The effect of recreational activities on older people’s rehabilitation


Abstract

Aim To explore the effect of a programme of recreational activities on older people undergoing a period of rehabilitation.

Method Following an exploration of quantitative methodologies, a qualitative approach was decided on. Face-to-face semi-structured interviews were conducted with six participants in a local patients’ club.

Results The analysis suggests that the stays in hospital were times of inactivity. In addition, social interaction was restricted by a combination of physical factors and the perception of a lack of staff time. The patients’ club was identified as a stimulating and motivating force during the stay. However, it appeared to promote activity rather than social interaction.

Conclusion The patients’ club was clearly beneficial to those who attended. However, while it filled the day, it did not address the issue of the limited social interaction that was the experience of the participants during their stay in hospital.

My practice as a healthcare professional has been influenced in part by my experiences as a recipient of health care. My sole experience of inpatient treatment was a three-night stay in hospital following minor surgery. The lasting memory of this time was that it seemed like an eternity. Even allowing for the combination of a general anaesthetic and a tendency towards laziness, I was left feeling extremely listless.

It is likely that there are many people who have had far worse experiences of being in hospital. During my nursing career I have often reflected on how people who are in hospital for a prolonged period cope with the tedium. What are the consequences of the lack of stimulation on the individual?

This has particular resonance when considering inpatient rehabilitation services for older people, where the healthy ageing process can have an effect on the individual’s auditory and visual skills, thus limiting communication. This is without considering the reason for admission to hospital.

The literature review

The literature is not encouraging. The classic text describing the extreme of a depersonalised, unstimulating environment, was Goffman’s Asylums (1961) (Box 1). Goffman did not look at rehabilitation wards for older people, but he produced a framework that many nurses and other healthcare professionals like to think is unrepresentative of their practice because of its focus on the needs of the institution rather than the individual (Higgs et al 1992).

However, some aspects of Goffman are an integral part of being a hospital patient and sharing a ward with other people. For the duration of the stay, most boundaries between different aspects of life are removed. Each phase of daily activity is shared with other people following a broad routine imposed upon them. In practice, these restrictions can relegate patients to a role of sitting by their beds, available for the next nurse, doctor, physiotherapist or visitor to come along and do something to them. Healthcare professionals are faced with the challenge of finding ways of minimising the experience of aimless passivity.

The literature suggests that in many healthcare settings this does not happen. Hyland (1996) conducted a study of 148 hospitalised people with cancer and found that 85 per cent said they had time on their hands and about 50 per cent complained of feeling bored. Hardy and West (1994) conducted a patient satisfaction survey in which 70 per cent of respondents complained there was not enough to do in hospital. It is surprising that the percentage of people complaining of boredom was so low.

Nolan et al (1995) undertook an observational study of patient activity levels on one long- and one short-stay ward. The highest level of social interaction that occurred was 7 per cent (50 minutes in a 12-hour period). On the long-stay ward, patients were passive for 87 per cent of the 12-hour period, with the remaining time taken up with instrumental activity, such as personal care and nutrition.

None of these studies were looking at rehabilitation areas, but they do give some indication of what people experience when they are in hospital. The picture painted is somewhat closer to the picture of people complaining of boredom being so low. It is likely that there are many people who have had far worse experiences of being in hospital.

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Key words

- Elderly
- Rehabilitation

Online archive

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Box 1. Features of Goffman’s ‘total institution’

- Removal of barriers between work, leisure and family
- All aspects of life controlled by a single authority
- Each phase of daily activity shared with a large number of people
- Everyone treated alike, having to do the same things together
- Activities following a strict routine imposed from above
- The routine designed to fulfill the official aims of the institution

Goffman’s ‘total institution’ than many nurses feel comfortable with. Armstrong-Esther et al (1994) suggested that in monotonous environments, even the least frail people would become passive and inactive. For people with memory problems who rely on regular stimulation to keep them orientated, the effect of such an environment would be to leave them vulnerable to confusion.

Perkins and Nolan (1993) suggested that the provision of recreational activity is not just a means of preventing boredom, but a reflection of an underpinning belief in the need to provide choice about how to spend time. In addition, Lopez and Mermelstein (1995) linked an increased sense of control with lower levels of depression. Ruuskanen and Ruoppila (1995) found that psychological wellbeing influenced ability to perform physical tasks. Numerous other studies, such as Green (1995) and Clark and Bowling (1989), support the suggestion that activity programmes result in increased engagement and better psychological wellbeing.

The literature, therefore, implies that involvement in recreational activity should have a beneficial effect on an individual’s rehabilitation. However, in a health service that demands evidence, the question that remains is can these benefits be quantified?

The patient’s club

A local hospital rehabilitation service for older people had a well-established initiative to overcome the monotony of being in hospital: a patients’ club. This was separate from the wards and had its own complement of nursing staff. The club was open Tuesday to Friday morning, and Monday to Friday afternoon. There was an identified weekly timetable, which had the flexibility to change according to staff perceptions of client demand. On Monday evenings there was a social event that usually consisted of a live performance of music, with alcoholic and non-alcoholic beverages available.

Before each session, the staff from the club visited the wards, reminded people about the event that was planned and invited them to attend. In a hospital of 72 patients, about 20 would go to the club.

Method

A common approach to evaluating the effect of programmes of recreational activity is small-scale quantitative research (Turner 1993). Usually this involves a ‘before and after’ approach: choosing a variable related to the wellbeing of the patient that can be measured; collecting quantitative data in an area that does not offer recreational activities; introducing activities; repeating the data collection; and comparing the results.

However, this is not possible in an area that already offers a programme of recreational activity. An alternative approach is the randomised controlled trial (Field and Morse 1985). As the programme was already on offer to all patients, this raised further ethical concerns. By randomising people in or out of the trial, some patients would be denied access to a service that would have been available to them had the trial not been taken place, thus contradicting the edict from the Royal College of Physicians (1996) that the research should not do this.

Alternative quantitative approaches might involve using quantitative techniques to compare people who attended the club with those who did not. However, such approaches would lose the random element, making it unclear whether the variable under consideration was being overshadowed by some other, unknown variable.

For these reasons, a quantitative approach was not possible, meaning that the study would not achieve its original aim of quantifying the benefits of the recreational activity. However, qualitative techniques have benefits. Carr (1994) suggested that they have an holistic focus which enables flexibility, in turn allowing the research to focus on the individual, rather than that of the researcher. Clifford and Gough (1990) added that with qualitative approaches the theory will emerge as the data are analysed, rather than being formulated before their collection. This would mean the question being asked is: ‘What are the benefits (if any) of a programme of recreational activities to people who take part in them?’

There are limitations to this type of research. Clifford (1997) suggested that because qualitative studies usually relate to such small samples, they have low reliability in the wider population. Carr (1994) added that the relationship between the researcher and respondent might distort the findings, either with the researcher losing a sense of objectivity or because the relationship becomes therapeutic to the respondent. Field and Morse (1985) pointed to a number of practical issues: it is time-consuming to collect the data; once collected it is difficult to arrange for the purpose of analysing; and it is difficult to summarise the findings in a concise report.

Clifford (1997) identified two approaches to qualitative research – observation and interview. The choice depends mainly on the research question. As the study’s aim was to examine the benefits to the individual, the interview seemed to be a logical approach. Observation would involve a greater degree of interpretation by the researcher.
Crabtree and Miller (1992) proposed three approaches to the conduct of a research interview: unstructured, semi-structured and structured. The unstructured interview is similar to an everyday conversation, where the interviewer encourages the respondent to talk about a chosen topic with prompting limited to keeping the participant to the topic. A semi-structured interview has questions from the interviewer, but these are formulated in an open-ended manner that helps the respondent to develop answers along a theme of his or her choice. The structured interview is more rigid, with structured questions that require restricted answers. As the aim of the study was to hear the voice of the participant, an unstructured approach to the interviews was chosen.

Gaining access to participants involved securing the support of the manager of the patient's club, the senior nurse manager in the directorate and the resident ward managers, and receiving approval from the local research ethics committee. The research proposal was accepted on first submission. In addition, the ethics committee provided a clear framework for communication with patients and hospital staff. Copies of patient and ward information sheets, together with a consent form, had to be reviewed by the committee. They provided strict guidance about informing patients of their right to decline to participate in or withdraw from the study at any time, and the minimum length of time that must lapse between the invitation to take part in the study and the patient signing the consent form.

A small opportunistic sample of nine people fitting certain criteria were invited to participate in the study. The criteria were that they should be able to speak and understand English, have no obvious signs of severe mental confusion, be familiar with the club and have positive feelings about it.

A pilot interview with one patient was carried out, revealing that the style of interview needed to be reconsidered. The respondent was so keen to say how marvellous every aspect of the hospital stay had been, that little information was offered that could be attributed to the club. Structure was added to the interview.

As Zimmer et al (1995) argued that the major value of recreational activities was that they promote social interaction, the interview focused on activity, interaction and boredom in the home, on the ward and in the club. Nine people were initially invited to participate but, as two declined and one formed the unsuccessful pilot, only six interviews were analysed.

Respondents were asked to discuss their social contacts, hobbies and interests, and how often they had been bored at home. They were invited to discuss the circumstances surrounding their admission into hospital and perception of their progress. They were then asked to discuss the good and bad things about being in hospital, and how they got along with the staff, other patients and their visitors. They were also asked how they kept occupied on the ward, and how they enjoyed the weekends when there was no club.

Respondents were asked about the club in general – what they thought of it and how often they liked to go. They were then invited to discuss the recreational activities offered by the club and how they got along with the staff and other patients, both in the club and when back on the ward.

Field and Morse (1985) said: ‘...the first major task in analysing interview data is to become extraordinarily familiar with the data’. To do this, written transcripts of the interviews were obtained and the researcher combined reading these transcripts with listening to the recordings. As the interviews had quite a degree of structure, the initial analysis was based around the themes identified by the researcher. After this the data were analysed for evidence of other categories of information.

Results

The home Three major factors emerged from the interviews about life at home: the primacy of social interaction in the lives of the participants, the role of solitary activities and the effect of bereavement and loss.

All respondents seemed to place great value on social interaction, yet recreational activity did not seem to be a way of securing it. One man could identify no hobbies but he lived with his wife and had plenty of visitors and expressed satisfaction with his life. Similarly, a woman who had visitors every day except Sundays identified solitary activities as her only hobbies, yet identified Sunday as the only boring day of the week.

It seems that for the people who lived alone, solitary activities were pursued out of necessity rather than choice, and more value was placed on social interaction.

The effect of bereavement and loss were highlighted by two participants. One had lost her husband in the previous year and was struggling to come to terms with this. While she expressed boredom with life at home, this appeared to have its basis in the unwelcome change in her circumstances. The other expressed the difficulty of finding that her social circle was shrinking because of bereavement – the struggle to maintain contacts being defeated by death.

With this small sample, social interaction in the home took precedence over recreational activity.
Physical frailty and bereavement limited the capacity for this. This meant that solitary activity played a major role in the lives of the participants, but this appeared to be because of necessity rather than choice.

The ward
The major factors of note concerning comments on the ward were the tendency of the participants to focus on their health, the extent to which the ward functioned as an institution, and the limited interaction between the nursing staff and participants.

When they were asked to discuss the good and bad things about being in hospital, the major focus of the respondents was on their health. Even when health was not directly mentioned, there were expressions of gratitude about the availability of staff day and night.

Comments about the ward functioning as an institution stemmed from the fact that the participants took few trips out of the hospital and some of the visitors had difficulty visiting the hospital, cutting some participants off from their social circle. In addition, those who had more limited social contacts were more likely to experience this.

Two participants identified the dining room as a good place for social interaction with other patients—a combination of the physical geography of the ward and the hearing and sight difficulties of many patients made communication difficult elsewhere. However, they felt a pressure to leave the dining room soon after meals so that the staff could clear up. This suggested that the needs of the ward were considered to be more important than the needs of the individuals.

The general opinion of the nursing staff was that they were nice, did speak occasionally, but were generally too busy to talk for long. Comments about the ward functioning as an institution stemmed from the fact that the participants took few trips out of the hospital and some of the visitors had difficulty visiting the hospital, cutting some participants off from their social circle. In addition, those who had more limited social contacts were more likely to experience this.

The general reflections of the participants about the club were that it had a beneficial effect on them—it appeared to be a stimulating and motivating force during the stay. However, only two of the participants expressed satisfaction with the opportunities to talk to the other patients who attended the club. The others felt that a combination of communication difficulties and the fact that they were too busy playing games meant there were few opportunities for social interaction, despite it being identified as a need. Perhaps, even in the club, patients resorted to recreational activity as a second best to social interaction.

Conclusion
The small scale of the study meant that it was not possible to quantify the benefits of providing recreational activities for older people undergoing a programme of rehabilitation. However, this qualitative study highlighted some interesting points. For some people, as they and their social circle become increasingly frail, it becomes difficult to maintain meaningful social contacts. This is made worse by the effect of bereavement. A move into hospital can dislocate them from their social world because of a combination of this frailty and physical distance.

This study supports the contention that many hospital patients experience a lack of social interaction during their stay. It is possible that the nursing staff expected visitors or the patient’s club to fulfill this task but, in the case of the latter, this implied that they were happy that more than two-thirds of the patients in the hospital experienced limited social interaction. In addition, this study suggests that the club might be used more to provide activity rather than encourage interaction. It seemed that the dining room was the most popular place for patient interaction. As this was such a small study, there is scope for further work in this area. It is necessary to explore whether an activity-based or interaction-based recreational facility was most appropriate to meet the needs of these patients. Also, it is necessary to question whether the presence of a patients’ club encouraged the nursing staff to ‘opt out’ of the stimulation/interaction role, believing that the club was meeting this need. It would be useful to consider the many patients who did not take advantage of the facility, possibly exploring whether their progress and experience of their stay in hospital, was significantly different from those who did choose to attend.

The people interviewed perceived that attendance at the patients’ club was beneficial to them. However, there is scope for much work to be done before it can be established whether, and to what extent, such a facility benefited the majority of patients.

The author completed this study as part of his MA in Gerontology at Keele University

Implications for practice
- Many patients experience minimal social interaction and much boredom during their stay in hospital.
- Ward activities such as meal times offer an opportunity to enable social interaction among patients.
- While recreational activities help to relieve boredom, they need to be carefully organised if they are to promote social interaction.