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Article Title: Lack of meaningful activity on acute physical hospital wards: older peoples' experiences.

**British Journal of Occupational Therapy (Accepted for publication October 2017)
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Key words: meaningful activity, hospital wards, in-patient experiences, older people, interpretative phenomenological analysis.

Abstract

Introduction: Research suggests that older people on acute physical hospital wards are at increased risk of physical and mental health decline due to inactivity during their stay. Whilst studies have highlighted potential causes of such inactivity, there exists a paucity of occupational therapy research that explores engagement in meaningful occupational from patients' perspectives in hospital settings.

Method: Interpretative phenomenological analysis was used to gain a deeper understanding of how eighteen older people spent their time on hospital wards and the impact this had on their feelings of well-being. Interviews were carried out and analysed using Interpretive Phenomenological Analysis (IPA) guidelines.

Findings: Patients experienced a lack of meaningful activity on the wards which resulted in feelings of passivity, boredom and sense of alienation from their normal roles, routines and sense of self. Despite a willingness to engage in activity, barriers were suggested as limited resources, hospital routines and personal limitations. Suggestions of potential meaningful activities were made.

Conclusion: Occupational therapy services need to review service provision and provide an occupation-focused service, ensuring that patients' engagement in meaningful activities is seen as an integral part of their role in order to maintain patients' mental and physical well-being. Recommendations for further research are highlighted.

Introduction and literature review

In England, between 2004-05 and 2014-15 the number of hospital admissions of people aged 60-74 grew by 51.1% (Age UK 2017). People over 65 account for more than 41% of acute hospital admissions (NHS Digital, Hospital Episode Statistics 2014-15) and length of stay increases with age from 6.5 days (aged 65-74) to 10.1 days (over 85) (AgeUK 2017). The number of people aged 60 and over is projected to increase from 14.9m in 2014 to 21.9m by 2039 (NHS Confederation 2017)with a

89.3% projected rise in the number of over 75s to 9.9 million, and 1 in 12 being over 80, by 2039 (Office of National statistics 2014). These figures are concerning in light of research that has consistently demonstrated a decline in the health and functional abilities of many older people when hospitalised (Boyd et al., 2008; Fisher et al., 2011).

O'Brien et al (2012) suggest that functional decline can start within 24 hours of admission and is difficult to reverse. The potential results of inactivity in hospital are multiple and the majority of those affected will require higher levels of care when discharged, will not return to their own homes, and a significant number will die prematurely (Volpato et al., 2007). These negative impacts result in distress for older patients and their families as well as high costs for health and social care budgets (Hoogerduijn et al., 2007). Several studies indicate that inactivity leads to longer term functional decline, notably in mobility and activities of daily living (ADL) (Boyd et al., 2008; Fisher et al., 2011).

There has been almost no research carried out to investigate reasons for inactivity on hospital wards from the perspective of older patients themselves. That which has taken place identifies barriers to activity such as age (Volpato et al., 2007), disability and social issues (Rambini and Okafor, 2008), physical environment (Cheah and Presnell, 2011), compromised dignity (Calnan et al., 2013), and lack of autonomy (Boltz et al., 2010).

Attempts to prevent functional decline have had varied success. Typically, studies have compared outcomes for treatment as usual with those for an enhanced service which provides additional rehabilitation, largely comprising of ADL and mobility practice (O'Brien et al., 2012). Eyres and Unsworth's (2005) randomised control trial suggested potential benefits of receiving additional occupational therapy intervention in the form of a self-care programme, ADL tasks and community and functional mobility activities, although results were not statistically significant. Similarly, Bynon et al. (2007) initiated a programme of daily therapy aimed at minimising the effects of occupational disruption, optimising the health-enhancing effects of engaging in meaningful activity and reducing deconditioning. Positive findings from their pilot programme were reported as improved occupational performance and reduced length of stay. Whilst these studies demonstrate some immediate improvement in function, long term outcomes are needed to measure sustained improvement.

Only a small number of qualitative studies have investigated engagement in meaningful activities (defined by the National Institute for Health and Care Excellence (2013 p17) as 'physical, social and leisure activities that are tailored to the person's needs and preferences') on hospital wards from patients' perspectives. In a nursing study, Chan et al. (2012) interviewed 12 patients of all ages in a private hospital in Hong Kong. Most said they were bored, despite the provision of a range of electronic bedside devices for entertainment. In an occupational therapy study, similar to the current study, Cheah and Presnell (2011) interviewed 6 older patients on Australian hospital wards and identified a contrast between perceived meaningful occupations pre-hospital and the unfamiliar occupations in hospital. They highlighted how the foreign nature of the ward environment resulted in previously meaningful occupations losing their sense of meaning, the lack of activity taking place on wards and time spent waiting. These, and several other, authors make recommendations for more activity on hospital wards for older people (Kuys et al., 2012, Timmer et al., 2015) although the concept of activity is often confined to mobility and ADL rather than meaningful activity which is important to the individual and potentially more motivating and beneficial to well-being (Wilcock 2006). Whilst these studies highlight key issues, they have been carried out outside of the UK and as such make transferability difficult due to the different nature of health and social care provision abroad. It is possible that patients in the UK may have different experiences, and these need to be captured in light of a lack of UK research. This will add to the small body of existing knowledge in this topic and enable international readers to determine any resonance with their own settings and consider practice accordingly.

This qualitative study therefore asked older patients on acute wards in a hospital in England how they spent their time in hospital, and if they were able to do activities of their choice. It aimed to:

1. Explore how older people spend their time in hospital.
2. Understand how older people feel about how they spend their time in hospital and the impact, if any, on their feelings of well-being.
3. Explore whether older people would prefer to spend their time in hospital in other ways and, if so, how.

Design and methodology

Drawing on hermeneutic phenomenology's principles of exploration of lived experience, Interpretive Phenomenological Analysis (Smith et al., 2009) was used to gain a rich understanding of participants' experiences of their occupational engagement during their hospital stay. This approach incorporates both the participant's and researcher's perspectives in the interpretive process (Smith et al 2009) and is considered a particularly useful methodological approach for occupational therapists (Clarke 2009).

Ethical approval was obtained from the University of Brighton and the National Research Ethics Service. Local research governance approval was obtained from the participating trust. Patient participants were recruited by occupational therapists working on four medical and two orthopaedic wards using the following criteria:

- Over the age of 60, of either gender, an inpatient for 1 week or more.
Whilst some may argue that 65 is now considered older adult, age 60 was included as Age UK include this age group when discussing 'later life'.
- Patients were excluded if they were unable to give informed consent or participate in an interview due to acute medical or mental health problems, inability to express themselves clearly in English, had hearing impairments or communication difficulties.

Recruitment

The study was situated within a large general hospital, serving a large geographical area and typical of other physical hospitals across the UK. The occupational therapist (second author) working in the hospital gave a presentation to the occupational therapy team working on the medical and orthopaedic wards about the study and briefed them on the inclusion and exclusion criteria. The therapists then screened for potential participants through patient records and discussion, when needed, with nursing staff.

Once identified as potential participants, the occupational therapists approached patients and verbally explained the study. Those who expressed an interest were given a copy of the Information Sheet to read. It was highlighted to all patients, when introducing the study and in the information sheet, that they did not have to take part and if they declined this would not impact on any service provided. A note was kept of who had been approached so that those who declined were not contacted again. Those who expressed initial interest were approached again after 24 hours and, if still in agreement, were asked to sign the consent form.

The second author maintained a list of consenting patients on a password protected computer at the hospital site. This was not viewed by the other authors. These names were then passed to research assistants, who liaised with the patient and ward staff to agree a mutually agreeable time for the

interview. Once data had been collected the patients were assigned a pseudonym and the list of names deleted.

Eighteen participants took part in the study; 7 men (2 from orthopaedic and 5 from medical wards) and 11 women (5 from orthopaedic and 6 from medical wards). Length of stay ranged from one week – 5 months.

To avoid personal patient data being kept by student researchers, specific data such as age, diagnosis, was not collected. However, during the interviews, some participants discussed reasons for admission, including hip replacement, broken ankle, septicaemia, chest infections, cancer, Crohn's disease.

Data collection

Four MSc (pre-registration) occupational therapy students acted as research assistants for data collection and were supervised by the third author, who provided interview skill training and practise for the students. Interviews took place either at participants' bedsides or in a secluded room near the ward, dependent on their choice. Interviews were a maximum of 1 hour and recorded with participants' consent. Questions included:

- ☐ How do you typically spend a day in hospital?
- ☐ How do you feel about the activity you do in hospital?
- ☐ How did you spend your time before you came into hospital?
- ☐ What do you hope to do when you leave hospital?
- ☐ Is there anything else you would like to do while you are in hospital?

Data was gathered over a three month period. Recordings of interviews were deleted once they had been transcribed and pseudonyms assigned.

Data analysis

Data analysis followed IPA guidelines (Smith et al., 2009), which requires analysts to put themselves in the position of the participant, thus demanding detailed consideration of content, language used and context. IPA is an inductive approach so pre-identified concepts were not used to analyse the data. Transcripts were initially analysed individually by the second and third authors. They each devised a list of emerging concepts which, when compared, were similar. Agreement was then reached on naming and clustering concepts and the development of draft themes that is was felt best reflected each person's experience of being in hospital. Sadly the third author then passed away and the lead author became involved in the study. She spent time familiarising herself with the data, carried out her own analysis and then reviewed this against the draft themes originally agreed. Themes were then explored across transcripts and master themes and sub-themes developed that it was felt illuminated the commonalities and divergences of the patients' experiences and the meaning that the individuals ascribed to their hospital stay.

The emic (insider) position required by IPA enabled the authors to understand the patient's narrative and place their experiences at the centre of their account. Likewise, the etic (interpretative, outsider) position (Larkin et al., 2006) encouraged the authors to make sense of the data by bringing in their own interpretations and theoretical ideas, using verbatim quotes to illustrate these interpretations. Reflexive discussions played a key role throughout the data analysis process to identify where the authors' interpretations had been made and rationale for such interpretations. This reflexivity was important, for example, for the second author who had identified the need for the research and was aware of her own biases related to her experiences of working on the wards, recognising a lack of occupation and listening to patients' anecdotal stories. Similarly, as an academic, the first author was

mindful of the influence of her knowledge and interest in occupational science concepts and philosophy on the way she approached the data.

Rigor

Smith et al. (2009, p181) refer to rigour as the “thoroughness of the study”. This study presents details of the decisions made and followed IPA guidelines as thoroughly as possible. The lead author completed her PhD using IPA and, as such, has extensive experience of using it as a methodology, ensuring that data analysis for this study was carried out in an idiographic, systematic and interpretative manner by all authors. Careful attention was given to interviews to ensure that the authors listened closely to what was said and quotes show the reader how themes and author interpretations reflect both individual and shared experiences and provide a plausible and convincing argument.

Whilst IPA studies do not seek generalisability, sufficient details of the study have been provided for readers to assess whether the findings may be transferable to other settings. Biggerstaff and Thompson (2008, p212) suggest that findings are useful when validated by the “phenomenological nod”, whereby findings have resonance with readers who may recognise their own experiences in the account. In relation to this study, findings may have resonance for occupational therapists working in hospital settings and encourage deeper consideration of practice.

Findings

Three main themes were identified (Table 1). These are a result of the authors' interpretations and it is acknowledged that others may have interpreted the data differently. All names are pseudonyms.

| Main Theme | Sub-theme |
|------------------------------------|--|
| Waiting to see what happens | <ul style="list-style-type: none"> • All I do is sit • It's just boring • Wanting to get back to normal • You've got to put up with it |
| Meaningful activity isn't possible | <ul style="list-style-type: none"> • Meshing with the organisation • It's like being in prison • I can't do it at the moment |
| Desire for meaningful activity | <ul style="list-style-type: none"> • Willingness to engage • Suggested activities |

Table 1: Table of themes

Theme 1: Waiting to see what happens.

This theme reflects participants' experiences of engagement in activity on the ward. They experienced time as an endless phenomenon, expressing feelings of boredom and passivity and compared their time on the ward unfavourably with their active, fulfilling lives at home. They also described strategies used to cope with their in-patient stay.

- **All I do is sit**

This sub-theme reflects the long periods of physical inactivity and resulting passivity that was expressed throughout all the interviews. Participants' daily routines were punctuated by activities that met their basic hygiene and nutritional needs and medical, nursing or therapy interventions. In between, significant stretches of time were spent waiting for staff to do something, restful activity or sitting doing nothing.

This passivity was a common experience for all participants, regardless of length of stay, highlighted by phrases such as *"I just sit and stare at the walls"* (Louise, 1 week), *"all I do is sit"* (Janet, 3 months), *"they get me out and I sit in the chair most of the day"* (Susan, 1 month). This conjures up images of lifeless individuals that had little, if any, control over their day. There was, for many, a frustration and reluctance to conform to this passivity and an inauthenticity with how they wanted to be; *"I'm not one for sitting about, I don't want to do it"* (Patrick), *"it's terrible to sit down in the day and not do anything"* (Rosemary).

Inactivity led to time being perceived as passing more slowly, *"Laying there and seeing the day go by on the clock"* (Donald) and *"counting the days"* (Geraldine). For those that had been in hospital for a significant period of time, the days appeared to merge into one and for some this became disorientating: *"every day is the same; you can't tell no difference in the days... What's today?"* (Janet- 3 month stay).

Participants spent a lot of time waiting for some sort of external stimulation and longed for activities that would break up the monotony of the day: *"waiting for phone calls that break up the morning"* (Janet), *"I sit and wait for therapists to turn up... it's the only thing in the system that breaks up being here"* (Duncan), *"The highlight of the day the meals"* (Geraldine).

Whilst sitting doing nothing was clearly a source of frustration the worst experiences were for those who were on complete bed rest, necessitated by their medical condition. For some this was almost intolerable and affected their mental well-being: *"It been hard for me I can tell you, never been so fed up in my life, can't move, can't do nothing, it's a horrible feeling"* (Patrick, immobile for two weeks following fracture).

- **It's just boring**

Boredom was the most frequently used word to describe the days: *"it's very boring being stuck in hospital"* (Patrick), *"Im bored, very bored"* (Wendy), *"that's my day, very very simple and very boring"* (Sally). This was heightened in the evenings and weekends when visitors had gone home and daily routines or interventions were finished: *"the worst bit is between 8 and 11, nothing happens, so it's a very long evening"* (Geraldine), *"it's the weekends that are boring, they're quieter.. therapy is closed Friday night until Monday"* (Duncan). This was even worse for those who were in a ward with really unwell people or for those that did not have visitors: *"there was a week when people in my room didn't want company... that was a heavy time"* (Geraldine), *"it's a long day when you have no visitors"* (Wendy). The negative impact of this boredom on mood was clearly evident and appeared to leave some feeling alienated from themselves: *"I wish it wasn't so boring, you know, it really gets you down"* (Janet), *"I'm bored out my mind"* (Sally), *"I'm bored to tears sitting here"* (Doris). This intense boredom was experienced as acutely by those such as Patrick who had been in for two weeks as well as those with longer stays such as Janet who had been in for 3 months. For Sally, the boredom appeared to be intensified by being nursed in isolation for 3 months.

Participants used different coping strategies to deal with these feelings. Some chose avoidance, *"I ask nurses to help put me to get ready for bed early because I'm just bored, I would rather go to sleep"* (Wendy), whilst others tried to be positive and identified self-initiated activities such as reading, watching TV, crosswords, talking to patients and staff. Some people created activities to

stimulate their minds or focused on having things to look forward to and religious faith: *"It's quite entertaining, I've done a study of human beings and how they all work differently...In here you dream of the good things, you must have focus on better things and that's what keeps you going"* (Geraldine), *"My faith is very important and keeps me going"* (Doreen). Here the repetitive phrase 'keep me going' suggests a need for some external meaning to help with their resilience and move forward in their recovery.

- **Wanting to get back to normal**

Participants compared their passivity in hospital with their more active, meaningful lives at home, recalling activities such as gardening, holidays, shopping trips, meeting friends, dog walking, looking after grandchildren. They missed these activities and longed to *"get back to normal"* (Rosemary) and their previous level of independence; *"All I want to do is get back to my usual routine"* (James), *"I miss the social chit chat, I shall enjoy getting back to my bowls"* (Brenda). The loss of these participants' daily routines and activities was felt, despite having been in hospital the least amount of time (1-3 weeks).

Donald highlighted how familiar activities at home were not possible in a hospital environment and increased his sense of isolation: *"I like music in the background, that's what I'm missing in here, it keeps you from feeling lonely"*. However, Donald also highlighted that some meaningful activities at home lost meaning in hospital: *"I would like to get home and sit in my chair and watch telly... I know I said I don't like telly in here but it's not like your own home"*.

- **You've got to put up with it**

Whilst the majority of participants found their stay frustrating and boring, some adopted an attitude of acceptance. However, they did not seem to be describing a positive experience, rather a positive attitude to a negative experience. Stoicism, for example, appeared to be a coping strategy for some: *"it's not the Ritz is it, it's a hospital, you just have to put up with it"* (Geraldine), *"you've got to put up with it in hospital haven't you?"* (Patrick). These statements reflect a lack of personal agency; things were out of their control and they had to accept the way things were.

Theme 2: Meaningful activity isn't possible

This theme highlights the external and personal barriers that participants felt prevented them from engaging in more meaningful activities.

- **Meshing with the organisation**

Many participants described a routine dictated by staff and treatment regimens with which they had to comply. Duncan highlighted how he had little choice over his routine stating: *"people turn up when it suits them rather than me having a set routine, you know turn up and tell me what they want me to do for the morning"*. Gerald also highlighted how the day was shaped by the requirements of the ward and his phrases *"you are taken along by the system... the one who is acted upon rather than acts on others"* and *"you realise quite quickly your job is to mesh with the organisation.... You're simply a medium of them achieving their agenda"* highlight his perceived loss of personal identity and person centred care and a diminished locus of control.

When asked whether they would like activities on the ward, a common concern was how these would 'fit in' with a ward routine that was perceived to be the priority: *"You have to fit in with doctors, mealtimes, visiting hours, I don't know how you'd cope with it [doing activities]"* (Rosemary), *"I don't see how there could be time"* (Kath), *"The system is utterly comprehensive, I can't imagine"*

how you could change it" (Gerald). This suggests that the 'routine' was seen by participants as inflexible and perhaps impenetrable. It is interesting that Kath suggests a lack of time, despite participants previously revealing long periods of inactivity. Here it would appear she is referring to the busyness of staff but which excluded meaningful activity for the patients themselves.

Despite their experiences, participants were complimentary about the nursing staff, describing them as *"1st class" (Donald) "brilliant" (Rosemary), "very kind and compassionate" (Julie).* Participants felt nurses were good at providing personal care but did not perceive them as having the time to facilitate activities. It was, however, noted by participants that had been in for over 3 months that nursing staff may be motivated to do this if they had more resources: *"I think they would if they had the time, they are run off their feet" (Janet), "it's shambolic because they are so over-stretched they don't have time" (Sally).* No reference was made to occupational therapy staff providing activities.

- **It's like being in prison**

A lack of facilities and stimulation on the wards was suggested as a reason for participants' inactivity. Janet repeated *"There's nothing to do in the day, you know there's nothing to do"* and Wendy felt that if they *"supplied a jigsaw or pack of cards that would be good... keep us occupied"*. Gerald suggested this was not a priority of the staff and it was up to the patients to manage their own activities: *"they expect the patient to cope seamlessly with 12 hours between 8pm and 8am with no visual or auditory stimulation... You're left on your own to get on with it"*.

Where there were facilities for watching television or listening to the radio, participants found it *"very expensive" (Brenda)* or that *"the radios don't work in here" (Donald).* There was also limited scope for going outdoors and it was suggested that the extreme of *"being in prison might be better because you get free telly, walk around the yard" (Sally),* suggesting perhaps even human rights were at risk. Prison was also a word used by Wendy to describe her experience *"It's just like being in prison, if we did activities, even if you're rubbish at them it's something to do"*.

- **I can't do it at the moment**

Nine participants stated that they felt too unwell, tired or traumatised to participate in activity, particularly in the first week: *"I haven't wanted to talk to anyone because I'm just basically coping with the pain" (Gerald), "I don't feel well enough to care really" (Sally).* However, Geraldine suggested this may depend on the type of ward, highlighting that, unlike on acute medical wards, *"orthopaedic people aren't usually ill and that's why you need things to occupy your mind"*.

Personal restrictions were also identified as barriers to engaging in their normal activities, for example reduced mobility, poor eyesight, lack of concentration: *"usually I'm a sewing addict but I can't sew because of my arm" (Louise, fractured arm), "I can't do crosswords in here as I can't concentrate" (William, surgery).* For those being nursed in isolation, barriers to occupational engagement was exacerbated: *"there isn't a lot you can do when you can't go and mix, I can't touch anything" (Sally, Crohn's Disease).*

Theme 3: Desire for meaningful activity

This theme reflects participants' willingness to engage in ward based activities and identifies some of the activities they would like to do.

- **Willingness to engage**

The majority of participants wanted to engage in activities, believing it would *“help fill the days and make the time go quicker”* (Janet). They suggested that willingness to engage would however depend on *“what you like”* (Louise), indicating that activities needed to be meaningful.

It was noteworthy that most of the women appeared more willing to try activities than the men and made more suggestions for things they could do, for example *“if they had flower arranging I would go”* (Rosemary), *“personally I’m not bothered”* (Duncan), *“I can’t think of anything I would like to do”* (James).

Seven of the participants reported to be satisfied with how they were spending their time. Most of these were focused on leaving hospital and saw the primary aim of their stay as getting well: *“I’m quite happy with what I’m doing... What I’d really like to do is get out of hospital”* (William). Four participants felt that being in hospital was meaningful because of the care and treatment received: *“that’s why I’m fairly relaxed, you know it’s leading to something”* (Duncan). It is possible that engaging in their recovery was, for them, their meaningful activity.

- **Suggested activities**

The most common potential activities that participants identified were crosswords, board games, reading/ book groups, listening to music, quizzes, flower arranging, cooking, relaxation, gardening, arts/ crafts, reminiscence and current affair discussions. Some participants felt that the evenings and week-ends would be the best time for activities and Janet suggested they needed to be those that *“everyone can join in, have some fun and not make people tired”*.

Whilst the most popular activities on the list could be considered sedentary, they are cognitive activities which were considered important for *“keeping the mind active”* (William) and *“the brain alive”* (Brenda). Participants justified their choices of activities by recounting stories of how they carried out these activities at home or in the past, revealing personal meaning.

Discussion and implications for practice

This study highlights high levels of passivity experienced by patients on hospital wards, a finding consistent with other studies (Cheah and Presnell, 2011; Kuys et al., 2012). This has significant implications for health and well-being as inactivity in hospital has been shown to lead to deconditioning, functional decline and increased fear of falling, all of which are commonly associated with reduced independence in self-care activities (Boyd et al., 2008; Hoogerduijn et al., 2007). This decline is likely to have a profound impact on ADL if not prevented or addressed prior to discharge. Participants in this study expressed their desire to return to their normal daily activities once discharged. However, to achieve these goals, it is essential that preventing functional decline and ensuring maintenance of abilities, health and wellbeing through meaningful occupational engagement is considered a high priority for occupational therapists (Cheah and Presnell, 2011; Eyres and Unsworth, 2005). Here, occupational engagement is defined more broadly than just being able to participate in activities; it is something that requires motivation, purpose, readiness and an affirming environment (Kennedy and Davis, 2017), factors that needed to be considered in light of the findings that highlight challenges posed by the hospital environment.

The high prevalence of boredom expressed by participants was consistent with patients in other hospitals (Cheah and Presnell, 2011; Chan et al., 2012). Research suggests boredom is a phenomena caused by a combination of lack of meaningful occupation, boredom proneness, poor attention and dissatisfaction (Martin et al., 2012) and cited by Wilcock (2006, p171) as *“the most common emotional response to lack of occupation”*. Where boredom leads to mental health issues, research suggests poorer outcomes such as reduced treatment adherence, longer hospital admissions,

increased readmission rates and functional decline (Boyd et al., 2008). This clearly impacts not only on the individual but also on NHS resources where patients remain in hospital longer or need additional services to ensure their mental well-being. This study did not explore boredom proneness or attention levels but findings would support the view that a lack of meaningful activity and dissatisfaction with occupational engagement on hospital wards leads to feelings of frustration, boredom and low mood. It was clear that occupational opportunities were limited and participants' comparison of their hospital stay with that of prison suggests a risk of occupational deprivation, where "people are precluded from opportunities to engage in occupations of meaning due to factors outside their control" (Whiteford 2000, p200). It is here that occupational therapists play an important preventative role, using their professional philosophy to promote the relationship between meaningful activity, health and well-being and create an occupation-focused service. However, in their scoping review of practice in acute hospital settings, Briton et al. (2015, p375) identified that "an opportunity to complete occupational therapy intervention targeting areas of occupational performance outside self-care was not commonplace". This was reflective of this service where the predominant focus of occupational therapy was assessing and preparing for safe discharge planning, for example self-care tasks, transfers, provision of equipment, with little or no time spent engaging people in, or preparing them for other, occupations. Although ADL's may be considered important by occupational therapists, findings revealed that patients did not discuss ADL practise and instead stated they did nothing on the wards and just wanted to get back to their normal daily activities, roles and routines, suggesting perhaps that they do not find ADL tasks meaningful in the same way as other activities in their lives, something that requires further research. Whilst traditionally, occupational therapists become involved with patients once discharge is being planned, this study highlights the importance of occupational engagement from an earlier stage in the admissions process to maintain feelings of well-being as well as preventing functional decline as highlighted in literature.

Despite patients' motivation to engage in activities their personal agency was affected by their in-patient status and they felt they had no choice but to 'put up with it', similar to those in Cheah and Presnell's (2011) study. This was inauthentic with their normal 'way-of-being' as an active, independent person with daily activities, routines and purpose in the community. Here they appeared to adopt a patient-way-of-being that was incongruent with who they really were, afraid to challenge the system or ask for anything extra. The dominance and priorities of the hospital system identified in this study, that exacerbated their sense of disempowerment, were congruent with those highlighted by Boltz et al., (2010) and Calnan et al., (2013) who call for changes in ward cultures and practices to meet the needs of older patients. This study also highlighted how occupational engagement in hospital was completely different from usual routines, roles and activities at home, consistent with findings of Cheah and Presnell (2011, p123) who suggest there is a sense of 'foreignness' when the person's usual roles become meaningless in hospital. This should alert therapists to the possibility that hospital stays may induce feelings of occupational alienation through the lack of choice and opportunity for meaningful occupation, feelings of unfamiliarity and enforced routine. In her Casson Lecture, Bryant (2016:525) defines occupational alienation as "when a person is doing something they are not engaged with or that they are struggling to engage with". She suggests this alienation can be occupational, social or interpersonal and as highlighted in this study can be associated with boredom and isolation. She recommends that occupational therapists look at the occupational form of an activity (the way it is carried out) to help rediscover meaning and purpose, a notion that has applicability here in helping patients continue to engage in activities that had meaning at home or to see a sense of purpose in hospital activities, thus assisting recovery.

This study revealed that participants drew on personal resources to overcome the temporary void in meaningful occupation. Closely linked to occupational deprivation, Eyres and Unsworth (2005) highlight how hospital environments and acute illness can reduce the opportunity and ability to

engage in valued occupations and refer to this as temporary disengagement as occupational disruption. Social networks, religious faith and physical resources such as books or crosswords, along with psychological resources such as an attitude of acceptance or stoicism appeared important coping strategies. Crotty et al. (2010) discuss how optimism, mastery and perceived control positively impact health recovery, occupational engagement and psychological wellbeing for patients following a hip fracture. Findings of the current study would suggest that these factors should be considered by professionals working in all hospital settings.

Some participants, however, spoke about being left to cope with the experience of hospitalisation and occupational void without any support from staff. Van der Meide et al. (2015) also found that older hospitalised patients in their study also felt abandoned and uncertain about how to deal with their situation, leading to negative feelings of fear, frustration and powerlessness. Steel and Linsley (2015) state that in order for staff to recognise the impact of psychosocial factors on physical symptoms and disease processes, there needs to be a move away from the more traditional biomedical model to a biopsychosocial model that recognises the interactions between the psychological, social and physical and fosters empowerment and choice; a model congruent with occupational therapy practice (Whalley Hammell, 2013).

Half of the participants suggested they were too unwell to engage in activity. Factors such as illness, pain, fatigue and injury identified by participants in this study have also been found elsewhere to pose limitations to engagement in activity during an acute admission (Bynon et al., 2007). Using a person-centred partnership with the patient to establish optimum timing of interventions and utilising the occupational therapists' core skills of activity analysis and grading to utilise a person's strengths and compensate for performance difficulties may increase motivation through empowerment (Wilcock, 2006).

This study demonstrated a large variation in the activities participants would like to participate in. It would appear that men may be less concerned about engagement in activities than women. Some gender differences in activity preferences could be attributable to tradition and societal expectations of acceptable activities for men and women. Ball et al., (2007) found that in their sample of well older people, men participated in more sports than women, and women participated in more sedentary and social leisure activities than men. This could have implications for facilitating meaningful activity on wards for men, where the environment lends itself more to sedentary and social activities. A fuller understanding of these different perspectives is needed in order to facilitate engagement in meaningful activity for all.

Limitations of the study

This study was carried out in one hospital and may not reflect patients' experiences in other settings. Data was collected by students who were developing their interviewing skills and as such the depth of data in some cases was not as rich as others. Whilst data was not collected by the author who was an occupational therapist in the setting, she had identified the research topic and was involved in data analysis. Whilst reflexivity and transparency were included throughout the study to minimise researcher bias, this cannot be entirely ruled out. However, it is not the intention in IPA studies to exclude researchers' previous experiences and knowledge but to use this to help make sense of data.

Whilst at the time of the study it was not considered necessary to collect specific demographic data, on reflection such data would have assisted with deeper data analysis, enabling further consideration of the findings in relation to factors such as diagnosis, age.

Implications for practice and research

Consideration of occupational therapy practice on hospital wards is required with a need for therapists to focus more widely on patients' engagement in meaningful activity to promote health and well-being. To avoid issues such as occupational alienation and deprivation the occupational therapists' person-centred approach may be invaluable in helping patients maintain a sense of meaning and identity whilst in hospital, a view supported by Cheah and Presnell (2011) and Eyres and Unsworth (2005) who emphasise the importance of providing patients with opportunities to exercise choice and control within meaningful activities. Intrinsic motivation is derived from activities that are meaningful, enjoyable or interesting to the person, and improves performance and therefore outcomes (Wilcock, 2006). It is therefore important to set individualised functional goals that incorporate activities that are meaningful to the person and therapists will need a wide variety of activities to cater for different interests, preferences and abilities.

Future research must focus on evaluating the effectiveness, at both individual and organisational levels, of occupational therapy with regards engagement of patients in meaningful occupations on hospital wards. This is not only important for patients' well-being but also in raising the profession's profile as findings suggest a lack of awareness of the aims of occupational therapy with no participant highlighting the lack of occupational therapy, despite discussing the lack of meaningful activity. Bynon et al., (2007) provide an overview of the challenges of providing a more occupation-focused approach and offer useful strategies for this setting.

Further studies are warranted in other settings to explore the transferability of the findings. Deeper understanding is needed of different gender experiences, as well as exploring variations of experience dependent on stage of admission. It is suggested here that future studies focus on specific, more homogenous, population's e.g. acute admissions, pre-discharge, medical, elective and rehabilitation patients to ensure that a deeper understanding is gathered of their specific needs related to occupation, health and well-being whilst in hospital.

Conclusion

This study explored older peoples' experiences of occupational engagement whilst being patients in a physical hospital setting. Findings suggest that for some older hospitalised people, there is the potential for occupational alienation and deprivation which needs to be addressed. Barriers such as having to fit in with the routine of the ward, physical limitations, lack of activity, resources and staffing were highlighted as barriers to engagement in meaningful activity. There was a willingness from the majority of participants to engage in activities and suggestions for activities were made. The study has implications for occupational therapy services in these settings, ensuring that an occupation-focused approach to practice is maintained and that a person's occupational engagement whilst in hospital is considered to enhance their well-being.

Key findings

- older people on hospital wards experience feelings of boredom due to a lack of meaningful occupation
- barriers such as resources, hospital routines and personal limitations need to be addressed in order to facilitate occupational engagement
- occupational therapy services need to ensure that patients' engagement in meaningful activities is seen as an integral part of their role in order to maintain well-being.

What the study has added

This study has provided a deeper understanding of UK older peoples' experiences of engagement in activity on physical hospital wards.

Acknowledgements

The authors would like to thank the participants in this study who gave up their time to share their experiences with us and the students from the University of Brighton, MSc (Pre-registration) Occupational Therapy course that collected the data. This paper is dedicated to author Dr Marion Martin, a highly valued colleague that was the inspiration for this research.

Ethical approval: Ethical approval was obtained from the Faculty of Health and Social Science Research, University of Brighton approval July 2014 and NRES Committee- North of Scotland, REC reference: 13/NS/0091, IRAS project ID: 115311, Approval: 24 July 2015. All participants provided written consent.

Declaration of conflicting interests: The authors confirm there was no conflict of interest.

Funding: This research received no specific grant support from any funding agency in the public, commercial or not-for-profit sectors.

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