**Developing a social support group for older people in a physical rehabilitation setting**

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*Quality of life and recovery from a variety of conditions, can be positively affected by social support. This article describes the development of an activity-based support group at an inpatient rehabilitation hospital for older people.*

There is substantial literature detailing the positive contributions social support makes to recovery of many conditions (Glass, Matchar, Belyea, & Feussner, 1993). Studies looking at quality of life and success of rehabilitation demonstrate the importance of social support (Ch'Ng, French & McLean, 2008; Huang, et al., 2010) and peer support has been recommended by NHS Improvement as a level one intervention for stepped care after stroke (NHS Improvement, 2013). Previous work has piloted an activities based in-patient support group in a stroke rehabilitation setting and found that it was viewed positively by participants (Hull, Hartigan & Kneebone, 2007). A later evaluation identified broad benefits including stimulation, social networking and "time out" from rehabilitation (Dewar, Jenkins & Kneebone, 2009). Similar work piloting a peer support group within a younger stroke population also found benefits such as improved socialization (Muller Toth-Cohen & Mulcahey, 2014). The group was structured around education and cognitive behavioural activities including goal setting and identifying coping strategies.

The status and recognition of support groups as routine in healthcare is demonstrated by performing a Google search. Combining the term [NHS] with ["support group"] elicited 1,350,000 results (May 8th 2016). Support groups are also routinely available outside the NHS. With respect to stroke for instance, there are over 700 survivor support groups listed on the Stroke Association website (http://www.stroke.org.uk/support/search).

This current project evaluated a social support group designed and run at a rehabilitation hospital for an older adult, inpatient population undergoing rehabilitation for a variety of conditions. The primary objective of the inpatient support group was to increase social support via facilitation of social interaction through group activities.

## Methods

### Setting

The group was developed in a rehabilitation hospital, specialising in the care of older adults, aged 65 years and over requiring intensive rehabilitation. The hospital has two wards consisting of single gender bays and single person side-rooms.

### Sample

There were a total of 244 individual attendances over both pilot and subsequent weeks. Inpatients were both male and female (aged between 65 to 101). Medical conditions varied but included stroke, fall related injuries, subcortical haemorrhage, urinary tract infection, Parkinson's disease and cancer. Due to the inclusive ethos at the rehabilitation hospital, only those who chose not to attend and those identified as too medically unwell by the nursing team were not invited to participate.

### Design of Groups

An initial, flexible drop-in focus group was conducted with inpatients and healthcare staff, facilitated by an honorary assistant clinical psychologist and a trainee clinical

psychologist. The group was developed on ideas from the focus group and previous literature (e.g., Hull et al., 2007). Activities were planned that would facilitate group interaction. Sessions were a standalone format, due to the unpredictability of attendees' medical status and high turnover of inpatients, running once weekly for one hour. The group was initially piloted for 6-weeks. It then continued for 30 more weeks. One facilitator was always present but the varying functional ability of attendees meant that it was often more appropriate to have two facilitators. Assistant psychologists, trainee clinical psychologists, a clinical psychologist, student nurses and a volunteer also facilitated sessions. Facilitators were actively involved with those attending to allow them to engage effectively. A range of activities were prepared and chosen on the day contingent on group size and abilities of the members attending. At week 33, a second focus group was conducted with staff, facilitated by an honorary assistant clinical psychologist, to obtain constructive feedback on the group.

**Evaluation Measures**

In every session, inpatients were asked to complete an inpatient satisfaction scale, which had previously been used in a group run by the same psychology service. This consisted of a numerical rating scale from 0 (low satisfaction) to 10 (high satisfaction). It was identified after early sessions that for some individuals the abstract nature of this scale was challenging and so the numbers were coloured akin to a distress thermometer (Roth, et al, 1998). Lower satisfaction ratings were red, neutral satisfaction ratings were orange and high satisfaction ratings were green

Facilitators completed an observation measure, which had been adapted from a measure previously utilised by the same psychology service. This measure evaluated; Interaction/relationships; confusion/inappropriate comments; enjoyment; interest/participation (both available from authors at request).

**Results**

**Main Sessions**

Self-reported satisfaction scores were calculated for each of the 30 week post-pilot sessions and a median split was conducted to establish activities presented in the higher and lower rated weeks (Table 1). The satisfaction scores demonstrated good overall satisfaction with the group, particularly on one session, which was rated 10 by all.

"TABLE 1 HERE"

The observational measure will be discussed by each of the four areas in turn for the 30 weeks post-pilot.

### Interaction/Relationships

Only one attendee was observed not to contribute or speak to others. Attendees were consistently observed speaking to at least one other group member, or making spontaneous comments to the whole group. There were recorded instances where members helped others in the group to take part, without assistance from facilitators.

### Confusion/Inappropriate Comments

There were only two occasions where attendees chose to contribute nothing at all to the group and only one occasion where the majority of contributions were confused. Generally, confusion in the sessions remained low.

### Enjoyment

There was only one occasion where the observed enjoyment of an attendee was classified as minimal or very infrequent. There were no occasions where an inpatient could be classified as showing no enjoyment.

### Interest/Participation

There were only two observed instances where attendees did not respond or contribute to the activity provided. It was observed that attendees might only choose to engage in one of the activities provided in a session if several were presented. However, the majority of

attendees engaged with all activities with minimal support, though facilitators were required on occasions to prompt some group members.

**Change over Time**

Although the group was designed to run as stand-alone sessions, during the 30 weeks the group ran after the pilot, five inpatients attended six sessions of the group (not necessarily the same six sessions). This enabled analysis of change over time.

### *Confusion/Inappropriate Comments*

Figure 1 shows confusion observations collated and illustrates that confusion for five regular attending inpatients remained low and stable throughout sessions attended.

"FIGURE 1 HERE"

### *Enjoyment*

Figure 2 illustrates the observed enjoyment observations collated. The data shows that there was no occasion in which no enjoyment was evident and often the majority of the sessions were enjoyed.

"FIGURE 2 HERE"

**Staff Focus Group**

At week 33, an honorary assistant clinical psychologist conducted a 10-minute focus group with five staff members from one ward at the rehabilitation hospital. This was to evaluate the usefulness of an inpatient support group. Feedback given can be considered in terms of patient benefits, staff benefits and comments about practicalities.

Staff felt that "the patients have benefited" with one staff member further saying, "personally I have had some really good feedback from patients about how much they love it" and went on to say that patients had asked, "oh are we having our group again on Friday", demonstrating that the support group was something that inpatients wanted to look ahead to and plan for. Staff used descriptions such as "animated" to describe the patient's enjoyment

of attending the group. One staff member mentioned that, "it was nice for us to see the patients down in the dayroom engaging in something else rather than just sitting" and how "the different rooms were mixing as well which was nice". All were in agreement that the group "takes their mind off why they're here because they can actually discuss all sorts of other things".

Staff also identified that it had been beneficial to them as healthcare professionals, with the group allowing them to gain a different perspective on patient care. One staff member said, "we see them as a medical person as a patient rather in a bed whereas that's all about them as a person rather than about their condition". They also spoke about how the group can assist their role and give them more time to do other jobs they need to. It was felt that this was highly beneficial to the team as they could have some time away from worrying about the wellbeing of patients as they could be assured that the patient was safe and happy to be in the group. It was mentioned that, "patients that tend to wander a bit…they seem to settle in that group because they are distracted…they are actually quite happy to participate in the group not just sit there but actually participate".

Practical concerns or considerations were encouraged to be spoken about. One staff member had this to say;

> "I think at the very beginning we had to get into the mind set of we must get those patients ready and get them down…but actually now it's part of Friday and actually it's great because everyone knows and you just kind of automatically… its habit"

When staff reflected on the weeks that had passed one member said "I can't see any down side to it personally" and this was strengthened when it was mentioned that the group "has been a real plus for the ward and the longer it can go on I think the better it would be for everyone". One particular benefit mentioned was that "it has promoted lots of cross-activity

among the patients". It was also explicitly expressed that "the patients are happy to open up and get involved", and it was considered that patients are voluntarily attending these sessions. This is an indication that it was something wanted by patients. Staff felt that, "it should be part of the hospital make up… it should happen on a weekly basis full stop".

**Discussion**

Initial evaluation of this inpatient support group is positive. Activities chosen were cohort relevant and a significant majority engaged with the activities. In general, there were very few instances where satisfaction was low. Group dynamic, size and activity provided may explain some of the lower satisfaction scores. This promotes the importance of careful planning and preparation before sessions and implementation of a variety of activities both within a session and from session to session, allowing facilitators to appeal to the widest audience. The results reveal that inpatients unable to perform certain activities due to increased disability do gain enjoyment from successfully engaging in day-to-day activities such as playing cards. The results evidence that confusion and inappropriate comments from attendees was low, remaining consistent in those that attended several sessions. This is particularly important as some who attended the group had urinary tract infections or dementia, conditions that are associated with higher levels of confusion. These findings strengthen support for the inclusive ethos of the group, and also suggest that the group is not detrimental to inpatients levels of confusion.

A potential outcome of these sessions was that attendees may achieve behavioural activation, which could improve mood (Cuijpers, van Straten, & Warmerdam, 2007). Although not authentic behavioural activation, the group offered inpatients the increased likelihood of engaging in enjoyable activities, the positive reinforcement and potential mastery experiences coupled with this and furthermore, the opportunity to plan to attend the

following weeks session if desired. Although this service evaluation did not measure mood directly, high reported enjoyment levels may be indicative of a positive effect on mood.

Although both assessment measures used showed positive results, measures assessing mood directly might be preferable. Ideally mood ratings are collected pre and post attendance, but within this current group format pre and post assessment would have been impractical due to time constraints and the drop in format of the group.

Future work could develop this support group to enhance the positive results seen.. Particularly it might be pertinent to learn from what activities were and were not preferred by this cohort. Careful piloting of activities, as well as inclusion of patients in planning could ensure a well attended and accepted group. There may be scope too for such groups to more formally offer behavioural activation and target mood more directly.

This service evaluation has laid foundations for the implementation of a more holistic rehabilitation environment. This is something that is becoming more recognised within clinical psychology (Kneebone, 2006) and was identified as important to the healthcare team at the rehabilitation hospital. Although it is understood that resources are limited, the informal social support, behavioural activation and pleasant experiences had by inpatients has seemed to be an important addition to the rehabilitation regime at this hospital. Despite challenges that would be faced by healthcare settings to provide regular activity based inpatient support groups, it is evident there might be great benefits. These appear to be experienced not only by the inpatients undergoing rehabilitation but also to the healthcare team at the hospital.

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Tables / Figure

Table 1: Tables summarising more preferred and less preferred activities

| Preferred Activities | Non preferred activities |
|---|---|
| <ul><li>Playing cards</li><li>Themed Quizzes</li><li>Passing the ball</li><li>Board Games</li><li>Beetle Drives</li><li>Current event related activities (i.e. Olympic games)</li><li>20 questions</li><li>Word games (i.e. proverb/ sayings games, articulate etc.)</li><li>Bingo</li><li>World landmark/ flag games</li><li>Singing</li></ul> | <ul><li>Listening to music/ reading books</li><li>Reminiscence activities</li><li>Life Stories game</li><li>Origami</li><li>Discussions about past newspaper headings</li><li>Brainteasers</li></ul> |
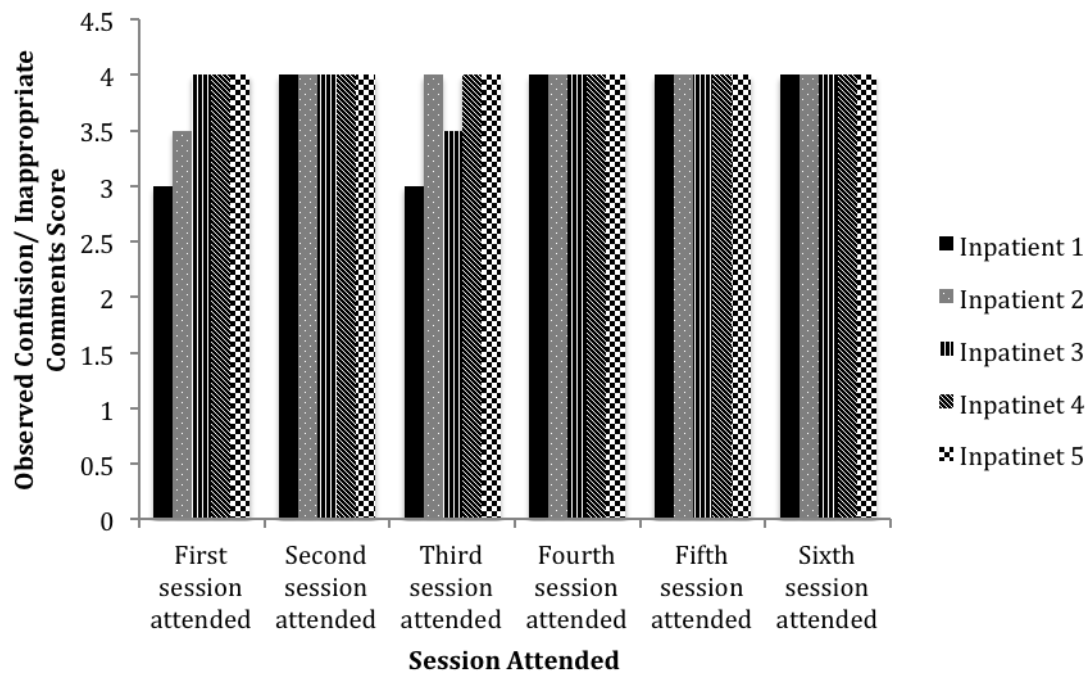
*Scale:
1. Did not contribute anything
2. Almost all contributions confused / inappropriate
3. Some contributions confused /inappropriate
4. All contributions appropriate

*Figure 1: Graph showing confusion/ inappropriate comment scores for 5 inpatients over 6 weeks.*
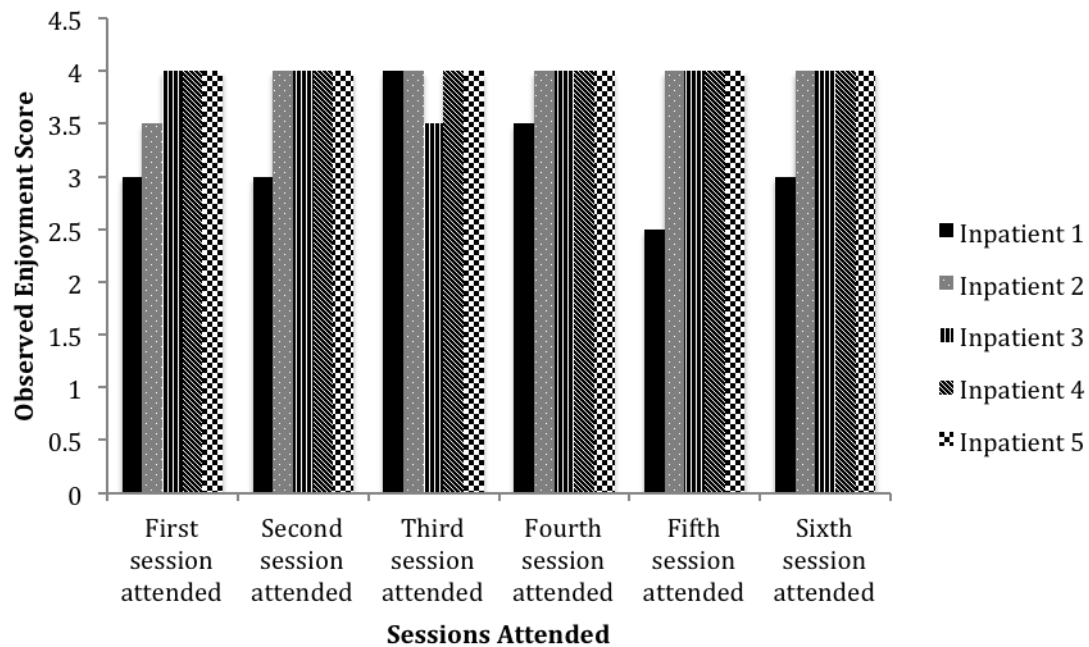
Scale:
1. Showed no enjoyment
2. Occasionally showed enjoyment
3. Enjoyed majority of session
4. Thoroughly enjoyed session

*Figure 2: Graph showing observed enjoyment scores for 5 inpatients over 6 weeks.*