Table of included studies that focus on Namaste Care.

All but Magee were included in the scoping in Phase 1.

<table>
<thead>
<tr>
<th>Author, Year and Country</th>
<th>Type of item (e.g. qualitative, descriptive etc)</th>
<th>Participants (number of severity of dementia)</th>
<th>Core components and duration/frequency</th>
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<tbody>
<tr>
<td>Baldwin (1) Australia</td>
<td>Commentary on Chang pilot study of NAMASTE (Nicholls 2013)</td>
<td>NA – describes NAMASTE and talks about Chang study but no participants involved</td>
<td>NA</td>
<td>NA</td>
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<td>Duffin 2012 (2) UK</td>
<td>Description of implementation of NAMASTE</td>
<td>Home had 33 residents with moderate to advanced dementia and 18 with complex physical conditions. Not clear how many involved in NAMASTE</td>
<td>• Residents spend an hour in the NAMASTE room in the morning and there are elements of the programme in the afternoon. Includes: • Massage • Foot washing • Movement exercises • Watching a DVD • Reminiscence activities</td>
<td>Anecdotal evidence only (no figures to support the claims) • staff worked better as a team • Residents sleep better • Less antipsychotic medication • Reduction in falls • Namaste techniques appear to be staff intensive, &amp; there is start-up cost of about £300</td>
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<tr>
<td>Fullarton &amp; Volicer (2013). (3) UK</td>
<td>Letter to editor.</td>
<td>9 residents in 1 nursing home. Average age 85. With advanced dementia (other details not given)</td>
<td>• 9AM to 4PM every day Activities included: • Massage • Shaving for men • Drinks provided • Sensory activities • Taken outside to feed the chickens</td>
<td>Presents outcomes but not clear how data was collected • Decrease in use of psychotics • Apparent improvements in aspects of QoL • Increase in use of analgesics</td>
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<tr>
<td>Goodwin 2010 (4) Australia</td>
<td>Case report – relates to Chang pilot study of NAMASTE (Nicholls 2013)</td>
<td>Briefly mentions one resident with advanced dementia but little information provided</td>
<td>NA</td>
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</table>
| Kaldy 2008 (5) USA | Interview with Joyce Simard – no data is provided | JS says Namaste room isn’t right for every person with dementia. “You can’t have someone who is crying, screaming, or acting out,” she said. It also is not a good match for individuals with terminal illnesses—such as cancer—who are still alert and cognitively intact. However, anyone can receive Namaste services in their rooms or after hours with | • Specially designated room  
• Loving touch  
• Soft music  
• Lavender  
• Stuffed animals  
• Manicures or hand massages etc | Anecdotal – no evidence reported |
| King 2013 (6) USA | Describes the process of setting up NAMASTE | People with advanced dementia MMSE 0-7  
Participants had challenges in communicating, needed total assistance with personal care and were nonambulatory | From 3-8pm every day  
Small group programs  
Sensory programming  
Developed a core group of caretakers – because relationships key in building trust  
Massage, use of essential oils  
Tasty snacks  
Cuddly animals and dolls | Anecdotal evidence from staff and families about improvements – e.g. improved communication, peace |
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| Lourde, K. (2007). (6) USA | Commentary on Namaste in 3 nursing homes in the US | | • Specially designated room  
• Loving touch  
• Soft music  
• Lavender  
• Stuffed animals  
• Manicures or hand massages etc | • Anecdotal evidence about the benefits – e.g. increased family satisfaction, improved care, economic benefits for care homes as increase in referrals |
| Magee 2017 (7) UK (Northern Ireland) | Before/after study looking at feasibility of introducing NC into nursing home and integrating it into usual care | N=9; 1 male, 8 females. 7 diagnosed with dementia, 1 described as having advanced dementia | • Dimmed lighting  
• Soft background music  
• Relaxing and calming ambience  
• Loving touch  
• Welcome  
• Snacks and drinks  
• Aromas  
• Visual aspects (e.g. lava lamp, pictures)  
Programme ran for 4 weeks.  
2 sessions a day was soon found to be too much for the staff to engage with, and the programme was reduced to 1 session held after lunch.  
Run from Monday to Friday (not 7 days)  
Set up each day took longer than expected which reduced the time for activities | • Small increase in mean weight was recorded over the course of the study (qualitative evidence that residents ate and drank more)  
• Those with behavioural disturbances showed an improvement (measured using CMAI, CBS, Cornell)  
• Suggest that grouping together residents with similar interests would make tailoring the activities easier. |
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| McCormick 2011 (8) USA   | Describes use of Namaste by EPOCH, Massachusetts (one of several papers about EPOCH) | N=9: 1 resident was moderately impaired, 4 residents were severely impaired and 4 were very severely impaired | • Takes place every day for 4 hours, 2 hours in morning and 2 in afternoon  
  • Specially designated room  
  • Food and drink treats  
  • Lavender oil  
  • Reminiscence  
  • Stuffed animals and dolls | Anecdotal |
| Manzar, B., & Volicer, L. (2015). (9) UK | Before/after pilot study & qualitative study. 9 residents, 9 relatives, 8 staff (6 hands on Namaste carers & 2 senior staff). | | Data collected at baseline and 3 and 7 weeks by carer.  
  Pain (PAINAD)  
  QoL (QUALID) – say it improved QoL score in all and decreased perception of pain in some residents | |
| McNiel, P., & Westphal, J. (2016). (10) USA | Qualitative study. 14 staff members (certified nursing assistants, registered nurses, clergy, and therapists). 1 long-term care facility in the US. | Eligibility to participate in the Namaste Care™ program included diagnoses of Alzheimer’s disease, dementia, strokes, cognitive and behavioural issues. Staff were encouraged to use nursing judgment and invite residents to trial the Namaste Care™ program for a brief period of time to assess potential resident benefits for program enrolment | • Maximum capacity 8  
 • Little description of what components of NAMASTE they used | Anecdotal evidence from staff and families about improvements |
Nicholls et al (2013). (11) Australia
NB this study by is referred to in several publications – but we were unable to find a publication reporting final results

| Qualitative 7 focus groups consisting of 31 participants were conducted separately for each of the study cohorts: family members of residents, AINs and RNs. 6 RACFs (3 intervention, 3 control) | Mini-Mental State Examination score < 7 and bed-fast or chair-fast – End stage of dementia trajectory, requiring palliative care but this paper only reports staff and relatives’ views of the impacts of NAMASTE | High touch intervention – combines 1) intensive train the trainer package for care staff; 2) family conferences facilitating end of life discussions, 3) delivering NAMASTE Care Programme (not further defined) | Qualitative exploration of importance of touch |

Simard 2005 (12) USA
Describes set up of Namaste in care home in Vermont. Focuses on one resident

| One man with advanced dementia at end of life | • Usual elements of the program but not clear if delivered in group or one to one | Anecdotal evidence that quality of death for this resident was improved |

Simard 2007 (13) USA
Describes the use of Namaste by one long-term care company (EPOCH in Massachusetts)

<p>| Suggests participants should have: 1. a diagnosis of irreversible dementia, 2. an MMSE score &lt; 7, 3. unable to participate in scheduled activities, 4. non-ambulatory, 5. difficulties communicating, 6. total care with ADLs. Others recommended to benefit from Namaste are people with COPD, Parkinsons disease and other terminal illnesses or those who are agitated | Activities include: • Aromatherapy diffuser • Essential oils, especially lavender • Stuffed animals • Music • Sensory material • Humorous items (e.g. wigs) • Antique items • Reading material | Anecdotal evidence about benefits for staff and residents |</p>
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| Simard & Volicer (2010). (14) USA | Before/after study. 86 residents. 6 EPOCH Senior Living Healthcare Centres in the USA. | N=86: 1 participant was borderline intact, 2 had mild CI, 23 had moderate CI, 23 had moderately severe impairment, 14 had severe impairment, and 23 had very severe impairment. However, none of the residents was rated comatose. | • Namaste carers were selected on desire to be involved in the program.  
• The number of residents in the program ranged from 6 to 11 with 1 Namaste carer or another staff person always present in the room.  
• The program was supervised usually by a Director of Nursing or Assistant Director of Nursing | Analysis of minimum data set when residents had been involved in programme for at least 30 days showed decrease in resident’s withdrawal, Social interaction & delirium indicators |
| Simard 2012 (15) | Describes NAMASTE and one of the first residents to be part of the programme | Simard says she uses this story (of Evelyn Groves) to encourage carers to try Namaste on even the most difficult residents | • Specially designated room  
• Loving touch  
• Soft music  
• Lavender  
• Stuffed animals  
• Manicures or hand massages etc | Anecdotal – describes benefit for one resident |
| Soliman & Hirst (2015). (16) UK | Before and after study. 2 care homes in London. | N= 11-14 people with advanced dementia | • 3-5 sessions in each home per week activities tailored to individual preferences, including:  
• Hand/foot massage  
• Reminiscence;  
• Food and drink treats;  
• Personal care including hair brushing or face washing  
• Specially designated room | Outcomes included:  
• Aggressive or challenging behaviour (10/14 showed a reduction)  
• QoL – improvements shown  
• Sleeping patterns  
• Appetite  
• Staff, residents and relatives’ satisfaction – data not available |
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| Stacpoole 2014 (17) UK   | Before/after & qualitative evaluation (staff / relative separate focus groups and manager interviews). Action research. 30 Residents and also relatives, care staff and managers. 5 care homes in England. | 30 residents with a dementia diagnosis and a Bedford Alzheimer’s Severity Scale score of >16 | • Takes place every day for 4 hours, 2 hours in morning and 2 in afternoon  
• Dedicated space  
• Soft music, scents, greenery  
• Residents are welcomed by name  
• Pain management  
• Sensory stimulation  
• Food treats/hydration etc | • Primary measures NPI-NH and Doloplus-2 behavioural pain assessment  
• Baseline and at 3, 1-2 month intervals  
• Neuropsychiatric symptom severity & disruptiveness decreased in four CHs but increased in one CH  
• Slight reduction in effectiveness towards end of intervention |
| St. John & Koffman 2015 (18) UK | Qualitative - feasibility and effectiveness of Namaste Care in a large inner-city teaching hospital in UK  
No residents involved in this study. Type of participants not specified | 8 semi-structured, face-to-face interviews with members of the multidisciplinary ward team  
No residents involved in this study. Type of participants not specified | • Group or one to one sessions (Mon-Fri). Grp sessions last 1 hr and one to one between 20-30 minutes – but doesn’t say how often each person receives it  
• Units day room developed into a sensory room  
• Loving touch, foot and hand massage, reminiscence etc | • Anecdotal, qualitative reports from staff on the potential benefits. |
| Trueland 2012 (19) UK (relates to Stacpoole 2014) | Commentary – describing NAMASTE and the Stacpoole study  
Not specified but assume is same as Stacpoole 2014 | Not specified but assume is same as Stacpoole 2014 | • Residents are welcomed by name  
• Settled comfortably with blankets and pillows  
• Soft music  
• Massage  
• Reminiscence  
• Delicacies such as ice lollies and orange slices | Anecdotal  
• Better pain assessment  
• Reduction in pressure ulcers  
• Increased intake of fluids |
References

8. Mccormick C. Namaste Care at EPOCH Senior Living. cmccormick@capecodonline.com. 2011;