UiT
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Physiotherapy practice in reablement services

A qualitative study with observations and interviews

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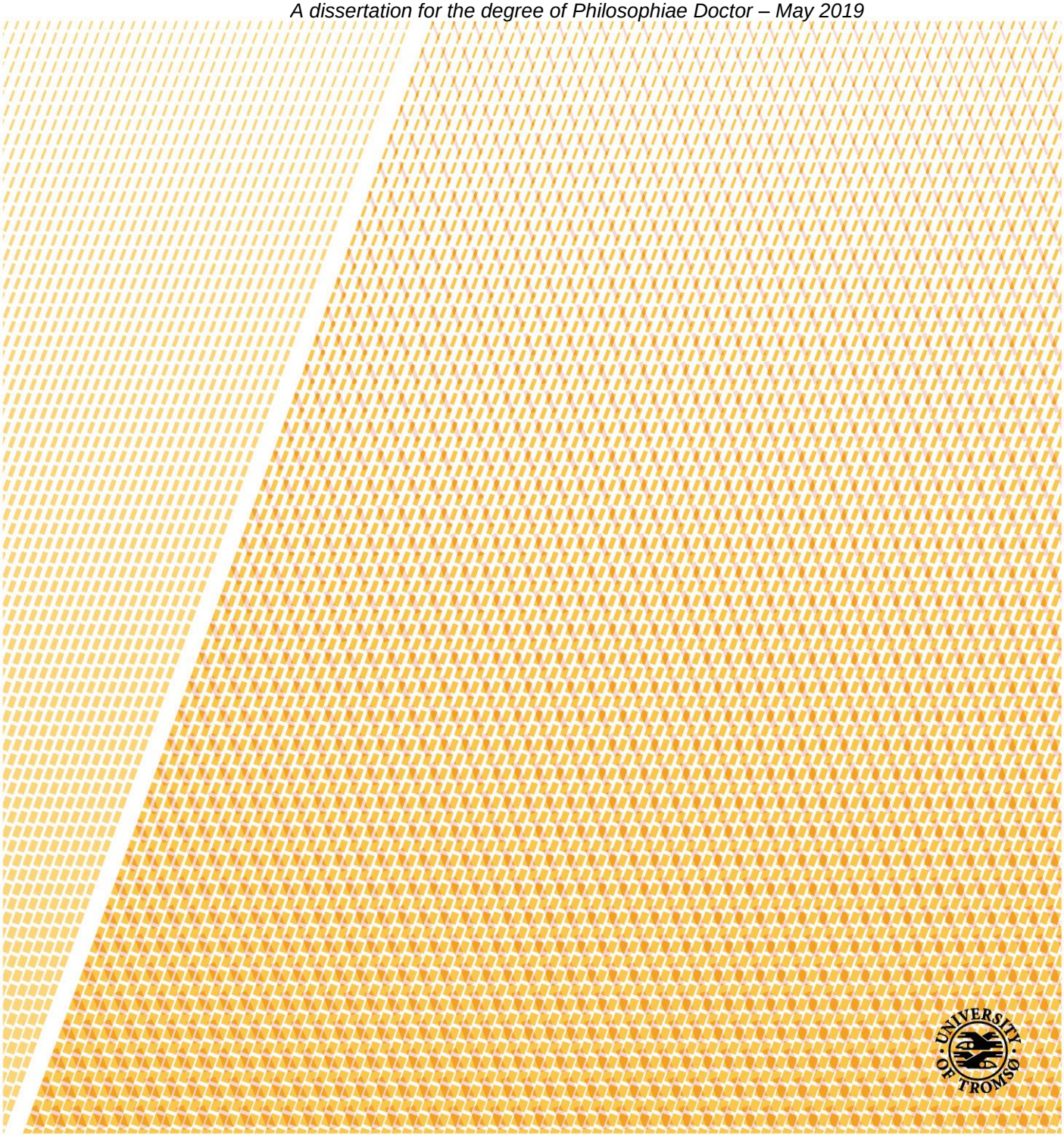

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Abbreviations

ADL	Activity of daily living
HT	Home trainer
COPM	The Canadian Occupational Performance Measure
EBM	Evidence-Based Medicine
NFF	Norsk Fysioterapeutforbund [Norwegian Physiotherapist Association]
NPM	New Public Management
OT	Occupational therapist
PT	Physiotherapist
SPPB	Short Physical Performance Battery
WCPT	World Confederation for Physical Therapy
WHO	World Health Organization

List of papers

Paper I: Eliassen, M., Henriksen, N., Moe, S. (2018). Variations in physiotherapy practices across reablement settings. *Physiotherapy theory and practice*. DOI: 10.1080/09593985.2018.1481162

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Abstract

Background: With regard to an increased number of older people and people who have complex and chronic health conditions, the Norwegian government, similarly to other nations, has argued for a reorganization of health and care services. Strategies that emphasize self-management and independent living in addition to sustainable utilization of resources have been advocated. Reablement is a community-based health care service aiming to enable people with (or those at risk of) functional decline to stay independent in their own homes. The service entails short-term, goal-oriented interventions provided by an interprofessional team. Support personnel, referred to as home trainers (HTs), mainly conduct the treatment initiatives under supervision of professionals including physiotherapists (PTs), occupational therapists (OTs), and nurses.

There is a lack of knowledge about the roles of PTs and practices in reablement teams. The PTs' supervision practices and the contents of services have been sparsely investigated. This dissertation explores how the new organization of reablement may challenge traditional physiotherapy professionalism. The discussions are based on empirical studies targeting the practices of PTs in reablement, the supervision of HTs by PTs in reablement teams, and the contents of services provided by HTs based on PT supervision.

Methods: Through a constructionist research paradigm, we produced qualitative data based on fieldwork in seven Norwegian reablement teams involving workplace observations, video recordings of user visits, and interviews with PTs and HTs. The data were thematically analyzed in a systematic manner, and theory within a constructionist perspective guided the interpretation.

Results: This study revealed large variation in the practices of Norwegian reablement teams. Through our analysis, we created two typologies of reablement teams. Teams with a fixed division of labor provided limited assessments and supervision and used nonspecific approaches. Teams with a flexible division of labor provided thorough assessments, regular supervision and user-tailored interventions. Structural frames and collaborative practices were fundamental to achieve user-tailored approaches.

Discussion: Fixed and strictly defined frames and team structure may enhance effective health promotion services by targeting user groups with minor functional decline who may benefit from a standardized and general approach. However, if the purpose is to target a user group in need of rehabilitation to regain function, a flexibly structured service that enables close

collaboration and competence development should be emphasized. This calls for a clearer definition of user groups and an awareness of the varied reablement practices. Physiotherapy practices with fixed structured teams were characterized by mechanical labor, limiting individualization and contextual adaptations. In flexibly structured teams, PTs utilized their traditional professional competence and extended their practices towards a broader and more holistic perspective due to interprofessional collaboration.

Contribution: At an organizational level, this dissertation provides a suggestion for how to implement reablement services in regard to the needs and purposes of municipalities. On a professional level, it serves as a framework for the practical performance of reablement including team collaboration, assessment, supervision and training intervention. PTs should increase their awareness of professional competence, including tacit and theoretical knowledge and organizational competence, in order to avoid deprofessionalization.

1 Introduction

Due to an increasing aging population, including persons with chronic and complex diseases, economic challenges and a shortage of health professionals have been reported worldwide (Beard & Bloom, 2015; Krug & Cieza, 2017; World Health Organization, 2011, 2015). This situation is also highly relevant in Norway, and authorities have suggested reablement as an approach to meet these current challenges (Norwegian Ministry of Health and Care services, 2015b, 2018).

Reablement is an interprofessional, team-based approach to home rehabilitation that aims to enable community-dwelling people who have or are at risk of functional decline to cope with everyday life. The service is intensive, time-limited and person-centered, as it is based on the user's goals (Cochrane et al., 2016). Professional health care providers have superior professional responsibility and have been described to perform a consultant role by delegating tasks and supervising nonprofessionals, who are the main providers of initiatives (Hjelle, Skutle, Alvsvåg, & Førland, 2018; Meldgaard Hansen & Kamp, 2018).

In reablement, the role of physiotherapists (PTs) has broadened to include supervision (Hjelle et al., 2018; Tessier, Beaulieu, McGinn, & Latulippe, 2016), which requires them to share their knowledge and skills with support personnel. Physiotherapy is described as evidence-based and specialized services provided to people with movement problems and diminished functional abilities. The goal of physiotherapy is primarily to improve functional abilities that are relevant and meaningful for the patient (World Confederation for Physical Therapy, 2016). This dissertation focuses on the practices of PTs, the transfer of physiotherapy knowledge and skills in the context of reablement services, and the service provided by nonprofessionals under supervision by PTs.

The literature on reablement is sparse, and the evidence of its effect is limited (Cochrane et al., 2016; Legg, Gladman, Drummond, & Davidson, 2016; Pettersson & Iwarsson, 2017; Tessier et al., 2016). There is a lack of descriptions of the contents of these new practices and the contents of supervision and knowledge transfer, which are essential but not highlighted aspects of reablement.

This dissertation aims to explore how the new organization of reablement may challenge traditional physiotherapy professionalism. Through studies of practices in reablement, the purpose is to achieve an understanding of the professionalism of physiotherapy in the social and societal context of reablement. Empirical studies of the practices of PTs that highlight the

aspects of supervision and knowledge transfer in the context of the service provided to users will serve as a foundation for the discussion. This knowledge is important for optimizing reablement services and contributes to the overall discussion of physiotherapy as a profession due to societal changes.

1.1 Background

In this section, I will begin with a brief introduction of the demographic situation due to an increasing older population. Further, I will describe the Norwegian welfare system, which has the responsibility to provide services for this part of the population. Reablement is a service that is implemented to meet current health care challenges that will be discussed in this section. Further, I will describe how interprofessional teamwork is essential before I question the role of PTs in reablement services. The section ends with a summary of the existing research in the field and a further clarification of the scope of this dissertation.

1.1.1 An aging population

The World Health Organization (WHO) (2011, 2015) has reported a rapid increase in the proportion of older people as well as increased longevity. At the same time, birth rates have not increased to the same extent, which disturbs the proportional balance between the older population and the working part of the population.

The WHO reported that approximately 524 million people in the world were aged 65 or older in 2010; this number was estimated to be approximately 1.5 billion people in 2015 (World Health Organization, 2011). In Norway, the number of people over 67 years of age is expected to double from 2000 to 2050. In 2000, there were 4.7 people of working age per older person older than 67 years. In 2050, this number is expected to decrease to 2.9 (Norwegian Ministry of Health and Care Services, 2018). This encompasses two central challenges. First, there will be a large population of older people with needs for health care services for complex health conditions and functional disabilities. Second, estimates show that there will be a shortage of health care professionals to meet the increasing task demands due to the older population (Norwegian Ministry of Health and Care services, 2015a; Rogne & Syse, 2017; World Health Organization, 2006).

Aging does include changes in biological, social, or psychological processes. Biological changes involve changes such as loss of muscle strength, decreased bone mass density, and reduced vision and hearing abilities. These changes may increase the prevalence of physical disability among the older population (World Health Organization, 2015). Social changes may

include decreased social contact and participation in social and societal activities. Many older people experience loss of close individuals, while they simultaneously experience a changed role in the family, moving from independence towards receiving support from others. Psychological changes may be connected to cognitive aspects, such as reduced cognitive capacity. In addition, a loss of social relations as well as a reduced ability to perform activities that are perceived as important and meaningful may induce health challenges for the older person (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Norwegian Ministry of Health and Care Services, 2018; Ong, Uchino, & Wethington, 2016). However, stereotypical assumptions of older persons as frail, disengaged and mentally reduced still exist and may upheld approaches that inhibit active aging. Instead, approaches that aim to support the older population to cope with their challenges, targeting physical, social and psychological aspects of active daily living are assumed to be preferable (Beard & Bloom, 2015; World Health Organization, 2015).

There is a diverse discussion concerning whether the older population's additional years involve more years of good health or more years of bad health (Beard & Bloom, 2015; Rogne & Syse, 2017; World Health Organization, 2011). Even though a larger proportion of the current older population in Norway reported better functional ability than past generations, many people do experience loss of function and disability in daily living activities. The prevalences of comorbidities and complex diseases and health challenges increase in the older population (Beard & Bloom, 2015; Norwegian Ministry of Health and Care Services, 2018; World Health Organization, 2015). Among the Norwegian population over 75 years of age, more than a half of individuals have reported four or more diseases that induce the need for assistance (Rogne & Syse, 2017). To prevent an increased need for health care services and long-term care, reports from the Norwegian authorities suggest that priority should be given to interventions aiming to promote personal independence (Norwegian Ministry of Health and Care services, 2015a, 2018).

1.1.2 Norwegian health care system

To prepare for the new demographic reality, the authorities argue for reorganization of health care services. The Nordic welfare states involve available and extensive public services that are mainly organized, financed and provided by the state (Rostgaard, 2012) and are among the most service-intensive states in the Western world (Vike, 2017).

In Norway, the provision of heath care services are in accordance with the Nordic welfare model, and a characteristic is decentralization of service provision; thus, the responsibility for delivery of services is placed "far down" in the system. The municipalities are assigned the responsibility for primary health care, including rehabilitation and home care services, among other services (Vabø, 2009; Vike, 2017). The municipalities are free to organize health care services as they consider appropriate for the local context and needs. Placing the responsibility of provision at the municipal level allows for flexibility and adjustments due to variation among municipalities. Vike uses the metaphor of a "low center of gravity" when he explains the responsibility of welfare services in Norway: *"when the center of gravity is relatively low, maneuverability increases"* (Vike, 2017, p. 22). However, this decentralized responsibility leads to two central challenges:

First, when responsibility is "pushed down" while the power and policy decision making remains at the "top", service providers are put in a value squeeze position (Svensson, 2008; Vabø, 2014a; Vike, 2017). Hence, health care providers are responsible for both the particular needs of the users, while they are also expected to manage and safeguard central policy decisions. Scholars have used the term 'street-level bureaucrats' to define this position of employees in human service organizations (Lipsky, 1980; Svensson, 2008; Vabø, 2014a). This "dual role" may potentially create value conflicts in practice (Hood, 1991; Orvik & Axelsson, 2012; Vabø, 2014a).

Second, the flexibility and responsibility provided to municipalities have been criticized for lacking administrative control and transparency (Noordegraaf, 2016; Vabø, 2012). The working conditions of health care services, which primarily work with and for human beings, are continuously changing and differ fairly for each individual context (Svensson, 2008; Vabø, 2014a). This type of labor requires extensive use of clinical decision making and professional discretion regarding local context and individual adjustment. This 'particularism' has been argued to conflict with the principle of equal treatment of users (Rostgaard, 2012; Svensson, 2008). Equality in service provision requires publicly funded services for all citizens regardless of financial situation, social status, gender or age (Vabø, 2012). The principle of equal rights is one of the most central principles of the Norwegian welfare state policy and is referred to as 'universalism' (Vike, 2017), which implies a general uniform standard of services for all citizens (Rostgaard, 2012).

To increase control over welfare services, authorities have developed several reforms over the last few decades. A characteristic of several of these reforms is the aim for control and

standardization of the local organization and performance of health care services, often arguing the value of equal services for all users (Vabø, 2012). Simultaneously, there has been an increased interest in administration forms inspired by New Public Management (NPM), which is a generic term for several reforms emphasizing market-like and corporate-like structures aiming for efficient services (Hood, 1991; Vabø, 2012). This reorganization has led to several changes in health care services, such as increased reporting routines, fragmentation of services, and strict timetables for home care services. These changes are claimed to limit the possibility for adjustments to particular contexts and individualization (Vabø, 2012).

Rostgaard (2012) has argued that quality reforms in Denmark have been divided between the principles of standardization and individualization. She claims that the most influential reforms have emphasized the principles of standardization, aiming for increased transparency and economical control. Simultaneously, reforms emphasize quality in health services, individualized and user-centered approaches and interprofessional team-based services (Norwegian Ministry of Health and Care Services, 2009, 2018).

This brief background description of the Norwegian health care system is important to consider through the further descriptions and discussions of reablement as a health care service. In 2015, the Norwegian Ministry of Health and Care services (2015b) explicitly suggested reablement as an approach to meet the challenges of an increased older population, although reablement has already been mentioned in political documents as early as in 2011 (Norwegian Ministry of Health and Care Services, 2011). By possibly reducing the demand for long-term support from health care services, this approach has been suggested to provide an efficient and sustainable service (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016; Fürst & Høverstad ANS, 2014; Ness et al., 2012).

1.1.3 Reablement

In the last decade, nearly half of Norwegian municipalities have implemented reablement as a service in some form (Tuntland, 2017) in accordance with the government's suggestion (Norwegian Ministry of Health and Care services, 2015b, 2018). These services may vary in organizational form and practices (Birkeland, Langeland, Tuntland, Jacobsern, & Førland, 2018; Birkeland, Tuntland, Førland, Jakobsen, & Langeland, 2017), but a common definition is outlined by Førland and Skumsnes (2016, p. 11) and further translated by Tuntland (2017, p. 99):

> *"Reablement is a time-limited, intensive and goal-oriented rehabilitation in the home and the local community of older persons who have experienced functional decline, where therapists, nurses and other employees in home-based services in the municipality collaborate and assist the person in daily practice and adaptation of everyday occupations which matter to the individual".*

This definition is constructed within the Norwegian context of health care services. Other countries have other descriptions and definitions, as well as other nomenclature for reablement-like services, such as restorative home care in Australia and the US (Ryburn, Wells, & Foreman, 2009; Tinetti et al., 2002), reablement in the UK (Rabiee & Glendinning, 2011), and everyday rehabilitation in Scandinavia (A. Moe & Brataas, 2016). Reablement in Norway is inspired by experiences from both Sweden and Denmark, in particular the municipalities of Östersund and Fredericia, where reablement was implemented in the beginning of the 21st century (Hartviksen, 2017; Ness, 2014). Although similarities are found across reablement services in Nordic countries (C. Moe & Brinchmann, 2018; Ness, 2014), there are also differences. While the model in Fredericia emphasizes prevention and early intervention, the reablement model in Östersund has focused more on users with more extensive rehabilitation needs (Rambøll, 2012). The diversity of the service objectives also provides space for different organizational forms and practices (Ness, 2014). Overall there is a lack of agreement on the definition internationally and domestically. Although some characteristics of the service are defined, the descriptions are wide and lack a specified definition regarding clinical and demographic characteristics of the target population, which results in a heterogeneous user group as well as diverse and ill-described content of the service (Legg et al., 2016). In a study from 2016 including 225 participants, Tuntland, Aaslund, Langeland, Espehaug, and Kjeken (2016) reported that the majority of users had health conditions, such as fractures, balance problems, pain, or stroke, whereas only 3.1% reported that the main issue was unspecified functional decline. The participants had a median of three additional health conditions. This supports the assumption that the user group is diverse.

Reablement is a rehabilitation service carried out in the user's home. In contrast to ordinary rehabilitation, a central element in reablement is that professional health care personnel, such as PTs, occupational therapists (OTs) and nurses, perform a consultant-like role that includes assessments of the users, delegation of tasks and supervision of care personnel who are supposed to carry out the interventions (Hartviksen, 2017; Hjelle et al., 2018; Kjellberg,

Ibsen, & Kjellberg, 2011; Meldgaard Hansen & Kamp, 2018; Tessier et al., 2016; Tuntland & Ness, 2014). Care personnel in reablement are often referred to as home trainers (HTs), which is a new concept in Norwegian health care services and does not require any formal competence or education. However, auxiliary nurses (two years of a formal education program) and care assistants without formal education often tend to hold these positions (Hjelle et al., 2018). HTs primarily carry out the daily interventions in users' homes, and their main tasks are described to involve encouraging users to perform everyday activities while conveying a sense of security (Hjelle et al., 2018).

By organizing the reablement team as an interdisciplinary group of professionals and nonprofessionals, the intention is to "spread" the ideology and attitude towards enabling practice and professional knowledge and skills to the entire home care service. A change in attitude from passive caring initiatives towards emphasizing independent coping with daily life is central (Hartviksen, 2017). The main purpose of reablement is to improve the individual's function and ability to cope with daily activities, which are self-reported as valuable for the individual (Tuntland & Ness, 2014). By asking the user "what are important activities in your life now?", the aim is to develop individually tailored approaches targeting the users' goals (Birkeland et al., 2017; Langeland et al., 2019; Tuntland et al., 2016).

With regard to these elements of reablement, the service is based on two potentially contrasting argumentations. First, reablement is developed in search for a more economical efficient service in order to meet economic challenges of health care services (Kjellberg et al., 2011; Kjerstad & Tuntland, 2016; Lewin, Concanen, & Youens, 2016; Norwegian Ministry of Health and Care Services, 2018; Rostgaard et al., 2011). Second, the service intend to fulfill the ideology of "active aging", aiming for individualized, person-centered interventions emphasizing enablement of the user's participation in daily activities, in contrast to passive approaches in traditional domiciliary care[1] (Ness et al., 2012; Norwegian Ministry of Health and Care Services, 2018; Tuntland, 2017; Tuntland & Ness, 2014). The argument for reablement emphasizes a cost-saving, sustainable service that at the same time enhances quality of life for the recipient (Bødker, 2018). Hence, reablement is politically obligated to combine *health promotion* by preventing long-term service demands (Cochrane et al., 2016; Gustafsson, Östlund, Zander, Elfström, & Anbäcken, 2019; Langeland et al., 2019), and *rehabilitation* by facilitating users to regain functional ability after a period of illness or

[1] Although it has been argued that traditional domiciliary care cannot be defined as a passive approach (Fæø, Petersen, & Boge, 2016).

hospitalization (Cochrane et al., 2016; Hartviksen, 2017; Langeland et al., 2019). Although these arguments overlap in several ways, the conflicting value base may result in different structural frameworks for practice.

Concerning the low administrative level of service provision in Nordic welfare states, the municipalities have the freedom to organize services that are considered most appropriate within the local context (Vike, 2017). This has led to a diversity of organizational forms of reablement. In Norway, two main organizational forms have been described (although hybrids do exist): a specialized model and an integrated model (Birkeland et al., 2018; Fürst & Høverstad ANS, 2014; Langeland et al., 2016). The specialized model implies independent reablement teams that are separate from other services and work independently and exclusively with reablement users. This model is thought to favor motivated team members, intensive focus on rehabilitation and close collaboration among team members, implying high competence (Birkeland et al., 2018; Fürst & Høverstad ANS, 2014). The integrated model implies reablement services implemented as an integrated part of the already existing home care services. Personnel from the home care service conduct reablement training initiatives under supervision by therapists, while they simultaneously are expected to maintain their regular home care services. This organizational form is thought to utilize already existing resources of home care services, which is advantageous for geographically outspread municipalities, and simultaneously increases the rehabilitation skills of the entire home care service (Birkeland et al., 2018; Fürst & Høverstad ANS, 2014).

Based on a multilevel analysis of 36 reablement teams, a Norwegian study concluded that the choice of model did not have any significant effect on user performance and user satisfaction with performance in daily activities (Langeland et al., 2016). However, classification of the models was limited to involve administrative organization and did not distinguish between different contents of practice. Focus group interviews were conducted with the employees in seven different reablement teams who claimed that the quality of the service did not depend on the organization form (Birkeland et al., 2018). However, what the quality of service provision implies was not discussed, and the content of practice was not studied. To my knowledge, no studies have evaluated the effect of reablement services with regard to the varying content of services or described the varying content.

1.1.4 Interprofessional teamwork

Interprofessional teamwork is a fundamental characteristic of reablement services (Birkeland et al., 2017; Cochrane et al., 2016; A. Moe & Brataas, 2016; Tessier et al., 2016) and is emphasized in political strategies aiming for seamless and well-coordinated health care services (Norwegian Ministry of Health and Care Services, 2009, 2015b).

Several scholars have tried to define the different forms of collaborative teamwork, and different concepts have been developed (Birkeland et al., 2017; Randström, Wengler, Asplund, & Svedlund, 2012; Reeves, Lewin, Espin, & Zwarenstein, 2010; Thylefors, Persson, & Hellström, 2005). A common characteristic feature of most of these concepts is that they describe a continuum ranging from practices with little collaboration towards highly collaborative practices.

Three different structures of teamwork are described: multiprofessional, interprofessional, and trans-professional teams. Multiprofessional teams consist of different disciplines sharing information with each other; however, they tend to carry out tasks independently. Interprofessional teams imply a higher level of communication, involving shared planning and decision making. Trans-professional teams are highly integrative and characterized by close collaboration and partly dissolved boundaries between disciplines (Thylefors et al., 2005).

Literature has suggested that traditional multiprofessional work is not sufficient in home-based rehabilitation services and that cooperation should consist of closer interprofessional interaction and collaboration in order to provide integrated and complementary services (Mitchell, Parker, Giles, & White, 2010; Moran, Nancarrow, & Enderby, 2015; Ness et al., 2012; Thylefors et al., 2005). Although some scholars have reported that teamwork with closer collaboration and a higher level of shared practices are more efficient and have a better work climate than less cooperative teams (Thylefors et al., 2005), others argue that the structure of team should be adjusted to the clinical purpose and local conditions (Reeves, Xyrichis, & Zwarenstein, 2018). Reablement literature alternates between the different concepts of teamwork, and multi-, inter- and transdisciplinary teamwork have been used to describe the service (Birkeland et al., 2017; Langeland et al., 2019; A. Moe & Brataas, 2016). However, there is no clear description of what the most appropriate form of teamwork is in reablement.

1.1.5 Physiotherapy as professional work

In addition to other professions with rehabilitation skills, PTs are considered to have a central role in reablement (Tuntland & Ness, 2014). The World Confederation for Physical Therapy (WCPT) (2016) has described the aim and scope of physiotherapy to "*serve individuals and populations to develop, maintain and restore maximum movement and function ability throughout the lifespan".* The work spheres of PTs are in health promotion, prevention, treatment and (re)habilitation (World Confederation for Physical Therapy, 2016). Initiatives are expected to be evidence based and imply a specific approach towards the performance of bodily movement and function in a competent manner (Nicholls & Gibson, 2010).

Individualization is a fundamental principle in physiotherapy involving tailored approaches targeting patients' specific needs (Norwegian Physiotherapist Association, 2012; World Confederation for Physical Therapy, 2016). Individualized approaches require sufficient assessments and clinical reasoning processes that address both body structure and function and contextual and situated aspects, such as social, psychological and environmental conditions. Physiotherapy is concerned with quality and accountability (French & Dowds, 2008), and PTs are specialists in analyzing, promoting and supporting human movement (Nicholls & Gibson, 2010). Aiming for individualization, PTs integrate theoretical knowledge, clinical experience and relational, ethical and contextualized skills (Bjorbækmo & Shaw, 2018; Dahlgren, Richardson, & Kalman, 2004). This interpretative integration of different knowledge sources is situationally conducted thorough interaction with the patient and is highly embodied within PTs actions and interactions (Bjorbækmo & Shaw, 2018; Nicholls & Gibson, 2010; Øberg, Normann, & Gallagher, 2015). Hence, such interactional approaches are not easy to describe and are only fully available through first-hand experience (Normann, Sorgaard, Salvesen, & Moe, 2014).

Due to societal and demographic changes, as described earlier, the roles of health professionals are undergoing constant processes of changes (Noordegraaf, 2016). The physiotherapy profession in Norway has developed considerably since it was introduced as a discipline in the country in the late 1800s. In the beginning, PTs were mainly perceived as subordinate assistants for doctors in the field of orthopedics. During this period, the main area of focus was orthopedics concerning posture and alignment of body structures. In 1936, physiotherapy became a publicly authorized profession in Norway and moved towards a more self-controlling profession, although the medical field and doctors still had an overarching responsibility for several of the services provided by PTs. During the postwar decades, the

subject of health promotion and rehabilitation emerged as a labor arena for PTs. The profession simultaneously underwent development towards increased demands for documentation and evidence-based approaches. In the end of the 20th century, the profession gained increased autonomy and became more or less independent of the medical field (Thornquist, 2014). In 1982, municipalities were legally mandated to provide physiotherapy services. This initiative not only gave the profession increased legitimacy but also greater social responsibility.

In recent decades, the authorities and the research field have emphasized development of the health professions towards a paradigm of collaborative and interprofessional work and profession neutrality involving shared tasks and task delegation (Norwegian Ministry of Education and Research, 2012; Norwegian Ministry of Health and Care Services, 2009, 2015b; Thornquist, 2014). This development has been argued to constitute a tension between a general, nonspecific approach on the one hand and a professional specific approach, targeting the peculiarity of physiotherapy on the other hand (Thornquist, 2014). Based on individual and functional assessments, the objectives of physiotherapy have traditionally aimed for rational and optimal movement, utilizing bodily efforts in both rehabilitation and health promotional work (Thornquist, 2014). Due to extended responsibility for training and supervising other personnel, the roles of PTs have extended to involve supervision and guidance of other professionals and assistants in several settings (Colbran-Smith, 2010; Ellis & Connell, 2001; Holmes, 1970; Saunders, 1998; Sørvoll, Obstfelder, Normann, & Øberg, 2018).

The role of the health professionals in reablement services (mainly concerning PTs, OTs, and nurses) are often described jointly. Descriptions mainly concern the professionals' responsibility for assessing and creating a rehabilitation plan and supervising HTs (Hjelle et al., 2018; Hjelle, Skutle, Førland, & Alvsvåg, 2016; Tessier et al., 2016; Tuntland et al., 2016). Some literature implies vague descriptions of delimitations of the boundaries between the tasks of professionals, indicating that PTs are mainly responsible for assessment of the user's physical functions and initiation of physical exercises (Ness et al., 2012; Tuntland & Ness, 2014). However, neither the tasks concerning the professional responsibility for the user nor the responsibility for supervision are thoroughly described in the literature. The national curriculum for physiotherapy education states a minimum of skills concerning supervision of users and others (Norwegian Ministry of Education and Research, 2004). Except from this,

there are no formal requirements for competence or experience with supervision among PTs in reablement services.

In Norway, home care services and physiotherapy services are normally organized separately (Moe & Hamran, 2014), and PTs are rarely employed in home care. Although working with rehabilitation and health promotion are well known fields for PTs, home care services may be a new arena for many PTs in Norwegian health care. The reablement literature has been concerned with new tasks and "mindset" for care personnel, changing from "caring for" their recipients to motivating users to take action for themselves (Hjelle et al., 2018; Legg et al., 2016; Meldgaard Hansen & Kamp, 2018). Both benefits (Hjelle et al., 2018; Meldgaard Hansen & Kamp, 2018; Rostgaard, 2016; Rostgaard & Mathiessen, 2016) and challenges (Hjelle, Skutle, et al., 2016; Rabiee & Glendinning, 2011) with the changing roles for care personnel have been portrayed. However, little is described about the perceptions of physiotherapists as professionals in reablement services.

1.2 Literature review

Six systematic reviews have summarized the existing effect studies on reablement (Cochrane et al., 2016; Legg et al., 2016; Pettersson & Iwarsson, 2017; Sims-Gould, Tong, Wallis-Mayer, & Ashe, 2017; Tessier et al., 2016; Whitehead, Worthington, Parry, Walker, & Drummond, 2015) and reported no clear conclusion in favor of reablement compared with traditional home care services. Despite limited evidence, some of the reviews indicated a possible trend in favor of reablement in some of the included studies; Tessier et al. (2016) reported positive effects in terms of functional capacity, service utilization and quality of life, and three reviews showed a modest tendency for improved independence (Cochrane et al., 2016; Sims-Gould et al., 2017; Whitehead et al., 2015). The extreme variation in the multifactorial and holistic approaches in reablement makes it challenging to evaluate the effect. To understand the mechanisms of reablement, there is a need for qualitative studies focusing on variation in services across local contexts (Bødker, 2018).

Some studies have tried to conceptualize and define reablement services (Aspinal et al., 2016; Doh, Smith, & Gevers, 2019) by drawing on existing literature. However, these fall short in accessing the in-nature practices and are limited to normative, descriptive summaries. Some qualitative studies do describe elements of reablement, such as employees' experiences with teamwork (Birkeland et al., 2018; Hjelle et al., 2018; Hjelle, Skutle, et al., 2016; Jørmeland & Vik, 2019) or the perceptions of users and relatives (Hjelle, Alvsvåg, & Førland, 2017; Hjelle,

Tuntland, Førland, & Alvsvåg, 2016; Jakobsen & Vik, 2018; Jakobsen, Vik, & Ytterhus, 2019), and may help to identify success criteria or appropriate approaches. However, these studies are based upon interviews and omit some aspects of professional work constituted in natural practical contexts.

Some observational studies have been conducted (Bødker, 2018; Meldgaard Hansen & Kamp, 2018; Rabiee & Glendinning, 2011) and mainly focused on the practices and roles of HTs, particularly regarding the challenged professional identities and logic of care personnel in reablement (Bødker, 2018). Meldgaard Hansen and Kamp (2018) have reported that care personnel engaging in reablement services experienced enhanced rehabilitative focus as a development of their labor towards a more professional and useful approach through a renegotiation of their identity. Some studies have reported that HTs perceive their work in a positive manner (Hjelle, Skutle, et al., 2016; Kjellberg et al., 2011; Meldgaard Hansen & Kamp, 2018), while some have indicated a resistance against changing their ways of working (Rabiee & Glendinning, 2011). Jørmeland and Vik (2019) reported that OTs and PTs had positive experiences with reablement labor, although there were challenges in regard of increased general and care-based tasks, which they undermined as "non-therapeutic". Based on experiences from one municipality in Denmark, Kjellberg et al. (2011) indicated potential challenges for therapists with following up on users, as they did not carry out the interventions themselves. They also indicated rather low satisfaction with the work form among therapists in reablement. However, to my knowledge, no existing studies have explicitly explored physiotherapy professionalism in reablement, regarding the tasks and role in the team. There is a need for a discussion of how the introduction of a new work field influences and possibly challenges the PT profession.

1.3 Aims and scope

The research field of reablement is sparse, and although some studies have assessed outcomes and experiences with reablement practices, there is a lack of descriptions of the contents of services. Most of the existing research on the field revolve around user outcomes and satisfaction or experiences among home care personnel. The practice of physiotherapy is not investigated and discussed. In an attempt to fill this research gap, this dissertation aims to achieve an understanding of professionalism of physiotherapy in the social and societal context of reablement. Based on studies of practices in reablement, the main aim of this dissertation is:

To explore how the new organization of reablement may challenge traditional physiotherapy professionalism.

The objective is operationalized into three subordinate questions that we addressed in the three papers included in this dissertation:

1. How is the practice of physiotherapy carried out across different reablement contexts?
2. How is physiotherapy supervision carried out in reablement services?
3. What are the contents of services delivered by support personnel who are supervised by physiotherapists?

2 Theoretical frameworks

In this dissertation, I draw on theories and methodologies grounded in a social constructionist perspective based upon the assumption and belief that our social reality is constructed within social processes (Collin, 2003; Creswell & Poth, 2017). Social constructionism will frame the interpretation of professionalism in reablement, with a specific focus on physiotherapy as a profession, which is of particular interest for the aim and scope of this dissertation.

The term 'constructivism' has often been used in a generic sense to describe how the social world can be interpreted as socially constructed. However, scholars have developed a distinction between constructivism and social constructionism (Andrews, 2012; Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014; Young & Collin, 2004). The first is described as an individually oriented approach occupied with individual and cognitive processes as the foundations of meaning making. The latter entails an understanding of the social world as historically and culturally constructed through social processes and interactions (Young & Collin, 2004). Social processes and interactions constituted in daily practices as well as organizational frames and conditions continuously affect professionalism through simultaneous processes. In this dissertation, I will employ the concept of social constructionism as a foundation for the methodology and theoretical interpretation.

2.1 Social constructionist perspective

The ontological assumptions related to the social constructionist paradigm is based on an understanding of the world through subjective meanings of experiences and involve a complexity of different views and aspects[2]. This does not reject an understanding of the world as "real"; however, our social life cannot exist without interactions among people, which entails continuous construction of the interpreted reality through social interactions (Berger & Luckmann, 1991). This perspective allows us to view the world as both a subjective and objective reality at the same time (Andrews, 2012). The specific context in which people live and work and interpretations of how the interactional processes forms and shapes our lives is emphasized, as stated by Berger and Luckmann; *"society is a human product. Society is an objective reality. Man is a social product"* (Berger & Luckmann, 2016, p. 117).

[2] Some constructionists claim that they do not take any ontological stand, except for methodological inquiry (Berger & Luckmann, 2016). Discussions regarding whether or not the physical "real" world is constructed or not has been a central discussion internal in social constructionism (Collin, 2003).

One key assumption in social constructionism is a critical stance towards a taken-for-granted understanding of the world (Berger & Luckmann, 1991). The normal and self-evident routines of everyday life are a kind of common sense knowledge that we share with others through social interactions. This common sense knowledge is habitualized through patterns of actions in everyday life and interpreted as "reality" or "the truth". This has an impact on how we perceive knowledge and science. Analytically, one can describe the constitution of "reality" in three simultaneously evolving processes. First, actions of individuals get externalized to the society. Second, actions are deposited as part of a collective taken-for-granted objectivity. Third, the social reality is individual internalized as objective through socialization processes in families, workplaces and other social settings. In this manner, subjectively created patterns become "objective truths" in practice and have the power to shape the individual actions. Nevertheless, the patterns of practice, which frame the actions, are constructed through social interactions, implying internal control of the individuals' actions (Berger & Luckmann, 1991).

The practices in newly implemented welfare services, such as reablement, to a large extent depend on the social interactions among the actors. Patterns of actions and interactions over time constitute and define the 'reality' of practice, setting the standards for further actions.

The epistemological assumption of constructionism perceives knowledge and "truth" as created not discovered (Andrews, 2012). However, these created realities are not individually grounded but rather negotiated through interactions with others based on social, historical, and cultural norms (Creswell & Poth, 2017).

The philosopher Bernard Lonergan (1992) poses a fundamental question about what knowledge truly is. His interpretation of the phenomenon is that knowledge is not something we have but rather something we do and supports the concept of *knowing* (cf. Polanyi, 1966) rather than *knowledge*. Lonergan describes processes of interpretation as crucial to how knowledge is adapted to the context and the situation in which it will be conducted and points out that this contextual interpretation of information is of particular importance in clinical settings. Based on this interpretation, knowledge is a social practice that occurs in interactions between people, in line with the basic perception of social constructionism. This perspective is fundamental for how I interpret the phenomenon of professional practices, supervision and knowledge transfer in clinical settings, as well as the choice of methodologies employed in this research.

2.2 Social construction of professionalism

The social constructionist perspective implies that professions are socially constructed. Several have tried to determine a definition of professionalism (Abbott, 2014; Freidson, 2001; Parsons, 1951); however, a clear consensus is lacking. Despite his effort on developing a definition, Freidson (2001) claims that any such attempt is condemned to fail because professionalism is dynamic and historically contextualized. Descriptions and definitions of professionalism have changed in line with societal developments.

Professions were traditionally described to be based on central characteristics, such as protected jurisdiction, sheltered market, internally controlled training and fundamental ideology. Thus, they are distinguished from other forms of labor because they are self-controlling and independent from the market and administrative interference (Freidson, 2001). Additionally, Freidson (1999) described that the particularity of knowledge and skills of a profession also contribute to distinguish professionals from other workers. He claims that professional work requires a certain discretion based on theoretical knowledge and skills contextually tailored to each particular situation. This is what Freidson (1999) refers to as *theoretically-based discretionary specialization,* which he explicitly distinguishes from noncritical procedural work that easily could be learned and performed by anyone, which is referred to as *mechanical specialization*.

According to Freidson (2001), professions have had monopoly of tasks and skills and a privilege to form the content of the profession themselves. To achieve specific expertise, skills and moral obligations connected to the profession, professionals must complete the required education and perform work in line with professional standards. Based on this, professionals have been granted autonomy to regulate clinical practices. Knowledge, skills, norms and standards are socially regulated by the professionals themselves in a self-controlled manner (Freidson, 2001; Noordegraaf, 2016).

However, due to the social regulation of professions, professional boundaries are never static. Societal, historical, and political conditions contribute to a continuous renegotiation of professional boundaries and the objectives of the professions. The self-regulating model of professionalism "worked" for decades, but in the late 70s, this form of professionalism was criticized for being counterproductive because professional conduct was lacking administrative control and transparency. Accordingly, organizational structures and systems forced professionals towards more accountable and evidence-based ways of working, thereby

shifting the control of the contents of services from professionals to organizations (Noordegraaf, 2016).

2.3 Changes in professionalism

In regard with societal changes, professionals are constantly subject to changes. The health care policies today display a picture of neoliberal-influenced systems, more empowered service users, technological innovations, interprofessional work, and workforce shortages resulting in task delegation and an increased number of unskilled workers (Nancarrow & Borthwick, 2005). Each of these factors has the potential to influence the roles and boundaries between different professionals.

Noordegraaf (2016) describes how the establishment of neoliberal policies and managerialism, such as the New Public Management (NPM), have impacted the development of professionalism. These changes are described to turn human service organizations into businesslike organizations, embedded in cost- and customer-oriented managerial frameworks. Due to this change, professions have become more fragmented and specialized. Garrow and Hasenfeld (2014) have argued that neoliberal organizations have limited the promotion of social needs in society. In health care services in which professionals are dealing with humans as their "raw material" (Hasenfeld, 2010), the administrational steps towards more transparent and organizational controlled services have made services less sensitive to the particular needs of individual recipients (Vabø, 2012). Based on studies of home care services in Norway, Vabø (2012) claims that the creative enabling process in home care is being undermined when attention is drawn towards accountability work, such as formal assessments and reporting. Professional work involves professional discretion and moral work (Hasenfeld, 2000; Vabø, 2014a).

Rostgaard (2012) has argued that cost-efficiency objectives and administrational changes in Nordic health care services have created a potentially conflicting dichotomy between the principles of individualization and standardization of professional work. According to Rostgaard (2012), some of the most influential reforms in Danish health care have increased standardization of home help. One may build on both principles to argue for increased quality in health care services; however, increased standardization, following standardized procedures and guidelines, may cause dequalification of care workers. Thus, different ideologies and values may affect professional practices. I will elaborate on this, drawing on Hood's (1991) concept of public management values.

The in-between position of serving both the user's needs and the overarching demands from the welfare state constitute a "dual role", which may potentially create value conflicts in practice (Hood, 1991; Orvik & Axelsson, 2012; Vabø, 2014a). As an example, the principle of universalism may conflict with individual adaptations, and the principles of efficiency and standardization may conflict with the principle of autonomy in work and use of discretion. Hood (1991) has described three different categories of core values in public management: *Sigma-type*, *Theta-type* and *Lambda-type* values. Sigma-type values represent efficiency and productivity and are emphasized by an organization with clearly defined tasks in which the central concern is avoiding use of more resources than absolutely necessary. Theta-type values represent fairness and transparency and are characterized by reporting systems and extensive reporting. Lambda-type values are present in "organically" structured organizations with broadly defined tasks and vertical communication and are related to resilience and adaptivity. These organizations require a high degree of "slack" to provide extra capacity for learning and development. Figure 2.1 illustrates how the different values deviate from each other. Vabø (2009) argued that Lambda-type values are essential to health care services to respond and adapt to the dynamic nature of people's lives. Which values are emphasized depends on conditions given by administration of the organization. However, they are also developed through interactions among the employees throughout the daily routines and actions. This entails that societal changes regarding policy, organizational administration and values do affect the way professions are constantly changing.

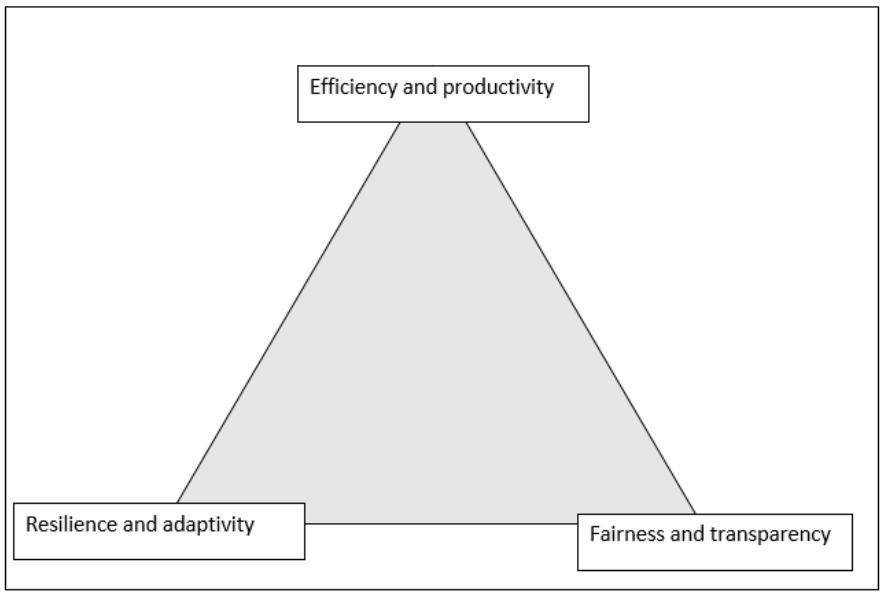

Figure 2.1: Conflicting values in public management. Freely translated from Vabø (2014b, p. 22)

Nancarrow and Borthwick (2005) have developed a theoretical framework to examine the changing boundaries in the health workforce based on the terms '*diversification', specialization',* and *'substitution'.* I will employ their interpretation of the terms in order to explore how reablement services have influenced the professionalism of physiotherapy.

Diversification involves an expansion of the existing professional boundaries and may involve new work markets or work settings, new ways of providing services or new philosophies of care (Nancarrow & Borthwick, 2005). The establishment of reablement involves a new market (home care settings and home care recipient), new work forms (supervision and consultant role), and a change in the philosophy of service provision (involving care personnel in enabling processes). In this matter, reablement is likely to provide some new directions for the professional boundaries of physiotherapy, as well as of other involved professions.

Specialization is defined as a change that involves an increased level of expertise regarding a specific area or branch of the professional field, often legitimated through a particular title or specific training. For example, a physiotherapist specialist is a physiotherapist who in addition to the basic physiotherapy education possesses postgraduate practical expertise to a certain extent. However, informal specialization may also occur, involving a delimitation of the area of labor. Due to specialization, there has been an increased number of assistants who undertake routine tasks of therapists. Task delegation may therefore be a consequence of specialization of a profession. Specialization may be seen as the counterbalance of 'generalization', and central debates in professionalism have targeted the conflicting notions of generalists and specialists (Freidson, 1999; Haug, 1972). Freidson (1999) warns against both extremes. He claims that excessive specialization of professions may result in inappropriate stratification of work, limiting broad and holistic views of situations, which are essential for discretionary skills in changing contexts. On the other hand, he also argues against generalization of professionalism, which he is concerned may result in a 'deprofessionalization'. Freidson argues that this may threaten the distinctiveness and particularity of professions, resulting in simplified and routinized tasks, which may lead towards a loss of monopoly of knowledge and skills and reduced public trust and acknowledgement.

Substitution involves the interdisciplinary changes in professional boundaries and may refer to changes in boundaries between professionals with the same level of training, expertise and status and includes *horizontal substitution*, or changes across professions with different levels

of status, and *vertical substitution* (Nancarrow & Borthwick, 2005). The first form may involve overlapping or collaborative tasks and is increasing due to the ideology of user-centered teamwork, typically in home-care services (Nancarrow & Borthwick, 2005). The growth of interprofessional practices is believed to increase the occurrence of horizontal substitution. The literature is ambiguous regarding the effect of such changes. While some scholars have characterized interprofessional work by central benefits, such as increased learning, decreased duplication of effort, and enhanced coordination, others are concerned that this substitution may result in lack of role clarity and conflicts between occupations (Hugman, 1991; Mitchell et al., 2010; Thornquist, 2014). Vertical substitution typically involves delegation of more standardized or routinized tasks to assistant personnel, and the introduction of therapy assistants without therapy training is one example (Nancarrow & Borthwick, 2005). It is assumed that substitution of the workforce may be advantageous when there are workforce shortages or to reduce expenditures by replacing practitioners with lower cost workers (Francis & Humphreys, 1999; Nancarrow & Borthwick, 2005). On one hand, vertical substitution involves narrowing of professional boundaries and delegating tasks to other disciplines. On the other hand, it involves an extended role concerning responsibility for supervision and training of the substituted personnel.

In this section, I have described how professionalism may be interpreted as a social construct that continuously changes due to societal influence, in accordance with Noordegraaf's statement: *"The "outside world" is increasingly penetrating professional domains, work, and practices"* (Noordegraaf, 2016, p. 786). I have accentuated administrative and organizational changes regarding neoliberal policies as an essential cause of development of professionalism during the last decades. However, policies alone cannot account for all changes, and a broader and much more complex picture of institutional, social and societal settings, such as technology, science and other innovations also influence the professions (Noordegraaf, 2016). Professionalism may develop in different ways, and I will employ the concepts of diversification, specialization, and substitution in order to discuss professionalism of physiotherapy in reablement in this dissertation.

In a society where collaboration and interdisciplinary approaches are increasing, as with reablement, the physiotherapy profession faces some serious questions: In which role should a PT engage within an interdisciplinary team? What kind of tasks can be delegated to other professions or even nonprofessionals? How can PTs guide and supervise others in order to utilize professional resources optimally? To answer these questions, it is essential to

understand the essence of the competencies required in physiotherapy as well as the process of acquiring such knowledge. In the following, I will present a theoretical framework for the interpretation of practical knowledge and learning, which frames the later discussions of supervision and team-collaboration in reablement.

2.4 Learning in a social constructionist perspective

To discuss the new role of PTs in reablement services, which to a large extent involves supervision and support of nonprofessionals, I find it necessary to highlight a constructionist interpretation of knowledge and learning, which is fundamental in this dissertation. In accordance with the constructionist perspective, knowledge is not an object that can be "sent" and "received" but rather a fluid set of understandings that is continuously shaped by those who produce and use it. New knowledge is being related to already existing knowledge, imposing it with meaning in an interpretive manner (Thomas et al., 2014).

Sfard (1998) describes two concepts of learning through the acquisition metaphor and the participation metaphor. While the first emphasizes learning as the individual's cognitive acquisition of knowledge, the second suggests an explanation where social, contextual and situated processes are emphasized in learning. In this latter perspective, the term knowledge is often replaced with the noun knowing, indicating action as a central part, and ongoing learning activities cannot be considered separately from the context in which they take place (Sfard, 1998).

Learning and supervision in reablement involve both competencies that require specific skills of the individual and processual learning that require contextual and social interaction. To grasp this complexity, I have included theory from both perspectives of learning. In the articles included in this dissertation, I have referred to different scholars in an attempt to describe the processes of supervision and learning in reablement (Benner & Sutphen, 2007; Dreyfus & Dreyfus, 1986; Lave & Wenger, 1991; Schön, 1991). Some aspects of these theories overlap at some points, while they contrast each other at other points. Combining these theories has been challenging. Nevertheless, it has been necessary to employ these theories, as they provide a complementary frame to interpret the processes of learning based on both a perspective of acquisition and participation (Sfard, 1998).

The model of skill acquisition by Dreyfus and Dreyfus (1986) presents five levels of proficiency, ranging from novice to expert. The "novice" practitioner performs tasks mainly based on rules and guidelines, with limited ability to make discretionary judgements and

contextual adaptations. The second stage describes the “advanced beginner” and involves a certain recognition of the context of importance for the skill. At the third stage, “competence”, the practitioner recognizes the complexity of the skill and the diversity of opportunities, which may result in uncertainty and frustration. At the fourth stage, “proficiency”, practitioners perceive situations as a whole, rather than in terms of fragmented aspects. Concerning clinical settings, this involves the ability to recognize the expected normal clinical picture or the absence of normality (Benner, 1982). At the fifth stage, the practitioner is referred to as an “expert” and has achieved the ability to make subtle and refined discriminations.

This theory has been criticized to be linear and one-dimensional, omitting the procedural and social aspects of learning (Lahn & Jensen, 2008). However, Dreyfus (2004) describes that the development of practical skills is not achieved automatically, and moving from one competence level to another requires learning through reflection and discussion. It is problematic that the skill acquisition model entails a “last stage”, “the expert”, as this may signal that learning involves a beginning and an end, which contrasts an essential aspect of the constructionist interpretation of learning; namely, that learning is a continuous process that does not have an end.

Donald Schön (1991) theorizes the production and development of practical *knowing-in-action,* which involves actions, recognitions and judgements. Through this perspective, he draws upon the philosopher Michael Polanyi (1966), who emphasized the tacit knowing that we cannot verbalize. Furthermore, he includes the embodied aspect of knowing, which is consistent with the phenomenological perspective of knowledge as embodied, prereflective and habitual (cf. Merleau-Ponty, 2002). Schön (1991) describes that knowledge is expressed in the actions performed by the individual and requires both reflection-in- and on-action. Reflections adds up with a repertoire of prior experience and develops and evolves into knowledge (Schön, 1991).

Both Dreyfus’ model of acquisition and Schön’s theory of knowing-in-action involves a primary focus on the individual aspect of learning, while the interactional aspect is less clear. Some critics highlight the weaknesses of Schön's theory of knowledge. Molander (1996) accuses Schön of being unequivocally concerned with experiments and models of theory, omitting to contextualize his theory in practice. In the 1990s, scholars developed theories that embraced the social-cultural aspect of learning, emphasizing learning as constructed through interactions with others within certain contexts.

Lave and Wenger (1991) described learning as primarily social, in contrast to the traditional assumption of learning as a cognitive process. They introduced the concept 'communities of practice' to define how interactions within groups of people with shared concerns or passions produced learning. Wenger (1998) described three hallmarks of communities of practice: First, participants are mutually involved and brought together as a social unit. Second, the community is linked to a joint activity. Third, the participants possess a common repertoire of practices, tools and symbols.

This theory has also been criticized for equating acquirement of complex professional theories with more or less unconsidered participation in communities of practice and in this matter reducing the meaning and value of professional knowledge (Lahn & Jensen, 2008). However, learning does not entail solely *being* in a social network but is the result of individuals active participation, developing relationships and changing positions in relation to the other participants in the community (Lave & Wenger, 1991). Based on this, the concept of *legitimate peripheral participation* was developed. This concept describes how individuals' position themselves and are positioned in the various social relationships and communities. Newcomers in practice communities usually possesses a legitimate peripheral participation, where the periphery represents how to initiate a less active participation, but as greater responsibility evolves and knowledge and skills develop, the position changes towards more central participation. The participation and engagement in a community of practice can be seen as a constituent part of our identity that cannot be turned on and off. Participation means that understanding and experience are in constant interaction (Lave & Wenger, 1991).This tells us that active participation of the individual is required in order to achieve learning, which is essential for supervision in reabelement.

In this dissertation, I have employed these different theories of learning, which together constitute a framework to interpret the multifactorial, but simultaneous, learning processes that may take place in reablement practices.

The position in this dissertation is that physiotherapy as a profession is socially constructed and hence continuously reconstructed in accordance with societal conditions. In addition to the theoretical framework, the constructionist perspective has contributed to the methodological choices used in this project. To capture the contents of practices, which in a constructivism perspective are created in the actual meetings between the participants, observations of practice are crucial (Justesen & Mik-Meyer, 2012; Polit & Beck, 2012; Yin, 2014). Capturing the studied participants' interpretations of the phenomenon of practice,

which demands the voice of the participants, is also emphasized. In the next section, I will present the methods that were used to create the results of this study.

3 Methodology and methods

In this study, we explore the physiotherapy practice in reablement services, emphasizing the professional supervision of support personnel. The study is conducted within a social constructionist perspective to enable an understanding of practices and the learning processes embedded within practices. This perspective also entails that the scientific inquiries of this study are interactive and interpretive processes constructed through social interaction between the researchers, participants and reader (Blaikie, 2007; Creswell & Poth, 2017). To gain insight into the processes of collaboration and learning, we have based this study upon data developed from fieldwork in reablement practices including observations and interviews. These different methods are used to achieve a broad picture of the complexity of practice, typically emphasized in a constructionist perspective (Creswell & Poth, 2017).

3.1 Study design

The study is conducted through a qualitative approach. To obtain access to the context of reablement, which frames the professional actions and social interactions, we conducted observations in the work environment within the reablement teams. To capture the interactional processes of supervision and knowledge transfer, as well as the actions played out in cooperation with the users, we conducted video-recorded observations of user encounters. To explore the professional knowledge, which formed the basis for decision making and learning, it was also essential for us to capture the PTs' and HTs' clinical reasoning and discussions about the user's situation. Therefore, we performed individual interviews with the PTs and the HTs evolving around the observed clinical encounter as well as experiences with practices in reablement in general. Based on systematic analyses and scientific interpretations, the observations and interviews complemented each other and provided nuanced data about the practices in reablement.

In conjunction with the social constructionist perspective, the researcher is always situated and positioned in relation to the subjects under study, which is decisive for the interpretation and presentation of the results (Justesen & Mik-Meyer, 2012). This requires transparent reflections about the researcher's position and discussions regarding potential influence of the interpretation of the study. In the next section, I will discuss how my previous knowledge, experiences and expectations may have contributed to inform this study.

3.2 Reflexivity

Researchers' background and position will affect what they choose to investigate, and reflexivity is an attitude of attending systematically to the context of knowledge construction at every step of the research process (Creswell & Poth, 2017; Justesen & Mik-Meyer, 2012; Malterud, 2012). By transparently "positioning myself" as a researcher, Ie can try to acknowledge how my interpretation is based on my personal, cultural and historical experiences (Creswell & Poth, 2017). My preunderstandings and positioning relative to the field must be transparently reflected upon whiledifferent perspectives will inform the results accordingly. However, this must not be misunderstood as a bias of qualitative studies but rather as an inevitable condition that creates a foundation for interesting and relevant analysis (Justesen & Mik-Meyer, 2012).

During the work of the study protocol, I had limited knowledge about or experience with reablement. My knowledge was restricted to what I had read about the service through reports and theoretical descriptions during preparatory work. The reablement literature in the Norwegian context has generally described the service to be almost exclusively beneficial for service users, municipality administrators, and service providers (Fürst & Høverstad ANS, 2014; Ness et al., 2012; Tuntland & Ness, 2014). As I read documents in preparation for the study, I became increasingly convinced that reablement could potentially be a beneficial service innovation. In my professional work and during my master's degree studies (Eliassen, 2014), I have been especially interested in health promotion and prevention and have seen the need to provide health care services to a group of users who are often given low priority.

Simultaneously, I had a distracting feeling of doubt about the practice described where nonprofessionals and support personnel were supposed to carry out tasks that had traditionally been acknowledged as physiotherapy tasks. The physical rehabilitation of users with complex needs and challenges requires a highly specific and subtle approach. Several years of experiences as a teacher in the bachelor program for physiotherapists had taught me that the complexity of practical knowledge and skills is challenging to transfer to others.

In an early stage of the project, I found myself alternating between a critical and optimistic perception of the concept. Although it felt confusing at that time, I believe that this may have contributed positively during the fieldwork, as with enthusiastic curiosity. I found myself in a slightly "naive" position, where I allowed my curiosity to explore both the field of study, as well as my own positioning towards the field. Looking back, I recognize the ambiguity of my

presumptions in the results of the study. The questions that I had in the preparation of the study have influenced the focus of the study, and contributed in the production of the study results.

Approaching a field about which I had limited knowledge, and in which little research existed was exciting but also frightening. The research questions in the protocol were only tentative, and I had to be open-minded for unpredicted themes and concepts during the work. The importance of being prepared for the unexpected is conjunctive with the constructionist perspective (Esin, Fathi, & Squire, 2013). The ambivalent attitude of optimism and criticism followed me throughout the process, based on the diversity of practices that we discovered in the fieldwork. This was essential in order to develop the two typologies of reablement practices, which are fundamental to the discussions in this dissertation.

3.3 Preparations and becoming familiar with the field

At the time when we developed the study protocol (2015), the literature on reablement in the Norwegian context was sparse. To be able to design a study that was relevant for practice, I realized that I needed to achieve a deeper insight in the field. Developing research that is relevant for practice by emphasizing study designs that are suited for the context of practice is a priority in health care research (Norwegian Ministry of Health and Care Services, 2014). To become acquainted with the field of study during the production of the study protocol, my main supervisor and I carried out visits in a reablement team, aiming for insight into daily practices and allowing team members to share their thoughts and ideas with me to create a study design suited for the practice context of reablement. I contacted the daily manager of a reablement team that had been existing for approximately three years and asked for an invitation to visit the team. I informed the team members that the purpose of the visits was to achieve insight into the team's practices, which could contribute to the development of an appropriate study design.

We visited the team three times, where we engaged in team meetings, user interventions, and informal conversations in the work environment. Informal conversations between the researchers and the team members evolved around practical and organizational issues concerning labor as well as professional issues concerning user situations. The team members were encouraged to openly describe personal experiences concerning challenges and advantages of reablement practices and professional supervision, as well as issues which, according to their perception, could be relevant to our study.

During these visits, it became clear that there were different perceptions of how reablement practice should be conducted. The observed team consisted of two PTs, one of whom had experiences from working in another reablement team. She referred to the practice from her earlier experience, and emphasized that particular practice as "the right way" of performing reablement, limiting PT practices to standardized assessments and supervision. However, the other PT, who had a long experience as a PT in the field of rehabilitation, emphasized a more interactional and "therapeutic" approach. This observation gave rise to further interest in and focus on the variation of physiotherapy practices, and potentially the diversity of services provided to users. This deviation is recognizable in the two typologies that constitute a finding in the study. These visits also indicated that the work environment was crucial in order to get access to practices of collaboration and relevant context for physiotherapy practice. Based on this, we included field observations in work environment as part of the methods, in addition to video observations of encounters and interviews, which was the primary intention (Appendix 6).

Field notes based on the observations and conversations with the team were conducted immediately after the visits. The field notes were used as a basis to develop the research questions, the observation guide (Appendix 1) and the interview guide (Appendix 2).

3.4 Study setting

The study was conducted in seven reablement teams within different Norwegian municipalities. The municipalities where this study was conducted were strategically chosen to obtain a varied population size. The smallest municipality consisted of less than 15 000 inhabitants, while the largest consisted of more than 100 000 inhabitants. Six of the included reablement teams were organized as specialized teams independent from the home care service, while one team was organized as an integrated team, drawing upon the existing home care services in the municipalities.

I visited the reablement teams twice. During each visit, I performed a one-day observation of practice in the work environment. These observations were mainly conducted in open landscape offices, meeting rooms and lunchrooms. The observations of reablement interventions occurred in the users' homes. All of the interviews were conducted in meeting rooms at the PTs' and HTs' workplace.

3.5 Participants and recruitment

This study explored practices in seven reablement teams. Although the teams consisted of several different disciplines, we included a PT, an HT, and a user from each team in order to refine the focus on the role of PTs and physiotherapy knowledge transfer in line with the aim of the study. We were interested in obtaining access to employees who had some experience with reablement. However, since reablement is relatively new, we found it unrealistic to recruit persons with lengthy experience; hence, the inclusion criterion for the PTs and HTs was at least 6 months of experience with reablement. The team members were delegated the responsibility to recruit users. Users who were allocated to reablement based on the respective teams' criteria were included in the study. The different teams had different inclusion criteria for users; hence, the included users in our study were highly diverse, although they were all older than 65 years. All participants had to be able to consent to participate; therefore, cognitive impairment was an exclusion criterion.

We contacted general managers of reablement teams to inform them about the study. General managers, who consented to participate, distributed the study information to team members of the respective teams, who were further included after consenting to participate in the study. The respective PTs distributed information and recruited users who were about to receive reablement. Those who gave their written consent to participate were included. Immediately after a user agreed to participate, the PT contacted me to arrange for data collection.
In line with the social constructivist perspective that guided this paper, coworkers of the included PT and HT were also treated as participants, as they were subject to field observations in the work environment. Collaborative coworkers in one of the reablement teams did not consent to participate, and the work environment was not observed in this team. However, the results from interviews with the PTs and HTs provided rich information about the work environment and collaborative practice in this team, and we therefore decided to include these data. From our point of view, both the users and the cooperating team members also contributed to the production of the results based on their contextual interference even though they were not interviewed. Table 1 in Paper 3 provides more information about the participants.

3.6 Data development

My professional background from the field of physiotherapy, in addition to impressions from prestudy visits in a reablement team and a literature review of reports and government documents inspired the development of an observation guide (Appendix 1) and an interview guide (Appendix 2). The data were collected from January to June 2016. We wanted to capture the initial stage of interventions to explore the assessments, the clinical reasoning that formed the foundation for the planned interventions, as well as the physiotherapy supervision. In addition, we wanted to investigate the content of the interventions provided by the HTs, and how the users were followed up throughout the process. To ensure that we captured these aspects, I visited the reablement teams twice.

The first visit was conducted during the user's first week of reablement. In addition to observations of the work environment at the workplace of PTs and HTs, I carried out video-recorded observations of a user encounter when both the PT and the HT were present in the user's home. Immediately after the observation, I conducted an interview with the PT. The previously observed user intervention was the main topic for the interviews, and clinical reasoning and supervision strategies were discussed.

The second visit was carried out approximately halfway through the user's reablement process (approximately two to three weeks after the first visit). Workplace observations were performed this time as well, in addition to a video-recorded observation of the user encounter, in which the HT carried out interventions. The observation was followed by an interview with the HT to conduct reflections about the preceding observation as well as the professional support and supervision from the PT. Data from the workplace observations were utilized in Paper 1 and 2, while observations of user encounters and interviews were used in all Papers. Table 1 provides more information about how the varied data were applied in the respective articles.

Table 1: How different data material was used in the three papers.

	Research questions	Data material
Paper 1	How is the practice of physiotherapy carried out across different reablement contexts?	Work environment observations Video observations of user encounters Interviews with PTs and HTs
Paper 2	How is physiotherapy supervision carried out in reablement services?	Work environment observations Video observations of user encounters Interviews with PTs and HTs
Paper 3	What are the contents of services delivered by support personnel who are supervised by physiotherapists?	Video observations of user encounters Interviews with PTs and HTs

3.6.1 Observations in the work environment

During my research visits with the reablement teams, I carried out observations in the work environment at the workplaces of PTs and HTs. These work environment observations where conducted in order to capture interactions between the PT and HT that would potentially provide information about collaboration and supervision. In addition, it was essential to capture the context that served as a framework for the practice. During each visit, I conducted observations during one work day, which constituted approximately 75 hours of workplace observations.

In five reablement teams, which were organized as specialized teams (independent from the home care services), the work environment observations were performed in open landscape offices, lunch rooms and meeting rooms as well as in the car travelling between the users' homes. Additionally, on two occasions, I followed the PT and HT during user encounters. These user encounters were not video recorded nor were they part of the data material representing user assessments and initiatives. However, the interactions between the PT and HT were noted. I attended three formal team meetings, where all the team members were present, and one user-specific meeting, where two team members were present, in addition to informal day-to-day conversations in the environment.

In the last reablement team, which was organized as an integrated team (involving the ordinary home care services), the workplace observations were carried out in a joint meeting room. All of the home care staff assembled in this work area in the morning and in the middle

of the work day, exchanging daily reports and taking a lunch break. Additionally, I followed the HT during several user encounters. These user encounters were connected to the HT's traditional tasks in the home care service and were not part of the reablement tasks. These observations gave a rich and nuanced impression of the context of a work day in the home care service.

The current appearance of the work environment, the internal communication within the teams regarding professional discussions, the exchanges of clinical knowledge, and the instructions and guidance were noted and documented within the field notes that I created immediately after the observations.

3.6.2 Video recorded observations in the users' homes

To capture the situated and interactional accomplishments of practical action, the interventions were video-recorded (cf. Heath, Hindmarsh, & Luff, 2011). In a clinical setting, multiple components of interactions and bodily movements occur simultaneously; hence, it was essential to analyze the details of how both PTs and HTs interacted with each other and the users. Video recordings are recommended as a tool to grapple with the complex character of practice and to capture the small details that are inextricably embedded within interactions. These details are difficult to access in other ways, as they are barely conscious to the participants themselves (Heath, Luff, & Sanchez Svensson, 2007).

During the first visit, I aimed to capture the PTs' clinical reasoning concerning user assessment, as well as the supervision of the HT. Interactions between the PT, HT and the user were emphasized. The key points of the observation guide were 1) treatment setting, 2) content of actions regarding assessments or training, 3) instructions, 4) verbal and nonverbal communication, and 5) changes in the user's function or movement.

During the second visit, the focus of attention was the HT's conduction of reablement intervention, emphasizing the interactions and alterations of the user's function and movement. The PTs were not present during these observations. The same observational guide was applied to all user encounters.

During the video-recorded observations, I used a discreet, handheld camera, and primarily remained in the background to limit disturbance to the interactions of the participants. A wide video angle was used to capture all participants, although when it was found essential to capture details, I moved discreetly closer or zoomed in through the camera to obtain a closer

observation of the users' movements. One of the users did not consent to video recordings; therefore, the encounters were audio recorded and commented in thorough field notes.

In total, 14 observations of user sessions lasting from 20–90 minutes were conducted. Twelve of these observations were videotaped, and 2 were audiotaped due to the user's request.

3.6.3 Interviews with the PTs and the HTs

During the first data collection visit, I conducted semistructured interviews with the PTs immediately after the video-recorded user encounter. The PTs provided a meeting room at their respective workplace, where I could carry out the interviews undisturbed. The questions were based on the interview guide (Appendix 2), and aimed at revealing clinical reasoning regarding the observed intervention, required knowledge and skills, and communication and collaboration between team members. The participants were informed about the topics to discuss in the written information that they received in advance (Appendix 3). I used open-ended questions and relevant follow-up questions, and encouraged the interviewees to speak freely about their experiences, emphasizing an informal conversation about the topics, in line with constructivism approach (Creswell & Poth, 2017; Kvale & Brinkmann, 2009).

During the second data collection visit, I interviewed the HTs immediately after the video-recorded user encounter. These interviews were carried out in meeting rooms at the HTs workplace. The interview focused on the preceding observation and the HT's experiences with supervision.

Each interview started by allowing the participants to present themselves and their work experiences and to further their experiences with reablement. During most of the interviews, it appeared that the participants were eager to talk positively and enthusiastically about reablement as concept. They were generally confident that reablement, as a way of organizing health care services, was beneficial both for the users and the municipalities' economy. A great amount of their argument was recognizable from normative descriptions of reablement, as provided in national reports and governing documents. After noticing this, I encouraged the participants to talk more about specific experiences and practice situations from their own work days in addition to the specific interactions during the recently observed user encounter. This way of operationalizing the query into concrete concepts and contexts that are recognizable to the participants is in line with recommendations about how to perform qualitative interviews (Kvale & Brinkmann, 2009).

It was important for me to establish trust and confidence with the participants. I made it clear that my aim was exclusively to explore the practices as they were normally performed. I also expressed that I had no personal experience in working with reablement myself, and in that matter, they were the ones with the experiences. However, the HTs, in particular, would sometimes become uncertain regarding clinical reasoning. In these cases, they wanted me, as a PT, to explain certain conditions regarding the users functional (dis)abilities. For example, one HT had struggled during training with an old lady who experienced balance challenges. The HT could not understand why the lady did not manage to lift her legs from the floor both during exercises and walking; "I don't understand it. She is a strong woman, I know she has the strength to lift her feet. Is it the balance? I don't know. This is not my field of work". As a PT, I had immediately observed how the lady's lack of lateral weight shifting correlated with her balance challenge. The lack of lateral weight shift complicated her ability to lift her feet. Instead of "giving" the HT "the answer", I used these situations to explore the HTs practices regarding such clinical issues. By asking further about their strategies for solving such problems, they were able to reflect about their own clinical reasoning or how they would seek support by the reablement PTs.

In total, the data included 14 interviews that were approximately 45–90 minutes in length. All the interviews were audio-recorded.

3.6.4 Combining different methods

Combining different methods may strengthen the validity of a study (Yin, 2014). The combination of observations and interviews provided us with the following complementary information: 1) the organizational structure and frames for interaction, 2) interaction in its original context of supervision sessions and user encounters, and 3) the clinical reasoning and reflections, which were essential for how the practices were performed.

3.7 Data analysis

The aim and objectives of the project, in addition to the involved researchers' background and experiences (Siri Moe is a PT and Nils Henriksen is a sociologist, both are experienced researchers) have contributed to providing direction to the analysis scope. Interpretation has been a central element of the analyses, and the results must not be seen as objective facts. In social constructionist approaches to research, analyses are not understood as a linear process but rather as a continuous process in all stages of the project. The analyses were conducted as

an iterative process, including alternations between categorization of data and continuously checking our interpretations against the raw material as well as theoretical concepts.

The software program NVivo 10 (QSR International, 2017) was used and supported the systematic coding and categorization of the data.

We used traditional qualitative methods for thematic analysis, including coding, categorization, interpretation and representation (Creswell & Poth, 2017). However, analyses were carried out in two steps. First, a preliminary analysis process was employed to achieve an overall impression of the data. Second, a specific analysis was guided by the subordinate research questions for the respective papers of this thesis (Paper 1-3). These analyses were inspired by systematic text condensation, described by Malterud (2012) (Paper 1) and abduction, described by Tjora (2017) and Blaikie (2010) (Paper 2-3). The different processes of theses analyses are described in more detail in the following sections.

3.7.1 Preliminary analytical process

Immediately after each fieldwork visit, I produced field notes, including my overall impression from the observed work environment, user encounters and interviews. These field notes were used to develop a preliminary thematic list. Initially, the thematic list included supervision, teaching and instruction by the PTs. However, during an early stage, I discovered that the division of labor was also essential for practice in reablement, and organizational and contextual issues also became central themes in the preliminary thematic list.

Further, I transcribed all of the data in order to transform all raw materials into text material. This was an essential step in order to link the data from different methods, enabling the different data to complement and supplement each other.

The interviews were transcribed verbatim in the interviewee's dialect within hours after conducting the interviews. In addition to the spoken words, I added pauses and laughter. Words that were stressed in the interview were highlighted as bold font. This situational method of transcription, which remained as close to the real situation as possible, enabled me to recreate a memory of the interview situations when reading the transcribed material even years after the interviews. This was done to preserve the contextual content of the interviews so that it was as accurate as possible (cf. Kvale & Brinkmann, 2009).

To be able to categorize the multiple and continuous aspects of interactions in the video-recorded observations, I decided to transcribe the observations in a schematic matrix

(Appendix 4) inspired by descriptions of Heath et al. (2011). Six aspects of interactions were categorized: 1) what was done, 2) how it was done, 3) explanation or reasoning, 4) instructions of the user, 5) supervision of the HT, and 6) communication. These categories were predetermined based on the key points in the observation guide and included both verbal and bodily interactions. During these preliminary analyses, only the basic aspects of the activities and events were written down. Transcriptions of conversation were not rigidly verbatim, although the essence of the meaning of the conversation was incorporated with the actions described in the different categories in the scheme. Transcriptions of the observations were continuously developed throughout the consecutive analyses for each paper, emphasizing more detailed descriptions on specific relevant situations and interactions, in line with Heath et al. (2011). This required that I had to watch the videos multiple times, repetitively throughout the analysis process.

Influenced by the preliminary thematic list, I extracted preliminary codes from the entire text material and sorted the codes into the three main themes: division of labor/organizational conditions, supervision/knowledge transfer, and user approaches/initiatives. The three main themes were the foundation for the papers of this thesis (Paper 1-3).

3.7.2 Consecutive analysis

In Paper 1, we conducted a four-step systematic content analysis inspired by Malterud (2012). We considered this approach appropriate for analyzing data from both interviews and observations, which enabled us to merge the data from the different methods. I had primary responsibility for the coding and initial sorting of the data. Further, my supervisors, Siri Moe and Nils Henriksen, contributed to the analysis through discussions in regular collaborative meetings.

The first step described by Malterud (2012) aims to gain an overall impression of the data. In this process, I created a summarizing text and noted preliminary themes. The basic and initial transcriptions of the video-recorded observations were extended with more detailed descriptions of excerpts that were particularly relevant for the aim of the current paper.

During the second step, I identified and coded meaningful units in the text material from all data sources. Categorization of the codes allowed for a merge of the different data sources. The observation material provided a perspective on the actions and interactions in the practical settings, while the interviews elaborated this through insights into the rationales and

reasoning that the practice was based on. Initially, 16 codes were identified and sorted into code groups and further subgroups (cf. Malterud, 2012).

During the third step, I developed a summary text for each subgroup based on central quotes and excerpts from the observations. This text was the result of several interpretive discussions with my supervisors.

In the fourth step, I reconceptualized the subgroups by developing an analytical text based on the most salient content of the data, thorough deliberations of the initial text material and preliminary topics. The final texts are presented in the Results section of Paper 1. Table 2 in Paper 1 presents the analytical process in a schematic way.

The analysis in Paper 2 and 3 had, to a large extent, similarities to the first paper. However, aiming to disentangle the analysis from a linear recipe, I strived for a continuous interpretive approach. At this point, I was inspired by scholars emphasizing the constructionist approach in research methodology and analysis, such as Blaikie (2010) and Tjora (2017). In these processes, I emphasized creating codes that were direct wordings from the original text material, allowing for an initial inductive approach and highlighting the voice of the participants and the interactions in the context observed. Simultaneously, the approach allows theoretical interpretation continuously throughout the process, which is more in line with the constructionist perspective (Blaikie, 2010). This abductive approach (cf. Blaikie, 2007) allowed for a creative theoretical interference with the data. Different empirical findings opened up for different theoretical views, and different theoretical views opened up for varied empirical findings to emerge. For example, when I got aware of the importance of collaboration, I turned to theories of team work, which emphasized the importance of organizational conditions. This led my attention towards empirical findings of division of labor and structural frames, and further investigation of organizational theories. The process was constantly altering between empirical findings and theory, and I had to go back to the raw material several times, particular the video recordings, in order to explore new perspectives.

After creating the codes, I sorted them into code groups and further merged them into themes. I created summarizing texts for all the codes and code groups. To enhance the reliability of the results, the results were associated with direct quotes and extracts from the observation sessions.

3.8 Methodological considerations and trustworthiness

This qualitative study is exploratory and naturalistic[3], where the purpose is to investigate the conditions as they unfold in their natural environment (cf. Lincoln & Guba, 1985). The validity of qualitative studies is related to whether the results are convincing, relevant and interesting (Justesen & Mik-Meyer, 2012). To achieve trustworthiness of the study, a transparent documentation of all the processes involved in the research is required (Creswell & Poth, 2017). The processes involved in the research in this project are transparently documented through descriptions in all three articles (Paper 1-3). The items of the Consolidated Criteria for Reporting Qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) were considered throughout the research process, and relevant items were reported in the articles.

Different concepts and descriptions have been proposed to define the inquiry of scientific quality in qualitative approaches. In this thesis, I base my reflections on Lincoln and Guba's (1985) four terms, *credibility*, *transferability*, *dependability*, and *confirmability*, to operationalize the discussion of the trustworthiness of this study.

3.8.1 Credibility

Lincoln and Guba (1985) describe different aspects involved in the establishment of the credibility of research. Becoming acquainted with the research field and achieving trust in the field is one aspect. In this project, I spent several months before the data collection process to establish knowledge about the fields by reading governmental documents, research on the field and theory that could enlighten the field of study. My background as a physiotherapist has given me an advantage concerning previously achieved knowledge and experiences[4]. In addition, I conducted prestudy visits to a reablement team to achieve insight into the reablement settings and day-to-day actions and interactions. The field observations of the work environment conducted during data collection also provided an opportunity to develop knowledge of the field and establish trust in the co-construction with the group studied.

[3] This must not be confused with an interpretation of the world as a naturalistic objective. Through the social constructionist perspective, which informs this study, we acknowledge that the results are constructed throughout the research process, through interactions among the participants, as well as the researcher.
[4] Although conducting research in one's own field will always be influenced by prejudice and knowledge in advance, one should be aware of how prejudice may limit interpretation of the data (Malterud, 2013).

Triangulation of data is also claimed to be an important aspect of credibility. Triangulation can be achieved by studying different sources, combining different methods, and discussing topics with different investigators (Creswell & Poth, 2017; Lincoln & Guba, 1985). In this study, we decided to study the practice of reablement through different sources: PTs, HTs and collegues in different reablement teams. We also applied three different methods: observations of the working environment with field notes, video-recorded observations of user encounters, and interviews with both PTs and HTs. The raw data were converted into written materials, which were further linked with common codes and categorization. Congruent data from all three methods supported and validated each method's data, while discrepancies were further analyzed to achieve an understanding of the inconsistency. Triangulation of different investigators was achieved through regular collaborative meetings with the supervisors. The triangulation in this study contributed to validating the findings.

Peer review processes and debriefing by an external affiliate is also claimed to be an essential part of credibility that aims to allow for an external and critical appraisal of the results (Creswell & Poth, 2017; Lincoln & Guba, 1985). The supervisors in this project engaged in discussions and critical reviews throughout both the analysis and the writing process. The results have been discussed in different collegiate forums, including in the research group 'The multidisciplinary research group for health and care services in the municipalities', where I was an affiliated member during this project. In addition, all three papers have been through extensive review processes by the external peer-reviewers of three different scientific journals.

3.8.2 Transferability

Lincoln and Guba's (1985) concept of transferability is used to describe how the findings can be transmitted and used in other contexts. Qualitative research aims to create in-depth descriptions that clarify contextual relationships of significance to the studied phenomena (Creswell & Poth, 2017). Qualitative research concern contextual and situated phenomenon, which implies that transferability depends on interpretation of each individual context and situation.

The sample in this study is based on a purposive sampling approach (cf. Polit & Beck, 2012), including different municipalities of population sizes and locations. Based on the distinct variety of practices that was extracted from the thick descriptions, we decided that the data

material was sufficient in order to answer the research questions. The methods in this study provided rich, comprehensive descriptions of the contextual framework for reablement practice, which allows different perspectives to emerge and be discussed. These thick descriptions are the core essence in providing results that are transferable, as Lincoln and Guba state:

> *"It is not the naturalist's task to provide an index of transferability; it is his or her responsibility to provide the data base that makes transferability judgements possible on the part of potential appliers"* (Lincoln & Guba, 1985, p. 316).

The thick descriptions in this study provide results that are highly relevant not only in a reablement setting but also in similar and adjoining practices in primary health care contexts that involve professional supervision, teamwork and interprofessional collaboration.

3.8.3 Dependability

Dependability is suggested to describe how the results can be affected by changes and unstable contextual relationships (Lincoln & Guba, 1985). In qualitative methods essential to describe and discuss the situational and contextual settings that may contribute to construct the results (Creswell & Poth, 2017). The different participants, the varied contexts of practices, and my interference as an observer and researcher during the data collection have had an impact on the results of this study. Therefore, I have described and reflected upon the context of data collection in detail in this Methods section and have reflected upon my own interference as a researcher. In line with the constructivist paradigm, the researcher's interference in the situated setting of data collection is unavoidable (Justesen & Mik-Meyer, 2012). This must not be misinterpreted as a research bias; in contrast, it is an essential part of the study design, co-constructing the results in a situational and contextual manner. Despite this, my intention was to achieve an insight in "normal" practices in reablement settings. Both the PTs and the HTs as well as the users gave me the impression that the observed encounters represented typical reablement sessions.

3.8.4 Confirmability

Lincoln and Guba (1985) highlight the importance of displaying a transparent description of how the results are grounded in the data. The analysis section describes the process of transforming raw data to the representative results in this study. Table 2 in Paper 1 provides a visual impression on how the work was done, and Appendix 4 provides information about how video material was developed into text. To ensure that the results are grounded in the raw

material provided through practice, the main results are exemplified with relevant direct quotes or excerpts from the observations in Paper 1-3.

Confirmability is also described to involve descriptions of "negative evidence" (Lincoln & Guba, 1985). Descriptions of how the researcher has handled and included conflicting findings is required to achieve confirmability. When conflicting results were discovered in the analysis process, the conflicting elements were discussed with my supervisors until we achieved an understanding of the diverse phenomenon. In this study, the conflicting results have been the foundation for the main results and descriptions of the variations of practice, which are based on the diverse contexts and varied supervision in reablement teams. Inconsistent results gave rise to two typologies of reablement, which has contributed to the development of a concept about the practices in reablement.

3.9 Ethics

This study was approved by the Norwegian Centre for Research Data (Norwegian Centre for Research Data, 2017) (Ref number 44747) (Appendix 5) and was conducted according to the guidelines in the Helsinki Declaration (World Medical Association, 2017). All participants received written information about the study (Appendix 7) and provided written consent (co-workers, users, PTs and HTs) before any data was collected. Data were managed confidentially and with respect. The anonymity and confidentiality of all the participants were maintained throughout the study by ensuring that all data materials were stored in a safe manner, while all written material was depersonalized. The raw materials were stored with a password-secured software program (SION) that met stringent information security requirements, and only my main supervisor and I had access. Additionally, a safety copy was stored on an external hard disk that was securely locked. Participant information was encrypted, locked and stored at a separate place from the raw material. Fieldwork in some of the teams included my attendance at home visits to users who were not included as participants in this study. In these cases, I did not collect written information from the users. However, the employee who I was observing provided information about me and why I was present. I did not collect any personal information about these users, and they were neither video- nor audio-recorded. Although these observations did not form part of the data material, they provided confirmation of the material due to recognizable patterns of practice.

Although all the formal requirements of ethical handling of research data were taken care of, collecting qualitative data in practice by interacting with both employees and users involves

continuous ethical challenges. My appearance in the practice field was not necessarily unproblematic. Several individuals were present during the field work and were therefore also believed to influence on the results. Being observed and interpreted by a researcher can be experienced as degrading, and it can create pressure on those involved (Malterud, 2013). I decided to obtain written consent from all the involved staff in and around the reablement teams even though they were not formally included as participants in the study. In one of the reablement teams, some of the co-workers did not consent to field observations. Therefore, observations were not conducted with the particular team. However, I do believe that I obtained sufficient information and insight regarding the contextual situation through the interviews and the user encounters in this team that provided relevant and important descriptions regarding work environment and contextual issues.

Entering a reablement user's home as a researcher with a video camera also calls for ethical discussion. Although all of the users assigned to participate had received written information about the study and provided their written consent, it was important for me to explicitly express that my supervisor and I were the only ones who had access to the video recordings and that it was not going to be broadcasted on television (as some of them asked). I informed all the participants that they were able to withdraw from the study at any time. One of the users did not consent to video recordings. However, she was eager to participate in the study, and we jointly decided that the observation could be audiotaped.

4 Results

The overarching aim of this dissertation was the following:

> *To explore how the new organization of reablement may challenge traditional physiotherapy professionalism.*

Through studies of practices in reablement, the purpose was to achieve an understanding of the professionalism of physiotherapy in the social and societal context of reablement. By exploring the PTs' practices and pinpointing the aspects of supervision and knowledge transfer in context of the service provided to users, we addressed the current questions:

1. How is the practice of physiotherapy carried out across different reablement contexts?
2. How is physiotherapy supervision carried out in reablement services?
3. What are the contents of services delivered by support personnel who are supervised by physiotherapists?

I will start with a brief presentation of the main results from each of the three papers and further interpret the results in the context of each other to create a juxtaposed response to the dissertation's main research aim.

4.1 Paper 1

The object of this article was to explore how physiotherapy practice is performed in reablement settings and the contents of the services that are provided to reablement users. The analyses were based on observational data from the beginning and midway through the reablement process, in addition to interviews with both PTs and HTs. The workplace observations were essential in this paper to explore the context and structural conditions of practice. The analyses revealed that the way the reablement teams structured their practices, especially concerning division of labor, influenced physiotherapy practices. Hood's (1991), organizational theory that emphasizes administrative values informed the analysis. We identified two typologies that enabled us to classify the varied reablement practices, namely, fixed structured teams and flexibly structured teams. We described how assessment and interventions were conducted differently in accordance with the varied forms of the division of labor.

<u>Division of labor</u>

The fixed structured teams were characterized by a clear distinction of the division of labor, where the PTs, in addition to the OTs and nurses, were designated "catalysts" of the teams who performed assessments and created reablement plans. In contrast, the HTs appeared as assistants who followed the instructions of the "catalysts". Commonly, the PT conducted an assessment of the user's goals and functional ability and further supervised the HT to conduct a training program in the following weeks. The PT was rarely present with the user during the reablement period, but typically returned for an evaluation assessment at the end of the period. The teams arranged some formal meetings, where the "catalysts" led the discussions while the HTs mainly remained silent. Primarily, the "catalysts" discussed logistical and coordinating issues.

The flexibly structured teams were also characterized by their flat structure, in which all the team members, including the HTs, had equal responsibility for tasks. Both therapists and HTs conducted assessments and performed training to some extent. Typically, the PTs visited the users on a regular basis, often together with the HT, which provided insights into the users' home situations and everyday functions and an opportunity for follow-up supervision and discussion with the HT. Observations of meetings in these teams revealed that the HTs engaged in discussions on the same level as the therapists, and discussions were also carried out in informal meetings during the work day. To a larger extent, these teams discussed professional aspects regarding the users' goals, functional abilities and initiatives.

Assessment

Standardized assessment tools were used in all the observed reablement teams. Typically, they used the Canadian Occupational Performance Measure (COPM) and the Short Physical Performance Battery (SPPB)[5]. In the fixed structured teams, the PT rarely performed assessments or specific examinations except from the standardized tests.

In the flexibly structured teams, the PT characteristically performed extended examinations and assessments in addition to the standardized tests. The PTs reported that they conducted functional analyses regarding the movement and structure of muscles and joints.

[5] The COPM was designed to identify, prioritize, and evaluate performance and satisfaction with the performance of self-reported activities that are important to users' lives (Carswell et al., 2004; Tuntland et al., 2016). The SPPB is a screening test that identifies risk of functional decline, assessing balance, leg strength and gait endurance (Gómez, Curcio, Alvarado, Zunzunegui, & Guralnik, 2013; Guralnik et al., 1994). Both have been tested for validity and reliability (Freiberger et al., 2012; Kjeken, Slatkowsky-Christensen, Kvien, & Uhlig, 2004) and are frequently used in Norwegian reablement services (Tuntland et al., 2016).

Interventions

In the fixed structured teams, it was typical for the PTs to initiate exercise-based training, targeting balance, leg strength and gait endurance. Standardized training programs, such as the "Helbostad exercises"[6] or the "Otago exercises"[7], were frequently used. The argumentation for choosing an exercise-based approach was that the physical conditions were a prerequisite for functional abilities. In addition, it required a minimum of physiotherapy supervision of the HTs to manage the instruction of the exercises.

In the flexibly structured teams, exercises were also frequently used. However, these were often seen as a supplement to the activity training. By integrating both training on daily activities and physical exercises, the PTs argued that they were able to address both the user's goals and their functional limitations. The HTs in these teams reported that this form of work was exciting and educational. However, in a flexibly structured team with poor PT resources, the HT found it challenging and felt that she needed more supervision and support.

The paper's contribution

Teams with a fixed division of labor provided limited assessments and nonspecific approaches. Teams with a flexible division of labor were characterized by close collaboration between the PT and HT, thorough assessments and user-tailored measures. Organizational theory concerning administrative values informed the discussions and contributed to an understanding of why reablement practices appear to be drastically different. Our argument is that values emphasizing responsivity enable a flexible and individually tailored reablement approach, in contrast to values emphasizing efficiency, which facilitate a nonspecific approach. The paper is an important contribution to the reablement literature, describing different team structures, practices and approaches. In addition, it contributes to the ongoing international debate about human service organization and management, showing how administrative values influence health care practices and the contents of services.

4.2 Paper 2

The object of this article was the content of PTs' supervision of HTs in reablement teams. The data from all the user visits, interviews, and workplace observations were subject to analysis,

[6] An exercise program consisting of four exercises for leg strength and balance: sit-to-stand, knee lift, toe stand, and knee bend in a weight-bearing position (Helbostad, Sletvold, & Moe-Nilssen, 2004).
[7] A home-based balance and strength program documented to prevent falls (Kyrdalen, Moen, Røysland, & Helbostad, 2014).

interpreted by the theory of situated learning (cf. Lave & Wenger, 1991). The results revealed that supervision included elements of instruction, demonstration and reflection. However, practices varied widely across different teams, especially regarding the reflection aspect, which we found to be particularly essential for learning. Frequent meetings, both formal and informal, were found to be essential to enable learning through reflection. The HT's engagement was also important for the learning process.

Instruction, Demonstration and Reflection

Three different forms of supervision were employed during the observations. The first form, instruction, revolved particularly around *what* to do. These instructions were often transferred through written information, in the form of a rehabilitation plan or an exercise map that included descriptions and drawings of exercises. This form of supervision was seen in all of the reablement teams but was reported as particularly important in the team that was integrated in the home care service, where the PTs and HTs were not located together.

In addition to the instructions, the second form of supervision referred to demonstration of *how* to perform training measures. Most of the HTs reported that, in addition to written and verbal instructions, it was important that the PTs demonstrated both how the exercises were supposed to be conducted as well as how the PT instructed the user. They also emphasized the importance of practicing the exercises themselves, which enabled them to perceive and experience how different positions targeted different muscles.

The third form of supervision concerned reflection about *why* the measures were performed. PTs emphasized that the HTs achieved an understanding of the clinical reasoning in order to tailor the interventions to the individual user. Reflecting together enabled a joint understanding and shared knowledge.

Working Together

Working together facilitated close collaboration between the PT and the HT. Although all of the teams arranged formal meetings occasionally, informal meetings and the day-to-day communication were found to be at least as important. Collocation and joint user visits were especially important to be able to combine instruction, demonstration and reflection.

HTs' Motivation and Involvement

The PTs claimed that they often had to supervise the HT indirectly through the communication with the user. The PTs expected the HTs to absorb the information that was addressed to the users, which required the HTs to be highly observant and motivated to learn.

The paper's contribution

This paper identifies and discusses fundamental elements of PTs' supervision practice in reablement teams, which is also relevant for similar interprofessional settings. Written or verbal instruction is not sufficient to carry out supervision of complex and practical measures, while it requires joint reflection and close collaboration in a community of practice (cf. Lave & Wenger, 1998). Paper 2 may serve as a contribution to develop a theoretical framework for supervision in reablement practices. Managers of reablement programs should be aware of the powerful impact that structural conditions have on the practice of supervision, such as collocation and flexibility to carry out joint user visits and informal meetings.

4.3 Paper 3

The aim of this article was to explore how the HTs follow up instructions and supervision by PTs in reablement. Analyses were mainly based on data from the second user visit and interviews with the HTs and PTs. However, these data were seen in connection to the first visits, where supervision and assessment were conducted. The theory of professional skill acquisition (cf. Dreyfus & Dreyfus, 1986) informed the analysis. The content of the practices of the HTs 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.

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

HTs were responsible for observations and assessments of the user's challenges and needs and to report any circumstances of importance to the PT, such as users reporting pain, fall incidences or adjustments of exercises. The HTs reported a low threshold to contact the PTs. However, analyses revealed that close collaboration was a prerequisite to actually contact the PT. HTs who mainly based their approach on the written reablement plans rarely recognized any need for further adjustments or supervision, in contrast to HTs who reflected upon the user's quality of movement during the training.

Standardized approach following the predefined 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 PTs, which mainly involved exercises for strength and balance. The HTs' instructions to the user revolved around the amount of repetitions of the exercises. Adjustments of the exercises were also limited to increasing or decreasing the number of repetitions.

Individually tailored approaches targeting quality of movement

Although several of the PTs provided detailed instructions regarding the quality of movement and continuous adjustments of technique in the exercises, only a few of the HTs paid attention to small details during the training sessions. It appeared that specific and detailed approaches were based on the HTs' ability to recognize the nuances in movement and to distinguish between optimal quality of movement and constraints in movement. The HTs explained that this knowledge was achieved by regularly working in pairs with the PTs. Working in pairs enabled the HTs to recognize irregularities, which further lead to reflections and clinical reasoning, enabling adjustments and individual adaptations.

The paper's contribution

The results in this study revealed that in some cases, support personnel managed to provide complex initiatives tailored to the users' needs. However, close collaboration and frequent PT supervision were prerequisites for acquisition of knowledge and skill development. PTs should be aware of their professional responsibility to follow up on delegated tasks. It should be discussed whether the treatment of certain conditions or user groups should or should not be delegated to support personnel. Health care administration should also be aware of the diversity in reablement practices. The fiscal sustainability of the different forms of supervision needs consideration.

4.4 Synthesis of the results

The diversity of reablement practices is consistent for all the three papers. In Paper 1, we presented two typologies, fixed and flexibly structured reablement teams, in order to categorize the different practices. It is important to highlight that these distinctions are analytical concerning content of practice and that the typologies are different from organization forms described in reablement literature elsewhere[8] (Birkeland et al., 2018; Fürst

[8] The specialized model ant the integrated model.

& Høverstad ANS, 2014; Langeland et al., 2016). While organizational forms mainly describe how reablement is grounded in the municipality administratively, our typologies describe the contents of the practices in the teams, including the division of labor and tasks, internal collaboration and communication in the teams, and the contents of services provided.

In Paper 1, we discussed the different physiotherapy practices regarding division of labor, assessment and interventions in the fixed and flexibly structured teams. In Paper 2, we displayed the different forms of supervision practices, instruction, demonstration and reflection. Close collaboration between the HT and the PT was characteristic for the practices that combined all three forms of supervision, and high motivation and engagement among the HTs was also essential. This is in line with the characteristics of the flexibly structured teams and is supplemental to the theory describing the different typologies.

In Paper 3, we elaborated on the services provided to the users, focusing on the practices of the HTs. The results from this article highlight the diversity of reablement approaches ranging from standardized approaches that followed predefined procedures to individually tailored approaches that targeted quality of movement. The standardized approaches were seen in teams where supervision was limited to mainly relying on written plans and where collaboration between the PT and HT was sparse, in line with descriptions of fixed structured teams. The individually tailored approaches were seen in teams where PTs were frequently involved in supervision and user visits and where collaboration lead to reflections and clinical reasoning processes, in line with the descriptions of flexibly structured teams.

In summary, the two typologies described in Paper 1 represent different practices of reablement concerning physiotherapy practice, supervision and collaboration, which ultimately result in different service provision to the reablement users. The further discussion in this dissertation will evolve around these distinct typologies, discussing the professionalism of physiotherapy in fixed and flexibly structured reablement teams.

5 Discussion

This dissertation addresses the variations and diversity of reablement in a convenience sample of Norwegian reablement teams, aiming to discuss how it affects and develops the physiotherapy profession by drawing on the two typologies described in Paper 1. Through a social constructionism perspective, I will discuss how diverse administrative values and organizational frames contribute to constitute diverse practices, which may contribute to a development of physiotherapy professionalism. In the first part of the discussion, I intend to elaborate on the conceptualization of the two typologies, arguing that they represent two different forms of services. It is important to bear in mind that the typologies are an analytical dichotomization between different reablement teams, while in reality, there are several forms of team compositions. However, in order to illuminate the diversity of practices, I have chosen to draw upon these extremes in this discussion. In the second part of the discussion, I discuss the practices of the two typologies in the light of the theory of professionalism, aiming to explore how reablement may develop, and possibly challenge, physiotherapy as a profession.

5.1 Two different typologies of reablement teams: two different services?

Reablement is defined by several common hallmarks (Ness et al., 2012; Tuntland & Ness, 2014). However, our study highlights that practices are fairly diverse regarding professional practice, team collaboration and supervision, and service provision to reablement users. Although some studies have suggested that the organizational conditions may influence the team practices (Birkeland et al., 2018; Birkeland et al., 2017; A. Moe & Brataas, 2016), no clear evidence indicates that one organizational form is better suited for reablement practice (Langeland et al., 2016).

The observations of the dynamic and interactional processes in our study provides a contribution in discussions of the diversity of reablement practices. The internal team structures regarding the division of labor, meeting places and collaboration, had a great influence on practice, which stands in contrast to what has been found for administrative organization regarding integrated and specialized teams (Birkeland et al., 2018; Langeland et al., 2016).

In the next sections, I will present an argument for the typologies as two different forms of service provision based on the empirical findings of our study (Papers 1-3) and in light of existing research in the field.

5.1.1 Fixed structured reablement teams

The fixed structured teams in our study were characterized by a clear division of responsibility and tasks, which is in line with principles of successful teamwork (McInnes, Peters, Bonney, & Halcomb, 2015; Randström et al., 2012; Reeves et al., 2010). However, in our study, the results pointed in a different direction, as we indicated that a firm and fixed structure inhibited the collaborative processes and the HTs' learning (Eliassen, Henriksen, & Moe, 2018a). Extending this finding, it limited the possibility for services to be individualized and tailored (Eliassen, Henriksen, & Moe, 2018b). In the fixed structured teams, the time schedules were tied to the predefined tasks that were clearly divided among the team members. This limited "free time" for informal meetings between the team members resulted in a fragmented manner of conducting work and limited collaboration. These practices were in line with descriptions of teamwork with limited collaboration, such as *multiprofessional* teams. Multiprofessional teams are described to involve different disciplines sharing information with each other but mainly carry out tasks independently, which contrasts with *inter-* and *transprofessional* teams that involve a higher level of collaboration (Birkeland et al., 2017; Thylefors et al., 2005).

Assessment is highlighted as an important part of reablement practice and should form the fundamental aspect for development of reablement plans (Tuntland, 2014; Tuntland et al., 2016). In the fixed structured teams, assessments were often limited to involve standardized tools (COPM and SPPB). Although some have shown certain challenges with the goal setting tools (Bødker, 2018; Moe, Ingstad, & Brataas, 2017)[9], these tools are frequently used in Norwegian reablement teams and supported by several scholars (Hartviksen, 2017; Kjeken & Hunnålvatn, 2014; Tuntland, 2014; Tuntland et al., 2016; Zingmark, Evertsson, & Haak, 2018). A multicenter, clinical controlled trial conducted in Norway (Langeland et al., 2019) instructed the participants to use the mentioned assessment tools as part of the study methodology. The tools were crucial to assess effects in the study, and this approach appears to have become hegemonic in practices in Norwegian reablement. However, based on our results, I claim that the excessive focus on standardized tools may omit additional examinations that are crucial for individual- and context-based clinical reasoning.

[9] Questions have been raised concerning whether the goal setting really reflects the users own goals, or if the personnel tend to construct the goals on behalf of the user (Moe et al., 2017). Assessment tools are also claimed to be perceived as abstract for users and that quantification of function may conflict with the logic of care (Bødker, 2018).

Supervision in the fixed structured teams was limited to involve instruction (often written exercise sheets) and demonstration. What professional supervision in reablement should entail is not described in the literature, however, it is claimed that the professionals have the responsibility to develop reablement plans that HTs are supposed to carry out (Hjelle et al., 2018). The sparse descriptions of supervision may have resulted in the limited supervision practice in the fixed structured teams

The measures provided by the fixed structured teams were often based on standardized exercise programs, targeting gait endurance, leg strength and balance. The excessive use of exercise programs that we observed in our study was rather surprising. Descriptions of the contents of initiatives in reablement are sparse (Pettersson & Iwarsson, 2017); however, supporting and motivating users to engage in functional, daily activities themselves is emphasized. Training on daily activities has been reported to be part of the interventions (Hjelle et al., 2018; Hjelle, Tuntland, et al., 2016; Ness et al., 2012; Winkel, Langberg, & Wæhrens, 2015). Nevertheless, exercise-based training targeting muscle strength and balance is also found in the literature, especially literature of reablement in Australia (Burton, Lewin, & Boldy, 2015; Burton, Lewin, Clemson, & Boldy, 2013; Lewin, Alfonso, & Alan, 2013; Lewin et al., 2014; Lewin et al., 2016) but often as a supplement to activity training. The extensive focus on exercise programs in the fixed structured teams may stem from several circumstances. It is likely that a parallel can be drawn to the SPPB-test, which was frequently used to screen gait endurance, balance and leg strength (Gómez et al., 2013; Guralnik et al., 1994). A low score on this test indicate a need to increase these functional properties. Additionally, several of the PTs indicated in the interviews that physical conditions were fundamental to the users' function, and they were easily instructed to both the HTs and the users, which would be beneficial from an efficiency perspective.

Research demonstrates the positive effects of regular exercise and physical activity for older adults, such as a reduced risk of falling (El-Khoury, Cassou, Charles, & Dargent-Molina, 2013), a reduced level of frailty (Lozano-Montoya et al., 2017), and an improved performance in ADL (Chou, Hwang, & Wu, 2012). However, rehabilitating from severe functional decline, such as bone fractures, stroke and complex situations involving additional health conditions, which is reported as frequent issues among reablement users (Tuntland et al., 2016), requires specific and individually tailored initiatives (Gjelsvik & Syre, 2016; Norwegian Directorate of Health, 2017). The standardized training programs often resulted in very similar programs across user groups and were rarely adjusted during the reablement process. Legg et al. (2016)

argue that a ‘one size fits all’ model is unlikely to suit most users, and the importance of individualization and goal orientation is described as key hallmarks. Universalism and the principle of equal access to services must not be confused with equal approaches to all citizens. The question “what are important activities for you?” is central in reablement, aiming for a person-centered approach (Aspinal et al., 2016; Cochrane et al., 2016; Newton, 2012; Tuntland et al., 2016). In this matter, citizens are entitled equal rights for individually adapted approaches, which paradoxically entails unequal approaches to each one. The practices we observed in the fixed structured teams do not correspond with this description, nor do they fulfill the ideal of individualization in physiotherapy.

5.1.2 Flexibly structured reablement teams

Team members from the flexibly structured teams often visited the users together, and several of the team members would engage in assessments, which is also found beneficial by others (Moe & Brataas, 2016). Informal meetings enabled professional discussions regarding the users’ goals and functional abilities, and our analyses indicated that these practices facilitated individually tailored approaches. This corresponds with research by Hjelle et al. (2018) and Moe and Brataas (2016) who emphasized formal and informal meeting points for the team members, claiming that it would facilitate close collaboration. Flexibility is also described to enhance collaboration, facilitate learning processes, avoid traditional task boundaries and rationalize resource coordination (Hjelle et al., 2018; Moe & Brataas, 2016; Moe & Brinchmann, 2018; Rabiee & Glendinning, 2011). The practices in these teams are in line with descriptions of *interprofessional* teams, which involve a relative high level of communication and joint planning and decision-making and to some extent *transprofessional* teams, which involve integrated work where boundaries between disciplines are partly dissolved (Birkeland et al., 2017; Thylefors et al., 2005).

The flexible structure also allowed the PTs to visit the users regularly, which enabled continuous *assessment* of the user. An ongoing assessment during the reablement period is also claimed to be important in order to identify new targets and assess development (Hjelle et al., 2018; Rabiee & Glendinning, 2011). Assessments in the flexibly structured teams entailed the same standardized tools as described for the fixed structured teams. In addition, they often accompanied the assessment tools with some form of clinical examinations of body functions and structures as well as activity and environmental demands and requirements, which is in accordance with traditional physiotherapy assessment (Gjelsvik & Syre, 2016; P. Johnson, 2009; Norwegian Physiotherapist Association, 2012; Shumway-Cook & Woollacott, 2017;

World Confederation for Physical Therapy, 2016). Hjelle et al. (2018) also referred to PTs in reablement services who emphasized the importance of thorough movement analyses in order to assess the prevailing cause of impairment. This is in line with WCPT's (2015) description of physical therapy:

"Physical therapists are qualified and professionally required to:

- *undertake a comprehensive examination/assessment of the patient/client or needs of a client group*
- *evaluate the findings from the examination/assessment to make clinical judgments regarding patients/clients"*

(World Confederation for Physical Therapy, 2015)

Supervision in the flexibly structured teams was described as an ongoing process involving joint 'reflection-in-action' and 'reflection-on-action' in accordance with Schön (1991). Reflections constituted learning was appreciated by the HTs and is in line with other studies that have described HTs' perceptions of the new work form to be enjoyable (Hjelle, Skutle, et al., 2016; Kjellberg et al., 2011). The learning processes were clearly connected to the social interaction among the team members, in alignment with the situated learning theory (Lave & Wenger, 1991). By actively paying attention to the PTs' instructions to users, HTs possessed a 'legitimate peripheral participation' (cf. Wenger, 1998). Through active engagement and attention, involving collaborative and individual reflections, they would gradually acquire increased competence and confidence.

Thorough and ongoing assessment seemed to facilitate the individually tailored *measures*. Not only did they include more activity-based practice in accordance with the users' individual goals, but they also tailored the exercises in accordance with the users' body structures and contextual challenges and resources, which is an important aspect of physiotherapy (Gjelsvik & Syre, 2016) that is rarely mentioned in the reablement literature. Research has found that rather than completing structured exercise programs focusing on repetition and load volume, many older home-dwelling users prefer to incorporate exercises into their daily routines and tasks and that such lifestyle exercises may be just as effective as traditional exercise programs (Burton et al., 2013).

Motor learning and relearning is based on a complex interaction between the individual, the task and the environment (Shumway-Cook & Woollacott, 2017). From this perspective, the individual's constraints and abilities, the task and the environment affect the user's functional movements. This perspective is fundamental for rendering appropriate adaptations and

solutions for the user who aims to regain function or relearn activities. The neurobiological foundation of learning is synaptic plasticity, which is an experience-dependent strengthening or weakening of postsynaptic potential (Kandel et al., 2013) and depends on principles such as specificity, intensity, meaningfulness and transferability (Kleim & Jones, 2008).

The quotation below (from Paper 2) highlights how a PT in our study emphasized the quality of body movement during training.

> *For example, the lady we visited earlier today, who was doing her hip abduction exercise beside the kitchen counter. [The purpose is] to stabilize, not just 'topple over', you know. They need to understand how the user should be moving to target the right muscles. There are several ways to compensate. Consequently, the user will not achieve the effect that I had planned for. That's why it's important to demonstrate and further explain the importance of doing the exercise right.* (PT).

Movement quality is associated with the efficiency and effectivity of movement and is described as essential for optimal performance of tasks in various contexts. The concept of movement quality is frequently used in physiotherapy; however, several perceptions of the term exist, and a common conceptualization has not been achieved (Gjelsvik & Syre, 2016; Skjaerven, Kristoffersen, & Gard, 2008). Skjaerven et al. (2008) attempt to clarify the phenomenon by regarding movement quality as a notion that consists of an interaction between the inseparable preconditions of biomechanical, physiological, psycho-sociocultural, and existential processes. All the processes should be targeted in order to optimize the individual's functional movement.

5.1.3 Two different services?

The two different approaches, which represent the extremes of a continuum of variety, are fundamentally different regarding structural frames, collaboration and supervision practice and, last but not least, training measures. A central issue is that reablement is expected to fulfill different societal tasks by reducing health care expenditures, enabling active and independent aging, increasing the level of competence among care personnel, and reforming the mindset within the community health care services. Hartviksen (2017) explicitly states that reablement is a service within the domain of rehabilitation, prevention and health promotion.

However, it is assumed that users with multiple needs may not benefit as much as users with lower support requirements and that reablement is not designed to resolve specific healthcare issues (Cochrane et al., 2016). The target group is ill-defined, and the distinction between who

should receive reablement and who would benefit from traditional services[10] is not clear (Legg et al., 2016). Considering that only 3.1% of Norwegian reablement users reported unspecified functional decline while the majority of users reported fractures, balance problems, pain, or stroke as main issues with a median of three additional health conditions (Tuntland et al., 2016), it is reasonable to question whether reablement is the appropriate approach.

Several have reported that reablement services need to be adjusted to local conditions regarding the municipalities' needs, the citizen composition and the already existing services (Fürst & Høverstad ANS, 2014; Langeland et al., 2016; Moe & Brinchmann, 2018). However, a framework that enables municipalities to develop a service tailored to particular needs and objectives have been lacking. The current studies in this thesis serve as such a framework.

The results from our study revealed that the standardized approaches in the fixed structured teams lack the specific and individually tailored aspects, which often define reablement. However, C. Moe and Brinchmann (2016) have described reablement through a set of concepts, such as "appreciating a push", "physical strengthening", "adapting the environment", and "building confidence". These categories are more in line with our observations of the standardized approach in the fixed structured teams. Based on principles of *health promotion* among an older population, this approach may be appropriate for citizens with minor functional decline.

Based on principles of motor learning and relearning, I argue that users with complex *rehabilitation* needs may require tailored interventions that involve clinical reasoning and professional discretion. Hence, reablement services should not be a substitute for traditional rehabilitation delivered by professionals but should rather target those who would not receive traditional rehabilitation. However, our results revealed that within the framework of a flexibly structured reablement team, which involves time and professional resources to constitute close collaboration, skill development and tailored initiatives, it is possible to develop a service that may benefit users who have complex needs. Reablement may meet demands that tend to be lacking in traditional rehabilitation, such as interprofessional collaboration, an intensive and time-limited approach, the involvement of health care

[10] In reablement literature, 'traditional care' often refers to home care. However, I would like to highlight that traditional care may as well entail traditional rehabilitation through specific and individualized approaches provided by personnel with rehabilitation training, as PTs or OTs. Although municipalities are advised not to replace traditional rehabilitation services with reablement, my concern is that it may occur due to the ill-defined target group.

personnel and home-based training (Norwegian Ministry of Health and Care Services, 2009; Riksrevisjonen, 2011). The flexibly structured reablement teams may therefore be an extended contribution to the community-based rehabilitation services and should include a different target group than those in the fixed structured teams.

The HT's motivation was also found to be essential for the supervision, as it was important that the HT paid attention to the interaction between the PT and the user during the training in order to capture instruction and assess details. Although the HTs in the flexibly structured teams sometimes found their work challenging, they highlighted that it was motivating and educational, in line with findings of Hjelle, Skutle, et al. (2016).

These results indicate that the flexibly structured reablement teams may meet two of the objectives of reablement services: an individualized and qualitative service for recipients, and an increased motivation for care personnel. However, the economic aspects should be further investigated. One should also be aware of different amounts of resources required in the varied practices, as a flexible approach may require more time and personnel per user, which others have also pointed out (Birkeland et al., 2017; Hjelle, Skutle, et al., 2016).

Based on the two typologies of reablement teams presented in this dissertation, it is reasonable to ask why the reablement practices have developed diversely in the Norwegian context. As indicated above, the win-win-win-ideal for the service aiming for rehabilitation, health promotion and prevention in a diverse user group and emphasizing decreased expenditures and increased job satisfaction, may have facilitated diversity. In the following section, I will discuss the different practices in reablement by drawing on Hood's (1991) concept of how different values of public management affect services.

5.2 Conflicting values creates diversity in practice

In the Introduction section in this dissertation, reablement was presented as a solution to the assumed challenges with the increasing older population. However, arguments that emphasize reablement are divided between two stances. While one argumentation evolves around the economic aspects, questioning the sustainability of services facing the potentially increasing user group, another argumentation points towards values emphasizing quality of life, active aging and independent lives (Aspinal et al., 2016; Cochrane et al., 2016; Lewin et al., 2016; Ness et al., 2012; Norwegian Ministry of Health and Care services, 2015b; Rostgaard, 2016; Rostgaard et al., 2011; Slater & Hasson, 2018).

Reablement is described as a "win-win-win-service" (Hartviksen, 2017; Tuntland & Ness, 2014); hence, it aims to increase independence for the users, increase job satisfaction for the employees, and decrease health care expenditure in the long term (Aspinal et al., 2016; Tessier et al., 2016). To achieve a service that aims to meet the economic interests and increase the efficiency of the service, so called *sigma-type* values, Hood (1991) states that a firm and mechanistic organization structure is preferred. However, this organizational structure is best suited for 'mechanistic' structured work, where goals are fixed and contexts are stable (Hood, 1991); therefore, it is not suitable in the complex and shifting conditions in health care services (Vabø, 2009). The principles of universalism and citizens' equal rights of services are fundamental in the Nordic health care services. This is often a fundamental argument for transparency and standardization of services, which correspond with what Hood (1991) refers to as *Theta-type* values. However, it is important not to confuse 'equal rights of services' with 'rights of equal services'. In reablement, it is essential that the services are tailored to the individuals' needs and contexts, which paradoxically entails different approaches. This may conflict with practices that base the approaches on standardization. The sigma-type and theta-type values were perceived as fundamental aspects in the fixed structured reablement teams and were reflected in the practices of standardization and the limited time and resources for collaboration.

A core element in health care services is a response to individual needs and preferences (Rostgaard, 2012), which is in line with *lambda-type* values that emphasize resilience and adaptivity. To meet these values, the organizational frameworks must allow for flexible and dynamic approaches (Hood, 1991; Vabø, 2009). Such practices prevailed in the practices of the flexibly structured reablement teams, including thorough supervision, frequent visits by professionals and the opportunity to work in pairs. This may conflict with the values of efficiency and frugality (Hood, 1991).

This theoretical assumption indicates that conflicting values may complicate the attempt on creating a "win-win-win-service". The conflicting value base of reablement may have influenced the diversity of practices, which further results in different service provisions for the recipient.

5.3 Changing physiotherapy professionalism in reablement

As mentioned earlier, PTs are claimed to have a central place in reablement, although the role and tasks are not clarified. It is enlightened in the literature that care personnel need to

undergo a change of attitude and mindset, and reorient their professional tasks towards an increased focus on rehabilitation, due to the implementation of reablement (Fürst & Høverstad ANS, 2014; Hartviksen, 2017; Meldgaard Hansen & Kamp, 2018). However, there is little discussion regarding the new roles and work settings for physiotherapists. The PT's practices observed in our study were highly diverse. In the following, I will discuss how practices in reablement may influence, and potentially challenge traditional physiotherapy professionalism.

According to changes in society and organizations, professions are constantly developing, and with regard to reablement services, the physiotherapy profession is entering a new labor market that encompasses new tasks and constitutes new positions. This change in professionalism is in line with the concept of *diversification* (Nancarrow & Borthwick, 2005). Working in a rehabilitative context that emphasizes independence in daily performance is not new for PTs (similarly for other health professions); it is rather a core labor, which is likely why reablement has been accused for being a "new wrapping" of already existing practices (Fæø et al., 2016). However, PTs in reablement are entering a new labor field, where home care personnel traditionally have had a monopoly. Supervision in physiotherapy is also not new (Colbran-Smith, 2010; Fogstad & Christiansen, 2011; Lähteenmäki, 2005; Normann et al., 2014; Sørvoll et al., 2018; Ustad et al., 2016). However, a service that has institutionalized supervision of nonprofessionals as a core task constitutes, to my knowledge, a new way of providing physiotherapy in the Norwegian context. How these new roles are embodied and how the division of the new labor is performed inform how physiotherapy practice is constituted in reablement services.

5.3.1 Fixed structured teams: moving towards a mechanical specialization?

In the fixed structure teams, PTs had the same tasks as OTs and nurses but had clearly different tasks than the HTs and were often labeled as "catalysts", referred to as consultants in the literature (Hjelle et al., 2018). During the interviews, the HTs expressed that they perceived the PTs in the same way as the OT and nurse and had not reflected on the different knowledge or skills that the different professions possessed. They conducted the same standardized assessment tools as the other professionals in the team and to a large extent provided similar exercise programs, which were distributed to the HTs.

This blurred distinction between the different professionals in the reablement team is in line with what Freidson (1983) refers to as *'deprofessionalization'.* The PTs argued that by

choosing standardized exercise programs that were easy to instruct, they could easily delegate tasks to the HTs. In the quote below, from Paper 1, a PT explained how she simplified her assessment due to the context of reablement:

> "*I never do any specific tests, like muscle length or specific strength […] I don't ask them to take off their pants or anything like that… or lay on a bench […]I mean, it's more like a conversation… I don't find it natural to assess any movements. Therefore, you know… the details… I don't describe them in the journal or talk to the HTs about it."*

By simplifying and routinizing services to a level that lay people, nonprofessionals or even computers can take over the performance, Freidson (1983) admonishes that the deviation and particularity of the professions may be neglected. In the extension, he claims that the profession could eventually lose its status and monopoly on knowledge and autonomy, which have been core elements in the attempt to define professionalism.

The clear boundaries between the tasks of the PTs and the HTs were characteristic of the fixed structured reablement teams. By delimiting the tasks of the professionals to involve assessment, supervision, and delegation of the therapeutic tasks to nonprofessionals, the profession is moving towards a direction similar to what Nancarrow and Borthwick (2005) refers to as *specialization.* This typically happens when a profession increases the level of expertise in a specific particular branch or area of the field, delegating routine tasks to others. However, in reablement, this task delineation is not due to increased expertise but rather to an objective of efficiency. Although the delimitation of professionalism in reablement is not in concordance with the traditional interpretation of the term 'specialization', the same limitations and challenges of the profession apply.

By limiting "free time" for informal meetings and standardizing and routinizing initiatives, it was claimed that one could reach out to a large amount of citizens, which would be beneficial from a fiscal efficiency perspective. Determining which part of the occupation is defined as formal and which is labeled as informal and available for delegation is based on social rules, rather than the nature of the work itself (Nancarrow & Borthwick, 2005). By arranging reablement in a fixed manner, the therapeutic tasks and training are defined as informal and are available for delegation to nonprofessionals, while the consultant labor is defined as the formal professional work. This change may be due to the professional demand in decision making due to assessment and planning. However, decision making in physiotherapy is not limited to a preassessment; hence, it is essential throughout the continuous rehabilitation process (Johnson & Thompson, 1996).

Freidson (1983) describes how professionalism may change regarding capital inquiry. He claims that by formal stratification of conduct through rationalizing and simplifying tasks, services can be performed in a manner that maximizes the profits, while at the same time, increases the governmental control of the work. He conceptualizes this change of professionalism by the term; *'proletarianization'* and claims that this process leads towards a loss of professional autonomy. This movement changes professions in the direction towards industrial labor subject to capitalism. Fæø et al. (2016) have also criticized the increased standardization and rigidity of reablement, which they claim limit a professional and contextual flexibility. While PTs in fixed reablement teams conduct their labor as consultants, assessing and delegating tasks in an administrative manner, they seem to move towards a "rank-and-file" labor. Freidson (1983) is concerned that moving away from the conduct of the daily work may create a discrepancy from the "real" work, thus limiting the understanding of and moral connection to the labor.

Concerning the standardization of assessment and training programs, labor in fixed reablement teams may be perceived as stratified and simplified, which can be easily delegated to and performed by 'anyone'. Rabiee and Glendinning (2011, p. 499) reported that HTs who conducted such procedural tasks in reablement perceived their work as *"standing and watching"* without a clear perception of their work as important. This may indicate that this form of work is less motivating for the HTs. Job satisfaction has been argued to be a potential benefit of implementing reablement services (Aspinal et al., 2016; Tessier et al., 2016; Tuntland & Ness, 2014). Although increased satisfaction among reablement employees has been indicated in the literature, this effect was related to increased training, supervision and flexibility in the job (King, Parsons, & Robinson, 2012). Freidson (1983) conceptualizes the standardized and routinized labor that potentially could be performed by anyone, as *'mechanical specialization'*, which he claims is distinguished fundamentally from professional work. The latter requires considerable discretion to adapt specific knowledge and skills to the particular context, conceptualized as *'theoretically-based discretionary specialization'.* In accordance with an interpretation of Freidson's professionalism, the professional tasks and positions of PTs in fixed reablement teams are moving in a direction away from the definition of professionalism. This practice deviates from the ideals of physiotherapy that emphasizes specific approaches towards the performance of bodily movement and function in a competent manner (Nicholls & Gibson, 2010). However, a different development was seen in the flexibly structured teams.

5.3.2 Flexibly structured teams: towards a theoretically-based discretionary specialization

The flexibly structured teams were characterized by the close collaboration within the interdisciplinary teams. A flexible time schedule and team members who met frequently served to enable close collaboration, involving both practical coordination of tasks and professional discussion and supervision. Interprofessional teamwork intends to enhance problem solving, improve planning and avoid job duplication and fragmentation (Atwal & Caldwell, 2005; Mitchell et al., 2010). However, studies exploring the efficiency of interprofessional teamwork are diverse, and while some studies report positive outcomes, others display incidences of team conflicts and poor outcomes (Mitchell et al., 2010). This indicates that interprofessional teamwork is not exclusively associated with enhanced quality or efficiency of service, and the benefits that are described depend on knowledge transfer between the different professionals in teams (Mitchell et al., 2010). The composition of a team alone is not sufficient in order to succeed; hence, the interactions and collaboration between team members are decisive.

A quote in Paper 1 represents how the PTs' work expands by including tasks of adjacent professionals due to interdisciplinary work:

> *"You turn into a Jack-of-all-trades in a way because that's how it is. How we have to work. If I step my little toe into an ADL [activity of daily living] assessment, I don't pull it back up. Instead, I stay in it and discuss the situation with the occupational therapist later on or bring her with me to observe, maybe. I would think that she should evaluate the situation together with me, for example. However, I bring along what I see and the assessments I do."* (PT)

The PT refers to a situation where she identifies an area of the work that traditionally would have involved an aspect of another profession. Instead of withdrawing from the task, she would use her skills and knowledge to assess the situation as well as possible and to further involve the OT (in this case) for elaborate discussion and assessment.

According to Nancarrow and Borthwick (2005), engaging in interdisciplinary work is likely to move professional boundaries, taking on tasks or roles traditionally performed by others. The abovementioned example involved a PT who adopted tasks traditionally in the domain of another discipline with a similar level of expertise (the OT), referred to as *horizontal substitute.* It is impossible to draw a distinct professional boundary between OTs and PTs, because their fields of labor overlap and they may often engage in similar tasks, although the approaches and methods may vary. However, the quote above implies that the PT would take on tasks that she interpreted to be an 'OT-task', thereby engaging the OT through

collaboration and support. *Vertical substitute* involves delegation or adaptation of labor or tasks across disciplines where the level of expertise is unequal (different length of education and wage level, etc.). The quote below shows how a PT engaged in tasks traditionally performed by care personnel incorporates the observations and experiences with her knowledge and skill as a PT and conducts a thorough and holistic assessment of the user:

> *"I find it interesting to observe situations such as morning care, for example. It provides me with lots of information. I evaluate how the user get out of bed, how they achieve a stance position, how they manage to take a shower. The whole "package" is extremely valuable for me as a PT. [...] I get a holistic impression of the user and the whole situation. I mean... I don't only see the small things, I see the whole setting, and that's inspiring. It's motivating."* (PT)

The quotation above displays not only an example of the PT who takes on tasks of another discipline but also a PT who combines the tasks of home care and physiotherapy, integrating prevailing knowledge and skills within the new field of labor and providing holistic information about the user's function ability. Hjelle et al. (2018, p. 313) also emphasize the importance of preserving the particular expertise and knowledge of the profession in the intersectional work to prevent a "*woolly group of people who only have little knowledge about everything*".

The discussion of 'deprofesionalization' and 'generalization' due to interprofessional work has evolved around a concern that tasks would be simplified and routinized (Freidson, 1983). However, the results from the flexibly structured teams indicate the opposite. Instead of simplifying tasks, the PTs combine their core competences with new knowledge provided through interaction and collaboration in the teams, thus expanding the boundaries of professionalism towards an increased holistic and activity-based approach.

5.4 Arising awareness of the knowledge base in physiotherapy

In Paper 2, we defined three different forms of physiotherapy supervision that took place in reablement: instruction, demonstration and reflection. All of the PTs who participated in this study conducted some form of instruction of the HTs, often in combination or supplemented with practical demonstration to supervise, for example, training exercises or strategies to carry out functional activities. However, the supervision form that we evaluated as having the greatest potential for learning was when the PT and HT discussed and reflected upon the user's situation both during and after user consultations, in line with Donald Schön's theory of The Reflective Practitioner (Schön, 1991). The latter aspect of supervision was seen in the flexibly structured teams.

In the reablement literature, it is described that PTs and other professional practitioners have professional responsibility and are expected to supervise HTs to conduct the training (Hjelle et al., 2018; Tessier et al., 2016; Tuntland & Ness, 2014). This description may imply that knowledge is something that can be delivered from one person to another as a "package", as there is no further deliberation of *how* to supervise. Considering that knowledge could be transferred in a "complete manner", the fixed team structure would be preferable as an effective and resource-saving way to "spread knowledge" to several HTs, who could further be able to provide a professional service to a large amount of users. However, through a social constructionist perspective, this perception of knowledge is problematic.

The results from our study indicate that this skill acquisition is dependent on a much more complex process than a mechanical "knowledge delivery" through instructions and demonstrations. In line with the situated learning theory (cf. Lave & Wenger, 1991), we observed that working together regularly through close collaboration involving discussion and reflection enabled the HTs to recognize new details of significance for the quality of movement. This was essential in order to be able to adjust and adapt the training to the individuals' body impairments and contextual frames. The HTs had difficulties with describing how they had acquired that specific knowledge, but by working in pairs with the PT, they experienced a continuous input of "small tips" of knowledge, which increased their ability to conduct their own observations and reflections.

To prioritize the reflection aspect of supervision and learning, it is important that the PTs are aware of their own knowledge and skills. Elements of physiotherapy competencies often become part of an implicit and 'taken-for-granted' understanding (cf. Berger & Luckmann, 2016). These competencies often involve tacit and practical knowledge, which are not easy to describe verbally. According to Bjorbækmo and Shaw (2018), it is the tacit and practical aspects of physiotherapy that entail the power of the profession, thereby enabling clinical judgement regarding the individual tailoring of approaches. The interactional, embodied and tacit knowledge and skills of physiotherapy tend to be undermined and neglected compared to the explicit knowledge in the field. The increased demands for standardization and documentation of practices, such as the introduction of "evidence-based medicine" (EBM), and strategies inspired by NPM, have additionally decreased the recognition of the tacit ways of knowing (Bjorbækmo & Shaw, 2018). PTs must increase their awareness and recognition of this aspect of their professional competence to be able to supervise HTs in performing tasks that require practical and tacit knowledge.

Concerning the great impact organizations have on professional practices (Noordegraaf, 2011), professionals should aim for an institutional competence (Allen, 2014b; Orvik, 2015). During the last decades, 'organizing work' has become increasingly recognized as an important part of labor in the field of nursing (Allen, 2014a, 2014b; Benner, 1984; Olsvold, 2012). Based on the results in our study, I claim that there is a need for such awareness concerning organizational work in physiotherapy as well. The professionals themselves should be aware of the organizational issues concerning their labor. In addition, tasks such as coordination, collaboration, supervision, ongoing assessments, and discretionary work require time and resources. This calls for awareness at an administrational level as well. In a society with an increasing demand for documentation and standardization of labor, these "invisible" (cf. Allen, 2014a) but highly time-consuming and resource-demanding tasks may be easily neglected. The actions constituting the content and conditions of collaboration and supervision should therefore be elaborately explored and theorized.

5.5 Limitations

Due to the aim of the empirical study, which serves as a fundamental topic for this dissertation, the main focus has been on the interplay and interactions between the PT and the HT, while the team collaborations were much more complex and interdisciplinary. It would have enriched the study to include other team members' practices. However, the employed data of team interactions through work environment observations and from the interview was sufficient to respond to the research questions in this project. Additionally, the complex interactions between the user and reablement employee are decisive for the approach. However, this aspect is limited in this work, due to the objectives of the study.

We had only access to the field in the beginning and midways during the reablement process, thus this study does not cover the last part of the reablement process. Following the participants over a longer period of time could have provided us with more detailed information about the HTs' learning processes.

The current study is based upon fieldwork in seven different reablement teams. The typologies presented in this study represent characteristics along a continuum of the varied practices. My assumption is that there are more variants of practice that are not described in this work. As stated in the Introductions section, reablement interventions also differ widely across nations, and political and administrational differences will affect practices differently

across national borders. This dissertation does only target the Norwegian context, hence, implications for other nations should be evaluated regarding contextual issues.

Although this dissertation indicates some connections between organizational issues and practices, the small sample of reablement teams in this study cannot provide any conclusion about how the described typologies are related to the integrated organizational model and the specialized organizational model (cf. Birkeland et al., 2018; Fürst & Høverstad ANS, 2014).

In this dissertation, I have indicated that the flexibly structured reablement teams may require more resources than the fixed structured teams. However, it is important to note that based on the data in our research, we cannot draw any conclusion regarding the efficiencies of the different typologies. Additionally, we cannot conclude that one or the other typology provides a better effect regarding user outcomes.

The discussions in dissertation revolves questions on a meso-level, regarding professionalism and organizational frameworks and practices. However, discussions on a micro-level, concerning *what* happens during the distinct interactions in collaboration or *how* actions and interactions are embodied in the learning processes, is not thoroughly discussed here. Such micro-level analysis are essential in order to understand the processes of interaction and learning, and should be investigated.

The theoretical interpretation and my choice of interpretative view provide only one of several possible perspectives upon which to draw the discussion. Other perspectives may result in other relevant discussions.

6 Concluding remarks and implications

The overarching aim of this dissertation was to explore and understand how the service innovation of reablement may challenge the profession of physiotherapy. I have presented a synthesis of the results from a study targeting physiotherapy practice in Norwegian reablement teams. Based on the synthesis, I have constructed an analytical framework to distinguish between the contents in the different reablement practices. Fixed and strictly defined frames and team structure may possibly enhance an effective health promotion service by targeting a user group with minor functional decline who may benefit from a standardized and general preventative approach. However, if the purpose is to target a user group in need for rehabilitation in order to regain function in a complex matter, an individually tailored approach emphasizing quality of movement, bodily impairment and resources in the context of task and environmental issues is required. Flexibly structured reablement teams may be appropriate in some cases due to the close collaboration and competence development among the team members.

This new knowledge is important at the municipal administrative level to organize the health care services in conjunction with the local goals and contexts. The descriptions of practices may serve as a framework for reablement employees to optimize reablement tasks concerning assessment, collaboration, supervision and initiatives.

The concept of different typologies in reablement needs elaboration. A clear description of the user group for the fixed and flexibly structured teams should be developed. The different typologies should be viewed in the context of the organization forms, integrated or specialized teams, in order to map out potential patterns of similarity or inequalities. Moreover, evaluating both costs and user outcomes, in order to evaluate the different reablement approaches is needed to analysis the effect of the different typologies.

The main goal in this dissertation was to explore how the new organization of reablement may challenge traditional physiotherapy professionalism. The results of our study indicate that physiotherapy practices are performed differently due to diverse team structures, and may change the professionalism of physiotherapy in different directions. In accordance with an interpretation of Freidson's descriptions of professionalism (Freidson, 1999, 2001), physiotherapy tasks and roles in fixed reablement teams are moving in a direction away from the definition of professionalism. These practices deviated from ideals of physiotherapy, which emphasize specific approaches that target optimal performance of movement and

function in a competent manner (Nicholls & Gibson, 2010). However, in the flexibly structured teams, the PTs combined their core physiotherapy competences with new knowledge provided through interactions and collaborations among team members. Instead of simplifying tasks, they expanded the boundaries of the profession towards an increasingly holistic and activity-based approach in accordance with the core objective of reablement (Cochrane et al., 2016; Ness et al., 2012) and political strategies (Norwegian Ministry of Health and Care services, 2015b). These assumptions contribute to increasing an awareness of the professional boundaries of physiotherapy.

Organizational structures and ideologies are under continuous development. This dissertation has demonstrated how professional boundaries may change in reablement services. However, the results of our study may have implications for other service organizations, as well, and they are particularly relevant for health care services involving interprofessional teamwork, collaboration and supervision.

The knowledge base that describes the actual contents of practices in physiotherapy labor concerning collaboration, supervision and jointly discretion is sparse. I call for a further examination and theorization of the field.

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Paper I-III

Appendices

Appendix 1: Observation guide

Appendix 2: Interview guide

Appendix 3: Written information to study participants and consent form

Appendix 4: Cataloging matrix for transcripts of video observations

Appendix 5: Approval from the Norwegian Centre for Research Data (NSD)

Appendix 6: Change form to NSD

Appendix 1. Observation guide

Work environment observations

- Location: How is the work place shaped? Open landscape? Offices? Make drawings.
- Meeting places: What possible meeting points exist during the working day?
- What are the actions of the employees (the PTs, HTs, OTs nurses, others)?
- Who communicates with whom? Who takes the initiative of the communication?
- Topics that are discussed?
- Meetings: Who leads the meeting? Who contribute with comments? What is being discussed (topics, professionality, clinical discretion, coordination, etc.)?
- Lunch break: Jointly or individually? Who communicates with whom? What do they talk about?
- Supervision: Can you recognize any form of supervision (verbal or bodily)?

The video recorded observations

- The observation starts when the physiotherapist and home trainer meet the user.
- Video recordings start as soon as possible after the meeting is established and the participants are made aware that filming starts.
- The observer position should be a few meters away from the participants. The participants' faces should, as far as possible, be captured without the camera angle being directly in front of the faces.
- Handheld camera operation is used to change position and angle. The observer should try to maintain a discreet appearance and not move around in the room unless it is necessary to follow the situation or capture the movements and interactions of the participants.

1) Treatment setting
- Participants: roles, clothes
- Timeframe
- Local: environment, temperature, lighting conditions
- Equipment

2) Content of actions
- Activities, exercises and movements. What measures are being implemented? How are these conducted? How does the user move? How does the PT move? How does the HT move? What do they do?

3) Guidance and instruction
- Concrete guidance/training. Who takes "control" in the situation?
- Who instructs whom (The PT's instruction/supervision of the HT, the PT's instruction and guidance of the user, or the HT's instructions to users)?
- What forms of training/guidance and instruction are seen (verbal, bodily/mirroring, hands-on)?
- How does the PT support/motivate the HT and the user? (verbal, bodily, mimicry/facial expressions?)
- How does the HT support/motivate the user?

4) Communication
- The PT's verbal communication
- The PT's nonverbal communication
- The HT’s verbal communication
- The HT's nonverbal communication
-The user’s communication
- The participants' position in relation to each other

5) Changes in user function
- How does the user respond to instruction?
- Is there a change in the movement?

Reflections after observation
- How did you perceive the situation? What are your immediate reactions?
- Did the participants have any comments on the situation in the aftermath?
- Did any new questions or themes to explore further occur?

Appendix 2: Interview guide

The questions are only leading and were not followed systematically. Relevant follow-up questions were asked, and the informants where encouraged to talk freely.

Theme	Questions to the PTs	Questions to the HTs
Context	Job description? Labor divided between team members? What does a characteristic work day look like? How do you perceive the different roles in the team?	
Education and competence	Demand for specific competence in the job? Your competence of reablement/rehabilitation? Education, course or other relevant training?	
Supervision and reasoning about the user	Priorities due to supervision Situations that went well/did not go well Cooperation PT and the HT Leaving responsibility of the user to the HT The PTs role in the team? Strategy for the supervision? Further plan for follow up?	Reflections about the PTs supervision. Did you learn anything new? Did you perceive adequate support and training? How did the PTs supervision contribute to your performance?
Reablement requirement	Reflections about initiatives required for this user (individual, environment and task)? Knowledge and competence required to carry out the interventions?	Reflections about -user's needs (goals and initiatives) -supervision session and training session. -reablement process (adjustments or needs for supervision) -requirements in the job What do you perceive has been essential for the reablement in this case? (motivation, cooping, goals) Relationship with the user
Professional knowledge	How is your professional knowledge expressed in reablement labor?	

	Expression of professional knowledge in the observed situation? Practice of professional updating	
PT's and HT's communication and collaboration		Communication with the PT following the initial supervision? The PT's participation in the process? Has there been any evaluation, further assessments or decisions based on consultation with the PT (or others)? Do you perceive the supervision as sufficient? How can the PT contribute further in the process?

Appendix 3: Written information to study participants and consent form

FORESPØRSEL TIL FYSIOTERAPEUT

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

«HVERDAGSREHABILITERING – FYSIOTERAPIVEILEDNING VED OPPGAVEDELING»

BAKGRUNN OG HENSIKT

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor fysioterapeuters veiledende funksjon i hverdagsrehabilitering undersøkes. Studien er en del av et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved Det Helsevitenskapelige fakultet ved UiT Norges Arktiske Universitet. Universitetet er ansvarlig for denne studien.

Du forespørres til å delta i studien fordi du er fysioterapeut i hverdagsrehabiliteringsteamet i en av åtte utvalgte norske kommuner som er inkludert i denne studien.

På bakgrunn av helsepolitiske endringer i Norge de senere årene, har fysioterapeuter fått tildelt ekstra ansvarsområder, som blant annet dreier seg om veiledning av annet personell. Studien har som mål å fremskaffe kunnskap om fysioterapeuters veiledende funksjon i denne type oppgaver. Det er ønskelig å se på hvordan veiledningen foregår, samt hvordan fysioterapeut overfører sin kunnskap til hjemmetrener som fungerer som den «utøvende part» i rehabiliteringen.

HVA INNEBÆRER PROSJEKTET?

For å få kunnskap om dette temaet vil det være ønskelig å observere og filme en veiledningsøkt/samarbeidsøkt mellom deg og hjemmetrener. Det er ønskelig at veiledningen er i oppstartsfasen på hverdagsrehabilitering for bruker. Veiledningen skal foregå som normalt, og vil i liten grad forstyrres av doktorgradsstudenten, som kun vil fungere som en observatør. Det er også ønskelig å gjennomføre et intervju med deg hvor det stilles spørsmål knyttet til din rolle som fysioterapeut og veileder i hverdagsrehabiliteringsteamet. Intervjuet vil vare ca. 1 time, og vil bli tatt opp på båndopptaker. I tillegg er det ønskelig å følge deg og dine kollegaer på arbeidsplassen for å få et innblikk i arbeidsmiljøet du er en del av. (Senere i forløpet vil prosjektet omfatte en ekstra observasjon av treningsøkt med hjemmetrener og bruker, samt intervju av hjemmetrener. Du vil ikke berøres av denne intervensjonen)

Alle personopplysninger vil anonymiseres under bearbeidelse av materialet. Prosjektet er godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

MULIGE FORDELER OG ULEMPER

Arbeidet vil foregå som normalt, og det vil ikke gjennomføres noen ekstra undersøkelser eller trening i denne sammenheng. Doktorgradsstudenten kommer til å være tilstede i arbeidet hvor du, hjemmetrener og bruker samhandler, samt i deres arbeidsmiljø forøvrig. Intervjuet vil kun omfatte spørsmål tilknyttet dine arbeidsoppgaver som fysioterapeut med veiledende/tverrfaglige oppgaver. Foruten dette forventes det ikke at denne studien vil medføre noen ekstra belastning for deg.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få konsekvenser for din videre behandling. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede videoopptak. Materiale som allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner kan ikke slettes i ettertid. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte doktorgradsstudent Marianne Eliassen på telefon 99709940, eller e-post: marianne.eliassen@uit.no eller prosjektleder, førsteamanuensis Siri Moe , Institutt for helse- og omsorgsfag, UiT Norges Arktiske Universitet, på telefon 77645265, eller e-post: siri.moe@uit.no.

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Under arbeidet med studien vil videomateriale oppbevares innelåst. Ingen andre enn doktorgradsstudenten og veiledere vil ha tilgang til dette. Videofilmen vil bli slettet når prosjektet avsluttes, etter plan ved utgangen av 2019. Videomaterialet vil kun bli brukt som hjelp til å beskrive hva som skjer i veiledningen og treningssituasjonen. Det vil ikke bli brukt bilder eller video hvor du kan gjenkjennes i oppgaven eller andre publikasjoner.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

FORESPØRSEL TIL HJEMMETRENER

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

«HVERDAGSREHABILITERING – FYSIOTERAPIVEILEDNING VED OPPGAVEDELING»

BAKGRUNN OG HENSIKT

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor fysioterapeuters veiledning av hjemmetrener i hverdagsrehabilitering undersøkes. Studien er en del av et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved Det Helsevitenskapelige fakultet ved UiT Norges Arktiske Universitet. Universitetet er ansvarlig for denne studien.

Du forespørres til å delta i studien fordi du er hjemmetener/hjelpepleier i hverdagsrehabiliteringsteamet i en av åtte utvalgte norske kommuner som er inkludert i denne studien.

På bakgrunn av helsepolitiske endringer i Norge de senere årene, har fysioterapeuter fått tildelt ekstra ansvarsområder, som blant annet dreier seg om veiledning av annet personell. Studien har som mål å fremskaffe kunnskap om fysioterapeuters veiledende funksjon i denne type oppgaver. Det er ønskelig å se på hvordan veiledningen foregår, samt hvordan fysioterapeut overfører sin kunnskap til hjemmetrener som fungerer som den «utøvende part» i rehabiliteringen.

HVA INNEBÆRER PROSJEKTET?

For å få kunnskap om dette temaet, vil det være ønskelig å observere og filme en veilednings-/samarbeidsøkt mellom deg og fysioterapeut. Det er ønskelig at veiledningen er i oppstartsfasen på hverdagsrehabilitering for bruker. 1-2 uker senere vil det være ønskelig å gjennomføre en ny observasjon av treningsøkt mellom deg og bruker. Veiledningen og treningen skal foregå som normalt, og vil i liten grad forstyrres av doktorgradsstudenten, som kun vil fungere som en observatør. Det er også ønskelig å gjennomføre et intervju med deg hvor det stilles spørsmål knyttet til din erfaring med å samarbeide med fysioterapeut i oppgaver tilknyttet hverdagsrehabilitering. Intervjuet vil vare ca. 1 time, og vil bli tatt opp på båndopptaker. I tillegg er det ønskelig å følge deg og dine kollegaer på arbeidsplassen for å få et innblikk i arbeidsmiljøet du er en del av.

Alle personopplysninger vil anonymiseres under bearbeidelse av materialet. Prosjektet er godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

MULIGE FORDELER OG ULEMPER

Behandlingen vil foregå som normalt, og det vil ikke gjennomføres noen ekstra undersøkelser eller trening i denne sammenheng. Doktorgradsstudenten kommer til å være tilstede i arbeidet hvor du, fysioterapeut og bruker samhandler, samt en treningsøkt med deg og bruker. Doktorgradsstudenten vil også bære tilstede i arbeidsmiljøet du er en del av de dagene datainnsamlingen foregår. Foruten dette forventes det ikke at denne studien vil medføre noen ekstra belastning for deg.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på neste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få konsekvenser for din videre behandling. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede videoopptak. Materiale som allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner kan ikke slettes i ettertid. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte doktorgradsstudent Marianne Eliassen på telefon 99709940, eller e-post: marianne.eliassen@uit.no eller prosjektleder, førsteamanuensis Siri Moe, Institutt for helse- og omsorgsfag, UiT Norges Arktiske Universitet, på telefon 77645265, eller e-post: siri.moe@uit.no.

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Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Under arbeidet med studien, vil videomateriale oppbevares innelåst. Ingen andre enn doktorgradsstudenten og veiledere vil ha tilgang til dette. Videofilmen vil bli slettet når prosjektet avsluttes, etter plan ved utgangen av 2019. Videomaterialet vil kun bli brukt som hjelp til å beskrive hva som skjer i veiledningen og treningssituasjonen. Det vil ikke bli brukt bilder eller video hvor du kan gjenkjennes i oppgaven eller andre publikasjoner. Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

FORESPØRSEL TIL BRUKER

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

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Du forespørres om å delta i denne studien fordi du har fått innvilget hverdagsrehabiliering av en av åtte norske kommuner som er inkludert i denne studien. Fysioterapeut og hjemmetrener fra ditt hverdagsrehabiliteringsteam har sagt ja til å delta.

På bakgrunn av helsepolitiske endringer i Norge de senere årene, har fysioterapeuter fått tildelt ekstra ansvarsområder, som blant annet dreier seg om veiledning av annet personell. Studien har som mål å fremskaffe kunnskap om fysioterapeuters veiledende i funksjon denne type oppgaver. Det er ønskelig å se på hvordan veiledningen foregår, samt hvordan fysioterapeut overfører sin kunnskap til hjemmetrener som fungerer som den «utøvende part» i rehabiliteringen.

HVA INNEBÆRER PROSJEKTET?

For å få kunnskap om dette temaet, vil det være ønskelig å observere og filme en treningsøkt, først sammen med deg, fysioterapeut og hjemmetener i hverdagsrehabiliteringsteamet. En til to uker senere, vil det være ønskelig å observere og filme en ny treningsøkt med deg og hjemmetreneren. Treningen skal foregå som normalt, og vil i liten grad forstyrres av doktorgradsstudenten, som kun vil fungere som en observatør.

Alle personopplysninger vil anonymiseres under bearbeidelse av materialet. Prosjektet er godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

MULIGE FORDELER OG ULEMPER

Behandlingen vil foregå som normalt, og det vil ikke gjennomføres noen ekstra undersøkelser eller trening i denne sammenheng. Doktorgraden kommer til å være tilstede på to treningsøkter sammen med deg og personale fra hverdagsrehabiliteringsteamet. Foruten dette forventes det ikke at denne studien vil medføre noen ekstra belastning for deg.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

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Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Under arbeidet med studien, vil videomateriale oppbevares innelåst. Ingen andre enn doktorgradsstudenten og veiledere vil ha tilgang til dette. Videofilmen vil bli slettet når prosjektet avsluttes, etter plan ved utgangen av 2019. Videomaterialet vil kun bli brukt som hjelp til å beskrive hva som skjer i veiledningen og treningssituasjonen. Det vil ikke bli brukt bilder eller video hvor du kan gjenkjennes i oppgaven eller andre publikasjoner.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

FORESPØRSEL TIL ØVRIGE ANSATTE I HVERDAGSREHABILITERING

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

«HVERDAGSREHABILITERING – FYSIOTERAPIVEILEDNING VED OPPGAVEDELING»

BAKGRUNN OG HENSIKT

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor fysioterapeuters veiledende funksjon i hverdagsrehabilitering undersøkes. Studien er en del av et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved Det Helsevitenskapelige fakultet ved UiT Norges Arktiske Universitet. Universitetet er ansvarlig for denne studien.

Du forespørres siden du er tilknyttet hverdagssrehabiliteringsteamet hvor fysioterapeut og hjemmetrener i hverdagsrehabiliteringsteamet du er en del av har sagt seg villig til å delta. Det er først og fremst fysioterapeut og hjemmetrener som vil være hovedfokus i studien, men det er også ønskelig å få et innblikk i hvordan hele teamet arbeider og arbeidsoppgavene er fordelt.

Fysioterapeuter delegerer arbeidsoppgaver som tradisjonelt har vært fysioterapifaglige til andre og veileder andre i å utføre disse oppgavene. Studien har som mål å fremskaffe kunnskap om fysioterapeuters veiledende funksjon i hverdagsrehabiliteringsarbeid. Det er ønskelig å se på hvordan overføringen av kunnskaper foregår, samt hvordan den som utfører hjemmetreningen gjennomfører oppgavene.

HVA INNEBÆRER PROSJEKTET?

For å få kunnskap om disse forhold skal det gjennomføres observasjoner av fysioterapeut og hjemmetrener i utførelsen av oppgavene, med påfølgende intervju med dem. I tillegg er det ønskelig å være tilstede som observatør i miljøet evt. tverrfaglige møter i teamet som du er en del av. Målet er at arbeidet i minst mulig grad skal forstyrres av at doktorgradstudenten er tilstede. Alle personopplysninger vil anonymiseres under bearbeidelse av materialet. Prosjektet er godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

MULIGE FORDELER OG ULEMPER

Arbeidet vil foregå som normalt. Deltakelse vil derfor ikke medføre ekstra ressursbruk i form av tid og det forventes ikke at denne studien vil medføre noen ekstra belastning for deg ut over at doktorgradstudenten er tilstede i miljøet.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på neste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlet datamateriale. Materiale som allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner kan ikke slettes i ettertid. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte doktorgradsstudent Marianne Eliassen på telefon 99709940, eller e-post: marianne.eliassen@uit.no eller prosjektleder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag, UiT Norges Arktiske Universitet, på telefon 776 45265, eller e-post: siri.moe@uit.no.

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Under arbeidet med studien vil datamateriale oppbevares innelåst. Ingen andre enn doktorgradsstudenten og veiledere vil ha tilgang til dette.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

Jeg har mottatt og forstått skriftlig informasjon og er villig til å delta i studien.

Sted og dato	Deltakers signatur
	Deltakers navn med trykte bokstaver

Appendix 4: Cataloging matrix for transcripts of video observations

Date/ File	Team no:	First visit					
	What	How	Explanation or reasoning	Instruction to the user	Supervision of the HT	Communication	
Date		Second visit					
	What	How	Explanation or reasoning	Instruction to the user	communication		

Appendix 5: Approval from the Norwegian Centre for Research Data (NSD)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD
Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr: 985 321 884

Marianne Eliassen
Institutt for helse- og omsorgsfag UiT Norges arktiske universitet

9037 TROMSØ

Vår dato: 03.11.2015 Vår ref: 44747 / 3 / AMS Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 18.09.2015. All nødvendig informasjon om prosjektet forelå i sin helhet 02.11.2015. Meldingen gjelder prosjektet:

44747	*Hverdagsrehabilitering - fysioterapiveiledning ved oppgaveglidning*
Behandlingsansvarlig	*UiT Norges arktiske universitet, ved institusjonens øverste leder*
Daglig ansvarlig	*Marianne Eliassen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.12.2019, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Anne-Mette Somby

Kontaktperson: Anne-Mette Somby tlf: 55 58 24 10
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 44747

FORMÅL
Studien har som mål å fremskaffe kunnskap om fysioterapeuters veiledende funksjon i hverdagsrehabilitering.

INFORMASJON OG SAMTYKKE
Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Det er utarbeidet informasjonsskriv til alle deltakergrupper, fysioterapeuter, hjemmetrenere og pasienter. Informasjonsskrivene mottatt 02.11.15 er godt utformet.

DATAMATERIALETS INNHOLD
Det innhentes opplysninger om veiledningen gjennom intervjuer med fysioterapeut og hjemmetrener, samt gjennom videoopptak av veiledningsøkt med pasient.

Det kan behandles sensitive personopplysninger om helseforhold.

INFORMASJONSSIKKERHET
Personvernombudet legger til grunn at forsker etterfølger UiT Norges arktiske universitet sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på mobile enheter, bør opplysningene krypteres tilstrekkelig.

PROSJEKTSLUTT OG ANONYMISERING
Forventet prosjektslutt er 31.12.2019. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lyd-/bilde- og videoopptak

Appendix 6: Change form to NSD

Endringsskjema

for endringer i forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt
(jf. personopplysningsloven og helseregisterloven med forskrifter)

Endringsskjema sendes per e-post til: personvernombudet@nsd.uib.no

1. PROSJEKT	
Navn på daglig ansvarlig: Marianne Eliassen	Prosjektnummer: 44747
Evt. navn på student:	

2. BESKRIV ENDRING(ENE)	
Endring av daglig ansvarlig/veileder:	*Ved bytte av daglig ansvarlig må bekreftelse fra tidligere og ny daglig ansvarlig vedlegges. Dersom vedkommende har sluttet ved institusjonen, må bekreftelse fra representant på minimum instituttnivå vedlegges.*
Endring av dato for anonymisering av datamaterialet:	*Ved forlengelse på mer enn ett år utover det deltakerne er informert om, skal det fortrinnsvis gis ny informasjon til deltakerne.*
Gis det ny informasjon til utvalget? Ja: __x__ Nei: ____ Hvis nei, begrunn:	
Endring av metode(r): Observasjon utvides til også å omfatte arbeidsoppgaver og samhandling i arbeidsmiljøet, evt. tverrfaglige møter ved arbeidsplassen. Denne utvidede observasjonen vil ikke innbefatte bruk av video (som den tidligere beskrevne observasjonen).	*Angi hvilke nye metoder som skal benyttes, f.eks. intervju, spørreskjema, observasjon, registerdata, osv.*
Endring av utvalg: Kollegaer av de allerede oppnevnte i utvalget vil kunne bli inkludert for å få innsikt i tverrfaglig samhandling Disse vil innbefatte sykepleier(e), ergoterapeut(er), andre fysioterapeuter og hjemmetrenere/hjelpepleiere utover de som allerede er beskrevet som del av utvalget fra tidligere prosjektbeskrivelse.	*Dersom det er snakk om små endringer i antall deltakere er endringsmelding som regel ikke nødvendig. Ta kontakt på telefon før du sender inn skjema dersom du er i tvil.*
Annet:	

3. TILLEGGSOPPLYSNINGER

4. ANTALL VEDLEGG	
Vedlegg 1: Oppdatert informasjonsskriv til fysioterapeut, hjemmetrener og bruker Vedlegg 2: Informasjonsskriv til øvrige ansatte i hverdagsrehabilitering	*Legg ved eventuelle nye vedlegg (informasjonsskriv, intervjuguide, spørreskjema, tillatelser, og liknende.)*

Har du spørsmål i forbindelse med utfylling av skjemaet, ta gjerne kontakt med Personvernombudet hos NSD, telefon 55 58 81 80

tir. 26.01.2016 12:07

Anne-Mette Somby <anne-mette.somby@nsd.no>

Prosjektnr: 44747. Hverdagsrehabilitering - fysioterapiveiledning ved oppgaveglidning

To Eliassen Marianne

We removed extra line breaks from this message.

Viser til endringsmelding mottatt 18.1.16.

Vi har registrert at du også skal observere tverrfaglig samhandling som omfatter sykepleiere, ergoterapeuter, fysioterapeuter og hjemmetrenere/hjelpepleiere. Disse skal ikke videofilmes.

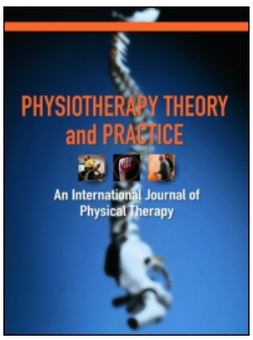
Vi bekrefter å ha fått oppdaterte informasjonsskriv.

Ta kontakt om det er andre endringer enn de som er beskrevet her.

--
Vennlig hilsen

Anne-Mette Somby
Seniorrådgiver
NSD Personvern

Tlf. direkte: (+47) 55 58 24 10
Tlf. sentral: (+47) 55 58 81 80
Email: Anne-Mette.Somby@nsd.no
www.nsd.no/personvern



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Variations in physiotherapy practices across reablement settings

Marianne Eliassen MSc, PT, Nils O. Henriksen PhD, MSc & Siri Moe PhD, PT

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Variations in physiotherapy practices across reablement settings

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Department of Health and Care Sciences, UiT The Arctic University of Norway, Tromsø, Norway

ABSTRACT

Background: Reablement aims to improve the self-dependence of people with or at risk of functional decline. Physiotherapists (PTs) are responsible for assessments, developing interventions and supervising home trainers (HTs), who mostly conduct the reablement training. The content of reablement practice is not clearly described. This study explores how physiotherapy practice is performed in reablement settings and the content of the service provided to reablement users. **Methods**: Fieldwork was performed in seven Norwegian reablement teams. We conducted observations of seven triads, including PTs, HTs, and reablement users, followed by interviews with the PTs and HTs. We then conducted a systematic content analysis. **Results**: Three themes emerged from the analysis: 1) division of labor; 2) assessment; and 3) intervention. Different practices within these three characteristics of practice revealed two typologies of reablement teams. Teams with a fixed division of labor provided limited assessments and a nonspecific approach. Teams with a flexible division of labor were characterized by interdisciplinary collaboration, thorough assessments, and user-tailored interventions. **Discussion**: Values emphasizing responsivity enable a flexible and individually tailored reablement approach, in contrast to values emphasizing efficiency, which facilitate a nonspecific approach.

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KEYWORDS
Division of labor; home-based rehabilitation; interprofessional; multi-professional; cooperation

Introduction

Reablement is an intensive, time-limited, person-centered, goal-oriented intervention for people with or at risk of functional decline (Aspinal et al, 2016; Tessier, Beaulieu, Mcginn, and Latulippe, 2016). An interdisciplinary team conducts the approach in the users´ home environment, aiming to encourage them to live independent lives (Cochrane et al., 2016). Internationally, various terms for reablement have been used including: restorative home care in Australia and US (Ryburn, Wells, and Foreman, 2009; Tinetti et al., 2002); reablement in the UK (Rabiee and Glendinning, 2011); and everyday rehabilitation in Scandinavia (Moe and Brataas, 2016). The terms appear to be inconsistent. Furthermore, the lack of agreed specified set of clinical and demographic characteristics makes the target population highly heterogenous and difficult to define (Legg, Gladman, Drummond, and Davidson, 2016). Scholars have even merged different terms and developed the concept '4R' to over-define health care services for people who need support to live at home (Sims-Gould, Tong, Wallis-Mayer, and Ashe, 2017). Systematic reviews have concluded that there is neither established solid evidence of an effect regarding health benefits and governmental cost efficiency (Cochrane et al., 2016; Legg, Gladman, Drummond, and Davidson, 2016) nor a clear description of a conceptual or theoretical framework to define the content of the service (Legg, Gladman, Drummond, and Davidson, 2016). More high-quality research is required to determine the concept of and effect of reablement (Cochrane et al., 2016; Legg, Gladman, Drummond, and Davidson, 2016; Pettersson and Iwarsson, 2017).

Norwegian health and social care services are publicly funded and should be offered to all citizens regardless of their financial situation, social status, gender or age. An increasing number of older adults and a growing demand for complex services have placed pressure on local governments to offer proactive interventions to strengthen citizens' ability to remain independent in their home environment. The goal is to delay and reduce demands for long-term support from health care services (Norwegian Ministry of Health and Care Services, 2015). The Norwegian government has suggested reablement as an approach for people with or at risk of functional decline. Although reablement shares features with other rehabilitation services, Norwegian authorities emphasize that reablement should be provided to a large extent by home care workers, in contrast to traditional rehabilitation services, which are provided by health professionals (Norwegian Ministry of Health and Care Services, 2015). This solution aims to meet the challenges in Norwegian health care

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services. Despite the lack of evidence of effect, the Norwegian government allocated 63.4 million NOK (8.4 million US dollars) in the period from 2013–2015 to implement reablement services within 47 Norwegian municipalities (Langeland et al., 2016).

To improve the knowledge base for reablement in Norway, the Norwegian Association of Local and Regional Authorities initiated a report on reablement practices in Norwegian municipalities (Fürst and Høverstad, 2014). Two main models were described in the Norwegian context: 1) a specialist model; and 2) an integrated model. The first model consisted of multidisciplinary teams including physiotherapists (PTs), occupational therapists (OTs), nurses and home trainers (HTs). These teams were organized independent of the traditional home care services and were working exclusively with reablement users. The second model was incorporated into the traditional home care service. Personnel from the home care service were supposed to conduct the reablement training initiatives under supervision by the therapists but were still expected to fulfill their regular home care services (Fürst and Høverstad, 2014). A Norwegian study aimed to investigate the efficiency of different models of reablement. Based on a multilevel analysis of 36 reablement teams in 33 Norwegian municipalities, the study concluded that the choice of model did not have any significant effect on user performance and user satisfaction with performance in daily activities (Langeland et al., 2016). However, the study had weaknesses regarding sample size and a lack of description of content of practice, while classification of the models was limited to involving administrative organization.

The Norwegian Association of Local and Regional Authorities' report identified some common assessment tools; the Canadian Occupational Performance Measure (COPM) and the Short Physical Performance Battery (SPPB) have frequently been used in reablement (Fürst and Høverstad, 2014; Tuntland et al., 2016). The use of these tests was mandatory for the reablement teams in the aforementioned 47 municipalities (Langeland et al., 2016), and they have also been widely suggested as assessment tools for other reablement teams (Førland and Skumsnes, 2016; Fürst and Høverstad, 2014; Ness et al., 2012). The COPM was designed to identify, prioritize, and evaluate performance and satisfaction with the performance of activities self-identified as important to users' lives (Carswell et al., 2004). The SPPB is a screening test that identifies risk of functional decline (Gomez et al., 2013).

Reablement intervention is described as involving both physical exercises and guidance in everyday activities (Hjelle, Tuntland, Forland, and Alvsvag, 2017; Langeland et al., 2016). Beyond this, we found no descriptions that could provide insight into the actual events and interactions in practical interventions; thus, we gained little specific knowledge about the service offered to reablement users. The lack of description of content of reablement may give rise to a varied practice with varying quality. The Norwegian Association of Local and Regional Authorities (Fürst and Høverstad, 2014) states that reablement is an appealing solution to ensure quality in health and care services in an efficient manner and that quality and efficiency should be emphasized as equally important. Studies of practice may reveal how these potentially conflicting values (Hood, 1991) are played out in reablement service.

In Norway, PTs play a core role in reablement by contributing to assessments and guiding HTs regarding exercises tailored to the user's individual function (Ness et al., 2012). Basic to physiotherapy practice is the use of specific knowledge and skills to identify potential for movement and to maximize quality of life (World Confederation for Physical Therapy, 2016). Individual examinations and clinical reasoning are fundamental to tailored and individualized interventions and treatment (Johnson and Thompson, 1996).

We wanted to investigate how physiotherapy was integrated into clinical interventions in reablement, including the clinical reasoning and rationales that the intervention was based on. The extended use of care workers, without training or education in essential skills and knowledge, to perform home training may be a barrier to optimal and well-tailored interventions. Therefore, we also wanted to explore the service provided to users by HTs. This study targeted reablement practice in both specialist teams and integrated teams. The aim of this study was to explore how physiotherapy practice is performed in reablement settings and the content of the service provided to reablement users.

Methods

In this exploratory study, we used qualitative methods. Our interpretation is that people within a social world both construct and perceive the meaning of the world and thereby create a taken-for-granted reality that forms their practices (Andrews, 2012). Aiming to explore the content of interactions in practice, the results were generated in a social constructionist perspective. We collected data by observing PTs and HTs in their work environment and observing reablement sessions with users. Based on these observations, we conducted interviews with both PTs and HTs after the sessions.

Study setting

This study was conducted in seven reablement teams within seven different Norwegian municipalities. The municipalities were strategically chosen to obtain a varied population size. The observations of practice in the work environment were conducted at the participants' workplace, which entailed open landscape offices and meeting rooms. The observations of reablement interventions occurred in the users' homes. We conducted all the interviews immediately after the observations in meeting rooms at the PTs' and HTs' work place.

Participants and recruitment

A triad from each team, seven triads in total containing one PT, one HT and one user was included. The inclusion criterion for the PTs and HTs was at least 6 months of experience with reablement. The inclusion criterion for the users was that they were about to begin or were in the first week of reablement. All users had to be able to consent to participate; those with cognitive impairment were therefore excluded. Except for being offered reablement service, we had no inclusion criterion for the users regarding age, gender or diagnosis. This study was approved by the Norwegian Centre for Research Data (Ref number 44747) and was conducted according to the Helsinki Declaration (World Medical Association, 2017). All participants received written information about the study and provided written consent before the data were collected. Data were managed confidentially and with respect.

General managers of the teams were contacted and informed about the study. After agreeing to participate, the managers distributed information about the study to PTs and HTs. The PTs then recruited users who were about to receive reablement. Written information was distributed, and when a user agreed to participate in the study, the PT contacted the first author (ME) to arrange data collection. Coworkers of the included PTs and HTs were also treated as participants, as they were subject to observations in the work environment. Table 1 provides further information about the PTs, HTs, and users.

Data collection

The first author (ME), who is a researcher and a PT, collected data from January to June 2016. To ensure that we captured the practice of physiotherapy assessment, the reasoning that is the foundation of therapeutic plans, and the service provided to the users by HTs, we visited the triad twice. The first visit was conducted during the user's first week of reablement, followed by a second visit two to 3 weeks later. The key points of the observation guide were: 1) treatment setting; 2) content of actions regarding assessments or training; 3) instructions; 4) verbal and nonverbal communication; and 5) changes in the user's function or movement. The intervention was video-recorded to ensure that the situated and interactional accomplishments of practical action were captured (Heath, Hindmarsh, and Luff, 2011). It was essential for the aim of this study to analyze the fine details of how both the PTs and the HTs interacted with each other and the users. In a clinical setting, multiple components of interactions and bodily movements occur simultaneously. Video use is recommended as a tool to grapple with the complex character of practice and to capture the small details that are inextricably embedded within interactions but are barely conscious to the participants (Heath, Luff, and Svensson, 2007).

The researcher (ME) used a discreet, handheld camera and primarily remained in the background to avoid disturbing the interactions of the participants. A wide video angle was used to capture all three participants, although when it was found essential, she discreetly moved closer or zoomed in through the camera to obtain a closer observation of the users' smaller movements.

During the first visit, the researcher observed the user interventions when both the PT and the HT were present with the user. Immediately after the first observation, the researcher conducted an interview with the PT. The previously observed user intervention was the main topic for the interviews, and clinical reasoning was discussed.

At the second visit, video-recorded observation of the interactions between the HT and the user was conducted, followed by an interview with the HT that reflected on the preceding observation. Interviews with both the PTs and HTs were semi-structured, with

Table 1. Information about the PTs, HTs, and users.

Participants	Gender	Age	Experience	User goals
PTs	Female: $n = 6$ Male: $n = 1$	>25	Novice (<5 years as a PT): $n = 2$ Experienced (>5 years as a PT): $n = 5$	
HTs	Female: $n = 7$ Male: $n = 0$	>40	Experience from home care. practice: $n = 3$ Experience from institutional care practice: $n = 3$ Experience from both: $n = 1$	
Users	Female: $n = 7$ Male: $n = 0$	>70		Showering, cooking, going to the mall, attending the day care center, walking outside, household chores, walking up/down stairs, walking independent of human assistance, walking inside with a walking stick, feeling safe at home, traveling alone by public transport.

open-ended questions and relevant follow-up questions (Appendix). The interviewees were encouraged to speak freely about their experiences and clinical reasoning. All the interviews were audio-recorded.

In addition to the observations and interviews, field observations of the reablement team's work environment were conducted to examine the context that serves as a framework for the practice. The researcher (ME) followed the PTs and the HTs from six of the triads at their work place (one team was excluded from the observations in their office due to disapproval of coworkers). Two days of observations of both formal meetings and informal meetings were conducted. The current appearance of the work environment, internal communication within the teams regarding professional discussions, exchanges of clinical knowledge, and instructions and guidance were noted.

The combination of observations and interviews provided us with the following complementary information approximately: 1) the interaction in its original context; 2) the organizational structure of the interaction; and 3) the clinical reasoning and reflections, which are essential for how the practice is performed. These data gave us rich and detailed material.

Data analysis

We conducted a four-step systematic content analysis inspired by Malterud (2012). We considered this approach appropriate for analyzing data from both interviews and observations, which enabled us to merge the data. ME had the primary responsibility for transcribing, coding and the initial sorting of the data. Further, NH and SM (a sociologist and a PT, both experienced researchers) contributed to the analysis through discussions in regular collaborative meetings.

During the first step, the ME developed a summary text after all the research interventions, where overall impressions were noted. Further, all raw material was transformed into text material. The interviews were transcribed verbatim, while the video observations were transcribed and described in a scheme in which six aspects of interactions were categorized: 1) what was done; 2) how it was done; 3) explanation or reasoning; 4) instructions provided; 5) guidance provided; and 6) communication. These categories were predetermined based on the key point in the observation guide and included both verbal and bodily interactions. This way of cataloguing video-recorded data was inspired by Heath, Luff, and Svensson (2007) to capture the multiple aspects of interactions in video observations. At first, the basic aspects of the activities and events were written down. Transcriptions of conversation were not rigidly verbatim, although the essence of meaning of conversation was incorporated with the actions described in the different categories in the scheme. Throughout the analysis, descriptions were made more detailed. During several substantial views of the videos, some fragments appeared as especially essential for the aim of the article. These fragments were further described in even more detail. In this way, the scheme was continuously elaborated regarding the visible and verbal content throughout the process (Heath, Luff, and Svensson, 2007).

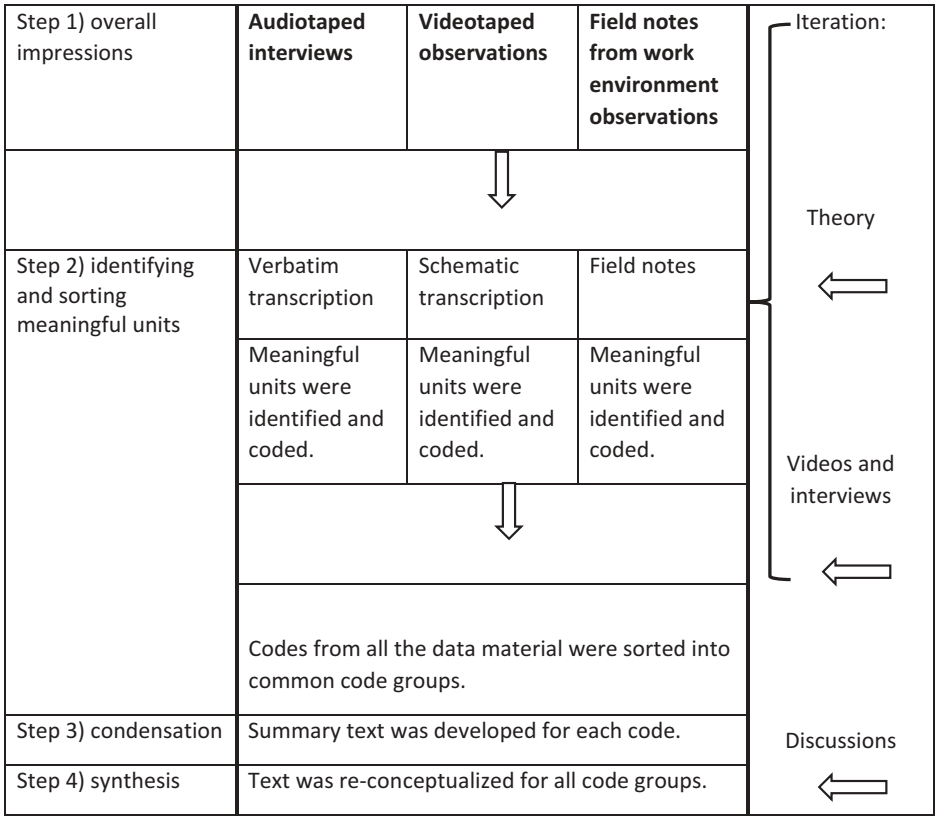
During the second step, we identified and coded meaningful units in all text material from all data sources, which were further linked together, supplementing each other. The observation material provided a third-person perspective on the actions and interactions that occurred in the practical setting where it was provided. The interviews elaborated this through insights into the rationales and reasoning that the practice was based on. Initially, 16 codes were identified and sorted through an iterative process. Searching for correspondence and deviations, we found considerable variations within the three themes, and two typologies of working methods evolved. We refer to these typologies as fixed reablement teams and flexible reablement teams in the remainder of this article. This clear distinction of structural frames in reablement settings caught our interest and contributed to further structuring of the data material.

During the third step, we developed a summary text for each subgroup based on central quotes. The fragmented observations were summarized in a text that provides examples of actions essential for the aim of this article.

During the fourth step, we reconceptualized the subgroups by developing an analytical text based on the most salient content of the data, thorough deliberations of the initial text material and preliminary topics. The final texts are presented in the results section. Central quotes from the interviews are presented in the text and summarizing extracts of the observations are provided in figures and outline the essence of the practice. The analysis was supported by the use of QSR NVivo 11 (QSR International) qualitative data analysis software.

Table 2 presents the analysis process in a schematic way. Although the process may seem linear and rigorous, following predetermined steps, this was not the case. The analyses were performed as an iterative process, continuously moving between interpretations, relevant theory and the data material (i.e., the video material was watched several times). Discussions occurred in regular meetings with all three authors. Theoretical interpretation (Malterud, 2016) contributed to develop and validate the

Table 2. Analysis process inspired by Malterud (2012).



findings. Triangulation of multiple data sources was achieved by linking the data through common code groups. Congruent data from all three methods supported and validated each other, while discrepancies were further analyzed to achieve an understanding of the inconsistency. This iterative process contributed to the validation of our findings.

Results

In total, the data included 14 interviews approximately 45–90 minutes in length and 14 observations of user sessions lasting from 20–90 minutes (12 of them were videotaped, and 2 were audiotaped due to the user's request). Through the analysis of video observations, interviews, and field notes, three themes representing three features of practice in reablement emerged: 1) division of labor; 2) assessment; and 3) intervention. Based on variations in the data regarding these themes, two typologies of reablement teams were established: fixed structured and flexibly structured teams (Table 3). Characteristics of the respective typologies are presented in all three themes. Important quotations from the interviews are presented in italics, while illustrative excerpts from the observations are presented in figures.

Division of labor

Field observations, elaborated with the participants' reflections from the interviews, highlighted some

Table 3. Characteristics of reablement teams.

		Division of labor	
		Fixed structure (1 team with integrated model, 3 teams with specialist model)	Flexible structure (3 teams with specialist model)
Organization	Team leader	Yes	No
	Schematic distribution of tasks	Yes	No
Assessment	Use of COPM and SPPB	Yes	Yes
	Complementary assessments	No	Yes
Intervention	General approach based on standardized programs	Yes	Some
	Individually tailored training	No	Yes
	Training on daily activities	Some	Yes

feature characteristics of roles and interactions, which influenced the division of labor in the teams. There was a clear difference between the two typologies of reablement teams.

One characteristic of the fixed structured teams was that the PTs and the HTs played different roles. PTs, in addition to the OTs and nurses, were designated "catalysts" of the teams who performed assessments and created reablement plans. In contrast, the HTs appeared as assistants who followed instructions from the "catalysts". The reablement process was scheduled with certain fixed meeting points for the "catalysts" to visit the users: during the implementation, halfway through rehabilitation and at the end of the rehabilitation process. These meetings included informational sessions, baseline assessments, implementation of exercises, and retesting at the end of treatment.

Field observations revealed that in a typical team meeting, the "catalysts" led the discussions, while the HTs largely remained silent. Primarily, the "catalysts" discussed logistical issues, such as capacity for new users and coordinating transportation to users. In one of the fixed teams, the "catalysts" and HTs were not located at the same workplace (an integrated team model), and communication rarely occurred outside of the meetings, which were held every second week. Through observations of the work environment in the fixed structured teams, it appeared that the HTs were barely present at the office.

Typical features of the user interventions, in which both a PT and an HT were present, were that the PT was in charge of the information provided, the assessments conducted and the instructions regarding training exercises, while the HT stayed in the background.

The field observations indicated a clear division of labor, where the "catalysts" had the responsibility for conducting assessments and developing a reablement plan, while the HTs conducted interventions based on the predefined plans. This observation was in accordance with data from the interviews. One HT in a fixed reablement team described the division of labor as follows:

> *"My task is to carry out the exercises together with the user. First, the catalysts [PT, OT or nurse] pay them a visit. They, I guess, provide a plan together with the user. At that first visit, they talk about reablement and evaluate whether the user is a suitable candidate. [. . .]They do the SPPB and COPM, those tests you know, and normally they bring us [HTs] along on the second visit. Then, we review the plan and the PT supervises me in conducting some exercises, perhaps. [. . .] And then, after about two weeks, they join us again."* (HT)

A PT claimed that the clear distinction of division of labor was intended to utilize the different professions' expertise and knowledge and avoid chaos. She said the following:

> *"Our work is complementary because we have different tasks. We have different qualifications, so it would be unnatural that we all should do everything. I believe that we should do what we do best. I think that would have been. . . In such a large team as ours, that would simply have led to chaos. So, I believe that a firm structure on things is essential."* (PT)

One PT also argued that by entrusting the HT with the responsibility for executing the training sessions, they could serve a larger population compared with a traditional rehabilitation approach. Another PT justified the practice in which the HTs mainly executed the interventions, as follows:

> *"We do not want to interfere much during the reablement period, since it should be a learning setting for the HTs. So, if we were to pursue and control them all the time, we could rather have done the work ourselves. It's the empowering mindset that strikes in, you know. That they get the responsibility for this. . ."* (PT)

The characteristics of a flexible team were a flat structure in which all the team members, including the HTs, had equal responsibility for tasks. Both therapists and HTs conducted assessments and performed training interventions. Observations of meetings in these teams revealed that the HTs engaged in discussions on the same level as the therapists and nurses. Both formal and informal meetings contained professional discussions and knowledge exchanges. Since all the team members had visited most of the users, they all contributed to the discussions based on their specific expertise and experiences.

Observations of user sessions in which both the PT and the HT were present showed that, similar to the fixed structured teams, the PTs were leading the interventions. However, during the sessions, the HTs in the flexibly structured teams were more involved than those in the fixed teams. They frequently commented on the quality of the user's movement during exercises and made suggestions about changes to the technique. Typically, the PTs visited the users on a regular basis, which provided insights into the users' home situation and everyday function. A PT said the following:

> *"I find it interesting to observe situations like morning care, for example. It provides me with lots of information. I evaluate how the user get out of bed, how they achieve a stance position, how they manage to take a shower. The whole "package" is extremely valuable for me as a PT. [. . .] I get a holistic impression of the user and the whole situation. I mean. . . I don't only see the small things, I see the whole setting, and that's inspiring. It's motivating."* (PT)

One PT used the metaphor "Jack-of-all-trades" to describe how she had to adjust to different tasks and settings and how this contributed to interdisciplinary cooperation:

> *"You turn into a Jack-of-all-trades in a way because that's how it is. How we have to work. If I step my little toe into an ADL [activity of daily living] assessment, I don't pull it back up. Instead, I stay in it and discuss the situation with the occupational therapist later on or bring her with me to observe, maybe. I would think that she should evaluate the situation together with me, for example. But I bring along what I see and the assessments I do."* (PT)

Employees on these teams emphasized the importance of cooperation and preferred to work in pairs on several occasions. HTs also highlighted the importance of sufficient access to PT supervision. Our analysis revealed that the division of labor affected the assessments and training interventions as described in the following sections.

Assessment

One characteristic of the assessments in all the reablement teams explored in this study was that they used the COPM and SPPB assessment tools. Figure 1 presents an excerpt of the performance of the SPPB test from an observed baseline assessment. The characteristics of this observation were applicable to all the teams observed. The PT focused on the quantified results in terms of counting seconds and did not respond to the patient's complaints about functional restrictions. One PT claimed that this test always resulted in the same conclusion of impaired strength, balance or gait function.

Typically, in the reablement teams with a fixed structure, the PT rarely performed assessments or specific examinations other than the standardized tests mentioned earlier. A PT from a fixed reablement team expressed the following:

> *"I never do any specific tests, like muscle length or specific strength [...] I don't do that... I don't ask them to take off their pants or anything like that... or lay on a bench...[...] I mean... it's more like a conversation... I don't find it natural to assess any movements. Therefore, you know... the details... I don't describe them in the journal or talk to the HTs about it. "* (PT)

Since the PTs in the fixed structured teams seldom visited the users, they claimed that it was the responsibility of the HTs to make continuous observations during the training process and to report the essential conditions to the "catalysts". One PT stated that the "system" could not be dependent on the PTs conducting the visits.

In the flexibly structured teams, the PT characteristically performed extended examinations and assessments in addition to the standardized tests. The PTs reported that they conducted functional analyses regarding the movement and structure of muscles and joints. One PT in a flexible team described how she performed a specific functional analysis when she considered it necessary:

> *"It's really fun if ... well, it's not fun if there is something wrong with the user. Anyway, it's interesting if it suddenly turns out that there is a little "slack" due to the hip, which means that maybe I should do an examination on the couch. That is real fun. I may just check if anything has happened, because "Mrs. Hansen" has fallen, for example, during the weekend. If she complains about increasing pain due to the exercises we do... Check out if there is anything... Is there any pain caused by, for example, traction, retraction? Is the range of motion equal on both sides? Could it be hip osteoarthritis that is causing more pain?"* (PT)

The PTs in flexible teams visited the users on a regular basis, which enabled consecutive assessments throughout the rehabilitation process. The example in Figure 2 shows how the PTs obtained more information about users' functions by analyzing their movement during a training session. Regular PT involvement with users was perceived by the respondent to be a core component of the flexible reablement teams, as one HT stated:

1. The PT and HT mark a distance of 4 meters on the floor and tell the user to walk this distance. The PT keeps an eye on her stopwatch throughout the test. When the user crosses the 4-meter mark, the PT reports the time to the HT, who writes it down on a form. The user is instructed to perform the test once more, and the second time, the PT says: *"You are already faster"*. The user says that she feels disabled in standing straight up; *"it resists when I'm about to..."*, and she demonstrates by exaggerating a flexed posture. The PT answers that this feeling might be associated with her hip operation. *"Yes, this is where I feel restricted when extending"*, the user complains while pointing to her hip. The HT writes down the results from the stopwatch, and the PT moves on to the next exercise.

Figure 1. Observation of conduction of the 4-meter gait test, an element of the Short Physical Performance Battery (SPPB).

2. The user stands beside the kitchen worktop in a gait position and receives instructions to lift both her arms toward the ceiling. The PT observes that the user does not achieve the full range of extension in one hip. While standing close to the user, the PT lays her hand on the anterior part of the user's hip and the other hand behind the sacrum and says, "Eventually, you will get more straight up…" and gives a little push, facilitating hip extension. The user complains about a feeling of tightness in front of her hip. The PT moves her hand on the user's back higher up toward the thoracic region and facilitates extension of the column, asking"Can you feel the tightness even more now? You can feel that it pulls your posture down".

Figure 2. Observation of additional assessment.

> *"Yes, she [the PT] is very dutiful in regularly being among the users. Additionally, to see how it goes and stuff, she wants to be updated. She is there, somehow, all the way. I think it is very good, that she is regularly present to observe and maybe consider doing some other exercises or advancing them. She [the user] has this problem with her foot… Yeah, so that's what I think she [the PT] will check out when she comes tomorrow."* (HT)

The PTs also noted the importance of visiting the users together with the HT, as these joint meetings could result in useful discussions and exchange of knowledge.

The next section presents how different specifics of the assessments resulted in different intervention contents.

Intervention

Observations of the practice revealed that reablement plans contained elements of both exercise and daily activities. The exercises mainly targeted balance, leg strength, and gait endurance, whereas daily activities could involve getting dressed, showering, and walking to the grocery store.

For the teams with a fixed division of labor, PTs characteristically initiated interventions concerning exercise regimens, while the HTs generally initiated activity training, which tended to be considered less important. In the interviews, a PT in a fixed structured team stated the following about activity training:

> *"I'm kind of not involved in that […] It may happen that the HTs are like … more focused on the exercises - strength and balance and so on. They forget the user's goals. Preparing food is a particularly common goal, but it is rarely tried out. So now I try to be a bit like, "you have to do…", because it is no point to do the closing session if they say "I didn't try it" or "I don't know."* (PT)

During the observations of the fixed structured teams, standardized training programs written on a sheet, such as the "Helbostad exercises"[1] or the "Otago Exercise Program",[2] were applied. One PT confirmed that this was characteristic of a typical reablement approach in a fixed structured team:

> *"The training is seldom about technique, or whatever you call it. To get dressed, take a shower… That is stuff that the user has done all her life. So, in reablement it is like… we should train on preparing a meal, but it is actually nothing to really train on. She has prepared meals for years. She knows how to do it. She just needs … I mean… we always fall back on the physical functions, really. Balance training and strength training. That is the core of everything."* (PT)

Figure 3 demonstrates how a user appears to question the relevance of the exercise she has been given. The HT cannot provide a clear answer to her concern, but

3. The HT instructs the user to walk sideways while supporting her hands on the kitchen counter. The user asks why she has to walk sideways, to which the HT answers, *"Because you are supposed to work on your walking "*.User: *"But I walk so much otherwise"*. The HT assures the user that this exercise is familiar to her and says, *"Soon we will walk outside* (which is the user's main goal), *so you will need some strength in your legs, right? We are going out for a walk soon"*. The user asks when they will be going out. HT: *"One day. When the weather gets better"*. User: *"One day, yes… What day?"* HT: *"We'll think about that"*. Then, she shifts the topic of conversation.

Figure 3. Observation of instructions of a nonspecific exercise.

[1]An exercise program consisting of four exercises for leg strength and balance: sit-to-stand, knee lift, toe stand, and knee bend in a weight-bearing position (Helbostad, Sletvold, and Moe-Nilsen, 2004).

[2]A home-based balance and strength program documented to prevent falls (Kyrdalen, Moen, Røysland, and Helbostad, 2014).

tries to motivate her to complete her exercise program. Another reason for using the general exercise programs was that they did not require much instruction or supervision, which simplified the transfer of exercises from the PT to both the HT and the user.

On the flexible teams, training for daily activities in addition to exercises was an important component of interventions. Video observations revealed details of clinical adjustments in the training sessions due to the user's individual physical ability, decline and experience of movement. Both PTs and HTs continuously corrected the execution of exercises in terms of quality and technique and were sensitive to changes in the user's functional level. Figure 4 presents an excerpt of an Intervention in which the PT and HT conducted a training session with the user. The PT analyzed the movement in detail and adjusted the exercises accordingly to target the problem, in this case motor ability. In doing so, the PT intervention addressed the user's goals and the functional limitations. During the observations, the PTs explained the purpose of an exercise and promoted bodily awareness of the user.

In flexibly structured teams that reported sufficient PT resources, HTs stated in the interview that this type of intervention was exciting and educational. In contrast, an HT from a team with poor PT resources found it challenging to implement complex training interventions. One HT stated a preference for standardized exercises in some cases:

> *"It's not my subject in a way. I just have to do my best and listen to what she [the PT] has to say [. . .] No, I don't find it very easy. To evaluate what is the right exercise, no, that's not my subject, really. That's my experience. At least if there are any limitations, pain for example, if they are in pain or they feel that it takes. . . that they are exhausted afterwards, or. . . No. No. In some cases, we have these typical 'Helbostad' exercises, where we do those four exercises. Thirty on each, you know. That is more tangible. But in the more diffuse cases, it is not that simple, I think."* (HT)

Both PTs and HTs in flexibly structured teams preferred to visit the user together as a pair as often as possible to optimize the professional supervision and exchange of knowledge.

Discussion

As described, two main typologies of reablement teams emerged, namely a fixed and a flexible structured team. This subdivision of reablement differs from the earlier described organizational models of "specialist teams" and "integrated teams", and it demonstrates that reablement practices vary considerably within the same organizational model. Models of reablement must not be perceived as homogenous practices. Physiotherapy assessments and interventions were found to differ according to division of labor. In teams with a fixed structure, the assessments were limited to standardized measurement tools, and the devised rehabilitation plans mainly involved general exercise programs. In teams with a flexible structure, assessments of physical function were conducted in addition to standardized measurements. PTs were more involved in the process and interventions appeared to be more individually tailored and adapted to the user's goals and functional decline. We have used Hood's (1991) concept of organizational values to discuss how conflicting values in health care services may provide a varied practice across different reablement teams.

Conflicting values in fixed structured reablement teams

The fixed structured teams emphasized reaching a large proportion of the population in a resource-efficient way. Defining clear distinctions between tasks counteracted an excessive use of resources. According to Hood (1991), this structure is an example of practice based on what he refers to as Sigma-type organizational values, which emphasize frugality and characterize output-oriented management with limited slack for using more resources than absolutely necessary.

The main practice of these fixed organized teams was a streamlined service based on standardized assessment tools and general exercise programs, and was hardly individually tailored. A qualitative interview study indicated that standardized training programs are insufficient in reablement (Hjelle, Tuntland, Forland, and Alvsvag, 2017) and several studies have suggested that reablement initiatives should be individually tailored

4. The PT instructs the user to climb the stairs. While watching the user from behind, the PT moves her eyes from the foot to the hip, then back to the foot again. Suddenly she turns her head slightly toward the HT and asks *"Do you see that?"* while she points toward the user's right foot, which constantly moves in a barely noticeable circular motion during the swing phase. This attention toward details of the user's movement makes the PT adjust the intervention program to involve exercises that specifically focus on the hip abductors and flexors.

Figure 4. Observation of the PTs' distinct attention to small details of movement.

(Cochrane et al., 2016; Legg, Gladman, Drummond, and Davidson, 2016; Lewin, Concanen, and Youens, 2016; Newton, 2012). A flexible intervention with opportunities for employees to be creative has been reported as a success factor of reablement (Rabiee and Glendinning, 2011; Tessier, Beaulieu, Mcginn, and Latulippe, 2016).

All users got similar initiatives, which is compatible with organizational values referred to as Theta-type values (Hood, 1991), which emphasize transparency and fairness of service. This seemed to compromise the quality of the physiotherapy assessments and initiatives and services offered to the users. This finding also corresponds with the results of a study where efforts to make home care organizations more transparent and well run made staff less sensitive to the specific contexts of individuals' lives (Vabø, 2012).

Health care services are unstable and unpredictable and require a high degree of discretion. A lack of discretion may result in a variety of therapeutic challenges (Schmid and Hasenfeld, 1993). These reflections support our conclusions about the constraints in flexibility and individuality of the fixed structured reablement teams.

Conflicting values in flexible structured reablement teams

The more thorough assessment and ongoing evaluation of practice in the reablement teams with a flexible structure enabled a user centered assessment and an intervention sensitive to users' abilities, restrictions, and goals. Several of the team members visited the user and influenced the reablement process with complementary knowledge. The involvement of different team members enabled interprofessional collaboration based on clinical discussions that combined and utilized the potential of professional diversity. Labor was broadly defined and shared problem solving was essential. This organizational structure is consistent with practices emphasizing Lambda-type values (Hood, 1991).

The Lambda-type values allow space for learning and adaptation and a high degree of slack and adaptivity regarding users' characteristics and unpredictable circumstances. However, flexible structured reablement teams require thorough supervision, frequent visits by the PT, and visits with both PTs and HTs present at the same time. This may conflict with the values of efficiency and frugality and the flexible practice may be a more resource-demanding way of organizing reablement. Cost effectiveness across different reablement practices should be further evaluated.

The results of this study revealed that, compared to fixed structured reablement teams, PTs and HTs in flexibly structured teams provided user centered interventions. Literature has argued that reablement approaches should target individual goals and focus on activities that people are themselves motivated to do to impact on the user's sense of autonomy in everyday life (Gregory, Mackintosh, Kumar, and Grech, 2017; Newton, 2012). Additionally, this article argues that it is likely that services should be individually tailored due to physical ability and constraints. Potentially, this practice may be preferable from a long-term perspective in terms of the reduced needs for home care services and hospitalization and enhanced user satisfaction. Larger studies are needed to investigate this assumption.

Cross-professional teamwork

In reablement teams with a fixed division of labor, the content of practice tended to be more standardized and formally described to ensure that almost anyone could perform the intervention. This form of labor leaned toward what Freidson (1999) refers to as mechanical specialization and cannot be categorized as professional work, which requires discretion based on theoretical knowledge and skills and tailoring to each situation. From this perspective, it seems reasonable to ask whether a professional, such as a PT, is necessary in reablement teams in which the tasks are simplified and standardized in such a manner that anyone can perform them.

However, in the flexibly structured teams, the tasks were more varied, and the interventions were based on physiotherapy knowledge, which would qualify as what Freidson (1999) denotes as theoretically based discretionary specialization. This practice requires a high level of both professional knowledge and skills to work successfully.

In addition to a more thorough professional approach, a deeper level of collaboration was observed in the flexibly structured teams in this study. This occurred through in-depth discussions, shared practices and multiple meeting points. Literature has suggested that traditional multi-professional work is not sufficient in home-based rehabilitation services. Cooperation should consist of an even closer interprofessional interaction and collaboration to provide integrated and complementary services (Mitchell, Parker, Giles, and White, 2010; Moran, Nancarrow, and Enderby, 2015; Ness et al., 2012; Thylefors, Persson, and Hellstrom, 2005).

A continuum based on collaborative intensity among the team members defines three different team structures of cross-professional teamwork: multi-professional; interprofessional; and trans-professional teams. Multi-professional teams consist of different disciplines working independently, but sharing information with each other.

Interprofessional teams imply a higher level of communication, shared planning, and mutual decision-making. Trans-professional teams are characterized by integrative work and partly dissolved boundaries between disciplines (Thylefors, Persson, and Hellstrom, 2005).

The structural factors characteristic of flexible teams, namely, collocation and a large number of informal meeting points, do not by themselves secure interprofessional cooperation. However, they enable social interaction among coworkers. The close collaboration, shared tasks and common goals generated by working together with the same user resulted in a perception of common responsibility for a task. The flat structure reduced the asymmetric relationship between coworkers, allowing for mutual participation in professional discussions, in accordance with trans-professional teamwork.

The same collaboration pattern did not appear in the fixed structured teams. In these teams, the employees assessed and treated users independently and then shared information later on, as is characteristic in multi-professional practice (Thylefors, Persson, and Hellstrom, 2005). Structural issues, such as different locations, rigidly defined divisions of labor and limited common insight inhibited the possibility of discretionary problem solving. Thylefors, Persson, and Hellstrom (2005) reported that the closer the collaboration, the higher the efficiency and the better the work climate. To a certain extent, the fixed practice may contribute to a disintegrated professional practice, which can cause a fragmented user care (Kodner, 2002).

Limitations

Our results stem from a limited number of participants and teams, and other ways of structuring physiotherapy practice in reablement may exist. However, the two typologies illustrated in this study are relevant to similar reablement teams with regard to analytic generalizations, in accordance with Malterud (2001). Only one of the teams in this study was organized as an "integrated model" of reablement, organized in home care services, while the six other teams were organized as "specialist teams" independent from home care services. The integrated team had a stereotypical fixed structure, as described in this article. However, we cannot draw conclusions from this single unit about definitive relationships between organizational models and content of practice and further research on organizational models is required. In this study, PTs and HTs were the main subjects, while other team members contributed through discussions and interactions in the work environment during field work. Nevertheless, collaboration between all team members should be further investigated. Reablement users were not interviewed, and their perspective of the service provided was not taken into account.

In this study, the included PTs recruited the users for participation. This design may have potentially caused bias. The important subjects of this study were the PT practice and the service provided to the users by the HTs. We considered the potential for bias to be of less importance concerning the aim of this exploratory study.

Implications for practice and further research

This study highlights how different structures of labor provide the opportunity for varied practices among PTs and for different contents of health care services. Both PTs and municipality management staff should be aware of how an imbalance in management values may result in unintended consequences for the implementation of physiotherapy practice in reablement. Previous effect studies have addressed reablement as a homogeneous service. However, this study reveals diverse reablement practices. Our findings call for attention to cooperation between team members, especially in PTs' supervision of HTs in the transfer of knowledge. Further studies on work practices in reablement are needed. It is important for both health care leaders and municipal administrators to be aware of how administrative values influence health care practices and the quality of services. In this sense, this study contributes to the ongoing international debate about human service organization and management.

Conclusion

We found that reablement involved a wide range of variation in the content of practice. How the teams distributed tasks internally influenced the intervention. Two typologies of reablement teams appeared: fixed structured teams and flexibly structured teams. This study showed that clinical reasoning and individualized approaches were limited when teams had a distinct and predefined division of labor. Furthermore, a flexibly structured team, with fewer formal distinctions between work tasks, promoted more thorough assessments and tailored interventions based on interprofessional discussions between team members. However, the flexible structure required sufficient physiotherapy resources and frequent supervision of HTs.

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Declaration of Interest

The authors declare no conflicts of interest.

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Appendix

Interview guide. The questions are only leading, and were not followed systematically. Relevant follow-up questions were asked, and the informants where encouraged to talk freely.

Theme	Questions to the PTs	Questions to the HTs
Context	Job description? Labor divided between team members? How does a characteristic work day look like? How do you perceive the different roles in the team?	
Education and competence	Demand for specific competence in the job? Your competence of reablement/rehabilitation? Education, course or other relevant training?	
Supervision and reasoning about the user	Priorities due to supervision. Situations that that went well/not went well. Cooperation PT and the HT. Leaving responsibility of the user to the HT. The PTs role in the team? Strategy for the supervision? Further plan for follow-up?	Reflections about the PTs supervision. Did you learn anything new? Did you perceive adequate support and training? How did the PTs supervision contribute to your performance?
Reablement requirement	Reflections about initiatives required to this user? (individual, environment, and task). Knowledge and competence required to carry out the interventions?	Reflections about -user's needs (goals and initiatives) -supervision session and training session. -reablement process (adjustments or needs for supervision). -requirements in the job. What do you perceive has been essential for the reablement in this case (motivation, cooping, and goals)? Relationship with the user.
Professional knowledge	How is your professional knowledge expressed in reablement labor? Expression of professional knowledge in the observed situation? Practice of professional updating.	
PT's and HT's communication and collaboration		Communication with the PT had following the initial supervision? The PT's participation in the process? Has there been done any evaluation, further assessments or decisions based on consultation with the PT (or others)? Do you perceive the supervision as sufficient? How can the PT contribute further in the process?

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ORIGINAL ARTICLE

Physiotherapy supervision of home trainers in interprofessional reablement teams

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ABSTRACT

Physiotherapists (PTs) in reablement are responsible for the supervision of support personnel, referred to as home trainers (HTs), who carry out training and initiatives. There is a lack of knowledge about the significance of physiotherapy supervision in reablement. The aim of this study was to explore the content of PTs' supervision of HTs in reablement teams. We conducted fieldwork in seven reablement teams in Norwegian municipalities. The methods included observations of practice and individual in-depth interviews with PTs and HTs. We analysed data thematically through an iterative inductive-deductive process. The results were generated in a social constructionist perspective and situated learning theory guided the analyses. Analyses revealed that supervision included elements of instruction, demonstration and reflection. However, practices varied widely across different teams, especially regarding the reflection aspect, which was highlighted as essential for learning. Frequent meetings, both formal and informal, were essential to enable learning through reflection. This paper identifies and discusses fundamental elements of PTs' supervision practice in reablement teams, which is also relevant for similar interprofessional settings. Managers of reablement programs should be aware of the powerful impact that organizational conditions have on the practice of supervision.

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Increasing costs of health care services and an aging population are leading to a shortage of health care personnel. As a result of these driving forces, authorities in countries worldwide are reorganizing and changing the priorities of health care services (World Health Organization, 2006). Task shifting (or task sharing) is described as the delegation of tasks to existing or new candidates with narrowly tailored training; it is a potential strategy with which to address challenges stemming from the shortage of human resources in health care services (Fulton et al., 2011; Kakuma et al., 2011). Authorities in several high-income countries have suggested reablement as a resource-utilizing approach to meeting current workforce challenges (Cochrane et al., 2016; Legg, Gladman, Drummond, & Davidson, 2016).

Reablement is a relatively new interprofessional, team-based approach to home-rehabilitation that aims to enable people with – or at risk of – functional decline to cope with everyday life. The service is intensive, time-limited and person-centred, as it is based on the user's goals (Cochrane et al., 2016). In contrast to traditional rehabilitation, interventions in reablement are, to a large extent, delivered by support personnel without a professional background, often referred to as home trainers (HTs).

The content and organization of reablement services vary across different countries (Legg et al., 2016; Pettersson & Iwarsson, 2017). However, literature often notes that health care professionals such as physiotherapists (PTs), occupational therapists (OTs) and nurses play an essential supervisory role in reablement (Birkeland, Tuntland, Førland, Jakobsen, & Langeland, 2017; Fürst & Høverstad ANS, 2014; Ness et al., 2012; Rabiee & Glendinning, 2011; Tessier, Beaulieu, McGinn, & Latulippe, 2016).

PTs, in particular, have knowledge and skills pertaining to bodily structures, body functions and movement, all of which should be assessed and targeted in reablement interventions (Ness et al., 2012). Physiotherapy is concerned with quality and accountability (French & Dowds, 2008), as PTs are specialists in analysing, promoting and supporting human movement (Nicholls & Gibson, 2010). In their work, PTs integrate theoretical knowledge, clinical experience and relational, ethical and contextualized skills (Dahlgren, Richardson, & Kalman, 2004). However, knowledge of the complex and multifaceted body is more or less interwoven in physiotherapy practice and is not easy to describe verbally (Nicholls & Gibson, 2010). Normann, Sørgaard, Salvesen, and Moe (2014) argue that practical knowledge in physiotherapy is available only through first-hand experience and that such knowledge is achieved through reflection during and following action, in accordance with the concepts of 'reflection-in-action' and 'reflection-on-action' (Schön, 1991).

Studies describe PTs' (serving as practice educators) supervision of PT students (Fogstad & Christiansen, 2011; Lähteenmäki, 2005; Stainsby & Bannigan, 2012), specialist PTs' supervision of community PTs (Normann et al., 2014), and paediatric PTs' supervision of the caregivers of disabled children (Sørvoll, Obstfelder, Normann, & Øberg, 2018). These studies emphasize that physiotherapy supervision is a process where knowledge is transferred through interaction and reflection and that action, context and culture are essential for learning (Korpi, Peltokallio, & Piirainen, 2014). However, literature on PTs' supervision of non-professionals is sparse, and the content of supervision in reablement services is, to the best of our knowledge, not described.

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Supervision of HTs in reablement largely represents the foundation of the service provided to reablement users. The aim of this study was to investigate the content of physiotherapy supervision and knowledge transfer in reablement teams. Study results may contribute to improving both the knowledge and skills applied in the provision of the service.

Theoretical framework

Physiotherapy practice is concerned with continuous clinical reasoning, involving various aspects of knowledge and skills. Awareness of body position, quality of movement and communication is essential for physiotherapy practice. According to Grimen (2008), these aspects of knowledge are difficult to verbalize and cannot be fully transferred through descriptions.

We have used theory of learning as a socio-cultural process to analyse and understand the transfer of knowledge in reablement. Socio-cultural learning theories conceptualize learning as a complex process of human interaction. From this perspective, learning is considered to be constructed through interaction with others within a certain context; such contexts are referred to as 'Communities of Practice' (Wenger, 1998). In defining learning, Wenger (1998) described three hallmarks of communities of practice: First, participants are mutually involved and brought together as a social unit. Second, the community is linked to a joint activity. Third, the participants possess a common repertoire of practices, tools and symbols. This perspective was used as a frame to develop the research question, create the observation- and interview guide and to analyse the data.

Methods

Aiming to explore the actual interactions in practice, the results were generated based on a social constructionist perspective, which acknowledges the experiences of individuals through their interactions with others as well as through historical and cultural norms (Guba & Lincoln, 1989).

Study design

This is a qualitative, explorative study based on fieldwork in reablement teams. We collected data through a) observations of interactions between PTs and HTs in their work environment; 2) videotaped observations of user interventions; and 3) in-depth interviews with both PTs and HTs based on the observation sessions.

Study setting

We obtained data from seven reablement teams within seven different Norwegian municipalities. The municipalities were strategically chosen to obtain a varied population size. Observations of practice were carried out at the participants' workplaces. Observations of supervision and reablement sessions took place in the users' homes. All interviews took place in meeting rooms at the PTs' and HTs' work places.

Participants and recruitment

Two members (a PT and a HT) from each of the seven reablement teams were included as participants (N = 14). However, reablement users and other collaborating team members contributed to production of data through their interactions.

Collaborative co-workers in one of the reablement teams did not consent to participate, and the work environment was not observed in this team. However, results from interviews of the PTs and HTs gave rich information about the work environment and collaborative practice in this team as well, and we therefore decided to include these data.

Inclusion criteria for the PT and HT were at least 6 months of experience with reablement. The inclusion criteria for the users were that they were about to start with – or were in the first week of – reablement. All participants had to be able to consent to participation, and users with cognitive impairment were therefore excluded.

General managers of the teams were contacted, and they consented to distribute information about the study to PTs and HTs. The PTs distributed information and recruited users. When a user agreed to participate in the study, the PT contacted the first author (ME) to arrange for data collection.

Data collection

The first author collected data between January and June 2016. We visited the teams during the users' first week of reablement, followed by a second visit two to three weeks later. In this study, the key points of the observation guide that was used in the patient-intervention observations were 1) treatment setting, 2) content of actions regarding assessments or training, 3) instructions to users, 4) instructions to HTs, and 5) verbal- and non-verbal communication. The intervention was video-recorded to ensure that the situated and interactional accomplishment of practical action were captured (Heath, Hindmarsh, & Luff, 2011). We primarily remained in the background in order to avoid disturbing the interaction of the participants and used a discreet, handheld camera with a wide video angle to capture all participants.

During the first visit, we observed the user interventions when both the PT and HT were present with the user. Immediately after the first observation, we conducted an interview with the PT focusing on the previous observation and on strategies for supervision.

The second visit included video-recorded observation of the encounter between the HT and user, followed by an interview with the HT. The interview focused on the preceding observation and the HT's experiences with supervision. Interviews with both the PTs and HTs were semi-structured, with open-ended questions and relevant follow-up questions. The interviewees were encouraged to talk freely about their experience with supervision and clinical discussions (Kvale & Brinkmann, 2009). All interviews were audio-recorded.

In addition to the observations and interviews, field observations of the reablement teams' work environment were conducted to analyse the context that serves as a framework

for the practice. The first author followed the PT and HT from six of the reablement teams at their work place. Observations in the office, lunchroom and meeting rooms captured both formal and informal meetings and interactions between the team members.

Data analysis

A thematic analysis was conducted through an inductive-deductive process, where the inductive analysis was used to allow the patterns, themes and categories of the data material to emerge (Lincoln & Guba, 1985), and the deductive theoretical interpretation contributed to developing and validating the findings (Creswell & Poth, 2017).

The interviews were transcribed verbatim, while the video observations were formatted as text through descriptions in a scheme where six aspects of interactions were categorized: 1) what is done? 2) how is it done? 3) explanation or reasoning, 4) instructions provided, 5) guidance provided, and 6) interaction. The descriptions included both verbal talking and bodily interactions. The cataloguing of video-recorded data was inspired by Heath, Luff, and Sanchez Svensson (2007) and aimed to capture the multiple aspects of interaction in video observations.

Further, we identified and coded meaningful units in all text material. During this process, all data materials were linked together, supplementing each other, through common code groups and themes. The interviews elaborated the observations through the insights of both the PTs' and the HTs' experiences with physiotherapy supervision. Congruent data from all three methods supported and validated each other, while discrepancies were further analysed to achieve an understanding of inconsistencies. Simultaneously, the three authors engaged in theoretical reading and discussions. The analyses were performed as an iterative process, continuously moving between an inductive and a deductive perspective and between the data material and relevant theory. The triangulation, reflexivity and theoretical interpretation contributed to the validation of the findings.

The analysis was supported by the use of QSR NVivo 11 (QSR International, 2018), a qualitative data analysis software.

Ethical considerations

This study was approved by the Norwegian Center for Research Data (Ref number 44747) and was conducted according to the Helsinki Declaration (World Medical Association, 2017). All participants received written information about the study and provided written consent before the data production.

Results

Three main themes emerged through the analysis: 1) Forms of supervision; instruction, demonstration and reflection, 2) working together, and 3) home trainers' engagement. Citations and excerpts from the observations are presented consecutively.

Instruction, demonstration and reflection

Three different forms of supervision were employed during the observations. The first form;*instruction* revolved particularly around *what to do*. This was often defined in a reablement plan, which was based on the PT's (or the PT in collaboration with other team members') assessments and the user's goals; it usually included exercises or daily activities that the user was supposed to do. These instructions were often transferred through written information, in the form of a rehabilitation plan or an exercise map that included descriptions and drawings of the exercises. In the team where the HT was a member of the home care service and not co-located with the therapists, the HT highlighted that this written information was a central source of supervision. The HT explained that she had not felt the need to contact the PT for any further supervision:

> The PT sends me a, what should I call it… a description. The exercises are carefully described as well as the user's goals. Everything you need to know is there, you know, for the entire period. 'The startup date is… the user's goals are… perhaps to increase strength and balance', Well, we just have to carry it out (HT).

In addition to the instructions, the second form of supervision referred to *demonstration* of *how* to perform the intervention. In contrast, the other HTs claimed that a drawing of the exercises was not always sufficient and that it was essential for the PT to demonstrate how the exercises should be performed. They also emphasized the importance of practicing the exercises themselves, which enabled them to perceive and experience how different positions targeted different muscles. Supervision where the PT demonstrated the exercises often took place in the user's home but could also happen in the office, without the user present.

PTs that visited the user together with the HT were able to carry out supervision related to the user's individual technique and quality of movement. One PT said:

> For example, the lady we visited earlier today, who was doing her hip abduction exercise beside the kitchen counter. [The purpose is] to stabilize, not just 'topple over', you know. They need to understand how the user should be moving to target the right muscles. There are several ways to compensate. Consequently, the user will not achieve the effect that I had planned for. That's why it's important to demonstrate and further explain the importance of doing the exercise right. (PT).

The third form of supervision concerned *reflection* about *why* initiatives were done. Through fieldwork, we observed that the PTs justified their choice of exercises and techniques based on the user's goals and based on the constraints of the user's physical abilities. They emphasized that the HTs achieved an understanding of the clinical reasoning in order to tailor the interventions to the individual user. Reflecting together enabled a common understanding and shared knowledge. As one PT explained:

> You know, it's important that they [the HTs] understand and observe the same as I do. Sometimes we practice here in the office. We carry out the exercises to experience how it should be done; 'what happens if you get a little support here?' and 'can you feel this and that?'[…] I emphasize that they should know how it feels, and learn what to look for' (PT).

Instruction and demonstration were seen in all the observed teams. However, reflection, which enabled a deeper understanding among the HTs was more frequent in reablement teams in which the PT and HT met frequently during the workday. This is presented in the following section.

Working together

All of the reablement teams had established formal meetings where all team members gathered together. The frequency of these meetings varied across teams, from every second week to once a day. The participants discussed both organizational and coordination issues, as well as issues regarding reablement users – including user goals, physical capacities and constraints. In addition to the scheduled meetings, some of the teams had arranged courses where the PT demonstrated exercises based on requests from the HTs.

Even though all the teams arranged formal meetings, they argued that informal meetings and the day-to-day communication were at least as important. With the exception of one team in which the HTs were organized under the home care services, the team members were located together. Observations and interviews revealed that all the team members were communicating at the office, during lunchtime, through phone calls and in the car between the users' homes and the office. The discussions involved the user's goal, physical abilities and exercises. They also discussed their own performance during the user visit in order to evaluate how both the PT and the HT could adjust and improve the approach. The HTs reported a low threshold for contacting the PTs if they were unsure of something. Co-located PTs and HTs said that the common premises were essential to achieving close collaboration. One PT explained that the daily contact enabled less-hierarchical communication by creating dialogue and discussion rather than a session where the PT lectured the HT:

> We don't have anything that we call supervision-sessions specifically. It all happens through day-to-day communication at the office. […] If we had called it supervision, I think it would have been more of a "top-down" approach, in that the PT always was the one with the right answer. I don't think that would have been advantageous for the work environment. The informal contact and low threshold to discuss with each other is better (PT).

Although much of the supervision happened in the office, it was explained that the most important arena for supervision was the user's home when both the PT and the HT were present. Usually, the PT and HT visited the user together during the first days of reablement to conduct assessments and implement exercises. This was highlighted as essential, as one PT noted:

> Because it happens a lot during the user meetings, that is challenging to write or explain if they [the HTs] are not present […] so it is important that the HT is present in these meetings (PT).

The participants highlighted the benefits of visiting the user together as often as possible. Most of the HTs reported that it was a common practice to ask the PT to attend training sessions throughout the reablement period if they felt uncertain. Occasionally, the PT would attend the training session, even though there was no particular need, simply to follow up on the user's progress and to provide feedback on the HT's interaction with the user.

HTs' motivation and involvement

The PTs claimed that they often had to supervise the HT indirectly through the communication with the user because the supervision was, to a large extent, conducted in the users' homes. The PTs expected the HTs to absorb the information that was addressed to the users, which required the HTs to be highly observant:

> I have to learn from the PT and the user's communication, so you have to be observant. You have to be 'all in' even though you're just an observer. You can't just sit around. You have to watch and listen carefully (HT).

The PTs also highlighted the HTs' motivation and engagement as essential to the supervision, as one said:

> She is a quick learner and she is genuinely interested in her tasks. She reads a lot and is truly passionate about the work she is doing. My experience is that it is very easy to transfer knowledge to her because she is interested and asks questions if she is unsure (PT).

The HTs reported that they were more motivated when they received new challenges and that they positively perceived reflections and discussions with other team members.

Discussion

The results show that different forms of supervision, namely instruction, demonstration and reflection, are essential to transferring professional knowledge from PTs to HTs. Shared reflections were emphasized as especially crucial to the learning process. Formal and informal meetings, as well as the HTs' motivation and engagement, particularly enabled reflections.

Practical knowledge

Mostly, PTs distributed reablement plans and training programs as written information to the HT. However, almost all the participants reported that both demonstration of exercises and observations of PTs' interactions with users were essential. Reablement approaches involve practical actions that are complex and contextually unique. Such approaches require knowledge about how to move in a functional and efficient way, how to support and guide the user through verbal and bodily instructions and, at the same time, observe and assess for compensating movements. Verbal instructions are not always sufficient to transfer context-specific practical knowledge. Donald Schön wrote:

> Often we cannot say what it is we know. When we try to describe it we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinarily tacit, implicit in our patterns of action and in our feel for the stuff with which

> we are dealing. It seems right to say that our knowing is in our action (Schön, 1983, p. 49)

This is consistent with educational theories of practice, which emphasize active learning techniques and claim that learning is not solely transmitted by direct instruction (Biggs, 1999).

The example mentioned earlier, where the HT was satisfied with the written information about exercises, is an example of what Schön (1991) referred to as a technical approach, which he critiqued as a potential danger for practice. The HT considered her task to be carrying out the content of the written instruction, without any further adjustments to the context of the intervention. In a qualitative study of reablement services, Rabiee and Glendinning (2011) also found that some HTs considered their job as passively 'standing and watching', without any interference due to adjustments. Although our study revealed that reflection in some reablement teams was sparse, other teams with closer collaboration and frequent meetings emphasized that reflection and discussion were essential for the HTs' learning. An ongoing study is exploring the content and quality of service delivered in reablement teams that employ varied supervision practices (Eliassen, Henriksen, & Moe, 2018).

PTs in this study reported that the discussions enabled the HTs to understand the users' situation better, which further enabled them to take clinical decisions based on their acquired knowledge. Reflective practice is known to be essential for learning practical skills in health and social care services (Kinsella, 2010), as well as in physiotherapy (Ernstzen, Bitzer, & Grimmer-Somers, 2010). By visiting the users together, the PT and HT created 'reflection-in-action', which Schön (1991) described as reflection while acting. Both informal and formal meetings outside the user's home enabled consecutive 'reflection-on-action' (Schön, 1991). Frequent meetings and shared practice were important prerequisites for the discussions.

Learning in a professional and collaborative environment

Analysis revealed that reablement teams that engaged in common meetings and close collaboration had more thorough discussions of professional issues compared with teams where the PT and HT rarely met each other. Birkeland et al. (2017) also found that learning in reablement depended on how closely the participants collaborated. They indicated that organizing reablement teams outside the home care service could contribute to greater interdisciplinary collaboration compared with integrated teams within the traditional home care services. In accordance with social theories, learning is situated (Lave & Wenger, 1991) and is largely dependent on our experiences of participation in daily life, particularly when learning entails engaging in 'communities of practice' as described by Wenger (1998). The reablement teams investigated in this study may be seen as a type of community of practice.

Participants in this study noted that close collaboration and informal meetings produce a non-hierarchical environment. This complies with a central hallmark of Wenger's definition of community of practice, namely a social unit characterized by joint enterprise (Wenger, 1998). A study that explored reablement employees' experiences argued that regular meetings and a common arena for communication enabled the therapists to appreciate the HTs' work (Hjelle, Skutle, Førland, & Alvsvåg, 2016). Results from our study revealed that informal meetings and day-to-day communication was the most important arena for supervision. This required flexible working where PTs could attend HTs user-encounters whenever it was needed. Other studies have also reported that a flexible structure in interprofessional teams is important (Eliassen, Henriksen, & Moe, 2018; Randström, Wengler, Asplund, & Svedlund, 2012).

The participants reported that the HTs' engagement was essential to the transfer of knowledge. The PTs' supervision in the context of a user visit appeared to be challenging due to the ambiguous demand of interacting with the user and at the same time supervising the HT. The PT often conducted supervision indirectly through the communication with the user, which required an observant and engaged HT. It has been reported that the HTs' motivation is necessary in reablement (Rabiee & Glendinning, 2011). According to Wenger (1998), active participation is an important aspect of learning in a community of practice.

In teams where PTs and HTs worked closely together, the PTs were present during the users' home visits on several occasions. Both the PT and the HT could engage mutually in professional discussions based on their common knowledge about the user. Moe and Brataas (2016) reported that reablement approaches require several types of competences, and thereby several professions should be involved in patient assessment and initiatives. A pluralistic approach is valued, as it provides a range of interpretations and views due to the complexity of care (Reeves, Lewin, Espin, & Zwarenstein, 2010).

Teamwork or collaborative work

Joint discussions produced common knowledge and understanding of the user's situation; such knowledge may be seen as a shared repertoire which, according to Wenger (1998), is considered to be essential for a learning environment. However, this was not observed in the team where the PT and HT were not co-located and had few meetings. Ultimately, we question the use of the concept 'team' in these cases. According to Reeves et al. (2010), there are different forms of interprofessional work. 'Teamwork' is characterized by team identity, interdependence between team members and shared responsibility, in line with the observations of the co-located and highly reflective teams. However, the reablement teams with limited reflective supervision were more comparable with what Reeves et al. (2010) define as 'collaboration', where the shared identity and integration of individuals are less important. Birkeland et al. (2017) also found that reablement team members that experienced close collaboration appeared to have an effective qualitative and quantitative follow up of the users. This has also been reported in team-work in similar health care settings (Thylefors, Persson, & Hellström, 2005).

Although we have described contrasting findings regarding supervision in reablement due to collaboration, it is not our intention to point out 'good' or 'bad' reablement teams. According to Reeves, Xyrichis, and Zwarenstein (2018), the design of the team needs to match the clinical purposes. The

service's intention, including the definition of the target population, must guide the choice of design. Birkeland et al. (2017) argue that the organization of reablement services is a question of resources, which also favour local adaptations. However, we argue that complex interventions in reablement services – with a demand for specialized and individually tailored approaches – may benefit from the learning processes used in the more collaborative interprofessional teams, which emphasize reflection in supervision.

Study limitations

Our results stem from a limited number of participants and teams, and other ways of conducting physiotherapy supervision in reablement may exist. However, the results of this study are relevant to reablement services and to other interprofessional work in similar settings regarding analytical and theoretical generalizations. One of the reablement teams did not consent to perform fieldwork in their work environment, and observations of collaboration between other team members in this team were not performed. This may have limited the ability to contextualize the findings from this particular team. However, we considered data from the observations and interviews as sufficient to conduct relevant analyses. In our study, PTs and HTs were the main subjects, while other team members contributed through discussions and interactions in the interprofessional work environment during fieldwork. However, collaboration – including other professions – should be further investigated. This study revealed that reablement practices vary according to service organization and supervision, but their effectiveness across the varied practices has not been studied in this work, and there is a need for further investigation.

Concluding comments

This study provides a perspective on knowledge development as a social process, constructed in communities of practice exemplified in the reablement context. The findings of this study show that physiotherapy supervision in reablement involves elements of instruction, demonstration and reflection and that reflection was vitally important to the learning process of the HTs. However, organizational frames such as frequent meetings and close collaboration were essential to promote reflections in and on practice. Nevertheless, the structure of reablement teams needs to be designed in accordance with the clinical purpose and local context of the service.

Task shifting due to reorganization of health care services has resulted in new tasks for professionals as well as for support personnel (Allen, 2014). The content of these tasks must be identified and manifested as part of the practice. This paper contributes to highlighting supervision as an important and potentially resource demanding task that must not be taken for granted in collaborative interprofessional teamwork.

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RESEARCH ARTICLE

WILEY

The practice of support personnel, supervised by physiotherapists, in Norwegian reablement services

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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, 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, whereas 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

1 | 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 (Colbran-Smith, 2010; Fulton et al., 2011; Kakuma et al., 2011; Lizarondo, Kumar, Hyde, & Skidmore, 2010; Munn, Tufanaru, & Aromataris, 2013; World Health Organization, 2006).

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 (Colbran-Smith, 2010; Ellis & Connell, 2001; Holmes, 1970; Saunders, 1998).

The World Confederation for Physical Therapy, 2017 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; Legg, Gladman, Drummond, & Davidson, 2016; Munn et al., 2013; Nelson, 2013).

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 United States, Canada, Australia, and the United Kingdom. However, a 2-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 and 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; Cochrane et al., 2016; Legg et al., 2016; Winkel, Langberg, & Wæhrens, 2015). Tuntland, Aaslund, Langeland, Espehaug, and Kjeken (2016) studied 225 participants, of whom the majority reported health conditions such as fractures, balance problems, pain, or stroke, whereas 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, 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 (Eliassen, Henriksen, & Moe, 2018; Hjelle, Skutle, Førland, & Alvsvåg, 2016; Tessier et al., 2016). HTs working in reablement may include support personnel with or without any formal training.

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 (Eliassen et al., 2018; Legg et al., 2016). 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.

2 | 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. Benner, 2004; Dreyfus & Dreyfus, 1980) informed the results.

2.1 | 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 and HTs. 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.

2.2 | Data collection

We conducted a study with two visits to each reablement team. During the first visit, the first author (M. E.) conducted video recordings of supervision as work with a new user commenced, followed by a semistructured 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 semistructured 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 *semistructured 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: (a) the clinical reasoning regarding the observed intervention (b) the required knowledge and skills, and (c) the communication and collaboration.

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 to manage personal hygiene, go to the mall, attend the day care centre, 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, 1 year in reablement	7	Nurse assistant, 1 year in reablement	7	Stroke, aiming to walk inside without a walker, going to the grocery

Note. PTs: physiotherapists; HTs: home trainers.

2.3 | Analysis

The first author 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, and 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. We 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, whereas discrepancies were further analysed to achieve an understanding of the inconsistencies.

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

N. H. and S. M. (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.

3 | RESULTS

The main themes that emerged from the data were as follows: (a) the HT is responsible for recognizing and reporting on the user's needs; (b) standardized approaches following predefined procedures; and (c) individually tailored approaches target the quality of movement.

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.

3.1 | 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)*

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)

3.2 | Standardized approaches following predefined procedures

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 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)

3.3 | 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 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

TABLE 2 Excerpt from fieldwork in a reablement team with standartized approaches

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 programme 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 5 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 10 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 min 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.

Note. PT: physiotherapists; HT: home trainer.

TABLE 3 Excerpt from reablement team focused on quality of movement and individual adjustments

An older lady with a recently fractured upper and lower limb was about to start up her reablement programme 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 whereas 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, whereas 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 2 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 2 weeks earlier. "You may challenge the balance by letting go of the kitchen counter," she said, and the user carefully lowered the supporting arm. The user still lifted her heel from the floor, so the HT got up on her feet again and demonstrated the exercise with her own body. "Look at me. My heel is still on the floor (she pointed towards her heel), and then I lift (she pointed towards her toe)". The HT observed the user and said "Yes, now you've got it!"

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

4 | 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 and 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.

4.1 | Instrumental and standardized reablement approach

The two examples presented in Tables 2 and 3 clearly contrast with each other. In the first example, the HT followed the predefined 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 and Glendinning (2011). They 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).

4.2 | 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, and 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 (Moe & Brataas, 2016; Rabiee & Glendinning, 2011).

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 and Sutphen (2007) argued that home care professionals need an interpretive form of rationality, rather than a technical rationality of instrumental problem solving.

4.3 | Task delegation

Task delegation has been argued to potentially improve the quality of patient care (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 had 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).

4.4 | 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 postinstitutionalized 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 neither between different approaches nor between target groups.

4.5 | 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 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.

5 | 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 predefined 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.

5.1 | 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.

AUTHORSHIP

All authors qualify according to the criteria from International Committee of Medical Journal Editors (ICMJE). Contributions are accurately illustrated in the list of authors.

ETHICAL APPROVAL

This study was conducted in accordance with the Helsinki Declaration (World Medical Association, 2018) and was approved by the Norwegian Centre for Research Data (Ref. number 44747). All participants provided written consent based on written information about the study. Data were managed confidentially.

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CONFLICT OF INTEREST

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the article.

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