can offer, and provided 'on the spot' post-diagnostic counselling and emotional support as appropriate.	Alzheimer Society dementia support workers	Session 1 was designed to be open access. Session 2 was a drop-in session, which was held alongside an outpatient memory clinic.	Session 1: main entrance foyer of the hospital Session 2: private meeting held alongside an outpatient memory clinic	Session 1: open access Session 2: usually lasted 30 minutes	The level of support allocated was dependent both on what the patient and their family required, and what they felt comfortable with.	NR	Authors suggest the need to send regular information to hospital staff to maintain awareness of the programme, which relies on staff referral	NR

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			available to be taken away.									
Brooke, 2017;{Brooke, 2017 #22} Dementia-friendly wards	Plwd	Changes to the ward aimed to support decision making, reduce agitation and distress, improve independence of activities of daily living, and increase socialisation and safety.	– Themed bays with names, colours and pictures – flooring matt wooden effect –activity room – designated area for social dining – clocks and dates clearly visible – clear signage –coloured doors for toilets, clinical room doors the same colour as the corridor – large pictures along the corridors – convert each nursing station to a social area – sensory machine	– Alzheimer's Society representatives based in the hospital once a month to provide support and advice to patients and their families – 'Information about me' booklet – Forget-me not signage – Use of twiddlemuffs – Reminiscence sessions – Development and implementation of the Activities Care Crew – Tier 2 dementia simulation training	Staff	Nurses completed notes on patient wards rather than nursing bay; otherwise NR	Three wards in a District General Hospital	NR	NR	NR	Authors suggest staff need encouragement, training and education to support and engage with patients beyond providing physical care	Some staff were resistant to change, questioning the purpose of the environmental changes and disliking documentation on words
Spencer, 2013;{Spencer, 2013 #84} **Spencer, 2014**; **Goldberg, 2014**; Dementia friendly wards	PIwd (PCC), carers (more inclusive), staff (training; physical ward environment more supportive to PCC)	33% of acute hospital admissions in the UK is of a confused older person; the quality of their care is commonly criticised, staff describe feeling underprepared and lacking in skills and confidence. The	1. Employment of specialists in dementia on the ward 2. training for existing staff 3. organised therapeutic and diversionary activities 4. Adaptation of the	An existing acute geriatric ward was converted to a specialist unit for older patients with cognitive impairment	Trainers Healthcare staff	Activities provided in activity room Ward adapted to support orientation and independence of patients Inclusive to carers through increased communication, liberal visiting times	Large hospital, Medical and Mental Health Unit (comparison standard care wards)	Not all patients were able to take part in activities	Activities were matched to retained abilities	NR	Hospital's focus on process measurement and staffing numbers were felt to be barriers in delivering person-centred care. Positive ward leadership and close team working were crucial for success.	Only half of carers interviewed had been asked by staff to complete the information tool During interviews staff said they did not have time to speak to carers as much as carers wanted

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		specialist Medical and Mental Health Unit (MMHU) is a ward adapted to support care for PwD	environment to facilitate care for people with CI 5. Proactive and inclusive approach to family carers			and the invitation to be involved in day-to-day care						Specialist staff (mental health nurses, activity coordinators) were called away from PCC to take a 'specialing' role due to staff shortages
Margot-Cattin, 2006;{Margot-Cattin, 2006 #64} Access technology	Plwd	There is a need to understand how technology can best be used to facilitate well-being in people with dementia. This study sought to describe how access control technology influenced the everyday lives of people with dementia living in a secure unit.	The Swiss Foundation for Rehabilitation Technology created Quo Vadis II, which unlocks doors only for authorised patients and staff members.	Each door in the unit was equipped with an electronic system which controlled locking and unlocking. A person wearing an authorised chip card who entered the antenna's perimeter would unlock the door, granting access.	N/A	System-level change	A secure unit specialising in investigation and short-term treatment for dementia care	The study was conducted over a 6 month period	Access was granted according to the needs of the person	The access technology needed a phase of testing and adaptation after installation to resolve issues such as angle of approach and placement of key cards on patients	Authors emphasised that implementation issues had to be resolved before the approach could provide benefit, and then, the patients, carers and staff had to have a key card in order for it to work	Once technological issues were resolved and a system for attaching cards to patients was developed, good fidelity