

## Driving forces for home-based reablement; a qualitative study of older adults' experiences

Kari Margrete Hjelle MSc<sup>1,2</sup>, Hanne Tuntland MSc<sup>1,2</sup>, Oddvar Førland MSc<sup>2,3</sup> and Herdis Alvsvåg MSc<sup>3</sup>

<sup>1</sup>Department of Occupational Therapy, Physiotherapy and Radiography, Faculty of Health and Social Sciences, Bergen University College, Bergen, Norway, <sup>2</sup>Centre for Care Research Western Norway, Bergen University College, Bergen, Norway and <sup>3</sup>Haraldsplass Deaconess University College, Bergen, Norway

Accepted for publication 26 November 2015

### Correspondence

Kari Margrete Hjelle  
Department of Occupational Therapy,  
Physiotherapy and Radiography  
Faculty of Health and Social  
Sciences  
Bergen University College  
Postbox 7030, 5020 Bergen, Norway  
E-mail: kari.hjelle@hib.no

### What is known about this topic

- Reablement is on the Norwegian and on international health and social care policy agendas.
- Reablement has potential for enhanced effectiveness if the persons' own priorities are in focus.
- There is little research on older people's perspectives on reablement.

### What this paper adds

- Driving forces in the reablement process are a dynamic interaction between intrinsic and extrinsic motivational factors.
- The support must be adjusted to the older adults' resources and health in their process of regaining confidence to perform activities themselves.
- The municipal primary healthcare services need to consider individualised programmes for follow-up after the reablement period.

### Abstract

As a result of the ageing population worldwide, there has been a growing international interest in a new intervention termed 'reablement'. Reablement is an early and time-limited home-based intervention with emphasis on intensive, goal-oriented and interdisciplinary rehabilitation for older adults in need of rehabilitation or at risk of functional decline. The aim of this qualitative study was to describe how older adults experienced participation in reablement. Eight older adults participated in semi-structured interviews. A qualitative content analysis was used as the analysis strategy. Four main themes emerged from the participants' experiences of participating in reablement: 'My willpower is needed', 'Being with my stuff and my people', 'The home-trainers are essential', and 'Training is physical exercises, not everyday activities'. The first three themes in particular reflected the participants' driving forces in the reablement process. Driving forces are intrinsic motivation in interaction with extrinsic motivation. Intrinsic motivation was based on the person's willpower and responsibility, and extrinsic motivation was expressed to be strengthened by being in one's home environment with 'own' people, as well as by the co-operation with the reablement team. The reablement team encouraged and supported the older adults to regain confidence in performing everyday activities as well as participating in the society. Our findings have practical significance for politicians, healthcare providers and healthcare professionals by contributing to an understanding of how intrinsic and extrinsic motivation influence reablement. Some persons need apparently more extrinsic motivational support also after the time-limited reablement period is completed. The municipal health and care services need to consider individualised follow-up programmes after the intensive reablement period in order to maintain the achieved skills to perform everyday activities and participate in society.

**Keywords:** community rehabilitation, community services for the elderly people, multiprofessional collaborations

## Introduction

The number of older people is growing and forming an ever-larger share of the world's population (OECD 2013, UNECE 2015). However, the range of lifestyles and of physical, mental and social capabilities among older people leads in turn to diverse demands and needs regarding healthcare services (UNECE 2015). In addition, western countries have major challenges regarding the recruitment of professionals with the necessary expertise (OECD 2013). Currently in Europe as well as in the United States, an increasing proportion of very old people remain living in their homes despite declines in physical and mental health (Iwarsson *et al.* 2007, UNECE 2015). Furthermore, there is evidence that many older people prefer to 'age in place' (Boldy *et al.* 2011, Wiles *et al.* 2012) and therefore remain in their homes for as long as possible, provided they have appropriate levels of support to meet their needs (Cutchin *et al.* 2009, Cochrane *et al.* 2013). New health and social care services need to be developed that aim to promote active user involvement (UNECE 2015).

Accordingly, there has recently been a growing international interest in the new intervention termed reablement (Cochrane *et al.* 2013). Reablement is an early and time-limited home-based intervention with emphasis on intensive, goal-oriented and interdisciplinary rehabilitation for persons in need of rehabilitation or at risk of functional decline (Wilde & Glendinning 2012, Cochrane *et al.* 2013). Furthermore, reablement is individualised, based on the person's participation, and his/her resources. Rather than performing personal care and household tasks *for* people, reablement enables people to relearn skills and regain confidence in performing daily activities themselves. In USA, Australia and New Zealand, reablement is known as restorative care, which emphasises its role in restoring independent living skills, which may have been lost after a period of illness or injury (Wood & Salter 2012).

The development of reablement in Norway started in 2012, and up to date 28% of the municipalities have implemented it as one specific mode of organising rehabilitation services. In Norway, rehabilitation is defined as time-limited, planned processes with clear goals and measures, where several providers collaborate in assisting the person's own efforts in achieving the optimal level of coping and functional ability, independence, and social participation (Ministry of health and care services 1999). Reablement complies with all the criteria described in this definition. However, reablement means home-based rehabilitation, and is not institution- or hospital-based.

A central initial question to the participants in a reablement programme is: 'What are important activities for you nowadays' (Tuntland & Ness 2014, p. 38). In order to define activity goals and document the person's performance and satisfaction in daily activities, the instrument Canadian Occupational Performance Measure (COPM) (Law *et al.* 2014) is used in Norway, both initially and at the end of the reablement period. A co-ordinated multidisciplinary team and the home-care services, works together with the older adult towards shared goals, which is one of the main characteristics of reablement, as described in Table 2 (Cochrane *et al.* 2013, Tuntland *et al.* 2014). This is different from traditional rehabilitation in Norway, where the healthcare providers to a larger degree have profession-specific focuses, making the services more fragmented and the older adults' goals less visible for the rehabilitation team. Also, collaboration within the multidisciplinary team is more committing in reablement. In addition, reablement is a generic form of rehabilitation, while traditional rehabilitation may be more specialised and diagnosis specific.

There are currently few publications (Wilde & Glendinning 2012, Hansen *et al.* 2015) exploring older peoples' experiences of participating in reablement. Wilde and Glendinning (2012) revealed in their study from England that the participants were positive towards reablement, even if they called for a greater focus on social and leisure activities and outdoor mobility. Hansen *et al.* (2015) found in their study from Denmark that the older adults who participated in reablement wanted to be independent and to regain skills in order to manage everyday activities on their own and not waiting for others to help. Still, even if they wanted to be independent, some participants did not understand why the professionals did not do the tasks *for* them. Nonetheless, the professionals' feedback, supervision and support were perceived as important. However, there are still some questions about the reablement process, especially concerning topics as how older adults experience the co-operation with staff, or being in charge of their own goals, and how they are or become motivated. The aim of our study was to describe how older adults in Norway experience participation in reablement.

## Methods

### Design

The study was designed as a qualitative descriptive study (Sandelowski 2000, Sandelowski & Leeman

2012). Qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events. The analysis is based on de-contextualisation and re-contextualisation, which represents an inductive way of reasoning.

### Ethics

Ethics approval was given by the Norwegian Regional Medical Ethics Committee (2012/733REK West).

### Participants and context

The current study is a part of a larger research programme on reablement in home-dwelling adults, which includes a randomised controlled trial in a rural municipality in Norway (Tuntland *et al.* 2014). Participants were recruited by the local project leader among people applying for, or referred to home-based services, and purposeful sampling was performed. The office responsible for the allocation of public health services in the municipality, identified potential participants among the applicants, who were informed about the new reablement service, and invited to participate. Participants in the intervention group in the randomised controlled trial accepted to be part of the current study, and the sample included four men and four women aged 64–92 years (Table 1). The staff of the reablement team obtained the participants' written consent before starting the interviews.

### Reablement intervention

The intervention lasted for a maximum of 3 months. The intervention was tailored according to the participants' goals and thus the components of the rehabilitation plan varied as described in Table 2.

### Data collection method

The participants were interviewed face-to-face in their own homes by the first author of this paper. With four participants, interviews were conducted 1 month after starting, and once again after ending the reablement, while for other four participants, only one interview was conducted about 1 month after ending the reablement. In one case the participant's partner, and in another case the participant's daughter, were present during the interview and contributed to parts of it.

Two semi-structured interview guides were developed, one for each of the interviews, according to Kvale and Brinkmann (2009). In the first interview, the informants described how they experienced

reablement according to own goal-setting, shared decision-making and experiences with the exercise programme. To explore the participants' experiences in detail, descriptive questions were used (Sandelowski 2000, 2010), such as: 'What did you practice the last time someone from the reablement team visited you?' In the second interview, we explored the participants' experiences at the end of the reablement process. The second interview was also an opportunity to validate and deepen the data gained in the first interview, and to elaborate further on the participants' reflections about the topic under study.

Each interview lasted about 60–90 minutes. The interviews were conducted between February 2013 and June 2014. The data material was digitally recorded and later transcribed verbatim by the first author.

### Data analysis

A qualitative content analysis was used as the analysis strategy (Sandelowski 2000, 2010, Kvale & Brinkmann 2009). All authors have separately and together analysed the transcribed data, through an inductive approach, with a four-step analysis procedure (Sandelowski 2010, Malterud 2012, Elo *et al.* 2014).

In the first step of the analysis, all authors read each interview as these were carried out over time, and a preliminary analysis started, in order to be able to go more in depth in the second interview. Some topics from the initial analysis were more in focus when new participants were interviewed only once. Once all the interviews and transcriptions were completed, all material was put together and treated as a whole, and all the authors read all the transcripts in order to get a general sense of the whole data set.

In the second step of the analysis, we identified meaning units, which are defined as text fragments reflecting information about the participants' experiences of reablement. Then we started coding by identifying and sorting meaning units. A meaning unit encompassing experiences of being at home as an important factor for training was for example coded *being with my stuff and my people*. During this phase of de-contextualising, we reflected on the similarities and differences of each code. The final codes were based on the consensus of all authors after reading all the transcripts.

The third step of the analysis implied systematic abstraction of meaning units within each of the code groups established in the second step of analysis. The transcripts were read systematically in order to identify and classify the meaning units into thematic code groups.

**Table 1** Selected demographic characteristics of participants (N = 8)

Gender	Man (no. 1)	Woman (no. 2)	Woman (no. 3)	Man (no. 4)	Man (no. 5)	Man (no. 6)	Woman (no. 7)	Woman (no. 8)
Age	86 years	92 years	84 years	72 years	70 years	64 years	84 years	81 years
Status/living arrangement	Married Living with spouse Widower (in second interview)	Widow Living alone	Widow Living alone	Widower Living alone	Single Living alone	Single Living with sister	Widow Living alone	Widow Living alone
Housing status	Single-family house	Apartment house for elderly adults with areas for group activities	Single-family house	Apartment accessed by people with a disability	Single-family house	Single-family house	Apartment accessed by people with a disability	Single-family house
Diagnosis	Heart attack	Back-pain after falling Transient Ischaemic Attack	Hip fracture Osteoporosis	Pelvis fracture Hemokromatose Glaucoma Contracture of left hand	Stroke Heart attack Diabetes Asifhma	Stroke Knee arthrosis Diabetes	Hip fracture Osteoporosis	Pelvis fracture Rheumatoid arthritis Osteoporosis
Goals for reablement	To put on trousers, socks and shoes To dare to go alone to the toilet To turn in bed To get out of bed To be able to walk to family members in the neighbourhood	To walk without walker indoors To do own shopping To wash floors and bathroom To participate in a painting course To join a walkgroup every Wednesday	To walk without walker indoors To walk without walker outside To clean the house	To climb stairs To walk without walker outside	To clean floors To dust To walk safely in the natural environment	To climb stairs safely To hammer nails in the wall To use a wheelbarrow To collect mail from the mailbox	To shower independently To walk without walking aids indoors To walk to the grocery store with one crutch To clean floors	To groom myself in the bathroom To climb stairs from first to second floor To walk without walker indoors To prepare dinner To walk to Edith's house
Time-point for interviews	February 2013 September 2013	February 2013 September 2013	September 2013	October 2013	September 2013	February 2014	March 2014 June 2014	April 2014 June 2014

**Table 2** Features of the reablement intervention (Tuntland *et al.* 2014)

General features	Individual features
<ul style="list-style-type: none"> <li>• The rehabilitation period lasted a maximum of 3 months.</li> <li>• An occupational therapist or physiotherapist conducted the COPM interview and developed the rehabilitation plan together with the participant based on the identified activity goals. Thereafter, an integrated multidisciplinary team with shared goals guided the participant during the whole rehabilitation period.</li> <li>• In addition to home-care personnel assisted training, a minimum of 1 hour physiotherapist and/or occupational therapist-assisted training each week.</li> <li>• The treatment involved repetitive training and multiple home-visits by healthcare personnel, who were present during daily training for the purposes of building confidence and relearning skills.</li> <li>• All healthcare personnel stimulated the participant in self-management and self-training.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Training in daily activities</i> such as dressing, food preparation, vacuuming, bus transport, visiting friends at a club or being able to knit.</li> <li>• <i>Adaptations</i> such as advice on appropriate assistive technology or adapting the activity itself or the environment, in order to simplify activity performance.</li> <li>• <i>Exercise programmes</i> such as indoor or outdoor walking with or without walking aids, climbing stairs, transferring and performing exercises to improve strength, balance or fine motor skills. The exercises was incorporated into daily routines and the person was given a manual explaining each of the exercises and encouraged to train on their own.</li> </ul>

In the fourth step of the analysis, data were re-contextualised by developing descriptions providing stories that reflected the wholeness of the original context. This was outlined in core themes and sub-themes, and is presented in the findings. To indicate the trustworthiness of the core themes and subthemes identified, representative text elements from the transcripts are used as quotations in the reporting of results.

## Findings

As a result of the analyses, four themes emerged: (i) My willpower is needed, (ii) Being with my stuff and my people, (iii) The home-trainers are essential for me and (iv) Training is physical exercises, not everyday activities.

### My willpower is needed

Several of the participants described, directly or indirectly, how their own determination was an important factor in the reablement process. The willpower to manage personal care or some housework alone was evolving as they recovered. Though they differed in age, participants reflected about the determination to do physical exercises and everyday activities, so as to become as good as before the accident, decline or illness, and as a personal matter which they had to take responsibility for. As one participant said:

It depends on the willpower. Yes, that is what you need, the willpower ... if you sit down, then you're not going anywhere. You must have the drive to come ahead in life. Goal-setting, has been important and my willpower to exercise. [participant no. 8]

The willpower is perceived as important to exercise and performing everyday activities to achieve the goal for reablement. Setting goals (see Table 1) was experienced by the participants as important for looking forward to be the person they were before.

### Being at home with my stuff and my people

Being with my stuff and my people included dimensions of being in a known and beloved context, having regular visits and having the opportunity to continue taking part in leisure activities and social life. It was expressed as:

It is all the stuff one feels connected to; it is the pictures of all the grandchildren. One gets to love all these things we have over the years. I have lived here for a long time. Here I have all my good neighbours and it is important that they, friends and my family can visit me. It is important for me to go outside the home to have fresh air and meet some people. I enjoy myself here in my home. You feel at home because you have stuff and people all around you. I think it has been a great deal that the reablement service came home to me. [participant no. 8]

Participants in this study described how reablement in their homes enabled them to be independent and to have autonomy. They preferred to plan themselves how everyday life should be with regard to training and participating in activities. They emphasised that they wanted to adjust everyday life according to their day-to-day health condition. As two participants said:

...however, it is strange..., when you come home again ... you are your own master in a way ... you do what you cope with, what you want to do. When I am doing it myself here, I use the time I need ... I have my



own time. I do not hurry, it is not good for elderly people, we do not like to rush. [participant no. 7]

If you are going to exercise some other place than home, you must have an appointment. However, when you are at home you can do the exercises when you are ready for it, you have the control yourself. [participant no. 1]

Several participants said they were active in their own environments as they continued with their familiar and habitual life patterns, though some of the activities had to be adapted. One woman [participant no. 7] said:

...you are more active at home, at least for those who want to. There is activity in everything we do. I am more active at home. If I was somewhere else, it would be as *they* wanted, here it is the way *I* want to, that's actually important for me.

### **The reablement team is important for me**

The essential support of the reablement team as a co-partner was expressed in various ways: 'they encourage me', 'the clue' and 'someone who provides care and sees me as a person who needs support'. This is illustrated in the following quotation:

The reablement team was so nice people, they were a bright spot, and very cheerful and friendly. They came several times a day in the beginning of the reablement period. I was taken care of. I knew they were coming and I believe it is very positive, that you in a way recover faster. [participant no. 8]

This theme is encompassing two subthemes: (i) Encouragement to take responsibility in daily training and (ii) Encouragement to feel confident doing everyday activities on one's own.

#### *Encouragement to take responsibility in daily training*

Daily training consists of practising everyday activities and doing physical exercises. The reablement team is not performing the activities *for* the person, but rather facilitate the older adult to do the activities himself/herself. One woman [participant no. 7] stressed that the professionals of course were only observing her, otherwise it would be of no help for her if they would be cleaning the floor and while she would be observing them. They observed how she did it and supervised her in performing the activity. Other participants [no. 8] expressed it this way:

I have the responsibility to train to get better. There is no one else who can do it. The team supervised me, and I asked questions in order to do it the right way, to have benefit of training activities of daily living (ADL). It wouldn't be the same if the therapist did the activities *for* me, because

then I had not remembered it, and I had not learned how to perform them. That is essential when I want to exercise and practice on my own. I have received much praise from the team. I believe it is because I have been active myself that I have recovered quite well now.

The team encouraged the participants to take responsibility to be active in reablement. This responsibility gave the older adults a feeling of freedom. They could decide if and when to perform an activity without being dependent on professionals' time and availability of help. One woman said this:

I have the responsibility ... and you feel a little freer in a way. You can do as you did before the illness. I used to go for a walk every day, however I don't go down to the main road yet, but I walk a little further each day. It is the freedom to decide yourself when you want to go for a walk. It was like a new life when I could go outside. [participant no. 8]

#### *Encouragement to feel confident doing everyday activities on one's own*

Reablement focus on encouraging and supporting people to regain their confidence and skills in order to continue to participate in everyday activities. The professionals adjust their support so the older adults might feel confident and safe. One participant expressed this:

In the early stage of the reablement, the professionals walked next to me up the stairs, I did not *trust* myself. I regained some confidence after intensive training, and they walked behind me. When the reablement was nearly coming to an end, I walked up and down the stairs myself, however, the staff was in the house. I felt completely secure when I knew they were in the house. [participant no. 9]

One woman [no. 7] described how she became safe and regained confidence to shower herself:

They supported me in the beginning, so I showered myself while someone from the reablement service was here. I got a chair to sit on to be more secure when showering. They were here until I felt secure to shower myself.

Other participants told similar stories about how the professionals' support in the beginning of the reablement period contributed to increased confidence in doing tasks alone. For some participants it was more important to have confidence to manage outdoors activities than household management. For example one woman, who lived alone, needed support the first time in the reablement process when she wanted to go by bus to the town centre and home again. Already the day after, she was ready to go by bus on her own.

Some participants expressed how the staffs' encouragement, support and supervision stimulated them to exercise both when the home-trainers were at their house, and when training on their own. One participant [no. 6] described the reablement team as 'a driving force supporting me in the training'. The professionals and the reablement service were 'the best that ever happened to me'. Another participant [no. 1] said: 'It was like winning the big lottery'. However, some participants were only motivated to train when someone from the team was visiting them, otherwise they would not do exercises. When the reablement period ended, a few participants expressed how they missed the staff and how they felt lonely doing the exercises on their own. Some participants continued with exercises, others did not, because no one encouraged and supported them anymore.

### Training is physical exercises, not everyday activities

In our study many of the participants' goals were ADL, see Table 1. How the participants achieved their objectives was expressed as something that was almost coming by itself. They did not *exercise* in the activities of showering, dressing, cooking, walking to the grocery and so on. One participant expressed it this way:

I didn't train showering ... I have showered all my life that is no exercises or training for me. It was one of my goals to manage showering, and I adapted the showering by having the towel and clothes just next. I cannot imagine me saying training showering. Another goal for me was to clean the floor. I *practised* or *tried* to clean the floor with the reablement team, I did not train to clean the floor. [participant no. 7]

Several participants expressed that they understood training in reablement as doing physical exercises in order to improve physical strength, balance and range of motion. Participants were given written information with drawings explaining how and which exercises should be done. However, performing ADL was not training, though the professionals facilitated training in performing different ADL activities as well as suggesting various physical exercises.

Finally, the older adults had to be active themselves with or without supervision from the reablement team. This seemed to give the persons an experience of having done the rehabilitation themselves. As participant [no. 3] said: 'I have actually trained myself to be better'.

### Discussion

The aim of this study was to describe how older adults experience participation in a reablement programme. The participants highlighted driving forces as intrinsic and extrinsic motivation working together to enhance the process of coping with and performing everyday activities.

The willpower was one important driving force for achieving goals that matter for the person. In our study the participants were enabled to define activity goals without restrictions and this was a major contribution to the willpower and intrinsic motivation. Many goals were related to social, leisure and outdoor activities and participating in the society. This is in contrast to the study of Wilde and Glendinning (2012), where these activities were not in focus. However, individual goals require that the work of the multiprofessional team is streamlined and co-ordinated, where the person and the team make decisions together.

Being at home with 'their stuff and their people' was another driving force. In their home, the participants had the opportunity to plan their everyday life themselves, such as about when to train and when to participate in activities indoors and outdoors. In addition, family, friends, neighbours and social environments were essential elements to regain confidence performing everyday activities. Similar findings were presented by Wiles *et al.* (2012) and Haak *et al.* (2007), where ageing in place was found to enable older people to maintain independence, autonomy and connection to their social environment. As in our study, the participants in these studies experienced security and familiarity in their homes and communities.

A major driving force in the reablement process was the co-operation between the person and the reablement team. During the initial COPM interview, the participants' motivation was stimulated through defining own goals. The participants experienced that their motivation was further enhanced due to the professional staff's support and supervision. The reablement team co-operated closely with the home services, and this integrated approach focusing on the older adults' goals was crucial for encouraging the participants' drive.

The physical presence of the healthcare providers and the co-operation were essential for regaining confidence. The team focused on assisting and supporting the older person to regain confidence, skills and competence in order to continue to participate in everyday activities. They encouraged the participants

to take responsibility to exercise and perform activities, with or without adjustment and assistance, with the professionals or the home-trainers being present. This is supported by the findings of Trappes-Lomax and Hawton (2012) and Hansen *et al.* (2015) who describe a working co-operation between the staff and the older adults as essential. In these studies, as in ours, the key factor in the co-operation appears to be confidence and the way the staff motivate older adults to engage in reablement. They used positive feedback, encouraged and gave support. According to Ryan and Deci (2000) extrinsic motivation as positive feedback, communication and rewards enhance motivation for an action.

In our study, the participants experienced the staff as a source of safety when performing everyday activities. When the participants were unconfident about own skills and did not *trust* themselves, the reablement team's support, encouragement and adjustment of activities, and being in house, enhanced them to train or perform everyday activities on their own. This supporting approach to optimise independent functioning is an important feature of reablement.

Although some of the participants in our study preferred and were motivated to exercise on their own, others remained dependent on extrinsic motivation to exercise and perform activities during the entire rehabilitation period. When the extrinsic motivation failed, also the intrinsic motivation weakened. Ryan and Deci argue that (2000) intrinsic motivation requires supportive conditions, and our findings indicate that some older persons are dependent of extrinsic motivation for longer time than others. Furthermore, our research gives reason to propose that benefits from the reablement process might be weakened when the older adults' intrinsic motivation is weak and they are dependent on extrinsic motivation in order to maintain their level of functioning. The municipal primary healthcare services need to consider individualised programmes for follow-up after the reablement period in order to maintain the achieved level of function and independence.

Finally, another interesting finding in our study was the fact that the concept of 'training' was, for most participants, associated with physical exercising, and not with everyday activities. When they talked about training, they referred typically to a private fitness centre under the guidance of a physiotherapist. In our study, the participants did not conceive reablement as 'real training', though they practised performing everyday activities themselves. This is in line with Hansen *et al.* (2015) descriptions of how older adults in Denmark did not perceive that reablement

had followed a specific plan. Reablement as a rehabilitation mode consists of regaining some 'natural' and ordinary skills being performed throughout life. When older adults gradually experience progress in performing everyday activities, this may be interpreted as spontaneous recovery which is not due to the reablement training. However, some of the participants in our study did not perceive the reablement as 'training' at all, and it was rather termed as 'trying to do everyday activities'. However, these efforts were still a driving force in order to be the person they were before their experienced functional decline. Their efforts led to progress and became increasingly a driving force.

### Methodological considerations

The strength of our study applying a qualitative approach to older adults' experiences with reablement is that the study has provided valuable insight from those at stake. When researching and developing the notion of reablement, it is important that the voices of those trying out this rehabilitation approach are heard.

One limitation of our study is the fact that, as the participants were recruited from the intervention group of the randomised controlled trial (Tuntland *et al.* 2014), they all were, from the beginning, positive to the reablement, with willpower in place. Moreover, the project leader who recruited the participants may have asked persons who were satisfied and had a successful reablement, to take part in this study, which may have added another bias to a sample with a limited number of participants. This means that the study's participants do not necessarily represent other older people being offered or trying out reablement services. Still, the study provided more in-depth insight into a few cases that could be related to similar situations or cases (Kvale & Brinkmann 2009, Sandelowski 2010, Sandelowski & Leeman 2012). For example, practising and training with daily activities while getting support in one's own home and social environment might be motivating for a larger number of older adults.

### Conclusion

The older adults' own understanding, of which activities are important for him/her to focus on in reablement, is essential for success. The personal determination and responsibility are intrinsic motivational factors and a driving force to achieve goals for the reablement process. Another driving force and an important extrinsic motivational factor is the reable-



ment team as a working co-operation. This study highlights the importance of understanding how reablement is influenced by both intrinsic and extrinsic motivational factors to optimise older adults' healthy ageing. It seems to be critical to ensure that, for some persons, home-based services should provide an individualised follow-up programme after ending the intensive reablement period, in order to maintain the achieved level of functional independence. This implies that responsible stakeholders allocate the necessary resources to such community-based rehabilitation services.

### Acknowledgements

KMH, HT, HA and local research assistants are sponsored by Regional Research Funds Western Norway, grant number 229759. In addition, the Norwegian Association of Occupational Therapists supported KM. We thank all the participants who willingly shared their experiences of reablement with us. Thanks also to the local project leaders, Torill Hunnålvatn and Synnøve Herre, for recruiting participants for our research.

### Conflicts of interest

None declared.

### References

- Boldy D., Grenade L., Lewin G., Karol E. & Burton E. (2011) Older people's decisions regarding 'ageing in place': a Western Australian case study. *Australasian Journal on Ageing* **30** (3), 136–142.
- Cochrane A., McGiloway S., Furlong M., Molloy David W., Stevenson M. & Donnelly M. (2013) Home-care 're-ablement' services for maintaining and improving older adults' functional independence. *Cochrane Database of Systematic Reviews* **11**, Art. No.: CD010825. doi:10.1002/14651858.CD010825.
- Cutchin M.P., Coppola S., Talley V., Svihula J., Catellier D. & Shank K.H. (2009) Feasibility and effects of preventive home visits for at-risk older people: design of a randomized controlled trial. *WiBMC Geriatrics* **9** (1), 54.
- Elo S., Kääriäinen M., Kanste O., Pölkki T., Utriainen K. & Kyngäs H. (2014) Qualitative content analysis a focus on trustworthiness. *SAGE Open* **4** (1), 1–10.
- Haak M., Fänge A., Iwarsson S. & Dahlin Ivanoff S. (2007) Home as a signification of independence and autonomy: experiences among very old Swedish people. *Scandinavian Journal of Occupational Therapy* **14** (1), 16–24.
- Hansen E.B., Eskelinen L., Rahbæk M.Ø. & Helles J.N. (2015) *Ældres oplevelse af hverdagsrehabilitering [Older Adults' Experiences of Reablement]*. København, KORA, Copenhagen.
- Iwarsson S., Wahl H.-W., Nygren C. et al. (2007) Importance of the home environment for healthy aging: conceptual and methodological background of the European ENABLE-AGE Project. *The Gerontologist* **47** (1), 78–84.
- Kvale S. & Brinkmann S. (2009) *Interviews: Learning the Craft of Qualitative Research Interviewing*. Sage, Los Angeles, CA.
- Law M., Baptiste S., Carswell A., McColl M.A., Polatajko H.J. & Pollock N. (2014) *COPM: Canadian Occupational Performance Measure*. Nasjonal kompetansesenter for revmatologisk rehabilitering (NKRR), Oslo.
- Malterud K. (2012) Systematic text condensation: a strategy for qualitative analysis. *Scandinavian Journal of Public Health* **40** (8), 795–805.
- Ministry of Health and Care Services (1999) *Responsibility and Coping: Towards a Holistic Rehabilitation Policy [Ansvar og meistring: mot ein heilskapleg rehabiliteringspolitikk: St.meld. nr 21]*. Ministry, Oslo.
- OECD (2013) *Health at a Glance 2013: OECD Indicators*. OECD Publishing, Paris.
- Ryan R.M. & Deci E.L. (2000) Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist* **55** (1), 68.
- Sandelowski M. (2000) Focus on research methods: whatever happened to qualitative description? *Research in Nursing and Health* **23** (4), 334–340.
- Sandelowski M. (2010) What's in a name? Qualitative description revisited. *Research in Nursing & Health* **33** (1), 77–84.
- Sandelowski M. & Leeman J. (2012) Writing usable qualitative health research findings. *Qualitative Health Research* **22** (10), 1404–1413.
- Trappes-Lomax T. & Hawton A. (2012) The user voice: older people's experiences of reablement and rehabilitation. *Journal of Integrated Care* **20** (3), 181–195.
- Tuntland H. & Ness N.E. (Eds) (2014) *Hverdagsrehabilitering [Reablement]*. Gyldendal Akademisk, Oslo.
- Tuntland H., Espehaug B., Forland O., Hole A.D., Kjerstad E. & Kjekken I. (2014) Reablement in community-dwelling adults: study protocol for a randomised controlled trial. *BMC Geriatrics* **14**, 139.
- UNECE (2015) *Innovative and Empowering Strategies for Care*. Policy Brief on Ageing. UNECE, Geneva.
- Wilde A. & Glendinning C. (2012) 'If they're helping me then how can I be independent?' The perceptions and experience of users of home-care re-ablement services. *Health & Social Care in the Community* **20** (6), 583–590.
- Wiles J.L., Leibing A., Guberman N., Reeve J. & Allen R.E. (2012) The meaning of "aging in place" to older people. *The Gerontologist* **52** (3), 357–366.
- Wood C. & Salter J. (2012) *Housing Providers Can Play a Vital Role in Rehabilitation and Reablement...: The Home Cure*. Demos, London.