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Tailoring reablement: A grounded theory study of establishing reablement in a community setting in Norway

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Abstract

Reablement is an interprofessional, home-based rehabilitation service that aims to enable senior residents to cope with everyday life and to prevent functional impairments. Systematic accounts of what practitioners actually do when establishing reablement are lacking. This study aims to generate a grounded theory of practitioners' patterns of action when establishing reablement. The study is located in Norway, and grounded theory is the methodological approach. Data were collected from January 2014 to August 2016 through participant observations, focus group interviews and individual interviews. Informants are municipal healthcare employees in different organisational areas associated with the process of establishing reablement services (managers of conventional home care and representatives from the administration and service-provider offices). Altogether, 17 individuals are interviewed. The empirical data are analysed several times using open, selective and theoretical coding. The grounded theory, "tailoring reablement," includes three phases—replicating, adapting and establishing—and the strategies of collaborating, developing knowledge, habituating and filtering. The theory of tailoring reablement also includes the impact of the contextual factors. The study seeks to bridge the gap between research and practice. The theory of tailoring reablement emerges from an inductive approach and theorises participants' actions. The theory focuses on the phases from innovation to implementation. Establishing a new service model in a complex welfare setting requires a wide range of actors and agencies. Tailoring reablement also requires flexibility and professional autonomy. It is important to create terms and conditions for this within a stringent health and care service. The insights of this study have implications for practice development of reablement and can fit other public sector fields.

KEYWORDS
grounded theory, implementation, public health, qualitative research, reablement

1 | INTRODUCTION

Reablement (also known as restorative care) is an interprofessional, home-based rehabilitation service that aims to enable senior residents to cope with everyday life and to prevent functional impairments. The method consists of using physical training and adaptive equipment to strengthen actions the individual defines as important (Ryburn, Wells, & Foreman, 2009; Tuntland, Aaslund, Espehaug, Førland, & Kjeken, 2015; Winkel, Langberg, & Wæhrens, 2014). Reablement is increasingly offered to those who meet local eligibility criteria for home-care services. Nevertheless, ageing persons (65+) are the most common recipients of reablement services.

Reablement supposedly represents a shift away from reactive home care to a preventative and proactive model based on early intervention and active engagement (Legg, Gladman, Drummond, & Davidson, 2015). In the context of an ageing population, the proportion of dependent older people is likely to increase. The anticipated shortage of health and care personnel and the increase in financial pressures have led to concerns about the sustainability of existing services. A collaborative research project on reforms in European home care for older and disabled people, LIVINDHOME, presents reablement as a key strategy for facing future care challenges (Rostgard et al., 2011) and has emerged as a key aspect of government reforms (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016).

Reablement is a priority area in many Nordic municipalities (Hjelle, Tuntland, Førland, & Alvsvåg, 2016; Randstrom, Wengler, Asplund, & Svedlund, 2012). The Norwegian government also encourages municipalities to establish reablement in their health services (The Norwegian Ministry of Health and Care services, 2014–2015). Despite massive governmental encouragement to establish reablement, there is little knowledge available on the process of establishing such initiatives for seniors in Norway. However, there is material available from the United Kingdom on the implementation of reablement. Pilkington (2008) has identified a number of essential elements for those aiming to implement such a service. These include thorough pre-planning, including which type of service to provide and the eligibility criteria, a capacity to accommodate the new role, and a phased implementation (i.e., by running a pilot and then rolling it out). The usual challenges with establishing new services from other settings are mismatches between the characteristics of the new population, the local community and the original programme. Particular objectives, approaches or activities may be too politically charged or controversial for the new local community or they may be irrelevant in the new setting. It is also possible that an agency may lack the funding, staffing, expertise or other resources needed to implement the programme as it was originally designed (Card, Solomon, & Cunningham, 2011). Different countries and different municipalities within the same country implement reablement in different ways, including both policy and practice (Aspinal et al., 2016). Practitioners need to balance maintaining the treatment fidelity of the original programme and maximising the fit with the new population and context (Metzelthin et al., 2017). Systematic accounts of what practitioners actually do when establishing reablement remain lacking (Francis, Fisher, & Rutter, 2011).

Because of the complexity of ageing people's health situation, the improvement of services requires the consideration of many components of care (Oliver, Foot, & Humphries, 2014). This study seeks to embrace the complexity of establishing reablement as a new service model. To identify the process of establishing such a complex intervention, this study implemented a long and intimate follow-up time. The process includes multiple components and personnel, and the study seeks to explore the professional practitioners' process of establishing reablement. The aim of the study was to generate a grounded theory. The following research questions guided the study: what is the participants' main concern, and how do they resolve it?

What is known about this topic
- Reablement is a priority area in many western municipalities.
- The evidence base of reablement is increasing.
- Little is known about the process of establishing reablement.

What this paper adds
- Establishing reablement in a complex healthcare setting takes time.
- Reablement must be tailored to the existing services, and the geographic and demographic conditions.
- Phases in the tailoring process are replicating, adapting and establishing.

2 | METHODOLOGICAL APPROACH

A grounded theory approach was considered suitable for exploring the actors' patterns of action with the aim of generating theory (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967).

Grounded theory focuses on human action and interaction and seeks to discover patterns that emerge in the data and to formulate theories that are grounded in the world of the participants (Glaser, 1978; Walsh et al., 2015). We therefore use the data to discover the participants' main concerns and the social processes that explain how the participants resolve them. Grounded theory is a constructive process in what Glaser and Strauss (1967) called the "constant comparative approach".

2.1 | Study context and participants

The present study is part of a Norwegian project investigating various perspectives on reablement (reablement as an innovation and the perspective of service recipients) (Moe & Gårseth-Nesbakk, 2015; Moe & Brinchmann, 2016). The study took place in a Norwegian municipality consisting of both urban and rural areas. The reablement success of a Danish municipality, Fredericia, has inspired the municipality under study. Reports from the Danish Institute for Health Services Research suggest that the Fredericia reablement programme has the potential to reduce the need for public help and simultaneously reduce healthcare costs (Kjellberg & Ibsen, 2010). In the municipality in question, the policy makers and professionals agreed in 2012 to establish a reablement service inspired by the Fredericia model.

The new reablement team comprises a nurse, two occupational therapists, three physiotherapists and four nurse assistants. The initial study participants were the reablement team and the pilot project manager because they have knowledge about the subject area (Glaser & Strauss, 1967). Participants were then recruited based on a need for additional information and because the emerging theory required

TABLE 1 Examples of codes and categories

Transcribed text	Selected open codes	Category
It is something about attitudes. Yes, the attitudes must change. Both our attitudes and the attitudes of the recipients.	Change of attitude	Habituating
We need to balance between challenging enough to make a development, but not so much that they do not experience coping. Then they rather need support.	Balancing challenge and support	Developing knowledge
Especially when it is hand-over to the home care, we need to communicate. We explain; you shall help him showering, but you are supposed to stay outside to make him feel safe. You are not supposed to wash his back or help shampooing.	Hand-over to home care Communication	Collaboration

more diverse perspectives. Informants were municipal healthcare employees in different organisational areas associated with the process of establishing reablement services (managers of conventional home care and representatives from the administration and service-provider offices). The composition of practitioners in the interdisciplinary team changed during the research period.

2.2 | Data collection

Data were collected using a variety of methods. The main source of empirical data was participant observations of selected meetings and home trainings beginning in January 2014. The participant observations were conducted by the first author and were ongoing until the autumn of 2016. Meetings about organisational matters, service-user evaluations and everyday practice development were considered relevant. Altogether, 180 hr of participant observation were conducted. Participants in these meetings included primarily the reablement practitioners. Expanded meetings also included health service managers, representatives from the service-provider office, the pilot project manager and representatives from a union and the Council for the Elderly. Notes were handwritten during the observations and comprise 200 pages. The objective was to capture discussions and statements related to the scope of the study. Informal conversations occurred before and after meetings. These are included in the empirical data.

Interviews were conducted based on fieldwork observations. Three focus group interviews were planned and conducted in accordance with the practices outlined by Hernandez (2012). Group one consisted of three therapists and one nurse. Group two consisted of four home trainers, and group three consisted of three home-care managers. Six individual interviews were conducted with key individuals related to the process of establishing reablement services. The interviews included people who participated in selected meetings. In accordance with grounded theory, we did not use an interview guide. We prepared keywords for each interview based on the ongoing analysis. Still, all participants were encouraged to speak openly about their actions and experiences related to reablement. The interviews took place at each interviewee's workplace and lasted between 45 and 90 min. All interviews were audio-recorded and transcribed verbatim.

Detailed notes and memos about incidents and ideas about concepts and the emerging theory were recorded throughout the data collection and analysis. Altogether, 17 individuals were interviewed.

For a detailed overview of interviewees, see Supporting Information.

2.3 | Data analysis

In accordance with grounded theory methodology (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967), analysis and data collection were carried out simultaneously. The transcripts were read line-by-line and analysed several times using open, selective and theoretical coding (Glaser, 1978). The open coding focused on coding incidents in the data. Codes were sorted into categories, examples of which are shown in Table 1.

As part of the constant comparative method, memo writing focused on the relationships between codes and categories. Memos were hand sorted as part of the process of searching for participants' main concern. A set of questions was applied to the data during the coding process: What is this a study of? Which category does this incident indicate? What is the participants' main concern? After the participants' main concern was identified, a core category was conceptualised. Categories related to the core category were identified (selective sampling) and sorted into four main strategies (subcategories). The strategies were sorted in phases, and new data were collected to saturate the emerging concepts. By writing memos on memos, we developed the theoretical codes further: "In the beginning, the participants were rigid and rule-governed. Now, they do discretionary assessments, involving the individual life situation and available resources" (memo 06.03.15).

As each category became saturated and integrated into the theory, theoretical sampling was closed for that category. In the final phase of the analysis, we constructed Table 2 for an overview of codes, strategies and phases, and the theory of "tailoring reablement" was formulated.

2.4 | Research ethics

The study conforms to the principles outlined in the Declaration of Helsinki. The Norwegian Data Inspectorate (reference 36770) and the

TABLE 2 An overview of codes, strategies and phases

	Strategies			
Phases	Collaboration	Developing knowledge	Habituating	Filtering
The theory of tailoring reablement				
Replication	Within the team With the service users	Merging of interprofessional knowledge		Rigid and rule-based
Adaption	Others: Carers Health services Volunteers Private actors	Discretionary assessments Ethical awareness Balancing	Adversity Meeting in the middle New way of community planning	
Establishing (consequences)	Appropriate service organisation Increased referrals Better discharge or hand-over	Self-supporting residents New practical knowledge	Changed attitudes New habits New practice	Flexible Creative Individual assessments Residents having the right help at the right time Appropriate use of public resources

Municipal Director of Health and Care Services in the studied municipality approved the study. All participants who were interviewed received written and verbal information about the study and gave informed consent. Participants in the meetings in which participant observation was conducted were informed about the study and consented to the researchers' presence. All data have been treated confidentially.

3 | THE THEORY OF TAILORING REABLEMENT

The participants' actions are motivated and caused by their main concern, which is perceived in this study to be "how to integrate reablement in the existing health service." Despite listening to advice about how to establish reablement, the participants experienced several barriers: habitual ways of offering health services and a lack of professional and societal knowledge about the rehabilitation potential of seniors and the benefits of being active in late age. The participants also experienced organisational barriers. The theory of tailoring reablement explains the process of how the study participants act to resolve their main concern. Tailoring is an evolving process, meaning that it develops gradually. It is a subtle process in which participants move from replicating a "full-package reablement programme" to an adapting phase and, finally, to an established reablement service model tailored to local conditions. The tailoring process therefore undergoes the three phases of replicating, adapting and establishing.

The phases and their strategies are described in greater detail in the next sections. The strategies continue throughout the process, and the theory shows that the establishing phase is time-limited. The public sector is influenced by economic constraints, limited access to qualified practitioners and other factors that lead to the services
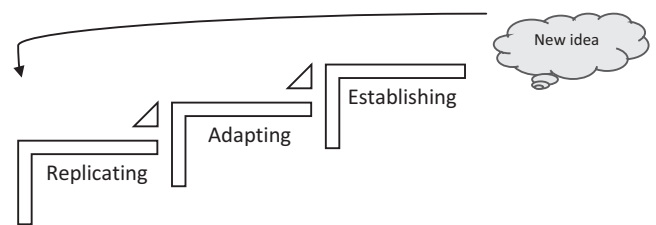

FIGURE 1 The process of tailoring reablement

being assessed and changed regularly. Public sector innovation is also a focus area in many countries, which leads to new ideas. Figure 1 shows that the process of replicating, adapting and establishing begins again when new ideas appear.

The timeline of this process varies based on the complexity of the new initiative. For reablement, this period has lasted for years.

3.1 | The replicating phase

Replicating is the initial phase and explains how reablement services appear as a replication of the Danish Fredericia model. Replicating means to copy the Fredericia organisational model, the philosophy and everyday routines. The participants visit the Fredericia team for training and focus on offering a similar service to the senior residents in their municipality. This phase is characterised by enthusiasm and optimism and by the strategies of collaborating and developing knowledge about how to rehabilitate the seniors.

The participants find the process to be relatively straightforward. In this phase, collaborating deals with collaborating with service users and collaborating within the team. The collaboration between the service user and reablement practitioners is a cornerstone of reablement and aims to ensure the participation and motivation of the seniors and a more person-centred service:

I have never worked like this before. We ask the service user, "what is important for you?" It is fantastic. We collaborate with the service users and build the intervention on their resources.

(Nurse)

The collaboration within the team is about the interdisciplinary work and tailoring the team to the task at hand, involving distributing responsibilities and everyday practice routines based on the Fredericia recommendations. The most dedicated and enthusiastic professionals are chosen to establish the reablement service, which might be why they do not experience collaboration challenges within the team early in the process. The interdisciplinary organisation of the team involves several benefits: "we see a person in different ways, so now we see more than we used to on our own" (Occ. Therapist 2).

Developing knowledge about how to rehabilitate seniors explains how practitioners build their competence. Reablement depends on a complexity of factors that influence the individual's ability to use their resources. These factors include the service user's motivation, pain, nutritional state, mental state and cognitive function. The development of knowledge includes merging each professional's competence:

We explain to each other. This intervention is because of this … and I made that observation. In that way, we take part in each other's knowledge.

(Occ. therapist 2)

3.2 | The adapting phase

The adapting phase is the second phase. This phase means that presenting the positive outcomes from Fredericia, team collaboration and rehabilitation efforts are insufficient. To integrate reablement into the broader health service, tailoring the collaboration within a broad network is required. The reablement team depends on others to recruit service users and follow-up on reablement. Adapting explains both adapting the reablement service to local conditions and adapting the community to this new way of offering and receiving public health services. The adapting phase is characterised by participants facing a complex reality and being both frustrated and creative. Expanded collaborating and habituating are identified as the main strategies.

Expanded collaborating explains how other actors are included in the reablement process, such as carers, other municipal and governmental care providers, voluntary associations and private care providers. Carers are necessary team players, and information and relational work with carers provide security and support: "Some carers are sceptical and believe this is a money-saving initiative. Carers need information about the ideology, and information about the risks of a senior being passive. When people realise what this is about, they find reablement reasonable" (Physiotherapist 1 and Occ. Therapist 1). The expanded collaborating includes establishing new communication lines and new service-user pathways. Barriers to collaboration include complex electronic medical records and communication systems.

Tailoring reablement to an established healthcare system includes cultural and methodological change. The habituating strategy relates to the municipality's aim of changing the public view of how public health services are offered, meaning that residents are expected to be active participants and aware of their personal accountability: "everyone has to take responsibility for his or her life throughout the life-cycle" (Pilot project manager). Habituating is also about changing from reactive home care to one focused on coping and prevention. Habituating involves all actors and involves questioning old practices, habits and routines. The participants experience adversity, as illustrated by others not referring candidates to the service, not continuing ongoing reablement initiatives or displaying attitudes in opposition to the reablement philosophy. Therefore, dialogue, information and support are conditions needed to change habits and patterns of action:

We have a culture of saying that when you get old, you are supposed to sit still and we will take care of you. Of course, in many situations, that is the right thing to do. However, we also see that we have made people more helpless than necessary.

(Manager 6)

Therefore, habituating is performed by clarifying the expectations that senior residents can have from the welfare state and the expectations the care providers can have from service users. A general impression is that proper elder care compensates for frailty. Therefore, no one tells seniors that they can become stronger and healthier. Habituating also includes a changed view of community planning. The physical design of the community has a great impact on the seniors' ability to be active. Walking paths, benches, curbs, snow removal and icy roads are significant components. Therefore, habitual changes include several municipal agencies. The adapting phase is essential to tailoring reablement. The service cannot be integrated into the general health service without a focus on the municipality as a whole. Adapting leads to a gradual change of attitudes and habits related to the municipal care of senior residents. There remains a need for this process to continue:

There is still a great need for cultural change. People are not aware of the benefits of being active in their late age. They benefit in several ways. It is good for the muscles, internal organs, digestion, appetite, sleep and cognitive function. Still, so many people become inactive due to ageing.

(Home trainer 2)

Due to the knowledge development strategy, it now becomes clear that rehabilitating others involves discretionary assessments and tailoring the service to each person's situation. Flexibility and professional autonomy are properties of reablement. Reablement also involves an ethical awareness of keeping the service users' own goals in mind. The service users' goals are sometimes contrary to the municipal pressure to reduce the hours of care provided, and the practitioners are required to balance several needs:

We all have a cross-pressure between quality and budgets. We must try to balance and to maintain quality.

(Occ. Therapist 2)

3.3 | The establishing phase

Establishing is the final phase and explains how the reablement service integrates into the municipal health service, into the healthcare providers' work practices and into the community. Establishing is considered a consequence of the adapting phase. The establishing phase includes "filtering" as a significant strategy:

First now, the participants have time to systemise the filtering. They do not agree about the responsibilities of home carers. They [the reablement team] believe reablement is the responsibility of the home care too, but the home care says they do not have the time. I believe that allocating responsibilities is part of filtering.

(memo 12.02.16)

Filtering is to filter those who can make use of the reablement service from those who cannot. Filtering also involves filtering public responsibility from each individual's personal responsibility and allocating responsibilities between services. Gaining knowledge about and awareness of filtering is part of the process of tailoring reablement. Filtering depends on the workload of the reablement practitioners. The assessments change depending on the pressures the team is under. When they have waiting lists, reablement practitioners use more stringent criteria. The number of referred candidates is therefore a condition that influences the framework for the filtering process. Filtering evolves from a rigid and rule-based strategy, towards a flexible strategy important to the tailoring of a sustainable reablement service. The consequence of filtering is that municipal residents receive the right help at the right time and that public resources are used more appropriately:

Not everyone needs reablement, but everyone should have a proper screening to get the help that they need. We screen several people that do not fit the reablement service who we redirect to other services. Sometimes service users even increase allocated care hours from the conventional home care after we are finished. We discover new functional impairments.

(Nurse and Occ. therapist 2)

In addition to the filtering strategy, the other strategies continue throughout this phase. In the establishing phase, collaborating leads to a more appropriate service organisation, increased referrals and a better discharge or hand-over to other services. Developing rehabilitation knowledge leads to self-supporting residents and new professional practical knowledge. The habituating strategy leads to changed attitudes and new habits.

The establishing phase is the last phase of tailoring reablement. This phase is characterised by a frail stability because the health service is part of a constant process of change, and several components are continuously being questioned. In summer 2016, health managers in the municipality decided to change the organisational model for reablement. They search for inspiration from other municipalities and plan to visit a specific municipality to learn how to organise the service. Thus, the process of tailoring reablement begins all over again (see Figure 1).

4 | DISCUSSION

The theory of tailoring reablement explains how study participants act to integrate reablement into health and care services. The theory describes a process consisting of three identified phases: replicating, adapting and establishing. Despite massive governmental and municipal administrative support for the programme, the participants experience several barriers to the integration of reablement. They realise that the establishment of reablement is a complex process that takes place both within the reablement service and at the organisational and societal levels. From the employee perspective, establishing reablement is more than simply replicating a "full-package service model" and mechanically learning new methods. It develops old practices into new practices and requires a service tailored to local conditions. Tailoring is making the new service fit the local resources and the demographic and geographic conditions. In contrast, a new technical device with clear instructions does not involve external factors to the same degree. This study contributes to the existing theory of and research on reablement, an area that has not yet been fully analysed. In this section, we situate the findings from this study in the existing reablement literature and discuss our contribution. We also discuss practical implications and directions for future research.

A key challenge faced by the global health community is how to implement proven interventions or new practices within a real-world setting (Nilsen, 2015). There are debates about whether reablement is a proven intervention (i.e. Cochrane et al., 2016). Internationally, billions are spent on health innovations but little is spent on how they are actually employed (Peters, Tran & Adam, 2013). Human services are complex, and the practitioners are fully exposed to the variations of life. Therefore, to bridge the gap between research and practice, we need to be as empirically rigorous in choosing our implementation strategies as we are in choosing our interventions (Fixsen, Blase, Naoom, & Wallace, 2009). The findings of the present study raise awareness about the complexity of this human service intervention and the impact of the contextual factors. Practitioners' strategies are empirically chosen based on the actual local barriers.

The strategies for tailoring reablement are identified as collaborating, developing knowledge, habituating and filtering. Collaboration has become an important issue in the development of the modern welfare state. Welfare services are specialised and include not only public services but also services provided by private actors, volunteers and service-user networks, which creates a growing need for the integration of welfare services overall (Ahrgren & Axelsson, 2005; Axelsson & Axelsson, 2006). The strategy of developing knowledge evolves during the research period and emerges as a significant tailoring strategy.

From a rigid and rule-based starting point, participants find that rehabilitating others requires an awareness of several components. The practitioners develop knowledge of how to assess these components. Manuals and procedures are not sufficient. Reablement is tailored when practitioners have the awareness to make individual and situational assessments, as also found by Hjelle et al. (2016). Habituating involves all stakeholders in juxtaposed positions. Tailoring reablement is therefore more than implementing research-based interventions in practice. It is about changing habits, attitudes and mindsets. Practitioners face barriers grounded in habitual ways of doing things. Existing practices are embodied in the practitioners' everyday routines and habits in their familiar daily practices (Wackerhausen, 2009). Reablement practitioners gradually aim to change habits of a large number of municipal actors by informing, participating in meetings and teaching new methods and approaches. Filtering service users has two dimensions. The first dimension is to gain knowledge about who is most suitable for reablement services. Research shows that reablement works best with people who have recently experienced a disabling accident or illness but who previously had a high level of independence and are determined to regain it (Newton, 2012; Rabiee & Glendinning, 2011). As in the present study, a British study shows movement towards an inclusive approach despite practitioners having gained greater knowledge of which users benefit the most from reablement services (Glendinning et al., 2010). The other dimension of filtering is to clarify the responsibilities of the public services and of the individual. The professionals in the welfare state have taken over several tasks that previously were the relatives' responsibility. Still, it has not been clarified how the public service responsibilities should be limited in relation to the relatives' responsibilities (Hernes, 1987). The establishing of reablement services is a consequence of tailoring several components that are integrated into the emergent grounded theory.

4.1 | Strengths and limitations of the study and credibility

The strengths of our study are the researchers' closeness to the reablement team's establishing process and the long-term follow-up. The participant observations continued for over 2 years. The variety of data collection methods provides rich empirical data, thereby facilitating a more complete understanding of the process. The tailoring of reablement involves a change for the actors involved. A methodological approach such as grounded theory is well suited to studying people's responses and actions related to change, as the focus is on human action. To ensure the credibility of the study, we used the constant comparative method (Glaser & Strauss, 1967), which involves always comparing new data with the existing data, helping us validate our preliminary findings during the research process. The constant comparative method also requires the researchers to keep on track and makes the research process rigorous. To assess the quality of the grounded theory, we used the criteria of fit, work, relevance and modifiability (Glaser, 1978). The categories must fit the data. The concepts were constantly modified as new data emerged, and all concepts and

strategies can be tracked to the empirical data. By work, we mean that we need to ensure that the theory explains what is going on in the substantive area. Our theory evolved as data and concepts emerged, and these were constantly crosschecked with the existing analysis. The constant reanalysis gave us confidence that the theory explained what is going on. The theory is relevant to the participants because it evolves directly from the data. We believe the theory works for those involved in establishing reablement and for other municipalities planning to establish a new service in a complex empirical setting. Because there is great enthusiasm and growing interest in reablement, the theory has relevance for practice development. The theory will also be relevant to other areas of public sector implementation of human services. It shows how establishing a new service takes time and includes a variety of actors and agencies. Our findings show that barriers to implementation are traditional patterns of action, individual and social attitudes towards activating senior residents, technological communication systems and rigidity stemming from ideas from new public management. Modifiability means that the theory changes during the research process, as the collection of new data requires modifications of what came before. Furthermore, it means that the generated theory is always modifiable. New data that may be collected from other areas can be used to modify the theory in future studies (Glaser, 1978).

5 | CONCLUSIONS AND IMPLICATIONS

This study contributes to the existing reablement literature by exploring the process of establishing reablement services and by focusing on what professional practitioners actually do. The theory of tailoring reablement focuses on the phases from innovation to implementation. Implementation studies normally apply theories borrowed from disciplines such as psychology, sociology and organisational theory (Nilsen, 2015). The current theory emerges from an inductive approach that theorises participants' actions. Our findings show the importance of having practitioners be wholeheartedly committed to reablement. However, being an engaged and motivated professional practitioner is not enough. The reablement service cannot be established in isolation. Establishing a new service model in a complex welfare setting requires a wide range of actors and agencies. Tailoring reablement requires flexibility and professional autonomy. It is crucial to create terms and conditions for this within a stringent health and care service. Even though establishing is presented as the last phase and integrates the service in existing systems, there is still much work to be done. The significant strategies are ongoing processes. There are also areas identified as having potential for improvement, such as the use of carers as a reablement resource, the collaboration with home-care services and the accommodation of a flexible service within a stringent system. Reablement is relatively new in western countries, and there is a lack of research-based knowledge about the establishing process. Therefore, the insights of this study have implications for practice development. A collaborative approach, developing knowledge, changing habits and filtering are central. The theory of tailoring reablement also includes the impact of contextual factors.

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AUTHORS' CONTRIBUTIONS

Both authors contributed to the research design. The first author collected data from interviews, participatory observations and document reviews, performed the data analysis and drafted the manuscript. The second author was a moderator of two focus group interviews, participated in data analysis and provided comments on the manuscript. Both authors read and approved the final version of the manuscript.

COMPETING INTERESTS

The authors declare that they have no competing interests.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.