Received: 12 July 2022 | Accepted: 7 August 2023

DOI: 10.1111/1467-9566.13710

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE

Making assessment protocols workable: Navigating transparency and person-centredness in Norwegian reablement

Maya Christiane Flensborg Jensen[1] | **Mia Vabø**[2]

[1]VIVE – The Danish Center for Social Science Research, Copenhagen, Denmark

[2]NOVA, Centre for Welfare and Labour Research, OsloMet – Oslo Metropolitan University, Oslo, Norway

Correspondence
Maya Christiane Flensborg Jensen.
Email: maje@vive.dk

Funding information
Research Council of Norway, Grant/Award Number: 273696

Abstract

Western welfare states are facing great challenges as they strive to optimise their health and social systems in response to the realities of an ageing population. Many countries put a stake on reablement services—short-term rehabilitative interventions aiming to help older people regain functional capacity. To ensure a person-centred approach and outcome measures, service providers are recommended to follow a protocol designed for the dual purpose. In this article, we explore how reablement staff perceive and work around these person-centred assessment protocols. Departing from the perspective that standards never operate in isolation, but in social settings already infused with values and interests, we explore the various kinds of work involved in aligning the protocol with ongoing day-to-day assessment practices. The article demonstrates that professionals continuously engage in processes of tinkering to navigate between different values and concerns: they tinker with workflows (articulation work), with clients (identity transformation work) and with protocols (editing work). Exploring the different forms and intensity of tinkering enables us to discuss the practical and moral

difficulties inherent in making assessment protocols workable.

KEYWORDS
active ageing, assessment protocols, care work, home-based reablement, tinkering

INTRODUCTION

In response to the constraints imposed by limited societal resources and the growing demand for long-term care for ageing populations, western countries have turned to approaches that aim at enabling older people to become as self-reliant as possible (WHO, 2002). An example of this is home-based reablement, which has gained ground as a short-term intervention aimed at postponing and reducing the need for traditional long-term care (Bødker, 2019; Clotworthy et al., 2021; Metzelthin et al., 2020). Reablement interventions are early intervention, time-limited, intensive programmes involving activities and training that aim to help the older person regain or maintain their independence in daily life. The service is couched as a person-centred practice. This implies that it aims at restoring older people's capabilities by taking into account the individual's 'unique experience, values and preferences' (Lydahl, 2021, p. 104). One key element of effective reablement is individualised and person-centred goal setting (Ebrahimi & Chapman, 2018). The underlying assumption is that actively inviting elderly people into the delivery, goal setting and evaluation of their own care will empower them, allowing them to perform daily activities that are meaningful and satisfactory to them, while simultaneously reducing their need for more costly long-term care. Hence, grounded in the principles of social investment (Rostgaard, 2016), reablement operates on the premise that although it may require intensive and costly resources in the short term, it ultimately proves to be cost-effective in the long run. However, as existing evidence regarding the effectiveness of reablement remains inconclusive (Bødker, 2019; Metzelthin et al., 2020; Rostgaard, 2016), both clinical researchers and supranational policymakers are calling for a stronger evidence base (Langeland et al., 2019; Metzelthin et al., 2020).

In its policy framework *Active Ageing*, the WHO (2002, p. 37) calls for researchers to better define and standardise the tools used to assess ability and disability and to provide policymakers with evidence and learning lessons on key enabling processes. These recommendations are echoed at the national level. In Norway, which is the context of the case study discussed here, the Canadian Occupational Performance Measure (COPM) has been highly recommended, not only as a tool to support reablement staff in their interventions but also to demonstrate accountability upwards to the funding authorities. Internationally, COPM is a generic assessment protocol used by occupational therapists for capturing how individuals perceive their own performance in everyday living and for measuring changes in this performance over time (Carswell et al., 2004; Langeland et al., 2019; Polloc, 1993).

Assessment protocols like COPM constitute a part of a massive standardisation movement in health care that is commonly associated with evidence-based medicine (Berg, 1997; Timmermans & Epstein, 2010), a movement that has been both embraced and highly criticised for its shortcomings. Reviewing how various kinds of standards have been created and implemented and have impacted practical fields such as health care, Timmermans and Epstein (2010) argue for a sociology of standards that will trigger a research avenue moving away from simplistic views that label standards as either purely good *or* technical dehumanisation. Instead, they propose conducting thorough empirical research to explore the processes of adaption and adjusting standards,

taking into consideration the full spectrum of the consequences of standardisation. One of their key messages is that, although every standard implies a 'script' that specifies the various roles of users and final outcomes, any of these factors may not play out the way the creators of the standards intended. Rather, in a real world, standards will also be affected by complex social settings that are already populated by practices, people and other standards (Berg, 1997; Timmermans & Epstein, 2010). Health-care professionals, for instance, are not reduced to mindless followers of protocols. On the contrary, to make the protocols 'workable in practice', they continuously engage in processes of tinkering to align the guidelines of the protocol with the needs of a heterogeneous population of clients and other constraints present in the local context (Lydahl, 2021; Mol, 2006; Timmermans & Berg, 1997, p. 291; Timmermans & Epstein, 2010). Despite seeing these processes of tinkering as necessary to make standards workable, Timmermans and Epstein (2010, p. 83) note that '[o]nce standards are established, they render invisible the work required to make them possible and the uncertainty and ad hoc tinkering that accompanied standard implementation'. Hence, like Star and Strauss (1999) they hint that the work required to make standards work tends to become 'obvious', deeply embedded and rendered invisible to outsiders, and that it is precisely this 'obviousness that sociologists should critically interrogate' (Timmermans & Epstein, 2010, p. 85).

In this article, we aim to conceptualise and make visible what kind of work is considered necessary to make the mentioned COPM protocol workable. We ask how local teams and individual professionals work around and tinker with the protocol in their day-to-day assessment routines and what kind of advantages and challenges they meet in reconciling the protocol with local contingencies. Our study is based on ethnographic data collected from the natural settings of two Norwegian reablement teams. Inspired by Anselm Strauss's interactionist concept of work, we aim to disentangle and characterise various kinds of work involved in ongoing tinkering. Before we turn to the empirical analysis, we provide a description of the role of COPM in Norwegian reablement services and unfold the theoretical framework for our analysis, which combines research on 'tinkering' and 'work'.

THE ROLE OF STANDARDISED ASSESSMENT PROTOCOLS IN NORWEGIAN REABLEMENT

In Norway, reablement services became widespread and popular following a comprehensive R&D project commissioned by the Norwegian Government in 2014. The project included a multi-centred controlled trial in which primary outcomes were measured using COPM (Langeland et al., 2019; Tuntland et al., 2016). The COPM protocol and several other assessment tools used in this R&D project were later recommended for clinical and administrative use by the Norwegian Association of Local and Regional Authorities (Fürst & Høverstad, 2014) and by the Norwegian Association of Occupational Therapists. The Norwegian occupational therapists' (OTs) journal, with reference to Alison Laver-Fawcett, a British professor of occupational therapy, provided international endorsement of the value of rigorous and well-standardised assessment tools. Laver-Fawcett argued that transparency is inescapable for OTs and that they have 'an ethical responsibility to ensure they have the up-to-date knowledge and skills to select, implement, analyse and report the results of standardised outcome measures'. She added that '[u]sing non-standardised assessments to evaluate interventions is no longer acceptable to service commissioners/funders' (Laver-Fawcett, 2014, p. 35).

The COPM protocol is widely valued for its dual function of guiding a person-centred practice and providing a rating scale for performance, making it possible to measure how performance changes over time (Donnelly & Carswell, 2002). It comprises a five-step process based on a semi-interview protocol, which is typically conducted by OTs in collaboration with the client. The steps comprise

problem definition, problem weighting, satisfaction and performance scores, reassessment and follow up (Donnelly & Carswell, 2002; Langeland et al., 2019; Polloc, 1993). Initially, clients are asked to formulate and prioritise the daily activities that matter to them within pre-defined activity areas and then to rate how well they manage to perform these activities using a 10-point rating scale. The client and therapist then determine and prioritise the goals of rehabilitation and training. To capture the clients' performance over time, the process of rating their own level of performance and satisfaction with performance must be repeated after the intervention programme.

The COPM protocol was originally developed as a generic tool to conceptualise and guide the client-centred practice of occupational therapy for all age groups (Polloc, 1993). However, clinical scholars have since then questioned its universality. For instance, in a review and comparison of the clinical utility of individualised outcome measures in occupational therapy, Donnelly and Carswell (2002) state that COPM may be time consuming and difficult to administer and the scales for scoring may be difficult for some clients. These objections are echoed in the aforementioned research project from Norway (Tuntland et al., 2016). This project recognised that some older participants had difficulties scoring and expressed that they were not accustomed to thinking in this abstract and theoretical manner. Despite their concerns about the universality of COPM, the clinical scholars did not go on to explore *how* professionals tinker with the protocol to work around the problems they face in their daily work. Instead, they have criticised an observed growing tendency to abandon the COPM protocol in Norwegian municipalities, arguing that this tendency may result in gradually diluting person-centeredness as a vital element for the effectiveness of reablement (Tuntland & Ness, 2021). Hence, they simply seem to take for granted that the COPM is beneficial and manageable.

WORKING AROUND STANDARDS

Studying how medical protocols function in clinical decision-making, Timmermans and Berg (1997) argue that protocols in itself do not make actions comparable over time and space. Rather, universality is produced contingently and collectively, and inevitably intertwined with localisation. Through several examples, the authors demonstrate how protocol's explicit written demands are tinkered with to make them work for heterogeneous patient trajectories. However, with these instances of tinkering, the authors do not intend to demonstrate 'the resistance of actors to domination'. Rather, they argue that 'the ongoing subordination and (re)articulation of the protocol to meet the primary goals of the actors involved is a sine qua non for the functioning of the protocol' (Timmermans & Berg, 1997, p. 291).

Similar to Timmermans and his colleagues, a substantial amount of current empirical research from health and social care fields utilises the term 'tinkering' to emphasise that professionals are not simply controlled by technologies but actively participate in a continuous process of navigating and reconciling conflicting values and care principles. By taking into consideration that caring is never 'pure' but inherently entangled with technologies, these studies demonstrate how the continuous process of tinkering that occurs in endless cycles of adapting the 'tool to a specific situation while adapting the situation to the tool' are based on feedback and experimentation (Mol et al., 2010, p. 15). For instance, researchers have revealed that, to adapt to patient responses, healthcare professionals abandon life-quality questionnaires (Mann, 2021), they switch to less demanding blood-measuring standards (Mol, 2006), scale down the ambitions embedded in assessment protocols (Bødker, 2019), rephrase questions in a person-centred questionnaire (Lydahl, 2021) or even redesign the whole protocol (Cohn et al., 2013). Mol et al. (2010) argue that this persistent tinkering that reconciles different values signifies 'good care'. However, some of the above-mentioned

studies highlight that tinkering involves difficult moral decisions and trade-offs (Mol, 2006). For example, besides tinkering with the protocol, clients may also be tinkered with (to fit the standards), to the extent where the consequences and validity of the outcome are brought into question (Bødker, 2019; Lydahl, 2021).

The concept of 'tinkering' may be useful as a sensitising concept (Blumer, 1954) to draw attention to the messy and mutual becoming of standards, actors and social contexts. 'Tinkering' is, however, a rather loosely defined concept, and it is sometimes used with additional concepts to highlight a more nuanced understanding of the different forms tinkering may take. For instance, in her study of reablement, Bødker (2019) uses 'motivation work' to describe the considerable effort it took to convince older clients to participate in reablement trials. Likewise, studying how nurses using a person-centred assessment protocol strived to find ways of coordinating contradictory information and tasks, Lydahl (2017) uses what Strauss et al. (1985) refer to as 'articulation work'.

To specify the different kinds of work involved in processes of tinkering, scholars have, thereby, directly or indirectly drawn on Anselm Strauss's interactionist concept of work. For Strauss et al. (1985), work encompasses not only the technical aspects of tasks but also the social interactions, relationships and organisational structures that shape and influence work. Based on this perspective, Strauss et al. (1985) explored in detail the multiplicity of the work health-care staff perform within complex and technologised hospitals and conceptualised how treating and managing illness entails different types of work.

One type of work is 'articulation work', which refers to the coordination and communication endeavours undertaken by individuals to achieve collective tasks, particularly within complex and interdependent work settings where unforeseen circumstances arise. Another type of work highlighted by Strauss et al. (1985) is 'sentimental work', which encompasses several subtypes of work involved in managing patients' emotional responses to illness and treatment. One such subtype is 'interactional work', which involves tasks such as listening, informing and explaining matters to the patient. Another subtype, 'identity work', goes beyond gathering patients' social history and encompasses the psychological efforts aimed at helping individuals maintain and enhance a sense of self in the face of difficult illness (Strauss et al., 1985).

In a similar vein to empirical research that employs the term 'tinkering', Strauss et al. (1985) maintain that these types of work should not be seen as opposed to standardised trajectories and technologies. Rather, they should be recognised as fundamental prerequisites for rendering these standardised approaches viable and effective. Furthermore, regardless of whether researchers use the concept of tinkering (Mann, 2021; Mol et al., 2010; Timmermans & Epstein, 2010) or refer to articulation or sentimental work (Lydahl, 2017; Strauss et al., 1985), they share a common concern about the way these prerequisites risk being squeezed or undervalued. In contrast to the explicit specifications of standards, the tinkering and work described above tend to remain implicit and deeply embedded in professionals' work processes and are thus often not reported in patients' medical records. By disentangling and labelling the various forms of implicit work performed to make assessment protocols work in reablement, we hope to make visible challenges and undertakings that are largely taken for granted in clinical research.

METHOD

The article uses case study data from a comprehensive Danish/Norwegian research project exploring how current policy ideas of integrated, person-centred care have been translated into practice in national and local contexts. The project was designed as a multiple, layered case study

(Patton, 2002), allowing analysis across and within four different local service contexts in Denmark and Norway, and concentrated on various layers and focal points within these four cases. In the present article, we focus on reablement teams within two Norwegian local settings—one urban and one rural setting. The Norwegian sites were intentionally selected as information-rich cases for studying how standardised assessment tools are worked around in practice.

The two Norwegian reablement teams comprised, like most reablement teams in Norway, physiotherapists (PTs), OTs, registered nurses (RNs) and licensed practical nurses. Both teams were entrusted the role of assessing who would benefit from a reablement programme. They used several formalised assessment tools, including COPM (in the urban setting) and a modified version of COPM (in the rural team).

Data sources used in the case study included (1) national and local policy documents, job descriptions and guidelines, (2) interviews with managers and key professionals and (3) data collected through 'rapid site-switching ethnography' (Armstrong, 2018; Baines & Cunningham, 2011). A team of researchers shadowed professional care providers and conducted semi-interviews within a relatively short timeframe (4 days in each setting). The fieldwork was a typical 'naturalistic inquiry' that took place in the real-world settings of service provision with no efforts of intervention on the part of the researcher (Patton, 2002). Informed consent forms were collected from all interviewees. Staff were informed of the guidelines for privacy protection and research ethics with regard to observing participants.

Four researchers, including the two authors, conducted the fieldwork in the Norwegian reablement service settings. Over the course of 4 days, each researcher attended several components of the reablement interventions, such as morning meetings, assessment meetings and training sessions in the homes of older people. By shadowing staff in their natural settings, we gained a snapshot of several stages of the reablement trajectory.

Data on the two reablement teams comprised of documents such as assessment templates, information leaflets and reablement plans as well as researcher field notes from observation days and recorded and transcribed interviews with managers and professionals working in the team. All employees ($N = 4$) from the rural team were interviewed: one OT, one PT, one RN and one PN. In the urban team, we interviewed one OT, two PTs, one RN and two PNs ($N = 6$).

In the data analysis, we used a grounded theorising approach (Hammersley & Atkinson, 2007) involving a constant interplay between data and theory throughout the research process. Data was analysed from the moment we entered the field and on an ongoing basis, as the team of researchers had reflection meetings both during and after the fieldwork. Routines and tensions related to formal reablement assessments caught the attention of the first author at an early stage. For the purpose of this article, the two authors did a close reading of all interviews and field notes to explore how professionals experienced and used the formal assessment protocols. We also made a follow-up interview with reablement team leaders to validate our data.

In the analysis, the notion of 'tinkering' and Anselm Strauss's broad concept of work were used as sensitising concepts (Blumer, 1954) to help us identify the different kinds of effort involved in assessment processes. We thematically and critically explored whether and how different kinds of work occurred and whether the work we observed overlapped with, or added to, work described in previous research. In addition, we coded how professionals experienced the advantages and disadvantages of assessment tools.

FINDINGS

Following the recommendations of clinical scholars and reablement experts, both reablement teams had adopted a version of the COPM assessment protocol. As will be further outlined in the first section of the analysis, the professionals expressed ambivalence towards the protocol: on the one hand, they regard it as a helpful tool for guiding goal setting and practice and for contributing to making their work transparent, and on the other hand, it is seen as cumbersome and time consuming. Next, based on our shadowing of professionals during assessment routines, we show that they always engaged in ongoing tinkering with workflows, actors and protocols—even when the work they were engaged in was less intensive and strenuous. To exemplify how various kinds of work (not specified in the protocol) are involved in ongoing tinkering and how the process of tinkering can be more or less demanding, we present two contrasting illustrative clients: Mrs. Hansen[1] who, apart from a wounded hip after an episodic accident, was fairly well-functioning and Mr. Thomas who was chronically and acutely ill and rather disillusioned about the future.

The assessment protocol—A double-edged sword

In their initial presentation of the reablement service, team leaders and staff were keen on emphasising the managerial advantages of employing a formal assessment protocol. By utilising these protocols, it was possible (in principle) to aggregate scores and illustrate the service's effectiveness using the powerful language of numbers (Czarniawska-Joerge, 1993). In the urban setting, we heard about a local evaluation project that had concluded that reablement recipients' own perceptions of performance had increased from 3.4 to 6 after a period of reablement. Similarly, the team leader of the rural team reasoned that reporting on various outcome measures was important in case politicians asked about the effectiveness of reablement. She recounted with pride how her team had 'survived' recent cutbacks thanks to being able to report facts and figures about their results. However, as we will return to, the team leaders did not directly address the quality or validity of these figures even though they both seemed to view the figures as proof of the effectiveness of the reablement service. As argued by Czarniawska-Joerge (1993), the symbolism of numbers representing something concrete or precise is strong.

Besides legitimising the reablement services as being effective, the assessment protocols served as effective devices for involving recipients in reablement. Several of the interviewees stressed that the protocol's open-ended questions and goal-setting helped clients hold on to the aspects of life that matter to them. As an OT explains:

> We aim to inform the service recipients that they are the ones who set the goals. We should not enter their home as professionals saying, "this is what you are going to manage". If you do that—then you have an entirely different starting point.
>
> (OT, rural team)

The protocol was seen as highly beneficial because it allowed the client to be involved as a responsible partner right from the start instead of aimlessly pursuing objectives set by the professionals. Additionally, the formal goals set by the client helped discipline both the client and the staff. An OT interviewee described how the protocol and subsequent care plans ensured streamlined and

efficient processes, preventing them from becoming overwhelmed by the complexities of everyday life and the numerous requirements of their clients:

> This is our working document that tells why we're here. The document is very important to us, because it's too easy to drift into the role of visiting friends. Sometimes we're the only people the older person sees. That's why it's important [points at the document] that this is what we are supposed to collaborate about—we're not here to drink coffee or tea.
>
> (OT, urban team)

While professionals found the protocols to provide stability (see also Cohn et al., 2013), they also mention the tensions that sometimes arise during the assessment process, particularly when working with clients who have diverse needs and abilities:

> We need to obtain a lot of information [during assessment meetings] and the clients are not always capable of providing answers [...] It takes a lot of time to go through the manual, and this can be quite overwhelming for some of them.
>
> (OT, urban team)

> Generally, the assessment procedure tends to work well. Occasionally, clients are opposed to all the rating scale questions; they are asked to give so many numbers. It's difficult to make them do this. It's difficult for them to do the scoring. Then after a while they get a little exhausted.
>
> (PT, urban team)

As these quotes illustrate, tensions arising from the assessment protocol varied among clients. Several interviewees acknowledged that they frequently encountered difficulties with the assessment protocols when interacting with older individuals who sometimes struggle to provide answers and sometimes find formal procedures tiring and overwhelming. As a result, they explained that adhering to the protocol's instruction would sometimes generate new complicated tasks, which again required that the professionals improvise (see also Lydahl, 2017). In the following sections, we provide more detailed insight into the specific efforts required to overcome these obstacles and to make the protocols feasible and workable.

Adapting to clients: The significance of 'articulation work' and 'identity transformation work'

Professionals from both the rural and the urban team shared a common insight: they had learned from their experience that a crucial part of ensuring the feasibility of the protocol was to prepare clients before conducting formal assessments. Hence, the process of tinkering did not happen at one specific moment (see also Cohn et al., 2013). Rather, tinkering with the workflow normally started prior to the formal assessment visit. Staff would normally contact clients over the phone and would often pay them an informal visit. If the client was already enroled in the municipal service system, they would also contact colleagues who were familiar with the client to learn more about their medical history and life situation. The work involved in these pre-events was not described in the assessment protocol, but it was still regarded as a natural part of their

person-centred service approach. As noted by Lydahl (2017), who also found that additional tasks were required to make a person-centred assessment protocol workable, this kind of informal practice is an example of 'articulation work'; that is, situational coordination work that is regarded as necessary to keep work on track.

Staff members explained that the pre-events allowed them to informally explore how the clients experienced managing at home and to prepare clients to consider what kind of activities they would like to resume. According to a PT from the urban team, these pre-events also ensured that clients got a chance to come to terms with themselves after a stay in hospital and to experience how good they were at daily activities. Although these pre-events served to minimise the risk of generating tensions during the formal assessment procedure, we found that how much work was required, and the nature of this work, varied from client to client. The distinct efforts put in by reablement staff during the pre-events are illustrated by the contrasting experiences of our two clients, Mrs. Hansen and Mr. Thomas.

Mrs. Hansen is a 92-year-old woman who is recovering from a hip fracture. Tom, a PT working in the urban team, is tasked with assessing Mrs. Hansen's potential to benefit from reablement services. The observing researcher met with Tom at his workstation shortly after he had concluded a phone call with Mrs. Hansen during which he had introduced her to the reablement service. According to Tom, Mrs. Hansen was cognitively sound and motivated to regain her ability to independently manage daily activities following her hip fracture. We noticed that Mrs. Hansen's motivation and openness to the benefits and possibilities of reablement facilitated a smooth transition to the formal assessment process.

In contrast to the relatively easy case of Mrs. Hansen, we have Mr. Thomas. Mr. Thomas is a severely disabled man who is currently receiving regular home-care services. He was referred to the rural reablement team with the objective of undergoing an intensive training period to potentially delay referring him to a (costly) place in a local care home.

Sofia, Mr. Thomas's PT, told the observing researcher that she had been briefed by colleagues in the home-care department about Mr. Thomas's inherent suspicion to reablement. Based on this, Sofia decided to invite Hanne, a practical nurse whom Mr. Thomas trusted deeply, to join her in a pre-visit. Sofia and the observing researcher met with Hanne outside Mr. Thomas's front door.

Hanne remarked on the notable decline in Mr. Thomas's health over the past four or 5 months, despite him being *only* 70 years old. She mentioned that he had lost a lot of weight (13 kilos), suffered from multiple recent falls and was exhibiting an increased level of confusion. Upon entering Mr. Thomas's apartment, the team found him seated in his armchair in the open kitchen–dining area, with his walker positioned nearby.

> Sofia initiates the conversation by showing him a leaflet with a picture of the reablement team—all of them smiling. She proceeds to explain the basic principles of reablement and the purpose of conducting training within the home. Acknowledging that Mr. Thomas is concerned about costs, Hanne interjects, assuring him that the training is free. Building upon this introductory information about reablement, Sofia asks Mr. Thomas what she can do for him. Instead of answering her question, Mr. Thomas explains that he, after several accidents and a broken back, has been prescribed an exercise programme, which he has followed but with no results. Sofia explains that the reablement team has been in service for five years and has offered in-home training, which has yielded very positive outcomes. She emphasises the importance of remaining physically active, particularly to strengthen the legs and

> prevent falls. She proceeds: "I can't promise that we can alleviating your back pain. However—I think you can strengthen your legs and improve your balance—so you don't fall and hurt yourself. I believe you'll be able to manage daily activities in your apartment." Mr. Thomas reiterates his negative experiences with training: "I've been in and out of rehabilitation centres ten times! To my great disappointment. I have spent a lot of money in vain—no effects!" Sofia remains steadfast, emphasising that she cannot provide assistance specifically for his back condition.
>
> (Field note)

The process of tinkering with Mrs. Hansen and Mr. Thomas to prepare them for a formal assessment procedure involved 'interactional work' (Strauss et al., 1985) that comprises efforts such as informing and explaining the advantages and effects of reablement. As demonstrated above, Mrs. Hansen seemed responsive to the information provided by the reablement professions; she quickly accepted and adapted to the need and role of regaining functions. However, because Mr. Thomas was rather reluctant, the staff had to engage in what previous studies have referred to as 'motivational work' (Bødker, 2019; Meldgaard Hansen, 2016). This involves not simply 'finding' existing motivation but also 'inducing' motivation by persuading individuals that it is in their best interest to participate in reablement (Bødker, 2019). Despite persistent efforts to convince Mr. Thomas about the potential positive effects of reablement, he remained unwilling to embrace the role of an active participant working in partnership with reablement staff. Instead, he responded to the persuasive discourse by sharing his own life story of chronic illness, pain and disappointment. This situation shifts the focus to Hanne, who engages in a parallel discourse centred around Mr. Thomas's identification with his illness and understanding of his body in the context of chronic illness.

> Hanne follows up: "What we're worried about is that you've lost a lot of weight. You're not very mobile, and you've had many falls. We want to slow down your functional decline." Mr. Thomas hesitantly mentions the bruises on his body. Sofia continues her persuasive discourse by saying: "We have an exercise programme. We get good results from this programme almost every time." Mr. Thomas dismisses her statements by recounting his past negative experience and his lack of improvement despite receiving assistance from "the very best specialists." He argued: "it turned out again and again that the training wasn't helping me." Sofia maintains: "Could we disregard your back?" Mr. Thomas hesitantly responds: "I might try, but I don't expect any results." At this point Hanne interjects empathetically, acknowledging Mr. Thomas's scepticism: "Yes, based on the years of unsuccessful attempts, I understand very well that you feel doubtful. Now you're being offered help, I would recommend accepting it." Sofia adds that reablement is an optional offer, not compulsory. Mr. Thomas nods. In response, Sofia informs him that she has some additional questions.
>
> (Field note)

In contrast to the relatively brief informative phone call made to Mrs. Hansen, the process of preparing Mr. Thomas for reablement required a significantly greater investment in terms of staff resources and psycho-social skills. The efforts made were more comprehensive and profound, reflecting the need for a deeper level of engagement and support to address his specific challenges and concerns. Sofia 'infused' (Bødker, 2019) Mr. Thomas with motivating encouragement

by asking him to skip the underlying logic of his sense of self as an incurably ill person, while Hanne compassionately addressed Mr. Thomas's psychological challenges stemming from his irreversible and difficult health condition. We call this form of work, 'identity transformation work', because it emerged as an effort to regulate and *transform* the client's self-perception and the underlying framework of their subjective thoughts regarding their personal history and physical condition. It can be seen as a reverse variation of 'identity work' (Strauss et al., 1985)—psychological efforts aiming at helping patients *maintain* a sense of identity in the face of severe illness and impending death. Within the context of reablement, professionals are entrusted with the responsibility of not only preserving but also facilitating the transformation of the individual's sense of identity. Their aim is to instil a renewed belief in their ability to regain independence and effectively manage their lives at home. However, the issue of person-centredness emerges as an ambivalent matter (Mol, 2006) because the two cases demonstrate that clinical and personal understandings of a client's needs are fuzzy—attuned in some cases, while conflicting in others.

Tinkering with the assessment tools: The significance of 'editing work'

Having discussed the process of preparing patients for assessment procedures, which primarily entails tinkering with workflows and clients, it is important to note that the formal assessment process also prompts staff to tinker with the assessment protocol itself. As previously mentioned, the rural team had implemented authorised local modifications to the COPM protocol. During the pilot phase preceding the establishment of the reablement service, the team received support from an OT researcher. As a result, they revised the generic COPM protocol and made their own simplified and local version (see also Cohn et al., 2013). They removed questions with little relevance for older people, reduced the number of rating scale questions, changed the order of questions and added some probing questions and visual representations to help people reflect upon their everyday activities. However, as will be further outlined below, even this simplified local protocol was tinkered with incomplex assessment situations like the assessment encounter with Mr. Thomas. The observing researchers were also surprised to find that tinkering with the generic COPM protocol occurred even with clients who had intact cognitive functioning, like Mrs. Hansen, a client who had been referred to the urban team.

When Tom, the PT assigned to Mrs. Hansen's team, called Mrs. Hansen, he got the impression that she was capable and motivated for reablement. This impression was confirmed when Tom met with her shortly afterwards. Upon entering her apartment, Tom introduces himself and explains the purpose of his visit. He explains he will ask her to complete a form aimed at identifying her challenges so they can agree on a suitable reablement plan together. Tom emphasises that there are no right or wrong answers to the questions to ensure that Mrs. Hansen feels comfortable and understands the non-judgemental nature of the process.

Proceeding with the assessment form, Tom tells Mrs. Hansen to think about an ordinary day in her life when answering his questions. Mrs. Hansen nods in approval, indicating her willingness to cooperate. Following the manual quite strictly, Tom reads the questions aloud and takes notes as Mrs. Hansen politely responds to his formal inquiries regarding her daily activities. She provides detailed elaborations on her routine tasks and how she used to manage them before her hip fracture, including activities such as going to the hairdresser and chiropodist and attending her book club. Working together, Tom and Mrs. Hansen manage to identify her difficulties, such as her inability to shower on her own. While Tom adheres to the questions in the manual,

it is clear that he skips the problematic rating scale questions, saving them for the end of the interview:

> Before he starts asking the rating scale questions, Tom carefully explains to Mrs. Hansen that the upcoming task involves scoring the activities they have just identified. Responding to her puzzled look, Tom reassures her by saying they can skip the first set of ratings because they have already talked about how well she can perform these activities. He then goes on to ask whether she can rate them on a scale from 1 to 10 to indicate how important she finds the identified activities. Mrs. Hansen is clearly confused about the numerical options. She suggests the score six for one activity, but shortly after changes it to a ten. She ends up scoring all activities as ten—all activities matter a lot to her. For Tom, however, an effective reablement plan requires Mrs. Hansen to prioritise certain activities. Mrs. Hansen emphasises that she finds all the activities important. To solve the problem, Tom shifts to the more straightforward question, focusing on what to concentrate on in the reablement training programme. By doing so, he indirectly helps her translate her preferences into ranked goals.
>
> (Field note)

The situation described above aligns with similar observations made by Bødker (2019) who states that employing a standardised tool for the seemingly straightforward task of goal setting and scoring functional abilities on a scale from zero to 10 can give rise to ambiguous practice. Through Tom's tinkering with the COPM protocol, including modifying the question order, reducing scaling questions and assisting Mrs. Hansen prioritise goals and ratings, Tom, like the therapists observed by Bødker (2019), played a role in scaling down the protocol's ambitions. Although these adjustments were made to make Mrs. Hansen feel more comfortable and at ease during the assessment, it is noteworthy that the final reablement plan was the result of subtle negotiations between Tom and Mrs. Hansen rather than a reflection of Mrs. Hansen's own desires and preferences (see also Bødker, 2019; Lydahl, 2021). To emphasise that this type of tinkering concerns modifying the protocol in ways that may influence the final outcome of the reablement plan, we propose labelling Tom's efforts as 'editing work'. This term signifies that modifications risk overriding the client's own words, desires and preferences and thereby shift the final outcome away from solely reflecting a person-centred and transparent process.

In the case of Mr. Thomas, who, despite initially hesitating, finally accepted to give reablement a try, the researcher observed that Sofia (the OT) engaged in considerable editing work to prevent him from experiencing confusion and emotional distress. Once Mr. Thomas had agreed to the service, Sofia saw this as an opportunity to conduct the assessment procedure promptly:

> "The first question I have is about why you want help." Sofia looks at Mr. Thomas and before he manages to answer she continues: "and is it that your physical function is reduced?" Mr. Thomas doesn't answer. Instead, he turns to Hanne: "Youve been so nice and helpful," he says warmly. Sofia asks a new question: "What do you want to achieve?" Mr. Thomas says a little hesitantly, "To get better." Sofia says, "We could also write, 'to avoid that your condition gets worse.'" Mr. Thomas nods. Sofia proceeds: "You need help and guidance for training. We suggest that we come every day." Mr. Thomas looks shocked "That's much too often!" Sofia replies: "How about Monday, Wednesday and Friday?" Hanne nods: "That's a good idea." Sofia takes

notes and looks at Mr. Thomas: "Think a little about the goals you want to reach. It doesn't have to be big things like jumping without a walker..." She laughs and says: "But you can think about it. Is there anything we need to pay special attention to?" Mr. Thomas starts to recount a deeply personal and tragic tale of his involvement in two separate car accidents, one of which resulted in the loss of a life. Interrupting the story, Sofia continues to interview him about what type of home care service he is receiving. Hanne reels off: "Alarm service, nursing care, dinner call every day and food delivery." Mr. Thomas looks appreciatively at Hanne: "Hanne has arranged so many things for me—it's amazing." Hanne replies: "You've made a wise decision today. Something good can come out of this."

(Field notes)

The case above illustrates that the editing work undertaken in this situation extended beyond merely scoring and scaling questions. In contrast to Tom, who mainly tinkered towards the end of the assessment process to assist Mrs. Hansen in quantifying her experiences, Sofia engaged in tinkering with the protocol right from the beginning. Sofia employed proactive measures such as rephrasing the qualitative questions (see also Lydahl, 2021). Specifically, she enacted changes to the questions pertaining to Mr. Thomas's reasons for applying for services. Additionally, she took it upon herself to answer some of the questions on Mr. Thomas's behalf, reframing his expressed desires and disregarding his spontaneous comments, for instance, his assertion that receiving home-based care is a crucial aspect of his life. The researcher also noticed that Sofia asked Mr. Thomas to reflect upon his reablement goal before the next meeting. Her comment exemplifies how working around the assessment protocol was sometimes conducted incrementally or in several small steps or bits and pieces.

Members of both teams acknowledged that this approach to tinkering with the protocol was not uncommon. On the contrary, it was consistently intertwined with the subtle and gradual process of tinkering with workflows and clients. For example, a PT from the urban municipality explained how he sometimes had to split the formal assessment into smaller parts to ensure a smooth process, and how he had learned to 'draw out answers' from the clients, skilfully guiding their responses and eliciting specific information (see also Bødker, 2019; Lydahl, 2021). Most staff seem to take editing work for granted as a part of their busy daily practice. The OT from the rural team made this reflection:

Some clients have trouble understanding the question, "What matters to you?" They may give answers like: "Well, I guess I just want to stay here." If they do that, I try to come up with some examples [of what can possibly matter to them]. Often, I just leaf through the manual thinking: I'll just have to skip these sections. Then, instead, I just talk a little about how things used to be—and then, from there, try to elicit some kind of response. What kinds of interests did you use to have? What did you usually do? Is there something you have stopped doing that you would like to take up again? Sometimes we [the staff] notice that there are questions we should **not** ask. You avoid poking at something that you know is difficult. (...). [T]he reablement team will turn up, confronting them with manuals and brochures. Then they get a bit stressed: 'Wow, 'reablement' that is a fancy word." They don't get what it is. Then we help them a little along the way. (...) Later, when I look at what's written in the plan, I can recognise my own words, but I still feel I have got them involved because we have talked about it.

(OT, rural team)

The OT's reflections suggest that the process of editing work played a role in alleviating tensions stemming from various concerns, including optimising efficiency, establishing an effective reablement plan for clients to improve their functional capacity and ensuring client involvement without causing unnecessary stress. At the same time, the OT remarks that she recognises her own (rather than the client's) words in the plan.

CONCLUDING DISCUSSION

Reablement is regarded as a promising innovation to postpone and reduce the cost of long-term care by enabling older people to become self-reliant. However, as existing evidence on the effect of reablement remains inconclusive, the COPM protocol has been widely valued in Norway for its dual function of guiding a person-centred approach and providing a rating scale for performance. By taking into consideration the caution raised by Timmermans and Epstein (2010) about not blindly accepting standards as effective tools for achieving desired outcomes, we contribute to the sociology of standards by exploring the ways in which the COPM protocol is made to work in practice. Through disentangling and characterising the various kinds of work involved in ongoing tinkering, we develop a deeper understanding of how professionals adjust and modify assessment routines in reablement settings.

A significant finding in our study is how various types of work comprise an integral part of staff's ongoing ways of navigating and tinkering with the *protocols, clients* and *workflows* to ensure that the assessment process stays on course. As formulated by Mol et al. (2010, p. back cover), in care practices 'all ⟫things⟪ are (and have to be) tinkered with persistently'.

We show that indispensable but not explicitly outlined parts of making protocols workable concerned tinkering with the workflow in ways that align with the concept of 'articulation work' (Strauss et al., 1985). Within our reablement teams, a significant instance of articulation work involves staff efforts to align prescriptions of the assessment protocol with perceptions, needs and life conditions of individual clients. For instance, informal pre-visits and phone calls prepared clients for formal assessments. In addition, to adapt to the pace and life-worlds of the clients, formal assessment protocols and processes were broken down into several smaller operational events.

We have also identified how staff to make the assessment protocol workable tinkered with the clients directly by using various subtypes of the kind of work Strauss et al. (1985) refer to as 'sentimental work'. For instance, to manage clients' emotional responses to their illness and prospects of focusing on training and enabling activities, professionals engage in 'interactional work' (Strauss et al., 1985). This work includes tasks such as informing clients about reablement, addressing their concerns, answering their questions and listening to their worries. In line with previous studies on reablement, 'motivational work' which as noted by Meldgaard Hansen (2016) and Bødker (2019) involves staff effort to encouraging potential reablement clients to recognise the benefits of participating in reablement programmes, also emerged as an important type of work to manage client responses to the protocols.

We also introduce the new concept of 'identity transformation work' to shed light on a subtype of sentimental work that Mr. Thomas's case illustrates. This term underscores the idea that motivational work can sometimes evolve into a more profound psychological intervention focused on reshaping the individual's sense of identity and body understanding. We draw a connection to Strauss et al.'s (1985) concept of 'identity work' that is primarily used to assist individuals who are severely or mortally ill in *maintaining* their sense of self. In

contrast, the notion of 'identity transformation work' suggests that the efforts undertaken in the context of reablement are directed at regulating and *transforming* the client's identity and personality.

Finally, an essential aspect of making assessment workable was the tinkering with the prescriptions of the actual assessment protocol. As seen in other studies (Bødker, 2019; Lydahl, 2021), we found that staff adjusted and translated the wording and logical sequence of questions and responses, and in some cases omitted certain questions when they noticed that clients were struggling to comprehend these questions. To strengthen analytical conceptualisations of this form of tinkering, we label this specific aspect of work 'editing work' as it involved modifying the fundamental components of protocols and outcome measures.

The specifications of the forms of improvised tinkering show that learning lessons on reablement are not reducible to the 'visible' evidence base produced by manageable COPM protocols. Since COPM is inherently entangled in reablement contexts, it is crucial to broaden the learning lesson perspective. This bring us into a long-standing concern within the sociology of standards as underscored by Timmermans and Epstein (2010) and Star and Strauss (1999). This concern revolves around the risk of neglecting unpredictable and time-consuming aspects of work while rewarding more visible and formalised elements. In the worst cases, these vital aspects of work may be disregarded, undervalued and deprived of the necessary resources and recognition they deserve. Moreover, relegating these aspects to the background may divert attention from reflecting on the moral dimensions inherent in all human service work.

Hence, as pointed out by previous research on standards, we found that diverse forms of tinkering were carried out to navigate between competing concerns of doing 'good' in the reablement context. Of particular importance, in line with Lydahl's (2017, 2021) studies on person-centred protocols at a Swedish hospital, we find that the observed tinkering seemed centred around alleviating tensions stemming from various concerns, including optimising efficiency of reablement treatment and ensuring client involvement without causing unnecessary stress. As argued by Lydahl (2021, p. 103), even though the protocols were designed to reconcile such concerns, the relationship between the 'contrasting values' had to be 'adjusted' in situ.

Our detailed exploration of the more or less intensive and strenuous tinkering required to make the protocol work in heterogeneous client cases also adds nuances to Lydahl's (2021) insights. The cases foreground that it is impossible to establish a predefined and encapsulated notion of whether the abstract principles of person-centredness and efficiency are contrasting or compatible values in situ, because this depends on the individual client and the aspect of the assessment process you are focusing on. In fact, it was next to impossible, despite performing demanding tinkering, to make the principles compatible in cases like that of Mr. Thomas, while it was less demanding in cases involving well-functioning and motivated clients, like Mrs. Hansen, who to a higher extent seemed to live up to the role of a client as specified in the 'script' of the protocol (Timmermans & Epstein, 2010). Although it is beyond the scope of this study and its methodology to delve into the longitudinal impact of COPM *and* tinkering, these divergent cases bring us to discuss the observed impact.

Based on their seminal book *Care in Practice*, Mol et al. (2010, p. 14) argue that they would summarise 'good care' as the 'persistent tinkering in a world full of complex ambivalence and shifting tension'. Our analysis of tinkering in the heterogeneous cases also underscored that tinkering is a vital aspect of the functioning of COPM, but it also addresses the potential limitations of COPM *and* tinkering. Hence, we will argue that the strength of making 'identity transformation work' and 'editing work' visible through identifying and labelling them is that this may help raise new research questions in the field of reablement.

Firstly, by alluding to the 'identity transformation work' observed in the case of Mr. Thomas, we raise the question of whether person-centred protocols actually ensure what Lydahl (2017) refers to as 'true' person-centredness, when assessment processes may require older individuals to alter their self-perception and needs to align with potentially paternalistic clinical language and goals of reablement. Secondly, by highlighting the significance of 'editing work', in line with previous studies (Bødker, 2019; Lydahl, 2021), we raise the question of whether person-centred outcome measures are valid or may contribute to generate mediated or false numeric figures about the effectiveness of reablement *if* staff even manage to collect them.

AUTHOR CONTRIBUTIONS

Maya Christiane Flensborg Jensen: Conceptualization (equal); data curation (equal); formal analysis (equal); funding acquisition (supporting); investigation (equal); methodology (equal); project administration (supporting); resources (supporting); software (equal); supervision (supporting); validation (equal); visualization (equal); writing – original draft (lead); writing – review & editing (lead). **Mia Vabø**: Conceptualization (equal); data curation (equal); formal analysis (equal); funding acquisition (lead); investigation (equal); methodology (equal); project administration (lead); resources (lead); software (equal); supervision (lead); validation (equal); visualization (equal); writing – original draft (supporting); writing – review & editing (supporting).

ACKNOWLEDGEMENTS

This study has been approved by the Norwegian Centre for Research Data (NSD). The article is based on research funded by the Research Council of Norway, project number 273696 and is a part of the research project 'Creating Integrated Person-centered Care in Different Settings' (CONTEXT).

DATA AVAILABILITY STATEMENT

Research data are not shared due to privacy or ethical restrictions.

ORCID


Maya Christiane Flensborg Jensen https://orcid.org/0000-0001-8111-4226

ENDNOTE

[1] All interlocutors' names have been replaced with pseudonyms.

REFERENCES

Armstrong, P. (2018). Introduction. In P. Armstrong & R. Lowndes (Eds.), *Creative teamwork. Developing rapid, site-switching ethnography*. Oxford University Press.

Baines, D., & Cunningham, I. (2011). Using comparative perspective rapid ethnography in international case studies: Strengths and challenges. *Qualitative Social Work*, *12*(1), 1673–1688. https://doi.org/10.1177/1473325011419053

Berg, M. (1997). *Rationalizing medical work: Decision-support techniques and medical practices*. MIT Press.

Blumer, H. (1954). What is wrong with social theory? *American Sociological Review*, *19*(1), 3–10. https://doi.org/10.2307/2088165

Bødker, M. N. (2019). Potentiality made workable - Exploring logics of care in reablement for older people. *Ageing and Society*, *39*(9), 2018–2041. https://doi.org/10.1017/S0144686X18000417

Carswell, A., McColl, M. A., Baptiste, S., Law, M., Polatajko, H., & Pollock, N. (2004). The Canadian occupational performance measure: A research and clinical literature review. *Canadian Journal of Occupational Therapy*, *4*(71), 210–222. https://doi.org/10.1177/000841740407100406

Clotworthy, A., Kusumastuti, S., & Westendorp, R. G. J. (2021). Reablement through time and space: A scoping review of how the concept of 'reablement' for older people has been defined and operationalised. *BMC Geriatrics*, *21*(61), 1–16. https://doi.org/10.1186/s12877-020-01958-1

Cohn, S., Fritz, Z. B. M., Frankau, J. M., Laroche, C. M., & Fuld, J. P. (2013). Do not attempt cardiopulmonary resuscitation orders in acute medical settings: A qualitative study. *QJM: An International Journal of Medicine*, *106*(2), 165–177. https://doi.org/10.1093/qjmed/hcs222

Czarniawska-Joerge, B. (1993). *The three dimensional organization: A constructionist view*. Studentlitteratur.

Donnelly, C., & Carswell, A. (2002). Individualized outcome measures: A review of the literature. *Canadian Journal of Occupational Therapy/Revue Canadienne D'Ergothérapie*, *69*(2), 84–94. https://doi.org/10.1177/000841740206900204

Ebrahimi, V., & Chapman, H. (2018). *Reablement services in health and social care: A guide to practice for students and support workers*. Bloomsbury Publishing.

Fürst, R., & Høverstad, L. (2014). *Fra passiv mottaker til aktiv deltaker. Hverdagsrehabilitering i norske kommuner. KS FoU-prosjekt nr. 134027*. KS.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. Abingdon.

Langeland, E., Tuntland, H., Folkestad, B., Forland, O., Jacobsen, F. F., & Kjeken, I. (2019). A multicenter investigation of reablement in Norway: A clinical controlled trial. *BMC Geriatrics*, *19*(29), 1–12. https://doi.org/10.1186/s12877-019-1038-x

Laver-Fawcett, A. (2014). Routine standardised outcome measurement to evaluate the effectiveness of occupational therapy interventions: Essential or optional? *Ergoterapeuten*, *4*, 28–37.

Lydahl, D. (2017). Visible persons, invisible work? Exploring articulation work in the implementation of person-centred care on a hospital ward. *Sociologisk Forskning*, *54*(3), 163–179. https://doi.org/10.37062/sf.54.18213

Lydahl, D. (2021). Standard tools for non-standard care: The values and scripts of a person-centred assessment protocol. *Health*, *25*(1), 103–120. https://doi.org/10.1177/1363459319851541

Mann, A. (2021). Abandoning questionnaires: Improving quality of life in daily nephrology practice. *Nordic Journal of Science and Technology Studies*, *9*(1), 53–64. https://doi.org/10.5324/njsts.v9i1.3545

Meldgaard Hansen, A. (2016). Rehabilitative bodywork: Cleaning up the dirty work of homecare. *Sociology of Health and Illness*, *38*(7), 1092–1105. https://doi.org/10.1111/1467-9566.12435

Metzelthin, S. F., Rostgaard, T., Parsons, M., & Burton, E. (2020). Development of an internationally accepted definition of reablement: A Delphi study. *Ageing and Society*, *42*(3), 1–16. https://doi.org/10.1017/S0144686X20000999

Mol, A. (2006). *The logic of care: Health and problem of patient choice*. Routledge.

Mol, A., Moser, I., & Pols, J. (2010). Care: Putting practice into theory. In A. Mol, I. Moser, & J. Pols (Eds.), *Care in practice: On tinkering in clinics, homes and farms*. Transcript Verlag.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Sage.

Polloc, N. (1993). Client-centred assessment. *The American Journal of Occupational Therapy*, *47*(4), 298–301. https://doi.org/10.5014/ajot.47.4.298

Rostgaard, T. (2016). Socially investing in older people–Reablement as a social care policy. *Research on Finnish Society*, *9*, 19–32. https://doi.org/10.51815/fjsr.110759

Star, S. L., & Strauss, A. (1999). Layers of silence, arenas of voice: The ecology of visible and invisible work. *Computer Supported Cooperative Work (CSCW)*, *8*(1–2), 9–30. https://doi.org/10.1023/a:1008651105359

Strauss, A. L., Fagerhaugh, S., & Suczek, B. (1985). *Social organization of medical work*. University of Chicago Press.

Timmermans, S., & Berg, M. (1997). Standardization in action: Achieving local universality through medical protocols. *Social Studies of Science*, *27*(2), 273–305. https://doi.org/10.1177/030631297027002003

Timmermans, S., & Epstein, S. (2010). A world of standards but not a standard world: Toward a sociology of standards and standardization. *Annual Review of Sociology*, *36*(1), 69–89. https://doi.org/10.1146/annurev.soc.012809.102629

Tuntland, H., Aaslund, M. K., Langeland, E., Espehaug, B., & Kjeken, I. (2016). Psychometric properties of the Canadian Occupational Performance Measure in home-dwelling older adults. *Journal of Multidisciplinary Healthcare*, *1*(9), 411–423. https://doi.org/10.2147/JMDH.S113727

Tuntland, H., & Ness, N. E. (2021). Hverdagsrehabilitering–ti år etter oppstart og veien videre. *Tidsskrift for omsorgsforskning*, *3*, 1–7. https://doi.org/10.18261/issn.2387-5984-2021-03-12

WHO. (2002). *Active ageing: A policy framework*. World Health Organization.

How to cite this article: Jensen, M. C. F., & Vabø, M. (2023). Making assessment protocols workable: Navigating transparency and person-centredness in Norwegian reablement. *Sociology of Health & Illness*, 1–18. https://doi.org/10.1111/1467-9566.13710