

The Practice of Support Personnel

**The Practice of Support Personnel, supervised by Physiotherapists, in Norwegian
Reablement Services**

Abstract

Objectives: Reablement is a relatively new service targeting people with or at risk of functional decline. The approach is team-based, and physiotherapists (PTs), occupational therapists (OTs) and nurses have the responsibility to guide and supervise the support personnel, referred to as home trainers (HTs). The aim of this study was to explore how the HTs follow up instructions and supervision by PTs in reablement.

Methods: This qualitative study included video recordings of practice and individual interviews in seven Norwegian reablement teams. The analysis involved a triangulation of all data.

Results: The results identified that HTs had the main responsibility to carry out interventions in reablement and were also expected to report back to the therapists if they recognized further need for assessment or adjustments. The content of the practices varied considerably along a continuum from rigidly standardized practices to individually tailored approaches emphasizing quality of movement. This paper presents analyses of two examples representing the two widely different approaches.

Conclusion: Practitioners and health authorities should be aware of the broad variation in reablement services in Norwegian municipalities. The results indicate that a standardized approach may be more efficient in the short term, targeting a large population, while a tailored approach, valuing quality of movement, is essential to provide high-quality movement training for users with complex rehabilitation needs. The target groups receiving the different reablement methods should be clearly identified.

Keywords: *Health care services, Physical therapy modalities, Qualitative research, Rehabilitation*

Introduction

Due to the increasing number of the ageing population with chronic and complex diseases, economic challenges and a shortage of health professionals have been reported worldwide (Krug & Cieza, 2017). To accommodate this, support personnel are engaged to provide clinical tasks traditionally performed by professionals (World Health Organization, 2006; Colbran-Smith, 2010; Lizarondo, Kumar, Hyde, & Skidmore, 2010; Fulton et al., 2011; Kakuma et al., 2011; Munn, Tufanaru, & Aromataris, 2013).

The Norwegian Ministry of Health and Care Services has suggested a need for reorganization to provide efficient and sustainable services. The authorities have suggested new roles for health professionals, including the extended responsibility for training and supervising other personnel (Norwegian Ministry of Health and Care Services, 2015). Accordingly, the role of the physiotherapist (PT) has broadened to include supervision, which requires them to share their knowledge and skills with support personnel (Holmes, 1970; Saunders, 1998; Ellis & Connell, 2001; Colbran-Smith, 2010).

The World Confederation of Physical Therapy (WCPT) (2016) has defined the aim and scope of physiotherapy broadly as intended to 'serve individuals and populations to develop, maintain and restore maximum movement and function ability throughout the lifespan'. Nevertheless, the distinct and unique aspect of physiotherapy is the approach targeting the performance of bodily movement and function in a competent manner (Nicholls & Gibson, 2010). Clinical reasoning and discretion due to the context and the abilities and constraints of individual patients are integrated in the PT's situational interaction with the patient (Oberg, Blanchard, & Obstfelder, 2014). Several have expressed concerns regarding the delegation of complex tasks to caregivers without professional training (Brentnall, Hemsley, & Marshall, 2008; Munn et al., 2013; Nelson, 2013; Legg, Gladman, Drummond, & Davidson, 2016).

The Practice of Support Personnel

The nomenclature of support personnel, as well as their role is diverse, including all forms of personnel assisting health professionals; aides, assistants or unlicensed staff (Ellis & Connell, 2001; Lizarondo et al., 2010; Munn et al., 2013). In Norway, there is no formal educational programme targeting personnel exclusively assisting PTs, as there is in several other countries, such as the US, Canada, Australia and the UK. However, a two-year formal education programme for a more generic health assistant, mainly affiliated with nursing, does exist.

Reablement is a service wherein PTs play an essential role in supervising the support personnel as they carry out interventions. The key characteristics of the service are the short-term, goal-oriented interventions provided by an interprofessional team. Support personnel, under the supervision of professionals, mainly provide the treatment initiatives (Tessier, Beaulieu, McGinn, & Latulippe, 2016). The approach targets home dwelling older adults with or at risk of functional decline, to preserve or regain functional abilities to stay independent in their daily life (Burton, Lewin, Clemson, & Boldy, 2013; Winkel, Langberg, & Wæhrens, 2015; Cochrane et al., 2016; Legg et al., 2016). Tuntland, Aaslund, Langeland, Espehaug, & Kjekken (2016) studied 225 participants, of whom the majority reported health conditions such as fractures, balance problems, pain or stroke, while only 3.1% reported unspecified functional decline as the main issue. The participants had a median of three additional health conditions. Apart from this study, we have found no clear description of the target population in the literature. .

The interprofessional teams usually consists of PTs, occupational therapists (OT) and nurses, who have the responsibility to supervise the support personnel, often referred to as home trainers (HT), who are the main providers of reablement services (Hjelle, Skutle, Førland, & Alvsvåg, 2016; Tessier et al., 2016; Eliassen, Henriksen, & Moe, 2018). HTs working in reablement may include support personnel with or without any formal training.

The Practice of Support Personnel

Reablement interventions are described to be person-centred and individually tailored (Cochrane et al., 2016). Considering the heterogeneous user group, this presupposes a wide range of skills by the HTs. The quality of reablement services provided by personnel without formal education, has been questioned. .. (Legg et al., 2016; Eliassen et al., 2018).

Reablement literature tends to describe *where* the user's training should be provided (the user's home environment) and *what* to target (the user's own goals). However, *how* to carry out the reablement interventions is not clearly described.

The aim of this study was to explore how the HTs follow up instructions and supervision by PTs in reablement.

Methods

This study utilized a qualitative method within a constructionist research paradigm. We collected data through fieldwork in reablement settings, including video recordings of supervision sessions and encounters between HTs and users. Additionally, we conducted interviews with PTs and HTs. Theory of professional development (cf. Dreyfus & Dreyfus, 1980; Benner, 2004) informed the results.

Context and participants

This study explored seven reablement teams, each of them represented by a triad of a PT, an HT, and a reablement user. The teams were recruited from seven different municipalities in Norway, based on a purposive sampling approach (cf. Polit & Beck, 2012). The inclusion criterion for the PTs and HTs was at least 6 months of experience with reablement.

We contacted general managers of reablement teams to inform about the study. General managers who consented to participate, distributed the study information to the PTs

The Practice of Support Personnel

and HTs, who consented to participate in the study. The PTs informed users, who were about to receive reablement, about the study, and those who gave their written consent to participate, were included. Table 1 provides more information about the participants.

Data collection

We conducted a study with two visits to each reablement team. During the first visit, the first author (ME) conducted video recordings of supervision as work with a new user commenced, followed by a semi-structured interview with the PT. Two weeks later, midway through the user's reablement process, the researcher conducted video recording of the approach conducted by the HTs in the user's home, followed by a semi-structured interview with the HTs.

The *supervision sessions* and *user interventions* were video-recorded with a handheld camera to ensure that the situational and interactional elements of the practice were captured (cf. Heath, Hindmarsh, & Luff, 2011). We developed an observation guide to outline what we wanted to capture during the video recordings. The focus in the observation guide was the training initiatives instructed by the HT and the changes in the user's function or movement.

The researcher subsequently conducted a *semi-structured interview* with the PT and the HT after the supervision session and the user encounter. Through open-ended questions, the interviewees were encouraged to elaborate on the following: 1) the clinical reasoning regarding the observed intervention 2) the required knowledge and skills and 3) the communication and collaboration.

Analysis

The Practice of Support Personnel

The first author (ME) did a verbatim transcription of the interviews and a schematic content transcription of the video recordings including verbal speech and bodily interactions, inspired by Heath, Luff, & Svensson (2007). The cataloguing transcript of the video recordings aimed to capture the multiple aspects of the interactions and movements. Transforming all data into text material enabled a common processing of the consecutive analyses. ME produced inductive codes for the entire text material and categorized it through common code groups and themes (Lincoln & Guba, 1985). Congruent data validated each other, while discrepancies were further analysed to achieve an understanding of the inconsistencies.

Continuously, the development and validation of the findings was inspired by theory in the field (Blaikie, 2007; Malterud, 2016; Creswell & Poth, 2017).

NH and SM (respectively, a sociologist and a PT) contributed to the analysis through an iterative process of discussions, emphasizing a common perception of the data material and enhancing the validity of the study (Creswell & Poth, 2017). The triangulation of different methods, reflexivity and theoretical interpretation also contributed to validation of the findings.

QSR NVivo 11 (QSR International, 2017), a qualitative data analysis software, was used during the coding and categorizing of the data material.

Results

The main themes that emerged from the data were as follows: 1) the HT is responsible for recognizing and reporting on the user's needs, 2) there is a standardized approach following a pre-defined procedure, and 3) individually tailored approaches target the quality of movement.

The Practice of Support Personnel

Our analysis revealed that the content of the service provided displayed considerable variation across reablement teams. The target group was diverse for the teams, and users ranged from those with general functional decline to users with complex health conditions (see Table 1). Excerpts from *two* different practices are highlighted to demonstrate the variety. Data from all the included reablement teams serve to support these results.

The HT is responsible for recognizing and reporting on the user's needs

The interviews with both the PTs and the HTs revealed that the HTs had the essential responsibility to observe and assess the user's challenges and needs. Several PTs said that the HTs had the best insight into the user's situation based on their regular visits, and therefore, claimed that the HTs had the exclusive responsibility to report any circumstances of importance to the PT. One stated:

“[The supervision] is not a fixed routine. The HT has to let us know if she needs any further instructions or support. Then, we can provide additional supervision [...] Somehow I just have to trust that the HT tells me if the approach doesn't work or if there is any need for changes according to the plan”. (PT)

The HTs reported that they would contact the PT if they felt uncertain about a situation. Typically it would be due to pain, fall incidences, to determine if the user was ready to walk without assistive device, or to adjust the exercises provided. These adjustments were seen as the responsibility of the PTs, as one HT said:

“To clarify what exercises are the best... that is not my subject. Especially when there are any constraints. Pain for example. [I contact the PT] if the user has pain or if they complain about exhaustion after the exercises”. (HT)

The Practice of Support Personnel

One HT claimed that there was a low threshold to contact the PT if she needed any supervision or a second opinion regarding the user's reablement initiatives. However, when asked if she had ever contacted the PT in addition to the scheduled meetings, she answered:

“No...no... I haven't actually done that. Well, we meet them occasionally ... and, we talk... but... it's a busy workday, so... I haven't actually contacted them, because it's all about the planning. If the reablement approach is well planned from the beginning, you don't need to”. (HT)

Standardized approach following the pre-defined procedure

In reablement teams where the HTs had limited contact with the PT, the HTs appeared to carry out intervention in accordance with the written information on a reablement-plan provided by the therapist.

The example in Table 2 shows that the HTs were mainly concerned with counting repetitions and did not attempt to follow up on the instructions provided by the PTs regarding the quality of movement or to correct compensatory movements during exercises. The observed exercises rarely related to the users' activity-based goals, which was a finding confirmed in the interview materials. One PT said:

“The HTs tend to be more focused on the exercises for strength and balance. They forget the activity-based goals”. (PT)

Additionally, HTs and PTs in practices that emphasized the standardized approach claimed that it was advantageous to implement simple and recognizable exercises that could easily be explained to the HT and the user. In the reablement teams where the HTs mainly based the approach on general exercises and standardized programmes, they also tended to do minimal adjustments and progression. If the user reported pain, the normal response was to exclude the

The Practice of Support Personnel

provoking activity or exercise. If the exercises appeared to be too easy, their suggestion was to carry out more repetitions. One HT said:

“Well, if she doesn’t get tired, we’ll simply increase the amount. Instead of doing one round, we can do two. Or three. So, we’ll do more and more, so she eventually gets stronger”. (HT)

Individually tailored approaches targeting quality of movement

During observations of some of the HTs’ training encounters, we recognized the PTs’ supervision regarding quality adjustments on some of the reablement teams. The example in Table 3 is a typical approach where we observed how the HT tried to achieve appropriate movements according to instructions from the PT. One of the PTs claimed that through movement analysis and an approach targeting the quality of movement, they could achieve optimal functional abilities and prevent any further functional decline:

“We can see that they have a shambling walk and think that it is normal for older people if you haven’t thought it through. For example, how people get up from or settle in a chair. The HT hadn’t thought like that before I told her my reflections about it. If you just drop down in the chair every time, you’ll miss the quality of movement. By addressing some small, specific adjustments, they quickly get a different quality of the movements and are able to take advantage of it in many situations. Just by analysing movements. We can’t let go of that and believe that there is no need for the PT”. (PT)

Video observations revealed that, despite the PTs’ instructions, only a few of the HTs paid attention to the small details regarding quality of movement. Through analysis of the field observations and interviews, it appeared that these specific approaches were based on the HTs’ ability to recognize the nuances in movement and to distinguish between optimal quality

The Practice of Support Personnel

of movement and constraints in movement. The HTs had difficulties with pointing out exactly what they looked for on a general basis, but they explained that this was the knowledge they learned along the way by regularly working in pairs with the PT during the user visits. In that way, they experienced a continuous input of "small tips" of knowledge, which increased their ability to conduct their own observations and reflections. One PT claimed:

“They have become good at doing their own observations. She can come to me and say: “The user has a weakness in her hip. I can see that when she is walking, her hip is moving sideways... It kind of drops”. It is really helpful for me that they can bring that information back. Sometimes they say, “We have been doing these exercises for a while now, and... we need something more challenging”. (PT)

The PTs and HTs who emphasized quality in movement, also said that it was essential for the HT to achieve a deep understanding of the user’s situation. This was further claimed to lead to reflections and clinical reasoning enabling adjustments and individual adaptations during the approach. One said:

“It is important to explain thoroughly about possible causations between this and that. You know, to achieve an understanding and get them to reflect about things. I experience that they can come to me and say, “Today I observed this and that, and I was wondering what that could be, and finally I figured how it all went together”, they absolutely do some clinical reasoning themselves”. (PT)

The HTs argued that this discretionary reasoning enabled them to adjust the approach based on progression, individual adaptations and contextual variations. One HT explained how to adjust the treatment to the individual user:

“I have to target the approach from different angles. Approach the user in relation to what is important for the individual. Sometimes you have to be more direct and other

The Practice of Support Personnel

times you have to take a small detour to 'reach in'. You cannot approach all the same way". (HT)

Discussion

HTs in reablement teams were the main providers of training sessions with the users and were expected to carry out observations during home visits and to report to the therapists any further need for therapeutic assessments or supervision. However, the fulfilment of this task varied considerably across teams. The identification of the need for additional therapeutic supervision requires a certain degree of judgement based on specialized knowledge about physical ability and quality of movement. This puts the HTs in a challenging position where the expectations are not necessarily proportional to their knowledge and skills, as also reported among PT assistants in paediatric physiotherapy (Sørvoll, Obstfelder, Normann, & Øberg, 2018).

The varied practices were analysed in conjunction with the quality of the service the HTs provided to the users. The model of skill acquisition by Dreyfus & Dreyfus (1980) presents five levels of proficiency, ranging from novice to expert and has been used to understand the differences between experienced and novice staff in health care practices (Benner, 1982; Benner, 2004). We have applied this perspective to clarify the different practices in reablement.

Instrumental and standardized reablement approach

The two examples presented in Table 2 and 3 clearly contrast with each other. In the first example, the HT followed the pre-defined written procedure without attending to the quality of movement. A passive involvement where the HTs watched the user carry out exercises while counting repetitions was also reported by Rabiee & Glendinning (2011). They

The Practice of Support Personnel

found that reablement staff employed in the home care services referred to their job as ‘standing and watching’ and were ambivalent about the importance of their job.

The HTs who conducted this kind of instrumental approach reported that they rarely needed additional support from the PT. Their ability to recognize the physical constraints regarding the user’s functional ability appeared to be limited, and they were not aware of what to look for.

This practice bears similarities to the description of a ‘novice’ practitioner (Dreyfus & Dreyfus, 1980), whose task performance is mainly rule-based, with limited ability to make discretionary judgements and contextual adaptations (Benner, 1982). This approach focused mainly on the procedural aspect of the initiatives, in contrast to the initial vision of reablement as person-centred and individually tailored (Cochrane et al., 2016).

Specific and tailored reablement approach

Table 3 demonstrates a reablement practice where the HT engaged in clinical reasoning and paid attention to the quality of movement. This enabled the HT to report to the PT on specific conditions regarding the users’ functions and abilities. A vital aspect of this practice seemed to demand close collaboration and frequent supervision by the PTs and may be more demanding of resources than the predominantly instrumental approach.

HTs who included clinical judgements also adjusted and tailored interventions according to users’ needs and constraints during intervention. This practice appeared to be more flexible. According to Randström, Wengler, Asplund, & Svedlund (2014), flexibility is vital for the ability to adjust initiatives to the users’ wide range of physical and psychosocial needs and to secure positive outcomes of the intervention. Other scholars have also reported that the flexible approach, enabling adjustments, is preferable in reablement (Rabiee & Glendinning, 2011; Moe & Brataas, 2016).

The Practice of Support Personnel

According to the fourth level of the Dreyfus model, 'proficient' practitioners perceive situations as a whole, rather than in terms of aspects. The ability to recognize the expected normal clinical picture or the absence of normality is characteristic of the proficient health care provider (Benner, 1982). The HTs' ability to recognize situations that required further PT assessment or supervision is an example of a proficient HT practice in reablement. The holistic approach enabled the HT to engage in decision making, by modifying plans in response to a variety of contexts and events. The example where the HT targeted small adjustments in foot position, weight transfer and hand support during an exercise shows how she was able to recognize the broader picture of the exact targeting movement, and the underlying details. Benner & Sutphen (2007) argued that home care professionals need an interpretive form of rationality, rather than a technical rationality of instrumental problem solving.

Task delegation

Task delegation has been argued to potentially improve the quality of care and safety of patients (Lizarondo et al., 2010). It is therefore a paradox that in some reablement settings, the delegation of tasks led to poor quality regarding individually tailored approaches.

In this study, there was no relationship between how long the HT has been working and the level of skill acquisition. The development of practical skills is not achieved automatically. Dreyfus (2004) describes that moving from one competence level to another requires learning through reflection and discussion. This study indicate that a close collaboration between the PT and the HT is essential for an individually tailored service emphasizing quality of movement, which agrees with the results of a study that indicated that organizational conditions and the supervision by PTs influenced the service (Eliassen et al., 2018).

Different practice to different target groups?

The two examples of practice presented in this paper represent a variety of reablement services. The target group was broadly defined, and we did not find any clear descriptions that differentiated among users in the various approaches. Users may range from independent older adults with an initial functional decline to post-institutionalized patients with complex rehabilitation needs. It has been discussed whether users with multiple needs benefit as much as users with lower support requirements (Cochrane et al., 2016). A Norwegian report on reablement (Fürst & Høverstad ANS, 2014) reported that municipalities with limited rehabilitation services may define the target group broadly, hence including users with complex and comprehensive challenges. Approaches should be adjusted according to the needs of the different target groups.

Citizens with minor functional decline may benefit considerably from a standardized approach. However, patients with complex rehabilitation conditions may require adjusted and modified interventions, which involve understanding and judgement. Hence, we argue that reablement services should not be a substitute for traditional rehabilitation delivered by professionals. Reablement should rather target those who would not receive traditional rehabilitation. The existing studies on reablement approaches have not distinguished between different approaches nor between target groups.

Methodological considerations

The study design limits generalization. However, the results may be analytically applied to similar contexts (Malterud, 2001). Other possible practices may exist. However, this will not contradict our conclusion regarding the wide variability in reablement practices.

The Practice of Support Personnel

The objective in the current study was interpreted within a physiotherapy perspective. The quality of practice may be interpreted differently when viewed from other perspectives, emphasizing other values than quality of movement.

Conclusion

The HTs in Norwegian reablement teams were expected to recognize and report the users' needs to the PT and to carry out interventions. Practices varied from instrumental and standardized approaches to approaches individually tailored to the user's abilities and constraints. The first approach follows pre-defined plans. The latter involves clinical adjustments and discretion regarding the quality of movement.

There are challenges and benefits with both practices, depending on the target group. A clarification of the target group is essential to tailor the reablement practices in accordance with the user's functional level.

Implications for physiotherapy practice

Due to the extended role of PTs that now includes the supervision of support personnel, it is important to be aware of the different practices that may be provided based on physiotherapy supervision. The results of this study revealed that in some cases, support personnel managed to provide complex initiatives tailored to the users' needs. However, the fiscal sustainability of the supervision required for this approach needs consideration. PTs should be aware of their professional responsibility to follow up on delegated tasks. It should be discussed whether treatment of certain conditions or user groups should be delegated to support personnel. Health care administration should also be aware of the diversity in reablement practices. Implementation of the service should emphasize local conditions regarding target group needs.

References

- Benner, P. (1982). From novice to expert. *AJN The American Journal of Nursing*, 82, 402-407.
- Benner, P. (2004). Using the dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science, Technology & Society*, 24, 188-199.
- Benner, P., & Sutphen, M. (2007). Learning across the professions: The clergy, a case in point. *Journal of Nursing Education*, 46, 103-108.
- Blaikie, N. (2007). *Approaches to social enquiry: Advancing knowledge*. Cambridge, UK: Polity.
- Brentnall, J., Hemsley, B., & Marshall, E. (2008). *Therapy services in the disability sector: Literature review*. Sydney: Department of Family and Community Services NSW
- Burton, E., Lewin, G., Clemson, L., & Boldy, D. (2013). Effectiveness of a lifestyle exercise program for older people receiving a restorative home care service: Study protocol for a pragmatic randomised controlled trial. *BMC Health Services Research*, 13, 419. doi:10.1186/1472-6963-13-419.
- Cochrane, A., Furlong, M., McGilloway, S., Molloy, D.W., Stevenson, M., & Donnelly, M. (2016). Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. *Cochrane Database of Systematic Reviews*, 10, CD010825. doi:10.1002/14651858.CD010825.pub2.
- Colbran-Smith, M. (2010). *White paper: Physiotherapist support personnel study*. Canadian Physiotherapy Association. Retrieved from https://physiotherapy.ca/sites/default/files/site_images/Assemblies/white-paper-physiotherapist-support-personnel-study.pdf.

The Practice of Support Personnel

- Creswell, J.W., & Poth, C.N. (2017). *Qualitative inquiry and research design: Choosing among five approaches*. London: Sage Publications.
- Dreyfus, S.E. (2004). The five-stage model of adult skill acquisition. *Bulletin of Science, Technology & Society*, 24, 177-181.
- Dreyfus, S.E., & Dreyfus, H.L. (1980). *A five-stage model of the mental activities involved in directed skill acquisition*. Berkeley: University of California-Berkeley Operations Research Center.
- Eliassen, M., Henriksen, N.O., & Moe, S. (2018). Variations in physiotherapy practices across reablement settings. *Physiotherapy Theory and Practice*, 1-14.
doi:10.1080/09593985.2018.1481162.
- Ellis, B., & Connell, N.A.D. (2001). Factors determining the current use of physiotherapy assistants: Views on their future role in the south and west uk region. *Physiotherapy*, 87, 73-82.
- Fulton, B.D., Scheffler, R.M., Sparkes, S.P., Auh, E.Y., Vujicic, M., & Soucat, A. (2011). Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health*, 9, 1. doi:10.1186/1478-4491-9-1.
- Fürst & Høverstad ANS. (2014). *Fra passiv mottaker til aktiv deltaker [from passive recipient to active participant]*. Retrieved from <http://www.ks.no/globalassets/blokker-til-hvert-fagomrade/ny-mappe/ks---hverdagsrehabilitering---sluttrapport-endelig.pdf>.
- Heath, C., Hindmarsh, J., & Luff, P. (2011). *Video in qualitative research*. London: SAGE Publication Ltd.
- Heath, C., Luff, P., & Svensson, M.S. (2007). Video and qualitative research: Analysing medical practice and interaction. *Medical Education*, 41, 109-116. doi:10.1111/j.1365-2929.2006.02641.x.

The Practice of Support Personnel

- Hjelle, K.M., Skutle, O., Førland, O., & Alvsvåg, H. (2016). The reablement team's voice: A qualitative study of how an integrated multidisciplinary team experiences participation in reablement. *Journal of Multidisciplinary Healthcare, 9*, 575-585.
- Holmes, T.M. (1970). Supportive personnel and supervisory relationships. *Physical Therapy, 50*, 1165-1171.
- Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M.R., Desiraju, K., Morris, J.E., . . . Scheffler, R.M. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet, 378*, 1654-1663. doi:10.1016/S0140-6736(11)61093-3.
- Krug, E., & Cieza, A. (2017). Strengthening health systems to provide rehabilitation services. *Neuropsychological Rehabilitation, 1-3*. doi:10.1080/09602011.2017.1319391.
- Legg, L., Gladman, J., Drummond, A., & Davidson, A. (2016). A systematic review of the evidence on home care reablement services. *Clinical Rehabilitation, 30*, 741-749. doi:10.1177/0269215515603220.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park: Sage.
- Lizarondo, L., Kumar, S., Hyde, L., & Skidmore, D. (2010). Allied health assistants and what they do: A systematic review of the literature. *Journal of Multidisciplinary Healthcare, 3*, 143-153. doi:10.2147/JMDH.S12106.
- Malterud, K. (2001). Qualitative reasearch: Standards, challenges, and guidelines. *Lancet, 358*, 483-488.
- Malterud, K. (2016). Theory and interpretation in qualitative studies from general practice: Why and how? *Scandinavian Journal of Social Medicine, 44*, 120-129.
- Moe, A., & Brataas, H.V. (2016). Interdisciplinary collaboration experiences in creating an everyday rehabilitation model: A pilot study. *Journal of Multidisciplinary Healthcare, 9*, 173-182S. doi:10.2147/JMDH.S103696.

The Practice of Support Personnel

- Munn, Z., Tufanaru, C., & Aromataris, E. (2013). Recognition of the health assistant as a delegated clinical role and their inclusion in models of care: A systematic review and meta-synthesis of qualitative evidence. *International Journal of Evidence-Based Healthcare, 11*, 3-19.
- Nelson, R.M. (2013). The next evolution. *Physical Therapy, 93*, 1415-1425.
doi:10.2522/ptj.2013.mcmillan.lecture.
- Nicholls, D.A., & Gibson, B.E. (2010). The body and physiotherapy. *Physiotherapy Theory and Practice, 26*, 497-509. doi:10.3109/09593981003710316.
- Norwegian Ministry of Health and Care Services. (2015). *Meld. St. 26 (2014-2015) fremtidens primærhelsetjeneste – nærhet og helhet [the primary health and care services of tomorrow – localised and integrated]*. Retrieved from <https://www.regjeringen.no/contentassets/d30685b2829b41bf99edf3e3a7e95d97/no/pdfs/stm201420150026000dddpdfs.pdf>.
- Oberg, G.K., Blanchard, Y., & Obstfelder, A. (2014). Therapeutic encounters with preterm infants: Interaction, posture and movement. *Physiotherapy Theory and Practice, 30*, 1-5. doi:10.3109/09593985.2013.806621.
- Polit, D.F., & Beck, C.T. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins.
- QSR International. (2017, April 3). What is nvivo, 2017. Retrieved from <http://www.qsrinternational.com/>
- Rabiee, P., & Glendinning, C. (2011). Organisation and delivery of home care re-ablement: What makes a difference? *Health & Social Care in the Community, 19*, 495-503.
- Randström, K.B., Wengler, Y., Asplund, K., & Svedlund, M. (2014). Working with ‘hands-off’ support: A qualitative study of multidisciplinary teams’ experiences of home

- rehabilitation for older people. *International Journal of Older People Nursing*, 9, 25-33.
- Saunders, L. (1998). Managing delegation: A field study of a systematic approach to delegation in out-patient physiotherapy. *Physiotherapy*, 84, 547-555.
- Sørvoll, M., Obstfelder, A., Normann, B., & Øberg, G.K. (2018). Perceptions, actions and interactions of supervised aides providing services to children with cerebral palsy in pre-school settings: A qualitative study of knowledge application. *European Journal of Physiotherapy*, 1-9. doi:10.1080/21679169.2018.1452978.
- Tessier, A., Beaulieu, M.D., McGinn, C.A., & Latulippe, R. (2016). Effectiveness of reablement: A systematic review. *Healthcare Policy*, 11, 49-59.
- Tuntland, H., Aaslund, M.K., Langeland, E., Espehaug, B., & Kjekken, I. (2016). Psychometric properties of the canadian occupational performance measure in home-dwelling older adults. *Journal of Multidisciplinary Healthcare*, 9, 411-423. doi:10.2147/JMDH.S113727.
- Winkel, A., Langberg, H., & Wæhrens, E.E. (2015). Reablement in a community setting. *Disability and Rehabilitation*, 37, 1347-1352. doi:10.3109/09638288.2014.963707.
- World Confederation for Physical Therapy. (2017, January 17). What is physical therapy, 2016. Retrieved from <http://www.wcpt.org/what-is-physical-therapy>.
- World Health Organization. (2006). *The world health report 2006: Working together for health*. Geneva: World Health Organization.
- World Medical Association (2018). Wma declaration of helsinki – ethical principles for medical research involving human subjects. Retrieved from <file:///C:/Users/mae029/Downloads/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects.pdf>.

The Practice of Support Personnel

Table 1: Information about Participants

PTs	Experiences	HTs	Experiences	Users	Impairment and goals
1	<5 year as PT, 6 months in reablement	1	Nurse assistant, 5 years' experience in reablement	1	Hip fracture, aiming for personal hygiene, go to the mall, attend the day care center, cook meals
2	>10 years as PT, 2 years in reablement	2	Nurse assistant, 2 years in reablement	2	Hip and upper arm fracture, aiming to walk outside
3	>10 years as PT, 2 years in reablement	3	Nurse assistant, 1 year in reablement	3	Hip fracture, aiming to walk up and down stairs, walking outside, managing domestic tasks
4	<5 years as PT, 1 year in reablement	4	Nurse assistant, 2 years in reablement	4	multiple fractures in the back, aiming to walk up/down stairs, walk outside
5	>10 years as PT, 2 year in reablement	5	Nurse assistant, 2 years in reablement	5	General functional decline, aiming to manage domestic tasks, and walk outside
6	5-10 years as PT, 3 years in reablement	6	Occupational therapist, 2 years in reablement	6	General functional decline, aiming to feel safe at home, walk up/down stairs, walk outside, travel by public transport
7	>10 years as PT, one year in reablement	7	Nurse assistant, one year in reablement	7	Stroke, aiming to walk inside without a walker, going to the grocery

The Practice of Support Personnel

Table 2

During fieldwork, we observed one reablement team that was integrated into the ordinary home care, hence several different HTs were involved in delivering training. During the first encounter, both PT and HT visited an old lady together. The PT instructed the user to carry out a workout program with six exercises and additionally two more exercises, targeting strength and balance. Simultaneously, the PT pointed out a number of conditions for the HT to pay attention to regarding the quality of movement to “achieve the specific movement and affect the right muscles”, as he said. According to the plan, the user was supposed to receive training five days a week.

Two weeks later, we visited the same lady who seemed surprised greeting us by the door: «Good that you are here! It’s been a while since any one has carried out any training with me. Well, I’ve already been working out a bit in the stairways”. We entered the apartment and the HT told the user to start her training. The user glanced at the exercise sheet, and started training. The HT placed herself on a distance, counting repetitions. After completing ten repetitions, the user began with the next one. The HT counted; “eight, nine, ten”, and the user carried on. The user carried out six of the eight exercises, which the PT had instructed earlier. About 10 minutes after we arrived, we were on our way out.

During the interview with the same HT, she said that normally, if the user had already been working out in the stairways, a response would be to move on to the next user. She explained that it might have been the reason why the user claimed that no one had been there for a while. On the question about the last two exercises, which the PT had instructed, but not written on the exercise sheet, she responded that she could not remember any more exercises, and claimed that her job was to carry out the content of the reablement plan.

Table 3

An older lady with a recently fractured upper and lower limb, was about to start up her reablement program when we visited her the first time. The user had decreased mobility and function in both her arm and leg, which limited her function in her home. The PT started instructing the user and the HT in some exercises targeting the mobility in the shoulder. The PT claimed that the pelvic position is the foundation for the shoulder’s movement. She instructed both the user and the HT to move the pelvic forward while at the same time straighten the upper body and stretch both arms against the ceiling. “Can you feel that it is easier this way? We must strive for an upright position to achieve the maximal potential of movement”. Later on during the training, the PT instructed the user to carry out an exercise for leg strength and balance. She points out the importance of shifting her weight from one foot to the other, while at the same time use her arms as little as possible for support.

Two weeks later, while observing the HT carrying out training with the user, several of the aspects from the PT’s supervision were recognizable. The HT pointed out the user’s pelvic position and commented that she could observe that the user managed to maintain her upraised position. However, she pointed out that the right arm did not reach as far as the left, and said that she would discuss that further with the PT, who was scheduled to return to the user for further assessments two days later. Further, the HT instructed the user during her leg exercises. The user was standing sideways by the kitchen counter in a walking-stance position. The HT verbally instructed the user to move her body back and forward from one foot to the other. The user responded by bending both her knees without any weight transfer. The HT got down on the floor beside the user’s foremost foot. She placed one hand on the user’s ankle and one hand behind her heel while she instructed her to move back and forward, in accordance with the PTs instructions two weeks earlier. “You may challenge the balance by letting go of the kitchen counter”, she said, and the user carefully lowered the supporting arm.