The home care reablement study: A mixed methods study.

PhD thesis, University of Nottingham.

By

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Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy.

I. Abstract

Background

In England in 2021/22, there were 818,000 people who received funded long-term social care support, primarily in residential, nursing homes, or in their own homes. In addition, there were 224,000 episodes of short-term care provided. Reablement is a short-term service mostly provided in the person's home to help them become independent in activities of daily living and reduce dependency. Traditionally, home carers are trained to 'do things' for people, whereas reablement services aim to get people to engage in activities for themselves.

ACT reablement is a programme especially developed by social care occupational therapists to train independent sector home carers to deliver reablement. ACT (adult care training) involves training reablement competency through action learning sets, ongoing reflective case work discussion, and proactive, responsive occupational therapy solutions.

The underpinning philosophical positions developed in this thesis were aligned to the critical realism philosophical perspective, strength-based approach, positive psychology theory and occupational science.

The aim of the studies in this thesis were to define reablement, investigate reablement outcomes, understand home carers' experiences of reablement, to define ACT, evaluate and refine its delivery and to provide recommendations for future research.

Ethical approval was given by the Nottingham University Research Ethics Committee reference FMHS-261-0521.

Methods

A scoping literature review was completed to explore and define reablement. A systematic literature review of randomised controlled trials (RCTs) was completed to determine the effectiveness of reablement.

A before and after study of ACT was completed. The ACT training was defined and refined using the literature review findings, and training resources were co-designed by an expert group. Home carers were recruited from one home-based care provider. Data was collected from 22 home carers using a before and after training survey, with missing data for 1 participant. Post-training interviews, and focus groups, were completed with a subset of 14 participants.

Survey data was analysed using descriptive statistics and results presented as median average with interquartile range, and proportion of grouped positive or negative responses. The transcribed semi-structured interview and focus group data were coded using a two-step coding method and thematically analysed using Framework Analysis. The survey, interview and focus group data was synthesised using a mixed methods convergent design. This enabled a collaborative cycle of improvement to refine the ACT programme.

Results

The scoping review sourced 42 studies from 11 countries spread over 10 years. The results highlighted that reablement interventions varied in content, aim, duration, and service delivery model. Few studies reported on whether reablement interventions changed people's behaviour or outcomes, worker training, staff competencies, or professional support.

The systematic review found eight RCTs, with 1,777 participants, from six countries between 2012 – 2021 with diversity in interventions. Outcome measures featured change in home care hours, functional ability, mobility, and quality of life. Studies with an occupational therapist involvement showed greater, but non-statistical, improvement in outcomes.

The pre-and post training survey was completed by 21 (95.5%) home carers, 19 (86.5%) were female with an average age between 35-44 years; 19 (86.5%) identified as belonging to white ethnicity, and 2 (9%) as belonging to a black, asian or minority ethnic group; 13 (59%) had more than 11 years experience as a home carer.

Before training, 9 (41%) of the home carers were clear about the difference between reablement and standard home care. Whereas after, this increased to 21 (95.5%). Before training, 6 (28%) found it difficult to engage people in reablement goal attainment conversations, after training 21 (95.5%) indicated they were happy about having these conversations. Before training, 10 (45%) found motivating people difficult, and after training 21 (95.5%) said they had no difficulty in motivating people. Before training, 11 (50%) were confident identifying improvements in people and after training this had risen to 21 (95.5%). Finally, before training, 16 (73%) were confident feeding back to the occupational therapist and after training 21 (95.5%) were confident. After the training, 14 (63%) of the home carers participated in interviews two months later, or attended focus groups the same day. Two themes emerged.

1. The home carers experience of reablement – the home carer`s believed that people associated home care with having things done for them, including housework. They frequently found family expectations were challenging when relatives had a different mindset or opinion. They felt this led to dissatisfaction, power imbalance and conflict for home carers and the people. They found it difficult to recognise a person’s capability for improvement or judge whether people could progress due to being sent to different people each day. They were perplexed when the person had achieved a level of independence and then the care package was not reduced. Some home carer`s felt that the time needed to deliver reablement was justified, whereas others felt it was better to help the person and have a shorter visit.
2. Knowledge and skills – some of the home carer`s were confident and positively articulated their knowledge and use of reablement, whereas others were uncomfortable about doing this. Most were able to describe the key elements of reablement and were happy to take responsibility for managing risk and make autonomous decisions. A few home carer`s expressed dissatisfaction that reablement was designed to only reduce costs and not improve lives.

> Contrasting views and attitudes emerged about doing things for people. There was a lack of understanding from most of the home carer`s about the use of equipment.

The interview and focus group findings confirmed that ACT training was acceptable, had fidelity and was feasible to deliver in other settings. The home carer`s preferred an interactive face-to-face, discussion-based learning style. As a result, ACT was refined to one five-hour, face-to-face session incorporating action learning sets, strength-based competency training, goal setting, activity analysis, pacing activities and reflective case discussions with an occupational therapist.

Conclusions

Reablement is a complex intervention, poorly defined and delivered by a range of health and social care workers. Training is variable and rarely evaluated. These findings are in line with other research studies.

This study provides evidence that ACT can be delivered and is acceptable to independent sector home care workers. It has been proven to positively change the mindset of home carers, but we do not know if this influenced their behaviour long-term, and whether this has an impact on the well-being of the person who needs care. Home carers are ready to be involved in research this is one of very few studies that has heard their voice. More research is needed with this under served community.

Relevance to patients/public, other scientists

Independent sector home carers need to be trained to deliver reablement. By defining the ACT programme, and determining it`s feasibility and fidelity it is possible to evaluate it further for delivery to other home care providers.

II. Acknowledgements

I would like to extend my gratitude to the home carer`s who participated in this research without whom this study would not have been possible. Marion Wardell gets a special mention for her contribution as the PPI representative, her experience and insight was invaluable.

My academic supervisors Professor Pip Logan and Dr. Frances Allen have been truly amazing, their experience, attention to detail, kindness, humour and has got me through this study. I cant thank them enough for believing in my work, and encouraging me to write about it.

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III. Statement from funder

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IV. Associated publications and dissemination

Published work.

Bennett, C. and Hodge, S. (2021) 'A systematic review of the effectiveness of occupational therapy interventions delivered in reablement homecare: A protocol' Available at: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021237209

Bennett, C., Allen, F., Hodge, S., & Logan, P. (2022). 'An investigation of Reablement or restorative homecare interventions and outcome effects: A systematic review of randomised control trials.' *Health & Social Care in the Community*, 30(6), e6586 – e6600. Available at: https://doi.org/10.1111/hsc.14108

Bennett, C. (2022) 'Finding new ways to deliver services.', *OTNews,* (Dec 22), pp. 30-31. Available at: https://www.rcot.co.uk/news/otnews

Bennett, C. (2023a) 'The main features of Reablement delivered in a community setting: A Scoping Review Protocol'. Available at: https://osf.io/e5mqd/

Bennett, C. and Mottram, A. (2023) 'Research priority 6: How can occupational therapy services be more inclusive of mental and physical health?', *British Journal of Occupational Therapy*, 0 (0) pp. 1-3. DOI: 10.1177/03080226231197307. Available at: https://journals.sagepub.com/doi/epub/10.1177/03080226231197307

Bennett, C (2023b) 'How do we develop our career in social care in England?' OTnews, March 23. 36-37. Available at: https://www.rcot.co.uk/news/otnews

Presentations

University of Nottingham Presentation at UNICAS sand pit event Feb 23

University of Nottingham Presentation at Sue Watson event April 23

University of Nottingham presentations at postgraduate research impact events

Royal College of Occupational Therapists conference presentation 14.06.23

Posters presentations

Nottinghamshire Integrated Care System 05.07.23

University of Nottingham research impact forum 15.09.23

NIHR conference 10.10.23

V. Table of abbreviations

NIHR	National Institute if health and care research
ARC	Applied Research Collaborative
DHSC	Department of Health and Social Care
UK	United Kingdom
OT	Occupational Therapist
CQC	Care Quality Commission
CPA	Care Provider Alliance
CPD	Continuous Professional Development
PIS	Participant Information Sheet (PIS)
NCC	Nottinghamshire County Council
NCOA	National Council of Ageing
SCIE	Social Care Institute of Excellence
RCOT	Royal College of Occupational Therapists
NHS	National Health Service
NIC	National Insurance Contributions
LGA	Local Government Associations
TLAP	Thinking Local Acting Personal
WFOT	World Federation of Occupational Therapists
RCT	Randomised Control Trial
ADL	Activities of Daily Living
CASP	Critical Appraisal Skills Programme
NEADL	Nottingham Extended Activities of Daily Living
COREC	Consolidated criteria for reporting qualitative research tool
JSNA	Joint Strategic Needs Assessment
COPM	Canadian Outcome Performance Measure
WONCA	World Organization of Family Doctors (WONCA) European Research Group
PDSA	Plan Do Study Act

VI. Thesis plan

1

- Introduction: the context of reablement, why this study is needed, the strength-based, person-centred philosophical stance, and researcher reflexive lens

2

- Scoping literature review: defining reablement interventions, nature and characteristics.

3

- Systematic review of RCTs: invesigating the effectiveness of reablement intervenions and outcomes

4

- Research methodology and methods: Research study design, data collection, data management, coding methods, synthesis methods, strengths and weakness of methodology.

5

- The ACT intervention: Historical context and description of ACT training, complex intervention and logic model, organising and delivering the sessions.

6

- Analysis and findings: Evaluation of the acceptability of the ACT intervention, using data collected from a before and after training survey, semi-structured interviews and focus groups.

7

- Analysis and findings: home carers experience of reablement, and the knowledege and skills they use, gathered from semi structured interviews and focus groups.

8

- Analysis and findings: Home carers learning, using acyle of improvement to refine training, an alternative data driven logic model, and recommendations for change locally and nationally.

9

- Discussion: Summary, recommendations and conclusions, links back to introduction and literature review, and results from chapter 5, 6, and 7.

10

- Appendices

11

- References

VII. Index of tables

VIII. Index of figures

IX. Contents.

Chapter 1. Introducing the concept of reablement.

1.1 Background context.

According to the Department of Health and Social Care (DHSC), the core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life (Department of Health and Social Care, 2023a). This can be in the form of personal and practical care and support that people may need because of their age, illness, cognition, disability, or other circumstances and includes support for family members or other unpaid carers. The term`s, person, or people, referred to in this thesis, represent the recipient of the service, patient, or client as the language is more strength-based.

People can fund their home care privately, or request adult social care funding based on assessed need and a financial means test. As a result, a persons' home care is either provided in-house (state run) by adult social care services, by the independent home-based care sector, and / or by family and friends.

Nationally, workforce demographics indicate that there is a deficit in community home care capacity, with an estimated 29% annual turnover (Skills for Care, 2022). Organisational constraints have been identified to cause unhealthy work conditions due to shift work, time pressure and staffing challenges impacting on worker wellbeing (Grasmo, Liaset and Redzovic, 2021). The stable part of the caring workforce are women aged 40 to 60 whose children have become independent (Skills for Care, 2022). Employment as a home carer is not well-paid, terms and conditions are unattractive, and carers report feeling undervalued (Unison, 2023). Significant workforce reform is required. Training and investment in home care as a career are proposed solutions to address the shortfall in home care capacity (Department of Health and Social Care, 2021).

Independent home-based care providers are regulated by the care quality commission (CQC) (CQC, 2023). Home carers must complete the Care Certificate – a 15-module programme – to work independently or have started it and be working under direct supervision. This can be delivered by the home care provider or commissioned (Argyle *et al.*, 2017);(Skills for Care, 2023a). There are also level, 2, 3 and 4 adult care worker apprenticeships available if employers choose to procure them (Institute for Apprentices, 2023).

Training within the independent home-based care sector varies widely (Dibsdall, 2021). Often nurse-led, focusing on delivery of personal care, it is not clear whether the independent home-based care providers, personal assistants, and indeed family members taking on an unpaid carer role, have benefited from policy drivers designed to empower carers to "enable" rather than provide "care". This enabling is known in the sector as reablement, and Table 1 shows this difference between reablement and standard homecare. There is a risk that carers who aren't trained in reablement can inadvertently create dependency by doing things for a person believing they are helping them.

The research in this thesis is specifically interested in reablement from the perspective of home carers who work in the independent home-based care sector with the view to influencing reablement training, to improve service delivery, and to give better outcomes for people.

This chapter will provide a background to the concept of reablement, considered from a UK and international perspective, along with the political and policy drivers influencing social care in England. It will also investigate the philosophies underpinning the thesis and will end with the purpose of the primary research.

1.1.1 Reablement.

Reablement is restorative home care supporting individuals physically, socially, and psychologically to regain the health, skills and independence required for daily living (Clotworthy, Kusumastuti and Westendorp, 2021). It is valued for its potential to decrease demand for home care (Cochrane *et al.*, 2016), facilitate hospital discharge processes (Slater and Hasson, 2018), improve peoples outcomes (Tuntland *et al.*, 2017), and is cost effectiveness (Francis, Fisher and Rutter, 2011); (Kjerstad and Tuntland, 2016). Furthermore, economic modelling by Bauer *et al.* (2019) indicated a 94.5% probability that reablement costs less than standard home care.

People who benefit most from reablement have mild or moderate frailties, or live alone (Lewin *et al.*, 2013). Furthermore, reablement has been shown to have no impact on the burden of informal care givers, compared to standard care (Senior *et al.*, 2014). The ethos of reablement is that the carer works `with’ the person to achieve goals, rather than doing the activity `for’ the person (Metzelthin *et al.*, 2020). The differences between reablement and standard home care can be seen in Table 1. According to Social Care Institute of Excellence (SCIE) the ideal reablement harnesses strengths, with meaningful and achievable goals, focusing on what matters to the person (SCIE, 2020). Doh, Smith and Gevers (2020) argue it should also feature a high functional and social connectivity focus.

Table 1 The difference between reablement and standard homecare

Reablement	Standard homecare
Activities are done with the person	Activities done for the person
Practice components, tasks, or activities	Person is passive, looked after
Person has choice and control	Person has less choice and control
Risk enablement	Risk adverse
Confidence building	Safety and comfort

There has been a mixed understanding of reablement since its beginnings and a lack of clarity as to whether it is an intervention, concept, or framework. Grey literature and opinion articles put forward useful descriptors, Aspinal *et al.* (2016) identified that labelling a service “reablement” does not always deliver the aim, interventions or outcomes of reablement to “help older people to retain, regain or gain skills so that they can manage everyday living skills as independently as possible.” (Aspinal *et al.*, 2016 p.574).

Reablement has been a consistent service offer provided by Local Authorities in England, as part of their social care services for the past 15 years or more; some operate with integrated occupational therapy and others use a direct care model

(Beresford *et al.*, 2019b). Local Authorities in England can commission independent home-based care to provide a "reablement focused" service. According to Beresford *et al.* (2019b), 14% of English reablement services were provided by the independent care sector, whereas Local Authorities delivered 53% and of these 17% included occupational therapists. This means service delivery models vary depending on service capacity, demand, and organisational constructs, making it unclear which regulated health and social care professionals are best positioned to give improved outcome for recipients.

The academic literature is also unclear on the specific professional roles involved in reablement (Pettersson and Iwarsson, 2017); (Metzelthin *et al.*, 2020). Magne and Vik (2020) queried whether services models are characterised by population health demand or organisational resources. Inconsistencies in service delivery could pose a risk of health inequalities, created because people receive a different service provision, leading to a better or worse prevention offer or outcome. This risk could be further exacerbated if home carers lack the training, knowledge and skills to deliver reablement.

Changes to NHS discharge guidance over the past four years, with the introduction of the 'home first' approach, cement the need for integrated therapy-led preventative services (NHS England, 2024d). Therapy-led interventions are a unique and vital way of meeting people's needs that deliver sustainable and cost-effective outcomes. Occupational therapists are trained to analysis the relationship between the person, their environment, and the activity the person is doing, and they work with the person on goals to improve volition, change behaviour or to remove environmental barriers to optimise independence. When working in this way, the occupational therapist is also influencing the informal and employed carers to enable them to better support the person to do more for themselves. The most successful reablement according to (SCIE, 2020), has occupational therapy input. Although, the Royal College of Occupational Therapists (RCOT) argue that occupational therapist`s are best placed to deliver the most specialist and complex reablement interventions, supervise or train others, due to the scope of their professional training (RCOT, 2019).

It is a statutory requirement for adult social care in England to provide prevention services under the Care Act, and occupational therapists are generally considered best placed in these services. Where services are commissioned from the independent sector there is a risk that reablement outcomes won`t be optimised without specific guidance and collaboration with regulated professionals.

In the independent home care sector, the responsibility for training, competency, and supervision of home carers is with the provider but who does this role varies depending on the organisation providing the service. Quality assurance of practice is inspected by CQC regulators because the outcomes for people can be affected by the quality of the training and supervision of staff.

Defining the optimum professional, or mix of professionals, to train home carers competency on reablement interventions requires more in depth investigation.

A scoping review is required to define the nature of reablement interventions, and to determine how home carers, or reablement workers, learn the skills to deliver reablement interventions. Furthermore, a systematic review of randomised control trials is required to investigate the effectiveness of those reablement interventions, outcomes, who delivers them and when, to give insight to which professional role, or combination of roles can influence better reablement outcomes, and where they might be positioned to optimise the service delivery.

1.1.2 Social care in England: political context and drivers for change.

The Kings Fund (2023) describe the legislative history of social care to begin with the National Assistance Act 1948. The Act established the National Health Service (NHS), the welfare state, and social care services organised through local authorities subject to means tested charges for residential and non-residential services (*The National Assistance Act*, 1948). Next, the Health Services and Public Health Act 1968, allowed social services to provide preventative interventions, such as: home adaptations, recreational activities, meal services and social care services for older people (*The Health Services and Public Health Act*, 1968).

The Local Authority Service Act 1970 required local authorities to establish social services departments that were responsible for the planning and delivery of local social services (*The Local Authority Services Act* 1970). In 1977, joint finance was introduced to allow better care planning and to finance care for those with health and social care needs. This was followed by Griffiths (1983) government report introducing a then controversial notion of the local authority as care managers and brokers for care, as opposed to being responsible for providing direct care (The Kings Fund, 2023).

The NHS and Community Care Act 1990 enshrined the duty for the local authority to organise community care, provide support for people in their own homes whenever possible, and introduced the requirement for local authorities to promote the independent social care sector (*The NHS and Community Care Act*, 1990). Later the Community Care Direct Payments Act 1996 gave people the choice over how they commissioned their own care (*Community Care (Direct Payments) Act*, 1996).

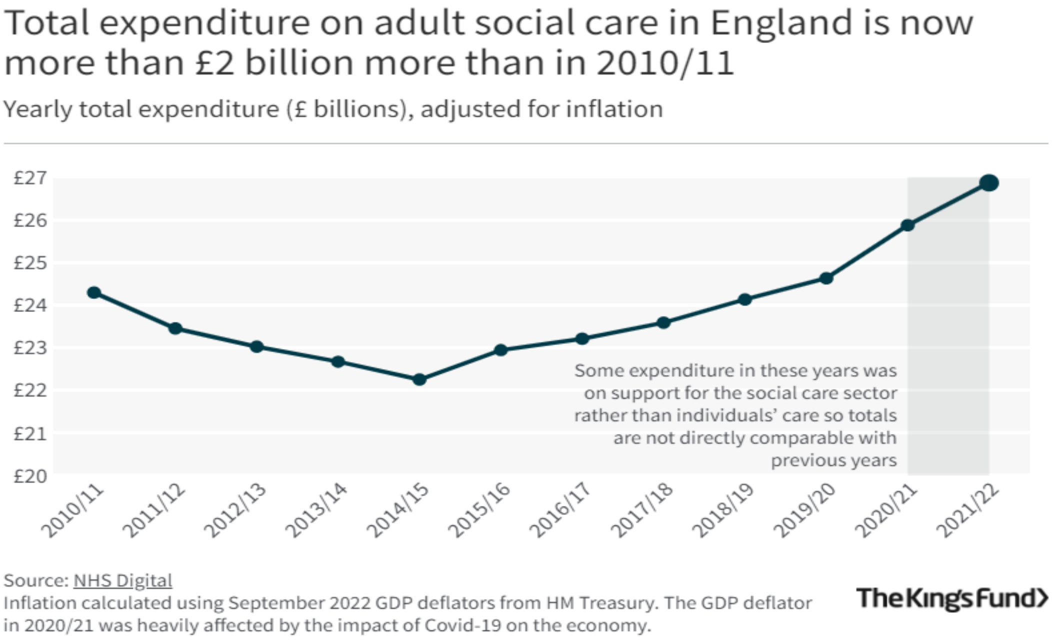
Historically, social care focused on a person's needs and the ensuing service provision and this inadvertently created a deficit model of practice (James and Mitchel, 2020). Around 2008, a specialised type of home care called 'reablement' started to emerge in the UK (Glendinning and Newbronner, 2008). This was designed to provide a window of opportunity to determine whether any longer-term care and support should be commissioned at an optimum level in order to maximise the person's independence (SCIE, 2020).

Despite considerable reports, research, and government think-tanks in the next ten years, the Care Act 2014 was the most significant modern legislation change for social care (*The Care Act*, 2014). The Care Act brought about reform in the way services were delivered, preventative services were recognised as enshrining and promoting independence and person-centred care into everyday social care practice. It also introduced a more generous means test, with a threshold of savings over £23,000 for those who needed to pay personal contributions to fund their social care (Tew *et al.*, 2014);(Bennett, Honeyman and Buttery, 2018).

In 2021, the UK Government published a strategy for social care reform, a 10-year vision. The white paper *People at the Heart of Care* (Department of Health and

Social Care, 2021) proposed major improvements across adult social care. At that time in England, in 2021/22, there were 818,000 people who received funded long-term social care support, primarily in residential, nursing homes, or in their own homes. In addition, there were 224,000 episodes of short-term care provided; the cost of this, to local authorities as shown in Figure 1, was £26.9 billion. Furthermore, approximately £8.3bn is spent on privately purchased social care per year. In 2021/22 around £3.2 billion of this was contributed by people for their own social care (The Kings Fund, 2021). The historical government investment in adult social care is illustrated in Figure 1, showing a steady decline in funding from 2010 to 2014, and then an slight increase year-on-year (The Kings Fund, 2021).

Figure 1 Total government expenditure on social care 2010 to 2021



Total expenditure on adult social care in England is now more than £2 billion more than in 2010/11

Yearly total expenditure (£ billions), adjusted for inflation

Some expenditure in these years was on support for the social care sector rather than individuals' care so totals are not directly comparable with previous years

Source: NHS Digital
Inflation calculated using September 2022 GDP deflators from HM Treasury. The GDP deflator in 2020/21 was heavily affected by the impact of Covid-19 on the economy.

More recently, the Health and Care Act 2022 enshrined the NHS, Social Care and Public Health responsibility for improving people's health outcomes through collaborative delivery at a local, integrated and system-wide level, in law to tackle health inequalities (*The Health and Care Act*, 2022). The Act formally merged NHS England and NHS Improvement, giving the secretary of state powers of direction over the national NHS bodies and local Integrated Care Systems. Integrated Care Boards replaced Clinical Commissioning Groups (CCGs) to support, fund and oversee the financial governance of locally based Integrated Care Partnerships.

Specifically for social care, the Health and Care Act 2022 established a cap of £85,000 that could be paid by people towards their own care costs. The government strategy, Build Back Better: *Our Plan for Health and Social Care* (Department of Health and Social Care, 2022a), outlined how the proposed cap would work using a health and social care levy, funded from increased national insurance contributions (NIC). Political change followed, government restructures, two different prime ministers from the same political party, and the plan to fund the proposed cap via NICs was dropped (HM Treasury, 2022).

In March 2023, a government policy *Next Steps to Put People at the Heart of Care* outlined the proposals for adult social care workforce reform (Department of Health and Social Care, 2023a).

> *"Our plan will help care workers pursue their careers and get the professional recognition they deserve." Helen Whately MP (Department of Health and Social Care, 2023a).*

Criticism by Kings Fund and Care Provider Alliance (CPA), for not delivering or delaying on several key elements, led to the government developing regulations to quality assure adult care services (Warren and Botterly, 2022); (CPA, 2023).

Social care is a key area of political debate. At the time of this thesis the conservative party were in power, and the opposition parties had commitment to tackling social care reform. The labour party committed to free, person-centred care for older people, and said they would address the social care workforce crisis through investment (The Labour Party, 2019); (The Labour Party, 2023). Similarly, the Liberal Party's vision for a national care service would provide free care funding for people up to set thresholds, with sliding scales of contribution thereafter and they would scrap the Health and Social Care Act 2022 (*The Health and Care Act*, 2022), (The Liberal Party, 2023). Whereas, The Green Party policy advised they would increase funding for local authorities so they could provide good quality public services with a single budget for health and social care (The Green Party, 2022).

The Labour Party commissioned the Fabians Society in collaboration with Trade Unions, to research how their vision could be structured and funded (The Fabion Society, 2022). The immediate priority focusing on providing better pay, training and rights for carers and stronger national standards (Masson, 2022).

Around the same time, The Church of England independently commissioned *Care and Support Reimagined,* proposing a National Covenant to establish guiding principles, developed nationally through a sustained programme of public dialogue and engagement, to set out the rights and responsibilities of national and local government, communities, families, and citizens (Church of England, 2023).

> *"The care system is complex, confusing, and difficult to navigate for those who draw on care and support, while those providing care, both paid and unpaid, feel overstretched and undervalued. By spring 2022 over 500,000 people were waiting for social care. There are several million 'unpaid' carers who are largely invisible and frequently exhausted. Staff shortages have worsened, with 'care deserts' in parts of the country." (Church of Church of England, 2023 p8.).*

Notwithstanding this unsettled, post pandemic political climate, the Care Act remains the key legislation for adult care practice, and thus the statutory responsibility for local authorities to prevent or delay people developing needs for social care and support (*The Care Act*, 2014). The Care Act brought about a change in culture to accommodate the rising demographic of people who needed care and support, and to manage capacity and flow following hospital discharge or crisis. It demanded through its legislative framework that the principles of person-centred care, choice and control were embedded into all services, including reablement (*The Care Act*, 2014); (Tew *et al.*, 2014).

1.1.3 Person-centred care.

The principles of person-centred care are to focus on the person and consider them an expert of their own experience (SCIE, 2021). As such, their personal preferences, needs and values should guide clinical decisions; the ensuing care is respectful and responsive to their wishes (Health Education England, 2021).

The overarching philosophy of a person-centred approach, originally derived from the work of psychologist Carl Jung, is that health and well-being outcomes are co-produced with the person, in partnership with the multi-disciplinary team; evidence suggests that this provides better outcomes, and costs less to health and care systems (Fazio *et al.*, 2018).

Underpinning this are six principles that should be met: care and support is personalised, coordinated and empowering; commissioned services are created in partnership with citizens and communities; focus is on equality and narrowing inequalities; carers are identified, supported and involved; voluntary, community and social enterprise and housing sectors are involved as key partners and enablers; and volunteering and social action are recognised as key enablers (People and Communities People and Communities Board, 2016). Studies have shown that barriers to the implementation of person-centred care are the traditional practices, structures, resources, time, skills and attitudes of professionals (Moore *et al.*, 2017); (Jobe, Lindberg and Engström, 2020).

1.1.4 Co-production.

Significantly, in recent years, the movement and mobilisation of people who want more choice and control in their care and support has occurred. Through listening and collaborating with people, organisations are shifting to co-produce adult care strategies for the future. The term co-production is described by Thinking Local Acting Personal (TLAP) as a way of working, whereby everybody works together on an equal basis to create a service, or come to a decision, which works for them all (Thinking Local Acting Personal (TLAP), 2021). This is different from taking part or being present. It means actively contributing and being a co-creator, and as such having an equal, more meaningful and more powerful role in service planning, development and delivery (SCIE, 2021).

> *'Co-production is not just a word, it is not just a concept, it is a meeting of minds coming together to find shared solutions. In practice, co-production involves people who use services being consulted, included, and working together from the start to the end of any project that affects them. When co-production works best, people who use services and carers are valued by organisations as equal partners, can*

> *share power, and have influence over decisions made' (Thinking Local Acting Personal (TLAP), 2021).*

The principles of equality, diversity, accessibility and reciprocity are critical values needed for successful co-production (SCIE, 2021). Being diverse and inclusive can be challenging but must be tackled to address unequal power relationships between professionals and people who use services (SCIE, 2021); (Cox *et al.*, 2021).

Consumer engagement must be a two-way process, this means being proactive, reaching out and including under repenetrated groups. Attention must be given to accessibility, physical and sensory environments, language used and how information is presented to ensure inclusion and equal contributions. Reciprocity means ensuring that people receive something back for their contribution, this builds on people's desire to feel needed and valued, and that they are actively collaborating to a whole that is greater than the sum of its parts. A scoping review by Cox *et al.* (2021) conducted on engagement in occupational therapy health-related research, found 39% involved consumer engagement, 13% involved consumer collaboration, but only 14.5% included co-production in all stages of the research process.

1.2 Philosophical concepts.

Reablement was developed nationally using the following theories and later in this thesis they are used to shape the Adult Care Training (ACT) programme evaluated in the following chapters.

1.2.1 Strength-based approach.

Strength-based models and paradigm shifts in approaches were embraced within American academic social work in the 1980's (Rapp, 1998); (Saleebey, 2006). The term strength-based is derived from positive psychology (Buckingham and Clifton, 2001). The strength-based perspective is a lens through which to view the world and it has been labelled as social work practice theory that emphasises people's self-determination and strengths (McCashen, 2005).

Interestingly, Hammell (2011) recognised a theory, construct or model developed in a more powerful nation may have achieved widespread use because of superior marketing, and not superior theorising. Nonetheless, the strength-based approach, developed in occupational therapy practice, mainly in mental health and forensics settings (Rapp, 1998); (Judge, Yarry and Orsulic-Jeras, 2009); (Potvin, Vallée and Larivière, 2019). Although, Kivnick and Stoffel (2005) and Scobbie, Wyke and Dixon (2009) developed it`s focus on improving well-being in a physical setting.

Illuminating resilience and building a collaborative relationship with people to elicit their knowledge and resources to tackle problems, are the cornerstones of the strength's perspective (Saleebey, 2006). Therefore, working in collaboration with the person, and their network of support, is vital to maximise potential, capability, resource, and capacity, and this will enable empowerment and an improved quality of life.

A strengths-based approach invites us to consider people's assets in a co-produced way, considering what is important to the person, and what qualities and abilities they have, rather than focusing on what is wrong with them, or their situation (DHSC, 2019). It isn't about covering up problems and deficits, or reframing problems with a positive slant (Rapp, 1998).

Behaviours previously labelled as negative, are reframed as useful, and give context and depth to understanding the person. Shifting attention from things that cause and drive pain, to the factors and experiences that energize and pull people forward, can have a motivating effect (Wade and Jones, 2014).

Crucially, the language health and social care practitioners use has an impact on peoples' outcomes (Shannon, 2021). Language has power, it can uplift, inspire, demoralise and damage (Saleebey, 2006). The focus and attention given to things can create a new reality; including the way professionals write about people (Braun, Dunn and Tomchek, 2017).

"*People internalise the negative images conveyed upon them by their oppressors*."

(Rapp, 1998 p12)

Strength-based practice is about supporting people to have meaningful lives. It is about the person, their social and family networks, and their communities, and how all of them link together to maximise outcomes for the person (DHSC, 2019). This can support people to participate in meaningful occupations, feel a sense of belonging and enable them to socially integrate into their communities.

The therapeutic application of occupational theory into practice involves a holistic interpretation of the whole human system, and analysis of how various factors affect a person's daily living. Occupational therapy interventions are designed to enable a person to achieve more for themselves or improve their ability to do daily activities and occupations, thus promoting independence and well-being. Therefore, occupational therapy core values align with a strengths-based approach (Dunn, 2017).

1.2.2 Positive psychology.

Grounded in humanistic and existential thinking, positive psychology formally shifted the emphasis from the person's clinical pathological treatment to their overall well-being and engagement within their community (Carr, 2011). This approach allowed a positive shift from an inaccurate portrayal of the disabled person as vulnerable (Perrin, 2019) and the harmful sigmatisation of mental and physical conditions within society. It also encouraged a social justice approach, where disparities are acknowledged, diversity is celebrated and harnessed to influence change to inequalities (Perrin, 2019).

The work of three psychologists are of relevant to reablement and the ACT programme. Maslow (1943), who theorised human motivation is based on people seeking fulfilment and change through personal growth influenced by both personal and social factors (Maslow, 1970); Erikson (1950) who`s theory of the eight stages of lifelong psychosocial development, which led to the concept of Vital Involvement (Erikson, Erikson and Kivnick, 1987), and Bandura (1997) who`s theory of self-efficacy and mastery modelling was became an effective method of human enablement.

Maslow (1970) identified that to enable growth, basic physiological needs, such as: food, drink and warmth, and safety factors, such as financial security, need to be in place before psychological factors can improve. Maslow later refined his theories, extending the five-step hierarchy to include cognitive, aesthetic needs and transcendence needs, also saying the order of needs is flexible and dependent on individual and external circumstances (Maslow, 1970).

Whereas, Bandura (1997) asserted that self-efficacy can be enhanced in four ways: experiencing success (task mastery); vicariously learning by observing others; persuasion from respected others, and through physiological and/or psychological arousal and wellness, referred to as the managing or reframing of distressing emotions (Bandura, 1997). A meta-analysis conducted by Bolier *et al.* (2013) found positive psychology interventions were effective in boosting subjective and psychological well-being and helped to reduce depression symptoms.

Self-efficacy can be used to reduce self-limiting barriers that can be created by institutionalisation, giving back control over choices, and supporting engagement in occupational pursuits (Bandura, 1997). On the other side, financial hardship, and disability, ethnic or sexual discrimination can cause disadvantage and deprivation. This can result in negative bias from society, which then affects on a person's sense of self-control and choice, eroding the personal self-efficacy required to self-improve talents (Bandura, 1997).

Mastery modelling is an effective method of human enablement (Bandura, 1997), first model the skill; then support guided practice in a controlled environment; then apply the newly learnt skill in new environments and conditions. Mastery of skills is an opportunity to instruct people in a way that persuades them that they have the potential and learning capabilities to succeed in completing occupational activities; having belief in an ability to learn gives greater self-efficacy (Bandura, 1997).

This method of role modelling is a powerful tool to increase self-efficacy, seeing others who have similar abilities succeed in occupational activities. Their behaviour, and consequences of their actions, increases the person's confidence and raises the potential for improved occupational performance (Bandura, 1997).

Furthermore, Luthans *et al.* (2007) investigated the role of positive psychological capital and found that it is positively correlated with increased occupational performance, satisfaction and commitment. In addition, confidence is the likelihood that we will immerse ourselves in the task and welcome the challenge, leading to increased effort, motivation, and resilience; each aspect of psychological capital can be defined, as follows:

- Hope: a positive motivational state that is based on will power and control, a combined sense of successful goal directed energy and planning to achieve goals.
- Resilience: positive coping or adaptation in the face of risk or adversity. For example, being able to recover from uncertainty, conflict, failure, or even positive change.
- Optimism: the objective assessment of what can be realistically done in a specific situation, considering the available resources.
- Efficacy: judgment or belief of how well one can do and what is needed in each situation

Erikson, Erikson and Kivnick (1987) explored the psychosocial aspect of healthy life development and established three principles: Life in time, dynamic balance of opposites and vital involvement. Defined by Kivnick and Wells (2013) as the internal work of balancing psychosocial themes, including both positive and negative behaviours, inseparable from a person's meaningful engagement with the people, resources and other things that constitute the environment or community.

> *"This Vital Involvement construct helps us understand both clinical processes of helping clients deal with pain, anxiety, fear, and trauma, and also the everyday, psychosocial work that constitutes each person's normative psychosocial development, within multiple layers of environment". (Kivnick and Wells, 2013 p46),*

Kivnick and Stoffel (2005) embed these psychosocial principles in the context of strength-based working, describing Vital Involvement as engaging meaningfully with the environment around oneself; Stoffel, an occupational therapist, applied this to occupational science and presented practice based occupational profiling tools.

1.2.3 Occupational science.

The science that underpins occupational therapy theory, has traditionally originated from other disciplines such as sociology, psychology or medicine (Erna Imperatore and Henny-Kohler, 2000). Its development was led by Dr Elizabeth Yerxa in the late 1980s to generate knowledge about human occupation. Defined as:

> *"The study of the things that people do in their everyday lives and how those occupations influence and are influenced by health, well-being and their environments." World Federation of Occupational Therapy (WFOT) (WFOT, 2021 p1)*

The critical thinking, questioning and synthesis of philosophy, science, and ideology in a culture, or in this case a profession, enables its conceptual development. Therefore, for the occupational therapy profession to function and thrive in a social care setting, there is a need for a shared philosophy between occupational science, occupational therapy, social science, and social work. Furthermore, this must embrace and celebrate diversity, cultural and regional differences (Hammell, 2011).

Occupational well-being domains include competence, autonomy, contentment and pleasure, hope, identity and belonging (Saraswati, Milbourn and Buchanan, 2019). Meaningful occupation, which connects a person to their life world and sense of self, has the potential to consolidate recovery from anxiety and depression (Mulholland and Jackson, 2018). Key themes relating to definitions of occupational engagement were explored by Black *et al.* (2019) which included: active involvement in occupation, finding value and meaning, balanced engagement, subjective experience of engagement, developing identity through occupation, and social and environmental interactions. According to Hammell and Iwama (2012), contemporary occupational therapy theory lacked focus on well-being and the meaning that people attach to valued occupations.

Embracing concepts, such as strength-based practice, without due regard to how it fits with occupational science, may impact on professional philosophical beliefs and occupational therapy's unique contribution to practice (Erna Imperatore and Henny-Kohler, 2000). That said, the depth and breadth of the definition of well-being in occupational science, examined by Aldrich (2011), concluded that well-being must also focus on uncertainty and the creation of possibilities for people in any given situation.

Critical appraisal of any assumptions around healthy and unsanctioned occupations is needed, to respond with sensitivity to people's needs and experience, without perpetuating the marginalisation and discrimination they might face (WFOT, 2019); (Potvin, Vallée and Larivière, 2019). Furthermore, occupational justice, a human right, is defined by the World Federation of Occupational Therapists.

> *"Occupational justice is the fulfilment of the right for all people to engage in the occupations they need to survive, define as meaningful, and that contribute positively to their own well-being and the well-being of their communities" (WFOT, 2019 p1).*

Occupational science and occupational therapy share many philosophical beliefs, one of which is empowering people to become autonomous and to have choice and control of their lives (Erna Imperatore and Henny-Kohler, 2000).

1.3 Purpose of this research.

Austerity, and an increased demand through an ageing population, has forced the recognition that an asset based, community led response to adult care and support, is required to meet ongoing and future requirements (Tew *et al.*, 2014); (Bennett, Honeyman and Buttery, 2018); (Bolton, 2019), and that strength-based, preventative interventions, delivered by occupational therapists, can reduce social care budgets (RCOT, 2019).

Without a robust evidence base, there is a risk that the key components of reablement could be lost, or move away from improving people's independence goals beyond basic personal care outcomes (Tuntland *et al.*, 2020); (Doh, Smith and Gevers, 2020); (Oliver, 2022). The link with occupational therapy and improved outcomes in reablement has been identified (SCIE, 2011); (SCIE, 2020), but more evidence from rigorous controlled studies is required.

The intervention studied in this thesis is called ACT, a three component reablement intervention delivered by occupational therapists to home carers working in the independent home-based care sector. ACT is made up of reablement competency training for home carers, reflective case discussion, and responsive occupational therapy focused solutions.

It was unknown whether ACT would be acceptable to the home carers or the occupational therapist delivering the training, and whether the home carers thought it was appropriate based on their experience of the reablement. Therefore, when examining the acceptability of the training their perceived effectiveness of the content, attitudes towards attending, and self-efficacy post-training required investigation.

It was also unknown how feasible it would be to deliver ACT to home carers in the independent sector, and this meant considering a range of practical factors like training content, venues, costs, and rotas to explore how or whether it should be refined or proceed.

1.3.1 Study aims.

The aims of this thesis are to explore reablement interventions and outcomes, and to understand home carers experience, knowledge, and training needs to deliver reablement by answering three research questions.

1.3.2 The research questions.

1. What interventions are used with adults receiving reablement? Who delivers them and when?

2. How effective are the interventions delivered during reablement? How are the outcomes measured and evaluated? Are there any long-term benefits?

3. What is the home carer experience and knowledge of reablement, and is it acceptable and feasible to deliver ACT reablement competency training to independent sector home carers?

1.3.3 Study objectives.

Table 2 summarises the research objectives linked to each research question, and the methods used in each study.

Table 2 Research objectives

Research question	Research objective	Research method
1. What interventions are used with adults receiving reablement? Who delivers them and when?	• To define reablement, its nature, characteristics, and outcomes. • To understand the types of interventions delivered during reablement. • To identify who delivers those interventions and when.	Chapter 2 is a Scoping Review using JBI methodological framework to explore the breadth and depth of the topic of reablement.
2. How effective are the interventions delivered during reablement? How are the outcomes measured and evaluated? Are there any long-term benefits?	• To describe the outcome measures used in RCTs investigating reablement. • To examine the effectiveness of those reablement interventions investigated by RCTs. • To examine whether there is any lasting or long-term effect of reablement interventions investigated by RCTs.	Chapter 3 is a Systematic Review of RCTs undertaken using the preferred reporting items for systematic reviews and meta-analyses (PRISMA) methodological framework to examine the effectiveness of the reablement intervention.

3. What is the home carer experience and knowledge of reablement, and is it acceptable and feasible to deliver ACT reablement competency training to independent sector home carers?	• To understand home carers’ experiences of reablement, considering their views, attitudes and beliefs towards the interventions delivered during a period of reablement. • To explore the knowledge and skills home carers have about reablement. • To identify the elements of acceptability for delivering ACT reablement competency training. • To evaluate the learning that home carer`s experienced during ACT reablement competency training.	Chapters 6, 7 and 8 are a Mixed methods study using a convergent design investigating a codesigned reablement training intervention, delivered at a single site with a carers from one independent sector home care provider. Chapter 8 includes a plan-study-do-act cycle of improvement as a method to refine the training, this was not identified as a research objective.

1.4 Conclusion.

This thesis will explore how home carers from the independent sector align their knowledge and skills with the principles of reablement. It contains a critical analysis of the existing research on reablement, using systematic review methods laid out in chapters two and three, and an empirical mixed methods study using robust research methodology laid out in chapter four, with the analysis and findings presented over chapter`s five, six and seven. The research will establish whether ACT reablement is acceptable to the home carers in this single-site setting, provide recommendations for improvements, determine whether it is feasible to deliver it to a wider group of home carers or across different site settings, and whether any future research on this area of practice is required.

By working collaboratively with regulated professionals, independent home care providers can help ensure that reablement services are delivered effectively, leading to better outcomes for individuals receiving care. Likewise, It makes economic sense that if the local authority invests in occupational therapists to work collaboratively with home carers in the independent sector, more people will be reabled and less people will need funded social care.

Chapter 2. Defining reablement interventions: A scoping review.

2.1 Introduction.

The overall aim of this thesis is to explore reablement interventions and outcomes, and to understand home carers knowledge, experience, and training needs to deliver reablement. When presenting the concept of reablement in chapter one, the lack of clarity about what it is, a concept, intervention or framework was identified. Therefore, this chapter will explore the breadth and depth of modern reablement, the nature, type and characteristics of the interventions involved and who delivers them, using a systematic scoping review to identify published, peer reviewed primary research that might define reablement to support home carers understanding of what reablement is.

Rapid reviews of this type are not designed to be detailed, but rather to map the field of study identifying sources of evidence, concepts and theories, and pinpointing any gaps in the research or to determine where a systematic review might be feasible (Arksey and O'Malley, 2005); Peters *et al.* (2015).

A scoping review can include all types of literature, for example: primary research studies, systematic reviews, grey literature (Peters *et al.*, 2015). However, for this scoping review, the evidence was drawn from primary research studies with quantitative, qualitative, or mixed methodologies. Scoping the research in this way is particularly useful to clarifying working definitions of reablement and conceptual boundaries because it has evolved over time and the primary research is heterogeneous (Pham *et al.*, 2014).

Several comprehensive literature reviews have been published about reablement (Legg *et al.*, 2015); (Whitehead *et al.*, 2015); (Cochrane *et al.*, 2016); (Pettersson and Iwarsson, 2017); (Sims-Gould *et al.*, 2017); (Doh, Smith and Gevers, 2020); (Clotworthy, Kusumastuti and Westendorp, 2021); (Buma *et al.*, 2022); (Bergström *et al.*, 2022). When conducting this scoping review, it became apparent that earlier literature reviews were outdated, due to the complex, heterogeneous nature of reablement which had evolved over time (Tricco *et al.*, 2018). Hence the need for a broad, up-to-date view of research to define reablement and the interventions used during the reablement period, using robust literature searching methods.

2.2 Method.

2.2.1 Aim.

The aim of this scoping review was to find, map and appraise primary research on reablement examining all methodologies, and from all counties, to answer the scoping review question using trustworthy and transparent methods (Peters *et al.*, 2020). As the concept of reablement has emerged over time, the search eligibility focused on studies published in the past ten years to give a modern understanding.

2.2.2 Research question for the scoping review.

What interventions are used with adults receiving reablement, who delivers them and when?

2.2.3 Objectives.

The question for this scoping review was formulated using population, concept, context to give clear focus and scope of the review (Peters *et al.*, 2020). This allowed specific objectives, broad enough to capture the depth and range of published primary research.

The population studied was adults over 18 years who met the inclusion / exclusion criteria, the concept was reablement interventions, and the context was people who lived at home in the community. The objectives were:

1. To define reablement, its nature and characteristics, and outcomes.
2. To understand the types of interventions delivered during reablement.
3. To identify who delivers those interventions and when.

The JBI approach was used as the methodological framework to conduct this scoping review (Peters *et al.*, 2015) with the congruent PRISMA-ScR checklist to quality assure the standard (Tricco *et al.*, 2018). The search strategy is presented so an independent researcher could repeat the search, apply the eligibility criteria, check the data collection forms, and then synthesise the results. The protocol was published in an online depository (Center for Open Science, 2021), with the intention to publish the scoping review (Bennett, 2022a).

2.2.4 Eligibility criteria.

The search strategy examined title and abstract and did not restrict the country of origin. Studies were limited to published peer reviewed journals, dates ranged from 2013 to 2022 to allow a broad search of modern research on the topic and written in the English language, because the cost of translation services was out of scope for a literature review to inform a PhD thesis.

2.2.5 Data information sources.

The database search was undertaken using NuSearch, the University of Nottingham search engine via an Open Athens account, to give access to: AMED (Ovid), ASSIA (ProQuest) CINAHL (Ebsco), EMBASE (Ovid), HMIC (Ovid), MEDLINE (Ebsoc), PsycINFO (Ovid), PubMed (Ncbi) and Web of Science (Clarivate Analytics). Google Scholar and ClinicalTrials.gov were also searched, and a Zetoc email alert was set up to allow for new studies to be identified (ZETOC, 2020). The search for primary research included hand searching of relevant references, from literature reviews and grey literature: such as, policy and procedure documents, conference abstracts, organisational and public opinion, and research dissertations for completeness.

2.2.6 Search strategy and eligibility criteria.

The search strategy included the keywords below in the title or abstract, the database hits are tabulated in Appendix 1.

Keywords.

1. "reablement" or "rehabilitation" or "restorative"
2. “reablement”
3. ("reablement" and “interventions”)
4. "occupational thera*" AND ("reablement" OR "rehabilitation" OR "restorative")
5. "occupational thera*" and ("reablement")
6. "occupational thera*" AND ("reablement" OR "rehabilitation" OR "restorative”) AND ("home care" OR "home care provider")

Inclusion criteria.

- Peer reviewed and published primary research of any methodology, qualitative, quantitative, or mixed methods.
- Studies reported in English and conducted in any country.
- Studies that involved either occupational therapy specifically aligned to home care, or reablement or restorative home care, delivered to people who live at home in the community.
- Studies evaluating the training of staff in reablement.

Exclusion criteria.

- Studies that involved people who were living in a residential or nursing home.
- Studies that included people with moderate to severe dementia as determined by a psychiatrist or health professional or MMS of greater than eighteen.

- Studies that involved people who are palliatively unwell or who are end of life.

2.2.7 Screening.

Studies were deemed eligible based on the inclusion and exclusion criteria. The title and abstracts were checked for all studies identified through this broad search strategy. Studies that met the inclusion criteria were read in full to ensure they met the eligibility criteria. This planned systematic and transparent screening process is outlined in the Prisma flow chart (Page *et al.*, 2020).

2.2.8 Data charting process and data items.

In scoping reviews, the data extraction process is referred to as data charting (Peters *et al.*, 2020). The data was collected on JBI recommended forms (Appendix 2), piloted by the researcher (Peters *et al.*, 2020) and summarised on a table in Excel spreadsheet format. The description of individual reablement interventions were recorded as additional interventions until there were no more. The following data items were identified.

- Study author identification
- Published date.
- Sample size.
- Population (all ages, adults, older people).
- Intervention concept (reablement, rehabilitation, restorative).
- Service delivery type (regulated professionals integrated with home care).
- Intervention delivery by role (professional discipline, or multi disciplinary team and regulated or unregulated worker).
- Timing and frequency of intervention (number of professional visits, number of weeks).
- Intervention type.
- Primary and secondary outcome measures.
- Results.

2.2.9 Quality assurance method.

Each eligible study was critically appraised for quality using appropriate tools for each methodology (Joanna Briggs Institute, 2022);(Critical Appraisal Skills Programme, 2020). The data item outputs were summarised on an excel spread sheet. This supported the evidence required for synthesis of the results, academic supervision discussions and any disagreement moderation.

2.2.10 Synthesis of results method.

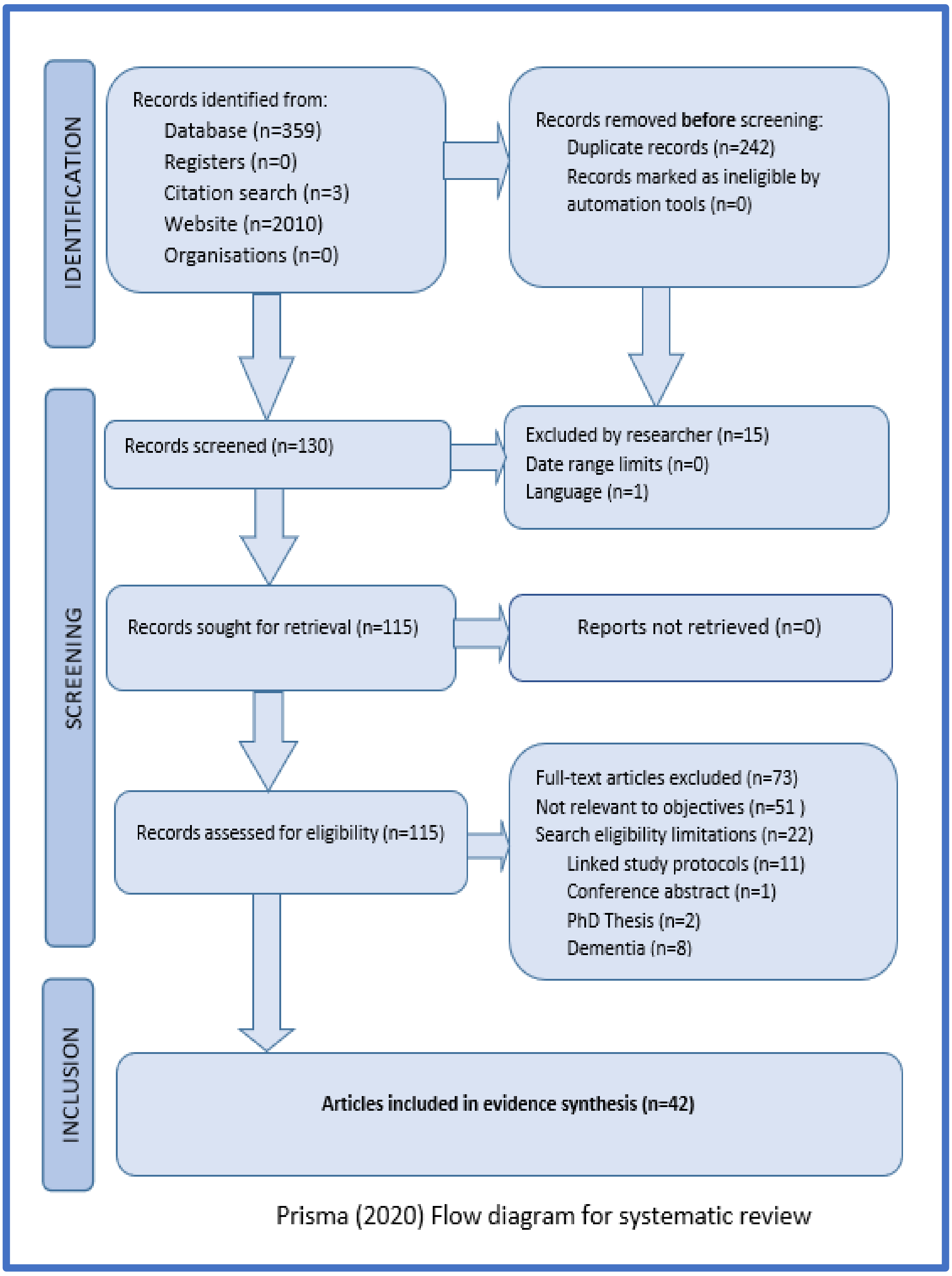
The criteria for the synthesis method were based on identification and mapping of the population, concept and context (Peters *et al.*, 2020). An artificial intelligence literature searching and reference tool (ResearchRabbit, 2023) was used to visualise networks of papers and co-authorships. The data was reported visually in tables, then the intervention and outcomes were narratively summarised and grouped by study design. Each research objective was then taken in turn to synthesise the results. There was no assessment of the risk of bias or the certainty of the evidence.

2.3 Results.

2.3.1 Selection of sources of evidence.

The studies selected, rejected and screened as eligible are visually presented in Figure 2 using the Prisma flow diagram (Page *et al.*, 2020) to show the reasons for inclusion and exclusion.

Figure 2 Prisma (2020) diagram for screening and selecting studies in the scoping review.



The search strategy found 115 published articles, 42 of these met the inclusion criteria, and are shown in Appendix 3, and 73 published articles were excluded, these are reported as a supplementary appendix available from the author on request.

Taking the excluded studies first, twenty-two studies did not meet the search limitations (eight involved participants with dementia, one not in the community setting, eleven were protocols), and of the 51 which did not meet the study objectives, three were duplicates and one had not enough detail published in the peer reviewed conference abstract to make a judgement on eligibility.

From the 42 studies included in this review, there were 19 quantitative studies, 18 qualitative studies and five mixed method studies. Figure 3 presents the included studies by publication year showing a gradual increase in research on reablement interventions between 2014 and 2017, a peak in publications in 2019, and a steady decline over the past three years.

Figure 3 Publication date of included studies in scoping review.

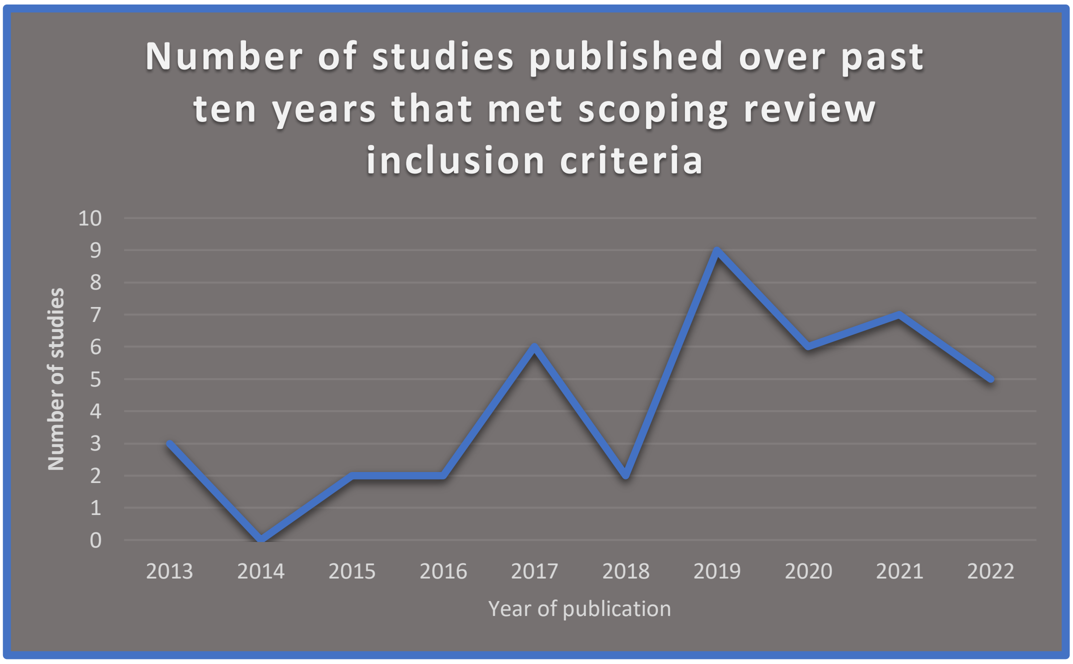
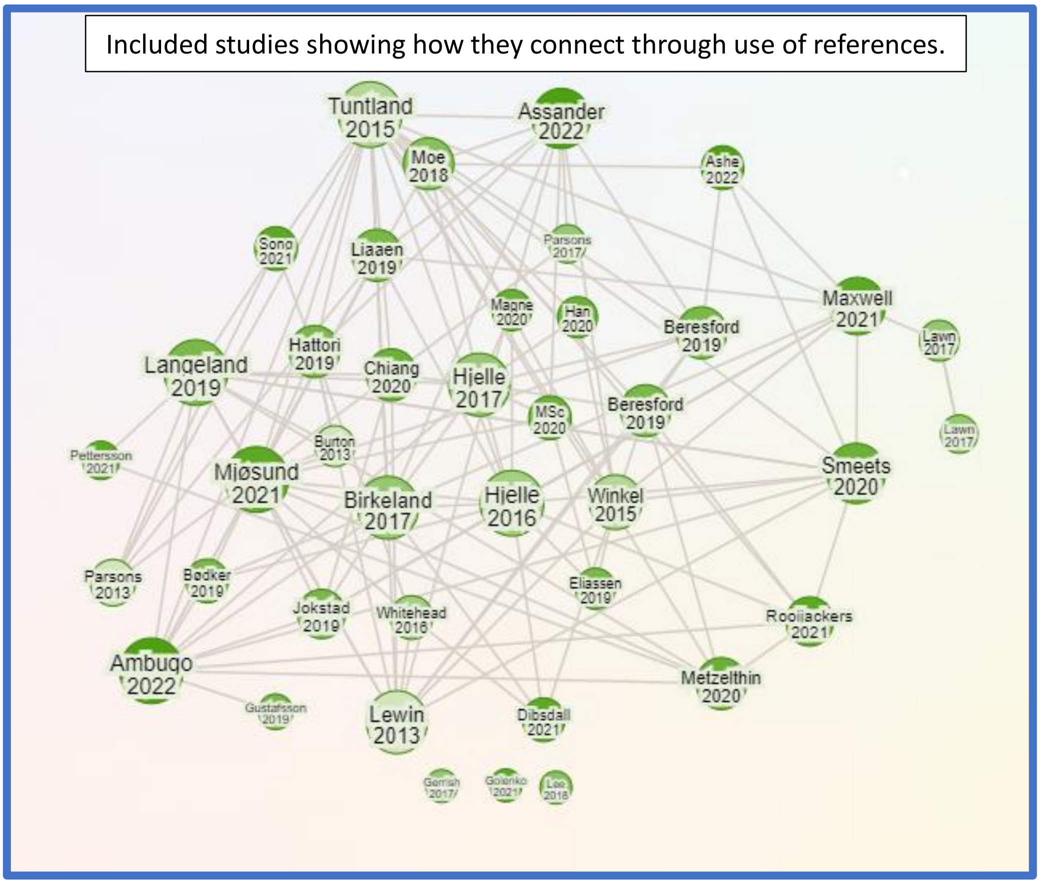


Figure 4 illustrates the links between included research studies, based on referencing of work, building on ideas and concepts. This evidenced research on training workers to deliver reablement was not well connected (Lawn *et al.*, 2017b); (Smeets *et al.*, 2020); (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2022).

Figure 4 Included studies with their reference connections.



2.3.2 Characteristics of sources of evidence.

The evidence from each data source is presented in Table 2, each characteristic of the intervention, the role, dose, and timeframe of service delivery, linked the study to the scoping review objectives and research question.

2.3.3 Population, concept, and context results.

All articles reported on the concept of reablement (or restorative homecare or rehabilitation with homecare) in the context of the person living at home, although (Hattori *et al.*, 2019) and (Song, Lin and Hung, 2021) also conducted additional group sessions with their participants at a community day centre. Appendix 3 shows the included studies were equally split between the professionals perspective of the intervention (21 studies), and the recipients or their informal carers perspective (21 studies).

All the articles reported on reablement delivered to older people (or over 65s), with five studies specifically including all adults over 18 years (Winkel, Langberg and

Wæhrens, 2015); (Whitehead *et al.*, 2016); (Chiang *et al.*, 2020) or adults over 20 years (Hattori *et al.*, 2019); (Eliassen, Henriksen. and Moe, 2020).

Only five studies referred to their intervention as reablement (Winkel, Langberg and Wæhrens, 2015); (Langeland *et al.*, 2019); (Beresford *et al.*, 2019b); (Chiang *et al.*, 2020); (Han, Chuang and Chiu, 2020). Others called their intervention by a distinct name, TARGET (Parsons *et al.*, 2013); LIFE (Burton *et al.*, 2013); CoMITT (Hattori *et al.*, 2019); Stay Active At Home (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2021b); (Rooijackers *et al.*, 2022), and ASSIST (Assander *et al.*, 2022a). Other studies referred to their intervention as home care with multi-component rehabilitation (Tuntland *et al.*, 2015); (Lee *et al.*, 2018), or restorative home care (Lewin *et al.*, 2013); (Maxwell *et al.*, 2021).

Four studies evaluated the effectiveness of a reablement training programme on a sample of older people, and they all described the reablement interventions in detail (Lawn et al., 2017a); (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2022) (Assander *et al.*, 2022a). Four studies evaluated staff experience of reablement training (Lawn *et al.*, 2017b); (Smeets *et al.*, 2020); (Dibsdall, 2021); (Maxwell *et al.*, 2021).

Some of the included published journal articles were linked to data from another trial, giving both quantitative and qualitative insight using the same sample of participants. Therefore, when studies referenced specific interventions, this is visually presented in Table 3 with the caveat that these results correspond to a broad representation and not a consensus position.

Table 3 The reablement Interventions described.

Study	Year	Method	Country	Service provision timeframe	Dose	Integrated professional with home care	Non-integrated professionals (and standard homecare)	Reablement Homecare (non integrated professionals)	Outcome measures used	Progress review	Equipment & Adaptations	Assistive technology	Indoor mobility (Strength and balance)	Goal Orientated plan	Functional ADL assessment	Person centered assessment of needs	Activity Analysis	Doing "with, not for"	Motivating self determination	Confidence building & Praise	Pacing or energy conservation techniques	Guided Practice to master ADL task	Advice on self management & signposting	Medication management	Social integration & participation	Outdoor Mobility	Training or Coaching Workers (Behavioural change)
Ambugo, Dar, & Bikova	2022	Qualitative	Norway	0	0	√	0	0	0	0	√	√	√	√	√	√	0	√	√	√	√	0	0	0	0	0	0
Ashe, M.	2022	Mixed Method	Canada	TL	0	√	0	0	0	√	√	√	√	√	√	√	0	0	0	0	0	√	√	0	0	0	√
Assander et al	2022	Mixed Method	Sweden	8-10w	M	0	0	√	√	√	0	0	0	√	√	√	0	√	0	0	0	√	0	0	√	0	√
Beresford et al	2019b	Quantitative	UK	<6w	M	√	√	√	√	√	√	0	√	√	√	√	0	√	0	√	0	0	√	0	√	√	0
Beresford et al	2019a	Mixed Method	UK	TL	0	√	√	√	√	√	0	0	√	√	√	√	0	√	0	√	0	0	√	0	√	√	0
Birkeland, et al	2017	Qualitative	Norway	0	0	√	0	0	0	0	0	0	√	√	√	√	0	0	0	0	0	0	√	√	0	0	√
Bødker, et al	2019	Qualitative	Denmark	8w	0	√	0	0	0	√	0	0	0	0	√	0	0	0	0	0	0	0	0	0	0	0	√
Burton et al	2013	Quantitative	Australia	<2w	M	0	√	0	√	√	0	√	√	0	√	√	√	0	0	0	0	0	0	√	0	√	√

Chiang et al	2020	Quantitative	Taiwan	TL	0	0	√	0	√	√	√	0	0	√	0	√	0	√	√	√	0	√	0	0	0	0	√
Dibsdall, L	2021	Qualitative	UK	TL	0	√	0	0	0	0	√	0	√	√	√	√	√	√	0	0	√	√	√	0	0	0	√
Eliassen, et al	2019	Qualitative	Norway	TL	0	√	0	0	0	0	0	0	√	0	0	0	0	0	0	0	0	√	0	0	0	0	√
Eliassen, Henriksen & Moe	2020	Qualitative	Norway	TL	0	√	0	0	0	√	0	0	√	√	√	0	0	0	0	0	0	√	0	0	0	√	√
Gerrish, et al	2017	Mixed Method	UK	6w	0	0	√	0	0	√	0	√	0	0	0	0	0	√	0	√	√	√	√	√	0	0	√
Gustafsson, et al	2019	Qualitative	Sweden	TL	0	√	0	0	0	√	0	0	0	√	√	√	0	0	√	√	0	0	√	0	0	0	√
Golenko, Paine, & Meyer	2022	Qualitative	Australia	4m	0	0	√	0	0	0	√	√	√	√	0	√	0	√	0	0	0	0	√	0	√	0	√
Han, Chuang & Chiu	2020	Quantitative	Taiwan	6w	M	0	√	0	√	√	0	0	√	√	√	0	√	0	0	0	0	√	0	0	0	0	0
Hattori et al	2019	Quantitative	Japan	5m	M	0	√	0	√	√	√	0	√	√	√	√	0	0	√	0	0	√	√	0	√	0	√
Hjelle et al	2016	Qualitative	Norway	3m	0	√	0	0	0	0	√	√	√	√	√	√	√	√	√	0	0	√	√	√	√	√	√
Hjelle et al	2017	Qualitative	Norway	3m	0	√	0	0	0	0	√	√	√	√	√	√	√	√	√	√	0	√	0	0	√	√	√
Jokstad, et al	2018	Qualitative	Norway	6w	0	√	0	0	0	√	0	0	√	√	0	√	0	√	√	0	0	√	√	0	0	0	0
Langeland, et al	2019	Quantitative	Norway	<10w	M	√	0	0	√	√	√	√	√	√	√	√	√	√	√	√	0	√	0	0	√	√	√
Lawn, et al (a)	2017	Qualitative	Australia	0	0	0	0	√	0	0	0	0	√	√	0	√	0	√	√	√	√	√	√	0	√	√	√
Lee, et al	2018	Quantitative	Hong Kong	3-6m	M	0	√	0	√	√	√	0	√	√	√	√	0	0	0	0	0	√	√	0	0	0	0
Lewin et al	2013	Quantitative	Australia	12w	0	0	0	√	√	√	√	√	√	√	√	0	√	0	0	0	0	√	√	√	0	0	0
Liaaen, & Vik	2019	Qualitative	Norway	0	0	√	0	0	0	0	0	0	0	√	0	√	0	√	√	0	0	0	0	0	0	0	0
Magne, & Vik	2020	Qualitative	Norway	TL	0	0	√	0	0	0	0	0	√	√	0	√	0	0	0	0	0	√	0	0	√	0	0
Lawn, et al (b)	2017	Quantitative	Australia	0	0	0	0	√	0	0	0	0	√	√	0	√	0	√	√	√	√	√	√	0	√	√	√

Maxwell et al	2021	Qualitative	Australia	TL	M	0	0	√	0	0	0	0	0	0	0	√	0	√	0	0	0	0	0	0	0	0	√
Metzelthin et al	2020	Quantitative	Netherland	TL	M	√	0	√	0	√	√	0	√	√	√	√	0	√	0	0	0	√	√	0	√	0	√
Mjøsund, et al	2021	Qualitative	Norway	<10w	M	√	0	0	0	√	√	√	√	√	√	√	√	0	√	√	0	√	√	0	√	√	0
Moe & Brinchmann	2018	Qualitative	Norway	0	0	√	0	0	0	0	√	0	√	0	0	√	0	0	0	0	0	0	0	0	0	0	√
Parsons, et al	2013	Quantitative	New Zealand	0	0	0	0	√	√	√	0	0	√	√	√	√	√	0	0	0	0	√	0	0	0	0	√
Parsons, et al	2017	Quantitative	New Zealand	0	0	0	0	√	√	0	0	0	√	√	√	0	0	0	0	0	0	√	0	0	0	0	√
Pettersson, Zingmark, & Haak	2022	Quantitative	Sweden	<6w	M	√	0	0	√	√	√	0	√	√	√	√	0	0	0	0	0	√	0	0	√	√	0
Rooijackers, et al (a)	2021	Quantitative	Netherland	0	M	√	0	0	√	√	√	√	0	√	√	0	0	√	√	0	0	√	√	0	√	0	√
Rooijackers, et al (b)	2021	Mixed Method	Netherland	0	M	√	0	0	√	√	√	√	0	√	√	0	0	√	√	0	0	√	√	0	√	0	√
Rooijakkers, et al	2022	Quantitative	Netherland	0	0	√	0	0	√	√	√	√	0	√	√	0	0	√	√	0	0	√	√	0	√	0	√
Song, et al	2021	Quantitative	Taiwan	10w	M	0	√	0	√	√	0	0	√	0	√	0	0	0	0	0	0	0	0	0	0	0	0
Smeets, et al	2018	Qualitative	Netherland	TL	0	√	0	0	0	0	0	0	√	√	√	√	0	√	√	√	0	√	0	0	√	0	√
Tuntland et al	2015	Quantitative	Norway	10w	M	√	0	0	√	√	√	0	√	√	√	√	0	√	0	0	0	√	0	0	0	√	√
Whitehead et al	2016	Quantitative	UK	6w	M	0	√	0	√	√	√	0	√	√	√	0	√	0	0	0	0	√	√	0	0	√	0
Winkle et al	2015	Quantitative	Norway	TL	M	√	0	0	√	√	√	0	√	√	√	√	√	√	√	√	0	√	0	0	0	0	√

Key: TL Time limited. M Multiple. D Daily. m Months. w Weeks. 0 Not documented in article. √ Documented in article.

2.3.4 Synthesis of results.

Firstly, the results are narratively described, grouped by research design with the outcomes reported by year chronologically. Then, each scoping review objective is taken in turn to synthesise the results. The results in Table 3 gave the detail of the concepts, themes, and types of evidence available linked to the objectives of this review.

Quantitative designed studies intervention, components, and outcomes.

In 2013, Parsons *et al.* (2013) evaluated the effectiveness of the TARGET intervention alongside restorative home care, in New Zealand. In this study care-coordinators supported participants to set goals, evaluating outcomes by measuring physical function and need for social support. The study found that there were greater positive changes over time in participant`s physical function, because of restorative care and TARGET, but no associated decrease in social support.

Whereas Lewin *et al.* (2013) Australian study evidenced participation in a short-term restorative programme appeared to reduce the need for ongoing home care support at 3 and 12 months. The authors identified they had issues around the randomisation process which they felt led to limitations in their results. Nevertheless, this was a large sample RCT with statistically significant results.

Both Parsons *et al.* (2013) and Lewin *et al.* (2013) used restorative home care without integral professionals. However, despite investigating similar outcomes they cannot be compared due to heterogeneous outcome measures. The Dukes Social Support Index (Koenig *et al.*, 1993) used by Parsons *et al.* (2013) measured multiple dimensions of social support, including informal carers, whereas Lewin *et al.* (2013) used a dichotomous measure; yes or no requirement for a home care service.

Using the same Australian restorative home care provider as Lewin *et al.* (2013), Burton *et al.* (2013) aimed to evidence the effectiveness of the LIFE intervention with a summary variable. They tested a composite collection of valid and reliable outcome measures (the full list of these is shown in Table 3), to measure change in functional ability following the LIFE intervention but although there was significant improvement in the intervention group for some individual outcome measures, they did not find any statistical significance for change in functional ability because of the summary variable.

Three Norwegian reablement studies produced significant results when reablement was delivered by integrated multi-disciplinary professionals and home care teams. Winkel, Langberg and Wæhrens (2015) found the effect of reablement on the ability to perform daily living activities improved significantly over time and was maintained at 10 months' follow-up. Tuntland *et al.* (2015) who documented a clear analysis, found statistically significant improvements from the reablement group for activity performance at three, six and nine months, and better satisfaction with performance at nine months. Whereas Langeland *et al.* (2019) found significant effects in the intervention group at ten weeks and at six months for functional ability and satisfaction with functional ability, significant effects for balance and walking after six months, and sit-to-stand after twelve months.

In 2016, a feasibility randomised controlled trial (RCT) was conducted in the UK by Whitehead *et al.* (2016), who added occupational therapist input to an existing reablement home care team evidencing that functional ability increased post intervention, but decreased slightly in effect at six months.

Lawn *et al.* (2017b), also an Australian study, conducted a pre-test, post-test survey to evaluate restorative care training modules on support workers knowledge, skills and confidence around communication, complexity, behaviour change and chronic condition self-management support. They found the support workers reported greater awareness, skills, and confidence in working with complexity, reinforcing the value of their existing practices and skills. The study did not capture the level of home carer experience in the demographic information, and this may have influenced the results, missing responses were not clearly accounted for, and there was a lack of clarity in the description of the Likert scale used to evaluate.

Parsons *et al.* (2017) investigated whether restorative care influenced people remaining at home using a primary outcome measure of death or admission to residential home. They found that although the number of people, who died or were admitted to residential care was lower following restorative home care, it was not statistically significant in the intervention group. A reported limitation of this study was lack of blinding due to the nature of the intervention and a lack of study power due to sample size for an RCT.

Lee *et al.* (2018) conducted a matched-control quasi-experimental study in Hong Kong to test the impact of homebased rehabilitation with no integrated home care service, using a small sample and a short study period. They found that when compared to the control, the intervention group showed improvements across all the primary outcome measures after three months, including a reduction in hospital services use, but these were not statistically significant. The study identified there were some issues with the matching of groups, in terms of age characteristics, it was suggested that a more rigorous RCT was required.

Beresford *et al.* (2019b) found a positive effect across all outcome domains in their UK study with improvement noted after hospital discharge retained at six months for most people. The importance of assessing both basic and extended activities of daily living and informal carer time resource was raised. This study was limited by under recruitment and as a result were unable to compare the three service delivery models, which were occupational therapist within team, reablement case load only, and mixed caseload (reablement and home care) leaving a gap in the research for comparison of service delivery models.

In a Japanese study, Hattori *et al.* (2019) used non-integrated multi-disciplinary professionals delivering the reablement intervention in a group setting for older people who had standard home care. They found 11.1% of the intervention group reached independence and 3.8% in the control groups, with no difference in the risk of serious adverse events between the groups. The CoMMIT programme plus standard home care was found to be superior to standard home care alone in enhancing the independence from long-term care services of older adults with mild disability. The secondary outcome measure was arguably not sensitive enough to determine activities of daily living improvement and as such was incomparable to other studies.

Chiang *et al.* (2020) also used non-integrated professionals plus standard homecare in an unblinded, non-randomised study with a small sample from two home care services in Taiwan. The primary outcomes investigated, using a pre-test, post-test design, were the home carers' self-reliance concept, job satisfaction and sense of achievement; quality of life for recipients; and caregiving burden for family caregivers. They found reablement has a statistical effect improving home carers' job satisfaction and self-reliance competency and reducing informal family caregiver's stress.

In Han, Chuang and Chiu (2020) study, also conducted in Taiwan, non-integrated professionals delivered reablement plus standard homecare. The intervention group showed statistically significant improvements in the functional ability scale suggesting reablement has potential for enhancing how people do daily living tasks. However, no significant differences were noticed for self perceived difficulty, suggesting people are not aware of these improvements. The findings may have been limited by a small sample from one hospital location, with an intervention delivered once a week.

Metzelthin *et al.* (2020) conducted an international Delphi study with the aim of reaching agreement on the characteristics, components, aims and target groups of reablement. The study consisted of four web-based survey rounds and found consensus on six characteristics, eleven components, seven aims and six target groups. From the 82 participants there was a mixture of reablement experts and academics who had published peer reviewed research on reablement (all members of the ReAble network). Consensus was agreed by 62 participants (79%); this was 100% from experts representing Canada, Ireland, New Zealand, Taiwan, and the USA. However, of the 17 (22%) participants who disagreed with the final statement there was a high level of disagreement (42%) from UK experts. This Delphi study had robust methodology and reached established consensus rates, over 70%. However, all participants were purposefully selected members of the ReAble network, an international group of academics who had completed research on reablement. Overall, the disagreement reasons were too much focus on physical functioning, raised by eleven participants (65%); reablement was not delivered by an inter-disciplinary team in their context, raised by three participants (18%), and too little emphasis on the meaningfulness of activities, raised by three participants (18%). The time-limited nature and reablement that can be delivered in different settings were both raised as disagreements by one participant (3%). The study outcome was a 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"* (Metzelthin *et al.*, 2020 p11)

Song, Lin and Hung (2021) study of non-integrated professionals delivering reablement plus standard homecare, used a pre-test, post-test research design on a small sample of 24 people in Taiwan. They found the intervention significantly improved the primary outcomes measured: mobility, cognition, activities of daily living performance and satisfaction with activities of daily living, with medium-to-large statistical effect sizes. This study evidenced that combining individualised reablement in the person's home, with group-based multicomponent training, was superior to group courses alone in enhancing the functional abilities of community-dwelling older adults with mobility deficits.

Rooijackers *et al.* (2021a) RCT had an appropriate sample size, and similar attrition rates between control and intervention arms of the study. It found no effect on the sedentary behaviour of over 65s when they delivered the Stay Active at Home reablement training programme to Dutch homecare services. The same intervention was presented in a process evaluation (Rooijackers *et al.*, 2021b), and

Rooijackers *et al.* (2022) measured the effect of the Stay Active at Home reablement training programme on nursing and domestic worker self-efficacy, the outcome expectations showed no effect.

Pettersson, Zingmark and Haak (2022) conducted a cross-sectional survey, completed by occupational therapists and physiotherapists in Sweden over a three-month period. It examined data on organisations, target groups, content and focus of intervention, use of assessments and collaboration with other professionals using four web-based surveys. The self-design survey used dichotomous measures to determine the primary measure. It found that in 93.2% of cases, the assessment, goal setting and intervention were focussed on basic needs, whereas in 6.8% of cases the intervention was focussed on social participation. It also revealed that a higher proportion of people, with no home care and minor functional dependency, were more likely to get the interventions focusing on social participation than people with major functional dependency. Although this study self identified a limitation that informal, or family carers, were not considered as a controlled variable.

The outcome measures used in the experimental studies are presented in Table 4 highlighting the primary and secondary outcomes, type of outcome, dichotomous (D), continuous (C) or other effect (O), with the measure, timing and follow up period. The main reablement outcomes studied included: a person's perceived functional ability, observed functional ability, quality of life, cognition, and functional mobility. Although others measured home carers' competency (Chiang *et al.*, 2020) and care givers' strain (Lee *et al.*, 2018). Functional ability is the term used to describe how participants complete activities of daily living, such as: washing and dressing, independent living skills, shopping, and housework. Functional mobility was the term used to describe ability to sit to stand, balance and walk.

As shown in Table 4, standardised, valid and reliable outcome measures were used by (Parsons *et al.*, 2013); (Burton *et al.*, 2013) (Tuntland *et al.*, 2015); (Winkel, Langberg and Wæhrens, 2015) (Whitehead *et al.*, 2016); (Parsons *et al.*, 2017);

(Langeland *et al.*, 2019); (Beresford *et al.*, 2019b); (Han, Chuang and Chiu, 2020) (Song, Lin and Hung, 2021); (Assander *et al.*, 2022a).

In contrast, Lewin *et al.* (2013) and Hattori *et al.* (2019) both used a binary ADL measure that is unreferenced and incomparable. A summary variable score was created by Burton *et al.* (2013), using a combination of measures which are reported to be valid and reliable when used on their own (Podsiadlo and Richardson, 1991); (Steffen, Hacker and Mollinger, 2002). Chiang *et al.* (2020) used a mix of measures, some referenced and some not, suggesting the use of unvalidated, self-designed scales. Finally, Lee *et al.* (2018) report that they used the Chinese version of the Barthel Index and Lawson Independent Activities of Daily Living (IADL) measures without clarifying or referencing to validity of these versions. The dichotomous binary measure of no ongoing service is used by Lewin *et al.* (2013); Parsons *et al.* (2017) and Hattori *et al.* (2019), with information taken from an admin database.

Table 4 Quantitative study outcome measures

Study	Outcomes (Primary or Secondary)	Outcome measure	Type	Follow up
Parsons et al (2013)	Primary: Health related quality of life	Short-Form 36 Health Survey (Ware, Kosinski and Dewey, 2000)	C	Baseline & 6 months
	Secondary: Change in participants' physical function over time	Short physical performance battery (Guralnik *et al.*, 1994)	O	Baseline & 6 months
	Secondary: Change in social support	Dukes social support index (Koenig *et al.*, 1993)	O	Baseline & 6 months
Lewin et al (2013)	Primary: No ongoing personal care services at 3 months and 12 months	Binary measure	D	Baseline, 3 & 12 months

	Secondary: Functional Status ADL and IADL	Binary measure (not referenced) (Lower ADL score = higher dependency)	D	Baseline, 3 & 12 months
Burton et al (2013)	Primary: Change to Functional ability	Composite measure: incorporating balance, strength, mobility summarised by measuring functional reach, Chair Sit-to-Stand, Tandem walk (Steffen, Hacker and Mollinger, 2002) and Timed Up and Go (Podsiadlo and Richardson, 1991)	C	Baseline & 8 weeks
	Secondary: Level of function and disability in everyday activities.	The Late Life Function and Disability instruments (Haley, Jette and Coster, 2002)	C	Baseline & 8 weeks
Winkel et al (2015)	Primary: Change in ADL	ADL-Interview (ADL-I) (Wæhrens, Kottorp and Nielsen, 2021),	C	Baseline & 12 weeks
Tuntland et al (2015)	Primary: Change to self-perceived ADL performance satisfaction with ADL	COPM (Carswell *et al.*, 2004).	C	Baseline, 3 & 9 months
	Secondary: Functional Mobility	Timed up and go (Podsiadlo and Richardson, 1991).	C	Baseline, 3 & 9 months
	Secondary: Health related quality of life	COOP/Wonka (revised version) (Kinnersley, Peters and Stott, 1995).	C	Baseline, 3 & 9 months
	Secondary: Grip strength	Jamar Dynamometer (Bohannon *et al.*, 2006).	C	Baseline, 3 & 9 months
Whitehead (2016)	Primary: Aspects of feasibility	Eligibility, recruitment, intervention delivery, attrition and suitability and sensitivity of outcome measures.	C	2 weeks, 3 & 6 months

	Secondary: Independence in Activities of Daily Living	Barthel Index (Colin *et al.*, 1988).	C	2 weeks, 3 & 6 months
		Nottingham Extended Activities of Daily Living (Nouri and Lincoln, 1987)	C	2 weeks, 3 & 6 months
	Secondary: Health-related and social care-related quality of life	EQ5D (Barton *et al.*, 2007).	C	2 weeks, 3 & 6 months
		ASCOT (PSSRU, 2018).	C	2 weeks, 3 & 6 months
		SF-36 PCS (Ware, Kosinski and Dewey, 2000) SF-36 MCS (Ware, Kosinski and Dewey, 2000)	C	2 weeks, 3 & 6 months
Lawn et al 2017b	Primary: change in support worker knowledge, skills, confidence, and practical skills.	Survey to measure changed effect in communication, motivation, and behaviour change.	C	Baseline, 3weeks and 3 months
Parsons, et al (2017)	Primary: Death or permanent residential care placement.	Binary measure.	D	
	Secondary: Physical function, health status, social support, and service use. Informal caregiver health-related quality of life (HRQoL). Informal caregiver experience.	interRAI Home Care (interRAI HC) instrument (Landi *et al.*, 2000) . EuroQoL thermometer visual analogue scale (Holland *et al.*, 2004). Physical and mental component subscales (SF-36) (Ware and Sherbourne, 1992). Caregiver Reaction Assessment (CRA) (Given *et al.*, 1992); (Nijboer *et al.*, 1999).	C	Regular intervals

Hattori (2019)	Primary: Independence (No long-term personal care services required).	Binary measure	D	Baseline, 4 & 7 months
	Secondary: Functional ADL.	Difference in ADL and IADL (not referenced).	D	Baseline, 4 & 7 months
	Secondary: Non adverse risk.	Hospitalisations or death.	D	Baseline, 4 & 7 months
Lee et al (2018)	Primary: Mobility. Functional ability. Cognition. Quality of life. Caregiving strain. Service provision	7-item Elderly Mobility Scale (EMS) and Timed Up and Go test.	C	Baseline & 3 months
		Modified Barthel Index (Colin *et al.*, 1988) Lawton's Instrumental ADL Scale.	C	Baseline & 3 months
		Mini-Mental State Examination.	C	Baseline & 3 months
		World Health Organization Quality of Life Scale, Short Form, Hong Kong version (WHOQOL-BREF [HK]).	C	Baseline & 3 months
		Caregiver Strain Index.	D	Baseline & 3 months
		Hospital services utilization.	D	Baseline, 3 & 6 months
Beresford et al (2019.b)	Primary: Healthcare and social care related quality of life, functioning, mental health, and resource use (service	EQ-5D-5L (Barton *et al.*, 2007) ASCOT -SCT4 (PSSRU, 2018). General Health Questionnaire.		Baseline, 3 & 6 months

	costs, informal carer time, out-of-pocket costs)	Nottingham EADL (Nouri and Lincoln, 1987). Barthel ADL index (Colin *et al.*, 1988)	C	Baseline, 3 & 6 months
		Service resource use (service costs, informal carer time, out-of-pocket costs).	D	Baseline, 3 & 6 months
Langeland, et al (2019)	Primary: activity performance and satisfaction with performance	Canadian Occupational Performance Measure (COPM, 1–10).	C	Baseline, 10 weeks & 6 months
	Secondary: Mobility Health related quality of life	Short Physical Performance Measure Battery (SPPB) European Quality of Life Scale (EQ-5D-5L) Sense of Coherence Questionnaire (SOC).	C	Baseline, 10 weeks & 6 months
Chiang et al (2020)	Primary: Disability level	Barthel Index (Colin *et al.*, 1988)	C	Baseline & 3 months
	Self-reliance concept	Self-reliance home care scale Home Care competency test	C	Baseline & 3 months
	Job satisfaction for care attendants	Sense of accomplishment scale	C	Baseline & 3 months
		WHO Quality of Life-BREF [31]	C	Baseline & 3 months
	Quality of life	Level of difficulty of caring for the care recipient’s scale 14-item Family Caregiving Burden scale [32]	C C	Baseline & 3 months

	Caregiving burden			
Han et al (2020)	Primary: activity performance and satisfaction with performance	Canadian Occupational Performance Measure (COPM) Barthel Index-based Supplementary Scales (BI-SS).	C C	Baseline & 6 weeks
Song, et al (2021)	Primary: mobility, cognitive function, activities of daily living (ADL) function, physical function and self-perceived activity performance and satisfaction with performance.	de Morton Mobility Index (DEMMI) Saint Louis University Mental Status (SLUMS) Examination Barthel Index (BI) (Colin *et al.*, 1988) Short Physical Performance Battery (SPPB) Canadian Occupational Performance Measure (COPM).	C	Baseline & 10 weeks
Rooijackers et al, (2021)	Primary measure: Sedentary time	Tri-axial wrist-worn accelerometers (ActiGraph GT9X Link, ActiGraph Inc.).	D	Baseline, 6 months & 12 months
	Secondary measure: Daily functioning in (I)ADL Physical functioning Psychological functioning Falls	GARS (score range 18–72).34 Short physical performance battery (SPPB) (score range 0–12) Patient Health Questionnaire-9 (PHQ-9) (score range 0–27) Question asked, "How often did you fall during the past six months?"	C	Baseline, 6 months & 12 months
Rooijackers et al, (2022)	Staff self-efficacy Staff outcome expectations	Client Activation Self-Efficacy Scale for Nurses (CA-SE-n) and Domestic Workers (CA-SE-d) (Resnick et al, 2008) Client Activation Outcome Expectations Scale for Nurses (CA-OE-n) and Domestic Workers (CA-OE-d) (Resnick et al, 2008)	C	Baseline, 6 months & 12 months

Pettersson, et al (2022).	Primary measure Focus and content of intervention, target population groups, use of assessments, and collaboration with other professionals.	Basic need vs. social participation Number of contacts Duration of the intervention.	D	3 weeks to 3 months
	Secondary measure Age, gender, level of functioning	Over or under 80 years Male/female No home care/minor functional limitation /major functional limitation	D	3 weeks to 3 months

Mixed method designed studies intervention, components, and outcomes.

Gerrish *et al.* (2017) evaluated a UK medicines reablement initiative involving health and social care, and patients, using questionnaires and semi-structured interviews. Pharmacy Technicians delivered a competency-based training programme to the home care staff. They assessed and set goals with patients to facilitate independence in self-administration of their medication, and provided on-going support to home care staff who were helping patients to reable. After six weeks 20% of the patients, discharged from hospital to intermediate care, were assessed to be suitable for medicines reablement. Of these patients, 44% were successfully reabled and a further 25% benefited from the input of a pharmacy technician. Patients and staff were positive about medicines reablement, emphasising the importance of independence in medication self-administration. The staff valued on-going access to pharmacy technicians for timely support, help with problem solving and advice. This study presented an emerging area of reablement practice development.

Beresford *et al.* (2019a) investigated UK reablement service delivery. This mixed method research was extensive with three work packages, giving rich additional insight into the content of reablement service delivery and outcomes. The quantitative outcomes analysed in work package two were published separately (Beresford *et al.*, 2019b). Work package one is of interest to this scoping review as it investigated organisational characteristics, service delivery and practice, service costs and caseload. A total of 201 services in 139 local authorities took part in the survey. The results showed services varied in their organisational base, their relationship with other intermediate care services, their use of outsourced providers, their skill mix, and the scope of their reablement interventions. These characteristics influenced aspects of service delivery and practice, and the average cost per case was £1,728.

Rooijackers *et al.* (2021b) is a mixed methods process evaluation for the RCT and investigated the Stay Active at Home initiative, previously appraised. A sample of 154 staff members (23 nurses, 34 nurse assistants, eight nurse aides and 89 domestic workers), from five working areas, received the programme. Data on the feasibility of the implementation, possible mechanisms of impact (home care staff knowledge, attitude, skills, and support) and context were collected. A limitation of this study design was the lack of reflexivity to reduce bias. The researcher who performed the interviews with staff members was a programme trainer potentially introducing an element of social desirability bias. Two of the programme trainers were researchers, potentially introducing experimenter bias. Nevertheless, these process evaluation results, like Gerrish *et al.* (2017), presented rich learning for training on reablement. In particular, Rooijackers *et al.* (2021b) found good staff compliance, on average 73.4%, and workers accepted the programme, valuing its practical elements. The staff experienced positive changes in their knowledge, attitude, and skills about reablement, and enjoyed working as part of the team. The trainers wanted to be more flexible and tailor the programme to meet the participants for the process of behaviour change. Despite this, the process evaluation found that the extent to which home care staff implemented reablement in practice, varied. The reasons given were summarised into four themes: staff receptiveness; lack of understanding; willingness to adopt the reablement ethos, and ability to change.

Ashe *et al.* (2022) used a three-step online mixed method concept mapping exercise to categorise person and caregiver elements for participation; key reablement components for success; reablement content and delivery; organizational factors; and provider beliefs and training. They discovered goal setting and attainment, and person-centred care were the highly rated statements. However, this mapping was completed by a small group of participants, all of whom were researchers who restricted their mapping to an interdisciplinary model of reablement that was time limited. Therefore, these results do not reflect all reablement services, or the lived experience of older adults and family caregivers.

Assander *et al.* (2022a) investigated ASSIST:1 a reablement programme in a feasibility study using mixed methods. The study design in relation to the mix of methodologies unclear (Plano-Clark and Ivankova, 2017). The quantified change in effect used the outcome measures COPM and EQ-5D-3L, these measures detected a positive significant difference within both intervention and control groups after ten weeks, although the intervention group had a slight increase compared to the control. This was despite the small sample size, recruitment difficulties and other organisational barriers that compromised the study. Assander *et al.* (2022) also conducted qualitative interviews with recipients, and staff. However, the interview data analysis method is not reported, and the findings are summarised without quotes leading to reduced rigor (Aveyard, 2014). Nevertheless, they found staff reported they were already practicing the reablement ethos, although they weren’t supporting recipients to set goals and so the training helped them understand how to do this in a collaborative way. Some of the people receiving reablement reported they were motivated to work on their goals independently before the home carers visited, whereas others needed prompting and / or support to perform the specific activities. Over all, Assander *et al.* (2022a) found recipients reported their motivation and ability to achieve the set goals was influenced by the collaboration with the staff from the regular home care service, or contact with a significant other.

Qualitative designed studies interventions, components, and outcomes.

The qualitative studies define reablement, its nature, characteristics, and outcomes differently, giving rich descriptive insight into the experience of delivering or receiving the intervention.

Hjelle *et al.* (2016) and Hjelle *et al.* (2017) are both qualitative studies using the data collected during Tuntland *et al.* (2015) RCT. The aim of Hjelle *et al.* (2016) study was to explore and describe how an integrated multidisciplinary team in Norway experienced participation in reablement. Three themes emerged from a diverse range of professionals: the older adult`s goals are crucial; a different way of thinking and acting – a shift in work culture; and reablement. These give a better framework for cooperation and application of professional expertise and judgement.

Hjelle *et al.* (2017) describe older adults' experience of participation in reablement. Eight people were interviewed, and through qualitative content analysis, four themes emerged: my willpower is needed; being with my stuff and my people; the home-trainers are essential; and training in physical exercise not everyday activities. The study concluded intrinsic motivation in interaction with extrinsic motivation, if required, was needed for successful participation in reablement. This insightful study is limited by potential bias as the participants were drawn from a RCT arm receiving the reablement intervention, meaning the professional team may have influenced their motivation around the themes.

Lawn *et al.* (2017a) looked at the support workers' perceptions following a reablement initiative designed to change practice and enhance knowledge, skills, and confidence to support behaviour change in people with complex health care needs. Data was collected from a small purposefully selected sample of support workers, coordinators and people who had received the intervention by interview and focus groups. The responses were highly positive, reporting improvement in the quality of interactions with clients, health outcomes, care coordination, communication, and teamwork, although there was a gap in staff knowledge of mental health. Despite the sampling bias limitations, this research showed support workers are ideally placed to be more actively involved in motivating clients to achieve behaviour change goals.

Birkeland *et al.* (2017), explored how the interdisciplinary collaboration in reablement worked in Norway. They found it was dependent on people defining their own reablement goals, and this was what unified the various professions to create the collaboration. Studies of this nature can be affected by the people in the focus group on the day, for example experience with reablement or different teams may have affected the results of the study.

Jokstad *et al.* (2018), like Hjelle *et al.* (2016) also explored professionals' experiences in reablement but in Norway, where reablement had been already been implemented. The study recruited 18 professionals from home care services and used focus groups to collect data and analyse it using content analysis, finding that transforming user-involvement, from ideal to reality, was a demanding process. Four sub-themes emerged from this: an ideal of self-determination and co-operation; diverse ability to commit to what user-involvement requires; continuous co-creation processes; and workers were challenged by old traditions. The study concluded that involving the person in reablement is a valued ideal that professionals strive towards. That spending sufficient time and having patience with people during the initial stage of an intervention and starting an intervention by introducing small tasks that people can master was required. The study also identified that if interdisciplinary meetings were lacking, then professionals could revert to traditional attitudes and practices when people disengaged from the intervention. A criticism of this study`s methodology was the lack of reflexivity to manage bias given that the participants and research were known to each other, e.g. participants may have answered questions in a way they thought the researcher would want to hear, and researchers might ask leading questions or use body language to promote a more favourable response.

Moe and Brinchmann (2018) aimed to generate theory about professionals' actions when establishing reablement in a Norwegian study, using grounded theory. Seventeen employees, associated with managing, coordinating, or administrating standard home care services from different organisations, participated in interviews, focus groups and observations. Data was analysed using open, selective, and theoretical coding. The grounded theory emerged, described as tailoring reablement and included three phases from innovation to implementation: replicating, adapting, and establishing, using strategies of collaborating, developing knowledge, habituating, and filtering. This study was attentive to the grounded theory research design, using a constant comparison method to validate new data against preliminary findings giving credibility.

Liaaen and Vik (2019) aimed to develop a theory about reablement by providing knowledge of home care service providers' experiences. This qualitative study design is part of a larger study, although its not clear which study. Data was gathered from five focus group discussions with 25 healthcare professionals working in community health care in two municipalities using a grounded theory analytical approach. The study found participants engaged but had two challenges when working with reablement: creating sustainable change and negotiating the line between helping and enabling. The first described how increased focus on enabling people's participation during reablement created sustainable changes considered to be a positive change for both the recipients and the health professionals. The second illustrated reablement to be a process of negotiation with recipients and this challenged the professionals.

Bødker, Langstrup and Christensen (2019b) used a sample of 13 professionals, for ethnographic fieldwork over multiple sites in one municipal area, to investigate the normative dynamics involved in transitioning from one form of care to another in Denmark. They found that professionals considered reablement to represent a desirable shift from passive compensatory care, towards enabling practice focused on independence. They also demonstrated that therapists are valued as 'good carers' due to their ability to focus on development and training. On the other hand, nurses, and in particular home helpers, were devalued as 'bad carers' due to their caring, compensatory nature and their lack of technical and theoretical skills needed for documentation work.

Gustafsson *et al.* (2019a) explored the inter-professionals' experience of using short-term goal-directed reablement interventions with older adults, using written narratives collected after an intervention analysed using a phenomenological-hermeneutic approach. Four themes emerged: reliable relationship; empowered participation; negotiated approach; and time for growth. The study concluded that the process of reablement appeared to be strengthened by collaboration between professions, and that teamwork enables professional confidence and knowledge of reablement. A limitation of this study was that the mix of professionals was not equal as the sample was predominantly nurses.

Eliassen, Henriksen and Moe (2019) explored physiotherapy as a reablement intervention using fieldwork in seven Norwegian reablement teams, using observation and interviews of home trainers. This study identified that home trainers had the main responsibility for carrying out interventions in reablement and were also expected to report back to the therapists if they recognised further need for assessment or adjustments. The content of the practices varied considerably, from rigidly standardised to individually tailored approaches, emphasising quality of movement.

Eliassen, Henriksen. and Moe (2020) used the same sample as Eliassen, Henriksen and Moe (2019) but used a different research method, content analysis of observed practice of the seven triads, physiotherapists, home trainers and reablement recipients, followed by interviews. Three themes emerged from the analysis: division of labour; assessment; and intervention revealing two typologies of reablement teams. The study identified teams with a fixed division of labour provided limited assessments and a nonspecific approach, whereas teams with a flexible division of labour were characterised by interdisciplinary collaboration, thorough assessments, and person-centered interventions.

Magne and Vik (2020) study was also part of an unidentified larger research project, and aimed to explore and describe how older adults engage in daily activities within the context of reablement. They interviewed ten older adults, and three main themes were identified: What to achieve with reablement and feeling a sense of security to participate in daily activities; how to carry out wanted activities using different skills; and how the social network is important for enabling active living. These findings evidence the importance of social networks, and the need to strengthen participation in daily activities as part of reablement services. Strengths of this study are the researcher was independent for the service, professional bias was explored through reflexive discussion and participants were not incentivised to engage in the study.

Smeets *et al.* (2020) investigated the experience of nurses and domestic workers who had undertaken the Stay Active at Home reablement training programme in the Netherlands. Later the same training programme is evaluated in a RCT (Rooijackers *et al.*, 2022); (Rooijackers *et al.*, 2021a). Smeets *et al.* (2020) study focused on staff experience of knowledge, skills, self-efficacy, and social support. Whilst the study showed that staff perceived the programme as useful, they also needed more support with mastering reablement skills, especially compensatory equipment and dealing with challenge. In particular, the most appreciated component were activities that were learnt from each other through knowledge and experience exchange. The study identified limitations around purposeful sampling and lack of reflexivity, the researcher was a nurse employed by the same provider organisation suggesting there may have been selective recruitment bias.

Mjøsund *et al.* (2021) looked at how health care professionals integrate physical activity into their professional reasoning during reablement in Norway using a credible and trustworthy study design. They interviewed 16 professionals from four municipalities including occupational and physical therapists, registered nurses, and other home care staff. Content analysis gave an overarching theme: Improving the person’s ability to participate in meaningful activities. Two sub-themes emerged: Increasing physical capacity or improving activity performance. Both themes generated different reasoning aspects and diverse perspectives on how to integrate physical activity into reablement.

Maxwell *et al.* (2021) explored care coordinators,’ and direct care staffs’ experience of translating a taught reablement training programme into practice in an Australian restorative homecare service, without integrated professionals. The study found several organisational and person-centred challenges. Specifically, these were communication, functional partnerships, staff education and resourcing. The study used a convenience sample and conducted focus groups and interviews with 13 care coordinators and four direct care workers to understand their experience of reablement, two months after they had undertaken co-produced reablement training. They found there were several organisational challenges: communication, functional partnerships, staff education and resources. Enablers were sharing reablement stories to create a reablement culture. A barrier to support this was access to the office and whether training should be happening in paid working time.

Dibsdall (2021) used a realist synthesis to test three case studies in a reablement service in England through observations and interviews with occupational therapists, reablement support workers and managers. It was found that occupational therapists' education and experience underpin their ability to undertake assessments and person-centred goal setting and that they utilise a range of intervention techniques, selecting from their toolbox of interventions, to support people. The study also identified occupational therapists have a role in training reablement support workers to work in an enabling way, although there was no description of the training components. Notwithstanding, Dibsdall (2021) found knowledge of each other's roles, regular communication and co-location, supported levels of trust and shared purpose between members of the reablement team.

Ambugo *et al.* (2022) interviewed healthcare workers who provided reablement from six localities in Norway. They described several reablement interventions, involving assessments of people's functional needs, safer home environments, and identification of people's goals, and their pace. The staff promoted the principle of 'doing with,' not 'doing for' to promote independence, the safe and responsible use of assistive technology and compensatory equipment. The staff reported their constraints to effective reablement, such as: heavy workload, high staff turnover, insufficient training in reablement, and poor collaboration across care-units. There were recognised limitations to this study in relation to sample size, time for interviews and resource constraints that affected the depth and breadth of data collection, and this may have hindered data saturation.

Golenko, Paine and Meyer (2022), study was conducted over three community sites in Australia and aimed to understand the older person's experience of a well-being and reablement approach, including home carers' experiences of the training package. Eight staff underwent training and were asked to use the approach with at least one of 18 older people engaged in the four-month programme. They used semi-structured interviews with older people and staff to gather data on completion of the programme. They found some older people were unfamiliar with, or displayed negative attitudes towards, goal setting. The reasons given were negativity towards health decline or ageing, emotional barriers such as: apathy, frustration, embarrassment, and a sense of helplessness. In contrast, enabling factors that triggered a positive emotional response, enhanced goal progress, and got better outcomes were assistive equipment, staff knowledge and understanding, and social connection. This credible study design produced rich insightful data, and whilst the findings are not generalisable, the method included attempts to reduce bias through reflexivity and adherence to the research protocol.

2.3.5 Defining reablement's nature, characteristics, and outcomes.

Based on the description of reablement service delivery in each of the published articles, three different service types were identified. Table 2 shows some studies described all three models by the nature of their exploratory methodology.

1. Reablement home care with integrated professionals**.** Twenty-five journal articles described either multi-disciplinary regulated professionals or single disciplinary regulated professionals in a team integrated with home care. As presented in Table 3, those articles originated from Norway (Tuntland *et al.*, 2015), (Winkel, Langberg and Wæhrens, 2015); (Hjelle *et al.*, 2016), (Hjelle *et al.*, 2017), (Birkeland *et al.*, 2017), (Jokstad *et al.*, 2018), (Moe and Brinchmann, 2018), (Eliassen, Henriksen and Moe, 2019), (Langeland *et al.*, 2019), (Liaaen and Vik, 2019), (Eliassen, Henriksen and Moe, 2019), (Mjøsund *et al.*, 2021), (Ambugo *et al.*, 2022); or the Netherlands (Smeets *et al.*, 2020), (Metzelthin *et al.*, 2020), (Rooijackers *et al.*, 2021a), (Rooijackers *et al.*, 2021b), (Rooijackers *et al.*, 2022); or the UK (Beresford *et al.*, 2019a), (Beresford *et al.*, 2019b), (Dibsdall, 2021); or Sweden (Gustafsson *et al.*, 2019b), (Pettersson, Zingmark and Haak, 2022); or Denmark (Bødker, Langstrup and Christensen, 2019b); or Canada (Ashe *et al.*, 2022).

2. Reablement home care with no integrated professionals. Twelve journal articles described a model of home care with no integral regulated professionals, meaning onward referrals to other services were required for regulated professional input. Those studies originated in Hong Kong (Lee *et al.*, 2018); or Taiwan (Chiang *et al.*, 2020), (Han, Chuang and Chiu, 2020), (Song, Lin and Hung, 2021); or Japan (Hattori *et al.*, 2019); or Australia (Burton *et al.*, 2013), (Golenko, Paine and Meyer, 2022), and the UK (Whitehead *et al.*, 2016), (Gerrish *et al.*, 2017), (Beresford *et al.*, 2019a), and (Beresford *et al.*, 2019b). Only one study using this model originated from Norway (Magne and Vik, 2020).

3. Reablement by regulated professionals with standard home care**.** Ten journal articles described a model where the regulated professionals delivered reablement, but the home care service was standard provision, or informally provided by family or friends. Those studies describing this model were from Australia (Lewin *et al.*, 2013), (Lawn *et al.*, 2017a), Lawn (Lawn *et al.*, 2017b), (Maxwell *et al.*, 2021); or New Zealand (Parsons *et al.*, 2013), (Parsons *et al.*, 2017); or Sweden (Assander *et al.*, 2022a); or the Netherlands (Metzelthin *et al.*, 2020) and the UK (Beresford *et al.*, 2019a), and (Beresford *et al.*, 2019b).

As shown in Table 3, the timeframe for service delivery across all studies varied between less than six weeks to less than six months, although some studies did not give a timeframe, and some described the service as time limited. The shortest intervention provision was just two weeks (Burton *et al.*, 2013). In six studies the reablement intervention was delivered within six weeks (Whitehead *et al.*, 2016); (Gerrish *et al.*, 2017); (Jokstad *et al.*, 2018); (Han, Chuang and Chiu, 2020); (Beresford *et al.*, 2019b); (Pettersson, Zingmark and Haak, 2022). Although Pettersson, Zingmark and Haak (2022) staff survey described interventions delivered mainly in six weeks, with a few people in less than ten weeks. One study delivered the intervention in eight weeks (Bødker, Langstrup and Christensen, 2019b). Five studies described intervention provision in less than ten weeks (Tuntland *et al.*, 2015); (Langeland *et al.*, 2019); (Mjøsund *et al.*, 2021); (Song, Lin and Hung, 2021); (Assander *et al.*, 2022a).

In three studies, the intervention took place over a slightly longer period, up to 12 weeks (Lewin *et al.*, 2013), and a maximum of three months (Hjelle *et al.*, 2016), (Hjelle *et al.*, 2017). Whereas, in three other studies, it was delivered in a much longer period between three and six months (Lee *et al.*, 2018), less than 16 weeks (Golenko, Paine and Meyer, 2022) and over five months (Hattori *et al.*, 2019). Eleven of the studies do not describe the intervention time period at all (Parsons *et al.*, 2013); (Parsons *et al.*, 2017); (Birkeland *et al.*, 2017); (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Moe and Brinchmann, 2018); (Liaaen and Vik, 2019); (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2021b); (Rooijackers *et al.*, 2022); (Ambugo *et al.*, 2022). Finally, twelve studies refer to a time limited service provision (Winkel, Langberg and Wæhrens, 2015); (Eliassen, Henriksen and Moe, 2019); (Gustafsson *et al.*, 2019b); (Magne and Vik, 2020); (Smeets *et al.*, 2020); (Chiang *et al.*, 2020); (Eliassen, Henriksen. and Moe, 2020) (Metzelthin *et al.*, 2020); (Dibsdall, 2021); (Beresford *et al.*, 2019a); (Maxwell *et al.*, 2021); (Ashe *et al.*, 2022).

2.3.6 The types of interventions delivered during reablement.

The breakdown of intervention components reported in each study are presented in Table 3. These have been grouped into common themes: functional ability, functional mobility, and community and social participation. Overarching this was the overall approach, two thirds of the articles (30) described how reablement should focus on being person-centred. Some described this as strength or asset based or conducting a person-centred assessment. The twelve studies that did not specifically mention being person-centred were (Lewin *et al.*, 2013); (Parsons *et al.*, 2017); (Whitehead *et al.*, 2016); (Gerrish *et al.*, 2017); (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019); (Song, Lin and Hung, 2021); (Eliassen, Henriksen. and Moe, 2020), (Han, Chuang and Chiu, 2020); (Rooijackers *et al.*, 2021a) (Rooijackers *et al.*, 2021b); (Rooijackers *et al.*, 2022).

Functional Ability.

More than half (31) of the articles described a functional assessment of activities of daily living. The ten studies that did not describe this were (Gerrish *et al.*, 2017); (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Eliassen, Henriksen and Moe, 2019), (Jokstad *et al.*, 2018); (Moe and Brinchmann, 2018); (Liaaen and Vik, 2019); (Chiang *et al.*, 2020) (Maxwell *et al.*, 2021); (Golenko, Paine and Meyer, 2022).

Activity analysis, the knowledge and skill required to break an activity down into smaller more achievable parts was described by 11 studies, and as shown in Table 2 most studies (31) did not mention this technique at all. However, most articles (30), did describe guiding or practising activities of daily living. The twelve that did not were (Burton *et al.*, 2013); (Moe and Brinchmann, 2018); (Liaaen and Vik, 2019); (Beresford *et al.*, 2019a); (Beresford *et al.*, 2019b); (Bødker, Langstrup and Christensen, 2019b); (Gustafsson *et al.*, 2019b); (Golenko, Paine and Meyer, 2022); (Ambugo *et al.*, 2022).

Table 2 showed that most (35) studies described a goal orientated plan intended to enable goal attainment. Those few studies that did not were (Burton *et al.*, 2013); (Gerrish *et al.*, 2017); (Moe and Brinchmann, 2018); (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019); (Song, Lin and Hung, 2021) and (Maxwell *et al.*, 2021).

Pacing, a method of conserving energy to prioritise important activities, was only mentioned in five studies (Gerrish *et al.*, 2017); (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Dibsdall, 2021); (Ambugo *et al.*, 2022). By far, most studies did not mention pacing or energy conservation at all.

Half of the studies (21) mentioned advice on self-management, education on conditions or signposting for self-directed support. Motivating people to have self-determination was mentioned in 17 articles, and 25 did not mention this intervention. Hjelle *et al.* (2017) specifically studied the intrinsic motivation people need to participate in meaningful activities. Table 3 shows confidence building was only mentioned in 13 articles, and the majority of 29 studies did not mention it. However, Doing with, not for, a way of describing the hands-off approach Home Carers use to encourage people to do more for themselves during reablement, is mentioned in 23 studies as an intervention, (19) did not mention it.

Medication management, an important reablement intervention to reach true independence, was surprisingly only mentioned in five studies (Lewin *et al.*, 2013)

(Burton *et al.*, 2013); (Hjelle *et al.*, 2016); (Gerrish *et al.*, 2017), (Birkeland *et al.*, 2017). The majority of studies did not mention using reablement as a strategy to promote independence in self-medication management. Gerrish *et al.* (2017) study was unique in that it was looking at this from the pharmacy profession perspective.

Half (22) the articles reviewed mentioned using compensatory equipment and adaptations. Although, only a few of those articles (11), mentioned assistive technology equipment such as the use of telecare call systems, telehealth systems, and the internet of things, for example: amazon echo, smart plugs and switches and movement sensors. Burton *et al.* (2013) and Gerrish *et al.* (2017) both mentioned assistive technology, but not other types of compensatory equipment, and a further 18 other studies that did not talk about compensatory equipment and adaptations as a reablement intervention, were (Parsons *et al.*, 2013); (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Parsons *et al.*, 2017); (Jokstad *et al.*, 2018); (Gustafsson *et al.*, 2019b); (Liaaen and Vik, 2019); (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019); (Eliassen, Henriksen. and Moe, 2020); (Han, Chuang and Chiu, 2020); (Magne and Vik, 2020), and (Smeets *et al.*, 2020).

Functional Mobility.

Overall, by and far the majority of 32 articles described some use of interventions to improve indoor mobility, or strength and balance. Those that did not were (Gerrish *et al.*, 2017); (Bødker, Langstrup and Christensen, 2019b); (Gustafsson *et al.*, 2019b); (Liaaen and Vik, 2019); (Chiang *et al.*, 2020); (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2021b); (Rooijackers *et al.*, 2022), and (Assander *et al.*, 2022a). Of interest, is that the Rooijackers *et al.* (2021a) RCT investigating the effectiveness of the stay active at home training programme used change in mobility as an outcome measure but with no clear reablement strategy to improve strength and balance or indoor mobility. There were only five studies that specifically focused on strength and balance exercise as a reablement intervention, and these were (Burton *et al.*, 2013); (Eliassen, Henriksen and Moe, 2019); (Eliassen, Henriksen. and Moe, 2020); (Mjøsund *et al.*, 2021); (Song, Lin and Hung, 2021).

Table 3 showed less than a third of the articles (13) mentioned outdoor mobility as an intervention. However, it was notable that outdoor mobility was not linked to social or community participation in all studies. Only nine studies mention both outdoor mobility and community participation (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Hjelle *et al.*, 2016); (Hjelle *et al.*, 2017); (Beresford *et al.*, 2019a); (Beresford *et al.*, 2019b); (Mjøsund *et al.*, 2021); and (Pettersson, Zingmark and Haak, 2022).

Community and social participation.

Nearly half of the articles (18) mentioned social participation as an intervention, and this considered broadly to be outdoor activity, leisure, social contacts and communication. Pettersson, Zingmark and Haak (2022) found social participation to be a complex and undefined term, with only 6.8% of cases focused on this in their cross-sectional survey, despite using a broad range of aspects to describe social participation: outdoor mobility, leisure, social contacts, and communication. Despite many studies measuring quality of life as an outcome, no experimental studies investigated interventions designed to improve social interaction or social participation as part of a reablement intervention, although Hattori *et al.* (2019) and Song, Lin and Hung (2021) both delivered their reablement intervention in a group setting with positive results.

2.3.7 Who delivers reablement interventions and when?

The dose, or amount of intervention visits varied, less than half of the journal articles gave descriptions of who visited and for how long, with some describing multiple visits, where this was described it has been summarised alongside the description of the worker role delivering the intervention, which also varied, in Table 5.

Table 5 Detail of reablement dose and role

Study	Date	Delivery dose and role
Assander, et al	2022	Multiple visits from nurse assistants over 2 weeks
Burton, et al	2013	3 visits by Care Manager
Beresford et al	2019b	Average of 12 sessions over 6 weeks

Lewin et al	2013	At least 3 reablement worker visits
Han et al	2020	50 minutes, once a week for 6 weeks by an OT
Song, et al	2021	1.5-hour group session by OT and PT, and 1 hour OT session at home weekly.
Hattori et al	2019	12 weekly sessions by rehabilitation specialists for 2-3 hours plus home care
Langeland, et al	2019	Intensity was five times a week (48%, n = 17) and three to four times a week (33%, n = 12) by a member of the MDT
Lee, et al	2018	45 mins from PT, OT, and RA
Metzelthin et al	2020	Intensive multiple visits
Mjøsund, et al	2021	2-5 visits for 20-50 minutes weekly by OTs, PTs, Home Care Assistants, Nurses, and HCP
Pettersson et al	2022	5 OT contacts
Rooijackers, et al (a & b)	2021	Registered nurses, nurse assistants, and nurse aides who provided short visits several times a week
Tuntland et al	2015	5 professional visits and 7 home care visits a week
Whitehead et al	2016	5 OT visits 45mins
Winkle et al	2015	Three 1-hour OT visits, plus 45 min a week for 12 weeks by Home Carers.

*OT=Occupational Therapist, PT=Physiotherapist, NA=Nursing assistant, RA=Rehabilitation Assistant, HCP=Health Care Professional

The earlier studies gave less detail on role. This may be because non-specific care managers were used for a restorative home care service. Table 4 shows, Lewin *et al.* (2013) gave little detail of frequency other than a minimum of three reablement visits or three hours of conventional home care was required for study eligibility. Likewise, Burton *et al.* (2013) identified three visits from a care manager.

Conversely, Table 5 summarises that Winkel, Langberg and Wæhrens (2015) gave more detail, the occupational therapist delivered three one-hour home visits, in combination with sessions of 45 minutes per week by home carers; the occupational therapist completed the analysis of activities, set goals and the home carer implemented them with the client; inferring that the occupational therapist three hourly visits had reduced the home care time.

On the other hand, Tuntland *et al.* (2015) identified that the total time resources, for the number of visits and intervention time, was similar between the control and intervention groups. However, they also found that the reablement group had more therapy time and less nursing time, compared to the usual care group; implying that better ADL performance and satisfaction with performance are directly related to increased occupational therapy intervention time.

Whitehead *et al.* (2016) were also explicit about the frequency of visits but did not examine whether more or less frequency would be as effective. Table 4 shows the average number of occupational therapist visits was five, and took 45 mins.

Later studies are also shown in Table 5 to be more specific about the intervention time and role of the worker delivering the intervention (Lee *et al.*, 2018); (Langeland *et al.*, 2019); (Han, Chuang and Chiu, 2020); (Rooijackers *et al.*, 2021a); (Rooijackers *et al.*, 2021b) (Rooijackers *et al.*, 2022) and (Pettersson, Zingmark and Haak, 2022).

Overall, the results in Table 5 showed most studies seemed to be delivering one hour of occupational therapist's time, weekly. The two studies using community group sessions, varied in how long the session lasted, two to three hours weekly (Hattori *et al.*, 2019) and one and a half hours weekly (Song, Lin and Hung, 2021). What is still not clear from this scoping review analysis, is the optimum number of professional visits, and which professional role alongside the reablement home care is most effective.

2.3.8 Training and supervision.

Training or coaching reablement workers was mentioned by over half of the articles (29), suggesting that the knowledge and skills required to deliver reablement interventions are over and above standard home care. It was not always clear if training was to deliver study, the intervention, or designed to be sustainable in a way that empowered home carers to change their mindset or behaviour long term.

Three studies explicitly described the content of reablement training, these were experimental studies examining the effectiveness of training reablement workers, on the recipients of reablement (Lawn *et al.*, 2017a); (Rooijackers *et al.*, 2021a); (Assander *et al.*, 2022a), another studied the effect training had on the workers behaviour (Rooijackers *et al.*, 2022), and four evaluated staff experience of reablement training (Lawn *et al.*, 2017b); (Smeets *et al.*, 2020); (Maxwell *et al.*, 2021); (Dibsdall, 2021).

Maxwell *et al.* (2021) describe training sessions as lasting two hours (two months apart) and identified that the workers access to the office and training in paid working time as enablers. Whereas (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019) and (Dibsdall, 2021) all identified the value of professional supervision and on-the-job competency training to enhance support workers practice but gave little detail on the reablement training programmes or content.

Lawn *et al.* (2017a) describe a three-phase training programme: understanding and identifying risk factors; goal attainment and motivating people to change behaviour; and reflection. Lawn *et al.* (2017b) talk about the same training involving four modules that could be delivered as a total single workshop or in distinct, shorter sessions to accommodate service needs and support worker availability. The learning competencies set out in Lawn *et al.* (2017a) are broad: motivating clients, supporting behaviour change; dealing with challenging behaviours; conversations to help identify and communicate changes in clients' needs to others; introduction to chronic condition self-management approaches; person centered practice, effective communication; express encouragement and support; apply problem-solving, negotiation and mediation skills and effectively engage and motivate people towards goal attainment. Ultimately, Lawn *et al.* (2017a) found the home carers clearly demonstrated their capacity to understand many core concepts around motivation, goal setting, and behavior change, and that attending the training allowed them and others to recognise the depth and complexity of the care they delivered.

Rooijackers *et al.* (2021b) describe the Stay Active at Home training, a nine month programme delivered to a sample of nurses and domestic staff in the Netherlands by an occupational therapist. It consisted of structured bi-monthly meetings, practical assignments, weekly newsletters, taught sessions on motivating people, increasing engagement in daily activities, goal setting, action planning, involvement with social networks and assessing people's capabilities. A criticism of this study is they did not consider whether the professional group they were training might be biased towards a “caring for” ethos, as opposed to a reablement ethos. Instead, the study authors recommended more research on scales that quantify determinants of staff behaviour and outcomes (Rooijackers *et al.*, 2022). Later, the effect of Stay Active at Home was evaluated using a RCT methodology to determine the effectiveness of training on two different outcomes, recipients’ sedentary behaviour (Rooijackers *et al.*, 2021a), and staff self-efficacy on recipients’ outcomes (Rooijackers *et al.*, 2022). No statistical difference was found between the two study arms, the activity tracker positioning reported to be a failing of the study (Rooijackers *et al.*, 2021a), and the reablement intervention may not have been implemented well in practice because of the organisational service delivery. This is because staff experienced barriers around delivery of reablement interventions due to time constraints and staff shortages (Rooijackers *et al.*, 2022), and this is similar to findings in other studies (Ashe *et al.*, 2022); the Stay Active at Home training programme was not recommended for widespread implementation.

Assander *et al.* (2022a) feasibility study refers to coaching staff, as apposed to training. In the protocol, Bergström *et al.* (2019) give more detail of workshops intended to be delivered over 10 weeks conducted by an occupational therapist, covering topics such as: person centered approach, the lived experience of ageing, activities, and health, and coaching the recipient of reablement. The fidelity of the training was determined by Assander *et al.* (2022a) by analysing the interviews with the workers and recipients in the intervention group, as well as the content in the logbooks. The logbooks included information about e.g., planned and executed workshops and coaching sessions, attendance at and themes for the workshops, strategies of the provided support to the older adult, and the older adult’s engagement when working with their set goals. The study found the ASSIST 1:0 programme, of which the reablement staff workshops were just one aspect, to be acceptable, feasible in terms of study design.

2.4 Discussion.

This scoping review of 42 studies published between 2013 and 2022, has indicated the complex nature of defining and evaluating reablement as an intervention. It is clear that published research on reablement has expanded considerably in the past five years, and that researchers' ideas have connected and interwoven.

Two thirds of the included studies referred to reablement as a person-centered assessment, more than half described a functional assessment of activities of daily living with most studies describing a goal orientated plan. The majority of the studies described guiding or practising activities of daily living, yet very few mentioned activity analysis. Half of the studies mentioned equipment and adaptation, although few mentioned assistive technology.

More than half of the studies talked about doing 'with,' not 'for,' or taking a hands-off approach during reablement. Although, less studies mentioned motivating people to have self-determination, the majority did not mention confidence building or pacing activities. Half mentioned giving advice on self management, education on conditions, but very few mentioned encouraging independent medication management an interesting area for more research.

Most studies referred to interventions to improve indoor mobility, or strength and balance but less than a third of the articles mentioned outdoor mobility. Only a third of articles mentioned social participation as an intervention.

The discussion will take each objective in turn to give structure to the review.

2.4.1 Reablement: what, where, how, whom and for how long.

There were three descriptions of different models of service delivery: Professionals who were integrated with reablement home care, reablement home care without integrated professionals, and professionals who were delivering reablement interventions but with either a standard home care service or informal carers. It is worth noting that some people choose to look after relatives within the family unit, and this will impact on economics if they are of working age (Aspinal *et al.*, 2016). It is unclear whether people who are supported solely by informal carers are benefiting from reablement interventions. Further research to explore this would be beneficial.

There was no other primary research found comparing different reablement service models. Beresford *et al.* (2019b) study was hampered by recruitment difficulties. Beresford *et al.* (2019a) recommended identification of service and intervention characteristics deemed important and relevant to commissioners, strategic leads, and service managers, so these can be investigated in a large-scale, multisite, evaluation of reablement.

The term reablement was used interchangeably with rehabilitation in some studies. Reablement was described as \`everyday\` rehabilitation in the home by Moe and Brataas (2016), and Gustafsson *et al.* (2019b) and Han, Chuang and Chiu (2020) use this term in their studies. Similarly, Magne and Vik (2020) referred to utilising the rehabilitation mindset through home-based services, and Moe and Brinchmann (2018) referred to an interprofessional, home-based rehabilitation service. A helpful explanation of the terminology, given by Chiang *et al.* (2020) clarifies that reablement aims to reduce the need for long-term care by helping people regain confidence, learn or practice the skills needed to maximise their independence, whereas rehabilitation aims to restore physical function to achieve the person's highest level of abilities.

An international Delphi study (Metzelthin *et al.*, 2020) gave a consensus definition of reablement, and yet illuminated the different understandings of reablement; it is interesting to note the clusters of agreement and disagreement by country. Furthermore, some researchers evidence disagreement through critical appraisal (Mjøsund *et al.*, 2020), omitting part of the statement (Bennett *et al.*, 2022); (Pettersson, Zingmark and Haak, 2022), or by not referencing it at all (Dibsdall, 2021).

A lack of descriptive content of reablement interventions may give rise to a varied practice with varying quality. Therefore, it was imperative that this scoping review captured the types of interventions commonly delivered, and Table 2 presented this visually. This information was taken from Appendix 2, the included primary research studies, involving the people who deliver reablement, both regulated and unregulated professionals, and people who have experienced reablement.

Early studies, excluded from this scoping review date range, evidenced that interventions delivered in the community alongside home care had the potential to improve functional independence (Sheffield, Smith and Becker, 2012); (King *et al.*, 2012) and both studies recognised that the policy change and training required for restorative home care would be huge. During the period 2013 to 2016 reablement intervention was described as being goal focused (Cochrane *et al.*, 2016) involving both physical exercises and guidance in everyday activities (Tuntland *et al.*, 2015). Later, reference to community and social participation as a reablement outcome becomes more explicit (Doh, Smith and Gevers, 2020).

This scoping review took an up-to-date, ten-year range and found high numbers of articles describing interventions focusing on functional ability, practising, and mastering activities of daily living, goal planning and attainment, use of compensatory strategies like equipment and adaptation provision, and using strength and balance interventions to improve indoor mobility. Lacking was the mention of activity analysis, a unique occupational therapy skill that informs goal planning (Thomas, 2012), and specific assistive technology connected to the internet to diagnosis, prevent, monitor or give control over the home environment (Department of Health and Social Care, 2023b).

However, Pettersson, Zingmark and Haak (2022) found that whilst functional independence is the main goal of reablement, functional mobility was the most difficult but most prioritised occupation, when people experience functional decline. Furthermore, they identified occupational performance difficulties with outdoor mobility are more common than indoor mobility.

Community physiotherapists are the professional experts for mobility assessments, strength and balance training, and walking aids. However, in England, Public Health commission community falls prevention services. There is a gap in the research around how reablement fits in the continuum between low level community exercise groups and community health physiotherapy services designed for more complex mobility assessment. Reablement, can and should be working in this space identifying people at risk from falls, and connecting with them on a preventative journey by introducing non-complex, low risk (chair based) strength and balance exercise at home.

People have different motivations for performing different activities, and Magne and Vik (2020) identified a key element of reablement was the need to focus on strengthening the cooperation between the person and their social network. It makes sense then, that reablement should be addressing outdoor mobility goals along with social and community participation (Doh, Smith and Gevers, 2020), (Clotworthy, Kusumastuti and Westendorp, 2021).

Interestingly, only two studies (Hattori *et al.*, 2019) and (Song, Lin and Hung, 2021) investigated bringing people together in a group setting to teach reablement recipients that self-determination was required to remain independent in later life. Neither study explored whether this impacts on community or social participation, or the optimal session time, how often and the role of professionals delivering the session.

Overall, this review discovered primary research on reablement interventions mentioning outdoor mobility and social and community participation to be low. The gap in research around social and community participation could be determined in a future comparison study.

A component of reablement, not well researched, is medication management. This review included one study (Gerrish *et al.*, 2017). The input of pharmacy technicians to the reablement pathway could support greater independence for people who receive care for medication only needs. Medication management requires expert advice from community pharmacists, commissioning community pharmacists to load assistive technology dossette boxes for people who don't have informal carers to do this for them would require investment from the local authority, but potentially save money long term if medication supervision by a home carer was the persons only care and support need. Gerrish *et al.* (2017) identified further research on the outcomes of this and how effects can be sustained when people move out of reablement to standard home care.

A few studies focus on the role of the reablement support worker to encourage behaviour change (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Liaaen and Vik, 2019). They described interventions such as: self-direction, motivation and carers or support workers `doing with, not for', or described in home carers own words, as "working with our hands on our backs" (Liaaen and Vik, 2019 p4). Crucially, this is the skill that enables the person to feel safe when performing or practising activities (Magne and Vik, 2020). This is affirmed by Azim *et al.* (2022) who`s literature review identified six behaviour change strategies used by reablement workers: goal identification and planning; social support; antecedents; feedback and monitoring; shaping knowledge; and repetition and substitution.

This scoping review found that a common theme in most studies investigated was an element of teaching home carers the intervention. However, only three studies evaluated the effectiveness of reablement training on the recipient (Lawn *et al.*, 2017a); (Rooijackers *et al.*, 2021a); (Assander *et al.*, 2022a). The implications of training staff to deliver reablement with the intervention it will lead to better outcomes, were raised by Lawn *et al.* (2017b) and Maxwell *et al.* (2021) in Australia, and by Smeets *et al.* (2020) and Rooijackers *et al.* (2022) in the Netherlands, who evaluated worker experience of reablement training programmes. In a UK study, Dibsdall (2021) identified the role of occupational therapist in training local authority reablement workers. There is a risk without training workers, the outcomes of reablement could be negatively impacted.

Teaching the intervention and it being embedded in practice in a sustainable way are different as Smeets *et al.* (2020) identified, workers learn from each other through knowledge and experience. This is further evidenced by Rooijackers *et al.* (2022) who found self-efficacy and outcome expectations were not significantly changed after training. However, Rooijackers *et al.* (2021b) identified home carers and regulated professionals training together made the home carers feel part of the reablement team. Likewise, Dibsdall (2021) found the mechanism of trust and co-location to be valuable ways to enhance collaborative working in reablement.

Reablement is person-centered (Metzelthin *et al.*, 2020), therefore there was an expectation that this scoping review would find a diverse set of interventions that can be tailored to support people to meet a wide range of goals. This was evident in the scoping review, although twelve studies did not refer to being person-centered when describing interventions, and this was concerning. For example, Eliassen, Henriksen and Moe (2019) described diverse content of service provision reporting this exposed considerable variation across reablement teams. Conversely, Dibsdall (2021) who did recognise reablement as being tailored to the individual, referred more broadly to occupational therapy professionals selecting from a toolbox of interventions. Due to the person-centered nature of reablement, the professionals' response needs to be tailored to individual circumstances, as the skills of nurse, physiotherapist, or occupational therapist are all relevant. The combination of professional roles to deliver reablement was found to be complex, arguably, at least two assessor visits, are required to set goals and to review progress, but this did not feature in all descriptions.

Whitehead *et al.* (2015), and Pettersson and Iwarsson (2017), identified the need for professional roles to be better described. Earlier studies (Lewin *et al.*, 2013) and (Parsons *et al.*, 2013) used care coordinators to assess, and reablement home care workers to deliver interventions. Other studies examined the effectiveness of reablement delivered by multi-professionals (Burton *et al.*, 2013); (Tuntland *et al.*, 2015); (Winkel, Langberg and Wæhrens, 2015); (Langeland *et al.*, 2019); (Mjøsund *et al.*, 2021), et al., 2021), and by occupational therapists (Whitehead *et al.*, 2016); (Han, Chuang and Chiu, 2020); (Pettersson, Zingmark and Haak, 2022). A process evaluation by Lewin et al (2016) acknowledged occupational therapy skills and knowledge are important for the delivery of reablement, but presented the opinion that they are not essential team members, provided they can be accessed in a timely way and that they are involved in the training of reablement workers.

Arguably, if there is not clear evidence for the effectiveness of occupational therapy on reablement outcomes then recruiting this professional group to deliver services, offer professional supervision, or train others is unlikely to occur. Given that a clear common feature of reablement identified in this scoping review is goal setting and practice of activities of daily living both occupational therapy interventions, this warrants further research.

Furthermore, activity analysis, a unique occupational therapy skill used to reason how the person’s strengths can be effectively used, how the task can be simplified or environmental barriers changed (Thomas, 2012), and only eleven articles were identified in this scoping review that acknowledged this.

This scoping review found evidence of three reablement models when examining the international articles, despite Beresford *et al.* (2019b) identifying four different patterns of staffing and skill mix in the UK: (a) reablement workers only, (b) home care reablement, (c) reablement with occupational therapy and (d) inter-disciplinary reablement approaches; the reablement worker, with no home care function, did not feature in any of the articles examined. It is not clear which of the identified reablement service delivery models are more effective, and this warrants further comparative research, both in the UK and internationally.

Home care in England funded by the local authority can be provided as direct care or commissioned from the independent home care sector. It remains a mystery as to how effective this kind of commissioned service is, and how it might align with the other professionals involved in assessment or provision of reablement interventions. It is noted that Dibsdall (2021) concluded that co-location and communication with occupational therapists supports levels of trust and shared purpose between members of the reablement team.

An issue over the past 10 years has been the parameters for the reablement intervention. Table 3 shows the timeframe for intervention delivery is varied, from two weeks to six months. The question emerges as to whether there is any difference in outcome depending on the length of the service, and this requires further research.

Furthermore, this scoping review found the description of timeframe for the intervention delivery to be vague, less-than or more-than, rather than a specific number of days or weeks. In an operational “real-world” setting reablement is used to ensure hospital discharge flow and home care provision is pressured by capacity and demand (Flemming *et al.*, 2021). To enable research to transfer to evidence-based practice the detail on dose and timeframe for intervention delivery should be improved in published research.

Robust systematic reviews have restricted eligibility criteria to include interventions, or service, delivered in less than six weeks (Legg *et al.*, 2015), or less than ten weeks (Cochrane *et al.*, 2016), excluding key studies as a result. Specific time-frame was contentious in the Delphi study definition of reablement (Metzelthin *et al.*, 2020). Others argue reablement service delivery should be time-limited, not time specific (Doh, Smith and Gevers, 2020); (Clotworthy, Kusumastuti and Westendorp, 2021).

It is right therefore to debate the issue of the service delivery timeframe, as reablement delivered in too short a timeframe suggests the service is targeted at those who are just convalescing and who would become independent without any intervention. For example, Lewin *et al.* (2013) observed 50% of their intervention group were already independent with showering at the three-week assessment point before any interventions, despite this being their referral need. Similarly, Pettersson, Zingmark and Haak (2022) found a larger proportion of people, with major functional limitations, received reablement over a longer period, seven weeks or more (22.2%), compared to those with no home care (16.9%) and those with minor functional limitations (19.1%). This shows a flexible time-limited approach is more realistic to accommodate those who need more time to reable. Furthermore, the transition between reablement and standard long-term home care, and the risk of dependency emerging, is another area poorly researched. If all home care providers were trained in the reablement ethos this risk would be mitigated, and this could be economically beneficial.

There is good reason for accepting a less restrictive timeframe for intervention or service delivery from a research perspective, as evidence through primary research studies, may be distorted by the parameters of the study, data collection and outcome measurement. In reality, when a research intervention becomes operationalised, the service delivery is likely to become quicker.

A final observation from the literature is staff satisfaction with their work when undertaking reablement. Organisational constraints were found to limit reablement (Assander *et al.*, 2022a). Whereas collaborative working was found to give greater job satisfaction (Birkeland *et al.*, 2017); (Gustafsson *et al.*, 2019a); (Dibsdall, 2021).

Overall, the scoping review has lead to acknowledgement that there are still gaps in the literature around reablement. The outcomes of reablement are positive, they can improve people`s functional ability and mobility, quality of life and reduce the need for ongoing care. However, it is still unclear what combination of interventions have the greatest effect, mainly because reablement interventions are designed to be broad and tailored to a wide range of individuals needs. This review found only half of the articles described the person having a progress review during, or whilst receiving, the intervention and so it is not clear how the impact of the intervention on them was measured – a limitation in the research.

The outcome measures used to evidence reablement's effectiveness varied, and therefore a limitation of all studies examined in this scoping review is diversity in the range of outcome measure tools used, meaning synthesis of data across several studies isn't possible. A recommendation for future research is to investigate suitability of measures to determine the effectiveness and outcomes of reablement.

Training workers to deliver reablement, and which profession is best placed to lead this an under researched area. An outcome of this scoping review was identification of the need to evaluate reablement training and supervisory support for home carers, and investigate any input from the regulated professionals who deliver reablement interventions, using robust research methods.

The synthesis within this scoping review of the reablement workers' experience of reablement, suggested that multi professional, collaborative models give a better outcome in terms of worker satisfaction and more effective outcomes for the person (Birkeland *et al.*, 2017); (Gustafsson *et al.*, 2019a).

Liaaen and Vik (2019) sum up reablement as a framework for multiple professionals to apply their practice leading to changes in the way professionals think and act, which contribute to sustainable changes for the people who receive reablement.

Notwithstanding this, further research is required to determine whether occupational therapists are the best placed professional to influence reablement training and supervise home care workers.

2.4.2 Strengths and limitations of the scoping review method.

The strength of this scoping review is its broad nature, examining a range of study designs and methodologies enabling a vast amount of published work to be examined in order to understand the nature and characteristics of an intervention or concept (Peters *et al.*, 2020).

In extracting data on reablement interventions it became apparent that, despite the restriction on data to the last ten years, the breadth of the review lent itself to a high number of ineligible or out of scope studies. Two significant RCT`s were excluded from the scoping review due to the date limitation, and these were included in the systematic review of RCT`s in chapter 3. There was very little primary research on the effectiveness of reablement, previous systematic reviews of RCT (Legg *et al.*, 2015); (Cochrane *et al.*, 2016) are now outdated given the development of modern reablement.

The search strategy was limited due to the range of keywords used. Narrow searches for reablement as a keyword excluded studies from USA and Australia, and broader searches, using the terms rehabilitation and restorative, generated a significant number of irrelevant studies. This clearly reinforced the need for a broad search strategy using a range of relevant keywords, with a structured filtering method and dedicated timeframe to search for relevant studies.

A different search limitation was excluding the studies that investigated reablement for mental health conditions. Beresford *et al.* (2019a) mixed method study was included, and arguably should have been excluded, because work package three was specifically concerned with reablement for people with Dementia. However, work packages one and two were relevant to the study objectives and the published material reported them as stand-alone study designs, methods, and results.

There was no opportunity to present quality appraisal of the literature found, to determine bias within the methods and certainty of the study results. This is appropriate for a scoping review aiming to give a comprehensive overview of the evidence. Systematic literature review methods involve synthesis of data, use methodological critical appraisal and risk of bias tools (Higgins *et al.*, 2021); (Robertson-Malt, 2014). Despite the researcher having completed systematic review analysis on some of the studies included in this scoping review those results were not presented as it would be methodologically incorrect.

Presenting the studies by methodology highlighted a mixed method design, where changed outcome effects could have been reported more impactfully in the quantitative study section (Assander *et al.*, 2022a).

When undertaking a scoping review and mapping primary research, it becomes noticeable how the voices of researcher's cluster together in their opinions, in regions around the world, and in periods of history. Several published journal articles linked to one large trial giving both quantitative and qualitative insight to various aspects, this connectivity was apparent through the clinical trial registration identifications, and Figure 4 illustrated how this can be better understood through the use of research artificial intelligence tool (ResearchRabbit, 2023). Tuntland *et al.* (2015) RCT had various associated studies, using different methodologies, that reported on the data collected (Kjerstad and Tuntland, 2016); (Hjelle *et al.*, 2017). Likewise, Langeland *et al.* (2019) clinically controlled trial produced several other primary research studies (Tuntland *et al.*, 2016); (Birkeland *et al.*, 2017); (Tuntland *et al.*, 2017); (Tuntland *et al.*, 2020).

Equally important to note is two RCTs used the same Australian reablement HIP service delivery model but looked at the effectiveness of different interventions (Lewin *et al.*, 2013). Similarly, Rooijackers *et al.* (2021a) and Rooijackers *et al.* (2022) RCT`s on the effectiveness of the Stay Active at Home reablement training programme supplied the data for (Rooijackers *et al.*, 2021b), and the methodology is reported in a published protocol (Metzelthin *et al.*, 2018). Whereas, Metzelthin *et al.* (2017), and Smeets *et al.* (2020) refer to data collected from an earlier

Norwegian trial called Better Care Revisited which included an evaluation of the Stay Active at Home reablement training programme.

This scoping review intentionally did not combine results or make judgements on the certainty of the outcomes from source evidence as this was not the aim (Peters *et al.*, 2020). Instead, it presents a broad overview of relevant studies considering only the strengths and limitations reported in the published material. Furthermore, this scoping review does not offer a consensus position on what is classed as a reablement intervention despite each intervention component being counted for the included studies. Instead it demonstrates the scope and breadth of reablement, in line with the purpose of the scoping review methodology (Dickinson and Bowland, 2017).

Therefore, a final limitation of the method is that the results cannot be used for specific comparison as the study variables are too broad and the review method has not addressed bias through quality appraisal (Arksey and O'Malley, 2005).

A systematic review, focusing on randomised control trials, the gold standard of research design, would be the most appropriate method to examine effectiveness of an intervention (Bowland, 2017), and chapter three will investigate the effectiveness of reablement and its outcomes in detail using systematic review methods. Notwithstanding this, the results of the scoping review build a greater understanding of the key components of modern reablement.

Aside from these limitations the methodological framework used for this scoping review (Peters *et al.*, 2015), gave strength and transparency (Pham *et al.*, 2014). The researcher reflexivity, addressed through academic supervision and reflective diary log, enabled identification, challenge and reduction of bias throughout the literature review process.

2.5 Conclusion.

This scoping review highlighted the heterogeneity of the reablement studies. No studies used exactly the same definition of reablement, despite a consensus study creating a definition of reablement, it found the time-frame for reablement to be contentious (Metzelthin *et al.*, 2020). Timeframe for the intervention was also found to be diverse in this review.

The role of the professional best suited to deliver reablement, was not clear, but there were some clearly important components such as goal setting, practice of activities of daily living, that were aligned to occupational therapy.

Reablement training was identified in half of the studies. Although, only three investigated reablement training content as an intervention in itself. It was clear from these studies training and supervision is a complex area to determine quality, effectiveness and outcomes. Four studies explore staff experience of reablement training, it wasn't clear whether training changed their mindset or behaviour, although one study did examine the effect training had on changing the workers behaviour and found no significant results (Rooijackers *et al.*, 2022). Further research on the benefits and effect of training workers to understand and deliver reablement interventions is essential to prevent the risk of home carers delivering a deficit model or standard home care approach.

A Systematic Review of RCTs is presented in the next chapter to investigate the clinical effectiveness of reablement interventions and outcomes, and this has been published in a peer reviewed journal (Bennett *et al.*, 2022).

Chapter 3. Investigating the effectiveness and outcomes of reablement: A systematic review of RCTs

3.1 Introduction.

Having described the multi-faceted interventions that make up reablement, the effects of those interventions can be described and their outcomes investigated in more detail through a systematic review of RCTs establishing what specific reablement components make a difference to peoples outcomes, and whether this is sustainable, as this will inform the codesigned training for home carers.

The scoping review in chapter two, and other historical systematic reviews, indicated a need for evidence on the effectiveness of reablement interventions (Cochrane *et al.*, 2016); (Legg *et al.*, 2015); (Boniface *et al.*, 2013). Other scoping literature also evidenced a lack of clarity on the specific professional roles involved in reablement (Metzelthin *et al.*, 2020); (Pettersson and Iwarsson, 2017), and that the service delivery models varied depending on organisational constructs.

This systematic review aims to critically appraise RCTs investigating the effectiveness and outcomes of reablement interventions with the purpose of establishing a clear link between evidence-based practice and the intervention. by answering the following research question.

How effective are the interventions delivered during reablement? How are the outcomes measured and evaluated? Are there any long-term benefits?

The objectives are:

1. To describe the interventions and outcome measures used in RCTs investigating reablement.
2. To examine the effectiveness of those reablement interventions investigated by RCTs.
3. To examine whether there is any lasting or long-term effect of any reablement interventions investigated by RCTs.

3.2 Materials and Method.

The research question was based on the PICO framework (O'Connor, Green and Higgins, 2008) population, intervention, control, and outcomes. The reviewers used the preferred reporting items for systematic reviews and meta-analyses (PRISMA) (Page *et al.*, 2020) to report the search results. The protocol for this systematic review (Bennett and Hodge, 2021), was published online on the PROSPERO systematic review database (CRD42021237209).

3.2.1 Search Strategy and study eligibility.

The search for RCT on adults receiving reablement interventions, as apposed to standard home care, where there was a between group difference on outcomes. The date range was from database inception to 31st August 2021 to include all relevant RCT`s. There was no restriction placed on Language, country, and historical date. There were no studies found in languages other than English that met the search criteria.

3.2.2 Key words.

i. "Occupational thera*" and ("reablement" or "rehabilitation" or "restorative") and ("RCT" or "randomised control trial")
ii. “Occupational thera*" and ("reablement" or "rehabilitation" or "restorative”) and ("home care" or "home care provider") and (“RCT” or “Randomised control trial”)
iii. ("reablement" or "restorative") and ("RCT" or "randomised control trial")

3.2.3 Study eligibility.

The review included consenting adults over 18 years living in their home in the community, receiving reablement home care, or receiving an occupational therapy service designed to align with home care. The reviewers excluded studies if participants had no home care, residential or nursing-home dwelling, palliative diagnosis, diagnosis of dementia, or Mini Mental score of less than 18 (Folstein, Folstein and McHugh, 1975).

The database search included AMED, ASSIA, BNI, CINHAL, EMBASE, HMIC, MEDLINE, PsycINFO, PubMed, Google scholar, Web of Science and Clinicaltrials.gov. A hand search of references, grey literature, and a Zetoc email alert was set up (ZETOC, 2020).

Two reviewers independently undertook the search, critically appraising the studies for eligibility using a recognised tool (Critical Appraisal Skills Critical Appraisal Skills Programme, 2020) and disagreements were resolved through careful re-examining of the data and discussion. All completed data collection forms and other study information are stored digitally on University of Nottingham OneDrive, and are available from the author on request.

3.2.4 The synthesis method.

The synthesis method involved a three-stage process. Firstly, the reviewers established the interventions and comparisons in the protocol.

Secondly, the reviewers completed the data extraction process establishing the characteristics of each study, tabulating each outcome in full enabling comparison. The "intention to treat" outcome effect was used to evidence assignment to the intervention, and missing data was reported in the risk of bias analysis (Higgins *et al.*, 2020).

The reviewers used Rob2 risk of bias framework tool (Cochrane, 2021), to establish the internal validity of the studies. The tool has structured signalling questions with detailed explanations and an embedded answer algorithm to determine the level of concern about issues that are likely to affect the ability to draw reliable conclusions from the study (Higgins JPT *et al.*, 2019). The risk domains are randomisation process; deviations from intended interventions; missing outcome data; outcome measurement; selection of the reported results. In addition, the reviewers used the supplementary questions for cluster RCT trials (Eldridge *et al.*, 2020). The Rob2 criterion for overall risk of bias is based on a combination of the embedded algorithm and assessor judgement, the assessor's decision has the final influence on risk weighting. Higgins JPT *et al.* (2019) define the criteria as: Low-risk of bias (all domains low-risk); some concern (at least one domain had a concern, but not high-risk of bias in any domain); high-risk of bias (either high-risk of bias in one domain, or some concerns in multiple domains).

Finally, stage three pulled the strands of the analysis together to determine the quality. Two reviewers discussed and determined each risk decision, including the direction and strength to give certainty of bias for each study, strengthening the link between study design and the resulting intervention effects (Sterne *et al.*, 2019). The cumulative evidence synthesis was coherently summerised to determine that the true effect lies within a particular range or side of a threshold, using the definitions established by the Grade, Recommendations, Assessment, Development, and Evaluation (GRADE) working group (Hultcrantz *et al.*, 2017) using GRADEpro (2021). The reviewers strengthened the reporting of the synthesis by using SWiM (Campbell *et al.*, 2020) a framework designed to improve narrative reporting of the analysis process, supported by visual data to describe the range, distribution, and effects (Robertson-Malt, 2014).

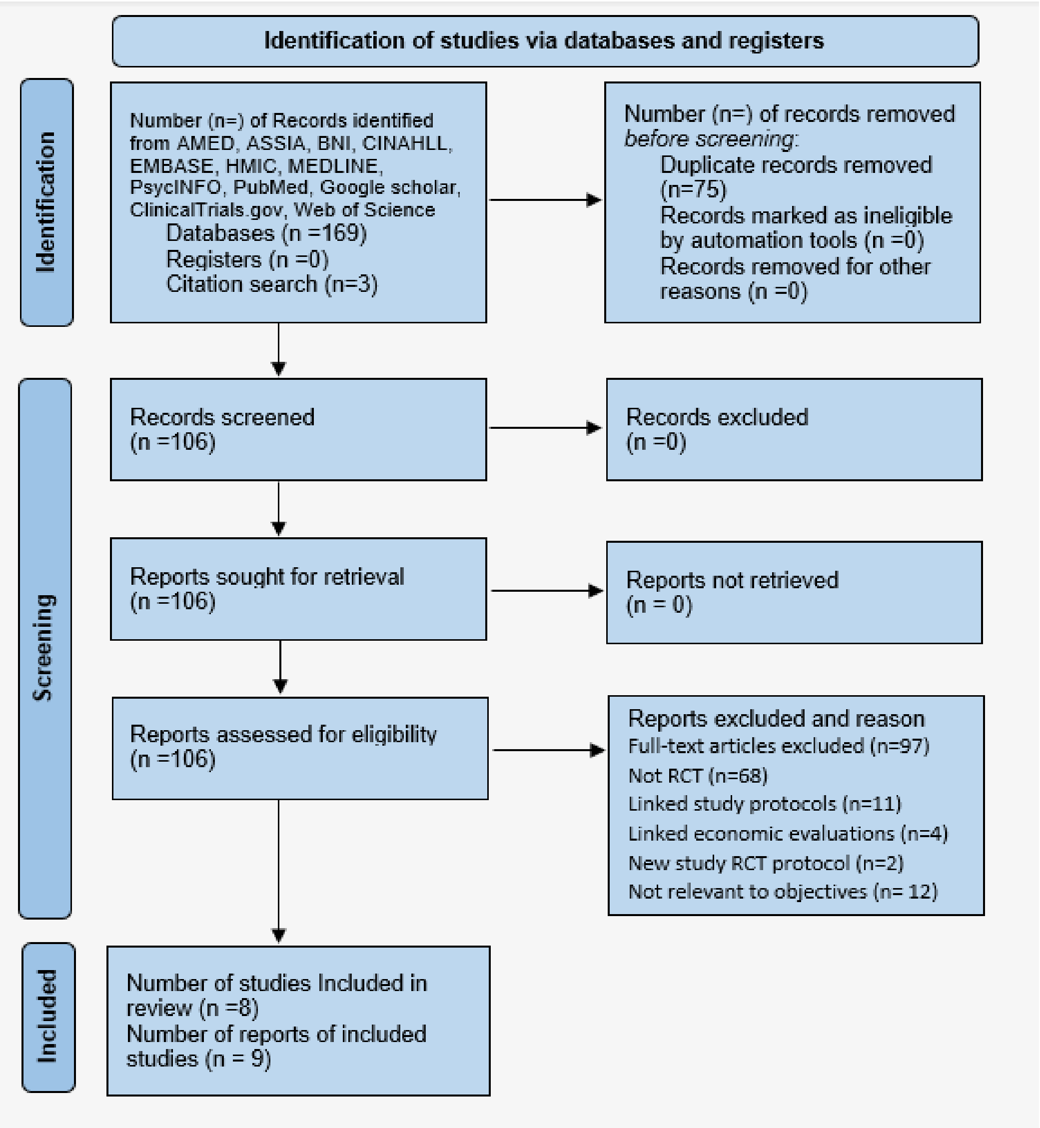
3.3 Results.

3.3.1 Search strategy results.

The database searches shown in Appendix 4 gave comprehensive results, 169 studies were identified through the combinations of key words, and a further 3 studies were discovered through snowball reference searches.

Figure 5 shows the detail of the search strategy results, presented using the Prisma [2020] Flow diagram for systematic reviews (Page *et al.*, 2020), and Appendix 5 shows the included and excluded studies, and the reasons for exclusion. After duplicates were removed 106 studies were examined in more detail. Out of the 97 studies examined for eligibility, 68 were not RCTs, of those that were RCTs-12 did not meet the review objectives, 4 were economic evaluations, and 13 were protocols. Two published journal articles (Parsons *et al.*, 2012) and (Parsons *et al.*, 2013), reported the same registered RCT, the reviewers included both in the analysis to capture the risks associated with the secondary outcome measure documented in (Parsons *et al.*, 2013). The search strategy concluded that nine journal articles, reporting eight studies met the study eligibility criteria.

Figure 5 The systematic review search strategy using Prisma (2020) (Page *et al.*, 2020)



3.3.2 Population.

Table 5 shows the demographics for participants in each study. All studies included more females than males. All participants had difficulty in completing activities of daily living at home, requiring home care. People who lived alone, reported in six studies, showed a higher incidence in the intervention group for all studies, except (Burton *et al.*, 2013).

Age, over 65 years, was an inclusion criterion in five studies. In addition, Parsons *et al.* (2012) and Parsons *et al.* (2013) included over 55-year-olds from Māori or Pacific

Islander ethnicity, and Tuntland *et al.* (2015) and Whitehead *et al.* (2016) included adults over 18-year-olds. Table 6 shows the mean average age for each study, and from this data, the mean age of the 1777 participants included in the systematic review was 80.35 years.

Table 6 Population characteristics at baseline

	Age		**Gender**				**Lives alone**	
Study	**Intervention** n (SD)	**Control** n (SD)	**Intervention**		**Control**		**Intervention** n (%)	**Control** n (%)
			Female n (%)	Male n (%)	Female n (%)	Male n (%)		
Sheffield et al (2012)	81.05 (±9.06)	82.43 (±10.01)	32 (82%)	7 (18%)	25 (78%)	7 (22%)	-	-
King et al (2012)	80.5 (±6.3)	78.4 (±6.5)	72 (77.4%)	21 (22.6%)	65 (69.9%)	28 (31%)	63 (67.7%)	47 (50.5%)
Parsons et al (2012 & 2013) *	79.08 (±6.93)	76.90 (±7.61)	77 (71.3%)	31 (28.7%)	59 (60.8%)	38 (39.1%)	69 (63.9%)	60 (61.9%)
Lewin et al (2013)	81.84 (±7.19)	82.73(±7.7)	226 (70.1%)	112 (29.9%)	242 (64.5%)	133 (35.5%)	192 (51.2%)	159 (42.4%)
Burton et al (2013)	80.2 (±6.4)	79.58 (±6.2)	30 (75.0%)	10 (25.0%)	36 (90.0%)	4 (10.0%)	24 (60.0%)	27 (67.5%)
Tuntland et al (2015)	79.9 (±10.4)	78.1 (±9.8)	22 (70.9%)	9 (29.0%)	19 (63.3%)	11 (36.6%)	10 (32.3%)	4 (13.3%)
Whitehead et al (2016)	82.93 (±9.02)	81.93 (±12.96)	11 (73.3%)	4 (26.6%)	6 (40.0%)	9 (60.0%)	9 (60.0%)	11 (73.3%)
Hattori et al (2019)	80.0 (76.3–84.0)	80.0 (76.0–84.0)	131 (68.9%)	59 (31.1%)	119 (64.3%)	66 (35.7%)	-	-

*Parsons et al (2012 & 2013) are two separate journals reporting on different outcomes from the same RCT.

3.3.3 Intervention.

Table 7 documents the intervention, role, components, dose, comparator, and service delivery timescale for each included RCT. All service models had an element of reablement home care. However, the service delivery varied, described as including a care coordinator assessment with home carers following a reablement plan (King *et al.*, 2012); (Parsons *et al.*, 2012) and (Parsons *et al.*, 2013), and an assessment followed by face-to-face monitoring or review of the persons reablement progress (Sheffield, Smith and Becker, 2012); (Burton *et al.*, 2013); (Tuntland *et al.*, 2015); (Whitehead *et al.*, 2016); (Hattori *et al.*, 2019).

Table 7 Intervention components

Study	Intervention	Role	Intervention component	Dose	Comparator	Service Timescale
Sheffield et al (2012)	Ageing in Place: restorative occupational therapy with home care	Occupational Therapists (OTs received enhanced training and supervision)	Adaptative equipment, home modifications, goal setting	4 visits, 9 hours, including travel time	Standard Home care	Not reported
King et al (2012)	Restorative home care	Care Coordinators (Enhanced supervision and training for home care staff)	Goal facilitation. Practice of ADL exercises	1 needs assessment for home care to follow	Standard Home care	Not reported
Parsons et al (2012 & 2013) *	Restorative home care	Care Coordinator (Gave 2 weeks training and supervision to home care staff)	TARGET goals setting and steps to achieve them.	1 needs assessment for home care to follow	Standard Home care	Not reported
Lewin et al (2013)	HIP: Restorative care	Not stated	Daily living activities (task analysis and redesign, work simplification) equipment (assistive technology) exercise (strength, balance, and endurance)	Min 3 Reablement visits	Standard Home care	12 weeks
Burton et al (2013)	LIFE exercise programme	Multi-disciplinary Care Managers Including OTs	Enhanced OTEGO Exercise Programme falls prevention developed in New Zealand (National Council On Ageing (NCOA), 2023), combined with	3 visits to monitor daily practice	Standard Otego and home care	8 weeks

			everyday ADL activities.			
Tuntland et al (2015)	Multi-component rehabilitation	Occupational Therapist (delivery, training, or supervision)	Training in daily activities, adaptations to the environment and activity exercise programs.		Standard Reablement Home care	10 weeks
Whitehead et al (2016)	OTHERS: Targeted ADL	Occupational Therapist (delivery and weekly progress reviews with Reablement service)	ADL activity's goal setting practising activities, equipment provision and environmental or activity modification	5 x OT visits of 45 mins	Standard Reablement Home care	6 weeks
Hattori et al (2019)	CoMMIT Reablement	Occupational Therapist (Delivery, training, or supervision) and Rehab Specialist (supervised by OTs)	Motivational interview with participants, goal attainment self- management skills: to maintain oral health, nutrition, physical activities, activities of daily living and instrumental ADL	2 to 3 hours weekly	Standard Home care	12 weeks

*Parsons et al (2012 & 2013) are two separate journals reporting on different outcomes from the same RCT.

The professional background of the reablement assessor ranged. Table 6 shows non-specified case coordinator (King *et al.*, 2012); (Parsons *et al.*, 2013); (Lewin *et al.*, 2013); case managers including occupational therapists (Burton *et al.*, 2013), or occupational therapists (Sheffield, Smith and Becker, 2012); (Tuntland *et al.*, 2015); (Whitehead *et al.*, 2016); (Hattori *et al.*, 2019).

In terms of the total service delivery, studies reported reablement was achieved in six weeks (Whitehead *et al.*, 2016), less than twelve weeks (Lewin *et al.*, 2013); (Burton *et al.*, 2013); (Tuntland *et al.*, 2015); (Hattori *et al.*, 2019); or wasn`t specified (Sheffield, Smith and Becker, 2012); (King *et al.*, 2012); (Parsons *et al.*, 2012); (Parsons *et al.*, 2013). Table 6 shows the intervention components were clinically heterogeneous focusing on a complex range of strategies to increase motivation, functional ability, and mobility.

3.3.4 Control.

In all RCTs investigated the control group received standard home care. Although three RCTs, (Burton *et al.*, 2013); (Tuntland *et al.*, 2015) and (Whitehead *et al.*, 2016), used standard reablement home care as the control with the intervention delivered by a regulated professional. Burton *et al.* (2013) also gave an exercise information leaflet to their control group, describing OTEGO Exercise a falls prevention programme developed in New Zealand by National Council on Ageing (National Council On Ageing (NCOA), 2023).

3.3.5 Outcomes.

In the scoping review in chapter 2, Table 4 described the outcome measures for experimental studies. Two RCTs used the dichotomous measure of no ongoing home care service as a primary measure, taken from administrative databases (Lewin *et al.*, 2013); (Hattori *et al.*, 2019), three other RCTs report on this outcome as an incidental finding (Sheffield, Smith and Becker, 2012); (King *et al.*, 2012); (Whitehead *et al.*, 2016).

Two RCTs used unreferenced, non-comparable dichotomous ADL measures (Lewin *et al.*, 2013); (Hattori *et al.*, 2019). A summary measure was created by Burton *et al.* (2013) using combined scores from four outcome measures, valid and reliable when used on their own. The other studies used continuous data to quantify change in primary or secondary outcomes, these were standardised, valid, and reliable.

Appendix 6 shows the detailed results of each RCT, the data was heterogenic, unsuitable for meta-analysis, and justified a narrative reporting method. Five RCTs measured average difference in outcome effect with 95% confidence interval, (King *et al.*, 2012), (Burton *et al.*, 2013), (Parsons *et al.*, 2012), (Parsons *et al.*, 2013), (Tuntland *et al.*, 2015), (Whitehead *et al.*, 2016). Two RCTs measured change in effect using odds ratio with 95% confidence interval, (Lewin *et al.*, 2013) and (Hattori *et al.*, 2019), and one RCT measured with coefficient and standard error (Sheffield, Smith and Becker, 2012).

What are the interventions, when and where are they delivered, and by whom?

All RCTs delivered reablement interventions with individuals in their home except Hattori *et al.* (2019), who delivered educational aspects to participants in a community group setting.

The interventions investigated were multifaceted, with each study focusing on different combinations, as shown in Table 5. Sheffield et al., (2012) examine goal setting, adaptative equipment, home modifications. King et al., (2012) goal setting and practice of ADL. Lewin et al., (2013) ADL, adaptations, and exercise. Tuntland et al.,(2015) and Whitehead et al., (2016) research practise of ADL, equipment provision, and environmental modifications. Burton et al., (2013) focused on falls prevention, strength and balance training combined with ADL activities. Parson et al., (2012) and Parsons et al.,(2013) explored participant behaviour changes and motivation to attain goals, and Hattori et al.,(2019), examine self management, behaviour change, and motivational coaching for participants. Lewin et al., (2013) specifically refer to task analysis. Two studies refer to activity modification, a resulting intervention strategy implying analysis has taken place (Tuntland *et al.*, 2015); (Whitehead *et al.*, 2016).

In Table 5, professional role was summerised. Five studies reported occupational therapists actively involved in the delivery of interventions, training, or supervision of home care staff. Home carers and generic case managers delivered the interventions in three studies. Whitehead et al., (2016) used service evaluation data to evidence delivery of intervention, timing, and amount showing an average of five occupational therapist visits, each lasting 45 mins.

Three RCTs reported on training or supervision for home carers to varying degrees. King et al., (2012) refer to the assessment staff and home care coordinators and Tuntland et al.,(2015) trained all health-care workers on the ethos of self-management, with therapists providing supervision for home carers that focused on encouraging the participant to exercise and do the daily activities themselves with adaptions to the environment or the activity. Hattori et al., (2019) reported occupational therapists' supervised all initial home-visit assessments and trained the rehabilitation specialists.

How are the effects measured and evaluated?

The results for each RCT outcome effect are tabulated in Appendix 6. All studies measured the effect of reablement with a primary outcome: no ongoing service; change to functional ability; change to quality of life; the primary outcome Whitehead *et al.* (2016) measured were the aspects of feasibility. All the RCTs had secondary outcomes, change to functional ability and functional mobility the most relevant to this review. The issue was the diverse range of tools used to measure outcomes, as some were valid and reliable others not and this had a consequence the interpretation of results.

Are there any long-term benefits?

Table 8 shows that five studies reported a decreased need for ongoing home care post intervention. The lack of reported data for between group difference and lack of transparency of methodology, affected the comparison across studies reporting an incidental effect.

Table 8 Studies that measured the need for reduced home care.

Studies that measured the need for reduced home care					
Study	Timing of measure (Months/ Weeks)	Intervention n (%)	Control n (%)	Between group difference	Certainty grade
Sheffield et al (2012)	3m	17/46 (39%)	0/46 (0%)	Not reported	Not Graded
King et al (2012)	4m	27/93 (29%)	0/93 (0%)	P < 0.001**	Not Graded
Lewin et al (2013) *	3m	103/375 (27.5%)	238/375 (63.5%)	Odds ratio 0.18 (0.13 to 0.26) p<0.001**	⨁⨁◯◯Low
Lewin et al (2013) *	12m	67/375 (17.9%)	151/375 (40.3%)	Odds ratio 0.22 (0.15 to 0.32) p<0.001**	⨁⨁◯◯ Low
Whitehead et al (2016)	2 wks.	9/15 (60%)	7/15 (46%)	Not reported	Not Graded
Whitehead et al (2016)	3m	13/15 (86%)	9/15 (60%)	Not reported	Not Graded
Whitehead et al (2016)	6m	9/15 (60%)	9/15 (60%)	Not reported	Not Graded
Hattori et al (2019) *	4m	21/190 (11%)	7/185 (3.8%)	Odds ratio 7.3 (2.0 to 12.5) p=0.007**	⨁⨁⨁◯ Moderate

*Primary outcome measure **p<0.05

Figure 6 shows that where the need for ongoing home care was a primary outcome measure, effect measured using odds ratio with 95% confident intervals showed a statistical significance.

Figure 6 Likelihood of no ongoing homecare.

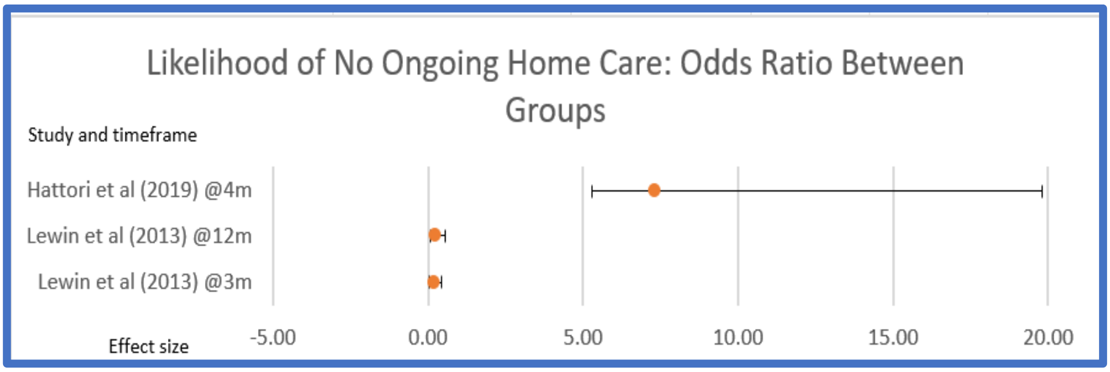


Table 9 shows the long-term benefits for functional ability. There was an increase in effect post intervention reported in four studies, with a slight decrease after six months (Whitehead *et al.*, 2016) and 9 months (Tuntland *et al.*, 2015).

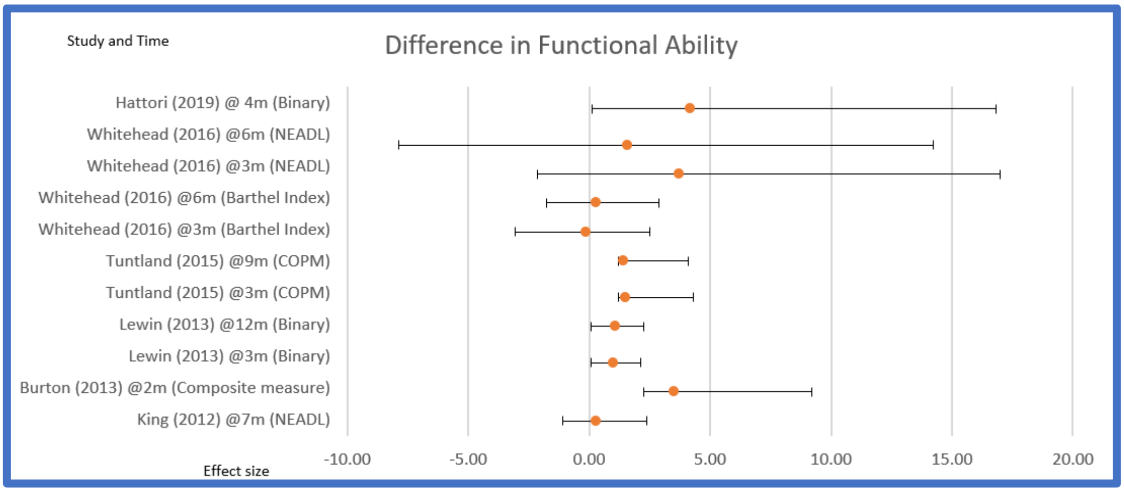
Table 9 Change in functional ability.

Change in Functional Ability				
Study	Outcome measure	Timing (months)	Difference between groups (95% confidence interval)	Certainty Grade
Sheffield et al (2012)	FIM*[Mackintosh, 2009]	3m	p=0.15**	⊕⊕⊕◯ Moderate
King et al (2012)	NEADL [Nouri & Lincoln, 1987]	7m	0.3 (-1.4 to 2.1)	⊕⊕⊕⊕ High
Burton et al (2013)	Composite measure*	2m	3.5 (1.25 to 5.70) and p=0.003**	⊕⊕⊕◯ Moderate
Lewin et al (2013)	Binary Scale (not referenced)	3m	Odds ratio 1.02 (0.95 to 1.09) P=0.529**	⊕⊕◯◯ Low
Lewin et al (2013)	Binary Scale (not referenced)	12m	Odds Ratio 1.08 (1.00 to 1.17) p=0.048**	⊕⊕◯◯ Low
Tuntland et al (2015)	COPM* [Carswell et al, 2004]	3m	1.5 (0.3 to 2.8) p= 0.02**	⊕⊕⊕⊕ High
Tuntland et al (2015)	COPM*[Carswell et al, 2004]	9m	1.4 (0.2 to 2.7) p= 0.03**	⊕⊕⊕⊕ High
Whitehead et al (2016)	Barthel Index [Colin et al, 1988]	3m	−0.13 (1.33) (CI −2.91 to 2.65)	⊕⊕⊕⊕ High
Whitehead et al (2016)	Barthel Index [Colin et al, 1988]	6m	0.28 (1.12) −2.06 to 2.61	⊕⊕⊕⊕ High
Whitehead et al (2016)	NEADL [Nouri & Lincoln, 1987]	3m	3.72 (4.58) (-5.85 to 13.27)	⊕⊕⊕⊕ High
Whitehead et al (2016)	NEADL [Nouri & Lincoln, 1987]	6m	1.58 (5.28) (19.47 to 12.64)	⊕⊕⊕⊕ High
Hattori et al (2019)	Binary Scale (not referenced)	4m	ind=4.2 % (-4.1 to 12.6) dep =13.9% (4.0 to 23.7) dep in 2 or more= 4.3 % (-4.0 to 12.6)	⊕⊕⊕◯ Moderate

*Primary outcome measure. ** p<0.5

Table 9 shows each study reporting a positive effect, and figure 7 visually presents changed effect where data is comparable. Sheffield, Smith and Becker (2012) used the Functional Independence Measure (Mackintosh, 2009), reporting statistical effect as a p value but with no further between group comparable data. Next, King *et al.* (2012) use Nottingham Extended Activities of Daily Living (NEADL) (Nouri and Lincoln, 1987), measuring the between arm mean difference in score, from baseline to 7 months as 0.3 (-1.4 to 2.1), p=0.71.

Figure 7 Difference in functional ability



The third study, (Tuntland *et al.*, 2015) used Canadian Occupational Performance Measure (COPM) (Carswell *et al.*, 2004), reporting a statistically significant self perceived mean difference at 3 months, 1.5 (0.3 to 2.8) p=0.02. In the same study, at 9 months, the results show the mean difference between intervention was 1.4 (0.2 to 2.7) p= 0.03.

Whereas, Whitehead *et al.* (2016) the fourth study, also used NEADL (Nouri and Lincoln, 1987) to report the median average difference with interquartile range due to the small sample size. At 3 months, the difference in functional ability was 3.72 (4.58) with 95% confidence interval (-5.83 to 13.27) and at 6 months, 1.58 (5.28) with 95% confidence interval (-9.47 to 12.64).

Table 10 shows change in quality of life, and four RCTs evidenced improvement. Tuntland *et al.* (2015) used COOP/Wonca score (Kinnersley, Peters and Stott, 1995), whereas others used the Short Form SF-36 health survey (Ware, Kosinski and

Dewey, 2000), reporting effect based on the total score for SF-36, combining the physical and mental aspect.

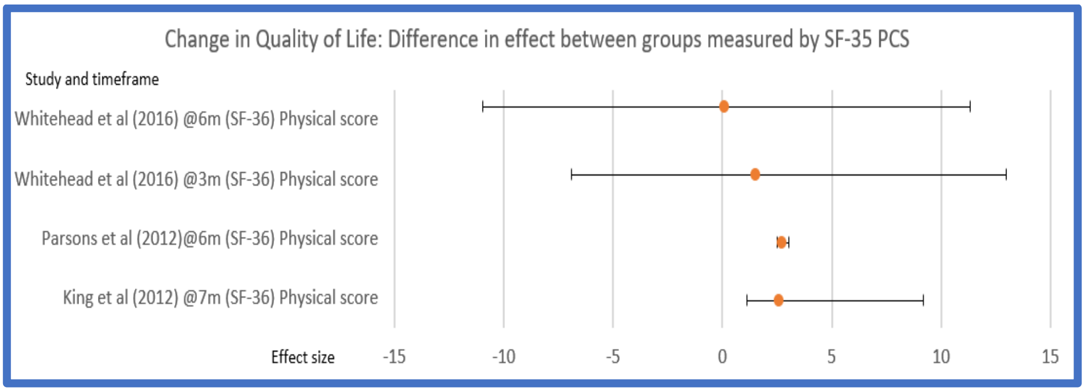
Table 10 Change in quality of life.

Change in quality of life: Difference in effect between groups			
Study	Timing (Months)	Outcome Measure	Average difference between groups n (95% confidence interval)
King et al (2012)	7m	(SF-36) Physical score [Ware et al, 2000]	2.6 (-1.5 to 6.6) p=0.22*
Parsons et al (2012)	6m	(SF-36) Physical score [Ware et al, 2000]	2.7 (-0.2 to 0.35) p=0.0002*
Tuntland et al (2015)	3m	COOP/Wonca Score [Kinnersley et al, 1995]	-0.4 (-0.9 to 0.2) p=0.21*
Tuntland et al (2015)	6m	COOP/Wonca Score [Kinnersley et al, 1995]	−0.4 (−0.3-0.5) p=0.22*
Whitehead et al (2016)	3m	(SF-36) Physical score [Ware et al, 2000]	1.52 (4.75) (−8.43 to 11.47)
Whitehead et al (2016)	6m	(SF-36) Physical score [Ware et al, 2000]	0.09 (5.33) (−11.06 to 11.24)

*p<0.5

Figure 8 shows comparisons between studies measuring quality of life with a similar difference in effect for the SF-36 physical score at six to seven months. King *et al.* (2012) and Parsons *et al.* (2012) used a similar sample size, whereas Whitehead *et al.* (2016) report less effect at both three and six months with a smaller sample.

Figure 8 Change in quality of life.



Lastly, Table 11 shows three RCTs report the positive effect on functional mobility, and this is visually presented in Figure 9. Burton *et al.* (2013), did not achieve their primary outcome using a composite of valid and reliable outcome measures, aiming to evidence the statistical effect of LIFE interventions as a summary variable at two months. However, they did report the change in mobility results using the Timed Up and Go (Podsiadlo and Richardson, 1991).

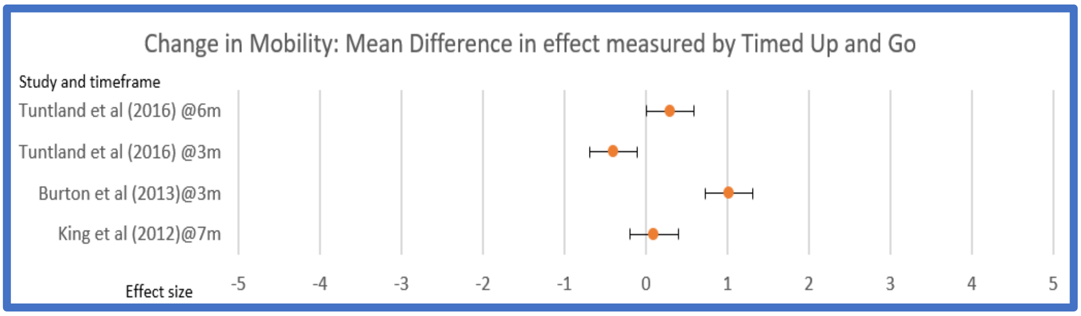
Table 11 Change in mobility.

Change in Mobility			
Study	Timing (Months)	Measure	Average difference between groups (95% confidence interval)
King et al (2012)	7m	Timed up and go. [Podsiadlo & Richardson, 1991]	0.1 (-4.2 to 4.1) p=0.98
Burton et al (2013)	3m	Timed up and go. [Podsiadlo & Richardson, 1991]	1.02 (-4.86 to 2.83) p=0.983
Tuntland et al (2016)	3m	Timed up and go. [Podsiadlo & Richardson, 1991]	-0.4 (-4.4 to 3.5) p=0.82
Tuntland et al (2016)	6m	Timed up and go. [Podsiadlo & Richardson, 1991]	0.3 (-3.7 to 4.3) p=0.88

*p<0.05

In Figure 9, a comparison is shown, as King *et al.* (2012) and Tuntland *et al.* (2015) also used the Timed Up and Go, which is considered to be a valid and reliable outcome measure (Ashley *et al.*, 2019), as a secondary outcome. Despite a positive effect, the studies using this measure were unable to report a statistically significant short or long-term effect for change to functional mobility.

Figure 9 Change in functional mobility.

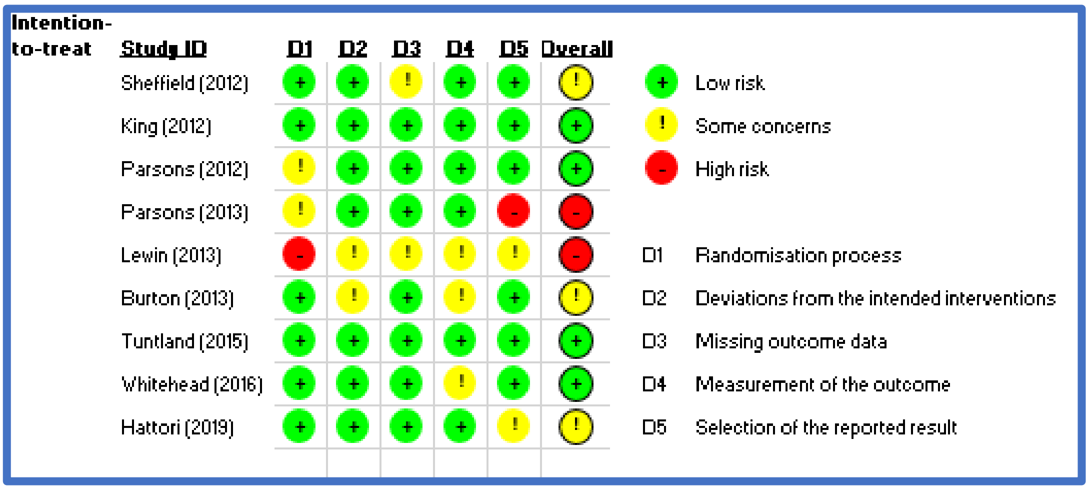


In summary, Figure 6 showed there was an improved effect for reduced home care in five studies, statistically significant in two RCTs. There was improved effect for increased functional ability in five RCTs, shown in Figure 7, and this was statistically significant in four of them. Figure 8 showed the improved effect of quality of life was statistically significant in three RCTs. There was improved effect in mobility in three RCTs and this is shown in Figure 9 but no RCTs showed a statistically significant result.

3.3.6 Risk of Bias.

Overall, four RCTs scored low risk of bias, three had some concerns about the risk of bias, and two had a high risk of bias, Figure 10 presents this visually. There was no identified risk of bias in any domain in Tuntland *et al.* (2015), or King *et al.* (2012) who justified using a cluster design to facilitate the staggered paid home care worker training, avoiding contamination between the groups.

Figure 10 Overall risk of bias in included studies.



Intention-to-treat

Study ID	**D1**	**D2**	**D3**	**D4**	**D5**	**Overall**
Sheffield (2012)	+	+	!	+	+	!
King (2012)	+	+	+	+	+	+
Parsons (2012)	!	+	+	+	+	+
Parsons (2013)	!	+	+	+	-	-
Lewin (2013)	-	!	!	!	!	-
Burton (2013)	+	!	+	!	+	!
Tuntland (2015)	+	+	+	+	+	+
Whitehead (2016)	+	+	+	!	+	+
Hattori (2019)	+	+	+	+	!	!

\+ Low risk
! Some concerns
\- High risk

D1	Randomisation process
D2	Deviations from the intended interventions
D3	Missing outcome data
D4	Measurement of the outcome
D5	Selection of the reported result

The reviewers considered each risk domain for each outcome. In Parsons *et al.* (2012), the randomisation domain was a concern because there was little detail on the process reported. The reviewers took the study on face value and assumed integrity, assessing it as low risk overall.

Whitehead *et al.* (2016) used valid, and reliable standardised outcome measures but there was a concern about missed data or misinterpretation of data, and the study did not identify this limitation. Despite blinding the occupational therapy assessor, the unblinded participants and home care staff meant the assessor could have guessed the allocation group. The collection of outcome data was face-to-face in the participant's home and immediately entered on a database, and so a judgement was made to reduce the overall risk of bias.

The concerns about those RCT`s with overall risks of bias, were upheld by the first and second reviewer. In Sheffield, Smith and Becker (2012), it was in the missing outcomes domain due to a high attrition rate explained as "age ineligibility", those participants who dropped out had higher dependency score on the Functional

Independence Measure. In Burton *et al.* (2013) it was deviation from intended interventions and outcome measurement that caused concern. In Hattori *et al.* (2019) selective reporting bias was identified because the nonsignificant results were reported in online supplementary files, and the referenced protocol detailing the analysis plan was unobtainable, despite an in-depth online search and email correspondence to the author.

There were high-risk concerns in every risk domain in Lewin *et al.* (2013) and Parsons *et al.* (2013) studies, most significantly in randomisation, and selective reporting. The randomisation process was a concern in Lewin *et al.* (2013) due to the lack of operator blinding in the electronic allocation sequence, and the participant baseline differences favouring the intervention. Bias identified in Parsons *et al.* (2013), was due to reported baseline imbalances weighted towards the intervention group, suggesting recruitment bias. For the secondary outcomes, the study only reported functional mobility and social support, despite the intervention focusing on goal attainment. Given that TARGET focused on person centred goal setting, and that Parsons *et al.* (2013) report they used an ADL outcome measure at baseline, this raised concern of a reporting bias based on favourable results.

3.3.7 Certainty of evidence.

The reviewer's quality assured the RCTs to determine certainty of effect based on assessment of five domains: risk of bias, inconsistency, indirectness, imprecision, and publication bias (Schünemann *et al.*, 2020).

There were five RCTs with risk of bias limitations shown in Figure 10, these were either in study design or execution of the method. There was no inconsistency in any study serious enough to downgrade the evidence. In all the RCTs reviewed, the evidence directly answered the review question, and there were no concerns about indirectness. In all studies, the reported results in Appendix 6 were precise, the reviewers upheld quality of evidence after grading the certainty.

There was a probability of publication bias in Parsons *et al.* (2013), however both reviewers agreed the reporting bias was not serious enough to downgrade the certainty of evidence. The reviewers considered the magnitude of the effect, in the case of Lewin *et al.* (2013) and agreed it was worthy of an upgrade to moderate certainty because of the large relative effect at three months using a large sample, a low odds ratio with narrow confidence interval, and statistically significant result.

As a result, this review found a strong recommendation for reablement interventions due to high certainty in the primary outcome effect for improved quality of life at six (Parsons *et al.*, 2012) and seven months (King *et al.*, 2012) and self-perceived improved functional ability at three months (Tuntland *et al.*, 2015). There was a weak recommendation in favour of reablement due to moderate certainty in the primary outcome for reduced ongoing home care (Lewin *et al.*, 2013); (Hattori *et al.*, 2019) and increased functional ability (Burton *et al.*, 2013).

3.4 Discussion.

The purpose of this systematic review, was to identify, describe, and critically appraise the interventions delivered and their effects on outcomes of reablement using robust methodology; eight RCTs met the eligibility criteria. The review found the data was methodologically heterogenic.

The search criteria for this systematic review were based on evidenced-based reasoning, that reablement interventions should continue until people have maximised their abilities and reached their person-centered goals; time-limited but not time-restricted (SCIE, 2020); (Doh, Smith and Gevers, 2020); (Clotworthy, Kusumastuti and Westendorp, 2021). Unlike previous reviews of RCTs, no restrictions were placed on intervention delivery timescale in the eligibility criteria.

This review challenged a historical systematic review of RCTs that found no evidence of effect for reablement delivered in six weeks (Legg *et al.*, 2015), strengthened a review that found low-quality evidence for interventions delivered up to twelve weeks (Cochrane *et al.*, 2016), and supported Sims-Gould *et al.* (2017) who found limited generalisability of results for interventions delivered under 6 months.

To enable the optimum content and configuration of reablement interventions (Boniface *et al.*, 2013), interventions must be person centered and delivered flexibly. This review grouped the multifaceted interventions, examining their effect on functional ability, functional mobility, and quality of life outcome measures. The only study that attempted to change peoples behaviour in a group setting (Hattori *et al.*, 2019), had selective reporting bias weakening the overall certainty of the results.

The outcome measurement tools for functional ability were incomparable, with exception of two studies shown in Figure 7 that used NEADL (Nouri and Lincoln, 1987). Tuntland *et al.* (2015) used a self-reporting measure to evidence improvement in ADL, use of a comparable assessor administered measure would have strengthened their study. Likewise, studies considering functional ADL could strengthened results using a recipient self-perceived measure. One study, (Burton *et al.*, 2013), attempted to use a summary measure to determine improved function, this was confusing and the number of measures extensive. The review found there was a risk of bias in this study due to deviations from intended interventions, and the overall certainty of evidence was graded as moderate. The unreferenced dichotomous measure used to measure functional ability by Hattori *et al.* (2019), was incomparable with Lewin *et al.* (2013), as neither clearly indicate high or low score as most effective, meaning comparison was not possible. Despite efforts to contact the authors for clarification, there was no response.

This review found improved effect for increased functional ability in five RCTs as shown in Table 9 and Figure 7. This was statistically significant in four of the studies, adding to the evidence base that interventions targeting ADL reduce dependency.

There was homogony for improved effect in mobility using the Timed Up and Go outcome measure, but Figure 9 showed no results were statistically significant.

There was homogony in the quality-of-life effect shown in Figure 8, where RCTs used the health-related SF-36. However, Parsons *et al.* (2012) used the SF-36 as a primary outcome measure for the effectiveness of goal setting. Using quality of life to measure clinical intervention effect is limiting because it is a personal construct, less accurate and responsive than specific outcome measures in situations where interventions aim to achieve a particular outcome (Higginson and Carr, 2001).

Furthermore, the method for calculating the SF-36 was unclear in both (King *et al.*, 2012) and (Parsons *et al.*, 2012). A scoping review of studies reporting a total quality of life score using SF-36, evidenced 129 (75.0%) of the 172 studies did not specify the method for calculating the SF-36 total score (Lins and Carvalho, 2016). The review compared the separate results of the SF-36 physical (PCS) and mental (MCS) scores (RAND, 2021). Figure 8 showed the improved effect of quality-of-life outcomes measured using SF-36 (PCS) were statistically significant in three RCTs suggesting that reablement interventions had a positive impact for people.

The heterogeneity of outcome measures has implications for comparison in systematic reviews, and choice of outcome measures can be a strength or limitation to the study. Beresford *et al.* (2019b) established the need for a range of outcomes, including self reports and mental health outcomes, measured over an extended time. This review goes further, arguing that a preferred homogeneous outcome measure for reablement interventions would enable comparison of effect. This should include functional ability, mobility, community and social participation, and quality of life. Until then, it would better to determine the benefits of reablement using other methodology.

The professional role of the person delivering interventions was unclear in studies with a non-specific care coordinator. Despite a positive effect on the requirement for ongoing services in the studies with occupational therapy involvement at three months (Whitehead *et al.*, 2016) (Tuntland *et al.*, 2015) (Sheffield, Smith and Becker, 2012) and at four months (Hattori *et al.*, 2019), it wasn`t possible to unequivocally determine whether professional role influenced the difference in outcome due to heterogenetic data. The only UK study, had a small sample for a RCT (Whitehead *et al.*, 2016) limiting the results for an otherwise methodologically sound study. The primary outcome was to explore feasibility of design for a larger RCT, and whilst the study evidenced the number of visits by role, it did not explore whether frequency of occupational therapists’ visits optimised the outcomes.

Pettersson and Iwarsson (2017) identified in their literature review, there was a lack of definition of interventions and professional roles, and this was a problem for evaluating reablement intervention outcomes in relation to economic effectiveness and quality assurance. Reablement services deliver interventions for people with varying degrees of complexity and need, and the cost of regulated specialist professionals is greater than unqualified workers, therefore the staffing role and responsibility should be clear in any research examining the effectiveness of reablement outcomes.

Whilst the evidence remains thin on the effectiveness of reablement, this review critically examined the types of intervention, outcomes, effect, professional role, providing new understanding of reablement. This systematic review of RCTs ascertained the need for clearly defined roles for reablement assessment, delivery, and progress review. It also identified competency to deliver interventions, training, and supervision were not clearly reported in the published journals.

Only three RCTs described reablement workers' competency to deliver interventions, their supervision, and training (King *et al.*, 2012); (Tuntland *et al.*, 2015); (Hattori *et al.*, 2019), and two them used occupational therapists for supervision and training (Tuntland *et al.*, 2015); (Hattori *et al.*, 2019), although they did not specify how this influenced or assured better outcomes (Sims-Gould *et al.*, 2017). This lack of detail evidenced a need for further research on the optimum professional to deliver reablement workers' competency, training, and supervision to enable a greater understanding of reablement as a complex intervention. This aligned with Dibsdall (2021), who believed occupational therapists have a role in training reablement workers to operate in an enabling way.

The impact of occupational therapists providing training for home carers on the reablement, and the risks of not training them, in relation to intervention outcomes will be examined in detail in later chapters in this thesis.

3.4.1 Strengths and limitations of the included studies.

The intervention effect was positive in all studies. However, the outcome measures were diverse. The reviewers found no scope for meta-analysis, subgroup analysis, or meta regression, limiting the extent they could accurately compare these studies.

Overall, five RCTs had risk of bias limitations in either design or method. These bias limitations affected confidence in the findings. The use of the GRADE criteria (Hultcrantz *et al.*, 2017) addressed the subjectiveness of the quality of studies strengthening the assessment of certainty in the effect. Reflexivity of professional bias was considered when determining confidence in the trustworthiness of the RCTs.

3.4.2 Strengths and limitations of the review method.

Overall, a strength of this systematic review was the use of reliable methodology (Page *et al.*, 2020). Data was recorded on a piloted recording form (Li, Higgins and Deeks, 2020), enabling challenge of preconceptions or selection bias, meaning the systematic review is reproduceable.

The search criteria was limited to RCT`s, this excluded other relevant experimental studies creating a narrower review (Schünemann *et al.*, 2020) that limited the findings. However, the unrestricted date limits ensured all relevant RCTs were included. A feasibility RCT (Whitehead *et al.*, 2016), and prospective RCT (Parsons *et al.*, 2012) were included as they met the search eligibility criteria.

The search terms were not extensive, and this was a limitation. The review excluded studies with participants not in receipt of home care, a limiting factor as it excluded informal care givers who deliver home care for cultural or financial reasons.

The synthesis method clearly identified data from the reviewed studies was heterogenic, the variety of outcome measures used gave no scope for meta-analysis, subgroup analysis or meta regression, limiting the extent for comparison.

The SWiM reporting guideline (Campbell *et al.*, 2020) strengthened the narrative reporting method.

The method gave an opportunity to consider confidence in effects, quality, similarities, impact of bias, and applicability of the findings to the research question. The review method assessed whether the effectiveness of the interventions was sensitive to clinical or methodological heterogeneity, and whether the intervention effect itself was enough to eliminate any risk in the bias domains; this sensitivity analysis ensured confidence in the intervention effect, strengthening the systematic review (Deeks, Higgins and Altman, 2020).

3.4.3 Can the findings be generalised?

The intervention delivery, amount, and type of interventions described in all RCT`s could not be generalised due to the methodological heterogeneity of the data. The review evidenced external validity in two studies with unrestricted age samples (Whitehead *et al.*, 2016); (Tuntland *et al.*, 2015). The only exclusions, dementia, and palliative care, suggest that reablement has efficacy in a diverse range of conditions. International health and social care organisational and policy drivers, staff, and population culture are varied, limiting generalisability.

3.5 Conclusion.

The review found diversity in the outcome measures indicating future research should establish agreed outcome measures for reablement, including functional ability, mobility, and quality of life, to evidence reablement effect.

The results showed the need for ongoing home care decreased in five RCT`s, with improved effect at three months shown in studies where reablement had occupational therapist involvement. Functional ability increased statistically in four studies at three months, increase in quality of life was statistically significant in three studies, at six and seven months. None of the RCT`s reported a statistically significant improvement for functional mobility. The outcome of reablement was most beneficial at three to four months, with sustainability beyond six months in two studies (Tuntland *et al.*, 2015); (Whitehead *et al.*, 2016).

Studies with occupational therapist involvement showed a greater positive effect on outcomes, this was not statistically significant; therefore, the effect of professional role could not be generalised. However, two of these studies used occupational therapists to train and supervise the home carers(Tuntland *et al.*, 2015); (Hattori *et al.*, 2019).

Overall, in the other studies, there was scant consideration of competency or training for the reablement worker delivering the interventions and whether this can improve outcomes, this warrants further research.

The reviewed RCT`s evidenced clinical feasibility and appropriateness (Robertson-Malt, 2014), multi-faceted reablement interventions are effective in the context of health and social care. A definitive large sample UK trial aiming to determine the effect of reablement interventions and comparison of professional role and service delivery is necessary.

Chapter 4. The research methodology and methods.

4.1 Introduction.

In chapter one, the over-arching study aim was to explore reablement interventions and outcomes, and to understand home carers knowledge, experience, and training needs to deliver reablement by answering three research questions. Using systematic review methods in chapter two and three, gave opportunity for a deep exploration of reablement interventions and the effects it had on peoples' outcomes, to answer the first two questions. This chapter will explain the methodologies used for the empirical research in this thesis, the research strategy, designs and methods used to answer the remaining research question.

The ACT intervention will be presented in chapter five. The analysis and findings of each element of the primary research methodology described in this chapter, will be reported over three chapters, six, seven and eight to evaluate home carers understanding of reablement.

The Consolidated Criteria for Reporting Qualitative Research (COREQ), was used as a design framework to strengthen the method and reporting of the interview and focus groups (Tong, Sainsbury and Craig, 2007).

4.1.1 Study aims and objectives.

The purpose of the empirical research in this thesis was to critically evaluate home carers' understanding and experiences of reablement, and to explore how feasible it would be to deliver reablement competency training to home carers working in the independent home-based care sector. The objectives of this part of the study were:

- To explore the knowledge and skills home carers have about reablement and promoting independence.
- To understand the home carers' experiences of reablement, considering their views, attitudes and beliefs towards the interventions delivered during a period of reablement.
- To identify the elements of feasibility for a reablement competency training programme called ACT - Adult Care Training.
- To evaluate the learning that the home carers experienced during ACT- the reablement intervention with associated reablement competency training.

To answer the research question, a mixed methods research design was selected, as this would allow integration of the different types of data obtained from the various aspects of this study.

4.1.2 The research questions.

What is the home carer experience of reablement, and is it acceptable and feasible to deliver ACT reablement competency training to independent sector home carers?

4.1.3 Research team.

This study involved co-design and collaboration with a stakeholder steering group including a public and patient involvement (PPI) representative, and an operational delivery group. The steering group followed the NIHR endorsed principles of public involvement standards (UK Public Involvement Standards Development Partnership, 2019). These collaborations ensured that the research question was current and that the study design had value to social care, occupational therapy, and the recipients of reablement services.

The study methods were strengthened through involvement of PPI who agreed to review the study objectives, the interview and focus group questions, and to engage in a reflective feedback conversation at each meeting, responding to the questions:

What went well? What could have been done better? What has been learnt from this experience and why?

The steering group involved equal partnership with the PPI representative (a carer and retired teacher), academic supervisor (physiotherapist), the director of the independent home based care provider, adult social care strategic commissioner with responsibility for home care, and senior operational manager for reablement. The operational delivery group involved the coordinator of the independent home-based care service, adult social care reablement team manager, and occupational therapists that co-designed and facilitated the training.

4.1.4 Reflexivity.

Each researcher has an individual personal perspective that they bring to coding gained from their own life experience, they view their study through their own lens. The PPI representative, Marion- a carer for her husband who has multiple sclerosis, had lived experience of the both reablement and standard home care services, she agreed to participate in the steering group to shape the study objectives (Jokstad, Landmark and Skovdahl, 2020). The researcher is an occupational therapist working in a local authority adult social care setting and is professionally motivated to evidence the effectiveness and improve the interventions delivered to people during a period of reablement. A reflective diary was kept throughout the study design, data collection and analysis phases to address researcher bias.

4.1.5 Study management.

The research study was managed from the University of Nottingham School of Medicine, Centre for Rehabilitation and Ageing Research. The Chief Investigator had overall responsibility for the study, including data custody and oversaw all study management. The intervention was delivered between September 2021 and February 2022, final data collection ended 31st March 2022.

4.2 Study design.

4.2.1 Theoretical framework.

The researcher's personal context, their personal philosophical assumptions, theoretical models, and background knowledge influenced the study design and how the research question was formed. For this reason, and because the aim was to interpret and explain home carers' experiences of reablement, gaining an understanding of the diversity of their reality, and examining any power imbalances with the purpose of influencing change, a critical realist paradigm was chosen for this applied research study.

Critical realism, a philosophical approach that emerged from Bhaskar`s work, is based on critical reasoning and the process of interpretation (Walliman, 2011). It combines realist ontology, observations of the nature of reality, being or becoming and subjective epistemology, the interpretation of theory drives knowledge. The knowledge of what exists enables the recognition of reality (Maxwell, 2012).

To answer the research question, objectivity was required to determine the feasibility of the study design used to evaluate home carers' experiences, knowledge, and skills. This led the researcher to identify the requirement a mixed methods approach that could integrate different types of data to enhance the breadth and inclusiveness of the study (Plano-Clark and Ivankova, 2017).

The critical theory approach considers that reality is made up of multiple layers, economic, political and cultural, influencing people's beliefs, behaviours, and experiences; understanding various viewpoints enables diverse voices to be represented (Maxwell, 2012). This explanatory approach was used to explore each of the research objectives, determining home carers existing knowledge and skills, how they are applied and the consequence of training on home carers confidence and clarity of understanding about reablement.

Following the critical theory paradigm, this study aimed to empower home carers, amplifying their voices and balancing any socially constructed inequalities (Holloway and Wheeler, 2010).

4.2.2 Research strategy.

There were a number of different methods used in this study to implement the project and to gather the data for research.

Firstly, the plan-do-study-act (PDSA) cycle, a quality improvement process method, was used to implement the intervention as an improvement project (Christoff, 2018). A whole system improvement approach was considered, but rejected as being too complex at this stage of the research design (Clarkson, 2020). The learning from one PDSA cycle should guide the cycles that follow, and each cycle uses four steps:

1. Develop a plan in which predictions of outcomes are clearly stated and tasks are assigned. The who, what, when, and where of the plan.
2. Implement the plan.
3. Study the plan. Data and results obtained are analysed and the plan is evaluated.
4. Act is where the plan is adopted, rejected, or adapted based on the evaluation in the prior step.

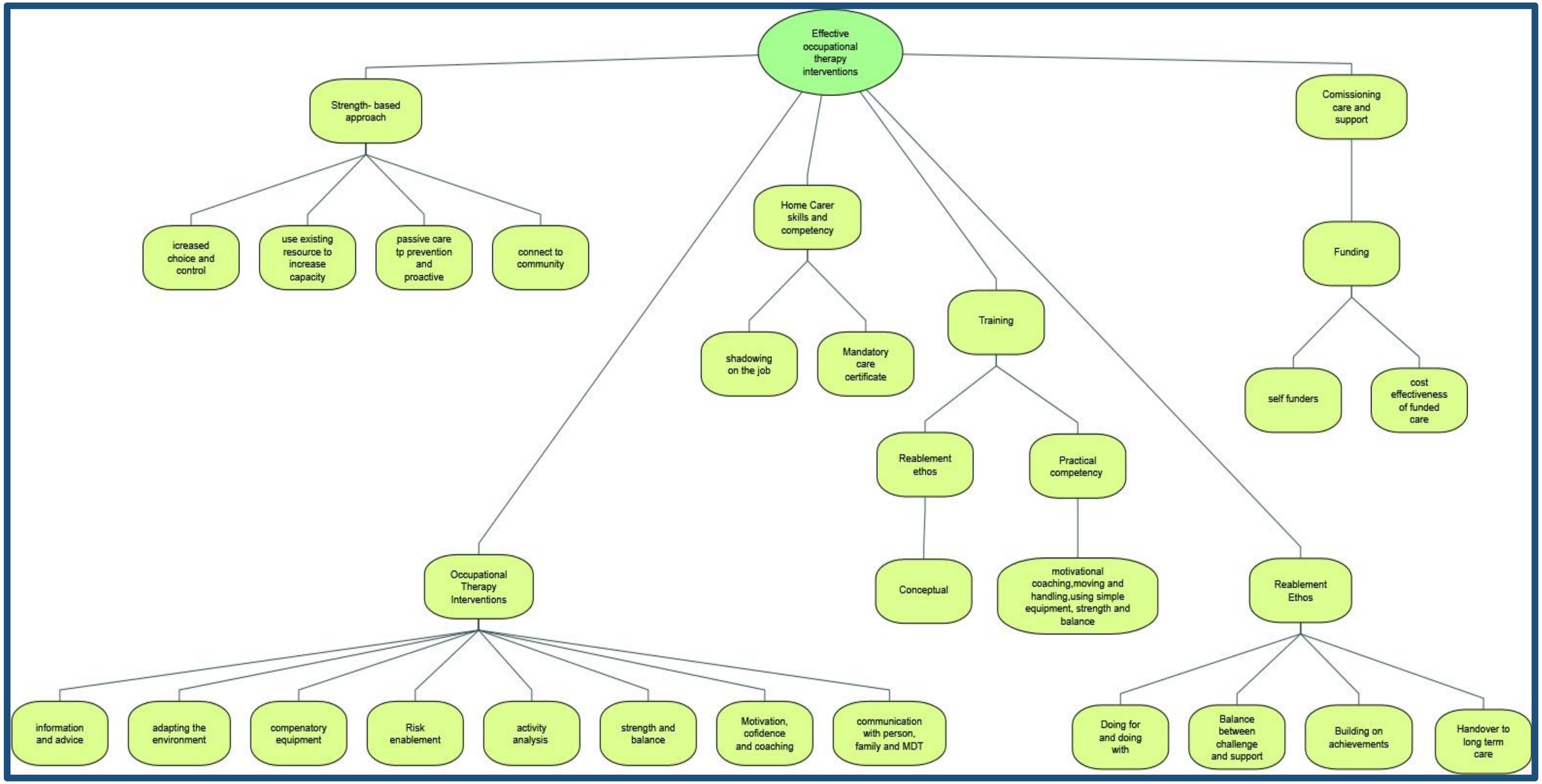
The concept map shown in Figure 12 illustrates the researcher's starting point, and their understanding, beliefs and assumptions. This process determined the connections and relationships of what was already known, as opposed to what was not known, and helped to identify what the study hoped to discover.

Co-design was also used as a method, this involved collaboration with occupational therapists to shape the ACT intervention, and with the home carers to evaluate the ACT training, and with both, when considering the intervention cycle of improvement. This collaboration is a type of participatory action research (Robson, 2002).

Action research emerged in the 1930`s from Kurt Lewin work, he wanted to raise the self-esteem of minority groups by involving them as equal representatives when participating in research (Adelman, 1993). The codesign process, and the learning from the scoping review, helped to identify what the study hoped to discover and mixed methods was deemed the most appropriate research design to achieve this.

Mixed methods research is described by Plano-Clark and Ivankova (2017) as a process where quantitative methods of data collection and analysis, and qualitative methods of data collection and analysis, are integrated to understand the research problem. They suggest a dynamic approach to designing a mixed methods study emphasising the interrelationship of components during the study process. Whereas, Creswell (2015) describes linear typologies, explanatory sequential, exploratory sequential, and convergent designs.

Figure 11 Concept map of researchers understanding of reablement.



Taking each in turn, Creswell (2015) advises explanatory sequential designs start by studying the quantitative data, then qualitative research is conducted to explain the quantitative findings. Exploratory sequential design explore the research problem using qualitative data collection and analysis, then use an additional strategy to create an intervention, measure, or tool that can be quantitively evaluated as an experiment, often this design includes a further qualitative evaluation. A convergent design strategy is used where quantitative and qualitative data collection and analysis methods run concurrently, or independently from each other, with emphasis on the integration of the data results (Creswell, 2015). For this study, a convergent design has been used because the data collection sources were independent of each other. The data could be integrated, and be presented visually, side-by-side to give depth to the findings (Guetterman, Fetters and Creswell, 2015).

Inductive reasoning was used to explore how home carers came to conclusions about the concept of reablement. By considering their views, observations, perceptions and experience it would be possible to determine how their diverse experience influenced their values and beliefs. Maxwell (2012), explains this process isn't absolute or fixed and that theories will change in the light of new evidence, demonstrating an increased congruence between the conceptual framework and the research methodology (Thurston, Cove and Meadows, 2008); (Teixeira de Melo, 2021)

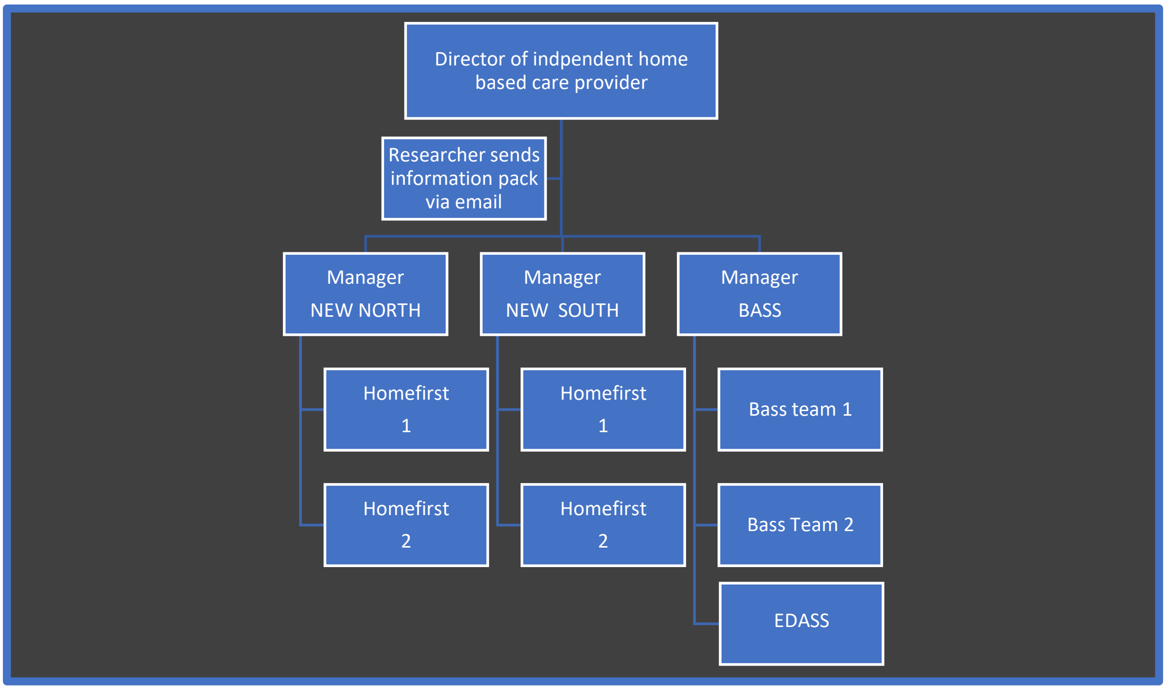
4.2.3 Participant recruitment.

Participants were recruited from an independent home-based care provider that was commissioned by the local authority to provide additional home care capacity to supplement its in-house reablement service. The option in the protocol to share the study information poster via the local authority social media account to raise awareness was not required.

As part of the communication strategy, engagement of the director of the independent home-based care provider was considered crucial to ensure commitment to the research and the ACT training. The director agreed to promote the research study information pack and poster with the managers, coordinators, and home carers. The researcher emailed the study information to the director of the home-based care provider, to be forwarded onto the managers. The managers were asked to share information about the study to home carers via email and verbally. They were also asked to print off a poster to advertise the study for display in their office space.

An additional recruitment strategy was implemented to engage the home-based care service coordinators by phone. This method was successful in engaging coordinators to nominate home carers to attend the ACT training. It was intended groups of fifteen home carers would attend the training session, selected from different teams, and this would continue until all home carers had attended the training. Figure 13 shows the configuration of the independent home-based care provider teams, 119 employed home carers were divided between four Home First teams, called north, south, bass, and EMASS. Each team had three managers, each team has a shift one and two to provide the cover for all operational hours, and EDASS was the out-of-hours emergency home care service.

Figure 12 Home-based care team structure.



This recruitment method was intended to give a convenience sample of home carers with a diverse range of experience who would attend the training. From this group, it was anticipated smaller groups would accept the invitation to participate in the research, eight participants are considered to be the optimum size for a focus group (Morgan, 2011).

The mixing of the home carers from different teams would facilitate different perspectives between groups, due to their role background rather than any preconceived assumptions on their attitudes (Morgan, 2011). In addition, this strategy would add variation and diversity to illuminate the full spectrum of experience and perspectives of a range of home carers that met the inclusion criteria (Holloway and Wheeler, 2010); (Morgan, 2011).

The inclusion criteria were broad to enable maximum recruitment potential. The exclusion around mental capacity reflected a precaution as telephone interviews were held in the workers own time, and variability in mental capacity can occur due to misuse of substances. The exclusion of unable to understand or speak English was implemented, as employing a translator was out of scope of the study costs.

Inclusion criteria.

- Adults over 18 who can consent to the study.
- Work as a home carer for an independent home-based care provider.
- Work in a community setting.

Exclusion criteria.

- Lack mental capacity to engage with action learning sets, interviews or focus groups.
- Unwilling to participate in interviews or focus groups.
- Unable to understand spoken or written English.

4.2.4 Sample.

The aim was to recruit a purposive sample of at least thirty home carers to the focus groups, with eight participants in each group to give homogeneity in terms of role characteristics (Ritchie and Lewis, 2012). The intention was to generate enough discussion to answer the research question and establish trustworthiness and credibility (Holloway and Wheeler, 2010). It was assumed that if the discussion content from each focus group was similar, no new understanding would be put forward and a level of data saturation would have been achieved (Morgan, 2011).

4.2.4 Setting.

The researcher offered a choice of venues at local authority offices, intentionally a short radius from the home carer`s normal working area, or home address. All venues had parking facilities, accessible toilets, and provision of cold drinks and snacks. Each training session lasted two hours, delivered over three separate sessions.

The final study design altered from the protocol, partly due to the Covid pandemic as the number of people allowed to congregate indoors was limited by government legislation to six, but also in response to how the home carers wanted to engage with the research. A minor ethical amendment was granted on 27.09.21 to modify the study design because the home carer`s who attended the training sessions mostly opted for a one-to-one interview over the phone, rather than participate in a face-to-face focus group.

4.2.5 Ethical and regulatory aspects.

Ethical approval was given by the Nottingham University Research Ethics Committee on 18.06.21, reference: FMHS 261-0521 the protocol details were then submitted with the ethics approval to the local authority research governance panel who gave their permissions for the research to progress.

4.2.6 Informed consent.

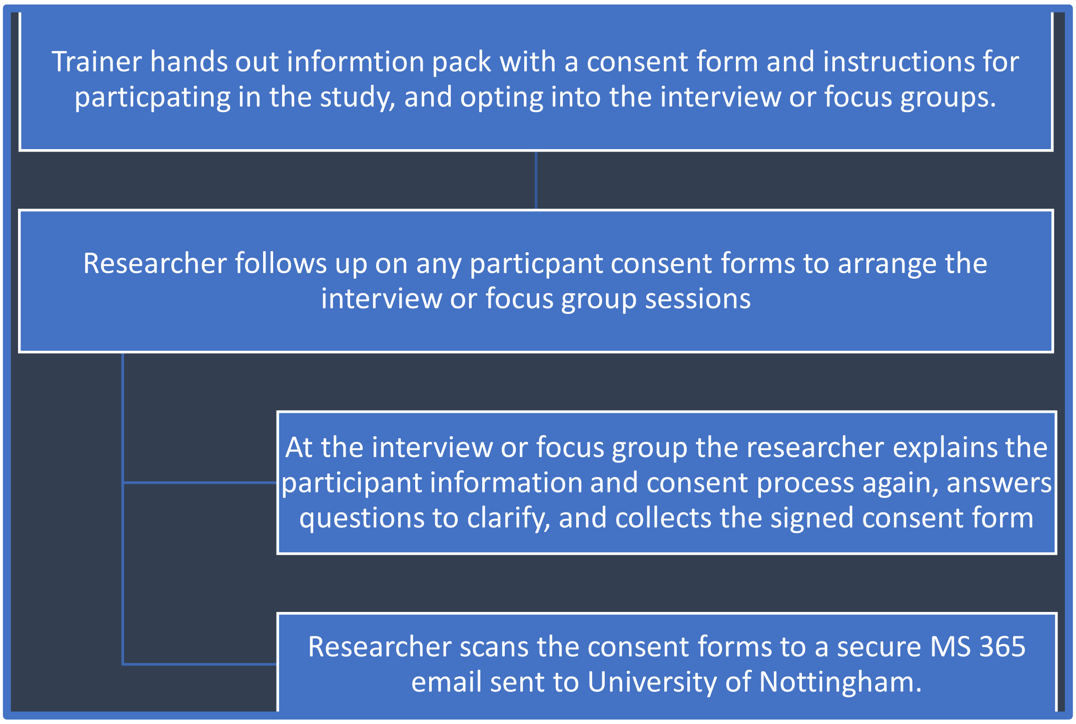
The flow chart in Figure 14 illustrates the stages of informed consent. The participant information sheet can be found in Appendix 7, and the participant consent form in Appendix 8. These were sent out by email with a participant invite letter via the independent home-based coordinator to all home carers two months in advance of the training.

The participant information sheet in Appendix 7 outlined the research project giving the details of the study aims and objectives and information on the ethics approval. It was explicit the study could be published in peer reviewed academic journals and used by other researchers for reference in the future. It also explained to the participants that entry into the study was entirely voluntary, and that their employment conditions would not be affected by their decision. Participants could withdraw at any time, however, if they wanted to withdraw after data had been collected and analysed, the data collected could not be erased.

Additional hard copies of the participant information sheet and consent form were given out by the trainer at the start of each training session, with advice that these were available in larger print if required; the content was verbally explained by the training facilitator. This allowed participants 90 minutes to consider whether to consent to giving their name, email, and phone number to be contacted to participate in the research. The trainer asked permission for the researcher to retain the consenting participants contact details: name, email, and phone number for the duration of the study, and assured all personal information, consent forms and survey data would be stored securely on University of Nottingham digital drives and would be deleted after the study completion.

The scheduling of interviews and focus groups was planned to be a flexible arrangement to suit the home carers. Telephone interviews were scheduled by text message, giving additional time to opt in, or to ignore. The focus groups were held at the end of the training session, as this was the participating home carers preference.

Figure 13 Participant information and consent to participate in the study flow chart.



Trainer hands out informtion pack with a consent form and instructions for particpating in the study, and opting into the interview or focus groups.

Researcher follows up on any particpant consent forms to arrange the interview or focus group sessions

At the interview or focus group the researcher explains the participant information and consent process again, answers questions to clarify, and collects the signed consent form

Researcher scans the consent forms to a secure MS 365 email sent to University of Nottingham.

4.2.7 Adverse effects.

Adverse effects data was not collected. However, as participants can disclose sensitive information during interviews and focus groups, a process for managing this was explained at the beginning of the sessions. A debrief was offered at the end of the session. Any safeguarding disclosures would be actioned appropriately after the session by the researcher, following university and local authority policies and procedures.

4.2.8 Criteria for terminating the study.

Compliance was through voluntary participation in the study. Should there be any reason for terminating the study, the investigating officer’s line manager would notify the academic supervisor, acting as chief investigating officer, who had responsibility for terminating the study.

4.3 Data management.

4.3.1 Quality assurance.

Quality assurance of study conduct, quality of documents and their safe storage was over seen by the researcher. Copies of consent forms, study records, before and after training survey, demographic survey, reflective field notes, and audio recordings were sent from the setting electronically using encrypted Microsoft 365 email, for filing on the University of Nottingham secure ICT drives. Only academic supervisors and the researcher were able to access electronic study documentation. The files will be kept for up to seven years and then archived. All source documents are available for inspection by the chief investigator, sponsor’s designee, and relevant regulatory authorities.

4.3.2 Data protection.

The student researcher took the role of investigating officer, with the oversight of academic supervisors. The participant’s right to privacy and informed consent was maintained as legislated in the Data Protection Act (*Data Protection Act* 2018). The study data forms only collected the minimum required information for the purposes of the study. Each participant was referred to by first name, and then after data collection they were assigned a case ID for analysis to protect confidentiality.

Study data forms were held securely in an encrypted password protected computer file, and paper copies were shredded. Access to the information was limited to the study staff, investigator, academic supervisor, and any relevant regulatory authorities.

4.4 Data collection.

4.4.1 Data collection methods.

Data was collected using the following methods:

- The demographic information.
- The before and after training survey.
- Semi structured interviews and focus groups.
- Training feasibility data recorded by the training facilitator.
- Reflective logs by training facilitator and researcher

Home carer`s were asked to complete the demographic profile questionnaire in Appendix 10 to record their age group, gender, ethnicity, how long they had been working as a home carer.

The home carer`s were also asked to complete the before and after training survey in Appendix 11. This recorded the participants' perceptions of their own specific capabilities, using a visual Likert scale (Likert, 1932) to measure any change in their knowledge skills, confidence and level of competency gained during the training (Sullivan and Artino, 2013). The before and after training survey was reviewed by the PPI representative, and they were consulted at the end of data collection and before data analysis, to ensure the data was reported without professional bias or selective interpretation of the findings.

A funnel strategy was used to design the interview and focus group questions in Appendix 9, and the same questions were used for both data collection sources (Morgan, 2011). The interviews began with an unstructured discussion around the topic, before transitioning to a more structured discussion using specific questions, in Appendix 9. The researcher used an indirect and direct moderator style to ensure the conversation flowed smoothly through the unstructured and structured format

(Morgan, 2011). The interviews and focus groups were audio recorded and lasted one hour. The audio data was stored on university secure drives.

At each training session, the training facilitator recorded whether the participants had completed previous sessions of the ACT training and when, and noted the details of the venue, time, and length of session. This allowed training feasibility data to be collected on the number of people; optimum training time frame; time to organise; staffing changes and turnover; format of delivery online or face-to-face venue; in order to give an understanding of the context.

4.4.2 Data extraction.

The demographic data and the before and after training survey data was recorded on Excel spreadsheets for analysis.

The semi structured interview and focus group data was extracted from audio files, transcribed verbatim by the researcher using a standardised transcription method (Jenson and Laurie, 2016), and typed onto Microsoft Word software by the researcher.

4.4.3 Data software.

NVivo 12 computer software (Lumivero, 2021) was used to support coding and analysis. Each participant was given a case ID for anonymity, and demographic attribute data was classified to each case.

4.5 Data analysis methods.

4.5.1 Reliability of coding.

The reliability of coding was determined by two independent reviewers, the PPI and an academic supervisor experienced in qualitative analysis who coded a small sample of two interview transcribes each. The inter-rated reliability was measured by a percentage agreement score.

The PPI representative was trained to understand the requirements of qualitative analysis, which was crucial to strengthen the analysis because both reviewers were likely to interpret the data through their own personal lens.

A mitigation plan to invite a third reviewer for perspective, and to mediate conflicting views on coding, was available but not required. The researcher undertook self-reflection using a reflexive diary to identify any bias or views that could affect the analytic process.

4.5.2 The before and after training survey analytical framework.

The before and after training survey, used a 5-point visual Likert scale with expressive emoji combined with descriptive text (Sullivan and Artino, 2013). This data was converted to numbers for analysis to show the number and proportion of staff that perceived a change in their understanding and confidence, in relation to the key skills and competencies learnt or practiced during each of the action learning training sessions.

Each participant’s response to a question, before and after the training, was examined. Each training session participant responses to a question were examined, to determine the influence of other variables such as different trainers or number of participants in the session.

Categorical demographic data was compared between individual participants to detect patterns across the participants, for example the age, gender, ethnicity and time working in the caring profession, this determined the relationships between the variables (Jenson and Laurie, 2016).

Ordinal data was presented as the median average, and proportionally, by grouping the two positive and negative responses from the numerical Likert scale. Simple statistics were used to analyse uni-variate data, count of participants attending training, proportion, median average, and interquartile range.

4.5.3 Interview and focus group analytical framework.

Framework analysis (Ritchie and Lewis, 2012) was used to generate themes. The five-step approach allowed a systematic and structured method to analyse data, by participant and themes, using matrices. Use of matrix formats enabled comparative analysis of key patterns, associations and abstractions to be identified (Goldsmith, 2021). Moving back and forth between the five stages of the analytical framework allowed the coded data to be rebuilt or woven into themes.

Step 1**:** Familiarisation.

The transcription of each interview was read several times to give a broad understanding of each participant's response. The participants in each focus group were treated as individual cases. However, where there was group discussion of a topic, this was coded separately by group (Morgan, 2011). As this immersion in the data evolved, memo notes were used to give early indications of emerging areas of interest, topics, and themes.

Step 2: Identifying themes.

To organise the data, the thematic framework was based on the themes identified in step 1. These early themes were reviewed against the research question, study aims and objectives and the final themes became the coding index.

Step 3: Indexing.

This involved linking the person to their demographic attributes and values, creating a case for each person, and then coding all relevant transcribed data, including analytic memos, to their case. In vivo, structural coding and values coding were used to give the home carers' perspectives and actions. Strength of sentiment was identified, positive, negative, or neutral, in relation to a code in order to determine how much emphasis was placed on it by each participant or group.

Selection of text for coding, comparison and analysis was undertaken with the aim of summarising the content without losing the diversity of viewpoints or nuances (Gale *et al.*, 2013). Consideration was factored in for energy levels and non-verbal reactions to a topic, for example, humour, enthusiasm, or boredom, this was noted on the memos. Each sentence and paragraph transcribed was considered in context and a judgement was made about its meaning, using an abductive approach to blend deductive and inductive labels that described what the data meant (Linneberg and Korsgaard, 2019); (Saldaña, 2021).

The coding was In Vivo, meaning, in the carer's own words, and two distinct first cycle coding methods were used, structured coding and values-based coding

(Saldaña, 2021); the code handbook is in Appendix 15. The structured coding involved indexing and categorisation of the data based on broad topics to enable comparison, commonality, differences, and relationships within the data. The values-based coding involved classifying the to affective constructs of attitude, value, and belief.

To do this, attitude was defined as the way the participant thought and felt about themselves or another person, thing, or idea. Values were defined as the importance participants placed on themselves, another person, something, or an idea. Whereas, belief included both values and attitude, but also the participants interpretation based on their knowledge, experience, opinions, morals, assumptions and bias (Saldaña, 2021).

The content and dimension of the phenomena were identified by a process of chunking transcribed text, also called lumping (Saldaña, 2021). Later this text was split, or micro-coded and more specific subcategories were developed. This meant all codes needed to be checked with a second indexing pass over the data to ensure systematic and comprehensive coverage, and that each interview or focus group transcribe was given the same treatment.

Step 4: Charting and summarising.

The transcribed text, converted to codes, quotes and memos were summerised to concepts, associations and patterns using Nvivo matrices (Lumivero, 2021), and cross tabular queries were used to probe the data (Wong, 2020a).

Step 5: Interpretation and mapping.

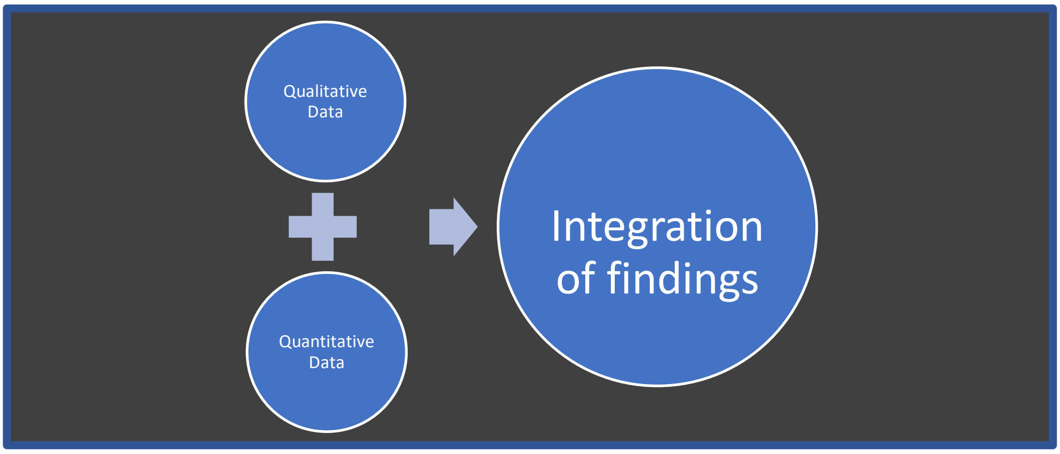
Further mapping and interpretation of the data on thematic matrix charts allowed associations relevant to the research question to be identified leading to the detection and interpretation of patterns. Saldaña (2021) describes these as: similarity; difference; frequency; sequence; correspondence and causation. These advanced matrix charts were developed to assign the pattern categories to classes, a higher level of abstraction. The final themes that emerged from the codes were what the home carers were drawn to talk about, and these gave the analytical framework validity.

4.5.4 Integrating the data.

After data collection and analysis, the findings were merged to give an integrated interpretation, drawing from all data sources to answer the research question. A convergent design was used allowing the results of all data sets to be integrated allowing complex phenomena and nuance to be articulated, and triangulation of the findings that strengthened the analysis (Creswell, 2015).

The purpose of the convergent design strategy shown in Figure 15, was to bring together the data sets after the separate results have been analysed to produce a more informed understanding of the data than one or other method on its own.

Figure 14 The convergent design.



Presenting the results in a visual format enabled a side-by-side comparison of the data, with narrative discussion of the implications. The results data was merged using the data transformation techniques shown in Table 12, producing a more complete and validated conclusion (Creswell, 2015).

Table 12 The data type, procedure undertaken and data transformation product.

Type of data	Procedures	Products
Quantitative data collection	Participant demographic survey Training feasibility data Excel spreadsheet. Knowledge and skills survey	Participant demographic profiles Number of participants trained. Training feasibility data Change in knowledge and skills as Likert scale data
Quantitative data analysis	Excel spreadsheet. Nvivo input case attributes (Lumivero, 2021)	Participant median average knowledge and skills data tabulated with 95% confidence intervals.

		Number of sessions participants attended acceptability of venue, number, and time frame of session. Training session cohort median average knowledge and skills data tabulated with interquartile range.
Qualitative data collection	Interviews and focus groups	Interview and focus group audio recordings. Researcher reflective diary. PPI reflections. Training facilitator reflections.
Qualitative data analysis	Transcribed interview data Participant Quotes Coding (first and second cycle) Themes Description of training feasibility variables	Narrative presentation of quotes, codes, and themes. Code mapping using diagram to link themes. Word cloud.
Merged interpretation	Data transformation.	Discuss the comparison in the table. Side-by-side joint display. Theme by statistic joint display.

The final integrated analysis will be summarised narratively with a description of context, and participant quotes will be used to shape the meaning.

4.6 Conclusion.

Participatory co-design supported the development of the research question, which will be answered using a mixed method research design to analysis data from a before and after training survey, semi-structured interviews and focus groups.

The training content was co-designed in line with the scoping review evidence base, delivered in action learning sets, the feasibility and impact of the training on the home carer`s understanding of reablement was explored and evaluated, and a cycle of improvement followed resulting in recommendations for further improvements.

Use of a mixed method convergent design to integrate the data gave greater validity and reliability to the analysis (Creswell, 2015). The quality of the methodology is supported by triangulation of data, participant checking, researcher reflexivity to address bias, repeatability of the method, and attention to participatory ideas and conflicting opinions to facilitate change.

In chapter five the ACT intervention is reported in detail, including the operational context, process of co-design with the occupational therapist and steering group and the ACT reablement training content.

In Chapter six the training feasibility will be presented, using data collected from the demographic survey, the before and after training survey, and descriptive data from the interviews and focus groups, merged to add richness to give a training feasibility evaluation.

In chapter seven, the values, attitudes, and belief of the home carers towards reablement will be reported using data from the semi structured interviews and focus groups. The thematic outputs will be narratively described when associations or patterns emerge, with equal attention given to reporting of outliers.

In chapter eight, data gathered form the semi structured interviews and focus groups will allow an analysis of home carers' learning preferences to support the intervention cycle of improvement. Use of a mixed method convergent design to integrate the data in this way gives greater validity and reliability to the analysis (Creswell, 2015).

Chapter 5. Describing ACT the reablement intervention

5.1 Introduction.

This chapter describes the intervention, called ACT reablement, and the process of intervention delivery to be investigated through empirical research. It will explain the roles of the individuals involved, the content of the training, the co-design and delivery process for its use with independent home-based care providers, and define the elements used to determine acceptability.

5.1.1 Background context.

The Nottingham County Council reablement service was set up in 2012 . All new home carers, called Reablement Support Workers receive induction training, an annual refresher, and Figure 18 shows the competency framework used for this.

Since 2015, the reablement service included occupational therapists who use the Person, Occupation, Environment model as a practice framework (Law *et al.*, 1996). They brought new skills to the reablement service and incorporated them in the training and the competency framework. The training material was co-created by occupational therapists, but contained no references to evidence-based practice, theoretical models, or frame of reference, although it was based on occupational therapist experience.

In 2020, there was an urgent need to increase reablement service capacity to accommodate the flow of people being discharged from hospital for people. Independent sector (not NHS and not local authority) home-based care providers were commissioned to provide a similar reablement service to increase capacity (Appendix 3.7).

Training for home carers is regulated by the CQC (CQC, 2023) and completion of the Care Certificate is the level of competency (Skills for Care, 2023a; CQC, 2022). Standard one of the care certificate is about home carers’ understanding their role in different settings, yet it gives no clarity or purpose for this. The onus is on the carer to be able to evidence understanding of their role in the following ways:

- 1.1a Describe their main duties and responsibilities.
- 1.1d Explain how their previous experiences, attitudes and beliefs may affect the way they work.
- 1.3a Describe their responsibilities to the individuals they support.

To ensure best outcomes for people using this service, and as part of the research for this PhD project, the county council invested in additional occupational therapists to deliver the additional commissioned service capacity and to train the independent sector home-based carers to deliver reablement interventions.

The researcher reviewed an earlier version of the reablement training content with the occupational therapists working in the local authority reablement service, to ensure it was evidence based. There were four studies found in the scoping review that were particularly influential (Lawn *et al.*, 2017a); (Lawn *et al.*, 2017b); (Metzelthin *et al.*, 2018); (Bergström *et al.*, 2019), this co-created version became the training component of the ACT intervention described in this chapter.

The work of three psychologists gave the most relevant theoretical foundations, Maslow (1943), who theorised human motivation is based on people seeking fulfilment and change through personal growth influenced by both personal and social factors (Maslow, 1970); Erikson (1950) who theorised the eight stages of lifelong psychosocial development, which led to the concept of Vital Involvement (Erikson et al., 1987), and Bandura (1997) who`s theory of self efficacy and mastery modelling was became an effective method of human enablement.

5.1.2 Aim.

To describe ACT, detailing each of its three components, the process for the training design and delivery, how acceptability of the training would be measured.

5.1.3 Objectives.

1. To describe ACT the intervention, who delivered it and when.

2. To describe how it was it designed and delivered.
3. To describe how its acceptability would be measured.

5.2 How the intervention was designed.

As reablement itself is complex and multi-faceted, typically goal-focused home care that promotes a persons' independence with aligned multi-disciplinary interventions, the Medical Research Council framework (MRC) (Craig *et al.*, 2008) was used to explain the intervention studied. A four-phase framework was used to describe the development of the intervention; test feasibility; evaluate, and implement (Medical Research Council (MRC), 2021).

5.2.1 ACT Reablement.

The intervention, called ACT reablement was novel because it was made up of three components, delivered by local authority social care occupational therapists. The three components were:

1. Knowledge and skills reablement competency training
2. Reflective case discussion, goal setting and coaching to get better outcomes.
3. Proactive advice, equipment, and responsive solutions

5.2.2 Reablement competency training content.

An occupational therapist and an occupational therapy assistant delivered the reablement competency training material, face-to-face over three sessions, using Microsoft PowerPoint format with embedded video content. Figure 16 summarises the three training sessions, and the training slides, and a detailed description of the content can be found in Appendix 12.

The purpose of the training sessions was to encourage discussion about a different way of working involving active participation from both home carers and occupational therapists. The overall objectives of the training were for the home carers to actively think about and reflect on health and social care practice past, present, and future; engage and contribute to the session discussions, and for the facilitator to introduce the reablement competency framework.

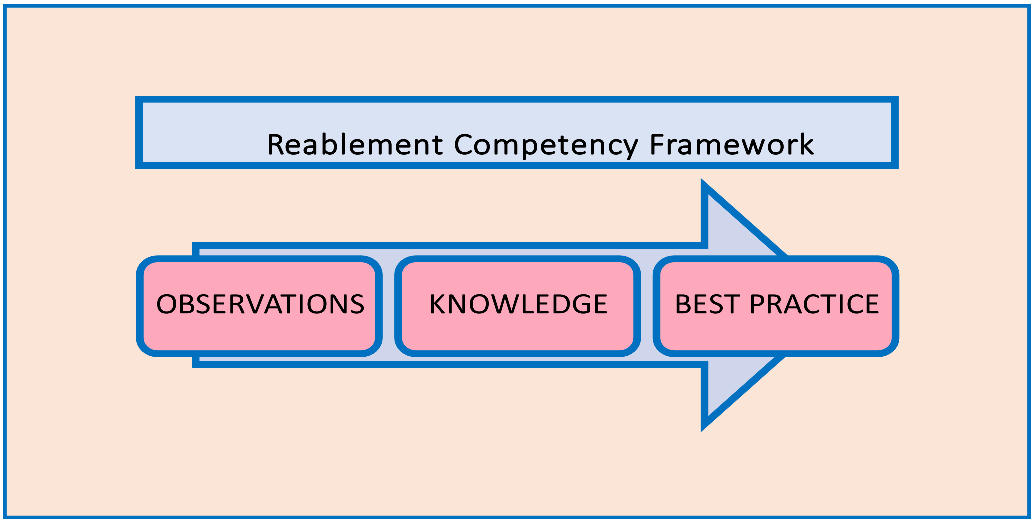
Figure 15 Reablement training sessions.

At the beginning of each training session, the facilitator explained the need to respect confidentiality, asking participants to refer to the people they care for, or work with, by first name only so that they are not identifiable to others, and to listen to colleagues rather than talk over them. The home carers were invited to speak if they had not commented on a question, through appreciative enquiry or natural conversation, so that everyone's views were heard.

The reablement competency framework in Figure 17 was designed to be used as a framework to quality assure practice through observation, to identify the home carer`s skills, how they can maintain and improve skills, and for supervisors to evaluate home carers' progress. It had been used by adult care reablement service since 2018, and is available by email request from the researcher.

The home carers were given a hard copy of the reablement competency framework booklet at the training session to facilitate their learning and to record their reflections. It was intended that paper booklet format would enable them to complete sections during their working day, between their daily visits with the aim that they would continuously reflect on their practice to improve outcomes for people who receive reablement.

Figure 16 Reablement competency framework.



The topics covered in the booklet:

- Identifying skills: recognise strengths, difficulties, abilities, and opportunities for change.
- Mastering, maintaining, and improving skills: understand and work to reablement goals; appropriately use a variety of reablement methods and techniques; respect safety, self-esteem, and individual beliefs.
- Evaluating, recording, and reporting progress: feeding back effectively, written, and verbal communication of progress and changes.

There are also eleven reflective stories of specific reablement practice and examples of good reablement record keeping included within the booklet. The electronic version of the booklet was shared with the independent home-based care coordinators to modify for their own quality assurance.

5.2.3 Reflective case discussion.

Occupational therapist`s delivered ACT reablement competency training in action learning sets, using a strength-based approach to introduce occupational therapy concepts and practical interventions. This was a new way of interacting with home carers, a novel approach intended to empower them as the reablement experts in a shared learning space.

Action learning sets are a participatory approach, used as a vehicle for change and engagement. This approach described by McKeown, Fortune and Dupuis (2016) as actively working towards a transformative cultural change of practise during research. The focus was on equal value of everyone’s perspective, learning new ways to communicate with each other, establishing relationships and partnership working. The occupational therapist delivering the training were not merely observing within this relationship but facilitating understanding, improvement, and change (Gelling and Munn-Giddings, 2011).

The intention was to use action learning sets to increase the home carers’ knowledge and skills, build relationships with them and facilitate reflective case discussions to empower them to be proactive in maximising peoples’ independence. This case discussion started at the training and continued as an ongoing intervention.

5.2.4 Proactive advice, equipment, and responsive solutions.

The occupational therapists were able to give advice during the session about a range of issues, management of health conditions, signpost referrals to other appropriate agencies, recommend compensatory equipment and adaptations using pictures within the training material to explain, and through demonstration of smaller equipment used for independent living. These occupational therapy interventions, and a solution focused approach, were part of the overall ACT intervention, although the impact was not quantified.

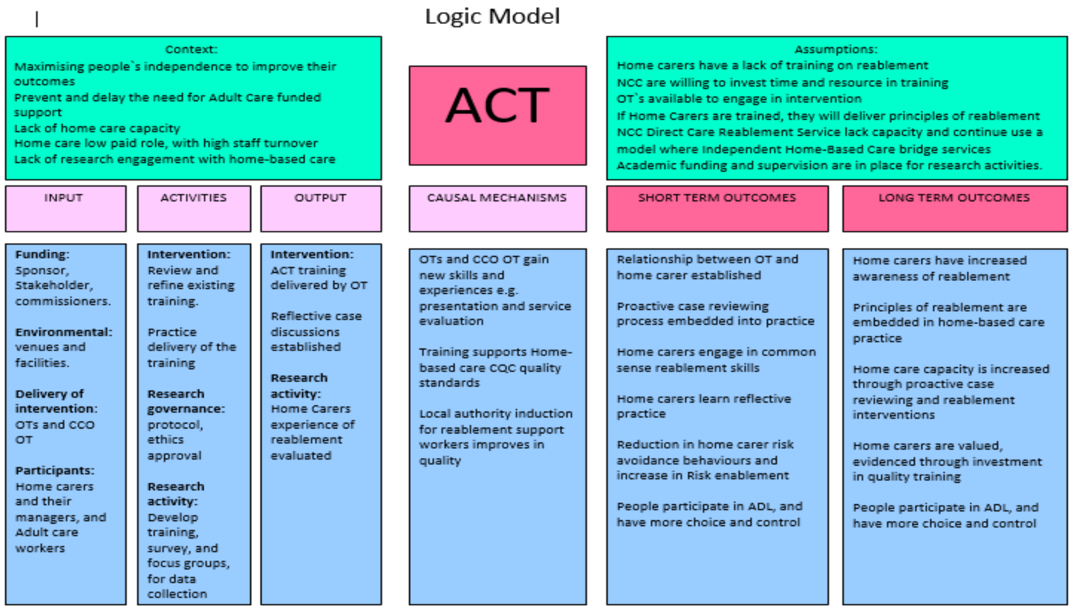
5:3 Act Reablement: a complex intervention.

A system thinking logic model, shown in Figure 19 was used to visually present the higher-level study outcome and expectations (Arnold and Wade, 2015); Timblin *et al.* (2018). This enabled the researcher to articulate the context and assumptions, intervention inputs activities and outputs, the causal mechanisms, and the expected short and long term outcomes The MRC outline the four main aspects for a logic model to inform intervention evaluation (Moore *et al.*, 2015).

2. Implementation refers to how a service or intervention gets delivered and what gets delivered in practice.
3. Mechanisms of impact relate to the mechanisms through which the intervention works and produces changes in the intervention recipients.

4. Outcomes are the changes that the intervention is trying to bring about for recipients.
5. Context refers to factors external to the intervention that might influence how the intervention operates.

Figure 17 The logic model.



Logic Model

Context:
Maximising people`s independence to improve their outcomes
Prevent and delay the need for Adult Care funded support
Lack of home care capacity
Home care low paid role, with high staff turnover
Lack of research engagement with home-based care

ACT

Assumptions:
Home carers have a lack of training on reablement
NCC are willing to invest time and resource in training
OT`s available to engage in intervention
If Home Carers are trained, they will deliver principles of reablement
NCC Direct Care Reablement Service lack capacity and continue use a model where Independent Home-Based Care bridge services
Academic funding and supervision are in place for research activities.

INPUT	ACTIVITIES	OUTPUT	CAUSAL MECHANISMS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Funding: Sponsor, Stakeholder, commissioners. **Environmental:** venues and facilities. **Delivery of intervention:** OTs and CCO OT **Participants:** Home carers and their managers, and Adult care workers	**Intervention:** Review and refine existing training. Practice delivery of the training **Research governance:** protocol, ethics approval **Research activity:** Develop training, survey, and focus groups, for data collection	**Intervention:** ACT training delivered by OT Reflective case discussions established **Research activity:** Home Carers experience of reablement evaluated	OTs and CCO OT gain new skills and experiences e.g. presentation and service evaluation Training supports Home-based care CQC quality standards Local authority induction for reablement support workers improves in quality	Relationship between OT and home carer established Proactive case reviewing process embedded into practice Home carers engage in common sense reablement skills Home carers learn reflective practice Reduction in home carer risk avoidance behaviours and increase in Risk enablement People participate in ADL, and have more choice and control	Home carers have increased awareness of reablement Principles of reablement are embedded in home-based care practice Home care capacity is increased through proactive case reviewing and reablement interventions Home carers are valued, evidenced through investment in quality training People participate in ADL, and have more choice and control

5.3.1 Who implemented the intervention, how and when.

The researcher, a PhD student led the research steering group, and as they were the principal occupational therapist in the local authority also took on the project manager role and chaired the operational delivery group.

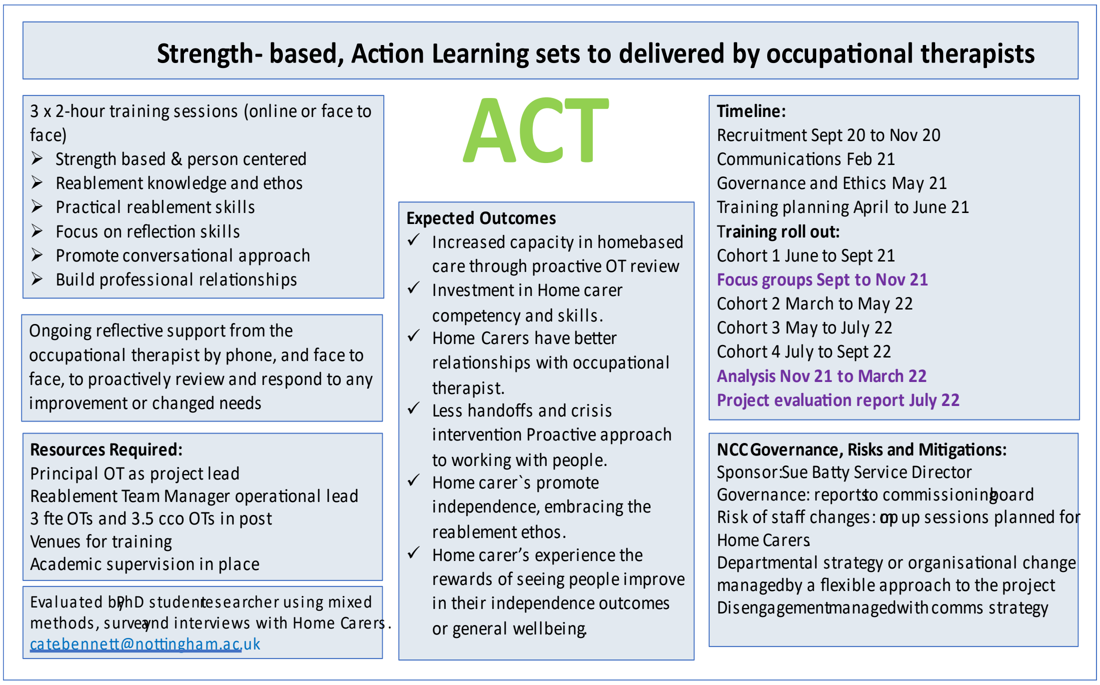
The occupational therapy resource allocated to the project was newly established and permanent in the local authority staffing structure, three full-time, and one part time occupational therapist, and the same number of non-regulated officers who support non-complex occupational therapy interventions. These were line managed by three reablement team mangers, who also managed the adult care in house reablement teams.

The Plan-Do-Study-Act (PDSA) method was used to implement and evaluate the project cycle, with local authority project tools that were familiar to the operational delivery group. The simple project on a page, shown in Figure 19, was used for communication and engagement with the project steering group and stakeholders.

A project initiation document (PID) was established by the researcher, with a Gant chart and a project review document to record project progress and risk. This enabled the researcher, academic supervisor, and colleagues to communicate and collaborate with clarity on the project aims and objectives, preventing drift.

The planned timeframe for project delivery was summer 2021, and the training continued through 2022. At the time, the covid pandemic was impacting health and social care significantly. Home care capacity was seriously compromised due to infection control rules, staff absence, and lockdown restrictions.

Figure 18 ACT Reablement: project on a page.



Strength- based, Action Learning sets to delivered by occupational therapists

3 x 2-hour training sessions (online or face to face)
- Strength based & person centered
- Reablement knowledge and ethos
- Practical reablement skills
- Focus on reflection skills
- Promote conversational approach
- Build professional relationships

Ongoing reflective support from the occupational therapist by phone, and face to face, to proactively review and respond to any improvement or changed needs

Resources Required:
Principal OT as project lead
Reablement Team Manager operational lead
3 fte OTs and 3.5 cco OTs in post
Venues for training
Academic supervision in place

Evaluated by PhD student researcher using mixed methods, survey and interviews with Home Carers.
catebennett@nottingham.ac.uk

ACT

Expected Outcomes
- ✓ Increased capacity in homebased care through proactive OT review
- ✓ Investment in Home carer competency and skills.
- ✓ Home Carers have better relationships with occupational therapist.
- ✓ Less handoffs and crisis intervention Proactive approach to working with people.
- ✓ Home carer`s promote independence, embracing the reablement ethos.
- ✓ Home carer's experience the rewards of seeing people improve in their independence outcomes or general wellbeing.

Timeline:
Recruitment Sept 20 to Nov 20
Communications Feb 21
Governance and Ethics May 21
Training planning April to June 21
Training roll out:
Cohort 1 June to Sept 21
Focus groups Sept to Nov 21
Cohort 2 March to May 22
Cohort 3 May to July 22
Cohort 4 July to Sept 22
Analysis Nov 21 to March 22
Project evaluation report July 22

NCC Governance, Risks and Mitigations:
Sponsor: Sue Batty Service Director
Governance: reports to commissioning board
Risk of staff changes: top up sessions planned for Home Carers
Departmental strategy or organisational change managed by a flexible approach to the project
Disengagement managed with comms strategy

5.3.2 The intervention operational delivery group.

The operational delivery group was essential for oversight of the project, and governance of the training delivery. The group met monthly, and included an adult care finance officer, operational senior manager, and strategic commissioner to oversee the governance of the operational elements of the project, and occupational therapy team manager, an occupational therapist to support with the delivery of the project. The PPI was included by special invite to relevant meetings only.

5.3.3 Training evaluation and outcome measures.

Table 13 presents the intended training outcome data, collected from a demographic survey, signing in sheet, a before and after training survey, reflective logs, and semi-structured interview and focus groups. The results of the training evaluation are presented in chapter five.

Table 13 Training evaluation domains and outcome measures.

Domain	Data source	Data collection method	Outcome measure	Timing
Reach	OTs leading the training sessions	Signing in sheet	Number of people attended. Demographic survey	Before each training session
Dose	OTs leading the training sessions	Signing in sheet	Number of sessions each person attended.	Before each training session
Fidelity	OTs leading the training sessions	Reflective log	Extent to which the training was implemented as planned	After each training session
Adaptions	OTs leading the training sessions	Reflective log	Any changes to the training to give a better fit on the day.	After each training session
Organisational contexts	OTs leading the training sessions	Reflective log	Any external issues from the participant, home care provider or Adult Care that might have influenced the training.	After each training session
Acceptability	Participants before and after training	Evaluation form	Number of people who were satisfied with the training.	Before and After each training session
Impact	Participants before and after training	Evaluation form	The number of people whose confidence, and clarity in knowledge and skills improved as a result of the training.	Before and After each training session

5.3.4 Training implementation challenges.

The home care service was commissioned to deliver reablement home care, but also delivered standard home care and had no training on reablement before involvement in this study. Therefore, the service delivery model is best described as regulated professionals (social care occupational therapists) delivering reablement, with standard home care.

The independent home-based care provider employed 119 home carers divided between four area teams and three managers. There were three full-time local authority social care occupational therapists employed to work on this project.

The volume of home carers identified for training was challenging, as the home care provider needed to balance home carers' operational duties. The occupational therapists were allocated time to attend the training in their working day. There was staffing turn-over amongst the occupational therapists, newly recruited workers required induction on the project aims and objectives, and coaching to enable them to facilitate the training.

Nevertheless, the occupational therapists were adaptable and motivated, able to book training sessions with the home care provider care coordinator weekly, giving flexibility to the staff rota considerations. This was further enabled by the location of local authority offices around the county with easy to book accessible facilities, and ease of access for the home carers to park.

5.4 Discussion.

The origins of the training and reablement competency framework were historical, well embedded into the adult care reablement in-house training. Senior occupational therapists were very familiar with the framework and supported the co-design method to review the training. A number of minor improvements evolved through co-design as the project moved forward.

The project planning, and delivery was during the early part of the Covid pandemic, at the time workers were only starting to embrace online collaboration. The operational delivery group approved production of the ACT training as e-learning, and whilst this took a further investment of time, it was not used.

To ensure consistent quality of the training sessions, the researcher attended two sessions as an observer, and the facilitators completed reflective accounts for every session. As intended, there was a large element of valuable reflective case discussion in each session. The occupational therapist was using a strength-based approach, coaching the home carers to think positively about the persons possible goal attainment using risk enablement strategies, rather than focusing on the negative, what they cannot do or are struggling with. As a result, the presentation slides were amended slightly to improve the flow without change to the content.

The occupational therapist`s had brought in small equipment for the home carers to look at, touch, and use themselves during the session. They had self-initiated this, as a response to the home carer`s at the first session who had not seen the equipment described on the presentation. In some localities of the UK, the person is expected to self-fund small equipment like a long-handled sponge. Practising with this whilst a reablement worker is present can mean a person confidently reaches independence. For some people, they cannot afford, or are not capable of self-funding this equipment. In these circumstances providing the equipment at a one-off cost of less than £10 will save the ongoing cost of a home carer assisting with bathing or showering, costing £18 per hour (Nottinghamshire Councy Council, 2023).

The occupational therapist introduced “green sheets” for home carer`s to record the person`s goal, to be left in the person’s home. This meant each home carer could track the previous day’s goal attainment, and the occupational therapist could focus on improving goal outcome.

The occupational therapist handed out contact details for each locality team occupational therapist, to enable the home carer`s to continue to access the proactive occupational therapy advice by phone. This meant the home carers could request any equipment, and an occupational therapist could give responsive solutions that would promote the persons’ independence.

A difficulty with this project was articulating the need for robustness of research methods, aligned to service improvement PDSA methods. The PDSA cycle was helpful to frame the project, the quality improvement language and tools were familiar to the local authority operational delivery group. Knudsen *et al.* (2019) identified widespread challenges with low adherence to key methodological features in the individual projects they analysed in their systematic review and how this poses a challenge for the legitimacy of PDSA-based quality improvement. This adherence to research methods was overcome by separating out the research steering group from the operational delivery group, and the PPI input to the research steering group was especially helpful in reinforcing reflexivity.

The steering group shaped the operationalisation of the project, with governance of service delivery outcomes reported at board level. A communication engagement plan was used throughout the project lifetime, this and the logic model in Figure 18 was used by the researcher, strategic commissioner, PPI, and the senior operational group manager for sharing key messages.

There were some operational risk issues for the project, mainly due to staffing capacity and operational demands caused by the covid 4th wave in winter of 21-22. There were staffing changes, within the home care provider senior management team, with occupational therapists and with home carers, meaning potential for disengagement at several levels. These were mitigated through communication and engagement, a flexible approach to the project delivery from the steering group forum, and project governance.

Significant operational time and resource by the researcher was required to coach new staff to deliver the intervention, to understand the project aims and objectives and facilitate the training for home carers. This had been planned for the project start but had to be accommodated on two more occasions during the project delivery due to occupational therapy staff changes. Fortunately, the non-regulated officers remained consistent throughout the project, giving stability.

In the end, the retention of staff didn’t affect the project roll-out, as the booking and planning of the trainings sessions was a delegated task to the occupational therapists and home care coordinators, and there was strong commitment to the project from them, no issues emerged in organising the training venues, or coordination of the home carers to attend the sessions.

5.5 Conclusion.

A team of three local authority occupational therapist`s, and three local authority non-regulated officers who deliver occupational therapy interventions, were responsible for delivering the ACT intervention to one large independent home-based care provider in 2021 to 2022.

The ACT reablement competency training, delivered over six hours, face-to-face, with groups of six home carers, by two occupational therapy trainers, included three core components: knowledge and skills competency training; reflective case discussion and responsive occupational therapy solutions.

The ACT reablement competency framework and reablement training, an established local authority programme, was refined based on research findings, the scoping review literature, co-design methods and project improvement methods, to produce the ACT reablement intervention.

To design and deliver the ACT reablement intervention the PDSA project quality improvement cycle was used, with a range of standard tools, a project initiation document, logic model, progress review, communications, and engagement strategy; these resources are digitally available on request.

It is recommended that delivery of the ACT intervention, and associated reablement competency training is overseen by an operational delivery group, which includes the training provider and the independent sector home-based care provider. The operational delivery group should report to the funder for governance.

Chapter 6 Analysis and findings of training acceptability.

6.1 Introduction.

The last chapter explained the ACT reablement intervention and training content in detail. The aim of this chapter was to evaluate the training to determine the acceptability to the home carers and the feasibility of delivering it again.

The objective was to determine whether participants understanding, confidence, knowledge and skills had changed following training, and which aspects of the training were acceptable or required reform.

A demographic survey, and non controlled before and after training survey were used to collect data to show change in knowledge. In addition, data collected during the semi-structured interviews and focus group, was used to give descriptive meaning to aspects of training. This combined analysis formed the training evaluation, by analysing and integrating the data, richer insight to the research question was gained (Creswell, 2015).

6.1.1 Sample.

Twenty-two home carers consented to participate in the training. Of these, fourteen went on to participate in telephone interviews, a median average of two months later, or focus groups which were held on the same day as the training session. The participants were identified by numerical ID, where this runs into double digits, the letter Z was used to keep the correct order on the Nvivo digital software (Lumivero, 2021).

There was missing survey data for two participants, z22 in cohort one and 8 in cohort two. Both had completed the before training evaluation and the demographic data, but neither had initialled the demographic survey. During the telephone call interview on 13.05.22, Participant 8 confirmed their demographics. Through a process of elimination, participant z22 was identified as missing data for the demographics and the after training survey.

6.2 Demographic findings.

Table 14 shows the results for the self-reported demographic survey in Appendix 10. Of the twenty two training participants, data was missing for one, nineteen identified as female, two identified as males and both consented to interview. Four of the participants that completed the survey worked part-time, these were all female; one female worked full-time as a home carer and had a second job.

Skills for Care (2022) estimate the average age of home carers in England to be 45 years. Table 13 evidenced, the median average age category of the participants in this sample was 35-44, with twenty home carers reporting they were over 25 years old, and only three over 55 years old. The home carers were experienced, thirteen had more than 11 years experience, and none who completed the survey had less than one year's experience working a home carer.

The ethnicity of the home carers who attended the training is shown in Table 14, seventeen identified as white British, and four identified they were from other ethnic groups. This is slightly higher that the Nottinghamshire Joint Strategic Need Assessment (JSNA) reported 12% of the Nottinghamshire population who are from a non white British ethnic group (Nottinghamshire Insight, 2023).

Table 14 Demographics of participants

ID	Additional data Source	Cohort	Gender	Age Group	Ethnic group	Experience	Employment status	Other job
1	Interview	1	Female	45-54	White British	> 11 years	Part time	No
2	Interview	4	Female	45-54	White British	> 11 years	Full time	No
3	Interview	1	Female	35-44	White British	3 to 5 years	Full time	No
4	Interview	1	Female	25-34	White British	>11 years	Full time	No
5	Interview	1	Female	35-44	White: other	> 11 years	Part time	No
6	Interview	1	Male	35-44	White: Irish	3 to 5 years	Full time	No
7	Interview	3	Female	25-34	Asian or Asian British	>11 years	Full time	No
8	Interview	2	Female	45-54	White British	> 11 years	Part time	No
9	Interview	3	Female	25-34	White British	> 11 years	Full time	Yes

Z10	Focus Group1	2	Male	35-44	White British	> 11 years	Full time	No
Z11	Focus Group1	2	Female	35-44	White British	> 11 years	Full time	No
Z12	Focus Group1	2	Female	45-54	White British	6 to 10 years	Full time	No
Z13	Focus Group2	4	Female	45-54	White British	> 11 years	Full time	No
Z14	Focus Group2	4	Female	35-44	White British	> 11 years	Full time	No
Z15	Training Evaluation only	2	Female	35-44	Black, African, Caribbean, or Black British	6 to 10 years	Full time	No
Z16	Training Evaluation only	2	Female	< 55	White British	1 to 2 years	Part time	No
Z17	Training Evaluation only	2	Female	< 55	White British	> 11 years	Full time	No
Z18	Training Evaluation only	2	Female	45-54	White British	3 to 5 years	Full time	No
Z19	Training Evaluation only	4	Female	18-24	White British	6 months to 1 year	Full time	No
Z20	Training Evaluation only	4	Female	25-34	White British	6 to 10 years	Full time	No
Z21	Training Evaluation only	2	Female	> 55	White British	> 11 years	Full time	No
Z22	Training Evaluation only	1	missing	missing	missing	missing	missing	missing

A smaller sample of fourteen home carers participated in qualitative interviews and focus groups, nine had individual interviews by phone. Two focus groups took place face-to-face, three participants attended the first group and two in the second group; there was no take up of on-line focus groups. No participants withdrew from the interviews and focus groups.

The participants in focus group two, z13 and z14 were from cohort four. Both were experienced home carers, 11 years plus. However, they were working in a quality assurance trainer role, as well as covering home care shifts. This meant that, unlike the other participants, they had responsibility for training other carers in the care certificate competencies and assuring the standards of practice.

6.3 Before and after training survey.

The purpose of the before and after training survey was to determine the home carers understanding, and their confidence in delivering reablement interventions, before and after the ACT reablement training. This was measured using a five-point anchored Likert scale, in response to the five questions in Appendix 11. Each of the five available answers described levels of significance to the participant using a visual emoji, written description, and an allocated numeric value. The lowest score counted as negative and highest score positive: 1= awful; 2= not very confident; 3= okay; 4= very confident; 5= fantastic.

The raw data from the before and after training survey is shown in Appendix 14. The proportion of participants with positive scoring of 4 or 5, neutral scoring of 3, or negative scoring of 1 or 2 were grouped, and these results were presented as a percentage with 95% confidence interval. Average participant response to questions was determined using the median because the ranked data was ordinal. This gave a truer representation of the distribution presented as lower and upper quartiles with interquartile range.

To explore any similarities or differences between the training groups the combined median average response was examined. Missing data for one participant, for the after-training survey, was calculated as the median for that cohort.

Finally, this all of the training survey data was integrated and presented side-by-side with any relevant qualitative data collected from the semi-structured interview and focus groups giving a richer descriptive insight and depth to the training evaluation.

6.3.1 The median average results of the training survey for all participants.

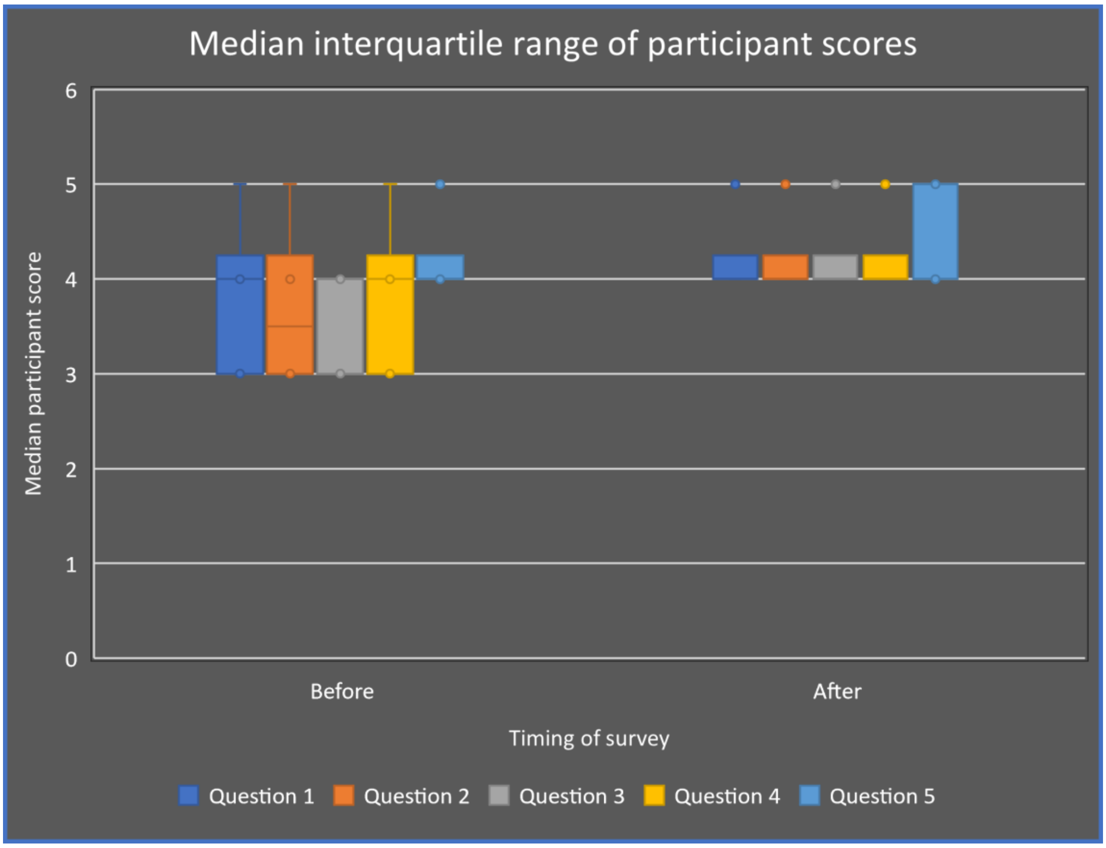
Table 15 shows the median average results for all 22 participants from the before and after training survey for each of the five questions, Figure 20 shows the results visually, with interquartile range.

Table 15 Median average training survey results for all participants.

	Before training survey					**After training survey**				
	Lowest	Q2	Median	Q3	highest	Lowest	Q1	Median	Q2	highest
Question 1	2	3	3	4	5	2	4	5	5	5

Question 2	2	3	3	4	5	2	4	4	5	5
Question 3	2	3	3	4	5	2	4	4	5	5
Question 4	2	3	3.5	4	5	2	4	4	5	5
Question 5	2	3	3	4	5	2	4	5	5	5

Figure 19 Before and after training survey showing median and interquartile range for all participants.



6.3.2 The before and after survey results for each question.

Individual participants' results are presented visually to show the grouped proportional response before the training in Figure 21 and after the training in Figure 22, then the results are narratively explained for each survey question in turn.

Figure 20 Participants before training survey response.

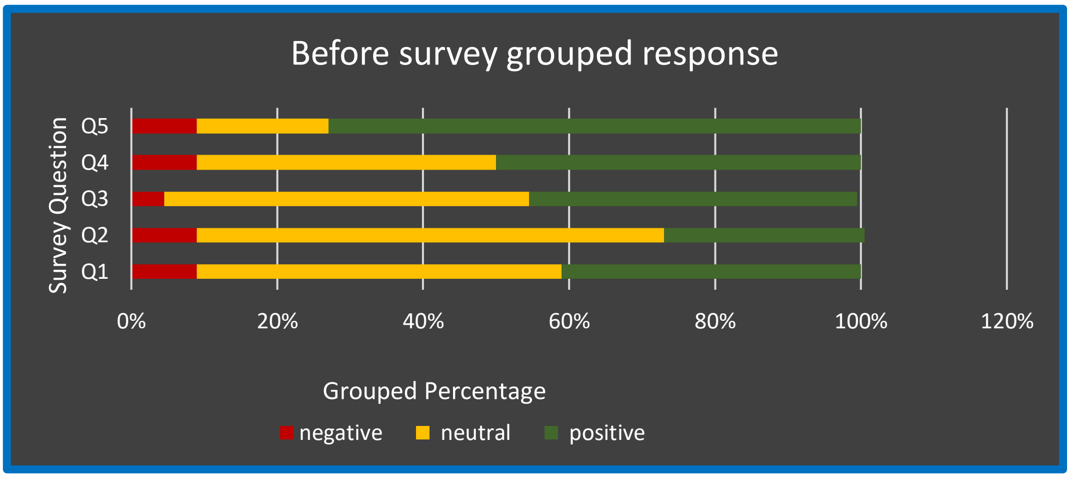
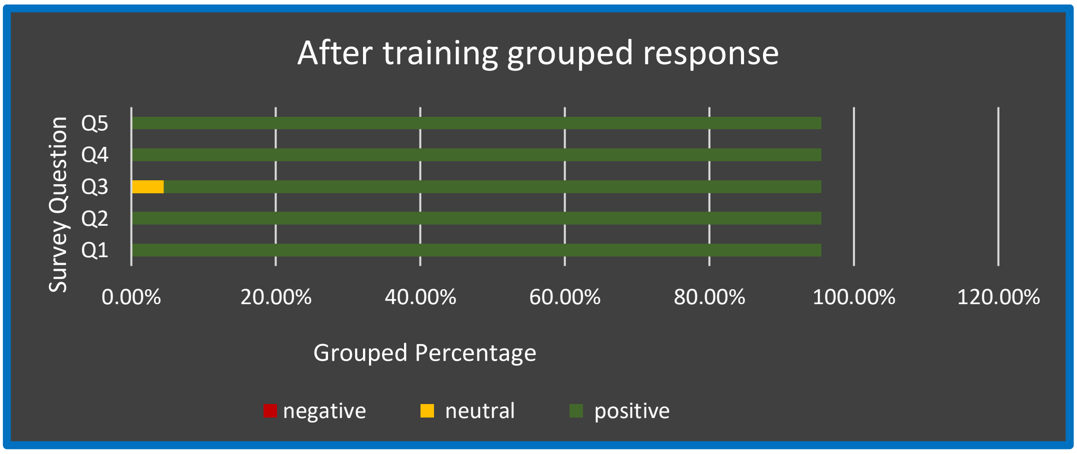


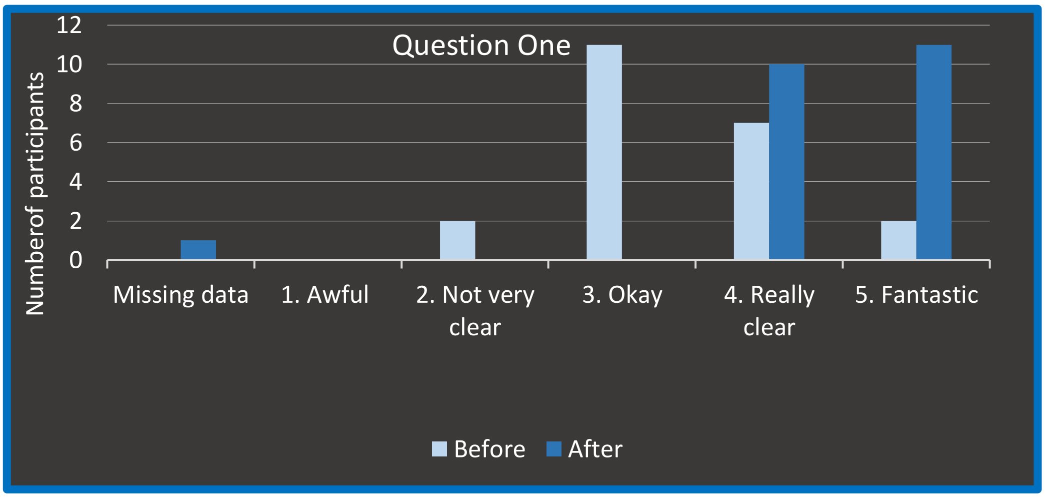
Figure 21 Participants after training response.



6.3.3 Clarity about the difference between reablement versus standard home care?

Taking the grouped responses for question one, before the training 9 /22 (95% CI 0.192 to 0.628) scored a positive response, 11 /22 (95% CI 0.183, 0.617) scored neutral, and 2/22 (95% CI 0, 0.217) scored a negative response. After the training, 21/22 (95% CI 0.871, 1) scored positively; 1 /22 (95% CI 0, 0.137) was missing data.

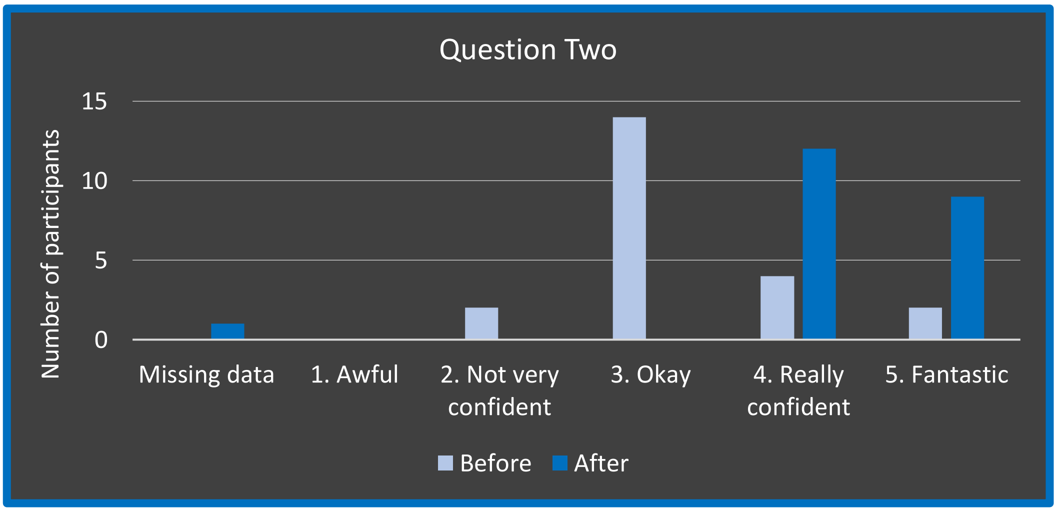
Figure 22 Participant response to question one.



6.3.4 Confidence challenging a reluctant individual with their reablement.

The grouped participant responses for question two, before the training 6/22 (95% CI 0.077, 0.473) scored a positive response, 14/22 (95% CI 0.427, 0.853) scored themselves neutral, and 2/22 (95% CI 0, 0.217) scored a negative response. After the training, 21 /22 (95% CI 0.863, 1) scored a positive response; 1 /22 (95% CI 0, 0.137) was missing data.

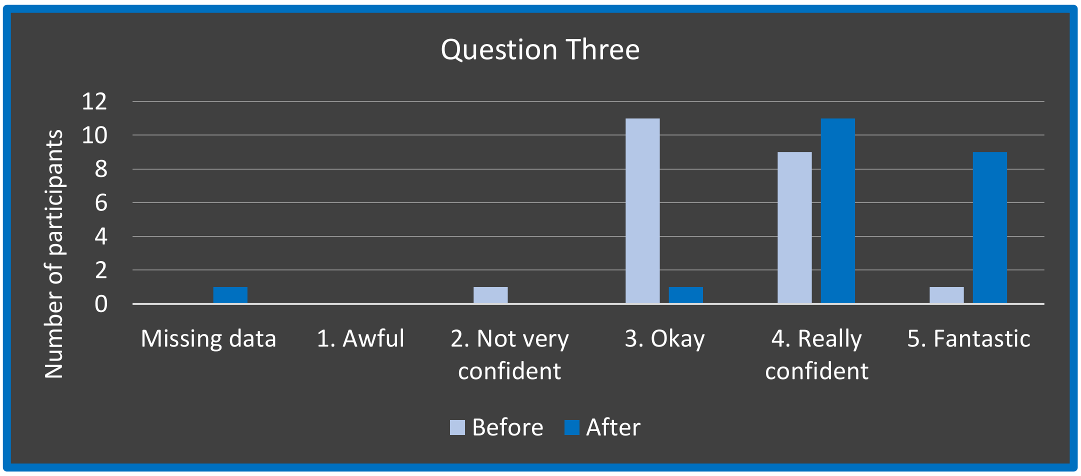
Figure 23 Participant response to question two.



6.3.5 Confidence motivating a reluctant individual with their reablement.

The grouped responses for question three, before the training 10/22 (95% CI 0.229, 0.671) scored themselves positively, 11/22 (95% CI 0.278, 0.722) scored neutral, and 1 /22 negatively. After the training, 20 /22 (95%CI 0.783, 1) were positive, 1/22 (95% CI 0, 0.137) thought they were okay; 1/22 (95% CI 0, 0.137) was missing data.

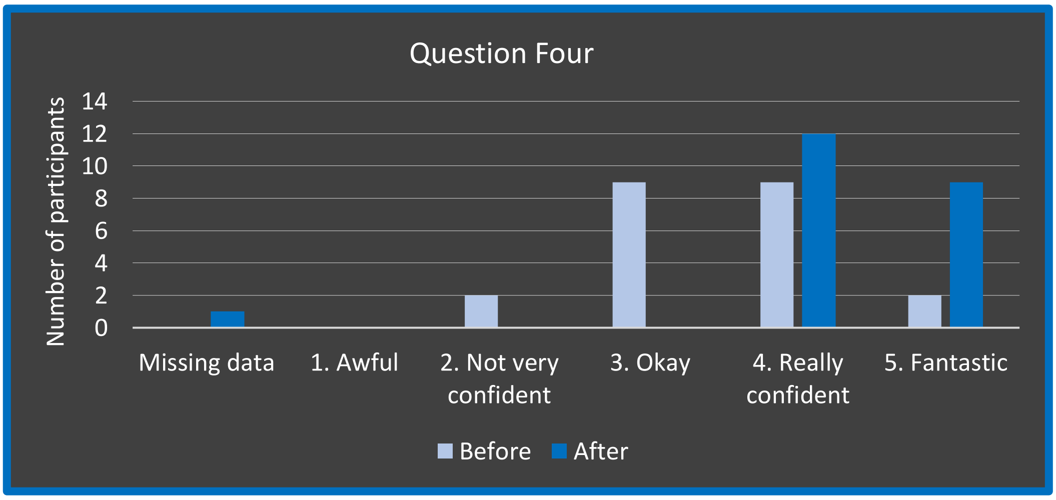
Figure 24 Participant response to question three.



6.3.6 Confidence identifying that someone is improving in their abilities.

The grouped responses to question four, before the training 11/22 (95% CI 0.278, 0.722) scored themselves positively, 9/22 (95% CI 0.192, 0.628) scored neutral, and 2/22 (95% CI 0, 0.217) negatively. After the training, 21 /22 (95%CI 0.853, 1) were positive; 1/22 (95% CI 0, 0.137) was missing data.

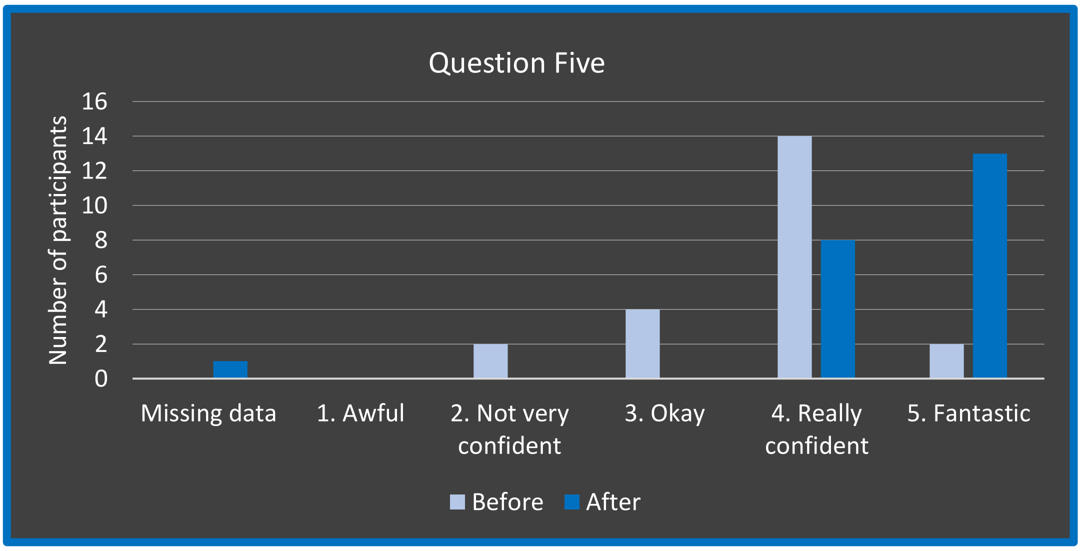
Figure 25 Participant response to question four.



6.3.7 Confidence feeding back to an occupational therapist.

The grouped responses, before the training, 16/22 (95%CI 0.533, 0.927) scored positively, 4/22 (95% CI 0.01, 0.35) scored neutral, and 2/22 (95%CI 0, 0.217) negatively. After the training, 21/22 (95% CI 0.853, 1) scored positively; 1/22 (95% CI 0, 0.137) was missing data.

Figure 26 Participant response to question five.



6.3.8 Survey results between cohorts.

The training was delivered over a 6-month period, with an inconsistency in occupational therapy facilitators due to staff leaving. Therefore, the data is presented in Table 16, and examine by training session cohort, to explore any difference in the grouped data that might suggest variability between the groups of participants, their collective understanding, or the training delivery.

Table 16 Before and after training survey median average scores with interquartile range

	Before training survey					After training survey				
Question 1	n=	Q1	Median	Q3	IQR	n=	Q1	Median	Q2	IQR
Cohort 1	6	3	4	4	1	5	4	4	5	1
Cohort 2	8	3	3	4	1	8	4	5	5	1
Cohort 3	3	3	3	3	0	3	4	5	5	1
Cohort 4	5	2.5	3	4	1.5	5	4	5	5	1
All cohorts	22	3	3	4	1	21	4	5	5	1
Question two	n=	Q1	Median	Q3	IQR	n=	Q1	Median	Q3	IQR
Cohort 1	6	3	3.5	4	1	5	4	4	5	1
Cohort 2	8	3	3	4	1	8	4	5	5	1
Cohort 3	3	3	3	3	0	3	4	5	5	1
Cohort 4	5	2.5	3	3	0.5	5	4	4	4	0
All cohorts	22	3	3	4	1	21	4	4	5	1
Question 3	n=	Q1	Median	Q3	1QR	n=	Q1	Median	Q3	IQR
Cohort 1	6	3	4	4	1	5	4	4	5	1
Cohort 2	8	3	3	4	1	8	4	4	5	1
Cohort 3	3	3	3	4	1	3	4	5	5	1
Cohort 4	5	3	3	4	1	5	4	4	4	0
All cohorts	22	3	3.5	4	1	21	4	4	5	1

Question 4	n=	Q1	Median	Q3	IQR	n=	Q1	Median	Q3	IQR
Cohort 1	6	3	4	4	1	5	4	4	5	1
Cohort 2	8	3	3	4	1	8	4	4	5	1
Cohort 3	3	3	3	4	1	3	4	5	5	1
Cohort 4	5	2.5	3	4	1.5	5	4	4	4	0
All cohorts	22	3	3.5	4	1	21	4	4	5	1
Question 5	n=	Q1	Median	Q3	IQR	n=	Q1	Median	Q3	IQR
Cohort 1	6	4	4	4	0	5	4	5	5	1
Cohort 2	8	3	3	4	1	8	4.5	4	5	0.5
Cohort 3	3	4	4	4	0	3	4	5	5	1
Cohort 4	5	3	4	4	1	5	4	4	5	1
All cohorts	22	3	3	4	1	21	4	5	5	1

There were four cohorts, the first had six participants, cohort two had eight, cohort three had three, and four had five participants. The median average with interquartile range is visually presented in Figure 28, 29, 30 and 31 to show the range in before and after survey scores for each training cohort. The missing data for the after-training survey was in cohort one, and so the median score for this cohort was used.

Figure 27 Cohort one median average score showing interquartile range.

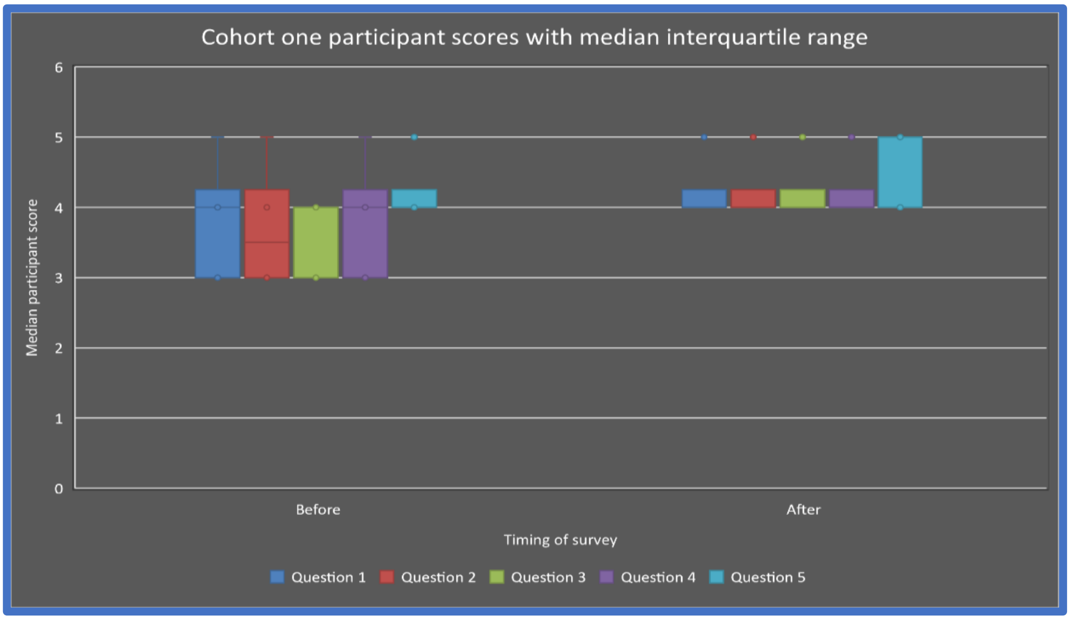


Figure 28 Cohort Two median average score showing interquartile range.

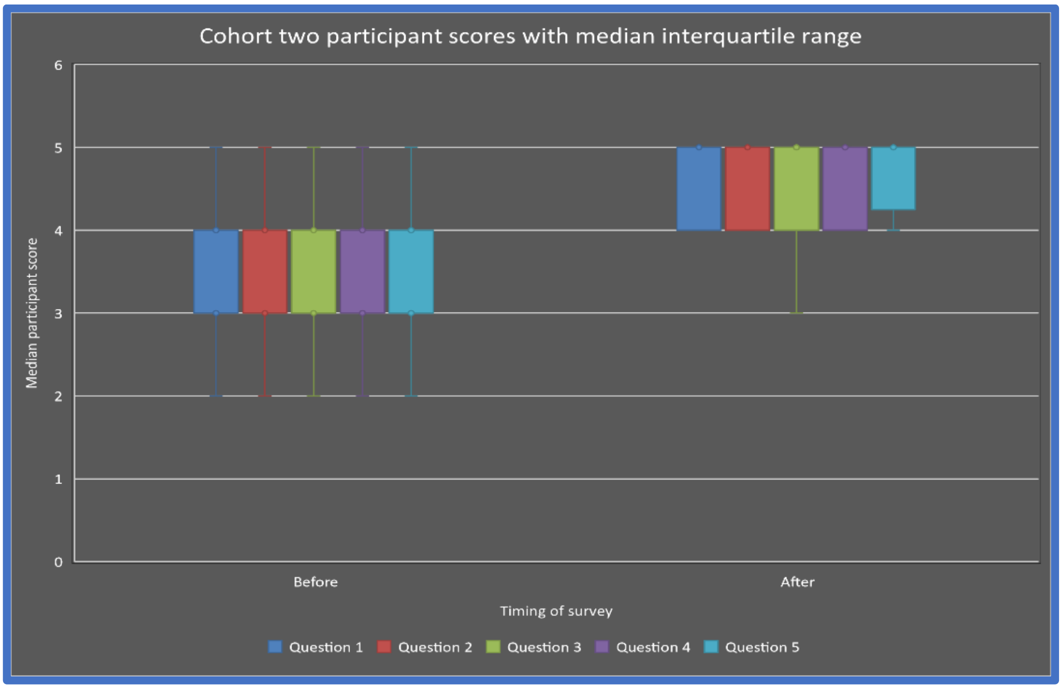


Figure 29 Cohort Three median average score showing interquartile range.

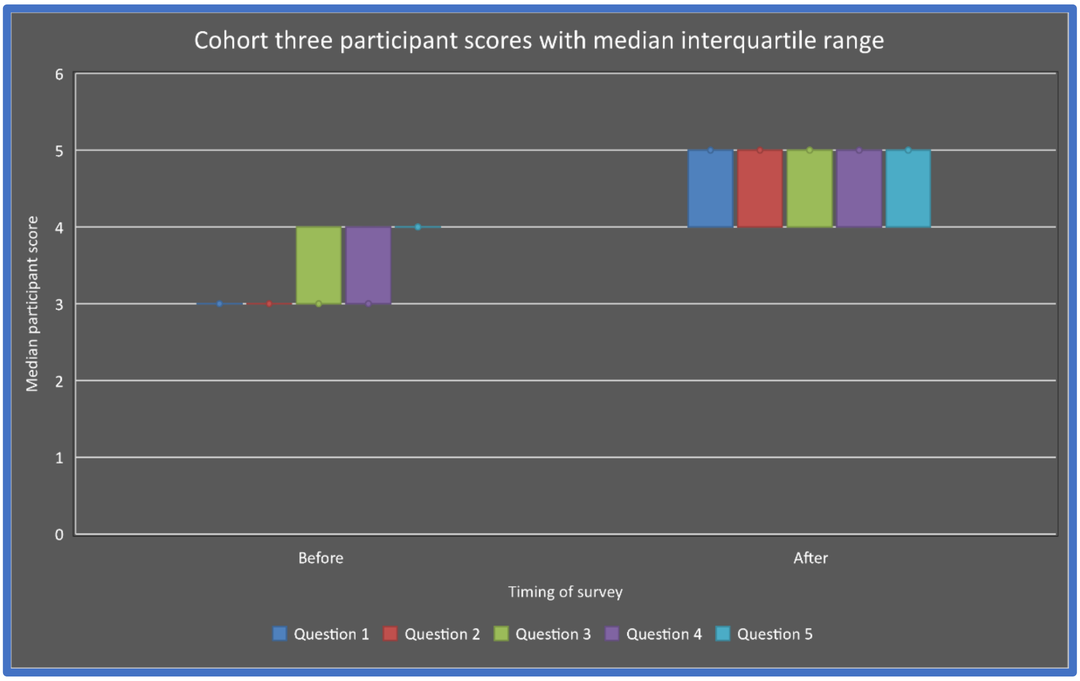
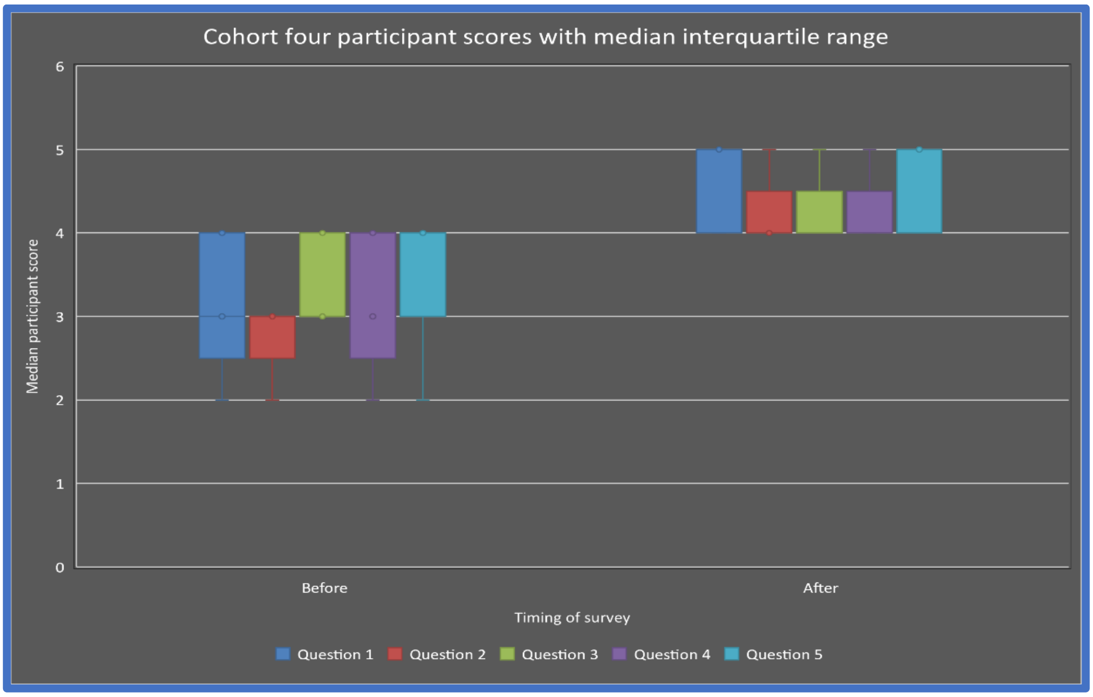


Figure 30 Cohort four median average score showing interquartile range.



The box and whisker graphs evidenced that participants in cohort two and four had the lowest level of clarity or confidence in their reablement knowledge and skills before the training and showed the greatest improvement after the training. Cohorts three and four scored higher on the after survey but this variance cannot be generalised, as being due to the occupational therapist delivering the session.

6.4 Qualitative findings from semi structure interviews and focus group used to evaluate the training.

During the interview and focus group, fourteen home carers were asked a different set of questions about their understanding of reablement, the semi-structured interview and focus group questions are in Appendix 9. Where responses were relevant to the training evaluation, descriptive data has been presented in this chapter, to add depth and richness to the training evaluation.

6.4.1 Clarity about the difference between reablement and standard home care.

Unfortunately, neither of the participants who scored excellent clarity in the survey, were involved in the semi-structured interviews, or focus groups. There were two participants (z12 in cohort 2, and z20 in cohort 4) who scored themselves as not very clear before the training; both had worked as home carers for six to ten years.

Of these, only z12 (cohort 2-focus group 1) participated in the qualitative data collection. She had worked for the company in a reablement role for 18 months. It was clear from the interview transcribe that she valued the training, and as a result of the training she realised she had not been delivering reablement interventions.

“Since we’ve been doing this for three weeks (ACT training), it’s made me realise actually we are supposed to be doing a lot more than just going in and just caring for them.” Participant z12 (cohort 2 -focus group 1).

6.4.2 Confidence challenging a reluctant individual with their reablement.

The grouped positive scores showed six had clarity in how to challenge people who were reluctant to engage in their reablement goals. This did not triangulate with all 14 participants in the interviews and focus groups, who struggled to describe the methods they had used or scenarios where they had positively challenged people.

The participant`s identified that they needed to use soft skills such as: encouragement, confidence building, reassurance, and persuasion. Two participant`s described tangible actions such as practising an activity with the person, challenging through the process of demonstrative action.

“It was just adding things every day to the routine. So, like, for a couple of days he was in so much pain he couldn’t do anything. So, we did everything for him and every day we added a bit to the personal care...why don’t you have a go at washing this today. Between me and the girl that worked opposite me, over the course of the four weeks, we had gone from him doing nothing to adding something to his personal care routine until he’d mastered it, and he could do it all.” Participant z11 (cohort 2-focus group 1).

Some home carer`s described scenarios in the context of not having the skills to challenge further.

“I don't know, all I would do is the encouragement side and say these are the goals to aim for. I don't know what else I can try and do.” Participant 2 (cohort 4-interview).

Others talked about the approach they used in this context, linking this to communication and relationship building skills and positive outcomes.

> *“You’ve got to be confident in what you are doing, and like I say, you’ve got to be able to read the clients that you are looking at to know what’s going to work for them...what approach is going to work for them.”* Participant 9 (cohort 3-interview).

The participants described the difficulties they experienced in challenging people who could do more for themselves. They described the expectations that people, informal carers and family members had of the home carer role. There was discussion about how this expectation had originated, historically and culturally, the participants’ perceptions of why people lose intrinsic control. Their experience of this is discussed in chapter six.

6.4.3 Confidence motivating a reluctant individual with their reablement.

The before training evaluation clearly showed ten participant`s considered themselves to be confident or fantastic at motivating a person to achieve their reablement goals. Positive and desirable motivation methods were described during the interviews.

> *“I says, come on I know you can do it. Come on shut me up...and she did, and when she had done it...I said, you see don’t be too hard on yourself, you can do it. If I believe in you...you’ve got to believe in yourself.”* Participant 9 (cohort 3-interview).

Similarly, participant 6 scored very confident before the training and fantastic after the training.

> *“To say to them, I think you could do this. Can we try doing that? I think you would benefit from doing it this way.”* Participant 6 (cohort 1-interview).

In chapter six, the negative methods of motivation, persuasion, or bargaining are explored in more detail. One participant who had six to ten years experience in caring and had been doing her reablement role for 18 months, scored negatively before the training on confidence in motivating an individual, and after the training scored okay. She reflected during focus group 1 on her learning from the training, and how this would change the way she would work.

"But, as I said, this has learnt me a lot. Doing this, and thinking, actually stand back a bit, and let them do this for themselves and practice. So, I have so that's good." Participant z12 (Cohort 2- focus group 1).

6.4.4 Confidence identifying that someone is improving.

The confidence to recognise that a person is improving and knowing what to do about it to get the best outcome for the person, is a skill and informs the feedback mechanism. Out of the fourteen participants interviewed, eleven (95% CI 0.541, 1) had 11 years plus experience as a home carer, and all had over three years experience.

Overall, before the training, half of the participants considered themselves to be confident in identifying that someone is improving in their abilities. There were strong attitudes about recognising and reacting to improvement from home carers who participated in interviews and focus groups. Most described making these decisions based on their relationship with the person, the person's choice, experience, and common sense.

"If you can build up a relationship with someone, you can kind of judge whether they need pushing in certain ways. Whether they're are not getting as much of their own potential as they could be." Participant 6 (Cohort 1-interview).

However, one carer admitted she found it difficult to allow people to do things for themselves. Another, understood people improving in ability in the context of needing less home care time, as opposed to the person being able to do more for themselves, whilst the carer stood back.

"Well obviously everything will stay the same until we feel that we don`t need as much time" Participant 8 (Cohort 2-interview).

6.4.5 Confidence feeding back to the Occupational Therapist.

Overall, before the training, sixteen scored positively about feeding back to the occupational therapist. There were two home carer`s who scored negatively before the training (z12 and z19), and one of them, z12 participated in the focus groups, she identified she had poor knowledge of occupational therapy during a discussion.

"You see, I haven't seen any of that equipment. Its all a learning curve. I feel a lot

> *more confident now that I can ring her and say, look I think this person needs this sort of equipment or can you come and have a look to see what equipment she needs?" Participant z12* (cohort 2- focus group 1).

Whereas five other interview participants demonstrated high levels of confidence and strong relationships with the occupational therapist during conversations.

> *"I'd be on the phone to her, can you come and check this one out? I've reduced him to a single from a double and she'd go out, and we could agree with stuff. So, it were good"* Participant 1 (cohort 1-interview).

> *"I did that training and was given the list of OTs to contact them. I mean, I went to one the other night he's got no equipment in place, he got a walk in shower that he could step into but there was no grab rail or shower seat, so he was going to be unsafe to shower this gentleman, so I emailed the OT and asked could they go out and visit him, because that's what he wants, he wants a shower."* Participant 4 (cohort 1-interview).

Even those who were critical of occupational therapy saw the point in feeding back and identified improvements for occupational therapists working on hospital discharge pathways.

> *"Yeah, because the hoist in hospital is different to the hoist at home. The environment in the hospital is a lot different to the environment at home. We can assess the environment that's what we do, but we can't deem if somebody is safe because we aren't occupational therapists"* Participant 9 (cohort 3-interview).

6.5 Integration of quantitative and qualitative data.

Integrating the training survey data with the semi-structured interview and focus group data allowed greater nuance to be articulated, and triangulation of these findings strengthened the analysis. A convergent design was identified to integrate and merge the data (Creswell, 2015). The purpose of this design strategy was to bring together the data sets after the separate results had been analysed. The strength of sentiment was coded for the interview and focus group data. Where relevant to the five survey questions this is presented in Table 17, to give a side-by-side comparison of the data, and a more complete and validated evaluation.

Table 17 Integrated data showing strength of attitude.

ID	Cohort	Q1 Purpose of Reablement			Q2 Challenging a reluctant Individual			Q3 Motivating an Individual			Q4 Identifying a person`s. Improvement			Q5 Feeding back. to OT		
		Before	After	Qualitative	Before	After	Qualitative	Before	After	Qualitative	Before	After	Qualitative	Before	After	Qualitative
1	1	4	5		5	5		4	5		5	5		5	5	Positive
2	4	3	4		3	4	Negative	4	4		4	4		4	4	
3	1	4	4	Positive	4	4	Positive	4	4		4	4		4	4	
4	1	3	4		3	4		4	4		3	4		4	5	Negative
5	1	4	4		4	4		4	4		4	4		4	4	
6	1	3	4	Positive	3	4		3	4	Positive	3	4	Positive	4	5	
7	3	3	4		3	4		3	4		4	4		4	4	Positive
8	2	3	4		3	4		3	4		3	4	Negative	3	5	
9	3	3	5		3	5	Positive	4	5	Positive	3	5		4	5	Negative
Z10	2	3	5		3	5		3	5		3	5		3	5	
Z11	2	4	5	Positive	4	5	Positive	4	5		4	5		4	5	
Z12	2	2	5	Positive	2	5		2	5	Positive	2	5	Negative	2	5	Positive
Z13	4	4	4		3	4		3	4		4	4		4	4	
Z14	4	4	5	Positive	3	4		4	4		3	4		4	5	
Z15	2	5	5	N/A	5	5	N/A	5	5	N/A	5	5	N/A	5	5	N/A
Z16	2	3	4	N/A	3	4	N/A	3	3	N/A	3	4	N/A	3	4	N/A
Z17	2	3	4	N/A	3	4	N/A	3	4	N/A	3	4	N/A	3	4	N/A
Z18	2	4	5	N/A	4	5	N/A	4	5	N/A	4	5	N/A	4	5	N/A
Z19	4	3	5	N/A	3	4	N/A	3	4	N/A	2	4	N/A	2	4	N/A
Z20	4	2	5	N/A	2	5	N/A	3	5	N/A	4	5	N/A	4	5	N/A
Z21	3	3	5	N/A	3	5	N/A	3	5	N/A	3	5	N/A	4	5	N/A
Z22	1	5	missing	N/A	3	missing	N/A	3	missing	N/A	4	missing	N/A	4	missing	N/A

key: 🟢 positive 🟡 neutral 🔴 negative

6.6 Training acceptability.

During the interview and focus group, participants were asked specific questions about the training delivery with the intention of exploring whether any improvements could be made. The integrated data is presented side-by-side in Table 18 to determine acceptability of the training attitude towards training in an action learning set, value of training content, timing of the session, venue, organisational considerations, and facilitator style, the results for each are presented in turn.

6.6.1 Participant attitudes to group interactive session.

The action learning sets, were described as group interactive sessions. The attitudes of ten participants towards training in an interactive group were positive, four scored neutral, and none were negative.

6.6.2 Participant attitude to the value of the training.

The attitude of nine participants towards the value of the training were positive, two were neutral, and three were negative. One participant who clearly valued the training and case discussions, said:

> *"It makes me feel more confident. I can see what they`re up to and apply it and feedback and it's worked this week". Participant z10 (Cohort 2-focus group 1)*

6.6.3 Best timeframe for the training sessions.

The sessions were delivered between 11am and 1pm, once a week over three consecutive weeks. Eleven participants liked the time of day and the length of the two-hour session. Participant 5 (cohort 1) would have preferred an afternoon session, so that she could do her home visits in the morning and the training in the afternoon, so the content was fresh in her mind for the case discussions during the training.

> *"I think it was the afternoon because the fact is, what we've learnt can be transpired over." Participant 5 (cohort 1-*interview*).*

Whereas participant 9 considered that her session could easily be compressed into a shorter timeframe, as she was the only carer who had turned up to the first session so she felt that the content could have be delivered quicker due to less interactive discussions.

> *"I turned up to the first one and I was the only one there, so that took just over an hour. So, depending on how big the group are." Participant 9 (cohort 3-*interview*).*

Some participant`s thought that the three sessions should be compressed and delivered in one session. The reasons given were shifts compromising attendance and absence due to leave or sickness.

> *"The other two, they came to the first session haven't been to the last two because of their shift, they work on a three-on-three off. So, I think if you did one session it would work better for them" Participant z13 (cohort 4-focus group 2).*

The majority preferred three sessions, reporting it was more relaxing and that there was time for valuable interaction between the carers. Discussion between participants in focus group 2 showed that they valued the space to learn from each other through their interaction.

> *Participant z12 …. yes, its more like team building.*
>
> *Participant z11…..yes, because we will see each other outside and chat...whereas if it were on Zoom we would have that...you just log on and its there...you speak when you are spoken to and you log off...whereas with this you have got more social interaction.*
>
> *Participant z12…. its nice to see your colleagues isn't it.*
>
> *Participant z11 …. yes*
>
> *Participant z12…. sometimes you don't see anybody, you don't see your colleagues.*

Two participant`s suggested it would be better to run the three sessions over one week; participant 1 was part-time and missed the final session.

> *"I think you could even do them in a shorter timeframe so that people have the information that they got fresh in their minds when they're doing the next session. Because you get so long, the time period between stuff, people forget stuff." Participant 6* (cohort 1-interview).

The idea of a refresher of the training was raised by six participants, some stated they would like this but weren't specific about how often, z13 thought this should be six months afterwards, whereas participants 1, and 2 thought every year.

To summarise, whilst the majority found the timeframe for delivery of the sessions acceptable, six suggested compressing the content into one session, with an annual refresher.

6.6.4 Where and how do participants want the training to be delivered?

The training was offered at any of the local authority offices in the county. The occupational therapist facilitating the training negotiated the time, date, and venue for each cohort with the care coordinator giving flexibility. In the main, the interviewed participants identified the venue was acceptable, two participants didn't respond to the question, and one thought although venue was acceptable the training should be delivered on-line.

Training format wasn't a specific question but given the context of delivering the training during the Covid pandemic it became an early consideration. In particular, participant z13, whose role was to train other home carers, had strong views on the training delivery format. Although participant z14, also a trainer, and part of focus group two didn't contribute her view to this discussion.

> *"Obviously over the last couple of years we have used Zoom. It's not ideal for everything, but you know, you can have small group work, you can have breakout rooms" Participant z13 (cohort 4-focus group 2)*

Eight of the fourteen participants' stressed that the sessions should be face-to-face, as opposed to on-line via ZOOM or MS Teams.

> *"Everyone's watching this thing but someone in the background is making a cup of tea, or off seeing to the dog. It's not an environment that's conducive to brainstorm things or to how people would approach things." Participant 6 (cohort 1*-interview*)*

To summarise, the venue and face-to-face, interactive format of delivery was acceptable to the participants. An on-line format is a feasible alternative should face-to-face delivery not be possible.

Table 18 Integration of training feasibility data showing strength of attitude.

ID	Cohort	Number of Sessions wanted	Time of day session wanted	Venue Accepted?	Refresher wanted?	Attitude towards Group Session	Qualitative data: How I like to learn?	Attitude towards Training	Qualitative data Value of training?
1	1	One	AM	Yes	Annual	🟩	*"I think I like the interactiveness. I tend to learn quicker. It`s doing it, instead of being told what to do. I think it is easier for me."*	🟩	*"Wow I just think all our support workers need to go on that training because I think its easy to forget. its easy to forget that it can actually be classed as abuse at the same time, by just cracking on getting on with stuff."*
2	4	One	11am to 1pm	Yes	Annual	🟨	*"Not everybody has got the confidence to talk some people are shy and we were a small group. Some people aren't comfortable, it doesn't mean that that not interested or not listening, it just means they clam up, they're not confident to speak"*	🟥	*"All of it it's good recap even though. It made me think. All of it the visual, the videos are good, that refreshes you over things. In that video like, I've seen awful bad practice in the NHS, especially when we were in institutions, terrible bad practice. We picked up on that straight away, everybody was quick to say that was bad and the good ones (videos), that's just expected of you, which is how it should be"*
3	1	Three	missing	Yes	missing	🟩	*"Face to face because the were a lot of chatting and people will sit back on the ZOOM and not say a lot. It were quite a vocal group we were all talking about things, and scenarios and people, but yeah, it was really good."*	🟩	*"I'm one of the first to do this course. So, I'm on this call (with another carer) and I say, what are you doing? and she says, I'm giving `em a wash. So, I say (to the person), can you do that? And they say, Yeh. So, I say, get ya `sen washed. I say, you really need to get on this course, because it annoys her the lady God, what`s up we ya, that's re-enablement, please get booked on that course, its amazing."*
4	1	Three	11am to 1pm	Yes	yes	🟩	*"I like to chat about things. I learn more that way. I'm not very good at sat there*	🟨	*"I'm happy with what I've learned but I always think refresher training is good because it brings*

						🟩	*concentrating and reading. I don't like watching telly or anything. I'm not very good at concentrating. I like to do things"*	🟨	*you back to what you were doing you can slip out of things can't you yeah, I always like doing refresher training because you remember things then"*
5	1	Three	PM	Yes	Missing	🟩	*"Me personally, I like Interactive and reflective. You can't guarantee that if its over the phone or ZOOM that everybody is gonna be attentive."*	🟩	*"So you`ve done the thinking and you`ve done some of the training and everything that you`ve done say the previous week, and then you gone to do your work in the morning and then gone to the group in the afternoon, and you said, well, you know this morning this is what have tried, and this is what happened, could you just advise me a bit more"*
6	1	One	11am to 1pm	Missing	Missing	🟩	*"I think if you make things interactive. So rather that just everyone looked up at what's coming up on this (power point), and people talking in the background, give them different situations to problem solve. I think that works better myself, give them a fictious situation where someone needs help. How would you go about doing that and get people to brainstorm, that worked really well."* *"Its better because it's the Interaction with other people as well. I think when you get Carers around and they are looking at things different points of view IT helps. Some one will say, I always use this to do that and sometimes its almost like a light bulb, oh I never thought of that."*	🟩	*"Its definitely worthwhile for carers to keep Reablement. People who are carers, they care there because they care for the person. If you can help someone to recover a bit of independence in their life, then I think that's gold. So, Reablement need to be part of all training to be able to help people to move forward with their lives."* *"I've had no problems with the course, with any information. Maybe something that she couldn't get to work, so we were watching really old videos. From a very long time ago, and I found out that a lot of what she was trying to say had changed from the old way of healthcare. I never knew so I had no experience of that."*
7	3	One	11am to 1pm	Yes	Yes	🟩	*"I'm hands on. I won`t remember anything if I read. I like doing things to learn."*	🟩	*"Obviously, now we have more one to one contact with the OTs than we had previously, when we just contacted the office. So, before I've contacted the office*

						🟩		🟩	*and they will have contacted the OT and then they will get someone to go to the client and now we have more contact with the OT ourselves, so fast.”*
8	2	Three	11am to 1pm	Yes	Missing	🟨	*“I think the videos were a good thing because everybody concentrates, so nobody talks because they know they`ve got to watch the video. If everyone wanted to take notes, they can write down the things they aren’t too sure about and ask after “*	🟥	*“Yes, because if they can actually do something, its better than nothing.”*
9	3	Three	11am to 1pm	Yes	yes	🟨	*“Yes, depending how big the group is. I turned up to the first one and I was the only one there, so that took just over an hour. So, depending on how big the group are”*	🟥	*“I think training is important for carers, not just me for all carers. I think its such an easy job to get into and it shouldn’t be. You should have training before you become a carer, that’s my opinion”.*
10	2	Three	11am to 1pm	Yes	missing	🟩	*“I’m not a lover of ZOOM. I think it should be in groups like this because you learn more, because you can fire questions. Its easier to have a group discussion.”*	🟩	*“It makes me feel more confident. I can see what they`re up to and apply it and feedback and it’s worked this week”*
11	2	Three	11am to 1pm	Yes	missing	🟩	*“I think its better in a group, you get to interact more because we will see each other outside and chat. Whereas if it were on Zoom, we wouldn’t have that. You just log on and its there. You speak when you are spoken to, and you log off. Whereas with this you have got more social interaction”*	🟩	*“I think, I’m probably going off, you know the aids- that sock aid and stuff like that. I think it would be good for some of the staff to see that and for them to be shown how they are actually used. There`s a lot of stuff like the memory bells and stuff and people don’t know how they work. It would be good in these sessions, for the staff to see them.”*
12	2	Three	11am to 1pm	Yes	missing	🟩	*“I prefer it this way, it was really good”*	🟩	*“Since we`ve been doing this with OT for 3 weeks (training), its made me realise actually we are supposed to be doing a lot more than just going in and just caring for them. Me personally, and I’ve been doing a lot more of that. Rather than, probably doing*

						🟩		🟩	*their breakfast whilst they are getting themselves dressed or whatever. Which is fantastic, but even so, wait and let them do their breakfast as well, with them and one thing and another. Where as before, I would have gone in and said, I'll just get your breakfast ready. Do you want a cup of coffee? Then I'll come and get you dressed. This (training), has opened my eyes up a little bit more."* *"This has learnt me a lot. Doing this and thinking, actually stand back a bit and let them do this for themselves and practice. So, I have. So that's good".* *"Equipment though, I've learnt over this last 3 weeks what's available and now we`ve got the phone because I didn`t have all that before, the numbers, stuff like that. its important to me."*
13	4	One	11am to 1pm	yes	6 months	🟨	*"I like to learn all ways me. I'm a visual person but I don't mind reading as long as it`s not a lot. I don't particularly like elearning. I quite like to zoom for some things. I quite like classroom based for some things, one to one sessions. I'm quite a blended learning person"*	🟨	*"Its quite important really, isn't it in fact I do talk about it especially in moving and handling. If we could get equipment in which enables that person, how fantastic it is for that client."*
14	4	One	11am to 1pm	Missing	Missing	🟩	*"I don't like elearning. I like visual learning. I'm not one, if you gave me something to read, I would not learn but that's just me. I struggle with reading big things by the time I got to the bottom, I wouldn't know what was at the top"*	🟩	*"When I used to do assessments, it would be, we are in place until you taken over by a long-term agency or a longer-term care package but actually now that might not be the case because we could re-enable them, and they might not need ongoing care."* *"We can incorporate that into our training and into our induction"*

15	2	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
16	2	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
17	2	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
18	2	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
19	4	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
20	4	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
21	3	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only
22	1	Missing	Missing	Missing	Missing	Missing	Training survey data only	Missing	Training survey data only

Key: 🟢 Positive 🟡 neutral 🔴 Negative

6.6.5 Organisational considerations.

The organisational considerations raised about the training feasibility were connected to shift and rota patterns. In general, the home carer`s worked 9am to 2pm or 1pm to 9pm shifts, with a three-on-three off system. The care coordinator and the training facilitator agreed when the training sessions would be best delivered for each cohort. Despite this twenty two participants attended at least one session, and ten did not attend all three sessions. From the fourteen interview and focus group participants, eight participants attended all three sessions (3, 5, z10, 8, z12, 9, z13 and z14). One raised concerns about tiredness, because they had worked an early shift before the training.

"Cos, they haven't done half the day like traveling everywhere and then all stressed out when they get to the training." Participant 1 (cohort 1-interview*)*

Another seemed to think it acceptable for carers to attend training on their day off.

"If it's their day off and they are willing to do it on their day off. Just gotta be easier that way, innit?" Participant 1 (cohort 1-interview).

Whereas another believed training should be fitted in between care visits whilst the carer is at work.

"I've been to all three sessions as has … (participants z14 and 2) ….and it's her day off so she's gone, but the other two they came to the first session haven't been to the last two because of their shift, they work on a three-on-three off." Participant z13 (cohort 4-focus group 2)

To summarise, coordinating sessions meant that some participants were disadvantaged due to their part-time hours or shift pattern, and participant 2 was known to have completed the training on a day off.

6.6.6 Training facilitator.

The training cohorts were delivered by an experienced occupational therapist, with an occupational therapy assistant supporting them. This was an agreed risk mitigation strategy to ensure delivery of the training given the Covid pandemic and increased need for people to isolate. There were two facilitators involved during the data collection period. The first, who delivered to cohort one and two, changed jobs. This meant coaching and practice sessions were repeated for the second facilitator, again after two cohorts changed jobs.

The facilitators also had operational duties, they prioritised the ACT reablement as part of their role and responsibilities. In addition to facilitating the ACT competency training, their remit was to build relationships with home carers, in order to establish strong communication, coach them to promote and undertake reablement interventions, and have reflective case discussions. Only two participants made specific reference to the training facilitator and their teaching style – both were positive. *"Be fun. I think if its quite robotic its when people switch off."* Participant 9 (cohort 3-interview); (The training was) *"About right. They were delivered well."* Participant 6 (cohort 1-interview).

6.7 Discussion.

The discussion critically appraises the findings, strengths, weaknesses, and limitations of the analysis, including identification of any bias and justification for the interpretation of the findings. A summary of the before training, grouped proportional scores is presented in Figure 31.

Figure 31 The before training grouped responses.

Before Training Evaluation Survey

9/22 were clear about the difference between reablement and standard home care.
6/22 were clear how to challenge people who were reluctant to engage in their reablement goals.
10/22 were clear how to motivate people who were reluctant to engage in their reablement goals.
11/22 were confident in identifying that someone is improving in their abilities.
16/22 were confident in feeding back to an occupational therapist

6.7.1 How do these findings fit with published research?

To ensure that home carers are providing the right type of care for the people they work with, maximising independence, choice, and control, they need to be clear on the purpose of reablement. When asked about this before the training, only nine home carers scored positively; after the training this increased to twenty one. This shift in the cluster of scores indicates an optimistic trend that the training improved home carers' clarity of understanding reinforced by qualitative feedback.

Nevertheless, it was evident that some home carers, even those with significant experience, lacked confidence about the purpose of reablement interventions and the role of a home carer to deliver those interventions.

It was hoped the training would enhance home carers' confidence to be able to challenge and motivate people, in an appropriate and professionally acceptable way, to enable people to progress with their reablement goals, a core reablement intervention and a skilled competency (Gustafsson *et al.*, 2019b).

The results showed that not all carers had the knowledge and skills to challenge or motivate. Before the training, six scored positively in their ability to confidently challenge and after the training, twenty one. Whereas ten scored positive to confidently motivate and after the training, twenty.

From this data, it was clear there were challenges for the home carers when working with reluctant or hard to engage people, and this resonated with the scoping literature review findings. For example, building a relationship with the person and their informal carer (Jakobsen and Vik, 2019); understanding the person's psychological intrinsic or extrinsic control (Hjelle *et al.*, 2017); the person, informal or families expectation of the home carer role (Jakobsen, Vik and Ytterhus, 2019); and the fact that adult care funded reablement services are free, but time limited (SCIE, 2020), were all mentioned by the home carers.

Without specific skills on how to challenge or motivate this we might see negative persuasion or bargaining methods. Learning the competency to positively challenge and motivate is required to enable home carers to support people to meet their reablement goals. Measuring improvement or deterioration in this skill is vital to support home carers to deliver the best outcomes for people.

The data is clear, before the training, only half the participants, eleven considered themselves to be able to identify that someone is improving in their abilities, although this increased after the training to twenty one. One home carer understood improving to be in the context of needing less home care, and another admitted they found it difficult to allow people to do things for themselves, saying

"I think its human nature to go in and help people." Participant z12 (Cohort 2-focus group 1).

From this training evaluation, if six of home carers found challenging people who are reluctant to participate or engage difficult, and ten found motivating people difficult, and eleven found identifying whether a person is improving difficult, then it is clear these are the areas of competency that need to be strengthened through training. These skills were identified in the literature as positive psychology competencies to enable home carers to connect with what people think, say and do (Moe and Brinchmann, 2018).

Home carers are a rich source of feedback for other health and social care professionals. They need the confidence to recognise that a person is improving, and knowing what to do about it to get the best outcome for the person, is a required skill. The training evaluation identified before the training, 16 considered themselves confident to feed back to the occupational therapist, increasing to 21 after the training. One experienced carer acknowledged that she had a poor knowledge of occupational therapy, during a discussion on equipment used to promote independence, but also described how her confidence had increased as a result of the training.

Five participants talked about their relationships with occupational therapists in the interviews and focus groups, three demonstrated their high level of confidence and strong relationship, and two were critical of occupational therapy and identified improvements for occupational therapists working on hospital discharge pathways.

The venue and face-to-face format of delivery was acceptable to all the participants. Conversely, only one participant expressed a preference for an on-line format, and ironically an e-learning version of the training had been produced due to the Covid pandemic.

Although most of the participants found the timeframe for delivery of the sessions acceptable, there were suggestions for improvement by four participants in terms of compressing the content into one session. This posed a risk of the case discussion time being compromised.

In the studies investigated in the scoping literature review, the time frame for training home carers varied. Four modules over one day or more sessions (Lawn *et al.*, 2017b), and sessions lasting two hours, two months apart (Maxwell *et al.*, 2021). Others, took place over much longer periods, 9-months (Rooijackers *et al.*, 2021b) and 10-weeks (Assander *et al.*, 2022a). What is not clear is whether more or less training improves the home carers' competency. Furthermore, this study reinforced the ongoing nature of ACT as an intervention, as it was not just a competency training, the elements of case discussion and proactive occupational therapy response were intended to stimulate home carers' knowledge, skills, and competency further.

There was a high level of non-attendance, only ten home carers attended all three sessions. There were three influencing factors affecting session attendance: Home care capacity, significantly impacted by home carer absence from work due to Covid self-isolation restrictions; some participants worked part-time; all participants had a three-on-three-off shift pattern. In future, greater attention to the coordination of the sessions, to ensure that home carers weren't disadvantaged by their absence, part-time hours, or shift pattern, is required. There is a need for the employer to ensure all carers are treated fairly, it was clear from the data that some participants had come to the training on their day off, it wasn't clear if they were reimbursed by their employer.

This analysis identified a need for training to enable home carer`s continuous professional development (CPD). In turn this raised the question how much CPD time do home carers require, and whether this should be regulated by the CQC.

> *"Investing in learning and development opportunities also supports staff retention. Workers feel valued because they can see you're investing in them".*
>
> (Skills for Skills for Care, 2023b)

This study evidenced there was no other reablement training provided by the independent home-based care provider despite them being commissioned to deliver a reablement service. It showed the ACT reablement training provided to home carers delivering reablement, was feasible, acceptable, and thus had fidelity. Like Castagnino and Blaskowitz (2022), this study found training delivered through an occupational therapy lens improved competency for home carers. However, although the training was evidenced to positively change home carers' mindset, it was not possible to determine whether this had a long-term impact or change in home carers' behaviour.

6.7.2 Strength of analysis.

The analysis was based on the intention to treat data, as outlined in the protocol and methods chapter four. Using mixed methods meant the before and after training survey data was strengthened and triangulated by integrating the qualitative data, and this gave a broader and deeper insight portrayed by descriptive explanations.

The Likert five-point scale used to gather quantitative data is a typical method for determining grouped responses. The self-ranked response gave an understanding of the scale of the participants confidence or clarity of a concept, converted to numbers to give quantitative data. This method of scaled rating is simple and user friendly, but not sensitive. Likert scales are a blunt instrument to establish effectiveness. The statistical tests used were appropriate for uni-variate data, but were limited, count of participants attending training, proportion, median average, interquartile range, and 95% confidence interval with standard deviation. Categorical data was compared to detect patterns within and across groups of participants, for example the age, gender, ethnicity, and time working in the caring profession, determining the relationships between the variables (Jensen and Laurie, 2016).

The open questions used in the semi-structured interview and focus groups allowed enquiry, probing, and reflection. However, the questions on the training feasibility were asked during the interviews and focus groups, and not as part of the training survey, despite this time-lag, and the fact that less home carers participated in the interviews and focus groups, they added richness and depth to the training evaluation.

Overall, the methods of data collection for the training evaluation were effective, with missing data, from one participant for the after-training evaluation. The missing data was transparently recorded and accounted for. The training evaluation had internal validity and was a reliable and accurate presentation of the results. The study design, implementation and data analysis minimised or eliminated bias. The before and after training survey determined the home carers' baselines, and change in knowledge and skills. The interviews and focus groups gave rich supporting data to triangulate; integrating the data in this way gave greater validity and reliability to the analysis (Creswell, 2015).

6.7.3 Limitations of analysis.

This was a single site study. The training was delivered countywide, in the central region of the UK, and so cannot be generalised for other regions. The study was small. Training delivery and data collection was limited by the Covid pandemic during winter 2021-2022 and occupational therapy staffing turnover within the local authority.

There are general limitations using an before and after non-comparative design to measure outcomes because of the lack of control of variables. In this study, there was no certainty whether the intervention caused the outcome, because the sample was small, not randomised or controlled, and the survey was not piloted for validity or reliability (Jenson and Laurie, 2016).

It was recognised that participants can be cautious about revealing their opinions, for example not wanting to divulge their self-perceived lack of knowledge about a subject. Clustering of data on the scale indicated a central tendency bias. This could be due to the influence of other participants in the group, a social desirability bias or the imagined expectations of the facilitator of the session, a demand characteristic bias (Jenson and Laurie, 2016).

It is common, when analysing Likert scales, to group data and present proportionally. Within a 5-point scale there are two positives, a neutral and two negatives. This can give the illusion of a more, or less, favourable outcome (Sullivan and Artino, 2013).

The statistical analysis presented a limitation due to the use of an ordinal scale, despite the scale being numerical, a five-point scale isn't sensitive. There is no sub-scale associated with the number, e.g., numerical value of "very confident-plus" or "almost fantastic." For this reason, when the individual question was examined to determine the number of participants who rated themselves on each point on the scale, the median was used to show the central tendency. On reflection, a ten-point scale would have given a more accurate numerical representation and in case discussion, a ten-point scale might be easier to visualise to measure any improvement outcomes.

A limitation of this analysis method is the small sample size overall and within each cohort, particularly cohort three. This reduces the reliability of results because it leads to a higher variability and sample error bias. Sampling errors can significantly affect the precision and interpretation of the results, which in turn limits the generalisability of the study.

6.7.4 Heterogeneity of study, participants, outcomes.

The demographic information gathered at the training sessions indicated that the median age range was representative of the national home care population (Skills for Care, 2022). The sample was not ethnically representative of the population of Nottinghamshire, as reported in the JSNA (Nottinghamshire Insight, 2023), or the estimated ethnicity of the home carer population in East Midlands region (Skills for Care, 2021), but was representative for the estimates for the whole of England (Skills for Care, 2022).

This evaluation presented limited numerical data, with a small sample and therefore no statistical tests were undertaken to measure diversity of effects. All calculations were based on the "intention to treat" number of samples. A Likert scale is a blunt measurement tool. The self-report before and after training survey is not a proxy for the understanding of reablement. It risks under estimating or over estimating knowledge and skills. However, measuring improvement, understanding, confidence or clarity of a concept, using a simple scale, can prove to be useful when determining home carers' progress, attainment, or outcomes.

The training sessions were delivered to four cohorts of home carers, with two different training facilitators. Whilst the training material was the same, clinical diversity in content, or delivery style, could not be excluded. There were differences in self-rated confidence and clarity in the after-training sessions evaluation between cohorts.

Using a mix of research methodologies allowed integration of data strengthening results (Creswell, 2015). The before and after training survey findings were representative of the home carers who attended the training session, and the qualitative descriptions representative of the individuals quoted (Pannucci and Wilkins, 2010). The training evaluation had internal validity, but limited external validity, and was only applicable to this setting, the presentation of the results is reliable and accurate.

6.7.5 Reflexivity.

The occupational therapist who delivered the session had the capacity to influence the study results. It was expected that an engaging delivery might equate to better results. This was investigated by an analysis of results between training session cohorts, and there were differences, but these couldn't be attributed to the solely to the training facilitator.

The open nature and de-personalisation of the questions on the before and after training survey, how confident are you…. eliminated researcher expectancy bias and the need for reverse coding to reduce acquisition bias (Jenson and Laurie, 2016).

Professional bias, due to the author being an occupational therapist, was reflected on throughout data collection, reporting of results, and analysis process, positively challenged by the PPI who was part of the research steering group. The likelihood of bias was mitigated through academic supervision and use of a reflective diary.

6.8 Conclusion.

The training was evaluated using mixed methods examining the quantitative data trends and the participants descriptive views on the training. This analysis integrated the findings from the demographic survey, training before and after survey, and the qualitative interviews and focus groups. The aim was to assess whether the home carers' understanding, confidence, knowledge, and skills taught during the session had changed.

The survey design, implementation, data collection and analysis were appropriate, and bias was minimised through reflexivity. There were limitations to the training evaluation, primarily the uncontrolled before and after training survey did not have validity, it had not been piloted to test reliability and therefore could not be generalised.

The format of training delivery must be accessible to home carers in order to maximise their learning. The ACT reablement training was deemed acceptable to home carers, and was well received. A recommendation to take forward is national competency training to ensure all home carers, who deliver reablement, have a clear understanding of its purpose. The findings and analysis around training content and cycle of improvements for the delivery of future training are presented in chapter eight. The next chapter, takes a deeper dive into the home carers' experience of reablement

Chapter 7. Analysis and findings of home carers experience of reablement.

7.1 Introduction

In chapter six, empirical research evidenced that participants understanding, confidence, knowledge and skills had changed following training, and identified which aspects of the training were acceptable; these will be addressed later in Chapter eight.

First, this chapter will explore the home carers experience of reablement and then delve into the knowledge and skills they use to deliver it, using qualitative methods as outlined in the methodologies Chapter 4. Considering the home carers' views, attitudes and beliefs towards reablement will add depth and richness to inform the overarching research aim, and an understanding of the knowledge and skills the home carers use will inform the improvement of the training content, together these findings aim to address the third the research question.

What is the home carer experience of reablement, and is it acceptable and feasible to deliver ACT reablement competency training to independent sector home carers?

7.1.1 The qualitative synthesis.

Framework analysis (Ritchie and Lewis, 2012) involved an iterative, five-step analytic hierarchy, used for the quantitative synthesis. This approach gave structure to data management, description of phenomena and provided explanatory accounts of how and why associations or links had been made. The analysis produced two overarching themes: the home carers' experience of reablement, and the home carers' knowledge and skills.

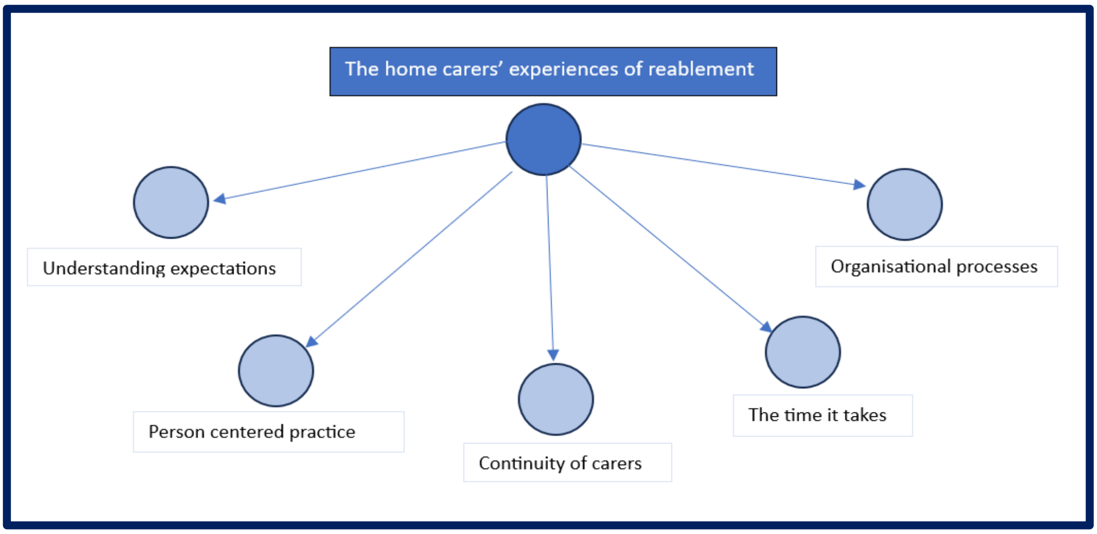
7.1.2 Sample.

The sample of home carers' demographics were outlined Table 13, in chapter six. Fourteen home carers' participated in the qualitative interviews or focus groups, nine had individual interviews by phone between one week and three months after the training, median two months. Two focus groups took place face-to-face, immediately after the training session, three participants in the first group and two in the second group. In focus group two, participants z13 and z14 were senior home carer`s who a undertook the role of in-house trainers, and quality assured other home carers' practice.

7.2 Theme one: The home carers' experiences of reablement.

Within this theme the participants described five sub-themes, understanding expectations of reablement; person-centred practice; continuity of carers; the time it takes to do reablement, and the operational processes involved, these sub themes are visually presented in Figure 32.

Figure 32 Visual presentation of the home carers' experiences sub-themes



7.2.1 Understanding expectations of reablement.

All participants spoke about this sub-theme. A number of associations were made around the expectations people, informal carers, and their own carer colleagues had of reablement.

Most participants' believed people who receive reablement perceived the role of the home carer was to do things for them. Two divergent and often conflicting discourses emerged around home carers doing things for people and them asking people to do things for themselves. They believed there were four reasons for this: Reablement is free home care; people have a loss of intrinsic control; there is a misperception of the purpose of reablement, and there is a preconceived perception of the home carer role.

According to participant z12, who believed it was human nature to do things for people, some people need time to recover after a hospital experience and as reablement is free, people cared for at home should let the carer do things for them whilst they recoup. Whereas Participant z10 believed people expected care to be free because they had worked all their lives. He also identified that others would refuse ongoing home care even if they needed it because they did not expect to have to pay for it.

Two of those interviewed suggested that letting the carer do things was due to the person's loss of intrinsic control, influenced by the experience of institutional hospital care. Participant 6 described this in simple terms as people`s personality or character, not lazy, but passive. Conversely, Participant z10 believed some people were lazy, he explained that it was his role to encourage people to do things they did not want to do but could do.

"I think, it just comes down to the persons character, some people are…not lazy…I don't think that's it but they are inherently…well...just let you let do stuff for them. I don't know what it is. Their passivity is such that they are told they need this help and they just accept anything, and not try to do anything for themselves."

Participant 6 (Cohort 1-interview).

The expectation of reablement, and the persons need to actively participate in doing more for themselves, involves the home carer reinforcing the ethos.

"She had a right go at me. She said, you need to wash me down there and I said, nah. She said, that's your job. And I explained to her, its actually not. We are here to promote your independence at the same time. So, although you`ve paid for your care, if you can do that, I should encourage that. I was quite shocked by it."

Participant 1 (cohort 1-interview).

Historically, society has set the expectation that home care is about a home carer doing personal care, washing, dressing and meal preparation for the person. Reablement has emerged in the last twenty years, and participant z11 believed people did not understand reablement. Unlike Participant z11, Participant 3 believed most people do understand the purpose of reablement. She challenged people's expectations by responding firmly to people they should do as much as they can for themselves, or they would lose their ability to do so.

Most participants agreed that people who received reablement had a preconceived idea of what a carer should and shouldn't do. This is to fill the allocated care call time; therefore, additional general housework tasks were in scope. This misperception caused negative attitudes from three participants (5, 3 and 8) towards the expectation they would do cleaning as part of their reablement role.

> *"I used to go to a lady, so independent it was unbelievable, but her perception of having care was so on the flip side. I`m having the care, so a carer should do this, a carer should do that. So, they wanted a carer to be practically a maid or to be a domestic servant. Yeah, that was with their idea of care."*
> Participant 5 (cohort 1-interview).

Conflict, in the form of power imbalance was suggested by one participant who believed that people treat home carers like they are cleaners when they have reablement.

> *"I went to one lady once she used to go to all sorts of clubs and things like that. She was quite able. Went out on the bus. And I had done her dinner, and she said can you pass me a tissue and the box of tissues was right next to her. And, that's not what I'm there for. I did say to her, your hands work. You can reach your own tissues."* Participant 4 (cohort 1-interview).

Similarly, participant z10 framed this as "*we are not slaves"*. He explained that a gentlemen barred him from his house and reported him to the office because he was asking him to wash his own face. Another described a person who can make a cup of tea independently between the carer calls yet expects her to do it when she is on her care call.

> *"You aren't going to be funny about it but I might say, oh you can get your own cup of tea while I'm here. You make one when I'm not here. And basically say, do you want to come with me whilst I make your tea and we can have a chat. You know,*

> *generally just to get him into what we normally do. I think some people forget they can do things, as well."* Participant 8 (cohort 2-interview).

When asked about why they thought people perceived the carer role as a form of servitude, the participants were unanimous in the view that it was because people felt entitled to it, either because the service was free or they had paid for it.

The participants' identified people associated home carers with doing things for a person, including housework, and this led to significant role dissatisfaction, power imbalance, and conflict.

Having examined the persons' expectation, the family or informal carer expectation of reablement can be explored. The emerging themes were supporting the unprepared family, families perceptions of the home carer role, and different mindsets or opinions as to what is best for the person.

Family members can be unprepared for carers coming around to their relative. Participant 1 gave an example of there not being a wash bowl available for the home carer when the person could no longer use the upstairs bathroom. She was positive towards making suggestions to the family about minor changes that would enable the person to be more independent, like purchasing a smaller easier to lift kettle.

According to one home carer, when the family live with the person, or are visiting, an additional challenge is presented. Participant 8 believed an abuse of reablement can occur when the family have already completed the personal care, and then ask the carer to do general housework. This correlates with the idea of a misperception of the home carer role.

> "They`ve been told that their Mum or Dad needs some support, and you can actually go in where your client is personal care and they'll say they don't need any personal care. We`ve helped them do it, but while you are here you can sweep up the floor or get the hoover out, change the bed. So, I think its more abuse of the care of what its supposed to be at their convenience. So they, some people do abuse it." Participant 8 (cohort 2 - interview).

Family expectations can be a challenge when relatives have a different mindset or opinion on what is best for the person. Participant z14 had a positive attitude towards carers asserting person centred practice, dignity, and respect, and identifying what people themselves thought and wanted to do. She suggested that families needed to hear a different dialogue around the purpose of reablement and to adjust their expectations.

Having examined the Informal carers expectation, the sub-theme of health and social care professionals' expectation of reablement can be explored. Most participants considered that the professional, who has set up the service either at point of hospital discharge or in the community, should set an expectation of the purpose of reablement. If that expectation is misrepresented, then the expectation that home carers will do specific tasks, including the cleaning, remains.

> *"The nurse said, you are going to do this. Well, the nurse is wrong, we make you do as much as you can or else you not be able to do it anymore."* Participant 3 (Cohort 1- interview).

Participant 3 said this was massive issue for her. She reflected on her experience of visiting people who have reablement commissioned but did not want it. She understood that a professional has deemed it necessary, and she believed her role was to feedback how the person was progressing during reablement. However, she described situations where she had turned up to a visit and the person sent her away because, either they did not need the care, or their family had stepped in to help them.

In focus group 2, both participants' queried what is said by professionals to set the expectation about reablement when the service is commissioned. They suggested that some home carers may have a knowledge gap or lack of insight about the way social care and support is commissioned.

In previous sub-themes participants identified the need for home carers to explain the purpose of reablement in order to establish expectations. Several participants framed this in the context of regaining independence and reducing the amount of home care or number of carers.

> *"When we go in and say, well actually no we're here to try and help you be re-gain this, so we could cut down care, so we can cut down on hospitalisations and you know, build your health up. Yeah, so like you say, its changing the perception of what care is and enablement is."* Participant 5 (Cohort 1- interview)

Overall, participants had a wide range of attitudes towards their expectations of reablement. Participant 3 believed the purpose of reablement was to reduce the number of calls. In contrast, participant 9 explained that her understanding was that reablement should be reduced when it is not required. Whereas participant z14 believed reablement was about supporting, but not taking over things, that it should be tailored for each person but focused on daily routines.

Interestingly, participant z11 had a strong attitude towards being independent. She explained she had personal experience of a family member with a disability. She strongly believed that people should be motivated to work towards greater independence.

> "And it grinds on me when someone says, I can't do this and I cant do that."
> Participant z11 (Cohort 2 -focus group 1)

When people don't need as much care as is commissioned, participant 4 believed that the home carer should speak up and report it to the office so that an adjustment could be made. This would free-up home care for those who get minimal care and who needed more when they were struggling. Similarly, those people who have home care, when they do not actually need it, were described positively by participant 5 who acknowledged responsibility to shift this expectation of what reablement is and is not with people. The dialogue in focus group 1, enabled participant 12 to share an opposing experience, of being a nurturer for the person, someone who does things for them; it was clear that she hadn't been setting the same expectation as her colleagues.

The independent care provider provided a range of other types of care services. Participant z13 explained that home carers are expected to be flexible and adaptable in their abilities and competencies. Participant z14 believed the skill set is interchangeable when staff work across distinct types of homecare.

> “We have end of life services as well as re-enablement. They've kind of got the same skills but they know how to incorporate them differently for each client.” Participant z14 (cohort 4- focus group 2).

It is evident that some participants are confident and positively articulate in their expectation of reablement, whereas others are uncomfortable or uneasy about doing this. Participants’ identified that the expectation of reablement, set by other professionals, required them to recalibrate peoples’ expectations. Some participants expressed a simplified view that reablement is about reducing care, not working towards independence goals.

7.2.2 Person-centred practice.

Person-centred practice, promoting choice and control, was valued by all participants. One home carer, who valued the change in care delivery over the past 15 years, had a positive attitude towards training in person-centred practice. She believed that taking independence away caused people to become reliant on care. Those who forget, or disregard the persons preferences, were considered to be abusive, by one participant.

> *“We don’t assume before we go into the property. We actually listen to what our person wants.* You know that it can actually be classed as abuse at the same time, by just cracking on getting on with stuff.” Participant 1 (cohort 1 – interview).

People having control over aspects of their lives and given a choice it was felt to be important by the majority of participants. When the person wants to do something themselves, carers accommodate and encourage this. An example was a gentleman who chose not to get dressed during the early morning care call.

> *“I’ve got to the stage where if he doesn`t want to get dressed at 8am in the morning. We had a discussion about this last week. I said right, you can either stay in bed or get up. He can actually dress himself but he struggles with his breakfast and he struggles with his medication. So now, I’ve give him the choice and I will go back later and he will be dressed.”* Participant z10 (cohort 4 focus group 1).

The participants placed great emphasis and value on relationships with people, informal carers, regulated professionals, and their carer colleagues. They linked positive relationships with successful reablement.

Listening to the person was considered vital because relatives, informal carers and friends can think it is better to have more care or be in opposition to the persons views or preferences. Carers accepting without challenge is not being person-centred, and people with mental capacity are encouraged to answer questions for themselves.

" I've done assessment before and the family have just been talking over the client. I know I've said, I'm gonna ask them the questions because they've got the capacity, they`re more than able to tell me. The family don't live with them. I get it if they live with them. That's fine, they work together but yeah, I've done assessments where the family have said, oh she needs this at lunchtime and the client, well it is taking their voice away, for me. I want to know what the client would like, how they do things" Participant z14 (cohort 4- focus group2).

Care being good enough was strongly valued and explained in the context of how participants would treat their own parents or wanted to be treated themselves. This empathy technique, putting themselves in another person's situation, to understand how they might feel, was used by several participants.

"I always do the mum test. So, if it's not good enough for my mum, is not good enough for the people that I'm working with." Participant 1 (cohort 1-interview).

In summary, listening and empathising were techniques used to promote choice and control. Person-centred practice was valued by all participants.

7.2.3 Continuity of carers.

Continuity and consistency of carers was valued by eight participants who believed that continuity of carers impacted on the achievement of reablement goals, four of them commented less frequently. All had negative attitudes towards operational delivery of the service, believing that turnover of people using the service, and changes to the staffing rota, meant that the home carer did not consistently see a person for longer than a few days.

Continuity of carers was necessary, participant 4 believed in order to give the person choice, for example, to have a shower at a specific care call or not. The care calls should be consistent enough to allow planning for the next visit, according to participant 5, who associated not forgetting the plan, with the need for continuity in documentation, and home carers being consistent in their approach to the intervention delivery.

“Instead of saying well, I've only got 45 minutes, so you can't try it now. But, can we try this or that, or next time I come in can I try that. Sometimes, I forget about it, you know.” Participant 5 (cohort 1- interview).

The need for continuity in documentation, case file update and carers being consistent in their approach and intervention delivery was valued. Different approaches for communicating information between home carers and the organisation caused the participants difficulty when seeking clarity on reablement progress.

Conflicting views emerged about where and how to record reablement progress; on the electronic case file update, in handwritten notes in the person’s home or verbally to home care colleagues. It was clear that the participant`s used different communication methods depending on the urgency of the situation.

The electronic case file was new. Several participants valued having access to read the file on their smart phones. Two participants positively described how they emailed the office from their phone to ask them to update the electronic case file system. Another, was more critical of how the electronic case file process worked believing it caused reablement progression delay, believing day-to-day progress should be logged in the handwritten case notes, despite thinking these are not read by all carers.

“We`re updating a support plan to say, this is what they can now do. We can do it in writing, we can give it back to the office and that detail might not be on for about 3-4 days, so then somebody's going in there for three or four days that doesn't know that, the technique goes back a couple of steps and has got to start again.”
Participant 5 (Cohort 1 -interview).

Conversely, participant 9 adapted to the need for more urgent consistency in communication by liaising, by telephone, with the home carer who operated on her days off. She associated this with successful outcomes when practising the tasks with people.

> *"I think for me it were the consistency in staff because one of his regular staff went into each call and the same, on my days off he had the same staff going in, so we could like liaise with each other and we knew how far along he was and what he was capable of doing."* Participant 9 (Cohort 3 -interview).

Continuity and consistency of the home carer are what makes reablement happen, according to participant 7, who placed value on establishing relationships. Conversely, a lack of home carer continuity caused conflict where there was an inconsistency in carer approach. Four interview participants linked getting to know the person with building trust.

> *"When we know each other they know what the expectations is and I know how much I can push them without upsetting them."* Participant 7 (cohort 3- interview).

In focus group 2, the value of continuity of home carers was discussed in the context of building trust and rapport between the person and the home carer. According to participant z13, continuity in carers was motivating for the person, who believed the home carers' interpersonal skills towards the person played a part in attaining reablement progress. Specifically, this related to the continuity of the communication style. Participant 10 identified the way the home carer asked the person to do things influenced the person's motivation to do the task.

The inconsistency of allocated visits impacted on the ability to deliver reablement and develop a relationship with the person, according to participant 6. He believed that a lack of consideration to the consistency of carers impacted on the person being cared for.

> *"Where we have very limited time with people and the rapidity with which we change between people…So, I might see someone today for half an hour at lunchtime and I might not see them again for another two weeks, so it's hard to be able to do any sort of reablement when the rota`s are so heavy and so…cos we`ve*

got a lot of people out of hospital at the moment and getting consistent time with someone to be able to help them…I find very difficult." Participant 6 (cohort 1-interview).

It was difficult for home carers to recognise the person's ability for improvement, and judge the person`s next stage for reablement progress, if they were not allocated to work with people continuously.

7.3.4 The time it takes.

Having time to work with people on their reablement goals was valued by the majority of participants. Time was closely linked to relationships and development of trust, but it was also associated with enough time for the person, to engage with, and complete reablement goals. Building trust in order to get a good rapport requires investment of time. Participants had positive attitudes associated with trust, and getting good reablement outcomes. Lastly, efficiency with the daily routine and how this freed up more time was raised.

If home carers are to observe what the person can and cannot do, they need to ask them to do things for themselves, this means time is needed to ensure that the activity is done safely and independently. Most participant`s agreed that if you don't have enough time allocated on your run of visits then you won't be able to re-able someone. This was critical, according to participant z11 who was clear there was not always time available to observe people doing activities.

"If you`ve got a busy run and you`ve not got time, then you have just got to do what you just have to do. If you`ve got call after call you are not going to have the time to re-enable somebody." Participant 9 (cohort 3 – interview).

Conversely, doing things for a person is quicker than asking them to do things for themselves when you are short on time. This example shows that it corresponds to a reduced opportunity for independence.

"It takes her an hour to walk from the living room to the bathroom, but she wants to walk. They (another home carer) said, who do I ring to get a commode so I can wheel her through. She's not gonna like it, but she's gonna have to because she only

gets half an hour. I said, you can't take that away from her if that's what she wants to do. If she wants to walk, let her do it. It might take an hour but you need to contact your office to increase her time so she can do that." Participant 4 (cohort 1-interview)

Time allocated for care visits was viewed negatively by four participants who believed that a more flexible approach was required. There was an association between restrictive time resource, ability to think creatively about reablement goals and home carer well-being.

"For our staff though it is those time constraints, isn't it? Actually the staff haven't got the time to think creatively because they know they've got to get certain tasks done and get out on time because they've only the right amount of time to travel to the next call. I think that's a big pressure for the staff." Participant z13 (Cohort 4 - focus group 2).

Asking the care coordinators in the office for more or less time was not perceived to be a problem, but the organisational process was. One participant described that she could ask for more time and be given it by one coordinator, and then another coordinator, seeing a space, will add in another call to her rota; she believed this should be stopped. Similarly, participants z10 and z12 believed that when more time was requested and given, it would only be for the next visit; the calls would then revert back after a day.

"*Some of them will accommodate you, but it takes such a long time to get that extension because of the way of the working*." Participant 5 (Cohort1-interview).

There were two different perspectives on the time it took to reable. Some believed the call time was reduced because of efficiency with the daily routine. Others believed that it took less time because the person had practiced and mastered the skill. Having explored how the time for reablement was experienced by the home carers, the process they described to get more or less time allocated for their calls, is considered.

7.2.5 Organisational processes.

How reablement was operationalised, home carer capacity, demand for home care and flow of people through the service, was explored by participants. They described how they fed back to the home care organisation on a person's progress, how they accessed specialist professional advice, and how they contributed to a formal review of the person's need for ongoing care and support.

Lack of home carers to do the work available was reported to be causing issues with the organisational processes, according to three participants. Whereas others experienced doing more calls in less time. The capacity for long-term providers to take on care after reablement was problematic.

> "*It's a constant battle on the planner's part (coordinator), to be able to just get enough people to take all the calls that we do have*." Participant 6 (Cohort 1- interview).

> "*We ain`t got the* (long term care provider*) care sat there at the minute to take over.*" Participant 1 (cohort 1 – interview).

The time allocated for each person's care call, determined on home carer`s first visit assessment, is often estimated, and not observed, or it may vary day-to-day, and this posed a challenge. Everything will stay the same until the home carer feels they don`t need as much time.

> "*You don't really know how long they actually take to walk to the shower*." Participant 8 (cohort 2- interview).

People are expected to improve during reablement, according to participant 4 usually within a week of being home from hospital. Half of the participants thought that carers needed to feedback reablement progress to the organisation so that care could be reduced when people improved, but participant 4 specifically identified the process for increasing care, after it's been decreased, was inflexible and difficult.

A pattern emerged, five participants had negative attitudes to continuing to provide care when it was not needed, and this was associated with being asked to fill in the visit time by doing cleaning tasks.

"I think that needs to be reported through. I think carers need to say, this person doesn't need this service because it then it frees up (carer capacity) because there is people who do need the service. They get minimal care and they don't ask for it, and they are struggling and things like that. So, it frees up people to go to other people." Participant 4 (cohort 1- interview).

Similarly, participant z10 had a negative attitude towards other carers who didn't bother feeding back to the office, and had an expectation that other carers should be honest about communicating feedback, to give a consistent approach.

*"What they do is they look back at what other carers have done and find out what other carers have gone over (*time*) as well and then they'll say, yes there a problem. If its only me that's gone over, then they'll say, well nobody else has gone over, but I might be doing it correctly and the others might be rushing."* Participant z10 (cohort 2 -focus group 1).

A sequence of events emerged, the home carer feed back to the office determined the time adjustment. When the home carer`s are not doing this consistently, then flaws in the operational process are exposed. Similarly, participant 1 thought it was obvious when people had too much time allocated for their care.

*"I've been into calls where I think this lady definitely need an extra 15 minutes and, on another call, this gentleman really doesn't need all of that 45 mi*ns" Participant 8 (Cohort 2 – interview).

"I just don't understand why, half the time they are not being reduced when they are supposed to be." Participant 1 (Cohort 1- interview).

Frustration, when action wasn't taken, after all the home carers had done to work with a person in order to reach an improved level of independence, was expressed. Participant 9 believed that it was because the office wasn't handing the information over to the adult social care worker to action the reduction in care.

People who received reablement, but did not need any home care, were viewed negatively by two participants. One who believed that care was not reduced in a timely way, despite reablement being a time-limited, short-term service. The other, Participant z12 believed that because reablement home care was free, people just accepted it whether they needed it or not. In situations where less care was needed, or two carers participated in care delivery but only one was required to assist the person, participants recognised that people had too much or too little carer capacity for their reablement needs.

"*He didn't need it. Like I say, he needed companionship. Like I say, I don't think that they take calls off them*." Participant 2 (Cohort 4 – interview).

Responsibility for communication of reablement progress, to input to a review of ongoing care and support needs, was clear to participant 1 who held a similar view to participant 9. They believed that the home carer role was to monitor the situation and feedback, to the office, who should in turn inform the adult social care worker to review the case.

"*I think it's the right thing to do because otherwise they`re gonna be on service for a lot longer when they don't actually need it and somebody else could be discharged and we could be supporting someone else*." Participant 1 (cohort 1- interview).

Conversely, another had a lack of understanding in the procedures. *"I don't actually know the ins and outs of how they reduced care"* Participant 2 (cohort 4- interview).

Communication with the occupational therapist was positively described by five participants. Conversely, participant 6 believed speaking to the manager was the best approach if something needed watching before requesting specialist advice. At the office, the CQC officer who was also a senior home carer gave advice.

"I usually get a photo saying this has been put in today and I don't know how to use it (laughs and gestures). Ring the OT." Participant z13 (cohort 4 -focus group 2).

A pattern emerged where feedback, from carer to senior assessor, was used before any specialist advice was sought – evidenced by five participants, with two examples given.

> *"If staff aren't aware then they aren't going to do it. Like for us, the carers get in touch with the assessor for us to get in touch with the OTs, and it takes ages but anybody can do it, but they don't realise that"* Participant 9 (cohort 3- interview).

> *"We mainly call for the OT. Like if its something that you cant leave or if its urgent or like the carers would let the office know. The office would have called for an OT. But now, the carer calls us. They say you have done the assessment for this client. We need sling or we need another commode or something. Now we (senior assessment carer) will call the OTs ourselves."* Participant 7 (cohort 3 – interview).

Since the ACT training, the home carer and senior home carer were contacting the occupational therapist themselves without handing over to the care coordinator in the office. They used a common-sense approach, based on their observation of the person's capability to manage activities of daily living independently. They knew how to request specialist advice and worked with those professionals to get better outcomes.

> "*Obviously now we have more one to one contact with the OTs than we had previously, when we just contacted the office. So before, I've contacted the office and they will have contacted the OT and then they will get someone to go to the client. Now, we have more contact with the OT ourselves, so fast" Participant 7 (cohort 3 – interview)*

The participants believed asking the office for a rota adjustment was supported or opposed by the consistency of carers and carer feedback. The recording of reablement progress was two-fold, granular detail was in the person's written notes left in the home and the office updated either via email or phone uploaded onto the case file system.

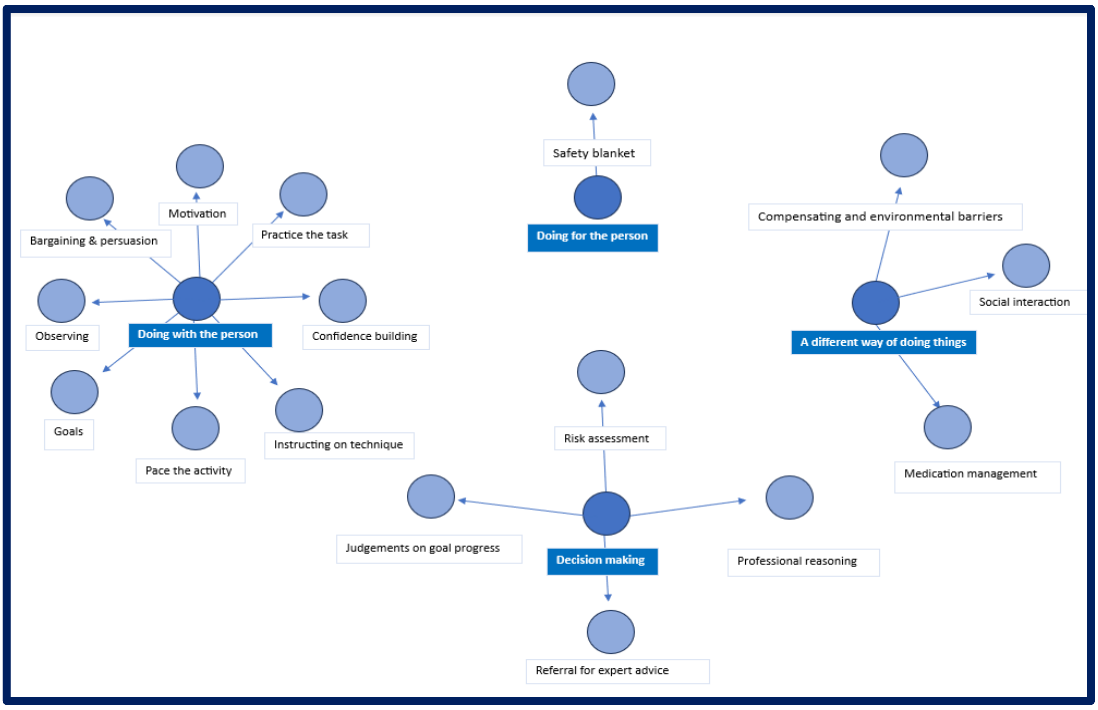
When the person had achieved a level of independence and care was not reduced, the participants were perplexed and believed this was due to one of two reasons, the office not reporting to Adult Care, or Adult Care over commissioning.

It was clear from the home carer`s accounts of their experience of reablement that there is a requirement to explore the depth of knowledge and range of skills involved in their role.

7.4 Theme two: The home carer`s knowledge and skills.

Understanding what knowledge, skills, and competencies the home carers valued was integral to the overarching research aim. This was multi-faceted, with four sub-themes, doing things with a person; doing things for the person; different ways of doing things, and decision making. Figure 33 visually presents the sub-themes and the knowledge and skills linked to them through interpretation of the descriptive data.

Figure 33 Visual presentation of the knowledge and skills sub-themes.



7.4.1 Doing things with a person.

Doing things with a person was a prolific sub-theme. The interventions the participant`s described were wide ranging, categorised using their own words: How they practice the task with the person; pace the activity; observe how the person does a task; use motivation as a strategy to encourage; instruct on technique; set goals to work towards; build-up the person’s confidence, and use bargaining and persuasion strategies. Each intervention is explored in detail to examine participants’ attitudes, beliefs, and the emerging patterns within themes.

Practice the task.

Asking the person to practice an activity or task was mentioned by all, except for participant z14 in focus group two. An equal number of positive and negative attitudes from participants emerged, six participants had positive attitudes towards asking the person to practice the activity, and six participants had negative associations, another participant took a neutral stance.

Practicing gave people the reassurance to do the activity on their own. Participant 1 gave an example of a lady who wanted to shower but who avoided doing the activity because she was scared of falling. Talking through the steps whilst asking the person to try to do the task themselves was a valued strategy. Participant 3 described how she broke the activity down, showed the person how to do it, talked the person through what was required, and then got them to practice a bit at a time, gradually building up to the full activity. Practicing the activity gave better outcomes, according to participant 3, because the person changed from sitting in a chair having everything done for them, to being able to do the things for themself.

> *"I`ll talk `em through it, show `em and then do a gradual bit at a time, and then if they can't do it, well then try again in a couple of days, and just do a bit more at a time, and like just build them up."* Participant 3 (cohort 1- interview).

Repetition of the activity was described as a positive intervention by three participants, who believed repetition of the sit to stand activity built up the person's physical muscle tone. These examples given were of people who were a range of ages and with various conditions. Participant 2 described working with a young person. Similarly, participant z10 practiced a repetitive sequence of tasks with a gentleman with dementia who regained his physical abilities. Whereas participant 6 valued the benefits of repetitive practice because eventually less home carer time was required – one carer could managed the call instead of two. Similarly, participant z10 like participant 6, associated practicing the task with improved outcomes for the gentleman and his wife as only one home carer was required to assist. However, participant 6 had an associated negative attitude towards the lack of additional time available to practice activities.

Recognising people’s strengths and capabilities to practice activities came with experience according to two participants. The ability to understand the person, and their trust and confidence in the home carer, delivered the best results, according to participant 7.

“She was quite scared to use her Zimmer frame. I was just encouraging her to use the Zimmer frame whilst standing up, instead of the rotunda. I knew she was able to do that, she had the strength, eventually we`ve managed to get her back on her feet in two weeks. If you can show the client you are confident and that you know what you are doing and you trust them, they are able to do something. They have more confidence then they will try things more, they will trust you more.” Participant 7 (cohort 3 -interview).

Similarly, participant 9 had a positive attitude and believed confidence in her knowledge and skills, her ability to understand the person and what approach to use, was what gave the best results.

“You`ve got to be confident in what you are doing, and like I say, you`ve got to be able to read the clients that you are looking at to know what’s going to work for them. What approach is going to work for them.” Participant 9 (cohort 3-interview).

Most participants associated practicing the task with better reablement outcomes. Surprisingly, the participant`s did not associate practising with the person`s use of compensatory equipment, such as: long handled dressing aids, long handled sponge, or sock aid.

Pace the activity.

Pacing the activity, was mentioned by four participants in a positive context for people who are fatigued or breathless. However, the majority of ten home carer`s did not mention pacing as a skill. Strategies to enable the person to rest and catch their breath to make the bathing or showering easier were valued by participant 1.

“It's just seeing how far they can go. I mean, she could get one leg in, she were really breathless so she couldn’t get her other leg in, and at that point I’d help her with stuff towards the end. Its as though she knew to go to sit on the toilet instead of trying to go in the shower. Obviously, the shower seat were a little bit higher. So,

she`d sit on the toilet instead, so she`d be able to just bend down and put her own pants on." Participant 1 (Cohort 1- interview).

Pace is different for each person. Sometimes it takes people longer to do things for themselves, or they might need environmental adaptations, but the aim must be for them to do it for themselves. People should be allowed to go at their own pace, but participant 3 acknowledged this takes longer.

"If they want to take their own clothes off independently, they might take ages doing it. You can't stand there and say, come on get them off a bit faster. You know, you can't say that. You have to let them go at their own pace." Participant 3 (cohort 1-interview).

Conversely, another participant valued pacing, but had a negative association with the time reablement takes and the organisational process implications.

"They was able to step up a little bit more and do a little bit more. However, because it was made slower, and you record this back to the office. And we are saying, I know this is a 45-minute call, but because we're enabling them to do it more, they need an hour." Participant 5 (cohort 1-interview).

The examples of pacing the activity show it was used appropriately as a reablement intervention. There is an association with the need for extra time to complete this intervention. The fact that ten participants do not mention it suggests it should be a clearer component of future training.

Observation.

Observing the person attempting the task, before doing the task for them, was only mentioned by four participants, all had positive attitudes to the skill of observation but different reasoning. Understanding the person's psychological or emotional perspective was important to participant 9.

"I needed to see her doing it, and she did it, but she was nervous." Participant 9 (Cohort 3 -interview).

Conversely, two participants valued observing and being present, and for participant 3 -this was always when there was an element of risk.

“We`re only a short-term service. So initially when they come out of hospital, they need full support, but you stand back and watch. I don't take that independence and watch within a week they've dropped a lunch call. They say, I can do my own lunch” Participant 4 (cohort 1- interview).

Finally, observation was valued as much as the person’s willingness to try an activity by participant 5 who associated observations with her autonomous decision making about the type of support she would give.

“It`s like observation as well and asking them the questions, do you think you could be able to do this?” Participant 5 (Cohort 1- interview).

Motivation.

Motivating people was the most frequently mentioned intervention, described in the context of encouraging people to do more for themselves. Often the home carers had to engage people in doing things they didn’t want to do, or weren’t motivated to do, before they could begin to work on reablement goals. Seven participants evidenced this sequence of events. Patterns emerged, with five participants expressing positive attitudes towards the skill of motivating others; one had a mantra, *“If you don't use it, you will lose it.”* Participant 4 (Cohort 1- interview).

All valued the relationship between themselves as the home carer and the person. Participant 7 believed that the person’s confidence in the home carers’ abilities was important; and participant 6 thought once you have established trust, you could determine whether you can push a person to get more potential. This suggested participants understood the person’s psychological as well as physical capabilities.

“If you can show the client you are confident and that you know what you are doing and you trust them, they are able to do something, they have more confidence, then they will try things more, they will trust you more.” Participant 7 (cohort 3- interview).

Furthermore, whilst participant 6 believed there was an association with peoples’ expectations (they are told by others that they need help from a carer and so they just accept this) and not trying to do things for themselves, he still had a respectful and strength-based approach to engage them in reablement.

> *"I think you could do this. Can we try doing that? I think you would benefit from doing it this way."* Participant 6 (cohort 1- interview).

Conversely, one participant believed that people who do not try were problematic, due to her positive personal experience of a loved one overcoming their significant disability and striving to be independent.

Participant z13 and z14 discussed motivating others in focus group 2. Participant z14 believed in the value of understanding the physical or psychological barriers that are impacting on reablement, evidencing the relationship between motivating others and autonomous decision making. Where as, z13 associated motivating others with the relationship each home carer had with the person, and the consistency of home carers visiting. She believed that people did not respond well if different home carer`s communicated in different ways.

Motivating others can be received negatively. A relationship conflict can occur, participant 3 described how people may not like the home carers at first because they are motivating them to do something that they do not want to do.

> *"I mean he didn't like me the first call. But then, when are you coming again. Because I`ve pushed him. Well I `ant pushed him, I`ve enabled him to more things for himself, and now he understand why I started like that. He even sent in a good report in about me."* Participant 3 (cohort 1- interview).

Specialist advice from an occupational therapist and physiotherapist was believed to be helpful by three participants. They believed that they were more confident in encouraging when a registered professional had given advice, especially when encouraging and motivating people who were fearful or anxious about falling.

Lack of confidence in their own reablement abilities was evident in two participants' accounts. Participant 5 understood that the aim was to encourage the person but also to be realistic. She asked the person what they wanted to do, suggesting that they might not be able to do things in the same way, but did not acknowledge her role as the re-abler who could work with them to do things in a different way. Instead, she focused on the need to bring in the expertise of a specialist professional.

> *“To get back to what they used to do before, I'd explain to them. Yes, you can theoretically go back. However, you must keep in mind that there are some things that you used to do before, but you might not be able to do as you used to do before. You might need a bit of help, a bit of assistance, or a piece of equipment.”*
> Participant 5 (Cohort 1-interview).

Whereas participant 2 was positive associating broader reablement goals as an incentive. However, she believed this is all she could do. This negative attitude was due to a corresponding belief that some people need, or want, home care as a safety blanket, or for social contact, and that no amount of encouragement or motivation would change the outcomes of reablement for them because it does not address that need.

In summary, seven participants evidenced a sequence of events where the home carer had to engage with the person to do something that they did not want to do, or weren’t motivated to do, before they could begin to work on reablement goals. Participant z13 associated motivating others to autonomous decision making. Participants 2 and 5 believed that they were less confident in their skills to motivate others.

Instructing to do the task.

Instructing involved explaining the task, demonstrating, and then prompting the person as they did the task themselves, and this was linked to practicing the task. Verbal instruction, as opposed to physical assistance was valued by eight participants. Of these, three participants had positive attitudes towards instructing on specific techniques following physiotherapist or occupational therapist advice, such as: sit to stand or walking with a wheeled zimmer frame.

Although promoting in the form of verbal instruction was perceived to be beneficial, one participant summed up a common negative attitude towards the time required to do this in the allocated care call.

"Our biggest bugbear is time. If we had an hour for each client, it would make it so much easier, don't you think? Whereas we could spend that time, well you get your milk out, get your breakfast." Participant z11 (Cohort 2- focus group1).

A discussion in focus group 2, around self-medication allowed the group to challenge each other, reiterating that verbal prompting to give medication takes longer than doing it for the person. The dynamic within the group was supportive, with some peer pressure from z11 and z10 to enable z12 to understand the skill involved in instructing a technique or intervention.

Goal setting.

Goal setting was viewed positively by six participants, but more than half the participants did not mention it at all. Those that did, seemed to be talking about broader long-term, person-centred goals, not smaller daily tasks. Nevertheless, there was satisfaction for the home carer when a person achieved their goal.

"When somebody regains what they can do or can get to a certain specific goal of what they want, I think it's brilliant." Participant 5 (cohort 1-interview).

On the first assessment visit, the person was asked what they wanted to achieve out of the care according to participant 4, who believed this was how the goals were set. It was unclear how much depth of understanding the participant`s had on goal setting or how to measure progress. Lack of confidence in goal setting was expressed by one participant, another believed goal setting to be a balancing act, interpreted to mean a balance between what the person wants and what is achievable.

"I don't know, all I would do is the encouragement side and say these are the goals to aim for. Don't know what else I tried. I don't know what else I can try and do." Participant 2 (Cohort 4 interview).

Understanding that meaningful goals are important for people to work towards, was framed in terms of responsibility to positively motivate the person to achieve their goals, as opposed to the person identifying their own goals and what is important to them personally.

Time to work on goals was a believed to be barrier. Two participant`s had negative attitudes towards lack of time specifically in relation to goal setting. They discussed how this could be managed concluding home carer`s should identify a goal and plan with the person, signpost the person to the goal plan at the busier call, then at a less busy call they can work together on a specific task to try and achieve the goal.

Goal setting was impacted by continuity of carers, according to participant z14, because a new trusting relationship had to be established before the carer could work with the person on a specific goal.

In summary, there was little content around goal setting as an intervention. This evidenced the home carers weren't using person centred goal setting skills and had limited knowledge of the value of goal attainment which conflicted with their aspirations about person centred practice.

Confidence building.

Confidence building as an intervention requires time and patience, not rushing people. This intervention is different to motivation where participants explored relationships, trust and being able to challenge people psychologically to do more.

Those that talked about confidence building had positive attitudes, describing skills to empathise, encourage, reassure and praise to build people's confidence in their abilities; five participant`s did not mention this. According to participant 8, everyone she worked with needed help getting their confidence back up, no matter how young or old they were.

The impact of falls, the effect this has on a person's confidence, and the strategies participants used was explored. They believed people think they can't do things for themselves anymore, and this is a permanent situation, as opposed to a temporary situation that they will recover from; participant z13 referred to this as getting people moving again.

> *"I walked in, and they are letting go (of the walking frame) and I'm saying, don't take your hands off, keep holding on. Its for your own safety. You`ve got to encourage them to realise. You know, if they are going to keep letting go of it, you*

> *are going to fall over. Its there for a reason, and I've gently helped them get their confidence back."* Participant 8 (cohort 2- interview).

An example of confidence building as a psychological strategy is given by participant 2, showing that even when people are functionally able, they benefit from the preventative value of reablement because without it people might end up paying for long term care unnecessarily.

Similarly, participant 4 believed that when people returned home from hospital they had to get used to their home environment. She believed in giving people lots of reassurance, telling them not to panic if they couldn't do the activity the first time, and made practical adjustments to the environment that helped effective confidence building.

Praise as encouragement strategy helped to build confidence was used by several participants, although two identified it was suitable for some but not for others depending on their personality. Both were clear that this should not be patronising.

> *"I just give a lot of encouragement tell em they doing good but not being patronising. You know. Since last week I've seen you move, do a lot more and yeah its it`s not just with one client, I`m doing it with every client where possible."* Participant 3 (cohort 1-interview).

One participant thought that some people needed to be believed in for them to achieve their reablement goals. She described the effect of encouragement when someone was fearful and anxious, articulating faith in the lady's abilities which increased her confidence enough to attempt the task, and how success was then rewarded with praise.

> *"I give them a lot of reassurance. I tell them not to panic if you can't do it the first time, reassure them. I told him don't worry about it. Yes, we will get there"* Participant 4 (cohort 1- interview).

To summarise, positive attitudes towards skills that involve a mixture of encouragement, praise, and reassurance, without being patronising, were most valued by the home carers. Having explored strategies like praise and encouragement, it is prudent to examine the attitudes and beliefs around bargaining and persuasion.

Bargaining and persuasion.

Persuasion was used in a positive way by most participants to explain that life would be better if people did things for themselves. If the person did not respond well to encouragement, praise and reassurance participants found it more difficult to persuade them to do things for themselves.

There was evidence from three participant`s that subtle negative strategies, like sarcasm or mild threat of readmission to hospital or paying for care, were used to persuade people to do things. They did not appear to have insight or recognise that these bargaining strategies could be perceived as negative or harmful.

"I often use that as a bargaining thing. You know. Like, if they can`t do something. I say, well if you can't do it and you have to have carers in that's £14.00 per hour and it comes out your own pocket, they soon change their mind about doing stuff for themselves." Participant z12 (cohort 2- focus group 1).

Having examined the range of knowledge and skills involved in the interventions participants do with people, let us turn to their experience of doing things for the person.

7.4.2 Doing things for the person.

This sub-theme explored how participants viewed doing things for the person, and this included doing it for them until they could do it for themselves. It was clear that the participants were experienced in doing things for a person and had strong contrasting views about doing things for others that conflicted with the reablement ethos.

Reablement can be used as a safety blanket, when people do not actually need care according to two participant`s.

"I've gone to a few people, and all you are doing is making a drink, and its made. All you got to do is put it in the microwave and carry it up stairs for them. A safety

> *blanket. The knowledge that somebody is just coming in, well that somebody actually cares"* Participant 2 (cohort 4- interview).

Although participant 2 believed this safety check was inappropriate, and the other participant 7 believed there was a need for carers to check in on a person to see if they were safe and well.

> *"Sometimes, it just gives them that reassurance. Someone to come and check on them. Especially if they are at low risk of falling, just to make sure they are OK and that they haven't had a fall."* Participant 7 (Cohort 3- interview).

People who had lost intrinsic control, and who want the home carer to do things for them when they could do it for themselves, were described as challenging by participants. The "doing for" behaviour created a risk of dependency where people were capable of doing things for themselves. This was perceived by some carers as oppressive, but as nurturing by others.

> *"If we go in and do it every day, then they`d end up sat there. Like, no life, doing nothing. Moving no arms. No nothing."* Participant 3 (Cohort 1-interview).

Two participants, talked about reablement in the context of doing things for a person. One described her skills as 'doing for' interventions, or chores, and believed that medication administration was an important care task that carries risk. For some people with dementia it was a task that needed to be done for the person. She also had a negative attitude to the risks people face when preparing a meal themselves. She believed that mistakes could be catastrophic, as opposed to an opportunity to learning, or do things differently. A pattern emerged, two participants were identified as carers who had a positive attitude towards doing things for a person, believing it was a humanistic thing to do.

> *"I think its human nature to go in and help people and you know they are getting pampered. Its a little bit of a pamper after they`ve come out of hospital and I think if you`ve got that empathy you want to go in and do that. Pamper them. Standing back is what I find much harder."* Participant z12 (focus group 1).

In summary, participants had contrasting views and attitudes about doing things for others, some views and beliefs conflicted with the reablement ethos. Having explored why home carers do things for a person, we can turn to look at their views on the different ways of doing things.

7.4.3 A different way of doing things.

This sub-theme is about participants' experiences of interventions that they think could or should be done differently. These have been grouped into social interaction, medication management, compensating and environmental barriers.

Social interaction.

Most participants spoke about social interaction. Their view was that there is a gap in long-term service provision but were vague in their understanding of how this need should, or could, be met by the community; three participants believed it was their role, as home carers to fill this space.

Conversely, companionship, described by participant 7 as taking time for social interaction during reablement work, was valued. Similarly, participant 8 believed that spending some time chatting to the person and building a relationship was important. Both participants put forward the idea that they could do paperwork whilst chatting.

> *"We`ve got a lot who we just need to keep company because they are lonely. Sometimes, say if you`ve got 15 mins and its not needed in general, you'll sit there and have a chat and do your paperwork."* Participant 8 (cohort 2– interview).

Loneliness was recognised as a reason that people wanted care calls when they were otherwise re-abled. Participant 9 didn't like having to draw attention to this unmet ongoing need for social interaction. Where as, participant z11 had a vague understanding that there were universal services that could provide befriending for social contact.

> *"I know people like to keep them in place for company and its awful, but we are not there for that. I feel awful saying that"* Participant 9 (Cohort 3 – interview).

Safe and well checks, or welfare calls as one participant described them, gave reassurance. There was no mention of alternatives to a home carer doing this, like assistive technology, or whether it is the person themselves, or their carers, who need the reassurance.

There is an association with home carers offering more social interaction when there is spare time available during reablement calls. Several participant`s believed that the need for social interaction was an unmet need following reablement.

Medication Management.

Managing risk associated with medication, and correct management, was acknowledged as an important knowledge and skill by all the home carers. Responsibility for medication management was taken away from people in hospitals according to participant z13, who believed that this created dependency.

> *"It's like medication. Yes, I can do my own medication because the nurses have just been handing it to them for the last two months. When they went into hospital, they were just taking 2 paracetamol when they had a headache, and now they've got 13 boxes, creams, inhalers."* Participant z13 (Cohort 4- focus group 2).

However, participant 8 believed short, medication only calls, are a misuse of home care. In focus group 1, participant z12 described not needing much time for medication only calls. Conversely, participant z11 used this focus group conversation as an opportunity for peer learning, explaining the smaller steps involved to promote independence in medication management.

> *"You see, I find with the medications as well, because a lot of people they need assistance with medication. So, a lot of staff will just go in and pop it and give it them. Were as, I'll stand there and say, today we`re going to do this and this, do you agree with that and I will show them, do you think that`s correct, and I'll do it with them."* Participant z11 (cohort 2- focus group 1).

Some pharmacists will not fill, and home carers cannot fill, the plastic compartment medication organisers known as dossette boxes. However, a family or informal carer could do this. Participant z13 explained that it is difficult to get medication pre-packed into blister packs by the pharmacist but understood the referral process for assistive technology and practical solutions like alarms, to support medication management.

In summary, participant`s prioritised medication management as a doing for activity that home carers undertook. The majority did not mention the range of compensatory technology, devices, or equipment available to help with medication management.

Compensating and environmental barriers.

There is a wide range of compensatory equipment available on the open market, and much of it is simple small aids used to promote independence in washing dressing and meal preparation. Five participant`s were aware of such equipment. Conversely, z12 stated she had no experience of these small aids, until she attended the ACT reablement training.

> *"Why you can't wash my back. I says, nobody will ever wash my back. So, you can buy something. I bought one, a long handled (back scrubber) and there's one you can put round your back and pull it."* Participant 3 (cohort 1- interview).

Furthermore, participant 5 had a clear understanding of the role that professionals played in accessing support in order to do things in a different way.

> *"If they got a broken arm and physically couldn't do something. They couldn't lift the kettle or something. If there was an OT who could get out tilting kettle to enable them to do that."* Participant z14 (cohort 4- focus group 2).

Environmental barriers, such as thresholds, steps and stairs can be restricting for people to navigate. Consequently people may believe that they need assistance as a result. For example, when people cannot access an upstairs bathroom, they might need to have a body wash using a bowl of water. One participant mentioned that carers often had to move things like tables, carpets, and rugs to enable a person to navigate around their home.

> *"Because you do come across carpets and rugs where you've not got that in hospital. So, it's just getting over that. You might have to move a few things out of the way so that your walking frame can get around"* Participant 4 (cohort 1- interview).

Another had a positive attitude towards explaining to family, or informal carer`s, the benefits of a person accessing the whole of their home. She was aware that the occupational therapist was a specialist professional who could lead on this work, but also that people, who are willing, could self-fund equipment.

In focus group 2, the difference between people being able to do things on the hospital ward, compared to the home environment, was discussed with reference to equipment that was needed for moving and handling people, such as hoists. They believed that people were tired when they came home from hospital. Participant z13 believed a home visit by the discharging professional, in anticipation of the person coming home, would stop a lot of unsafe discharges.

In summary, most of the home carer`s did not have an understanding of compensatory equipment that could be used for independence in activities of daily living, or how to use them effectively. They would benefit from further training on what is available and usage, to enable them to get better reablement outcomes.

7.4.4 Decision making.

This sub-theme included home carers' knowledge and skills about risk assessment, professional reasoning, judgements on reablement goal progress, and their understanding of when a referral for expert advice was needed.

The participant`s identified they were supporting people who face risks following hospital discharge. They complete a first visit assessment to determine the type of support the person needs. This is intended to be a personalised and detailed account of the person's daily routine, their preferences, medication requirements, and home environment risks.

The reality of completing the first visit assessment late in the evening following a hospital discharge, when people can decline very quickly, was discussed in focus group 2. Similarly, Participant 7 described how people were tired from the journey home from hospital and didn't want to demonstrate their abilities, making it difficult to take an autonomous decision about risk. She stated when she couldn't determine the person's functional mobility, she had to phone the carer who was on the morning shift to alert them to the risks. She believed that it was her role to call an ambulance if the person was visibly unwell, she had the capability of judging the hospital discharge unsafe. Conversely, participant 8 believed it was the responsibility of the office to take action, and that things remained the same until they did.

> *"They are so tired, and they`ve been waiting from 10 o clock in the morning to 5 or 6 o clock in the evening for an ambulance to come to go home. They are tired, and I ask them what I have to do for the assessment, and they don't want to show me how much they can do, or they just don't want to talk."* Participant 7 (cohort 3-interview).

Sometimes care is commissioned, and the person doesn't want it. Participant 3 described a situation where the informal carers wouldn't let her into the property for a first visit following hospital discharge, at 7pm. She persistently requested to speak with the gentleman, she was reluctant to ask the office to cancel the calls because a professional had thought he needed them.

When people`s needs change, the home carer must make autonomous decisions, to contact the GP, call an ambulance, or request a member of the multi-disciplinary team to get involved. One participant believed that she was competent at risk assessment. She had a positive attitude towards the judgements that she made and evidenced good professional reasoning. Similarly, another evidenced a strong understanding of the consequences of taking risks, and when there was a need for specialist advice.

> *"You've got to risk assess. I'll probably get like the OT`s and like everyone before you can like make those decisions yourself …like, stairs are a tricky one aren't they?"* Participant 2 (Cohort 4 – Interview).

Likewise, participant 5 gave an example of her knowledge of the risks of a urine infection. Her attitude was positive towards what to say and do in this situation and she responded promptly, safely, and appropriately. She was also able to link prevention of an infection to the risk of delirium.

Another told a story about a gentleman discharged from hospital who had a walk-in shower, but no grab rails or shower seat. He wanted to be able to shower, participant 4 knew to consult with the adult social care occupational therapist to get the equipment he needed. Furthermore, whilst she was not specific about the type of seat, or the positioning of the grab rail, she was able to assess his ability to shower safely based on common sense and observation of his functional ability to complete his daily routines.

Risk enablement, and when to push someone to achieve their goal, was described by participant 6 as the ability to reason and make autonomous judgements. He had a positive attitude towards using his instinct as a form of professional reasoning. Arguably, his common sense was amplified by his experience as a home carer. He described his repertoire of skills, a toolbox of things that work well in similar scenarios.

> *"It's almost like an instinct of judgement. You can tell. Yeah, he's going to be able regain some mobility and move again. But, maybe this can help. May be that will help."* Participant 6 (cohort 1- interview).

Disagreements about situations where a person does not need as much care as is commissioned were mentioned by several participants, one who had been consulted because of his experience as a home carer. Another described frustration when providing care with a colleague for a person who didn't need two carers. She was keen to point out where she considered people didn't need the care that had been commissioned, and appeared to have a proactive relationship with the adult social care occupational therapist who approved and made the changes.

> *"I`d be on the phone to her (adult social care occupational therapist). Can you come and check this one out. I've reduced him to a single from a double (two carers to one carer). And she`d go out, and we could agree with stuff. So, it were good."* Participant 1 (Cohort 1- Interview).

In summary, the home carer`s took responsibility for managing risk. They made balanced judgements based on common sense, and their experience. They determined the severity and urgency of the risk and took the appropriate course of action. They knew when to contact the office, emergency services, or ask for specialist support.

7.5 Discussion.

Uniquely, this chapter gave a voice to home carer`s working in the independent home care sector who were able to share their experience of delivering reablement. Through analysis of data, collected from semi-structured interviews and focus groups, two themes emerged home carers' experiences of reablement, and home carer`s knowledge and skills. The main findings are summarised, then considered in relation to published research.

The home carer`s who participated in this study held a common view that recipients of reablement and their informal carers weren`t clear about what the purpose of reablement is. Furthermore, they described having to adjust expectations of reablement set by other professionals, some were confident and positively articulated this, whereas others were less clear. Concerningly, some expressed a simplified view that reablement was about reducing care, as opposed to working towards independence, goals attainment, or celebrating needing less care.

Home carer`s valued person-centred care. However, they recognised, and described a power imbalance between the person and the carer, related to the person's perception of entitlement when receiving a service. This specifically played out where the person recognised the service was free for a time-limited period and they no longer needed support. This commonly resulted in requests for the home carer to complete cleaning or domestic chores to fill the care call time. Negative attitudes towards family members linked back to the same issue of perceived servitude and were accentuated if the family member lived with the person, and / or the home carer perceived them to be capable of completing domestic chores themselves. Taken together these factors suggested there was an association between perceived entitlement, expected service provision and servitude. Managing this expectation was challenging for the home carer`s who identified that it caused conflict and had a psychological impact on them.

Continuity of care was valued, the home carer`s had strong attitudes towards being able to work with a person consistently. An inconsistent carer approach to care delivery, caused conflict for the person negatively impacting on reablement progress, and between home carers. The organisational processes that created inconsistency in carers hampered them because building trust and rapport were such critical elements to a positive working relationship with the person.

Time for reablement was valued. The home carer`s spoke about this frequently, connecting it to better outcomes for people. Two distinct views emerged about the time it takes to reable someone, the call time shortened because of efficiency with the daily routine, or it took less time because the person has practiced and mastered the skill. Some home carer`s identified a causation between the time invested in the relationship, development of trust and the reablement effect. Without time allocated, they could not reable. Feeding back when more, or less, care was needed, was considered to be the home carers responsibility and they concluded a more flexible approach to allocating time was required.

The home carer`s knew how to request specialist advice and collaborated with other professionals to get better outcomes. However, several of them were perplexed when the person had achieved a level of independence and the care was not reduced. This was believed to be due to organisational processes (the office staff not reporting progress to adult social care), or the adult social care worker over commissioning the ongoing care.

Home carer`s described their knowledge and skills when doing things with a person. The most frequently used were practice, motivation, and confidence building, and least frequently used were goal setting and pacing. Practicing the task was associated with better reablement outcomes by most. Whereas, pacing the task was valued by a few, and was associated with the need for extra time. Surprisingly, the home carer`s did not associate practicing with compensatory equipment, such as: long handled dressing aids, long handled sponge, or sock aid.

There was little descriptive content about goal setting or attainment, evidencing the home carer`s had limited knowledge on its value, this conflicted with participants' aspirations and experience of person-centred practice. There were negative attitudes associated with lack of time to work on goals, the lack of continuity between carers, and how this impacted on setting or working on goals.

Motivation and confidence building were intrinsically linked, leading home carer`s to value relationships, trust and being able to challenge people to do more, and this led them to make autonomous decisions on risk. The value of confidence building was not recognised by every participant. Those that did, used positive strategies like encouragement, praise, empathy, patience, and reassurance. Persuasion was used positively, and by a few, negatively with no insight or recognition that sarcasm or mild threat were harmful bargaining strategies.

The home carer`s identified that there were two areas for development that were an unmet service need. Medication reablement and opportunities for people to socialise to prevent loneliness, they were accommodating both of these on their visits when they had time. Most home carer`s did not link socialising, to reablement interventions for improved strength and balance, indoor/outdoor mobility, or community participation.

7.5.1 How do these findings fit with published research.

Bergström *et al.* (2022) meta-synthesis aimed to capture the perceptions of recipients of reablement in terms of their outcomes or gains, and in doing this examined the views of regulated professionals and home carers, and found there was value placed on doing everyday, routine activities, to promote recovery and independence, choice and control (Bergström *et al.*, 2022).

The systematic review in chapter 3, found four RCT`s (Sheffield, Smith and Becker, 2012); (Burton *et al.*, 2013); (Lewin *et al.*, 2013); (Tuntland *et al.*, 2015) that evidenced statistically significant outcomes effect to reduce dependency in functional abilities using reablement interventions that targeted ADL (Bennett *et al.*, 2022). Function ability outcomes involve practice and repetition of the tasks that form part of the everyday activities that reablement home carers should encourage people to do.

Like Ambugo *et al.* (2022), this study found home carers experienced operational constraints that influenced whether they had the time to practice activities with recipients. Furthermore, this study also found like Bødker, Langstrup and Christensen (2019b), some home carers had the nurturing mindset and considered that caring was about doing things for people, and again like Bødker, Langstrup and Christensen (2019b), this study recognised that this might be because the home care provider delivered both reablement and compensatory care services, and the thus the home carers were required to be flexible in the types of person-centered intervention they delivered.

This chapter found whilst all the home carers valued a person-centered approach, some but not all, were using the internationally accepted `doing with, not for’ approach (Metzelthin *et al.*, 2020). The home carers had limited understanding of goal setting. Some had the right mindset, but only encouraged people to practice activities of daily living when they had time, as apposed to it being planned support.

Bergström *et al.* (2022) evidenced reablement recipients hoped to overcome challenges, through goal setting and self-determination by becoming active again, participating in more activities, and engaging or re-engaging in daily life. In contrast to this, Hjelle *et al.* (2017) found although recipients’ intrinsic motivations (motivation and will power) were a driver for reablement, it was through interaction with their extrinsic motivations (being in their own home environment and co-operation with the reablement team) that is occurred. For recipient`s to get the full value of reablement, the home carer must use the motivation and confidence building strategies that are considered to be reablement interventions.

Maxwell *et al.* (2021) identified a theme, where conversation enables action and partnerships in care. Considering the home carers in this study believed recipients and their informal carers expected them to serve, or do as they were told, the value Maxwell *et al.* (2021) placed on home carer`s working in partnership with reablement recipient`s is an important way forward, and a key learning point for new staff.

Liu, Chang and Chang (2018) literature review concluded that identifying the connection between home environment and lack of occupational performance was influential in promoting independence. It was refreshing that some of the home carer`s recognised that adaptations to the home environment could improve independence. However, helping people to practise using home adaptations, assistive technology devices and compensatory equipment was not commonplace for all the home carer`s who participated in this study.

Furthermore, the use of reablement strategies for independent medication self-management was raised by a few home carer`s who identified this as an intervention to develop, using techniques like supervised practice, repetition, and assistive technology alarms prompts. Schwartz *et al.* (2017) found that interventions related to advocacy, education, assistive technology, environmental modifications, self-monitoring, and good rapport were the active ingredients of medication reablement. Gerrish *et al.* (2017) advocated competency training led by pharmacy technicians for home carers to become skilled in reablement medication self-management.

Some of home carer`s in this research were aware of the benefits of social and community participation outside of the home, but they didn't know how recipients could access them, meaning there was a real need to join up services and educate home carers to address unmet needs around loneliness.

Doh, Smith and Gevers (2020) found this lack of social connectivity mentioned in studies they reviewed to be regrettable, recommending that social isolation requires reablement as much as lack of physical functional. Similarly, Welch *et al.* (2021) literature review found a lack of studies on reablement that considered personal mobility, accessibility adaptations (handrails and ramps), informal carer support, and advised a need to strengthen assessment of social support and mobility interventions.

In contrast, the scoping review in chapter 2 evidenced strength and balance training to be a characteristic of reablement in most studies. Although, the systematic review in chapter 3 evidenced a lack of statistically significant effective mobility outcomes. This was echoed by the home carers’ beliefs that there were a lack of interventions to improve indoor mobility. This aligned with Mjøsund *et al.* (2020), who found limited evidence of physical activity being integrated and targeted to older adults’ needs and preferences in a reablement setting. Eliassen, Henriksen and Moe (2019) found a standardised approach might be more efficient in the short-term for more people, whilst accepting an individual approach, was essential to provide high-quality movement training for people with complex rehabilitation needs. This research suggests training home carers to understand the value of chair based exercise, and basic strength and balance interventions to improve indoor mobility, and this could be a training component to take forward.

Considering all of the published research, alongside the home carers’ views and experience, there is much scope to develop reablement, to use it as a framework to tailor a number of person-centered strategies that can improve independence (Moe and Brinchmann, 2018). Training for home carers, could be tailored to give the perspective of a range of non-complex, multi-disciplinary interventions, to enhance their knowledge, skills, and competency.

7.5.2 Strength and limitations of the analysis method.

The qualitative data collected was vast and rich, with a lot of material unrequired in a focused study such as this. Robust and secure data management techniques supported future research questions.

The sample was not representative of all home carer`s who provide reablement and so the findings are cannot be generalised; it was a purposeful sample intended to capture diversity of participants’ experiences (Gale et al, 2013). Furthermore, there were contextual influences, such as: location of interviews, decisions about the timeframe for data collection, and reflexivity around the impact of the researcher’s role and professional bias, which increased subjectivity.

The benefits of using the framework analysis approach were its versatility and flexibility, it allowed dynamic changes throughout the analysis, a focus on the participant`s voice which wasn`t lost in the process, and as the analysis moved back and forth between the five stages, it enabled a systematic process for identification of themes, whilst controlling for bias (Hackett and Strickland, 2019).

The protocol plan to use simple pattern analysis for coding interview and focus group data, cited in (Jenson and Laurie, 2016) was rejected, in favour of Saldaña (2021) more structured two-cycle coding method. This could be attributed to poor study design planning, the researcher should have investigated the coding style more thoroughly before writing the protocol, or arguably it was more of a chicken and egg scenario, where learning knowledge and skills developed as the research itself developed, new theories and methods were discovered as a result. An example of this was using a values coding method as interpretation of the sentiment identified the affective constructs of values, attitude, and beliefs (Saldaña, 2021).

Coding, is subjective, as each researcher brings their individual personal perspective gained from their own life experience (Saldaña, 2021). There was, however, a temptation to count the number of participants who viewed things one-way, compared to another, rather than exploring the richness or depth of the participants' views; identified as a pitfall of using matrix spreadsheets (Gale *et al.*, 2013). Therefore the use of additional reviewers (academic supervisor and PPI), gave critical input during the indexing of codes adding strength and reliability to the method.

By examining the code categories and subcategories in their entirety, condensing and re-grouping them into conceptual themes, always linking to the analytical hierarchy and the Nvivo matrix format (Lumivero, 2021), the researcher was able show a transparent audit trail to assure integrity and quality of decision making (Gale et al., 2013), staying close to the participants voice and the original data, a strength of this study.

7.5.3 Reliability.

The reliability of coding was measured by two independent reviewers, who examined a transcribe each. One of these reviewers was the PPI, the other an academic supervisor who was an experienced qualitative coder. To enable the PPI rep to understand the requirements of qualitative analysis, training was provided further strengthening the coding method. The percentage agreement score is simply the percentage of information that was classified into the same category by two independent coders.

The researcher identified eight thematic categories, and a further 43 subcategories, with a total of 73 codes, documented in the code book in Appendix 15. A coding review, conducted with the PPI and academic supervisor, allowed discussion and review of all coding.

Table 18 shows the overall median average inter-rater reliability score was 67 (92%). The initial median average 6 (8%) disagreements were resolved through negotiation without the need for a third independent reviewer.

Table 19 Inter-rater coding agreement

Reviewer	Disagree n=	Disagree %	Agree n=	Agree %
PPI	6	8%	67	92%
Academic Supervisor	7	10%	66	90%
Researcher	6	8%	67	92%

The PPI asked that the “person” is given priority on any hierarchy list, even when the list is not in order of importance and this was respected, coding definition was changed to “A person” on the Nvivo software (Lumivero, 2021), shown in the code book in Appendix 15 . She also made suggestions for theme titles to give more clarity, this didn’t take away from the theme content but was helpful for the study write up. The outcome of the coding review meant some codes were merged under different themes or subcategories.

7.5.4 Reflexivity.

The researcher is an occupational therapist by profession, and invested in the relationship between home care, and people who experience it. To challenge and triangulate any bias, the involvement of the academic supervisor and PPI brought opportunity for reflection and change.

Both the researcher and the PPI were likely to interpret the data collected through their own personal lens, so collaborative partnership discussions were established to explore the findings with the intention of strengthening the analysis. Crowley *et al.* (2019) concluded that involving PPI in analysing qualitative research data provides a unique perspective, challenging researcher assumptions.

7.6 Conclusion.

Qualitative methodology has given a rich insight into home carers' experiences of reablement. Framework Analysis (Ritchie and Lewis, 2012) using semi-structured interview and focus group data was a suitable method for inductive and deductive analysis of the interviews and focus groups data (Gale et al, 2013).

Two themes emerged from the analysis: Home carer`s experience of reablement, and home carer`s knowledge and skills. The home carer`s believed that people associated home care with having things done for them, including housework. They felt this led to dissatisfaction, power imbalance and conflict for them as paid home carers, the recipients of reablement and their informal carers.

The home carer`s frequently found family expectations were challenging when relatives had a different mindset or opinion. They found it difficult to recognise a person's capability for improvement or judge whether people could progress due to being sent to different people each day. They were perplexed when the person had achieved a level of independence and then the care package was not reduced. Some home carer`s felt that the time needed to deliver reablement was justified, whereas others felt it was better to help the person and have a shorter visit.

The home carer`s were confident and positively articulated their knowledge and use of reablement, whereas others were uncomfortable about doing this. Most were able to describe the key elements of reablement and were happy to take responsibility for managing risk and make autonomous decisions. A few expressed dissatisfaction that reablement was designed to only reduce costs and not improve lives. Contrasting views and attitudes emerged about doing things for people. There was a lack of understanding from most home carer`s about the use of equipment.

Pulling these threads of the home carers’ attitudes towards reablement, their mindsets and their ensuing behaviour, identified areas for improvement to embed into future reablement training. The insight from this chapter, and the evidence from the literature reviews, indicates a need for behaviour change, and when this is coupled with the high staffing turnover in home care, a need for ongoing reablement training.

The next chapter presents an analysis and findings about how the home carer`s want to learn, and it considers their interpersonal skills, communication styles and barriers, and the training and supervision they routinely receive, giving new insight used to the cycle of improvement for the ACT competency training.

Chapter 8. Analysis and findings of home carers learning.

8.1 Introduction.

This chapter evaluates the learning that home carer`s experienced during ACT reablement competency training, it explores how home carers prefer to learn and applies this new knowledge to the PDSA cycle of improvement, to enable further codesign of the ACT intervention.

Home care is a vocational career attracting people who want to learn and use practical skills. The training available to home carers in England is a diploma (NVQ) or adult care worker apprentice in health & social care with five levels of progressive attainment: Level 2 being the recommended starting qualification for home carers. Alongside this, home carer`s must complete their Care Certificate (15 competency standards) to be able to give direct care on their own, or can work alongside an experienced home carer from when they have started the Care Certificate programme (Skills for Care, 2023a). In it`s current form, the Care Certificate in England does not include reablement as a concept or topic, or outline the competencies required to deliver reablement interventions (Skills for Care, 2023a).

Chapter five described the ACT intervention, the history of the local authority reablement service delivering it and the reablement competency training delivered as a component of it. As a reminder, this training was co-designed by experienced local authority occupational therapists. In its earliest form, it had no obvious reference to learning theory or other evidence-based reablement training.

Chapter six evaluated the reablement training, using a before and after training survey, and rich insightful findings from semi structures interviews and focus groups. From this, a picture emerged of the home carer`s knowledge and skills, and where they had gaps in their knowledge. The clarity and confidence expressed using the before and after training evaluation highlighted areas to focus on for future training, but more relevant were the descriptive findings that added depth to the evaluation. Here, strengths in the home carer`s knowledge and skills were evidenced especially around person-centred practice, and weaknesses in how to motivate or challenge people to do more for themselves when they were physically and/or cognitively able.

This chapter presents further insight from the semi-structured interviews and focus groups, specifically on how the home carer`s liked to learn, their communication styles, communication barriers, their interpersonal skills and the training and supervision they routinely received.

In chapters six and severn, the primary research concluded the ACT intervention and reablement competency training was not achieving the desired results and needed to be refined. Therefore, to enable reflexivity, review and improvement of the intervention using the PDSA method, where the final stage is adopt, adapt, or abandon, action was taken to adapt the training by codesign of improvements (Christoff, 2018). A revised logic model was used to evaluate ACT reablement (Mills *et al.*, 2022) with both steering group, and operational delivery group engagement and agreement.

8.1.1 Aim and objective.

The aim of this chapter was to review, refine and improve the ACT intervention and reablement competency training. The objective was to fully explore how home carers learn by integrating the systematically reviewed literature with the findings from the empirical research in this thesis to improve the training programme using an evidence informed revised logic model, visually presented as a cycle of improvement.

8.1.2 Background context and the evidence for reablement training.

In chapter two, the scoping literature review evidenced 28 studies that mentioned the value of training or coaching staff who deliver reablement interventions. However, only three experimental studies described the audience, rational and content of such reablement training (Lawn *et al.*, 2017a); (Rooijackers *et al.*, 2021b); (Assander *et al.*, 2022a). Published protocols were available for two of these studies (Metzelthin *et al.*, 2018); (Bergström *et al.*, 2019) although they were excluded from the scoping review due to the eligibility criteria.

Four other studies focused on staff experience of delivering or receiving reablement training (Lawn *et al.*, 2017b); (Smeets *et al.*, 2020); (Maxwell *et al.*, 2021); (Dibsdall, 2021). Wade and Jones (2014) believe personal power can be gained from sharing vulnerabilities through reflective supervision. Three studies (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019), and (Dibsdall, 2021) highlighted the importance of professional supervision and on the job competency training to enhance workers practice. The results of these studies are specifically important for shaping any future reablement training content and are summarised as:

- A nine-months training programme consisting of structured bi-monthly meetings, practical assignments, and weekly newsletters, with taught sessions on motivating people, increasing engagement in daily activities, goal setting and action planning, involvement of social networks, and assessing people’s capabilities was not recommended as effective for staff efficiency or improvement in older peoples’ sedentary behaviour (Rooijackers *et al.*, 2021b).

- Workers learnt from each other through knowledge and experience exchange activities (Smeets *et al.*, 2020).
- Using a structured goal setting tool for older people and providing support to staff through workshops was a feasible programme (Assander *et al.*, 2022a).
- Workers reported greater awareness, skills, and confidence in working with complexity, reinforcing the value of their existing practices and skills after the training which was designed to enhanced knowledge, skills, and confidence around communication, complexity, behaviour change and chronic condition self-management support (Lawn *et al.*, 2017b).
- Sharing reablement stories to create a reablement culture (Maxwell *et al.*, 2021).
- Knowledge of each others’ roles, regular communication and co-location supported levels of trust and shared purpose (Dibsdall, 2021).
- Supervision and on the job competency (Bødker, Langstrup and Christensen, 2019b); (Eliassen, Henriksen and Moe, 2019), and (Dibsdall, 2021).

8.2 Findings.

To understand the context and potential for developing and refining any future reablement training, it was relevant to explore the home carers’ experiences of the training methods used. As with other chapters, the methods for analysing the data to determine training feasibility were the same, using the data collected from the semi-structured interview and focus groups, integrated using a convergent design.

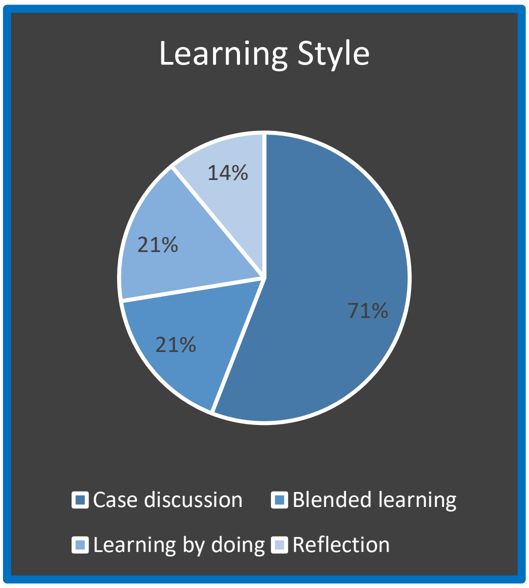
8.2.1 Learning styles.

Learning preference was explored with the 14 home carers who were interviewed or participated in focus groups, shown in Figure 34. Some home carer`s had more than one learning style preference.

Case discussion was classified as learning from talking about a situation or person with peers or a senior carer, verbally problem solving together. Blended learning was classified as a blend of reading, video content, taught content, and discussion. Learning by doing was classified by home carer`s who learnt by trying things out themselves, observing a colleague then copying (see one-do-one), practical tasks, or functional learning. Whereas reflection was classified as time to think and process, relating back to own experience and reflecting in action or on action.

Figure 34 Participants self identified learning style preference.

Learning style	**n=14**	**%**
Case discussion	10	71%
Blended learning	3	21%
Learning by doing	3	21%
Reflection	2	14%



In the context of the interview conversation, interactiveness a word used by two participant's, was interpreted to mean working together and influencing each other, and coded as a preference for case discussion. The case discussion method of learning was described by participant 5.

"So, you`ve done the thinking and you`ve done some of the training, and everything that you`ve done say the previous week. Yeah, and then you gone to do your work in the morning and then gone to the group in the afternoon, and you said, you know this morning this is what have tried, and this is what happened, could you just advise me a bit more." Participant 5 (Cohort 1- interview).

Of the six home carer`s who had other preferences to case discussion, one home carer liked a blended learning style; three stated they liked learning by doing, and two liked to reflect on things.

> *"I like to chat about things, I learn more that way. I'm not very good at sat there concentrating and reading. I don't like watching telly or anything, I'm not very good at concentrating. Yeah, I like to do things"* Participant 4 (cohort 1- interview).

Participant 5 stated she needed time to reflect to process information. Participant 2 talked about the communication style of home carers who lacked confidence to voice their opinion.

> *"Not everybody has got the confidence to talk, some people are shy, and we were a small group. Some people aren't comfortable, are they? It doesn't mean that they are not interested or not listening, it just means they clam up, they're not confident to speak"* Participant 2 (cohort 4-interview).

In summary, preferred learning styles varied amongst the home carers. The majority (10) preferred case discussion and were verbally sharing knowledge and skills. If three of the participant's identified they learnt by doing, they are in effect copying their colleagues. There was a low preference for a reflective learning style, and this was a concern. There are significant interpersonal skills required to communicate the reablement ethos and build a therapeutic relationship. Given that reflective practice was a component of the ACT reablement training, this is an area for training improvement.

8.2.2 Interpersonal skills.

The home carer`s communication methods were face-to-face with the person; with informal carers face-to-face, or by phone, whereas with professionals it was face-to-face, via phone and email. They communicated with each other and their office face-to-face, via their electronic case file and by phone. Interpersonal knowledge and skills were described by home carers as being important for reablement. These were categorised into communication barriers and communication style.

Communication barriers.

Communication is a skill, as well as a process, according to participant z13 who believed home carers need to be able use their communication skills effectively. This theme was raised by the PPI as an important area to cover given people might have varied sensory experience in any of the five sensory areas: visual, auditory, olfactory, somatosensory perception, or gustatory.

However, there was a lack of content, in the data collected, around communication barriers and its impact on reablement, only two home carers gave examples – suggesting this is an area for improvement. When working with people who have complex communication needs, for example people who are nonverbal, one home carer used a communication board and sign language skills.

“People who are nonverbal if they can't get their needs across you are playing guessing games. You know, looking back on what they like. You don't know whether they still like it.” Participant 2 (Cohort 4-interview).

The other example, from participant 7, was in the context of people needing social interaction, and how that might be delivered in a different way such as by telephone.

“If you have a hard of hearing client obviously, they won’t hear the phone to answer. You can put them at more risk by calling them because they are rushing towards the phone. It really depends on the client” Participant 7 (Cohort 3-interview).

Communication style.

If 3 of the 22 home carer`s were learning by doing, or copying their colleagues and 10 were learning through case discussion, the knowledge and skills required to communicate the reablement ethos and build a therapeutic relationship are also learnt in this way.

Some home carer`s identified that it was their communication style that was the key to building a rapport, this was identified by participant 14 as a skill, and participant 9 believed being able to switch between styles to suit a person got the best outcomes. Whereas, participant 9 valued the knowledge of how to be flexible with her personality, able to switch moods for people depending on what they like. She believed that you can’t be the same person for everybody, and that she needed to adapt and tone down or lift her personality to suit the person.

“I always say, your personality has got to be flexible because you have got to be able to, one client might like you being bubbly and having a laugh but then another

client might not. So, you`ve got to learn yourself to switch moods basically between people depending on what they like." Participant 9 (cohort 3-interview).

The two main approaches identified were extrovert and introvert communication styles, and these were coded in the home carer`s own words as listening skills and banter.

Listening skills were valued by three participants. Participant 2 believed this was what makes a carer competent. Conversely, banter – described as chatting and being humorous, was valued by five participants.

"I just look, smile when they say, or I just joke around. I know there is some banter to oil the wheels and then it works and then we know each other" (Participant 7 cohort 3- interview).

Whilst participant 9 described herself as bubbly and liking a laugh, participant z10 went deeper with his explanation believing chatting, and finding out about people, helped build stronger relationships, and he believed if they were smiling when he left, he had done a good job.

8.2.3 Independent home-based care training and supervision offer.

The independent home-based care provider not only provides a reablement service. Ongoing long-term and palliative care services were also provided for adults and children. Although each service contract was separately commissioned, the home carers moved between services to cover gaps in the rota. This may have been exacerbated due to the Covid wave experienced in the winter of 2021-22.

Being adaptable was considered a strength by three home carers. Participant 1 identified that she worked in other parts of the service but liked reablement work. The senior carers (participant z13 and z14), who quality assured others practice, specifically valued home carer`s that were flexible and adapted to different types of caring role.

"We have staff that work across different services. Like, we have end of life services as well as re- enablement. They've kind of got the same skills but they know how to

incorporate them differently for each client" Participant z14 (Cohort 4-focus group 2).

The compliance officer role was undertaken by an experienced and senior carer, with responsibility for training, supervision, and quality assurance of the home carers' practice. In the main, their role was to induct new workers, deliver in-house training, complete direct observations of home carers' competency, and be involved in interview processes.

"This week our new staff are going out for what we call a taster session. So, Wednesday they are going to shadow just for the morning, then in the afternoon they have a reflection. So, they come back can we talk about how they got on, any burning questions they have got. We have even had staff say this isn't for me and they haven't come back but that's better than it's done in the first week". Participant z13 (cohort 4-focus group 2).

Participant z13 described the in-house training as good, and competency-based using a range of materials, moving and handling people delivered face-to-face using appropriate basic equipment (bed, mobile hoist, Rotunda) and medication, nutrition and fluids using videos and power point presentations. The "see one-do - one" teaching method was used to teach new members of staff practical skills. Participant z14 believed this was effective.

"It's so important to get them working with experienced staff to build on that confidence, and I will say to them, watch them do it one day then maybe have a go yourself and get them (other care staff) to observe you. It's about building their self confidence." Participant z14 (Cohort 4- focus group 2).

The quality assurance of the home carer`s practice focused on direct observation. If there was a problem with how the care was being provided, for example moving and handling, the senior carer`s who were the compliance officers would go out and advise.

"If it was something that we thought was dangerous we would pull them up there and then on the call but otherwise well you would discuss with them afterwards and offer them more training to look at their development and things" Participant z14 (cohort 4-focus group 2).

Home care is a very skilled job, according to participant 9 who believed all home carers should have training before they start working with people. She believed she had the right values to be a home carer, understanding the difference between right and wrong, and was motivated to do additional training when it was available. She had a positive attitude to new workers having shadowing experience with another carer, to learn the job. However, she believed new home carers could learn negative behaviour from experienced carers, or from those who were also so new that they had only just completed their own Care Certificate.

“I think its such an easy job to get into and it shouldn’t be. You should have training before you become a carer, that’s my opinion” Participant 9 (Cohort 3- interview).

8.3 An alternative intervention model.

In chapter 3, Figure 19 showed how Moore *et al.* (2015) logic model was used to explain ACT reablement. As the empirical research gave new understanding of intervention activities, inputs and outputs with potential to influence causal mechanisms, the operational delivery group were asked to review a revised logic model using Mills *et al.* (2022) design shown in Figure 42, as a mechanism to improve and develop the intervention model.

Planning for an operational delivery group extended meeting to evaluate the proposed intervention improvement was essential to enable ideas to be shared effectively in a written format to enable participants to discuss and inform their opinions. Clarification through a process of summarising data was planned, and the academic supervisor was present to ensure accuracy and accountability. Due to competing demands, the operational delivery group members requested an online focus group. Microsoft Teams was chosen as the ICT platform due to the secure features and convenience of data sharing via Microsoft 365 applications.

Pre-meeting information reading was shared by email, including the original logic model and the improved real-world logic model, a summary of the research findings, an explanation of the operational delivery group purpose, agenda and to establish consent for the MS Teams meeting to be recorded. Three questions were posed for discussion:

1. What reablement interventions do we want home carers to understand and do?
2. What support do home carers need to enable them to be proactive in setting and reviewing reablement goals?
3. What can we do to support home carers so they can be adaptable to different types of home care provision, trusted and empowered in their role?

A summary of the empirical findings and an overview of the evidence base for learning theory was presented so they could consider how this might influence and shape the new logic model shown in Figure 37.

8.3.1 Learning theory.

For the findings of the studies on reablement training to be integrated into future theoretical training models, an understanding of learning theory was required because pitching training to the audience maximises the learning outcomes. (Eliassen, Henriksen and Moe, 2019) referred to the context of `learning by doing`, calling it experiential learning, where smaller tips of good practice are learnt (Eliassen, Henriksen and Moe, 2019), and (Dibsdall, 2021) called this on the job competency.

A brief overview of three experiential learning styles substantiates the development of a future training package, considering the evidence-based for learning theory.

Kolb (2015), theorised that people gravitate to one of four learning styles shown in Figure 35, as part of the experiential learning process. The four styles are combinations of his defined approaches, Kolb used this theory to design a Learning Style Inventory – a questionnaire to determine an individual's learning style (Kolb, 2015). Whilst this inventory is still used, it has been criticised (Manolis *et al.*, 2013) for using dichotomous, rather than continuous, variables on the abstract/concrete and reflective/action dimensions of experiential learning.

Figure 35 Kolb learning styles.

Kolb Learning Styles

1. Accommodator = *Concrete Experience + Active Experiment*: strong in "hands-on" practical doing.
2. Converger = *Abstract Conceptualization + Active Experiment*: strong in practical "hands-on" application of theories.
3. Diverger = *Concrete Experience + Reflective Observation*: strong in imaginative ability and discussion.
4. Assimilator = *Abstract Conceptualization + Reflective Observation*: strong in inductive reasoning and creation.

Honey and Mumford (2006) developed a learning style questionnaire, adapted from Kolb's work (Mumford, 1997). The learning styles were renamed: activist, reflector, theorist, and pragmatist. The learning cycle focused on experiences: having an experience, reviewing the experience, concluding from the experience, planning the next steps. The model focused on achieving desirable behaviour and how strengthening different approaches could facilitate experiential learning as opposed to how a person learns.

Barbe, Swassing and Milone (1979) proposed that people have strengths, rather than preferences, in three learning modalities: visual, auditory, and kinaesthetic; these change over time becoming integrated with age. Fleming (2014) extended this to include reading and writing, to form the VARK model shown in Figure 36. He theorised that not everyone has one preferred learning style, proposing two types of multi-modality learners: learners able to assimilate their learning style to those around them, and learners who need to receive input, or output, in all their preferred styles and who continue to work until all preferred learning areas have been met.

Figure 36 VARK learning style model.

Other learning style theories were not expanded on in this study because an opposing argument suggested there was a lack of scientifically valid evidence for use of learning styles in educational practice (Pashler *et al.*, 2008). A literature review by Cuevas (2015) examined research since Pashler *et al.* (2008), making recommendations for researchers to address this lack of validity, and concluded similar findings, the more methodologically sound studies tended to refute the hypothesis. However, a UK survey by Newton and Miah (2017) concluded that, whilst 90% of academics consider learning styles theory is flawed, 58% of them thought people learned better when taught in their learning style. This leads to the understanding that learning styles seem to be broadly accepted in practice, but most of the research evidence suggests it had no benefit to learning depth.

8.3.2 Training gap analysis.

As a result of the research findings, a training analysis tool was developed that home carers might use to self-assess their knowledge and skills about reablement. Operational delivery group opinion was sought to consider whether this tool was fit for purpose to use as a training gap analysis in order to measure outcomes in supervision, and/ or quality assure reablement training provision. It was considered appropriate but required testing for reliability as part of new or ongoing research.

8:3.3 A review of the logic model.

The original logic model described in Figure 19 was reviewed, and a more detailed template shown in Figure 37 was produced (Mills *et al.*, 2022). This enabled the evidence-based modifications from the training delivery to be discussed with the operational delivery group before any recommendations for change were made.

This review of the intervention activity components after the empirical research findings, identified the need to strengthen the home carer`s knowledge and skills in three areas: goal setting, goal attainment and progress; pacing activities; and understanding of effective use of compensatory equipment, assistive technology, and adaptations.

As shown in Figure 37, there was new focus on the outer context moderators of resources, support and networks and the inner context moderators of culture, leadership vision, staff, and structures. Looking at these in more detail, staff resources are required in the form of occupational therapy facilitators with the right expertise, and home carers who have time allocated to participate in the training. Support for the programme is required from both local authorities and independent home-based care managers. Networks need to be in place to establish a clear escalation process across organisations to prevent drift.

Inner context moderators can be influenced by local authorities, who have a cultural priority of empowered learning and improvement; an integrated system leadership vision, and managers and leaders who can clearly articulate the purpose of the training and culture change. Staff engagement in intervention and research is vital. It was strong at the start of the research project, and this helped to embed the training programme. Home carers should be seen as a vital part of the team as this structure would complement the training programme and outcomes. Facilitator evaluation was embedded in the original training, this means evaluation is continuous, even if staff change jobs.

The facilitator role must be adaptable, to deliver scaled up or scaled down capacity. Wrapped around the facilitator must be a leadership team that can give clear messaging. They need to be accountable for the quality assurance of the training programme, have insight into the value of proactive in-reaching across organisations to share knowledge and skills in a way that can change behaviour, and motivation so that the training and culture change can be embedded.

Soft outcomes.

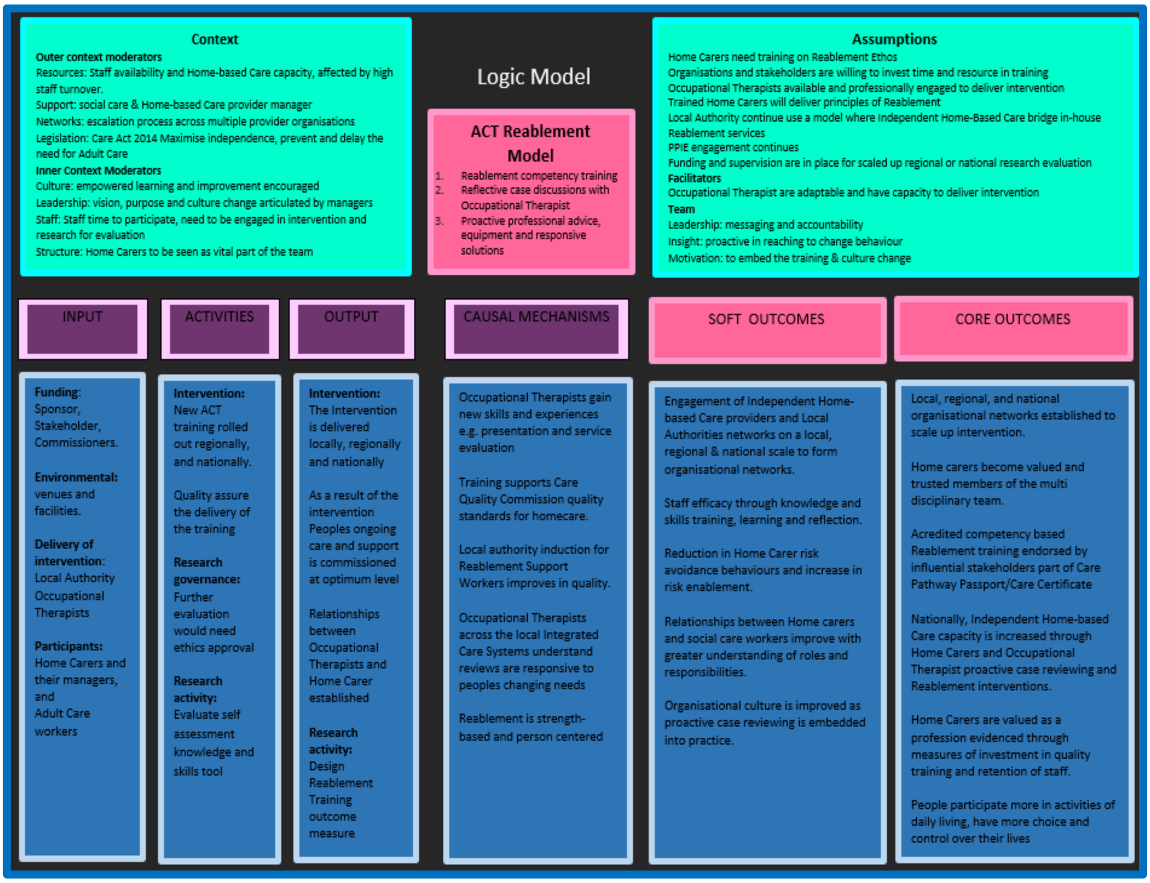
Engagement of independent home-based care and local authorities' networks, on a local, regional & national scale, is required to deliver scaled up effective reablement outcomes for people. Home care staff efficacy, and staff retention can be influenced as a result of meaningful training and the relationships established with social care workers. The ultimate softer outcomes of job satisfaction, feeling valued through empowerment of their role in the wider multi-disciplinary team, and organisation culture improvement, are achievable.

Core outcomes.

The core outcomes from this model will be better independence outcomes for the person; empowerment of home carers through trust in their assessments as valued members of the multi-disciplinary team – which in turn can lead to job satisfaction and retention of staff; and an increase in home care capacity because of home carers and occupational therapists working closely together to take a proactive, trusted approach to case reviewing. Local, regional, and national organisation networks need to be formed to enable the intervention to be scaled up.

The revised logic model in Figure 37 presents a visual summary of how the ACT reablement model can be changed. This would allow further feasibility research before recommendations could be made to scale up to a national accredited competency-based training. However, leading transformative change must be considered (Kotter, 2023), alongside any proposed change.

Figure 37 Revised logic model.



Logic Model

Context

Outer context moderators
Resources: Staff availability and Home-based Care capacity, affected by high staff turnover.
Support: social care & Home-based Care provider manager
Networks: escalation process across multiple provider organisations
Legislation: Care Act 2014 Maximise independence, prevent and delay the need for Adult Care
Inner Context Moderators
Culture: empowered learning and improvement encouraged
Leadership: vision, purpose and culture change articulated by managers
Staff: Staff time to participate, need to be engaged in intervention and research for evaluation
Structure: Home Carers to be seen as vital part of the team

ACT Reablement Model

1. Reablement competency training
2. Reflective case discussions with Occupational Therapist
3. Proactive professional advice, equipment and responsive solutions

Assumptions

Home Carers need training on Reablement Ethos
Organisations and stakeholders are willing to invest time and resource in training
Occupational Therapists available and professionally engaged to deliver intervention
Trained Home Carers will deliver principles of Reablement
Local Authority continue use a model where Independent Home-Based Care bridge in-house Reablement services
PPIE engagement continues
Funding and supervision are in place for scaled up regional or national research evaluation
Facilitators
Occupational Therapist are adaptable and have capacity to deliver intervention
Team
Leadership: messaging and accountability
Insight: proactive in reaching to change behaviour
Motivation: to embed the training & culture change

INPUT

Funding: Sponsor, Stakeholder, Commissioners.

Environmental: venues and facilities.

Delivery of intervention: Local Authority Occupational Therapists

Participants: Home Carers and their managers, and Adult Care workers

ACTIVITIES

Intervention: New ACT training rolled out regionally, and nationally.

Quality assure the delivery of the training

Research governance: Further evaluation would need ethics approval

Research activity: Evaluate self assessment knowledge and skills tool

OUTPUT

Intervention: The Intervention is delivered locally, regionally and nationally

As a result of the intervention Peoples ongoing care and support is commissioned at optimum level

Relationships between Occupational Therapists and Home Carer established

Research activity: Design Reablement Training outcome measure

CAUSAL MECHANISMS

Occupational Therapists gain new skills and experiences e.g. presentation and service evaluation

Training supports Care Quality Commission quality standards for homecare.

Local authority induction for Reablement Support Workers improves in quality.

Occupational Therapists across the local Integrated Care Systems understand reviews are responsive to peoples changing needs

Reablement is strength-based and person centered

SOFT OUTCOMES

Engagement of Independent Home-based Care providers and Local Authorities networks on a local, regional & national scale to form organisational networks.

Staff efficacy through knowledge and skills training, learning and reflection.

Reduction in Home Carer risk avoidance behaviours and increase in risk enablement.

Relationships between Home carers and social care workers improve with greater understanding of roles and responsibilities.

Organisational culture is improved as proactive case reviewing is embedded into practice.

CORE OUTCOMES

Local, regional, and national organisational networks established to scale up intervention.

Home carers become valued and trusted members of the multi disciplinary team.

Acredited competency based Reablement training endorsed by influential stakeholders part of Care Pathway Passport/Care Certificate

Nationally, Independent Home-based Care capacity is increased through Home Carers and Occupational Therapist proactive case reviewing and Reablement interventions.

Home Carers are valued as a profession evidenced through measures of investment in quality training and retention of staff.

People participate more in activities of daily living, have more choice and control over their lives

8.3.4 Operational delivery group feedback.

The operational delivery group considered the study results, training gap analysis and logic model, and made seven recommendations. They agreed the training could be condensed into one session, but that smaller refresher practical sessions should be more often. The depth and content of the training would remain flexible to tailor to the home carers’ experiences. It must include space for reflective case discussion and demonstration of small equipment to promote independence. The reablement competency training should be embedded into all hospital discharge pathway 1 services, including residential assessment beds. The results of the study should be fed into the national Care Certificate review. They considered there to be the need to collaborate with the home care provider managers, sharing the study findings and building new networks for future innovation. Extending occupational therapy skills to roll out the training further to other providers was also required.

8.4 Summary.

The way information is presented and how home carers learn must be considered to optimise training outcomes. The analysis of preferred learning styles in this chapter showed this varied amongst the home carers, although the majority of them preferred case discussion. There was a low preference for a reflective learning style, given reflective practice was a component of the ACT reablement, this was an area for improvement.

As mechanisms for learning, both case discussion, and experiential learning by doing (see-one-do-one), require experienced staff to supervise and support their peers. There was a risk that the quality of the knowledge, skills, and competency could be inadequate using these methods, as they are difficult to quality assure. Nevertheless, the evidence shows that the home carer`s identified they learn best when they are doing a task, practicing a scenario, and talking about it, rather than reading about the theory or watching a video. Reflection was woven into case discussion and brought into practical supervision sessions.

There was a conflicting disconnect between the view of the compliance officer, who described a training method as: induction demonstrations, go out and observe, and then reflect on the experience, with spot checks of observed practice, compared to a home carer`s view that more training was needed to prevent bad practice being learnt from colleagues.

The scoping literature review supported the findings of the ACT intervention cycle of improvement, providing evidence that home carers' learning should be repeated as a continuous mechanism, because reablement is person-centred and the combination of interventions multi-faceted and complex.

Improvement in the ACT training should cover interpersonal skills, relationships, communication styles, barriers and how these impact on reablement. The primary research in this study found building rapport, chatting, and finding out about people helped home carers build stronger relationships. The two main communication styles described by participants were banter and listening. Most participants knew they needed to be flexible in their communication style to suit the person.

The participant`s were clear, that provision of supervision and training is quality assured by CQC, and compliance is monitored within the provider organisation who are senior home carers. However, the experiential learning process of see-one-do-one was considered by one home carer to be an unreliable method, with potential for negative practice to be shared.

The original ACT logic model described in Figure 19, over simplified concepts of complexity, and focused on interventions alone. It missed consideration of the delivery settings into which interventions were placed (Mills *et al.*, 2022). For this study, a flexible approach to the delivery setting was required to enhance successful outcomes. The real-world logic model was used for evaluation as it provided a multi-level framework. It enhanced the review of the intervention development and provided a guide for scalability outside of the research setting (Mills *et al.*, 2022).

8.4.1 Recommendations for change.

1. Reduce the number of training sessions from three to one, and review the content to ensure activity analysis, goal setting and progress review are clear themes, whilst maintaining flexibility to accommodate the home carers’ requirements for case discussion. Include demonstration of assistive technology devises and compensatory equipment.
2. Roll out the intervention model to all home carers who support pathway 1 discharge from hospital to home, and to include other independent home-based care providers in the locality.
3. Collaborate with the home care providers, sharing the study findings and building new networks.
4. Lobby for national competency for reablement with training as part of Care Certificate.
5. Ensure social care occupational therapists are competently skilled to share knowledge and skills with independent home care sector.

8.4.2 Strength and limitations of method.

Using an improvement framework gave structure to the project ensuring that the person was kept at the centre, with opportunity for exploration. Improvement models give co-design cyclic iterations of solutions, and project risks can be viewed as strengths and opportunities (Clarkson, 2020). The PDSA method of quality improvement gave the knowledge to set about improving the intervention (Christoff, 2018). The key methodological features of the PDSA were retained, the iterative cyclic process, data collection was continuous, small-scale testing and use of a theoretical rationale were involved (Knudsen *et al.*, 2019). In addition to this improvement process, use of a real-world logic model to present the intervention, gave clarity for presenting the complex information to the operational delivery group, strengthening communication with strategic commissioning and senior operational managers.

8.4.3 Strength and limitations of analysis.

The strengths of the analysis of data involved in the cycle of improvement is woven into the methods and analysis from previous chapters investigating the training evaluation, and the analyse and findings from the semi-structured interview and focus groups. The data was limited in that there was only one question on the interview and focus group question schedule in Appendix 9 that addressed learning style: How do you like to learn? Had more questions been framed on learning preference, the analysis would have more depth and nuance, in turn this would the add value to the cycle of improvement. The method of co-design, consulting with the research steering group and operational delivery group at regular intervals during the study, increased reflexivity and reduced professional bias. The consultation with the academic steering group was light touch but effective, specifically to sense check findings and the implications for operational practice.

8.5 Conclusion.

As a result of the PDSA improvement cycle, research findings were presented which directly influenced the original logic model shown in Figure 19. Therefore, through evaluation, review, and codesigned improvement of the intervention and delivery process a revised logic model was developed shown in Figure 38.

This chapter provided evidence that the home carer`s learnt best through case discussion. Whilst a small number learnt from observing and doing, or a blended approach to learning, few had experienced reflective learning. The training was redesigned using these research findings, involving collaboration and codesign with the home carer`s and occupational therapists.

As a result of this cycle of improvement, training content was delivered over less sessions, with more emphasis on activity analysis, goal setting, pacing activities and compensatory equipment. The revised version of ACT training required further research to evaluate it, although given the primary research in this study showed the ACT training was feasible, the improved version is also likely to be feasible at a local level, if delivered with the same fidelity.

Chapter 9. Discussion and conclusions.

9.1 Introduction.

In this final chapter, the evidence from the literature reviews and primary research findings are integrated to answer the research questions, meet the thesis overarching aims and objectives, and to draw conclusions.

By completing an in-depth exploration of home carers' experiences of reablement, their knowledge and skills, and their reablement competency before and after the codesigned adult care training (ACT), it was possible to identify whether ACT reablement was acceptable to them and to make improvements to its content, design, and delivery.

A short summary of the findings from each chapter are presented, then an in-depth discussion of how the findings form the literature reviews and empirical research relate to the overarching aim of this thesis, which was to define reablement interventions and outcomes, investigate their effectiveness and to understand home carers experience, knowledge, and training needs to deliver reablement.

9.2 Summary of findings.

The scoping review and systematic review draw from international research on reablement regardless of service delivery provision, and identified some key gaps in the literature about reablement.

The scoping review did not produce enough clear knowledge on how home carers, or reablement workers learnt the skills to deliver reablement interventions (Lawn *et al.*, 2017a); (Eliassen, Henriksen and Moe, 2019); (Smeets *et al.*, 2020); (Maxwell *et al.*, 2021), or the effectiveness of these methods on reablement outcomes (Rooijackers *et al.*, 2021b). Few studies explored home carers' views on reablement itself. There was a specific gap in the research around home carers working in the independent home-based care sector in England, and their attitudes and beliefs towards the ethos of reablement were previously unknown.

In contrast to Beresford *et al.* (2019a), the scoping review found descriptions of three different service delivery models, reablement home care with integrated multidisciplinary regulated professionals; specific regulated professionals (usually occupational therapists, physiotherapists, or nurses) who delivered reablement using standard home care; or a reablement home care service with no integrated regulated professionals.

Like other recent literature reviews by Clotworthy, Kusumastuti and Westendorp (2021) and Buma *et al.* (2022) the findings of this scoping review corroborated that reablement interventions were person-centred and tailored to a wide range of individual's needs. These were based on activities of daily living practice, goal setting, goal attainment, equipment provision, strength and balance training, reassurance and confidence building, and that training staff, to deliver reablement interventions, was a feature in most studies.

The scoping review found the least common interventions described were activity analysis; pacing; assistive technology; motivating self-determination; confidence building; signposting for advice; medication management; outdoor mobility and social and community participation. Again, Clotworthy, Kusumastuti and Westendorp (2021) found similar, and identified that few countries have been able to implement programmes that adequately promote older people's goals, social involvement, or participation in their local community in a safe, culturally sensitive and adaptable way. Whereas, Doh, Smith and Gevers (2020) found the under-representation of social connectivity for clients, in the studies they reviewed, regrettable.

Broadly, the scoping review found the outcomes of reablement were described as positive, in that they can improve people`s functional ability and mobility, quality of life and reduce the need for ongoing care. However, which interventions had the greatest effect, at what stage, and how home carers learnt how to do these interventions was unclear. This identified a need to investigate the effectiveness of reablement interventions and the outcomes through a systematic review of RCTs.

The systematic review of RCTs examined the quality and certainty of evidence produced by eight RCT`s that met the search criteria. A diverse range of outcome measures were used to measure effect of reablement outcomes, some valid and reliable, others not. The systematic review showed that home care decreased in five studies, although only three measured this as a primary outcome with statistical significance (King *et al.*, 2012), (Lewin *et al.*, 2013), and (Hattori *et al.*, 2019). It discovered functional ability increased in four studies (Sheffield, Smith and Becker, 2012), (Lewin *et al.*, 2013), (Burton *et al.*, 2013), and (Tuntland *et al.*, 2015) and quality of life improved in three studies (King *et al.*, 2012), (Parsons *et al.*, 2013), and (Tuntland *et al.*, 2015). The outcome of reablement was most beneficial at three to four months, with some sustainability found beyond six months (Tuntland *et al.*, 2015) and (Whitehead *et al.*, 2016) and the most successful reablement services appeared to be those that had occupational therapist involvement.

The findings from the literature reviews informed primary research of the ACT intervention, and a cycle of improvement endorsed by a range of stakeholders, including experts and a person with lived experience. The results of the training survey provided evidence that the ACT training doubled the number of home care workers who confidently understood the reablement principles and practices. The interviews and focus groups highlighted that the home carer`s recognised reablement as a person-centred practice, and that it was a lengthy process requiring continuity of carers and full organisational support.

The ACT intervention was refined, the original three two-hour sessions were condensed to five-hours, delivered over one full day to address concerns from the independent sector on acceptability. The important new training components established through this primary research were home carers should repeat activities of daily living practice over many sessions, motivational interviewing, confidence building activities, goal setting, appropriate use of equipment, pacing activities, change of behaviour and understanding the reablement ethos. Other important components were supporting home carers to manage risk and make autonomous decisions. It is intended this new ACT intervention will be taken forward for further evaluation through robust research methods with a view to deliver at local, regional, and national level.

The critical analysis of the data collected evolved into a deep insight and understanding of home carers’ perspectives on reablement. The next section explores those findings in relation to the research questions.

9.2.1 Home carers’ experiences of reablement.

This critical analysis is novel, giving new deep insight and understanding of home carers’ perspectives on reality. It is rare to hear the voice of a home carer in academic research. Where we do, it tends to be in small numbers alongside other professionals (Ambugo *et al.*, 2022); (Maxwell *et al.*, 2021).

This study found, similar, to Ambugo *et al.* (2022) Norwegian study, and Maxwell *et al.* (2021) Australian study, that the home carers who participated in this study accepted reablement. Whilst some confidently and positively articulated their expectation of reablement, others had some discomfort or unease around doing this.

A strong attitude towards the purpose of reablement was shown by some home carer`s who believed people associated home care with having things done for them, including housework, which conflicted with the published reablement ethos (Metzelthin *et al.*, 2020). This led to a perceived power imbalance, conflict, and role dissatisfaction for some home carer`s. This finding is in line with the work of (Maxwell *et al.*, 2021) who found home carers believed people receiving reablement valued working together in a partnership, rather than a traditional worker/recipient relationship.

In this research the home carer`s expressed frustration as they were not always able to work with people continuously, which deterred them from using the ACT intervention to deliver reablement as they wished. Lack of time or organisational resources were highlighted as a conflict in other studies (Rooijackers *et al.*, 2021b), (Ashe *et al.*, 2022) and (Ambugo *et al.*, 2022).

One new and novel finding from this study was that the home carer`s articulated how perplexed they were when the person had achieved an improved level of independence and the care package was not reduced. This is unlike (Maxwell *et al.*, 2021) who found care staff were concerned because the person`s progression to independence meant they no longer had a role in the partnership. It was also unlike Ashe *et al.* (2022) who found newer staff were more aligned to the reablement ethos, and experienced staff less so; the home carer`s in this study were mostly 11 years plus experienced. This insight, and the confidence they had to raise the issue, had not been reported in other reablement studies investigated through the scoping review, and therefore this study considered is most likely a direct consequence of the ACT intervention.

9.2.2 Acceptability of ACT.

ACT was acceptable to the home carer`s if delivered with fidelity by local authority occupational therapists. However, despite the after-training survey showing an improvement on all questions, the analysis of the interview, and focus groups, showed that crucial elements of the learning hadn't embedded for some participant`s, and this was similar to Rooijackers *et al.* (2021b) findings.

In focus group 2, discussions evidenced that adapting to work in different types of home care was the norm, and flexibility to switch between different care roles a desirable asset. This contrasted with Ashe *et al.* (2022) who found switching between traditional home care and reablement to be a barrier, and Eliassen, Henriksen. and Moe (2020) who identified responsive reablement services valued a flexible and individually tailored reablement approach, rather than a traditional home care approach where service efficiency was valued. This study puts forward the opinion, for a strength based, person centered approach to be effective there is the need for quality training and supervision for home carers, this is supported by other research (Cooper *et al.*, 2017); (Lawn *et al.*, 2017b); (Maxwell *et al.*, 2021).

Training in a group setting was acceptable to most of the home carer`s, 10/14 had positive attitudes and more than half 9/14 were positive towards the value of the training. The occupational therapist delivering the training did not affect the outcomes. The majority of the home carer`s found the timeframe for delivery of the training sessions acceptable, although 6 of them suggested compressing the content into one session, with an annual refresher. The venue and face-to-face, interactive format of delivery was acceptable to the participants and more than half expressed a preference for training to be delivered face-to-face, rather than online.

The study found after the ACT training, the home carer`s mindset changed, they realised reablement was effective, and that the role of the reablement worker was more than just a name on a tabard. It evidenced the home carer`s valued reablement, and because of receiving the ACT training their attitudes and beliefs towards reablement changed. This was also recognised in Lawn *et al.* (2017a) who found home carers practice and behaviour change following reablement training.

There was considerable goodwill shown by the independent home based care provider and the occupational therapist to coordinate which carers could attend training and when, this ensured fidelity. Other studies, identified without this home carers are in a situation where they have to complete their work and attend training with no additional time or pay (Assander *et al.*, 2022a); (Maxwell *et al.*, 2021). This study identified home carers attended ACT training on their day off, and all of the interviews were held in the home carers own time as this was their choice. A recommendation from this thesis is for significant and sustainable investment in the training and supervision of the home care workforce (Department of Health and Social Care, 2021), in their paid work time (Maxwell *et al.*, 2021) to recognise and value home care as a respected vocational profession.

9.2.3 Home carer`s knowledge and skills.

This study found that before the training less than half, 9/22 of the home carers were clear about the difference between reablement versus standard homecare.

In the interviews and focus groups, there was little clarity around when recovery finished and reablement started, and how challenging a person to do more for themselves, or motivating them to set new goals could be beneficial. Contrasting views and attitudes were apparent amongst the home carers, about doing things for others, with some participants' views and beliefs in conflict with the reablement ethos. A picture emerged, evidencing a lack of depth in understanding about reablement ethos and the beneficial interventions that can enable independence.

A better understanding of the purpose and availability of compensatory equipment for independence in activities of daily living, and/or how to use it effectively, was required, as it was not understood by most and could easily be improved by supervision and training.

Additionally, when the home carer`s explained how they managed risks, particularly immediately after hospital discharge, they described making autonomous decisions as to whether onward referrals were required, or when care was no longer needed. They self identified they were the `eyes and ears' for feedback to diverse regulated professionals, meaning their role dimensions were multi-skilled and much broader than expected. The concept that some home carers have basic knowledge and skills of multiple regulated professions emerged, nurses, occupational therapist, psychotherapist, and social workers. Acceptable risk thresholds should therefore be explored with home carer`s in future training.

Notwithstanding all of this, all the home carers interviewed or who participated in focus groups valued person-centred practice, and they used their interpersonal skills to promote the person's choice and control. They described their communication skills as banter, listening and empathy. There was less clarity and confidence regarding their own positive psychology skills to encourage, praise, and reassure (without being patronising) and how these interpersonal skills were a contributory factor to motivate people to achieve better reablement outcomes.

Furthermore, these interpersonal skills didn't link to broader goal setting, planning, practicing and pacing activities required for reablement, and these interventions were less frequently described in the interviews and focus groups. Golenko, Paine and Meyer (2022) identified that the persons identification and engagement in meaningful occupational goals can be affected by negative ageing, and so home carers need to recognise these barriers and support engagement in goal setting with interpersonal strategies.

Therefore, it can be argued there would be potential for greater impact if home carers had better training around goal setting, planning, and pacing activities. This could connect people to their sense of self, through engagement in meaningful activities, which has the potential to facilitate recovery (Mulholland and Jackson, 2018). These specific skills, associated with occupational therapy were evidenced through the systematic review of RCT`s, to give better functional ability outcomes (Sheffield, Smith and Becker, 2012), (Lewin *et al.*, 2013), (Burton *et al.*, 2013), and (Tuntland *et al.*, 2015).

9.2.4 Reviewing and refining ACT - a cycle of improvement.

This study used the PDSA cycle of improvement, with robust research methods to evaluate the intervention, and a codesign approach to review and refine it.

The interview and focus group analysis and findings evidenced the learning as a result of the training did not fully triangulate with the after-training survey results, suggesting it was not sustained for all participants. Given only 12 of the sample of 22 home carer`s attended all three training sessions, and the third session had the content on activity analysis, goal setting, planning, and pacing, this would be true. Ashe *et al.* (2022) also found care staff tend to fall back into old habits and routines without occasional guidance. As a result, and in collaboration with the operational delivery group, the training element was condensed into one full day session, with an annual refresher.

The format of training delivery must be accessible for home carers to learn. Maxwell *et al.* (2021), talked about sharing case stories to create a reablement culture. Most of the home carer`s identified they learnt best through case discussions with experienced professionals, although some liked a blended learning approach with a combination of taught materials, visual learning, and case discussion. There was a low preference for a reflective learning style and experiential learning. This was a concern, as the see-one-do-one, experiential learning was a commonly described inhouse method for home carers.

Various approaches to reablement training were found in a scoping review by Bramble *et al.* (2022) who noted that Bandura (1997) theory of efficacy and change was used in many studies to explain mastery modelling as a method of human enablement. Coaching conversations were a feature of the ACT training (Kessler and and Graham, 2015). The occupational therapist aimed to empower the home carers with positive psychology during the action learning sets, to enable them to make person-centred decisions that would progress people towards their reablement goals, and to recognise when to seek regulated professional support.

Working collaboratively in this way helped both the home carers and the occupational therpaists to identify, reflect, and act responsively using a strength-based, person centered approach with people who are progressing well with their reablement; have functional capability but have a mental block to doing activities; who are deteriorating or getting unwell; where family members or informal carers are trying to "do for" things for them, and/or where people are being unnecessarily risk adverse.

The opportunity for social care occupational therapists to work in this way with home carers was powerful. The findings led to understanding that action learning sets, delivered by the regulated professionals involved in reablement, were an effective way of improving home carers’ knowledge and skills. But perhaps more relevant was the relationship built with the social care occupational therapist, and the ongoing professional support and advice given; referred to as a mechanism of trust (Dibsdall, 2021). The home carer`s mind-set was positively influenced by the training, and the sustainability of long-term behavioural change needs to be explored further.

In the interviews and focus groups the home carer`s explained their organisational process is to escalate risk to their supervisor. This implies that where they are not doing this, the risk of reduced progression towards independence is not prioritised compared to other risks. A recommendation of these findings is that home carers are taught that preventing dependency is a skill, that complacency can increase the risk of dependency, they should be empowered to make person-centred decisions with people to progress towards reablement goals, and the value of home carer`s feedback as a mechanism for case progression, should be explained through reablement training.

The home carers feedback is integral to the wider multi-disciplinary team to get the best outcomes for the person. They, or their senior home carers, are required to navigate the health and social care system to give this feedback. Occupational therapists work in several parts of the health and social care system, for example, acute hospital, community health and social care. This has the potential for duplication of responses and can be confusing for informal carers, family, and friends, and the home carer working in the independent home-based care sector.

This study found that the measuring of reablement outcomes was heterogeneous, and valid outcome measures are required to measure the effect of reablement. Davenport and Underhill (2023) found a lack of outcome measures used by occupational therapists in social care, recommending that time, resources, and manager support were needed for social care occupational therapists to measure occupational performance change and the impact of interventions.

This study recognises a specific outcome measure for reablement is required that focuses on functional ability, mobility, quality of life, and community and social participation, that has been evaluated through primary research and scholarly thinking. Beresford *et al.* (2019a) indicated value in the person self-reporting on their reablement outcomes, and designed a tool for professionals to measure the persons engagement in reablement, which was found to be a valid predictive measure (Mayhew *et al.*, 2019).

Notwithstanding this, service outcomes were captured in this study, care hours required at the start and end of the reablement service to evidence the success of reablement and the extent to which a person had regained independence (SCIE, 2013). This data was evaluated during the project life cycle, but not reported as a research objective.

9.2.5 Strengths and limitations of the study.

As the limitations for each of the research studies have been discussed within the chapters, the overall strengths of the thesis will be reviewed in this section.

The methods used were transparent. Systematic and rigorous processes were employed in both literature reviews to give confidence that the findings are accurate, appropriate, relevant and reproducible (Hemmingway and Brereton, 2009). The methodological protocols were published online in public facing depositaries, the scoping literature review on Center for Open Science (2021) (Bennett, 2022a), and the systematic literature review of RCTs on PROSPERO (PROSPERO, 2020) reference CRD42021237209 (Bennett and Hodge, 2021).

A strength of this thesis is its rigorousness. The research protocol, and the ethical approval on 18.06.21 for FMHS 261-0521 was adhered to, strengthening the research methodology, and the overall study design. The findings of this research are not intended to be generalisable, but they are intended to be relatable, the method repeatable and trustworthy.

The PDSA improvement cycle method gave a framework for the operational delivery of the project, and aligned well to research methodology. The ACT training was delivered by local authority occupational therapists to independent sector home carers, in a real world setting with accompanying operational limitations and opportunities. Therefore, co-design, also used as a method, gave equal voice to the occupational therapists and home carers to collaborate and participate in training design and improvements, through participatory research (Moll *et al.*, 2020). Slattery, Saeri and Bragge (2020) found varied applications of research codesign in their rapid review, and recommended when conducting this type of research method, train participators in research skills, ensure regular communication between researchers and participators, set clear expectations, and assign set roles to all parties involved in co-design.

The voice of home carers is not often heard. In social care research they are classed as a ‘hard to reach’ group who are difficult to engage in research. The strength of this study is that home carers’ voices have been elevated onto the written page.

The sample of 22 home carer`s who participated in the training survey, and 14 who went on to engage in the interviews and focus groups, was smaller than planned, and the interviews weren't in depth. However, saturation of the themes was achieved adding depth and richness of information, giving power to the study that defended the final sample size (Malterud, 2001).

The researcher used the academic steering group that included PPI representation to check agreement, and this whilst co-design was a feature, consensus was not formally addressed as a method in the research design. Consensus methods are not a research gold standard but they do help to strengthen the bridge between current intervention knowledge and any future intervention knowledge needing to be shared (King, Kelly and McMillan, 2022). Any future study design would build in formal consensus methodology, as the opinions of key stakeholders can create new knowledge, on the basis that agreement of a group of experts is more valid than one opinion.

The reliability of the study was enhanced by academic supervision, consultation with academic researcher and PPI to independently review and quality assure coding. The commitment from the PPI throughout the study gave a new perspective, and additional reflexivity. In particular, training the PPI to analyse qualitative research data (Papageorgiou *et al.*, 2022) provided a unique perspective, and allowed positive challenge to researcher assumptions (Crowley *et al.*, 2019).

The researcher was an occupational therapist working in the service, which again added in-depth knowledge and limitations. Self-reflection was used to identify any bias or views that could affect the analytic process, being responsive to self-reflection enhances trustworthiness and gives reflexive validity to the study (Holloway and Wheeler, 2010). This reflexivity was enhanced by consultation with the steering group and PPI expert, and use of a reflective diary to address anticipated bias.

The researcher was also professionally invested in the relationship between home care and the people who receive it. Holding the opinion that home carers are an integral and valued part of the multi-disciplinary team that wraps around a person to meet their needs. The subjectivity of professional power imbalance, and contextual influences: location of interviews, reflexivity around own role, training facilitator's role, data collection and coding decisions were considered, and this strengthened the study. By reflecting in this way, on key aspects of the methodology, any professional bias can be raised and tackled early, helping to identify subtle nuances that might be missed because the researcher is so deeply entangled in the study. It keeps the research real and more relevant for those it is intended to benefit, and strengthens the design and overall quality of the study.

This was a small-scale study with no additional academic administration resources. This meant observing, and taking notes, whilst conducting interviews and facilitating the focus groups, was too difficult for the researcher. Despite the verbal content from interview and focus groups being audio recorded, it was difficult to measure the strength of feeling that a participant displayed, limiting the method.

All participants gave informed consent, and to date there have been no requests for withdrawal from the study. There were no unforeseen events, or safeguarding concerns raised, and no requirement for debriefing. None of the participants requested copies of their interview script either verbally or by email, and this was omitted by the researcher. The intention was to share the transcribed interview scripts with the home carer`s to ensure accuracy. There was no logical reason for this oversight, other than the data collection and transcription, took several months to complete, and therefore this presents a methodological weakness.

Nevertheless, the before and after training survey determined the baseline and change of knowledge and skills of the home carers. The framework analysis gave rigour and transparency to the rich supporting interview and focus group data ensuring it could be integrated with the before and after training survey analysis; integrating the data in this way gave greater validity and reliability to the analysis (Creswell, 2015). Using a mixed methods design to integrate the results, allowed for description of context, triangulation of the data, and the benefits of participant quotes to shape meaning, and this ensured that reliability, and validity of the analytical process was determined.

Due to the Covid 4th wave in the winter of 2021-22, the plan to deliver small focus groups face-to-face, at local authority offices, had to be adapted. Government restrictions were in place for social distancing indoors in large groups. The sessions were restricted to groups of six people, in a well ventilated room. An alternative risk mitigation plan, to deliver the training on-line, was not used. Ethics amendment was approved to allow telephone interviews, as an alternative data collection method. This was beneficial as the participants were able to schedule their interviews more flexibly to suit their own diaries, with some home carer`s choosing to participate on their days off, or in the evenings.

9.4 Future implications.

Some health and social care ICT systems aren't yet fully integrated across all care systems in England (Department of Health and Social Care, 2023e). This presents organisational service constraints that limit the benefits of reablement within integrated care systems, mainly due to handovers to different services and waiting time for referrals.

Where reablement services have integrated multi-speciality professional roles, Zingmark, Evertsson and Haak (2020) found the focus and content of interventions from those professionals' roles, were complementary. If ideal reablement is integrated home care with multiple professional disciplines involved to oversee the range of interventions delivered: psychological strategies to build confidence, medication management, strength and balance, community participation and goal attainment of activities of daily living, then non-integrated services must arrange themselves to also deliver these interventions. A reablement practice framework, suggested by Bramble *et al.* (2022) would give the opportunity for non-integrated community health and social care services (including primary care and the voluntary sector), to join up, collaborate, or utilise a "trusted-assessor" model.

Training home carer`s to deliver the non-complex reablement interventions that are usually provided by regulated professionals such as: occupational therapists, physiotherapists, or nurses, is controversial and arguably driven by austerity. There is a balance required to enable specialist reablement interventions to be delivered by regulated health care professionals, and empowering home carer`s to have autonomy, especially in identifying people or feeding back suitability for progress review, or requirement for assistive technology and compensatory equipment.

Putting this into context, there is a national recruitment issue for home carers. There has been a lack of home care capacity in the social care system for several years (Bennett, Honeyman and Buttery, 2018). Unless the independent home-based care sector is commissioned to provide a specific service, it means that home carers are expected to be multi-skilled, adaptable, and able to switch between a range of service provisions.

The need for home carers to be adaptable was a finding in this study, and is comparable to Bødker, Langstrup and Christensen (2019b), who concluded complementary types of care were required for different circumstances. This research proposes independent home-based care providers source training for their carers to enable them to understand the purpose of different types of home care provision. Bramble *et al.* (2022) found most training they reviewed to be delivered by a single profession. This study puts forward the opinion, based on home carers' views that reablement training should have multi-disciplinary components to grow home carers with knowledge and skills in non-complex elements of nursing, occupational therapy, physiotherapy, and social work. This would include those elements the home carer`s raised as requiring improvement in this research like medication reablement, strength and balance training, social and community participation.

Delivering reablement training on a national scale would give a consistency in approach and skill competency, an approved reablement competency framework that could be delivered in-house or by a private training company would address this. It is clear home based care providers are expected to take responsibility to induct, support and train their home care staff to enable them to demonstrate the skills set out in the care certificate (CQC, 2022). The NHS Core Skills Framework (Skills for Health, 2023), like the Care Certificate (CQC, 2022) also excludes reablement as a topic. However, their proposed principle of a training passport to enable workers to evidence recognised learning if they move between sectors has been acknowledged (Department of Health and Social Care, 2021), but not yet nationally implemented for the home care sector (Department of Health and Social Care, 2022b).

This study found that home carers in England are not recognised as autonomous practioners carrying risk responsibility. Whilst they are valued as an essential component in the health and social care system, their low pay, status in society and poor career development suggests home carers aren't recognised, or valued, as a professional group (Unison, 2023). Like Assander *et al.* (2022b), this study recommends that policy changes are required to support the workforce transformation needed for the development of a sustainable and healthy home care profession.

9.4.1 Implications for clinical practice.

There are varied service delivery models generating mixed outcomes for reablement in the UK. This inconsistency can be addressed by comparison of reablement outcomes measured through evidence-based research. Measuring the impact of occupational therapy, especially the outcomes of early interventions like reablement used to prevent or delay the need for social care is valuable. Embedding the use of outcome measures across the intermediate care and reablement pathway, will support this.

To date the only competency framework in the UK for home care is the Care Certificate, designed as a result of the cavendish review report (Argile, 2015). Training in the reablement ethos, and its interventions is variable across England, because there is no module on the care certificate on reablement, or other national standardised training, and this has a clinical implication on outcomes.

This research described and tested the feasibility and acceptability of delivering ACT reablement, with associated reablement competency training to home carers in the independent sector, and found it had fidelity and acceptability. It could be implemented in other similar clinical practice settings, and this should be tested further through research.

9.4.2 Recommendations for future research.

This study identified the following four areas for future research:

1. Comparison of reablement service delivery models.
2. Identification of a homogeneous outcome measure for reablement interventions that would enable comparison of effect. This should include functional ability, mobility, quality of life and community and social participation.
3. Exploration of how informal carers are supported and trained to maximise independence and understand the reablement ethos.
4. Investigation of outcomes where independent home-based care providers take on proactive reviewing, or trusted assessor roles, working with health and social care professionals.

9.4.3 Dissemination of results.

This thesis will be shared with stakeholders: the study funder National Institute of Health and Care Research; Adult Care; Home Care Provider Network; Independent Home-based Care Providers, and Royal College of Occupational Therapy (professional body).

The empirical research findings can support continuous improvement of ongoing services and will be presented locally and regionally to home-based care providers forums. There is learning for stakeholders at a local, regional, and national level, and dissemination of this studies findings will be focused on conference presentations, with written abstract, academic poster, and verbal presentations. In addition, there is the intention publish findings in peer-reviewed academic international journals.

9.5 Conclusion.

This thesis presents an original contribution to knowledge. The philosophical paradigm for the primary research in this thesis uses realist ontology and subjectivist epistemology to form a critical realist position on home carers' experiences of reablement, what knowledge and skills they had, what training they required, and what causal mechanisms would bring about better outcomes for recipients of reablement.

The scoping literature review explored the past ten years of published primary research, on the topic of reablement to define its components, including who delivered what interventions and when. It found three different models of service delivery, and the most common reablement interventions to be person-centred assessment; guided activities of daily living practice; goal planning; equipment and adaptations; doing-with-not-for assistance, indoor mobility using strength and balance training.

Reablement was defined as a complex intervention with many components, including elements of personal care delivered by workers who have an enabling approach. The person-centered, goal focused interventions are associated with multiple health and social care disciplines, nursing, occupational therapy, social work, and physiotherapy.

As a result of the scoping review findings, a more focused systematic review of eight RCT`s was undertaken to investigate the effectiveness of reablement interventions and their outcomes, published in a peer-reviewed journal (Bennett *et al.*, 2022). This found reablement had a statistical effect on the quality of life at six and seven months (King *et al.*, 2012), (Parsons *et al.*, 2013), (Tuntland *et al.*, 2015); that functional ability was statistically improved at three months (Sheffield, Smith and Becker, 2012), (Lewin *et al.*, 2013), (Burton *et al.*, 2013), (Tuntland *et al.*, 2015), and effect was greater, but not statistically, when those interventions were delivered with occupational therapist involvement (Whitehead *et al.*, 2016), (Tuntland *et al.*, 2015), and as a result the effect of professional role could not be generalised.

The overall aim of this study was to improve the outcomes for people who receive a reablement service by exploring reablement interventions and outcomes, and understanding home carers experience, knowledge, and training needs when they worked in the independent sector.

In order to do this, ACT reablement, an intervention with an associated co-created competency training programme was delivered. This created an opportunity for both home carers and occupational therapists to reflect on what they do, why and how they do it, and how that influences the person they are working with.

The intention of the reablement training was to positively focus on the strengths and capabilities of the home carers, and increase their knowledge and skills, build relationships with the occupational therapist, and empower them to be proactive in maximising people`s independence. It was important, therefore, to understand the home carers' experiences of reablement. It was necessary to consider their views, attitudes, and beliefs towards the interventions they delivered during a period of reablement through robust research methods, the findings were intended to be used in a cycle of improvement. In doing this, the study determined whether the content of the current training session could be better tailored to the recipients, to give new knowledge and impart behaviour change, presenting better outcomes for people who receive reablement.

The research used a mixed-methods convergent design (Creswell, 2015). A strength of this study is the depth of description, and its validity through transparency of the method, researcher bias reflexivity, and the attention given to describing any outliers or deviant case analysis (Jenson and Laurie, 2016).

The home carer`s knowledge and skills were evaluated through data gathered from interviews and a before and after training survey. Analysis of Likert scale data was effective using median with interquartile range and grouped positive or negative proportions. Framework analysis was used effectively for interpreting interview and focus groups data. The quantitative descriptive data was lifted as In Vitro from home carer interview and focus group transcribes, to allow their voice to be heard. Two themes emerged home carers home carers' experiences of reablement and home carers knowledge and skills.

The home carer`s believed that people associated home care with having things done for them, including housework. They felt this led to dissatisfaction, power imbalance and conflict for home carers and the people. The home carer`s said that they frequently found family expectations were challenging when relatives had a different mindset or opinion. They found it difficult to recognise a person's capability for improvement or judge whether people could progress due to being sent to different people each day. The ACT intervention enabled and empowered some home carers to provide a different service, and more importantly to think for themselves. They were perplexed when the person had achieved a level of independence and then the care package was not reduced. Some home carer`s felt that the time needed to deliver reablement was justified, whereas others felt it was better to help the person and have a shorter visit.

Some home carer`s were confident and positively articulated their knowledge and use of reablement, whereas others were uncomfortable about doing this. Most were able to describe the key elements of reablement and were happy to take responsibility for managing risk and make autonomous decisions. A few home carer`s expressed dissatisfaction that reablement was designed to only reduce costs and not improve lives. Contrasting views and attitudes emerged about doing things for people. There was a lack of understanding from most home carer`s about the use of compensatory equipment. These findings suggested the home carer`s were unclear about the interventions they were delivering as part of their reablement approach, hadn't considered the things they were doing as specific skills, or as reablement interventions, or hadn't the knowledge that these skills could be beneficial in promoting independence.

Overall, the findings evidenced that the training was valued, acceptable and achievable in terms of the time of day, venue, how often the sessions ran, and the learning methods. All the home carer`s who were interviewed, or participated in focus groups, gave rich positive feedback on how they valued the training confirming its acceptability, and if it was delivered with fidelity, the training had feasibility. These findings led to further variables being identified, on the effectiveness and outcomes of occupational therapy interventions delivered during reablement, which can be examined in a future study (Archibald *et al.*, 2015).

Working as a home carer can be a rewarding vocational career, although low paid, with minimal qualifications required, and no accredited competency framework. This thesis found that (11) 79 % of the home carer`s, who participated in the interviews or focus groups, had over 11 years experience in the profession. This suggested that the participants enjoyed and valued care work, and therefore should receive society's respect in the form of regulated professional accreditation, better competency focused training, and financial remuneration.

Despite home carers being the lowest paid health and social care workers (Unison, 2023), the level of autonomous decision making they described in the interviews and focus groups was not commensurate with their role or expected competency. They should be empowered and upskilled to work with occupational therapists, and other regulated professionals if they are commissioned to deliver reablement.

This thesis, completed as a PhD, benefited from academic supervision throughout, involvement of PPI, an academic steering group and operational delivery group, who were involved in the research design, data collection, analysis, the improvement cycle, and dissemination of results. This meant the research was grounded in practice and accountable. Reflexivity, validity, and reliability are strengths of this study.

Chapter 9. Appendices.

Appendix 1 Scoping review data base hits.

Database	("reablement" or "rehabilitation" or "restorative")	"reablement"	("reablement" and "interventions")	"occupational thera*" And ("reablement" or "rehabilitation" or "restorative")	"occupational thera*" And ("reablement")	"occupational thera*" and ("reablement" or "rehabilitation" or "restorative") and ("home care" or "home care provider")
Amed	22594	10	4	4442	6	1659
ASSIA	*4757*	40	5	830	6	228
CINHAL	313	145	65	1685	29	18
Medline	86,313	115	62	1695	20	18
PsycINFO	5535	11	5	245	2	3
PubMed	10,937	149	35	2563	32	33
Google scholar	429	3070	2010	2	20	1
Ebsco (Health sciences database)	188,657	397	183	5301	80	55
Total			359 + 2010 = 2369			

Appendix 2 Scoping review data charting form.

Scoping Review Details	
Scoping Review title:	**The main features of reablement delivered in a community setting: a scoping review**
Review objective:	1. To define Reablement, its nature, characteristics, and outcomes. 2. To understand the types of interventions delivered during Reablement. 3. To identify who delivers those interventions, and when.
Review question:	*What interventions are used during Reablement, who delivers them and when?*
Inclusion/Exclusion Criteria	
Population	
Concept	
Context	
Type of empirical evidence	
Study design	
Evidence source Details and Characteristics	
Citation details (e.g. author/s, date, title, journal, volume, issue, pages)	
Country	
Context	
Participants (details e.g. age/sex and number)	

Details/Results extracted from source of evidence (in relation to the concept of the scoping review)	
Intervention type	
Intervention delivered by role	
Timing and frequency of intervention	
Results of Primary outcomes	
Results of Secondary outcomes	

Appendix 3 Scoping review included studies.

Author	YEAR	TITLE	Method	Population	Context	Intervention	Country
Ambugo, Dar, & Bikova	2022	A qualitative study on promoting reablement among older people living at home in Norway: opportunities and constraints.	Qualitative	Professionals	Persons home	Reablement	Norway
Ashe, et al	2022	Determinants of implementing reablement into research or practice: A concept mapping study.	Mixed	Professionals	Persons home	Reablement	Canada
Assander, et al	2022	ASSIST: a reablement program for older adults in Sweden – a feasibility study	Mixed	Older people	Persons home	Reablement	Sweden
Beresford, et al	2019a	Reablement services for people at risk of needing social care: the MoRe mixed-methods evaluation	Mixed	Professionals	Persons home	Reablement	UK
Beresford, et al	2019b	Outcomes of reablement and their measurement: Findings from an evaluation of English reablement services	Quantitative	Adults	Persons home	Reablement	UK
Birkeland, et al	2017	Interdisciplinary collaboration in reablement - a qualitative study	Qualitative	Professionals	Persons home	Reablement	Norway
Bødker, et al	2019	What constitutes 'good care' and 'good carers'? The normative implications of introducing reablement in Danish home care.	Qualitative	Professionals	Persons home	Reablement	Denmark
Burton, et al	2013	Effectiveness of a lifestyle exercise program for older people receiving a restorative home care service: a pragmatic randomized controlled trial	Quantitative	Older people	Persons home	Reablement	Australia
Chen-Yi, et al	2021	Effects of Community-Based Physical-Cognitive Training, Health Education, and Reablement among Rural Community-Dwelling Older Adults with Mobility Deficits	Quantitative	Older people	Community setting	Reablement	Taiwan
Chiang, et al	2020	Evaluation of Reablement Home Care: Effects on Care Attendants, Care Recipients, and Family Caregivers.	Quantitative	Adults	Persons home	Reablement	Taiwan
Dibsdall,L	2022	Selecting from their toolbox of interventions – A realist study of the role of occupational therapists in reablement services	Qualitative	Professionals	Persons home	Reablement	UK
Eliassen, et al	2019	The practice of support personnel, supervised by physiotherapists, in Norwegian reablement services	Qualitative	Professionals	Persons home	Reablement	Norway
Eliassen, Henriksen & Moe	2020	Variations in physiotherapy practice in Reablement settings	Mixed Methods	Adults (over 20 yrs.)	Persons home	Reablement	Norway
Gerrish, et al	2017	Medicines reablement in intermediate health and social care services	Qualitative	Professionals	Persons home	Rehabilitation	UK
Golenko, Paine, & Meyer	2022	Evaluation of a wellness and reablement approach in Australia: Learnings from a pilot project.	Qualitative	older people	Persons home	Reablement	Australia
Gustafsson, et al	2019	Working with short-term goal-directed reablement with older adults: Strengthened by a collaborative approach	Qualitative	professionals	Persons home	Reablement	Sweden
Han, et al	2020	Effect of home-based reablement program on improving activities of daily living for patients with stroke: pilot study	Quantitative	older people	Persons home	Reablement	Taiwan
Hattori, et al	2019	Effects of Reablement on the Independence of Community-Dwelling Older Adults with Mild Disability: A Randomized Controlled Trial	Quantitative	Adults (over 20 yrs.)	Community setting	Reablement	Japan
Hjelle et al	2016	The reablement team's voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement	Qualitative	Professionals	Persons home	Reablement	Norway
Hjelle et al	2017	Driving forces for home-based reablement; a qualitative study of older adults' experiences	Qualitative	older people	Persons home	Reablement	Norway
Jokstad, et al	2018	Ideal and reality; Community healthcare professionals' experiences of user-involvement in reablement	Qualitative	Professionals	Persons home	Reablement	Norway

Langeland, et al	2019	A multicenter investigation of reablement in Norway: a clinical controlled trial	Quantitative	older people	Persons home	Reablement	Norway
Lawn, et al	2017	Support workers can develop the skills to work with complexity in community aged care: An Australian study of training provided across aged care community services	Quantitative	Professionals	Persons home	Reablement	Australia
Lawn, et al	2017	Support workers as agents for health behaviour change: An Australian study of the perceptions of clients with complex needs, support workers, and care coordinators	Qualitative	Professionals	Persons home	Reablement	Australia
Lee, et al	2018	Evaluating the impact of a home-based rehabilitation service on older people and their caregivers: a matched-control quasi-experimental study	Quantitative	older people	Persons home	Rehabilitation	Hong Kong
Lewin et al	2013	A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults	Quantitative	older people	Persons home	Reablement	Australia
Liaaen & Vik	2019	Becoming an enabler of everyday activity: Health professionals in home care services experiences of working with reablement	Qualitative	Professionals	Persons home	Reablement	Norway
Magne & Vik	2020	Promoting Participation in Daily Activities Through Reablement: A Qualitative Study	Qualitative	older people	Persons home	Reablement	Norway
Maxwell, et al	2021	Staff Experiences of a Reablement Approach to care for older people in a regional Australian community :A qualitative study	Qualitative	Professionals	Persons home	Reablement	Australia
Metzelthin et al	2020	Development of an internationally accepted definition of reablement: a Delphi study	Quantitative	Professionals	Persons home	Reablement	Netherland
Mjøsund, et al.	2021	Promotion of Physical Activity Through Reablement for Older Adults: Exploring Healthcare Professionals' Clinical Reasoning	Qualitative	older people	Persons home	Reablement	Norway
Moe & Brinchmann	2018	Tailoring reablement: A grounded theory study of establishing reablement in a community setting in Norway	Qualitative	Professionals	Persons home	Reablement	Norway
Parsons, et al	2013	A Randomized Controlled Trial to Determine the Effect of a Model of Restorative Home Care on Physical Function and Social Support Among Older People	Quantitative	older people	Persons home	Reablement	New Zealand
Parsons, et al	2017	Randomised trial of restorative home care for frail older people in New Zealand	Quantitative	older people	Persons home	Reablement	New Zealand
Pettersson, et al	2022	Enabling social participation for older people: The content of reablement by age, gender, and level of functioning in occupational therapists' interventions.	Quantitative	Professionals	Persons home	Reablement	Sweden
Rooijackers, et al (a)	2021	Effectiveness of a reablement training program for homecare staff on older adults' sedentary behavior: A cluster randomized controlled trial	Quantitative	Older people	Persons home	Reablement	Netherland
Rooijackers, et al (b)	2021	Process evaluation of a reablement training program for homecare staff to encourage independence in community-dwelling older adults	Mixed Methods	professionals	Persons home	Reablement	Netherland
Rooijackers, et al	2022	Effectiveness of a Reablement training programme on self -efficacy and outcome expectations regarding client activation in homecare staff a randomised control Trial	Quantitative	Professionals	Persons home	Reablement	Netherland
Smeets, et al	2018	Experiences of home-care workers with the 'Stay Active at Home' programme targeting reablement of community-living older adults: An exploratory study	Qualitative	Professionals	Persons home	Reablement	Netherland
Tuntland, et al	2015	Reablement in community dwelling older adults: a randomised controlled trial	Quantitative	older people	Persons home	Reablement	Norway
Whitehead, et al	2016	Occupational Therapy in HomEcare Re-ablement Services (OTHERS): results of a feasibility randomised controlled trial	Quantitative	Adults	Persons home	Reablement	UK
Winkle, et al	2015	Reablement in a community setting	Quantitative	Adults	Persons home	Reablement	Norway

Appendix 4 Systematic review data base hits.

Data base	"Occupational thera*" and ("reablement" or "rehabilitation" or "restorative") and ("RCT" or "randomised control trial")	"Occupational thera*" and ("reablement" or "rehabilitation" or "restorative") and ("home care" or "home care provider") and ("RCT" or "Randomised control trial")	("reablement" or "restorative") and ("RCT" or "randomised control trial")
Amed	3	0	0
Assia	309	111	64
BNI	1	0	0
CINHIL	19	1	15
EMBASE	66	1	76
EMCARE	20	0	33
HMIC	0	0	0
Medline	26	0	49
PsycINFO	5	0	5
PubMed	1	0	2
NuSearch	0	8	26
Google Scholar	4	0	275
Web of science	45	0	61
NICE Healthcare Databases	141	2	180

Appendix 5 Systematic review included and excluded studies.

The included studies are green, excluded studies red, yellow are published protocols for RCT that might meet the inclusion criteria once results are published.

Author and Year	include	RCT	Consenting Adult Over 18	Receiving Homecare service	Occupational therapy interventions	Intervention delivered in Persons Home setting	Diagnosis of dementia	Diagnosis of Palliative or end of life
Stewart (2005)	no	yes	yes	no	yes	yes	not reported	not reported
Gitlin (2006)	no	yes	yes	no	yes	yes	yes (mms* >24)	no
Gitlin (2009)	no	yes	yes	no	yes	yes	yes (mms>23)	not reported
Claire (2009)	no	yes	yes	no	yes (great cognitive rehabilitation)	yes	yes (mms >18)	no
Gitlin (2010)	no	yes	yes	no	yes	yes	yes(mms >24)	no
Page (2011)	no	yes	yes	no	yes (ADL mental practice)	yes	no	no
Voigt-Radloff (2011)	no	yes	yes	no	yes	yes	yes (mms 14 to 24)	no
Sheffield (2013)	no	yes	yes	yes	yes (aging in place)	yes	no	no
King (2012)	yes	yes	yes	yes	yes (goal setting and ADL practice)	yes	no	no
Parsons (2013)	yes	yes	yes	yes	yes (target goal setting)	yes	no	no
Lewin (2013)	yes	yes	yes	yes	yes (hip)	yes	no	no
Burton (2013)	yes	yes	yes	yes	yes (life ADL exercises)	yes	no	no
Cameron (2013)	no	yes	yes	no	no (frailty)	yes	no	no

Senior (2014)	no	yes	yes	yes	no (case management and restorative home care)	no	no	not reported
Tuntland (2015)	yes	yes	yes	yes	yes	yes	no	no
Fairhall (2015)	no	yes	yes	no	no	yes	no	no
Whitehead (2016)	yes	yes	yes	yes	yes	yes	no	no
Parsons (2017)	no	yes	no (proxy consent by next of kin)	yes	no (comprehensive geriatric assessment with goals)	yes	yes	no
Kessler (2017)	no	yes	yes	no (6% receiving home care)	yes (coaching)	yes	no	not reported
Schwartz (2017)	no	yes	yes	no	no (medication)	yes	not reported	not reported
Chiung-ju (2017)	no	yes	yes	no	yes (3 step ADL workout)	yes	no	no
Yoshida (2018)	no	yes	yes	no	yes(skill balance)	no	no	no
Metzelthin (2018)	no	RCT protocol	yes	yes	yes (stay active at home)	yes	no	no
Szanton (2019)	no	yes	yes	no	yes (capable)	yes	no	No
Hattori (2019)	yes	yes	yes	yes	yes (commit)	yes	no	no
Bergostrom (2019)	no	feasibility for RCT	yes	yes	yes(assist1:0)	yes	no	no
Han (2020)	yes	yes	yes	no	yes	yes	no	no
Jeon (2020)	no	yes	yes	yes	yes	yes	yes (mms 16 to 30)	no

*mms= Mini Mental Score 0 to 17 is severe cognitive impairment

Appendix 6 Primary and secondary outcome results.

Primary Outcomes							
Outcome	**study**	**n=**	**t=**	**Illustrative comparative risks (95% CI)**		**Relative effect: odds ratio (95% CI) and p value**	**Certainty of evidence (GRADE)***
				Assumed risk (intervention)	Corresponding risk (control)		
No ongoing care services	Lewin et al (2013)	750	3m	103/375 (27.5%)	238/375 (63.5%)	Odds ratio 1.18 (0.13 to 0.26) p<0.001	⊕⊕◯◯ LOW upgraded to ⊕⊕⊕◯ MODERATE
		750	12m	67/375 (17.9%)	151/375 (40.3%)	Odds ratio 0.22 (0.15 to 0.32) p<0.001	⊕⊕◯◯ LOW upgraded to ⊕⊕⊕◯ MODERATE
No ongoing care services	Hattori et al (2019)	375	4m	21/190 (11%)	7/185 (3.8%)	Odds ratio 7.3 (2.0 to 12.5) p=0.007	⊕⊕⊕◯ MODERATE
Change in functional ability	Sheffield et al (2012)	90	3m	Coefficient (standard error) -2.14 (2.03)	Constant Coefficient (standard error) 28.44 (8.76)	P=0.15	⊕⊕⊕◯ MODERATE
Change in functional ability	Burton et al (2013)	80	2m	Mean (SD) 7.51 (5.98)	Mean (SD) 4.04 (3.32)	95% confidence interval 3.5 (1.25 to 5.70) and p=0.003.	⊕⊕⊕◯ MODERATE
Change in functional ability	Tuntland et al (2015)	61	3m	Mean (95% CI) 6.9/31(6.1 to 7.8) *COPM Scale 1 to 10 (highest best)	Mean (95% CI) 5.5/30 (4.7 to 6.3)	Mean difference (95%CI) 1.5 (0.3 to 2.8) p= 0.02 Adjusted effect size= 0.8	⊕⊕⊕⊕ HIGH
			9m	Mean (95%CI) 6.3 (5.0 to 7.6) *COPM Scale 1 to 10 (highest best)	Mean (95%CI) 4.8 (4.1 to5.5)	Mean difference (95%CI) 1.4 (95%CI 0.2 to 2.7) p= 0.03 Adjusted effect size=0.7	⊕⊕⊕⊕ HIGH
Change in health-related quality of life	Sheffield et al (2012)	90	3m	Coefficient (standard error) 0.08 (0.04) * EQ5D	Constant Coefficient (standard error) 0.19 (0.10)	P=0.3	⊕⊕⊕◯ MODERATE

Change in health-related quality of life.	King et al (2012)	186	4m	Mean (SE) Total:57.8 (1.2) SF36 PCS: 46.3 (1.2) SF36MCS: 65.7 (1.3)	Mean (SE) Total: 57.6 (1.5) SF36 PCS: 45.9 (1.6) SF36MCS: 65.7 (1.5)	NOT REPORTED	⊕⊕⊕⊕ HIGH
			7m	Mean (SE) Total: 59.5 (1.4) SF36 PCS: 46.4 (1.5) SF36MCS: 67.7 (1.4)	Mean (SE) Total: 57.7 (1.4) SF36 PCS: 45.4 (1.5) SF36MCS: 66.4 (1.4)	Mean difference (95%CI) and p value Total: 3.8 (0.0 to 7.7) P=0.05 SF36 PCS: 2.6 (-1.5 to 6.6) P=0.22 SF36 MCS: 4.2 (0.0 to 8.4) P=0.05	⊕⊕⊕⊕ HIGH
Change in health-related quality of life.	Parsons et al (2012)	205	6m	Least mean squared (SE) Total: 61.92 (3.32) SF36 PCS: 54.04 (3.52) SF36MCS: 63.46 (3.31)	Least mean squared (SE) Total:55.45 (3.10) SF36 PCS: 51.31 (3.42) SF36MCS: 58.52 (3.10)	P value Total <0.0001 SF36 PCS: p=0.0002 SF36MCS: p=0.0003	⊕⊕⊕⊕ HIGH
Change in functional mobility	Burton et al (2013)	80	2m	Mean (SD -0.55 (0.53)	Mean (SD) -0.29 (0.68)	95% confidence interval (-0.56 to -0.03) P=0.083	⊕⊕⊕◯ MODERATE
Change in fear of falling	Sheffield et al (2012)	90	3m	Coefficient (SE) -2.22 (1.29) *FES	Constant Coefficient (SE) 7.13 (3.30)	P value P<0.05	⊕⊕⊕◯ MODERATE
Change in Education	Sheffield et al (2012)			Coefficient (SE) -15.87 (2.07) *SAFER-HOME	Constant Coefficient (SE) 4.49 (5.18)	P value P<0.0005	⊕⊕⊕◯ MODERATE
Primary: Aspects of feasibility	Whitehead et al (2016)	30	3m			Average OT Visit = 5 Average time= 45 mins. 50/106 met the eligibility criteria. consent rate was 60% of those eligible.	Not graded as a feasibility of design outcome

Secondary Outcomes							
Outcome	**study**	**n=**	**t=**	**Illustrative comparative risks (95% CI)**		**Relative effect: odds ratio (95% CI) and p value**	**Certainty of evidence (GRADE)***
				Assumed risk (intervention)	Corresponding risk (control)		
Change in functional ability	King et al (2012)	186	4m	Mean (SE) 44.3/93 (0.9)	Mean (SE) 45 /93 (1.0)	NOT REPORTED	Not assessed
		186	7m	Mean (SE) 44.2/93 (1.0)	Mean (SE) 44.4/93 (1.1)	Difference (SE) (95%CI) and p value 0.3 (-1.4 to 2.1)	⊕⊕⊕⊕ HIGH
Change in functional ability	Lewin et al (2013)	150	3m	Not reported	Not reported	Odds ratio 1.02 (0.95 to 1.09) P=0.529	⊕⊕◯◯ LOW
		150	12m	n=100 (%) ADL and IADL functional outcome results based on completed data: * not intent to treat analysis	n= 98(%)	Odds Ratio 1.08 (1.00 to 1.17) p=0.048	⊕⊕◯◯ LOW
Change in functional ability	Whitehead et al (2016)	30	3m	Median (SE) Not reported	Median (SE) Not reported	Median difference (SE) (95% CI) 3.72 (4.58) (CI−5.83 to 13.27) *NEADL scale: 0–66 (highest best) −0.13 (1.33) (CI −2.91 to 2.65) *Barthel index scale 0-20(highest best)	⊕⊕⊕⊕ HIGH
Change in functional ability	Whitehead et al(2016)	30	6m	Median (SE) Not reported	Median (SE) Not reported	Median difference (SE) (95% CI) *NEADL scale: 0–66 (highest best) 1.58 (5.28) −9.47 to 12.64 *Barthel index scale 0-20(highest best) 0.28	⊕⊕⊕⊕ HIGH

						(1.12) −2.06 to 2.61	
Change in functional ability	Hattori et al (2019)	375	4m	n= (%) ind=3/46 (6.5%) dep=9/58 (15.5%) dep in 2 or more=9/86 (10.5%)	n= (%) Ind=1/44 (2.3%) dep =1/60 (1.7%) dep in 2 or more=5/81 (6.2%)	n=difference % (95%CI) *binary Scale ind=4.2 % (-4.1 to 12.6) dep =13.9% (4.0 to 23.7) dep in 2 or more= 4.3 % (-4.0 to 12.6)	⊕⊕⊕○ MODERATE
Change in quality of life	Tuntland et al (2015)	61	3m	mean (95%ci) *Coop/Wonka scale 1 to 5 (highest best) daily activities: 2.7 (2.3 to 3.1)	Mean (95%CI) 2.9 (2.5 to 3.2)	Mean difference (95%CI) -0.4 (-0.9 to 0.2) p=0.21	⊕⊕⊕⊕ HIGH
Change in quality of life	Tuntland et al (2015)	61	6m	mean (95%ci) *Coop/Wonka scale 1 to 5 (highest best) daily activities: 2.5 (2.0-3.0)	mean (95%ci) 2.8 (2.3-3.2)	Mean difference (95%CI) −0.4 (−0.3-0.5) p=0.22	⊕⊕⊕⊕ HIGH
Change in quality of life	Whitehead et al (2016)	30	3m	Median (SE) Not reported /15	Median (SE) Not reported /15	Median difference (SE) (95% CI) ** EQ5D (scale: −0.11 to 1) −0.03 (0.15) −0.35 to 0.28 ASCOT (scale: 0–1): 0.06 (0.11) −0.18 to 0.30 SF-36 PCS (scale: 0–100): 1.52 (4.75) −8.43 to 11.47 SF-36 MCS (scale: 0–100): 7.84 (3.17)1.17 to 14.51* *(1 outlier removed) ** all scales highest best	⊕⊕⊕⊕ HIGH
Change in quality of life	Whitehead et al (2016)	30	6m	Median (SE) Not reported /15	Median (SE) Not reported /15	Median difference (SE) (95% CI) ** EQ5D (scale: −0.11 to 1) 0.23 (0.22) −0.23 to 0.69 ASCOT (scale: 0–1): 0.04	⊕⊕⊕⊕ HIGH

						(0.10) −0.17 to 0.25 SF-36 PCS (scale: 0–100): 0.09 (5.33) −11.06 to 11.24 SF-36 MCS (scale: 0–100): 3.39 (4.90) −6.88 to 13.66 ** all scales highest best	
Change in functional mobility	King et al (2012)	186	4m	Mean (SE) 22.3 (1.1) *Timed up and go (in seconds)	Mean (SE) 22.3(2.0)	Mean difference (95%CI) and p value Not reported	⊕⊕⊕⊕ HIGH
Change in functional mobility	King et al (2012)	186	7m	Mean (SE) 22.6(1.5) *timed up and go (seconds)	Mean (SE) 22.4 (2.0)	Mean difference (SE) (95% CI) and p value -0.1(-4.2 to 4.1) P=0.98	⊕⊕⊕⊕ HIGH
Change in functional mobility	Parsons et al (2013)	205	6m	Least means squares +or- SE (95%CI) 6.8 +- 0.44 (6.3 TO 7.69)	Least means squares +or- SE (95%CI) 6.14+-0.52 (5.60 to 7.33)	Least means squares +or- SE (95%CI) p value P= 0.003	⊕⊕⊕○ MODERATE
Change in functional mobility	Tuntland et al (2015)	61	3m	Mean (95%CI) 19.6 (14.2 to 25.1) * timed up and go (in seconds)	Mean (95%CI) 17.9 (14.0 to 21.8)	Mean difference (95%CI) and p value -0.4(-4.4 to 3.5) P=0.82 Adjusted effect size=0.1	⊕⊕⊕⊕ HIGH
Change in functional mobility	Tuntland et al (2015)	61	9m	Mean (95%CI) *19.9 (14.7 to 25.0) * timed up and go (time in seconds)	Mean (95%CI) 18.1 (13.4 to 22.8)	Mean difference (95%CI) 0.3 (-3.7 to4.4) adjusted effect size= 0.88	⊕⊕⊕⊕ HIGH
Adverse effect	Hattori et al (2019)	375	3m	20/190 (10.5%)	16/185 (8.6%)	P=0.659	⊕⊕⊕○ MODERATE

n=number, t=time * The cumulative evidence synthesis was summarised to determine certainty of the evidence using the definitions established by GRADE (GradePro; 2020).

Appendix 7 The participant information sheet.

Study Title: The Independent Home-Based Care Reablement Study

PARTICIPANT INFORMATION SHEET

Research Ethics Reference: [ ]
Version 2.0 Date: 24/05/21

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. One of our team will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Please ask us anything that is not clear.

What is the purpose of the research?

The aim of this research is to investigate home carers understanding of reablement, their experience, views, and opinions, and to explore how new knowledge or understanding of reablement might impact or change their behaviours when they are working with people who receive home based care.

Why have I been invited to take part?

You are being invited to take part because you are an employed home carer, or you have experience of Adult Care Reablement Services. We are inviting 50 participants to take part.

To be included in the study you must be over 18 and under 67, able to consent to take part, and able to speak English. You must also work in a community setting for an independent homecare agency, or as an employed carer, or for Adult Care and have professional experience of reablement.

Unfortunately, if you are unable to speak or read English, or are unwilling to participate in the discussion session or if on the day you lack the mental capacity to consent to the discussion session, you would not be able to take part in the study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by letting the researcher know.

What will happen to me if I take part?

A researcher will contact you to go over the information sheet, explain the procedures, and go through a pre-screening with you to check if it is safe for you to participate. If you agree to take part in the study, you will be invited to come along to a one-off discussion session with around 6 other people who work in the home-based care profession, these may be your colleagues or work for a different agency.

The discussion session will last about 2 hours and will be held at a Nottinghamshire County Council venue that is local to your normal working area or home address, or online via MS teams if covid lockdown restrictions are in place.

The venue will have Covid social distancing rules in place for your health and safety, it has free car parking, accessible toilet facilities and refreshments will be provided. Please contact the me at cate.bennett@nottingham.ac.uk if you have any accessibility needs, or concerns e.g., require hearing loop or large print for forms.

If we do have to use Ms Teams, please ensure you are in a quiet and confidential space for the session, ideally free from distractions. If you need any technical ICT support to log into MS teams, please let me know on: cate.bennett@nottingham.ac.uk

Upon arrival, we will talk you through the study procedures and give you chance to ask any questions. If you are still happy to take part, then you will then be asked to sign a consent form.

You will be asked to complete a brief evaluation of your knowledge and confidence about reablement and a standard questionnaire on your demographic profile, name, age, gender, and ethnicity. You will also be asked for the name of the company that you work for and how long you have been working as a home carer.

During the discussion, you will be asked about your views and experience of reablement and given the opportunity to engage in free-flowing conversation on the topic of reablement with the researcher and the other participants. The researcher will audio record the conversations and collect this data for the study. The data collected will be anonymised and kept on a secure computer drive for a minimum of 7 years.

The study outcomes will be shared with you, Adult Care commissioners, and at Independent Home-Based Care provider forums. The study will be presented at conferences and published in peer reviewed academic journals and will also be used by other researchers for reference in the future.

What is a Focus Group?

A Focus Group is a discussion session about a topic, everyone`s views are heard, and no view is more important than another. When we use this conversational style, we generate new thought and ideas from each other.

Are there any risks in taking part?

There is little risk to taking part in this study, your contribution to this research is highly valued, and as such, every effort will be taken to ensure that participating is a positive experience. Confidentiality must be respected, and we ask you to only refer to people you work with by their first name to protect their identity.

A common concern is what If someone makes a disclosure about unsafe or unethical practice during the conversations? If this happens, the researchers will discuss in their own professional and academic supervision and will follow their organisations policy and procedures for reporting, if necessary.

The researcher will be available at the end of the session should any participant want any support, guidance, or further conversations.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research, but your contribution may help influence the type and methods of training that home carers receive. It is hoped that the public will benefit from the study, as research and evidence-based practice can shape service delivery.

Will my time/travel costs be reimbursed?

Participants will not be paid to participate in the study. Travel expenses will not be offered for any visits incurred because of participation, but every effort will be made to hold the sessions at venues that are local to the participants place of work or home address.

What happens to the data provided?

The conversations we have will be audio recorded, and then stored securely on Microsoft 365 one drive, for a minimum of 7 years. The research data will be stored confidentially using a code, transcribed into text, and analysed. We would like your permission to use fully anonymised direct quotes in research publications. The researchers will then evaluate the results in the context of existing research on the topic of reablement. The results of the study can be shared with you if you would like to give the researcher your contact details, these details not be accessible to anyone other than the researcher and will be stored separately to the research data.

The researcher intends to share the results at community-based forums, conferences and to publish the results in a journal article for other people to learn from this work.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research. We would like your permission to use anonymised data in future studies, and to share our research data (e.g., in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public. Data sharing in this way is usually anonymised (so that you could not be identified)

What will happen if I do not want to carry on with the study?

Even after you have signed the consent form, your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally identifiable information possible. It helps us, if you do decide to withdraw from the study, that you let the us know as soon as possible.

Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. Any audio digital recordings and electronic data will be anonymised with a code as detailed above. Electronic storage devices will be encrypted while transferring and saving all sensitive data generated during the research. All such data are kept on password-protected databases sitting on a restricted access computer system and any paper information (such as your consent form, contact details and any research questionnaires) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (Pip Logan) is the Data Custodian (manages access to the data).

You can find out more about how we use your personal information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

With your consent, we will keep your personal information on a secure database to contact you for future studies.

Although what you say to us in the focus group is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons. Reporting serious and unexpected events, including any safeguarding disclosures or illegal activity will be responsibility of the researcher, and will be responded to in line with the law, Nottingham University and Adult Care policies and procedures.

What will happen to the results of the research?

The research will be written up as a PhD thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

In addition to this, the studies reported results will be shared as a report with various interested parties, such as: the study funder, National Institute of Health Research; Adult Care; Home Care Provider Network; Independent Home-Based Care providers, and Royal College of Occupational Therapy (professional body). Results can support the continuous improvement of ongoing services, therefore will be presented at conferences orally, with written abstract and by poster presentations, in addition to published peer reviewed academic articles

Who has reviewed this study?

All research involving people is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Nottingham University Research Governance Team.

Who is organising and funding the research?

This research is being organised by the Principle investigating officer Pip Logan from University of Nottingham. The PhD student is being funded by National Institute of Health Research through the ARC workstream (Building Independence and Community Resilience).

What if there is a problem?

If you have a concern about any aspect of this study, please speak to the researcher, investigating officer Cate Bennett or Principal investigating officer Pip Logan, who will do their best to answer your query. The researcher should acknowledge your concern and give you an indication of how she intends to deal with it.

If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine, and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk. Please quote ref no: FMHS xx-xxx

In addition to this, the normal Adult Care complaints mechanisms will also be available by contacting: compliants@nottscc.gov.uk

Contact Details:

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Investigating officer (PhD Student): cate.bennett@nottingham.ac.uk

Investigating officer: frances.allen@nottingham.ac.uk

Principle investigating officer: pip.logan@nottingham.ac.uk

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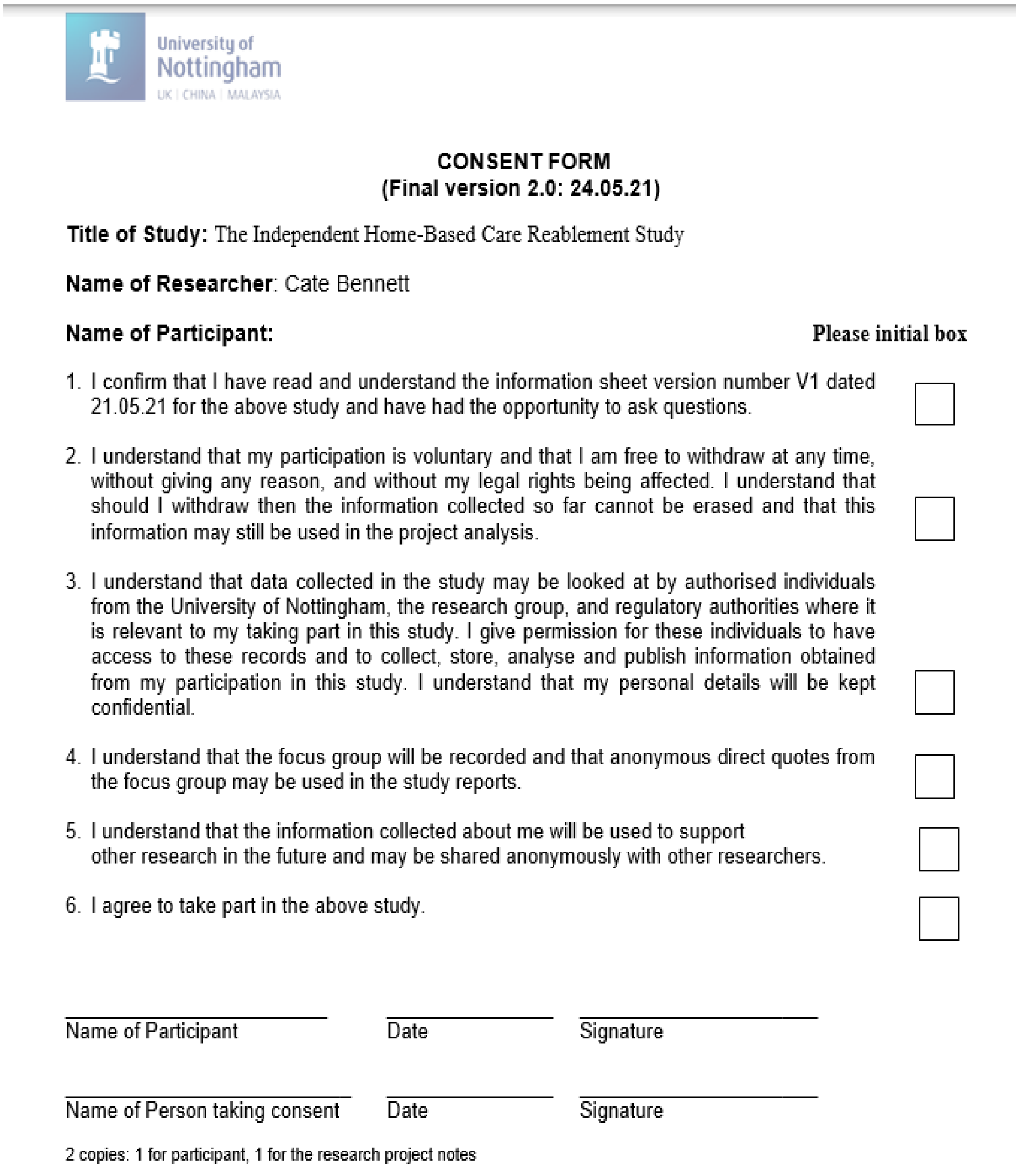
Appendix 8 The consent form.



University of
Nottingham
UK | CHINA | MALAYSIA

CONSENT FORM
(Final version 2.0: 24.05.21)

Title of Study: The Independent Home-Based Care Reablement Study

Name of Researcher: Cate Bennett

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number V1 dated 21.05.21 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group, and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the focus group will be recorded and that anonymous direct quotes from the focus group may be used in the study reports. ☐
5. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐
6. I agree to take part in the above study. ☐

____________________ ____________ __________________
Name of Participant Date Signature

____________________ ____________ __________________
Name of Person taking consent Date Signature

2 copies: 1 for participant, 1 for the research project notes

Appendix 9 The interview and focus group questions.

Interview and focus group questions

Welcome:
Introduce self and the study, check that everyone has had a copy of the information letter, collect in consent forms and participant demographics survey. Explain people can withdraw from the study if they chose to OR if they would like to continue to participate after this study, leave their email and phone number. Explain the venue housekeeping, toilets, drinks etc. Explain the confidentiality rule- "what is said in the room… stays in the room." Introduction and ice breaker question: name and favourite chocolate bar or snack

1. **What skills and competencies do YOU value as a carer?**
    - Please think about your skills and competencies as a carer. Which of your skills and competencies do you like doing the most, and least, and why?
    - What do you think is the reason for this? What has caused this?
    - Can you give me an example? Can you expand so that I understand?
    - Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? What is easier for you? What is harder for you? What could you do differently?
2. **What experience do YOU have of someone practicing and mastering a skill?**
    - Tell me about a time you have realised someone is trying to do something for themselves, what happened?
    - What do you think is the reason for this? What has caused this?
    - Can you give me an example? Can you expand so that I understand?
    - Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? What is easier for you? What is harder for you? What could you do differently?
3. **What does "reablement" mean to you?**
    - I am interested to know about what reablement means to you. Have you experienced reablement, what happened?
    - What do you think is the reason for this? What has caused this?
    - Can you give me an example? Can you expand so that I understand?
    - Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? What is easier for you? What is harder for you? What could you do differently?
4. **What do YOU think about prevention or reducing the need for care?**

- I am interested to know your thoughts about prevention or reducing care? What comes into your mind?
- What do you think is the reason for this? What has caused this?
- Can you give me an example? Can you expand so that I understand?
- Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? What is easier for you? What is harder for you? What could you do differently?

5. **What value do YOU place on your knowledge of reablement, independence and prevention?**
    - When you think about reablement, independence and prevention, what comes into your mind?
    - What do you want to do as a result? What do you think is the reason for this? What has caused this?
    - Can you give me an example? Can you expand so that I understand?
    - Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? what is easier for you? What is harder for you? What could you do differently?

6. **What experience of Occupational Therapy interventions do YOU have?**
    1. I am interested to find out your experience of occupational therapy, have you ever worked with an OT? What happened?
    2. What do you think is the reason for this? What has caused this?
    3. Can you give me an example? Can you expand so that I understand?
    4. Prompt: you mentioned this, but have you thought about that? What about the: care coordinator, family, manager, colleague? what is easier for you? What is harder for you? What could you do differently?

How feasible is it to roll out ACT reablement competency training to independent home-based care agencies?

1. **What is the best time of day and why?**
2. **Where is the best place?**
3. **How long should the session be?**
4. **How often should the sessions run?**
5. **How do you like to learn?**

De brief:
Thank everyone for attending and contributing to the study. Please take some time to reflect on our conversations today, I will stay behind should anyone with to talk some more about their experiences. The participant should never be left in an anxious or emotionally vulnerable state, the researcher will ensure additional time is given at the end of the focus group if the participant wishes, following up at an agreed time point if required.

Appendix 10 The demographic survey questions.

The independent home-based care reablement study demographic characteristics survey

What is your age group?

Under 18

18-24

25-34

35-44

45-54

Above 55

Which gender do you identify most with?

Male

Female

Do not want to say

Which ethnic group describes you?

White

English, Welsh, Scottish, Northern Irish or British

Irish

Gypsy or Irish Traveller

Any other White background

Mixed or Multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed or Multiple ethnic background

Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

    Any other Asian background

    Black, African, Caribbean, or Black British

    African

    Caribbean

    Any other Black, African, or Caribbean background

    Other ethnic groups

    Arab

    Any other ethnic group

What is your current employment status?

    Full-time employment

    Part-time employment

Are you?

    A Student

    Retired

    Have another job

How long have you been working in the caring profession?

    Less than 3 months

    3 to 6 months

    6 months to 1 year

    1 to 2 years

    3 to 5 years

    6 to 10 years

    11 years plus

Appendix 11 The before and after training survey.

Before training survey

Name:

Employer:

Date of training:

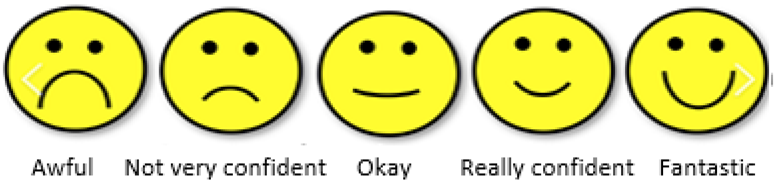
1. How clear are you about the difference between the purpose of reablement versus standard home care?

Awful Not very clear Okay Really clear Fantastic

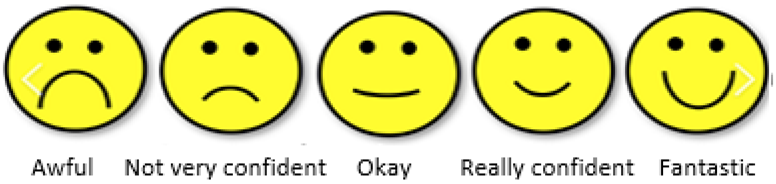
2. How would you rate your confidence in **<u>challenging</u>** a reluctant individual with their reablement?

Awful Not very confident Okay Really confident Fantastic

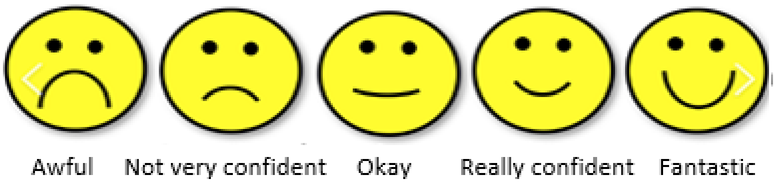
3. How would you rate your confidence in **<u>motivating</u>** a reluctant individual with their reablement?



4. How would you rate your confidence in **<u>identifying</u>** that someone is improving in their abilities?



5. How would you rate your confidence in **<u>feeding back</u>** to the Occupational Therapist?



After Training survey

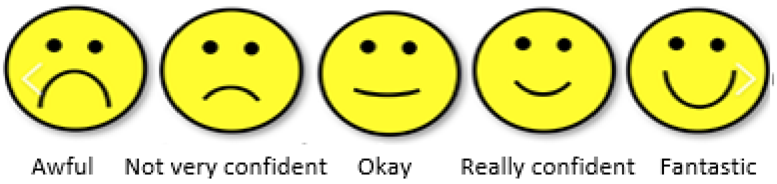
Name:

Employer:

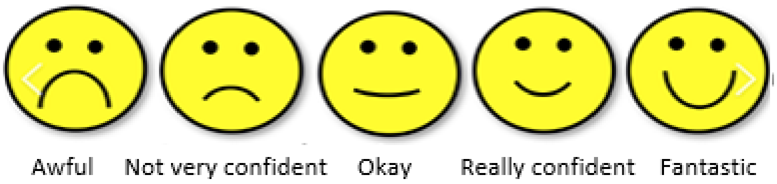
Date of training:

1. How clear are you about the difference between the purpose of reablement versus standard home care?

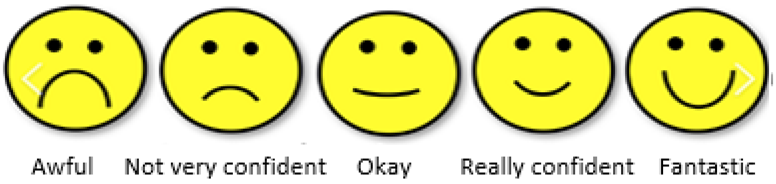
2. How would you rate your confidence in **challenging** a reluctant individual with their reablement?



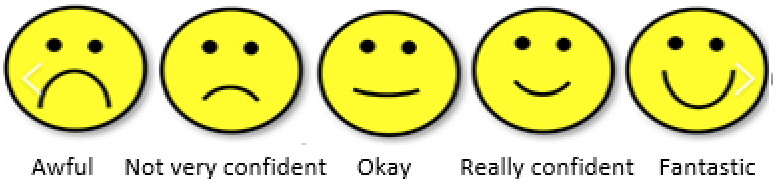
3. How would you rate your confidence in **motivating** a reluctant individual with their reablement?



4. How would you rate your confidence in **<u>identifying</u>** that someone is improving in their abilities?



5. How would you rate your confidence in **<u>feeding back</u>** to the Occupational Therapist?

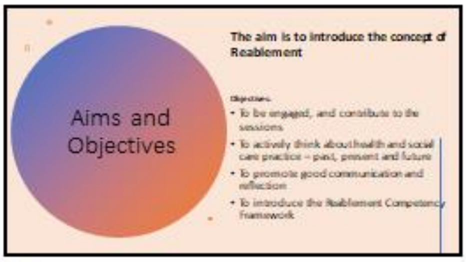


Appendix 12 ACT reablement training content.

Session 1: Transforming our practice (slides 1 to 18).

ACT Reablement Competency Training:

Transforming our Practice: session 1



Aims and Objectives

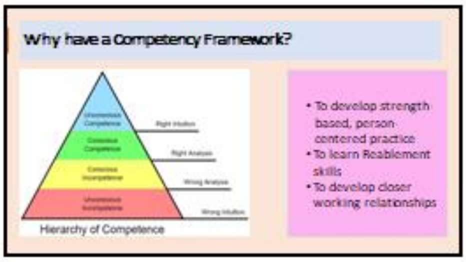
The aim is to introduce the concept of Reablement

Objectives.

- To be engaged, and contribute to the sessions
- To actively think about health and social care practice – past, present and future
- To promote good communication and reflection
- To introduce the Reablement Competency Framework

What is Reablement?

- What does Reablement mean to you?
- What experiences do you have of Reablement?



Why have a Competency Framework?

- To develop strength based, person centered practice
- To learn Reablement skills
- To develop closer working relationships

What is the Reablement Competency Framework?

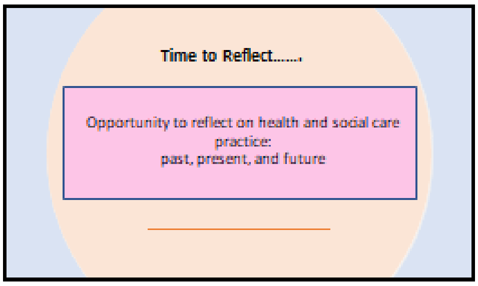
OBSERVATIONS

KNOWLEDGE

BEST PRACTICE

What is Reflection?

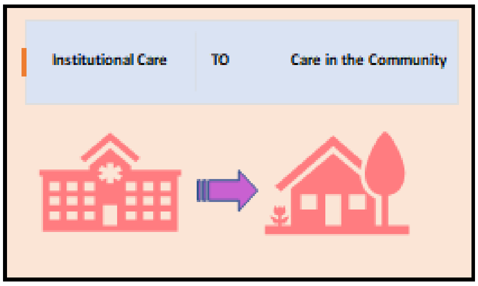
- How do I feel?
- How might others feel?
- Are my feelings affecting my behaviour?
- Can I do things differently next time ?



Time to Reflect…….

Opportunity to reflect on health and social care practice:
past, present, and future

7

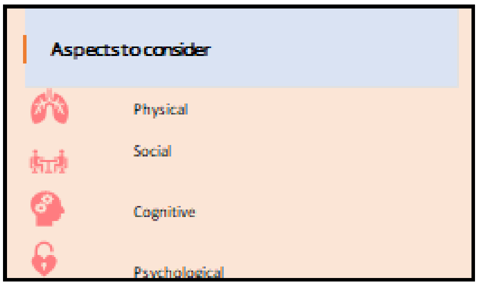


Institutional Care TO Care in the Community

8

Existing or Living?

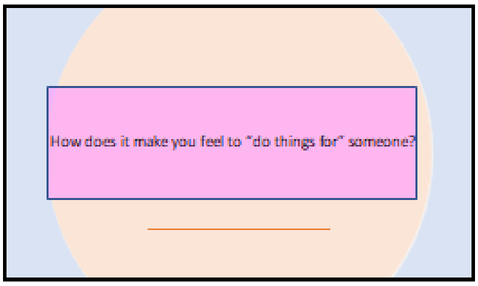
9



Aspects to consider

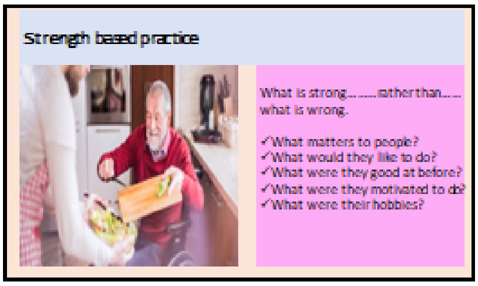
- Physical
- Social
- Cognitive
- Psychological

10



How does it make you feel to "do things for" someone?

11



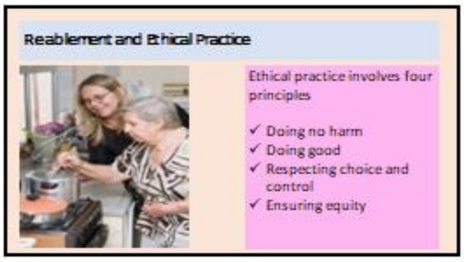
Strength based practice

What is strong……..rather than……. what is wrong.

✓What matters to people?
✓What would they like to do?
✓What were they good at before?
✓What were they motivated to do?
✓What were their hobbies?

12

13

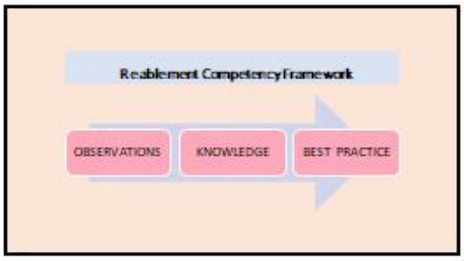


Reablement and Ethical Practice

Ethical practice involves four principles

- ✓ Doing no harm
- ✓ Doing good
- ✓ Respecting choice and control
- ✓ Ensuring equity

14



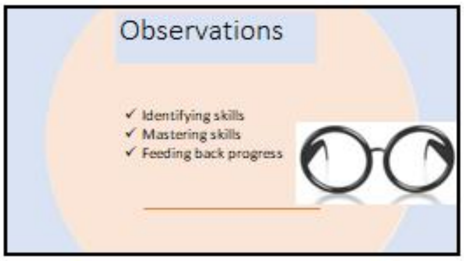
Reablement Competency Framework

OBSERVATIONS

KNOWLEDGE

BEST PRACTICE

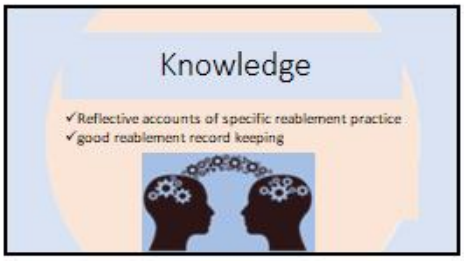
15



Observations

- ✓ Identifying skills
- ✓ Mastering skills
- ✓ Feeding back progress

16



Knowledge

- ✓Reflective accounts of specific reablement practice
- ✓good reablement record keeping

17

Questions and Answers

18

Firstly, the facilitator initiated an open discussion. The intention was to explore the experience home carers have of reablement, and the key line of enquiry was:

- What does reablement mean to you?
- What happened?
- What did they think was the reason for this?
- What caused this?

Next, the competency framework booklet was handed out with explanations about the scope of the action learning sets as an alternative to formal training, an ongoing supportive reflective learning space where they will be given more time and support from occupational therapists both face-to-face and by phone, with case discussions that will focus on the current people they are working with and therefore be more relevant. Each aspect of the reablement competency framework was explained to the home carers further.

Reflection was described, and four simple reflective questions were used as a tool for learning: How do I feel? How might others feel? Are my feelings affecting my behaviour? Can I do things differently next time?

The reflective learning activity that followed, facilitated thinking about how it makes you feel to “do things for” someone, and have things done for you. This is activity is used to explain the difference between traditional care and the reablement ethos and demonstrates how health and social care practice has changed over the years, how care has been transformed.

Strength-based practice means an emphasis on people's self-determination and strengths; people are resourceful and resilient in the face of adversity (Department of Health and Social Care, 2019). As this concept is presented to home carers, they are encouraged to focus on what is strong, not what is wrong when they work with people. Promoting questions were used to help the home carers practice engaging in a strength-based conversational style: What matters to you? What would you like to do? What are you good at? What are you motivated to do? What are your hobbies?

Next came a learning activity, involving critically appraising and discussing video content to explore physical, social, cognitive, and psychological impact of traditional care versus reablement, prepared handouts were used to record their ideas. The videos were LiveNotExist - Fred's Story - YouTube (RCOT, 2017) and Prevention: reablement | SCIE (SCIE, 2016a).

Session 2: Person-centred reablement and identity (slides 1 to 18).

ACT Reablement Competency Training

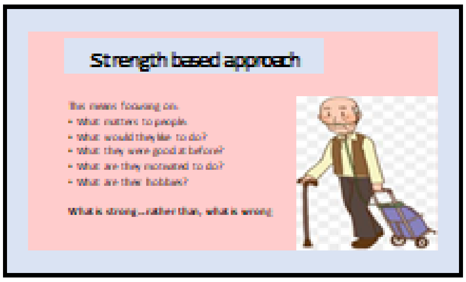
Person- Centred Reablement and Identity : Session 2

Aims and Objectives

What makes us unique
Dignity and Respect
Choice and control
Strengths based approach

Person centred care

- The whole person
- Their needs and wants
- How they want things done



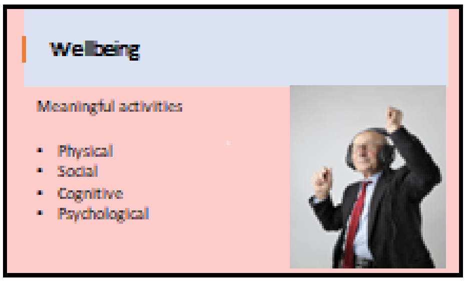
Strength based approach

This means focusing on:
- What matters to people
- What would they like to do?
- What they were good at before?
- What are they motivated to do?
- What are their hobbies?

What is strong....rather than, what is wrong

Your Influence

Can change an individual's:
- View of themselves
- Level of control in their life
- Ability to achieve their potential
- Ability to achieve their aspirations and goals
- Quality of life, motivation, confidence and mood



Wellbeing

Meaningful activities

- Physical
- Social
- Cognitive
- Psychological

Goals and aspirations

- Goals are unique to each person
- They motivate us
- Give us strength in times of adversity
- Help us reach our full potential
- Achieve better outcomes

Desert Island Activity

A famous person
Some music
A tv program or film

Can we guess the person from the choice?

What influenced our choices?

Identity

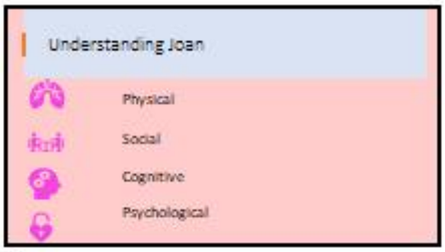
- How we see ourselves
- How others see us

HENRY

Positively supporting an individual's identity can.....
- Improve quality of life
- Improve choice and control
- Improve motivation
- Improve confidence
- Improve mood

Empathy
Putting ourselves in others shoes

13



Understanding Joan

- Physical
- Social
- Cognitive
- Psychological

14

How might Joan see herself?

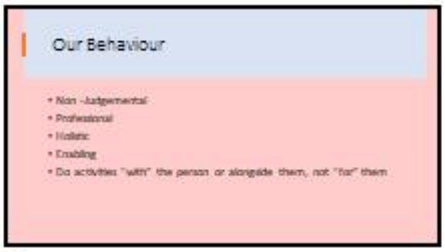
- Physical
- Social
- Cognitive
- Psychological

15

Physical
Social
Cognitive
Psychological

16

17



Our Behaviour

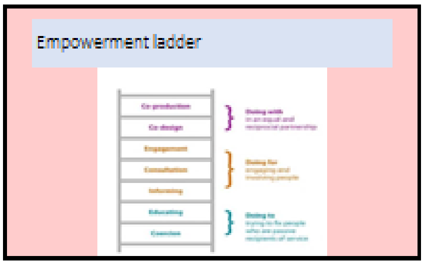
- Non -Judgemental
- Professional
- Holistic
- Enabling
- Do activities "with" the person or alongside them, not "for" them

18

Reablement : Empowering people

- To redefine their identity
- To identify and aspire to achievable goals
- Educating them and their family
- Giving information and advice for the future

19



Empowerment ladder

20

Reablement : Our Role

- An enabling care worker
- Adaptable to each person we work with
- Proactive, recognising and acting when people are improving
- Empowered and valued in our work

21

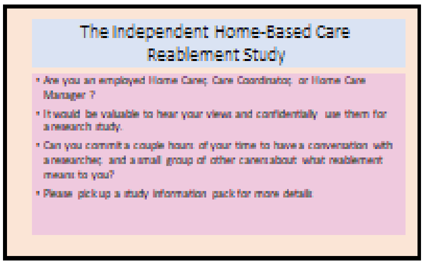
Adult Care Reablement Service

22

The Reablement ethos

- Strength based approach
- Choice and control
- The whole person
- Dignity, respect and inclusion
- Be active rather than passive
- Well being of the individual is central
- Living our best life

23



The Independent Home-Based Care Reablement Study

- Are you an employed Home Carer, Care Coordinator, or Home Care Manager ?
- It would be valuable to hear your views and confidentially use them for a research study.
- Can you commit a couple hours of your time to have a conversation with a researcher, and a small group of other carers about what reablement means to you?
- Please pick up a study information pack for more details

24

The second session aimed to explore how important identity and role are and how loss of these impact on wellbeing. The objective was to consider how changes to our physical, social, cognitive, and psychological self through illness or crisis can impact on the individual, and to show how using a strength-based approach can help us achieve person centered reablement. By encouraging the person to have confidence in themselves, they will gradually reach their previous levels of independence and regain their roles at home and in the wider community.

We used reflective discussions to help each other to understand people's uniqueness, the importance of them having choice and control, and how this enables people to live with dignity and respect. The home carers were asked to think about a person they work with, we used this as an empathy case study to help them understand the situation, and to practice encouragement and motivating others.

The home carers were told people can find more confidence if their home carer believes they can do something. They are asked to use this knowledge skilfully to influence positive change, so people can: change their view of themselves; have more control in their life; achieve their potential; achieve their aspirations and goals; have a better quality of life, motivation, confidence, and mood.

The focus of the next exercise was to use positive thinking, to be strength-based. The home carers were supported to think about their empathy case study differently: they are not a victim, not worthless, they are still a person, still useful and valued. They were asked to reflect on how this person's period of ill health or crisis might be making them feel, how the environment is impacting on them, or their ability to participate in activities that were important to them.

In doing this, the home carers were instructed to focus on what the person can do. If they can`t do an activity, can they do part of the task? Would equipment help, such as a long-handled sponge? And, when the person has practiced a skill, can they build on this to do more themselves?

Next, the home carers were introduced to the concept of wellbeing, and how reablement is about supporting people with their emotional and psychological wellbeing. Knowing when and how to reach out specialist services is explored through three examples.

- If you think someone is becoming low in mood they may need professional help, talk to them about speaking to their GP and tell your manager and the OT, who can speak to a friend or relative.

- Loneliness, community access for social integration and activities that will reduce social isolation is discussed.
- Environmental restrictions, if people cannot access the wider community, or are restricted to a one room existence they become occupationally deprived, recognise when to get expert help for people from the occupational therapist to adapt the environment or get them equipment.

Then the home carers were introduced to simple theory around why goals and aspirations, uniqueness, identity, and empathy are so important in reablement. They were told, goals are unique to each person. They motivate us and give us strength in times of adversity, help us to reach our full potential and achieve better outcomes. By positively supporting an individual’s identity we can improve their quality of life, choice and control, motivation, confidence, mood. By putting ourselves in others shoes we can empathise, and this helps us to be more person-centered in our work.

The next learning activities were a series of reflections and informal discussions. Each home carer was asked to identify one thing they enjoy doing for themself. Then reflect, if they had experienced a period on ill health, would doing this this be the goal to significantly improve their quality of life?

Then a reflective discussion around our own unique preferences, using a desert island theme where each home carer can take *a famous person*, *some music* and *television programme or film.* The purpose of this exercise was to reflect on the people we work with and appreciate their uniqueness because we can fall into a trap of making personality judgements based on our own view of the world.

The group discussion focused on two main points:

- How we can learn about people`s uniqueness through the personal stories they tell, what they read or watch on TV or listen to on the radio, photographs, and other Items in the property. Case files and records, relatives, friend, and neighbours accounts can also be informative.

- Identity is not just how we see ourselves with our fixed ideas originally formed in childhood, but also how our identity is affected by how other people see us, and how this can be influenced by relationships and communication with other people.

Next, the participants were asked to watch Henry's Story - YouTube (Music and Music and Memory, 2012). This video shows how person-centred care can change a person from being occupationally deprived and institutionalised, to an engaged person who interacts with the world around them.

The final Learning activity was an empathy case study, the home carers are asked to imagine they are Joan.

Case study:

Joan is 81 years old, her partner died 2 years ago. Her son lives 50 miles away. She has always led an active life, but in recent months has had to gradually reduce the frequency of her walks to the local shops. 3 weeks ago, she fell while out shopping and dislocated her shoulder. She was admitted to hospital where she was told she had a urine infection. On discharge from hospital, she was referred to reablement.

The occupational therapist asked the home carers to think about how Joan`s life has changed, how might others ‘see’ Joan. Joan may well see herself as the fit and healthy young woman she once was, a beautiful dancer, a wife, and a mum.

The home carers are asked to think about physical, social, cognitive, and psychological aspects, to identify what might Joan`s might be feeling.

Typically, the discussion included the following empathy responses and the occupational therapist prompted discussion where participants struggled.

- Physical: loss of ability, pain, fatigue, loss of muscle strength, loss of balance
- Social: loss of social contact, loss of roles, loss of control, challenge to health beliefs, chance to be independent again
- Cognitive: loss of concentration, confusion, agitated

- Psychological: worries about quality of life, worries about money, fears for the future, anxieties, delight at being home again

The home carers were challenged on their views of health and sickness and asked to think about how they need to adapt to everyone they work with to meet each persons needs and outcomes. They are asked to recognise reablement is a proactive home care service where carers recognise people's potential and react positively and effectively, for example purposefully responding to the office, requesting a review if two carers are not required as someone improves. They were asked to reflect on their role providing physical, social, emotional, and cognitive support.

The group were shown part two of the case study, how Joan visually presents to the reablement team is different to how she feels inside, and it is the home carers job to work with her holistically and with a reablement ethos.

Case study: Joan on the home carers first visit

Physical: avoiding doing some things, and more capable than current abilities allow for other things.

Social: old and needy, accepting of the change in social role and life, not wanting to spend money or go out into the community.

Cognitive: not able to make decisions, passive, difficult and unwilling to change.

Psychological: ignoring emotions related to recent experiences, tearful, unsure of what will happen.

The importance of engagement and communication with the informal carer and family, to establish the expectations of what will happen during and after reablement, and how they can support what the Home carer is doing, is shown using a video Role of carers and families (SCIE, 2016b).

Finally, the session was concluded with a summary about home carer`s role to enable behaviour change, and the value of advice for self -management. The occupational therapist explains the purpose of reablement is for home carers to help people identify aspirational goals and then work with them on the steps they can take to achieve those goals. By doing activities “with” the person or alongside them, not “for” them (Metzelthin et al, 2020), and using the occupational performance components physical, social, cognitive, and psychological, home carers can be holistic in their approach (law, et al 1996).

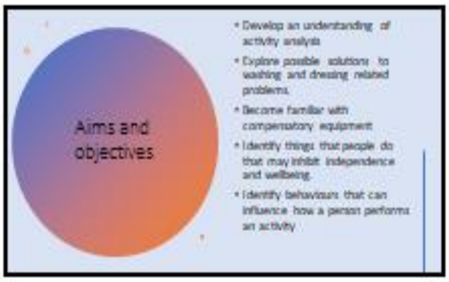
They were reminded they should support people to redefine their identity, reintroduce choice and control to their lives, reinforce how they should make the most of reablement, give information and advice to support and educate people and their family, being clear about what reablement is and is not.

The reablement ethos was explained again, a strength-based approach used to increase choice and control. The person is a unique individual, treated with dignity and respect. In reablement, the person is actively involved, rather than passive and their well-being of the individual is central so they can live their best life.

Session 3: Breaking the activity down (slides 1 to 22).

ACT Reablement Competency Training

Washing and dressing activity and skills : Session 3

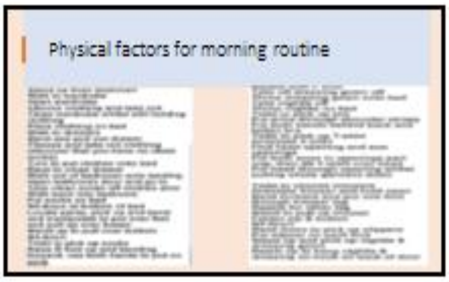


Aims and objectives

- Develop an understanding of activity analysis
- Explore possible solutions to washing and dressing related problems.
- Become familiar with compensatory equipment
- Identify things that people do that may inhibit independence and wellbeing.
- Identify behaviours that can influence how a person performs an activity

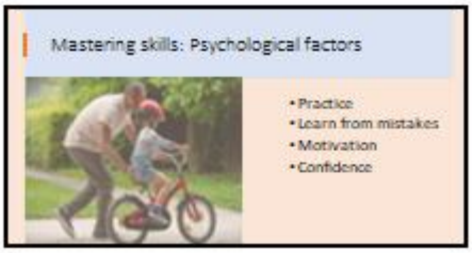
Activity Analysis: Breaking down the task

- Pacing
- Planning
- Prioritising



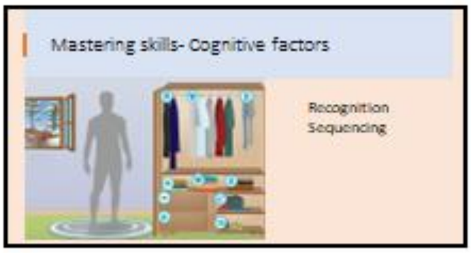
Physical factors for morning routine

Mastering skills: Physical factors



Mastering skills: Psychological factors

- Practice
- Learn from mistakes
- Motivation
- Confidence



Mastering skills- Cognitive factors

Recognition
Sequencing

Mastering skills: Social factors

Encouragement
Reassurance

Physical

- Hand function and Grip strength
- Bending
- Arm function
- Perception and Sight
- Touch

Psychological

- Practice
- Learn from mistakes
- Motivation
- Confidence

Cognitive

- Recognition
- Sequence

Social

- Do I need pants?
- Socially acceptable pants

Challenging situations

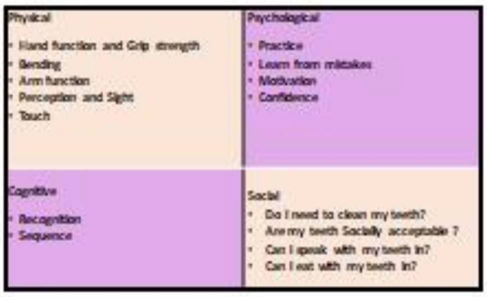
Challenges for Reablement: ACT

- Doing well
- Could do more
- Getting unwell
- OT Conversation required

Compensatory equipment: Dressing

Compensatory equipment: Bathing and Showering

Compensatory equipment



Physical

- Hand function and Grip strength
- Bending
- Arm function
- Perception and Sight
- Touch

Psychological

- Practice
- Learn from mistakes
- Motivation
- Confidence

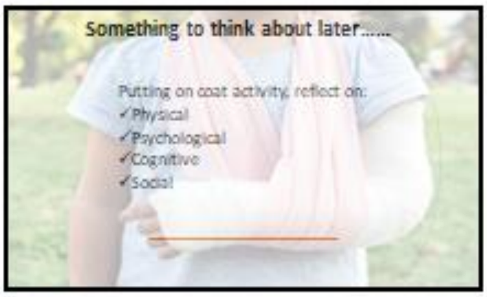
Cognitive

- Recognition
- Sequence

Social

- Do I need to clean my teeth?
- Are my teeth Socially acceptable ?
- Can I speak with my teeth in?
- Can I eat with my teeth in?

19



Something to think about later……

Putting on coat activity, reflect on:

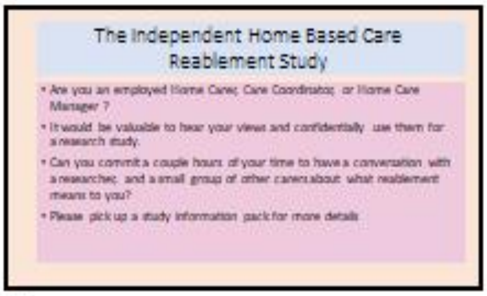
✓Physical
✓Psychological
✓Cognitive
✓Social

20

ACT : contact the occupational therapist….

- Person is progressing well with goals
- Person is deteriorating
- Person would benefit from equipment to achieve goals
- Relative would benefit from a conversation

21



The Independent Home Based Care Reablement Study

- Are you an employed Home Carer, Care Coordinator, or Home Care Manager ?
- It would be valuable to hear your views and confidentially use them for a research study.
- Can you commit a couple hours of your time to have a conversation with a researcher, and a small group of other carers about what reablement means to you?
- Please pick up a study information pack for more details

22

The third session covered activity analysis, practical solutions to washing and dressing limitations, equipment, barriers to independence and wellbeing, and behaviours that influence how a person performs an activity.

Described an observed assessment of what the person can and cannot do when attempting an activity and “breaking down the task” into stages, to determine the bits that people can do easily or with difficulty. The occupational therapist explained how it was their role to advise on structured goals to get a person to a point where they can do an activity themselves. They work with the home carer and the person, so each step can be practiced together, increasing the person`s confidence. The goals are realistic, person centred, and involve support where it is needed in the form of equipment or people, referral to other services, for example: ADVIS, voluntary services, community assets, Primary Care Link workers (social prescribers). The occupational therapist introduced a common-sense approach to doing activities called the 3 P`s.

The 3 Ps

- **Pacing:** is about taking your time and being able to rest if you need to
- **Planning:** is about making sure you have everything you need to hand before you start the activity (Home carers are experts at this!!)
- **Prioritising:** is doing the most important things at the best time of day e.g., having a shower can be tiring, it might be more important to practise kitchen skills and stay in dressing gown, than to drain energy

After the theory was presented, the group undertook a learning activity. Home carers were asked to think about their own morning routine when getting washed and dressed and then write down each stage step-by-step to complete this activity.

After the allocated time for the exercise the facilitator uses a power point slide to illustrate activities are more complex than people realise, the physical activities needed in a typical morning routine to get washed and dressed are around 46.

The power point slide has two pictures used to explain how people master skills through practice, using the framework of physical, cognitive psychological and social. The first is of a person in the bath washing themselves.

Physical component

The picture shows examples of different movements involved in washing. The home carers attention is drawn to the persons hand function and grip strength and the key physical skills to master are below.

- Hand function and grip strength to hold soap and sponge.
- Range of movement at the shoulder and elbow, or hips and knees to step over the bath side.
- Sensory awareness of bath water temperature.

Psychological components

The group of home carers were invited to shout out the important psychological factors when they learnt to ride a bike, or when you taught someone else to ride a bike. The key components are summarised by the occupational therapist and applied to the bathing scenario on the power point slide.

- There are many skills to master to reach a goal.
- These skills need to be practiced, as much as possible.
- Encouragement, learning from mistakes, having another go.
- Reduction in the level of support given allows people`s confidence to grow.

Cognitive components

Home carers were shown another picture, it's a cold day and a man has lots of clothes to chose from in the wardrobe. They are asked what does he need to understand to be able to do the activity? To understand what is required to do the activity the man in the picture needs to be able to recognise and process specific information. He needs to be able to sequence the task in the correct order. Home carers can help by verbal prompting, and people can relearn the skill through practice.

- The environment: is it warm, cold, wet?
- The purpose of the activity: is it to go out to the shops, or just to put the bins out?
- Are these pants: or are they some other colorful fabric?
- How do I put them on: do they go over my head, do I need to bend and reach, or stand on one leg?
- What order do I do the activity in: do I put them on before or after my shoes?

Social components

- Having time and opportunity to socialise is extremely beneficial to people's wellbeing and can improve people's health outcomes.

- After illness or crisis sometimes people withdraw, and do not feel as confident, this can lead to anxiety.
- Having a meaningful and purposeful goal to work towards is the difference between living a full life or just existing.
- To support people to socialise the Home Carers were asked to give encouragement and reassurance to participate in social activities, talk to them about what they used to do and what they hope to do again.
- The occupational therapist can support with signposting to suitable activities, for example:
    - Community volunteer activities: phone a lonely person scheme
    - Social activities: visit friends at cafe,
    - Creative activities: art classes, art, and music therapy.
    - Physical socialising: Thai chi or Yoga class at community centre

For the next three learning exercise discussion was encouraged but Home Carers are asked to make their own notes.

First, they were instructed to break down the activity of putting on underpants into the Physical, Psychological, Cognitive and Social factors. The occupational therapist facilitates the discussion, and at the ned summarises with example answers on the power point slide.

Physical components

- Pinching grip with fingers and thumb on waist band to pull up.
- Reaching down to pull pants up legs, balance.
- Range of movement and Muscle tone in arms
- See the object, judge the distance, judge space of leg hole.
- Feel the objects texture and construction.

Psychological components

- Overcoming difficulty, trying again, practise makes perfect, confident that these pants look good!!

Cognitive components

- Are they pants? are they, my pants?
- Put pants on before trousers unless I am Superman!
- Are they right for the weather, appropriate to the season?

Social components

- Are these pants socially acceptable?
- Are they clean?

Next, they were given the activity of cleaning their teeth. Each home carer was asked to work independently to break down the activity of brushing your teeth using the Physical, Psychological, Cognitive and Social framework. The occupational therapist talks through the considerations below.

Physical components

- Pinching grip with fingers and thumb on toothbrush and paste.
- Standing or sitting balance
- Range of movement and muscle tone in arms and hands
- See the object, judge the distance, judge space of mouth, feel the dentures texture and construction.

Psychological components

- Overcoming difficulty, trying again, practise makes perfect, confident that these dentures look good!!

Cognitive components

- Are they teeth? Are they, my teeth?
- Put dentures on before I eat.

Social components

- Are these teeth socially acceptable?
- Are they clean?

The third activity is reflective and presented as homework. The home carers were asked to think about putting on their coat, and to pretend they have broken an arm, it is fixed as though it is in a sling. The occupational therapist explains they will need to put the affected arm through the armhole first and bring the coat round their shoulders before putting the other arm in. The activity is to practice doing this and then ask someone you know to do the activity whilst standing back and prompting them, with no physical helping.

The final activity is to look at compensatory equipment useful for people to remain independent. The occupational therapist uses pictures, and in the room has simple equipment to pass around to enable a person to dress themselves.

The occupational therapist explains, all these items are available on the high street from the chemist, disability shops or online. However, they are no use unless the home carer knows how to use them, and has practiced the skill.

- Bath Lift – a hydraulic, electric powered bath seat charged by a removable fully waterproof battery. Flaps on each side of the seat need to be able to go up to the side of the bath, if handles are present then guides are needed to avoid them getting trapped. The suckers on the bath seat must be on a flat bath surface to stick. People should sit with their arms on their laps and not hold the seat when it is going up or down to avoid entrapment and put their legs out when going down. People must be able to get their legs over bath-side whilst seated.
- Shower board – people must be able to get legs over side of bath whilst seated. They are not suitable for individuals with poor trunk stability as people could fall backwards.

- Swivel bather - has a back on the seat, person must also be able to operate the lever to lock the chair or release the lock that allows chair to move to slots at 90-degree positions.
- Shower stool, no back on so the person must have good trunk strength, can be small enough to put under pedestal or other sinks.
- A corner shower stool, suitable for small cubicle showers, may need to be used with grab rails to push up from seat as it has no arms.
- A shower seat, full seat good for clients with poor trunk strength and need full seating whilst showering or need to sit down quickly.
- Soapy soles suitable for foot conditions or to improve circulation for those that can't reach their feet.
- L/H sponge for washing backs and lower legs, not needed for clients who shower.
- Sock aid- helpful for putting socks (or tights) on independently.
- Long handled toenail cutters

The last point the occupational therapist makes is about recognising how important the home carer role is, and acknowledging the difficult situations they are faced with daily. In Reablement the challenge is to identify and ACT in response to:

- Someone who is progressing well with their skills.
- Someone who has more functional capability but has a mental block.
- Someone who is deteriorating or getting unwell.
- Family members are risk adverse and trying to "do for" them.

To summarise, the training gave the opportunity to explore the knowledge and skills required to apply the reablement ethos. It introduced the home carers to the occupational therapists, so relationships were formed. As a result, home carers will ACT and contact the occupational therapist when:

- Person is progressing well with goals.
- Person is deteriorating.
- Person would benefit from equipment to achieve goals.
- Relative would benefit from a conversation.

But, above all the training sessions presented an opportunity for reflection on what home carers do, and how they do it, and how that influences the person with whom they are working.

Appendix 13 Participant demographic classifications.

Study ID	Cohort	Gender	Age Group	Ethnic group	Experience	Employment status	Other job
1	1	Female	45-54	White British	11 years plus	Part time	No
2	4	Female	45-54	White British	11 years plus	Full time	No
3	1	Female	35-44	White British	3 to 5 years	Full time	No
4	1	Female	25-34	White British	11 years plus	Full time	No
5	1	Female	35-44	White: other	11 years plus	Part time	No
6	1	Male	35-44	White: Irish	3 to 5 years	Full time	No
7	3	Female	25-34	Asian or Asian British	11 years plus	Full time	No
8	2	Female	45-54	White British	11 years plus	Part time	No
9	3	Female	25-34	White British	11 years plus	Full time	Yes
Z10	2	Male	35-44	White British	11 years plus	Full time	No
Z11	2	Female	35-44	White British	11 years plus	Full time	No
Z12	2	Female	45-54	White British	6 to 10 years	Full time	No
Z13	4	Female	45-54	White British	11 years plus	Full time	No
Z14	4	Female	35-44	White British	11 years plus	Full time	No
Z15	2	Female	35-44	Black, African, Caribbean Black British	6 to 10 years	Full time	No
Z16	2	Female	Above 55	White British	1 to 2 years	Part time	No
Z17	2	Female	Above 55	White British	11 years plus	Full time	No
Z18	2	Female	45-54	White British	3 to 5 years	Full time	No
Z19	4	Female	18-24	White British	6 months to 1 year	Full time	No
Z20	4	Female	25-34	White British	6 to 10 years	Full time	No
Z21	2	Female	Above 55	White British	11 years plus	Full time	No
Z22	1	missing	missing	missing	missing	missing	missing

Appendix 14 Training before and after knowledge and skills survey raw data.

ID	Cohort	Timing	Question 1	Question 2	Question 3	Question 4	Question 5
1	1	After	5	5	5	5	5
1	1	Before	4	5	4	5	5
2	4	After	4	4	4	4	4
2	4	Before	3	3	4	4	4
3	1	After	4	4	4	4	4
3	1	Before	4	4	4	4	4
4	1	Before	3	3	4	3	4
4	1	After	4	4	4	4	5
5	1	After	4	4	4	4	4
5	1	Before	4	4	4	4	4
6	1	Before	3	3	3	3	4
6	1	After	4	4	4	4	5
7	3	Before	3	3	3	4	4
7	3	After	4	4	4	4	4
8	2	Before	3	3	3	3	3
8	2	After	4	4	4	4	5
9	3	After	5	5	5	5	5
9	3	Before	3	3	4	3	4
Z10	2	Before	3	3	3	3	3
Z10	2	After	5	5	5	5	5
Z11	2	After	5	5	5	5	5
Z11	2	Before	4	4	4	4	4
Z12	2	Before	2	2	2	2	2
Z12	2	After	5	5	5	5	5
Z13	4	Before	4	3	3	4	4
Z13	4	After	4	4	4	4	4
Z14	4	After	5	4	4	4	5
Z14	4	Before	4	3	4	3	4
Z15	2	After	5	5	5	5	5
Z15	2	Before	5	5	5	5	5
Z16	2	Before	3	3	3	3	3
Z16	2	After	4	4	3	4	4
Z17	2	Before	3	3	3	3	3
Z17	2	After	4	4	4	4	4
Z18	2	After	5	5	5	5	5
Z18	2	Before	4	4	4	4	4
Z19	4	Before	3	3	3	2	2
Z19	4	After	5	4	4	4	4
Z20	4	Before	2	2	3	4	4
Z20	4	After	5	5	5	5	5
Z21	3	Before	3	3	3	3	4
Z21	3	After	5	5	5	5	5
Z22	1	Before	5	3	3	4	4
Z22	1	After	Missing	Missing	Missing	Missing	Missing

Appendix 15 The code book.

Name	Description	Files	References
Advice from regulated Professional	Theme: Professional led Interventions & advice: OT, Physio, SLT, SW or Nurse	13	233
Occupational Therapist	Category: occupational therapist or OT assistant, interventions, or advice	13	148
Different way of doing things	Subcategory: OT interventions that involve activity analysis	11	46
Equipment & adaptations	Subcategory-OT interventions that involve a compensatory approach such as equipment or adaptation provision to enable independence	13	62
Moving and Handling	Subcategory: interventions or advice on techniques, written plan, risk assessment, health, and safety.	6	14
Physiotherapy	Category: Physiotherapist or physio assistant interventions or advice	6	7
Social care worker	Category: Social worker or social care assistant interventions or advice	0	0
Speech and Language therapist	Category: speech and language therapy or assistant interventions, information, or advice	1	1
Carer experience	Theme: home carers describing their experience of types of care, time as a carer,	15	71
Job satisfaction	Category: reward, doing a good job, feedback	6	8
Communication	Theme: method, style, relationship (with person, carer, professionals)	20	597
Method	Category: email, face to face, ICT system, listening, phone,	11	89
Email	subcategory-use of email to communicate with others	4	9
Face to face	Subcategory: communicating with others face to face	4	10

Name	Description	Files	References
ICT system	subcategory: use of electronic notes or case file	2	7
Phone		10	22
Process	Category: using the communication mechanisms that are part of the organisational communication process e.g., make referrals to professionals	11	42
Relationships	Category: relationship with the person, informal carer, other employed home carer colleagues, and professionals	19	299
Relationship with family	Subcategory: relationship with family members who may live with the person or not, importance of, maintaining relationships, value of relationship, conflict, barriers, and enablers	7	11
Relationship with other carer colleagues	Subcategory: working relationships with colleagues, enablers, and barriers	10	24
Relationship with person	Subcategory: relationship with the person, trust, enablers, and barriers	17	95
Relationship with Professionals (OT)	Subcategory: relationship with professionals, enablers, and barriers	14	53
Style	Category: communication style, listening, banter, cheerful, low key, respectful	8	36
chatting and banter	subcategory: cheerful, joking, taking the micky, having a laugh	4	4
Empathy	Subcategory: carer putting themselves in their shoes	3	6
Humour	Subcategory home carer uses humour as a communication strategy	2	2
listening	Subcategory: active listening, hearing people, understanding through listening	4	4
Concepts	Theme: time, prevention and delaying care, dignity and respect, continuity, person centered practice	25	376

Name	Description	Files	References
Continuity	Category: consistency of carer, approach, method	8	18
Dignity and respect	Category: concept of treating a person like your own family, or like you would want to be treated.	9	19
Person centered practice	Category: home carers understanding, views, experience, application of person-centered practice	15	99
Prevent and delay care	Category: the concept of reduction of care to promote independence, carer’s role in prevention of dependency	23	118
Time	Category: concept of time, time to do the things that are important	21	122
Asking for more or less time	The process of asking for more or less time	0	0
The time it takes to reable	Subcategory: home carers perception of how long something takes, the office perception of how long it takes	7	13
Thinking time	Time needed to think and plan a reablement intervention	0	0
Expectation culture	Theme: home carers expectation of home care, and their perception of informal carers expectation, professionals’ expectation, persons expectation	21	378
Employed Home carer expectation	Category: What employed home carer expect when they do their jobs	21	129
Just a carer	subcategory: Not "just a carer" "not a slave"	5	12
Informal carer expectations	Category: what home carers think about the family member, friend, neighbour expectations	5	15
Person’s expectation	What home carers think about the Person receiving care or service`s expectations of that service or care	17	83
Domestic servant	home carer perceives the person to treat us "like slaves" or "like a maid"	5	9

Name	Description	Files	References
let you do stuff for them	the person lets the carer do things for them, loss of intrinsic control, carer role, power	3	6
Professionals' expectations	Category: what home carers think are the regulated professional, OT, SW, Physio, SLT, Nurse, or social care worker in assessment role, expectations of carers	7	16
Home carer Led Interventions	Theme: categories include autonomous decisions, Autonomous Decision, Bargaining or persuasion, Confidence building, Different way of doing things, doing things for the person, Encouragement, Environmental barriers, Goals, instructing on technique, Medication, Motivation, Moving and handling, Pace, Patience, Person centered practice, Planning, Practice the task, Reassurance, social interaction	21	884
Autonomous Decision	Category: Decision making, Judgements, Risk assessment, when to feedback	18	107
Different way of doing things	Category: the carer tries different ways of doing things, may be with or without professional advice	15	107
Doing things for the person	Category: carer does the task for the person	16	78
Doing things with a person		16	201
Bargaining or persuasion	Category: carer uses covert methods, bargaining, persuasion	6	21
Confidence building	Category: carer actively tries to boost persons confidence	9	37
Encouragement	Category: carer uses encouragement and reassurance to get the person to do something	15	75
Pace	Category: Pacing in relation to a person working towards goals	6	14
Practice the task	Category: Home carer understands that the person needs to practice a task, enablers, and barriers to do this	14	53

Name	Description	Files	References
Environmental barriers	Category: Carer recognises that there are barriers within the home environment that they can change, moving things around, stairs, downstairs living, one room existence	4	10
Goals	Category: identifying or working on specific goals	5	12
Instructing on technique	Category: following a plan, instructing based on professionals' advice, or with no advice	7	10
Medication	Category: administering, recording, checking	3	4
Motivation	Category: carer is actively trying to motivate the person, determining what motivates a person	6	19
Moving and Handling	Category: carers are moving and handling a person, with or without other carers, with or without equipment, health, and safety,	1	1
Observing	Subcategory home carer stands back and observes rather than doing something for the person	5	5
Patience	Category: carer personality quality, ability to recognise everyone has their own pace.	7	24
Planning	Category: carer able to plan to work on a goal	3	7
Social interaction	Category: carer has identified the need for social interaction, is doing the social interaction, can see a gap in service provision for social interaction	10	35
Support	Category: Carer identifies their role is to support, interventions are intended to be supportive,	10	19
Organisational processes	Theme: Adaptable roles, Consistency of staff, Handover process, Process of reducing care, Supervision, Training	24	600

Name	Description	Files	References
Adaptability	Category: carers are flexible, able to adapt between multiple types of caring role e.g., palliative, children`s, reablement	8	22
Consistency of staff	Category: the same carers are rostered to the same peoples calls, place-based care,	14	48
Handover process	Category: the carer hands over information about the case, the office handover information about the case, other carers communicate with each other about the person progress	17	96
Paying for care, equipment, and adaptations	Cost of care, self funding, grants, or social care funded care issues	3	17
Process of reviewing care package	Category: referral to OT or SW to commission new care reduction, increase or adjustment to care package	15	97
Responsive	Subcategory: quick process	3	10
Un responsive	subcategory: process of notifying to reduce care is slow or ineffective	3	4
Supervision	Category: staff supervision and observed practice, quality assuring home carer practice, reflective learning	4	28
Training	Category: Training of carers by organisation e.g., care certificate, shadowing, moving, and handling, quality of training, how often	4	42
Wellbeing	Theme: Home carers perception of the Mental or physical health of themselves, other employed carer, informal carers, or person	11	58
Employed Carers	Category: mental and physical wellbeing of home carer	5	7
Informal carer	Category: Home carers perception of the family member, friend, neighbour mental or physical wellbeing	0	0
Persons	Category: Home carers perception of the persons mental or physical wellbeing	11	36

Name	Description	Files	References
Fear	subcategory: fear of falling, being on their own, going back into hospital	2	3
Too old	subcategory	1	2
Z Attitude	Theme: Attitude: the way the home carer thinks and feels about themself or another person, thing or idea and the strength of thought or feeling, positive, negative, or neutral	25	1324
Negative attitude	Category: all negative attitudes, strong, medium, and weak	21	378
1. Strong	Sentiment is strong enough to quote	17	126
2. Medium	Sentiment is neither strong or weak, agreeable but no example, reference point or context	14	55
3. Weak	Sentiment is weak, yes or no answer only	15	51
Positive attitude	Category: all attitudes including strong, medium, and weak	24	671
1. Strong	sentiment is strong, worthy of quoting	19	197
2. Medium	Sentiment is neither strong or weak, agreeable but no example, reference point or context	18	167
3. Weak	Sentiment is weak, yes or no answer	13	48
Z Behaviour	Category: Home carers behavioural changes	4	16
Different	Subcategory: carer has a different behaviour	3	9
Similar	subcategory: carers behaviour is the same, or similar.	2	5
Z Belief	Belief: includes values and attitude, but also the home carers interpretation based on their knowledge, experience, opinions, morals, assumptions, and bias.	15	78
Z Values	The importance home carer places on themselves, another person, something,	20	235

Name	Description	Files	References
	or an idea and the strength of thought or feeling, positive, negative, or neutral		
Neutral	Home carer expresses indifference, not bothered	10	63
Strong	home carer finds something is very important to them	20	137
Weak	Home carer does not value something, places no importance on something	11	35
Zz Quotes	Category: any text that is suitable for a quote, rich statements by carers	15	66
Zz Typology	Theme: Action takers: cases that were proactive in reablement actions Debaters: cases that were unsure about the concept of reablement Delayers: cases that realised they should be reabling, but hadn't taken action Evaders: cases where they took no action or had no intention to reable	20	165
Action taker	Category: cases that were proactive in reablement actions	14	65
Debaters	Category: cases that were unsure about the concept of reablement	8	21
Delayers	Category: cases that realised they should be reabling, but hadn't taken action	12	40
Evaders	Category cases where they took no action or had no intention to reable	9	39
ZZZ Training feasibility	Theme: carers views on the feasibility of the ACT reablement training, CATEGORIES: Format of training delivery, organisational considerations, training facilitator, value of training.	25	338
Format of training delivery	Categories: optimum time frame, how I like to learn, relevance of training content, where the training should be delivered.	25	199
Best time frame for training	Category: number of sessions, length of sessions, refresh session.	11	86

Name	Description	Files	References
3 sessions in one week		2	3
one session		2	4
one session a week over 3 weeks		7	11
Refresher	reference to a repeat session	6	6
Time of day and length of session		11	19
How I like to learn	Subcategory: case scenario discussion, blended learning, learning by doing, and reflection	24	47
Blended learning	mix of video, taught, reading and discussion	3	3
Case discussion about a scenario	Subcategories: confidence to speak up and problem solving	12	15
confidence to speak up	carer is comfortable asking to discuss a case or to talk about a situation, talking about a case with peers or senior.	1	2
Problem solving	working through a situation and identifying what to do next, problem solving together 1;1, 2;1 or in a group.	1	1
Learning by doing stuff	carer like to learn through trying things themselves,” see one do one" learning, practical tasks, functional learning	4	4
Reflection	time to think and process, relating back to own case scenario, reflecting in action or on action	1	1
How relevant is the training content	Category: ideas for improvement, reflection on content, impact of training, learning materials	8	10
Where should the training to be delivered	Subcategory: venue, online,	12	22

Name	Description	Files	References
Online	Zoom or Ms teams	2	2
Organisational considerations	Category: time to organise; staffing changes and turnover; rota and shifts, staff availability	4	7
Training facilitator	Category: issues, reflections from OT delivering the training.	2	2
Value of the ACT training	Category: Importance, views, reasons	9	25
ZZZz Archive nodes		0	0

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