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Hospitality experience within hospitals

What aspects in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals?

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FOREWORD

Dear reader,

In front of you lays the master thesis for the Master Facility and Real Estate management at the University of Applied Science Saxion and the University of Greenwich.

Through my work at one of the participating hospitals and the upcoming hospitality within the care sector, the idea for this research emerged. It took a lot of time to find another three participating hospitals, because of the interviews with patients.

During the research I had guidance from several persons and without them I never achieved these results. Initially, I want to thank Mrs. H. van Sprang for helping to develop the idea for this research, feedback and guidance during the research. In addition, I want to thank my tutor Mr. M. van den Hoop for the guidance and the fast response on questions during the research. Finally, I want to thank the patients and the FREM managers of the four hospitals for participating on my research.

N.C.M. Lamfers

Huizen, August 17 2016

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MANAGEMENT SUMMARY

According to several authors, such as Bunner-Sperdin and Peters (2009), Ogorman (2010) and Hokkeling and Mar (2012), hospitality can be defined as an interpersonal exchange, in which the host wants to give the best experience, whereby the physical, spiritual, emotional and social well-being of the patient is paramount. Hospitality is focused on service provision, but also on the experience with which it is delivered to the user. The importance of hospitality lies in the upcoming competition between hospitals and hospitals have to deliver a good experience. Other trends and developments, like the financial system of hospitals, day-care admissions, vacancy of hospitals and the increasing number of chronic patients contribute to the importance of hospitality as well.

In addition, the perception is according to Berry, Wall and Carbone (2006) and Bitner (1992) influenced by three dimensions, being the service, behaviour and physical environment. As a result there has been research about the healing environment, but there is a lack of research about how to influence all three dimensions for a more positive hospitality experience. At the moment there is not a list of recommendations in what way the hospitality experience can be improved.

Therefore the objective of this research is to gain insight into the three dimensions that influence the hospitality experience of patients in a general ward of regional hospitals in the Netherlands. In addition, the researcher is aware of the fact that the medical side also plays a role in the hospitality experience. But there is consciously chosen to only focus on the three dimensions due to lack of time. The dimension service focus on nutrition being served in the patient room, the dimension behaviour on the behaviour of the nutrition staff and the dimension environment on the layout of the general ward and patient room.

The main research question is: *'What aspects in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals?'*

In the present research qualitative approach is used, which consists of semi-structured interviews, group interviews and a workshop. The questions asked are related to the expectations and the experiences of the patients regarding to the three dimensions. The results show that the aspects which (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals for service are: assortment, snacks, flavour enhancers, time and portions. The aspects for behaviour are: kindness, hospitality and knowledge. Finally, the aspects for environment are: space, common room, noise, privacy, natural elements and homely atmosphere.

In addition, the results show that all dimensions have an effect on the patient satisfaction, which lead to a higher hospitality experience within the hospital, because it is related to the overall healthcare quality.

The results of this research will provide hospitals with academic recommendations about aspects in the service, behaviour and environment dimensions, which (in) directly influence the hospitality experience. There is further research recommended, there has to be also looked at different departments for example the department neurology. Out of the interviews came forward that patients on the neurology department have a need for certain colourways to recognize the department. This is a starting point to research how not only a general ward has to look, but also how different departments have to look. This because patients with a specific disease have other expectations and experiences than a 'normal' chronic patient.

In addition, more research is needed regarding the influence of the medical side within the three dimensions on the hospitality experience of the patients. Therefore, it is recommended to research this further and especially to research the relation between the FREM side and the medical side within hospitals.

1. INTRODUCTION

In this chapter the research problem is getting introduced by background information, the trends and developments and the problem in the industry will be discussed. Finally, the research problem and objective will be discussed.

1.1 BACKGROUND INFORMATION

Aspects of Hospitality Management (HM) have become an integral part of the overall strategic identity of FM. The introduction of HM in Facility Management (FM) has generated a new approach that focuses not only on service provision, but also on the experience with which it is delivered to the user. It may be the experience rather than the service of the product itself. Experience is a feeling, the guest has to feel welcome (Dongelsmans & Roux, 2013). HM is an important part within FM, because by influencing the experience of customers, companies can attract more customers and keep these customers. In the hotel industry hospitality is already 'normal' because it is strategic requirement to live for the hotel industry and it is proved it has an added value and therefore hospitality is part of the mission of organisations. But also in other industries hospitality is getting more important and therefore normal. Because it is not only the product what makes the difference for the customers but also the experience. In addition, service quality of hospitality is important in the present competitive world. The level of hospitality can be used as a factor to stand out from competitors, in the form of a unique selling point (Gronroos, 1984).

Pine and Gilmore (1999) point out the growth of the importance people attach to experience, they call this the emerging experience economy. This occurs from consumers who unquestionably desire experience and Pine and Gilmore (1999) described experience as *'Not an amorphous construct, it is as real an offering as any service, good, or commodity'.* This experience occurs when a company intentionally uses services as the stage, and goods as props, to engage individual customers in a way that creates a memorable event" (p.98).

Organisations must design an experience that customers judge to be worth the price, which they can do with for example excellent design, marketing and delivery. In addition, one way to think about experiences is across two dimensions. The first dimension describes the customer participation and the second dimension describes the connection or environmental relationship that unites customers with the event or performance. Therefore the experiences consists of the following three dimensions, namely: service, environment and people (Pine & Gilmore, 1999). In addition, hospitality is defined by the standards of the guest, for example the guest determines if he experiences an environment welcoming or comfortable. But hospitality is also defined by the standards of the organisation, for example there is "Gastvrijheidszorg met sterren" which is a rating of the quality of the hospitality care. The aim of this organisation is to improve the quality of life of the patients, by stimulating good hospitality care. This ranking is associated with, what customers can expect (Gastvrijheidszorgmetsterren, 2015). This experience is partly determined by expectations a customer has upfront and is correlated with the type of organisation and the indication of the level of service. In addition, hospitality is a subjective phenomenon, because the experience of a customer is personal. Therefore hospitality is an interplay of guest and organisation standards, which together determines the degree of hospitality.

1.2 HEALTH CARE DEVELOPMENTS

Hospital financing (the system of financing hospitals) has changed substantially from January 1st 2005. From January 1, the invoicing of hospitals is going through "Diagnosebehandelcombinaties" (DBC's). Until December 31, 2004 the financing of hospitals was regulated through budgeting (NZA, 2015).

DBC is a representation of all activities and transactions that a patient in a hospital runs by (used for this one-year period for a chronic condition) for a fixed period. A DBC with four codes (type of care, demand for care, diagnosis, treatment) with any complaint and in what state a patient enters the hospital, the diagnosis is made, and it describes the proposed treatment. Hospitals may only charge tariffs for DBC's. A large part of the DBC's (known as segment A) by the "Nederlandse Zorg Autoriteit" (NZA) is assigned a rate. The rest of the DBC's (segment B) has only part in a fixed rate; the rest is "negotiable." Segment B comprised the first year about ten percent of hospital care, especially elective (non-emergency) care. The hospital and the insurer shall be deemed to enter into any negotiations with each other. As a result the Dutch Ministry of

Health will facilitate market forces in healthcare. In 2009, 34 percent of the DBC's were freely negotiable. The Ministry of Health had increased this percentage in recent years and in 2011 65 to 70 percent of hospital care was freely negotiable. The result of this method was that it encouraged to work efficiently (Donaldson & Magnussen, 1992).

In this 'new' system, a hospital receives a fixed amount per treatment and the medical specialist receives a fixed hourly rate. The goal is that hospitals and medical specialists work more efficiently and therefore the market forces in the health sector. Hospitals may not compete with each other on price and quality but the government wants to make patients more aware of the costs of care. But this new system has brought problems with it, the money is running out in some hospitals because they cannot send invoices and some health insurers' refuse to give advances. This is the result of the shortening of the duration of DBC's, this was 360 days and now it is 120 days (NZA, 2015).

However, the dividing up of DBC's in smaller packages is a complex operation and takes longer than was expected. The problem is that hospitals do not have new price lists yet for the new DBC's. As long as that new price lists are not ready, they cannot claim. The treatment of new patients can only be invoiced if the new rates are announced. As a result of that the flow of revenue of the hospitals declines. In the first months of 2015 they received money from invoices from the end of 2014, but this is not enough. Many health insurers have agreed to give advances to the hospitals, but some insurers impose additional conditions before they want to give advances. This results in a situation that hospitals are still negotiating over the health care 2015, which is far from completed in hospitals. The shortening of the duration of DBC's make these negotiations more complex, because prices change the volume of DBC's. If insurers do not give advances, the hospitals get in acute financial distress. It is unlikely insurers should do this, because they don't want to be the reason for bankruptcy as the result of a system change. But if this would happen than the hospitals have to go to the bank to bridge the liquidity gap, because then they cannot pay short-term payments obligations at all (Romani & Haraga, 2009). Therefore the DBC's is a complicated operation and if shortening of the DBC's once is settled, the hospitals will just get their money easier. In addition, the estimation of the value of these outstanding DBC's will cause problems in establishing the financial statements.

Furthermore in recent years the day-care admissions are increased. This shows that the traditional view of a hospital is going to change to more day-care admissions instead of the longer stay, this is leading to the fact that hospital are going to face vacancy, which lead to financial problems and possibly bankruptcies. The "Nederlandse Vereniging van Ziekenhuizen" says that the number of patients undergoing day-care-admissions has increased to over 50 percent. The reason is that people were admitted quicker (Houwelingen, 2015).

As mentioned before, hospitals will suffer of vacancy, this vacancy has to do with the shorter duration of patients in a hospital and because of the more day-care-admissions. In addition, more treatments take place in a general practice. This results in more empty beds and spaces in the hospital. According to 'Arcadis', a research bureau, will suffer all hospitals in the Netherlands will suffer of significant vacancy rates, rising to 40 percent. Nowadays hospitals has to reduce costs for not getting into financial difficulties and this is another reason. A possibility is to sell or rent the empty spaces or renting it to doctors or pharmacists. The Netherlands is aging and chronic diseases are increasing, but despite this rising demand for care, it is more quiet in hospitals, this can lead to the fact that staff is being cut. Hospitals have to take cuts otherwise it will go bankruptcy and patients have to travel further to another hospital. This applies more for the smaller general hospitals, because most of the time there is a few kilometers further, a similar hospital. But the smaller hospitals with a clear specialization have not to fear yet, but in 25 years they will also suffer of vacancy. The accounting firm BDO have calculated that one of the five hospitals are going to get in financial troubles, particularly small hospitals. Hospitals threaten to losing money because insurance companies do not reimburse any care at all hospitals (Houwelingen, 2015).

As mentioned before the number of chronic patients is going to increase, this was one of the most important results of the 2014 Healthier Netherland report. This reports concludes that an increase in the number of people living with a chronic disease. RIVM is expecting an increase of 5.3 million in 2011 to 7 million in 2030. Also the number of people suffering from two or more illnesses will also increase. Because of the ageing population the number of people suffering from a disease increased over the last decade and

this increasing trend will continue. As a result of the early diagnosis of diseases as well as improved treatment they will ensure that people can live longer with their illness. As a result of which the number of people with a disease will increase (Netherland, 2014).

1.3 TECHNOLOGY IN HEALTH CARE

The first technology development in health care is 3D printing, a manufacturing process that builds layers to create a three-dimensional solid object from a digital model. 3D printing has emerged as a disruptive technology in the healthcare field. Over the past 20 years, it has been used with great success to plan complex medical procedures, produce customer devices and instruments, and better train future clinicians. As accessibility to the technology increases, hospitals are beginning to adopt 3D printing programs within their institutions, with the goal of decreasing 3D printing lead times and building knowledge internally. Equal to the tremendous potential of 3D printing, there are also significant challenges to its adoption, for example reimbursement, lack of evidence proving efficiency, and technical limitations. One of the largest barriers to overcome is the technical know, how to implement such a new technology in the existing clinical workflow (Schubert, Langeveld, & Don, 2013).

Secondly, The Internet of things is a computing concept that describes a future where every day physical objects will be connected to the Internet and be able to identify themselves to other devices. By using the Internet of things, a lot of big data must be saved in a kind of information storage. By using this information storage, an organisation will be able to get more knowledge about their customers. Therefore they can recognize the needs of the customers and adapt them in their products and services and then benchmark their data with other organisations. Hospitals can use the Internet of things, to improve the hospitality within the hospital (PWC, 2015).

Finally, the nanotechnology, the study and use of structures between 1 nanometre (nm) and 100 nanometres in size, in the field of medicine could revolutionize the way we detect and treat damage to the human body and disease in the future. Nanotechnology in medicine involves applications of nanoparticles currently under development, as well as longer range research that involves the use of manufactured nano-robots to make repairs at the cellular level. One application of nanotechnology in medicine involves employing nanoparticles to deliver drugs, heat, light or other substances to specific types of cells. This reduces damage to healthy cells in the body and allows for earlier detection of disease (Emericha & Thanosb, 2005). Therefore by the newest technology there will be innovation in treatments and diagnostics (at home of using your mobile).

1.4 HOSPITALITY WITHIN HOSPITALS

Hospitality within the health care has created the healing environment, which is the design of a building, the physical aspects, which creates a pleasant and sustainable environment. (Fiset, 2006). A lot of hospitals want to create this healing environment, because it has proven this has to be a positive influence on the healing process of patients. According to Elders (2015), the Facility Manager of Tergooi, a hospital in Blaricum, hospitality is a trend which is around for a couple of years and is a continuing process. Many hospitals are engaged with hospitality, because providing quality health services are no longer enough, customers have a growing need for a valuable experience. The focus in FM is moving to hospitality within good services to the customers, good facilities and the physical environment of the building, which makes together the contents of the hospitality experience from the patient (Elders, 2015).

In addition, people can choose a care provider, therefore the industry is getting more commercial. People don't have to go to the hospital in the region anymore but can drive a little further to a hospital what meets the personal requirements. This is also a reason why health care organisations make their services rapidly customer friendly and adjust hospitality within the hospitals (Voordt & Prevosth, 2011). This does not apply for everyone, because the health insurance of people plays an important role in the choice of a hospital, this has to do with money. This means that hospitals have to improve their hospitality within the hospital, therefore they can attract more patients.

1.5 RESEARCH PROBLEM AND OBJECTIVE

Based on the introduction, it can be concluded that the experience from patients is important, with influencing this experience a hospital can attract more patients. Nowadays this is necessary, because the industry gets more commercial. In addition, with the day-care admission increased, there will be vacancy in the general wards of the hospital. This is also a reason why health care organisations make their services rapidly customer friendly and adjust hospitality within the hospitals. As a result there have been research about the healing environment, but there is a lack of research about how to influence all three dimensions for a more positively customer's experience, there is not a list of recommendations in what way the hospitality experience can be improved. In this research the experience from the patients will be called the hospitality experience and the focus will be in a general ward on all three dimensions. In the dimension behaviour only the behaviour of nutrition staff will be included, in the dimension service only the service will be included and in the dimension environment only the department and room layout will be included, because this is the only relevant behaviour, service and environment in the general ward (Cheung, Aiken, & Clarke, 2008).

Therefore the objective of this research is to gain insight into the dimensions that influence the hospitality experience of patients in a general ward. The focus will be on a general ward of regional hospitals in the Netherlands and on the three dimensions of hospitality, namely: service, environment and behaviour, because this is an interplay what makes the hospitality experience.

The results of this research will provide the regional hospitals with academic recommendations about aspects in the dimensions service, behaviour and environment dimensions, which (in) directly influence the hospitality experience.

2. LITERATURE REVIEW

In this chapter, literature is given about the keywords of this research. Finally, a conclusion on the literature review in the form of a conceptual model for this research.

2.1. HOSPITALITY

In literature there are many different definitions of hospitality, the word itself comes from the Latin word *hostis*, which means stranger (Vijver, 1996). The NEN-EN 15221-1 code, has defined hospitality as *"Providing a hospitable working environment making people feel welcome and comfortable"* and includes:

- Welcome, registration and guidance of visitors.
- Provision of food and beverage to personnel and guests
- The deliverance of support in arranging meeting rooms and events
- The deliverance, cleaning and keeping in good order of work wear for the staff, for instance security people, chauffeurs, room keepers, management and front office workers and other textiles
- The laundry of textiles (clothing, curtains/door mats/carpets, table linen, bed linen and towels (e.g. hotels, hospitals) including logistics and planning/organisation" (Nederlandse Normalisatie Instituut, 2006).

The NEN definition of hospitality is really about the hospitality in the workplace, the internal customer. Because hospitality does not only apply to the workplace, the following definitions of hospitality are about hospitality in general. According to Bunner-Sperdin and Peters (2009) hospitality is: *"The service delivery process which influence customers' satisfaction"* (p.171). Ogorman (2010) describes hospitality as *"The link between the host and the guest"* (p.5). According to Hokkeling and Mar (2012) *"Hospitality is the pleasant, welcoming feeling that the guest experienced in contact with the host and the service of the company"* (p.11). In addition, the host needs to know the needs and expectations of the guest; generosity, to please the will and respect for the guest as an individual are important (Gunnarsson, 2002). Brotherton and Wood (2008) found that hospitality anyway consists of two themes *"The first theme of hospitality is hospitality as a means of social control, especially the control of 'strangers', people who are essentially alien to a particular physical, economic and social environment. The second theme of hospitality is hospitality as a social and economic exchange"* (p.40). When hospitality is therefore a return, socially or economically, and that 'foreigners' are involved. These aspects are also included in the definition of the Experience & Service Design: hospitality is an interpersonal (social) exchange where the goal is to provide the "stranger" in a generous way of accommodation. The activity of hospitality can focus on personal or professional situations. When Knowledge focuses on the latter, the business side of hospitality, where "social exchange" and "economic exchange" come together in the experience of the guest (Thijssen, 2010, p. 26).

The definition of hospitality within this research is a combination of previous definitions, namely: Hospitality is interpersonal exchange, in which the host wants to give the best experience, whereby the physical, spiritual, emotional and social well-being of the patient is paramount.

Out of the definitions, it can be concluded that people, service and environment are important dimensions within hospitality. The following sources are about behaviour, service and environment. Brunner-Sperdin and Peters (2009) underscore also the importance of each, the human ware (employee characteristics that impact on interaction with customers) and hardware (design and ambiance). The behaviour part is influenced by the service and the environment. Berry, Wall and Carbone (2006) adds the influence of the senses and argues that there are three kind of service clues, namely functional (service), mechanic (environment), and humanic (behaviour). They argue that *"in interacting with organisations, customers consciously and unconsciously filter experience clues and organize them into a set of impressions, some more rational or calculative and others more emotional"*. *"An experience clue is anything in the service experience the customer perceives by its presence or absence. If the customer can see, hear, taste, or smell it, it is a clue"* (p.43). Those three clues determine together the hospitality experience, which makes the customer perception of the service. Figure 2.1.1. presents the Managing service experience clues model (Berry, Wall, & Carbone, 2006).

This model is all about carry out a strategy therefore companies must gain an understanding of the customer's journey from the expectations they have before the experience occurs to the assessments they are likely to make when it's over. Using that knowledge, companies can orchestrate an integrated series of "clues" that collectively meet or exceed people's emotional needs and expectations. The internalized meaning and value the clues take on can create a deep-seated preference for a particular experience and thus for one company's product or service over another's (Berry, Wall, & Carbone, 2006).

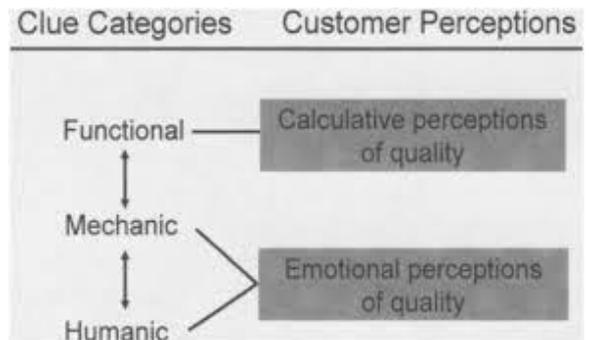


Figure 2.1.1. Clue Influences on customer perception (Berry, Wall, & Carbone, 2006).

An organisation's first step toward managing the total customer experience is recognizing the clues it is sending to customers. Companies that sense trouble would do well to consider undertaking the focused, comprehensive management of all the clues that give off signals to people. Fortunately, specific tools are available to help organisations with this process. And, as we'll show, some companies are using the tools of customer-experience management to create a competitive advantage that is difficult to match.

The servicescape of Bitner (1992) points out the impact of the physical environment, in which a service process takes place (Bitner, 1992). Bitner (1992) argues that "the environment in which the service is assembled and in which the seller and customer interact, combined with tangible commodities that facilitate performance or communication of the service" (p. 58). With this model there can be determined which dimensions in the physical environmental dimensions and behaviour are important for the experience. Figure 2.1.2. presents the Service cape model (Bitner, 1992).

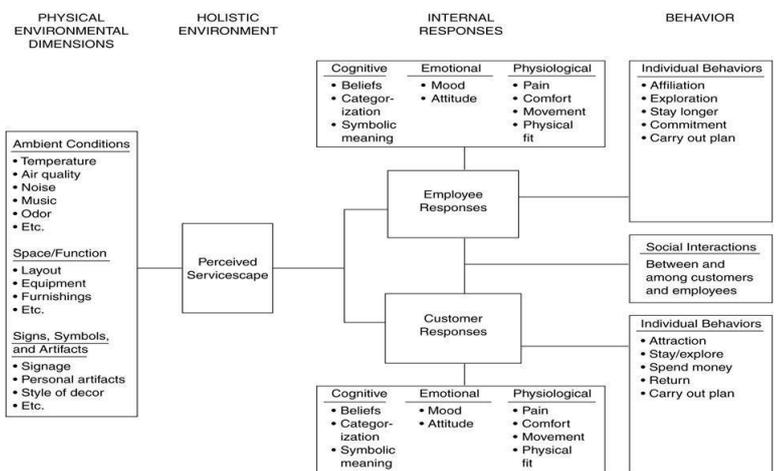


Figure 2.1.2. Servicescape (Bitner, 1992).

The meaning of this model that it can help assess the difference in customer experience between for example a fast-food restaurant and a normal restaurant. Whereas the quality of the food may be the same, the customer may perceive higher quality in the latter over the former based on the environment in which the service is provided. The assumption of the model is that the environment is the key in someone's experience combined with how the seller and customer interact.

If you compare the models of Berry et al (2006) and Bitner (1992), it can be concluded that it is all about the perception of customers. Bitner (1992) thinks the environmental aspects play the biggest role in this perception and Berry et al (2006) thinks it is more an interplay of the three dimensions and which interplay is the most important one depends on the clue the customer gives. In this research both models can be used to look which aspects are important for the patient experience regarding hospitality.

The overview in table 2.1.3. presents the three dimensions of hospitality, namely people, service and environment. This table comes out the journal article "The Role of FM in (Researchers') Images of Hospitality" which is been published in the International Journal of Facility Management (Groen, Sprang, Lub, & Pijls, 2014). This table shows the aspects within the three dimensions.

Table 2.1.3 Overview three dimensions of hospitality (Groen, Sprang, Lub, & Pijls, 2014)

Dimension	Dimensions	Authors
People	Behavioural	Shostack (1985), Brunner-Sperdin and Peters (2009), Bitner (1992), Slatten and Mehmetoglu (2009), Ariffin (2013), Lucas (2003), Wong (2004), Berry et al. (2006), Pullman and Robson (2007)
Service	Mechanics	Berry et al. (2006)
	Ambient conditions	Bitner (1992), Lucas (2003), Pullman and Robson (2007), Slåtten and Mehmetoglu (2009), Kim and Moon (2009)
	Sensory input	Brunner-Sperdin and Peters (2009)
Environment	Interior design	Brunner-Sperdin and Peters (2009)
	Signs, symbols and artifacts lay-out	Bitner (1992)
	Architecture	Slåtten and Mehmetoglu (2009)
	Amenities, design (signage, furniture fixture and equipment, lay-out)	Pullman and Robson (2007)
	Facility aesthetics, lay-out and seating comfort	Kim and Moon (2009)
	Seating comfort, decor, lay-out; cleanliness	Lucas (2003)

2.2. HOSPITALITY IN HEALTH CARE

In the health care many hospitals have adjusted hospitality, because of the increasing focus on the importance of patient experience. Much research has been done about creating physical environments that are pleasing to customers, for example about colour of scents. But also about how employees treat the patients. Hospitals have to accommodate patients in the same way hotels provide comfortable rooms to guests. Initially, a hospital has to think in the role of a patients, the goals are different if somebody is looking for an accommodation. These differences in goals are sufficient to consider what they mean in health care facility and service design. Those goals are the expectations the patients have before they enter the hospital (Gallan, 2012).

Secondly, consider also the context of health care and the professionals that deliver it. While hospitality employees are highly trained and skilled, they do not approach the training and demands that are placed on health care providers such as nurses and physicians. Health care providers are entrusted with the lives of people, and are treating patients' physical conditions and sense of dignity. Additionally, the dimensions of service quality upon which customers (and patients) judge a service are broader for health care services than for hospitality services. The point here is that knowledge-intensive businesses such as health care require a much broader integration of provider-customer information as to warrant resources (physical, mental, and emotional) from patients (Gallan, 2012).

Therefore a hospital that wants to integrating hospitality successful, has to recognize that satisfaction with a service is driven in part by goal attainment.

Specifically, recognize that satisfaction with a service is driven in part by goal attainment, especially for patients. Different factors are playing a part, such as food quality, bed comfort and noise, but also physical environmental components like hygiene. Finally, the personal interactions is important which occur between providers and patients. The satisfaction is important and more a result of staff interaction than facilities (Gallan, 2012). Recognition of those insights should motivate executives to allocate resources according to each dimension's importance in driving important patient experiences.

2.3. EXPERIENCES AND EXPECTATIONS

According to the Longman Dictionary of Contemporary English (2005) 'experience': *"That something happens to you or something you do, especially when this has an effect on what you feel or think"* (p.548). Perception is therefore dealing with feelings and thoughts. Emotion seems to be important to experience. Perception is a complex of emotions that occur simultaneously or sequentially (Boswijk & Peelen, 2008). If you experience something this undergoes the senses. Someone is positively or negatively stimulated by the experience, which leads to certain emotions such as joy, sadness, anger or fear (Thijssen, 2010, p. 27). Hopefully, this emotion return to the guest and he shares his experience with others (Nijs & Peters, 2002). Schmitt (1999) endorse it and expand it further: *"Experiences involvement the entire living being: our senses, feelings, intellect and bodies. Experience involvement both rational and the emotional side of human beings"* (p.56). An experience occurs when consumers get involved in such an extent that it leaves a lasting impression. The event is memorable and very personal. Consumers are emotionally, physically, intellectually or spiritually touched by it (Pine & Gilmore, 1999). Another important feature of experience is that it spreads over a longer period of time: an experience begins long before and after the actual experience far ends. The ultimate feeling of the experience depends on each touchpoint to the guest with the organisation. Together, these touchpoints determine how someone looks back on the experience (Voss & Zomerdijk, 2007).

In recent years, managers have become increasingly aware of the need to create value for their customers in the form of experiences. Unfortunately, they have often proceeded as if managing experiences simply meant providing entertainment or being engagingly creative. The issue is far more complex than that. Restaurants that put photographs of movie stars on their walls and retailers that hang motorcycles from their ceilings, will ultimately be disappointed in customers' responses if they fail to make such objects part of a well-conceived, comprehensive strategy of managing the customer's experience.

To determine how a patients experience something, different models can be used, the first one is the PGOBD model. This model was developed in 1988 by Bolier. The relationship between the provider and the guest is shown schematically. The arrows indicate the difference between the expectation of the host with regard to the service provider and the actual experience that has the guest of the service provider. The middle circle shows characteristics of both parties. The service provider is responsible for the Product, Behaviour and the Environment. The guest has his own needs and a Target. The relationships between these factors determine the degree of Hospitality. Therefore the P is standing for product, the G for behaviour, the O for environment and the B for the experience of the user and the D for the purpose of the user. This model shows that the experience is the result of the interaction of patient, with environment, service and behaviour (Gastvrijheid in bedrijf, 2016).

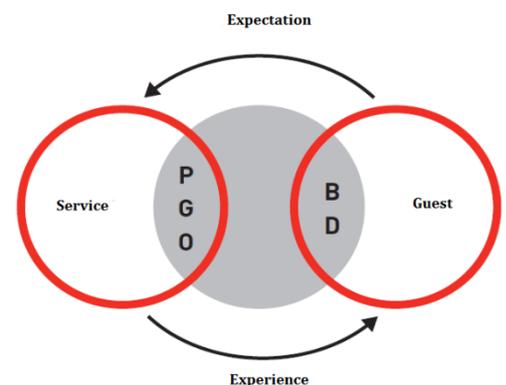


Figure 2.3.1. PGOBD Model (Gastvrijheid in bedrijf, 2016).

Finally, there is Thijssen (2010) with the Guest Journey, this model is based on the journey of the guest through the entire "buying process" (can be seen as the care process). The extent to which the guest appreciates the service depends on hospitality (relationship), the contents and value of the service (exchange), the place where the service (space) and the organisation (reputation).

2.3.1. Service

Service, consists of the nutrition and the service around this. The nutrition within a hospital and the service play an important role in the patient recovery and the quality of the nutrition can also influence the patient' satisfaction with their overall hospital experience. Initially, adequate nutrition intake is an important part in the healing process of the patient, because undernutrition is associated with loss of muscle strength and can lead to an increase infection rate. By promoting optimal nutrition through hospital foodservices, this can lead to a faster recovery and decreased length of hospital stay (Johansen, et al., 2004).

The health care in the United States is much larger than in the Netherlands and is the largest service industry in the world, but it exists also in a competitive environment, which means they have to provide excellent quality services. This is the reason why hospitals must monitor and address patient satisfaction and the nutrition is changing to be more focused on patient care. This can improve the patient satisfaction and this leads to a better hospitality experience. This because the foodservice quality is significantly correlated with overall patient satisfaction (Fottler, Ford, Roberts, & Ford, 2000).

Within the U.S. the health care is reshaped by the expectations of consumers, which makes the customer-orientated service. The relation between a customer-orientated service culture and patient satisfaction is that it is an environment that meets patient' expectations. (Fottler, Ford, Roberts, & Ford, 2000). But also makes this service culture that meets patient expectation requires a total commitment customer-orientated service. This can be done by training which helps define service excellence in a hospital his foodservice. But patient satisfaction is also linked to employees' satisfaction, employees their work can contribute to better patient care and all together the customer-orientated service will improve the patient satisfaction, which will lead to a better hospitality experience (Buzalka, 2008).

This is well recognized by that foodservice are important elements of the patient's overall perception of the hospitality experience. The more patient's expectations are met, the more satisfied they seem to be. To be able to meet this patient satisfaction, there is a trend within the foodservice in hospitals, the implementation of a full service system (McLymont, Sharon, & Stell, 2003). This system has several advantages:

- Improved patient control over food choices
- Improved patient satisfaction
- Improved food temperature
- Decreased waste

The main disadvantage of this service is increased cost and which mainly comes from investment in new equipment, computer software and training costs (Norton, 2008)

The traditional system has to look more at a service model and deploying this system can vary greatly between hospitals. Hospitals can choose if they offer the service system to every patient or only for chronic patients. But not all hospitals can afford this new system and implements parts of the system, in order to meet the customer-orientated service. But if hospitals want to implement this system they have to customize the system to its specific needs and to continue adapting after implementation (Buzalka, 2008).

The most substantial factor driving the growth of service is competition, because the satisfaction score is important for a hospital. Nowadays patients expect more and a hospital needs a service which can exceed these expectations (Norton, 2008).

There are several surveys about what patients wants regarding service in a hospital. The first research is done by asking about the positive and negative experiences in a hospital. Here it became clear that consumers are less forgiving of providers with whom they had a negative experience. PWC concluded that that expectations of today's healthcare consumers mirror other industries, with customers used to benefits like 24-hour service or mobile access (PWC, 2015). According to the report, the ideal experience is built on nonclinical factors like convenience, customer service and staff attitudes. The following aspects are important for patients (Cheung, Aiken, & Clarke, 2008).

- Facilities that offer multiple services in one location
- Ability to exchange information through online and mobile channels of communication
- Patient education during a visit
- Cafeteria and access to Wi-Fi and other entertainment

Another research shows that patients increasingly are looking for healthcare providers that offer digital services. This consists of wanting physicians to follow up with them after an appointment, wanting the option of online scheduling and wanting to ability to view their test diagnosis online. In general patients wants to be more involved and productive in their healthcare if they had online access (Dvorak, 2015).

2.3.2. Behaviour

Good staff communication to patients helps reduce the anxiety of patient and family and promotes better care within the hospital and after discharge and can also improve outcomes. But also good communication is the most important factor to improve the overall healthcare quality. Previous research has shown that patients are more satisfied with good communication from nurses, nutrition staff etc. when they are in a single room, this is because in a room with more patients the staff are reluctant to discuss patient issues or give information within hearing of a roommate, out of respect for privacy. And patients have a growing need for privacy and confidentiality, which is an advantage of single room (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004).

Besides that, all staff should behave towards patients in a way that promotes dignity during interaction and studies indicate that patients are vulnerable to a loss of dignity in hospital. Also respect and privacy were strongly associated with dignity. Patients are vulnerable within a hospital and the effect of the staff behaviour can give them dignity, which goes also together with privacy and control which were important to patients' dignity being upheld. Therefore the impact of the behaviour is important and can help the patient to recover quicker (Baillie, 2007).

Furthermore, behaviour is linked to the patient satisfaction, which is proven by case studies, which shows that when employees have more favorable attitudes about their place of work, patients are more satisfied. Also patients feel safer, by a more hospitable behaviour towards them, because a hospital creates an enormous stress for patients. Finally, a good behaviour is linked to the overall healthcare quality, which is related with the right organisational culture and leadership communications within the behaviour and can improve the overall healthcare quality. Therefore the behaviour of employees have a direct impact on the patient (Baillie, 2007).

In addition, a previous study examines the demographic determinants of organisational citizenship behaviour in a hospital setting, which shows that gender and profession have statistical relationship with organisational citizenship behaviour (P value= 0.00 and 0.01) but age, education, marital status and professional experience have no statistical relationship with the perception of organisational citizenship behaviour (Amin Bahrami, Montazeralfaraj, Hashemi Gazar, & Dehghani Tafti, 2013).

Also previous researches have shown that the behaviour of the staff is really important and the friendliness and attitudes contribute to a good or bad experience. Nowadays patients expect more than only friendly and hospitable behaviour towards the patients but they want more personal contact with the staff (Cheung, Aiken, & Clarke, 2008). The customer-orientated service culture and behaviour can be linked and can complement each other, because this customer service brings an expected behaviour with it. The nutrition staff has to be not only hospitable, but has to know dietary needs from the patients, the personalizing product and services. This means that the nutrition staff has to gain more knowledge about diets and nutrition (Goehring, 2002).

The research of PWC showed that the biggest reasons for positive experience was the staff. In their interactions with a hospital, doctor's office or other provider, consumers are about twice as likely as those in the airline, hotel and banking industries to say that staff friendliness and attitude contributed to a good or bad experience. In this research is only the behaviour of nutrition staff included (Cheung, Aiken, & Clarke, 2008). But also patients are expecting more, they want more personal contact because this may help distinguish the experience.

2.3.3. Environment

The environment, consists of the department and room lay out, which is important because consumers commonly look to the physical environment for clues about the firm's capabilities and quality before purchasing (Berry, Wall, & Carbone, 2006). Within hospitals those clues are especially important, because clinical outcomes are often intangible and difficult for consumers to measure. Therefore consumers sometimes rely on design clues to form opinions about the quality of care (Brooke, Robson, & Wu, 2013).

Furthermore, evidence shows that patient's perception of healthcare outcomes can be influenced by the design of a hospital. Previous research found that patients in physically attractive waiting areas give higher ratings on quality of care than those who were in unattractive waiting areas. This means that hospitals with a more hospitality-orientated environment had an increased patient satisfaction (Brooke, Robson, & Wu, 2013).

Nowadays many hospitals have adopted elements of hotel design and have implemented hotel-like patient rooms for example the single-patient rooms. Those rooms have been shown to help reduce medical error rates, less stress and shorten length of stay. But in these rooms there is a stay-over facility for family, which serves the role of a hotel for non-patient guest, who interact with the environment in new ways. Hospitals have to increasingly value patient's families as important partners in care, which can speed the recovery (Brooke, Robson, & Wu, 2013).

In addition, the environment can have impact on the health of patients within the hospital, which creates the healing environment, which is the design of a building, the physical aspects, which creates a pleasant and sustainable environment. This healing environment has proven to have a positive effect on health and well-being, gives a hospitable atmosphere and also supports the needs of patients, families and staff (Fiset, 2006).

Natural elements, such as daylight, fresh air and quiet play an important role within the design of healing environments, research has shown that contact with natural elements can reduce anxiety, lower blood pressure and less pain. There is growing evidence for the impact of the healthcare environment on patient and staff outcomes and is related to the natural elements, which are the key elements within the design and gives health benefits to the patients. Those nature elements stimulate the healing process of the patients (Berg, 2000).

In addition, research has shown that the physical environment has different effects on the patients, namely:

- Improve patients safety
- Reduce stress;
- Improve patient satisfaction and overall healthcare quality.

Initially, the design can improve patient safety by reducing risk from hospital-acquired infections, because the design of the physical environment strongly impacts hospital-acquired infection rates by affecting both airborne and contact transmission routes. Research suggest a clear pattern, for reducing infections by good air quality and patients in single-rooms. Besides that increasing accessible alcohol-based hand-rub dispensers or hand washing sinks can reduce infections (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004).

In addition, for reducing stress there has to be less noise and research has shown that there can be a lot of noise in a hospital and most of them unnecessarily, for example systems, alarms, staff voices, telephones and noises generated by roommates. But also surfaces, floors and walls and those are typical sound-reflecting surfaces of hospitals. Hospitals can implement environmental interventions that have proven especially effective for reducing noise, namely: installing high-performance sound absorbing ceiling tiles, eliminating or reducing noise sources and providing single-bed. By reducing noise, sleep of patients can be improved and literature shows that noise levels are high in hospitals and that noise is a major cause of poorer sleep for patients. Environments that reduce noise can improve sleep and reduce patient stress, which can be also done by view of nature (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004).

Also by reducing spatial disorientation the stress by patients can be reduced, because wayfinding problems in hospitals are stressful and have particular impacts on outpatients and visitors, who are unfamiliar with the hospital. And it is critical to design signage systems with logical room numbering and comprehensible nomenclature for departments within the hospital and a good ventilation through the use of improved filters (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004).

Finally, the environment can improve patient satisfaction and overall healthcare quality. The design can do this by providing single bed patient rooms, because this has advantages, namely: lower infection rates, fewer patient transfers, less noise, more patient privacy, superior accommodation for family and higher satisfaction with overall quality of care. The new design of a hospital can reduce the length of stay, which improves the patients satisfaction but also the overall healthcare quality and there is strong evidence that design makes the environment more comfortable, aesthetically pleasing, and informative relieves stress among patients and increases satisfaction with the quality of care provided. Research has found that environmental satisfaction was a significant predictor of overall satisfaction (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004)

As mentioned before there is the healing environment, which is focused on positively influence the healing process from the patients. In previous research patients have indicated what they want in a general ward (Prinjha, 2015). Initially, many said that the lights prevented them from sleeping properly as well as noise from other patients and their visitors, including arguments. This are definitely points that have to be taken into account, the light have to be natural and not to bright and prevent that patients can't hear the noise from the other patients in other rooms. But also poor hygiene and cleanliness was an important aspect, patients want to see there are cleaners and cleaning products like alcohol to disinfect your hands. Finally, patients want personal care and were satisfied if they were able to look around and talk to other patients on the ward and all the care and treatments they were given, that they were on the ward (Prinjha, 2015).

3. QUESTIONS, OBJECTIVES AND CONCEPTUAL MODEL

For a successful research it is important to formulate a research objective, main research question and sub-questions, based on the problem statement.

3.1. QUESTIONS AND OBJECTIVES

On the basis of the research the following objective, main research question and sub-questions are formulated:

Problem statement

Many hospitals are getting into financial trouble and want to attract more patients. Those patients can choose a care provider and in this process, the hospitality experience is getting more important in hospitals. This is the reason why hospitals want to improve their hospitality, therefore the patients' hospitality experience can be improved. As the experience usually is personal there will be looked at positive and negative experiences from patients. Here will be looked at the experiences from chronic patients, because the number of chronic patients is going to increase and those patients cannot get a day-in-care- admission and know the hospital the best. Therefore the hospitality experience consists of three dimensions, namely service, environment and behaviour. In this research there will be only looked at the room service, because this is the relevant service in a general ward. In addition, there will be only looked at the behaviour of the nutrition staff, because this is the relevant behaviour in the general ward. Finally, there will be only looked at the environment in the general ward, because this is the department and room lay out, which make together the general ward.

Research objective

"Gain insight into the dimensions that influence the hospitality experience of patients in a general hospital ward."

The research objective contributes to the FREM field by gaining insight in the hospitality experience of patients and to develop recommendations how the patients experience can be improved. This will be done by obtaining patients' experiences in the field of hospitality focused on the three dimensions, service, behaviour and environment to make recommendations to the FREM managers how to positively influence the patients experience and therefore improve the hospitality experience from patients.

Main research question

"What aspects in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals?"

Sub-questions

The sub-questions that arise from this research objective and main research question are:

1. *What are the expectations and experiences of the chronic patients regarding hospitality in a general ward? (This is in relation with the main research question, because you first need to know the needs of the patients to discover which aspects they want)*
2. *What is the effect of service on the hospitality experience of chronic patients? (This is in relation with the main research question, because it shows the importance of the dimension)*
3. *What is the effect of behaviour on the hospitality experience of chronic patients? (This is in relation with the main research question, because it shows the importance of the dimension)*
4. *What is the effect of the environment on the hospitality experience of chronic patients? (This is in relation with the main research question, because it shows the importance of the dimension)*

5. *What can FREM managers do to improve the hospitality experience of chronic patients? (This is in relation with the main research question, because it shows the strategical and tactical sides of the aspects within the three dimensions)*

Research breakdown

The conclusion of the five sub-questions will give an answer on the main research question and objective. The order, in which the research will be discussed, is shown in figure 3.1.1

Initially, the expectations and experiences of the chronic patients will be discovered by the positive and negative experiences by doing interviews and will be focused on a general ward in a regional hospital. After this, there will be a group interview with a new group of patients to check if the results are valid. In addition, the effect of service, behavior and environment on the hospitality experience of chronic patients will be discovered by doing literature review. Furthermore, the results of the first sub-question will help explore the influence of the three dimensions. Finally, the results of the interviews will be submitted by FREM managers from different hospitals in a workshop, in which they can discuss the results and come up with new ideas. The results of the research will be used for recommendations on how a hospital can research more how to positively influence the hospitality experience.

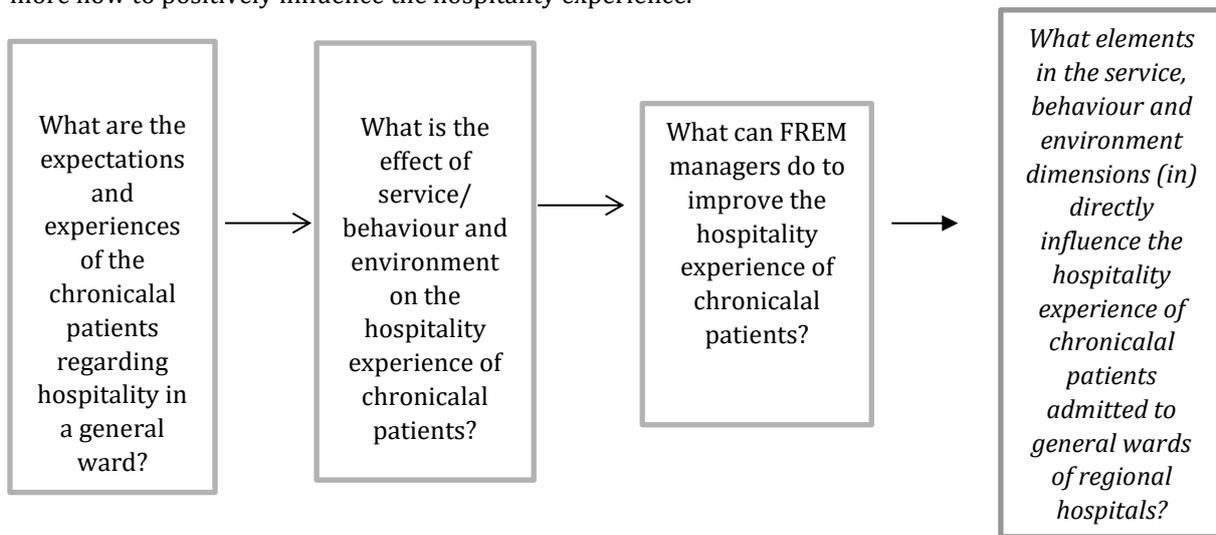


Figure 3.1.1. Research breakdown

3.2. CONCEPTUAL MODEL

For this research the PGOBD model will be used to understand the hospitality experience from patients and the expectations they have. This is a basic model, which have proven his value by still be useful after all these years. This model includes the core elements of how a patient his experience is created and have hereafter a positive of negative experience. The new element within the model is that after the experience of the patients, the FREM managers can positively influence this. Therefore the hospitality experience from the patients can be improved. The model also shows how the hospitality experience is the result of the experiences and expectations from the patients and the three dimensions of hospitality.

This model fits the best with the research, because is it linked to the sub questions of this research and can help understand the expectations and experiences from the patients. Those patients will be chronic patients 50+ of regional hospitals, because those hospitals provide general care for everybody. And for reasons of comparisons the hospitals includes in this study, need similar patients. Finally, in the dimension service only the room service will be included, in the dimension behaviour only the behaviour of nutrition staff will be included and in the dimension environment only the department and room lay out will be included

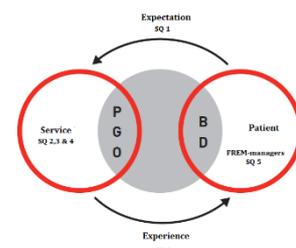


Figure 3.2.1. Conceptual model (Gastvrijheid in bedrijf, 2016)

4. RESEARCH METHODS

In this chapter the research methodology is discussed. In addition, the validity, reliability and limitations of the chosen methods and data analyses is discussed

4.1. RESEARCH DESIGN

This will be an inductive approach: *“An inductive approach is concerned with the generation of new theory emerging from the data”* (Wilson, 2010, p. 7). Inductive approach will usually use research questions to narrow the scope of the study and the aim is usually focused on exploring new phenomena or looking at previously researched phenomena from a different perspective. In addition, inductive approach is mostly associated with qualitative research. Within this research there is made use of research questions which narrow the scope of the study and the aim is to explore the researched phenomena. This is hospitality from a different perspective, to discover which elements in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospital (Gulati, 2009). The inductive approach is about building theory, which is a part of the research. Although, the research is also a little bit deductive, due to the fact that it is based on the literature that already exists about the topic, for example the basis of the conceptual model.

In addition, the school of thought of this research is constructivism, because experience is by nature subjective and hospitality is highly depending upon the context. Constructivism is a theory of knowledge that argues that humans generate knowledge and meaning from an interaction between their experiences. Their ideas and the type of research is mostly interviews and surveys and there will be make use of a multi-case study approach in 4 hospitals, which matches. Therefore constructivism matches this research (Saunders & Lewis, 2012).

The purpose of the research will be a descriptive-explanatory research. Initially, hospitality within hospitals will be discussed, the effect of the three dimensions, the expectations and experiences from patients and what FREM managers can do to improve the hospitality experience for the chronic patients admitted to general wards of regional hospitals. Therefore the recommendation give an overview on which front those effects can be improved, therefore the hospitality experience from the patients can be improved.

4.2. RESEARCH STRATEGY

The strategy of the research will be qualitative research, namely literature review, semi-structured interviews, group interviews and a workshop. By using those methods there will be a good overview of the best optimal design of the three dimensions of the hospitality experience. This strategy is based on the literature review and previous researches, because the expectations and experiences of the patients are the basis.

In this research there will be a purposive sampling, which consists of four regional hospitals focused on a general ward. This study will focus on regional hospitals, because those hospitals provide general care for everybody and for reason of comparison they need similar patients.

During this research there will be three steps taken:

Step 1: Interviews with chronic patients, because as mentioned before those patients are increasing and cannot get a day-care-admission, but really need the longer stay care, which is decreased by the day-care-admission. Those patients know the hospital the best and are the people who are the patients of the future. Those patients will be spread over the four hospitals. The number of patients depends on the extent to which new information is obtained. But there will be started with four patients at each hospital. Those patients have to be 50+, because this are the patients of the future and know the hospital the best. Therefore the research will be more reliable. The interviews will take place with total 32 chronic patients +50, which means a total of eight patients at each hospital.

Step 2: Group interview: For each hospital a new group of four patients will review results from step 1. This will add new findings to data and by means of a triangulated design the information obtained from the interviews will be checked whether it is correct or is different from each other. This ensures that the input from the interviews actually is applied in practice by doing the group interview with a new group of patients, which ensures the validity (Saunders & Lewis, 2012).

Step 3: Workshop with Facility Managers and Real Estate managers of the four hospitals involved (eight respondents), discussing results of step 1 and 2 and answering SQ5. This will be one Facility and one Real Estate Manager from each hospital. The workshop helps to combine the results out of the interviews with professional knowledge, to get reliable recommendations and design parameters for the three dimensions. Finally, the workshop will help think about new ideas for improving the hospitality experience by discussing the results of the interviews with the patients.

4.3. METHODS OF DATA COLLECTION AND MEASUREMENT INSTRUMENTS

This research will exist of a qualitative research and to increase the validity of this research, three different kinds of methods were used to collect data (triangulate data). Within this research there will be made use of interviews, desk research and a workshop, because with this methods at first there can be discovered what the patients' expectations and experiences are. Those results will be combined with literature, therefore we can see what the effect is of service, behaviour and environment are on the hospitality experience of chronic patients. Finally, the FREM managers can discuss the results of the patient interviews and come up with ideas what FREM managers can do to improve the hospitality experience of chronic patients. The aspects out of the patient interviews will be on operational level and the aspects out of the workshop with the FREM managers, will be on strategical and tactical level. With those methods the theory can be tested in practice, which ensures the reliability. A limitation of this research is that the research is only based on regional hospitals, because then the hospitals can be compared with each other. In addition, the medical side is not taken into account due to lack of time.

Finally, the used sources are literature, like books, journals and scientific articles. The researcher gathers information of the Greenwich portal, Saxion portal and Google Scholar, which can provide scientific journals, articles or books.

4.3.1. Interviews

Within this research, semi-structured interviews will be used. Semi-structured interviews are a qualitative method of research. This is a useful method to research the why of something and to obtain the right information from the person that is questioned (Saunders & Lewis, 2012). A semi-structured interview provided the possibility to ask further into the matter than by using predetermined questions. It presented the possibility to get a thorough insight into the topic. The predetermined questions can be found in appendix two, the interview guide, which are made with an operationalization schedule, which can be found in appendix one.

The amount of interviews conducted is 32. The reason for choosing 32 is mostly practical, due to the amount of time the research has to be done and there are in total four hospitals and from each hospital there will be four patients interviewed. After this there will be done a group interview with again four new patients, to ensure the validity of this research. By means of a triangulated design the information obtained from the interviews will be checked whether it is correct or if there are differences. This ensures that the input from the interviews actually is applied in practice by doing the group interview with a new group of patients (Saunders & Lewis, 2012). In addition all interviews are anonymous related to privacy of the patients and hospitals. The questions of the interviews will be the same during the 32 different interviews, which ensures that the results can be compared. Finally, a test interview will be done, which means that any ambiguities in the real interview can be avoided and ensures the reliability.

4.3.2. Desk research

Desk research fits the best within this research, because with this method there can be discovered out of literature what the effect is on the hospitality experience. But the results of the interviews will also be used to combine this with the literature. By combining literature and the results of the interviews, the influence

of the dimension can be explored. The desk research will consist a content analysis, because it is a qualitative research. In addition, in order to prevent any misunderstandings, the definitions are operationalized during the proposal, as interpreted during the research and this ensures that the construct is valid. Also the research will be reliable, because desk research will be used from reliable sources, which are named according to the APA method in the references. The sources are selected accurately by using mainly books and (scientific) journals (Saunders & Lewis, 2012).

The used sources are literature, like books, journals and scientific articles. The researcher gathers information of the Greenwich and Saxion portal, which can provide scientific journals, articles or books. In addition, the search machine Google Scholar will be used with keywords, such as hospitality and the three dimensions. Relevant books that the researcher will be using are for example *Hospitality Experience*, written by experienced lecturers at Hotel Management Schools in the Netherlands. *Moodmaker: Het ontwikkelen van gastvrije bedrijven*, written by Hokkeling, J. & Mar, L. de la (2012) and *Hostmanship; the art of making people feel welcome*, written by Gunnarson, J. (2002). But also the results of previous researches of PWC, which can be used as a starting point. By using multiple sources, there can be made a comparison between different sources. This comparison ensures a critical view on the used sources and ensures reliability.

4.3.3. Workshop

Within this research also a workshop will be done, because with this method the results of the patients interviews are given and there can be discussed what managers can do to improve the hospitality experience of chronic patients. This workshop will be with FREM managers and consists of one Facility and one Real Estate Manager from each hospital, which makes a total of eight respondents. Those hospitals, are the four participating hospitals within the research, out of the same region. There will be chosen four regional hospitals, because of the discrimination validity. This because factors as region and cultural background of the respondents can influence the results. Besides that, the hospitals need similar patients, this make the research more reliable, because the hospitals can be compared with each other. Finally, the used sources are the results of the interviews with the patients to start a discussion.

4.4. DATA ANALYSES

This sub-chapter describes the analysis that are carried out for the research. This research only consists an analyses for qualitative data.

Analyzing qualitative data

This qualitative data is non-standardized data and needs to be categorized. After all 32 interviews the data is transcribed by full transcriptions analyses and later on the data will be coded. The inductive approach is used, this means that there is done first open coding and hereafter axial coding and selective coding. Finally, all the interviews will be recorded and all interviews are anonymous related to privacy of the patients and hospitals. For the total of 32 transcriptions of the interviews and recordings, the researcher refers to the additional hard copy document (USB-stick). This also applies for the open coding of the interviews and the codebook can be found in appendix four.

In addition the data from the workshop will be analyzed by a lay out of the workshop, which consist of an agenda, a PowerPoint presentation and records of the workshop, which can be found in appendix five. In addition, the workshop will be recorded on videotape with sound, which can be found on the additional hard copy document (USB-stick). Finally, at the end of the workshop the reliability and validity will be ensured by making a summary of what the FREM managers can do to improve the hospitality experience in deliberation with the managers. The used sources are the results of the interviews with the patients to start a discussion.

5. RESULTS

In this chapter, the research questions will be answered. This research is focused on three dimensions within hospitality, based on the managing service experience clues model of (Berry, Wall, & Carbone, 2006) and the Servicescape model of (Bitner, 1992). Qualitative research is used to get the data to answer the research questions.

5.1. EXPECTATIONS AND EXPERIENCES OF THE CHRONICAL PATIENTS

This sub-chapter will answer the research question: *“What are the expectations and experiences of the chronic patients regarding hospitality in a general ward?”*

This subchapter will describe the expectations and experiences of the three dimensions for each hospital and therefore we can see the differences and the similarities between the hospitals. The results are based on the data generated by the semi-structured interviews and the group interviews. The interview guide can be found in appendix two, the codebook in appendix four and the total 32 transcripts and recordings (with open coding) can be found on the additional hard copy document (USB-stick).

Expectations

The following table 5.1.1. illustrates the expectations from each hospital, which shows the differences and similarities between the hospitals.

Table 5.1.1. Expectations of the four hospitals

	Gelre	Zgt	Slingeland	Tergooi
Service	Offer service, such as preparing the food	Service, such as preparing and cutting the food and be able to explain what it is	Preparing the food for patients, who cannot do this by themselves	Service, such as preparing the food an able to explain what it is
Behaviour	Friendly and hospitable, but also have knowledge about the nutrition.	Friendly and caring	Friendly and hospitable towards patients and helpful	Customer friendly and helpful
Environment	Innovative with a homely atmosphere and big rooms for privacy	Cozy and have enough space for privacy	Cheerful and enough space for privacy	Cozy with colour, enough space for privacy and day activities

Out of the table can be concluded that all patients from the four different hospitals have the same expectations for service, namely every patient expects that the service consists of preparing the food for the patients, who cannot do this by themselves and can explain what it is.

In addition, all patients have the same expectations for behaviour, namely that the nutrition staff is friendly and hospitable towards the patients.

Finally, there is a difference in what the patients expect from the environment. In general they expect a general ward and patient room, which is big enough and gives the patient enough privacy. In addition, they expect a cozy room but only at Tergooi they expect activities during the day, to keep them occupied.

Experiences

The following table 5.1.2. illustrates the experiences from each hospital splitt up in positive and negative experience, which shows the differences and similarities between the hospitals. Within the table there is shown more a total overview and within appendix three, a whole description of each hospital can be found.

Table 5.1.2. Experiences of the four hospitals

	Gelre	Zgt	Slingeland	Tergooi
Service	<p>P: Extensive assortment with variety, dietary needs and times of the meals to early</p> <p>N: More snacks and different meats, food bland, cannot choose portions</p>	<p>P: Snacks, dietary needs, times of the meals</p> <p>N: Variety, food bland and assortment a bit monotonous and a few choices and cannot choose portions</p>	<p>P: Extensive assortment, quality, dietary needs and choose portions</p> <p>N: Food bland and time of supper to early</p>	<p>P: Assortment, but can be more variety and choose portions</p> <p>N: Food bland, dietary needs not always taken into account, more snacks and times of the meals to early</p>
Behaviour	<p>P: Friendly , welcoming and make a chat with you, motivate patients to eat, knowledge and hygiene</p>	<p>P: Friendly, hospitable, enough knowledge and hygiene</p>	<p>P: Hospitable, knowledge, motivates patients to eat and are really hygienic</p>	<p>P: Friendly and hospitable</p> <p>N: Not everyone hospitable and have knowledge and show more being hygienic</p>
Environment	<p>P: Number of persons depends on disease and green view</p> <p>N: Lack of privacy, bigger rooms, more colour with homely atmosphere, less noise, temperature, television expensive and furniture old and no common room</p>	<p>P: Number of persons depends on disease, green view, temperature and multimedia</p> <p>N: Bigger rooms with bigger sitting areas for privacy, more colour with homely atmosphere, less noise, dim light , no day activities , closet not next to bed and no common room</p>	<p>P: Room arrangement, green view and own refrigerator</p> <p>N: Bigger rooms with bigger sitting area, light too bright, more homely colours, less carts within hallways, no day activities, temperature and power outlet too far away</p>	<p>P: Number of persons depends on disease, room arrangement and green view</p> <p>N: Lack of privacy, bigger rooms, closet and power outlet not next to bed, dim light, more homely colours, less carts within the hallways, less noise, no day activities, setting television yourself and not a own refrigerator</p>

Out of the table, it can be concluded that all patients from the four different hospitals have the same experiences for the service, namely the assortment is extensive, but there can be more choices and variety for people who have a longer stay. In addition, the nutrition is a little bit bland and they should indicate this and give salt by the meals or flavour enhancers. Besides that patients prefer to choose their portions, there have to be some snacks during the day and the time of the supper has to be later. But half of the patients will be satisfied with the current times, if they get a snack in the evening.

But there are also some difference in the experiences for the service, namely at Slingeland there is already enough assortment and snacks during the day, At ZGT there are snacks during the day, but the staff has to ask more often to the patient, if they want a snack. Also the service that visitors can join for dinner for a fee at Gelre is experienced very positive. Finally, there has to be more communication between the nutrition and medical staff within ZGT and Tergooi about the dietary needs, therefore the nutrition can offer more service towards the patients.

In addition, by all hospitals there are none negative experiences around the behaviour. The nutrition staff is in general friendly and hospitable, but also they have enough knowledge. In addition, they have a personal approach and show the patients they are hygienic around the nutrition. Only at Tergooi there are negative experiences around the behaviour, not everyone in the nutrition staff is friendly and hospitable and there has to be some sort of training. The same applies for the knowledge, not every employee has the same knowledge and they have to ensure this with a course about dietary. Also they are not showing that they are hygienic and they have to show this more to the patients.

Besides that, there are some similarities in the experiences in the environment, namely at every hospital the patient rooms were experienced as too small including the sitting area in the patient room. Also patients want a common room for daytime activities. In addition, the single room is for really sick people and the preference for a room for two persons or a room for four persons is depending on the personal wishes and they have to select this on disease. Besides that, all patients think the light is too bright and want to dim the light by themselves and have a preference for a green view. Also they want more colour on the walls with posters for a more homely atmosphere, but they have to take into account the cleaning. Also there is need for a constant temperature by a good air condition system. In addition, patients prefer less noise by setting up the general ward in a square and place the office of the medical staff in the beginning. Finally, there has to be storage for the carts, because there can be no carts in the hallways and the power outlet and closet has to be next to the patient bed.

In addition, there are some difference experiences in the environment, namely the furniture within Tergooi and Gelre has to be replaced and the television is too expensive and should be free. In addition, the closet of the patients has to be next to the patient bed for privacy and the television has to be adjustable within Tergooi and Slingeland. Only at ZGT the temperature was fine and this was the only hospital with multimedia (television, telephone and computer in one), but most people didn't use this, because they brought their own laptop or tablet. Within Slingeland there is a refrigerator in the patient room which was experienced as positive, but the patients within Tergooi where missing this in the patient room. Therefore they can drink more during the day. Finally, at every hospital there was a preference for a single room for really sick people. But Tergooi and ZGT have a preference for a room for two persons and a room for four persons. The room for two persons is not too crowded and the room for four persons is for social contact. And the preferences goes in Gelre to a room for four persons and in Slingeland to a room for two persons

Finally, in the interviews there is been asked if the patients want to give a mark for each dimension, In general the dimensions service and behaviour have an average of an eight and the environment have an average of an seven. Therefore it can be concluded that in the dimension environment there are the most improvement points, to improve the hospitality experience of the chronical patients in the general ward of a regional hospital.

The present research has shown that in general the patients want to see the following aspects in the three dimensions:

Table 5.1.3. Aspects within the three dimensions

Dimension	Aspect
Service	Extensive assortment for longer stay
	Flavour enhancers for supper
	Snacks during the day
	Choice in time of supper
	Choice size of portions
Behaviour	Friendly and hospitable (personal approach)
	Knowledge
Environment	Bigger patient rooms including sitting area
	Common room for daytime activities
	Preference one room for really ill patients and room for two or four persons depends on personal wishes, but select them on disease
	Dim light above the bed
	Green view
	Homely atmosphere within the patient room with colour and posters
	Constant temperature with air condition system
	General ward within a square and medical staff offices at beginning, for less noise
	Storage for carts, which ensures less noise and more space within the hallways
	Power outlet and closet next to the patient bed

The aspects within the table can be linked to underlying needs out of the literature based on previous researches. Initially, those underlying needs will be described and after this it will be linked to the aspects discovered out of the patient interviews.

Several international studies show that patients have three basic emotional needs namely: leaving the domain disease, control and privacy (Indora, 2016). In addition, another previous research shows that the greatest needs of patient in a hospital are 'attention' and 'getting better'. And the healing process can be supported by the basic needs: eating, drinking and sleeping. But providing just the basic needs of patients is no longer enough. People expect personal attention, an experience and customization, or the new need is personalizing a product or service (Conceptional, 2013) Finally, a previous research shows that nowadays the patient is standing more central, which means that hospitals organizing care based on their need. The growing need is flexibility, because the patient is more central and this consists of personal attention (Gooskens, 2015).

Table 5.1.4. presents the underlying needs of the patients based on the aspects, which came forward out of the experiences of the patients.

Table 5.1.4 Underlying needs

Dimension	Experience	Underlying need
Service	Assortment with enough choices and variety for longer stay	Personalizing a product or service
	The supper is a little bit bland	Personalizing a product or service
	Not enough snacks during the day	Personalizing a product or service
	The time of the supper is too early	Flexibility
	Cannot choose portions	Flexibility
Behaviour	The nutrition staff is friendly and hospitable towards the patients.	Personalizing a product or service
	Do (not) have enough knowledge about the nutrition	Control
Environment	Patient rooms including sitting area in the patient room to small	Privacy
	Missing common room for daytime activities	Personalizing a product or service
	Number of persons within the patient's room is too much	Privacy
	Light in the room above the bed is too bright	Control
	Not a nice view	Personalizing a product or service
	The patients rooms are not cozy	Personalizing a product or service
	Most of the time to hot within the building	Control
	Too much noise	Privacy
	Not enough space within the hallways	Control
Power outlet and closet too far away	Control	

Out of the table it can be concluded that the patients want more personalizing of a product or service. This is in relation with the trend that patients are standing more central and hospitals organizing care based on their needs. Hospitals has to respond to this need and take those needs into account in improvements, within the hospitality in the hospital. Finally, the needs flexibility, control and privacy are part of the personalizing product or service (Conceptional, 2013).

5.2. EFFECT OF SERVICE

This sub-chapter will answer the research question: *What is the effect of service on the hospitality experience of chronic patients?"*

This subchapter will describe the effect of service on the hospitality experiences of chronic patients. The results are based on the data generated by interviews and literature.

Service

Out of the interviews it can be concluded that the following aspects (in) directly influence the hospitality experience within the dimension service:

- Extensive assortment for longer stay
- Flavour enhancers for supper
- Snacks during the day
- Choice in time of supper
- Choice in size of portions

Out of the patient interviews it can be concluded that the aspects can be linked with underlying needs of the patient based on literature. The aspects within the dimension service are linked with more personalizing of a product or service and flexibility, which is part of the personalizing product or service.

The results of the interviews are in line with what was written in the literature review in chapter two, which states that the health care is reshaped by the expectations of consumers, which makes the customer-orientated service. The relation between a customer-orientated service culture and patient satisfaction is that it is an environment that meets patient' expectations (Fottler, Ford, Roberts, & Ford, 2000) .

The results and literature show that patients experience something more positive, if a hospital personalizes their products and services, the underlying need. The effect of this underlying need is that service can have a positive effect on the hospitality experience, because with personalizing products and service, the customer-service culture is increasing which improves the patient satisfaction. This patient satisfaction is linked to the hospitality experience, because the foodservice aspects are important elements of the patient's overall perception of the hospitality experience. The more the patient's expectations are met, the more satisfied they seem to be (McLymont, Sharon, & Stell, 2003).

It can be concluded that service plays an important role in patient recovery and foodservice quality is also a large influence on a patient overall hospital stay satisfaction. In addition, patients have need for a customer-orientated service, the personalizing of products and service. The trend in hospital foodservice is the implementation of a service model.

Therefore the effect of service on the hospitality experience of chronic patients is that by the customer-orientated service, the patient satisfaction is improving and this automatically leads to a higher hospitality experience. Hospitals can make the service a customer-orientated service, which ensures an improved hospitality experience and thus generates a positive effect.

5.3. EFFECT OF BEHAVIOUR

This sub-chapter will answer the research question: *What is the effect of behaviour on the hospitality experience of chronic patients?"*

This subchapter will describe the effect of behaviour of the nutrition staff on the hospitality experiences of chronic patients. The results are based on the data generated by interviews and literature.

Behaviour

Out of the interviews it can be concluded that the following aspects (in) directly influence the hospitality experience within the dimension behaviour:

- Friendly and hospitable (personal approach)
- Knowledge

Out of the patient interviews it can be concluded that the aspects can be linked with underlying needs of the patient based on literature. The aspects within the dimension service are linked to more personalizing of a product or service and control, which is part of the personalizing product or service.

The dimension behaviour is an important part within the service towards the patients. Out of the interviews it can be concluded that the behaviour plays a part in the dimension service. Patients indicated during the interviews that if behaviour was not well experienced the service neither. And also in the dimension behaviour, patients expect more than only a friendly attitude, but personal contact and that the nutrition staff has sufficient knowledge. Therefore it can be concluded that the dimension behaviour is related to the dimension service.

In addition, patients expect indeed more and desire that the nutrition staff knows all about the dietary needs of the patients and has enough knowledge about the nutrition. Therefore the behaviour has a strong effect on the hospitality experience of the chronic patients, because for those patients the dietary needs are important.

The results of the interviews are in line with what was written in the literature review in chapter two, which states that good communication is the most important factor within behaviour to improve the overall healthcare quality, between the patient and staff, which can be improved by use of single rooms (Ulrich, Zimring, Quan, Joseph, & Choudhary, 2004). Also staff should behave towards patients in a way that promotes dignity during interaction and behaviour is linked to the patients' satisfaction and has a direct impact on the patient (Baillie, 2007).

Therefore the effect of behaviour on the hospitality experience of chronic patients is that by a hospitable and personal behaviour, the patient satisfaction is improving, which also leads to a higher hospitality experience. Therefore there is a positive effect and the nutrition staff has to show dignity towards the patients, especially to the chronic patients.

5.4. EFFECT OF ENVIRONMENT

This sub-chapter will answer the research question: *What is the effect of the environment on the hospitality experience of chronic patients?"*

This subchapter will describe the effect of the environment on the hospitality experiences of chronic patients. The results are based on the data generated by interviews and literature.

Environment

Out of the interviews it can be concluded that the following aspects (in) directly influence the hospitality experience within the dimension environment:

- Bigger patient rooms including sitting areas
- Common room for daytime activities
- Preference one room for really ill patients and room for two or four persons depends on personal wishes, but select them on disease
- Dim light above the bed
- Green view
- Homely atmosphere within the patient room with colour and posters
- Constant temperature with air condition system
- General ward within a square and medical staff offices at beginning for less noise
- Storage for carts which ensures less noise and more space within the hallways
- Power outlet and closet next to the patient bed

Out of the patient interviews it can be concluded that the aspects can be linked to the underlying needs of the patient based on literature. The aspects within the dimension service are linked to more personalizing of a product or service and control and privacy, which are part of the personalizing product or service.

The results of the interviews are in line with what was written in the literature review in chapter two, which states that the environment plays the most important role within the hospitality experience and can improve patient satisfaction. Also there is need for control and privacy, the underlying needs within the design of the hospital (Brooke, Robson, & Wu, 2013). The effect of those underlying needs is that the

environment can have a positive effect on the hospitality experience, because the design, which gives control and privacy can improve the patient satisfaction, which is linked to the overall healthcare quality and hospitality experience.

It can be concluded that the environment is linked to the overall healthcare quality, which improves the patient satisfaction, because the patient's perception of healthcare outcomes can be influenced by the design of a hospital (Brooke, Robson, & Wu, 2013). This is the reason why some hospitals adopted hotel elements within the design. Besides that, there is the healing environment, which can have a positive effect on the healing process of the patients. Within this design the natural elements, such as daylight, fresh air and quiet are the key elements and the physical environment has different effects on the patients, such as: improve patients' safety, reduces stress and improves patient satisfaction and overall healthcare quality (Fiset, 2006).

To have a positive effect on the hospitality experience, hospitals have to provide most of all single bed rooms, because single rooms have been shown to lower hospital-induced nosocomial infections, reduce room transfers, less noise, improve patient confidentiality and privacy and increase patients' overall satisfaction with health care. But also new hospitals have to reduce noise, which can improve sleep. This can be done by environmental interventions, for example: providing single-bed rooms and installing high-performance sound-absorbing ceilings and by views of nature, develop wayfinding's system, ventilation system (Berg, 2000).

Therefore the effect of the environment on the hospitality experience of chronic patients is that, the design can be improved by adjustments, which improves the patient's satisfaction and the overall healthcare quality and has a positive effect on the hospitality experience.

5.5. IMPROVEMENT POINTS OF THE FREM MANAGERS

This sub-chapter will answer the research question: *What can FREM managers do to improve the hospitality experience of chronic patients?*

This subchapter will describe the improvement points for FREM managers, to improve the hospitality experience of chronic patients on strategical and tactical level. The results are based on the data generated by the workshop, which is on videotape with sound, which can be found on the additional hard copy document (USB-stick). The lay out of the workshop can be found in appendix five, which consists of an agenda, a PowerPoint presentation and records of the workshop.

5.5.1. Service

Out of the workshop it can be concluded that within the dimension service there has to be on strategic level, a hospitality policy. Within this policy there has to be agreements that employees can do something extra for the patients and they can offer more service, but this service can be offered if the top management has hospitality as a priority within the organisation, a service organisation. In addition, the organisation must have good relations with stakeholders, who also want a service organisation and want to show this identity and image to the outside world. Finally, the external parties such as catering and cleaning must have hospitality as a priority, which is a strategic choice to hire an external party with expertise. Therefore if there is a hospitality policy within the organisation, there can be things done on tactical level, to improve the hospitality experience.

The FREM managers take care of the structure of the organisation, the deployment of staff, resource allocation and management of the implementation process with support of the strategical level. Out of the workshop it can be concluded that the FREM managers can offer more service within the nutrition if they present an introduction program to the employees. With this introduction program, employees learn everything they need to know about dietary needs and can advise and explain things about the nutrition. Besides that, FREM managers can do the coordination of the external party, in which they make choices about the assortment, such as variety of the assortment, choice in portions and snacks. FREM managers can recommend an external party. Also the FREM managers have consultation with the top management about the coordination.

In addition, the FREM managers should have a network of ambassadors and coaches, to train the employees and think about which additional service they can offer to the patients. But also for training employees, FREM managers have to create a digital platform with courses. With this courses, the employees can gain knowledge about the nutrition and stay up to date and know their patients. To make this easier for the employees, FREM managers can introduce iPads on the work floor, with the patients' files, to offer the best service. By using the iPads, the employees will be more independent.

Furthermore, FREM managers can stimulate employees by working together, like one team around the patient. Also the FREM managers must make the functional support in all departments the same and all the employees have to report to the manager of the department, which reports back to the FREM manager. With this functional support there is a policy which can make sure that hospitality is the same in every department.

But also FREM managers have to make agreements for who to hire for the nutrition within the organisation, for example those people must have an education within service and the right skills. Those people need to understand the hospitality vision of the organisation and must possess the skills to show this to the patients.

Finally, the complaints system must be good, if there are any complaints the FREM managers have to check them and communicate those complaints to the managers of the departments and make a difference for the patients. Finally, FREM managers can do a mystery visit to look which services other hospitals provide to patients or in the organisation itself to give the employees feedback.

Improvement points

It can be concluded that FREM managers have improvement points for the hospitality experience of chronic patients on strategic and tactical level within the dimension service and table 5.5.1.1. summaries those improvement points.

Table 5.5.1.1. Improvement point FREM managers for service dimension

Level	Strategic
Improvement points	Hospitality policy
	Choice to hire external party
Level	Tactical
Improvement points	Making introduction program for employees
	Coordinate external party
	Doing consultation with top management
	Network with ambassadors and coaches
	Making a digital platform
	Taking care of implementation iPad's with patient file
	Stimulate employees
	Functional support the same in all departments
	Making agreements for hiring staff
	Taking care of a good complaints system
	Doing mystery visits

5.5.2. Behaviour

Out of the workshop it can be concluded that within the dimension behaviour there have to be on strategic level, a hospitality policy. With this policy, the organisation has hospitality as a priority and FREM managers can improve the hospitality experience. In addition, the organisation has to have a hospitality vision, to let employees behave hospitable towards the patients.

Hospitality is a behaviour of someone and come naturally and cannot be taught, but it can be stimulated. Within the hiring of new staff, this has to be taken into account. To stimulate this there has to be an example within the organisation for the employees, the FREM manager. The FREM managers have to show to the

employees that everyone can give their own personal twist in their behaviour towards the patients. For example that there is in every work hour, time to chat with the patient, give them attention and make them feel special. The most important thing is that employees listen to the patient and make use of this information, to be more hospitable, but also provide a better service. Therefore employees have to keep in mind that hospitality costs nothing, but is complicated and the goal is to exceed expectations of the patients.

In addition, the FREM managers have to make surveys for the patients, therefore the organisation will know what the patients want and with this information they can respond to the needs. Besides that, the FREM managers should do also a mystery visit for the dimension behaviour, by other hospitals and by the organisation itself to give the employees feedback.

The planning will be the responsibility of the manager of the department, but the FREM managers have to make some agreements about this with those managers. The managers must try to make work schedules in which the employees work some days in a row, therefore patient see the same person instead of every day someone new.

Finally, the FREM managers have to look in which way hotels show hospitality towards guests and see how they can implement this in the hospital. They have to organize trainings in hotels for the employees about hospitality.

Improvement points

It can be concluded that FREM managers have improvement points for the hospitality experience of chronic patients on strategical and tactical level within the dimension behaviour and table 5.5.2.1. summaries those improvement points.

Table 5.5.2.1. Improvement point FREM managers for behaviour dimension

Level	Strategic
Improvement points	Hospitality policy
	Hospitality vision
Level	Tactical
Improvement points	Making hospitality criteria for hiring staff
	Being a good example for employees
	Making survey's for patients
	Doing mystery visits
	Making agreements for planning
	Taking care of giving trainings

5.5.3. Environment

Out of the workshop it can be concluded that within the dimension environment there has to be also on strategical level, a hospitality policy. With this policy, the organisation has hospitality as a priority and FREM managers can improve the hospitality experience. In addition, the organisation has to operate from a strategic vision on care development in combination with target patient perspective and design, build and setting up the environment from this perspective.

To design, build and setting up the environment from this perspective, the FREM managers have a target group policy and have to be more aware of this group policy. To do this, they have to listen to the patients and do surveys to make visible, what patients want in the design of a patient room. Many aspects what patients want are clear to the FREM managers, for example patients have a need for a common room which provides day activities within the general ward. This room can be also used for rest and meeting. But also, no more carts in the hallways and the most important one, create more space in the patient room, because patients have a need for privacy. The FREM managers have to implement those aspects, this can be implemented in an existing environment or a new environment, which occurs if there is new construction. By building a new hospital, FREM managers have to see the construction plans of other hospitals, to come up with new ideas, but also let employees give their opinions about the design of the new environment.

Finally, the most important improvement point is that FREM managers have to take into account the healing environment in existing and new hospitals. This healing environment is a trend within the health care and supports the healing process. Within an existing hospital the FREM managers have to look what can be implemented and for a new hospital, there can be done research.

Improvement points

It can be concluded that FREM managers have improvement points for the hospitality experience of chronic patients on strategical and tactical level within the dimension environment and table 5.5.3.1. summaries those improvement points.

Table 5.5.3.1. Improvement point FREM managers for behaviour environment

Level	Strategic
Improvement points	Hospitality policy
	Strategic vision on care developments in combination with patient perspective
Level	Tactical
Improvement points	Making employees being more aware of the target group policy
	Making surveys for designing the environment
	Implement aspects within environment, which positively influence the hospitality experience
	Talk with employees, to gain new ideas
	Implement aspects of the healing environment

It can be concluded that FREM managers have improvement points for the hospitality experience of chronic patients on strategical and tactical level. Those improvement points are linked with the aspects on operational level, the aspects the patients want to see in the future, based on the interviews. Because with this link, there can be seen what has to be done to implement the aspects on operational level and table 5.5.3.2. summaries this.

Table 5.5.3.2. Aspects on strategic, tactical and operational level linked with each other.

Level	Operational	Tactical	Strategical
Service	Extensive assortment	Coordination external party	Strategic choice to hire external party
	Flavour enhancers	Stimulates employees	Hospitality policy
	Snacks	Coordination external party	Strategic choice to hire external party
	Choice in time of supper	Coordination external party	Strategic choice to hire external party
	Choice size of portions	Coordination external party	Strategic choice to hire external party
Behaviour	Friendly and hospitable	Hiring staff & Example	Hospitality vision
	Knowledge	Training	Hospitality policy
Environment	Bigger patient rooms including sitting area	Implement aspects within environment	Strategic vision
	Common room for daytime activities	Implement aspects within environment	Strategic vision
	Select numbers of persons within room on disease	Implement aspects within environment	Strategic vision
	Dim light	Implement aspects within environment	Strategic vision
	Green view	Implement aspects within environment	Strategic vision
	Homely atmosphere	Implement aspects within environment	Strategic vision
	Constant temperature	Implement aspects within environment	Strategic vision
	General ward within a square	Implement aspects within environment	Strategic vision
	Storage for carts	Implement aspects within environment	Strategic vision
	Power outlet and closet next to the patient	Implement aspects within environment	Strategic vision

Out of the table it can be concluded that on strategical level, hospitality has to be a priority within the organisation. Otherwise the FREM managers cannot do much to improve the hospitality experience . If hospitality has a prioity the FREM managers can implement the aspects on operational level with tasks on tactical level. Out of the table it can be concluded, which task the FREM manager has to do, to implement te aspects on operational level.

6. DISCUSSION

This chapter describes the discussion of the validity, reliability, and limitations of the research.

6.1. VALIDITY

Validity says something about the contents, what is measured is the intention in the research and is focused on preventing statistical mistakes (Verhoeven , 2011). To ensure this the results of the interviews were a starting point for the discussion within the workshop. And in order to prevent any misunderstandings, the definitions are operationalized during the proposal, as interpreted during the research and this ensures that the construct is valid. Also by the triangulated design the information obtained from the interviews are checked and the input from the interviews is applied in practice by doing group interviews with a new group of patients.

The method that is used for qualitative method is interviews. The limitation for the interview is purposive sampling, which consist of four regional hospitals focused on a general ward and is decreasing the external validity. In addition, the results are content generalizable for the regional hospitals within the Netherlands (Verhoeven , 2011). This because the patients are in general the same, only an important footnote is that hospitals can be different in region, for example, in Amsterdam the people are different and there has to be taken into account that some patients there have different needs. This has to do with the discrimination validity, because factors as region and cultural background of the respondents can influence the results and this is the reason why there has been chosen for the same region. But to increase the external validity of this research, the interviews were held on the same day and at the same time, namely: in the morning four semi-structured interviews and in the afternoon four group interviews. The interviews were held in the patient rooms of the hospitals. In addition, the results are not generalizable for all ages, but only for the chronic patients above 50 and can be only content generalizable for the general wards and not specific for one department (Verhoeven , 2011).

Furthermore the results are valuable for the literature about hospitals, due to less academic research about the three dimensions within the hospitals focusing on nutrition, nutrition staff behaviour and the lay out of the general ward and the patient room. Finally, in order to identify what needed to be measured, an interview guide was developed, which can be found in appendix two. This interview guide was developed after making an operationalization schedule, which can be found in appendix one. The three dimensions of hospitality are the focus of the interview guide (Saunders & Lewis, 2012).

6.2. RELIABILITY

Reliability has to do with the stability of the research result, this means that if the research will be conducted, the same results have to emerge. Therefore it includes a description of the way in which random mistakes are avoided (Verhoeven , 2011). With qualitative research, it is often difficult to achieve high reliability (Saunders & Lewis, 2012). To increase the reliability of this research study, the triangulation design was used. Data was collected using three different methods, namely: qualitative research, desk research and a workshop. In terms of qualitative research, there are conducted 32 patient interviews, which are made by using an operationalization schedule for the interview guide. This interview guide was used during interviews to ask questions and the semi-structured interviews give the possibility to ask further into the matter than by using predetermined questions. It presented the possibility to get a thorough insight into the topic.

In terms of desk research, data was collected by using literature review, by using only reliable sources, which are named according to the APA method in the references. The sources are selected accurately, by only selecting books and (scientific) journals.

The four participating hospitals were chosen on region, because they have to be situated in the same region in order to compare them with each other. The patients were selected on the facts that they have been staying in the hospital for recovery and that they have to be 50+. The influence on the results were that there was an expectation gap. Patients above 60+ expect less than patients between 50 and 60. The

researcher thinks this has to do in which generation the patients grow up. It would have been better to choose patients above 60, to get a more reliable research.

6.3. LIMITATIONS

This research is focused on three dimensions within the hospitality experience of chronic patients. Although, literature shows that the perception exists of also the medical side. Therefore, for a complete impression, this medical side should be researched as well. But it was not possible to research the medical side as well, due to lack of time and the complexity. In addition, literature states that private clinics provide the best service and that there are differences in countries, but this is left out of the research, due to the difficulty with researching it in patient interviews within the Netherlands.

In addition, the questions in the interviews were not completely clear for all patients. The questions should have been easier for the patients, therefore the patients understood them better. Due to the fact that the patients were sick and needed support in what way they have to think. But this was difficult, because the researcher didn't want to point out a direction for the patient.

The limitation for the interviews is that there were only 32 interviews, which means a total of eight patients at each hospital. This means that not every patient of the selected hospitals is involved, but the validity increased with the workshop, due to the FREM-managers.

Besides that, it was hard to find four participating hospitals, because of the privacy of the patients. This is the reason why the interview cannot take too long, because the patients were sick and have to rest. Finally, another limitation is the focus of the research, the chronic patients above 50+. As mentioned before this has to be 60+.

7. CONCLUSION

This chapter will answer the main research question 'What aspects in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals?'. The conclusion is based on the results of the sub-questions.

According to several authors, such as Bunner-Sperdin and Peters (2009), Ogorman (2010) and Hokkeling and Mar (2012), hospitality can be defined as an interpersonal exchange, in which the host wants to give the best experience, whereby the physical, spiritual, emotional and social well-being of the patient is paramount. Hospitality is focused on service provision, but also on the experience with which it is delivered to the user. The importance of hospitality lies in the upcoming competition between hospitals and hospitals have to deliver a good experience. Other trends and developments, like the financial system of hospitals, day-care admissions, vacancy of hospitals and the increasing number of chronic patients contribute to the importance of hospitality as well.

Experience plays a major role in hospitality and every patient has his own positive and negative experiences. But also the expectations of people play a role, patients expect something and can experience this quicker negative than positive. With the similarities within the expectations and experiences of the 32 patients' interviews, there can something to be said about, what are the experiences and expectations of the patients, which shows the aspects they want to see in the future.

Based on the results of the semi-structured and group interviews with the 32 patients, it can be concluded that within the service dimension there have to be the following aspects: extensive assortment, flavour enhancers, snacks during the day, choice in time of supper, choice in size of portions. In addition, within the behaviour dimension there have to be the following aspects: friendly and hospitable behavior (personal approach) and knowledge. Finally, within the environment dimension there have to be the following aspects: bigger patients room including sitting areas, common room for daytime activities, number of persons within room depends on disease, dim light, green view, homely atmosphere with colours and posters, constant temperature, general ward in a square, storage for arts and power outlet and closet next to the patient bed.

In addition, it can be concluded that patients have some underlying needs based on the aspects, namely: personalizing of a product or service, flexibility, control and privacy. Patients want more personalizing of a product or service, which is in relation with the trend that patients are standing more central and hospitals organizing care based on their needs. Hospitals have to respond to this needs and take those needs into account in improvements within the hospitality in the hospital. Finally, the needs flexibility, control and privacy are part of the personalizing product or service.

The research supports the literature about the effect of service on the hospitality experience of chronic patients, which is that by the customer-orientated service, the patient satisfaction is improving and this automatically leads to a higher hospitality experience. In addition, the research supports the effect of behaviour on the hospitality experience of chronic patients, which is that by a hospitable and personal behaviour, the patient satisfaction is improving, which also leads to a higher hospitality experience. Finally, the research supports the literature about the effect of environment on the hospitality experience of chronic patients, which is that the design can be improved by adjustments, which improves the patient's satisfaction and the overall healthcare quality. Therefore the results show that all dimensions have an effect on the patient satisfaction, which lead to a higher hospitality experience within the hospital, because it is related to the overall healthcare quality.

Based on the results of the workshop, it is shown what FREM managers can do to improve the hospitality experiences of chronic patients. It can be concluded that the FREM managers need aspects on strategical level, to do tasks on tactical level, which makes it possible to implements aspects on operational level. Within the service dimension there has to be on strategical level a hospitality policy, which makes it possible that there is an external party. On tactical level, this external party will be coordinated by a FREM manager, which has consultation with the top management about this. In addition, the FREM manager has to make an introduction program for employees, network with ambassadors and coaches, taking care of a digital

platform with trainings for the employees, taking care of implementation iPad's with patient file, stimulate employees. functional support in all departments the same, making agreements for hiring staff, taking care of a good complaints system and doing mystery visits to come up with ideas for a new or better service towards the patient and give feedback to the employees.

Within the behaviour dimension there has to be on strategical level a hospitality vision which makes it possible that the FREM manager can be an example for the employees in the terms of hospitable behaviour. In addition, the FREM manager has to make hospitality criteria for hiring staff, making surveys for patients, doing mystery visits, making agreements for planning and taking care of giving trainings to employees.

Within the environment dimension there has to be on strategical level a strategic vision on care developments in combination with patient perspective, which makes it possible that the aspects the patients want to see in the future in the patient room can be implemented. In addition, the FREM manager has to be more aware of the target policy, which the FREM manger can do with a survey with the patients about what they want to see in the environment. But also talk to employees about what to implement in the environment.

Out of the results it can be concluded that the aspects which (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals for service are: assortment, snacks, flavour enhancers, time and portions. The aspects for behaviour are: kindness, hospitable and knowledge. Finally, the aspects for environment are: space, common room, noise, privacy, natural elements and homely atmosphere.

Moreover, as mentioned before the literature, where the research is based on is mostly related to the nutrition and physical environment. The results of research focused on the three dimensions. Although, literature shows that the perception exists of also the medical side. Therefore, for a complete impression, this medical side should be researched as well. But it was not possible to research the medical side as well, due to lack of time and the complexity.

The results are aspects which hospitals can implement within the hospital to positively influence the hospitality experience of chronic patients within a general ward. But there has to be also looked at different departments for example the department neurology. Out of the interviews surfaced that patients on the neurology department have a need for certain colourways to recognize the department. This is a starting point to research how not only a general ward has to look but also how different departments have to look, because patients with a specific disease have other expectations and experiences than a 'normal' chronic patient.

Finally, the relation with the conceptual model is that this model shows the order of the research and shows that the hospitality experience of the patients can be improved. This model can be used in further research to help understand the hospitality experience from patients and the expectations they have, for example which additional needs, patients have with other diseases.

8. RECOMMENDATIONS

This chapter includes the recommendations based on the results and conclusions of this research for regional hospitals within the Netherlands and for the four regional hospitals involved in this research. Finally, it includes recommendations for further research. The recommendations are distinguished in practical, social and theoretical recommendations.

Practical recommendations for regional hospitals within the Netherlands:

Competition is going to play a role in the healthcare industry and this makes it for hospitals necessary to distinguish themselves. Therefore the experience is becoming more important and patients expect that the environment of the hospital positively influence the healing process and hospitality experience. The results made clear that it is possible to create such hospitals, by combining the positive and negative experiences and translate them to aspects, which ensures an improved hospitality experiences of the patients. But also patients want that hospitals personalize product or service within the hospitals.

According to literature, the environment of a hospital which can positively influence the healing process, is the healing environment. Therefore it is recommend to create a healing environment, which is the design of a building, the physical aspects, which creates a pleasant and sustainable environment. This healing environment has proven to have a positive effect on health and well-being, gives a hospitable atmosphere and also supports the needs of patients, families and staff. Therefore further research is needed about trends and developments within the healing environment or other trends and developments which positive influence the hospitality experience of patients.

Social recommendations for regional hospitals within the Netherlands;

The results show in combination with the literature that the healing process can be positively influenced by the physical environment. Improving the hospitality experience is related to this and patients want that hospitals personalize products and services. This can support the healing process and therefore it is recommended to research more thoroughly the influence of the medical side on the physical environment. This because this research is not focused on the medical side and this has the most influence on the healing process.

Also it is recommended to research more thoroughly to what extent the physical environment influences the healing process. And what the role of the social elements plays in this, for example the role of the behaviour of the medical staff, this can be done by asking opinions of patients.

Theoretical recommendations for the four regional hospitals involved within the research;

The results show that the four hospitals have to implement the aspects which were missing based on the positive and negative experiences of the patients. Those aspects for each hospital can be found in appendix three, where a whole description can be found what the patients want to see in the future.

In addition, those four hospitals can implement the improvement points for the FREM managers, to make it possible to implement the aspects on operational level, the aspects out of the patient interviews. Therefore with those implementations, the four hospitals positively influence the hospitality experience of the chronic patients within a general ward.

Theoretical recommendations;

Further research is recommended, there has to be also looked at different departments for example the department neurology. Out of the interviews came forward that patients on the neurology department have a need for certain colourways to recognize the department. This is a starting point to research how not only a general ward has to look but also how different departments have to look, because patients with a specific disease have other expectations and experiences than a 'normal' chronic patient.

Finally, more research is needed regarding the influence of the medical side within the three dimensions on the hospitality experience of the patients. Therefore, it is recommended to research this further and especially to research the relation between the FREM side and the medical side within hospitals.

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APPENDICES

In the appendices the operationalization schedule, the interview guide, the description of experiences of each hospital, the codebook and lay out of the workshop (agenda, PowerPoint presentation and records) can be found. For the total of 32 transcriptions of the interviews and recordings, the researcher refers to the additional hard copy document (USB-stick). This also applies for the open coding of the interviews and the video recording with sound of the workshop.

APPENDIX ONE: OPERATIONALIZATION SCHEDULE INTERVIEWS

This operationalization schedule is for the following sub question of the master thesis:

What are the **experiences** and **expectations** of the chronic patients regarding **hospitality** in a general ward?

KEYWORDS OF SUB QUESTION

The following are the key words of this sub question:

- Hospitality
- Experiences
- Expectations

OPERATIONALIZATION

Hospitality can be defined into three elements namely: service, behaviour and environment, which is based on literature. Those three elements will only focus on a particular element within the research, which is mentioned in the table below. Also the topics which comes out of those elements, which can be used for the interview questions.

Table 1.1. Operationalization schedule

Elements	Particular elements	Topic for interview questions
Service	<i>Nutrition</i>	Quality (taste, smell and presentation)
		Assortment
		Portions
		Dietary needs
		Time of the meals
Behaviour	<i>Behaviour of the nutrition staff</i>	Kindness
		Knowledge
		Hygiene
Environment	<i>Ward and room layout</i>	Drafting and distribution
		Light
		Colour
		Temperature
		Noise
		View of the rooms
		Interior
		Comfort

For the expectations there can be asked a few general questions to find out the expectations, which can be used for every element, namely:

- Which nutrition service/behavioural norms/ environmental aspects would you like to see in the ward and patient room?
- What do you expect from the ward and patient room in the words of hospitality within the nutrition service/behaviour of the nutrition staff/ward and room layout?

For the experiences there will be asked to the patients how they think and feel about the topics for the interview questions. Finally, there are a few general questions to find out the experiences of the patients, which can be used for every element, namely:

- What are your experiences with; the nutrition service/behaviour of the nutrition staff/ward and room layout?
- What rating would you give the nutrition/behaviour of the nutrition staff/ward and room layout?

APPENDIX TWO: INTERVIEW GUIDE PATIENT INTERVIEWS

Het thema gastvrijheid is opgedeeld in de volgende elementen: service (alleen gericht op de voeding), gedrag (van het voedings personeel) en omgeving (afdeling en kamer lay out). Voor elk element zal gevraagd worden naar de huidige situatie (de positieve en negatieve ervaringen van de patiënt) en naar de gewenste situatie (de verwachtingen voor de toekomst, op basis van de ervaringen).

Chronische ziekte:

Interviewer: Nicole Lamfers

Locatie:

Datum:

Service

Huidige situatie

1. Wat vindt u van het assortiment van de voeding (Ook tussendoortjes)? Kunt u dit toelichten?
2. Wat vindt u van de kwaliteit (smaak, geur, presentatie) van het eten? Kunt u dit toelichten?
3. Wat vindt u van de porties van de maaltijden? Kunt u dit toelichten?
4. Wat vindt u van de manier waarop er rekening wordt gehouden met dieetwensen? Kunt u dit toelichten?
5. Wat vindt u van de tijdstippen waarop de maaltijden geserveerd worden? Kunt u dit toelichten?
6. Wat zijn uw ervaringen omtrent de service (voorzieningen) van de voeding?
7. Welk cijfer zou u geven omtrent de service van de voeding?

Gewenste situatie

8. Welke verbeteringen in de service van de voeding zou u graag willen terugzien op de patiënt kamer?
9. Wat verwacht u van de zorgassistent/voedingassistent/medewerker gastenservice die u de maaltijd bezorgt? Is dit in lijn met de verwachting die u vooraf had? Zo nee, kunt u aangeven hoe dat verschil is ontstaan?

Gedrag

Huidige situatie

1. Wat vindt u van de zorgassistent/voedingassistent/medewerker gastenservice in het opzicht van vriendelijkheid en gastvrijheid? Kunt u dit toelichten?
2. Wat vindt u van de kennis van de zorgassistent/voedingassistent/medewerker gastenservice? Kunt u dit toelichten?
3. Wat vindt u van de omgang met betrekking tot de hygiëne van de zorgassistent/voedingassistent/medewerker gastenservice? Kunt u dit toelichten?
4. Wat zijn uw ervaringen omtrent het gedrag van de zorgassistent/voedingassistent/medewerker gastenservice?
5. Welk cijfer zou u geven omtrent het gedrag van de zorgassistent/voedingassistent/medewerker gastenservice?

Gewenste situatie

6. Welke verbeteringen in het gedrag van de zorgassistent/voedingassistent/medewerker gastenservice zou u graag willen terugzien op de patiënt kamer?
7. Wat verwacht u van het gedrag van de zorgassistent/voedingassistent/medewerker gastenservice? Is dit in lijn met de verwachting die u vooraf had? Zo nee, kunt u aangeven hoe dat verschil is ontstaan?

Omgeving

Huidige situatie

1. Wat vindt u van het aantal personen per kamer? Wat heeft u voorkeur en kunt u dit toelichten?
2. Hoe beoordeelt u de wijze waarop de bedden op de kamers zijn opgesteld? Wat heeft u voorkeur en kunt u dit toelichten?

3. Wat vindt u van het licht op de kamers en afdeling? Heeft u hier een voorkeur voor en kunt u dit toelichten?
4. Wat vindt u van de kleur op de kamers en afdeling? Heeft u hier een voorkeur voor en kunt u dit toelichten?
5. Wat vindt u van de temperatuur op de kamers en afdeling? Heeft u hier een voorkeur voor en kunt u dit toelichten?
6. Wat vindt u van de omgevingsgeluiden op de kamers en afdeling? Heeft u hier een voorkeur voor en kunt u dit toelichten?
7. Wat vindt u van het uitzicht van de kamers? Heeft u hier een voorkeur voor en kunt u dit toelichten?
8. Vindt u dat de omgeving (het interieur en opstelling) bijdraagt aan de comfort van uw opname en wat mist u hierin? Kunt u dit toelichten?
9. Wat zijn uw ervaringen omtrent de afdeling en kamer opstelling?
10. Welk cijfer zou u geven omtrent de omgeving van de afdeling en de kamer opstelling?

Gewenste situatie

11. Welke verbeteringen in de omgevings aspecten zou u graag willen terug zien op de patiënt kamer?
12. Wat verwacht u van de omgeving van de patiënt kamer? Is dit in lijn met de verwachting die u vooraf had? Zo nee, kunt u aangeven hoe dat verschil is ontstaan?

APPENDIX THREE: DESCRIPTION OF EXPERIENCES OF EACH HOSPITAL

In this appendix there can be found the description of the experiences of the patients of each hospital, which describes what the patients want to see in the future at each hospital.

Gelre

The interviews make it clear that in general the assortment is extensive enough with a lot of variety. Only one negative experience with the assortment is that there are only four different meats for on bread. The patients want also more snacks during the day, for example soup with the lunch. In general the food tastes good only a bit bland, because it is low salt. A negative experience is that patients cannot choose the portions of their meal, but there is a possibility for a smaller portion, but then you have less options. In addition, dietary needs are always taken into account and for each diet there is a special menu. Furthermore there are mixed feelings about the times when the supper is reserved, because half of the people think it is too early and the other half is fine with it, because you're in a hospital. There is a solution for this, because if the time stays the same, those patients want a snack in the evening. Therefore in general, the service is experienced as good and thus positive.

For the behaviour, the nutrition staff is always friendly and welcoming and always make a chat with you. In addition, they motivate you to eat and they know what a patient can and cannot eat. Besides that, the patients experience the hygiene around the nutrition as positive. Therefore in general, the behaviour is experienced as friendly and alert and thus positive.

Finally, the number of persons per room is positive experienced, but the preference goes out to a single room, if you are really sick. The choice between a room for two persons or for four persons depends on the personal wishes. But in general the preference goes to a room for four persons. The room arrangement is fine, but patients experience this negative by a lack of privacy, the rooms have to be bigger. In addition, the colour of the general ward and patient room is also experienced negative, because there is little colour and this has to be more, to give the patient a boost by a more homely atmosphere. Furthermore there is a lot of noise, which is experienced negative. The view is experienced positive, but this is different per room and the preference goes to a green view. Besides that the temperature is experienced negative, because most of the time this is too hot. Finally, the television is expensive and should be for free and the mattresses and furniture in the room need to be replaced. Therefore in general, the environment is experienced as not spacious enough and patients want a common room. Within the common room patients can eat together with visitors, because they offer the service that visitors can eat also in the hospital for a fee and thus more negative than positive.

ZGT

The interviews make it clear that in general the assortment is good, only a bit monotonous and a few choices and variety in the supper, if you have a long stay in the hospital. In general the food tastes good only a bit bland, it will be a good idea to give salt by the meal, only exception the heart patients. In addition, patients can get snacks during the day, but they have to ask for this. A negative experience is that patients cannot choose the portions of their meal. In addition, dietary needs are always taken into account and for each diet there is a menu and they prepare the food, if people cannot do this by themselves. The times when the supper is reserved is a little bit early in the evening, but this cannot be delayed because visiting hour starts at half past six. Therefore in general, the service is experienced as good and thus positive.

For the behaviour, the nutrition staff is always friendly and hospitable, but also they have enough knowledge about the nutrition. Patients can ask them anything about the nutrition and they give explanation if needed. Besides that, the patients experience the hygiene around the nutrition as positive, because the nutrition staff shows they disinfect the hands after serving every patient and wear gloves. Therefore in general, the behaviour is experienced as hospitable and thus positive.

Finally, the patients have experienced the number of persons per room as positive, but the preference goes to a single room for really sick people. And there are mixed feelings about a room for two persons or a room for four persons, this depends on personal wishes (because not all people want social contact). But the room arrangement within a room for two persons is more positive experienced than a room for four persons, because in a room for two persons you lay next to each other. But a negative experience around the room

arrangement is that the patient rooms have to be bigger, therefore patients have more privacy. This also applies for the sitting area in the patient room. In addition, the colour of the general ward and patient room is also experienced negative, because there is little colour and this has to be more, for a more cozy and homely room. They can do this for example with posters or paintings on the wall. Furthermore there is a lot of noise, which is experienced negative and it will be more logical to place the office of the medical staff far away of the patient rooms. Than the department will be more clear if it is set up in a square. The light in the room is experienced fine, but it would be nice if patients could dim the light, if they want to read something in the night, when they cannot sleep. Furthermore the temperature and view is positively experienced and the preference goes to a green view. Finally, the multimedia is positively experienced, but not many patients make use of it, because they have their own laptop or tablet with them. And some patients experience their day negative, because there were no activities during the day and the patients want their closet next to the bed. Therefore in general, the environment is experienced as not spacious enough and patients want a common room and thus more negative than positive.

Slingeland

The interviews make it clear that in general the assortment is positively experienced, because it is very extensive with a lot of different snacks. In addition, the quality of the food was good, it tastes and looks fine, but the food is a little bit bland. Better they say that the nutrition in a hospital is low salt and give salt or flavour enhancers. Dietary needs are always taken into account and are on the list of the patients. For example they know what a diabetic can and cannot eat and they motivate patients to eat and drink more during the day. But also prepare the food, if people cannot do this by themselves. The patients can choose their own portions and this is experienced as positive, for example if people are nauseous, they want a smaller portion, because otherwise it will be thrown away. The only negative experience is the times supper is reserved, it is a little bit early, but most people are fine with it, because in the evening they get a snack. Therefore in general, the service is experienced as good and thus positive.

For the behaviour, the nutrition staff is very hospitable and friendly and show that they have very much knowledge and they have a list from the medical staff which states what a patient can and cannot eat. Besides that they really motivate the people to eat in order to strengthen and give explanation. There are also really hygienic and on every bed there is a pump to disinfect hands and they are doing this at each patient before they prepare the food. Therefore in general, the behaviour is experienced as hospitable and thus positive.

Finally, within Slingeland the number of persons is positively experienced, but the preference goes to a room for two persons, because this is not too crowded and patients have social contact. The room arrangement of the general ward is negatively experienced, because it is not uncluttered and the general ward can be better set up in a square. Within this arrangement the office of the medical staff and kitchen have to be in the beginning, therefore the patients hear less noise. Besides that, patients experience the rooms as not spacious enough, the same applies for the sitting area in the patient room.

In addition, patients experience the light above the beds, as too bright and prefer to dim this by themselves. Also the colour of the rooms are very basic and were experienced negative. If a patient has a long stay, they prefer more homely colours, which makes the room cozy and homely with for example posters. In the hallways there are many carts, which produces a lot of noise and nuisance and have to be in a storage. Also patients' miss activities during the day. There is need for multimedia, which you can set yourself, because now the television is hanging not well. The views are experienced as positive, because most of the time there is a green view. The temperature is experienced as negative, because most of the time it is too hot and there no a good air conditioning system. Also many patients have a smartphone and want to charge this, but the power outlet is too far away for the wire. And the own refrigerator in the patient room was positively experienced, because the patient can drink every moment of the day. Therefore in general, the environment is experienced as too small and patients want a common room, for daytime activities and thus more negative than positive.

Tergooi

The interviews make it clear that in general the assortment is good, only a bit monotonous and a few choices and variety in the supper, if you have a long stay in the hospital. In addition, the food tastes good, only a bit

bland. A negative experience was that dietary needs are taken into account on the list of the patient, but there can be more communication between the nutrition and medical staff on what a patient can and cannot eat. Because sometimes they have to ask the medical staff a couple of times for which patient they have to prepare the food. Besides that the patients can choose their own portions and this is experienced as positive, but they don't get snacks during the day and experience this as negative and there is a need for this. The times when the supper is reserved were negative experienced, because it is too early and in the evening they get hungry and want a snack. If they get a snack, more people will be satisfied with the time of the supper. Therefore in general, the service is experienced as good and thus positive.

With regard to the behaviour, the nutrition staff is friendly and hospitable, but not every employee of the nutrition staff and this is experienced negative. The staff has to get a training for example, to ensure that every employee has the same hospitable behaviour towards the patients. The same applies for the knowledge, not every employee has the same knowledge and they have to ensure this with a course about dietary, because now it is experienced negative. The patients did not experience that the staff is very hygienic and they have to show this more to the patients by showing after each patient they disinfect the hands. Therefore in general, the behaviour is experienced as hospitable and thus positive but there is room for improvement

Finally, the patients have experienced the number of persons per room positive, but the preference goes to a single room for really sick people. And the choice for a room for two persons or a room for four persons, depends on personal wishes. Out of the interviews can be concluded that the room for four persons is too crowded if you're really sick. The room arrangement is experienced positive, only there is experienced a lack of privacy, because the closet is not next to the bed and the rooms are too small. The light is experienced as too bright and patients prefer to dim this by themselves. Also the colour of the rooms is white and were experienced negative. They prefer more homely colours, like grayscale and posters on the walls, but pick the right ones in relation with cleaning. The temperature was experienced as too hot. In the hallways there are many carts, which produce a lot of noise and nuisance and the patients can hear everything. Also patients' misses activities during the day, if they have a longer stay and experienced the daytime activities negative. There is need to set the television yourself, because now the television is hanging not well and that it is free of charge. The views are experienced as positive, because most of the time there is a green view. Finally, the power outlets are too far away from the patient, the furniture has to be replaced and there is no refrigerator in the patient room and both are experienced as negative. Therefore in general, the environment is experienced as too small and patients want a common room, for daytime activities and thus more negative than positive.

APPENDIX FOUR: CODEBOOK

In this appendix there can be found the code book for the patient interviews with the open coding and the axial coding, including the axial code tree. Finally, the last step of coding is selective coding, this part of coding focus on the elaboration of concepts to find a possible theory.

4.1. CODEBOOK OPEN AND AXIAL CODING

Below in table 4.1.1. there is the codebook which is made with the inductive approach with the open and axial coding, based on the patient interviews. Those codes are based on the interviews, as points what kind of expectations and experiences a patient had within the hospital in the specific element, namely service, behaviour and environment. The first column shows the umbrella codes, the core concepts. Hereafter the open codes (main aspects) and the axial codes (sub aspects), which are a merging of similar open codes.

Table 4.1.1. Codebook

Service		
Assortment	Choice	SER-ASSOR
	Variety	SER-ASSOR-CHOIC
	Snacks	SER-ASSOR-VAR
		SER-ASSOR-SNACK
Quality	Taste (bland and low salt)	SER-QUAL
	Smell	SER-QUAL-TAST
	Presentation	SER-QUAL-SMEL
		SER-QUAL-PRES
Portion	Choice	SER-PORT-CHOIC
	Size	SER-PORT-SIZE
Dietary needs		SER-DIET
	Explanation	SER-DIET-EXP
Times		SER-TIME
	Another time	SER-TIME-ANOTH
Service		SER-SER
Expectation	Difference	SER-EXP-DIFF
	No difference	SER-EXP-NODIF
Behaviour		
Hospitality	Kindness	BEH-HOSP
	Personal approach	BEH-HOSP-KIND
	Motivation	BEH-HOSP-PER
		BEH-HOSP-MOT
Knowledge		BEH-KNOW
	Explanation	BEH-KNOW-EXP
Hygiene		BEH-HYG
	Disinfect	BEH-HYG-DIS
Expectation	Difference	BEH-EXP-DIFF
	No difference	BEH-EXP-NODIF
Environment		
Number of persons	Single room	ENV-NUMB-SING
	Room for two persons	ENV-NUMB-TWO
	Room for four persons	ENV-NUMB-FOUR
	Selecting on disease	ENV-NUMB-DIS
Room arrangement		ENV-ROOM
	Bigger room and sitting area	ENV-ROOM-BIG
	Common room, daytime activities	ENV-ROOM-COM

Light	Not too bright Too bright	ENV-LIGH ENV-LIGH-BRIGH ENV-LIGH-TOOBRI
Colour	Atmosphere (homely) Posters or paintings	ENV-COL ENV-COL-ATMOS ENV-COL-POS
Temperature	No constant	ENV-TEMP ENV-TEMP-CONST
Noise	Hallway	ENV-NOIS ENV-NOIS-HALL
View	Green view	ENV-VIEW ENV-VIEW-GREEN
Comfort (interior and set-up)	Interior (television, closet and power outlet) Privacy Replacement	ENV-COMF-INTER ENV-COMF-PRIV ENV-COMF-REPL
Expectation	Difference No difference	ENV-EXP-DIF ENV-EXP-NODIF

4.2. AXIAL CODE TREE

Axial coding is a way to make the labels or codes more operationalised and validated. Based on the 32 patient interviews, the four figures illustrate the tree diagram of axial coding. Those tree diagrams include an operationalisation of the codes. The main topic is below in figure 4.2.1. split up in the core concepts.

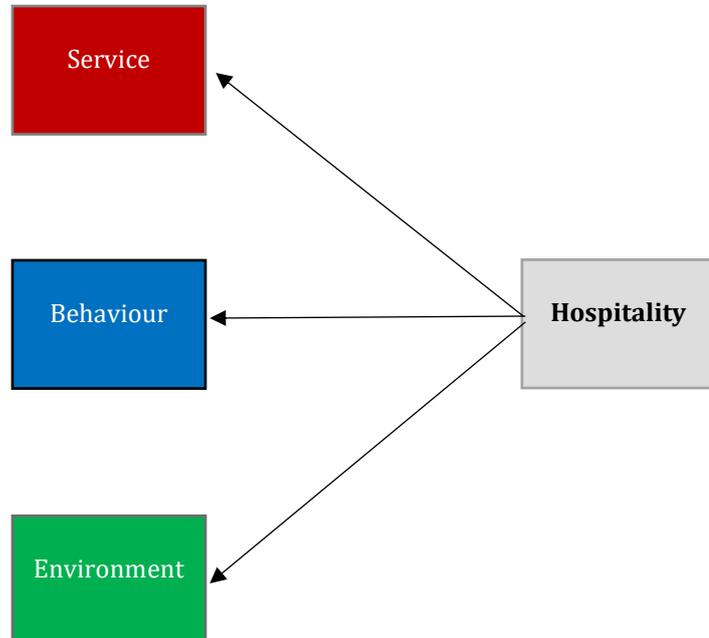


Figure 4.2.1 Axial code tree main topic

Below in figure 4.2.2, the tree diagram for the core concept service.

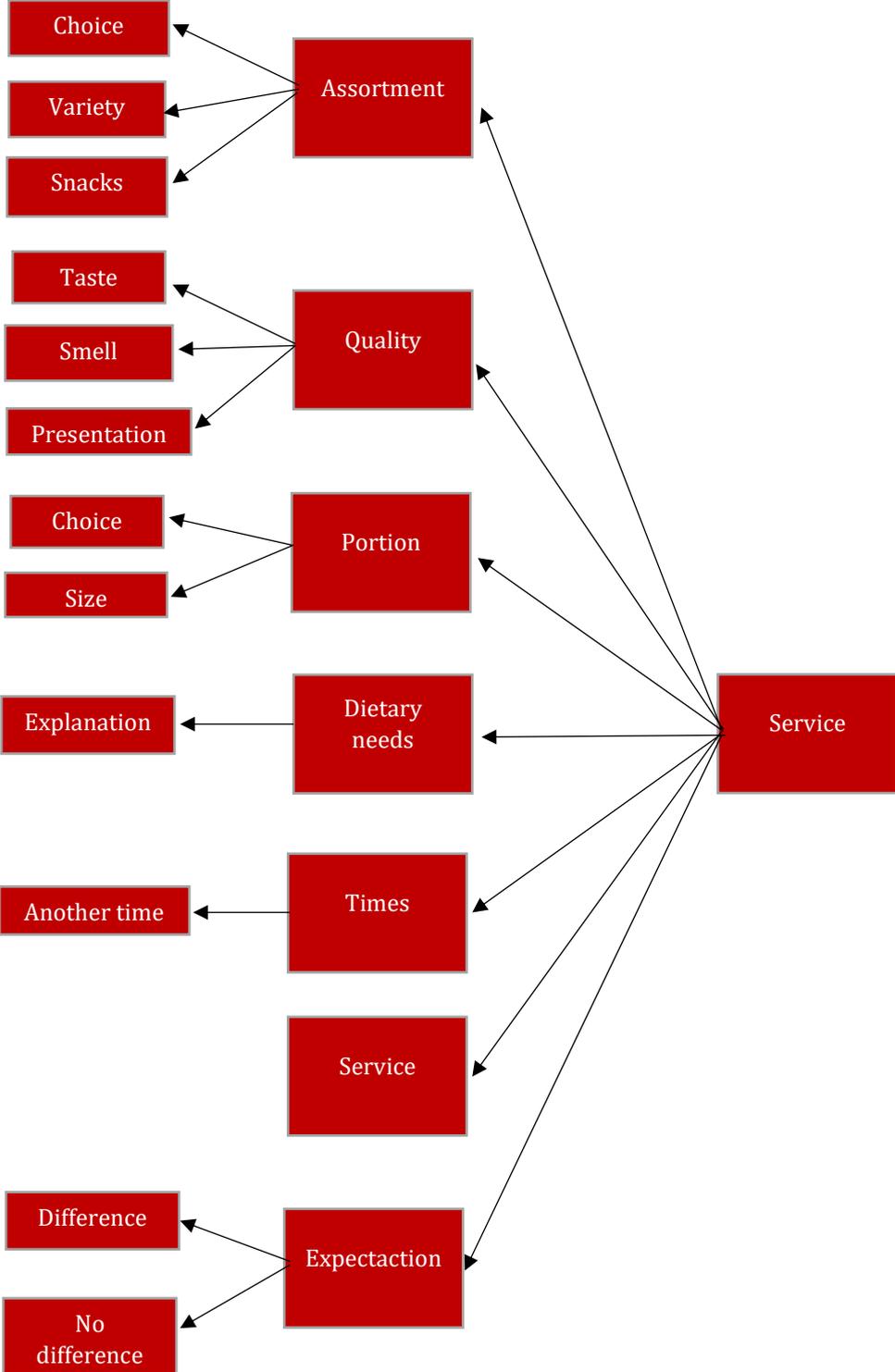


Figure 4.2.2. Axial code tree service

Below in figure 4.2.3, the tree diagram for the core concept behaviour.

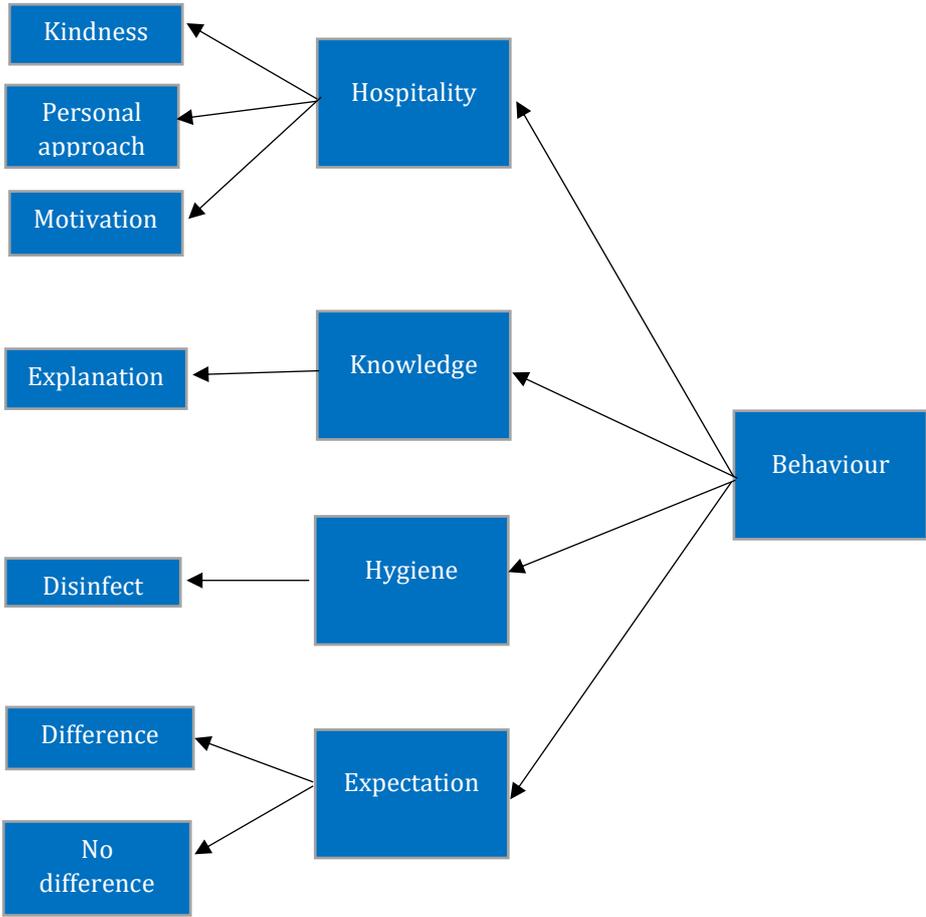


Figure 4.2.3. Axial code tree behaviour

Below in figure 4.2.4, the tree diagram for the core concept environment.

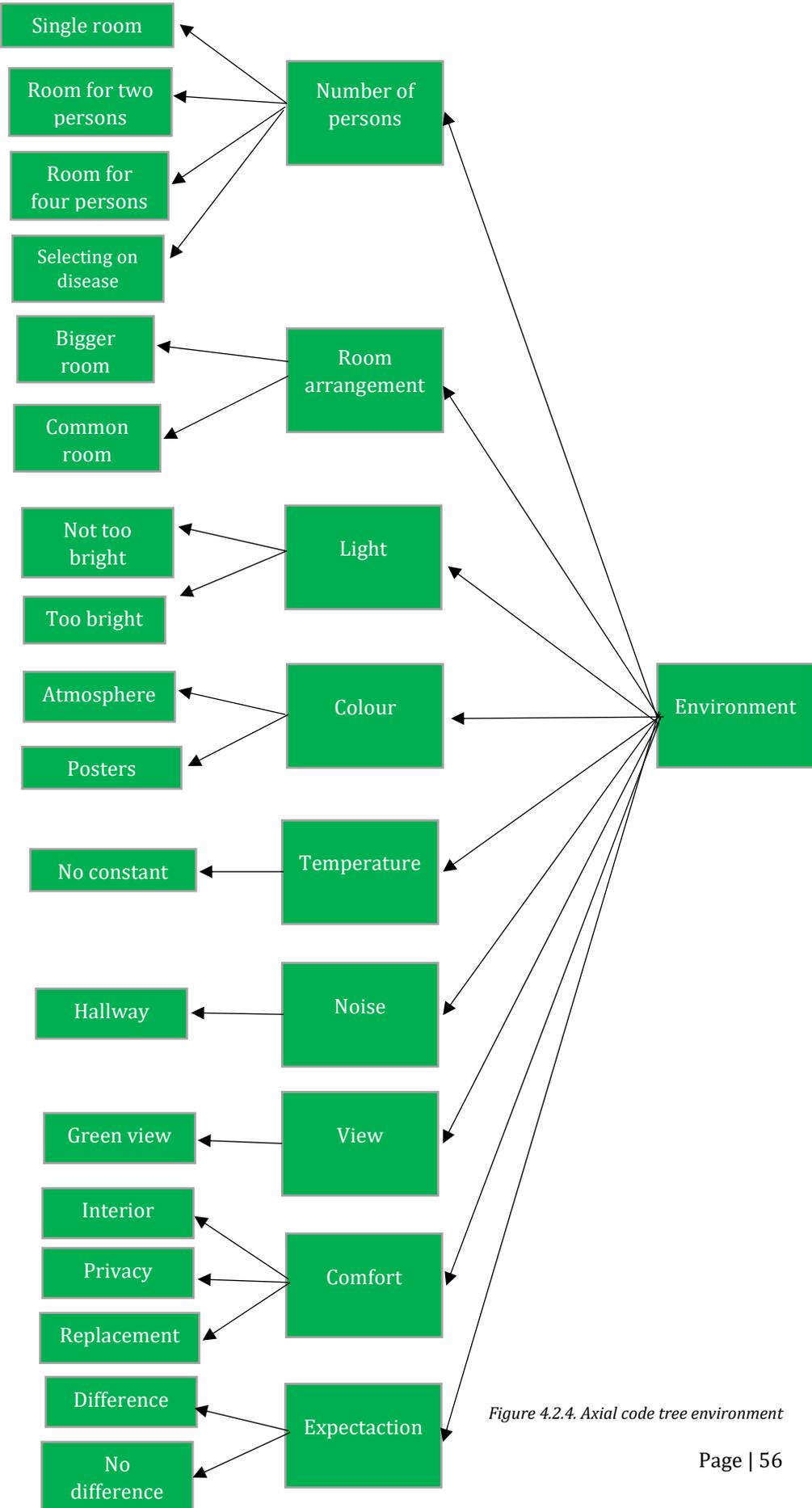


Figure 4.2.4. Axial code tree environment

4.3. SELECTIVE CODING

The last part is selective coding, which develops concepts to a theory. In this case the selective coding takes place by the discovery of relationships by looking at the frequencies in which these concepts occur in the interviews.

The following table illustrates the frequencies of the different codes (concepts) mentioned in the 32 patient interviews.

Table 4.3.1. Frequency

Core-concept	Main aspect	How often called
Service	Assortment	78
	Quality	78
	Portion	49
	Dietary needs	39
	Times	60
	Service	46
Behaviour	Hospitality	83
	Knowledge	37
	Hygiene	36
Environment	Number of persons	48
	Room arrangement	108
	Light	52
	Colour	71
	Temperature	52
	Noise	46
	View	43
	Comfort	67

The table illustrates that the following topics are mostly mentioned:

- Room arrangement
- Hospitality
- Assortment
- Quality

The combination of the most important aspects in the patient interviews and different literature sources leads to a number of points. For each topic there are theories in literature, but the following points are based on the most important aspects based on the interviews with the patients.

Room arrangement:

According to Prinjha (2015) the room arrangement is important for patients, because patients want personal care and were satisfied if they were able to look around and talk to other patients on the ward. This means that the patients do not only found the room arrangement important, but also appreciate social contact with other patients.

Hospitality:

Another important aspect for patients is hospitality. According to Cheung, Aiken and Clarke (2008) the hospitable behaviour is the biggest reason for a positive experience and people are expecting more, they want personal contact. This could explain why patients have the most experiences with hospitable behaviour.

Assortment:

The assortment is mostly called within the experiences and expectations, which can be split up into choice, variety and snacks. According to Dvorak (2015) patients want more healthy food within the hospital, which can have a positive influence on the experience of the patients.

Quality:

Within the literature quality is also an important aspect within the nutrition. According to Ulrich, Zimring, Quan, Joseph and Choudhary (2004) there can be concluded that the quality of the nutrition is related to the overall healthcare quality. This means that quality is one of the most important aspects.

This means that the most important aspects mentioned by the patients can be explained by literature, as mentioned above.

Conclusion

The following conclusion can be made based on the interviews with 32 patients and the literature review.

One of the research questions during this research was: *"What are the expectations and experiences of the chronic patients regarding hospitality in a general ward?"*

The most important aspects related to the patient interviews are room arrangement, hospitality, assortment and quality. The aspects assortment and quality are within the dimension service and can be influenced by, for example the director of the hospital to change these aspects.

The quality of the service is related to the behaviour it comes with and the environment in which the services can be provided. Therefore it can be concluded that the experiences and expectations within the dimension are related to each other and are mostly in the dimension service. This implies that within this dimension can be changes within the aspects. Finally, room arrangement was called most often, which means that this is the most important aspect to change within the environment.

APPENDIX FIVE: LAY OUT OF THE WORKSHOP

In this appendix the lay out of the workshop can be found, which consists of the agenda, PowerPoint presentation and the records of the workshop.

Agenda

Onderwerp:	Workshop		
Datum:	Dinsdag 28 juni 2016	Tijd:	13.00 – 16.00 uur
Plaats:	Saxion te Deventer in ruimte A0.31		
Voorzitter:	Nicole Lamfers	Notulist:	Sharon Hollander
Aanwezigen:	Marcel van Walraven +1 (Gelre ziekenhuis) Peter Elders +1 (Tergooi) Anita van Dijk +1 (ZGT ziekenhuis) en Hr. Groenendijk en Koen van der Linden (Slingeland ziekenhuis)		

1. Opening en agenda	5 min
2. Kennismakingrondje	30 min
3. Onderzoek en doel discussie	15 min
4. Uitkomsten patiënt interviews	20 min
5. Korte pauze	10 min
6. Discussie inclusief silent brainstorm	60 min
7. Korte pauze	10 min
8. Samenvatting besluiten	15 min
9. Sluiting	5 min

PowerPoint presentation

Slide 1



Slide 2



Slide 3



Slide 4

ONDERZOEK EN DOEL WORKSHOP

- Aanleiding
- Gastvrijheidservaring en focus
- Hoofdvraag:
 - "Welke aspecten in de drie dimensies hebben (in)direct invloed op de gastvrijheidservaring van chronische patiënten in een algemene afdeling, in een streekziekenhuis?"
- Patiënt interviews
- Beantwoording deelvraag:
 - "Wat kunnen FREM managers doen om de gastvrijheidservaring te verbeteren?"

Slide 5

UITKOMSTEN PATIËNT INTERVIEWS

Dimensie	Aspecten
Service	<ul style="list-style-type: none"> - Uitgebreid assortiment - Smakrecreatie voor warm eten - Pasties kiezen - Tuendoortjes - Later tijdsp. voor warm eten of sal kiezen
Gedrag	<ul style="list-style-type: none"> - Gastvrij, kennis van saken en noden van de eten - Ruime kamers met ruimere zithoek
Omgeving	<ul style="list-style-type: none"> - Dagbesteding - 1-persoonskamer voor erg ziek en 2 en 4-kamer selecteren op zichtbeeld en panorama's waken - Duindoel - Groen uitzicht - Ruimtelijk ontwerp en posters - Auto voor constant temperatuur - Afdeling in een vlakke - Ruimte voor karrages - Stopcontact en kast naast de patient

Slide 6

Dimensie	Ervaring	Oplossing/Aspect	Onderliggende behoeftes
Service	Aanbieding moet meer keuze en variatie hebben voor langere opname	Uitgebreid assortiment	Personalisatie van een product of dienst
	Het warm eten iszaam	Smakrecreatie	Personalisatie van een product of dienst
	Je kan niet zelf porties kiezen	Porties zelf kiezen	Flexibiliteit
Gedrag	Niet genoeg tuendoortjes	Tuendoortjes	Personalisatie van een product of dienst
	Het warm eten komt te vroeg	Later tijdsp. voor warm eten of sal kiezen	Flexibiliteit
	Het voedingsprogramma is geweldig, kennis van zaken en noden van de eten	Training en cursus	Personalisatie van een product of dienst
Omgeving	Kamer en stribok te klein	Ruime kamers	Privacy
	Geen dagbesteding	Creëren van kamers	Personalisatie van een product of dienst
	Met twee mensen op een kamer	Mensen op een kamer selecteren op zichtbeeld	Privacy
	Widde van de bed	Duindoel	Control
	Geen mooi uitzicht	Groen uitzicht	Personalisatie van een product of dienst
	De kamer zijn niet gezellig	Elke op de muur en posters	Personalisatie van een product of dienst
	Meestal te warm	Auto	Control
Tweedelaan	Afdeling in een vlakke en aangename hoogte	Privacy	
Niet genoeg ruimte in de gangen	Ruimte voor karrages	Control	
Stopcontact en kast te ver weg	Niet het bed	Control en Privacy	

Slide 7



Slide 8



Slide 9



Slide 10



DISCUSSIE

- Dubbelzagen en wat hoort bij elkaar
- Uitkomsten groeperen
- Welke dingen hangen samen met elkaar?
- Welke oplossingen/verbetermogelijkheden ziet u?
- Wat zijn randwoorden om verbetermogelijkheden te realiseren?
- Welke stakeholders moeten daarbij betrokken worden?

Slide 11



KORTE PAUZE

Slide 12



SAMENVATTING BESLUITEN

Wat kunnen FREM managers doen om de gastvrijheidservaring te verbeteren?

Slide 13



SLUITING

- Onderzoeksrapport

Bedankt voor uw aandacht en deelname
Wel thuis!

Records

Notulen masteronderzoek workshop

Onderwerp:	Discussie	Tijd: 13.00-16.00
Datum:	28 juni 2016	
Plaats:	Saxion te Deventer	
Voorzitter:	Nicole Lamfers	Notulist: Sharon Hollander
Aanwezig:	Marcel van Walraven +1 (Gelre ziekenhuis) Peter Elders +1 (Tergooi) Anita van Dijk en Elly Leferink (ZGT ziekenhuis) en Hr. Groenendijk en Koen van der Linden (Slingeland ziekenhuis)	

Samenvatting besluiten van wat kan de FREM manager verbeteren aan de gastvrijheidservaring.

ZGT ziekenhuis

- Met voeding ligt het eraan hoe het ziekenhuis gebouwd is.
- Gezamenlijke verantwoordelijkheid naar de patiënt toe.
- Tegenaan lopen dat patiënten van afdeling naar afdeling gaan en andere verzorging krijgen en andere voeding.
- Lunch met patiënt waardoor de medicus bewust wordt.
- Niet denken wat wij weten is het beste maar luisteren naar de behoefte van de patiënt.
- Bewuster worden van het doelgroep beleid.
- Ruimte voor rust en ontmoeting.
- Mensen worden gelukkig van contact hebben.
- Persoonlijke aandacht.
- Netwerk van ambassadeurs en coaches.
- Eigen verantwoordelijk voorop gezet.
- Inventarisatie met patiënten.
- Mystery guest.

Slingeland ziekenhuis

- Bieden ook smullen op maat aan.
- Assortiment met dertien verschillende soorten snacks. Afhankelijk van de medewerkers service.
- Gemiddelde leeftijd 60/68.
- Een team rondom de patiënt.
- Wat is de meerwaarde voor de patiënt.
- Functionele ondersteuning op alle afdelingen hetzelfde.
- Bieden op maat kan over de hele dag verdeeld worden.
- Proberen mensen zoveel mogelijk dagen achter elkaar te laten werken, zodat er niet elke keer een andere aan het bed staat.
- Vers koken.
- Werkdruk goed verdelen.
- Planning ligt bij de teammanager op de afdeling.
- Kijken naar competenties.
- Welke opleiding sluiten erop aan
- Gastvrijheid kost niks maar is wel het meest ingewikkeld.
- Mantelzorg in het ziekenhuis meenemen.
- Gastvrijheid verwachtingen overtreffen.

Tergooi

- Gastvrijheid overal hetzelfde, het zijn van de afdeling komt op een 2^{de} plaats.
- Teammanager van voeding en service moet ook heel dichtbij staan bij de medewerkersmanager.
- Hotelservice werkt negatief.
- Gedragsdingen uit de hotellerie moet je meenemen in het werk en de verpleegkunde daarbij helpen.
- Geef de patiënten meer persoonlijke aandacht.
- Denk aan praten met de patiënten.
- Laat de patiënten zich speciaal voelen.

Gelre ziekenhuis

- Taken verwisselen zodat je wel coördinatie hebt in verschillende dag taken.
- Via een iPad kan je de taken terugvinden en hierop staat ook het patiëntenbestand.
- Werknemers worden er zelfstandiger door, wat de vriendelijkheid verhoogt.
- Voor de planning van het werk is geen teamleiding meer nodig waardoor je het wel kan gebruiken voor het coachen.
- BBL opleiding service.
- Grotere klassen kunnen neerzetten.
- Naar een hotel voor training van gastvrijheid.
- Inwerk programma wat via internet gaat.
- Het gaat allemaal om het gedrag, voor gastvrijheid
- Feedback
- Medewerkers leren lef te hebben.
- Gun medewerkers om wat te kunnen doen.

APPENDIX SIX: WORK DECLARATION

In this appendix the work declaration of the researcher can be found.

MASTER THESIS BY NICOLE LAMFERS

Hospitality experience within hospitals

What aspects in the service, behaviour and environment dimensions (in) directly influence the hospitality experience of chronic patients admitted to general wards of regional hospitals?

Saxion University of Applied Sciences Deventer

Handelskade 75, 7417 DH Deventer, the Netherlands

&

University of Greenwich

Old Royal Naval College, 30 Park Row, London SE10 9LS, United Kingdom

I, Nicole Lamfers, declare that I have written the master thesis myself.

Date:

17-08-2016

Signature researcher:

Nicolamelampers