Evaluation of an inpatient occupation-based group program using a process evaluation framework

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FEATURE ARTICLE

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Evaluation of an inpatient occupation-based group program using a process evaluation framework

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Abstract

Introduction: Occupation-based groups are used in inpatient rehabilitation to enhance delivery and intensity of intervention; however, little research is available to understand their effectiveness. The aim of this study was to examine the process of an occupation-based group to understand mechanisms and success factors.

Methods: A mixed methods process evaluation using an evidence-based framework guided implementation and analysis. Participants were those involved in the 'LifeSkills' group run daily in an adult inpatient general rehabilitation ward. Quantitative administrative data, goal achievement outcome measures, group observations and qualitative semistructured interviews were conducted.

Results: Thirty participants were recruited. Factors for success included consistency in group structure and support, using meaningful practise opportunities and facilitating a real-world experience. There was no significant relationship between patient outcomes and dose of training or patient demographics.

Conclusion: This evaluation contributes to a growing body of evidence for incorporating occupation-based approaches into rehabilitation and offers insights into practice implementation.

KEYWORDS
occupation-based practice, Group, Instrumental activities of daily living, Inpatient, Rehabilitation

1 | INTRODUCTION

Occupation-based interventions are those where the occupational therapist uses engagement in occupation as the therapeutic agent of change (Fisher, 2014). In rehabilitation services, there is growing evidence for the use of occupation-based interventions to improve occupational performance and health outcomes (Dikmen et al., 2003; Hackett et al., 2000; Powell et al., 2016). Purposeful occupations have been seen to increase participation and enhance movement quality after upper limb injuries in comparison with nonmeaningful tasks (Collis et al., 2020). Occupation-based interventions have yielded similar improvements in occupational

performance in chronic stroke survivors when compared to repetitive task practise (Skubik-Peplaski et al., 2017).

Occupational therapists are presented with the challenge of incorporating occupation-based interventions into practice against competing service demands such as resource availability. Inpatient rehabilitation services are embracing group-based formats to enable frequency and intensity of service delivery for better functional outcomes (English et al., 2017; Hammond et al., 2015). Literature supporting this movement has focused on brain injury and stroke populations in structured, scheduled movement therapy such as group circuit classes to improve functional outcomes of walking ability, arm function and quality of life (Lohse et al., 2014; Schneider et al., 2016; Veerbeek et al., 2014). There has been limited research exploring occupation-based groups, occupational performance outcomes, as well as the impact on nonneurological populations. A recent scoping review by Spalding et al. (2020) reported on the use of occupation-based groups across a variety of inpatient rehabilitation population settings. While it was evident that these groups offered more opportunities to practise and influenced patient experience and satisfaction especially when a patient-centred, goal-based approach was used, the authors found limited high-quality evidence on the impact on patient outcomes of occupational participation and functional performance. The popularity of using therapy groups for time and resource efficiency makes it relevant to continue exploring the effectiveness of an occupation-based group treatment focus for all inpatient rehabilitation populations.

Recent work (Spalding et al., 2022) explored patient outcomes from a novel occupation-based group-based in an inpatient general rehabilitation ward focusing on instrumental activities of daily living (IADLs). The study demonstrated statistically significant improvements in occupational performance, satisfaction and confidence at discharge which was maintained at 90-day follow-up. However, given the lack of similar research, important questions remain in understanding key elements and underlying intervention mechanisms. It is relevant to explore how this group intervention is structured and implemented while honouring the individualised nature of occupation-based practice to support use in the clinical setting.

The Medical Research Council provides guidance on the use of process evaluations to identify the active components and explain causal mechanisms in complex interventions, such as group therapy programs with multiple interacting components. Process evaluations can provide a greater confidence in conclusions by assessing the quantity and quality of what was delivered and assessing the generalizability of its effectiveness (Moore et al., 2015). Occupational therapy researchers are using process evaluations to evaluate treatment fidelity, patient experiences and factors that affect practice intervention in areas such as in-home cancer-care (la Cour et al., 2020) and home modification (Lockwood et al., 2020).

Key Points for Occupational Therapy

- Practising occupations in a controlled environment of a group could be an appropriate therapeutic option enabling positive outcomes in inpatient rehabilitation.
- An occupation-based group may be successful when an evidence-based structure is used, when real-word experiences through meaningful opportunities of task practise are enabled, and a shared experience between all stakeholders is encouraged.
- Occupation-based practice can occur in a group environment while honouring the unique, client-centred nature of the approach

Therefore, the aim of this study was to complete a process evaluation of an occupation-based group in an inpatient general rehabilitation ward. The specific research questions were as follows: (1) who is involved in the group? (2) what is being implemented in the group and how? (3) what about the patient experience of the intervention affected change? and (4) is there an impact on patient outcomes?

2 | METHODS

2.1 | Study design

A mixed methods process evaluation was completed using an evidence-based framework to guide data collection, procedure and analysis (Figure 1). The framework was developed by the research team based on current literature (Liu et al., 2016) and theoretical frameworks including the RE-AIM framework to address questions of generalizability and translation into practice (Gaglio et al., 2014) and the Realist framework to highlight potential mechanisms of action (Moore et al., 2015). The framework headings explored each research question; Context: Who is involved?; Implementation: What is being implemented in the group and how?; Mechanisms

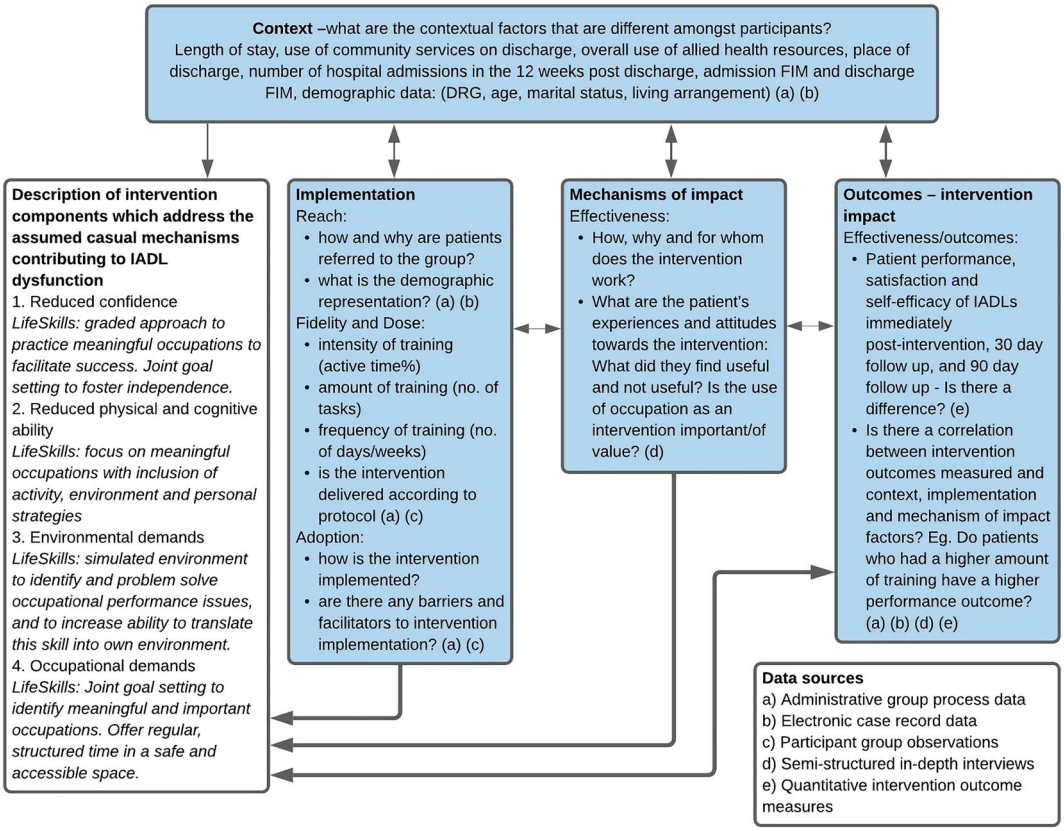

FIGURE 1 Process evaluation framework. *Note.* This figure was adapted with permission from 'Protocol for process evaluation of a randomised controlled trial of family-led rehabilitation post stroke (ATTEND) in India', by H. Liu, R. Lindley, M. Alim, *C. Felix*, D. B. C Gandhi, S.J. Verma, D.K. Tugnawat, A. Syrigapu, R.K. Ramamurthy, J.D. Pandian, M. Walker, A. Forster, C.S. Anderson, P. Langhorne, G.V.S. Murthy, B.R. Shamanna, M.L. Hackett, P.K. Maulik, L.A. Harvey, & S. Jan, 2016, *BMJ Open*, *6*, p. 4 (https://doi.org/10.1136/bmjopen-2016-012027). CC BY-NC 4.0.

of impact: What about the patient experience of the intervention affected change?; and Outcomes: Is there an impact on patient outcomes? The process evaluation was conducted alongside a longitudinal observational cohort study of the occupation-based group program with the results that are published elsewhere (Spalding et al., 2022). Ethics approval was obtained from university (GU Ref No: 2019/498) and hospital human research ethics committees (LNR/2019/QRBW/53152).

2.2 | Participants

All 30 participants from the cohort study participated in the process evaluation. Participant recruitment and consent are outlined in the published cohort study (Spalding et al., 2022). The participants were consecutively recruited as they were referred to the occupation-based group, called the LifeSkills group. Additional inclusion criteria were people aged 18 years or older, English-speaking, with a planned discharge destination of home, who could identify goal areas related to IADLs and could work in a group under semisupervised conditions. Participants were excluded if the planned discharge destination was a residential care facility. Purposeful sampling identified 15 of the 30 participants for the qualitative component of the evaluation, representing a wide range of perspectives and diversity in age, gender and diagnosis.

2.3 | Group intervention

Developed by the occupational therapy team of a large metropolitan hospital in Brisbane, Australia, the LifeSkills group was designed for adults in an inpatient general rehabilitation ward with various aetiologies. The group is based on five guiding theoretical principles: collaborative goal setting (Radomski, 2002), motor learning including the use of learning stages, type of task and feedback (Muratori et al., 2013), frequency and intensity of practise (Kleim & Jones, 2008) and meaningful and

purposeful occupations to enhance performance (Trombly, 1995). The group's objective is to use occupations as a therapeutic agent of change, focusing on repetitive practise of meaningful activities in a simulated environment to enhance performance in preferred IADL. Purposefully nonmanualised activities are tailored, based on individual goals, and practised within the context of a group. For example, several members with meal preparation goals may meet and practise their own cooking task which the facilitators have tailored to their individual therapy needs. Performance indicators of frequency and intensity of the activities practiced are also routinely recorded. The group runs in a manufactured home-like environment on the ward and is facilitated daily by student occupational therapists under the guidance of an occupational therapist. Participants remain in the group until they have reached their identified goals and are appropriate for discharge from the rehabilitation ward.

2.4 | Data collection

Quantitative data collected for all 30 participants as described in Figure 1:

- Participant group observations recorded using a standardised audit template adapted from Clarke et al. (2014) (see supporting information). Coded information was collected including how the intervention was delivered, key group principles observed, group member interactions and person and contextual factors influencing delivery.
- Administrative group process data reviewed to collect details of intervention delivery such as frequency and amount of training.
- Participant demographics collected from electronic case record data.
- Intervention outcome measures collected from data obtained through the concurrent cohort study. These include the Goal Attainment Scale for patient goal achievement, Canadian Occupational Performance Measure for performance and satisfaction and a Likert scale of self-efficacy in IADL occupations practiced in the group.

Qualitative data for the sampled 15 participants as described in Figure 1:

- Semistructured interviews conducted following an initial interview schedule of topic questions, for example, 'Tell me what being in the LifeSkills group was like for you?' and 'How did you find the group helpful in achieving your goals?'. Additional questions were added as they became apparent. All interviews were audio recorded and transcribed verbatim.

2.5 | Procedure

The principal investigator completed all data collection over three phases, reducing examiner bias by not being involved in the clinical administration of the group.

Phase one: Group observations were conducted as participants underwent the intervention as part of the cohort study. Each participant was observed for one full intervention session using the standardised audit template. Only information on how the group was run in relation to the participants was collected. Administrative group process data and the review of electronic case records for demographic details were collected for all participants.

Phase two: Postintervention and prior to discharge, the principal investigator individually met with the 15 purposefully selected participants in a quiet therapy room and conducted a 30-min semistructured interview face-to-face. To acknowledge reflexivity in this qualitative process, the principal investigator who conducted the interviews is a qualified occupational therapist from a metropolitan area in Brisbane. Development of the interview guide, interactions with participants, interpretation of the interview transcripts and understanding of the phenomenon may have been influenced by her professional background. Analysis was completed as a research team to ensure results were not influenced by personal bias or assumptions.

Phase three: Quantitative intervention outcomes from the cohort study were collected and collated.

2.6 | Analysis

Phase one: Evaluation framework headings of 'Context' and 'Implementation' were explored through quantitative process data. Group observation audit data were calculated, coded and analysed descriptively using an Excel spreadsheet based on these framework subheadings. For example, the frequency of key theoretical principles observed in the group was coded under the subheading 'Implementation: Adoption'. Administrative group process data and demographics in terms of mean (standard deviation) and frequency (percentage) were conducted in SPSS.

Phase two: Framework heading 'Mechanisms of impact' was explored through interpretive description of the qualitative data from the semistructured interviews (Thorne et al., 2004). First, the primary investigator carefully read and inductively coded the interview transcripts

in NVivo software, using breadth in data organisation to allow examination for a range of alternatives. These coded segments of text were transferred to an Excel spreadsheet, judiciously reviewed and sorted into larger concepts. A second research team member independently reviewed the interview transcripts and spreadsheet to confirm coding and concepts. Subsequent categorisation into themes was discussed by all research team members, taking care to synthesise meanings and theorise relationships to agree upon findings.

Phase three: Framework heading 'Outcomes—intervention impact' used quantitative intervention outcome data from the cohort study, analysed in SPSS and conducted last to avoid biassed interpretation of process data. Full analysis details are published elsewhere (Spalding et al., 2022). A Spearman's rank-order correlation was then used to explore the relationship between the process data dose of training, patient demographics and patient intervention outcome measures of goal achievement, performance, satisfaction and self-efficacy.

Findings from separately analysed quantitative and qualitative data were drawn together to synthesise results and provide an overall interpretation on the impact of the occupation-based group (Moore et al., 2015).

3 | RESULTS

3.1 | Context

Participants were 22 women and nine men, aged between 35 and 91 ($M = 68.87$, $SD = 14.78$), with a mean length of rehabilitation stay of 32.03 days ($SD = 16.74$). Fourteen had a nonneurological diagnosis, and 16 had a neurological diagnosis. For the semistructured interviews, the 15 participants (four men and 11 women) were aged 45–91 ($M = 72.3$, $SD = 13$) with a mean length of stay in rehabilitation of 32.5 days ($SD = 17.7$). Additional demographic characteristics of the sample are presented in Table 1.

3.2 | Implementation: What is being implemented and how?

3.2.1 | Reach, fidelity and dose

All 30 participants were observed and referred by the treating occupational therapist to address IADL goals for returning home. For most participants, the intervention

TABLE 1 Participant demographics

	Neurological diagnosis		Nonneurological diagnosis	
	Total $n = 30$	**%**	**Interview $n = 15$**	**%**
Neurological diagnosis	**16**	**53.33%**	**6**	**40.0%**
Stroke ischaemic (L) body involvement	7	23.3%	3	20.0%
Other nontraumatic brain dysfunction	3	10.0%	-	-
Other nontraumatic spinal cord dysfunction	1	3.3%	-	-
Stroke ischaemic bilateral involvement	1	3.3%	-	-
Stroke ischaemic (R) body involvement	1	3.3%	2	13.3%
Non traumatic subarachnoid haemorrhage	1	3.3%	-	-
Other neurological condition	1	3.3%	-	-
Traumatic brain dysfunction, closed injury	1	3.3%	1	6.7%
Nonneurological diagnosis	**14**	**46.67%**	**9**	**60%**
Reconditioning following medical illness	9	30.0%	7	46.7%
Fracture of femur	2	6.7%	-	-
Fracture of pelvis	1	3.3%	1	6.7%
Other orthopaedic fracture	1	3.3%	1	6.7%
Fracture of multiple sites	1	3.3%	-	-
Allied health used OT + PT	17	56.7%	10	66.7%
OT + PT + SP	13	43.3%	5	33.3%
Admission FIM	72.23(M)	20.58(SD)	74.8(M)	18.45(SD)
Discharge FIM	106.3(M)	9.12(SD)	105.53(M)	9.76(SD)

Abbreviations: FIM, functional independence measure; OT, occupational therapy; PT, physiotherapy; SP, speech pathology.

TABLE 2 Types of tasks practised

Task	$n = 85$	%
Meal preparation	31	36%
Laundry	24	26%
Shopping	8	9%
Washing dishes	5	6%
Making the bed	4	5%
Household cleaning	4	5%
Computer use	4	5%
Community access	4	5%
Medication management	1	1%

was delivered according to plan. On four occasions, this was either modified or ceased due to patient factors (e.g., pain) or tasks were upgraded due to new goals. The average intensity of training (i.e., active time participating in task practise) was 66.57%, the average frequency of training was 5.97 sessions and the average number of tasks practised in each session was 3.5. A total of 85 IADL tasks were practised by the 30 participants. Meal preparation ($n = 31$) and laundry ($n = 24$) were the most common (Table 2).

3.2.2 | Adoption

Groups of two to four participants were observed to interact with at least two student occupational therapists as group facilitators. Generally, all participants met as an entire group before splitting to work individually on an IADL goal either sharing a mutual space or task focus with others. For example, three participants were observed working in the kitchen completing meal preparation; however, they were making their own individual meal according to their goals. For six instances, participants worked in separate areas due to COVID-19 hospital restrictions in place at time of observation. Interactions between group members varied, with participants acknowledging other groups members in passing, for example, saying 'hello', during half of the observations. On four occasions, participants were observed to encourage and congratulate each other on performance success. Observed conversations were focused on seeing each other outside of group (i.e., at mealtimes) as well as sharing stories and experiences. Most interactions with group facilitators involved asking questions about the group process, their performance and goal achievement. Rapport building, including sharing past experiences and laughter, was also observed.

The five theoretical principles that guided the group's development, collaborative goal setting (Radomski, 2002), motor learning and feedback (Muratori et al., 2013), frequency and intensity of practice (Kleim & Jones, 2008) and the use of meaningful and purposeful occupations (Trombly, 1995) were consistently observed during the groups. Firstly, practise was related to individual goals on all 30 observations. Goals were made explicit during the session, and participants were observed to make clear links to the tasks. Secondly, it was ensured that tasks were meaningful to the participants in all 30 observations. Participants often had choice and control over the details of the tasks, that is, choosing to cook a certain meal. One participant had brought in her own laundry to practise washing. Thirdly, motivation and engagement were recorded in 25 observations. Socialising with other participants, sharing a common recipe and steps during a meal preparation task, appeared to support engagement. Timing participants performance also appeared to be an encouraging tool. Fourthly, the feedback loop was seen during 20 observations. Participants were observed to discuss and compare results from previous sessions with the facilitators, identifying new strategies for task practise. Finally, frequency and intensity of practise was only encouraged in 17 observations. Participants were provided explanations of the reason for repetition which appeared to encourage more activity. On two occasions, participants were encouraged to practise these tasks outside of the group, for example, doing their own laundry on the ward.

There were several factors that appeared to be barriers to implementing the intervention. Contextual factors impacting practise time occurred on nine occasions, including arriving late for therapy and schedule changes due to medical appointments. In three instances where new facilitators were running a group, additional supervision requirements appeared to impact intensity of training. Person-related factors such as pain, dizziness and fatigue impacted amount of training provided on eight occasions. Here, performance and tasks were modified enabling participants to complete the entire program.

3.3 | Mechanisms of impact: What about the experience of the intervention affected change?

The analysis of participant experiences and attitudes on how the group intervention affected change identified four main themes.

3.3.1 | Enabled choice and control

Participants consistently reported that the group gave them choice and control to achieve their goals. There was

a sense that the sooner they were able to achieve their goals, the less reliant they would be on others. For this, participants spoke about the importance of choosing activities specific to their needs over others. Participant 28 reported 'I chose [the activities] as they were my goals and important to me, rather than be important to [the student occupational therapists] studies'. Activities were chosen as they were necessary and specific to the tasks at home. Participant 12 reported 'I practised the major ones I was going to do at home … it's no use choosing something you are not going to do'. Several participants commented that all activities were 'the best fit' and tailored to the individual. Feeling in control was significant, with participants reporting a positive experience because they could do things their way. Having a connection over tracking goal achievement appeared to help them see improvement. Participant 18 reported 'we were timing things … I started off not being able to put a T-shirt on, to having a personal best of 15 seconds … I can see the improvements'. Allowing participants to have choice and control in the group process influenced their recovery.

3.3.2 | Encouraged confidence in abilities

Participants spoke often about how the group prepared them for home by increasing confidence of abilities, rather than improvement in skills. Participants reported that the repetitive nature of practicing tasks, even if mundane, increased their confidence. Participant 12 reported 'doing it over and over again, even though you hate it, it just makes you more confident in doing that task' and participant 17 reported 'I do not like folding washing … but I've gotten faster and faster and I know I've mastered it now'. Having an increase in awareness of abilities, even if not at pre-admission level, was important. Participant 3 reported 'I get a lot of satisfaction from [the group] because I have learnt my limits, and I can do things without pain'. Participant 12 reported 'I do not have to stress because I know what to expect when doing everyday things'. This awareness led to feelings of being ready for discharge. Confidence in abilities from group participation enabled a sense of preparedness for home.

3.3.3 | Allowed a connection to self and home

Participants described that the real-world nature of group task practise gave them a connection to not only their physical home but also who they were outside of hospital. Several reported that doing 'normal' things fostered a sense of realism, allowing them to transfer what they learnt to the real world. One participant reported that using the electric stove in the therapy kitchen was important as she has an electric stove at home. The repetitive structure of group task practise also helped in recalling task performance. Participant 10 reported 'when you are away from home … it does help you to remember what to do at home which is really helpful'. Many reflected that the group stimulated past experiences that impacted recovery. Participant 9 reported that his experience of taking on domestic duties after his wife died impacted his feelings of achievement. 'I think because I did that for my wife, I was able to handle this experience [in the group]'. Another reported to enjoy attending group with the student occupational therapists due to positive past occupation experiences training apprentices. Participants reflected on feelings of accomplishment after group participation. Participant 2 reported 'it's knowing that I did something in the day … gave me purpose'. Encouraging a practical connection to oneself and home in the group was an important element for success.

3.3.4 | Facilitated recovery through the shared experience

Finally, participants recounted how the shared experience between group members and facilitators aided recovery by enabling peer mentoring and support. Several participants reported the consistency of group facilitators, and the consequent therapeutic alliance allowed them to feel more comfortable and helped them to see improvement. The age and experience of the facilitator did not matter, as it was more the way they were treated that impacted recovery. Being treated with respect enabled feelings of value and self-worth, with participant 17 stating 'it made me feel like a person again'. Comradery between group members enabled acceptance of self. Providing encouragement to each other and working together on a task made recovery fun and helped with feelings of isolation. Success was due to being an equal member of the group, and it was important to not be treated like a person with a disability. Many participants reported that comparing themselves to others in the group increased their confidence, put life into perspective and helped them realise they were ready for discharge. Participant 8 reported 'if they can do it, I can do it'. Sharing the experience of recovery with others in the group was important for facilitating change.

3.4 | Intervention outcomes

Results on intervention patient outcomes have been described elsewhere (Spalding et al., 2022). In summary, there were statistically significant improvements in goal achievement, occupational performance, satisfaction and

self-efficacy at discharge which was maintained at 90-day follow up. There was no significant relationship between patient outcomes and dosage factors of amount of training, frequency of training and tasks nor contextual factors of age or diagnosis. There was a statistically significant positive correlation between length of stay and the intensity of training, $r^s(98) = 0.385$, $p < 0.036$, the length of stay and the frequency of training, $r^s(98) = 0.599$, $p < 0.000$ and the number of tasks practised in each session and the frequency of training, $r^s(98) = 0.526$, $p < 0.003$.

3.5 | Integration

Combining and comparing qualitative and quantitative results indicate that practising occupation-based tasks in a controlled group environment has a positive impact on patient experiences and outcomes. For example, exploring quantitative group format data of facilitator and member ratios helped authors to understand the qualitative thematic data that consistency significantly enhanced participant experience and recovery. Further data integration revealed the main factors in enabling group success relate to (1) how the group is structured and facilitated, (2) the use of real-world experiences and (3) enabling opportunities to practise.

4 | DISCUSSION

The purpose of this study was to conduct a process evaluation of an occupation-based group in an inpatient general rehabilitation ward to determine what was being implemented, what about the patient experience affected change and if there was an impact on patient outcomes. Integration of findings show that practising occupation-based tasks in a controlled group environment appeared to have a positive impact on patient experiences and outcomes. The overall interpretation led to three factors to success of the occupation-based group: (1) how the group is structured and facilitated, (2) the use of real-world experiences and (3) enabling opportunities to practise.

The way the group was structured and facilitated was the first factor to group success. Key theoretical principles underpinning group structure such as goal-based training, meaningful practise, motivation and engagement were consistently observed in group observations. The impact of these principles was echoed in participant experiences. Having choice and control over goals and practicing activities with meaningful connections to home enabled engagement in group therapy. Integrating evidence and theory into practice for better patient outcomes is a consistent approach within other reported occupation-based groups (Spalding et al., 2020) as well as an important aspect of healthcare policy (Hoffmann et al., 2017) Observations of group format showed consistency in facilitators and member ratios, reported by participants to significantly enhance experience and recovery. It is well recognised in the literature that groups provide meaningful opportunities for learning from peers (Cole, 2012; Yalom & Leszcz, 2005) which participants reported was important for recovery. What was interesting in this study was the equal importance participants held for the therapeutic relationship between participant and facilitator. Having a consistent facilitator interaction enabled feelings of value and self-worth which was key to seeing improvement. Models for group facilitation (McFadzean et al., 1999) recognise facilitators as the active ingredient to navigate individuals and groups through successful intervention implementation. There are also perceived values of the therapeutic use of self for occupational therapy practice such as patient participation and therapeutic efficacy (Cole & McLean, 2003; Taylor et al., 2009), and this study outcome provides more evidence to its effectiveness. It is suggested that when structuring an occupation-based group, facilitators use an evidence-based framework and focus on facilitating not only the shared experience between consumers but also that of the facilitator–participant interaction.

The use of real-world experiences was the second factor to group success. Participants reported experiences of using tailored activities in an environment that fostered a realism to home, aiding in the transfer of skills. Contextual data indicated all tasks were occupation-based and practised as a whole. There has always been the argument that practicing occupations in one's own meaningful environment compared with a simulated setting enabled better occupational performance improvement and skills translation (Doig et al., 2011; Gupta & Taff, 2015; Labbé et al., 2018). There may be concern that delivering the uniqueness of occupation-based practice in a replicated group setting may take away from the individualised nature of this approach. For this study, the application of a person- and goal-centred approach reduced this. Each occupation practised in the LifeSkills group was chosen by the individual, identified as significant and meaningful to their occupational performance and discharge goals. Giving a participant the opportunity to connect what they are doing in therapy to life after discharge gives purpose, directs performance and improves participation (Nilsson & Nygard, 2003; Patterson et al., 2017). Occupation-based groups that encourage real-word experiences through a person-centred approach can offer a connection to home and success even in a manufactured environment.

The final factor contributing to group success was enabling meaningful opportunities for practise. Participants reported that this frequency increased one's awareness of and confidence in occupational abilities. This is supported by patient outcomes of statistically significant improvements in self-efficacy at discharge and follow-up. Group observations also showed that that barriers to participation such as patient reported pain and dizziness were often overcome by providing opportunities of task modification. Consistent with previous studies of occupation-based groups in inpatient rehabilitation, enabling meaningful opportunities to link the doing of activities helps gain new insights, increases confidence and facilitates skill development (Nilsson & Nygard, 2003; Patterson et al., 2017; Zanca et al., 2013). Interestingly, correlation analysis found no significant relationship between patient outcomes and contextual factors of dose of training. The popular justification for group models in rehabilitation is that higher intensity of service results in better functional outcomes (English et al. 2017; Hammond et al., 2015). As patient outcomes from the cohort study were positive, it could be suggested that the significance of the group does not centre on how long one participates or how many tasks are completed. Perhaps it is simply having an opportunity to practise in a socially engaging and accepting environment that contributes to favourable outcomes. Further larger-scale studies examining this cause–effect relationship is warranted to assess the intervention's effectiveness across varied inpatient rehabilitation settings.

4.1 | Limitations

This study was conducted concurrently to a cohort study, so results should be viewed cautiously given the uncontrolled, nonrandomised design and small sample size. The population studied was a general rehabilitation ward with various aetiologies, and therefore, generalisation to other populations may be difficult. This paper did not explore other stakeholders involved in the group program such as group facilitators or family members and only looked at one sample site. Recent guidelines for process evaluations highlight the involvement of multiple stakeholders to understand the full impact of context on intervention mechanisms. Further exploration of these viewpoints could verify if this group program is generalizable, scalable and sustainable across different settings.

4.2 | Implications of the research

Group-based models of care in inpatient rehabilitation have been embraced for resource efficiency and to maximise patient outcomes. Literature to guide implementation of rehabilitation groups has focused on standardised, impairment-based therapy such as walking or arm-strength circuit classes (Lohse et al., 2014; Schneider et al., 2016; Veerbeek et al., 2014). The paucity of literature on the nature of occupation-based groups demonstrates variabilities in the group process, design and delivery (Spalding et al., 2020). This study contributes to this body of research by exploring factors for success. To address the growing need for accessibility to useful occupation-based interventions in inpatient rehabilitation, this body of research suggests that practising occupations in a controlled environment of a group could be an appropriate alternative to enable positive outcomes. It was demonstrated that a group with an evidence-based structure, enabling real-word experiences through meaningful opportunities of task practise and encouraging a shared experience between participant, facilitators and peers, provides success. This may be helpful for occupational therapy clinical settings wishing to embrace the trend of group model of care for organisational outcomes.

5 | CONCLUSIONS

It can be concluded that the practice of occupation-based approaches can successfully occur in a controlled group environment of an inpatient general rehabilitation ward with a positive impact on patient experiences and outcomes. Success occurs when an occupation-based group facilitates the shared experience and provides meaningful opportunities to practise real-world experiences within an evidence-based structure. This study contributes to a growing body of evidence to the benefit of incorporating occupation-based activities into inpatient rehabilitation and offers insights to how clinical settings could advance forward to incorporate this into practice.

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CONFLICT OF INTEREST

Professor Louise Gustafsson is the Editor-in-Chief of the Australian Occupational Therapy Journal and a co-author on this article. Professor Gustafsson was blinded to the peer review process; management of the peer review process and decision-making for this article was undertaken by an Associate Editor.

AUTHOR CONTRIBUTIONS

All authors were substantial contributions to the conception, design and analysis of the work. All contributed to the draft and review process, providing final approval of version publication and are accountable to accuracy and integrity of the work.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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