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Rehabilitation in a municipal setting:
A qualitative study of occupational therapists' contribution
to acquired brain injury rehabilitation

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Abstract

Introduction: As a consequence of the Norwegian coordination reform, patients now spend less time in hospital and are sent back to the municipality earlier than before. Studies show that occupational therapists experience acquired brain injury (ABI) patients a complex working field, and in some situations the occupational therapists fail to believe in their own professional expertise.

Objective: The goal of this study was to explore how the professional expertise of occupational therapists working with ABI rehabilitation in a municipal service provision is understood.

Material and Methods: The study had a qualitative approach where 5 focus group interviews with municipal coordinating units of rehabilitation and 1 mono-professional focus group interview with occupational therapists working in municipal service were conducted. Data were analysed using systematic text condensation.

Findings: The occupational therapists working in a municipal service have a diverse base of knowledge and label themselves as rehabilitators with multiple collaboration partners. The occupational therapists' holistic view and area of expertise within environmental adaptation, compensatory aids, and cognition are valuable in the municipal setting.

Concluding remarks: The study indicates that the occupational therapists in municipal service practice within several fields of expertise. The occupational therapists area of expertise within compensatory aids, environmental adaptation, and cognition are valued in ABI rehabilitation in a municipal setting. Their professional expertise which is based on a practical synthesis of knowledge enable the occupational therapists to cross boundaries in the interprofessional collaboration, where they contribute to the rehabilitation process as rehabilitators with a wide holistic view.

Keywords: Municipality, Occupational therapist, Acquired brain injury, Rehabilitation, Interprofessional collaboration.

Sammendrag

Innledning: Som følge av samhandlingsreformen oppholder pasienter seg nå kortere tid på sykehuset og sendes tilbake til kommunen tidligere enn før. Studier viser at ergoterapeuter opplever pasienter med ervervet hjerneskade som et komplekst arbeidsområde, og i noen situasjoner mister ergoterapeutene troen på sin egen faglige kompetanse.

Formål: Målsettingen med denne studien var å undersøke hvordan de faglige kompetanseområdene til den kommunale ergoterapeuten som arbeider med ervervet hjerneskaderehabilitering, blir forstått.

Materiale og metoder: Studien hadde en kvalitativ tilnærming hvor det ble gjennomført fem fokusgruppeintervjuer med kommunale koordinerende enheter for rehabilitering og et monofaglig fokusgruppeintervju med kommunale ergoterapeuter. Data ble analysert ved bruk av systematisk tekstkondensering.

Funn: Kommunale ergoterapeuter har en mangfoldig kunnskapsbase og beskriver seg selv som rehabilitører med mange forskjellige samarbeidspartnere. Ergoterapeutenes holistiske syn og kompetanse innen miljøtilpasning, kompenserende hjelpemidler og kognisjon er verdifulle i den kommunale settingen.

Avsluttende bemerkninger: Studien indikerer at de kommunale ergoterapeutene praktiserer innenfor flere kompetanseområder. Ergoterapeutenes kompetanse når det gjelder kompenserende hjelpemidler, miljøtilpasning og kognisjon er verdsatt i ervervet hjerneskaderehabilitering i kommunen. Deres profesjonelle kompetanse er basert på en praktisk syntese av kunnskap og gjør at ergoterapeuten kan krysse grenser i det tverrfaglige samarbeidet og bidra til rehabiliteringsprosessen som rehabilitører med et bredt holistisk syn.

Nøkkelord: Kommune, ergoterapeut, ervervet hjerneskade, rehabilitering, tverrfaglig samarbeid.

Contents

1 Introduction

Acquired brain injury (ABI) is a common cause of limitations in a person's daily life, and two of its dominant causes are stroke and traumatic brain injury (Holmqvist, Kamwendo, & Ivarsson, 2009), and their clinical presentations may seem almost similar. People with ABI are one of the main patient groups that are served by occupational therapists, and those who suffer from a stroke are one of the largest groups (Wolf, 2011).The impairments after ABI can be both physical and cognitive, which can seem a complex working field to the occupational therapists (Blackwood & Wilson, 2009; Wolf, 2011). Furthermore, ABI is one of the most frequent causes of death and disability and thus a major challenge for the patients as well as their relatives, the care system, and society (Bertilsson, Von Koch, Tham, & Johansson, 2015; Eriksson, Tham, & Borg, 2006; Fallahpour, Kottorp, Nygård, & Lund, 2015; Helsedirektoratet, 2010).

For most patients the goal of the rehabilitation is to increase their function to enable them to be able to keep living in their home environment. In these cases training in daily activities is considered the most important intervention (Helse- og omsorgsdepartementet, 2009; Kielhofner, 2009). Training in the particular skills that enable the patients to live their new lives requires several elements as practice and training in daily living, mobilisation, and independent skills (Dahl, Haugbølle, Jarl, Schjerning, & Thanning, 2007; Hammell, 2006; Kielhofner, 2009). This could, for instance, be skills used to organize activities or to handle tools used in our daily lives like one's toothbrush, hairbrush etc. Training to regain skills for such activities requires assistance from professionals and is usually described as the main responsibility area of occupational therapy (Dahl et al., 2007; Kielhofner, 2009). The Norwegian coordination reform that was passed in 2012 led to a shift of responsibility from the specialist healthcare in hospitals to the primary healthcare systems in the municipalities (Helse- og omsorgsdepartementet, 2015; Holmqvist et al., 2009). Nevertheless, the recent plan to escalate habilitation and rehabilitation from 2016 concludes that access to rehabilitation services is far from sufficient in several Norwegian municipalities (Helse- og omsorgsdepartementet, 2016b). Simultaneously with the increased responsibility, the responsibility shift leads to a situation where a larger patient group with more complex needs than previously will need rehabilitation in the municipalities. This requires an advanced level of professional expertise in the municipality where the patients live their daily lives (Helse- og omsorgsdepartementet, 2015, 2016b). In future, professional expertise in the rehabilitation

process in the municipality will therefore be even more important than previously. Furthermore, recent political guidelines say that from the 2020 all Norwegian municipalities should employ an occupational therapist (Helse- og omsorgsdepartementet, 2016a).

It is a well established fact that the expertise and work of the occupational therapist can be difficult to explain (Aiken, Fourt, Cheng, & Polatajko, 2011; Fortune, 2000; Spang & Holmqvist, 2015). This fact combined with the responsibility shift and the political decision about occupational therapists in the municipalities makes the study of occupational therapists' professional expertise in a municipal setting highly relevant.

This thesis is based on a qualitative study of the occupational therapist´s professional expertise that are used in the rehabilitation process when working with ABI patients in a municipal setting. The study was part of the project: Transitions in rehabilitation: Biographical reconstruction, experiential knowledge, and professional expertise at Oslo Metropolitan University.

1.1 Previous research

This section gives an overview of previous research that can be related to the occupational therapist's work in ABI rehabilitation. A literature review conducted using the PICO method (Haraldstad & Christophersen, 2008) (appendix I), followed by the snowball method (Malterud, 2011) is the basis for this section. The literature review uncovered that few studies that deal with the municipality perspective alone have been conducted. Thus, the following presentation of previous studies will also deal with the occupational therapist's work with ABI rehabilitation in other fields than just the municipal service provision.

The basic philosophy of occupational therapy is activity or occupational behaviour (Aiken et al., 2011; Fortune, 2000; Spang & Holmqvist, 2015). The occupational therapists assess the extent of the problem by observing activities (Holmqvist, Ivarsson, & Holmefur, 2014; Holmqvist et al., 2009) and find appropriate solutions for the patient to participate in activities in everyday life (Law, 2002).

Traditionally, occupational therapy deals with cognitive impairments, and the occupational therapist plays an important role in the professional team that cares for persons suffering from impairments following ABI (Holmqvist et al., 2009). These cognitive impairments often

cause what Eriksson et al. (2006) call occupational gaps. Occupational gaps are related to perceived activity limitations, and previous research reveals that occupational gaps typically appear because of cognitive impairment rather than physical impairment (Eriksson et al., 2006). The individual cognitive impairment is often invisible, but different cognitive impairments often affect each other which results in occupational problems. It is considered a complex affair to uncover what cognitive impairment causes the occupational problem, but it is important in order to choose the right intervention (Holmqvist et al., 2009).

Revealing the hidden cognitive impairments is a time consuming detective job, because problems with occupational performance are seldom obvious and usually emerge gradually (Holmqvist et al., 2009). In a Swedish study occupational therapists have described time as a major limitation factor that affected their work. They said that in addition to the fact that they do not have enough time with each patient, they also have to prioritize among the patients. Due to lack of time, not all patients suffering from ABI can get occupational therapy (Holmqvist et al., 2009). In addition to the lack of time, studies show that occupational therapists working with ABI patients feel uncertain about their own knowledge and expertise (Holmqvist et al., 2014; Holmqvist et al., 2009). This uncertainty leads to a lack of confidence in own knowledge. According to the same study, this lack of confidence can be due to a feeling of having an insufficient theoretical framework (Holmqvist et al., 2009).

Blackwood and Wilson (2009) describe the field of brain injury rehabilitation as an exciting area of practice for the occupational therapist. Nevertheless, they state that the field of brain injury rehabilitation includes a diversity and variety of problems and is a field with limited evidence-based standards to give the occupational therapists clear directions about what to do. This diversity and lack of precise directions can be the explanation why, in a study by Holmqvist et al. (2009), the occupational therapists express that they need to try to gain knowledge through their daily work with the patients. At the same time the occupational therapists in the study express that when working with ABI patients they acquire new and useful knowledge from every patient. This feeling of the necessity to gain knowledge through practice can be caused by what Blackwood and Wilson (2009) describe as a practice with a lack of detail concerning the theoretical basis of used intervention or scientific evidence to support the occupational therapist's daily practice. Consequently, the decision to use one approach over another is often based on non-scientific factors. This lack of available scientific evidence can be a challenge when performing evidence-based practice, however, this gained

practice experience might not be solely negative. Professionals' personal experience gained through practice is one of the three elements in evidence-based practice, and this ongoing gathering of experience based knowledge can be seen as an important factor for the professionals when they perform evidence-based practice and, on that basis, choose one approach over another.

2 Study aim

The aim of this study was to reveal how the professional expertise of occupational therapists working with ABI rehabilitation in the municipality service is understood, both within interprofessional collaboration settings and among occupational therapists reflecting in a mono-professional setting.

3 Contents of the thesis

This thesis is an article-based thesis which means that it consists of two parts; an article (chapter 9) and this thesis. The article written is planned to be submitted to the Scandinavian Journal of Occupational Therapy. The thesis is based on the article, and it is therefore a prerequisite that the article is read before the thesis. Nevertheless, in order to create coherence between the article and the thesis, some of the contents of this thesis will have certain similarities with the article.

In chapter 1 an introduction and previous research are presented. Chapter 2 covers the aim of the study. Theoretical perspectives are reported in chapter 4, which elaborates on evidence-based practice, professional knowledge, and professional collaboration in a broader perspective than in the article. Chapter 5 presents the research methodology including my pre-understanding, choices applied through the research process, the analysing process, and ethical considerations. Chapter 6 presents a summary of the article that is the basis for this thesis and it focuses on the main findings of the study. The summary of the article is followed by a discussion of the findings and methodological considerations in chapter 7. Chapter 8 contains concluding remarks summarizing the essence of the study. Finally, the article is presented in chapter 9.

4 Theoretical framework

The study was conducted with an inductive approach, and this contributed to shaping the direction of the theoretical framework which has been used to put the data into perspective. To be able to understand the empirical material in a larger perspective, the key concepts that are briefly presented in the article will be explained in more depth in this chapter.

The importance of evidence-based practice is underlined in educational literature (Dahl-Michelsen & Groven, 2018; Herbert, Jamtvedt, Hagen, & Mead, 2011) and was also a topic in the discussions in the focus group interviews conducted in this study. The performance of evidence-based practice requires three different elements of knowledge, including both scientific and personal experience-based knowledge. Furthermore, rehabilitation is considered a process involving several professionals (Sandvin, 2012), where collaboration skills are assumed to be necessary. Consequently, all three concepts: evidence-based practice, professional knowledge, and professional collaboration, will be clarified below.

4.1 Evidence-based practice

In Norway the term evidence-based practice is often referred to as knowledge-based practice (Terum & Grimen, 2009). According to Solvang and Slettebø (2012, p. 19) evidence-based practice can be seen as "making professional decisions based on systematically collected research-based knowledge, experience-based knowledge, and the patient's wishes and needs in the given situation". This indicates that the three elements in evidence-based practice are: scientific evidence, professional experience, and the patients' knowledge, wishes, and needs (Solvang & Slettebø, 2012). In the present study the professional experience is that of the occupational therapists, especially when they take part in ABI rehabilitation.

When discussing the emergence of evidence-based medicine, the general understanding is that evidence is mostly perceived as scientifically founded knowledge (Engebretsen, Vøllestad, Wahl, Robinson, & Heggen, 2015; Ramsdal, 2009). In the context of this particular study, scientific knowledge about ABI rehabilitation can either be aimed directly at occupational therapy or be of a more interprofessional character. However, to perform evidence-based practice other kinds of knowledge are required in addition to scientific evidence (Herbert et al., 2011). Skår (2013) supports this assumption by saying that it would be a challenge for the healthcare system if evidence-based practice limited the practitioners to finding solutions to

interventions or treatments only by searching through research material on the exact issue. Skår (2013) thus claims that knowledge based exclusively on results from scientific evidence will only give a precise direction for what to do in very few cases. The conclusion is that in most cases scientific knowledge combined with professional judgement will be necessary. This assumption implies that the knowledge must be interpreted and reflected upon before it is used in an real situation, which is one of the challenges of evidence-based medicine (Engebretsen et al., 2015).

The use of knowledge that depends on a professional judgement requires a personal and individual dimension (Skår, 2013). A personal dimension is not necessarily negative. Bjorbækmo and Billington (2015) argue that context sensitive knowledge and experiences are the core of all kinds of expert knowledge. In order to find suitable solutions to a problem, the professionals should constantly reflect on the importance and the role of knowledge in the professional practice (Skår, 2013). Unfortunately, various clinicians lack time and have limited access to research, and they also lack expertise when it is a matter of evaluating the scientific evidence emerged during research (Dijkers, Murphy, & Krellman, 2012; Straus, Tetroe, & Graham, 2009). There is therefore a long way from the research to the clinicians' practice (Dijkers et al., 2012; Menon, Korner-Bitensky, Kastner, McKibbon, & Straus, 2009; Wolf, 2011). The lack of ability to use evidence optimally is considered a global challenge which results in an inexpedient gap between evidence and practice (Menon et al., 2009; Straus et al., 2009).

To strengthen the practitioner's use of evidence in the form of scientific research and thereby evidence-based practice knowledge translation is of great importance. Knowledge translation is defined as a method for closing the gaps between knowledge and practice (Straus et al., 2009). Knowledge translation focuses on health outcomes and changing behaviour as a dynamic and iterative process that includes the application of knowledge. The intention is to improve health, provide more effective health services and products, and strengthen the healthcare system (Davis et al., 2003; Straus et al., 2009). Thus, knowledge translation is about taking the step from just disseminating knowledge to actually using it (Straus et al., 2009).

4.2 Professional knowledge

Evidence-based practice indicates that different elements of knowledge are necessary to provide good and secure healthcare services (Dijkers et al., 2012; Herbert et al., 2011; Vandvik, 2009).

Rønnestad (2008) considers the two specific elements of knowledge and expertise especially interesting in the study of a profession, and the Norwegian philosopher, Grimen (2008) claims that a profession's base of knowledge is a composed phenomenon. Grimen (2008) also claims that all kinds of knowledge can be articulated. If not, it is not knowledge. Knowledge that cannot be expressed verbally can be expressed in other ways as, for example, through actions. Grimen (2008) states that all knowledge can be translated between human beings, but not necessarily through descriptions alone. Moreover Straus et al. (2009) stress that strategies for knowledge translation should be adapted to both the type of knowledge that is being translated and the target audience.

Grimen (2008) distinguishes between two models to explain the relationship between theoretical and practical knowledge. The first, oldest, and most dominant model believes that practical knowledge is the application of a theory and sees the theory as the primary part as seen in evidence-based medicine. Thus, the theoretical and scientific knowledge Grimen (2008) refers to in his use of the term theoretical knowledge can be interpreted as scientific evidence, which is one of three elements in evidence-based practice. The other model claims that the theory floats on a layer of practice. Consequently, the practical part is the primary part where the theory is originated from practice, and the theory cannot be separated from the practical knowledge. This practical knowledge can be perceived as experience-based knowledge, which is also one of the three elements in evidence-based practice. When applying theoretical knowledge, the theory will be interpreted in a certain way, because the professionals have to choose different elements from theories depending on the situation (Grimen, 2008).

Homogeneous and heterogeneous

Grimen (2008) calls a base of knowledge homogeneous if the elements in the knowledge base are from the same scientific discipline or from the same field of knowledge. The knowledge base is, however, heterogeneous if the knowledge base is composed of elements from different scientific disciplines or different fields of knowledge. Furthermore, Grimen (2008)

claims that a base of knowledge is strongly integrated if all its elements have a logical connection within a system. Grimen (2008) also argues that the base of knowledge will be fragmented if the elements derive from fields that have little or no logical connection, like, for instance, chemistry and social science. Grimen (2008) thereby concludes that a base of knowledge will be poorly integrated if it is composed by heterogeneous elements.

Grimen (2008) argues that a profession's base of knowledge is mainly heterogeneous. He claims that professional performance in client-centred professions like, for instance, occupational therapy demands the use of knowledge from a lot of fields to achieve client-centered practice. These fields could, for instance, be biology, psychology, and social science. Accordingly, the profession's knowledge is built on scientific disciplines, but not one scientific discipline alone.

If a professional is to be able to act on the basis of professional judgement in practise, the basis of the composed elements in the heterogeneous base of knowledge is a main factor. This heterogeneity is considered important in the decision making in complex situations (Svensson & Karlsson, 2008) as they are, for example, seen in occupational therapy in the municipal service provision where a number of factors should be taken into account in the rehabilitation process. This can often be the situation for the occupational therapist when working with ABI patients, especially during the rehabilitation process in the home environment, where both the physical and social environment should be taken into account (Kielhofner, 2010).

By stating that health professions' base of knowledge is gathered by combining heterogeneous elements Grimen (2008) also perceives it reasonable to claim that because the professions' performance has a practical goal, their base of knowledge will be theoretically fragmented. Theoretical reflections and the attempt to seek theoretical contexts are not the aim for the professions' performance. Most people working in the health sector perform their profession relatively far away from the latest research in the scientific disciplines they are basing their knowledge on (Grimen, 2008). One explanation of this could be that the literature on evidence-based medicine is rather complicated and challenging to use in practice. Engebretsen et al. (2015) say that the literature on evidence-based medicine explains little about *how to* create a fruitful interaction between research, clinical expertise, and patient preferences. Grimen (2008) supports this by assuming that much advanced knowledge is lost on the way from the research field to the practitioner's practice. Moreover, Grimen (2008)

states that even if a profession's theoretical basis is well integrated, practice and knowledge gained through practice will play an important role.

Practical and theoretical synthesis

If what integrates the different elements of knowledge in a profession's base of knowledge is a comprehensive theory, Grimen (2008) considers it a theoretical synthesis. In contrast, it is a practical synthesis if the elements in the profession's base of knowledge are based on the claims made by the profession's professional practice, which in addition to theory includes the practical skills that are required to perform the professional performance (Grimen, 2008). Grimen (2008) stresses that in a practical synthesis it is not necessary for the elements of knowledge to be well integrated theoretically. This theoretically fragmented base of knowledge can be seen as consistent with occupational therapy's base of knowledge, which is built on a mix of theories that form the basis for the occupational therapist's actions (Melton, Forsyth, & Freeth, 2009). Furthermore, occupational therapy is an example of a profession where the elements in the profession's knowledge base are combined in a certain way because they make up a meaningful part of the profession's performance in a practical whole or unit (Grimen, 2008; Kielhofner, 2009). Grimen (2008) hereby makes the hypothesis that most professions have a practical synthesis rather than a theoretical synthesis. Grimen (2008) substantiates this assertion by the arguments that, first of all, theoretical knowledge must be useful in practice. Secondly, a lot of practice is well tested, but not theoretically explainable. Thirdly, he claims that since a profession's base of knowledge is usually considered heterogeneous, the main part of the profession's performance often alternates between and combines theoretical and practical elements of knowledge. The two types of knowledge can, as argued earlier in this chapter, be interpreted as being elements represented in evidence-based practice: The theoretical knowledge that can be seen as scientific knowledge or scientific research and practical knowledge that can be seen as the professionals' experience-based knowledge.

Indexation

Grimen (2008) operates with two components of knowledge: practical and theoretical knowledge, even though he argues that there is no clear distinction between those two. Practical and theoretical knowledge are part of a continuum of knowledge which results in an indexation (my translation from Grimen and Nortvedts Norwegian Language term indeksering), which can be seen as a unique composed personal knowledge that is tied to a

particular activity (Grimen, 2008; Nortvedt & Grimen, 2004). In indexation practical knowledge is characterized by the fact that the form and content of knowledge cannot be detached from the individual person or from the situation where it is learned and applied (Grimen, 2008). Practitioners of a profession develop their personal expertise through practise and interactions (Hjardemaal & Jordell, 2011; Lahn & Jensen, 2008). Furthermore, practical knowledge is often expressed in actions, professional judgment, assessments, and estimates (Grimen, 2008). Practical knowledge can be applied without speaking, but not without bodily performance in the form of action. Practical knowledge is thereby closely tied to the occupational practice which can only be gained in a first person perspective (Grimen, 2008).

4.3 Professional collaboration

Professional collaboration is considered central for the occupational therapist working with ABI patients (Holmqvist et al., 2009). However, the use of terms within this theoretic field is diverse (Willumsen, Sirnes, & Ødegård, 2016). In this thesis reference will be made to the terms defined by Payne (2000) who describes a continuum of collaboration from multi- through inter- to transprofessional collaboration and ultimately role release. In this process Payne (2000) distinguishes between the term "multi" and "inter". "Multi" indicates that different professional groups are working together, but they do not necessarily integrate by adapting each others' professional roles or skills. The term "inter", however, requires crossing boundaries by adapting each others' roles, knowledge, and skills as well as being able to adjust in relation to the other team members (Payne, 2000; Willumsen, 2009). In addition to "multi" or "inter" Payne (2000) adds either the term "professional" or "disciplinary". "Professional" is meant as a concern for different groups and functions and activities which are associated with those groups. "Disciplinary", however, suggests a concern with the knowledge and skills underlying particular professional roles of relevance. When combining the terms: multi, inter, and professional or disciplinary different types of teamwork are created. Multiprofessional or multidisciplinary teamwork implies that several professional groups with different bases of knowledge and skills are drawn together in a structure to provide a service, whereas interprofessional or interdisciplinary indicates that the professional groups make adaptions within the group. They take account of and interact with the roles of others to adjust their knowledge and skills bases (Payne, 2000). If you take yet another step, you will see transprofessional teamwork. In addition to the adaptation, transprofessional teamwork requires transfer of information, knowledge, and skills across disciplinary boundaries (Hagland & Solvang, 2017; Payne, 2000). When performing within a

transprofessional approach, it is important that the professionals are aware of each others' professional expertise. Additionally, is it crucial that the professionals are confident in their own profession's expertise areas to such an extent that they can cross the professional boundaries to the professions of the other team members and ultimately let professionals take roles usually associated with another profession in role lease (Payne, 2000). The concept of role release means that team members allow each other to take and use aspects of a primary function to another team member with a different professional background to be able to respond to the patient's needs (Payne, 2000). An example of role release can be seen when an occupational therapist provides the patient with pre-ordered medicine, a primary function that is usually related to a nurse.

Willumsen (2009, 2016) operates with four levels of professional expertise which should be taken into account when boundaries have to be crossed. Willumsen (2009, 2016) describes the four levels as follows: 1) Core expertise is an expertise that only this specific profession holds. 2) Overlapping expertise is expertise that several professions within the interprofessional team hold, but not necessarily all. 3) Shared expertise is common professional expertise like, for instance, terms and values that are integrated within the team. 4) Expert expertise is usually very narrow, specific expertise gained through further education (Willumsen, 2009, 2016). Consequently, Willumsen (2009, 2016) four levels of expertise will limit the transprofessional approach so that it is only possible within two of the expertise areas: the overlapping expertise and the shared expertise, because, according to Willumsen (2009, 2016), it demands a specific education to practice the two other areas of expertise, the core expertise and the expert expertise. If these four levels of expertise are accepted there will be certain limitations to the crossing of boundaries depending on the specific expertise area. Some boundaries cannot be crossed if the professional does not hold the specific education as, for example, activity analysis, which is a core expertise to the occupational therapist (Crepeau, Schell, Gillen, & Scaffa, 2013; Kielhofner, 2009). Furthermore, Willumsen (2009, 2016) definition of the four levels of expertise would entail that Payne (2000) role release is only possible within specific expertise areas. It is also important to be aware that crossing boundaries takes much more than coordinating tasks. Both practice and knowledge from different disciplines must be tied together (Hagland & Solvang, 2017).

5 Material and method

The basis for this thesis is a study of the occupational therapists' professional expertise in ABI rehabilitation in municipal service which was part of the project: Transitions in rehabilitation: Biographical reconstruction, experiential knowledge, and professional expertise at Oslo Metropolitan University. The thesis is based on material collected by several researchers with the same empirical method and approach. I as a master student was responsible for collecting the material concerning the mono-professional view as well as for the analysis presented in the article and this thesis. This chapter contains a description of the qualitative approach chosen, my position and pre-understandings as a researcher in addition to a more thorough description of the data collection and focus group design than the article provides. Furthermore, the analysis that applied the method of systematic text condensation is elaborated on in this chapter.

A research method that could explore the occupational therapists' professional expertise in the rehabilitation process when working with ABI patients in a municipal setting and get close to their behaviours and experiences was considered appropriate (Kvale & Brinkmann, 2015; Leseth & Tellmann, 2014). To be able to answer the research question, the characterization of the occupational therapist's work in a municipality setting was considered essential. Additionally, rehabilitation is performed in an interprofessional context (Sandvin, 2012), so an interprofessional view was considered vital for answering the research question. Consequently, an empirical design that approached the research question from different points of view (Postholm, 2010) was considered relevant. Interprofessional collaboration and the interprofessional view were considered crucial to be able to answer the research question, so interprofessional focus group interviews with 5 municipal coordinating units of rehabilitation were conducted. To be able to put the interprofessional view on the occupational therapists' expertise into perspective it was considered relevant to explore the occupational therapists' own perceptions of their expertise. Accordingly, a mono-professional focus group interview with only occupational therapists as participants was conducted in addition to the 5 interprofessional focus group interviews.

5.1 My position and pre-understanding as a researcher

Malterud (2012a) underlines the importance of being familiar with and open about your own pre-understanding before conducting a focus group interview. It is recommended that the researcher writes down his pre-understandings to prevent them from getting confused with the actual findings later in the study (Malterud, 2012a). Additionally, the process of writing the pre-understandings can help the researcher be aware of own prejudices (Fangen, 2010). Moreover, researching in one's own practice field can be a resource, but it can also weaken the critical view (Leseth & Tellmann, 2014). In my current position as an occupational therapist working in the municipal service, I should be aware of this possible impact of my own pre-understanding.

As an occupational therapist I often have to answer the question, "What does an occupational therapist actually do?" This question is not just asked by patients or relatives, but also by other health professionals. I therefore had a pre-understanding that not all other health professionals know the expertise areas of the occupational therapist. Furthermore, I suspected that this not knowing about the occupational therapist's expertise could influence the occupational therapist's position in the rehabilitation team. I assumed that not all coordinating units would include the occupational therapist in the rehabilitation team if the patient did not have an obvious need for compensatory aids. Additionally, as an occupational therapist working in a municipal setting, part of my pre-understandings is concerned with which professional occupational therapy expertise areas I see as important in the rehabilitation process when working with ABI patients. I have a professional pride concerning the occupational therapist's contribution to the rehabilitation process and am often eager to tell about the small important details that make a specific rehabilitation process successful. I therefore expected that the participating occupational therapists would be very detailed when describing their contribution to the rehabilitation process. I expected that the occupational therapists would be very focused on the ABI diagnose, its pathological consequences, and the occupational problems it might lead to.

The writing of my pre-understandings has been helpful during my reflections on my own subjective contribution to the study and a support in preserving what Kvale and Brinkmann (2015) call being subjective about one's own objectivity. Using my written pre-understandings systematically helped me, for instance, during the analysis where the rereading of my pre-understandings made me reconsider the first steps of the analysis to make

sure that I did not look for the obvious. Instead I tried to be aware of what was new and unexpected. During the writing of the discussion in the article (chapter 9) and in this thesis (section 7.1) and while working with the theoretical framework I became aware of and got a deeper understanding of some the important mechanisms in the interprofessional teamwork and interdependence in the collaboration. Simultaneously, the theoretical framework contributed to giving me as a researcher an analytical distance to the practice field studied, a field I am part of in my daily work as an occupational therapist working in municipal service.

5.2 Data collection

This section presents the data collection with the choices that have been made during the process, exploring how the professional expertise of occupational therapists working with ABI rehabilitation in municipal service provision is understood, as well as the theoretical recommendations the data collection is based on.

5.2.1 Participants and recruitment process

The study included both rural and urban southeastern Norwegian municipalities with populations ranging from 5,000 to 120,000 inhabitants. All the participants had experiences with the rehabilitation process in their work with ABI patients, but they had different positions in the rehabilitation process and were organized differently internally in the participating municipalities. The coordinating units of rehabilitation in the municipalities were primarily functional rather than organizational units. Therefore, differing terms were used for the coordinating units of rehabilitation depending on the municipality they worked in, even though they had the same purpose: To coordinate and ensure that the patient gets the necessary health services in the rehabilitation process within the municipality. While the coordinating units had a more coordinating function, the occupational therapists in the mono-professional focus group worked more directly with the patients.

The recruitment of coordinating units of rehabilitation in the municipalities was based on information provided by the specialized rehabilitation service that participated in another part of the Transitions in rehabilitation study. A total of 18 coordinating units of rehabilitation from different municipalities were invited to participate in the focus group interviews. 8 municipalities accepted the invitation, and focus group interviews were conducted (Slomic, 2018). 6 of the transcribed interviews were made available for the closer study of the occupational therapists' professional expertise. One of these was excluded as there was no

occupational therapist employed in the municipality. Consequently, 5 interviews were included in this study.

For the mono-professional focus group interview with occupational therapists, the recruitment started with an internet search. The internet search revealed which municipalities within the area included had performing occupational therapists as employees. The municipalities in question were first contacted by telephone and informed of the purpose of the study. If the municipality was interested in participating, a short description of the study (appendix II) was sent to the given contact by E-mail. The E-mail was later followed up by a phone call as a reminder. A total of 15 municipalities were asked to participate, and 6 said yes. 1 municipality sent 2 representatives, and the rest sent 1 which gave a total of 7 participating occupational therapists. It should be mentioned that some of the municipalities invited to participate wanted to exclude themselves from participating on the basis of the research question. These municipalities explained that their occupational therapists did not work with ABI patients or that their occupational therapists did not see themselves as part of the rehabilitation process because their only contribution was to provide the ABI patient with compensatory aids.

5.2.2 Focus group interviews

On the basis of the aim of this study I wanted to bring forward stories about how the professional expertise of the occupational therapists working with ABI rehabilitation in a municipality is understood. To be able to answer the research question a focus group design was chosen. The participants were brought together for a discussion. The intention was to hear narratives that would not be possible to get from individual interviews (Malterud, 2012a). Morgan (2012) describes two different types of research within the focus group design. The first one is "conversation-oriented" which focuses on the way things are said and thereby the interaction between the participants. The second one is "content-oriented" which deals with what is actually said, the contents. To explore how the professional expertise of the occupational therapists working in municipal service is understood, the focus in this study has been the content-oriented approach.

The purpose of the focus group design was not to give a "wall to wall" presentation of the topic, but had a more explorative ambition of opening new doors into a relatively unexplored field. Additionally, it can contribute to developing new research questions that are suited for further in-depth studies (Malterud, 2012a). The advantage of a focus group design is that

participants express multiple understandings and meanings and provide the researcher with a number of different perspectives in their own words. The participants in the focus group challenge each others' contradictions and respond to others' points of view (Ivanoff & Hultberg, 2006). The size of the focus groups was based on Malterud (2012a) recommendation for a maximum number of participants. In the focus groups with the coordinating units of rehabilitation the number of participants varied from 3 to 5 participants with various educational backgrounds, but in each of the focus groups included in this study there was an occupational therapist. The mono-professional focus group with occupational therapists had 7 participants. To produce maximum data variation, the participants in all the focus group interviews were strategically recruited (Krueger, 1993; Malterud, 2012a) as described in the section about participants and recruitment process (Section 5.2.1).

The 5 focus group interviews with the coordinating units were moderated by two PhD-students from the project: Transitions in rehabilitation. The mono-professional focus group interview with the occupational therapists was conducted with me as moderator. All the focus group interviews were audiorecorded for later transcription (Krueger, 1993). The focus and intention of the moderator was not to be controlling or responsible for creating the conversation, but rather to support the ongoing group dynamic to ensure a safe and open atmosphere, where the participants felt safe to express personal and contradictionary views on their understanding of the professional expertise of the occupational therapists´ working with ABI rehabilitation in a municipal setting (Kvale & Brinkmann, 2015; Morgan, 2012). The moderating of the mono-professional focus group interview with the occupational therapists was my first time as a moderator in a focus group interview. However, being the leader of other types of meetings was not new to me, and I could draw on my experiences from previous similar situations. I felt that my experience in chairing meetings was an advantage that made me feel comfortable as a moderator in the focus group interview.

Morgan (2012) uses the term "sharing and comparing" and says that this term is a fundamental part of the interaction within the focus group and one of its important strengths. When participants are mutually interested in the theme, the discussion often takes form by their sharing experiences and thoughts about the topic, as well as by comparing their own contribution to others' experiences. This can be in the form of making remarks on differences and similarities or by expanding the contents of the ongoing discussion. The best focus groups

do not only provide data concerning the participants' thoughts, but also explain why they think the way they do (Morgan, 2012).

5.2.3 Vignettes and interview guides

With the intention to create a concretization of the reflections as well as a common point of reference for the sharing of experiences upon the understanding of the occupational therapists' contribution in the ABI rehabilitation in a municipal setting, the conversations in the focus group interviews were facilitated by vignettes and a short interview guide. This combination was intended to encourage the participants to create their own path in the conversation (Malterud, 2012a; Morgan, 2012). In the focus group interviews with the coordinating units of rehabilitation, a vignette concerning a case person with a traumatic brain injury (appendix III), as well as an interview guide (appendix IV) were used. Both of these were prepared by the researchers who also conducted these interviews. In the mono-professional focus group interview with occupational therapists, two vignettes were presented. In addition to the vignette used in the interviews with the coordinating units, I created a vignette dealing with a stroke patient (appendix V). The purpose of introducing the topic of stroke was to expand the patient group as compared to the interviews that had been conducted with the coordinating units. Additionally, the vignette with the stroke patient was applied because patients suffering from a stroke are one of the largest groups that occupational therapists serve. Furthermore, the dysfunctions after both traumatic brain injury and stroke can be very similar (Blackwood & Wilson, 2009; Wolf, 2011). The vignette concerning stroke was presented as the first one in the interview with the occupational therapists. After approximately one hour of the interview, the vignette concerning the patient suffering from a traumatic brain injury was added. For the purpose of the focus group interview with the occupational therapists, I had also prepared another interview guide (appendix VI) to ensure that the research question was in focus. When conducting focus group interviews Malterud (2012a) stresses the importance of keeping the interview guide short. Too many questions from the moderator can have a negative impact on the quality of the data, and therefore she recommends no more than five to eight questions in the interview guide. The interview guide created for the focus group interview with the occupational therapists was an addition to the two vignettes and was consequently limited to four questions.

5.2.4 Transcriptions

The transcriptions of the interviews with the coordinating units were done by assistants from the project: Transitions in rehabilitation. The transcription of the interview with the occupational therapists was done by me.

5.3 Data analysis

Malterud (2012b) notes that within an explorative study there will not be a search for a complete description of all aspects of the phenomenon of the study. Consequently, the study is considered satisfactory when it opens doors to a, so far, unknown field and can give examples that can contribute to a new understanding of the perception of the professional expertise of the occupational therapists working within ABI rehabilitation in a municipal setting (Malterud, 2011, 2012b). Moreover, Kvale and Brinkmann (2015) state that in the analysis of interviews lies a step between the original story that was told to the interviewer and the final story that the researcher presents.

5.3.1 Systematic text condensation

Systematic text condensation is an explorative, descriptive data-based analysis containing 4 steps. Systematic text condensation is considered suitable for descriptive cross-sectional analysis of phenomena to develop new descriptions and terms, and various theoretical frameworks can be applied (Malterud, 2011, 2012b).

To present the contents of the experiences given in the data material, systematic text condensation entails analytic reduction. The analytic reduction is carried out with a specific alteration between decontextualization and recontextualization of the data (Malterud, 2011). The analysis in this study has been undertaken by me, but, during the process of the analysis, the progression and findings have been discussed with the supervisor of this study as well as other students from the master programme.

Step 1: Total impression – from chaos to themes

To get an overall impression I read through all the transcriptions. After reading all the transcriptions, 5 working themes were created. These themes did not constitute results, because this would demand a deeper and more systematic critical reflection (Malterud, 2012b). In an attempt to be flexible in the further analysing process, these themes were relatively wide and labelled as, for instance, collaboration and adaptation. After a second

perusal, the themes were adapted and narrowed further. Within this step Malterud (2011) stresses the importance of following the phenomenological perspective by being aware of excluding the theoretical perspectives as well as the researcher's pre-understandings to ensure that it is the participants' experiences that are stressed. Additionally, I made sure that the themes created were not too similar to the themes in the interview guide (Malterud, 2011).

Step 2: Identifying and sorting meaning units – from themes to codes

In step 2 of the analysis, I thoroughly read the transcribed material to identify meaning units that could illustrate how the participants understand the expertise of the occupational therapists working in ABI rehabilitation in municipal service (Malterud, 2012b). Malterud (2012b) describes a meaning unit as a long or short piece of text from the transcriptions which describes elements related to the aim of the study. Simultaneously, I made a coding that included identifying and classifying as well as sorting the meaning units that might be related into code groups (Malterud, 2011, 2012b). Each transcript was assigned a colour, and the potential meaning units were coloured in a specific colour. Thus the meaning unit was the same specific colour both in the transcribed material and when placed in the code groups. The colouring was made to facilitate following the empirical material during the analysing process. The process of systematic text condensation contained both decontextualization and temporary movement of part of the text from its original context (Malterud, 2011, 2012b). During the present analysis the meaning units were placed and reorganised several times within the code groups. Some of the meaning units that had first been identified as interesting were reconsidered and replaced or excluded, and a few meaning units were placed in more than one code group (Malterud, 2012b). Additionally, some of the code groups were split or gathered as well as renamed, and code groups that reflected previous research were deleted (Malterud, 2011).

Step 3: Condensations – from code to meaning

In step 3, the code groups were revaluated and some of them were considered as too comprehensive and others as too thin, which lead to the creation of subgroups (Malterud, 2011). Finally, the meaning units were systematically abstracted by creating condensates of the contents of the meaning units from the code groups (Malterud, 2011). A condensate consists of a condensation of the meaning units in the code group, it summarizes and gives the essence of the single group, and was used as a working note and basis for the presentation of findings created in step 4 (Malterud, 2011). An evaluation of the relevance of the meaning

units chosen was continued throughout the analysis, and some meaning units were either moved to another code group or deleted from the analysis. When the condensation of a subgroup of meaning units had been completed, authentic illustrative quotations were assigned for each subgroup (Malterud, 2012b).

Step 4: Synthesizing – from condensation to descriptions and concepts
Based on the condensates and the authentic illustrative quotations, the contents of the condensates were synthesized. Descriptions and concepts were developed to create a story that could describe the understanding of the expertise of the occupational therapists working with ABI rehabilitation in a municipal setting (Malterud, 2011, 2012b). Each of the code groups illustrated a relevant authentic illustrative quotation, and some of the relevant examples were integrated in the analytical text to illustrate the result further (Malterud, 2012b). Because the researcher's role in this step is to retell, the text was written in a 3. person perspective, which also helped me create an analytical distance. The analytical text should be considered the result of the study. The authentic illustrative quotations are only intended to illustrate the nuances of the analytical text. The final results were conveyed by creating illustrative headings for the final four categories presented in the article (chapter 9). These headings are based on the theoretical framework (chapter 4) and newly developed terms (Malterud, 2011, 2012b).

To add something more to the data than just the description of what has been experienced, it is recommended to see the findings in relation to previous research and theory (Malterud, 2012b) which contributes to seeing both characteristic, similarities and differences between the present and previous comparative studies (Fangen, 2010). The appliance of previous research and theory is conducted as part of both the article (chapter 9) and the section with the discussion of findings in this thesis (section 7.1). Previous research, theory and terms are applied to question the material and to improve the understanding of the findings concerning the perception of the occupational therapists' contribution in ABI rehabilitation in a municipal setting (Leseth & Tellmann, 2014; Malterud, 2011, 2012b). The discussions of findings in both the article and in this thesis are related to the theoretical framework presented: Evidence-based practice, professional knowledge, and professional collaboration, and the use of terms has become a link between the data material and the theory (Leseth & Tellmann, 2014).

5.4 Ethical considerations

For this specific study I applied for and received approval from the ethical committee with the Norwegian centre for Research Data (NSD) (appendix VII). All participants in the mono-professional focus group signed an informed consent form stating that they could decline participation without explanation at any time (appendix VII). The participants in the coordinating units' focus groups did the same. The participants' identities were only known to the researchers and were otherwise kept confidential. The transcriptions from the interviews with the coordinating units had already been made when this study started and had thus been anonymized. The anonymizations of the occupational therapists participating in the mono-professional focus group were also ensured during the transcription process.

6 Summary of the article

On the basis of the consequences of the Norwegian coordination reform which has resulted in greater need for rehabilitation in the municipalities and previous studies that have revealed that occupational therapists experience ABI a complex working field, the article (chapter 9) explores how the professional expertise of occupational therapists working with ABI rehabilitation in municipal service is understood. The article is based on a qualitative study with a focus group design including 5 focus group interviews with municipal coordinating units of rehabilitation and 1 mono-professional focus group with occupational therapists working in municipal service. By using the same 4 categories as in the article, this chapter will summarize the findings of the study and be followed by a short presentation of the main themes in article discussion.

Valuable expertise in a municipal setting

In the rehabilitation process in a municipal setting, the most visible areas of expertise of the occupational therapists were described as the providing of compensatory aids as well as the adaptation of the physical environment. In the coordinating units' discussions it was, moreover, underlined that the occupational therapist in municipal service provision adapts the environment to facilitate various activities depending on the patient´s situation of life. Additionally, two of the coordinating unit focus groups also discussed the occupational therapists' expertise within cognitive training and the importance of it within municipal rehabilitation. This more varied description of the occupational therapists' expertise which also included training in cognitive skills was more similar to how the occupational therapists

described themselves. In the mono-professional focus group cognitive training of awareness was stressed as an important field, a field that they considered one of the occupational therapist's most important area of expertise, also within municipal rehabilitation.

Adaptation from a holistic point of view

In the municipal rehabilitation process the occupational therapists in the mono-professional focus group see the revealing of the patient's interests as their main focus. The use of activity analysis and the patient's prioritizing of roles were discussed and considered important in the rehabilitation process in a municipal setting. These specific priorities were not talked about in the coordinating unit focus groups, but they had a similar perception of the occupational therapists' wide area of work, and it was said that the occupational therapists had the expertise of being able to see a complex life situation with a holistic view and help the patient adapt to his new life.

Conscious choices made on the basis of a composed knowledge base

In the mono-professional focus group the performing of evidence-based practice in municipal rehabilitation service was discussed. It was said that the complexity of cases often made it difficult for the occupational therapists to make use of scientific evidence and that their professional experiences as well as the patient's experiences play the main part in the daily practice in the municipal service. Based on this discussion the mono-professional focus group acknowledged that the occupational therapists' work may seem unstructured. Simultaneously, it was underlined that the occupational therapists' interventions are based on very conscious choices, but that the complexity of the cases often forces the occupational therapists to pick elements from different theories and tools to customize them to the individual case.

A rehabilitator with multiple collaboration partners

The occupational therapists in the mono-professional focus group labelled themselves as rehabilitators and explained that they believe that the ideology that is the basis for both occupational therapy and rehabilitation is activity and participation. Furthermore, the occupational therapists see the rehabilitation process as an interprofessional process and emphasize the importance of collaboration and underline that this collaboration is not limited to other health professionals as relatives are also important collaboration partners in the rehabilitation process in a municipal setting. As a collaboration partner the occupational

therapists see themselves as being in a good position to transfer knowledge to both collaboration partners and relatives.

In the article's discussion the occupational therapist's diversity and the labelling as rehabilitator are discussed both in relation to an uncertainty about the role of the occupational therapists, and more positively as an ability to adapt advanced collaboration forms as transprofessional collaboration and role release. An assumed practical synthesis composed by elements of knowledge is interpreted as the basis for the occupational therapists' widely holistic view and adaptability. Beyond this diversity adaptation, compensatory aids and cognition are discussed as valuable area of expertise in a municipal setting where the home environment becomes an important training arena in the ABI rehabilitation process.

7 Discussion

Based on the article (chapter 9), this chapter provides a further discussion of the findings and methodological considerations of this study which aimed at exploring the understanding of the occupational therapist' expertise in ABI rehabilitation within a municipal setting.

7.1 Discussion of findings

The article (chapter 9) provides a discussion of the findings of the study, where the mono-professional focus group reflected on their own work with ABI rehabilitation, and the coordinating units discussed the composite service in municipal rehabilitation including the occupational therapist's contribution in the interprofessional rehabilitation process. These different points of view on the occupational therapists' contribution in ABI rehabilitation in a municipal setting are further discussed in relation to previous research and theoretical perspectives. This section contains a discussion of the findings based on the central elements of the discussion in the article; however, this discussion will extend the interpretation of the findings in a different perspective than in the article. Additionally, the involvement of relatives and their importance in a municipal setting are discussed in this section. Indexation and expertise levels are, moreover, theoretical perspectives that are not presented in the article, but are explained and applied in this thesis.

Working with a client-centred approach and with a holistic view

The occupational therapists in the mono-professional focus group stated that they are working within a client-centred approach and always assess the patient and the patient's needs to find a proper intervention. This client-centred practice requires respect for and a partnership with the patient (Duncan, 2009; Fortmeier, Mathiasson, & Schrøder, 2007). Client-centred practice can thus be considered to address similar considerations as user involvement, which is a fundamental part of both the practice of occupational therapy, evidence-based practice, and rehabilitation (Andreasen, 2008; Duncan, 2009; Fortmeier et al., 2007; Herbert et al., 2011; Solvang & Slettebø, 2012; Towsend et al., 2009). The occupational therapists in the mono-professional focus group claim that they are taking both the person, the environment and their interaction into account (Kielhofner, 2010) which can be interpreted as practicing evidence-based practice. The environment, which can both facilitate and hinder the patient's occupational performance (Holmqvist et al., 2009; Kielhofner, 2010), is the basis when the occupational therapist assesses the occupational problem.

In the mono-professional focus group discussion the occupational therapists indicated that one of the elements they experience as especially important in the patient's home environment is to expand user involvement to also paying attention to the relatives. Each decision that is made concerning the patient also has an impact on the relatives, especially if these live together with the patient (Bertilsson et al., 2015). Relatives can therefore justly be considered an important part of the rehabilitation process, which can lead to a concept of an expanded interprofessional collaboration where the patient as well as the relatives are included in the team as active collaboration partners. Heggen and Kirkevold (2017) describe the expanded user involvement as bringing different kinds of resources into the assessment of the patient; something that a study by Holmqvist et al. (2014) reveals is seen more often in the occupational therapist's work in a municipal service than in the work of the occupational therapist working in the specialist health service. This widening of user involvement was highlighted as a very important element of the rehabilitation process in both the coordinating units' discussions as in the occupational therapists' mono-professional reflections.

It is in the home environment with the relatives that the patient is going to live his new life dealing with the impairment caused by the ABI. In addition to the relatives, the physical environment is also considered an important factor in this new life that has to be lived in the municipality. The findings indicate that the expertise concerning compensatory aids can be

interpreted as an essential expertise to satisfy a holistic view (Helse- og omsorgsdepartementet, 2016b) in the municipal rehabilitation process ensuring that the patient is able to live his new life in the home environment. The expertise of providing the patients with compensatory aids and adaptations within the environment is not specific for the occupational therapist working in municipal service. However, a previous study among occupational therapists working with ABI patients at different levels of the rehabilitation chain revealed that occupational therapists working in the municipality choose compensatory aids as a solution more often than therapists working in hospitals (Holmqvist et al., 2014). Nevertheless, the expertise concerning compensatory aids might be more necessary in the municipality than in the specialist health service where institutional environments are more adapted to universal use (Holmqvist et al., 2014; Holmqvist et al., 2009). Furthermore, the holistic view can have an impact on the necessity to adapt the environment as well as to provide compensatory aids.

In the coordinating units' discussions it was underlined that they wish to take the whole family's needs into account. One example was the wish to be able to play with one's children, which would probably demand a more comprehensive adaptation than if the adaptation was limited solely to the patient's needs. Taking the whole family's situation into account presupposes the extension of user involvement and collaboration partners as well as a wide holistic view, which is an approach that corresponds to the statement by the occupational therapists in the mono-professional focus group, who underlined that they assess the patient and his occupational needs. The assumption that the occupational therapists have a holistic approach is supported by a study conducted by Spang and Holmqvist (2015) who emphasize the occupational therapists' holistic approach to the patient's occupational challenges.

A rehabilitator with an indexed knowledge

In the article discussion (chapter 9) the term "rehabilitator" is discussed in relation to collaboration and the occupational therapists' heterogeneous knowledge base. The term "rehabilitator" originally originates from the mono-professional focus group, where the occupational therapists justified their interpretation of themselves as rehabilitators on the basis of a common ideology for both occupational therapy and rehabilitation. This ideology was referred to as activity and participation, an ideology that can be seen as presupposing a holistic view. This holistic view and the rehabilitators' ability to perform in many fields and positions in the rehabilitation process within the municipality can be a strength, but also a

weakness for the occupational therapist' professional identity and contribution in the ABI rehabilitation in a municipal setting.

In a qualitative study, Finlay (2001) revealed that some occupational therapists feel that they can be proud of their holistic approach, but they also experience that their holistic view might hide a lack of clarity about the occupational therapist's expertise. In the findings of the present study the mono-professional focus group with occupational therapists listed a number of acknowledged theories and standardized tools and described how they use their expertise in the rehabilitation process to, for instance, train cognitive skills or to pass on information to relatives and other collaboration partners. They also stressed that every rehabilitation process must be customized to ensure that the patient's needs are taken care of. Such a description can be interpreted as a positive one if it refers to the occupational therapists' ability to adapt and thereby ensure the patient's needs and the practicing of transprofessional teamwork as discussed in the article (chapter 9). Nevertheless, the occupational therapist's ability to adapt to the situation and use the necessary expertise in the given situation can also be perceived as what Fortune (2000) calls gap fillers, meaning that the occupational therapist fills the gaps that are left between the other professionals' practice and does what needs to be done unrelated to occupational therapy expertise. Seen in a positive view, gap fillers can also be interpreted as rehabilitators practicing in a transprofessional or role release position. The terms "rehabilitator" and "gap fillers" can, however, be perceived as negative for the identity of the occupational therapy profession and contribute to the uncertainty about the actual expertise the occupational therapists in a municipal service provision master.

In the mono-professional focus group the occupational therapists interpreted their adaptability and the term rehabilitator in a solely positive way. Even though the occupational therapists labelled themselves as rehabilitators, they stressed that their intervention is based on something structured and that they strive to perform evidence-based practice, even though they are aware that sometimes the scientific evidence fills the least in the given intervention. The article discussion (chapter 9) refers to the assumption that the occupational therapists' knowledge is combined in a certain way to meet the requirements from the clinical setting to compose a practical synthesis (Grimen, 2008). When the requirements to a specific clinical setting are referred to, it should be considered whether every new setting demands completely different expertise and whether the basic educational expertise is always sufficient in a complex field as ABI rehabilitation in a municipal setting or if personal professional

experiences are required. The evidence-based medicine's inclusion of the element of professional experiences reinforces the assumption that basic educational occupational therapy expertise, which is mainly theoretical knowledge, not practical knowledge, is not sufficient to be able to perform evidence-based practice in ABI rehabilitation in a municipal setting. An interpretation of this can be that the practical synthesis should contain professional experiences within this specific area to fulfil the demands of an evidence-based practice.

In the mono-professional focus group they talked about it that the occupational therapists often choose to mix or use single parts of a tool to achieve a specific result because of the complexity of the cases. Experience within the specific area is therefore considered an important resource in the daily practice of ABI rehabilitation. A combination of theoretical knowledge and practical knowledge leads to what Grimen (2008) calls indexation. Indexation has a strong personal dimension and is partly based on the experiences of the practitioner who develops his professional expertise through practice and interaction (Grimen, 2008; Hjardemaal & Jordell, 2011; Lahn & Jensen, 2008). This practical knowledge, which can only be gained in first person perspective, cannot be detached from the individual person or from the situation where it is learned and applied (Grimen, 2008). Consequently, personal professional experiences contribute to expanding the practical synthesis which again contributes to the shaping of the professional's personal indexed knowledge.

An expert expertise based on indexed knowledge and a practical synthesis

In the definition of indexation lies the assumption that the professional practitioner is an expert on his own previous experiences. These experiences are the basis for his practical knowledge, and these experiences are reflected in the professional's actions, his professional judgment, and in the assessments and estimates he makes (Grimen, 2008). In the article (chapter 9) it is underlined that the occupational therapist has an expertise when it comes to cognition. The extent of this expertise may, however, be seen as unclear in the focus groups interviewed. The occupational therapists' expertise within compensatory aids and cognition were talked about in the coordinating units' focus group discussions, but only two of the groups also discussed the occupational therapists' expertise within cognitive training. In the mono-professional focus group, the occupational therapists stressed that awareness is fundamental for almost all occupational behaviour and that training in cognitive skills is an important expertise area for the occupational therapist when working with ABI rehabilitation including those working in the municipal service provision.

Previous studies conducted in other practice fields than the municipality agree that the occupational therapist has an important role in the ABI rehabilitation when it is a question of cognitive impairments (Holmqvist et al., 2014; Holmqvist et al., 2009; Wolf, 2011). In spite of it that the occupational therapists are acknowledged for their expertise within cognitive impairment, the findings of this study indicate that this specific expertise might not have been used to the same extent in the municipal setting as in hospitals. This indicates that the practical synthesis to the occupational therapist in municipal service provision has not necessarily contained the expertise in cognitive training if it has not been a necessary expertise in the given municipal setting, because the cognitive training was primarily taken care of in the specialist health services. As a consequence of the Norwegian coordination reform a more comprehensive rehabilitation process in the municipality is now needed and this requires an advanced level of professional expertise, and the expertise within cognitive training might become an even more important expertise for the occupational therapist in municipal service.

In the mono-professional focus group, several tools and interventions to address cognitive impairment were emphasized. However, a number of the tools listed in their discussion are not considered standard tools in the occupational therapist's basic education, which indicates that some of the expertise used within this specific area should be considered what Willumsen (2009, 2016) calls expert expertise, which is narrow, specific expertise gained through further education. Moreover, in both the coordinating units' discussions and in the mono-professional focus group's reflections it was considered necessary to customize the individual rehabilitation process to the case and the impairment the patient is suffering from due to ABI. This customization indicates that experiences from previous similar cases could be useful, experiences that contribute to shaping the practical synthesis as well as the indexation of any occupational therapist, also in a municipal setting.

The occupational therapist's expertise within cognitive training is, in short, valued in ABI rehabilitation, but not yet as visible in a municipal setting as the expertise within compensatory aids and environmental adaptation. On the basis of a practical synthesis composed by both scientific knowledge and practice experiences the occupational therapists do, nonetheless, contribute to the evidence-based rehabilitation process as rehabilitators and also with specific narrow expert expertise depending on the individual case.

7.2 Methodological considerations

The methodology and design for the study are described in the method chapter of this thesis (chapter 5). In addition, a discussion of methodological considerations is briefly presented in the article (chapter 9). On the basis of the methodical considerations from the article this section will add further considerations and have a wider focus on the terms of reliability and validity, two central terms when a study should be evaluated (Malterud, 2011).

Reliability

Reliability is about the trustworthiness and transparency of the study and is related to the parts of the study that deal with the planning and conduction of the study (Kvale & Brinkmann, 2015; Leseth & Tellmann, 2014). The reliability can be strengthened through the transparency of the research process (Leseth & Tellmann, 2014), which is thoroughly described in the article and assignment.

The writing of my pre-understanding has helped me focus my effort when moderating the focus group interview so that it was not adversely affected by my own perceptions of the subject (Krueger, 1993; Postholm, 2010). The moderators in the interviews with the coordinating units of rehabilitation were a PhD-student in health science and a PhD-student of social work and social policy. This diversity in the moderators' professional backgrounds has influenced the conversations in the focus groups, which is important to be aware of when interpreting the results. Furthermore, the focus group interviews with the coordinating units of rehabilitation were originally designed for other parts of the Transitions in rehabilitation and were also the basis for the PhD-projects. The purpose of the PhD-projects was, *"To explore interaction within the rehabilitation teams at both the specialized and the municipal rehabilitation services paying attention to the transitions of patients with TBI and multiple trauma between services"* and *"To analyse transitions between the health care sector and the labour- and welfare sector".* The fact that the focus group interviews with the coordinating units of rehabilitation were originally designed for the two PhD-projects may have influenced this particular study. However, all three studies had specific focus on the interaction within the rehabilitation services. Interaction between healthcare services involved in the rehabilitation process requires collaboration and knowledge about the professions involved, a focus that is considered to justify including the coordinating unit focus group interviews in this present study.

Validity

The validity of a qualitative study is measured by whether there is a consistence between the aim of the study, the method used, and the theoretical perspectives applied. To fulfil this, deliberations on the validity of the study should be followed in all parts of the research process including the planning of the study design, the recruitment of participants, the collecting of data, the method of analyzing, the applying of theoretical perspectives, and the presentation of findings (Kvale & Brinkmann, 2015; Malterud, 2011). Malterud (2011) refers to two terms of validity: "Internal" validity which defines that the method used is one that will give validated answers to the research question. "External" validity refers to the transferability to other settings.

The strength of the focus group design is that the researcher is given the opportunity to understand the way people view their own reality, and it is particularly well designed to, for instance, determine how the occupational therapists' service and their expertise in the ABI rehabilitation process in a municipal setting are understood (Krueger & Casey, 2009). The focus group design can also contribute to revealing different meanings given to words and concepts (Palm & Windahl, 1988).

Some municipalities that were invited to participate in the mono-professional focus group with only occupational therapists excluded themselves (section 5.2.1), which can be seen as a bias considering the findings of the study. Nonetheless, those that did take part are considered representative for those who take part in the ABI rehabilitation in the municipality. It should also be mentioned that all the participants were females which was not a conscious choice. This can, however, be seen as a result of the gender distribution within the health professions in the municipality healthcare services.

A triangulation of methods in the form of data collecting strategies like, for instance, an observatory approach could have added to the validity of the study (Postholm, 2010). Nonetheless, the findings were generated from both the coordinating units' perspective and that of the occupational therapists in the context of vignettes. This variation can be seen as a data triangulation and strength for the validity of the study (Malterud, 2011; Postholm, 2010).

This study was not intended to generalize, yet the recruitment process (section 5.2.1) focussed on ensuring a variety of participants (Krueger, 1993; Krueger & Casey, 2009).

Transferability, also described as the external validity (Malterud, 2011) to other municipalities responsible for delivering services within the rehabilitation process of ABI patients, is therefore considered a possibility (Postholm, 2010).

The inductive approach has contributed to ensuring the consistence between the aim of the study which was to explore how the expertise to the occupational therapist working with ABI rehabilitation in a municipal setting is understood, the empirical material, and the perspectives applied (Kvale & Brinkmann, 2015) in this case both evidence-based practice, professional knowledge, professional collaboration and previous research. This has contributed to the validation of the terms used in the analysis as well as the internal validity of the study (Leseth & Tellmann, 2014; Malterud, 2011).

The study has been conducted in Norwegian and while translating the material from Norwegian into English the focus has been on preserving the meaning of the statements rather than making a literal translation.

8 Concluding remarks

The study indicates that the occupational therapists working with ABI rehabilitation in a municipal setting practice expert expertise in addition to their professional core expertise. Nevertheless, the occupational therapists' expertise within compensatory aids, environmental adaptation, and cognition are valued in ABI rehabilitation in the municipality. The occupational therapists' professional expertise which are based on a practical synthesis enable them to cross boundaries and perform role release within the interprofessional collaboration, where they contribute to the rehabilitation process as rehabilitators with a wide holistic view.

In summary, this study shows that the occupational therapists taking part in the rehabilitation process of ABI patients in a municipal setting should optimally master the same areas of occupational therapy expertise which previous studies show are used in the hospital healthcare services. However, the study indicates that the municipality context often requires a wider holistic view. This holistic view often results in extended interprofessional collaboration and the need for more adaptation of the physical environment than in an institutional setting. Further research is, however, needed to investigate and give a more in depth description of the different forms of interventions the occupational therapists contribute

with in the rehabilitation process when working with ABI patients in municipal service provision.

9 Article

Essential Expertise for the Occupational Therapist working with Acquired Brain Injury Rehabilitation in Municipal Service Provision

Background As a consequence of the Norwegian coordination reform patients now spend less time in hospital and are sent back to the municipality earlier than before. Studies show that occupational therapists (OTs) experience patients with acquired brain injury (ABI) a complex working field and in some situations the OTs fail to believe in their own professional expertise. ***Aim*** This qualitative study aimed to explore how the professional expertise of OTs working in ABI rehabilitation in municipal service provision is understood. ***Material and Methods*** One mono-professional focus group interview with OTs and five focus group interviews with municipal interprofessional coordinating units of rehabilitation were the basis for the study. Data were analysed using systematic text condensation. ***Findings*** The OTs work in a municipal setting is characterized by a holistic view and strategically selected areas of expertise. A composed base of knowledge enables the OTs to be rehabilitators who have multiple collaboration partners. ***Conclusion*** The OT's area of expertise within adaptation, compensatory aids, and cognition are considered valuable in ABI rehabilitation in a municipal setting. Moreover a practical synthesis of knowledge and the practice of transprofessional collaboration and role release enable the OT to take position as a multifarious rehabilitator.

Keywords: Municipality, Occupational Therapist, Acquired Brain Injury, Rehabilitation, Interprofessional Collaboration

Introduction

Acquired brain injury (ABI) is one of the most frequent causes of death and disability and is a major challenge for the patients as well as the relatives, the care system, and society [1, 2, 3, 4]. Patients with ABI are one of the main patient groups that occupational therapists (OTs) serve, and among these those that have had a stroke constitute one of the largest groups [5, 6].

The passing of the Norwegian coordination reform (In Norwegian 'Samhandlingsreformen'), which is concerned with cross-sector cooperation, has led to a shift of responsibility from the specialist healthcare in hospitals to the primary healthcare systems in the municipalities [7], a tendency that can be seen not only in Norway, but also internationally [5]. This shift of responsibility has resulted in patients spending less time in hospital and being sent back to the

municipality earlier than before [5, 8]. Consequently, the complexity and the number of tasks in the municipalities have increased, but in spite of a gradual responsibility shift there is still a lack of rehabilitation opportunities in the Norwegian municipalities [9]. The Norwegian coordination report stresses the importance of professional expertise and underlines that expertise is one of the main keys to succeed with rehabilitation at all levels [7]. Furthermore, the increased responsibility in the municipalities causes a demand for higher expertise in the healthcare services in the municipalities than previously [10].

For most patients the goal of rehabilitation is to increase their abilities to be able to keep on living in their home environment. To achieve this, training in daily activities is considered the most important task [7]. This training, which requires assistance from professional experts, is usually described as the main responsibility area of occupational therapy [11, 12, 13] that has activity and occupation as two important components in its philosophy [14, 15].

Previous studies show that the OTs experience ABI patients a complex working field [6, 16], and in some situations the OTs feel a lack of important knowledge relating to ABI, which leads to a missing trust in their own professional expertise and the feeling of not having a sufficient theoretical foundation [5] when they plan their interventions. However, literature review reveals that studies within this particular field have primarily been conducted in mixed fields with participants from different levels of the rehabilitation chain. In some, both hospital and municipality rehabilitation have been represented and in others the specialist health service exclusively [5, 17, 18]. Considering the tendency in the shift of responsibility from the specialist healthcare services to the municipalities, it is important to explore the professional expertise the OTs make use of in this complex practice field when working within ABI rehabilitation in a municipal setting.

More specifically the aim of this study was to reveal how the professional expertise of OTs working with ABI rehabilitation in the municipality service is understood both within interprofessional collaboration settings and among OTs reflecting in a mono-professional setting.

Key Concepts

The OTs work within ABI rehabilitation in a municipal setting requires different forms of knowledge, and together these forms of knowledge constitute the elements of evidence-based practice. Additionally rehabilitation is a process that requires collaboration from a number of different professionals.

The Norwegian philosopher Grimen [19] works with knowledge synthesis, and he labels the profession´s base of knowledge homogeneous if the elements in the base are from the same scientific discipline or from the same field of knowledge. In contrast the base of knowledge is considered heterogeneous if the knowledge base is composed by elements from different scientific disciplines or from different fields of knowledge [19]. According to Grimen [19], a profession´s base of knowledge constitutes a theoretical synthesis if the integration between the different elements is based on a comprehensive theory. It is a practical synthesis if what integrates the elements in the profession´s base of knowledge are the claims made by the profession´s professional practice [19].

The performance of evidence-based practice requires three elements that all emerge from a specific question regarding the relevant clinical question to be answered [20]. In the encounter with a patient, a practitioner should apply clinical research knowledge, the practitioner´s

professional knowledge, and questions to the patient about wishes and experiences [20, 21, 22, 23].

Professional collaboration can take different forms within a continuum from multi-through inter- to transprofessional collaboration and ultimately role release [24, 25]. Role release can be seen as the optimal form of cooperation for the professionals in the collaboration team. In the performance of role release, the professional team members make adaptations in their role to take into account and interact with roles from the other professionals in the same way as in interprofessional collaboration, and they transfer information, knowledge, and skills across professional boundaries as in transprofessional collaboration [24, 25]. In addition, role release requires that team members take and use aspects of the primary functions of other team members with a different professional background [24].

Material and Methods

A qualitative approach when conducting focus group interviews was used [26]. 1 mono-professional focus group interview with OT`s was conducted. Additionally, based on the aim of the study and the characterization of the work of the OT in a municipality setting, relations of interprofessional collaboration are considered essential during the rehabilitation process. Therefore, an empirical design that approached the research question from both an interprofessional and a mono-professional point of view was considered relevant [27]. Consequently, interprofessional focus group interviews with 5 municipal coordinating units of rehabilitation were added. The strategy of systematic text condensation [28] was applied for the data analysis.

The study was part of the project 'Transitions in rehabilitation: Biographical reconstruction, experiential knowledge and professional expertise'.

Recruitment Process and Participants

The study included both rural and urban municipalities in southeastern Norway, with populations ranging from 5,000 to 120,000 inhabitants. All participants had experience with ABI patients, even though they had different positions in the rehabilitation process and were organized differently internally in the participating municipalities. The inclusion criteria for the OTs reflecting in a mono-professional focus group were: OTs working in a municipal service with minimum 2 years of experience in working with ABI patients. 15 municipalities were asked to participate. 6 participated, 1 of them sent 2 representatives, the rest 1. The coordinating unit of rehabilitation in the municipalities was primarily a functional unit and was termed differently depending on the municipality, even though they all had the same purpose: To coordinate and ensure the patient got the necessary health services in the rehabilitation process within the municipality. 18 coordinating units of rehabilitation were invited to participate, 8 of those accepted the invitation, and focus group interviews were conducted [29]. 6 of the transcribed interviews were made available for the closer study of the OT's professional expertise. 1 of the interviews was excluded as there was no OT employed in the municipality. Consequently, 5 interviews were included in this study. These focus groups had a variation of 3-5 participants with various educational backgrounds, but with an OT represented in each of the focus groups.

Focus Group Interviews

The focus group interviews were undertaken using vignettes and interview guides [26, 30]. A case with a person with traumatic brain injury in need of rehabilitation in the municipality was

used as vignette. Since the dysfunctions after both traumatic brain injury and stroke can be very similar and since patients with a stroke constitute one of the largest groups that OTs serve [6], an extra vignette dealing with a stroke patient in need of rehabilitation in the municipality was presented in the interview with the OTs.

Data Analysis

The analysis was framed by Malterud`s systematic text condensation [28, 31]. 1) All the transcriptions were read through to obtain an overall impression of the understanding of the professional expertise of the OTs working in ABI rehabilitation in a municipal setting. 2) Meaning units that addressed the expertise areas of the OT were identified and coded. 3) The contents of the code groups were condensed. 4) Finally, the contents of the condensates were synthesized into descriptions concerning the understanding of the OT's professional expertise within ABI rehabilitation in a municipal service provision. Examples are shown in Table 1.

[Table 1. near here]

Ethical Considerations

This study was approved by the ethical committee at the Norwegian centre for Research Data (NSD). All participants signed an informed consent form stating that they could at any time refuse to participate without giving an explanation, and the participants' identities were kept confidential.

Findings

The findings are presented in four categories that all address the OT's work with ABI rehabilitation in a municipal setting.

Valuable Expertise in a Municipal Setting

A general understanding that emerged during the discussions in the coordinating unit focus groups was that the OT has a specific expertise when it is a matter of adapting the physical environment. Especially the providing of compensatory aids was discussed as highly visible in the municipal rehabilitation service. In one of the coordinating unit focus group interviews the OT´s work regarding adapting the environment was described as follows:

> The occupational therapist adapts the environment to facilitate activity and occupational behaviour depending on the patient´s situation of life. This can be at work and at home, for example in order to enable the patient to play with his children by providing the patient with the necessary compensatory aids to do so.

All 5 coordinating unit focus groups talked about compensatory aids in relation to both physical as well as cognitive impairments, furthermore, two of the coordinating unit focus groups also discussed the OT´s expertise within cognitive training and the importance of it in the municipal rehabilitation service. In the context of both physical and cognitive impairments the coordinating unit focus groups and the OT focus group all talked about the patient´s home environment as a preferred arena for both assessment and training. It was said that in the municipal setting, the goals for the rehabilitation were often linked to the patient´s home environment. The environment can often be adapted to compensate physical impairments, but the OT focus group furthermore underlined the frequency of cognitive impairments after ABI and emphasized that these cognitive impairments are quickly revealed during observation of activities and that the cognitive impairments also should be taken into account when adapting the environment. The OTs' discussion further highlighted training of awareness as fundamental for almost all occupational behaviour. When dealing with patients suffering from neglect, OTs consider training of awareness a central factor, both during training sessions and environmental adaptation. The OTs expressed that:

> Cognitive training of awareness is an important field, and a field that is one of the occupational therapists´ professional expertise areas.

Even though the OT's expertise within cognitive training was discussed in two of the coordinating unit focus groups as well as underlined by the OT focus group, the expertise within adaptation and the providing of compensatory aids are perceived the most visible areas of expertise of the OT working in the municipal service provision.

Adaptation from a Holistic Point of view

The OTs' focus group stated that the OT´s main focus in the rehabilitation process in a municipal setting is to try to reveal what is important for the patient. The OTs' focus group described that they use activity analysis to pinpoint which demands a specific activity requires from the patient´s functions and to identify needs for adaptation. Furthermore, in the OT focus group they described the clarification and the patient's prioritizing of roles as an important part of the rehabilitation process in a municipal setting. In the coordinating unit focus group interviews this was not said directly, but they acknowledged the OT´s expertise to adapt and facilitate a complex life situation with a holistic perspective. The OT focus group described their working process as follows:

> We assess the patient and try to discover what is important for the patient, and afterwards we find appropriate measures. These measures can be in the form of training, environmental adaptation, or compensatory aids. Unfortunately, everyone connects our profession with compensatory aids and thinks that this is our expertise. We, of course, know a lot about compensatory aids, but our main focus is the patient.

The OT focus group underlined that activity analysis is used to pinpoint the patient's occupational challenges and that the final solution to the occupational problem is chosen based on a holistic perspective.

Conscious Choices made on the Basis of a composed Knowledge Base

In the OTs´ focus group, they talked about evidence-based practice. The OTs underlined that they strive to work evidence-based, although they often feel that the complexity of cases involving several diagnoses make it difficult to make use of the available scientific evidence. The OTs expressed that they feel that the professional's experience-based knowledge and the patient´s knowledge and involvement play the main part in their daily practice in the municipal service provision. Nevertheless, they explained that they practice several acknowledged theories and methods like, for example, Bobath and A-one as well as standardized tools like, for instance, COPM. The OTs in the mono-professional focus group described it as:

> The occupational therapists´ work sometimes appears unstructured, but the things that are done in the interventions are based on something structured. The complexity of the cases, however, often forces the occupational therapist to pick out elements from different theories and tools to customize them to the individual case.

The OTs in the mono-professional focus group state that they are working within evidence-based practice, but that their interventions are indeed based on several conscious choices concerning the individual case and involve both the OT's and the patent's practical experiences.

A Rehabilitator with multiple Collaboration Partners

In the OT focus group the OTs labelled themselves as rehabilitators. They added that they have several collaborative partners in the municipal setting depending on the case, but that the physical therapist is a frequent collaboration partner. The OTs share important knowledge with the physical therapist and their respective fields of expertise complement each other well, especially in activity-based training. In the transferring of knowledge, the OTs

experience that they are in a good position to guide the care givers in the municipal rehabilitation service on, for instance, how to mobilise the individual patient, and to collaborate with them to customize a daily programme for the patient. In the OT focus group discussion they explained that:

> Through the interprofessional collaboration we see ourselves as rehabilitators. The ideology that is the basis of both occupational therapy and rehabilitation is activity and participation and that the team are working towards the same goal, but from different perspectives.

In addition to the professional collaboration partners, the OTs stress the importance of the relatives as collaboration partners during the entire rehabilitation process within the municipality. In cases where the ABI has resulted in cognitive impairment, the OTs see their expertise within cognition as being extremely valuable when they exchange information with the patient´s relatives. The mono-professional discussion underlines this by declaring that:

> Relatives are important collaboration partners from the beginning of the rehabilitation process all the way to the evaluation of the rehabilitation process, and it is important that the relatives are supported throughout this process.

The OTs underline that they have several collaboration partners including relatives, and by labelling themselves rehabilitators the OT focus group sums up its experiences of the OT´s contribution to the rehabilitation process.

Discussion of Findings

The study aimed at drawing attention to and exploring how the professional expertise of an OT working with ABI rehabilitation in municipal service provision is understood interprofessionally as well as mono-professional. The findings indicate that even though

compensatory aids are a highly visible expertise, the OTs' position in the rehabilitation process is multifarious as they are working from a holistic perspective. A diverse base of knowledge and multiple collaboration partners are described as characteristic for the OT. It is important to note that both the coordinating units and the OT focus group did not seem to be too concerned about the main diagnose, but rather the impairments and the challenges this could lead to. This observation corresponds very well with the study by Røsstad et. Al [32] who revealed that where the professionals in hospitals focus on diagnoses, the professionals in the municipality focus more on the patient's disabilities and have a more holistic view [32].

Collaboration Skills on the Basis of a Practical Synthesis

In the coordinating units discussions, the OTs were described as people belonging to a profession that works in many different fields and holds various positions. This perception can contribute to obscuring the clarity of the role of occupational therapy [33].The OTs themselves indirectly confirm this assumption by, for instance, calling themselves rehabilitators. This term 'rehabilitator' can be interpreted as a characteristic that can be referred to as the ability to adapt or transfer knowledge in transprofessional teamwork and perform role release [24]. This assumed ability to perform role release can be caused by occupational therapy's heterogeneous base of knowledge [19, 34, 35]. The OT's elements of knowledge are tied together through the requirements from the clinical setting to compose a practical synthesis [19]. This heterogeneity and practical synthesis can contribute to illuminate the OT´s widely embracing concern about a holistic view during the rehabilitation process [33, 34]. This widely holistic view can be seen as a necessity for the OT working within a municipal setting in order to be able to help a patient living with sequel after ABI back to a new life, but it can also reinforce the uncertainty about the role of the OT.

Three important Expertise Areas when working within a Municipal Setting.

The OTs' expertise within environmental adaptation and compensatory aids was frequently highlighted in the coordinating units' discussions. This expertise is not specific for the OT working in the municipality, but may be more visible in the municipality and private homes because of the often already more facilitated and adapted environment in institutions [5, 17]. Even though the overall impression of the coordinating units was that the OT´s contribution to the rehabilitation process within the municipality was compensatory aids, some members of the coordinating units acknowledged the OT's expertise within cognitive training. This view is in line with how the OTs in the mono-professional focus group see themselves. Cognition is also an expertise that is described in previous research on OTs´ contribution to the rehabilitation process of ABI patients [5, 16, 17]. The OT focus group expressed that they consider the training of awareness fundamental for almost all occupational behaviour and one of their important expertise areas. The expertise within cognition can be seen as an important contribution in the rehabilitation process within the municipality, because cognitive impairment is often a consequence after ABI [2, 5, 6]. Cognitive skills can be very difficult to both reveal and train in an unfamiliar environment [5] like, for instance, a hospital, and the transferability of the trained skills from one setting to another can be difficult [5]. Training conducted in the patient's home environment, which is the working field for the OT in the municipality, can thus be an important factor enabling patients suffering from ABI to live their new life as independently as possible.

In summary, the OT's areas of expertise within compensatory aids, environmental adaptation, and cognition are considered valuable in ABI rehabilitation within the municipality. Moreover the practical synthesis and the practice of transprofessional collaboration and role release

enable the OT to cross professional boundaries and take position as a multifarious rehabilitator in the rehabilitation process.

Methodological Considerations

The focus group design was chosen to get an understanding of the way the participants perceive the OT's contribution in the rehabilitation process [36]. The aim was not to give a presentation of the topic in depth, but a more explorative ambition [30, 37] and describe a cross-sectional analysis to develop more insight and understanding [31, 36]. This study was thus not intended to generalize [36], nevertheless it is considered transferable to other similar settings [27, 38]. Triangulation of methods could have expanded the validity of the study. Nevertheless, since focus groups share experiences, they express a collective, not the individual view [37, 39], even though it is important to be aware that a condensate in the analysis does not always contain contributions from all participants in the discussion. The validation in the analysis has come from testing out ideas with scholars and students in a rehabilitation research group. Further research is, however, needed to give a more in depth description of the professional expertise the OT contributes within ABI rehabilitation in a municipal service provision.

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Declaration of Interest

The author reports no conflicts of interest. The author alone is responsible for the contents and writing of the paper.

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Table 1. The analytical process with examples

Initial themes	Identifying and sorting meaning units	Condensation	Synthesising	Final category
Adaptation	…he is sitting on a chair while playing, and it is important to think: what is important for you to do with the children? Is it reading for them? Is it to swing on a swing in the kindergarten or is it kicking to a ball? There may be a lot of things that you have to go into, so it is going to be a bit of a job to figure out what to do. - I think. Here the occupational therapist is going to do a fantastic job, I think (coordinating unit).	The occupational therapists facilitate and adapt the environment to occupational behaviour at home like, for example, to enable the patient to play with his children and to provide him with the necessary compensatory aids to do so.	The occupational therapist has a specific expertise in adapting the physical environment	*Valuable Expertise in a Municipal Setting*
The patient's interest and roles as the main focus	… and there is this thing about roles which is very important. Here in Norway, and certainly also in several other countries, we are in such a hurry to go back to work. This is in a way our identity. And he is in a way, he cannot manage to be with his kids. He cannot manage to be at work. No wonder he is a bit depressed. So, in a way, he has not lost any value, that is a bit important I think I think (occupational therapist)	The clarification and prioritization of the patient's roles and resources is an important part of the occupational therapist's contribution in the rehabilitation process.	Clarification and the patient's prioritizing of roles is an important part of the rehabilitation	*Adaptation from a Holistic Point of view*
Theoretical knowledge versus Practical knowlegde	…experiences and the patient's knowledge, I think, are the factors that fill the most, and there is less research. Now I'm lucky to work in a team with a young physiotherapist who brings us some research articles and so on. That helps a little, but there is not much about occupational therapy in them (occupational	The occupational therapist's professional experiences and patient knowledge play the main role in evidence-based practice	The professional's experience-based knowledge and the patient knowledge and involvement play the main part in the daily practice	*Conscious Choices made on the Basis of a composed Knowledge Base*

	therapist)			
Collaboration	I am an occupational therapist, and that is indeed what I am. At the same time I am becoming more and more a rehabilitator, We work truly interdisciplinary in the team, and we work with the same things, but seen through a different pair of glasses; but you learn a lot from each other, and it is as if rehabilitation has become a profession. Occupational therapy is no longer the main thing (occupational therapist).	Through the interdisciplinary collaboration, the occupational therapists see themselves as rehabilitators.	The occupational therapists labelled themselves as rehabilitators	*A Rehabilitator with multiple Collaboration Partners*

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Appendix
Appendix I: PICO

Arbeids problemstilling: Hvilke profesjonelle kompetanser kreves/forventes/ønskes av den kommunale ergoterapeuten i rehabiliteringsprosessen i arbeidet med personer med ervervet hjerneskade?

SØKEORD

OR ↓ mellom ord i samme kolonne

	Søkeord 1(P)	**Søkeord 2 (I)**	**Søkeord 3(C)**	**Søkeord 4 (O)**
Norsk	Ergoterapeut ergoterapi	Rehabilitering Rehabilitering, kommunalt	Hjerneskade **og** ervervet	Profesjonell Ergoterapeutsik-praksis, -evidensbasert Ekspertise Kompet*
Engelsk	Occupational therapists Occupational therapy	Rehabilitation Rehabilitation, community - based	Brain injuries **and** Acquired	Professional Occupational-Therapy - Practice,- Evidense-based Expertice Compet*

→ AND →
mellom ord i forskjellige kolonner

SØKEHISTORIKK

Database / søkemotor / nettsted	Søk nr.	Søkeord/ søkekombinasjoner	Antall treff (pr. .....)	Kommentarer til søk / treffliste (fyll ut etter behov)
Chinal	1	Occupational tehrapy **or** Occupational therapists	28,446	
	2	Rehabilitation **or** Rehabilitation, community - based	108,478	
	3	Brain injuries **and** aquired	1,271	
	4	Professional **or** occupational therapy practice, evidence-based **or** expertise **or** compet*	267,098	
	5	S1 **and** S2 **and** S3 **and** S4	12	Ut fra overskrifter var 4 relevante
MedLine	1	Occupational tehrapy **or** Occupational therapists	22,492	
	2	Rehabilitation **or** Rehabilitation, community - based	328,652	
	3	Brain injuries **and** aquired	2,174	
	4	Professional **or** occupational therapy practice, evidence-based **or** expertise **or** compet*	711,118	
	5	S1 **and** S2 **and** S3 **and** S4	18	Ut fra overskrifter var 4 relevante
Academic Search	1	Occupational tehrapy **or** Occupational therapists	13,716	

Premier	2	Rehabilitation **or** Rehabilitation, community - based	227,436	
	3	Brain injuries **and** aquired	1,368	
	4	Professional **or** occupational therapy practice, evidence-based **or** expertise **or** compet*	1,330,237	
	5	S1 **and** S2 **and** S3 **and** S4	25	Ut fra overskrifter var 3 relevante

Artikler fremkommet ut fra søket:

Chinal: artikler 12→ lest overskrifter→ 4 artikler

MedLine: 18 artikler → lest overskrifter → 4 artikler (3 samme som Chinal)

Academic Search Premier: 25 artikler → lest overskrifter → 3 (2 samme som Chinal og MedLine)

<u>Artikler funnet i alt ut fra overskrift (Chinal, MedLine, Academic Searchh Premier): 6</u>

Finnes i alle 3 databaser:

- Therapeutic use of self as defined by Swedish **occupational therapists** working with clients with cognitive impairments following **acquired brain injury:** a Delphi study (Holmqvist, Holmefur, & Ivarsson, 2013).

- **Occupational therapist** practice patterns in relation to clients with cognitive impairment following **acquired brain injury** (Holmqvist, Ivarsson, & Holmefur, 2014).

Funnet både i Medline og Chinal:

- **Occupational therapists**' descriptions of their work with persons suffering from cognitive impairment following **acquired brain injury** (Holmqvist, Kamwendo, & Ivarsson, 2009).

Funnet kun i MedLine:

- The clinical reasoning that guides **therapists** in interpreting errors in real-world performance (Bottari, Iliopoulos, Wai Shun, & Dawson, 2014).

Funnet kun i Chinal:

- Guidance and direction: **occupational therapy** in **brain injury rehabilitation (Blackwood & Wilson, 2009)**

Funnet kun i Academic Search Premier:

- An Australian Survey of the Clinical **Practice** Patterns of Case Management for Clients with **BrainInjury.**(Lannin, Henry, Turnbull, Elder, & Campisi, 2012)

Etter gjennomlesning av de seks artiklene ble 2 ekskludert da de var skrevet på bakgrunn av tverrfaglig fokus og ikke skjelnet mellom ergoterapi og andre faggrupper, de var ikke knyttet opp mot kommunehelsetjeneste.

Etter gjennomlesning er følgende 4 artikler inkludert:

Finnes i alle 3 databaser:

- Therapeutic use of self as defined by Swedish **occupational therapists** working with clients with cognitive impairments following **acquired brain injury:** a Delphi study (Holmqvist et al., 2013).

- **Occupational** therapist practice patterns in relation to clients with cognitive impairment following **acquired brain injury** (Holmqvist et al., 2014).

Funnet både i Medline og Chinal:

- **Occupational therapists**' descriptions of their work with persons suffering from cognitive impairment following **acquired brain injury** (Holmqvist et al., 2009).

Funnet kun i Chinal:

- Guidance and direction: **occupational therapy** in **brain injury rehabilitation** (Blackwood & Wilson, 2009).

Blackwood, K., & Wilson, L. H. (2009). Guidance and direction: occupational therapy in brain injury rehabilitation. *New Zealand Journal of Occupational Therapy, 56*(2), 4-8.

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Appendix II: Kort beskrivelse av studien

Forespørsel om deltakelse i forskningsprosjektet

"Rehabilitering i kommunal regi: En studie av ergoterapeuters rolle i rehabiliteringsprosessen for personer med ervervet hjerneskade"

Bakgrunn og formål

Masterstudiet vil undersøke de ergoterapeutiske kompetansene som anvendes i kommunehelsetjenesten i tilretteleggingen av rehabiliteringsprosessen for personer med ervervet hjerneskade. Studien er forankret i forskningsprosjektet: Transitions in rehabilitation: Biographical reconstruction, experiental knowledge and professional expertise ved Høgskolen i Oslo og Akershus
Da du er kommunal ergoterapeut med minimum 2 års arbeidserfaring innen rehabilitering av personer med ervervet hjerneskade forespørres du om å delta i denne studien.

Hva skal studien føre til?

Prosjektet skal etter planen avsluttes i juni 2018 og munne ut i en artikkel som i tillegg til publisering skal inngå som en del av en masteroppgave.

Hva innebærer deltakelse i studien?

Som deltaker i studien skal du delta på et fokusgruppeintervju av ca. 90 minutters varighet. På fokusgruppeintervjuet vil du og de andre deltakerne bli presentert for 2 kasus, som dere skal diskutere. I tillegg vil det bli stillet et par spørsmål om din bruk av ergoterapeutiske kompetanser i rehabiliteringsprosessen ved arbeidet med personer med ervervet hjerneskade. Fokusgruppeintervjuet vil bli tatt opp på lydfil som senere vil bli transkribert med henblikk på analyse av materialet.

Praktisk avvikling av fokusgruppeintervjuet

Fokusgruppeintervjuet vil finne sted onsdag d. 06. september 2017 kl. 12:30 – 14:30 på HIOA, Pilestredet i Oslo.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt. Direkte personidentifiserbare detaljer vil bli sløret allerede ved transkripsjonen. Det er dermed kun prosjektgruppen som vil ha opplysninger om din identitet.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert

Dersom du har spørsmål til studien, ta kontakt med Helle Gregersen på tlf. 40 72 20 77 eller e-mail: s239946@stud.hioa.no.
Veileder på prosjektet er Professor Per Koren Solvang tlf.: 970 83 117 eller e-mail: per.koren.solvang@hioa.no

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Appendix III: Vignett med TBI

Rehabiliteringssykehus

Innlagt: 25.08.2014 Utskrevet: 12.09.2014 (3-ukers rehabiliteringsoppholdet)

Pasientansvarlig lege: xxx xxx

Dg: H82 Svimmelhetssyndromer ved sykdommer klassifisert annet sted

F07.2 Posttraumatisk hjernesyndrom

F33 Tilbakevendende depressiv lidelse

Pasient: Mann, 34 år, gift, 2 barn (2 og 4 år). Tømrer med fagbrev, 12års erfaring, p.t. sykemeldt. Kone i 50% permisjon uten lønn og fungerer som støtte og omsorgsperson i hjemmet.

Innlagt pga. behandling av tidligere diagnostiserte balanseproblemer som følge av en ulykke for 12 mnd. siden med hjerneblødning og lammelse i venstre ekstremiteter. En brist i hoftekam og flere ribbeinsbrudd godt leget. Lett/moderat depresjon diagnostisert etter skaden.

Fått tilbake funksjon i venstre ekstremitet, noe nedsatt styrke og problemer med dagligdagse funksjoner grunnet manglende finmotorikk i hendene. Behandling på intensiv avdeling, primær rehabilitering gjennomført ved Universitetssykehus. Anbefalt videre rehabilitering for svimmelhet og finmotorikk i spesialiserte rehabiliteringssykehus. Han er satt på venteliste. Fikk tilbud om plass etter 5 uker. Samtaleterapi grunnet depresjon som gjennomføres hos psykolog.

Gjennom oppholdet tydelig balanseproblematikk, samt problemer med finmotorikk. Han klager over dårlig hukommelse og sterke hodepine i tillegg til manglende energi til å hjelpe hjemme og med barna. Han utrykker et sterkt ønsker å ha energi til å leke med barna. CT av hode – uendret. Nevropsykologisk testing viser til en avgrenset kognitiv svikt med begrenset minnespenn. Konen blir beskrevet av ham som en god støtte.

V/utskrivelse: Både balanse og finmotorikk forbedret etter trening. Fysioterapeut og ergoterapeut anbefaler videre oppfølging og opptrening. Nevropsykolog anbefaler videre kognitiv terapi for hukommelsesproblemer. Medikamentell behandling for hodepine etter behov. Han ønsker å fortsette i sin jobb som tømrer, arbeidsgiver er positiv til dette. Fastlege mener han p.t. er 100% arbeidsufør.

Appendix IV: Intervjuguide, koordinerende enheter

Fremgang i intervju situasjonen:

Velkommen! Vi er takknemlig for at dere ønsker å delta i forskningsprosjektet, og ønsker å vise dere en tekst om en person som har vært igjennom første del av rehabiliteringen sin etter en ulykke hvor man har pådratt seg bl.a. en mild hjerneskade. Det vi ønsker er at vi leser denne teksten sammen, og stiller dere noen spørsmål om hvordan dere vil gå frem i denne saken.

Vi ønsker at dere presenterer dere selv med

-Fornavn

-Stilling

-Rolle

-Utdannelse

-Arbeidserfaring

-Hvordan er dere organisert internt?

Vignetten leses i Plenum. Hver deltager skal også ha en skriftlig versjon. Vignetten er utgangspunktet for diskusjonen, men diskusjonen er ikke begrenset av vignetten.

1. Når dere får inn en bruker i hans situasjon, hva vil dere gjøre i en slik sak?

   Hvilke spørsmål ønsker dere å stille ham (personen i vignetten)?

   -Hvorfor ønsker dere å stille ham de spørsmålene?

2. Hvorfor går dere frem slik?

3. Hva er deres begrensinger i å hjelpe ham? (tid, penger, personell?)

4. Hva ser dere som hans største problem?

5. Han er i slutten av sykepengeperioden, vil ha få arbeidsavklaringspenger i etterkant? Kan dere forklare hvordan dere tenker rundt dette?

   Hvis det svares overfladisk, lite utdypende spør mer for å avklare hva som menes.

   <u>Hvis det er stor enighet, ikke skap uenighet som ikke eksisterer (polarisering i fokusgruppen).</u>

Mulige spørsmål ved manglende diskusjon:

Hva er hans hovedproblemer slik dere ser det?

-Hvorfor synes dere det?

-Hva kan han selv gjøre?

-Hva kan dere gjøre for ham?

Tror dere han vil komme tilbake i arbeid/utdanning?

-begrunnelse?

-Har han andre muligheter?

Hva mener dere er det viktigste å ta tak i nå?

-Hvorfor det?

Hva er problematisk slik dere ser det for ham fremover?

-Hvordan kan dere hjelpe ham med det? Hvilke muligheter har dere til å støtte ham videre?

Det er viktig for ham å komme tilbake i arbeid/utdanning, hva mener dere om dette?

-Hva må i så tilfelle gjøres?

Hva kan dere gjøre for å hjelpe ham tilbake til arbeid?

-Hvorfor?

Hva med hans ønsker?

Dere forteller om mange muligheter, er det noen hindringer som gjør at disse ikke alltid vil bli utløst i praksis?

Forandringer i vignetten (komplisere saken):

«Hvis legen mente han hadde X% (rest) arbeidsevne, hva hadde vært fremgangen da?»

«Hvis arbeidsgiver hadde vært negativ (ev positiv) til å få ham tilbake, hva ville det betydd?»

«Hvis han var en ung mann som var under utdanning og ikke var kommet ut i arbeidslivet, hvordan ville dere jobbet da?»

«Hvis dette var en person på 59 år, hadde det forandret deres fremgangsmåte?»

Hvordan går dere frem for å motivere/realitetsorientere brukere?

Ville dere samarbeidet med andre rundt en slik bruker? Innad i NAV-kontoret eller utenfor?

Hvem ville det i så fall være? Og hva ville samarbeidet bestå i?

(koordinerende enhet, fastlege, andre i helsetjenesten f.eks)

I slike saker, hvor er det dere oftest møter utfordringer?

-Hva tror dere er grunnen til (disse) utfordringen(e)?

Så flytte samtalen litt videre fra den konkrete vignettpersonen og over på NAVs arbeid mer generelt:

Har dere mange slike saker som dette? Er dette en typisk sak? Hvis ikke, hvordan er den annerledes?

Hvordan fungerer samarbeidet mellom NAV og helsetjenesten?

(f.eks med koordinerende enhet, fastlegene, andre?)

Til slutt: Er det noe vi ikke har tenkt på å spørre om, som dere mener det er viktig at vi vet?

Appendix V: Vignett med slagpasient

Rehabiliteringssykehus

Innlagt: 28.02.2017 Utskrevet: 06.03.2017 (1-uke på nevrologisk avdeling)

Pasientansvarlig lege: xxx xxx

Diagnose:

I63.4 Hjerneinfarkt forårsaket av emboli

I48.0 Paroksysmal atrieflimmer

Pasient: Mann 69 år, bor med ektefelle i enebolig over 2 plan, med soverom og toalett i 2. etasje. Bruker er pensjonist, ektefellen arbeider 50% og er 50% ufør. 3 sønner og 5 barnebarn som bor i samme kommune.

Aktuelt: Innlagt etter fall i hjemmet med tegn på hjerneinfarkt, CT bekrefter embolisk infarkt og begynnende infarktforandringer omkring høyre insula. Antatt årsak er kardial emboli med bakgrunn i atrieflimmer. Brukers ektefelle fant bruker på kjøkkengulvet og det antas at bruker har ligget 2-3 timer før ektefellen kom hjem og fant han. Det er ikke konstatert noen brudd etter fallet.

Funksjonsnivå: Pasienten stelles nedentil i seng, forflyttes med passiv heis. Har sittet på sengekanten i samarbeid med fysioterapeut. Det er observert uttalt skyving. Anbefalt videre mobilisering. Svelgvansker, drikker av tutekopp og med fortykningsmiddel i vannet. Nedsatt verbal kommunikasjon, men det virker til at pasienten forstår hva der blir sagt. Pasienten viser tegn på nedstemthet og må motiveres til å delta på trening.

Har under innleggelsen vist tegn til bedring av funksjon i underekstremitet. Det forventes at pasienten vil komme seg ytterligere og at det da vil være aktuelt å søke om et rehabiliteringsopphold i spesialisthelsetjenesten.

v/utskrivelse: Pasienten overføres til kommunal rehabilitering. Tilnærmet paralytisk i venstre sides ekstremiteter, noe bevegelse og sensibilitet i underekstremitet, neglekt mot venstre. Dysartri og ekspressiv afasi. Fysioterapeut og ergoterapeut anbefaler videre oppfølgning. Bruker og ektefelle har et stort ønske om at bruker skal kunne flytte hjem i egen bolig.

Appendix VI: Intervjuguide, mono-faglig intervju

Fremgang i intervju situasjonen:

Velkommen! jeg er takknemlig for at dere ønsker å delta i forskningsprosjektet. Jeg vil starte med å vise dere en vignett om en slagpasient der kommer fra sykehuset og hjem til kommunen for videre rehabilitering. Vi leser denne teksten sammen, og deretter vil jeg gjerne hører hvordan dere vil gå frem i denne saken. Etter at vi har snakket om denne første vignett, vil jeg presenterer dere for en ny vignett omhandlende en person som har vært igjennom første del av rehabiliteringen sin etter en ulykke hvor han har pådratt seg bl.a. en mild hjerneskade.

Jeg ønsker at dere presenterer dere selv med

-Fornavn

-Arbeidserfaring

-Hvordan er dere organisert internt?

Vignetten leses i Plenum. Hver deltager skal også ha en skriftlig versjon. Vignetten er utgangspunktet for diskusjonen, men diskusjonen er ikke begrenset av vignetten.

Når dere får inn en bruker i hans situasjon, hva vil dere som ergoterapeuter bidra med i en slik sak?

Om dere ikke hadde noen begrensninger i hverken tid eller ressurser, ville dere da ha gjort noen ting annerledes?

Hvis dere skal reflektere over ergoterapeutens bidra i det tverrfaglige samarbeidet, hvordan vil dere da beskrive de ergoterapeutiske kompetansene i samspill med resten av det tverrfaglige team?

Er det noen kompetanser dere savner i møtet med pasienten, som dere hadde ønsket at dere hadde?

Hvis det svares overfladisk, lite utdypende spør mer for å avklare hva som menes.

Hvis det er stor enighet, ikke skap uenighet som ikke eksisterer (polarisering i fokusgruppen).

Mulige spørsmål ved manglende diskusjon:

Hva er hans hovedproblemer slik dere ser det?

Hva mener dere er det viktigste å ta tak i nå?

Hvordan ville dere ta tak i det?

Hva er problematisk slik dere ser det for ham fremover?

Hvordan kan dere hjelpe ham med det? Hvilke muligheter har dere til å støtte ham videre?

Hva tror dere skal til for at han vil kunne komme tilbake i arbeid/utdanning? *(OBS kun case med TBI)*

Har han andre muligheter?

Det er viktig for ham å komme tilbake i arbeid/utdanning, hva mener dere om dette? (OBS kun case med TBI)

Hva må i så tilfelle gjøres? Og er det noe dere som ergoterapeuter kan bidra med?

Hva med hans ønsker? På hvilken måte arbeider dere som ergoterapeuter med dem?

Dere forteller om mange muligheter, er det noen hindringer som gjør at disse ikke alltid vil bli anvendt i praksis?

«Hvis han var en ung mann som var under utdanning og ikke var kommet ut i arbeidslivet, hvordan ville dere jobbet da?»

«Hvis dette var en person på 59 år, hadde det forandret deres fremgangsmåte?»

Hvordan går dere frem for å motivere/realitetsorientere brukere?

I slike saker, hvor er det dere oftest møter utfordringer?

Opplever der e at spesialisthelsetjenesten har forespeilet brukeren noe der e av ulike årsaker ikke kan innfri?

Introduksjon av vignett nummer 2. Vignetten leses i Plenum. Hver deltager skal også ha en skriftlig versjon. Vignetten er utgangspunktet for diskusjonen, men diskusjonen er ikke begrenset av vignetten. Det tas opp samme spørsmål som ved vignett nummer 1.

Til slutt: Er det noe jeg ikke har tenkt på å spørre om, som dere mener det er viktig at få med?

Appendix VII: NSD godkjenning

Per Koren Solvang
Institutt for fysioterapi Høgskolen i Oslo og Akershus
Postboks 4 St. Olavs plass
0130 OSLO

Vår dato: 16.05.2017 Vår ref: 53911 / 3 / ASF Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 29.03.2017. Meldingen gjelder prosjektet:

53911	*Rehabilitering i kommunal regi: En studie av ergoterapeuters rolle i rehabiliteringsprosessen for personer med ervervet hjerneskade*
Behandlingsansvarlig	*Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*
Daglig ansvarlig	*Per Koren Solvang*
Student	*Helle Gregersen*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 28.06.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Amalie Statland Fantoft

Kontaktperson: Amalie Statland Fantoft tlf: 55 58 36 41

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Vedlegg: Prosjektvurdering
Kopi: Helle Gregersen s239946@hioa.no

Personvernombudet for forskning

Prosjektvurdering – Kommentar

Prosjektnr:
53911

Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet.

Personvernombudet legger til grunn at forsker etterfølger Høgskolen i Oslo og Akershus sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc eller mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 28.06.2018. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lydopptak

Appendix VIII: Samtykke skjema

Forespørsel om deltakelse i forskningsprosjektet

"Rehabilitering i kommunal regi: En studie av ergoterapeuters rolle i rehabiliteringsprosessen for personer med ervervet hjerneskade"

Bakgrunn og formål
Masterstudiet vil undersøke de ergoterapeutiske kompetansene som anvendes i kommunehelsetjenesten i tilretteleggingen av rehabiliteringsprosessen for personer med ervervet hjerneskade. Studien er forankret i forskningsprosjektet: Transitions in rehabilitation: Biographical reconstruction, experiential knowledge and professional expertise ved Høgskolen i Oslo og Akershus

Da du er kommunal ergoterapeut med minimum 2 års arbeidserfaring innen rehabilitering av personer med ervervet hjerneskade forespørres du om å delta i denne studien.

Hva innebærer deltakelse i studien?
Som deltaker i studien skal du delta på et fokusgruppeintervju av ca. 90 minutters varighet. På fokusgruppeintervjuet vil du og de andre deltakerne bli presentert for 2 kasus, som dere skal diskutere. I tillegg vil det bli stillet et par spørsmål om din bruk av ergoterapeutiske kompetanser i rehabiliteringsprosessen ved arbeidet med personer med ervervet hjerneskade. Fokusgruppeintervjuet vil bli tatt opp på lydfil som senere vil bli transkribert med henblikk på analyse av materialet.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt. Direkte personidentifiserbare detaljer vil bli sløret allerede ved transkripsjonen. Det er dermed kun prosjektgruppen som vil ha opplysninger om din identitet.

Prosjektet skal etter planen avsluttes i juni 2018 og data og opplysninger som ikke inngår i selve oppgaven eller artikkel vil deretter bli destruert.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert

Dersom du har spørsmål til studien, ta kontakt med Helle Gregersen på tlf. 40 72 20 77 eller e-mail: s239946@stud.hioa.no.
Veileder på prosjektet er Professor Per Koren Solvang tlf.: 970 83 117 eller e-mail: per.koren.solvang@hioa.no

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

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(Signert av prosjektdeltaker, dato)