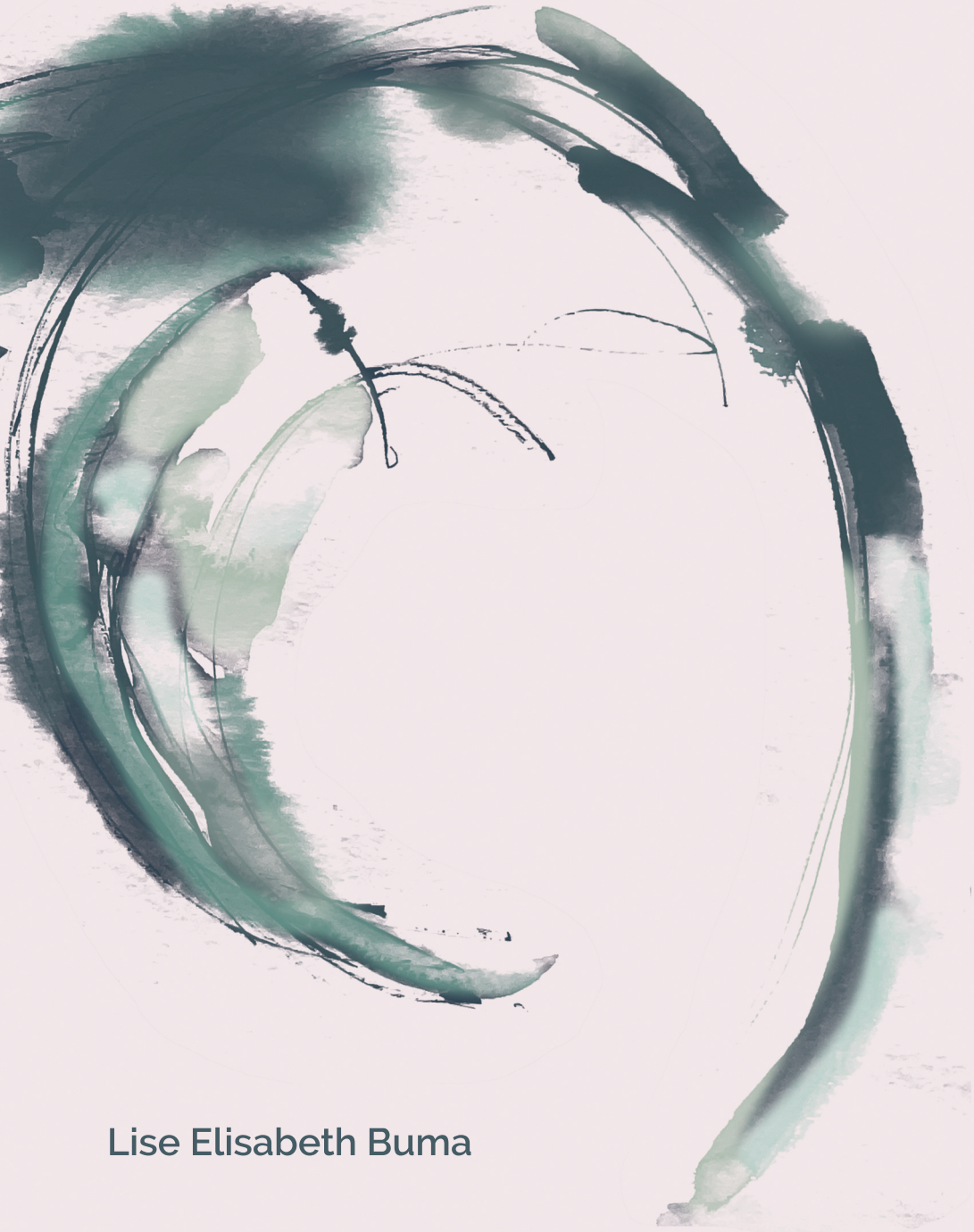
Reablement and the philosophy's goal

Paving the way for reablement in the Netherlands using global insights



Lise Elisabeth Buma

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The research presented in this dissertation was conducted at the Care and Public Health Research Institute (CAPHRI), department of Health Services Research, Maastricht University. CAPHRI is part of The Netherlands School of Public Health and Care Research (CaRe).

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The front cover features a pen drawing by my mother, Jennifer Slinkers, an artist who created this piece especially for my dissertation. It is called 'Beweging' ('Movement'), reflecting the rise of reablement in the Netherlands. The drawing also represents changes in care for older persons, the momentum and challenges of implementation, and the collective effort needed to sustain it.

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PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit Maastricht,
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volgens het besluit van het College van Decanen,
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Promotores

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Prof. Dr. I.N. Fabbricotti (Erasmus University Rotterdam)

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Voor papa en mama

Chapter 1

General introduction

Population ageing, coupled with the rise in chronic conditions, is driving increased demands for and greater complexity of care delivery.[1] The increasing number of older adults with complex care needs in combination with staffing shortages present significant challenges for healthcare systems, and will continue to do so in the coming years.[2] Older adults often prefer to age in their homes, which is associated with independence and comfort.[3] Globally, countries are implementing strategies in healthcare to enable older adults to age in their own homes, which is also known as an ageing-in-place policy. This approach aligns with the key objectives of the World Health Organization and the United Nations Decade of Healthy Ageing.[4] Promoting ageing-in-place is seen as a useful strategy to manage limited resources within healthcare systems.[5] The objectives include, among others, promoting functional ability and independence, strengthening health systems to better meet the needs of older adults, enhancing social participation, encouraging health behaviours, and preventative measures.

At present, healthcare is often organised reactively, addressing diseases and their consequences after they arise.[6] Shifting towards a more preventative approach could contribute to a more sustainable and effective healthcare system by reducing the prevalence of avoidable conditions, improving population health, and reducing strain on healthcare resources.[7,8] A more proactive, capabilities-based approach challenges the traditional disability-focused model, emphasising what individuals can do rather than what they cannot.[9] This embraces a biopsychosocial model that integrates physical, psychological, and social factors, moving beyond a purely biomedical perspective.[10] Moreover, community care is often fragmented, characterised by a lack of coordination and inadequate communication between care providers, clients, and informal caregivers.[11,12] It often fails to meet the existing needs due to the absence of a unified approach and insufficient integration of services.[13] Integrated care is essential to address these challenges, fostering collaboration and delivering coordinated, holistic, and person-centred care that aligns with individuals' preferences and promotes better outcomes.[14]

Towards health and well-being and focusing on strengths and capabilities

The theory of successful ageing underscores the importance of promoting not just the absence of disease, but also the active maintenance of physical health, mental well-being, and social participation.[15] In addition, the meta-model on successful aging by Baltes and Baltes[16] emphasises the importance of individuals setting goals to optimise their abilities for meaningful

activities. It also highlights the use of alternative strategies to compensate for limitations that can no longer be overcome. Successful ageing therefore advocates a strength-based model that encourages individuals to stay physically active, socially engaged, and mentally stimulated. Hence, healthcare professionals must transition from providing care that is largely passive and reactive – where tasks are performed for the individual – to a more active, collaborative model that supports individuals in maintaining their independence and autonomy.[7,8] This shift encourages a more person-centred approach for healthcare professionals and individuals to take an active role in their care and daily activities, helping them regain independence and enhancing their overall sense of purpose and well-being.[17] This approach aligns with the principles of Positive Health, a concept adopted by many Dutch healthcare organisations.[18] Positive Health endorses a holistic approach, promoting resilience and the individual's ability to adapt and navigate physical, emotional, and social challenges. This is illustrated by Huber's six dimensions of Positive Health: bodily functions, mental functions and perception, the spiritual/existential dimension, quality of life, social and societal participation, and daily functioning. Recognising that well-being is influenced by more than medical conditions helps bridge the gap between health and social care. Initiatives are needed that empower individuals to maintain and regain their independence and abilities, which can reduce strain on healthcare services and allow for proactive support, aligning with the broader goals of healthy ageing. Furthermore, focusing on strengths and abilities helps de-medicalise societal challenges and encourages solutions going beyond clinical interventions.[18] Reablement offers such a solution by using a person-centred, multidisciplinary, holistic approach that empowers individuals to (re)gain independence and confidence in performing daily and meaningful activities while encouraging social participation.[19] Reablement aligns with the rationales behind the concept of Positive Health and successful ageing models, encouraging care professionals to shift from a 'doing for' to a 'doing with' approach, in which they act as facilitators who focus on the individual's situation and provide tailored care and support, contributing to the resilience and well-being of older adults.[20,21]

The origin and evolution of reablement

The concept of reablement first emerged in the scientific literature at the end of the Second World War,[22] coinciding with a shift in rehabilitation from solely improving mobility to enabling individuals to resume specific tasks and roles related to work, self-care, or social participation.[23] Reablement was first introduced to the ageing population in the 1990s, emphasising the

importance of maintaining independence and quality of life as individuals age.[24] Starting from the early 2000s, the concept of reablement (also mentioned in the beginning as 'restorative care') was advanced by American researchers. Their reablement approach also emphasised the training of nursing staff, and the authors described it as grounded in principles drawn from geriatric medicine, nursing, rehabilitation, and goal attainment.[25] Around the same time, reablement was introduced in the United Kingdom, focusing on personal care, household tasks, and mobility, while emphasising client empowerment and promoting self-reliance.[26] As reablement expanded further in the United Kingdom, it also gained traction in Australia, New Zealand, and Sweden. In these countries, reablement was recognised as a more preventative approach and a promising alternative to traditional nursing home care, which is often more reactive.

Reablement has been adopted or is in the process of being integrated into the healthcare systems throughout the world.[27] It has continued to evolve, incorporating evidence-based practices and a more person-centred approach. Current reablement programmes emphasise a multidisciplinary approach, combining elements of physiotherapy, occupational therapy and social support.[23] Over the years, reablement has transformed from a narrow focus on mobility improvement to a broad, integrative approach that supports independence and quality of life across various dimensions of health and well-being, aligning with individual goals and preferences. These goals can be focused on activities of daily living or other meaningful activities and social engagement.[27] Multidisciplinary teams play a crucial role in reablement, as they motivate and guide older adults to recover or maintain independence, overall well-being, and social inclusion.[28]

Challenges in defining and evaluating reablement

Some studies suggest that reablement can improve client-level outcomes – such as daily functioning, physical functioning, and quality of life – and help reduce care needs and costs,[29-32] while others have reported inconclusive results on whether reablement leads to greater improvement compared with traditional home care.[33-35] The contradictory evidence seems to be linked to the conceptualisation of reablement. To start, in the past reablement has been described as an 'ill-defined intervention' due to the absence of a clear theoretical framework, which is crucial for its effective implementation and evaluation.[21,34,36] This lack of clarity is reflected in the many studies on reablement, which have demonstrated variation in

components and approaches. These differences exist both within and between countries, highlighting the ongoing lack of consensus on key aspects of reablement.[27] The absence of a uniform definition of reablement has led to a wide range of interpretations in the scientific literature, with the term often being used interchangeably with other interventions.[31] Furthermore, the inconsistency is also attributed to methodological variations in the existing research, including heterogeneity in study designs and outcome measures.[32,33]

Establishing common ground

Due to the worldwide interest in reablement, an international reablement network was established in 2018,[37] which has expanded over the years to a network of over 55 members from 12 countries. One of the network's initial steps was to develop a shared definition of reablement, ensuring a consistent foundation for research, given the significant variations in its interpretation and application across different geographical and healthcare contexts. By establishing a shared definition, the network aimed to promote conceptual clarity and facilitate comparability of findings across studies. Therefore, Metzelthin et al.[19] conducted a Delphi study with reablement experts to develop a consensus-based international definition of reablement:

> *"Reablement is a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting."*

This definition remains largely conceptual and lacks the specificity needed for practical application, as its components are highly context dependent and can vary between and even within countries.[19,27]

Context is key

The definition of reablement has been utilised for policy and research in several countries, including Sweden, Denmark, Norway, Belgium, and Taiwan. Moreover, the ReAble Network advocates for the development of country-specific operational definitions, building on the internationally accepted conceptual definition,[19] to ensure that national and local policy and institutional contexts are considered. Local policy and regulatory frameworks influence how reablement services are funded, delivered, and prioritised. For example, reablement can be offered as part of public healthcare, as seen in the United Kingdom, or initiated by local authorities, as seen in Norwegian municipalities.[38] In Denmark, reablement services are a standard offer following hospital discharge as part of the follow-up care when returning home. Additionally, resource availability, such as trained staff and technology, play a significant role. In countries with remote areas (e.g., Australia), reablement services can have long wait times or the costs may outweigh the available reimbursements, and there are challenges in recruiting and retaining trained staff.[39] Due to these contextual influences, distinctions in reablement services are also seen depending on their outcome focus areas, such as functional improvement or social connectivity.[40] Therefore, reablement is considered to be a context-driven approach, influenced by the specific social, cultural, economic, and healthcare contexts in which it is implemented.[41]

Reablement in the Netherlands

For about a decade, the Living Lab in Ageing and Long-Term Care has conducted scientific research about reablement in the Netherlands. The development of reablement was shaped initially by the long-standing experiences of countries such as the United States, New Zealand, and Australia. The growing interest in reablement has led to more care and welfare providers in the Netherlands experimenting with it. By drawing on international resources, insights, and practices, the Living Lab in Ageing and Long-Term Care has attempted to tailor and refine reablement approaches to meet the specific needs and circumstances of the Dutch healthcare system. Initially, the focus was on implementing the reablement philosophy in usual long-term care for older adults through training programmes such as Stay Active at Home.[42] However, Rooijackers[42] concluded in her PhD thesis based on a randomised controlled trial that training alone is insufficient, mainly because reablement in Dutch community care requires a fundamentally different approach compared to current care practices. Therefore, the I-

MANAGE model was developed and published in 2023,[43] guiding the implementation of reablement programmes in Dutch community care. It comprises six key components: improving assessment and goal setting; stimulating self-management during meaningful daily activities; optimising the use of the physical environment; optimising the use of the social environment; improving interprofessional collaboration; and supporting the informal caregiver. The model is structured around five chronological phases: (1) initiation, (2) intake, (3) care plan, (4) care delivery, and (5) evaluation.[43] Nevertheless, there is limited knowledge about which aspects of reablement are most promising, how they can be best executed, and which factors facilitate or hinder the implementation process.[44,45] Furthermore, the integration of reablement into usual care is hampered by the ongoing debate over its precise components and the lack of an operational definition in the Dutch context. The conceptual definition lacks the specificity needed for practical application, including clarity on key aspects such as the used interventions, target groups, and team composition.

Aim and outline of this dissertation

To advance the development of reablement in the Dutch context, it is important to continue to learn from reablement programmes across the world. This includes an understanding of how various factors might influence outcomes and recognising potential opportunities and challenges for implementation in the Netherlands. The overall aim of this dissertation was twofold:

1. To explore key features of reablement practices throughout the world; and
2. To apply these insights to define, implement, and evaluate reablement in the Dutch context.

Chapter 2 describes the results of a systematic review, providing an overview of reablement interventions across the world, their outcomes, and promising features. Chapter 3 is a comparative case study of three countries, focusing on goal setting and achievement, and interdisciplinary collaboration within reablement. Chapter 4 describes a Delphi study, where experts – that is, care professionals, managers, and policymakers – agreed upon a Dutch operational definition of reablement. Chapter 5 presents a feasibility study using a multi-stakeholder perspective to assess the small-scale implementation of a reablement programme in Dutch community care. Chapter 6 describes a qualitative exploration of professionals'

experiences with the implementation of reablement programmes in the Netherlands. Finally, Chapter 7 summarises and discusses the main findings of this dissertation, reflects on the theoretical and methodological considerations, and provides recommendations to move forward in policy, practice, and further research.

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Chapter 2

Effects on clients' daily functioning and common features of reablement interventions: a systematic literature review

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Abstract

This systematic review aimed to provide an overview of reablement interventions according to the recently published ReAble definition and their effect on Activities of Daily Living (ADL). In addition, the most common and promising features of these reablement interventions were identified. Four electronic bibliographic databases were searched. Articles were included when published between 2002 and 2020, described a Randomised or Clinical Controlled Trial of a reablement intervention matching the criteria of the ReAble-definition, and had ADL functioning as an outcome. Snowball sampling and expert completion were used to detect additional publications. Two researchers screened and extracted the identified articles and assessed methodological quality; discrepancies were resolved by discussion and arbitration by a third researcher. Twenty relevant studies from eight countries were included. Ten of these studies were effective in improving ADL functioning. Identifying promising features was challenging as an equal amount of effective and non-effective interventions were included, content descriptions were often lacking, and study quality was moderate to low. However, there are indications that the use of more diverse interdisciplinary teams, a standardised assessment and goal-setting method and four or more intervention components (i.e. ADL-training, physical and/ or functional exercise, education, management of functional disorders) can improve daily functioning. No conclusions could be drawn concerning the effectiveness on ADL functioning. The common elements identified can provide guidance when developing reablement programmes. Intervention protocols and process evaluations should be published more often using reporting guidelines. Collecting additional data from reablement experts could help to unpack the black box of reablement.

Introduction

With increasing age, older adults often experience functional disability, which is described as difficulty or dependency in the execution of daily functioning or Activities of Daily Living (ADL).[1-3] ADL can be divided into basic self-care skills such as eating, bathing or dressing (bADL); more complex and instrumental activities such as using a telephone, doing the laundry or managing medications (iADL); and advanced culture and gender-specific activities not necessary for independent living such as hobbies, religion and working (aADL).[4] Difficulties in executing ADL are associated with poor quality of life, depression, hospitalisation and nursing home placement, and increased disability.[5] It is therefore important to optimise older adults' active involvement and participation in daily functioning.[6]

Older adults can generally rely on help from health and social care staff in performing everyday activities. However, these professionals often work in a task-oriented fashion; they are used to doing tasks for or to the individual, rather than doing tasks with them in a more rehabilitative and person-centred manner.[6,7] This task-oriented approach can lead to a downward spiral, with a greater loss of functions and paradoxically greater care consumption.[8-10] Therefore, a paradigm shift in health respectively social care is needed, which focuses on person-centeredness and promotes older adults' active involvement and participation.

An innovative approach that can guide this shift is reablement. As there was ambiguity on the concept of reablement, a Delphi study was conducted among 81 international experts that saw reablement defined as:

> *"A person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications, and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting".*[11]

Due to the use of different definitions of reablement before the existence of the ReAble-definition, divergent results were found regarding the effectiveness. Reablement has shown positive effects on improving or maintaining ADL and physical functioning, quality of life, and reducing the risk of death or permanent residential care and healthcare costs,[10,12-14] while other reablement reviews have demonstrated no effects, reported a lack of intervention descriptions or could not include studies.[15-17] The contradictory evidence seems to link back to the conceptualisation of reablement. First, existing systematic reviews defined reablement differently, which led to different inclusion criteria and requirements. Consequently, different conclusions were drawn on the effects of reablement. As a result, one systematic review found no indication that reablement led to less dependency in ADL functioning.[15] In contrast, four systematic reviews found that reablement showed positive results in optimising ADL functioning.[10,13,14,18] Second, reablement is often used interchangeably with other interventions; for example, in the review of Sims-Gould et al.[13] four different types of interventions were included, namely reactivation, restorative, rehabilitation, and reablement. Lastly, another shortcoming is that the studied interventions show great variation in how reablement and its components are applied and shaped in practice. This is highlighted by Doh et al.[19] who point out the variation of reablement interventions between and even within different countries.

Currently, it is unknown what the evidence on reablement is when this definition is used as a starting point. Given the objective of reablement, increasing independence, it is particularly interesting to look at daily functioning. Therefore, using the ReAble definition as a starting point, this systematic review aims to provide a current overview of reablement interventions internationally, and their effect on clients' daily functioning, combined with identifying common and possibly promising features. This systematic review is guided by the following three research questions: 1) What are the effects of reablement on daily functioning among individuals in need of care irrespective of age, capacity, diagnosis, or setting? 2) What are the common features of reablement interventions according to the elements addressed in the ReAble-definition (e.g. assessment, goal-setting tools, and staff training)? And 3) What are the most promising reablement features?

Methods

A systematic review was conducted following the guidelines published by the Cochrane Collaboration and Preferred Reporting Items for Systematic reviews and META-analyses (PRISMA) statement. [20,21] A review protocol was established *a priori* and registered with PROSPERO (https://www.crd.york.ac.uk/PROSPERO/, ID CRD42020215245).

Eligibility criteria

Studies were eligible when the described intervention was in line with the criteria of the ReAble definition.[11] Therefore, participants included were ≥18 years old, and in need of care, irrespective of capacity, diagnosis or setting. Studies were included when interventions aimed to enhance an individual's physical and/or other types of functioning; increase or maintain independence in meaningful ADLs at the place of residence; or reduce the need for long-term services. The interventions had to be delivered by an interdisciplinary team, include an initial assessment followed by regular assessments and contained a goal-oriented support plan. Interventions were excluded when problem-oriented (e.g. malnutrition, pain, falls); focussed on assessment and/or care management only; not delivered at the place of permanent residence (e.g. group sessions or at a community centre); delivered by different disciplines, but did not include interdisciplinary collaboration and coordination; and when studies compared outpatient with inpatient care. Randomised Controlled Trials (RCTs) and Controlled Clinical Trials (CCTs) were included if ADL functioning was used as an outcome measure in terms of basic ADL/instrumental ADL/advanced ADL, if reablement was compared to usual care, and when they were published in English or Dutch between 2002 and 2020. The year 2002 was chosen because the study by Tinetti et al.[22] is the first known study to introduce the term reablement.

Search strategy

The following electronic bibliographic databases were searched in July 2020 and repeated in July 2021: PubMed, CINAHL (EBSCO), PsycInfo (EBSCO) and the Cochrane Library. An information specialist at Maastricht University verified the search string (see Appendix 1). It used terms relating to or describing the population, intervention, outcome, and study design. The search strategy used Medical Subject Headings (MeSH); if MeSH were not available,

appropriate keywords were used. The initial search was conducted in PubMed, and search terms were modified, if necessary, to make them applicable in other databases. To check the adequacy of the search string, two well-known references[23,24] were used as key references to check whether they were identified by the initial search. This method is known for optimising the search and assuring that all relevant studies will be identified.[25,26] *The initial search string did not filter on the ageing population, however, as a result, we found many articles on rehabilitation (that were diagnosis-specific), which did not meet the criteria of the definition. To enhance the specificity of the search results, the choice was made to filter on the ageing population as most studies on reablement have been aimed at this cohort. However, also studies that were not explicitly aimed at older adults were eligible for our systematic review. To guarantee that no relevant studies were missed we conducted snowball sampling by checking the references of the included papers and consulted experts in the field of reablement. The experts were specifically asked for studies that were conducted on younger people.*

Study selection

All search results from the different databases were merged, after which duplicates were removed. To facilitate the screening of results, the web-based application Rayyan was used.[27] Two researchers (LB and SM) independently screened the studies on title and abstract. If the inclusion criteria were met, both assessed the full text for eligibility. LB and SM decided independently whether the inclusion criteria were met. Both screened 5% of the studies using the title and abstract first; when the consensus was <80% overall, an additional 5% was screened, after which at least 80% consensus was reached. Discrepancies were resolved by discussion and, where required, arbitration by a third researcher (SZ). An additional snowball sampling was used on studies included in the final sample.[28] Their reference lists were screened and studies were included according to the screening process described above. Reference lists of existing reviews on reablement[10,12-16,18] were checked to ensure that no key publications were missed. After these steps, SZ performed a final check of which studies to include. The authors of the included studies were contacted, as were 39 experts affiliated with the Re-Able network (https://reable.auckland.ac.nz/reable-network), with a request to check whether any important studies had been missed. When additional studies were suggested, they were screened for inclusion according to the process described above.

Data extraction and analyses

All information was extracted using a data extraction template, shown in Appendix 2, which was created in Microsoft Excel for the current study.[29] Study characteristics (i.e. design, aims, hypotheses, and target group), common intervention components (i.e. team composition, duration, assessment, and goal-setting) and outcome data concerning the effects on daily functioning were also extracted. Study protocols and additional related publications were also used.

Risk of bias and quality assessment

The methodological quality of the included studies was assessed by LB and checked by SM using the Critical Appraisal Checklists provided by the Joanna Briggs Institute (JBI).[30] The checklist included the following criteria that were assessed: adequate method of randomisation (if applicable), allocation concealment, the similarity of groups at baseline, blinding of participants, personnel and outcome assessors, method of measurement, statistical analyses, and appropriate use of trial design. Risk of bias was rated for selection-, performance-, attrition-, detection-, and reporting bias. Each aspect of methodological quality, the risk of bias assessment, and the overall risk of bias for the entire set of the included studies were reported in tabular and narrative forms for each study. When an answer on the checklist items was "yes", a score of 1 was given, when the answer was "unclear" or "no", a score of 0 was given. The impact of methodological quality of studies was assessed using a narrative synthesis.

Results

Study selection

Searches of the electronic databases were carried out in July 2020 and yielded 7,844 articles. A total of 1,830 duplicates had been removed. The repeated search in July 2021 yielded an additional 876 unique articles. In total, 6,860 titles and abstracts were screened. Of these titles and abstracts, 105 studies were included for full-text screening. A total of fifteen articles describing fifteen independent intervention studies eventually met the eligibility criteria. An additional snowball sampling of the included studies and systematic reviews on reablement resulted in an extra thirteen studies. Finally, after consulting experts (from the ReAble network

and the first authors of included studies), an additional eight studies were obtained. After the full-text screening of the snowball sample and studies suggested by experts, five were included in the final sample (n = 20). The flow-chart of the screening process according to the PRISMA statement,[20] including reasons for exclusion, can be found in Figure 1.

Study and participant characteristics

The study and participant characteristics of the twenty included studies are shown in Table 1. Sixteen studies were RCTs and four were CCTs. The studies were conducted in eight countries. The twenty studies comprised a total of 6,798 participants (range 61–1,382), most were female 69.8% (range 21.6–87.5) and had a mean age of 79.5 ±7.8 years old (range 34.5–87.7). Thirteen studies were conducted in community care and seven studies in institutionalised long-term care. Four studies used the diagnosis of dementia as their main focus group instead of a specific setting.

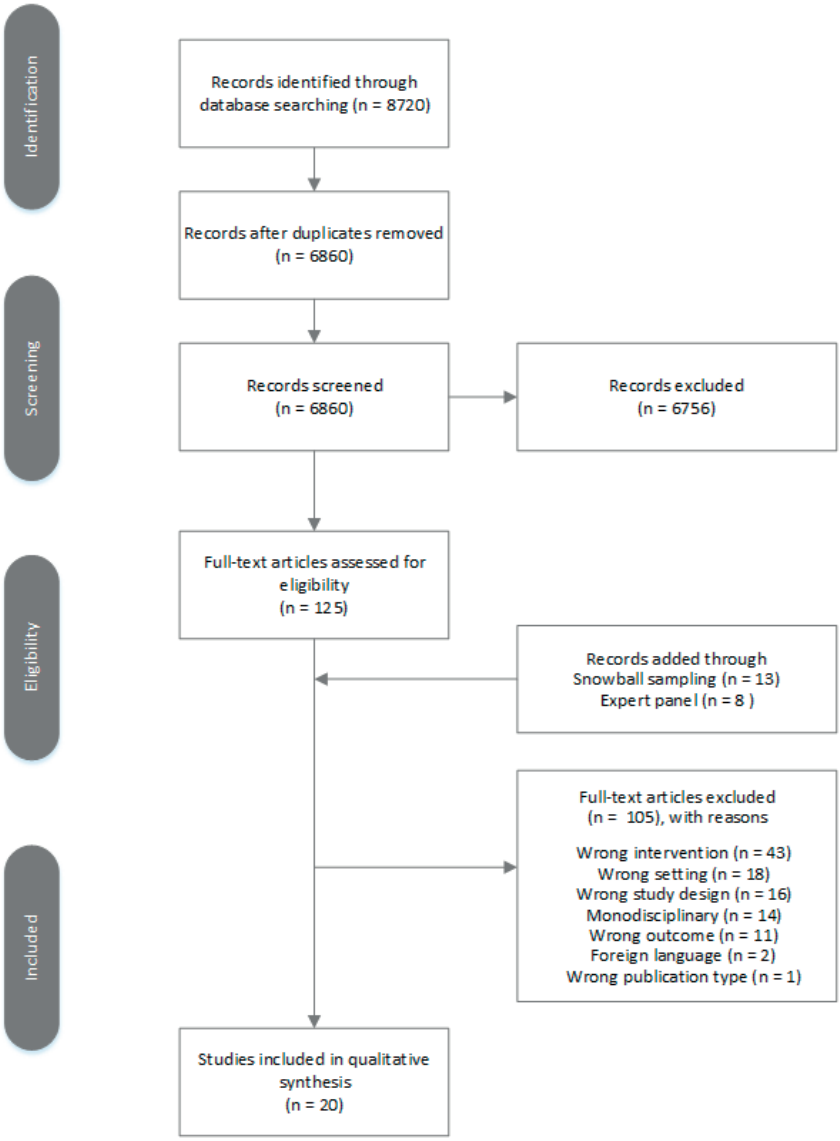

Figure 1. Flow Chart study selection process

Table 1. Study characteristics of the included studies (n = 20)

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
United States of America					
Galik (2014)[33]*	To determine the effect of Function-Focused Care for the Cognitively Impaired on function, physical activity, behaviour, and falls	Cluster-RCT Follow-up 3 and 6 months	Institutionalised long-term care	• ≥55 years old • MMSE-score ≤15 • Living in nursing home • Expected to stay in nursing home for at least 6 months	Mean age 83.7 (9.9), 77% female IG n = 53 CG n = 50
Galik (2015)[34]	To determine the effect of Function-Focused Care for the Cognitively Impaired on function, physical activity, behaviour, and falls	Cluster-RCT Follow-up 3 and 6 months	Institutionalised long-term care (dementia-specific)	• ≥55 years old • MMSE-score ≤15 • Living in assisted living • Expected to stay in assisted living for at least 6 months	Mean age 83.7 (7.2), 65% female IG n = 48 CG n = 48
Gitlin (2006)[31]*	To determine the effect of a multicomponent intervention to reduce functional difficulties, fear of falling, and home hazards and enhance self-efficacy and adaptive coping in older adults with chronic conditions	RCT Follow-up 6 and 12 months	Community care	• ≥70 years old • Cognitively intact • Not receiving home care • Having trouble with 2 iADLs or ≥1 ADLs • Not completely dependent or homebound • Not receiving services to address functional problems	Mean age 79 (5.9), 82% female IG n = 160 CG n = 159

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
United States of America					
Gitlin (2010)[39]*	To determine the effect of a non-pharmacologic, bio behavioural approach (COPE) to support physical function and quality of life for patients with dementia and the well-being of their caregivers	RCT Follow-up 4 and 9 months	Community care	• ≥21 years old • Diagnosis of dementia • Needing help with daily activities or having behavioural symptoms • Lived with or within 5 miles of family caregivers • Not having terminal illness, active cancer treatment, more than 3 acute hospitalisations in the past year, diagnosis of schizophrenia, bipolar disorder, dementia secondary to head trauma, MMSE-score of 0 or bed-bound mobility	Mean age 82.4 (8.9), 68% female IG n = 102 CG n = 107
Resnick (2011)[37]	To determine the effect of Function-Focused Care Assisted Living to alter the decline that AL-clients experience	Cluster-RCT Follow-up 4 and 12 months	Institutionalised long-term care	• ≥65 years old • MMSE-score ≥11 • Living in assisted living • Not in hospice or rehabilitation	Mean age 87.7 (5.7), 80% female IG n = 93 CG n = 78

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
United States of America					
Szanton (2019)[40]*	To determine the effect whether a 10-session, home-based, interdisciplinary programme (CAPABLE) reduces disability	RCT Follow-up 5 and 12 months	Community care	• ≥65 years old • Cognitively intact • Reporting difficulty with at least 1 ADL or ≥2 iADLs • Income <200% of federal poverty level • Not having active cancer treatment, more than 3 acute hospitalisations in the past year, inability to stand, apartment dwelling, plans to move within a year or use of home-based physical or occupational therapy services at enrolment	Mean age 75.7 (7.6), 88% female IG n = 152 CG n = 148
Tinetti (2002)[22]*	To determine the effect on functional status and the likelihood of remaining at home for persons receiving restorative care	CCT Follow-up every 60 day, and at discharge from homecare (average 35 days)	Community care	• ≥65 years old • Receiving home care • At risk for functional decline after acute illness or hospitalisation but potential for maintaining or improving their function • Not having severe cognitive impairment, requiring total assistance with care or bed-bound mobility	Mean age 79.8 (6.9), 59% female IG n = 691 CG n = 691

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
New Zealand					
Kerse (2008)[46]	To determine the effect of an activity programme (PIRC) in improving function, quality of life, and falls in older people in residential care	Cluster-RCT Follow-up 6 and 12 months	Institutionalised long-term care	• ≥65 years old • Cognitively able to set and remember goals to be achieved • Needing assistance with most iADLs and ≥2 ADLs • Can usually ambulate to some degree and feed themselves. • Not unable to communicate, having anxiety as main diagnosis, acutely unwell or in case of terminal illness	Mean age 84 (7.0), 75% female IG n = 330 CG n = 352
King (2012)[42]	To determine the effect of a long-term restorative home care service	Cluster-RCT Follow-up 4 and 7 months	Community care	• ≥65 years old • Receiving assistance from the home care agency • Not unable to participate in interviews due to poor health	Mean age 79.4 (6.4), 76% female IG n = 93 CG n = 93
Parsons (2017)[44]	To determine the effect of a restorative home support service on institutional-free survival in frail older people referred for needs assessment	RCT Follow-up at regular intervals over 24 months, not specified	Community care	• ≥65 years old • Assessed at high risk of permanent institutional care • Not needing nursing home placement	Mean age 83.1 (7.5), 61% female IG n = 56 CG n = 57
Parsons (2020)[43]	To determine the effect whether early Supported Discharge Teams (SDT) for older people admitted to hospital following a fracture enables earlier discharge from hospital and reduces readmissions and healthcare costs	RCT Follow-up 12 months	Hospital to community care	• ≥65 years old • Suffered an injury requiring hospital admission • In hospital at time of referral • Not requiring ongoing acute hospital-based treatment	Mean age 80.8 (8.1), 75% female IG n = 201 CG n = 202

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
Australia					
Lewin (2010)[32]*	To determine the effect of Home Independence Programme (HIP) on promoting functional dependency, morale, confidence in performing everyday activities without falling and functional mobility	CCT Follow-up 3 and 12 months	Community care	• ≥60 years old • Referred for home care services • Existing home care clients who request an increase in level or amount of service • Not having cognitive impairment, other progressive neurological disorders or when in need for acute or post-acute care	Mean age 79.7 (5.9), 75% female IG n = 100 CG n = 100
Lewin (2013)[23]*	To determine the effect of a new paradigm for home care (HIP)	RCT Follow-up 3 and 12 months	Community care	• ≥65 years old • Referred for home care services • Existing home care clients needing an increase of service • Needing assistance with one or more ADLs because of an ongoing disability. • Not having terminal illness, cognitive impairment due to dementia or progressive neurological disorder	Mean age 82.3 (7.4), 67% female IG n = 375 CG n = 375

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
United Kingdom					
Powell (2002)[36]*	To determine the effect of an interdisciplinary community-based outreach rehabilitation after severe traumatic brain injury	RCT Follow-up at end of treatment (average 24 months)	Community care	• Between 16 and 65 years old • Sustained traumatic brain injury • Referred from home or discharge at hospital • With long-term treatment goals to improve independence in activities of daily living, social participation, and psychological wellbeing • Severity of injury was at least moderate • No concurrent neurological disorders	Mean age 34.5 (10.5), 22% female IG n = 48 CG n = 46
Sackley (2009)[38]	To determine the effect of a programme of physiotherapy and occupational therapy in care home residents with mobility limitations dependent on carers in some ADLs	Cluster-RCT Follow-up 3 and 6 months.	Institutionalised long-term care	• Living in a care home • Experiencing limitations in mobility or ADL • BI-score between 6 and 16 • No admissions to hospital, nursing home or hospice	Mean age 85.0 (8.5), 74% female IG n = 128 CG n = 121
Sweden, Norway, Denmark					
Grönstedt (2013)[47]	To determine the effect of individually tailored physical and daily activities in nursing home residents on ADL and balance	RCT Follow-up 3 months	Institutionalised long-term care	• ≥64 years old • In need of daily assistance of minimum one personal ADL due to physical disability • Expected to stay in nursing home for at least 3 months	Mean age 85.0 (7.7), 74% female IG n = 170 CG n = 152 Sweden n = 85 Norway n = 171 Denmark n = 66

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
Norway					
Langeland (2019)[45]*	To determine the effect of reablement in home-dwelling adults on daily activities, physical function, health-related quality of life and coping as a sense of coherence	Multi-centre CCT Follow-up 10 weeks, 6 and 12 months	Community care	• ≥18 years old • Experiencing functional decline. • Not having terminal illness, cognitive impairment or in need for institution-based rehabilitation or nursing home placement.	Mean age 78.4 (10.9), 69% female IG n = 707 CG n = 121
Tuntland (2015)[24]*	To determine the effect on self-perceived activity performance and satisfaction with performance, physical functioning, and health-related quality of life	RCT Follow-up 3 and 9 months	Community care	• ≥18 years old • Referred for home-based services based on their self-reported activity limitations. • Not having terminal illness, cognitive impairment or in need of institution-based rehabilitation or nursing home placement	Mean age 79 (10.1), 69% female IG n = 31 CG n = 30
The Netherlands					
Henskens (2017)[35]	To determine the effect of Movement-oriented Restorative Care in preservation of ADL independence and quality of life in nursing home residents with dementia	CCT Follow-up 3, 6, 9 and 12 months	Institutionalised long-term care	• ≥65 years old • Diagnosis of dementia • Living in a psychogeriatric ward for at least 3 weeks. • Not having bad vision, psychotic symptoms, very severe dementia, MMSE-score of ≥24 or medical contraindications for physical activities.	Mean age 85.6 (6.2), 76% female IG n = 40 CG n = 26

Table 1. Continued

Author (year)	Study aim	Design and follow-up	Setting	Study population criteria	Sample
The Netherlands					
Rooijackers (2021)[41]	To determine the effect of Stay Active at Home on sedentary behaviour in older homecare clients	RCT	Community care	• ≥65 years old • Receiving home care services • Not unable to communicate, having terminal illness, bed-bound mobility or having cognitive or psychological impairment.	Mean age 82.1 (6.9), 67.8% female IG n = 133 CG n = 131

Note. RCT = Randomised Controlled Trial; CCT = Clinical Controlled Trial; MMSE = Mini-Mental State Examination; BI = Barthel Index; IG = Intervention Group; CG = Control Group; * Study effective on improving ADL functioning

Outcomes and effects of reablement interventions on ADL functioning

Outcome measures, follow-up periods and outcome effects are shown in Table 2. ADL outcomes were measured with twelve different measures, of which ten were validated and/or standardised. Seventeen studies used validated and/or standardised outcome measures, while three studies used a self-developed non-standardised tool.[23,31,32] The most common measure, used in six studies, was the (unmodified) Barthel-Index.[33-38] Six studies used a separate outcome measure concerning iADL.[22,31,32,39-41] In five studies, ADL was a secondary outcome measure.[23,41-44] In general, the total study duration varied from 4 to 48 months. Within these periods, the first follow-up varied from 10 weeks to 6 months, and the second to fourth follow-ups varied from 6 to 12 months.

With regards to the effects, ten studies described a significant improvement in ADL functioning in terms of bADL and/or iADL at the first follow-up.[22-24,31-33,36,39,40,45] At the second follow-up, six studies showed either a significant improvement in favour of the intervention group[23,24,32,36,45] or improvements were sustained from the first follow-up.[31] The studies that also measured iADL demonstrated significant improvements at the first follow-up in all except one study.[40] One study showed that improvements were sustained at the first follow-up,[31] and another study showed significant treatment effects in favour of the intervention group.[32]

Table 2. Outcomes measures and effects on daily functioning of included studies (n = 20)

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
United States of America			
Galik (2014)[33]	Barthel-index (range 0-100)	3 months	Significant improvement in mean scores in favour of intervention group: IG = 55.20 vs. CG = 44.32*
		6 months	No significant differences in mean scores between the groups.
Galik (2015)[34]	Barthel-index (range 0-100)	3 months	No significant differences in mean scores between the groups.
		6 months	No significant differences in mean scores between the groups.
Gitlin (2006)[31]	Activities of Daily Living index (range 1-5 difficulty in previous month)	6 months	Significant improvement in mean scores in favour of intervention group: IG = 1.58 vs. CG = 1.66, with largest benefits occurring in bathing and toileting*
		12 months	Significant improvement was sustained, not specified*
	Instrumental Activities of Daily Living index (range 1-5 difficulty in previous month)	6 months	Significant improvement in mean score in intervention group, decline in control group: IG = 1.97 vs. CG = 2.07*
		12 months	Significant improvements were sustained, not specified*
Gitlin (2010)[39]	Functional Independence Measure – Overall functional dependence (lower score indicates higher dependency)	4 months	Significant improvement in favour of intervention group: IG = 3.7 vs. CG = 3.3, with adjusted mean difference 0.24*
		9 months	No significant differences in mean scores between the groups.
	Subscale Activities of Daily Living dependence (lower score indicates higher dependency)	4 months	No significant differences in mean scores between the groups.
		9 months	No significant differences in mean scores between the groups.
	Subscale instrumental Activities of Daily Living dependence (lower score indicates higher dependency)	4 months	Significant improvement in mean scores in favour of intervention group: IG = 2.8 vs. CG = 2.5, with adjusted mean difference 0.32**
		9 months	No significant differences in mean scores between the groups.

Table 2. Continued

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
United States of America			
Resnick (2011)[37]	Barthel-index (range 0-100)	4 months	No significant differences in mean scores between the groups.
		12 months	Significant decline in mean scores to the detriment of control group: IG = 69.19 vs. CG = 64.42**
Szanton (2019)[40]	ADL score (range 0-16)	5 months	Significant improvement in mean scores in favour of intervention group: IG = 2.22 vs. CG = 2.82** Treatment effect in favour of intervention group in RR (95% CI) 0.70 (0.54-0.93)**
		12 months	No significant differences in mean scores between the groups.
	iADL score (range 0-16)	5 months	No significant differences in mean scores between the groups.
		12 months	No significant differences in mean scores between the groups.
Tinetti (2002)[22]	Self-care (range 0-12)	At completion of intervention (average 35 days)	Significant improvement in mean scores in favour of intervention group: IG = 11.0 vs. CG = 10.7*
	Home management (range 0-14)	At completion of intervention (average 35 days)	Significant improvement in mean scores in both groups: IG = 9.5 vs. CG = 9.2* Significant mean difference in both groups: IG =5.8 vs. CG = 5.6*
New Zealand			
Kerse (2008)[46]	Late Life Function and Disability Instruments (lower score indicates higher dependency)	6 months	No significant differences in mean scores between the groups.
		12 months	No significant differences in mean scores between the groups.
King (2012)[42]	Nottingham Extended Activities of Daily Living - index (range 0-66)	4 months	No significant differences in mean scores between the groups.
		7 months	No significant differences in mean scores between the groups.

Table 2. Continued

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
New Zealand			
Parsons (2017)[44]	interRAI Home Care instrument (lower score indicates higher dependency)	Regular intervals over 24 months, not specified	No significant differences in mean scores between the groups.
Parsons (2020)[43]	interRAI Contact Assessment (higher scores indicates higher dependency)	12 months	No significant differences in mean scores between the groups.
Australia			
Lewin (2010)[32]	Primary Assessment Form ADL (range 9-29)	3 months	Significant difference in change in favour of IG (Mann Whitney U test) z = -3.71**
		12 months	Significant difference in change in favour of IG (Mann Whitney U test) z = -2.90*
	Primary Assessment Form iADL (range 8-30)	3 months	Significant difference in change in favour of IG (Mann Whitney U test) z=-4.20**
		12 months	Significant difference in change in favour of IG (Mann Whitney U test) z=--3.24**
Lewin (2013)[23]	HACC Needs Identification (lower score, is higher dependency)	3 months	Significant improvement in mean scores in favour of intervention group, not specified* Significant improvement on independence of "showering": IG = 60% vs. CG = 23%**
		12 months	Significant improvement in mean scores was sustained, except iADLs were control group showed an increase in dependency, resulting in significant difference in favour of intervention group* Significant improvement on independence of "showering": IG = 58% vs. CG = 25%**
United Kingdom			
Powell (2002)[36]	Unmodified Barthel-index (range 0-20)	End of treatment (not specified)	Significant improvement in favour of intervention group: 35% vs. 20%* Median change score 0.00 due to ceiling effects.
	The Functional Independence Measure and Functional Assessment Measure	End of treatment (not specified)	No significant differences in mean scores between the groups.

Table 2. Continued

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
United Kingdom			
Sackley (2009)[38]	Unmodified Barthel-index (range 0-20)	3 months	No significant differences in mean scores between the groups.
		6 months	No significant differences in mean scores between the groups.
Sweden, Norway and Denmark			
Grönstedt (2013)[47]	Functional Independence Measure, items a-m (lower score indicates higher dependency)	3 months	Significant decline in mean score in control group: CG = 42* No significant differences in mean scores between the groups.
Norway			
Langeland (2019)[45]	Canadian Occupational Performance Measure - Performance (range 1-10)	10 weeks	Significant improvement in mean score in intervention group, decline in control group: IG = 3.19 (2.98, 3.40) vs. CG = 1.57 (1.12, 2.02))** Treatment effect mean difference in favour of IG (1.61 (1.13, 2.10))**
		6 months	Significant improvement and decline were sustained: IG = 3.19 (2.91, 3.46) vs. CG = 1.77 (1.21, 2.33)** Treatment effect mean difference in favour of IG (1.42 (0.82, 2.02))**
		12 months	No significant differences in mean scores between the groups. No significant treatment effect.
	Canadian Occupational Performance Measure – Satisfaction (range 1-10)	10 weeks	Significant improvement in mean score in intervention group, decline in control group: IG = 3.43 (3.23, 3.64) vs. CG = 1.96 (1.50, 2.42)** Treatment effect mean difference in favour of IG (1.47 (0.98, 1.97))**
		6 months	Significant improvement in mean score in intervention group, decline in control group: IG=3.41 (3.15, 3.67) vs. CG=2.04 (1.48, 2.61)** Treatment effect mean difference in favour of IG (1.37 (0.77, 1.98))**
		12 months	No significant differences in mean scores between the groups. No significant treatment effect.

Table 2. Continued

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
Norway			
Tuntland (2015)[24]	Canadian Occupational Performance Measure – Performance (range 1-10)	3 months	Significant improvement in mean scores in favour of intervention group: IG = 6.9 (6.1-7.8) vs. CG = 5.5 (4.7-6.3))*
		9 months	No significant differences in mean scores between the groups. Overall treatment effect mean difference in favour of intervention group (1.5 (0.4-2.6))**
	Canadian Occupational Performance Measure – Satisfaction (range 1-10)	3 months	No significant differences in mean scores between the groups.
		9 months	Significant decline in mean scores to the detriment of control group: IG = 6.5 (5.2-7.8) vs. CG = 5.2 (4.5-5.9)* Overall treatment effect mean difference in favour of intervention group (1.2 (0.1-2.3))*
The Netherlands			
Henskens (2017)[35]	Unmodified Barthel-index (range 0-20)	3 months	No significant differences in mean scores between the groups.
		6 months	No significant differences in mean scores between the groups.
		9 months	No significant differences in mean scores between the groups.
		12 months	No significant differences in mean scores between the groups.

Table 2. Continued

Author (year)	Outcome measure ADL[a]	Effect on ADL functioning	
		Follow-up	Results
The Netherlands			
Rooijackers (2021)[41]	Groningen Activiteiten Restrictie Schaal total score (range 18-72)	12 months	No significant differences in mean scores between the groups.
	Groningen Activiteiten Restrictie Schaal ADL-score (range 11-44)	12 months	No significant differences in mean scores between the groups.
	Groningen Activiteiten Restrictie Schaal iADL-score (range 7-28)	12 months	No significant differences in mean scores between the groups.

Note. CG = control group; IG = intervention group; ADL = Activities of Daily Living; [a] Activities of Daily Living in terms of basic ADL, instrumental ADL and advanced ADL; [b] Percentages are given due to ceiling effect at intake for 60% of participants, with 14% scoring 18 or 19 median change score is zero in both groups. Underlined scores indicate the most favourable scores; * = $p < 0.05$; ** = $p \leq 0.01$

Table 3. Intervention components of included reablement intervention studies (n = 20)

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
United States of America							
Galik (2014)[33]*	To promote nursing care on optimising physical activity in residents.		Nursing assistants, FFCC FFCN, nursing home staff not specified.	Coordination and collaboration method not specified.	Not specified.	Assessment by FFCN and input from family, staff, and FFCC.	• ADL training • Education • Physical and/or functional exercise
Galik (2015)[34]	To promote residents to participate in functional activities and be physically active.	Duration and intensity not specified.	Direct care workers, FFCC, FFCN.	Coordination and communication not specified.	Not specified.	Assisted Living Resident Assessment Form, therapy notes, range of motion and cognition by FFCN and FFCC with input from direct care workers and families.	• ADL training • Adaptations • Education
Gitlin (2006)[31]*	To compensate for declining abilities.	Maximum of 24 weeks 5 OT sessions of 20-90 minutes, 1 PT session of 90 minutes.	OT and PT.	Coordination between OT and PT for integrated approach, not specified.	Semi-structured clinical interview by OT Reassessment not specified.	Semi-structured clinical interview by OT.	• ADL training • Adaptations • Education • Physical and/or functional exercise

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
United States of America							
Gitlin (2010)[39]*	To decrease sensorial, physical, and cognitive demands, promote patients in daily activities, and increase functionality, alleviating caregiver burden.	Maximum of 16 weeks On average 8 – 12 sessions, 68.24 min face-to-face, and telephone sessions of 20.15 min by OT, and 6.27 min by nurses.	OT, advanced practice nurse, family caregiver.	Coordination and collaboration method not specified.	Interview of caregivers and test of cognitive and functional capabilities of client by OT Reassessment not specified.	Written action plan describing treatment goals, patient strengths, and specific strategies by OT.	• ADL training • Adaptations • Education • Physical and/or functional exercise • Functional disorder management
Resnick (2011)[37]	To change how direct care workers provide care to maintain and improve function and physical activity.	Duration and intensity not specified.	Direct care worker, FFCC, FFCN.	Coordination and collaboration method not specified.	Not specified.	Goal Attainment Forms by FFCN, with input from FFCC and staff.	• ADL training • Adaptations • Education • Physical and/or functional exercise

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
United States of America							
Szanton (2019)[40]*	To improve daily function and meet the needs of low-income older adults.	Maximum 20 weeks On average 8 – 10 sessions, OT ≤ 6 sessions for ≤ 1hour, an RN ≤ 4 sessions for ≤ 1hour)	OT, RN, handyman.	Coordination by OT for case-coordination with other interventionists. Collaboration method between the OT, nurse, and handyman through a secure share site.	Client-Clinician Assessment Protocol by OT and RN Reassessment at 20 weeks	Goal setting by OT and RN, not specified.	• ADL training • Adaptations • Education • Physical and/or functional exercise • Functional disorder management
Tinetti (2002)[22]*	To determine effect on functional status, remaining at home, duration and intensity of home care episode, emergency visits, and pain or dyspnoea.	On average 5 weeks. On average 12.5 sessions of PT (2.1), nurses (6.8) and home health aides (3.1)	Home care nurses, OT, PT, home health aides.	Coordination and collaboration method not specified.	OASIS-B standardized assessment by home care staff Reassessment not specified.	Goal setting by home care staff with input from family, not specified.	• ADL training • Adaptations • Education • Physical and/or functional exercise • Functional disorder management

Table 3. Continued

Author (year)	Intervention aim	Characteristics		Components			
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
New-Zealand							
Kerse (2008)[46]	To promote independence in residential care.	52 weeks Up to 30 min/day for more dependent residents.	Gerontology nurse, nursing assistant. PT and OT available on demand.	Coordination by gerontology nurse, assisted by PT and OT if needed. Collaboration method not specified.	Functional assessment by gerontology nurse with assistance of OT or PT if needed. Reassessment not further specified.	Goal setting by gerontology nurse, not specified.	• ADL training • Physical and/or functional exercise
King (2012)[42]	To reduce need for long-term support and promote quality of home care services.	Duration and intensity not specified.	Paid caregivers, coordinator (experienced RN). Referrals to OT, PT, meal preparation etc.	Coordination by RN. Collaboration method not specified.	TARGET by coordinator. Reassessment at 12 months.	TARGET by coordinator.	• ADL training • Functional disorder management

Table 3. Continued

Author (year)	Intervention aim	Characteristics		Components			
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
New-Zealand							
Parsons (2017)[44]	To meet the needs of high-risk older people at home.	Duration and intensity not specified.	RN, healthcare assistants.	Coordination by RN for case management. • Daily contact with non-regulated support workers • Clinical (assessment etc.) and non-clinical (supervision etc.) duties. Collaboration method not specified.	interRAI Home Care Assessment (complex care) by locality-based health professionals. interRAI Contact Assessment (non-complex care) by home care services health professional coordinators. Reassessment every 12 weeks.	Comprehensive geriatric assessment and "goal ladder" by RN case manager coordinator.	• ADL training • Physical and/or functional exercise

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
New Zealand							
Parsons (2020)[43]	To promote independence rather than foster dependence.	Maximum of 6 weeks. Intensity not specified.	OT, PT, RNs, healthcare assistants, consultant elderly care physicians	Coordination not specified to one person: RNs, OTs, and PTs responsible to intervention. Collaboration method by weekly team case conferences and collaboration with patient's community, care team, and hospital services.	InterRAI Contact Assessment by RN/healthcare assistant Reassessment not further specified	Goal facilitation tool by RN/healthcare assistant, not further specified.	• ADL training • Physical and/or functional exercise
Australia							
Lewin (2010)[32]*	To promote functioning, preventing or delaying functional decline, promoting healthy ageing and encouraging the self-management of chronic diseases.	Maximum of 12 weeks or until they achieve their goals, whichever is sooner, on average 9 weeks. Intensity not specified	OT, PT, RN, care manager Other caregivers available on demand.	Coordination by care manager Collaboration method by weekly HIP care team meetings	Comprehensive multi-dimensional assessment (MDA) by care manager Reassessment at 12 weeks	HACC Needs Identification (HNI) within MDA by care manager	• ADL training • Education • Physical and/or functional exercise • Functional disorder management

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
Australia							
Lewin (2013)[23]*	To promote functioning, preventing or delaying functional decline, promoting healthy ageing and encouraging the self-management of chronic diseases.	Maximum of 12 weeks or until they achieve their goals, whichever occurs first. Intensity not specified.	OT, PT, RN, care manager (interdisciplinary team member). Other caregivers available on demand.	Coordination by care manager Collaboration method by weekly HIP care team meetings	Comprehensive multi-dimensional assessment by care manager Reassessment at 12 weeks	Goal-oriented care planning by care manager, not specified.	• ADL training • Education • Physical and/or functional exercise • Functional disorder management
United Kingdom							
Powell (2002)[36]*	To promote independence in ADL, social participation, and psychological wellbeing	Maximum of 60 weeks, on average 28 weeks. On average 2-6 hours per week.	OT, PT, speech and language therapist, clinical psychologist, social worker.	Coordination and collaboration method not specified.	Functional Assessment Measure (FAM) by two therapists. Reassessment at end of treatment	"Contractually organised goal setting" by carer and team.	• ADL training • Physical and/or functional exercise

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
United Kingdom							
Sackley (2009)[38]	To promote independent living and mobility among care home residents over and above that achieved with standard care.	Maximum of 12 weeks. On average 6.4 sessions PT and 132.6 min contact, on average 9.8 sessions OT and 216 min contact.	PT, OT, home care staff	Coordination and collaboration method not specified.	Assessment physical and functional status and equipment needs by PT and OT. Reassessment not further specified	Functional goal setting by PT and OT, not specified.	• ADL training • Adaptations • Physical and/or functional exercise
Sweden, Norway, Denmark							
Grönstedt (2013)[47]	To prevent unnecessary functional decline	On average 10–13 weeks. On average 117 min/week.	OT, PT, nursing home staff.	Coordination by OT and PT, also providing guidance of staff. Collaboration method not specified.	Clinical assessment by OT and PT Reassessment not further specified	Listing important activities by OT and PT, not specified.	• ADL training • Adaptations • Education • Physical and/or functional exercise

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
Norway							
Langeland (2019)[45]*	To achieve the activity goals set in the interdisciplinary assessment.	Maximum of 10 weeks, on average 6 weeks. On average 3-5 sessions a week.	OT, PT, (auxiliary) nurse, and home helper.	Coordination not specified to one person: collaboration interdisciplinary team with participant. Collaboration method not specified.	Canadian Occupational Performance Measure by OT/PT/Nurse Reassessment at 10 weeks	Canadian Occupational Performance Measure by OT/PT/Nurse	• ADL training • Adaptations • Education • Physical and/or functional exercise
Tuntland (2015)[24]*	To promote independence in ADL, enable people to age in place, be active and participate socially in society.	Maximum of 12 weeks, on average 10 weeks. On average 6.5 sessions/1.9 hours per week.	OT, PT, (auxiliary) nurses, social educators, home helpers and assistants	Coordination not specified. Collaboration method by weekly informal meetings.	Canadian Occupational Performance Measure by OT/PT Reassessment at end 10 weeks	Canadian Occupational Performance Measure by OT/PT	• ADL training • Adaptations • Education • Physical and/or functional exercise.

Table 3. Continued

Author (year)	Intervention aim	Characteristics			Components		
		Duration and intensity	Interdisciplinary team	Coordination and collaboration method	Initial comprehensive assessment and regular reassessments	Goal-oriented support plan	Interventions to reach clients' goals
The Netherlands							
Henskens (2017)[35]	To optimise independence in ADL and QoL.	Maximum of 52 weeks.	Nursing staff, department heads, PT, OT, psychologists, elderly care physicians, and activity supervisors, volunteers and family members.	Coordination not specified. Collaboration method by staff meetings, not specified.	Selection and evaluation of functional capabilities by primary responsible caregiver. Reassessment not specified.	Goal setting by nursing staff, not specified.	• ADL training • Education • Physical and/or functional exercise
Rooijackers (2021)[41]	To reduce clients' sedentary behaviour and promote independence	Duration and intensity not specified.	RN, nurse assistants, nurse aides and domestic support workers	Coordination by district nurse. Collaboration method not specified.	No assessment tool used by nursing staff. Reassessment not specified.	Goal setting by nursing staff using the SMART-method	• ADL training • Education • Physical and/or functional exercise

Note. FFCC = Function-Focused Care Champion; FFCN = Function Focused Care Nurse; OT = Occupational Therapist; PT = Physical Therapist; RN = Registered Nurse; ADL = Activities of Daily Living; QoL = Quality of Life; SMART = Specific, Measurable, Attainable, Relevant, Time-bound; * Study effective on improving ADL functioning

Intervention characteristics

To identify common features of the included interventions, the following results discuss the features that the interventions (n=20) had most in common in terms of setting, duration, intensity, team composition, staff training, target group, and the different intervention components. All interventions used a person-centred and holistic approach. These intervention characteristics and content, based on the criteria of the ReAble definition, are shown in Table 3.

Setting

In thirteen interventions, the setting was the participant's home,[22-24,31,32,36,39-45] while in seven interventions, the setting was a long-term care facility.[33-35,37,38,46,47]

Intervention duration and intensity

Thirteen interventions were time-limited and had a mean duration of 15.7 weeks (range 5-60).[23,24,31,32,35,36,38-40,43,45-47] In two studies, the intervention could also end earlier, when participants had achieved their set goals.[23,32] Seven studies did not specify a maximum duration,[22,33,34,37,41,42,44] in addition, ten studies specified the intensity of the intervention, in terms of the amount and duration of sessions given.[22,24,31,36,38-40,45-47] Sessions varied from one session every four weeks to three sessions per week, with an average duration ranging from 0.1 to 6 hours per week. On average, the effective interventions had a slightly shorter duration compared to non-effective interventions (mean 15.4 weeks, range 5–60 vs. mean 17.5 weeks, range 6–52). The intensity in terms of sessions and minutes spent per week could not be compared due to a lack of intervention details.

Interdisciplinary teams

Most interdisciplinary teams consisted of registered nurses (RN), nursing assistants (NA), occupational therapists (OT), and physical therapists (PT). In two studies, a medical specialist was also involved.[35,44] On average, effective interventions had a more diverse team of healthcare professionals as a part of their interdisciplinary team than non-effective interventions (mean 3.5, range 2–6 vs. mean 3.2, range 2–7). In addition, results showed that

OTs and PTs were a standard part of the team in seven of the effective interventions,[22,23,31,32,36,45] in contrast to four of the non-effective interventions.[38,42,43,46,47]

All studies described a coordinated collaboration between care professionals, only the method of collaboration and communication was not always specified. Four studies reported details on the frequency of these team meetings, which took place weekly.[23,32,43,45] Five effective interventions described that a member of the interdisciplinary team coordinated the intervention; this was often an RN, OT, or PT,[23,31,32,40,45] other effective interventions did not provide further details on the coordinator. Six of the non-effective interventions described that a registered nurse was appointed as the intervention coordinator,[37,41-44,46] other non-effective interventions did not provide further details on the coordinator. The coordinators took the initial assessment and reassessment, set out goals with participants, monitored progress, and coordinated team meetings and the education of staff.

Training of the interdisciplinary teams

In all but two studies,[36,43] staff training was described. Staff received specific training regarding care delivery (e.g. goal-setting tools, assessment procedures, etc.) in the form of lectures, seminars, courses, and education by other members of the team. This training varied in duration from one day to the form of weekly educational meetings over the intervention period varying from 5 to 60 weeks. Staff training could not be compared between effective and non-effective interventions due to a lack of detail regarding the contents of the training sessions given.

Target group

The thirteen studies conducted in community care described their target group in general as individuals in need of home care services or experiencing a functional decline. All interventions were aimed at individuals of ≥60 years old, except for three interventions that also included individuals of ≥18 years,[24,39,45] and one intervention including individuals between 16 and 65 years-old.[36] In terms of participant capacity, all interventions were aimed at individuals that required assistance with one or more ADLs, and/or experienced functional decline but were not completely care-dependent. One intervention was not only aimed at individuals with a diagnosis of dementia but also their caregivers;[39] another was specifically aimed at individuals

with Traumatic Brain Injury.[36] The eighteen other interventions specifically excluded individuals in case of terminal illness, neurological disorder, and diagnosis of dementia because, according to the authors of these studies, these groups would benefit the least from the intervention or would eventually require institution-based rehabilitation or nursing home placement. Because only four non-effective interventions took place in community care,[41-44] the target group cannot be compared with the target groups of the fifteen effective interventions that took place in community care.

The seven studies conducted in institutionalised long-term care described the target group as residents with a minimum expected stay of 3 months, and a minimum age of 55 years old. Three interventions were specifically aimed at individuals with a diagnosis of dementia.[33-35] Regarding the participants' capacity, all interventions were aimed at individuals needing assistance in their ADLs, and not meant for individuals in rehabilitation or cases of terminal care. As only one effective intervention that took place in institutionalised long-term care showed effects,[33] the target group could not be compared with the target groups of the non-effective interventions.

Intervention components

Initial comprehensive assessment and regular reassessments

The assessment used in all interventions was generally interdisciplinary. A standardised instrument was used in ten interventions,[22-24,32,36,40,42-45] for example, the interRAI Home Care Assessment.[48] Six interventions used either a semi-structured interview method or a profession-specific intake assessment[31,35,39,42,46,47] and four interventions did not use a standardised or protocoled assessment.[33,34,37,41] Reassessments took place at intervals ranging from 10 to 52 weeks in seven interventions.[23,24,32,40,42,44,45] The other interventions did not specify either if or when the reassessment took place. The results show that in seven effective interventions,[22-24,32,36,40,45] a standardised or protocoled assessment method was used, whereas this was the case in three of the non-effective interventions.[42-44]

Goal-oriented support plan

In sixteen interventions, the assessment method was also used to identify activities the participant perceived as meaningful and to develop a person-centred goal-oriented support plan.[22-24,31,32,35,36,38-40,42-47] Four effective interventions and one non-effective intervention used

validated and standardised goal-setting instruments,[23,24,32,42,45] for example, the Canadian Occupational Performance Measure.[49] In the other interventions semi-structured interviews, the SMART method,[50] lists of important activities for the participant, or input from other healthcare professionals and their families were used to set goals.

Interventions to reach clients' goals

Five intervention components were identified. Effective interventions contained a broader offer of intervention components to reach clients' goals than non-effective interventions (mean 4, range 2–5 vs. mean 2.8, range 2–4). ADL training, physical and/or functional exercise, and education were the most common, and functional disorder management the least common components. Environmental adaptations were also an identified intervention component but did not recur as often as the other four. The specifications of these interventions are as follows:

First, ADL training was a recurring component in all effective and non-effective interventions. This entailed individual training in activities such as personal care and eating by encouraging clients to do (a part of) the activity themselves, followed by repeating and incorporating this training within the clients' daily life. The participant also learned strategies to adapt an activity and make use of helping aids. OTs or RNs usually gave ADL training. No statements about effectiveness can be made because the same amount of effective and non-effective interventions included ADL training.

Second, physical and/or functional exercise was also a recurring component in all effective and non-effective interventions. Physical and/or functional exercises focused on physical activity in the training of strength, balance, endurance, and fine motor skills, but also on promoting active engagement in social and group activities. Training took place both individually as well as in group sessions. In most cases, it was not specified who provided the exercises, but if they did, it was often the PT who offered them. No statements about effectiveness can be made because the same amount of effective and non-effective interventions included physical and/or functional exercise.

Third, education played a role in reaching clients' goals in nine out of ten effective interventions[22-24,31-33,39,40,45] and five non-effective interventions.[34,35,37,41,47] Participants were educated on self-management, building confidence, healthy ageing, problem-solving, prevention strategies, stimulating (physical) activity, and medication use. In addition to educating the participants, five effective interventions specifically described family and/or

caregivers also receiving education to stimulate the participant in becoming less dependent on care,[22,23,32,33,39] this was also the case in one non-effective intervention.[34] It was often not specified which member of the interdisciplinary team provided education.

Fourth, environmental adaptations played a role in six effective interventions[22,24,31,39,40,45] and four non-effective interventions.[34,37,38,47] Adaptations mentioned were the use of assistive technology (e.g. walking aids), home environment adaptations or repairs (e.g. safety rails), and providing medical equipment (e.g. blood pressure monitor). An OT often provided adaptations.

Last, the management of functional disorders, such as pain, continence, nutrition, skin integrity, testing of blood and urine, and management of medication, was incorporated in five effective interventions[22,23,32,39,40] and one non-effective intervention.[42] The coordinator or RN involved often provided functional disorder management.

Risk of bias

Findings on the risk of bias are shown in Table 4. The RCTs scored 62% (range 38–92) on average on the JBI Critical Appraisal Checklist for Randomized Controlled Trials,[51] and the CCTs 53% (range 44–56) on the JBI Checklist for Quasi-Experimental. [52] Four of the twenty studies were judged at low risk of bias,[24,31,40,43] eleven at moderate risk, and four at high risk.[22,23,34,37] No RCT was able to blind participants and delivery personnel to treatment assignment. In seven studies treatment groups were similar at baseline.[24,31,33,36,41,43,47] Risk of bias assessment demonstrated that in all CCTs the effect could also be explained by other exposures or treatments occurring at the same time. In most studies, follow-up was not adequately described and analysed and lacked appropriate statistical analysis. The latter was mainly due to a lack of power.

Overall, within the effective interventions, three studies scored low,[24,31,40] five scored moderate[32,33,36,39,45] and two scored high on the risk of bias assessment.[22,23] Within the non-effective interventions, one study scored low,[43] seven moderate[35,38,41,42,44,46,47] and two high on the risk of bias assessment.[34,37]

Table 4. Risk of Bias Assessment of included Randomised Controlled Trials (n=16) and Clinical Controlled Trials (n=4)

RCTs	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	% yes	Risk[a]
Galik (2014)[33]*	0	0	1	0	0	1	1	0	1	1	1	0	1	54%	Moderate
Galik (2015)[34]	0	0	0	0	0	0	1	0	1	1	1	0	1	38%	High
Gitlin (2006)[31]*	1	1	1	0	0	1	1	1	1	1	1	1	1	85%	Low
Gitlin (2010)[39]*	1	1	0	0	0	0	1	1	1	1	1	1	1	69%	Moderate
Resnick (2011)[37]	0	0	0	0	0	0	1	0	1	1	1	0	1	38%	High
Szanton (2019)[40]*	1	1	0	0	0	1	1	1	1	1	1	1	1	77%	Low
Kerse (2008)[46]	1	1	0	0	0	1	1	0	0	1	1	1	1	62%	Moderate
King (2012)[42]	1	1	0	0	0	1	1	0	1	1	1	0	1	62%	Moderate
Parsons (2017)[44]	1	1	0	0	0	0	1	0	1	1	1	1	1	62%	Moderate
Parsons (2020)[43]	1	1	1	0	0	1	1	0	1	1	1	1	1	85%	Low
Lewin (2013)[23]*	0	0	0	0	0	1	1	0	0	1	1	1	1	46%	High
Powell (2002)[36]*	1	1	1	0	0	1	1	0	1	0	1	0	1	62%	Moderate
Sackley (2009)[38]	1	1	0	0	0	1	1	1	1	1	1	0	1	69%	Moderate
Grönstedt (2013)[47]	1	1	1	0	0	1	1	0	1	1	1	0	1	69%	Moderate
Tuntland (2015)[24]*	1	1	1	0	0	1	1	1	1	1	1	1	1	85%	Low
Rooijackers (2021)[41]	1	1	1	0	0	0	1	1	0	1	1	1	1	69%	Moderate

CCTs	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	% yes	Risk[a]
Tinetti (2002)[22]*	1	0	0	1	1	0	0	1	0	44%	High
Lewin (2010)[32]*	1	0	0	1	1	0	1	1	0	56%	Moderate
Langeland (2019)[45]*	1	0	0	1	1	0	1	1	0	56%	Moderate
Henskens (2017)[35]	1	0	0	1	1	1	0	1	0	56%	Moderate

Note. Risk of Bias was assessed using the Joanna Briggs Institute Critical Appraisal Checklist for Randomised Controlled Trials and the Checklist for Quasi-Experimental Studies (non-randomized experimental studies) [51,52]. JBI = Joanna Briggs Institute; RCT = Randomised Controlled Trial; CCT = Clinical Controlled Trial; [a] Risk of bias ranked as high when percentage up to 49%, moderate when percentage from 50 to 69%, and a low percentage of more than 70% of "yes" scores. 1 indicates yes, 0 indicates unclear or no. * Study effective on improving ADL functioning

Discussion

Using the ReAble definition as a starting point, this systematic review aimed to provide a current overview of reablement interventions internationally and their effect on clients' daily functioning. Twenty relevant studies from eight countries were included in this systematic

review. Ten of these studies were effective in improving ADL functioning. In addition, we intended to identify the most common and possibly promising features in an attempt to "unpack" existing reablement interventions. However, the identification of the most promising features was challenging as an equal amount of effective and non-effective interventions were identified and intervention content was poorly described. Nevertheless, there are some indications that interdisciplinary teams with more diverse disciplines, the use of standardised assessment/goal-setting instruments and four recurring intervention components (i.e. ADL-training, physical and/ or functional exercise, education, management of functional disorders) positively influence the effectiveness of reablement concerning clients' daily functioning.

Concerning the outcome ADL functioning, we see a great variation in outcome measures used. Roughly, they can be divided into two groups: ADL measures that are goal-oriented and tailored to the individual (e.g. COPM), and more generic ADL measures (e.g. Barthel Index). These generic measures are less sensitive to detect small changes, which is essential when establishing minor improvements in independence.[53] However, combining more subjective measures, like the COPM, with more generic measures, such as the Barthel-Index, helps to place the subjective assessment of ADL functioning in the right context.[54] Unfortunately, in this systematic review it is not possible to conclude how the chosen ADL outcomes have influenced the study findings.

As for factors impacting the effectiveness of reablement, the included studies show that both the size and composition of the interdisciplinary team may influence the effectiveness, with a more diverse team showing more often positive outcomes regarding daily functioning. These positive effects might be explained by the fact that, within a more diverse interdisciplinary team, there is a much broader base of knowledge, skills and resources available, allowing the problem to be approached from more different perspectives.[55] However, with increasing team size, the complexity of interdisciplinary collaboration also increases, especially when it comes to dividing tasks and responsibilities, which makes coordination of teams of utmost importance.[56] In two-thirds of the included interventions, we see that often the RN, OT, and PT are a standard part of the reablement team. These disciplines could be valuable to include in a reablement team due to their educational background. For example, goal-setting is part of their curricula and they often have interdisciplinary training, which has shown to contribute towards better collaborative skills and attitudes with other healthcare professions.[57,58] Although, due to the differences in educational background, team members also have different values, beliefs, attitudes and behaviours, which emphasises the importance of training in teamwork.[56] Other

factors that should be taken into account concerning interdisciplinary collaboration are team familiarity, team members' experience, task complexity and time pressure.[56] Close cooperation and evaluation, as well as time for communication, shared planning and decision making, and goal-setting by the client contribute positively to interdisciplinary cooperation.[59]

All included studies used an assessment/goal-setting instrument, as goal setting plays an essential role within reablement. Goal-setting involves the client in the decision-making process and ensures that the client's values, autonomy and preferences are respected.[60,61] However, care professionals often indicate that they lack the knowledge and skills to involve clients in goal-setting, that clients are sometimes difficult to motivate, remain passive in the recovery process, and feel overwhelmed to take control of their rehabilitation.[62] Based on our systematic review there are indications that the use of a standardized assessment/goal-setting tool may lead to more positive outcomes regarding daily functioning. Also, Rose et al.[62] advise using standardized goal-setting tools to better involve clients in the process,[62] such as TARGET[63] and COPM,[49] which both facilitate the professional to identify activities meaningful to the client and set goals correspondingly. Nevertheless, it remains challenging to set good person-centred goals. To improve goal-setting and shared-decision making it is also recommended to train both health professionals and clients in shared-decision making and the associated communication skills.[62]

Regarding promising intervention components, it seems like effective interventions contained on average more diverse components. Complex interventions have gained increasing attention over the last years, but their content is often briefly reported or unknown, which makes it difficult to assess their effectiveness and to determine why they work or fail.[64] Ideally, the modelling and processes of outcomes of complex interventions should be described to identify why the intervention works or does not work.[64,65] This is necessary to understand underlying mechanisms within and between the different intervention components and to properly determine their effectiveness. As addressed earlier, we also had to deal with poor intervention descriptions in many studies. Nevertheless, four possibly promising intervention components were identified.

First, ADL training is a recurring intervention component, which is included in all identified reablement programmes. Within the occupational therapy literature, great benefits are found when ADL training in the elderly population is carried out in their home environment.[66] The use of home visits or home assessments is recommended to identify problems between the

individual's capabilities and the environment. Based on this home assessment, interventions and evaluations can be more tailored and thus increase effectiveness.[66]

Second, physical and/or functional exercises were also included in each reablement intervention. Mjosund et al.[17] studied how physical activity is integrated within reablement programmes. They found that most client goals were set in terms of functional mobility (such as walking, climbing stairs, outdoor walking). These exercises often focus on strength, balance or endurance, but specific details of the programmes were lacking. Liu et al.[66] found that physical exercise is often integrated into ADL training. When exercises are functional, task-specific, and meet client's wishes, they have more favourable outcomes on ADL performance than when they are more structured, constructive and repetitive.[66] According to the review by Blankevoort et al.[67] it is recommended to combine different exercises such as strength, endurance and balance training to improve progress in physical functioning and performance in ADL rather than only providing progressive resistance training. The best results were achieved with the highest training volume. These results are also confirmed by the review by Theou et al.[68] who looked at managing frailty in older people through exercise. The reviews both emphasise that exercise programmes that last longer than 12 weeks with an intensity of 3 times a week and sessions of 30-45 minutes produce the best results in functional, physical and psychosocial terms, and help prevent adverse health effects.

Third, education is regularly integrated into (effective) reablement programmes targeting the client and/ or their informal carers. On the one hand, education was given during educational meetings making use of handouts and leaflets, for example on how to motivate clients in daily and physical activities. On the other hand, advice was given by care professionals during regular care moments. Topics of education were, for example, on how to carry out (i)ADL-activities, use of (mobility)aids and self-management.

Additionally, management of functional disorders, which is often provided by nurses, was included in five out of six effective interventions. The literature on essential nursing care[69,70] emphasizes the importance of care activities like eating and drinking, comfort (including pain management), safety, prevention, and medication. However, this field of nursing care is often overlooked, undervalued and taken for granted, which can have a negative impact on client outcomes.[71]

Strengths and limitations

One of the strengths of this review is the process of obtaining the final study selection as a) the entire screening process was conducted independently by two reviewers, b) the final sample was checked and supplemented by experts with a broader view than only geriatrics, c) snowball sampling was used to reduce the risk of missing possible important articles, and d) the search was repeated after one year as the review should be as up to date as possible according to the methodological standards of the Cochrane Collaboration.[72] Moreover, grey literature was used to supplement the extracted data when available. The risk of bias assessment is another strength, as the reviewers completed the JBI checklists independently and reached a consensus through discussion in case this was necessary. Our systematic review focused on ADL functioning. Consequently, promising reablement features concerning other outcomes such as physical functioning, quality of life and fewer hospital admissions were not taken into account. Another limitation is that conclusions cannot be confidently drawn, as more than three-quarters of the included studies were of moderate to poor quality which hindered us to exclude the lower quality studies.

Methodological reflection

Reflecting on the capability of the used research design in answering the research questions, this review has been able to provide an overview of current evidence and reflect on the effects on ADL functioning. While we have been able to identify (promising) components of the programmes, we do not yet know much about the details of these components in practice and whether they were implemented as intended. Since the latter is not usually discussed within effect studies, including results of process evaluations could be potentially valuable. In addition, it is suggested to conduct multiple case studies to gather more in-depth information about existing reablement programmes.

Conclusions and practical implications

This study has several important implications for future practice regarding reablement interventions. First, reablement interventions should be delivered by a diverse interdisciplinary team, preferably including nurses, occupational therapists and/ or physical therapists, while attention should be paid to the training and coordination of the team and other factors that

influence the quality of interdisciplinary collaboration. Second, reablement interventions should make use of standardised assessment and goal-setting tools, which should be combined with training for both healthcare professionals and clients. Third, promising intervention components are (i)ADL-training, physical and/or functional exercise, education, and management of functional disorders.

A start has been made with 'unpacking' reablement, however, the review has only scratched the surface in terms of a better understanding of the determining factors for the effectiveness of reablement interventions. More research is needed to open the black box of reablement. First, more intervention protocols should be published that make use of reporting guidelines such as the TIDieR checklist[73] and the use of process evaluations should be emphasised to assess the variation in results of effect studies within the right context.[74] Second, collecting additional data from reablement experts, who have developed, evaluated and implemented reablement interventions, can provide more in-depth information about available reablement interventions. Third, more high-quality studies using outcomes tailored to the client's goals (e.g. COPM) are needed that aim to identify reablement features that are more promising than others and investigate which combination of features is most effective.

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Appendices

Appendix 1. Search strategy

PubMed

Date: July 24, 2020
Limits: 2002–2020; English and Dutch
Update: July 23, 2021

#1 Aged [mh] OR Aging [mh] OR geriatrics [mh] OR Frail elderly [mh] OR geriatric* [tiab] OR elder* [tiab] OR old [tiab] OR older [tiab] or ageing [tiab] or aging [tiab]

#2 Home care services [mh] OR home care service* [mh] OR rehabilitation [tiab] OR enablement [tiab] OR reablement [tiab] OR function focused care* [tiab] OR restorative care* [tiab]

#3 Activities of daily living [mh] OR independent living [mh] OR self care [mh] OR recovery of function [mh] OR self care [tiab] OR recovery of function* [tiab] OR disab*[tiab] OR daily function* [tiab] OR activities of daily living [tiab] OR instrumental activities of daily living [tiab] OR iADL [tiab] OR ADL [tiab] OR autonomy* [tiab] OR physical function* [tiab] OR functional status [tiab]) OR functional improvement [tiab]) OR functional decline [tiab] OR improving abilit* [tiab] OR independent living [tiab] OR independen* [tiab] OR "dependen* [tiab]

#4 randomized controlled trial [Publication Type] OR controlled clinical trial [Publication Type] OR randomized [tiab] OR placebo [tiab] OR Clinical Trials as Topic [mh] OR randomly [tiab] OR trial [Title]

#5 animals [mh] NOT humans [mh]

#6 #1 AND #2 And #3 and #4 NOT #5

EBSCO (CINAHL)

Date: July 24, 2020
Limits: 2002–2020; English and Dutch
Update: July 23, 2021

#1 (MH Aging) OR (MH Aged) OR (MH Geriatrics) OR (MH Frail elderly) OR TI (aged OR geriatric* OR elder* OR old OR older OR ageing OR aging) OR AB (aged OR geriatric* OR elder* OR old OR older OR ageing OR aging)

#2 TI (home care service* OR rehabilitation* OR enablement OR reablement* OR function focused care* OR restorative care*) OR AB (home care service* OR rehabilitation* OR enablement OR reablement* OR function focused care* OR restorative care*)

#3 (MH Activities of Daily Living) OR (MH self care) OR TI ((independent living) OR (recovery of function) OR (self care) OR disab* OR (daily function*) OR (activities of daily living) OR (instrumental activities of daily living) OR iADL OR ADL OR autonom* OR (physical function*) OR (functional status) OR (functional improvement) OR (functional decline) OR (improving abilit*) OR independen* OR dependen*) OR AB ((independent living) OR (recovery of function) OR (self care) OR disab* OR (daily function*) OR (activities of daily living) OR (instrumental activities of daily living) OR iADL OR ADL OR autonom* OR (physical function*) OR (functional status) OR (functional improvement) OR (functional decline) OR (improving abilit*) OR independen* OR dependen*)

#4 (MH randomized controlled trials) OR (MH double-blind studies) OR (MH single-blind studies) OR (MH random assignment) OR (MH pretest-posttest design) OR (MH cluster sample) OR TI (randomised OR randomized) OR AB (random*) OR TI (trial) OR (MH (sample size) AND AB (assigned OR allocated OR control)) OR MH (placebos) OR PT (randomized controlled trial) OR AB (control W5 group) OR (MH (crossover design) OR MH (comparative studies)) OR AB (cluster W3 RCT)

#5 (((MH animals+ OR MH (animal studies) OR TI (animal model*)) NOT MH (human))

#6 #1 AND #2 AND #3 AND #4 NOT #5

EBSCO (Psycinfo)

Date: July 24, 2020
Limits: 2002–2020
Update: July 23, 2021

#1 (DE Aging) OR (DE Aged) OR (DE Geriatrics) OR (DE Frail elderly) OR TI (aged OR geriatric* OR elder* OR old OR older OR ageing OR aging) OR AB (aged OR geriatric* OR elder* OR old OR older OR ageing OR aging)

#2 TI (home care service* OR rehabilitation* OR enablement OR reablement* OR function focused care* OR restorative care*) OR AB (home care service* OR rehabilitation* OR enablement OR reablement* OR function focused care* OR restorative care*)

#3 (DE Activities of Daily Living) OR (DE self care) OR TI ((independent living) OR (recovery of function) OR (self care) OR disab* OR (daily function*) OR (activities of daily living) OR (instrumental activities of daily living) OR iADL OR ADL OR autonom* OR (physical function*) OR (functional status) OR (functional improvement) OR (functional decline) OR (improving abilit*) OR independen* OR dependen*) OR AB ((independent living) OR (recovery of function) OR (self care) OR disab* OR (daily function*) OR (activities of daily living) OR (instrumental activities of daily living) OR iADL OR ADL OR autonom* OR (physical function*) OR (functional status) OR (functional improvement) OR (functional decline) OR (improving abilit*) OR independen* OR dependen*)

#4 TI (double-blind OR (random* assigned) OR control) OR AB (double-blind OR (random* assigned) OR control)

#5 #1 AND #2 AND #3 AND #4

Cochrane

Date: July 24, 2020
Limits: 2002–2020
Update: July 23, 2021

#1 ((aged OR geriatric* OR elder* OR old* OR ageing OR aging OR frail elderly).ti,ab) (Word variations have been searched)

#2 MeSH descriptor: [Frail Elderly] explode all trees

#3 MeSH descriptor: [Aging] explode all trees

#4 MeSH descriptor: [Geriatrics] explode all trees

#5 MeSH descriptor: [Aged] explode all trees

#6 #1 OR #2 OR #3 OR #4 OR #5

#7 ((home care service* OR rehabilitation OR enablement OR reablement* OR function focused care OR restorative care).ti,ab) (Word variations have been searched)

#8 MeSH descriptor: [Home Care Services] explode all trees

#9 #7 OR #8

#10 ((self care OR recovery of function* OR disab* OR daily function* OR activities of daily living OR instrumental activities of daily living OR iADL OR ADL OR autonom* OR physical function* OR functional status OR functional improvement OR functional decline OR improving abilit* OR independent living OR independen* OR dependen*).ti,ab) (Word variations have been searched)

#11 MeSH descriptor: [Activities of Daily Living] explode all trees

#12 MeSH descriptor: [Independent Living] explode all trees

#13 MeSH descriptor: [Self Care] explode all trees

#14 MeSH descriptor: [Recovery of Function] explode all trees

#15 #10 OR #11 OR #12 OR #13 OR #14

#16 #6 AND #9 AND #15

Appendix 2. Data extraction template

Study characteristics

Author	Year	Country	Quality	Title	Study aim	Hypotheses	Study design	Setting	Study sample	Baseline characteristics	Outcome measures	Limitations	Study protocol / related publications

Intervention content

Author	Year	Aims	Characteristics (intensive, person-centred, interdisciplinary, coordinated)	Components (assessment, goal-oriented, regular reassessment, training of daily activities, use of home modifications/assistive devices, involvement social network, reablement training and support of staff)	Target group (diagnosis, age, physical capacity, setting, type of problem)	Results

Outcomes

Study	Outcome measures	Results Follow-up, Mean (95% CI), p

Chapter 3

Exploring goal-setting and achievement within reablement: a comparative case study of three countries

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Abstract

Purpose: Over the last two decades, reablement programmes have been studied and implemented internationally. Goal-setting and multidisciplinary collaboration are central elements of reablement. Unfortunately, limited intervention descriptions leave questions on how they are applied in practice and how goals set by the user are achieved. As a consequence, healthcare providers and organisations often lack knowledge to implement and align reablement to their national and local context. This study aimed to collect data on goal-setting and achievement, and multidisciplinary collaboration within reablement services to provide insight into how these processes inform reablement practice as well as to explore the experiences of healthcare professionals in Norway, New Zealand, and the Netherlands.

Material and methods: A qualitative exploratory design was used comprising three focus group interviews with 20 healthcare professionals (nursing and allied health) involved in reablement programmes from the three countries. Purposive sampling was employed considering a mix of gender, age and educational level.

Results: Findings reflected healthcare professionals' experiences and reablement processes in three main themes: (1) Goal-setting processes; clearly demonstrating goal-setting as an essential part of reablement and contributing to better understanding of users' motives; (2) Impact of goal-setting on multidisciplinary collaboration; promoting a sense of community, learning climate, job satisfaction and task-shifting; and (3) Behaviour change techniques used to reach users' goals, promoting self-reflection and changing users' perspectives .

Conclusions: This study offers valuable insights from three countries. Goal-setting serves a crucial role enabling effective reablement implementation across diverse contexts. More specifically, to facilitate tailoring of reablement programmes to the user's needs as well as establish more effective multidisciplinary collaboration by promoting trust, shared vision, and utilizing each other's expertise. However, despite the acknowledgement of the significance of reablement, it was reported by all that a cultural shift is necessary for users, informal caregivers as well as healthcare professionals.

Introduction

Almost every country in the world is experiencing a proportional increase in its older population (65+) and although this is a success story of modern times, ageing does result in higher care dependency.[1] To address the ageing population, numerous countries have focused on developing services that enable older people to remain as independent as possible in their own homes and continue to participate in society whilst minimizing the use of formal funded services.[2] Therefore, concepts such as reablement have gained much attention within Western countries over the last decades and have been included in various national and international policies aimed at healthy ageing.[3] Reablement is defined as a holistic and person-centred approach that aims to enhance individuals' functioning, increasing or maintaining their independence in meaningful activities of daily living and reducing their need for long-term care. A trained and coordinated multidisciplinary team delivers interventions to meet individuals' meaningful goals. It is an inclusive approach irrespective of the person's age, capacity, diagnosis, or setting.[4] Although evidence concerning the impact of reablement on user outcomes remains mixed, satisfaction levels are high.[5] Moreover, healthcare professionals indicate that reablement facilitates a shift in work culture through a "different way of thinking", creates higher engagement, promotes professional development and offers a better framework for collaboration and application of reablement.[6-8] There are indications that reablement may be able to reduce the need for ongoing care and permanent admissions. [9,10]

Over the last two decades, reablement programmes have been studied and implemented partially or fully in 15 countries.[11] In these countries, levels of experience differ, leading to different stages of reablement implementation within each nation.[12,13] Much of the difficulty in interpreting the value of reablement comes from wide variability between countries and indeed within countries in relation to how it is delivered.[14] However, despite such variability, it is apparent that goal setting, achieving these goals and multidisciplinary collaboration are central aspects of reablement, irrespective of the model or method of delivery.[4,13] Goals serve as guidance, directing the efforts of healthcare professionals and users receiving care toward specific milestones and objectives.[15] These goals also offer a means to measure progress and success throughout the reablement process. By setting clear and individualized goals, healthcare providers can tailor their interventions to meet the users' wishes and needs.[16] Unfortunately, limited intervention descriptions leave questions on how these elements are applied in practice and how the goals set by the user are achieved.[11,17,18] As a consequence, healthcare providers and organisations lack the essential details needed to put reablement into

practice and fit their national and local context. A better description of reablement content and implementation aspects can enhance the provision of reablement and allow countries to learn from each other.[19] Relying solely on literature and textbook descriptions falls short of providing a comprehensive understanding. To grasp and uncover the practical aspects, it is imperative to obtain invaluable insights from the real-world experiences of healthcare professionals in their daily practice,[20] particularly when those perspectives arise from health professionals working within established reablement models.[4,21,22]

The current qualitative study aims to (1) collect data on the processes of goal-setting, achievement, and multidisciplinary collaboration within reablement to provide context, and (2) provide insight into experiences of healthcare professionals with these processes within reablement programmes in Norway (NO), New Zealand (NZ) and the Netherlands (NL). These three countries were selected because of their contrasting experience with implementing reablement programmes, healthcare policies, funding, geography, and years since reablement was implemented.[12,13] In NL, implementation of reablement is still in its early stages starting with a local training programme in 2015, and has no national guidance or policy.[14] NO and NZ have had centralized policies and plan structures in place since 2011 and 2000 respectively, that have provided a coherent and sustainable base for implementation.[14] Therefore, each country shows a different representation of what reablement can look like in practice, which corresponds to the variation we see internationally. All three countries have conducted larger trials and further developed reablement programmes based on their results, providing sufficient background information and experience to draw from.

Material and methods

Study design

This study employed a qualitative exploratory design and is reported according to the COnsolidated criteria for REporting Qualitative research (COREQ) to ensure transparency.[23] It comprised focus group interviews with health professionals involved in reablement programmes from Norway (NO), New Zealand (NZ) and the Netherlands (NL).

Setting

The data were collected from three different cases in the municipality of Bergen (NO), Waikato district (NZ), and the province of Limburg (NL). The ReAble network[24] provided an important method of selecting both countries and programmes and only those affiliated with the network were approached. The researchers (HT, MP and SFM) were asked to choose an example of a reablement programme in their country. Region-specific programmes, namely 'Everyday Rehabilitation' (NO)[25], 'START' (NZ),[21,22] and 'I-MANAGE' (NL)[26] were selected to recruit participants for data collection. Background information regarding these programmes is provided in Table 1.

Sampling and recruitment

A pragmatic sample of participants was selected based on the assessment of the involved researcher of the respective country. Participants were contacted via email, stating the study's background, objectives, and participation information. The participants were grouped per country, with a minimum of four to a maximum of ten individuals per group. The researchers aimed for a representative mix of healthcare professionals to establish a safe environment and equal distribution of roles and functions. Purposive sampling[27] was used to recruit these healthcare professionals by selecting individuals based on their capacity to provide relevant information regarding the reablement programme, considering a mix of gender, age and educational level. Healthcare professionals were defined as home care professionals, such as registered nurses and nursing assistants and allied health professionals, such as occupational or physical therapists.

Data collection

Focus group interviews were conducted face-to-face in NZ and NL and online using Microsoft Teams in NO. The focus groups were conducted between February 2022 and March 2023 for a duration of thirty minutes to one and a half hours. All participants provided signed informed consent after receiving information about the study and background information (i.e. age, gender, function and relevant working experience) was obtained. Three researchers (two females and one male), with extensive experience of conducting focus groups, participated in the data collection. Through a collaborative process, the researchers developed one interview

Table 1. Background information of reablement programmes in Norway, New Zealand and the Netherlands

	Bergen (Norway)	Waikato (New Zealand)	Limburg (The Netherlands)
Reablement programme since	Bergen-model of Everyday rehabilitation since 2015	START since 2010	I-MANAGE since 2022
Organisation and funding[13]	Vague national guidance of implementation, provided by municipalities Free of charge	Integration into national home and community support services, provided by health regions Case-mix funding	No national guidance or coordination, provided by local healthcare organisations/municipalities Fee-per-hour or lump-sum funding
Target group	No lower age limit. Remain in their own home, experience functional decline and are not excluded based on a particular diagnosis	Lower age limit of ≥65 years (Māori ≥55 years). Remain in their own home, medically stable, at risk of (re)admission to the hospital or nursing home and are not excluded based on a particular diagnosis	No lower age limit. Remain in their own home, experience functional decline, can learn and apply new skills and are not excluded based on a particular diagnosis
Patient inflow and initial assessment	The municipality has a multidisciplinary assessment team that evaluates care services applications. Enrolment is also possible based on the request from others, healthcare professionals. COPM is used for the needs assessment and is conducted mostly by OT, PT, or RN	The multidisciplinary team actively 'draws' patients to the Older Person's Assessment Liaison (OPAL) service in the hospital, or enrolment through the Needs Assessor Service Coordinators (NASC) linked to the general practitioner. The needs assessment is conducted mostly by an RN, sometimes PT or OT using interRAI Home Care Assessment	After a referral from the GP or ECP, an introductory meeting is scheduled with the OT employed by an elderly care organisation If eligible, the OT will conduct the needs assessment using the COPM and Positive Health Questionnaire
Duration	4 weeks	Up to 6 weeks	8 weeks

Note. RN, registered nurse; PT, physical therapist; OT, occupational therapist; GP, general practitioner; ECP, elderly care physician; COPM, Canadian Occupational Performance Measurement[28]; TARGET, Towards Achieving Realistic Goal in Elders Tool[29]; InterRAI, Inter-Resident Assessment Instrument[30]

guide for all focus groups, ensuring consistency across all sessions. The main themes addressed in the focus groups included: goal-setting, interventions used to reach set goals; multidisciplinary collaboration; and involvement of the user and informal caregiver. The researchers agreed on how to conduct the interviews to ensure the same principles were used. The focus groups that took place in NO, NZ and NL were moderated by researchers HT (PhD), MP (PhD) and SFM (PhD) respectively. As a moderator, they facilitated the focus groups and encouraged participants to participate in the discussions. Field notes were taken during and

after each focus group and all were recorded with written consent and transcribed verbatim using simple orthographic notation. An interpreter translated the transcripts from the native languages to English. Transcripts of the focus groups were checked against the audio recording by the researcher involved and a member check was offered to all participants to make sure everything was interpreted correctly. No comments were made on the transcripts by the participants.

Data analysis

The data collection was focused on information regarding the work processes, as well as experiences and perceived barriers and facilitators by the healthcare professionals. The process data were analysed using a deductive content analysis[31] and described both narratively and in tabular form.

The experience-based data were analysed using both deductive and inductive content analysis.[31,32] The deductive approach was chosen as the analysis was based on prior knowledge regarding the recurring components of existing reablement programmes and the aim was to uncover how these components were applied in different contexts. The collected data were therefore structured based on prior knowledge from a review by three of the current authors.[17] Following the inductive content analysis, researchers (HT, SFM and LEB) first familiarized themselves with the data by reading the transcripts several times. The transcripts were then imported to Atlas.ti software (Windows version 23.4.0).[33] Sentences or parts of sentences with content relevant to the research questions were identified during the coding process as a unit of analysis and recorded under the predefined themes based on the topic guide (Appendix 1). This was performed by LEB and checked by a second researcher (HT or SFM), to increase reliability. Identified open codes that did not fit into the analysis matrix but were still relevant to the aim of the study, were included using inductive content analysis to form additional (sub)themes.

Qualitative rigor

To increase rigor in terms of credibility, transferability, dependability and conformability;[34] member checking, uniform data collection methods, note-taking and direct quotations were used to analyse and present the data in this study.

Ethical considerations

The study was registered and approved by the FHML Research Ethics Committee of Maastricht University in the Netherlands for ethics review for all countries, under approval number FHML-REC/2021/118. Informed consent was provided in all countries including publication and anonymized responses. All participants received information about the study's purposes and the right to withdraw from the study. The procedures were conducted following the principles stated in the Declaration of Helsinki.[35] All interview data from NO and NZ were anonymized and stored on the research server of Maastricht University. By General Data Protection Regulation (GDPR), no data were sent outside Europe. Data transfer agreements were established between NL and NZ. In NO, data protection procedures were approved by the Norwegian Agency for Shared Services in Education and Research in February 2022 with reference number 689719.

Results

In total, 20 healthcare professionals participated in the three focus groups. Among the participants, there were four occupational therapists, four physical therapists, three managers, three registered nurses, two certified nurse assistants, one unregulated healthcare assistant, one elderly care physician, one nurse practitioner, and one informal care consultant. Of these, 19 were women, participants ranged in age from 28 to 60 years old (M= 44.5 years) and had on average 3.4 years of experience working with reablement, ranging from ten months to 11 years.

Based on the research questions and the data, three main themes could be identified: (1) Goal-setting processes; (2) Impact of goal-setting on multidisciplinary collaboration; and (3) Behaviour change techniques used to reach users` goals. Information regarding the processes of the aforementioned topics is shown in Tables 2, 3 and 4. The qualitative data are described below.

Goal-setting processes

This theme describes participants' experiences with identifying, prioritizing, setting, and evaluating goals. It highlights the collaborative nature of goal-setting in reablement, involving

the user, their support system, and the multidisciplinary team. The similarities and differences regarding the goal-setting processes in the three different countries are described in Table 2.

Formulating goals together

The methods used to set goals were perceived as facilitating by the participants, explaining that the goal conversation allowed them to dive much deeper into the problems of the user. However, they indicated that users were often not used to setting goals and looking at their problems and challenges in this manner, or were used to having others (e.g. care professionals) formulate the goals for them.

> *"But very many have such an expectation that there are others who set the goals for them and almost expect us as health professionals to define what is important to them." (NO)*

Consequently, they would ask the users about their request for help and what they would like to achieve. The goals were usually formulated in general terms by the user and often resulted in thinking of long-term goals at first. According to the participants, it was necessary to provide support in breaking down these larger goals (e.g. grocery shopping, watching the grandchildren) into more specific sub-goals (e.g. walking to the store, being able to bend down) or to help the users get started on formulating the goals differently. This process was perceived as challenging and time-consuming, yet, according to them, part of the very essence of reablement.

Table 2. Comparison of goal-oriented approaches within reablement programmes

	Norway	New Zealand	The Netherlands
Goal-setting			
Application and assessment	1. Preparation: Collecting and reviewing (medical) information regarding user 2. Assessment visit Assessing eligibility and help request for reablement by two therapists	*Similar to Norway, except for:* Referral through hospital discharge service or charge nurse manager Assessment mostly by an RN, sometimes PT or OT	*Similar to Norway, except for:* Assessment by OT and/or ECP
Identifying and prioritizing goals	3. Goal meeting: Setting goals with users using COPM semi-structured interview 4. Observation (action meeting): Observing users in the activities relating to the goals.	*Similar to Norway, except for:* TARGET and goal ladder are used for goal-setting.	*Similar to Norway, except for:* Questionnaire Positive Health with COPM used for goal-setting, after goal meeting the next step includes observation of all relevant HCPs
Setting goals	5. Setting final reablement plan during the multidisciplinary team meeting - Going from sub-goals to overall goals and vice versa	*Similar to Norway*	*Similar to Norway*
Type of goals	Everyday activity and social goals	*Similar to Norway*	*Similar to Norway*
Evaluation and follow-up	Revising goals along the way Evaluation at: - Halfway - End of programme Flexibility at end of programme 1-month follow-up after end of programme	*Similar to Norway, except for:* Weekly evaluations Follow-up at 3, 6, 9 and 12 months	*Similar to Norway, except for:* No structural follow-up

Note. OT, occupational therapist; ECP, elderly care physician; HCP, healthcare professional; COPM, Canadian Occupational Performance Measurement[28]; TARGET, Towards Achieving Realistic Goal in Elders Tool[29]

> *"We have sort of focused on the fact that it is important that we spend enough time on the goal-setting process itself that we do not rush there. […] It's so important. It is the very foundation of everything that happens." (NO)*

In addition, they emphasized the importance of the users formulating the goals in their own words, taking the time to let them think and letting the users be in the lead. When asked what kind of goals were set by the user, participants indicated that the goals were mainly everyday activity- and social-based. If goals originally were not based on everyday activities, the professionals would help reformulate the goals.

> *"The importance of having the goals in the person's own words, no one's ever said: 'I want to increase my exercise tolerance, obviously not, or improve my ADLs.' I think it's just having it in that person's own words and then working from there." (NZ)*

Participants also indicated when reformulating goals, it was important to go back to their basic needs and sense of purpose in their everyday lives, which were often overshadowed and forgotten due to the intensity of the care situation.

> *"But I think that what has become so basic, is that sense of purpose that has faded, where you would just go about the things you normally did in everyday life, like having a cup of coffee with the neighbour... Those things suddenly aren't so obvious anymore." (NL)*

Participants from NL mentioned that through the goal-setting process, they experienced a better understanding of the users' motives behind certain goals by implementing them through reablement.

> *"... and then you work together for a very long time and when you evaluate that patient has already forgotten what goals he had set himself. I don't have that now* [since working with reablement]." *(NL)*

Participants from all three countries mentioned that a lack of motivation, confidence and cognitive ability could hinder goal-setting. When users were unable to set goals themselves, participants felt that informal caregivers contributed positively to formulating the goals together.

> *"The next step is that I ask the informal caregiver to join me so that they* [user and informal caregiver] *can actually formulate the goals together. That's actually already going well." (NL)*

Working on a common set of goals

The fact that a goal conversation had taken place and therefore the team was working on a common set of goals, was in their view already facilitative for building a relationship with the user. In addition, users' awareness regarding goals and subsequent steps increased, which facilitated motivation and further conversations about, for example, more difficult topics and obstacles.

> *"I think for the healthcare assistants, […] it* [setting goals] *helps you establish an understanding with patients so that you can build that relationship more quickly." (NZ)*

Participants from NZ and NL reported that not every team member had access to the formulated goals and therefore, for example, reporting on the progress of goal achievement was difficult. Participants from NO did not experience these hindrances.

> *"There's one goal ladder, but I think we don't have the ability to integrate them very easily on the electronic* [patient file]*… Well, we're using a Word document and so there isn't the ability for the likes of PT to come in and just add their little bit, or the OT to add their little bit." (NZ)*

Evaluating goals

In NO and NZ no specific facilitators and barriers were experienced concerning the evaluation process. In NL however, participants indicated that they experienced the short period of the programme as both facilitating and hindering. They appreciated the time-limited approach but noted that users were often fearful of losing care.

> *"Here, you are very clear in advance about these are the goals and when these goals are achieved, the intention is that we stop the treatment. But by that time, they will have come up with other goals. And of course, that's fine if you work towards something step by step, but actually, people just don't want you to let go of them. They're very afraid of that." (NL)*

Impact of goal-setting on multidisciplinary collaboration

This theme describes participants' experiences and their perspectives on the impact of goal-setting within multidisciplinary teams. It highlights how goal-setting plays a central role in enhancing collaboration and communication among team members. Additionally, it describes how users, informal caregivers and healthcare professionals are involved in reablement programmes. Moreover, Table 3 describes the organisational structures of the multidisciplinary teams, the professions standardly involved and roles and task distribution.

Building relationships and trust

All participants experienced the mutual bonds and connection between the team members as valuable as it, amongst other things, strengthened the uniformity of the team towards the user. This promoted continuous coordination and opportunities to review and adapt the care plan.

> *"I just have to say that the dialogue we have together multidisciplinary is worth its weight in gold. To reach the goal, the collaboration is extremely important." (NO)*

Building relationships and mutual trust facilitated the team and their ability to allow themselves to be vulnerable to each other.

> *"The way the team is built up is that we have a great sense of confidence in one another, the trust… which we have built to each other during the time the team has existed. A lot of people have been involved for quite some time. And there is also great openness." (NO)*

Participants all emphasized that the bond built between the user and the reablement team was very important as, in addition to this, continuity of care was also promoted. The continuous dialogue between users and healthcare professionals was regularly mentioned as important for achieving goals. Moreover, since the user is in the lead, this facilitated active user involvement and a relationship of trust and was seen as a success factor for reablement.

> *"When it is mostly the same home trainer who goes every day, we build, we get to know the user very well and build that trust and observe the development along the way." (NO)*

Table 3. Comparison of organisational structures of multidisciplinary teams within reablement programmes

	Bergen (Norway)	Waikato (New Zealand)	Limburg (The Netherlands)
Roles and tasks			
Professions within the reablement team	PT, OT, RN and NA. The team only works with reablement and does not have other tasks within primary care	*Identical to Norway, except for:* HCA instead of NA GP and ECP on a consulting basis	*Identical to Norway, except for:* NA is not involved, IC is standardly involved and GP and ECP on a consulting basis. The team delivers reablement as one of their tasks in primary care
Task distribution	Task shifting: Roles are assigned regardless of occupation and based on availability	*Identical to Norway*	Fixed tasks: Roles are assigned solely based on occupation
Roles	1) Home trainer, in charge of daily training Advocate for the user Usually NA 2) Coordinator, team supervision, communication, meeting initiation and leadership, handles operations and logistics Can be OT, PT, or RN 3) Therapists - First therapist: coordinates, in charge of goal conversation, evaluations and development of the rehabilitation plan, supervises and talks to the home trainer daily Can be OT, PT, or RN - Second therapist: primarily consults, and participates in relevant meetings as supervisor/expert Facilitates referrals and dialogues with external HCP Can be OT, PT, or RN	1) Home trainer, in charge of daily training Advocate for the user Usually UNA 2) Coordinator, in charge of goal conversation, rehabilitation plan, team supervision, meeting initiation and leadership, handles operations and logistics Usually RN 3) Therapists Provide weekly training related to the goals and supervise the home care staff Can be OT or PT 4) Physician GP or ECP provides medical treatment and supervision when needed	1) Occupational therapist Coordinator: in charge of goal conversation, user follow-ups, rehabilitation plan, supervision and communication with the team. Provides training and coaching related to the goals for HCP and informal carers when needed 2) Physical therapist Provides training and coaching related to the goals for HCP and informal carers when needed 3) Registered nurse Combines direct care with coordination for home care staff 4) Informal care consultant Works with informal caregivers to increase capacity and reduce burden 5) Physician GP or ECP provides medical treatment and supervision when needed 6) Other healthcare professionals Involved when relating to the user's goals

Table 3. Continued

	Bergen (Norway)	Waikato (New Zealand)	Limburg (The Netherlands)
Collaboration			
User-related meetings during the treatment phase	Weekly team meeting Daily dialogue between home trainer and therapists	Weekly team meeting Regular dialogue between home trainer and therapists	Biweekly team meeting Coaching on the job when needed

Note. RN, registered nurse; PT, physical therapist; OT, occupational therapist; NA, certified nurse assistant; HCA, unregulated healthcare assistant; GP, general practitioner; ECP, elderly care physician; IC, informal care consultant; HCP, healthcare professional

Participants experienced that working on a common set of goals, strengthened collaboration and kept working according to the reablement philosophy in focus as a team.

> *"I just feel that it is not a challenge* [keeping the reablement philosophy in focus] *because we all agree that what is important for the user is in focus. And that we work for what's important to the user." (NO)*

Deeper understanding within the team

Contributing to better collaboration, they also obtained a deeper understanding of each other's work and capabilities related to each other's profession. It facilitated a learning climate, where team members learned with and from each other. All participants indicated that working together in a reablement team led to contacting each other faster when they had specific questions.

> *"We* [home trainers] *are happy to go with the therapist if we come upon challenges or something we are wondering about. Then they are happy to come in and go through it with us." (NO)*

> "*…those lines of communication with everyone* (within the team) *are very short and you work together on one set of goals. […] And now you can coordinate that very well on who does what part of the overall goal package. So I like that." (NL)*

Participants felt this enhanced the satisfaction within the team, as they found their work more fulfilling and rewarding when working with reablement.

> *"I must say that I experience that multidisciplinary collaboration works very well. Much better than what I have experienced before. Because we work so closely together in teams. So, we learn a lot from each other and it spreads to one another. So, I feel like it really works well." (NO)*

Hierarchy within the team

Participants also highlighted the fact that there was no hierarchy within the teams. The 'higher' educated professionals did not have a superior role. For example, home trainers in NO are seen as advocates of the users' wishes.

> *"It is not the case that some* [team members] *are more important than others, we are very equal. So, we do not have such a hierarchy in relation to it." (NO)*

Participants from NO and NZ indicated the collaboration process promoted "task shifting"; where roles are assigned based on availability regardless of occupation, while in NL roles are assigned solely based on occupation. Task shifting allows for improved coordination and collaboration and offers flexibility and faster deployment of reablement.

> *"I like to think that we're one of the true multidisciplinary teams. We have nurses setting up […] and ordering equipment and […] setting up a basic exercise programme until the PT or OT can see them, which is a really, really, good attribute." (NZ)*

Barriers during collaboration

No barriers in the collaboration process were perceived by NO participants. Participants from NZ mentioned the large time investment for the multidisciplinary team meetings as a barrier. As in NL reablement is a relatively new concept, participants mentioned they experienced difficulties organizing it, more specifically during the start-up phase of a new user.

> *"It's difficult if I* [physical therapist] *already get a patient, that might be a reablement trajectory […] but you can't start if the OT hasn't been there yet. […] And that is, when I think about it, often a problem. Being able to involve all professionals on time* [at the start of the programme]." *(NL)*

Techniques used to reach users' goals

This theme describes the behavioural and cultural changes necessary to reach users' goals. It highlights how behaviour change techniques play an important role when striving for goal achievement. Creating awareness, self-reflection and changing perspectives of the user played an important role in achieving and maintaining goals. Additionally, Table 4 provides examples of the behaviour change techniques groups and techniques mentioned by the participants. Michie et al.[36] described 93 behaviour change techniques clustered in 16 groups, while in the current study, 10 groups and 16 techniques are identified (Table 4). In the following text, the behaviour change technique groups are described as (Group name).

Changing user perception

Participants indicated that techniques focusing on the cognitive aspect of the users` reablement process were as important as the physical aspect.

> *"Yes, we work almost as much with the mental, I think, than the physical many times." (NO)*

The cognitive aspect (e.g. changing the way the user perceives certain things surrounding their care or performing activities) can be broken down into several techniques mentioned by the participants, such as techniques creating awareness using feedback on behaviour or outcomes (Feedback and monitoring) and using problem-solving techniques (Goals and planning).

> *"I think, if we can clearly say well we're doing this exercise which will help you with your lunging so you can get back to bowling, then we will have a better understanding of why we're doing it, as opposed to, I'm just doing this, but I don't know why." (NZ)*

> *"The users say: 'I want to learn to walk better.' Okay, but what do you need for that? You know, having that whole conversation beforehand about how are we going to walk better, what it is all about." (NL)*

User motivation

Moreover, participants felt that motivating users, and using techniques offering meaningful incentives (Reward and threat) and knowledge regarding what skills are needed to achieve the goals (Shaping knowledge), also contributed to progress.

> *"Sometimes I say: 'If you can't get them to exercise, say we're going to go to the cafe and get them to walk to the cafe.' […] We have a win-win. You get the exercise, and you get the coffee. So, we try and be creative about how we can motivate them because motivation is the biggest key here too." (NZ)*

By (re)framing the user's or informal caregiver's perspectives (Identity), participants used techniques attempting to change their cognitions or emotions on whether or not to do or take over certain tasks. (Re)framing (Identity) was used combined with techniques providing information on consequences (Natural consequences) to manage (unrealistic) expectations.

Table 4. Overview of behaviour change techniques used by reablement teams

Group	Behaviour change technique	Example
1. Goals and planning	Problem solving	Ask user to identify factors of influence and think of strategies to overcome barriers to perform desired behaviour
	Action planning	Detailed planning of performance of the desired behaviour (context, frequency, duration and intensity)
2. Feedback and monitoring	Feedback on behaviour	Observing and providing feedback on performance of behaviour
	Feedback on outcome(s) of behaviour	Observing and providing feedback on the outcome of performance of the behaviour
3. Social support	Social support (unspecified)	Arranging and/or providing practical or emotional help for performing the desired behaviour
4. Shaping knowledge	Instruction on how to perform the behaviour	Advise or agree on how to perform the desired behaviour
5. Natural consequences	Information about health consequences	Providing information about health consequences of performing the desired behaviour
	Information about emotional consequences	Providing information about emotional consequences of performing the desired behaviour
7. Associations	Prompts/cues	Using environmental or social stimuli to prompt or cue the behaviour
	Exposure	Systematically exposing to a feared activity to build confidence
	Associative learning	Teaching the user that certain behaviours or activities lead to positive outcomes or emotional responses
8. Repetition and substitution	Graded tasks	Setting easy-to-perform tasks, making them increasingly difficult, but achievable, until desired behaviour is reached
10. Reward and threat	Incentive (self)	Using activities meaningful (end-goal) to the individual as a reward if they put effort in reaching sub goals to achieve the behavioural outcome

Table 4. Continued

Group	Behaviour change technique	Example
12. Antecedents	Restructuring the physical environment	Changing the physical environment in order to facilitate the desired behaviour or create barriers to the old behaviour (other than prompts/cues, rewards and punishments)
	Restructuring the social environment	Changing the social environment in order to facilitate the desired behaviour or create barriers to the old behaviour (other than prompts/cues, rewards and punishments)
13. Identity	Framing/reframing	Suggesting to adopt a perspective or new perspective on behaviour (e.g. its purpose) to change cognitions or emotions about performing the behaviour

Note. Groups are numbered in accordance with the groupings of the behaviour change taxonomy by Michie et al. [36]

> *"But also, just to do it differently, because the daughter also found it very difficult to let go of the fact that her father folds laundry, so to speak, while he considers that as very important. And then I simply asked her the question, "But what would happen if he did it his way and you in your way?" And by making her think about that, you got another entrance. And she's really, as she just said and which then confirms a lot, she has radically changed certain things." [by not taking over certain tasks] (NL)*

All participants emphasized the importance of techniques that ensured conscious (re)iteration of goals and the use of graded tasks (Repetition and substitution). Graded tasks included setting easy-to-perform tasks and gradually increasing the difficulty while keeping it achievable, while reiteration of the goals led to a heightened awareness and deliberate practice of the objectives.

> *"There is a lot of focus on gradually challenging, so they should gradually do things more and more independently." (NO)*

This was often combined with techniques such as action planning (Goals and planning), but also using prompts and cues, associative learning and gradual exposure (Associations) to do it independently.

> *"Because they take the challenge right there […] And the next time we likely make a deal that the person walks to the store on their own and talk on the phone on the way. Or meet at the front door or ... That you quietly move yourself away […] when the user starts to achieve the goal themselves, it is very important we must pull out when we see that the user has achieved the goal." (NO)*

Involvement of others

Social support was also a technique frequently used by the participants, where informal caregivers were considered to be a resource (Social support).

> *"Yes, there are many […] wonderful relatives who want everything for their own and fix things almost faster than we come up with the idea to put it that way." (NO)*

However, when involving an overburdened informal caregiver, there was little room to expect anything from them during the programme as they quickly felt overwhelmed.

> *"The only thing that can hold back is when the informal caregiver is really overburdened and then has even more appointments to attend." (NL)*

Participants felt that focusing on techniques restructuring the physical and social environment (Antecedents) was beneficial, which was necessary to facilitate performance, improve the users' independence and remove the related barriers to reaching the goals. Participants experienced hindrances when informal caregivers and external healthcare professionals had different expectations of the programme or when they had other goals in mind than the user.

> *"I think there is a barrier at times for us with the expectations that they* (users) *come out of hospital with* [hospital creates false expectations]*, so goals really have to start right at the beginning." (NZ)*

As a consequence, the participants had unrealistic perceptions of what the reablement team would do, which in turn were projected onto the user. The lack of knowledge about reablement was referred to as a main cause.

> *"We've gotten to some different expectations here from the patient in START* [due to prior misinformation] *so we slowly ease them into how we do things here because they can be very adamant there. The users may state: 'I was promised six weeks of START. I was promised someone would come and do my house this weekend. I was promised they'd make my bed and stuff'." (NZ)*

Discussion

The purpose of this study was to collect data on the process of goal-setting, achievement, and multidisciplinary collaboration within reablement to provide context and facilitate meaningful interpretation as well as to provide insight into the experiences of healthcare professionals with these processes within reablement programmes in NO, NZ, and NL. The focus groups findings reflected healthcare professionals' experiences and the processes in three main themes: 1) Goal-setting processes; 2) Impact of goal-setting on multidisciplinary collaboration; and 3) Behaviour change techniques used to reach users' goals.

Both the results of this study and previous research state the users' needs and preferences as the foundation of goal-setting, considering the user an active partner which promotes users' motivation, the user-healthcare professional relationship and a deeper understanding of users'

motives.[16] The three countries followed a comparable process of goal-setting, despite the differences in patient inflow to the programmes (Table 1), which is comparable to the stages of goal-oriented care.[16] Compared to NO and NZ, NL had little experience with reablement, consequently they faced several challenges in the organisation of work processes (e.g. planning team meetings, sharing tasks, or offering regular evaluations). All countries acknowledged the difficulty of setting goals together with the users, especially when users were not used to looking at their problems and challenges in this manner or setting goals. In NZ and NL, exchanging data about goals and the corresponding care plans was challenging due to the use of diverse systems by professionals.

Trust and respect, continuous communication and shared vision were considered important factors for effective collaboration within a multidisciplinary team across all three countries, which is acknowledged by previous research.[37] Examples of such beneficial collaboration features are creating a sense of community, a feeling of shared responsibility within the team, a deeper understanding of each other's roles, increasing job satisfaction, and stimulating a learning climate.[6,38-40] In addition, some differences were seen regarding the organisation of the multidisciplinary teams and their level of collaboration between countries. First, within reablement teams in NO and NL, allied health appeared to play a more dominant role. This stands in contrast to NZ, where home care teams worked alongside home trainers without formal healthcare training, taking the primary responsibility for reablement delivery. Beresford et al. made a distinction between 'multidisciplinary reablement' (comparable with NO and NL) and 'home-care reablement' (comparable with NZ).[41] Multidisciplinary reablement is associated with a more 'comprehensive reablement', addressing goals across both functional and social domains, rather than focusing solely on one aspect over the other.[41] Whereas home-care reablement focuses more primarily on the functional rather than the social domain.[41] However, the NZ approach is noteworthy as the daily training was provided by unregulated healthcare assistants, meaning that they had undergone training but lacked formal healthcare education, exempting them from adhering to specific standards and regulations. This approach presents an appealing solution amidst global workforce challenges. Second, the organisational structures and processes within the teams in NO and NZ promoted "task shifting", which means that team members are assigned tasks and roles based on availability regardless of one's occupation. For example, the district nurse initiated an exercise programme with the user when the physical therapist was unavailable at that time. This phenomenon is described in several reablement studies, improving flexibility when allocating roles and tasks.[39,40,42] In contrast, NL reablement teams utilized "fixed tasks", which can be disadvantageous as it limits the

programmes and teams' flexibility. Nevertheless, the common set of goals ensured that the NL team members worked on the same tasks and had some degree of overlapping responsibilities. We argue that goal-setting can be used as a means to improve multidisciplinary practice, as it plays a crucial role by providing focus, fine-tuning, motivation, ownership and a way to measure results. When multidisciplinary teams establish clear and shared goals, they are better equipped to utilize the diverse expertise and perspectives of each team member to tackle complex problems and achieve meaningful results.

The findings confirm that reablement is a behaviour change intervention, which was also indicated by Azim et al.[19] Identifying the behaviour techniques used in reablement provision contributes to determining the active components of this intervention. Examining the techniques used to achieve goals, all three countries employed similar BCTs. Using behaviour techniques empowers users to regain or enhance their independence and functional abilities and addresses behavioural patterns that might hinder progress.[43,44] For instance, addressing the need for a safety net, leading to apprehension when care was diminished or engaging in activities more independently when using graded tasks. In addition to behavioural change, a cultural shift is necessary not only among users and informal caregivers but also among healthcare professionals. Promoting behavioural and cultural change can not only optimize care but also establish a more sustainable and user-centred healthcare system for the future, allowing for preventive and early interventions.

Reablement aligns with the broader goal of social responsibility by promoting inclusivity, well-being, and support for vulnerable populations.[45] Social responsibility states that individuals and organisations should contribute positively to the well-being of society.[46,47] By providing reablement services, societies and healthcare systems show their commitment to helping individuals overcome challenges, promoting autonomy, and facilitating their active participation in the community. In addition, there is a global obligation to deliver high-quality care and services despite workforce challenges and ageing populations.[45,47] By investing in reablement services, societies and healthcare systems contribute to a more inclusive and supportive environment, fulfilling their social responsibility to care for the needs of all members. Our study shows that despite the various ways in which reablement is integrated, each country experiences its successes and offers important lessons contributing to the design and implementation of reablement programmes in new contexts. For example, structuring the system around the reablement team to promote task-shifting consequently enables rapid care delivery regardless of the available healthcare professional.

Strengths and limitations

Several methodological considerations should be taken into account in this study. Purposive sampling was used to recruit participants, aiming for a mix of gender, age, and educational level. However, no guarantee can be made whether the participants were a representative sample of the population in their respective countries. Additionally, we chose to use a pragmatic sample resulting in three focus groups conducted as part of our case study with no repeated interviews, therefore data saturation might not have been not reached. Lastly, one of the focus groups took place online due to COVID-related circumstances, which may have resulted in less depth of data in this group. However, data analysis showed that on certain topics more depth and detail emerged from this group in comparison to the others. One of the strengths of this study is that it is the first study to offer a comparison of goal-setting in reablement programmes, combined with healthcare professionals' attitudes and perceived challenges across three countries with different healthcare contexts. In addition, meticulous attention was dedicated to the translation process of the Norwegian and Dutch focus groups, aimed at correctly presenting subtle nuances and minimizing the presence of potential misinterpretations.

Conclusions

In conclusion, this study offers valuable insights from three countries in relation to the delivery of reablement programmes. Goal-setting serves a crucial role in enabling effective reablement implementation across diverse contexts. Specifically, goal-setting was found to facilitate tailoring reablement programmes to the user's needs and can help define overarching objectives for the programme delivered as a whole. Furthermore, our study clarified that goal-setting fosters multidisciplinary collaboration and emphasizes the importance of a collaborative environment to promote trust, shared vision, and utilizing each other's expertise improving the effectiveness of multidisciplinary teams within reablement programmes. However, despite the acknowledgement of the significance of reablement, it was reported by all that a cultural shift is necessary for users, informal caregivers as well as healthcare professionals.

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Appendices

Appendix 1. Topic guide

Question	Prompts
TOPIC: GOALSETTING 1. How do you set goals? a. *COPM or other tool?*	• Phases 1. Identifying goals 2. Prioritizing goals 3. Setting goals 4. Evaluating goals • Challenges • Best practices/ tricks
2. Which kind of goals are set?	• (I)ADL • Other meaningful activities • Other goals
Give a summary of what was just discussed and ask for any additions/nuances (± 5 min)	
TOPIC: TREATMENT 3. How are clients' goals reached? a. *Specific (standardized) interventions/programmes?*	• Which interventions? • Challenges • Best practices/ tricks
Give a summary of what was just discussed and ask for any additions/nuances (± 5 min)	
TOPIC: INTERDISCIPLINARY COLLABORATION 4. How do you reach clients' goals? a. *Other professions involved besides dedicated reablement team?*	• Who does what? • Coordination • Collaboration & communication • Keeping reablement philosophy in focus • Challenges • Best practices/ tricks
Give a summary of what was just discussed and ask for any additions/nuances (± 5 min)	
TOPIC: INVOLVEMENT CLIENT & FAMILY 5. To what extent are clients and family involved as active partners?	• Shared-decision making ○ Goal-setting ○ Treatment • Doing *with…* instead doing *for…* • Family support • Challenges • Best practices/ tricks
Give a summary of what was just discussed and ask for any additions/nuances (± 5 min)	

Chapter 4

Defining reablement in the Dutch context: a modified Delphi study

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Submitted

Abstract

For the past decade, the Netherlands has been developing and implementing reablement programmes to promote independence and to empower older adults' autonomy. However, a key challenge has been the lack of clarity around the definition of reablement and how it relates to usual care practices. The existing international definition lacks specificity to account for contextual differences, such as variations in healthcare systems and cultural norms. Therefore, a modified Delphi study was performed to develop a definition of reablement that fits the Dutch health and social care system and extends beyond a conceptual definition, outlining its operationalisation in practice. The study comprised three expert rounds and three Delphi survey rounds. A total of 139 participants from Dutch health and social care, education, and research, as well as representatives of clients and informal caregivers, discussed and evaluated various statements within four sections: the target group, aims, type of care or support, and characteristics of reablement programmes. The key discussions during the expert rounds focused mainly on (1) the target group, emphasising the importance of involving individuals and their families, and (2) the characteristics of reablement, such as coordinating roles, team composition, and size. The input from the Delphi surveys and expert rounds led to the development of an operational definition for the Dutch context, agreed upon by 81% of stakeholders. The Delphi methodology proved valuable in identifying context-specific elements and incorporating expert perspectives, creating a culturally and contextually sensitive definition. The definition developed for the Dutch context distinguishes itself from the international definition by offering practical guidance on areas of application and interventions. It expands the focus beyond independence to promote social participation, well-being, and the involvement of the individual's social network. This definition represents an important step in advancing further research and policy development regarding reablement in the Netherlands.

Introduction

The increase in population ageing and high prevalence of chronic conditions are straining healthcare systems.[1] Reablement offers a solution by promoting independence and empowering older adults' autonomy through person-centred support and interventions.[2] Currently, more than 15 countries have embraced the reablement approach, either as a national care policy or as a promising care concept. Still, its interpretation and application can vary greatly depending on the country and healthcare system in which it is implemented. To address this ambiguity, Metzelthin et al.,[3] conducted a Delphi study in 2018 with 82 reablement experts from 11 countries to develop a conceptual, consensus-based, international definition of reablement:

> *"Reablement is a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting."*

The international consensus based definition of reablement has been utilised as a foundation for policy and research in several countries in Western Europe and Asia.[4] This definition outlines reablement in a broad, theoretical sense, and highlights its focus on enabling and empowering individuals. Due to contextual differences between and even within countries this conceptual definition lacks the specificity needed for practical application. For example, it requires more specific information about the target group, assessment tools, interventions, and processes. The ReAble Network[5] advocates for developing country-specific operational definitions, based on the internationally accepted conceptual definition.[6] Developing an operational definition for a specific context ensures that reablement practices are aligned with local needs and resources, such as the availability of trained professionals and cultural attitudes, thereby increasing their relevance and feasibility for practitioners and policymakers.

In the Netherlands, research on reablement has been conducted for over a decade. The focus has been on developing and implementing reablement programmes, as well as evaluating their

feasibility, stakeholder experiences and effectiveness in terms of client and care professional outcomes, and cost-effectiveness.[2,7,8] With the introduction of a national policy programme (Living, Support, and Care for the Elderly) by the Dutch Ministry of Health, Welfare, and Sport in 2022, reablement has gained increased national attention. It is presented as a sustainable solution to promote independence among older individuals and thereby reduce pressure on the healthcare system.[9] This growing interest has stimulated numerous health and social care providers in the Netherlands to integrate reablement into their daily practices. However, there is ambiguity regarding the definition of reablement and how it relates to usual care practices, with many organisations left to navigate its implementation without clear guidance. An operational definition is needed that fits the Dutch health and social care system. The term 'operational definition' in this study refers to guidance for policy and practice that extends beyond a conceptual definition, outlining the operationalisation of reablement in practice in terms of its target group, aims, type of care or support, and characteristics. We aimed to develop an operational reablement definition by incorporating the perspectives of various stakeholders across practice, policy, and research.

Methods

Study design

We conducted a modified Delphi study. It deviated from the traditional Delphi method by incorporating additional elements alongside the expert panel, such as the scientific literature and stakeholder input, obtained through open-ended questions.[10] The Delphi technique is used to identify the collective opinion of experts and to detect agreement.[11] In our Delphi study, three rounds of expert panel meetings and three Delphi survey rounds were conducted between April 2024 and September 2024 following the recommendations for Conducting and Reporting of Delphi Studies (CREDES) to increase robustness.[12]

Participants and recruitment

Expert panel

Purposive sampling was used to invite stakeholders to form an expert panel, to provide informed opinions and insights on reablement based on their experiences.[13] The professionals within the expert panel were associated with health and social care providers considered to be

frontrunners in reablement in the Netherlands. This included four project leaders, a policy advisor for the municipality, members of reablement teams (i.e., occupational therapist, physiotherapist, community nurse, and a district linking pin), as well as representatives of clients and informal caregivers.

Survey participants

Online surveys were used in all three Delphi rounds. For these online survey rounds, a large group of stakeholders across the Netherlands was recruited through word of mouth, email, and social media. This large group included a mix of stakeholders and the members of the expert panel, comprising all individuals involved in reablement or those who have experienced it firsthand – such as clients, informal caregivers, social workers, nursing staff, therapists, management, educators, researchers, and others – without any specific eligibility criteria.

Before the start of the study, all participants were provided an information letter, that stated the study's background, objectives, and participation information. Informed consent was obtained prior to the start of the study.

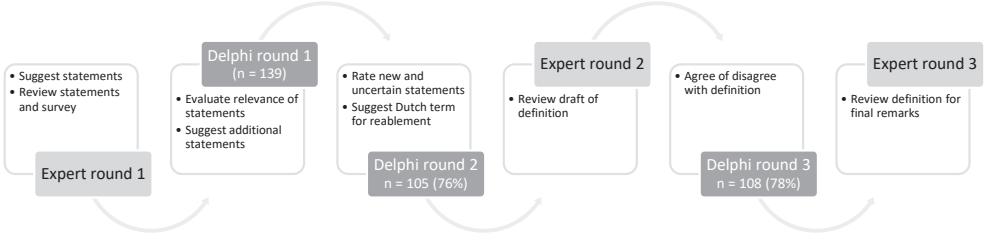

Figure 1. The modified Delphi process consisting of three online Delphi rounds and three expert panel meetings

Data collection

The surveys were conducted using the online survey programme Qualtrics (2024).[14] Background information such as gender, age, education, job title, primary field of work, work area, working experience, experience with reablement, and knowledge of reablement was collected from all participants. The research team, consisting of the authors LB, IM, SZ, SV, TS, and SM, was responsible for all aspects of the Delphi process, including preparation, execution, analysis, and reporting of the study. Figure 1 shows an overview of the steps of the Delphi process including an overview of the total number of respondents per round.

Expert round 1 (April - May 2024)

A literature search was conducted to gather existing descriptions of reablement from scientific papers. Drawing on the international conceptual definition by Metzelthin et al.,[3] the research team identified statements related to the target group, aims, characteristics, and components of reablement. These were used to create a preliminary set of statements. Then, an online survey was conducted with the expert panel, who were asked to generate statements about the target group, aims, characteristics, and components of reablement through open-ended questions, without prior knowledge of the literature-based statements. The research team incorporated the experts' contributions and the findings from the scientific papers and the international Delphi study to refine the statements. The resulting first survey was divided into four sections – target group, aims, type of care or support, and characteristics. The expert panel subsequently reviewed these statements, offering feedback and suggestions. The research team discussed all the feedback, which included recommendations on survey structure, language use, and the inclusion of examples. The final version of the survey included 80 statements.

Delphi round 1 (May – June 2024)

In the first survey, the participants were asked to evaluate the 80 statements using a nine-point Likert scale, where higher scores corresponded to greater agreement on that the statement was relevant to the question (see Figure 2). The participants were encouraged to suggest additional statements if they felt important topics were missing and were able to respond to the statements through open-ended questions. These additional comments were thoroughly

reviewed by two members of the research team (LB and SM). They were subsequently used in round 2 to rephrase and refine specific statements and text and were also incorporated into discussions with the expert panel during round 2. Statements with any ambiguity were reassessed in the subsequent round.

Below, you will find several statements regarding the potential target group for reablement in the Netherlands. Please indicate the extent to which you agree with each statement by clicking the corresponding box. 1 means 'strongly disagree' and 9 stands for 'strongly agree'.

Reablement is an inclusive approach, regardless of ...

	Strongly disagree								Strongly agree
Age	O	O	O	O	O	O	O	O	O
Diagnosis	O	O	O	O	O	O	O	O	O
Prognosis (chance at recovery)	O	O	O	O	O	O	O	O	O

Figure 2. Sample survey questions for the target group prompted the participants to provide their responses based on their ideal scenario for reablement in practice

Delphi round 2 (June – July 2024)

All participants from round 1 were invited for round 2. Two reminders were sent to increase the response rate. The adapted survey included additional statements as suggested by the participants in round 1. In addition, the statements with ambiguity from the first survey were evaluated using a binary response option (include versus do not include in the definition).

After collecting all the responses, the research team created a draft of the definition based on the statements. The text was divided into sections on the aims, target group, the individual's needs, and characteristics of reablement.

Expert round 2 (July 2024)

The draft was presented to the expert panel, who provided feedback during a two-hour online meeting led by two members of the research team (LB and SM). During the meeting, the panel was divided into two groups. Each group reviewed the text sections of the definition to refine nuances and to ensure the precision of the wording and terminology used. Notes were taken by the researchers. After both groups had discussed the definition, they reconvened and shared their findings with the other group. During each step, the panel members were allowed to

provide clarifications, add nuances, and make further contributions. The outcomes were collectively reviewed afterwards.

The draft was subsequently revised and refined by the research team based on the suggestions of the expert panel. Within the research team, agreement was also sought regarding the use of certain terms or concepts and keeping all of the participants' suggestions in mind.

Delphi round 3 (July – September 2024)

In the third round, the refined definition was shared with the participants form Delphi rounds 1 and 2. They were invited to indicate their agreement with the proposed definition or to suggest any modifications if they did not agree. Two reminders were sent to increase the response rate. After collecting all the responses, the research team revised the draft of the definition based on the feedback received. The, the revised draft was shared with the expert panel via email, allowing them to offer any final comments. These were incorporated into the document, resulting in the final version.

Data analysis

All analyses were performed using SPSS Statistics version 28.0.1.1.[15] Descriptive statistics were used to analyse the background characteristics of the participants (i.e., frequencies, percentages, means, and standard deviations [SDs]). For the questions employing the Likert-scale in Delphi rounds 1 and 2, median scores and inter-quartile ranges (IQR) were used to assess relevance and the level of consensus, respectively. Statements were deemed relevant if they achieved a median score of 7–9 and an IQR of ≤2.[16] Statements with a median score of 1–3 and an IQR of ≥2 were considered to be less relevant and lacking consensus and were subsequently excluded. [16] The remaining statements were considered uncertain. For questions employing a binary response option (include versus do not include in the definition, agree versus disagree with the definition draft), a threshold of 75% was established to determine agreement.[12]

The notes taken during various steps of the process were reviewed and discussed by the research team, and then thematically summarised to identify key messages and insights. This allowed us to capture and interpret significant topics and themes, providing a deeper understanding of the data.

Ethical considerations

The study was reviewed and approved by the Faculty of Health, Medicine & Life Sciences (FHML) Research Ethics Committee of Maastricht University in the Netherlands, under approval number FHML-REC/2024/014. The study was not subject to the Dutch Medical Research Involving Human Subjects Act (WMO). All participants received information about the study's purposes, provided informed consent, and had the right to withdraw from the study at any moment. All data were pseudo-anonymised and stored on the research server of Maastricht University and only accessible to the members of the research team.

Results

In total, 139 participants across the Netherlands participated in round 1 of the Delphi study; of these, 105 (75.5%) participated in round 2, and 108 (77.6%) participated in round 3. An overview of the participants' background information is presented in Table 1. Of the participants, 81.3% were primarily employed in healthcare, 7.2% within social care, 4.3% in education or research, and 7.2% in other sectors (e.g., health insurer, client, and caregiver representatives). Additionally, 37.4% held management-related positions (e.g., manager, policy advisor, project leader), while 54% were practitioners within health and social care (e.g., registered nurses, occupational therapists, and social workers). The participants had an average of 8.3 years (SD 7.8) of work experience in their current occupation, an average of 2.8 years (SD 4.2) of experience with reablement and self-rated their knowledge of reablement with an average 7.1 out of 10 (SD 1.5).

In the following sections, we present the findings and participant discussions for each part of the definition on reablement (i.e., the target group, aims, type of care or support needed, and characteristics) and present the final phrasing of each section. Figure 3 shows the proportion of statements related to each part of the definition that did or did not reach agreement in the Delphi rounds. A scoring summary of all statements of Delphi rounds 1 and 2 is provided in Appendix 1.

Table 1. Background information of the participants (n = 139)

	Delphi participants (n = 139)
Age (years), mean (SD)	44.8 (13.2)
Gender, n (%)	
Men	19 (13.7)
Women	119 (85.6)
Non-binary	1 (0.7)
Educational level[a], n (%)	
Low	16 (11.5)
Intermediate	72 (51.8)
High	51 (36.7)
Occupation, n (%)	
Healthcare professionals	70 (50.4)
Nursing professionals[b]	31 (22.3)
Medical and allied health professionals[c]	35 (25.2)
Advisors and case management[d]	4 (2.9)
Social care professionals[e]	5 (3.6)
Management	52 (37.4)
Manager	21 (15.1)
Policy and strategy officer or advisor	17 (12.2)
Project leader	14 (10.1)
Other	12 (8.6)
Researcher/educator	7 (5.0)
Client or formal/informal caregiver representative	4 (2.9)
Management assistant	1 (0.7)
Working experience in current occupation (years), mean (SD)	8.3 (7.8)
Experience with reablement (years), mean (SD)	2.8 (4.2)
Self-rated knowledge of reablement (1-10)[f], mean (SD)	7.1 (1.5)

Table 1. Continued

	Delphi participants (n = 139)
Primary field of work, n (per cent)	
Healthcare sector	113 (81.3)
Rehabilitation care	12 (8.6)
Institutionalised long-term care	36 (25.9)
Hospital care	1 (0.7)
Community care	49 (35.3)
Social care sector	10 (7.2)
Education/research	6 (4.3)
Other[g]	10 (7.2)

Notes. [a] Low: primary education, lower secondary education; Intermediate: intermediate vocational or higher secondary education; High: higher vocational education, university. [b] Registered nurse, certified nurse assistants, nurse assistants. [c] Occupational therapist, physical therapist, elderly care physician/nurse practitioner, speech therapist, psychologist. [d] Dementia case managers, behavioural advisor, informal care consultant. [e] Social worker, district linking pin, day care services worker, social prevention worker. [f] Higher score indicates higher self-rated knowledge. [g] Retired, ICT, member informal care and client council, welfare, health insurer, board member, self-employed. SD: standard deviation

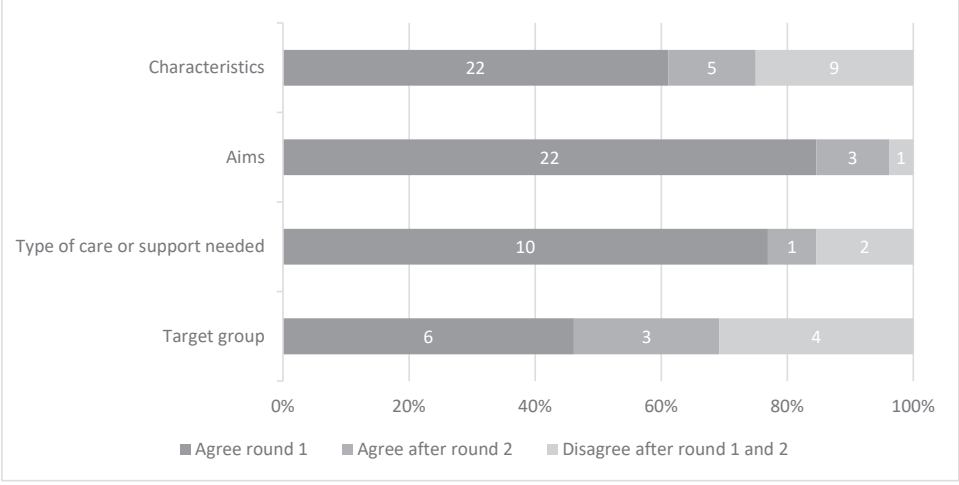

Figure 3. Proportion of statements related to each section of the definition that did or did not reach agreement after rounds 1 and 2 of the Delphi study. The numbers indicate the number of statements

Target group

Delphi rounds

In round 1, six target group–related statements were identified as relevant. Five were rated as uncertain (median score 6–7, IQR ≥2: prognosis, cognitive functioning, psychological functioning, learning ability, and motivation) and re-evaluated in round 2 (see Appendix 1). Agreement was reached for 'cognitive functioning' (75.2%), while the other four were excluded. The participants also suggested two new statements ('cultural background/ethnicity' and 'social support availability'), both of which were included after round 2 scoring. Feedback from open-ended questions during round 1 highlighted nuances, such as using the term 'diagnosis' and addressing both the individual and their family:

> *"The individual and their family are the centre of the treatment, and everything revolves around them." (Participant survey, round 1)*

Expert panel rounds

During each expert panel meeting in round 2, the target group for reablement was a key focus. Stakeholder suggestions were discussed alongside considerations about the intended population and the optimal wording to describe them. While the panel explored the characteristics of an ideal target group, the experts found it challenging to define this group precisely, resulting in a lack of clear criteria. They noted that eligibility is often determined by a combination of factors:

> *"Reablement is fundamentally always an option. It often involves a combination of factors that may render reablement no longer feasible; a single factor does not provide sufficient information on the matter." (Client and informal caregiver representative)*

In round 2, the expert panel discussed the term 'care avoiders', deeming it inappropriate as it relates more to willingness to engage with reablement. They emphasised that this group requires a different approach and excluded it from the definition. The panel also stressed the importance of considering individuals and their social network as a unit in the definition. They noted that learning ability should not determine eligibility for reablement if the social network can provide support. Additionally, they emphasised that reablement requires the target group to identify a specific goal or support need, recommending this be included under

characteristics. Motivation, viewed as a defining factor for the success of reablement, was included in the definition under the type of care or support needed.

Final definition of the target group

The final text regarding the target group, as agreed upon following the surveys and expert panel meetings, is as follows:

> *Reablement is an approach suitable for anyone with a care, support, and/or welfare need, regardless of age, culture, diagnosis, or level of physical, cognitive, and daily functioning. This approach can be applied both at home and within care organisations (such as hospitals, nursing homes, or rehabilitation centres) and is accessible to individuals living alone or with others. Reablement always focuses on both the individual and their surrounding social network.*

Aims

Delphi rounds

In round 1, 22 statements related to the aims were identified as relevant to the definition. Three were rated as uncertain (median score 5–8, IQR ≥3: 'reducing health and social care costs', 'facilitating discussions about the future', and 'enhancing informal caregivers' confidence') and re-evaluated in round 2 (see Appendix 1). Agreement was reached for including 'facilitating discussions about the future' (86.7%) and 'enhancing informal caregivers' confidence' (79.0%), while the remaining uncertain statement was excluded. The participants in round 1 suggested a new statement – 'deploying professional assistance where it is most needed' – but it was not included after round 2 scoring. Feedback from open-ended questions in round 1 offered further suggestions, such as removing certain statements or clarifying nuances. For example, some participants found the statement 'reducing health and social care costs' to be framed too negatively and noted that some questions were difficult to assess.

> *"I find it somewhat challenging to fill in. For example, I don't think the goal is to relieve either professional care or family members, but that this can be a beneficial side effect." (Participant, round 1)*

Expert panel rounds

During the expert panel meetings, stakeholder suggestions were reviewed alongside considerations regarding the aims, focusing primarily on the precise wording of statements and the final text. For example, 'participation' was revised to 'social and community participation'. Some phrases were found to be too negative or insufficiently precise and were adjusted in consultation with the panel across all three rounds. The experts highlighted that the initial draft in round 2 did not sufficiently differentiate reablement from usual care in its aims. This was addressed in the final version, emphasising the importance of focusing on meaningful activities, relationships, and participation, among other changes. The expert panel also stressed the importance of the social network and social care, noting that early drafts in round 2 were predominantly oriented towards health care, leaving these aspects underrepresented. Furthermore, they indicated the significance of prevention as a key component of reablement, recommending its explicit inclusion in the definition. These adjustments were incorporated into the aims and integrated across other sections of the text.

Final definition of the aims of reablement

The final text regarding the aims, as agreed upon following the surveys and expert panel meetings, is as follows:

> *Reablement aims to enhance individuals' autonomy and self-reliance, to improve their quality of life, and to enable them to remain in their living environment for as long as possible. It increases independence in both daily activities and activities and relationships that are meaningful to them. Moreover, reablement promotes social and community participation. Finally, reablement facilitates appropriate care and support, thereby potentially reducing the demand for professional care and support.*

Type of care or support needed

Delphi rounds

In round 1, ten statements regarding the type of care or support needed were deemed to be relevant to the definition. Two statements – related to 'care avoiders' and 'acute needs' – were rated as uncertain (median score 6–7, IQR =3) and re-evaluated in round 2 (see Appendix 1). Both were ultimately scored not relevant for inclusion by 60.0% and 67.6% of participants,

respectively. Additionally, a new statement suggested in round 1 – concerning short-term residence in institutions such as hospitals, care homes, or rehabilitation centres – was included following round 2 scoring. During round 1, a participant provided feedback on the type of care or support needed, indicating that they did not give maximum scores on the Likert scale because it strongly depends on the implementation of reablement.

> *"It (regarding the type of need for which reablement is implemented) strongly depends on how reablement is implemented. I believe that some needs do not necessarily require an interdisciplinary team with various healthcare professionals, as that might be excessive." (Participant, round 1)*

Expert panel rounds

During the expert panel meetings, stakeholder suggestions were reviewed alongside considerations about the type of care and support needed. Discussions also focused on refining the wording of specific statements and the final text, including examples related to 'support needs', 'well-being needs', and 'preventive needs'. A key topic in round 2 was identifying the types of needs suitable for reablement, although no clear consensus emerged. For example, there was debate about whether reablement is only appropriate for complex needs and how such needs should be classified as complex. The panel also discussed the roles of individuals and their social networks, concluding that while individuals should lead the process, their networks – often overburdened – must be considered as well. This reinforced the view that individuals and informal caregivers should be regarded as a unit. The panel emphasised that reablement must integrate the perspectives of both individuals and their informal caregivers. To reflect this, adjustments were made across multiple sections of the text in rounds 2 and 3 to ensure this emphasis was clearly conveyed in the final definition.

Final definition of type of care

The final text regarding the type of care or support needed, as agreed upon following the surveys and expert panel meetings, is as follows:

Reablement can be broadly applied to address both simple and complex issues related to independence and participation. It can assist with existing concerns or help prevent (future) issues. Reablement may focus on the following types of needs:

- *Care needs (such as community nursing and paramedical care);*
- *Support needs (such as assistance with household tasks and transportation services);*
- *Well-being needs (such as day activities and guidance); or*
- *Combination of the above needs.*

Reablement is also employed to balance the burden and resilience of the individual and their social network. While receiving informal care is not a prerequisite, it can either support or hinder the achievement of the established goals. Furthermore, motivation plays a crucial role in the success of reablement; for example, an individual may experience significant limitations but can still achieve success through strong motivation, or conversely, may struggle despite experiencing fewer limitations.

Characteristics

Delphi rounds

In round 1, 22 statements about the characteristics of reablement were deemed relevant to the definition. Nine statements were rated as uncertain (median score 4–8, IQR ≥3), including those addressing the programme's end, the core team, and the role of the individual and their social network, and were re-evaluated in round 2 (see Appendix 1). Four statements – 'it stops when the individual's goals have been achieved,' 'a coordinator is designated within the core team', 'the individual is part of the core team', and 'the individual appoints someone from their social network to be part of the core team' – were deemed relevant for inclusion, while the other five were excluded. In round 1, the participants also suggested four new statements related to characteristics: 'it can be monodisciplinary', 'the core team specifies which expertise is needed to achieve the goals', 'the individual takes on a coordinating role (possibly with professional support)', and 'the informal caregiver takes on a coordinating role (possibly with professional support)', as well as 'the individual is monitored even after goal attainment'. Among these, only 'the core team specifies which expertise is needed to achieve the goals' was included following round 2 scoring. Feedback from the open-ended questions during round 1 raised questions about who should hold the coordinating role within the core team. Additionally, one participant highlighted the importance of regular evaluations with the individual to ensure sustained results.

"A key component of the programme is that after achieving the goals, there should be monthly check-ins to assess progress, with evaluation, adjustment, and follow-up being essential. After all, circumstances in the individual's life and their environment are always changing. Restarting the process does not seem like a viable option. Someone from social care must remain closely involved, with a clear mandate for observation." (Participant, round 1)

Expert panel rounds

During the expert panel meetings, stakeholder suggestions from each round were reviewed, with particular attention to the wording of specific statements and the final text (e.g., 'behaviour change' can have a negative connotation). In round 2, discussions focused on the operationalisation of reablement and the characteristics essential for its implementation. The experts highlighted the importance of a comprehensive intake process that accounts for well-being and participation. They also stressed the significance of involving the individual as the owner of the process and aligning interventions with the individual's capabilities. The panel also discussed the value of providing tailored care and support, noting that achieving reablement goals does not always require a large, multidisciplinary team. These considerations were incorporated into the final text, with adjustments made in rounds 2 and 3 to ensure these principles were clearly reflected.

Final definition of the characteristics of the approach

The final text regarding the characteristics, as agreed upon following the surveys and expert panel meetings, is as follows:

Reablement is implemented by an interdisciplinary team comprising professionals from both health and social care (core team). The individual receiving care and/or support is considered to be a member of the core team and may appoint someone from their social network to participate as well. Collaboration among various disciplines and sectors facilitates a broad, integrated approach. Team members are trained in the principles of reablement and possess the necessary competencies to deliver a reablement programme. One team member assumes a coordinating role.

The reablement process begins with a comprehensive needs assessment that takes a holistic view of the individual's needs, wishes, and capabilities, alongside those of their social network. Following this,

the individual (and/or their informal caregiver) formulates goals tailored to their specific situation. The core team collaborates with the individual to develop a plan aimed at achieving these goals, ensuring that the individual and their informal caregiver(s) maintain reliance throughout. This plan outlines goals, interventions, and responsibilities. Regular evaluations and adjustments of the plan ensure the best possible outcomes are achieved. The level of care and support gradually decreases throughout the reablement process until the goals are met. Reablement is temporary in nature; if necessary, referrals to (long-term) care and support can be made upon completion.*

**The following interventions and techniques may be employed to achieve the established goals:*

1. *Awareness and empowerment – for example, education, positive reinforcement and feedback, motivational interviewing, goal setting and planning, self-monitoring, and reflection;*
2. *(Re)Learning cognitive, physical, emotional, and social skills – for example, memory training, fall prevention, exercise programmes, coping with stress and emotions, and establishing and maintaining social connections; and*
3. *Applying internal and external compensation strategies – for example, advising on and teaching the use of assistive devices, adapting tasks or environments, implementing strategies to enhance the balance between burden and resilience, and self-management.*

Refining the definition

After drafting the initial complete definition text, 88 (81.5%) of the 108 participants in round 3 agreed with the first draft (see Appendix 2). The 20 participants (18.5%) who did not agree with the definition were given the chance to refine the text. Their comments addressed aspects such as language use, the rationale, and the focus of reablement. Table 2 provides details on the suggestions made and how they were incorporated into the final version of the text.

Some experts' feedback focused more on the reablement mindset rather than the specific content of reablement as a programme. Additional suggestions led to a restructuring of the text to improve the readability. After the research team revised the text, it was forwarded to the expert panel for a final review. Three experts provided additional remarks, primarily focused on readability and word choice (e.g., 'needs assessment' instead of 'intake', with one expert suggesting the addition of more examples to improve operationalisation). In response, the research team further refined the text to ensure a more concise and polished formulation, resulting in the final definition presented in Appendix 3.

Table 2. Comments given by participants during Delphi round 3 that led to adjustments in the definition

Summary of comments	Adaptations
Several experts mentioned that the phrase 'actively participating in care' suggests that a person continues to receive care after reablement, whereas the core aim is to enhance self-reliance, empowerment, and personal control.	We decided to use the term 'culture change' and added that 'reablement encourages to help individuals learn to help themselves (again)'.
One expert found the phrasing regarding the application of reablement in a 'familiar living environment' to be too restrictive, as the approach is also suitable for use in nursing homes or temporary living arrangements.	We changed the term to 'living environment' to also include other settings.
An expert suggested adjusting the wording to make it clear that the individual sets their own goals.	We specified the fact that the goals are set 'together with the individual'.
Several experts indicated that it is not sufficiently clear when reablement should be initiated.	We added that reablement can be initiated for everyone 'with a care, support, and/or welfare need' and provided examples in the text.
One expert specifically mentioned that the temporary nature of reablement as an intervention is not adequately emphasised, creating the impression that it is a long-term process that may lose sight of its primary goal.	We added the phrase 'reablement is of a temporary nature'.
An expert suggested that prevention could also be included as a principle.	We added this to the aims of reablement.
One expert noted that the text did not sufficiently reflect the equality between the individual or their representative and the reablement team.	We adjusted the sentence structure to better reflect this equality in the section on the characteristics of reablement.
Several comments were made regarding informal care, including the point that reablement is not intended for the informal caregiver, but rather should focus on the individual.	We refined this by clarifying that within reablement, 'attention is also given to (potentially) overburdened informal caregivers, to help the individual remain in their living environment'.

Discussion

The expert and Delphi rounds led to the development of the operational definition of reablement in the Netherlands presented in Appendix 3, which was agreed upon by 81.5% of the stakeholders. The key discussions focused on the target group, such as the importance of involving individuals and their families, and the characteristics of reablement, including the coordinating role, team composition, and size.

The operational definition closely aligns with the international definition by Metzelthin et al.[3] when considering the scope and focus of both definitions. However, aligning with the intended operationalisation, the Dutch definition distinguishes itself by offering more detailed and

practical guidance on the implementation of elements such as areas of application and interventions that can be used to reach the clients' goals. Notably, in line with the international definition no specific target group was identified, highlighting the broad applicability of the approach. Moreover, the Dutch definition particularly focuses on social participation and connection, expanding its focus beyond independence to the individual's social network and well-being. This aligns with trends in Dutch healthcare that focus on integrated care, prevention, and person-centred approaches to support older adults in living fulfilling, independent lives while participating in society.[9,17] The focus on social connectedness and participation further positions the Dutch reablement definition as especially relevant within today's policy context, reflecting a shift towards more holistic care that integrates formal services with community and social support to enhance overall well-being and resilience. These trends highlight that care-related challenges do not always need to be solved solely through formal care; they can also be addressed through social care and the support of the individual's social network. The evolution of the concept and operationalisation of reablement towards the social domain and well-being is evident globally, as seen in the development of reablement practices over time. Initially, reablement was more focused on functional recovery from a biomedical perspective – for example, 'reabling' individuals back to work – and often aimed at specific conditions such as arthritis or cerebral palsy.[18] However, over the years, the importance of social care and overall well-being has emerged more often in the reablement literature. This is not surprising, given the shifts in broader perspectives on health throughout the world, such as the World Health Organization's concept of 'Healthy Ageing'.[19] Healthy Ageing is defined as the process of promoting and preserving functional ability to support well-being in later life. It focuses on enhancing an individual's capacity to engage in activities that are meaningful to them, enabling them to 'be' and 'do' what they value.[19]

Our data also revealed a distinction between reablement as a mindset and reablement as an intervention, with the participants discussing that fostering this reablement mindset is a prerequisite for successful implementation of the intervention. The distinction between mindset and intervention has also emerged within the reablement literature, with Metzelthin et al.[20] also making a distinction between grounded service models and time-limited intervention programmes in reablement principles. They argued that reablement service models aim to build capacity and foster environments enabling professionals to assist individuals in engaging in meaningful activities, thereby cultivating a reablement mindset rather than delivering time-limited interdisciplinary reablement interventions. This distinction influences the intended recipients and providers of reablement – for example, in how providers

are trained, or services are structured, it reflects a move from 'doing reablement' as a programmatic intervention to 'being reablement' as a holistic, integrated approach within care systems. Moreover, Vluggen et al.[21] highlighted the importance of first cultivating the right mindset before implementing the programme with clients. Attempting to implement the programme without focusing on the right mindset risks reducing it to a mere checklist, where the core principles of reablement are not fully realised. Conversely, focusing only on mindset without offering adequate descriptions and guides of the approach for its implementation and sustainability may fail to achieve lasting change.

Our study presents several important insights with implications for both practice and research. First, while the operational definition provides a guide outlining the operationalisation of reablement in practice, it does not provide information on how it relates to existing forms of care, which is necessary to clarify reablement's value and to receive the necessary resources and support to implement reablement into standard care. To achieve this, it is important to compare reablement with existing interventions such as traditional home care or outpatient rehabilitation. One example of how this comparison can be made is through patient journeys, which could illustrate key differences in outcomes and approaches.[22] This comparison can highlight both the differences and similarities, helping to clarify reablement's value and its potential to become part of standard care. Second, while the conceptual international definition helps to anchor what reablement is in a broad, theoretical sense, the operational definition describes reablement in practice by outlining specific actions, interventions, and processes. Together, these definitions offer both a theoretical understanding of reablement and practical guidance for its application. For policymakers, these definitions ensure consistent and clear guidance that can support the creation of policy aligned with the principles of reablement. For practitioners, they provide a tangible structure for defining roles, responsibilities, and measurable outcomes, helping to translate theory into effective practice. Third, the results of our study suggest that future reablement research should focus on outcomes related to well-being and social connectedness, as these areas are underexplored to capture the benefits of reablement and are often emerging themes in qualitative research. [23] This could provide a valuable addition to the existing outcome measures used within reablement, as there are often doubts as to whether these measures fully capture the impact of reablement.[24] Fourth, our study provides a valuable example for other countries facing difficulties in aligning reablement practices due to conceptual ambiguity arising from varying interpretations. By systematically engaging diverse stakeholders – for example, through the Delphi method – it is possible to generate context-sensitive insights into reablement's goals,

target group, core characteristics, and interventions. This process can help to bridge gaps in understanding and align practices with the broader philosophy of reablement. In doing so, it strengthens the foundation for effective implementation, collaboration, and robust evaluation of reablement services.

A major strength of our study is its robustness: we followed the CREDES guidelines for conducting and reporting our research.[12] Additionally, the Delphi methodology allowed for an iterative process to continuously refine and clarify the definition, incorporating data triangulation through expert and survey input to ensure a well-considered outcome. By engaging with a large group of stakeholders, we enhanced the applicability and relevance of our findings. The Delphi approach also ensured the definition was sensitive to the specific cultural and contextual aspects of the Dutch healthcare system. However, our study is also subject to certain limitations. For example, selection bias may have occurred, as most participants were from the healthcare sector and had a higher education, with a relatively small number from social care and those with lower levels of education. Consequently, the recommendations and conclusions drawn from the study might be less applicable or generalisable to these underrepresented populations. Finally, reablement is a relatively new concept in the Netherlands, as confirmed by the average of 2.8 years of experience reported by participants. This may have affected the depth of understanding and the overall generalisability of our findings, as reablement does not have an established standard in the Dutch healthcare system.

Conclusions

In conclusion, our study developed an operational definition of reablement in the Dutch healthcare context using the modified Delphi methodology. This approach proved to be a valuable tool for identifying context-specific elements and incorporating the experiences of experts, facilitating the creation of operational definitions that are both culturally and contextually sensitive. The developed definition serves as a guide for operationalising reablement in practice, extending beyond a conceptual definition to offer concrete, actionable guidance. By engaging with a diverse group of experts, we sought to capture context-specific insights that could clarify key characteristics and offer practical guidance for its implementation. Despite some limitations, the definition may contribute to both the theoretical and practical understanding of reablement. It could serve as a foundation for further research and policy development, helping to standardise and support the integration

of reablement in the Netherlands and provide an example for other countries aiming to develop context-sensitive definitions.

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Appendices

Appendix 1. Overview of statements regarding the target group, aims, type of care or support needed, and characteristics of reablement per round.

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Target group						
Age	8.0	2.0	√			√
Diagnosis	7.0	2.0	√			√
Prognosis (chance at recovery)	7.0	3.0	?	67.6 (71)	-	-
Cognitive functioning	6.0	2.0	?	75.2 (79)	√	√
Physical functioning	8.0	1.0	√			√
Psychological functioning	7.0	3.0	?	61.9 (65)	-	-
Daily functioning	8.0	2.0	√			√
Were the individual is residing (at home, institutionalised long-term care)	8.0	2.0	√			√
Whether the individual lives alone	8.0	2.0	√			√
Learning ability	6.0	2.0	?	67.6 (71)	-	-
Motivation	6.0	4.0	?	55.2 (58)	-	-
Additional statements round 1				*Median*	*IQR*	
Cultural background and/or ethnicity				8	2	√
Availability of support from the social environment				7	1	√

Appendix 1. Continued

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Needs						
Care needs	9.0	1.0	√			√
Support needs (e.g., household assistance, meal delivery)	8.0	1.0	√			√
Well-being needs (e.g., loneliness, meaningful daily activities)	8.0	2.0	√			√
Preventative needs (e.g., lifestyle interventions, increased physical activity, nutrition)	8.0	2.0	√			√
Risk of high burden on informal caregiver support system	8.0	2.0	√			√
Acute needs (care, support, or well-being)	7.0	3.0	?	67.6 (71)	-	-
Ongoing needs (care, support, or well-being)	8.0	2.0	√			√
Chronic needs (care, support, or well-being)	9.0	1.0	√			√
New needs (care, support, or well-being)	8.0	2.0	√			√
Standalone needs (care, support, or well-being)	8.0	2.0	√			√
Complex needs (care, support, or well-being)	8.0	2.0	√			√
Care avoiders	6.0	3.0	?	60.0 (63)	-	-
Additional statements round 1				*Median*	*IQR*	
During short-term residence in an institution such as a hospital, care home, or rehabilitation centre				8	2	√

Appendix 1. Continued

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Aims						
Enhancing the quality of life of the individual	9.0	1.0	√			√
Promoting the individual's autonomy and self-reliance	9.0	1.0	√			√
Supporting independent functioning in daily activities (e.g., personal hygiene, dressing, household tasks, transport)	9.0	1.0	√			√
Facilitating independent functioning in meaningful activities for the individual	9.0	1.0	√			√
Enabling the individual to remain in their familiar environment for as long as possible	8.0	1.0	√			√
Promoting social and community participation of the individual (allowing continued engagement in society)	8.0	1.0	√			√
Reducing the need for support under the Social Support Act	7.0	2.0	√			√
Decreasing the individual's need for care through the Health Insurance Act	7.0	2.0	√			√
Lessening the individual's need for care under the Long-term Care Act	7.0	2.0	√			√
Reducing health and social care costs	5.0	4.0	?	32.4 (34)	-	-
Alleviating pressure on care and support services (physical care, excluding other remote care)	7.0	2.0	√			√
Facilitating discussions about the future with the individual	8.0	3.0	?	86.7 (91)	√	√
Enhancing the individual's confidence	8.0	2.0	√			√
Increasing awareness and insight into the individual's capabilities	8.0	1.0	√			√
Learning and relearning skills for the individual	8.0	1.0	√			√
Coping with limitations in life for the individual	8.0	2.0	√			√
Relieving the burden on the informal caregivers	7.0	2.0	√			√
Enhancing the capacity of the informal caregivers	8.0	1.0	√			√

Appendix 1. Continued

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Aims						
Teaching family members to reduce their involvement in tasks	8.0	2.0	√			√
Enhancing the awareness of the informal caregivers in their own capabilities	8.0	2.0	√			√
Enhancing the informal caregiver's confidence	8.0	3.0	?	79.0 (83)	√	√
Promoting integrated care	8.0	2.0	√			√
Promoting person-centred, holistic care	8.0	2.0	√			√
Delivery of appropriate care	8.0	1.0	√			√
Instigating a cultural shift (from doing for… to doing with…)	8.0	1.0	√			√
Additional statements round 1				*Median*	*IQR*	
Deploying professional assistance where it is most needed				7	3	-
Characteristics						
A comprehensive intake assessment is conducted	8.0	2.0	√			√
Goals are set collaboratively with the individual and/or their informal caregivers	9.0	1.0	√			√
The goals align with the individual's capabilities and resources	8.0	1.0	√			√
A plan is developed based on the established goals	8.0	1.0	√			√
The goals and progress are regularly evaluated	8.0	1.0	√			√
Attention is given to the education of the individual (e.g., providing information, increasing insight, learning to ask for help, communicating needs)	8.0	1.0	√			√
Attention is given to the education of informal caregivers (e.g., understanding burden capacity, exploring support options)	8.0	2.0	√			√

Appendix 1. Continued

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Characteristics						
Attention is given to training in daily activities (e.g., establishing routines, compensatory strategies, personal hygiene, use of assistive devices, participation in traffic)	8.0	1.0	√			√
Attention is given to training in meaningful activities in addition to daily activities (e.g., hobbies, social activities)	8.0	1.0	√			√
Attention is given to training in physical skills (e.g., balance, stair climbing, walking short distances)	8.0	1.0	√			√
Attention is given to training in cognitive functions and skills (e.g., memory, concentration, compensatory strategies)	8.0	2.0	√			√
Attention is given to training in emotional skills (e.g., self-confidence, coping with stress and emotions)	8.0	2.0	√			√
Attention is given to social skills (e.g., making and maintaining contacts)	8.0	2.0	√			√
Attention is given to behaviour change for the individual	8.0	2.0	√			√
Attention is given to supporting informal caregivers based on their needs	8.0	1.0	√			√
Attention is given to involving the social network	8.0	2.0	√			√
The programme is concluded after a set number of weeks (temporarily).	7.0	3.0	?	62.9 (66)	-	-
It stops when the individual's goals have been achieved	7.0	3.0	?	73.3 (77)	√	√
It is delivered by an interdisciplinary core team	8.0	2.0	√			√
The core team consists solely of healthcare staff	5.0	5.0	?	29.5 (31)	-	-
The core team consists solely of social care staff	4.0	5.0	?	21.9 (23)	-	-
The core team comprises staff from both the healthcare and social domains	8.0	2.0	√			√
A coordinator is appointed within the core team	8.0	3.0	?	84.8 (89)	√	√

Appendix 1. Continued

	Round 1 (N = 139)			Round 2 (N = 105)		End result
	Median	IQR	Result	Include % (N)	Result	
Characteristics						
The approach is considered not only from a healthcare perspective, but also from a well-being perspective	9.0	1.0	√			√
The individual is part of the core team.	8.0	3.0	?	81.0 (85)	√	√
Informal caregivers are part of the core team	7.0	3.0	?	65.7 (69)	-	-
The individual's social network is included in the core team.	6.0	3.0	?	42.9 (45)	-	-
The individual appoints someone from their social network to be part of the core team	7.0	3.0	?	72.4 (76)	√	√
The staff in the core team are trained in the implementation of reablement.	8.0	1.0	√			√
The underlying philosophy is a prerequisite for its application	9.0	1.0	√			√
Additional statements round 1				*Median*	*IQR*	
It can be monodisciplinary				4	4	-
The core team specifies which expertise is needed to achieve the goals				8	1	√
The individual takes on a coordinating role (possibly with the assistance of a professional)				6	3	-
The informal caregiver takes on a coordinating role (possibly with the assistance of a professional)				5	3	-
The individual is monitored even after goal attainment				7	3	-

Note: √: identified as relevant, ?: identified as uncertain, IQR: interquartile range

Appendix 2. First draft of the operational definition of reablement in the Dutch context

Background

The philosophy of reablement is characterised by the provision of integrated, person-centred, and holistic care and support. Reablement aims to foster a cultural shift by moving the focus from passively receiving care and support to actively participating in it. This approach promotes appropriate care and support, potentially reducing the pressure on professional care services. This philosophy is put into practice through intervention programmes that facilitate the implementation of reablement. The definition below describes the goals, target groups, application areas, and characteristics of reablement in the Netherlands, where the philosophy and the programme approach are intrinsically linked.

Goal of reablement

Reablement aims to enhance individuals' autonomy and self-reliance, improve their quality of life, and enable them to remain in their familiar living environment for as long as possible. It increases independence in daily activities as well as meaningful activities and relationships. Additionally, reablement promotes social participation. Another aim is to balance the individual's and the system's capacity and strain.

Who is reablement for?

Reablement is an approach suitable for everyone, regardless of age, culture, diagnosis, or level of physical, cognitive, and daily functioning. This approach can be applied both at home and within care organisations (such as hospitals, nursing homes, or rehabilitation centres) and is accessible to individuals living alone or with others. Reablement always focuses on both the individual and their surrounding social network.

Application areas of reablement

Reablement can be broadly applied to address both simple and complex issues related to independence and participation. It can assist with existing concerns or help prevent (future) issues.

Types of issues for which reablement can be applied include:

- Care needs (such as community nursing and paramedical care);
- Support needs (such as assistance with household tasks and transportation services);
- Well-being needs (such as support in reducing loneliness)
- Or a combination of the above needs.

Reablement can also be applied when a caregiver is at risk of becoming overburdened, enabling the individual to continue living independently in their familiar environment. While receiving informal care is not a prerequisite, it can either support or hinder the achievement of the established goals. Furthermore, motivation plays a crucial role in the success of reablement; for example, an individual may experience significant limitations but can still achieve success through strong motivation, or conversely, may struggle despite experiencing fewer limitations.

Characteristics of reablement

Reablement is implemented by an interdisciplinary team comprising professionals from both health and social care (core team). Collaboration among various disciplines and sectors facilitates a broad, integrated approach. Team members are trained in the principles of reablement and possess the necessary competencies to deliver a reablement programme. One team member assumes a coordinating role. The individual receiving care and/or support is considered a member of the core team and may appoint someone from their social network to participate as well.

Reablement begins with a comprehensive intake, during which the needs, desires, and possibilities of the person and their system are assessed from a broad perspective. Following this, the individual (and/or their informal caregiver) formulates goals tailored to their specific situation. The core team develops a plan to achieve these goals, ensuring the person and possibly their caregiver(s) remain in control. This plan outlines objectives, interventions (see Box 1), and responsibilities. Regular evaluations and adjustments of the plan ensure the best possible outcomes are achieved. The level of care and support gradually decreases as the goals are met. If necessary, a referral for (long-term) care and support can be made at the end of the process.

Box 1. Application Areas and Interventions for the person and their caregiver(s)

Reablement focuses on increasing self-reliance and participation in:

- *Daily activities (e.g., washing and dressing)*
- *Household tasks (e.g., ironing and cooking)*
- *Outdoor mobility (e.g., going to the supermarket or using public transport)*
- *Meaningful activities (e.g., hobbies and social activities)*

The following interventions and techniques can assist with this:

1. *Personal Development*

- *Examples: Education, positive reinforcement and feedback, motivational interviewing, goal setting and planning, self-monitoring, and reflection.*

2. *(Re)learning Cognitive, Physical, Emotional, and Social Skills*

- *Examples: Memory training, fall prevention, exercise programmes, coping with stress and emotions, and establishing and maintaining social connections.*

3. *Learning Internal and External Compensation Strategies*
    - *Examples: Use of assistive devices, adapting tasks or environments, implementing strategies to enhance the balance between burden and resilience, and self-management.*

Appendix 3. Operational definition of reablement in the Dutch context

Background

The philosophy of reablement is characterised by the provision of integrated, person-centred, and holistic care and support. This philosophy is often translated into intervention programmes to promote the necessary cultural change. The definition below outlines the goals, target groups, application areas, and characteristics of reablement in the Netherlands, where the philosophy and the programme approach are intrinsically linked.

Goals of reablement

Reablement aims to enhance individuals' autonomy and self-reliance, to improve their quality of life, and to enable them to remain in their living environment for as long as possible. It increases independence in both daily activities and activities and relationships that are meaningful to them. Moreover, reablement promotes social and community participation. Finally, reablement facilitates appropriate care and support, thereby potentially reducing the demand for professional care and support.

Who is reablement for?

Reablement is an approach suitable for anyone with a care, support, and/or welfare need, regardless of age, culture, diagnosis, or level of physical, cognitive, and daily functioning. This approach can be applied both at home and within care organisations (such as hospitals, nursing homes, or rehabilitation centres) and is accessible to individuals living alone or with others. Reablement always focuses on both the individual and their surrounding social network.

Application areas of reablement

Reablement can be broadly applied to address both simple and complex issues related to independence and participation. It can assist with existing concerns or help prevent (future) issues.

Reablement may focus on the following types of needs:

- Care needs (such as community nursing and paramedical care);
- Support needs (such as assistance with household tasks and transportation services);
- Well-being needs (such as day activities and guidance); or
- Combination of the above needs.

Reablement is also employed to balance the burden and resilience of the individual and their social network. While receiving informal care is not a prerequisite, it can either support or hinder the achievement of the established goals. Furthermore, motivation plays a crucial role in the success of reablement; for example, an individual may experience significant limitations but can still achieve success through strong motivation, or conversely, may struggle despite experiencing fewer limitations.

Characteristics of reablement

Reablement is implemented by an interdisciplinary team comprising professionals from both health and social care (core team). The individual receiving care and/or support is considered to be a member of the core team and may appoint someone from their social network to participate as well. Collaboration among various disciplines and sectors facilitates a broad, integrated approach. Team members are trained in the principles of reablement and possess the necessary competencies to deliver a reablement programme. One team member assumes a coordinating role.

The reablement process begins with a comprehensive needs assessment that takes a holistic view of the individual's needs, wishes, and capabilities, alongside those of their social network. Following this, the individual (and/or their informal caregiver) formulates goals tailored to their specific situation. The core team collaborates with the individual to develop a plan aimed at achieving these goals, ensuring that the individual and their informal caregiver(s) maintain reliance throughout. This plan outlines goals, interventions*, and responsibilities. Regular evaluations and adjustments of the plan ensure the best possible outcomes are achieved. The level of care and support gradually decreases throughout the reablement process until the

goals are met. Reablement is temporary in nature; if necessary, referrals to (long-term) care and support can be made upon completion.

*The following interventions and techniques may be employed to achieve the established goals:

1. Awareness and empowerment – for example, education, positive reinforcement and feedback, motivational interviewing, goal setting and planning, self-monitoring, and reflection;
2. (Re)Learning cognitive, physical, emotional, and social skills – for example, memory training, fall prevention, exercise programmes, coping with stress and emotions, and establishing and maintaining social connections; and
3. Applying internal and external compensation strategies – for example, advising on and teaching the use of assistive devices, adapting tasks or environments, implementing strategies to enhance the balance between burden and resilience, and self-management.

Chapter 5

Feasibility of a Reablement programme in community care in the Netherlands: a qualitative study

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Abstract

Introduction: Many older individuals face complex health and social care issues that require an integrated care approach. However, current health and social care services are often fragmented in terms of financing, organisation, and delivery, and therefore do not fit the needs of older individuals. Reablement is an innovative integrated approach that aims to 'help individuals to help themselves' by providing goal-oriented, person-centred care. An interdisciplinary team works intensively with individuals towards their goals, while considering their capabilities and contextual factors.

Description: The aim of this study was to assess the feasibility of a Dutch reablement programme in terms of acceptability, implementation, practicality, adaptation, integration, and limited efficacy. Using qualitative methods, six clients, three informal caregivers, eight care professionals, and one programme director were interviewed, complemented by data from electronic care files. Findings indicated positive stakeholder experiences.

Discussion: Despite positive experiences, three key challenges emerged: 1) behaviour change; 2) in- and external interprofessional collaboration; and 3) enrolment. The study underscores the complexity of implementing and integrating reablement in community care.

Conclusion: Our findings offer critical insights that could guide future efforts to implement reablement programmes more effectively.

Introduction

Most older individuals prefer to stay at home for as long as possible, as resembled by a national aging in place policy that focuses on providing support and services to older individuals to remain living in their familiar home.[1] Older individuals often have complex health and social needs that require a coordinated, holistic approach.[2] However, current care and social services are often fragmented in terms of financing, organisation, and delivery, hindering collaboration and coordination.[3-5] The movement towards a more integrated approach is necessary to avoid the unilateral focus of different professionals from their field of expertise and the consequent inability to coordinate care to the person's needs[6,7] Consequently, many countries show increasing interest in integrated care approaches. Integrated care requires a shift in the current healthcare system from merely focusing on care and wellbeing, towards providing demand-oriented care, focusing on the needs and preferences of individuals.[8] Moreover, care professionals must support clients to become more self-reliant by not taking over care tasks as has been done for many years.[9]

Reablement is such an integrated approach that prioritises both care and wellbeing while promoting demand-oriented care.[10] Reablement is suitable for everyone regardless of age, diagnosis and setting.[10] Reablement aims to 'help individuals to help themselves' by delivering goal-oriented, person-centred care. An interdisciplinary team works intensively with individuals towards their goals, while considering their capabilities and contextual factors. The international movement towards reablement began to take serious shape from 2000 onwards when care organisations in various countries adopted reablement as an alternative to traditional home care services.[11] Currently, more than 15 countries have been or are currently in the process of integrating a reablement approach into their healthcare systems.[12] There are indications that reablement improves health and well-being, reduces care needs, and saves costs.[13-15] It also seems promising as it offers high satisfaction levels across all stakeholders involved including caregivers and care receivers.[15-17] However, the existing evidence about the effectiveness of reablement is inconclusive.[18-21] Next to methodological issues (e.g. variation in study designs, outcome measures) this may be explained by differences in the core components and characteristics of reablement programmes.[21]

To address these variations and enhance the consistency and effectiveness of future reablement practices, recently, a reablement model was developed in co-creation with care professionals, policymakers, client representatives, informal caregiver (representatives), and scientific experts: the I-MANAGE model.[22] The I-MANAGE model can guide the design and

implementation of reablement programmes in Dutch community care and can be tailored to the context in which it is implemented and consists of six essential components namely, improving assessment and goal setting; stimulating self-management during meaningful daily activities; optimising the use of the physical environment; optimising the use of the social environment; improving interprofessional collaboration; and supporting the informal caregiver. It consists of five chronological phases: 1) initiation, 2) intake, 3) care plan, 4) care delivery, and 5) evaluation.[22] It emphasizes interdisciplinary collaboration and includes practice-oriented training. During eight to twelve weeks, the individual and their informal caregiver(s) are supported and monitored by a dedicated reablement team. Details regarding the specific content and development of the I-MANAGE model are described elsewhere.[22]

The I-MANAGE model was used to guide the development of a reablement programme for community care. The aim of this study was to assess this programme's feasibility in terms of acceptability, implementation, practicality, adaptation, integration, and limited efficacy following the feasibility framework of Bowen et al. [23] using a multi-stakeholder perspective.

Methods

Study design

A qualitative feasibility study was conducted between April 2022 and July 2023, assessing the programme's feasibility according to the constructs of Bowen's feasibility framework.[23] The data comprised individual interviews and a focus group interview to explore stakeholders' experiences with the reablement programme implemented in the community care setting.

Setting

The study was conducted at a long-term care organisation in the southern part of the Netherlands, providing various forms of clinical and long-term care. As part of the organisation's strategy to sustain care services and empower older individuals to maintain their independence at home for as long as possible, the organisation has initiated a pilot project to implement reablement in community care using the reablement model I-MANAGE.[22]

Implementation of the reablement programme

The care organisation used and tailored the I-MANAGE model (i.e., team composition, target group) to implement reablement within the organisation. A detailed description of the reablement programme can be found in Appendix 1. The interdisciplinary team consisted of an occupational therapist (OT), physical therapist (PT), informal care consultant (ICC), community care nurse (CCN), and an elderly care physician (ECP). Other healthcare professionals were consulted based on the goals set by the individual. The OT conducted the initial assessment using Positive Health principles,[24] with additional assessments by other disciplines if needed. Care professionals were trained in the principles of reablement and Positive Health,[24] and OTs received specific training on the coordinator role and the Canadian Occupational Performance Measure (COPM).[25] The COPM is a goal-setting tool which uses a semi-structured interview to capture a client's self-perception of performance in areas of self-care, productivity and leisure in terms of satisfaction and performance.[25] PTs received a brief OTAGO training and CCNs were briefed about the programme during one of their team meetings. OTAGO is a tailored balance and strength fall prevention programme.[26]

The programme targeted community-dwelling older individuals receiving community care with a decline in daily functioning, referred by the CCN, general practitioner (GP) or ECP, excluding those receiving rehabilitation, with terminal illness, or severe cognitive impairment.

Sampling and recruitment

Participants of the study were individuals participating in the reablement programme, their informal caregivers, members of the reablement team and the innovation director of the care organisation. The OTs asked all older individuals involved in the programme, alongside their informal caregivers to participate in the study. Criterion sampling was used by the project leader of the organisation to select care professionals.[27] In addition, the programme director was also asked to participate. Eligible professionals had to be involved during the development, deployment, and/or implementation of reablement ensuring a well-rounded representation of professionals. All study participants were expected to be proficient in Dutch and to provide informed consent.

Data collection

Data were collected in line with the feasibility aspects from Bowen et al. [23]; implementation, adaptation, integration, acceptability, practicality, and limited efficacy testing. An overview of the research methods used can be found in Table 1.

Background characteristics (e.g., age, sex, educational level) were collected from all participants. To reduce the burden of data collection, electronic care files tracked client progress and goal related outcomes, including COPM goals, used interventions, progress reports, and final outcomes. Semi-structured interviews with clients and informal caregivers were conducted by researcher LB at participants' residences after programme completion, focusing on goal setting, care received, informal caregiver roles, shared decision-making, points for improvement, and overall experiences. The interviews were conducted following a topic guide based on Bowen et al. [23]

Simultaneously, at one of the locations of the care organisation a focus group involving care professionals was conducted by researchers LB and SM, discussing interdisciplinary collaboration, care delivery, barriers, facilitators, points for improvement, and programme experiences. In addition, a semi-structured interview with a similar topic guide was conducted with the programme director by researchers LB, IM, and SM.

The interview data were supplemented by field notes taken by the researchers during and after the interviews to capture intricate details. The interviews were audio-recorded, anonymised, and transcribed verbatim using simple orthographic notation. Additional field notes were used to capture intricacies observed during the implementation and execution of the programme. Interview guides are available in Appendices 2-4.

Table 1. Data collection according to feasibility concepts of Bowen et al. [23]

Area of focus	Definition	Data collection			
		Data sources	Data collection methods	Operationalisation	Timing of data collection
Implementation	To what extent can a new idea, programme, process, or measure be successfully delivered to intended participants in some defined, but not fully controlled, context?	• Care professionals • Programme director	• Focus group interviews	• Facilitators and barriers of the programme's implementation • Perceived quality of implementation	• After implementation
		• Researchers	• Field notes • Electronic care files	• Adherence to protocol	• Throughout implementation
Adaptation	To what extent does an existing idea, programme, process, or measure perform when changes are made for a new format or with a different population?	• Care professionals • Programme director	• Focus group interviews	• If applicable: changes in content, procedures, activities, and processes	• After implementation
		• Researchers	• Field notes • Electronic care files		• Throughout implementation
Integration	To what extent can a new idea, programme, process, or measure be integrated within an existing system?	• Care professionals • Programme director • Clients and informal caregivers	• Focus group interviews • Semi-structured interviews	• Perceived fit with infrastructure	• After implementation
		• Researchers	• Field notes	• Perceived sustainability	• Throughout implementation

Table 1. Continued

Area of focus	Definition	Data collection			
		Data sources	**Data collection methods**	**Operationalisation**	**Timing of data collection**
Acceptability	To what extent is a new idea, programme, process, or measure judged as suitable, satisfying, or attractive to programme deliverers? To programme recipients?	• Care professionals • Programme director • Clients and informal caregivers	• Focus group interviews • Semi-structured interviews	• Perceived satisfaction, appropriateness, and intent to continue use • Perceived positive or negative effects on organisation • Opinion about the programme	• After implementation
Practicality	To what extent can an idea, programme, process, or measure be carried out with intended participants using existing means, resources, and circumstances and without outside intervention?	• Care professionals • Programme director • Clients and informal caregivers	• Focus group interviews • Semi-structured interviews • Electronic care files	• Engagement with the programme and application in practice • Positive/negative effects on target participants	• After implementation
Limited efficacy	Does the new idea, programme, process, or measure show promise of being successful with the intended population, even in a highly controlled setting?	• Care professionals • Programme director • Clients and informal caregivers	• Focus group interviews • Semi-structured interviews • Electronic care files	• Intended pre- and post-effects of programme	• After implementation • After implementation

Data analysis

Content analysis[28] was conducted by researcher LB and reviewed by researchers SV or SM to extract the information related to Bowen et al.'s areas of focus within the interview data.[23] The researchers familiarised themselves with the data by reading the transcripts several times while making notes. The transcripts were then imported to Atlas.ti software (Windows Version 23.4.0) for coding. Relevant segments were identified, coded and categorised following the areas of focus by Bowen et al. [23] Codes were refined and organised into a matrix, mapping key areas across stakeholder groups. This matrix allowed for comparison and synthesis of insights. The analysis was iterative, with ongoing discussions and arbitration to resolve disagreements. Fieldnotes were compared with the data to assess implementation, adaptations, and programme integration.

Demographic characteristics of the participants were analysed using descriptive statistics. Frequencies and percentages were calculated for categorical variables (e.g. sex, educational level, employment status), while mean and standard deviation were computed for continuous variables (e.g. age). Data analyses were performed using SPSS version 27.0 (IBM Corp., 2020).

Ethical considerations

The study was reviewed and approved by the FHML Research Ethics Committee of Maastricht University (FHML-REC/2022/048). Informed consent was provided, and all participants received information about the study's purposes and the right to withdraw from the study. All data was anonymised and stored on the research server of Maastricht University.

Results

In this study, data was collected from a total of six clients participating in the reablement programme, three informal caregivers, eight care professionals and one programme director. The sample of care professionals consisted of two PTs, two OTs, one CCN, one ECP, one ICC, and one nurse practitioner (NP). The background characteristics of all participants are displayed in Table 2.

All data collected (Table 1) related to five domains of feasibility as outlined by Bowen et al. [23] The results were merged into three core sections; 1) Implementation, adaptation, and

integration; 2) Acceptability and practicality; and 3) Limited efficacy. Within each section, the collected data are synthesized to offer a thorough depiction of the feasibility. Concluding the results section, a case description based on the collected data is included to illustrate the programme's feasibility.

Table 2. Background characteristics of participants (n = 32)

	Clients (n = 6)	Informal caregivers (n = 3)	Care professionals (n = 8)	Programme director (n = 1)
Age (years), mean (SD)	77.5 (6.9)	77.3 (5.0)	42.5 (10.6)	58 (n/a)
Sex, n (%)				
Male	2 (33)	1 (33)		
Female	4 (67)	2 (67)	8 (100)	1 (100)
Educational level*, n (%)				
Intermediate				
High			8 (100)	1 (100)
Years of experience, mean (SD)				
Professional role			11.9 (7.7)	3 (n/a)
Reablement			2.0 (0.0)	2.0 (n/a)

Note. *Intermediate: Intermediate vocational or higher secondary education; High: Higher vocational or university education.

All data collected (Table 1) related to five domains of feasibility as outlined by Bowen et al. [23] The results were merged into three core sections; 1) Implementation, adaptation, and integration; 2) Acceptability and practicality; and 3) Limited efficacy. Within each section, the collected data are synthesized to offer a thorough depiction of the feasibility. Concluding the results section, a case description based on the collected data is included to illustrate the programme's feasibility.

Implementation, adaptation, and integration

According to the field notes, new clients were usually enrolled in the programme through referral of their GP and/or CCN, through the elderly care physician following their assessment, or following clinical rehabilitation. During the initiation phase, care professionals also

conducted eligibility screenings to determine which clients qualified for the reablement programme. However, due to insufficient client enrolment, eligibility criteria were broadened to the extent that severe cognitive problems, terminal illness, and lack of support from the client's social network were the only exclusion criteria remaining. Within the focus group interview, care professionals expressed that a too strict eligibility screening may have been the main cause of insufficient client enrolment. In addition, they indicated occasional problems due to miscommunication in team meetings when discussing new referrals, possibly leading to uncertainty about a client's eligibility to enter the reablement programme.

During the focus group interview, OTs experienced that the exploratory conversation using the Positive Health questionnaire proved beneficial for setting goals during the intake assessment. They indicated that this helped them to better understand the client's situation.

> *"So, I believe that because there is a lot of attention given to the intake of the reablement programme, it allows you to... I think by asking questions differently, or perhaps when the question is posed by someone else, you can get to the fundamental parts more effectively." (Community care nurse)*

Initially, administering the Positive Health questionnaire and the COPM involved two separate home visits. However, OTs found the separate visits approach time-consuming and opted to send the Positive Health questionnaire to the client by e-mail before the assessment.

To formulate the care plan, the first team meeting was typically scheduled within the initial two weeks of the programme. However, within the focus group interview, care professionals indicated that occasionally it was scheduled prematurely, resulting in rescheduling due to insufficient time to gather all necessary information. After the first enrolled client in the programme, the reablement team decided that the intake by the ICC should be scheduled after the OTs initial assessment, as it provided them with more background information prior to their intake with the informal caregiver. Moreover, care professionals indicated it was often difficult to schedule team meetings due to the large size of the team. Over time, they felt the whole process became more efficient, but they expressed the need for fixed timeslots for team meetings and clear guidelines and logistics regarding work processes. In addition, occasionally, some interventions or therapies were initiated later than planned as not all necessary care professionals were available at the start of the programme. When asked about the implementation of coaching on the job during care delivery by the team, care professionals indicated this was implemented occasionally and rather unconsciously.

The care plan was documented in the electronic care file, but access to all reports and the reablement plan was limited to care professionals within the organisation. Consequently, individuals in the focus group expressed that external professionals were therefore reliant on the team meetings to follow progress and actions taken toward achieving clients' goals.

In addition, care professionals indicated that within the electronic care file, it was often unclear who was already involved, and existing forms were not user-friendly and difficult to modify. Furthermore, it became evident that the reporting of the COPM was not carried out consistently, possibly because it was a new part of the procedure. As a result, pre- and/or post-assessment data were incomplete for four of the six clients. This inconsistency was also observed in other areas, as gaps in reporting were identified during the analysis of the electronic care files.

As documented in the electronic care files, coordination was organised by the OT, personal care needs by the CCN and functional training and stimulating participation by the PT. When requested, additional support for the informal caregiver was provided to decrease their burden. Moreover, the electronic care files showed the programme was extended on two occasions. One occasion, due to the unavailability of a psychologist, the programme was temporarily paused and resumed afterwards. The other instance occurred because the client required more time to achieve their goals.

Acceptability and practicality

In the interviews, clients indicated that their interaction and collaboration with the reablement team was pleasant and highly appreciated. They appreciated that the team looked beyond just their status as patients to find solutions together. Moreover, some clients mentioned that actively participating in the tasks and goals based on the exploratory conversation was satisfying. Clients felt listened to, connected on a personal level, involved during the process, and empowered to decide for themselves. Informal caregivers expressed high satisfaction with the programme and their interaction with the team, feeling supported and able to rely on them.

> *"Both of us were truly impressed by the dedication of all those involved; they truly make things happen, and we have greatly benefited from their efforts. We have nothing but praise in this regard. […] Overall, I feel they genuinely went above and beyond for us, which has been truly remarkable. While at times it felt like a lot, in general, their efforts were effective." (Informal caregiver 2)*

In addition, clients perceived the team's collaboration with already involved external care professionals as good, mentioning regular communication and exchange of information at the end of the programme as positive attributes. Generally, informal caregivers were positive about the guidance and practical support from the informal care consultant but mentioned repetitive questions from different care professionals.

During the focus group interview, care professionals expressed that the scheduled team meetings helped them to align and coordinate tasks within the team and to regularly assess care delivery concerning the established goals. In addition, OTs felt supported by the care organisation in organising the reablement programmes, as they were allocated specific hours for coordination. The importance of effective coordination among the different stakeholders involved was emphasised during interviews with care professionals and the programme director, especially due to overlapping responsibilities. Care professionals indicated that they experienced the various perspectives of each team member as valuable. The fact that the community care nurse and the informal care consultant were now structurally involved in the meetings through the programme were mentioned as a promoting factor. Positive Health[24] and interdisciplinary collaboration also facilitated different perspectives, leading to a broader and deeper understanding of the issues, which was positively perceived by both clients and care professionals.

> *"By administering the Positive Health questionnaire beforehand, you can already bring up a few more things that you can discuss. […] So usually they've already filled it out, and then I have more time to delve into it more deeply. So, then I already know roughly where the problems lie, and they've also been thinking about it a bit more. And then in the second meeting, when I administer the COPM, they can indicate their goals or request assistance more consciously." (Occupational therapist 1)*

Care professionals highlighted the significance of having a fixed team to successfully deliver the reablement programme feeling certain experience and expertise was necessary. They indicated this became apparent when external care professionals were involved, as not sharing the same approach and mindset could hinder achieving clients' goals. Additionally, care professionals felt the GP's involvement was insufficient, with a lack of feedback and communication, possibly because they were not sufficiently familiar with reablement.

> *"But I do think that it is very important that there is a fixed team of experts involved. People who know exactly what it's (reablement) about and who have a better*

> *understanding of it, [...] I think it also needs to suit you. It's a different way of doing your job. And it's not just a standard home visit. You have to be able to build a certain level of trust in a very short time. If you want to administer that (Positive Health questionnaire), people need to be able to show a certain vulnerability." (Nurse practitioner)*

Moreover, the programme director mentioned that friction arose when external care professionals, such as a case manager, who typically fulfil a coordinating role within community care, were involved. This tension mainly stemmed from unclear role definitions within the programme, particularly in relation to other team members, with the programme director explaining that unclear role agreements create confusion and lead to feelings of friction.

The focus group revealed ambiguity about the programme's content and purpose due to its confusing name and a lack of familiarity among community care nursing teams. The programme field notes showed that only CCNs had received information regarding the programme and were responsible for disseminating it to the rest of the team. In the interview, the programme director highlighted the importance of generating support from various stakeholders and the time needed for behaviour change.

> *"What you see is that we won't achieve it with only an informative strategy. […] The seduction strategy of the behaviour change […] also […] underlies, right, to move from 'doing for' to 'doing with', you really must load (behaviour change) that as well. And […] that's a multi-year process. That's not something you accomplish in one year. And […] you still need to pay attention to […] behaviour change, and how you guide it in your organisation in a good way." (Programme director)*

The programme director, care professionals, and clients frequently mentioned a change towards a reablement mindset because of the programme's implementation. Moreover, care professionals were aware of the urgency for change due to current societal challenges, emphasizing its necessity for both clients and informal caregivers. However, they did regularly experience conflicts with clients and informal caregivers regarding their views on care delivery, negatively influencing the course of the programme. They indicated clients and informal caregivers often assert that they "have the right" to receive care, and still expect to receive care as promoted in the past by the government's welfare state. However, this sentiment was not mentioned by the clients and informal caregivers themselves during the interviews.

> *"And that clashes regularly (different mindsets on care delivery). People also think […] that they have a lot of rights to things. Because they have worked their whole lives and they have paid a lot (health insurance), and now they deserve certain privileges. They often tell me, 'You can simply come over because we've been paying for health insurance our entire lives, so we have every right to this; therefore, you must comply'." (Community care nurse)*

OTs indicated that prioritising the goals with the client often led towards more practical and achievable goals. They mentioned it was crucial that clients formulated their own goals for intrinsic motivation and successful outcomes. This was confirmed by clients, stating that a goal-oriented approach motivated them. Clients emphasised that incorporating their social and physical environment promoted their recovery. Informal caregivers experienced significant support from the team but considered a good connection to be essential. Most clients indicated the care delivered was person-centred and each step taken was clearly explained, although some had trouble recalling programme details. Additionally, informal caregivers felt the delivered interventions were well aligned with the clients' goals. They indicated the team consciously articulated the set goals during care and therapy sessions to emphasise the importance of certain interventions or activities. However, most clients struggled to recall these goals and felt they were not reiterated during the programme.

Supporting materials and technology promoted the implementation according to care professionals, for example, the use of videoconferencing for the team meetings increased flexible scheduling. Further mentioned facilitators were the time-limitedness of the programme and the team working on a common set of goals. The programme director identified funding as a clear barrier for the programme, as existing reimbursements were often too restrictive for the delivered care and support. Care professionals acknowledged this, indicating the care and support they deemed necessary could not always be delivered due to reimbursement restrictions.

Other barriers during implementation in terms of time were experienced, as the execution of the programme asked for significant time investment from the coordinator and the 8-week duration caused problems in the delivery of supporting services. For example, municipality waitlists for supporting services often exceeded the 8-week duration. In addition, there were some doubts whether the 8-week period was sufficient to establish behaviour change. Care professionals also mentioned the higher burden of the programme on both clients and their

informal caregivers due to its short but intensive character, especially during the first two phases of the programme. This sentiment was shared by a client and informal caregiver as well.

> *"What I do feel is […] it was a lot to handle, especially at a time when (client's name) experienced a significant setback, making things much worse. [...] With all those limitations, I found it to be quite overwhelming."(Informal caregiver 2)*

Limited efficacy

Overall, both interview data and information from electronic care files indicated that most clients progressed in their functioning and were able to engage more in activities important to them. Examples are, being able to shower (again), cook, build and maintain social connections, and being able to walk to the community centre. One client initially hesitated to participate in day care activities but became convinced of their value after trying them once, reflecting a mindset shift resulting from the programme. An informal caregiver noted that the advice provided by the team was often more readily accepted by the client, facilitating a smoother transition towards change. Two clients faced setbacks during their programme due to unforeseen circumstances but felt supported by the team in overcoming these setbacks.

Interview data showed that informal caregivers were very satisfied with the progress achieved. They experienced more freedom to engage in personal activities, became more comfortable relinquishing tasks, learned to approach things differently, felt relieved from their concerns and were able to express their thoughts and worries openly with the team. The support of the team empowered informal caregivers and made them feel confident to look for solutions together with the client. Informal caregivers felt supported by the team and capable of looking for solutions together with the client. When asked whether the programme had impacted their relationship, they reported no differences.

> *"(When my partner is at day care) I can go shopping or take the dog for a long walk. [...] because you're just worried: what will he do? Will I find him injured again? He fell last Friday; he fell again on Monday." (Informal caregiver 1)*

In the focus group, care professionals expressed high satisfaction with the programme's results, mentioning improved communication and insight into each other's professions due to the more intensive collaboration. However, they noted that maintaining client's progress over time would require significant attention as the programme currently does not include a structural

form of aftercare. In addition, the programme director emphasised the challenge of assessing the programme's impact, highlighting the importance of long-term follow-up to evaluate its effects.

> *"In the post-care phase of the programme, I noticed that we need to make some improvements. [...] I remained involved with three reablement clients after they completed the programme. And I do notice that ensuring sustained actions is still a challenge. One client [...] reverted to old habits just a month later. This happened because she lost her motivation, and at that moment, the caregiver also didn't know how to guide her, purely because we were no longer involved. He didn't have that support anymore." (Occupational therapist 2)*

Exemplary case

Box 1. Case description of a client and their informal caregiver within the reablement programme

Emily's situation

Emily (70) has an autoimmune disease that severely limits her mobility. She spends most of her time in a chair downstairs. "I hardly get out of the house anymore, even moving around inside is a challenge." Her husband, John (71) acts as her primary caregiver. Home care supports with bathing twice a week, while John manages the rest. Due to delirium, Emily's care became too demanding, prompting a referral for reablement

Goal setting

Together with the occupational therapist, Emily determined what was most important to her. She set goals to improve her independence using the COPM:

1) Walking with a mobility aid i.e., to be able to attend medical appointments.
2) Climbing stairs to shower independently upstairs, except for washing her lower legs and feet.
3) Participating in household tasks, including dusting, and preparing meals with her husband.

John also set personal goals with the help of the informal care consultant, focused on letting go of some responsibilities and seeking support with household administration, a task he now manages due to Emily's condition. "Because Emily has been ill for years, I tend to take over more and more tasks."

Box 1. Continued

The reablement programme

Over eight weeks, the reablement team – comprising an occupational therapist, physiotherapist, psychologist, informal care consultant, and elderly care physician – including Emily and John, worked on these goals. Biweekly team meetings were held to track their progress and to adjust the programme when needed. The occupational therapist assessed their home environment to ensure they could continue living there and helped Emily to explore ways to actively participate in the household again. The physiotherapist focused on improving Emily's walking function and ability to climb stairs, enabling her to shower upstairs again. Emily also did balance and strength exercises. The psychologist supported Emily's delirium-related needs, while the informal care consultant assisted John with administration and emotional support.

Emily's and John's achievements

After eight weeks, Emily was pleased with her progress: "Not everything worked out, but many things did." She can now shower upstairs with assistance and cook meals with her husband. Dusting is something Emily can do herself again, much to John's satisfaction, as he finds it awful to do. Although she still sleeps downstairs due to frequent nighttime bathroom trips and discomfort with climbing stairs alone, Emily made good progress improving both her performance and satisfaction scores on the goals set using the COPM. John feels more capable of leaving the house and taking some time for himself, though not for extended periods, as he is still adjusting to these changes.

Discussion

The aim of this study was to assess the feasibility of a reablement programme based on the I-MANAGE model[22] in the community care setting. The study employed a qualitative design using a multi-stakeholder perspective to assess the programme's feasibility in terms of acceptability, implementation, practicality, adaptation, integration, and limited efficacy following Bowen et al. [23] The results of our study reflect positive experiences with the programme by all stakeholders, implementation challenges and exposed ongoing fragmentation in healthcare and coordination issues with external professionals, as well as the need for cultural shifts towards a reablement mindset. In sum, the complexity of implementing and integrating a reablement programme in community care manifests through three key challenges which will be discussed below: 1) behaviour change; 2) interprofessional collaboration both within and outside the organisation; and 3) enrolment.

The first challenge concerns behaviour changes towards a reablement mindset among all internal and external professionals involved. Professionals seem to struggle with inconsistent approaches and mindsets, and behavioural changes were not always sustained. This aligns with international research, which emphasise the need for structured support to sustain behavioural change for professionals as well as clients and informal caregivers involved.[29] Similarly, Beresford et al. [30] found that without sustained support, professionals reverted to traditional care models, highlighting the need for comprehensive training and organisational support. Additionally, behaviour change requires time, communication strategies, collaboration mechanisms, and integrated training.[31] This could be accomplished by implementing structural processes and providing resources, such as team meetings and creating sufficient time to prioritise the promotion of self-reliance.[32]

The second challenge is interprofessional collaboration, especially with external care professionals. For example, current reablement training is centred on the interdisciplinary team within the care organisation potentially leading towards a compartmentalised approach, hindering the delivery of integrated care and full integration of the programme in the community beyond the care organisation itself.[33-35] International experiences highlight the necessity of alignment among all stakeholders, particularly in a complex approach like reablement that has multiple organisations and parties involved.[30,36] Moreover, reimbursement structures in Scandinavian are structured to incentivise collaboration rather than competition among care providers.[37] A supportive system is needed that enables this approach, rather than allowing reimbursement structures to dictate the care provided as indicated by the care professionals in our study.[38]

Third, a too strict selection process at the start may have resulted in a low programme enrolment rate and the inclusion of participants with substantial and higher care needs only. Additionally, the knowledge, motivation, and tools of those screening clients for participation may also played a significant role.[39] Furthermore, participants were often referred by general practitioners, reflecting a more reactive approach.[40] Adopting a more preventative approach could be beneficial in proactively identifying individuals at risk before they require more expensive care.[40]

Studies on the feasibility of reablement programmes across different countries support our findings, highlighting that while reablement shows promise its success depends on careful adaptation to context and adequate support for clients and caregivers. For example, studies from Sweden and Australia identified challenges in coordination and training,[41-43] similar to the

improvements we found. Issues with interprofessional collaboration align with findings from England and Australia, emphasizing the importance of teamwork and training.[30,36] Our study also mirrors the integration challenges highlighted by Assander et al. [43] and Chiang et al. [44] including healthcare fragmentation and coordination with external professionals. The enrolment difficulties echo those found by Jeon Jeon et al. [42] where recruitment and eligibility criteria posed difficulties to obtain sufficient eligible individuals. Ingstad et al. [45] further highlight the importance of user involvement and co-creation, aligning with our findings on personalised care. Overall, these studies reveal the need for tailored strategies to address challenges like adaptability, staffing, and system fragmentation to optimise reablement implementation.

Our study has some limitations that need to be acknowledged. For instance, our results are based on a small study sample and our results may not fully reflect the broader population. Additionally, care professionals have seen only a limited number of clients which can limit generalisability of their experiences. However, a strength in our study is providing detailed insights into the experiences and perspectives of various stakeholders. This helped to highlight important factors, that may not be evident through quantitative methods, which are useful to tackle challenges during future implementation of reablement programmes. It is important to note that, involvement of older adults and informal caregivers in this study aligns with the consultation level of the ladder of participation.[46] Participants were actively consulted to share their experiences, provide feedback, and highlight areas of importance related to the reablement programme. Importantly, lived experience informed the development of the I-MANAGE model used in this study, a process that is detailed elsewhere.[22] Furthermore, the works and patient councils of the care organisation were actively involved in decision-making, ensuring organisational support and alignment with broader stakeholder interests.

Lessons learned

Despite its small-scale and limitations, our study can suggest several courses of action for policy and practice to promote further integration and ensure the feasibility of reablement programmes.

- Management and organisational policies must facilitate sustained behaviour change through structural processes to avoid reverting to old routines.

- Address siloed care by promoting cross-organisational collaboration, interdisciplinary training, and policies aligned with reablement principles, including reimbursement models.
- Expand client inclusion criteria to adopt a preventative approach, enabling early interventions, enhancing reablement's effectiveness, and ensuring timely support.

Conclusion

Overall, the reablement programme implemented in Dutch community care resulted in positive stakeholder experiences. At the same time, it highlights the complexity of implementing and integrating reablement in community care, thereby revealing three key challenges including behaviour change, interprofessional collaboration, and client enrolment. As our results closely align to results from various international reablement feasibility studies, our findings add to the knowledge base to improve implementation of future reablement programmes.

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Appendices

Appendix 1. Description of the implemented reablement programme based on the phases of I-MANAGE model[22]

<table>
<tr><td colspan="3">Referral of the client to the reablement programme:
• Community care nursing
• General practitioner
• Elderly care physician</td></tr>
<tr><td>Start of the programme</td><td>Phase 1: Initiation
• Provide information to client (and informal caregiver)
• First visit by the occupational therapist
o Exploratory conversation using the Positive Health questionnaire[24]</td><td rowspan="5">Interdisciplinary collaboration:
• Appointed coordinator
• Regular team meetings
• Shared electronic care file
• Coaching on the job</td></tr>
<tr><td>Week 1</td><td>Phase 2: Intake
• Home visit by the occupational therapist
o Environmental assessment if needed
o Set meaningful goals using COPM
• Informal care consultant contacts informal caregiver to assess the burden and needs
• Intakes by other care professionals if necessary</td></tr>
<tr><td>Week 2</td><td>Phase 3: Care plan
• Determine interventions and actions to reach goals
o Guided by preferences of the client and informal caregiver
o Specific attention to the client's capabilities, social network and physical environment
• The reablement plan is shared and discussed with the reablement team and recorded in an electronic care file</td></tr>
<tr><td>Week 3 - 8</td><td>Phase 4: Care delivery
• Care provided as described in the reablement plan
• Bi-weekly evaluations by the reablement team
• If needed, initiate additional support for informal caregivers</td></tr>
<tr><td>Week 8</td><td>Phase 5: Evaluation
• Continuous evaluation during home visits and team meetings leading towards adaptations of the plan if needed
• Formal evaluation after 8 weeks using COPM</td></tr>
<tr><td colspan="3">Aftercare
1. Continue the programme for a maximum of 2 weeks
2. Referral to usual care if needed</td></tr>
</table>

Note. COPM; Canadian occupational performance measure

Appendix 2. Semi-structured interview guide clients

1. How did you first encounter the reablement programme?
    a. What was your home situation like before you started the programme?
2. Could you share your experience of the initial conversation with the occupational therapist?
    a. How did you find this discussion?
    b. Were you able to talk about everything you wanted to?
    c. Did you feel that your concerns were heard?
3. What goals did you set for yourself?
    a. How did you arrive at these goals?
    b. Why are these goals significant for you?
    c. How did you find the process of setting goals?
    d. Are there any other aspects that you consider important, and were these also discussed?
4. How did you go about working towards your goals?
    a. Who did you collaborate with on this?
        i. How was your interaction with the care providers?
5. What are your thoughts on working towards goals?
    a. In what ways were you involved in the process?
6. Were there any adjustments made to the goals or the programme along the way?
    a. If so, what prompted these changes?
    b. How did you feel about these adjustments?
7. Were you able to achieve the goals you set?
8. How did the care you received differ from what you experienced before?
    a. Did the care providers effectively tailor the care to meet your needs?
    b. How well did the care providers coordinate with each other?
9. What was your overall experience of the reablement programme?
    a. What impact has the programme had on you?
    b. What aspects worked particularly well?
    c. What challenges did you face, and what didn't go as planned?
10. What helped you in working towards and achieving your personal goals?
    a. Could you elaborate on this?

11. What obstacles did you encounter that made it difficult to work towards your personal goals?
    a. Can you provide more details about this?
12. If you could make changes, what improvements would you suggest for the programme?

Appendix 3. Semi-structured interview guide informal caregiver

1. How do you currently experience caring for your loved one?
    a. What do you enjoy about caring for [your loved one]?
    b. What challenges do you face in providing care to [your loved one]?
    c. What impact does this have on your daily life/relationship with [your loved one]/your well-being?
        i. How do you cope with this?
        ii. How do you currently experience caring for your loved one?
2. Can you tell me more about the care [your loved one] received during this period?
    a. How was this different from before?
    b. What impact did this have on you as a carer?
        i. And on your relationship with your loved one?
3. How were you supported?
    a. How was your relationship with the care team?
4. How did you experience the programme?
    a. What went well?
    b. What didn't go so well/what challenges did you encounter?
5. What has the programme meant for you/what did it bring you?
    a. What has changed for you compared to before the programme?
6. What do you think enabled this programme to be carried out?
7. What do you think hindered the application of this programme?
8. Looking back on the past period, what do you think could be improved in the programme?

Appendix 4. Semi-structured interview guide professionals

1. Which factors did you experience as facilitating when implementing reablement?
    a. Why was this a facilitating factor?
2. Which factors did you experience as hindering when implementing reablement?
    a. Why was this a hindering factor?
3. What challenges did you face during the implementation of reablement?
4. How can these problems be solved?
5. What do you think are the advantages and disadvantages of reablement compared to conventional home care?
6. To what extend has current legislation and regulations influenced the implementation of reablement?
7. To what extend have other factors outside the organization influenced the implementation of reablement?
8. To what extend has the organization facilitated or hindered the implementation of reablement?
9. In what way has communication within the organization and within the reablement team influenced the implementation of reablement?
10. To what extend does reablement fit within the organization's current policy and how did this affect the implementation of reablement?
11. Which people supported you in the implementation of reablement?
    a. How did they support you?
12. Which people hindered you in the implementation of reablement?
    a. How did they hinder you?
13. Was the reablement program implemented as intended?
    a. If not, why not?
14. What strategies were used to implement the reablement program as planned?

Chapter 6

A qualitative exploration of professionals' perspectives on the implementation of reablement programmes in community care

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Abstract

Reablement is considered a complex intervention due to its multicomponent, person-centred, holistic approach promoting older adults' active participation in daily activities. It is important to consider the unique context in which complex interventions are implemented, as contextual factors may interact and influence implementation outcomes. As part of the European TRANS-SENIOR project, this qualitative study aimed to gain insight into professionals' experiences with reablement implementation in Dutch community care. Using the Consolidated Framework for Implementation Research, four focus groups were conducted comprising 32 professionals. Two groups were formed: one at operational level, including therapists, nursing staff, social workers, and domestic support; and one at organisational/strategic level, including project leaders, managers, directors, municipality representatives and health insurers. Participating care organisations had at least 6 months of experience with deploying and implementing reablement. The findings reflected three themes: 1) strength of interdisciplinary collaboration; highlighting the significance of sharing goals and beliefs; 2) integrating the reablement philosophy into the organisation, underscoring management's role in fostering support across all organisational layers; and 3) achieving a culture change in the healthcare system, emphasising current funding models impeding value-based care tailored to the individual's goals and needs. The results offer valuable insights for the implementation of complex interventions, like reablement.

Introduction

Many countries stimulate aging in place, promoting older individuals to remain living at home independently for as long as possible.[1-3] Aging in place provides a stable foundation during times of significant change in the lives of older adults, promoting not only autonomy but also contributing to the preservation of their own identity.[4,5] It refers to the ability of older adults to live independently and comfortably their own homes or communities as they grow older. The concept encompasses not only the physical residence but also the community and social networks they are a part of.[6,7] Moreover, aging in place is often the preferred goal of older adults, despite increasing care needs.[2,6,8,9] Therefore, there is a need for sustainable, cost-effective, and patient-centred initiatives, focusing on improving quality of life and preventing or postponing institutionalization and in-patient care.[10] Reablement is considered an appropriate response to these needs.[10] It is a person-centred, holistic approach that promotes older adults' active participation in daily life through social, leisure, and physical activities chosen by the older person in line with their preferences, either at home or in the community.[11] Reablement has some core principles and common features, for example, goal setting, an interdisciplinary approach, and a practice-oriented staff training.[12-14] A reablement trajectory is often time-limited and consists of several phases (i.e. initiation, intake, care plan, care delivery, and evaluation).[12] Instead of taking over tasks, care professionals identify the capabilities and opportunities of individuals to maximize their independence by supporting them to achieve their goals, through training in daily activities, home modifications, assistive devices, and involvement of their social network.[11,15-17] Reablement is not a 'one size fits all'-approach, meaning it is tailored to both the patient (i.e. their needs, preferences, and capabilities) and their environment.[13,18]

As the aging population continues to grow and individuals continue to live longer, the complexity of care needs and health issues also increases, often involving multiple health conditions.[19] To continue to meet these changing needs and adhere to the wish of older adults to age in place, care provision and health care interventions also become more complex. Reablement can be considered a complex intervention, which is typically difficult to implement in everyday practice.[20] Complex interventions generally include many interrelated components and factors and are provided and evaluated at different levels.[20,21] The complexity is more than the sum of all components, as other factors, for example, the implementation process, context, and participants, also have a major influence on achieving desired outcomes.[21-23] Much research has been done to unravel the barriers and facilitators influencing the implementation

of complex interventions in health care (e.g., availability of resources, communication, culture, motivation and knowledge, etc.).[24-28] Previous research has revealed important aspects related to the implementation of reablement, such as the engagement of all parties involved, flexibility and professional autonomy, and shared vision and commitment.[18,29-32] However, some of these results were mainly based on researchers' responses,[29,31] drawn from multilevel analyses,[30] or only based on the experiences of care staff.[18,32] Therefore, this needs to be further explored, especially from the perspective of multiple professionals involved in the implementation of reablement, since this has not been investigated previously. Moreover, it cannot be assumed that these factors are also applicable to the implementation of all reablement programmes, across all settings. As complex interventions, like reablement services, are context-dependent,[30,33,34] it is important to consider the unique context in which they are implemented, as contextual factors such as organisational culture, networks and communication, and resources, may interact and influence implementation outcomes.[35] Therefore although reablement has been successfully implemented into usual care in, for example, Denmark and Australia,[14] it cannot be assumed that this applies to every context.

This study aims to gain insight into the experiences of healthcare professionals, management, and funders with the implementation of reablement in Dutch community care. By understanding and advancing reablement implementation, healthcare providers and policymakers are better equipped to successfully implement reablement both nationally and internationally. This study aims to address the following research question: how do professionals (i.e. operational, strategic, and organisational) experience the implementation of reablement in community care?

Methods

Design

The current study used a qualitative descriptive research design to closely align interpretation and data analysis with participants' responses. The study was guided by the Consolidated Framework for Implementation Research (CFIR), i.e. preparation of the interview guide and data analysis.[36] The CFIR is a meta-theoretical framework consolidating 19 foregoing implementation theories. The framework can be used to prepare for innovation implementation and/or evaluative purposes to better understand factors influencing implementation outcomes, making CFIR both dynamic and valuable.[37] Moreover, the

framework provides useful tools and aids to guide data collection, analysis, and reporting.[38] The Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was used to strengthen the reporting of this study.[39]

Setting and participants

The study was conducted at three large care organisations that can be considered early adopters of reablement in the Netherlands (i.e. they started the implementation of a reablement programme at least six months prior to the start of the study). All organisations provide a range of services: from home care and (medical) treatment, to clinical rehabilitation and inpatient long-term care.

Criterion sampling was used to select professionals.[40] Eligible professionals had to be involved during the development, deployment, and/or implementation of reablement ensuring a well-rounded representation of professionals (i.e. variety of disciplines on operational, strategic, and organisational levels). Two groups of professionals were formed: 1) at the operational level, from here on referred to as care professionals, including occupational therapists, nursing care staff, physiotherapists, social workers, and domestic support workers; and 2) at the organisational or strategic level, from here on referred to as management, including project leaders, managers, directors, and policymakers, as well as representatives from the municipality and health insurance companies, who played essential roles in the programme's implementation. Care organisations were contacted via email, stating the study's background, objectives, and participation information. The project leaders within each organisation were responsible for distributing the invitation to eligible professionals. Eligible participants received study details, including an information letter and informed consent form. Participants were requested to provide their written informed consent at the beginning of each interview.

Data collection

Participant demographics (i.e. age, sex, and educational level, organisation of employment, occupation, years of experience in the field, and years of experience with reablement) were collected through a questionnaire.

At each care organisation, an on-site focus group was conducted with care professionals. Additionally, one overall online focus group was conducted with management. The separation

of care professionals and management was maintained to create a safe environment when sharing their experiences. All focus group interviews were planned between December 2022 and February 2023 for a duration of one and a half or two hours. No repeat interviews were conducted. All researchers conducting interviews were female and had prior experience with conducting interviews. Authors IM or LEB (doctoral students) led the interviews and were assisted by one observer IM, LEB, or SFM (assistant professor). Interviews were guided using a semi-structured interview guide (Appendix 1) based on the five domains of CFIR,[36] namely Intervention Characteristics, Outer Setting, Inner Setting, Characteristics of Individuals, and Process. The interview guide started with an open question about experiences with the implementation of reablement and what hindered or facilitated them therein. This first question was answered using sticky notes on which participants could write down hindering and facilitating factors. Subsequently, the sticky notes were clustered into themes and were discussed with the group. Follow-up questions were based on the five CFIR domains[36] to obtain participants' views on each domain. Field notes were taken during and after each interview and all interviews were audio-recorded to capture the intricate and nuanced data that characterize this type of research.

Data analysis

Descriptive analyses of the background characteristics were performed using IBM SPSS Statistics (Version 25). Qualitative data was coded and analysed using the qualitative data analysis software Atlas.ti Windows (Version 23.0.8). All interviews were pseudo-anonymized and transcribed verbatim. For exploration and refining purposes, the data was first coded using inductive content analysis, the initial themes and categories were developed through iterative coding and discussions among IM, LEB, and SFM. Afterward, the data was analysed and structured according to the CFIR domains using deductive content analysis[41] with guidance from the CFIR information site[42] while following the steps of the Framework Method as described by Gale et al.[43] IM and LEB conducted the analysis collaboratively. The authors familiarized themselves with the data by reading the transcripts and taking notes. All coding was done independently, reviewed and compared, and discrepancies were discussed and resolved. The deductive coding was supplemented with the prior inductive coding for comprehensive analysis, ensuring no data was missed. Summarized data were organized into a matrix using Microsoft Excel 2016 (Microsoft Corporation, Redmond, WA, USA). This was reviewed and adapted by authors IM, LEB, and SFM.

Rigor and reflexivity

Multiple strategies were used to increase rigor in terms of credibility, dependability, and conformability.[44] Member checking was done during and at the end of each focus group using interpretation checks, and afterwards with summaries of key findings providing participants with the opportunity to respond, which was used by one participant. Investigator triangulation was applied in both data collection and data analysis. The iterative process allowed for re-examining initial findings using insights that emerged during analysis. Results were discussed within the research team until consensus was reached. To reflect on the process, choices made, and intermediate results, a research diary was used by IM and LEB. During data collection, objectivity was ensured by consciously formulating the posed questions and prompts. However, knowledge of the subject matter and close involvement in practice may have influenced the decisions during data analysis and thematic selections. These decisions were discussed within the research team on a regular basis to prevent such influences, involving members less directly involved in practice.

Ethics

The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Ethics Committee of Maastricht University, Faculty of Health, Medicine and Life Sciences (approval number FHML-REC/2022/126). Participants voluntarily signed informed consent after they were fully informed about the purpose and procedures of the study and had the opportunity to ask additional questions or raise any concerns. The written informed consent stated that participation was completely voluntary and withdrawal from the study was possible at any moment, without providing a reason, by contacting one of the researchers (IM/LEB/SFM).

Results

In total, 32 professionals participated in the study. Eighteen professionals were involved in the three focus group interviews with care professionals. The care professionals included: occupational therapists (n=4); physiotherapists (n=4); district nurses (n=3); certified nursing assistants (n=2); a nurse practitioner (n=1); elderly care physician (n=1); community consultant (n=1); consultant informal care (n=1); and a work planner domestic support service (n=1).

Twelve professionals were involved in the online focus group with management. Management included: directors (n=3); managers (n=3); project leaders (n=3); an implementation coach (n=1); a policymaker from the municipality (n=1); and a team leader (n=1). Additionally, two healthcare insurer representatives participated in the online focus group at organisational and strategic levels, from here on referred to as funders. Table 1 provides an overview of all participants involved, including information about their age, sex, educational level, discipline or professional role within the organisation, and years of experience within their discipline and reablement.

Table 1. Background information of participants (n = 32)

	Care professionals (n = 18)	Management (n = 12)	Funder (n = 2)
Age (years), mean (SD)	41.7 (11.0)	48.1 (9.6)	37 (0.0)
Sex, n (%)			
Male	2 (11.1)	2 (16.7)	1 (50.0)
Female	16 (88.9)	10 (83.3)	1 (50.0)
Educational level*, n (%)			
Intermediate	3 (16.7)		
High	15 (83.3)	12 (100.0)	2 (100.0)
Organisation, n (%)			
Care Organisation A	8 (44.4)	3 (25.0)	
Care Organisation B	5 (27.8)	5 (41.7)	
Care Organisation C	5 (27.8)	3 (25.0)	
Municipality		1 (8.3)	
Healthcare insurer			2 (100.0)
Years of experience, mean (SD)			
Professional role	10.3 (8.0)	7.5 (8.9)	3.5 (0.7)
Reablement	1 (0)	1.6 (0.7)	2.0 (1.4)

Note. * Intermediate: Intermediate vocational or higher secondary education; High: Higher vocational education, university

The results reflected three overarching themes: (1) strength of interdisciplinary collaboration, (2) integrating the reablement philosophy into the organisation, and (3) achieving a culture change in the healthcare system. The data corresponding to the domains and constructs of the CFIR are presented as '*(Domain: Construct)*'.

Strength of interdisciplinary collaboration

This theme describes how aspects related to the architecture and application of the programmes impacted implementation. However, the key focus was on collaboration, both internal and external, and was mainly related to the CFIR domains: Inner setting; Outer setting; and Intervention Characteristics.

Internal collaboration

All care professionals perceived reablement's interdisciplinary character as facilitating (*Inner Setting: Networks & Communications*). They mentioned a more intensive collaboration due to increased insight into each other's profession and capabilities, which was also noticeable beyond the programme. In addition, care professionals indicated that, together with the client, they gave more consideration to which professionals should be involved. In their view, the structured team meetings improved communication, and the shared set of goals created shared ownership. These facilitating factors were endorsed by management.

> *"That [collaboration] really has improved. You also know what everyone does, what you can find each other for. […] It's as if the threshold has somehow disappeared. They know who you are, they know what you do and they also come to you with different questions about very different things, not just reablement." (Occupational therapist, Care Organisation C)*

However, most care professionals also indicated hindrances, such as scheduling meetings and intake assessments, limited access to others' reports, and lack of overview of the care professionals involved (*Inner Setting: Structural Characteristics*). Furthermore, management indicated unclear task distribution among professionals with coordinating roles sometimes caused tension. For example, when the occupational therapist took on a coordinating role, this sometimes felt threatening to district nurses or case managers.

> *"But, where the friction often arises is in the coordinating role [...] that has nothing to do with professionals feeling more or less than another. But, that they […] don't quite understand what their [...] role looks like within that reablement programme, and that the coordination might temporarily lie with the occupational therapist […], or temporarily with the district nurse. If those agreements are unclear, that's the feeling you get." (Director, Care Organisation A)*

External collaboration

Participants indicated a lack of structural collaboration with external professionals, including domestic support workers, general practitioners, case managers, and municipalities (*Outer Setting: Cosmopolitanism*). In particular, the lack of collaboration and involvement with general practitioners was experienced as hindering due to a lack of background information and was reported to hinder clients' independence. This was also the case when external care professionals were involved who did not follow reablement principles.

> *"We also get regular referrals of clients saying, 'Go take a shower twice a week and pretend to be worse than you are, because then you might get a long-term care indication and then you can move [to a nursing home].' Because there are care professionals [outside the organisation] who think they should move." (Physiotherapist, Care Organisation B)*

Integrating the reablement philosophy into the organisation

This theme reflects on the role management played in integrating the reablement philosophy throughout all actors involved. Their efforts to establish a strong foundation were considered crucial for successful implementation. Additionally, this theme reflects on what influenced the necessary readiness for change, both for professionals as well as clients and their informal caregivers. These findings were mainly related to the domains: Inner setting, Outer setting, Characteristics of the individual, and Process from the CFIR framework.

Role of management in programme integration

Care professionals felt both facilitated and hindered by management; while they experienced freedom to experiment with reablement, they also expressed a need for clearer boundaries (*Inner Setting: Implementation Climate – Learning Climate*). Additionally, home care teams experienced change fatigue due to the simultaneous implementation of numerous projects during the time reablement was implemented (*Inner Setting: Implementation Climate – Relative Priority*). Most care professionals expressed that they felt unheard by management when raising issues and missed feedback and follow-up (*Inner Setting: Networks & Communications, Readiness for Implementation – Leadership Engagement*). They also mentioned a lack of clarity in terms of the programme's purpose, which resulted in mismatched expectations of care professionals (*Inner Setting: Implementation Climate – Goals & Feedback*).

Management endorsed the need for a communication strategy beyond just providing information. Lastly, care professionals felt pressure to deliver positive results due to high expectations from both management and researchers.

> *"Policy, management, ministry and so on all come up with plans. We have to implement it, but there is no connection. We have to pass on signals all the time. It takes an awful lot of time. Moreover, it is very incomplete, because we have to put it into words, […] then you have to meet with your quality officer again. […] I just don't have time for this." (Community consultant, Care Organisation C)*

However, participants also emphasized the vital role that management played to sustain the reablement philosophy within their organisations and acknowledged management's successful efforts. For example, hiring an implementation coach, conducting regular evaluations and project group meetings (*Process: Planning, Engaging, Reflecting & Evaluating*), sharing success stories, and establishing low-threshold communication with care professionals and clients (*Process: Engaging*) were mentioned as facilitators for the implementation of reablement to resonate both inside and outside the organisation (*Inner Setting: Readiness for Implementation, Leadership Engagement*).

> *"What has also helped us a lot is the success stories […] that are there, and to celebrate and share them. And collaboration […] also very beneficial. Because then they will have achieved something together which they can be proud of. And, well, that totally contributes to the whole process of getting […] the change going, and to be especially mindful of that." (Manager, Care Organisation B)*

Readiness for change

Nearly all participants indicated that the implementation of reablement programmes led to a change in perspective among care professionals, facilitating interdisciplinary collaboration and promoting equality and sustainability. (*Characteristics of the Individual: Knowledge & Beliefs about the Innovation, Individual Stage of Change*). However, a lack of mutual beliefs (e.g. external professionals) was perceived as hindering (*Outer Setting: Cosmopolitanism, Characteristics of the Individual: Knowledge & Beliefs about the Innovation*). Care professionals' readiness for change was said to be influenced by personal factors, such as years of experience, educational level, and motivation (*Characteristics of the Individual: Individual Stage of Change, Other Personal Attributes*).

> *"You notice that the people who were already working in home care […] find it much more difficult [to change]. Because then it's like, 'Oh, I'll just do that quickly and then I'll finish earlier and I can move on to the next one quicker, so no one has to wait'. But with the younger generation, you notice that it really is easier [to change]." (District nurse, Care Organisation A)*

Care professionals indicated that it was mainly personal factors among clients and informal caregivers that influenced their readiness for change. For example, their motivation, expectations, whether they had been receiving care for a long time, perceptions of care among the older generation, knowledge, and health literacy (*Characteristics of the Individual: Individual Stage of Change, Other Personal Attributes*). To facilitate change, and consequently the success of the programme, care professionals stressed the importance of conducting the intake and goal-setting in a way that helps clients and informal caregivers become aware of the necessary steps to achieve their goals and creates a sense of ownership (*Characteristics of the Individual: Knowledge & Beliefs about the Innovation*).

> *"We really 'do with' and most people are really still 'doing for' […] that does clash regularly. Clients also feel, and I think this is especially true for wealthier people, that they are entitled to a lot of things. Because they have worked hard all their lives and paid a lot and now we will have to [care for them]. […] I am often told, 'Yes, you could just come anyway, because we have been paying health insurance all our lives, so we are entitled to this, so you should do it.'" (District nurse, Care Organisation A)*

Achieving a culture change in the healthcare system

This theme reflects on the shift towards a 'doing with' rather than 'doing for' approach, which means that instead of taking over tasks from clients, self-management is stimulated. This empowers clients to actively participate and take ownership, with a focus on prevention, which matches the ongoing care transformation in the Netherlands. It also explores the societal responsibility that healthcare organisations bear in this transformation. Participants discussed funding issues and the prerequisites for successfully navigating this transition. These findings were related to the domains: Inner setting, Outer setting, Characteristics of Individuals, and Intervention Characteristics from the CFIR framework.

Funding

All participants perceived current funding of reablement as hindering the deployment of the reablement programmes as desired. Current insurance reimbursement in the Netherlands falls short for some aspects of reablement, for example, team meetings, physiotherapy, and a sufficient amount of occupational therapy (*Outer Setting: Needs & Resources of Those Served by the Organisation*). Subsequently, care professionals mentioned that clients were reluctant to pay for additional non-reimbursed costs and therefore possibly would not participate in the programme (*Inner Setting: Readiness for Implementation – Available Resources*). Moreover, management indicated that the possibility of implementing reablement more preventatively is also hampered by the financial and administrative rules of the current reimbursement system in primary care. Both management and care professionals therefore expressed a need for a form of funding that is not project-based and facilitates integral reimbursement (*Outer Setting: Needs & Resources of those Served by the Organisation*).

> *"We also hope that eventually there will be an integral reimbursement for this issue so that you can really look specifically at the client: 'Hey, what do they need now?' And that you don't have to weigh up every time, like: 'They can get a bit more occupational therapy [reimbursed] now, so we use that a little bit more, because physiotherapy is not in the [reimbursement] package.' You don't want to look at it that way. You really want to look at: 'Hey, what are the goals and […] what can we deliver to reach that?'" (Project leader, Care Organisation C)*

From management's perspective, the current project-based approach to implementing and funding reablement is hindering its permanent positioning within the healthcare system (*Inner Setting: Implementation Climate – Relative Priority*). They felt this approach leads to perceptions that reablement is merely an add-on, lacks commitment, and may not replace or supplement existing care services effectively. One of the funders endorsed that not having integral funding is hindering, but emphasized that they need to know what the added benefits of reablement are compared to usual care (*Intervention Characteristics: Trialability*).

> *"We are really not looking to know it all. We don't need huge thick files to back it up, but we do want to be able to compare it. […] What is the difference with usual care, except, that clients are more in the lead and have more autonomy. I'm all in favour of that, but can we also make it clear what it means? What the other way of working entails, compared to the old way?" (Funder, Care Organisation C)*

Care transformation and prerequisites

Management mentioned that they felt external pressure due to the societal mission set by the Dutch government, which emphasizes the need for affordable and accessible health care (*Outer Setting: Peer Pressure, External Policy & Incentives*). Care professionals and management consider reablement an essential change to address the growing demand for care (*Inner Setting: Tension for Change*). They see it as a way to offer more preventative care, reducing clients' dependency on services, and possibly delaying more complex care (*Inner Setting: Implementation Climate – Relative Priority*).

> *"What I sincerely believe is that reablement will very much contribute on prevention. That this will ultimately keep people out of long-term care facilities, or at least not until a later stage. We also see now – certainly the group that is currently applying through the municipality – we see that when on time... Being involved much earlier, that's really going to result to needing less hospital care and other expensive forms of care." (Project leader, Care Organisation C)*

To implement reablement on a larger scale, management believes that maintaining a dialogue with professionals and expanding collaboration with other organisations is crucial (*Inner Setting: Implementation Climate – Relative Priority*). However, they also mentioned that the time and effort required to establish behavioural change among care professionals may be a hindrance. They also felt this transformation was insufficiently supported by national policies. In their view, prerequisites, laws, and regulations needed to implement reablement in the Dutch context are largely absent (*Outer Setting: External Policy & Incentives*). Additionally, management believes that, besides staff shortages, they have a responsibility to facilitate a new professional standard, as current standards are lacking and missing the necessary skillset needed for effective reablement delivery (*Characteristics of Individuals: Individual Stage of Change*).

> *"We need to move towards a new professional standard, especially for district nursing. And you don't achieve that by quickly scaling up. I personally believe that in the long run, once you have it implemented correctly, you can enable many clients to take care of themselves in the community with district nursing, reablement, and potentially other aids. [...] The entire programme must be delivered by occupational therapists. And we don't have 10.000 of them either. So […] I think we shouldn't think it [upscaling] is just done like that. Because, in my view […] it's moving too fast. It's too complicated for that." (Manager, Care Organisation B)*

Discussion

This study aimed to gain insight into professionals' experiences with the implementation of reablement, a complex interdisciplinary intervention in Dutch community care. The findings reflected three overarching themes: 1) strength of interdisciplinary collaboration; 2) integrating the reablement philosophy into the organisation; and 3) achieving a culture change in the healthcare system. Through the perspective of multiple professionals on different levels (i.e. operational, strategic, and organisational), the findings reflected the characteristic interrelations of different components and influences associated with the implementation of complex interventions.

Care professionals experienced improved interdisciplinary collaboration, enhanced understanding of each other's roles, and shared ownership, which was mainly facilitated by structured team meetings and shared goals. Interdisciplinary collaboration is experienced as positive and essential amongst healthcare professionals working with reablement,[45-47] for example, in getting perspectives from different angles.[48,49] However, other studies endorsed the hindering factors (i.e. scheduling conflicts and lack of accessible reports) found in our study.[47,50] The most important finding relates to the challenges encountered due to a lack of mutual beliefs, structural collaboration and alignment with external parties, and consequently, the extent to which all involved care professionals adhered to the reablement principles. Therefore, causing ambiguity and possibly leading to suboptimal contributions of some team members.[45] However, competing logics among involved parties should not hinder implementation.[51] This can be strengthened when all parties work towards a shared goal, align their beliefs, and establish more structured forms of collaboration.[52] In addition, it is essential to enable care professionals to learn from each other's perspectives thereby complementing and enhancing their skills.[49]

The success of the implementation seems to depend on the integration and upkeep of the reablement philosophy throughout all professionals involved. In accordance with prior research,[49] the most important finding was management's pivotal role in sustaining the reablement philosophy within the organisations. Especially in these contexts, where the collective shift of mindset and professional role identity depends on the expectations of multiple professionals, achieving cultural change relies on rethinking institutional logics (i.e. shared beliefs and values determining behaviour, shaping actions and decisions) and interrelationships.[52] Management's initiatives were seen as facilitating the implementation and have proven to be effective when applied within all layers of the organisation.[47,53] However,

Fakha et al.[27] confirm that the lack of continuity indicated by the participants (i.e. disrupted information flow, communication, etc.) can impede the implementation of innovations. Establishing strong external networks and clear communication is essential to foster implementation.[27] Therefore, it is recommended to maintain open communication across all organisational layers and provide time, space, and resources necessary to reconsider institutional logics.[49,52,54] This engagement can be further enhanced when staff are given the opportunity to provide input and feedback (e.g. during interactive sessions with management), through which they can voice their opinions and concerns, ask questions, offer suggestions, and feel heard.[49,54,55]

It became evident that funding and supporting regulations in the Netherlands were perceived as impeding for nationwide implementation of reablement. Current funding and reimbursement schemes fall short of covering all costs related to reablement programmes and their accompanying interdisciplinary collaboration.[56] Consequently, this hampers care professionals from delivering care based on the client's goals and needs, as the care provided is dictated by reimbursement criteria. This is in line with Parsons et al.[34] who emphasize the need for a funding model that facilitates goal-oriented, holistic, and person-centred home care. Both management and care professionals expressed a need for a more integrated form of funding as the current fee-for-service model does not encourage value-based care, fosters fragmented health care, and encourages volume-based incentives.[14,57] In addition, the current model does not incentivize preventive care and early interventions.[57,58] Moreover, a strong and shared national vision regarding a new way of delivering home care is needed (i.e. supporting organisational procedures and national policies).[17] An integrated funding model could potentially provide a solution, providing high-quality care tailored to the client's needs, ultimately reducing healthcare costs by promoting preventive care and early interventions.[59,60]

Some methodological considerations have to be made. First, we used a criterion sample of professionals based on the personal judgement of the research team and previous collaboration with the professionals, which could lead to a selection bias of more motivated participants. However, it allowed us to obtain insight from the professionals who were closest to the implementation process. Second, to minimize time investment and effort required from organisations and professionals, the decision was made to conduct four focus groups instead of pursuing data saturation. In addition, the uneven distribution of participants raised a concern, especially since one of the interviews involved 14 participants, potentially limiting the representation of some participants in our combined analysis. Nevertheless, our study presents

a methodologically sound and comprehensive understanding of the factors influencing a nationwide implementation of reablement from an implementation science perspective, for example, by using a well-known framework (i.e. CFIR[36]) to guide our study. It is important to note that the CFIR framework was updated during the preparation of this research.[61] The revised version highlights the importance of including the end users' perspective which ensures care meets their needs, enhancing person-centred and effective healthcare.[62] As a consequence, our study only reflects clients' experiences through professionals' views.

Notwithstanding these limitations, this study offers valuable insights for the implementation of reablement across diverse (international) settings and offers lessons applicable when implementing complex interventions. It can serve as a starting point to determine suitable, and effective strategies to address the identified influences on implementation. Linking our findings to the CFIR provides sufficient guidance to choose appropriate strategies for implementation.[63] Future research could quantify a mix of key influences and explore their impact due to reablement's context-specific character, further tailoring the chosen strategies. For practical application, care organisations should foster an innovation climate promoting open communication throughout all layers of the organisation, as well as with service users. Policy should prioritize adopting an integrated funding model, which offers structure when implementing complex, interdisciplinary, interventions such as reablement, especially early on in the care process.

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Appendices

Appendix 1. Semi-structured interview guide

A. Overall experiences with implementing reablement

1. Which factors did you experience as facilitating when implementing reablement?
    a. Why was this a facilitating factor?
2. Which factors did you experience as hindering when implementing reablement?
    a. Why was this a hindering factor?

B. Domain 1: Intervention characteristics

3. What challenges did you face during the implementation of reablement?
4. How can these problems be solved?
5. What do you think are the advantages and disadvantages of reablement compared to conventional home care?

C. Domain 2: Outer setting

6. To what extend has current legislation and regulations influenced the implementation of reablement?
7. To what extend have other factors outside the organisation influenced the implementation of reablement?

D. Domain 3: Inner setting

8. To what extend has the organisation facilitated or hindered the implementation of reablement?
9. In what way has communication within the organisation and within the reablement team influenced the implementation of reablement?
10. To what extend does reablement fit within the organisation's current policy and how did this affect the implementation of reablement?

E. Domain 4: Characteristics of the individual

11. Which people supported you in the implementation of reablement?
    a. How did they support you?
12. Which people hindered you in the implementation of reablement?
    a. How did they hinder you?

F. Domain 5: Process of implementation

13. Was the reablement programme implemented as intended?
    a. If not, why not?
14. What strategies were used to implement the reablement programme as planned?

Chapter 7

General discussion

Main findings

Key features of reablement practices throughout the world

A systematic review was conducted to address the first aim of this dissertation, exploring key features of reablement programmes throughout the world (Chapter 2). Out of 16 randomised controlled trials and 4 clinical controlled trials, conducted across 8 countries, 10 trials demonstrated effectiveness in improving activities of daily living (ADL). The findings indicated that effective programmes used diverse interdisciplinary teams, a standardised assessment and goal-setting method and at least four intervention components (i.e., ADL training, physical and/or functional exercise, education, and management of functional disorders). However, the intervention descriptions lacked essential details for practical implementation and contextual adaptation. Furthermore, goal setting within reablement proved is crucial for understanding individuals' wishes and needs while fostering interdisciplinary collaboration (Chapter 3). Experiences from 20 care professionals from Norway, New Zealand, and the Netherlands revealed that behavioural change techniques were often used to foster self-reflection and to shift perspectives, helping individuals achieve their goals. Additionally, goal setting improved interdisciplinary collaboration by promoting a sense of community, enhancing the learning environment, increasing job satisfaction, and facilitating task-shifting.

Define, implement, and evaluate reablement in the Dutch context

The second aim of this dissertation was to apply these insights and to define, implement, and evaluate reablement in the Dutch context. In the Netherlands, there is a growing interest in reablement, which has created the need for a definition of reablement in the Dutch context. A common understanding of reablement is important to determine its position within the healthcare system and possibly facilitate its integration as part of usual care. In a three-round Delphi study, 139 experts in the Netherlands – that is, care professionals, managers, and policymakers – agreed upon a definition of reablement tailored to the Dutch healthcare context (Chapter 4). The Dutch definition provides detailed information regarding the goals, target group, areas of application and characteristics of reablement in the Dutch healthcare context. Compared with the international definition, it emphasises the individual's social network and well-being, extending the focus beyond independence to actively promote social connectedness and participation. In a pilot implementation focusing on acceptability, implementation, practicality, adaptation, integration, and limited efficacy, clients, informal

caregivers, and professionals reported positive experiences with reablement (Chapter 5). In addition, three main challenges for its implementation were found: (1) behavioural change, (2) internal and external interprofessional collaboration, and (3) enrolment. While reablement showed positive results in terms of acceptability and implementation, the study showed that its success depends on careful adaptation to the context and adequate support for the involved stakeholders. Given the context-dependent nature of reablement, it was crucial to investigate how contextual factors in the Netherlands, such as the organisational culture and resources, influence implementation across different settings. Key facilitators and barriers were identified by care professionals and managers, such as the strength of interdisciplinary collaboration, which helped create an understanding of each other's roles and shared ownership (Chapter 6). The qualitative exploration of reablement implementation across three different organisations in the Netherlands also highlighted the pivotal role of management in integrating and sustaining the reablement philosophy within the organisations. Finally, we identified that supporting funding schemes and regulations are needed to achieve nationwide implementation of reablement, as the current situation hinders care professionals from delivering care based on individuals' goals and needs.

Methodological considerations

Lost in translation

While this dissertation shows important lessons learned from Norway and New Zealand (Chapters 2 and 3), it underscores that implementing reablement is not a simple copy-paste exercise. One of the biggest challenges when developing and implementing complex interventions is to achieve the right fit to the context.[1] The successful translation and implementation of reablement knowledge depends largely on a key question: have we gained enough insight into international and Dutch contexts to effectively adapt and integrate a multifaceted intervention such as reablement into the complex Dutch care landscape? If we do not address these contextual influences, we may struggle to integrate reablement effectively, potentially contributing to the existing limitations in the effectiveness and applicability of the research findings.[2] To learn from reablement in different contexts, we must have insights regarding the contextual influences – cultural (e.g., differing focus on well-being), organisational (e.g., centralised versus fragmented care systems), and stakeholder-specific (e.g., involving informal caregivers) factors – as well as the modelling of processes and

outcomes tailored to the local setting.[1,3] If overlooked, these factors can significantly reduce the likelihood of reablement's success and provide challenges to its further development and scalability in other contexts.[1] While much has been documented and compared about various reablement programmes internationally, context-specific characteristics are often described only briefly or superficially (**Chapter 2**), and there has been little exploration of their influence on the design or practical implementation of these programmes.[4] For example, while we compared reablement programmes across three countries (**Chapter 3**), it remains unclear whether and how a centralised care system, such as that in Norway, impacts factors such as the speed of implementation or promotes collaboration among care professionals compared to a more fragmented system, such as that in the Netherlands. Moreover, to explore, among other factors, the contextual influences on the implementation of reablement programmes in the Netherlands (**Chapter 6**), we used the Consolidated Framework for Implementation Research (CFIR).[5] This comprehensive tool aims to assess and understand factors that influence implementation by using five domains: innovation, outer setting, inner setting, individuals, and the implementation process.[5] While the CFIR helps identify key contextual factors (e.g., reimbursement policies), it does not fully address the underlying mechanisms[6] – such as how financial constraints might impact team composition or programme length. Moreover, the updated CFIR places an even stronger emphasis on stakeholder and contextual influences, such as roles, characteristics, organisational culture, leadership, and available resources, which could further enrich the depth and completeness of future analyses.[5,7] Building on the call from Damschröder et al.[1] for a deeper exploration of contextual factors in the updated CFIR, Bleijenberg et al.[5] stressed the importance of applying a realistic approach to understand underlying mechanisms and how interventions interact with the unique realities of a given context.[1,5] Moreover, Bleijenberg et al.[1] highlighted the added value of shadowing or participant observation for in-depth exploration of a problem. Ethnographic observations can capture real-time behaviours and interactions, revealing informal practices, unconscious actions, and socio-cultural influences that may not be evident through self-reporting.[8,9] These approaches could address critical questions, such as: what works, for whom, and under which circumstances?[10] They could shed light on how contextual factors influence the design and delivery of reablement programmes and the implications of these influences for outcomes.

Navigating professional roles in qualitative research

Reflexivity is crucial in qualitative research, particularly in acknowledging how researchers' backgrounds, biases, and relationships with participants may shape each stage of the research.[11] Within this dissertation, mainly explorative, qualitative designs were used to address its aims. This choice was made because qualitative research methods provide in-depth insights into the complexity of reablement practices, capturing nuances that might otherwise have been overlooked with quantitative designs. By using qualitative methods, the perspectives of the various stakeholders involved were explored to provide insight into their perceptions, experiences, and attitudes towards reablement. Moreover, the qualitative designs also helped to gain an initial insight into contextual factors that influence the successful implementation of reablement (Chapters 3 and 6). In qualitative research, trustworthiness is essential and includes quality criteria such as credibility, transferability, dependability, and confirmability, as well as reflexivity.[12,13] The latter, a concept rooted in the social sciences, involves critically reflecting on how a researcher's subjectivity influences the research process.[11] It is described as 'the process of critical self-reflection about oneself as a researcher (own biases, preferences, preconceptions), and the research relationship (relationship to the respondent, and how the relationship affects the participant's answers to questions)'.[12] This dissertation was conducted at the Limburg Living Lab in Aging and Long-Term Care.[14] Conducting this research in close collaboration with a long-term care organisation exemplifies the strong connection between academic research and practical application, a feature that characterises the projects within the Living Lab in Ageing and Long-Term Care.[15,16] In my PhD project, the impact of practice was even greater due to my role as an employee of Cicero Zorggroep. My dual role in the project, bridging the lab and the care organisation, aligns with the 'Officer' posture described by Crouzat et al.,[17] which involves supporting decision-making and facilitating the integration of reablement. A potential pitfall in this context is that if the Officer cannot maintain neutrality, their stance may shift towards that of a '(stealth) Advocate', where decision-making becomes less impartial and leans more towards certain (personal) preferences. Given my background as a geriatric physiotherapist, and my strong beliefs in the concept of reablement, it is therefore worth questioning how these factors have influenced my research. For example, empathy towards the participants' challenges or shared professional roles may have shaped the way they responded and were engaged with, possibly influencing how responses are interpreted or prioritised. Later in the project, as I took on the role of project leader for the implementation of reablement within Cicero Zorggroep, my personal and professional experiences also provided valuable insights into the practical realities of reablement programmes and their

implementation. Both these backgrounds may have facilitated the elicitation of deeper insights, not only in the analysis but also in the execution of the project. However, they could also pose as a potential pitfall, as my close involvement in the implementation might have led to conflicts of interest or influenced my interpretation of the data. To address potential reflexive influences, continuous efforts were made to minimise them, primarily through the active involvement of the research team. This team-based reflexivity[18] utilises the different backgrounds, skills, and expertise of each member of the research team in each stage of the research process, ensuring that multiple perspectives are considered. Regular team discussions, peer feedback, and cross-checking of data interpretations contributed to the robustness of the research, strengthening the overall quality and trustworthiness of the findings in this dissertation.[12] By integrating reflexive practices and prioritising participant perspectives, future studies can offer richer, more authentic insights into the personal and contextual factors influencing the success of reablement.[19]

Theoretical considerations

Breaking down silos: collaboration as an essential yet fragile foundation for success

The findings of this dissertation emphasise that the success of reablement relies heavily on the interdisciplinary character of the reablement team and the strength of their structural collaboration. Although reablement is defined as an interdisciplinary approach both internationally and nationally (Chapter 4), the findings of this dissertation show that reablement is often organised in a multi- instead of interdisciplinary manner in the Netherlands. Rosenfield et al.[20] stated that multidisciplinary, interdisciplinary, and transdisciplinary collaboration differ in how disciplines integrate expertise. Multidisciplinary collaboration works within distinct frameworks, but interdisciplinary collaboration integrates perspectives to address a common problem while maintaining boundaries. Transdisciplinary collaboration transcends these disciplinary boundaries, merging concepts and approaches into a shared framework.[20] Within Dutch community care, professionals continue to work largely within their own 'silos' and do not collaborate structurally.[21] Chapters 3, 5, and 6 revealed an increasing trend towards interdisciplinary collaboration, supported by the use of structural factors such as clear and shared goals, regular structured meetings, the use of a shared electronic care file, and the presence of a coordinator. However, we also observed collaboration with other, primarily external, professionals (e.g., social care providers or general practitioners) remained

multidisciplinary. They continued to work within their disciplinary boundaries and did not meet on a structural basis to align their efforts (**Chapters 5** and **6**). While interdisciplinary collaboration ensures the integration of diverse expertise, the conditional nature of the system also highlights moments where transdisciplinary approaches might be advantageous within reablement. For example, the barriers identified in **Chapter 6**, such as high turnover or lack of alignment, suggest that transdisciplinary collaboration could enable team members to move beyond specific roles, to share responsibilities, and to adopt a unified approach. There are several preconditions for transdisciplinary work: a lack of hierarchy, role fluidity, a shared conceptual framework, and a focus on addressing real-life problems.[22] In the Netherlands, transdisciplinary collaboration could enhance reablement by fostering a shared understanding, offering flexibility, and improving care efficiency. The Dutch definition of reablement in **Chapter 4** can contribute to the shared understanding within the team, although there is room for improvement in role fluidity.[22] As shown in **Chapter 3**, countries such as Norway and New Zealand already implement role fluidity, which we described as 'task-shifting', where team members step beyond their disciplines and share duties based on availability rather than job titles. Moreover, as reflected upon in **Chapter 3**, each professional contributes their unique expertise and skills, making effective collaboration between these professionals crucial for achieving the goals set by the individual undergoing reablement. In addition to the aforementioned preconditions, the ability to initiate effective interdisciplinary or even transdisciplinary collaboration – especially with external parties – lies in the team's ability to remain adaptable and flexible.[22,23] Teams need to be able to adjust to new challenges and information, requiring stability to avoid reverting to ad hoc collaboration.[24,25] It is therefore important to look for stabilising factors to guide the team through periods of instability, such as the structural factors found in this dissertation: clear and shared goals, regular structured meetings, the use of a shared electronic care file, and the presence of a coordinator. These can anchor the collaborative efforts even when internal or external factors change.[24]

Stuck in transition

While Dutch policies focus on the transition to and greater integration of health and social care, implementation remains challenging. Without systemic changes, initiatives such as reablement fail to reach their full potential and ultimately are at high risk to stumble over systemic barriers such as governance and funding. Policies such as the Integrated Care Agreement (Integraal Zorgakkoord [IZA])[26]; the Housing, Support, and Care for Older People programme (Wonen,

Ondersteuning en Zorg voor Ouderen [WOZO])[27]; and the Healthy and Active Living Agreement (Gezond en Actief Leven Akkoord [GALA])[28] advocate for a holistic approach to care that integrates health and social care, where healthcare is no longer viewed in isolation, but rather as part of a broader network that includes social support, community resources, and individual well-being. This aligns with the World Health Organization's framework on integrated people-centred health services (IPCHS), which aims to transform healthcare towards a system based on the needs, preferences, and values of individuals and communities.[29] Despite policy alignment, the findings of this dissertation show that these policies are not yet reflected in practice. For example, Dutch reablement teams, as described in **Chapters 3**, **5**, and **6**, are currently primarily healthcare oriented, and the current funding infrastructure hinders collaboration across sectors.[30] In contrast, countries like Norway and New Zealand have more integrated systems where social care is better aligned with healthcare (**Chapter 3**). Both IPCHS and the comprehensive theory of integrated care by Singer et al.[31] identify governance as a key driver for integration. While policies seem to be aligned with reablement organisational structures to support its implementation are still lacking (**Chapters 5** and **6**). Professionals often work in isolation, with different reporting structures and responsibilities that hinder collaboration (**Chapter 6**). Hence, IPCHS[29] and Singer et al.[31] advocate for creating an enabling environment that fosters a culture of shared responsibility and a focus on long-term goals. An example is included in **Chapter 3**: in alignment with the types of integration outline by Singer et al.,[31] we observed a high level of functional and interpersonal integration. Healthcare professionals from Norway, New Zealand, and the Netherlands emphasised that the development of relationships, trust, and a collaborative environment – characterised by mutual learning, shared goals, and the lack of hierarchy – enhanced teamwork and supported long-term, sustainable alignment with the reablement philosophy. This approach could help reduce the limitations mentioned in **Chapter 6** regarding project-based work and enhance the required sense of urgency. Moreover, IPCHS recommends training management in transformational leadership and change management strategies, such as engaging and empowering professionals, as well as implementing shared frameworks and information systems to align cross-sector activities and support monitoring and evaluation. Additionally, IPCHS highlights the importance of reforming payment systems, including the use of mixed payment models and bundled payments, to align financial incentives with integrated care objectives.[29] Furthermore, professional roles and practices are deeply rooted in sector-specific traditions, making cultural and behavioural changes difficult (**Chapters 5** and **6**). Professional roles are often shaped by traditional perspectives, where healthcare is still narrowly defined, for example, lacking focus

on well-being, and healthcare providers and educators adopt a limited, discipline-specific view. This is evident in professional profiles, such as that of the registered nurse, where tasks are still framed within a primarily conventional perspectives with a focus on care. This often limits opportunities for the meaningful necessary integration of care and well-being.[32] A valuable example of how roles can evolve is seen in the recent revision of the professional profile for geriatric physiotherapy in 2023, which took steps towards a broader view of the healthcare provider's role.[33] Singer et al.[31] discussed interpersonal and normative integration, which address social aspects related to what people believe and how they behave together. Organisations must have leaders – or managers – who actively ensure effective communication and coordination between different care providers (**Chapter 6**).[29,31] This involves high-quality care as well as listening to the preferences and needs of individuals and their families, which, in the case of reablement, is reflected in the goals set by the team (**Chapters 3**, **5**, and **6**). While leaders cannot enforce these changes alone, they can influence how well it works in practice, by setting a strong example and providing clear guidance.[31] This dissertation illustrates that reablement has the potential to contribute to the shift towards the integration of health and social care. However, significant barriers persist, and to fully realise this shift, significant systemic and cultural changes are required, including overcoming traditional silos, fostering cross-sector collaboration, and adapting professional cultures and practices.

Cultivating and sustaining change

Innovation readiness is essential for driving and sustaining the change needed to embed innovations such as reablement into routine practice. Innovation readiness refers to an organisation's ability to successfully implement any type of innovation.[34] It covers the entire innovation process, rather than focusing solely on the adoption of newly developed innovations. Without it, the shift towards normalising innovations within everyday care is unlikely to succeed: the core principles will not be fully realised and there is a risk that they will be diluted or misapplied. Van den Hoed et al.[35] identified four main factors that positively contribute to innovation readiness in long-term care: a clear strategic course for innovation, a tailored innovation journey, inspirational leading for innovation, and hands-on learning for innovation. Applying these principles to the findings from **Chapters 5** and **6**, it becomes clear that the frontrunner organisations are already investing significantly in innovation readiness. This is evident in their prioritisation of a clear strategic course for innovation as seen by their organisation of inspiration sessions to share key themes from their innovation strategy with

employees. Regarding the organisation and communication of innovation, frontrunner organisations described resources such as the use of an implementation coach, sharing success stories, and facilitating a shared electronic care file are implemented (Chapter 6). However, we observed differences in innovation readiness between the frontrunners, with varying levels of integration of innovation practices into their operations. We could not pinpoint the exact cause and extent of these differences because we did not systematically evaluate innovation readiness. However, the project-based positioning of reablement within the organisations, as identified by the care professionals in Chapter 6, hinders the innovation process by creating a sense of temporariness and non-committal. Our findings (Chapters 3, 5, and 6) indicate that the implementation of reablement frequently succeeds at the individual level, aligning with hands-on learning approaches for innovation. Nevertheless, reablement is still perceived as 'new' and has yet to make the critical transition to being fully embedded in regular work processes. According to innovation readiness, this falls or stands with a structured approach to the innovation but also leadership for the innovation. As discussed in Chapter 6, we identified gaps at the management level that present a risk for reablement's long-term sustainability. Effective management requires more than strategic alignment; it demands a commitment to fostering an innovation-friendly culture, with middle managers playing a pivotal role in embedding innovative practices within the broader organisational context.[36] They must prioritise innovation by explicitly articulating its importance, setting clear expectations for employees, and creating opportunities for staff to engage with and contribute to the innovation process.[36] For example, although regular structured meetings and feedback loops are effective in fostering involvement, care professionals indicated that these are not consistently implemented (Chapter 6). Based on the findings in Chapter 6, it would be more accurate to say that while the front-running organisations are making significant strides towards being innovation ready, they are not yet fully prepared for sustained innovation.

Implications and future directions

The findings presented in this dissertation have several implications for policy, practice, research, and education.

Policy and practice

This dissertation provides recommendations for policy and practice to integrate reablement into the Dutch healthcare system and enhance its long-term sustainability. However, their successful implementation hinges on a critical factor, which became evident during the research conducted and described in **Chapters 4**, **5**, and **6**. Although the government's transformation plans advocate for integrated collaboration between health and social care,[26-28] existing infrastructures are inadequately designed to facilitate this shift, posing a significant barrier to progress. Without addressing the identified structural and cultural barriers, the extent to which these recommendations can be realised and effectively implemented in practice remains uncertain.

Organisations must foster the conditions essential for interdisciplinary collaboration. Professional roles and practices are deeply rooted in sector-specific traditions, making it challenging to foster the cultural and behavioural changes necessary.[31] This necessitates eliminating siloed working practices and requires recognition of the unique roles and expertise of all stakeholders, coupled with a commitment to establishing a shared perspective as a starting point.[35,37] This shared understanding could serve as a foundation for advancing towards transdisciplinary collaboration and enabling task-shifting.[38] However, without a unified system or shared platform to align priorities, processes, and goals across sectors, efforts to promote collaboration often stall.[29] To achieve this, stable organisational infrastructures and working processes are essential, with the stabilising factors identified in **Chapters 3**, **5**, and **6** – such as shared goals, regular structured meetings, and the use of a shared electronic care file – offering valuable guidance.[23] Moreover, organisations must be innovation ready to embrace the cultural and behavioural changes required to adopt and sustain the reablement philosophy.[35] Management should invest in and prioritise the creation of a learning environment for staff, offering opportunities for training, on-the-job coaching, and reflective practices such as peer coaching. Embracing a perspective of normalisation is crucial to integrating innovations like reablement into routine care delivery, ensuring they become permanent components of practice rather than temporary initiatives.[39]

Research

Based on this dissertation, several future research directions can be identified to deepen our understanding of reablement and its implementation. To properly address the complexity of reablement, future studies should adopt more integrative and holistic approaches. Frameworks such as the CFIR and methodologies like realist evaluation could help discover valuable insights into the mechanisms underpinning international and national reablement practices – mechanisms that this dissertation has only slightly touched upon (Chapter 6).[40] Furthermore, the qualitative methodologies used in this dissertation could be complemented by ethnographic approaches. These methods could further illuminate the cultural and social dynamics affecting reablement and its integration, offering a deeper understanding of day-to-day practices and perceptions.[8,9] This aligns with discussions in related research which question whether practices truly align with clients' core needs and wishes.[41] Additionally, future studies should continue to incorporate participatory research designs, including stakeholder participation, as a key component of the research approach.[19] Engaging professionals, clients, and informal caregivers through approaches such as experience-based co-design, user-centred design, or community-based participatory research would ensure a comprehensive understanding of needs, experiences, preferences, and interests.[19] These future directions underscore the importance of a context-sensitive, multidimensional approach to reablement research, addressing its complexity while remaining grounded in the lived realities of its end-users.

Education

The findings of this dissertation are also significant for the development of education for management and policy advisors, professionals, and older adults and their informal caregivers. First, as highlighted in Chapter 6, effective leadership is critical for transitioning from traditional care models to approaches such as reablement. Managers and policy advisors need educational programmes that equip them with the tools to develop vision, to drive change, and to create environments that facilitate inter- and transdisciplinary collaboration across sectors. Creating the right organisational culture and climate – aligned with principles such as innovation readiness – is essential to support these efforts. Second, professionals should be provided with resources and opportunities to develop the skills essential for successful reablement, including conducting initial assessments, applying behaviour change techniques, and involving older

adults and informal caregivers. Educational curricula should enhance interprofessional learning, and training approaches should promote autonomy and self-management and foster cross-sector collaboration. To sustain and embed the principles of reablement in standard care, it is essential to prioritise lifelong learning. This includes providing tools to embrace a continuous learning cycle – not only for professionals in training, but also for experienced staff across sectors. Third, older adults and informal caregivers should be empowered to take a proactive approach to defining their goals, needs, and preferences, as emphasised in Chapter 3. For example, the government also has a crucial role in organising campaigns that promote autonomy, self-management, and health, helping to shift their mindset and engagement with these practices. Encouraging social support and networks is equally important, such as through neighbourhood walking groups or local initiatives like 'caregiver cafés' for peer support. General practitioners, community nurses, and municipalities can play a key role in referring individuals to such programmes and fostering connections with resources that enhance physical and mental health, while strengthening social ties and promoting a sense of belonging.

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Addenda

Summary

The ageing population and the increase in chronic conditions lead to higher demands and more complex care needs. Many older adults prefer to live at home, as this environment provides independence and comfort. Reablement is a promising approach that helps older adults stay at home longer and at the same time provides a solution to the challenges faced in care for older adults. It is a person-centred, interdisciplinary approach that helps individuals regain or maintain independence and confidence in daily tasks, while encouraging social involvement. This dissertation explored key features of reablement worldwide and aimed to apply these insights to define, implement, and evaluate reablement in the Netherlands.

Chapter 1 outlines the challenges of ageing and the organisation of healthcare, which is increasingly shifting its focus from disability and disease towards well-being, strengths, and capabilities of the individual. It also elaborates on the origin and international development of reablement, addressing its variation across different contexts and the challenges in defining it consistently. The chapter concludes by describing reablement's development in the Netherlands and identifying research gaps that will be addressed in this thesis.

Chapter 2 presents a systematic literature review that explored the most common and promising features of reablement programmes and their effect on daily functioning (ADL). Twenty relevant studies on reablement programmes from eight countries were identified, of which ten reported a positive impact on daily functioning. Several common features were found across the reablement programmes, such as the use of interdisciplinary teams with a diverse composition, a standardised assessment and goal-setting approach, and the use of at least four intervention components to improve daily functioning (e.g., ADL-training, physical and/or functional exercise, education, management of functional disorders). However, an equal number of programmes were shown to be effective and ineffective. Often programme descriptions were vague and incomplete. The study quality of the trials ranged from moderate to low, making it difficult to determine which features were most promising in improving daily functioning or whether reablement programmes can indeed improve daily functioning. In conclusion, while the identified common elements can provide guidance for developing future reablement programmes, further research into the components of reablement is needed to implement reablement effectively in different contexts.

In **Chapter 3** a comparative case study looked at one of the key features of reablement: goal setting and achievement across three countries, as well as its impact on interdisciplinary collaboration. Three group interviews were held with 20 healthcare professionals (nurses and allied healthcare staff) from Norway, New-Zealand, and the Netherlands. They shared their experiences with goal setting and related processes within reablement programmes. The results were grouped into three main themes. First, goal setting was mentioned to be an essential part of reablement and contributed to a better understanding of individuals' motives. Second, goal setting was mentioned to improve teamwork by creating a sense of community, a positive learning environment, increasing job satisfaction, and promoting task-shifting. Third, behaviour change techniques were identified to support individuals in achieving their goals, encouraging self-reflection and changing their perspectives. The study highlights the important role of goal setting in understanding individuals' needs and wishes.

Chapter 4 presents a three-round modified Delphi study involving 139 Dutch experts, including health and social care, education, and research, as well as representatives of clients and informal caregivers. The study comprised three expert rounds and three Delphi-rounds using an online survey programme. Participants discussed and evaluated various statements across four sections: the target group, aims, type of care or support, and characteristics of reablement programmes. Key discussions focused on the target group, emphasising the importance of involving individuals and their families, and on the characteristics of reablement, such as the coordinating role, team composition, and size. The input from the surveys and expert rounds led to the development of an operational definition for the Dutch context, which was agreed upon by 81% of stakeholders, providing detailed information regarding the goals, target group, areas of application, and characteristics of reablement in the Dutch context. The definition distinguishes itself from the international definition by providing more than just a description; it includes areas where reablement can be used and the types of interventions that help to achieve its goals. According to the Dutch definition, reablement goes beyond promoting independence, expanding the focus to include social participation, well-being, and the involvement of the individual's social network. This definition represents an important step in advancing further research and policy development regarding reablement in the Netherlands.

Chapter 5 explores the feasibility of a Dutch reablement programme, focusing on acceptability, implementation, practicality, adaptation, integration, and limited efficacy. In the study interviews with six clients, three informal caregivers, eight care professionals, and one programme director were conducted. In addition, data from electronic care files were used to track client progress and goal related outcomes, used interventions, progress reports, and final outcomes. The results showed positive feedback from participants, but three main challenges were found. These challenges related to 1) behaviour change among all professionals involved, 2) teamwork between professionals, and 3) recruiting participants for the programme. The study highlights the difficulties of introducing and making reablement work in community care, offering valuable insights for future reablement programmes.

Chapter 6 presents a qualitative study that explored professionals' experiences with reablement implementation in Dutch community care. The study involved professionals of three long-term care organisations, each with at least six months of reablement experience. A total of 32 professionals took part in group interviews, including health and social care professionals, managers, and insurers. They identified key facilitators and barriers for reablement implementation, grouped into three themes: 1) strength of interdisciplinary collaboration; highlighting the importance of working together with shared goals and beliefs., 2) integrating the reablement philosophy into the organisation; underscoring the role of management in gaining support from all levels of the organisation, and 3) achieving a culture change in the healthcare system; emphasising how current funding models make it hard to provide personalised, value-based care that matches each person's needs and goals. In conclusion, the study provides insights and can offer guidance on the factors influencing the successful implementation of reablement in Dutch community care.

To conclude, Chapter 7 summarises the main findings of all studies included in this dissertation and reflects on methodological and theoretical considerations. Methodologically, the chapter reflects on mapping contextual factors to better understand the context for the effective adaptation and integration of a complex intervention like reablement, as well as reflecting on navigating professional roles and biases within qualitative research. Theoretically, the chapter reflects on the presence of interdisciplinary collaboration within reablement in the Netherlands, identifying barriers and areas for improvement. It also emphasises the importance

Samenvatting

De vergrijzing van de bevolking en de toename van chronische aandoeningen leiden tot hogere eisen en complexere zorgbehoeften. Veel ouderen willen zo lang mogelijk thuis blijven wonen, omdat dit hen onafhankelijkheid en comfort biedt. Reablement is een veelbelovende benadering die ouderen helpt langer zelfstandig thuis te blijven, en tegelijkertijd een oplossing biedt voor de uitdagingen in de zorg. Het is een persoonsgerichte, interdisciplinaire aanpak die mensen helpt hun onafhankelijkheid en vertrouwen in dagelijkse activiteiten te herwinnen of te behouden, met daarnaast aandacht voor sociale betrokkenheid. Dit proefschrift onderzocht de belangrijkste kenmerken van reablement wereldwijd en had als doel deze inzichten toe te passen om reablement in Nederland te definiëren, implementeren en evalueren.

Hoofdstuk 1 behandelt de uitdagingen van veroudering en de veranderende organisatie van zorg, die steeds meer de nadruk legt op welzijn, sterke punten en capaciteiten van het individu in plaats van ziekte en beperking. Het hoofdstuk gaat ook in op de oorsprong en internationale ontwikkeling van reablement, met aandacht voor de variatie tussen verschillende contexten en de moeilijkheden bij het consistent definiëren van reablement. Het hoofdstuk wordt afgesloten met een beschrijving van de ontwikkeling van reablement in Nederland en de hiaten in onderzoek die in dit proefschrift aan bod komen.

Hoofdstuk 2 presenteert een systematische literatuurreview die de meest voorkomende en veelbelovende kenmerken van reablement programma's onderzocht, evenals hun effect op het dagelijks functioneren (ADL). Twintig relevante studies uit acht landen werden geïdentificeerd, waarvan tien een positief effect rapporteerden op het dagelijks functioneren. Er werden verschillende gemeenschappelijke kenmerken van de programma's gevonden, zoals het gebruik van interdisciplinaire teams, gestandaardiseerde methoden voor de intake en het stellen van doelen, en het gebruik van ten minste vier interventiecomponenten om het dagelijks functioneren te verbeteren (bijvoorbeeld ADL-training, fysieke en/of functionele oefeningen, educatie en behandeling van functionele stoornissen). Toch bleken evenveel programma's effectief als ineffectief. Vaak waren programmaomschrijvingen vaag en onvolledig. De studiekwaliteit van de trials varieerde van gemiddeld tot laag, waardoor het moeilijk was te bepalen welke kenmerken het meest veelbelovend waren in het verbeteren van het dagelijks functioneren en of reablement programma's daadwerkelijk het dagelijks functioneren kunnen verbeteren. Concluderend, hoewel de geïdentificeerde

gemeenschappelijke kenmerken richting kunnen geven bij het ontwikkelen van toekomstige reablement programma's, is verder onderzoek naar de componenten van reablement nodig om reablement effectief te kunnen implementeren in verschillende contexten.

Hoofdstuk 3 presenteert een vergelijkende casestudie naar een van de hoofdkernmerken van reablement: het stellen van doelen en het behalen daarvan in drie landen, en de impact hiervan op interdisciplinair samenwerken. Er werden drie groepsinterviews gehouden met 20 zorgprofessionals (verzorging, verpleging en paramedici) uit Noorwegen, Nieuw-Zeeland en Nederland. Zij deelden hun ervaringen met het stellen van doelen en daarbij behorende processen binnen reablement programma's. De resultaten werden onderverdeeld in drie hoofdthema's. Ten eerste werd benoemd dat het stellen van doelen een essentieel onderdeel is van reablement en droeg het bij om beter inzicht te krijgen in de beweegredenen van individuen. Ten tweede werd benoemd dat het stellen van doelen benoemd de samenwerking van het team te verbeteren door het creëren van een gemeenschapsgevoel, het bevorderen van een positieve leeromgeving, het vergroten van werkplezier en het stimuleren van taakverschuiving. Ten derde werden technieken voor gedragsverandering geïdentificeerd die individuen ondersteunden bij het behalen van hun doelen, zoals het stimuleren van zelfreflectie en het veranderen van hun perspectief. De studie benadrukt de belangrijke rol van het stellen van doelen in het begrijpen van de wensen en behoeften van individuen.

Hoofdstuk 4 presenteert een aangepaste Delphi-studie bestaande uit drie ronden, waaraan 139 Nederlandse experts deelnamen, waaronder zorg- en welzijnsprofessionals, onderwijzers en onderzoekers, en vertegenwoordigers van cliënten en mantelzorgers. De studie bestond uit drie expert-rondes en drie Delphi-rondes via een online-enquêtesysteem. De deelnemers bespraken en evalueerden verschillende stellingen in vier secties: de doelgroep, doelen, soort zorg of ondersteuning en de kenmerken van reablement-programma's. Belangrijke discussies richtten zich op de doelgroep, waarbij het belang van het betrekken van individuen en hun naasten werd benadrukt, en op de kenmerken van reablement, zoals de coördinerende rol, teamsamenstelling en grootte. De input van de enquêtes en expert-rondes leidde tot de ontwikkeling van een operationele definitie voor de Nederlandse context, die door 81% van de deelnemers werd goedgekeurd. Het bevat gedetailleerde informatie over de doelen, doelgroep, toepassingsgebieden en kenmerken van reablement in de Nederlandse context. De

definitie onderscheidt zich van de al bestaande internationale definitie door meer te bieden dan alleen een beschrijving; het omvat gebieden waar reablement kan worden toegepast en de soorten interventies die ingezet kunnen worden om de doelen te bereiken. Volgens de Nederlandse definitie gaat reablement verder dan het bevorderen van onafhankelijkheid, waarbij de focus wordt uitgebreid naar sociale participatie, welzijn en de betrokkenheid van het sociale netwerk van het individu. Deze definitie vertegenwoordigt een belangrijke stap in het bevorderen van verder onderzoek en beleidsontwikkeling met betrekking tot reablement in Nederland.

Hoofdstuk 5 onderzoekt de haalbaarheid van een Nederlands reablement programma, met focus op acceptatie, implementatie, praktisch nut, aanpassing, integratie en beperkte effectiviteit. In de studie werden interviews afgenomen met zes cliënten, drie mantelzorgers, acht zorgprofessionals en één programmamanager. Daarnaast werden gegevens uit elektronische zorgdossiers gebruikt om de voortgang van de cliënten en doel gerelateerde uitkomsten, gebruikte interventies, voortgangsrapportages en eindresultaten te volgen. De resultaten lieten positieve feedback zien van de deelnemers, maar er werden ook drie belangrijke uitdagingen gevonden. Deze uitdagingen hadden betrekking op 1) gedragsverandering bij alle betrokken professionals; 2) samenwerking tussen professionals; en 3) het werven van deelnemers voor het programma. De studie benadrukt de moeilijkheden van het introduceren en werkbaar maken van reablement in de eerste lijn en biedt waardevolle inzichten voor toekomstige reablement programma's.

Hoofdstuk 6 presenteert een kwalitatieve studie die de ervaringen van professionals met de implementatie van reablement in de Nederlandse eerstelijnszorg onderzocht. De studie betrof professionals van drie ouderenzorgorganisaties, die elk ten minste zes maanden ervaring met reablement hadden. In totaal namen 32 professionals deel aan groepsinterviews, waaronder zorg- en welzijnsprofessionals, managers en verzekeraars. Zij identificeerden belangrijke factoren die de implementatie van reablement bevorderden of belemmerden, gegroepeerd in drie thema's: 1) de kracht van interdisciplinaire samenwerking; waarbij het belang van samenwerken met gemeenschappelijke doelen en overtuigingen werd benadrukt, 2) het integreren van de reablement-filosofie binnen de organisatie; waarbij de rol van het management in het verkrijgen van steun op alle niveaus van de organisatie werd onderstreept,

en 3) het bereiken van een cultuurverandering in het zorgsysteem; waarbij werd benadrukt hoe de huidige financieringsmodellen het moeilijk maken om gepersonaliseerde, op waarde gebaseerde zorg te bieden die aansluit bij de behoeften en doelen van ieder individu. Concluderend biedt de studie inzichten en handvatten voor de factoren die de succesvolle implementatie van reablement in de Nederlandse eerstelijnszorg beïnvloeden.

Tot slot vat Hoofdstuk 7 de belangrijkste bevindingen van alle studies in dit proefschrift samen en reflecteert het op een aantal methodologische en theoretische overwegingen. Methodologisch reflecteert het hoofdstuk op het in kaart brengen van contextuele factoren om de context voor de effectieve aanpassing en integratie van een complexe interventie zoals reablement beter te begrijpen, evenals het omgaan met verschillende professionele rollen en vooroordelen binnen kwalitatief onderzoek. Theoretisch reflecteert het hoofdstuk op de aanwezigheid van interdisciplinaire samenwerking binnen reablement in Nederland, waarbij barrières en verbeterpunten worden besproken. Het benadrukt ook het belang van bereidheid om te vernieuwen en de rol van leiderschap in het creëren en behouden van verandering binnen een organisatie, evenals de noodzaak van systeemveranderingen om te zorgen dat reablement zijn volledige potentieel kan bereiken. Het hoofdstuk concludeert met verschillende aanbevelingen voor beleid, praktijk, onderzoek en onderwijs.

Impact

Understanding the key elements of reablement (Chapters 2 and 3) along with exploring its definition, implementation, and evaluation in the Netherlands (Chapters 4, 5, and 6) becomes truly meaningful when this knowledge is shared, applied in practice, and used as a foundation for further development. This chapter, therefore, focuses on the societal contribution of this dissertation, its scientific impact, and the efforts made to disseminate the findings.

Societal impact

Practice

"This project has really changed my perspective on care." (Physiotherapist)

The chapters in this dissertation capture the research undertaken in direct response to developments in practice, as reablement became a key concept in various policy and governmental documents.[1-6] Conducting this research in close collaboration with the long-term care organisation Cicero Zorggroep exemplifies the strong connection between academic research and practical application that characterised the projects within the Living Lab in Ageing and Long-Term Care. My dual role as a researcher and practitioner, specifically as a physiotherapist and project leader within Cicero, deepened this collaboration. For example, as a practitioner, I worked closely with care professionals and managers, facilitating the direct application of research insights to practice. This included organising workshops, presentations, and training sessions, where these insights were discussed and implemented to improve reablement practice within the organisation. In this role, l served as a 'linking pin' to bridge the gap between academic insights and care practices related to reablement, ensuring academic rigour and practical relevance. Because the research questions were shaped by academic inquiry as well as the needs and insights from practice, the resulting research activities are highly relevant and impactful. Moreover, it created opportunities for key stakeholders – such as care professionals, managers, insurers, policymakers, and researchers – to reflect together, to share success stories, and to explore challenges and best practices in reablement. These discussions allowed for learning from various perspectives, drawing insights from both national and international contexts, and these insights contribute to a better understanding of reablement in practice. For example, the focus groups in Chapter 6 highlighted the strong belief in reablement across all long-term care organisations and its potential benefits for older individuals. However, it also revealed that management indicated reimbursement issues

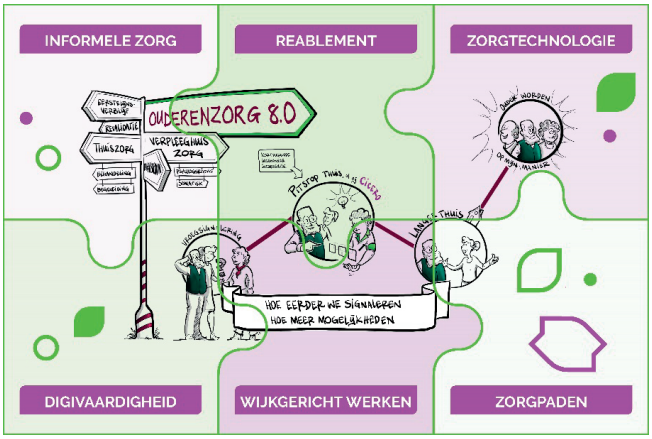
currently dictate the programme's contents. The work done owes its success to the invaluable contributions of diverse stakeholders, including older adults, informal caregivers, care professionals, managers, and policymakers. Their insights enriched every aspect of the work, enabling a holistic approach to reablement research and practice. For example, in Chapter 5, conversations with older adults revealed that they often did not remember which goals had been set, indicating the need for care professionals to ensure that goals are remembered and understood, possibly improving the effectiveness of the reablement process and intrinsic motivation of the older adult. With research and practice working closely together, this dissertation created an opportunity to make a meaningful societal impact. In the following paragraphs, this impact is explored from the perspectives of the stakeholders involved.

Healthcare organisations

This dissertation provides practical guidance for long-term care organisations to implement reablement, such as the operational definition outlined in Chapter 4. The definition offers actionable insights for embedding reablement into standard care practices and aligning it with national policy developments with an emphasis on interdisciplinary (cross-domain) collaboration, goal setting, well-being, and the inclusion of informal caregivers. Furthermore, Chapter 6 underscores the need for a cultural shift within healthcare organisations, advocating for a change in how care professionals approach and deliver care. This cultural shift, in the context of reablement, involves embracing goal setting, self-reflection, and interdisciplinary collaboration and has the potential to significantly enhance the overall quality of care across the healthcare system. Moreover, as reablement gains popularity, there is a risk of the concept being diluted or misapplied under the guise of reablement, and it could become a vague or superficial concept. To safeguard the integrity of reablement, it is essential to build and share robust evidence on its practices. The dissemination of rigorous research, as outlined in this dissertation, can help ensure the quality of reablement in daily practice, aligning with both organisational objectives and national policies.

> *"I'm now more proactive in seeking collaboration with other primary care practices and healthcare groups. I no longer see them as 'competitors', but as colleagues with whom I can work together to achieve client goals. This aligns with the regional transformation plans and the push for stronger collaboration."* (Occupational therapist)

Illustrative of its practical impact, the research and findings presented in this dissertation have facilitated Cicero Zorggroep in the sustainable integration of reablement within their existing processes and structures. This includes developing and defining a reablement care pathway, allocating resources, and establishing policies that actively support reablement. Consequently, as principles of reablement strongly align with the organisation's strategy, it has now been incorporated as a core component (Figure 1). In practice, this means that within Cicero, reablement currently forms the foundation for all community-based care and treatment, with plans in the coming years to implement this within their long-term residential care facilities. For employees, this represents a shift from 'doing for' to 'doing with', and for Cicero's clients and their social network, there is a greater focus on their independence and autonomy.



"I now integrate reablement more into other projects, such as informal care, by focusing on what clients can continue to do independently, as well as the valuable contributions informal caregivers can make." (Project leader)

Figure 1. Reablement has been integrated as a key component of Cicero Zorggroep's strategy

These efforts have positioned Cicero Zorggroep as a national pioneer in the implementation of reablement. The organisation is now viewed as one of the leading organisations in the Netherlands in this field.[7] As a frontrunner, Cicero has not only recognised the potential of reablement, but has also successfully gained the opportunity to apply for a ZonMw grant in 2023 to investigate the effectiveness and scalability of reablement.[8] As a result of the reablement activities related to this dissertation, the knowledge and learning network on reablement, coordinated by the Living Lab in Ageing and Long-Term Care, was initiated. Within this network, care organisations like Cicero share their insights and innovative approaches while learning from the experiences and best practices of other organisations. In addition, these care organisations actively participate in a large-scale evaluation of reablement in the Netherlands. Overall, this participation reinforces the frontrunning organisations positions as leaders in advancing reablement and has facilitated meetings with key stakeholders, including

the Ministry of Health, Welfare and Sport (VWS), the Dutch Healthcare Authority (NZa), and healthcare insurers, to discuss the future of care for older individuals and the current challenges in providing this care.

Supported by the findings of this dissertation on reablement's key components (Chapters 2, 3, and 4) and feasibility (Chapters 5 and 6), knowledge and experiences from the learning network have been shared across the Netherlands. Examples of outputs partly resulting from the dissemination of findings in this dissertation include digital Q&A sessions, which served as a platform to address questions and share best practices with organisations interested in implementing reablement but uncertain about how to proceed. Conferences, such as the IZA conference 'Samen Werken aan Zorg en Welzijn', have provided opportunities to share insights with a broader audience, fostering dialogue and collaboration.

> *"We see reablement as a movement involving both professionals and older adults, it is part of the societal mission we have together. The core of our approach lies in fostering a mindset shift and driving a societal transition towards ensuring that access to care remains available for those who need it, despite the growing gap between care demand and care capacity."* (Programme director)

Care professionals

The scientific knowledge gained through this dissertation and the steps taken to implement reablement in the community care setting are both relevant and valuable to all care professionals involved in the care of older adults living at home. By establishing the definition in Chapter 4, this dissertation contributes to a shared understanding of reablement. This is crucial for consistency and coherence when implementing reablement across different care settings, helping care professionals in aligning their approach. The findings of this dissertation underscore the importance of interdisciplinary collaboration and goal-oriented care within reablement programmes.

> *"When setting goals, I am now much more intentional about ensuring they reflect the client's or their system's needs, rather than the goals I or other professionals have in mind. We no longer decide FOR the client, but WITH the client and their system."* (Occupational therapist)

This dissertation provides care professionals with practical guidance, such as the studies exploring the implementation in the I-MANAGE model in Chapters 5 and 6. These studies highlight key lessons, such as the importance of structured team meetings and fostering a

better understanding and recognition of each other's skills and expertise, which enhances collaboration and accessibility in community care, even beyond the reablement programme. Moreover, the findings were disseminated during a keynote presentation for the Dutch Association for Physiotherapists in Geriatrics (NVFG), at the annual symposium of the Living Lab on Ageing and Long-Term Care, the Geriatrics Days (Geriatriedagen), and in meetings with other long-term care organisations. These meetings included participants such as older adults and informal caregiver representatives, care professionals, nursing staff, and management teams. In addition, publications in professional journals such as a feature in the Dutch practice journal TvZ (Journal of Nursing)[9] and interviews in the Dutch Journal of Geriatric Physiotherapy (NTGF)[10] and in ActiZ's brochure on Prevention and Health[11] have further contributed to the dissemination of evidence-based knowledge to practitioners in the field. Additionally, an inspiration guide, currently under development, aims to offer practical tools and strategies to support the implementation of reablement practices.

> *"For me, reablement is of great value in the services we offer to the general practitioner, and ultimately to the client and their family, in situations where progress is stagnating." (Elderly care physician)*

Moreover, this dissertation inspires us to collaborate in a more goal-oriented manner, such as the best practices described in Chapter 3 emphasising the perceived benefits such as shared ownership within the team. By fostering a more coordinated, team-based approach, care professionals could potentially enhance the effectiveness of care delivery, improve outcomes for older adults, and ensure that the goals remain central throughout the care process. Opportunities have been created for care professionals to undergo training, equipping them with the necessary skills and competencies to enhance their practice and enable reablement implementation (Chapters 5 and 6).

> *"We often focus solely on the individual and forget to address the system, which is key to long-term sustainability. How often does someone rehabilitate well, only for the situation to worsen later because the system was overlooked?"* (Physiotherapist)

Older adults and informal caregivers

This dissertation also impacts older adults and informal caregivers regarding the possibility of providing a better quality of care and outcomes (Chapter 5). Through the reablement approach, care professionals engaged in more meaningful conversations with older adults, taking a deeper look at their wishes and needs (Chapters 3 and 5). Reablement enabled a shift towards person-centred, holistic care, focusing not only on disability, but rather on areas such as self-sufficiency, quality of life, and autonomy. This potentially helped create a more supportive system to enable older adults to remain at home, in line with their wishes and on their terms.

"I have taken control of my life again, and that feels great." (Participant in reablement)

Furthermore, informal caregivers, who are often overburdened and caught off guard by the demands of caring for their loved ones, have indicated they felt supported due to the reablement programme. For example, a key finding from the care organisation's evaluation of the pilot was that informal caregivers often reject support due to the overwhelming demands of caring for their loved ones. In response, the programme was revised to make caregiver support an active and proactive component, rather than offering it only upon the caregiver's request.

Education

This dissertation highlights the need for the integration of principles of reablement into both initial and continuing education for care professionals. By incorporating reablement principles (Chapter 4) into the curricula of healthcare programmes, future and current care professionals could be better equipped to apply these principles in their practice. This assists the shift from a 'doing for' to a 'doing with' approach and enables students to develop skills in effective team working, communication, and goal setting. Additionally, this dissertation highlights the importance of the role of (future) management in helping care professionals understand and navigate the current and future challenges within the healthcare system, making it crucial to equip managers with skills in areas such as change management and implementation. Furthermore, this dissertation encourages educational institutions to foster a deeper understanding of the role of informal caregivers, equipping care professionals to involve and support them proactively. Reablement has increasingly become a core topic in recent years

within the bachelor's (e.g., Health Sciences, Nursing, Physiotherapy, and Occupational Therapy) and master's (e.g., Health Policy, Innovation, and Management) programmes at Zuyd University of Applied Sciences and Maastricht University. Moreover, reablement research is a central component of the Living Lab in Ageing and Long-Term Care, which fosters ongoing collaboration with higher education (HBO) and vocational (MBO) institutions across Limburg. This dissertation contributes valuable knowledge to these efforts by providing insights from practice, such as the importance of adopting a broader perspective on care for individuals (looking beyond disability; Chapters 4, 5, and 6) and identifying the key components that determine the success of reablement (Chapter 2). The growing interest in the findings of reablement research, including the insights presented in this dissertation, is also evident in requests from various educational institutions, professional associations, and community-driven initiatives. Additionally, my recent part-time position at Zuyd University of Applied Sciences provides me with an opportunity to integrate this expertise into regular education and lifelong learning (LLO) – for example, for nursing and allied health professionals – further strengthening the connection between research, education, and practice.

Policy

The development of reablement in the Netherlands is closely aligned with advancements in national healthcare policy, such as IZA,[2] WOZO,[1] and GALA.[3] These policies have promoted a shift towards more preventive and person-centred care, with a focus on maintaining independence and quality of life – core principles that are also central to reablement. Research on reablement in the Netherlands, including the findings presented in this dissertation, has had a direct impact on both healthcare policy and practice. Reablement is increasingly recognised as a promising approach to support older adults in their pursuit of autonomy, well-being, and a meaningful quality of life. This is accompanied by ongoing discussions about what reablement entails, with the definition in Chapter 4 making a positive contribution by advancing the clarification of the concept. Moreover, the results of this dissertation underscore the need to integrate reablement into standard care structures and have highlighted several challenges related to organisation and funding. Addressing these issues requires among others, exploring sustainable, integrated funding to encourage interdisciplinary, cross-domain collaboration. This has resulted in active discussions with health insurers, alongside care organisations, municipalities, care offices, and national stakeholders, including VWS and NZa, to establish the necessary conditions (i.e., policies and funding mechanisms) to embed reablement successfully

into the healthcare system. Additionally, the knowledge acquired through this dissertation contributed to discussions at the V100 – an annual event by VWS that brings together 100 stakeholders to weigh in on policy questions and challenges in the healthcare sector. In a broader context, the efforts outlined in this dissertation have contributed to the ongoing shift towards the vision for healthcare that emphasises 'working and caring differently', aiming to foster a system focused on collaboration, prevention, and long-term sustainability rather than reactive, fragmented care.[1-3] Reablement contributes directly to this shift by focusing on individual and informal caregiver needs, encouraging self-management, and using interdisciplinary collaboration across health and social care to provide better support.

Scientific impact

The scientific impact of this dissertation lies in its comprehensive exploration of reablement practices both internationally and within the Netherlands. Internationally, this dissertation was disseminated through active participation within the ReAble Network,[12] including online meetings where the results were presented, as well as at international conferences such as the Nordic Congress of Gerontology (NKG). From 2025, I will further strengthen this role by representing the Netherlands as one of the international ReAble Network's coordinators, promoting the dissemination of Dutch insights and experiences, and encouraging cross-national learning. This dissertation identifies the key features and components of reablement that show promise (**Chapter 2**) and subsequently delves into specific elements to examine how they are applied in practice (**Chapter 3**). By doing so, this work contributes to unpacking the 'black box' of reablement and differences in reablement practices throughout the world. Furthermore, it provides valuable input for shaping reablement practices and research in the Netherlands and adds to the growing body of research on reablement in the Dutch context. The facilitators and barriers identified in **Chapters 5** and **6** offer guidance for future research, for example, by exploring how interdisciplinary collaboration can be strengthened or how enrolment strategies can be adapted to ensure reablement is introduced earlier in the care process. Such insights can advance the scientific understanding of the mechanisms underlying successful reablement implementation and contribute to the body of knowledge. Additionally, the Dutch definition of reablement proposed in **Chapter 4** guides both national and international research efforts. Internationally, the study methodology can contribute to the development of context-specific definitions of reablement tailored to the unique needs of

different healthcare systems. In the Dutch context, this definition provides a clear and consistent foundation, which can enhance the comparability of the findings across studies and contribute to a more robust evidence base. Future research could focus on its applicability when developing and evaluation reablement programmes. Finally, this dissertation highlights the importance of collaborating and involving stakeholders – including older adults, informal caregivers, care professionals, and policymakers – in research on reablement. Participatory research ensures that reablement interventions are contextually relevant and practically feasible and fosters a sense of ownership, which is crucial for their adoption and sustainability. By conducting practice-oriented research, this dissertation demonstrates the value of such an approach and shows how combining roles (dual roles) can create significant impact for both science and practice. For the further development of reablement in the Netherlands, participatory research is crucial: stakeholders need to be involved at an early stage to inform the design, implementation, and refinement of reablement practices. This approach will enhance the possibility of its successful and sustainable integration into care systems, ensuring it is both relevant and realistic within the specific context. A useful tool that can be used to gain insight and to reflect on stakeholders' roles and levels of participation is the stakeholder participation matrix (Figure 2). For example, this tool was used during the different stages of our feasibility study in **Chapter 5**. It helped us understand the roles of each stakeholder in different phases of the research and highlighted gaps where additional input from stakeholders could be sought. The matrix represents the five ascending levels of stakeholder participation, based on the participation ladder and theoretical thinking of Arnstein.[13]

Figure 2. Visualisation of the participation matrix used in the feasibility

Dissemination

The findings of this dissertation have contributed to international insights into reablement practices and have and will be used to guide discussions on the changes required for the operationalisation of reablement within the Dutch context. A key focus was on engaging and informing stakeholders involved in the care of older adults in the community, with the aim of

fostering greater awareness, support, and collaboration. The findings of this dissertation have been disseminated through a variety of channels targeting both academic and non-academic audiences, including conferences, meetings, and national and international publications. These efforts have included advisory roles for organisations seeking to implement reablement, as well as presentations at national and international conferences and in professional journals. Of the five articles in this dissertation, three were published in peer-reviewed international journals and the other two are currently under review. One of the articles was published in a special issue of *Scientific Reports* focused on the implementation of complex interventions. During the last five years, multiple poster presentations at national and international conferences further supported knowledge dissemination. For more detailed information about the publications and presentations delivered to various audiences, including care professionals, researchers, and policymakers, see the 'Publications' addendum.

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jaar plannen we een weekend weg met z'n twaalven, maar tijdens mijn promotietraject hebben jullie er flink werk van gemaakt om dat aantal bijna te verdubbelen. Dit jaar gaan we dus met z'n 21-en, en ik kijk er nu al naar uit! Dank voor de gezellige barbecues, borrel- en spelletjesavonden. In het bijzonder een dankjewel aan de dames voor de momenten van ontspanning zonder onze mannen – die zeker welkom waren, vooral wanneer het gesprek weer eens alleen over bouwmaterialen en -technieken ging ;)

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Papa en mama, waar moet ik beginnen, ik ben ontzettend dankbaar voor alles wat jullie voor mij hebben gedaan en nog steeds doen. Mama, ik vind het zo bijzonder dat wij alles kunnen delen en ook soms eng hoeveel ik op jou lijk. Dat is soms heel confronterend (als ik het zelf nog even niet wil in zien en jij mij allang doorzien hebt), maar ook heel fijn omdat we precies snappen wat de ander bedoeld. Ondanks dat de wetenschap voor jou een hele andere wereld is, snapte je heel goed waar ik onderzoek naar deed en konden we daar inhoudelijk vaak over praten omdat het onderwerp zo dicht bij jullie staat. Onze (bijna) wekelijkse FaceTime koffies en kooksessies hebben me er doorheen gesleept. Papa, dat olifantengeheugen en aandacht voor detail heb ik van jou. Door jouw werk op de universiteit had je een goed beeld bij wat ik deed en snapte je de hindernissen die daarin soms voorbijkomen. Fijn is het om samen met jou 's avonds laat een doorzakkertje te doen op de bank, waarbij we soms tot diep in de nacht kunnen kletsen. Maar ook dat als ik midden op de dag een vraag heb (maakt niet uit over wat) jij bereikbaar bent en mij indien nodig voorziet van berichten of mails met alle informatie die ik zocht. Dankjulliewel dat ik altijd kan aanschuiven voor het eten en er een logeerbed klaarstaat, maar nog het meeste dat jullie me altijd gesteund hebben in mijn keuzes en daarin ook mijn klankbord zijn.

En dan mijn lieve viervoeter Alfie – Alf, Alfinator, muppet, makker, boefje. Natuurlijk verdien jij een plek in dit dankwoord. Halverwege mijn promotietraject kwam jij bij ons wonen, een eigenwijze pluizenbol van vijf maanden oud. Vanaf dat moment was geen online meeting meer hetzelfde—mijn collega's hebben volop kunnen meegenieten van jouw spontane verschijningen in beeld en je onnavolgbare lighoudingen. Ik durf met zekerheid te stellen dat jij een belangrijke rol hebt gespeeld in mijn werk-privébalans. Onze trainingen, wandelingen en stoei- en knuffelsessies hielpen mij om écht af te schakelen. En hoewel ik je soms nog steeds achter het behang zou willen plakken, ben ik je dankbaar voor je onvoorwaardelijke liefde, je speelse afleiding en de ontspanning die je me dagelijks brengt.

Lieve Rik, muppie, mijn letterlijke partner in crime, mijn mede-Brabander, mijn alleskunner — in deze metafoor ben jij misschien wel zowel de aannemer als alle werklui onder hem. Ik zou

echt niet weten hoe ik dit promotietraject was doorgekomen zonder jou. Vlak voor ik begon, kochten wij ons eerste klushuis – niet wetende dat we er zoveel plezier zouden dat we na vier jaar besloten dat het tijd was voor een nieuw project. Na bijna 12 jaar samen en twee verbouwprojecten kan ik vol overtuiging zeggen: jij bent mijn stabiele basis, mijn houvast en degene die me in balans houdt. Jij voelt mij feilloos aan en weet soms (oké misschien vaak) beter dan ikzelf wat ik nodig heb – behalve wanneer je zelf ook hangry bent. Je geeft me ruimte om te groeien en dromen, maar weet me ook met beiden voeten op de grond te houden. Waar ik het even niet voor elkaar kreeg om 'projectleider' thuis te zijn pakte jij dit op. Samen reizen we heel wat af, het liefst richting de bergen en naar plekken waar goed eten nooit ver te zoeken is. Je blijft me verrassen, want wie had gedacht dat we nu een paar keer per week om 7 uur 's ochtends gaan sporten? Dank je wel voor alles. Op naar nog veel meer mooie projecten—zowel in huis als in het leven, met jou is geen uitdaging te groot. Maar laten we die badkamer (en daarmee mijn bad) snel fixen, oké?

About the author

Lise Elisabeth Buma was born on May 1, 1990, in Geldrop. In 2008 she received her high school diploma (Atheneum) at Christiaan Huygens College in Eindhoven. Lise continued her education at Zuyd University of Applied Sciences in Heerlen, initially studying Occupational Therapy for a year before switching to Physiotherapy. She completed her bachelor's degree in Physiotherapy in 2012. Since 2013, she has worked as a physiotherapist at Cicero Zorggroep, a care organisation for older adults, while also gaining experience in a primary care practice in two years. Since 2013, she has advanced her physiotherapy expertise, specialising as a geriatric physiotherapist through a master's programme in Geriatric Physiotherapy, while also gaining additional qualifications as a lymphoedema and shoulder physiotherapist. She has experience in long-term care, geriatric rehabilitation, and primary care. Driven by her passion and affinity for complex cases, she has collaborated with geriatric specialists and other therapists to consult general practitioners on challenging cases through geriatric assessments.

This collaboration inspired Lise to start her PhD in 2020 at the department of Health Services Research within the Living Lab in Ageing and Long-Term Care, alongside her physiotherapy work. Her research focused on exploring key features of reablement practices worldwide and to apply these insights to help define, implement, and evaluate reablement in the Dutch context. She shared her findings at national and international conferences and contributed to education within bachelor's (Health Sciences) and master's (Health Policy, Innovation and Management) programmes as a tutor, trainer, and thesis supervisor. She also gave lectures on reablement, falls and sarcopenia in older adults to trainee specialists in geriatric as well as rehabilitation medicine. In 2023, Lise became a project leader in Innovation and Organisational development at Cicero Zorggroep. In this role, she has various projects on reablement and community care, including a ZonMw-funded reablement project, to which she contributed in the proposal development. She is currently a member of the related knowledge and learning network on reablement, led by the Living Lab. Lise's commitment to advancing reablement extended to the international stage when she joined the ReAble network in 2020. As of 2025, she represents the Netherlands as one of the network's coordinators and continues her work on reablement as a postdoctoral researcher and practice-based Linking Pin within the Living Lab at the Department of Health Services Research, in partnership with Zuyd University of Applied Sciences, combined with her role as project leader at Cicero Zorggroep.

List of publications

International scientific journals

Mouchaers, I., **Buma, L.E.**, Verbeek, H., Zwakhalen, S., van Haastregt, J. C. M., Vlaeyen, E., Goderis, G., & Metzelthin, S. F. (2024). A qualitative exploration of professionals' perspectives on the implementation of reablement programs in community care. Scientific Reports, 14(1): 11391.

Buma, L.E., Tuntland, H., Parsons, M., Zwakhalen, S., Metzelthin, S.F. (2024). Exploring Goal-Setting and Achievement Within Reablement: A Comparative Case Study of Three Countries. Journal of Multidisciplinary Healthcare. Volume 17:1203-1218.

Buma, L.E., Vluggen, S., Zwakhalen, S. Kempen, G. I. J. M., Metzelthin, S.F. (2022). Effects on clients' daily functioning and common features of reablement interventions: a systematic literature review. European Journal of Ageing. 19(4):903-929.

National scientific journals

Metzelthin, S.F., **Buma, L.E.**, Vluggen, S., Satink, T., Zwakhalen S.M.G. (2024). Innovatieve benadering ouderenzorg. TVZ - Verpleegkunde in praktijk en wetenschap. 134(6):16-18.

Conference contributions

Buma, L.E., Mouchaers, I., Metzelthin, S.F., (2024, 4 October). Reablement kansen en uitdagingen. 17e Nationaal Gerontologiecongres 'Samen Ouder Worden: Een Inclusieve Toekomst', NVG-Knows, 's-Hertogenbosch, the Netherlands [workshop]

Buma, L.E., Tuntland, H., Parsons, M., Zwakhalen, S., Metzelthin, S.F. (2024, 12-14 June). Exploring Goal-Setting and Achievement Within Reablement. A Comparative Case Study of Three Countries. 27th Nordic Congress of Gerontology 2024, Stockholm, Sweden [oral presentation]

Buma, L.E., Mouchaers, I., Verbeek, H., Zwakhalen, S., van Haastregt, J. C. M., Vlaeyen, E., Goderis, G., & Metzelthin, S. F. (2024, 8-9 February). Reablement implementeren in de eerste lijn, hoe doen we dat? Een studie naar ervaringen van professionals. Geriatriedagen 2024, 's Hertogenbosch, the Netherlands [oral presentation]

Buma, L.E., Tuntland, H., Parsons, M., Zwakhalen, S., Metzelthin, S.F. (2023, 8 – 12 November). Goal-setting, a key mechanism in reablement programs. The Gerontological Society of America's 2023 Annual Scientific Meeting, Tampa, USA [poster presentation]

Buma, L.E. Reablement: Waar hebben we het over? (2023, 29 September) Jaarcongres Nederlandse Vereniging voor Geriatriefysiotherapie, Utrecht, the Netherlands [key note presentation]

Buma, L.E., Tuntland, H., Parsons, M., Zwakhalen, S., Metzelthin, S.F. (2023, 7 June). An international perspective on goal setting and interdisciplinary collaboration within reablement programmes: a qualitative study. CAPHRI Research Day, Valkenburg, the Netherlands [poster presentation]

Buma, L.E., Vluggen, S., Zwakhalen, S. Kempen, G. I. J. M., Metzelthin, S.F. (2022, 8 – 10 June) Effects on clients' daily functioning and common features of reablement interventions: a systematic literature review. 26th Nordic Congress of Gerontology 2022, Odense, Denmark [oral presentation]

Buma, L.E., Vluggen, S., Zwakhalen, S. Kempen, G. I. J. M., Metzelthin, S.F. (2022, 10 – 11 February) Effect op het dagelijks functioneren van cliënten en meest voorkomende elementen van reablement programma's: een systematisch literatuuronderzoek. Geriatriedagen 2022, the Netherlands (online) [oral presentation]

Buma, L.E., Tuntland, H., Parsons, M., Zwakhalen, S., Metzelthin, S.F. (2021, 10 – 13 November). Effects on clients' daily functioning and common features of reablement interventions: a systematic literature review. The Gerontological Society of America's 2021 Annual Scientific Meeting, Phoenix, USA (online) [oral presentation]

Other presentations

Reablement van zelf doen naar meedoen. Presented at Themabijeenkomst 'Zelfredzaam Thuis Wonen in Meerssen' organised by Zuyd University of Applied Sciences, 3 October 2024, Meerssen, the Netherlands.

A qualitative exploration of professionals' perspectives on the implementation of reablement intervention programs in community care. Presented at the ReAble Network webinar, 1 October 2024 (online).

Reablement in de praktijk: Van onderzoek naar implementatie. Workshop presented at 'Academische Werkplaats Ouderenzorg Limburg'-symposium, 20 June 2024, Venlo, the Netherlands.

Aan de slag met reablement. Workshop presented at 'Senioren sterker maken'-symposium, 20 April 2023, Rotterdam, the Netherlands.

Reablement combining research with practice. Presented at the work visit of Canadian researchers to AWO-L partner Cicero Zorggroep, 7 June 2023, Amstenrade, the Netherlands

Effects on clients' daily functioning and common features of reablement interventions: a systematic literature review. Presented at the ReAble Network webinar, 9 May 2022 (online).

Diverse guest lectures on reablement for diverse audiences, including dementia care case managers, the GP network Meditta, and training programmes for physicians.

Living Lab in Ageing and Long-Term Care

Living Lab in Ageing and Long-Term Care

This thesis is part of the Living Lab in Ageing and Long-Term Care, a formal and structural multidisciplinary network consisting of Maastricht University, nine long-term care organizations (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Intermediate Vocational Training Institutes Gilde and VISTA college and Zuyd University of Applied Sciences, all located in the southern part of the Netherlands. In the Living lab, we aim to improve quality of care and life for older people and quality of work for staff employed in long-term care via a structural multidisciplinary collaboration between research, policy, education and practice. Practitioners (such as nurses, physicians, psychologists, physio- and occupational therapists), work together with managers, researchers, students, teachers, and older people themselves to develop and test innovations in long-term care.

Academische Werkplaats Ouderenzorg Limburg

Dit proefschrift is onderdeel van de Academische Werkplaats Ouderenzorg Limburg, een structureel, multidisciplinair samenwerkingsverband tussen de Universiteit Maastricht, negen zorgorganisaties (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Gilde Zorgcollege, VISTA college en Zuyd Hogeschool. In de werkplaats, draait het om het verbeteren van de kwaliteit van leven en zorg voor ouderen en de kwaliteit van werk voor iedereen die in de ouderenzorg werkt. Zorgverleners (zoals verpleegkundigen, verzorgenden, artsen, psychologen, fysio- en ergotherapeuten), beleidsmakers, onderzoekers, studenten en ouderen zelf wisselen kennis en ervaring uit. Daarnaast evalueren we vernieuwingen in de dagelijkse zorg. Praktijk, beleid, onderzoek en onderwijs gaan hierbij hand in hand.

PhD-theses Living lab in Ageing and Long-Term Care

Proefschriften Academische Werkplaats Ouderenzorg Limburg

Lise Buma. Reablement and the philosophy's goal. Paving the way for reablement in the Netherlands using global insights. 2025

Niklaus S. Bernet. Fair and meaningful comparison of inpatient fall rates in acute care hospitals. 2025

Caroline Gurtner. Exploring Shared Decision Making in Swiss Acute Psychiatric Care. 2025

Coen Hacking. AI in Nursing Homes. Utilizing artificial intelligence to enhance data-analysis in long-term care for older adults. 2025

Merel van Lierop. Keep on learning! Fostering continuous learning and improvement in long-term nursing care. 2025

Johanna Rutten. Are we walking or just talking? Enhancing relationship-centered care in nursing homes. 2024

Anne G.R. Visser. Deprescribing in Nursing Home Residents: when less is more? 2024

Ines Mouchaers. Managing Everyday Life: Exploring the Essential Components of Reablement and User Experience. 2024

Lindsay Groenvynck. The transition from home to a nursing home: The perspectives and experiences of older people with dementia, informal caregivers and professional caregivers. 2024

Svenja Cremer. Undervalued & Unexplored. Underpinning and Guiding Nursing Care in Activities of Daily Living. 2024.

Katinka Pani – Harreman. The place to be. Guiding the activation of a community to facilitate ageing in place. 2024.

Vincent Moermans. Struggling with Daily Care Dilemmas. Insights in Involuntary Treatment Use among Persons Living with Dementia Receiving Professional Home Care. 2023

Chandni Khemai. There is an I in WE. Collaborative Awareness in the dedicated palliative care approach for persons with dementia. 2023.

Amal Fakha. Improving the implementation of transitional care innovations. 2023

Tom Vluggen. Towards improved multidisciplinary stroke care for older people: assessing feasibility and effectiveness of an integrated multidisciplinary geriatric rehabilitation programme for older stroke patients. 2023

Priscilla Attafuah. Quality of life, health, and social needs of slum-dwelling older adults in Ghana. 2023

Ron Warnier. Frailty screening in older hospitalized patients. 2023

Megan Davies. Tri-national ethnographic multi-case study of person-centred care and quality of life in long-term residential care. 2023

Christoph Golz. Technostress among health professionals: The blame game between health professionals and technology. 2023

Simone Paulis. Dehydration in the nursing home. Research into the prevalence, risk factors, diagnosis, roles and current collaboration between (in)formal caregivers and nursing home residents. 2023.

Sheizi Sari. Pressure injuries in Indonesian community-dwelling older adults: prevalence, prevention and treatment by the (in)formal support system. 2022.

Teuni Rooijackers. Supporting older adults to STAY ACTIVE AT HOME. Process, effect and economic evaluation of a reablement training program for homecare staff. 2022

Anne van den Bulck. Differences that matter: Understanding case-mix and quality for prospective payment of home care. 2022

Marlot Kruisbrink. Towards enhanced management of fear of falling in older people. Unravelling interventions and measuring related avoidance of activity. 2022

Ruth Vogel. Nurses in the Lead: empowering community nurse leaders to implement evidence into practice. 2022

Fabian Groven. The bed bath with or without water? It's a wash! Experiences with the washing without water intervention used for the bed bath. 2021

Roy Haex. Take a look through my eyes: The development of an experienced quality measure with clients, informal, and formal caregivers in Dutch home care. 2021

Sascha Bolt. The fundamentals of a DEDICATED palliative approach to care for people with dementia. 2021

Angela Mengelers. To risk or to restrain? Involuntary treatment use in people with dementia living at home. 2021

Katya Sion. Connecting Conversations. Experienced quality of care from the resident's perspective: a narrative method for nursing homes. 2021

Linda Hoek. Change begins with choice. Supporting the autonomy of nursing home residents with dementia through partnership. 2020

Mirre den Ouden. Every step counts. Daily activities of nursing home residents and the role of nursing staff. 2018

Theresa Thoma-Lürken. Innovating long-term care for older people. Development and evaluation of a decision support app for formal caregivers in community-based dementia care. 2018

Eveline van Velthuijsen. Caring about confusion: on the daily practice of diagnosis and management of delirium in older hospitalised patients. 2018

Bram de Boer. Living at a green care farm. An innovative alternative for regular care in nursing homes for people with dementia. 2017

Nienke Kuk. Moving forward in nursing home practice. Supporting nursing staff in implementing innovations. 2017

Irma Everink. Geriatric rehabilitation. Development, implementation and evaluation of an integrated care pathway for older patients with complex health problems. 2017

Ramona Backhaus. Thinking beyond numbers. Nursing staff and quality of care in nursing homes. 2017

Martin Van Leen. Prevention of pressure ulcers in nursing homes, a big challenge. 2017

Mariëlle Daamen-Van der Velden. Heart failure in nursing home residents. Prevalence, diagnosis and treatment. 2016

Armand Rondas. Prevalence and assessment of (infected) chronic wounds. 2016

Hanneke Beerens. Adding life to years. Quality of life of people with dementia receiving long-term care. 2016 (Cum Laude)

Donja M. Mijnarends. Sarcopenia: a rising geriatric giant. Health and economic outcomes of community-dwelling older adults with sarcopenia. 2016

Tanja Dorresteijn. A home-based program to manage concerns about falls. Feasibility, effects and costs of a cognitive behavioral approach in community-dwelling, frail older people. 2016

Basema Afram. From home towards the nursing home in dementia. Informal caregivers' perspectives on why admission happens and what they need. 2015

Noemi C. Van Nie-Visser. Malnutrition in nursing home residents in the Netherlands, Germany and Austria. Exploring and comparing influencing factors. 2014

Silke F. Metzelthin. An interdisciplinary primary care approach for frail older people. Feasability, effects and costs. 2014

Jill A.P.M. Bindels. Caring for community-dwelling frail older people: a responsive evaluation. 2014

Esther Meesterberends. Pressure ulcer care in the Netherlands versus Germany 0-1. What makes the difference? 2013

Math J.M. Gulpers. EXBELT: expelling belt restraints from psychogeriatric nursing homes. 2013

Hilde Verbeek. Redesigning dementia care. An evaluation of small-scale homelike care environments. 2011

Judith M.M. Meijers. Awareness of malnutrition in health care, the Dutch perspective. 2009

Ans I.E. Bouman. A home visiting program for older people with poor health. 2008

Monique Du Moulin. Urinary incontinence in primary care, diagnosis and interventions. 2008

Anna Huizing. Towards restraint free care for psychogeriatric nursing home residents. 2008

Pascalle Van Bilsen. Care for the elderly, an exploration of perceived needs, demands and service use. 2007

Rixt Zijlstra. Managing concerns about falls. Fear of falling and avoidance of activity in older people. 2007

Sandra Zwakhalen. Pain assessment in nursing home residents with dementia. 2007