

# ‘Doing with ...’ rather than ‘doing for ...’ older adults: rationale and content of the ‘Stay Active at Home’ programme

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1–12

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This series of articles for rehabilitation in practice aims to cover a knowledge element of the rehabilitation medicine curriculum. Nevertheless they are intended to be of interest to a multidisciplinary audience. The competency addressed in this article is teaching home care professionals to deliver goal-oriented, holistic and person-centred services focusing on supporting older adults to maintain, gain or restore their competences to engage in physical and daily activities so that they can manage their everyday life as independently as possible.

## Abstract

**Background:** Owing to increasing age, accidents or periods of illness, home care services are provided to community-dwelling older adults. Traditionally, these services focus on doing things *for* older adults rather than *with* them; though from a rehabilitative perspective, it is important to assist older adults to attain and maintain their highest level of functioning. Consequently, a re-orientation of home care services is required away from treating disease and creating dependency towards focusing on capabilities and opportunities and maximising independence. To achieve this behavioural change in home care professionals, the ‘Stay Active at Home’ programme was developed.

**Aims and methods:** The aim of this article is to give a detailed description of the rationale and content of the ‘Stay Active at Home’ programme by making use of the TIDieR (Template for Intervention Description and Replication) Checklist.

**Approach:** ‘Stay Active at Home’ is a comprehensive training programme that aims to equip home care professionals (i.e. community nurses and domestic support workers) with the necessary knowledge, attitude, skills and social and organisational support to deliver day-to-day services at home from a more rehabilitative perspective. More specifically, home care professionals are expected to deliver goal-oriented, holistic and person-centred services focusing on supporting older adults to maintain, gain or restore their competences to engage in physical and daily activities so that they can manage their everyday life as independently as possible.

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## Background

Like most Western countries, the Netherlands provides home care services to many older adults to enable ‘ageing in place’. Older adults who experience difficulties with personal care (e.g. washing and dressing) or domestic tasks (e.g. cleaning or doing the laundry) receive support from paid community nurses and/or domestic support workers, who attend their homes to provide assistance with these tasks. However, traditionally home care professionals tend to focus on doing things *for* older adults rather than *with* them.<sup>1</sup> Thereby they – despite their best intentions – may deprive older adults of their opportunities to engage in a routine range of movements necessary for maintaining underlying capability, resulting in further deconditioning and functional decline.<sup>1,2</sup>

In contrast, from the perspective of rehabilitation, it is important to assist older adults to attain and maintain their highest level of physical and psychological functioning with the aim to reduce their dependency or at least to maintain their current level of independence as long as possible. For example, instead of washing and dressing clients, their level of dependency can be reduced by encouraging them to engage in these activities with the help of assistive devices, breaking down the tasks into simple steps, and/or offering exercises to improve range of motion and strength so that the individual has the underlying capability to bath and dress independently.

While these principles are well-known and widely disseminated in rehabilitation practice, they are not well-established in traditional Dutch day-to-day home care. Therefore, a re-orientation is required away from treating disease and facilitating dependency towards a focus on capabilities and opportunities and maximising independence.<sup>3</sup> However, home care professionals often lack the necessary knowledge, attitude and skills to generate the proven benefits of rehabilitation in day-to-day home care.<sup>4,5</sup> Furthermore, a facilitating social and physical environment is needed to promote this innovative way of home care delivery.<sup>4,5</sup>

The ‘*Stay Active at Home*’ (in Dutch: ‘*Blijf Actief Thuis*’) programme was developed to equip home care professionals (i.e. community nurses and domestic support workers) with the necessary knowledge, attitude, skills and social and organisational support to deliver their services from a more rehabilitative perspective focusing on capabilities and opportunities and maximising independence. This article describes the rationale and the content of ‘*Stay Active at Home*’ by making use of the TIDieR (Template for Intervention Description and Replication) Checklist.<sup>6</sup>

## Methods

The ‘*Stay Active at Home*’ programme is primarily based on the concept of reablement,<sup>3–5,7,8</sup> which is similar to the concept of Function Focused Care.<sup>2,9</sup> Despite some differences across and even within countries, reablement and Function Focused Care have in common that day-to-day services are meant to be goal-oriented, holistic and person-centred, taking into account the capabilities and opportunities of older adults instead of focusing on disease and dependency. In other words, an attitude of ‘*doing with ...*’ rather than ‘*doing for ...*’ older adults is promoted among professionals.

While Function Focused Care has its origin in institutionalised long-term care settings in the United States (US), the concept of reablement has been developed and delivered in home care across Australia, New Zealand and the UK over the last 10–15 years.<sup>4,5,7,10–12</sup> More recently, reablement is also being disseminated across other countries, notably Canada, Norway and Denmark.<sup>4,8,13,14</sup> Owing to the similarities between reablement and Function Focused Care we took both concepts into account when developing ‘*Stay Active at Home*’.

## Development of the ‘*Stay Active at Home*’ programme (January 2013–July 2016)

To overcome cultural and organisational differences between countries and settings, we systematically

adapted the concepts of reablement and Function Focused Care to the Dutch home care setting, in co-creation with international researchers and a group of relevant Dutch stakeholders (i.e. nurses and other healthcare professionals, older adults, policy makers, training officers, management and the board of directors).<sup>15,16</sup>

For the adaptation process, a seven-step approach<sup>17</sup> was applied, which facilitates the systematic adaptation of available programmes in a new context. Briefly, after identifying publications in the fields of reablement and Function Focused Care (Step 1, 2013), the articles and any original programme materials were gathered and studied (Step 2, 2013). Furthermore, several work visits to the US, New Zealand and Australia were conducted to gain insight into the theory of the chosen programmes and their application in practice (2013–2014). Subsequently, a programme theory was developed (Step 3) and the core components were identified based on the previous steps (Step 4, 2014). Both the programme model and core components and its potential relevance for Dutch home care services were discussed during an expert meeting with international researchers in the fields of reablement and Function Focused Care. In the next step (Step 5, 2014) mismatches between the chosen programmes and the new context were identified by the earlier mentioned Dutch stakeholders. Finally, the original programme model (Step 6) and intervention materials (Step 7) were adapted in close collaboration with these stakeholders (2014–2015). As a last step of the adaptation process, a pilot study was conducted to finalise the ‘*Stay Active at Home*’ programme (November 2015–July 2016).

## Description of the ‘*Stay Active at Home*’ programme

In this article, the 12-item TIDieR checklist<sup>6</sup> was used to provide a complete description of the ‘*Stay Active at Home*’ programme.

### Item 1: Brief name

‘*Stay Active at Home*’ programme (in Dutch: ‘*Blijf Actief Thuis*’).

### Item 2: Rationale, theory and aim of the elements essential to the intervention

The *rationale* for the development of ‘*Stay Active at Home*’ is the fact that many community-dwelling older adults have a highly sedentary lifestyle, especially those receiving homecare services.<sup>18</sup> They spend approximately 80% of their awake time in sedentary activities, which represents eight to 12 hours per day.<sup>19,20</sup> There are many factors that negatively influence older adults’ willingness to engage in physical and daily activities, including motivation, fear, depression and lack of belief in the benefits of physical activity.<sup>21</sup>

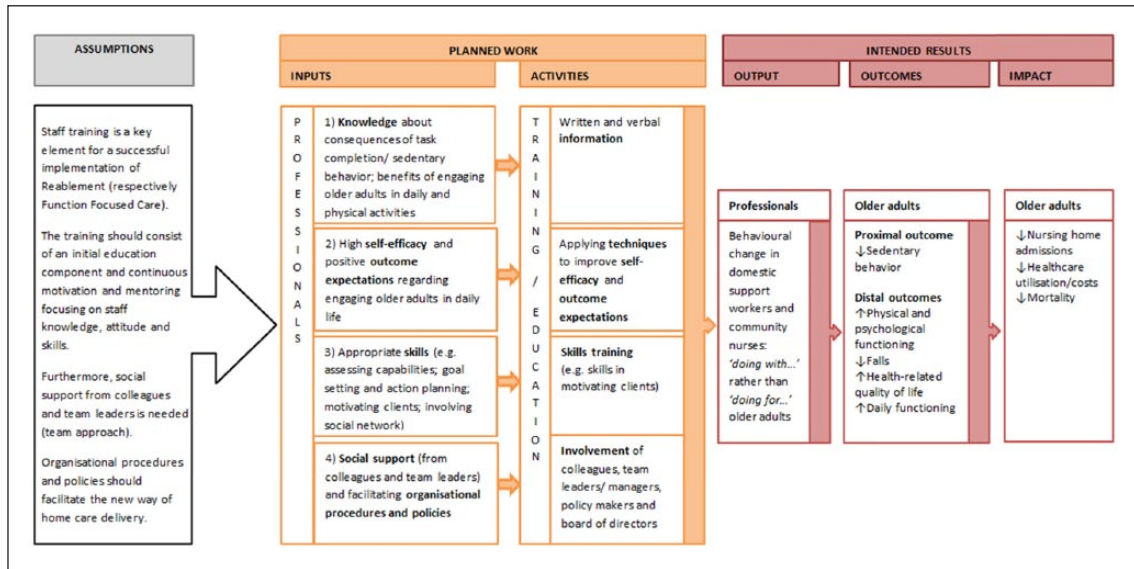
One option to reduce their sedentary time is to offer an additional (classical) exercise programme. However, ‘exercise’ can also be integrated into regular care. Home care professionals, in particular, can play a central role here, as they provide most of the direct care<sup>2</sup> and can stimulate older adults continuously in a one-to-one relationship to be more active in daily life, for example:

- giving instructions to the client on how to use helping aids to be able to wash him or herself independently;
- asking the client to sit down on a chair to change the pillowcase, while the domestic support worker changes the bedcover.

However, as addressed earlier, this requires a re-orientation of Dutch home care services away from treating disease and facilitating dependency towards a focus on capabilities and opportunities and maximising independence.<sup>3</sup>

To promote this re-organisation we made primarily use of the *concept* of reablement, which is defined by Aspinall et al.<sup>4</sup> as services that

focus on improving individuals’ full or partial independence in activities of daily living inside the home, but also focuses on helping people to access their local community and to reconnect with their preferred social, leisure, and physical activities. Moreover, instead of looking to older adults primarily in terms of frailty, there is a need to emphasise the resilience and the ability of older people to overcome losses, adapt and regain independence. (Aspinall et al.<sup>4</sup>)



**Figure 1.** Programme model 'Stay Active at Home'.

The aim of 'Stay Active at Home' is to equip home care professionals with the necessary knowledge, attitude, skills and social and organisational support to adopt the concept of reablement in the delivery of their services. Based on the concept of reablement, a couple of elements were identified, which are summarised in the programme model of the 'Stay Active at Home' programme (see Figure 1). Such a model describes and visualises the underlying (1) assumptions; (2) planned work; and (3) intended results of the programme.<sup>22</sup>

1. It is assumed that staff training is a key element for the re-organisation of home care, as community nurses and domestic support workers have to change their day-to-day professional behaviour. The training should consist of an initial education component and continuous motivation and mentoring focusing on staff knowledge, attitude and skills. Furthermore, professionals need social support from their colleagues and team leaders (team approach).<sup>2,7</sup> Last but not least, it is important that the organisation facilitates the re-organisation of home care by providing a strong and shared vision regarding a more rehabilitative approach to home care, including organisational procedures and policies that are

in line with the new way of delivering home care.<sup>2,7</sup>

2. The planned work describes what is needed to achieve the required behavioural changes in home care professionals in terms of inputs and activities (see TIDieR item 4 for more details).<sup>22</sup>

3. The intended results of 'Stay Active at Home' can be divided into outputs, proximal and distal outcomes and impact.<sup>22</sup> Outputs refer to the direct products of the programme activities. The output of 'Stay Active at Home' is the intended behavioural change in community nurses and domestic support workers (i.e. 'doing with ...' rather than 'doing for ...' older adults). This behavioural change is expected to increase older adults' participation in daily and physical activities and reduce their sedentary behaviour (i.e. proximal outcome), which consequently leads towards beneficial outcomes with regard to their physical and psychological functioning, a reduction in falls and improved health-related quality of life and daily functioning (i.e. distal outcomes). In the long term, it is expected that 'Stay Active at Home' reduces nursing home admissions, healthcare utilisation and costs and mortality (i.e. impact).

**Table 1.** Content of ‘Stay Active at Home’ manual.

<p>Part I: Introduction</p> <p>This part provides some background information on why a re-orientation of home care is needed:</p> <ul style="list-style-type: none"> <li>- Consequences of task completion/sedentary behaviour</li> <li>- Benefits of engaging older adults in daily and physical activities</li> </ul>	<p>Part II: Description of the training</p> <p>This part consists of the following:</p> <ul style="list-style-type: none"> <li>- Aims of ‘Stay Active at Home’</li> <li>- Overview of activities (see Figure 2, available online)</li> <li>- More indepth explanation of the activities (i.e. kick-off, team meetings, assignments, Tip of the Week, booster session)</li> </ul>	<p>Part III: Toolkit for professionals</p> <p>This part describes how professionals can engage their clients more in daily and physical activities. Topics that are addressed are: (1) assessment of older adults; (2) behavioural change theory; (3) goal-setting and action planning; (4) engaging older adults in daily activities (e.g. by making use of task analysis and redesign, helping aids or assistive devices, adapting patient-provider communication); (5) engaging older adults in physical activities (e.g. by making use of an exercise booklet); (6) motivation techniques (based on Bandura’s self-efficacy theory<sup>23,24</sup>); (7) evaluating goals and actions.</p> <p>Furthermore, this part consists of materials for daily practice:</p> <ul style="list-style-type: none"> <li>- Forms to assess the capabilities and opportunities of older adults (i.e. self-reflection list focusing on clients’ participation in daily and physical activities; observation lists regarding (instrumental) activities of daily activities; an ecogram to assess the social network)</li> <li>- A goal-setting form for long-term and short-term goals</li> <li>- An action plan: Who does what?</li> <li>- An exercise booklet for older adults including 10 Otago-based exercises<sup>29</sup> and an exercise diary</li> </ul>
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### **Item 3: Materials used in the intervention delivery or in the training of intervention providers**

‘Stay Active at Home’ is described in a detailed manual (in Dutch; available upon request). The manual consists of three parts: (1) an introduction that provides relevant background information; (2) a description of the training, including an overview of the aims and activities of ‘Stay Active at Home’; and (3) a toolkit for professionals to deliver day-to-day services at home from a more rehabilitative perspective. See Table 1 for more detailed information.

For the interventionist, who provides the training to home care professionals, PowerPoint

presentations, short videos, discussion questions and assignments are available. Furthermore, a collection of weekly newsletters was created. All materials are in Dutch and available upon request. For more details about the training activities see TIDieR item 4.

### **Item 4: Procedures, activities and/or processes used including enabling or support activities**

The ‘Stay Active at Home’ programme has been developed to equip home care professionals with the necessary knowledge, attitude, skills and social and organisational support to deliver day-to-day services



in older adults' homes from a more rehabilitative perspective. Therefore, several training activities are chosen, which are combined in a comprehensive training programme for home care professionals. Briefly, the training consists of face-to-face meetings and weekly newsletters. The face-to-face meetings can be subdivided into a kick-off meeting and a series of (bi-)monthly team meetings, and a booster session (see TIDieR items 6 and 8 for more details).

The newsletters (see Figure 2 for example, available online) are primarily aimed at professionals' knowledge, while the face-to-face meetings are more focused on attitude, skills and social support. During the face-to-face meetings home care professionals learn skills to: (1) assess the capabilities of older adults; (2) implement goal-setting and action planning; (3) increase engagement of the older adults in daily and physical activities; (4) motivate older adults by taking into account their phase of behavioural change and making use of Bandura's self-efficacy theory<sup>23,24</sup>; and (5) involve the social network of older adults.

The face-to-face meetings start with a short presentation about one of these topics. Consequently, home care professionals receive a skills training in a safe environment including assignments, group discussions and role plays (see Box 1 for examples). During the meeting, the interventionist uses strategies that apply Bandura's self-efficacy theory<sup>23,24</sup> to promote high levels of self-efficacy and positive outcome expectations among professionals regarding a more rehabilitative approach to home care. For example, the interventionist provides information, stimulates the exchange of success experiences or sets goals with the team regarding the new way of home care delivery. In-between the team meetings, professionals are asked to do a practical assignment to stimulate the implementation of new skills in daily practice. Professionals' practice experiences are discussed during the next team meeting. Furthermore, professionals are also stimulated to give each other feedback to increase the level of social support.

#### Box 1. Examples of skills training.

##### *Example 1: Community nurses*

After a presentation about goal-setting and action planning, professionals receive a client case history:

- *Ms Bergsma, 73 years old, needs assistance with bathing. She lives alone and has one son. Owing to her osteoporosis she has pain in her shoulders and her bathroom is not safe. The client also forgets to take her medicines in time and does not eat on a regular basis.*

Professionals are asked to form pairs. Together they formulate Specific, Measurable, Attainable, Relevant, Time-bound (SMART) goals for this client and come up with a service plan, including actions and responsibilities for all involved parties. Next, the goals and service plans are discussed with the other team members to learn from each other. After practicing in a safe environment, the community nurses are asked to conduct goal-setting and action planning with one of their own clients. During the next meeting, their experiences are discussed and feedback is provided.

##### *Example 2: Domestic support workers*

After a presentation about motivational techniques, domestic support workers watch a short video about a professional who motivates a client to participate in a domestic task:

- *The client is reading the newspaper when the domestic support worker enters the living room. The domestic support worker wants to dust the cupboard together with the client. However, the client does not want to participate owing to her back pain. The domestic support worker explains the benefits of engaging in daily and physical activities. For example, she highlights the beneficial effects of physical activity with regard to pain reduction. After some discussion, the client is willing to help. The domestic support worker does the higher and lower cupboards, while the client does the cupboards at her eye level. During and after the activity the support worker compliments the client.*

The behaviour of the role model in the video is discussed by the team. Afterwards the domestic support workers are invited to share their own experiences with the new way of home care delivery.

After the last team meeting, home care professionals are asked to formulate three personal learning goals, including an action plan to reach these goals. The achievement of these goals is evaluated during the booster session, which is intended to reinforce knowledge, attitude, skills and team support. Furthermore, role plays with a professional actor are done to practice situations that are still being experienced as challenging by home care professionals.

Finally, in addition to social support by colleagues and team leaders, organisational support is assumed to be essential to achieve the intended behavioural changes required of the home care professionals. As a consequence, it is important to ensure that team managers, policy makers and the board of directors have an understanding of the approach and are supportive of it. Therefore, they need to be regularly informed about the aims and content of and the progress of the training. In addition, facilitators and barriers regarding the way of home care delivery have to be discussed and addressed with managers, policy makers and the board of directors. In addition, the team leaders of the nursing teams and the team managers of the domestic teams are invited to participate in all training activities and also receive the weekly newsletters (see also TIDieR item 5).

#### ***Item 5: Expertise and background of interventionist***

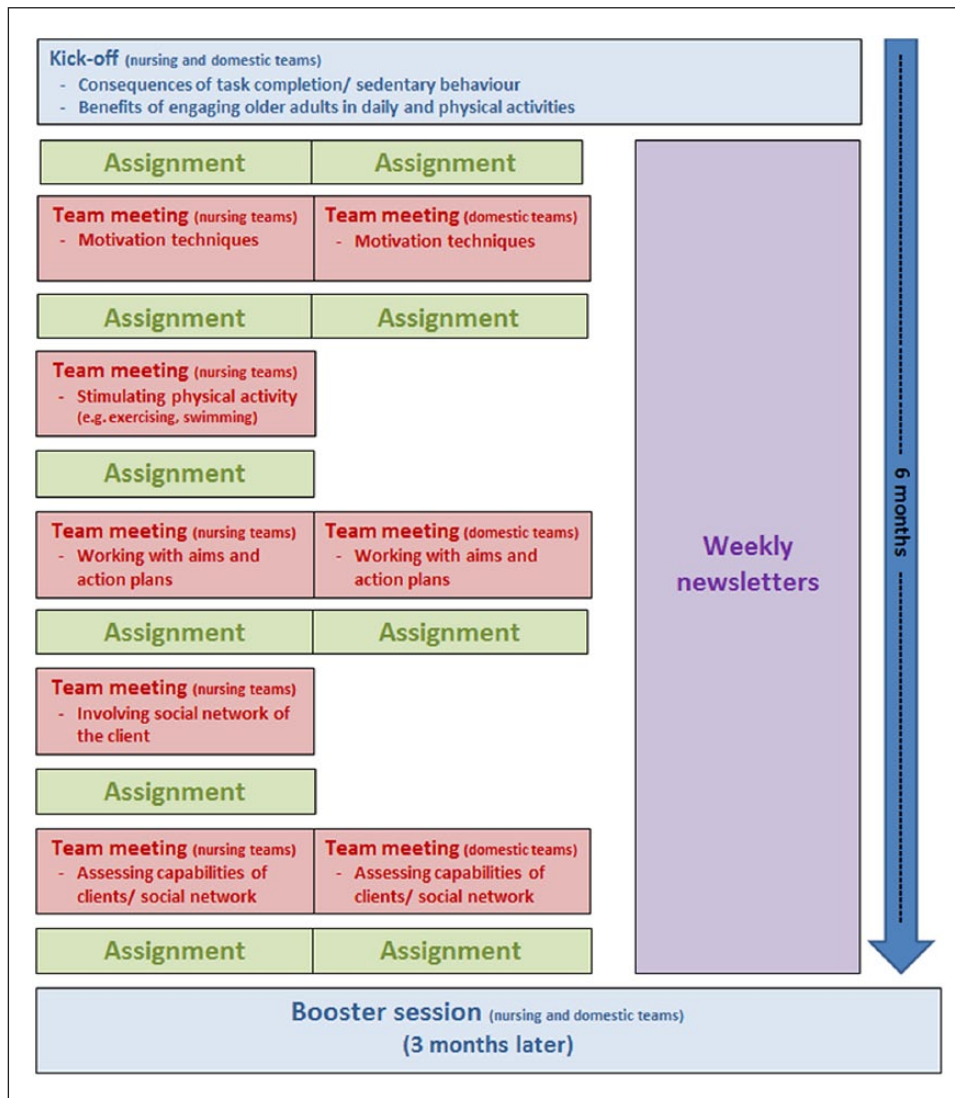
During the pilot study (November 2015 until July 2016) the ‘*Stay Active at Home*’ training was delivered by author SFM, who has a background in occupational therapy and health sciences. She developed ‘*Stay Active at Home*’ together with her coworkers and was involved during the whole adaptation process. During the pilot study, she was supported by two training officers of the pilot organisation and the team leader of the nursing team and the team manager of the domestic teams. Team leaders and team managers join all training activities and are stimulated to actively participate by asking questions or giving feedback.

#### ***Items 6 & 8: How, when and how much***

The ‘*Stay Active at Home*’ programme (see Figure 3) consists of: (a) an initial kick-off meeting (two hours); followed by (b) regular team meetings for home care professionals for a period of six months (monthly for community nurses (each 1 hour) and bimonthly for domestic support workers (each one hour); and finally (c) a booster session (two hours) three months after the last team meeting. The meetings are conducted face-to-face. The initial kick-off meeting is organised for all community nurses and domestic support workers together to get to know each other. Knowing each other is important, as it is likely that community nurses and domestic support workers provide services for the same clients. The subsequent team meetings are organised for community nurses and domestic support workers separately, as they are more focused on discipline-specific tasks. Furthermore, short weekly newsletters with the ‘Tip of the Week’ are provided to all professionals by email during these six months. The training ends with a booster session three months after the last team meeting. This meeting is again organised for all home care professionals together.

#### ***Item 7: Location(s) where the intervention occurred, including necessary infrastructure or relevant features***

To deal with an ageing society, Dutch policy makers facilitate ‘*ageing in place*’. Consequently, the proportion of older people in Dutch long-term care facilities is decreasing and community-based home care is becoming more important.<sup>25</sup> Also the majority of older adults, even with fragile health and faced with challenging social situations, prefer to stay at home for as long as possible.<sup>26</sup> To enable Dutch older adults to age in place, home care services are available, which can be divided into domestic services (e.g. cleaning, washing) and nursing care. The latter can be subdivided into personal care (e.g. assistance with bathing and dressing) and specialised nursing care (e.g. wound care, catheter insertion).



**Figure 3.** Format of the 'Stay Active at Home' programme.

Domestic services are financed by the municipalities and delivered by domestic support workers. Domestic support workers often have a low level of education and have limited possibilities to exchange their experiences with their colleagues or to join training activities. Domestic support workers are coordinated by a team manager.

Nursing care is financed by healthcare insurance. In the Netherlands, nearly all citizens are covered by

healthcare insurance and services are easy accessible.<sup>27</sup> Nursing care is delivered by a team of community nurses (i.e. a mix of certified nurse assistants, vocational-trained nurses and baccalaureate-educated nurses). Most of the time, a baccalaureate-educated nurse fulfils the role of team leader. The teams organise the care delivery by themselves under supervision of a team manager. The manager is responsible for several nursing teams.



The ‘*Stay Active at Home*’ programme was pilot tested in one nursing team and two domestic teams.

### **Item 9: Tailoring – what, why, when and how**

The procedures, activities and processes of ‘*Stay Active at Home*’ are standardised and executed as described above (see also TIDieR items 4, 6 and 8). However, home care professionals are stimulated during the face-to-face meetings (i.e. kick-off meeting, (bi-)monthly team meetings and booster session) to talk about their personal experiences with the new way of home care delivery. These practice cases are discussed with their colleagues and team leaders and the interventionist. Consequently, the meetings are tailored to their individual needs. When implementing ‘*Stay Active at Home*’ in another setting, within or outside the Netherlands, it should be taken into account that the programme is potentially not replicable in another setting without changes owing to cultural or organisational differences between settings.<sup>17,28</sup> The adaptation needed may pose major challenges for programme developers, as they have to find a balance between maintaining the treatment fidelity of the original programme and maximising the fit with the characteristics of the new priority population and implementation context.<sup>17, 28</sup>

### **Items 10 & 12: Modifications, adherence and fidelity**

These items cannot be completed until an intervention study is completed. Therefore, they are not applicable in this article, which is primarily aimed at a description of the programme.

### **Item 11: Strategies to improve and maintain fidelity**

During the pilot study, the training was delivered by the author SFM. In subsequent studies, other interventionists will be recruited as well, preferably baccalaureate-educated nurse who are working in the field. To maintain fidelity, the interventionists

receive the training manual and all materials (see TIDieR item 3) in advance. Furthermore, there will be regular communication between author SFM and the interventionists to ensure that ‘*Stay Active at Home*’ is implemented as planned.

Domestic support workers and community nurses consequently receive the training as described above (see also TIDieR items 4 and 6 & 8). The assignments between the team meetings, the weekly newsletters with the ‘Tip of the Week’ and the booster session are particularly designed to improve and maintain fidelity.

During the pilot study and subsequent studies, fidelity is evaluated by means of questionnaires, group interviews and observations. The aim is to assess whether ‘*Stay Active at Home*’ succeeds in equipping professionals with the necessary knowledge, attitude, skills and organisational support to deliver services from a more rehabilitative perspective.

## **Discussion**

This article describes the rationale and content of the ‘*Stay Active at Home*’ programme. The programme has been developed to equip home care professionals (i.e. community nurses and domestic support workers) with the necessary knowledge, attitude, skills and organisational support to deliver day-to-day services at home from a more rehabilitative perspective by making use of the concept of reablement.<sup>3-5,7,8</sup>

Reablement<sup>3-5,7,8</sup> is similar to rehabilitation. Rehabilitation is defined as ‘*services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living*’.<sup>5</sup> However, rehabilitation principles are not well-established in Dutch day-to-day home care, as these services traditionally focus on doing things *for* older adults rather than *with* them. Reablement can be used as a vehicle to implement the principles of rehabilitation in traditional home care.

However, the concept of reablement has some limitations. First, although reablement seems to be promising in delivering day-to-day services at home from a more rehabilitative perspective, it has to be

acknowledged that several literature reviews<sup>3,5,7-9</sup> resulted in limited and partly conflicting evidence for its effectiveness.<sup>3,5,7,8</sup> This is partly owing to the fact that reablement is a relatively new concept in home care and [high-quality] studies are still scarce. Furthermore, there are differences between and even within countries in how reablement is implemented. Nevertheless, several systematic reviews<sup>3,7,8</sup> have shown that reablement has some potential to result in beneficial results with regard to client outcomes (e.g. physical activity, daily functioning, safety, health-related quality of life), professional outcomes (e.g. job satisfaction and turn-over), healthcare utilisation and cost-effectiveness.

Second, reablement is a person-centred intervention, which is assumed to be applicable to diverse people, irrespective of age, diagnosis and capacity.<sup>4</sup> Consequently, it is difficult to come up with a definition of what reablement looks like in practice. Despite this variability, reablement provision shares several key features.<sup>4</sup> Nevertheless the person-centredness of reablement is also a strength, as reablement is individually tailored to assist clients to meet their individual goals given their particular capabilities and difficulties. In addition, this flexibility gives interventionists and researchers the opportunity to adapt the concept of reablement to the cultural and organisational circumstances of their individual setting.

Third, Legg et al.<sup>5</sup> argue that reablement lacks a clearly defined theory of change and well-operationalised core components. We agree with these authors that more research regarding the conceptual or theoretical framework of the key elements of reablement is needed, which can possibly be adopted from rehabilitation research.

This study also has some strengths. First, it has been conducted in collaboration with several experts in the fields of reablement and Function Focused Care, which enabled us to combine the components of various best practices. Second, we followed a systematic approach in developing the ‘*Stay Active at Home*’ programme to prevent a loss of effectiveness by affecting the original programme’s theory or removing core components of the programmes. Third, relevant Dutch stakeholders (i.e. nurses and other healthcare professionals,

older adults, policy makers, training officers, management and the board of directors) were involved in the development to increase the cultural appropriateness, local acceptance and feasibility of the final version of ‘*Stay Active at Home*’.

Finally, although detailed descriptions of interventions are necessary to replicate and build on research findings, the reporting of interventions in trial reports and reviews is remarkably poor.<sup>6</sup> Therefore, we used the TIDieR Checklist for a detailed description of ‘*Stay Active at Home*’, including a visualisation of the programme model including assumptions, planned work and intended results.

Currently, the ‘*Stay Active at Home*’ programme is evaluated in an early trial (ZonMw #520002003, trial registration #NCT02904889) as part of the ZonMw project BASIC CARE REVISITED<sup>30</sup> (ZonMw #520002003, trial registration #NCT02904889). This early trial will provide relevant information regarding: (a) the implementation of specific intervention components; (b) key components of the chosen methodology (e.g. outcome measures); (c) rates of recruitment and retention; and (d) the expected effect size. This information is highly relevant with regard to the subsequent main trial, which is planned to start in September 2017 (ZonMw #50-53120-98-014). The first results of the trials are expected by summer 2017 and spring 2018, respectively.

### Clinical messages

- ‘*Stay Active at Home*’ is a comprehensive training programme for home care staff.
- it aims to equip home care professionals with the necessary knowledge, attitude, skills and social and organisational support to deliver day-to-day services at home from a more rehabilitative perspective.

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### Contributors

All authors – SFM, GARZ, EvR, JMMG, BR, GL, MP and GIJMK – were involved in the development of the ‘Stay Active at Home’ programme. SFM wrote the first draft of the article. All authors reviewed the manuscript and approved the final version. SFM is the guarantor of the study.

### Conflict of interest

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