Received: 24 March 2020 | Revised: 18 January 2021 | Accepted: 20 January 2021

DOI: 10.1002/hsr2.249

Health Science Reports Open Access WILEY

RESEARCH ARTICLE

Valuable aspects of home rehabilitation in Sweden: Experiences from older adults

Anette Johansson[1,2] | Marie Ernsth Bravell[2] | Ann Britt Karlsson[2,3] | Sofi Fristedt[2,4]

[1]Health Care Administration, Jönköping Municipality, Jönköping, Sweden

[2]School of Health and Welfare, Jönköping University, Jönköping, Sweden

[3]Social Administration in Jönköping Municipality, Jönköping, Sweden

[4]Department of Health Sciences, Lund University, Lund, Sweden

Correspondence
Anette Johansson, School of Health and Welfare, Jönköping University, SE 551 11 Jönköping, Sweden.
Email: anette.johansson2@ju.se

Abstract

Background and aim: Home rehabilitation is an increasing service in many countries due to the aging population. The body of knowledge in home rehabilitation is growing but results are inconsistent, and there is still lack of knowledge from user perspectives to guide practice and home rehabilitation programs. The purpose of this study was to explore valuable aspects of home rehabilitation experienced by older adults.

Methods: Fourteen older persons (nine older adults and five next of kins) were interviewed about their experiences of receiving rehabilitation in their homes. Nine de-identified interviews were analyzed as secondary data and with qualitative content analysis.

Results: A familiar home environment, inclusive collaboration, and the mastering of everyday life were aspects of value for older adults in home rehabilitation. Creating a tailor-made rehabilitation together with competent staff, building trust, and providing a sense of security in their homes were also considered valuable.

Conclusion: When using the home as an arena for rehabilitation and collaboration, interventions can be planned based on the older adult's unique conditions and the knowledge and skills of the multidisciplinary team, including the older adult and their next of kin. A valuable home rehabilitation can then be achieved that creates motivation, which in the long term probably also generates desired effects for the older adult. More research is needed on older adult's experiences of content in home rehabilitation programs so that practice develops in accordance with citizens' needs, individual resources, and relationships.

KEYWORDS
competent staff, home environment, home rehabilitation, person-centeredness, teamwork

1 | INTRODUCTION

Since people are healthier and living longer, populations are aging at a rapidly increasing rate worldwide.[1] Although older age does not necessarily imply dependence, older adults are at risk of suffering from chronic and multiple diseases or injuries, which can lead to disabilities in everyday life.[2] This demographic transition will increase the demands on society in terms of provision of social care, health care, and rehabilitation and will bring the need for changes and implementation of new strategies in these settings.[1,3,4] A general policy in many

countries, as in Sweden, is to encourage older adults to stay in their ordinary homes for as long as possible (*stay-in-place policy*[5]) and avoid the use of institutional care. In addition, many older adults wish to continue to live in their ordinary homes, since their existing home or community is related to their sense of identity and autonomy.[6] In line with this, the Swedish health care system is gradually undergoing a reformation in which resources are transferred from residential care to primary care and home care to increase proximity to patients and facilitate preventive work.[7] The number of residential care beds and length of stay in hospitals are being continuously reduced[8] and fewer older adults are offered residential care in nursing homes.[9] In all, there will be an increasing number of people who will remain in their ordinary home for a longer period of time, with an expected increased need of care and support in their homes. In Sweden, the municipalities have the overall responsibility for older adults' social care, health care, and rehabilitation.[7] The home thus becomes a place for multidisciplinary work performed by health care providers such as registered nurses and certified nursing assistants, occupational therapists, physiotherapists, and rehabilitation assistants, along with social service provided by, for example, home care nursing assistants and social workers. In line with the stay-in-place policy, municipalities have increased their services and many of them now offer structured home rehabilitation programs.

In several countries, home rehabilitation is often implemented as a national or local strategy to deal with the aging population.[10-13] Home rehabilitation programs sometimes only involve one professional category, such as physiotherapist,[14] but because the focus in this study is programs implemented by multidisciplinary teams, findings from such studies are less relevant for the purpose of the present study and not considered in the following text. Multidisciplinary home rehabilitation is not a uniform concept and programs have been independently developed in different parts of the world, for example, *reablement*, *active service model*, *home independent program*, *restorative home support*, or *restorative care*.[15] In Norway and Denmark, *reablement* programs have been growing in recent years. It is a timely approach to improve home-care services for older adults needing care or experiencing functional decline. Occupational therapists and physiotherapists develop a rehabilitation plan and then instruct the home care staff how to assist the older adult with daily training in everyday activities.[16,17] In Sweden, it is more common that occupational therapists and physiotherapists are the core executors in home rehabilitation programs while working in close collaboration with home care services,[15,18] and this was also the case in the present study. Although the home rehabilitation programs vary in approach and content, some common features are recognized; they are time-limited, intensive, multidisciplinary, person-centered, and goal-directed.[19,20] They are also aimed at promoting independence and supporting older adults to remain in their homes for as long as possible.[17,20] There is a growing body of knowledge when it comes to the effects of multidisciplinary home rehabilitation, for example, improved ability to perform activities of daily living (ADL), self-reported activity performance, quality of life,[16,17,21] and less use of home care services.[12] But results are also inconsistent, where studies demonstrate the opposite, that is, no better effect in personal ADL, physical functioning, and health-related quality of life is found.[22] A systematic review also claims that the benefits of home care reablement are unproven.[23] Taken together, the lack of robust evidence and the increasingly growing interest in home rehabilitation call for further research across different health and social care systems.[19] The organization of home rehabilitation initiatives and the resources provided through these programs differ,[4,24] where knowledge is still limited on what components actually have an impact.[15] There are studies that explored older adults' experiences during home rehabilitation in terms of environmental facilitators and barriers,[25] loneliness,[26] and participation.[27] However, more research is needed to provide knowledge from user perspectives to guide practice and home rehabilitation programs.[19] Establishing perspectives from older adults about the value of home rehabilitation is vital to understand components for success and is also an important complement to the large body of research focusing on effects. Therefore, the aim of this study was to explore valuable aspects of home rehabilitation experienced by older adults.

2 | METHODS

The present study is based on existing de-identified interviews conducted in a home rehabilitation project in a municipality in the southern part of Sweden. Citizens living in one selected geographical area of the municipality were offered home rehabilitation based on a program in which occupational therapists, physiotherapists, and rehabilitation assistants increased their rehabilitation efforts in the person's home and immediate surroundings. The intervention was time-limited (maximum of 12 weeks) and goal-oriented based on user involvement. It also included close collaboration with registered nurses and certified nursing assistants within home health care and other actors, for example, social workers and home care nursing assistants. The interviews were conducted with older adults receiving home rehabilitation and their next of kin in order to evaluate and further develop the program, and ethical principles to preserve the participants' well-being, autonomy, and integrity were considered.[28]

2.1 | Participants

The study population consists of older adults residing in ordinary homes, receiving rehabilitation in their home according to the home rehabilitation program described above, and these older adults' next of kin. The rehabilitation staff were informed of applicable ethical requirements prior to the interviews,[29] both orally at meetings and in writing by the third author (AK). The rehabilitation staff conveyed oral and written information to a convenience sample, including nine older adults and five next of kin (Table 1). First, the nine older adults were asked for informed consent, thereafter their next of kin were also asked for informed consent. They all gave their informed consent in line with the Declaration of Helsinki. The rehabilitation staff communicated the older adults contact information to AK, who contacted them to agree on a time and place for the interview. The sample included nine older adults (five men and four women) and five next of

TABLE 1 Characteristics of the 14 participants

Older adult			Proxy			
No.	Gender	Age (years)	No.	Gender	Relation	Age (years)
P1	M	74	N1	F	Wife	64
P2	M	80	N2	F	Wife	80
P3	F	69	N3	M	Husband	74
P4	M	86	-		-	-
P5	M	77	N5	F	Wife	63
P6	M	76	N6	F	Wife	74
P7	F	96	-		-	-
P8	F	73	-		-	-
P9	F	79	-		-	-

kins (one man and four women) (mean age of 76 years). The characteristics of the older adults are provided in Table 1 along with information concerning how the older adult and next of kin are related (with related persons sharing the same number).

2.2 | Data collection

The interviews had an exploratory approach related to the purpose of the present study. All interviews were conducted by the third author (AK) from June to August 2017 in the participant's home except one, which was done over the phone. When the older adult had a next of kin, the interviews were conducted with them present to serve as proxies when necessary and if the older adult and next of kin so wished. Before the interview started, AK once again repeated the information in accordance with ethical principles of research[29] and asked for informed consent from both parties. The exploratory interview guide was based on these questions: *Have the efforts of home rehabilitation had any significance for you, and if so how? What has been especially valuable to receive support with?* Follow-up questions were formulated based on answers received. Responses were documented verbatim on a laptop during the interviews and regularly read back to the participants for supplementary information and adjustments. Few new perspectives arose by the end of the process, indicating that the experiences from nine older adults and their five next of kin were sufficient for the purpose of the present study. Access to the de-identified interviews for this study was granted by the municipality in line with Swedish laws and regulations.[30]

2.3 | Analysis

Nine de-identified interviews were analyzed with an inductive qualitative content analysis accordingly to Elo and Kyngäs.[31] The approach in this analysis was to find similarities and differences in the material based on the manifest content. First, the written interviews were read several times by the first author to make sense of the data and then the data were aggregated to a single document. Meaning units were then identified from the whole material based on the research question: *What are the valuable aspects of home rehabilitation from the perspective of the older adult receiving it?* and were then initially condensed and coded.[31] All authors read the material where discussions and analysis from their unique perspectives (ie, gerontology, social work, and rehabilitation) were conducted until an agreement was reached about the labeling of codes. The coding remained close to the data, and the participants' own words were often used as content-describing code names. The condensing process was subjected to further critical discussion within the research group, resulting in abstraction to eight subcategories and three main categories. Interviews were conducted in Swedish, and the quotes that have been included in this article were translated by the authors. An example of a category built from meaning units, condensed meaning units, codes, and a subcategory is shown in Table 2. An overview of main categories and subcategories is shown in Figure 1.

The study is based on already collected data, and no personal contact with the participants was taken prior to the analyses. The material was de-identified to not disclose any data that could reveal the identity of the participants. We considered it to be of value to study the material scientifically on the grounds that the results would lead to positive consequences for citizens' rehabilitation in the future and that there would be no risk of causing injury by doing so.

3 | RESULT

Three main categories emerged describing the valuable aspects of home rehabilitation according to the participants: "Advantages of a familiar home environment," "Relationship-building encounters with competent professionals," and "Creation of a tailor-made rehabilitation." These categories provide a structure for the results and are supported by quotes. Information on participant number, age, and gender is also given in parentheses after each quote.

3.1 | Advantages of a familiar home environment

This category describes valuable aspects of being in a familiar home environment for the rehabilitation process and outcome. It consists of three subcategories:

TABLE 2 Example of meaning units, condensed meaning units, codes, a subcategory, and a category from the content analysis process

Meaning unit	Condensed meaning unit	Code	Subcategory	Category
(N6, F): They also ask me as a next of kin and that I am not used to …	(N6, F): They ask me as a next of kin and I am not used to that.	Been asked as a next of kin	Building an arena for inclusive collaboration	Advantages of a familiar home environment
(P9, F): Most importantly now when I have had home rehabilitation period, are these 4; from home rehabilitation and home care, we have become good friends, and the home care, they have also improved … because the home care help to train now	(P9, F): Most important during the home rehabilitation period are those from home rehabilitation and home care. Home care has improved because they help to train now	Home care has improved; they help to train now		
(P1, M): we have worked as a team, the staff [Home rehab] I have met are fantastic, give answers to questions, adapt, they also say to M [next of kin] to slow down a little now …	(P1, M): we have worked as a team. They also say to M [next of kin] to slow down	We have worked as a team		

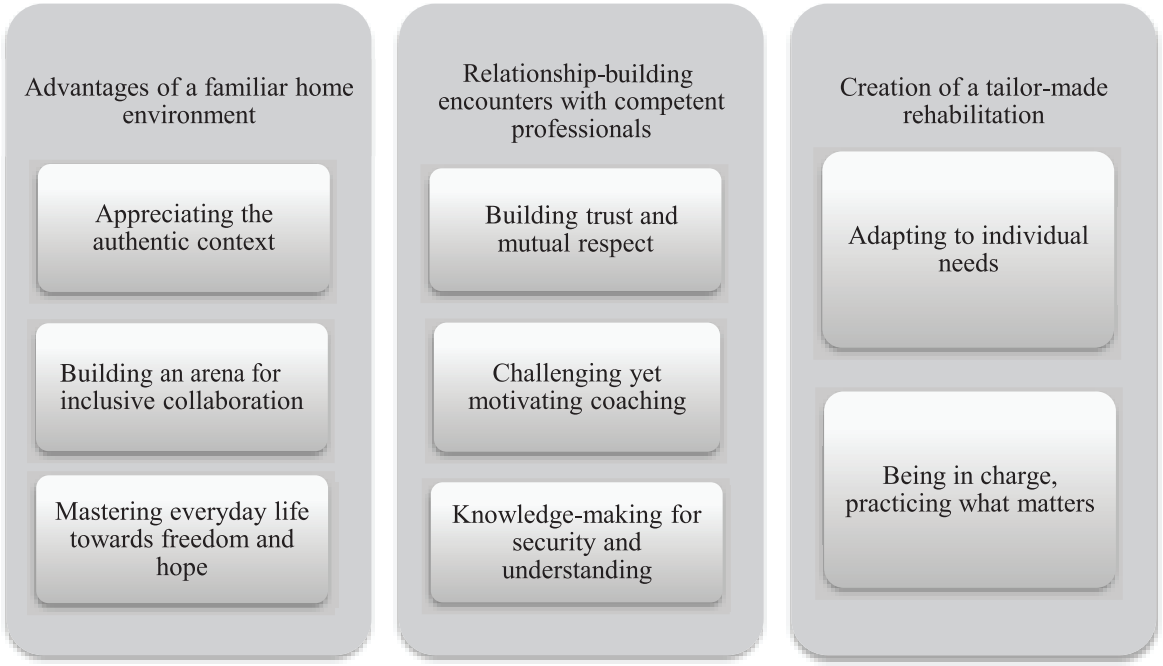

FIGURE 1 Overview of the three main categories and eight subcategories that emerged from content analyses of interviews conducted with participants with experiences from home rehabilitation

3.1.1 | Appreciating the authentic context

Practice in natural contexts where real problems exist or arise was described as being of utmost importance by the older adults in home rehabilitation. In fact, some of their activity problems were directly linked to the home environment and could not be addressed elsewhere: "*Most important [for me was] that we were in the home environment. The problems are here and not elsewhere. Everything is in the home environment*" (P1, male, 74 years). The physical environment in the home and in adjacent areas, for example, stairs, were often described as a barrier that limited participation in everyday life. The older adults mentioned that activities like using the stairs, taking a shower, or leaving the house in their wheelchair presented difficulties for them. Together with the rehabilitation staff, they found out where the problems were, practiced in that exact situation, and then, in some cases, compensated with assistive devices and/or adaptations:

"*The occupational therapist said; 'can I look around a little … how do you cross the threshold of the shower cubicle'? [Patient changes perspective to talk about herself:] It is a big problem which means I haven't showered in a very long time …*" (P8, female, 73 years). Home adaptations such as railings, shower cubicles, and ramps, therefore, became a solution and an opportunity to resume everyday activities. As such, when the rehabilitation took place in the home, the provided support was perceived as closer to them and their individual needs and resources. The rehabilitation staff also used the physical surroundings as part of the training to gradually increase the level of difficulty and also to encourage new goals: "*When I reached my goals, we set new goals. The physiotherapist then suggested practicing walking up the stairs to the second floor. Then I used [the stairs] for the first time in five months*" (P3, female, 69 years).

3.1.2 | Building an arena for inclusive collaboration

The participants' social relationships, for example, husbands/wives, children and friends, were very important to them and they considered these relationships to be supportive. Wives and husbands were included in home rehabilitation discussions and practice and that seemed to be a new experience. The next of kin were given advice and support in their role and were involved as a resource in the rehabilitation, and that was received with gratitude and appreciation. Several participants had more than one caregiver visiting their homes, for example, health care registered nurses and home care nursing assistant, and the home became a meeting point for cooperation and teamwork. The participants emphasized that in home rehabilitation they felt part of a team working together to achieve their goals. Importantly, the home care nursing assistant supported the participants to maintain the results of rehabilitation initiatives, and the close cooperation in the home led to a changed way of working among the home care staff: "*The home care now works better because they [nursing assistants] help [me] to train now*" (P9, female, 79 years). The meeting at the end of the home rehabilitation period was of great importance to the participants. Involved staff participated in the meeting, for example, social workers, home care nursing assistants, health care registered nurses, and rehabilitation staff, and reviewed the results. That gave the participants a sense of security since everyone then knew what would apply after the home rehabilitation period.

3.1.3 | Mastering everyday life towards freedom and hope

The most important thing for the older adults was to achieve a better functioning in their homes and in everyday life. The home rehabilitation included goal-oriented interventions directed at both body functions and activities the older adults had previously usually done themselves, and this made the rehabilitation meaningful and comprehensible. Achieving independence was commonly the most important overall rehabilitation goal for the older adults. They were grateful to receive support in the home but to have staff at home could sometimes be stressful. As a participant put it: "*We want to manage as much as we can ourselves, because even if people [staff] are nice, it is not that we want people [staff] here at all times*" (P2, male, 80 years). A wife explained that her husband did not go to the short-term facility as usual during the home rehabilitation periods, which meant that she could not get her long-awaited and much-needed sleep, with consequences for them both. So, for the next of kin, home rehabilitation could also sometimes mean increased responsibility. Although the main focus was on coping with everyday life in their homes, it was also of great importance for several of the participants to be able to go outdoors and, for example, sit on their terrace, take a walk in the garden or in the woods, and participate in social activities again. It was important not to get stuck in their homes because the social sphere and well-known surroundings were a source of energy and quality of life. The ability to manage everyday life raised positive emotions of joy and gratitude among the participants. Progress in terms of increased mobility and independence in the home environments provided a sense of happiness and freedom, whether this concerned being able to get between floor levels, wash the car, or take the car out to the countryside again: "*We have practiced and it is now possible [for me] to get outdoors. This has been my biggest wish … I want to be able to get outdoors and to walk. Get some fresh air and not just be indoors*" (P7, female, 96 years). The progress they have made together with the rehabilitation staff gave them hope and the courage to look forward with confidence.

3.2 | Relationship-building encounters with competent professionals

This category describes valuable aspects from the participants' experiences of the rehabilitation staff's approach toward them. It consists of three subcategories:

3.2.1 | Building trust and mutual respect

Several participants described the rehabilitation staff's ability to see the older adults as persons with unique needs, individual resources, and relationships. Through questions and an ability to listen, staff were able to create a dialog to understand and gain insight into what was important for each and one of them: "*They have a very good approach, listen and understand what is important to me here*" (P5, male, 77 years). The participants experienced that the rehabilitation staff had a genuine interest in them and were able to find common areas of interest that created a positive connection on equal terms. The rehabilitation staff were perceived as reliable and a trusting relationship with mutual respect emerged during the rehabilitation process. The participants expressed that the rehabilitation staff saw the big picture in every situation, and sometimes also did something extra, as exemplified by one next of kin: "*It was very valuable that the physiotherapist came to the short-term facility so that NN could practice what was*

important there as well, because he does not like being there [at the short-term facility]" (N1, female, 64 years).

3.2.2 | Challenging yet motivating coaching

The attitude of the rehabilitation staff was experienced to be determined and distinct, but in a friendly and good way; "*They 'give you a kick in the butt' and you put a little more effort into it …*" (P3, female, 69 years). The motivating pep talk approach led the older adults to dare to challenge themselves and also gave them the confidence to push a little bit harder, even more than some of them thought was possible. This encouragement, along with strengthening conversations with the rehabilitation staff, led to an increased belief in themselves and their own individual resources. A woman expressed: "*They are so nice and treat me so well. When I got sick, I felt ashamed, but I have gained better self-esteem now. I now feel that I am good enough*" (P8, female, 73 years).

3.2.3 | Knowledge-making for security and understanding

Many participants highlighted the rehabilitation staff's competence in their field and how that gave a trustworthy impression. The rehabilitation staff were perceived as skilled and able to transfer that knowledge to the participants. It was perceived to be of great importance to be able to ask questions and to receive understandable answers, and the rehabilitations staff's knowledge and ways of explaining gave a sense of security and support. It also gave the participants an increased understanding of the disabilities and functional limitations as well as why and how to work to decrease these limitations in real-life situations in their homes, and that understanding gave them a push forward: "*The physiotherapist has explained so that I understand. That makes me motivated*" (P9, female, 79 years). Participants also mentioned that it was important to receive input and advice on home-made self-training programs, so their training could continue safely between sessions and after the home rehabilitation period: "*They listen to us and what we have done. We have done [our own] training program and they gave us new input*" (N1, female, 64 years).

3.3 | Creation of a tailor-made rehabilitation

This category describes valuable aspects from the participants' experiences of getting the rehabilitation adapted to themselves and their own unique situation, based on two subcategories:

3.3.1 | Adapting to individual needs

In the home rehabilitation, several participants emphasized that they had the freedom to schedule dates, number of training sessions per week, and time of day. For example, the number of training sessions per week varied among the older adults from one session per week, which for some was experienced as quite sufficient, to up to five sessions per week: "*They were responsive to daily rhythms. Before the end [of training period], NN wanted them to come on a daily basis*" (N1, female, 64 years). An older adult stated that the frequent visits was a contributing factor to his progress and results. This responsiveness to the older adult's daily rhythms and needs was of great importance to the participants and they felt involved in decision-making and in planning. However, there was some disappointment about not receiving sufficient information about how long the rehabilitation period itself would be, which then affected planning of other important activities during that time. Participants noted that with home rehabilitation, training became more intense and individually adapted to their specific needs and desires than it was at day care centers. One woman said: "*I get to practice what helps me and not just stand in a group [at the day care centre] and do the same movements as the others*" (P9, female, 79 years). When the rehabilitation took place in their own home instead, the intervention was experienced as personally adapted and appropriate, giving the older adults a sense of being in focus.

3.3.2 | Being in charge practicing what matters

According to the participants, the rehabilitation staff let the older adults be in charge and based interventions on what was currently important to the older adults including their next of kin. The participants appreciated having been given the opportunity to design the rehabilitation based on individual needs they found important: "*What matters most to me, we do!*" (P7, female, 96 years). What was most important varied between the older adults. For some, it meant resuming a previous interest, and for others it was to walk independently indoors with a rollator: "*With the occupational therapist [I have] started to play boule again … it was fun*" (P4, male, 86 years). In fact, all older adults express that the training was targeted toward their own goals and their own needs and wishes. The older adults formulated the goals for the rehabilitation plan together with the rehabilitation staff and that was of great value to them: "*It is my goals that matter! Those are my words written there now!*" (P7, female, 96 years). The rehabilitation staff's actions and support were compliant to the participant's will and the older adults were also allowed to say no, and those things together gave them a sense of control and a feeling of being in command of the home rehabilitation process: "*It has worked well, we've got [it] the way we wanted it*" (P5, male, 77 years).

4 | DISCUSSION

Exploring perspectives from older adults about the value of home rehabilitation is vital to understand components for success and is also an important complement to the large body of research focusing on effects. Therefore, the aim of this study was to explore valuable aspects of home rehabilitation experienced by older adults.

The results describe that perceived value from the participants view is the possibility of participating in a tailor-made rehabilitation in their familiar home environment and close relationships, by competent staff with whom they have built a good relationship. As described earlier, there are various ways to design a home rehabilitation program. This study highlights the perceived value with competent staff, in this case occupational therapist and physical therapist, who planned and supervised most of the training. The participants emphasized the rehabilitation staff's approach toward them during rehabilitation, how they were treated with respect and kept in center where the rehabilitation staff saw them as a whole and considered them to be equal partners. This is supported in the person-centered approach, which requires certain attributes from the health professionals, such as being professionally competent, having developed interpersonal skills, being committed to the job, and being confident in themselves.[32] Altogether, the rehabilitation staff were perceived as being committed, sympathetic, and guided by a holistic approach, where the goal-setting, planning, and implementation of the interventions were based on what was important to the participants, corresponding to the person-centered process[32] and also confirmed by Randström et al.[25] The close collaboration in the home between the older adults, the rehabilitation staff, and the home care nursing assistants was also valuable to the participants. Teamwork is not only an important part of a person-centered approach, but is also experienced as a prerequisite for user involvement and sense of security[33] and a major driving force[34] of home rehabilitation efforts.[15] In our study, the meetings in the home with all involved professionals provided security, and the participants experienced that during home rehabilitation process the home care improved and became an active and natural part in the rehabilitation. The results, therefore, indicate that a successful concept for teamwork in home rehabilitation contains regular face-to-face multidisciplinary meetings with guidance, supervisions, and follow-ups.[15] Guidelines for multidisciplinary collaboration across organizational functions should be developed within home rehabilitation programs by policy makers. More research is also needed on older adult's experiences of teamwork during home rehabilitation to inform guidelines designed to meet citizen's needs, individual resources, and relationships.

The participants emphasized the value of being in their familiar home environment during rehabilitation with the goal of overcoming the different obstacles that they felt restricted their mobility, independence, and freedom in their homes and everyday life. The result indicates that the confidence of knowing the environment and the ability to master it again were connected with feelings of being competent.[35] The environment is also an important part of the person-centered approach, meaning that person-centeredness can only happen if there is a person-centered culture in place in settings that enable staff to experience person-centeredness and work in a person-centered way.[32] In this study, the setting was the participants' home environment and that seemed to have facilitated person-centered culture with effective teamwork and sharing of power and decision-making between the staff and participants, indicating that the home environment has the potential to create conditions for a person-centered approach.

4.1 | Strengths and limitations

Secondary data have been analyzed in this study, bringing both limitations and strengths. Reusing interviews is beneficial to avoid burdening a frail group[36] and still make their voice heard. However, simply keeping notes during an interview can result in data to be reduced in an unsystematic manner,[37] but every effort was taken to ensure richness. Moreover, regular member-check was carried out with possibility of clarification and further development of the reasoning. The original purpose of the interviews matched well with this study's research question but there was no opportunity to ask follow-up-questions to deepen the findings. It is possible that participants felt pressured to participate as they were asked by their own rehabilitation staff.[38] However, careful preparations were made with oral and written information to rehabilitation staff on research ethical principles to minimize that risk. Informed consent was also established by AK before and repeatedly during the interviews. Differences in terms of gender, age, and civil status increased the possibility of having the research question elucidated from different perspectives. This study was performed in a limited geographic area in Sweden and the results need to be interpreted as such, but the findings are potentially applicable in similar settings.

5 | CONCLUSIONS

In order to plan and create a valuable home rehabilitation, the rehabilitation staff need to use the home as an arena for inclusive collaboration, and see the older adult's individual resources and challenges in the familiar home environment. When using the home as an arena for rehabilitation and collaboration, interventions can be planned based on the older adult's unique conditions and the knowledge and skills of the multidisciplinary team, including the older adult and their next of kin. A valuable home rehabilitation can then be achieved that creates motivation to participate with influence in the home rehabilitation, which in the long term probably also generates desired effects for the older adult.[39]

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

Conceptualization: Anette Johansson, Marie Ernsth Bravell, Sofi Fristedt

Formal analysis: Anette Johansson, Marie Ernsth Bravell, Sofi Fristedt

Investigation: Ann Britt Karlsson

Supervision: Marie Ernsth Bravell, Ann Britt Karlsson, Sofi Fristedt

Validation: Marie Ernsth Bravell, Ann Britt Karlsson, Sofi Fristedt

Visualization: Anette Johansson, Marie Ernsth Bravell, Ann Britt Karlsson, Sofi Fristedt

Writing—Original Draft Preparation: Anette Johansson, Marie Ernsth Bravell, Ann Britt Karlsson, Sofi Fristedt

Writing—Review & Editing: Anette Johansson, Marie Ernsth Bravell, Ann Britt Karlsson, Sofi Fristedt

All authors have read and approved the final version of the manuscript.

Anette Johansson, as the corresponding author, confirms having full access to all of the data and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.

TRANSPARENCY STATEMENT

Anette Johansson confirms that the manuscript is an honest, accurate, and transparent account of the study being reported and no important aspects of the study have been omitted.

DATA AVAILABILITY STATEMENT

Initial data may contain sensitive information, which due to ethical restrictions may not be shared, even if it is anonymized.

ORCID

Anette Johansson https://orcid.org/0000-0002-9414-8203
Marie Ernsth Bravell https://orcid.org/0000-0003-4149-9787
Sofi Fristedt https://orcid.org/0000-0003-2322-8115

REFERENCES

1. World Health Organization. *World Report on Aging and Health*. Geneva: World Health Organization; 2015. https://www.who.int/ageing/publications/world-report-2015/en/.
2. The National Board of Health and Welfare. Utveckling av indikatorer för äldres rehabilitering [The development of indicators for rehabilitation of older adults]. 2014. Available from https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19619/2014-12-12.pdf. Accessed Oct 20, 2020.
3. England K, Azzopardi-Muscat N. Demographic trends and public health in Europe. *Eur J Public Health*. 2017;27:9-13.
4. Gustafsson U, Gunnarsson B, Sjöstrand Å-B, Grahn B. Hemrehabilitering för äldre i olika stora kommuner: Upplevd kvalitet, funktionsförändring, organisationsförutsättningar, resursförbrukning och statliga stimulansmedels betydelse för utvecklingen [Home rehabilitation for older adults in municipalities of different size: perceived quality, functional change, organizational conditions, resource consumption and the importance of governmental funding for development]. FoU-rapport 2010: 11. Växjö: FoU Kronoberg; 2010.
5. Ministry of Health and Social Affairs. Nationell handlingsplan för äldrepolitiken [National actionplan for elderly policy]. Prop. 1997/98: 113, ed. 1997. https://www.regeringen.se/rattsliga-dokument/proposition/1998/04/prop.-199798113/. Accessed October 12, 2020.
6. Wiles JL, Leibing A, Guberman N, Reeve J, Allen RES. The meaning of "aging in place" to older people. *Gerontologist*. 2012;52(3):357-366.
7. Swedish Government Official Reports. God och nära vård - en primärvårdsreform [Good and close care—a primary care reform]. Stockholm: SOU; 2018:39.
8. Ström M. Fortsatt färre vårdplatser i Sverige [Still fewer hospital beds in Sweden]. Läkartidningen. 2018;115:EY66.
9. The National Board of Health and Welfare. Vård och omsorg om äldre – lägesrapport 2019 [Health care and social care od older adults – status report 2019]. Stockholm: The National Board of Health and Welfare; 2019.
10. Bauer A, Fernandez JL, Henderson C, Wittenberg R, Knapp M. Cost-minimisation analysis of home care reablement for older people in England: a modelling study. *Health Soc Care Community*. 2019;27(5):1241-1250.
11. Lewin G, Alan J, Patterson C, Knuiman M, Boldy D, Hendrie D. A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service. *Health Soc Care Community*. 2014;22(3):328-336. https://dx.doi.org/10.1111/hsc.12092.
12. Lewin GF, Alfonso HS, Alan JJ. Evidence for the long term cost effectiveness of home care reablement programs. *Clin Interv Aging*. 2013;8:1273-1281.
13. Langeland E, Førland O, Aas E, et al. Modeller for hverdagsrehabilitering – en følgeevaluering i norske kommune; Effekter for brukerne og gevinster for kommunene? [Models for everyday rehabilitation – a follow-up evaluation in Norwegian municipalities; Effects for users and benefits for the municipalities?]. Bergen: Center for Care Research Vest; 2016.
14. Ryburn B, Wells Y, Foreman P. Enabling independence: restorative approaches to home care provision for frail older adults. *Health Soc Care Community*. 2009;17(3):225-234.
15. Tuntland H, Ness NE. Hverdagsrehabilitering 1. utg. [Everyday Rehabilitation 1st ed.] Oslo: Gyldendal Akademisk; 2014.
16. Tuntland H, Aaslund MK, Espehaug B, Førland O, Kjeken I. Reablement in community-dwelling older adults: a randomised controlled trial. *BMC Geriatrics*. 2015;15(1). http://dx.doi.org/10.1186/s12877-015-0142-9.
17. Winkel A, Langberg H, Wæhrens EE. Reablement in a community setting. *Disabil Rehabil*. 2015;37(15):1347-1352.
18. Zingmark M, Evertsson B, Haak M. The content of reablement: Exploring occupational and physiotherapy interventions. *British Journal of Occupational Therapy*. 2019;82(2):122-126. http://dx.doi.org/10.1177/0308022618792188.
19. Cochrane A, Furlong M, McGilloway S, Molloy DW, Stevenson M, Donnelly M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. *Cochrane Database Syst Rev*. 2016;2016(10):CD010825.
20. Aspinal F, Glasby J, Rostgaard T, Tuntland H, Westendorp RGJ. New horizons: reablement – supporting older people towards independence. *Age Ageing*. 2016;45(5):574-578.
21. Langeland E, Tuntland H, Folkestad B, Førland O, Jacobsen FF, Kjeken I. A multicenter investigation of reablement in Norway: a clinical controlled trial. *BMC Geriatr*. 2019;19:29.
22. Lewin G, de San Miguel K, Knuiman M, et al. A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults. *Health Soc Care Community*. 2013;21(1):69-78.
23. Legg L, Gladman J, Drummond A, Davidson A. A systematic review of the evidence on home care reablement services. *Clin Rehabil*. 2016;30(8):741-749.
24. Månsson M. Hemrehabilitering: vad, hur och för vem? 1 uppl [Home rehabilitation: what, how and for whom? 1st ed.). Solna: Fortbildning AB/Tidningen Åldreomsorg; 2007.
25. Randström KB, Asplund K, Svedlund M. Impact of environmental factors in home rehabilitation – a qualitative study from the perspective of older persons using the international classification of functioning, disability and health to describe facilitators and barriers. *Disabil Rehabil*. 2012;34(9):779-787.
26. Lykke S, Handberg C. Experienced loneliness in home-based rehabilitation: perspectives of older adults with disabilities and their health care professionals. *Glob Qual Nurs Res*. 2019;6:2333393619831661.
27. Vik K, Nygård L, Borell L, Josephsson S. Agency and engagement: older adults' experiences of participation in occupation during

home-based rehabilitation. *Can J Occup Ther/Revue Canadienne D'Ergothérapie*. 2008;75(5):262-271.
28. World Medical Association (WMA). *World medical association declaration of Helsinki: Ethical principles for medical research involving human subjects*. 2013. Available from https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/. Accessed October 23, 2019.
29. The Swedish Research Council. *Good Research Practice*. 2017. https://www.vr.se/download/18.5639980c162791bbfe697882/1555334908942/Good-Research-Practice_VR_2017.pdf. Accessed October 23, 2019.
30. Swedish Parliament. Off entlighets- och sekretesslag (2009:400) [Public Access and Secrecy Act (2009: 400)]. Stockholm: Swedish Parliament.
31. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62(1):107-115.
32. Brendan M, Borg M, Cardiff S. Person-centredness – the 'state' of the art. *Int Pract Dev J*. 2015;5(Suppl):1-15.
33. Jokstad K, Skovdahl K, Landmark BT, Haukelien H. Ideal and reality; community healthcare professionals' experiences of user-involvement in reablement. *Health Soc Care Community*. 2019;27(4):907-916.
34. Hjelle KM, Tuntland H, Førland O, Alvsvåg H. Driving forces for home-based reablement; a qualitative study of older adults' experiences. *Health Soc Care Community*. 2017;25(5):1581-1589.
35. Haak M, Fänge A, Iwarsson S, Dahlin Ivanoff S. Home as a signification of independence and autonomy: experiences among very old Swedish people. *Scand J Occup Ther*. 2007;14(1):16-24.
36. Ziebland S, Hunt K. Using secondary analysis of qualitative data of patient experiences of health care to inform health services research and policy. *J Health Serv Res Policy*. 2014;19(3):177-182.
37. Lantz A. *Interview Methodology*. 3rd ed. [Intervjumetodik. 3. uppl. ed.] Lund: Studentlitteratur; 2013.
38. Kalman H, Lövgren V. *Ethical dilemmas: research participation, consent and vulnerability. [Etiska dilemman: forskningsdeltagande, samtycke och utsatthet]*. Malmö: Gleerups; 2019.
39. Newton C. Personalising reablement: inserting the missing link. *Work Older People*. 2012;16(3):117-121.

How to cite this article: Johansson A, Ernsth Bravell M, Karlsson AB, Fristedt S. Valuable aspects of home rehabilitation in Sweden: Experiences from older adults. *Health Sci Rep*. 2021;4:e249. https://doi.org/10.1002/hsr2.249