

The contribution of hospitality services to person-centred care: A study of the palliative care service ecosystem

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Abstract

This paper presents a new perspective on person-centred care, examining the role hospitality plays in palliative care. Despite a burgeoning, clinically derived and focused evidence-base, the constituent parts of person-centred care in this service ecosystem are not fully understood. An assessment of hospitality and healthcare literature concludes that the contribution of hospitality services to palliative care are seldom appreciated. Systematic stories (n=239) collected from patients, families, and the bereaved accessed via five hospices, a hospital-based Palliative Care Unit, and a general hospital, geographically dispersed around the UK, are examined through the application of a storytelling tool designed to capture the transitional nature of service experiences. Hospitality services are found to play a profound role in care at this lifestage. They are integral to a person-centred care model which ascends through knowledge, emotions, amenities, social, and holistic steps over time. Research limitations and opportunities for future research are detailed.

Keywords: end-of-life care; hospices; patient experiences; person-centred care; trajectory touchpoint technique; operant; operand

1. Introduction

Whilst health more generally has enjoyed an elevated status in service research in recent years (see for instance Danaher and Gallan 2016; Ostrom et al., 2015), and hospitality research (see for instance Kotera et al., 2021; Zhang et al., 2020), the needs of those experiencing life limiting and terminal illness are currently under-researched (Lugosi et al., 2022). This service context is referred to under the umbrella term of palliative care. The World Health Organisation (WHO) describes this as: "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (WHO, 2015). It is a transitional stage. It does not always symbolise imminent death, (Giovanni, 2012, NHPCO, 2015), yet does signal a shift away from curative treatment.

Hospice care, a philosophy rather than a specific service provider, provides palliative care to people with a terminal illness. Etymological studies of the term indicate a long-standing relationship with the hospitality sector. It can be traced back to Latin and Greek terms 'hospe' and 'hospitium', equating with 'hospitality, an inn' (Ottenbacher et al., 2009). Over time this relationship has become obscured by a more clinically derived dialogue which commonly associates palliative care service delivery with specific hospice units, hospital environments, care homes and care at home. Whilst other providers do exist, see for instance Hay's (2015) account of 'dark hospitality' and the role hotels can play in end-of-life care, the nuances of 'hospitality' in palliative care and the contribution such makes to the 'dying well' narrative (National Palliative and EOLC Partnership (NPEOLCP), 2015) dominant at this time remains to be appreciated.

Person-centred care, the health care model championed at this final stage of life, seeks to co-create value by putting “the person who uses the services at the centre of their care, treatment and support, ensuring that everything that is done is based on what is important to that person from their own perspective” (Care Quality Council (CQC), 2014). Dignity, compassion and respect, facilitated through co-ordinated, enabling, personal care are themes recurring within the core literature. Although the model has been extensively reviewed within the healthcare literature linked to older people and health care professionals, notably the nursing profession (Edvardsson et al., 2010; McCormack 2004; Packer 2000; Ross et al., 2015), it has been entirely neglected in the hospitality literature. The primary aim of this paper is to compensate for this shortfall by empirically examining the contribution of hospitality to person-centred care for service users at this life stage. The data collected is interrogated through a service ecosystem lens.

The service ecosystems lens, rooted in Service-Dominant Logic (SD-L), and currently prominent within service science research, is defined by Vargo and Lusch (2016, p. 161) as a “relatively self-contained, self-adjusting system of resource-integrating actors connected by shared institutional arrangements and mutual value creation through service exchange”. It is particularly well suited to understanding what happens between actors, institutions, and environments which provide service, integrate resources, and co-create value as in the case of healthcare (Edvardsson et al., 2011; Vargo and Akaka, 2012). It is capable of focusing upon collective wellbeing rather than solely collective intent (Vargo and Lusch, 2017), and is positioned as a framework capable of organizing knowledge in a way that is impactful, offering value and meaning to practitioners (Vargo and Lusch, 2011; O’Leary and Boland, 2020).

This paper utilizes a service ecosystem lens to better understand the hospitality-healthcare relationship. ‘Because ecosystems can be boundless’ (Baron et al., 2018, p. 145), we specify hospitality services as the service concept and palliative care as the central actor of the study (Baron et al., 2018). A service ecosystem lens incorporates actors, institutions, and operant and operand resources. We focus particularly upon operant and operand resources in mining the empirical findings of our seven-year study of this service ecosystem. This work is timely given the increasing reference to integrated health care systems (Charles, 2021) and need to move away from considerations of patient care through an easy to measure linear trajectory (White and Willis, 2002) into one of complexity and relational understandings if person-centred care is to be achieved.

2. Literature Review

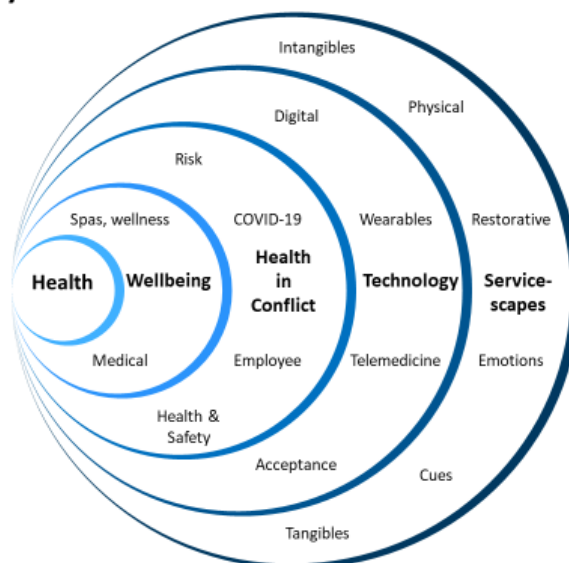
2.1 Hospitality and Health

Multiple streams of literature exist illustrating the hospitality and health relationship. Emergent themes can be broadly categorised into four areas; wellbeing; health in conflict; technology; and servicescapes (Figure 1), each with multiple sub-themes.

Figure 1

Health and Hospitality

Theoretical Underpinnings



2.1.1 Wellbeing

Studies of wellbeing regularly coalesce around research linked to spas, wellness and medical travel (Smith and Puczko, 2014). Often particular destinations feature in research. Smith (2015) for instance explores what sets Baltic Health Tourism apart from, and what it has in common with, other health tourism destinations. Similarly, Huijbens (2011) explores Iceland as a wellness destination, reflecting upon the importance attributes specific to a destination play in enhancing the attractiveness of the experience and product on offer. This theme of place attachment is embedded within a range of associated literature as the work of He et al., (2022) illustrates. Exploring the recovery experience associated with wellness tourism, these authors consider the intangible and emotional feelings generated through place attachment and the contributions such make to the recovery process. The association with behaviours is addressed within the work of Koskinen and Wilska (2019) who seek to both identify and better understand the attitudes of spa tourists to wellness and also Sigurðardóttir (2018) who focuses upon the opportunity equestrian tourism presents for wellness. Literature extends beyond the specifics to include studies particularly of seniors. Here, wellbeing and retirement considerations are

central to the work of Emerson et al., (2022), whilst the dining out behaviours of seniors features in the work of Kim and Jang (2019), who focus upon the role physical, psychological and economic health play in driving experiential consumption of hospitality environments.

2.1.2 Health in Conflict

Four sub-themes illustrate this theme, although each are covered by varying degrees of research. Lindøe and Olsen (2004) for instance explore health and safety systems associated with the hospitality industry. They utilise a case study of the aluminium industry in Norway to illustrate opportunities for quality enhancement. In a similar vein, Jin et al., (2017) consider how consumers react and respond to individual health concerns. Utilising the restaurant sector as the point of reference, experiential and behavioural considerations are identified as playing a pivotal role. Kotera et al., (2021) meanwhile explores the mental health of hospitality workers, a subject explored more broadly in relation to occupational health too (Zhang et al., 2020). For Dorta-Afonso et al., (2023), it is the potential for employee burnout when working in high performance work systems which is of concern, addressed in part by the work of Kim et al., (2023) who explore the support on offer for employee wellbeing in the hospitality industry, particularly in relation to work-family supportive benefits, programmes, and policies.

Crisis and COVID-19 feature in a literature which ranges from examining the impact of the pandemic upon hospitality workers job insecurity (Abbas et al., 2021), to exploring the consequences of the pandemic upon hotel booking patterns (Ju and Jang, 2023). In this latter research the focus is upon communication and how to deliver messages to encourage brand loyalty in a time of intense uncertainty. The impacts of crises more generally upon tourism destinations (Duan et al., 2022) and hotel services specifically (Lagiewski and Perotti, 2023) introduce us to both geographical (ASIA, Europe and North America) and systems distributions

of impacts (micro, meso and macro) as in the case of Duan et al., (2022), alongside questioning whether hotels provide a help or hindrance in times of crisis. Utilising multiple types of text analysis to explore this latter question, Lagiewski and Perotti, (2023) conclude that whilst hotels are well positioned to offer care and provisions during times of crisis, there is a literature which suggests such may have unintended consequences, in some cases impairing the well-being of individuals utilizing hotel services during a disaster. Opportunities to explore unintended consequences are outlined in the work of Das et al., (2021) who champion the need to more fully explore the relationships between pandemics and marketing.

2.1.3 Technology

Telehealth, “the use of information and telecommunications in health care delivery for a specific patient involving a provider across distance or time” (Totten et al., 2016), technology acceptance (Jayawardena et al., 2022), telemedicine (Cheng et al., 2021) and wearable technology (Mejia et al., 2021) all feature within the contemporary hospitality literature. For Jayawardena et al., (2022), understanding the role technology is playing within the transformation of the hospitality industry is linked back to the Technology Acceptance Model, a Model which positions perceived usefulness, and perceived ease of use as pivotal attributes. For Mejia et al., (2021) wearable technology is both useful, and easy to use as a solution and research agenda for housekeeper safety and health. A similar theme of usefulness, and empowerment is evident within the work of Cheng et al., (2021), who finds value within hospitable telemedicine experience as a means of reducing isolation and anxiety, returning a sense of empowerment and coping in times of high anxiety and isolation, as experienced during the COVID-19 pandemic.

2.1.4 Servicescapes

A particularly insightful area of literature exploring the hospitality servicescapes in healthcare focuses upon the application of a hospitality culture to the healthcare industry. Such thinking is not new as the work of Lee (2004) illustrates. Drawing upon both personal experiences of managing a hospital and, later, working for the Disney corporation, Lee (2004) posits that adopting, in effect, a hospitality driven culture and behavioural strategy provides a map for healthcare organisations to challenge the under-performing customer service philosophy endemic in healthcare. Focusing upon what cannot be measured, decentralising authority, celebrating courtesy and imagination are all building blocks suggested by Lee (2004) to be capable of shifting cultural norms into a more powerful empathetic experience for those on the receiving end of associated services.

Coining the term restorative servicescapes, Mody et al (2020) explores the influence of hotel-like attributes on patients arguing that such contribute to perceived wellbeing. Song et al., (2021) question the influence of substantive and communicative servicescapes on healthcare traveller emotions by way of reference to accommodation type and interior design style. The role of the physical servicescape dominates the work of Lugosi et al., (2022) who explore how cancer patients with potentially life-threatening illnesses navigate their way through waiting spaces, concluding that the expectations, perceptions and satisfaction with waiting experiences are dependent upon ambient conditions, perceptions of wayfinding and privacy features. Attention to these factors have the capacity to override other deficits prevalent in the physical servicescape. Understanding these relationships is piecemeal though for as the case of Lugosi et al., (2022) illustrates, so much of existing research focuses upon single units of case examples.

Our empirical review attempts to bridge the inevitable void by drawing from a multi-site study and collaborations with a range of organisations offering palliative care services. It also draws upon the concept of a Hospitality-Oriented Patient Experience (HOPE) framework (Hunter-Jones et al., 2020) designed to embed the principles of customer experience management (CEM) across the multiple touchpoints of the patient experience journey. Previously empirically untested, it is suggested that such an approach might be of relevance to multiple healthcare presentations including palliative in nature. Such is tested in this study where the concept of touchpoints is pivotal to the approach employed.

2.4 Service Ecosystems

SD-L in general, and service ecosystems in particular, are useful frameworks within which to examine hospitality in healthcare systems for three major reasons. First, a service ecosystem perspective has collaboration at its heart, and collaboration between actors is required for positive health outcomes and increased efficiencies (Frow et al., 2019). Second, health services are highly complex and dynamic (Grudniewicz et al., 2018), hence complex systems thinking, as antecedents to the concept of service ecosystems (Vargo et al., 2008) is pertinent because complex socio-technical health systems (Hewett et al., 2009) are subject to intense institutional pressures and regulatory requirements as well as being restricted by scarce resources. Third, service systems, and indeed perceptions of value, are entrenched in wider social systems (Edvardsson et al., 2011). Rather than just collective intent, service ecosystems ultimately emphasize collective wellbeing (Vargo and Lusch, 2017), therefore this perspective is preferred when considering social needs, rather than many traditional organizational theories that put the organization at the center of thinking (Meynhardt et al., 2016; Vargo and Akaka, 2012). Indeed, as open systems which impact other systems (Vargo and Lusch, 2011), service ecosystems “represent the assemblages and sub assemblages of society” (Vargo and Lusch, 2016, p.17).

Value cocreation is central to SD-L, and occurs when multiple actors integrate resources (Edvardsson et al., 2011). Hence, a single actor cannot deliver value (Vink et al., 2021). Cocreation processes within healthcare, then, includes patients and families as well as a range of healthcare professionals. The actors that benefit perceive value. The resources that are integrated include operant resources such as the skills and knowledge of clinicians and the health self-management practices of patients, and operand resources such as expensive and specialized machinery like MRI scanners. Noteworthy is that it is operant resources that are the fundamental source of strategic benefit (Vargo and Lusch, 2016). The purpose of value cocreation is to increase wellbeing of the actors and the system (Wieland et al., 2016). Hence, the service in health is patient wellbeing, while a service ecosystem perspective examines the wellbeing of the ecosystem overall.

2.3 Understanding the palliative care service ecosystem

Globally, life expectancy has increased by almost 20 years over the last five decades. Overall morbidity rates have not changed (UN, 2015). With the post war baby boom, and consequential aging population overall, a death boom is projected in the next two decades (NHPCO. 2015). This extended living process has had multiple consequences. Patients are now living with more complex co-morbidities which require medical interventions (Pollock, 2015). Medical interventions require policy oversight and funding enveloped within increasing regulation (Borgstrom, 2015). This period has also witnessed an increasing demand for hospice care (Bone et al., 2017; Clark et al., 1997). Multiple drivers underpin this including a transition in the traditional place of death from home, overseen by a priest (Clark et al., 1997; Corner and Dunlop 1997), to a more 'medicalised death', managed by a site based e.g. hospice, healthcare professional. With advances in medical care, greater employment opportunities, alongside

smaller and more fragmented families, demand for this ‘medicalised death’ and associated services is set to grow (Candy et al., 2011; Hospice UK, 2015).

In the UK, the location for this study, the palliative care landscape has been marked by a number of influential policy documents over the past decade united in their ‘dying well’ narrative (National Palliative and EOLC Partnership (NPEOLCP), 2015). Central to policy rhetoric, as observed more generally by McColl-Kennedy et al., (2017), has been a shift from a paternalistic medical model to a person-centred model of health care service delivery. As an evolving concept, person-centred care continues to receive research interest and attempts at definitions (The Health Foundation, 2014). To Edvardsson (2015, p. 66) it is “holistic, flexible, creative, personal and unique (...) it is not reductionist, standardized, detached and task-based. Not unless the person wants it to be”. It has been investigated within multiple research contexts. Research linked to long term conditions, dementia for instance (Brooker and Latham 2016), is indicative of the common line of inquiry.

Person-centred care is an integral part of palliative academic research (see for instance McCormack, 2004; Price, 2006). McCormack (2004) identified four core concepts associated with person-centred care: *relationships* between nurses and patients; *decision-making* and activities; impact of ‘*place*’ on care; and self-awareness and patient *values*. Mediating factors included: transparency and mutuality; patient voice being heard; a sense of belonging; and companionship. For Price (2006), knowing the person and their needs, inviting them to share narratives, having a caring relationship with purposeful actions and a work environment characterised by inter-professional working are the hallmarks of effectively delivering this service model. Both studies drew their findings from the nursing profession. Neither included the voice of the patient, a voice which is so central to this research study. Through this inclusion

our findings make not only a unique contribution to the hospitality literature, but extend understanding in the wider palliative research community too.

2.4 Understanding hospitality in palliative care

There are limited empirical insights currently into the place of hospitality in palliative care. Some sense of experiences that matter is provided by Rosenbaum and Smallwood (2011). The importance of experiencing the familiar shines through with this paper positioning the home as a more 'normal', familiar setting for dying/death relative to hospices which are considered 'other'. In research beyond the home, objects are found to be particularly valuable for creating a sense of familiarity and homeliness in hospices and other patient facilities. Whether this be bedside objects (Kellehear et al., 2013) including photographs (Collier et al., 2015), personal clothes and bathroom items to CD players and books (Hilário, 2016). Each play a symbolic role. Photographs for instance create a sense of warmth and serve as a reminder of other times and places as well as being emblematic of family support (Cleeve, et al., 2018). Objects are significant in other ways too. How flowers are arranged or how clothes are handled is indicative of signs of care.

According to Rasmussen and Edvardsson (2007), hospitality in palliative care can be interpreted as things contributing to a welcoming atmosphere, an atmosphere of safety, and an atmosphere of everydayness. Findings conclude that day care patients, who initially feel lost and alienated upon entering a hospice, become more comfortable over time. Relationships with other people, objects, and places to relax and rejuvenate, become appreciated, contributing to a sense of safety, positivity, and purpose. In turn, patients are able to 'venture' and move forward in a meaningful way, whether that be undertaking new opportunities, making friends,

or having complimentary therapies. Limits may be imposed to venturing, however, by wanting to avoid sensitive places particularly those associated with closeness to death.

3. Methods

3.1 Framing the study palliative care service ecosystem

Our study focuses upon palliative care services delivered via hospice, hospital or home contexts. It is UK focused, a research limitation we return to in the conclusions. In the UK there are over 200 hospices, adult and child focused, supporting around 200,000 patients annually and receiving an average of 32% of their funding from the government, with the rest coming from fundraising (Hospice UK, 2015). Engagement with a hospice is a piecemeal affair as they fall outside the standard National Health Service (NHS) offering in the UK. Ambiguity over who and how to access these services is an inevitable consequence. Hospices welcome multiple patients including Day Patients, Outpatients, Residential Patients, and, some, respite patients. They deliver their services through Inpatient Units, Outpatient and Day Care Centres, programmes (e.g. Living Well), and clinics (e.g. Breathlessness Clinic and Lymphoedema Clinic). The combination is specific to the unit in question. Additionally, services are also provided within specialist hospital units, more general hospital contexts and through hospice@home services too.

3.2 Research Design

To overcome previously acknowledged research limitations in palliative care research (Beattie et al., 2014; Candy et al., 2011; Sulmasy et al., 2002) we adopted an interpretivist-constructionist approach collecting data through pathographies (stories of illness). Five hospices, one hospital based Academic Palliative Care unit and two general hospitals, and one Hospice@Home service participated in the study. Adult and child services were included with

participant representation from all service activities, including the bereaved. While geographically dispersed throughout the UK, our study is predominantly UK focused, though we have previously tested the tool we utilize to collect the pathographies in a general hospital in New York City (Sudbury-Riley and Hunter-Jones 2016; Sudbury-Riley et al., 2020). Three researchers are at the core of the study, supported by research assistants at different stages.

3.3 Sample and Data Collection

Table 1: Sample

PATHOGRAPHIES										
Participant	N	Gender		Age				Socio-Economic Status		
		M	F	13-34	35-54	55-74	75+	AB	C	DE
In-Patients Out-Patients Family, Carers, Friends Bereaved	239	74	165	17	53	111	58	114	84	41

Source: Primary Data

3.3.1 Pathographies

Given the holistic nature of palliative care it was important to include all service user stories in the study. Cognizant of the arguments of Turley and O'Donohoe (2017) and Frank (1991, 1995) that pathographies are well suited to extremely ill people, and can give agency to those otherwise limited due to severe illness, we utilized this means to document stories of illness. Stories generated may take many forms (Frank, 1991, 1995). Their application to healthcare contexts is particularly valuable as the discourse generated contributes to the 'person-centred' care agenda favored in healthcare delivery (Care Quality Council, 2014). Working with our gatekeepers at each unit, we used a purposeful sampling approach to collect pathographies from in-patients (n=34), out-patients (n=45), carers, family and friends (n=73), and bereaved families (n=87). We utilized the Trajectory Touchpoint Technique (The Authors, 2016; 2020),

a method that uses rich pictures of potential touchpoints throughout a customer journey to collect data. A pilot study (n=38) revealed that data saturation occurred at around twenty respondents. The remaining studies all included at least twenty respondents in line with this.

3.5 Ethics

Defended by the research team at a full University Central Ethics Panel, the ethical principles of choice, respect for privacy, integrity, quality, transparency, and risk were central to the research design. Ethical approval demanded voluntary participation and informed consent, with withdrawal possible to a specified time period. Approaches to patients were made via gatekeepers who shared Participant Information Sheets and Consent Forms with potential participants securing their participation, or otherwise. Distress protocols were designed to include details of professional support services and contacts should the need arise. Data were stored in secure password-protected files accessible solely to the research team.

3.6 Data analysis

With multiple datasets contributing to this study, a consistent and rigorous approach was essential. Structured data collection, as in the case of pathographies and interviews, was recorded (with permission) and transcribed verbatim. To mine the data for this study we have applied an iterative manual thematic analysis to make sense of the data (Braun and Clarke 2006). In step one, three experienced researchers separately examined the data identifying core and sub-themes associated with each of the seven touchpoints. We shared and reviewed these themes in step two interrogating these themes further in relation to the four concepts associated with person-centred care (McCormack (2004): relationships; decision-making; place; and values. These concepts are embedded in the findings which follow. The narrative discourse begins with life prior to hospice arrival.

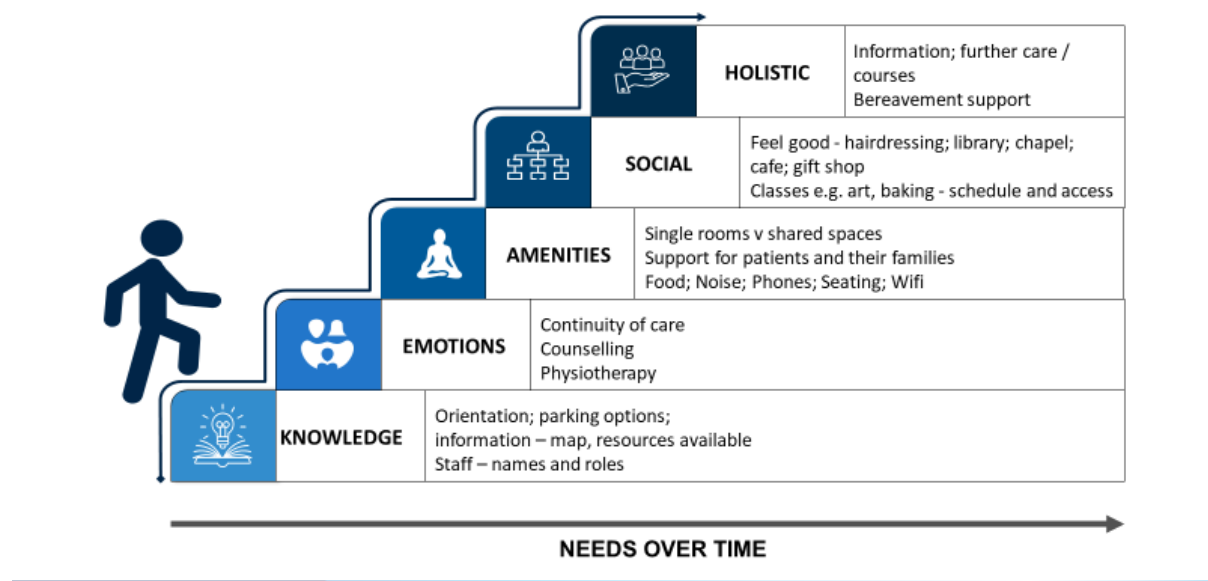
4. Findings and Discussion

We visualise the findings that follow through a staircase (Figure 2) which encapsulates the differing needs over time of different services users and the blossoming consequential relationship with hospitality services. The order of stairs, *knowledge*, *emotions*, *amenities*, *social*, and *holistic*, and that they are ascending over time, is significant. Amenities are incidental if service users lack operant resources (Baron and Warnaby, 2011) i.e. are unaware (knowledge) of the services on offer. Social interactions will be compromised if psychological (emotional) needs are unmet and so on. Each stair also is associated with practical characteristics. Stair one, *knowledge* needs, are dominated by communication and orientation issues. Stair two, *emotional* needs, are underpinned by symptom, pain and medicine management. Stair three, *amenities*, link to facilities and hospitality operand resources i.e. beds and bedroom furniture. Stair four, *social* needs, link to wellbeing and leisure offerings. Stair five, *holistic* needs, equate to aftercare and information provision

Figure 2:

The Hospitable Staircase

Journeying through Palliative Care



Source: Primary data

4.1 Knowledge

Many examples of inhospitable healthcare experiences pre-hospice arrival were shared. These stories were dominated by compromised operant resources, knowledge deficit, (Baron and Warnaby, 2011) which fell into three categories: knowledge of terminology (health literacy); knowledge of associated services; and knowledge of access and referral systems.

Misconceptions about the word ‘hospice’ instilled fear and unease into participants who frequently associated this environment with:

‘The Death House’ (day patient)

and somewhere:

‘people don’t return from’ (outpatient).

Such was exacerbated by a lack of knowledge about the type of services which exist when facing a potentially terminal diagnosis:

‘I didn’t know where to start to look for information (...) what type of services are there? What help do we need?’ (relative).

Incomplete knowledge of access and referral systems was central to many conversations. Signposting was often via multiple information sources shared through both informal (family, friends and the local community) and, formal networks (General Practitioners (GPs), specialist nurses, hospital and district nurses, carers, occupational therapists, and a speech therapist). Experiences differed substantially as a result.

The lack of familiarity and uncertainty of this stage is the antithesis of a hospitable encounter.

Person-centred care is heavily compromised. There is a deficit in operant resources as patients, unsure of what the palliative care environment has to offer, lack trust, and confidence in the reputation, credibility and comfort of hospices pre-arrival (Baron and Warnaby 2011; Thuy et al. 2016). Indeed, the complexity of accessing these health care settings, compromises the decision-making abilities of patients and their families, unsure of the access arrangements (place) and values attached to the service provider. Orientation will be enhanced with greater co-ordination and connectivity of providers within the service ecosystem, primary care referral systems inter-connected to secondary and tertiary providers.

4.2 Emotions

Once key orientation information was provided pre-arrival, parking options, maps, information detailing resources, staff names and roles, participants quickly relaxed into stories of hospitable person-centred care from the outset of their hospice experience. *Cultural resources* are pivotal to a hospitable experience at this stage. They are associated with knowledge, management skills, capacity, quality of service, and technical expertise (Baron and Warnaby 2011). Thuy et al. (2016) translate this into staff expertise (technical quality), service procedure (administrative quality), and staff interaction (interpersonal quality) in the healthcare environment.

Preparations undertaken by the hospice prior to their arrival projected feelings of a hospitable, warm, welcoming and caring environment:

‘...because they were expecting us, we were met at the doors’ (bereaved family).

They felt immediate connections from the initial point of arrival, which were frequently described as:

'...welcoming and also there's a calmness as well – I can't explain it – you're all chatting but it's calm' (outpatient).

Emotions dominated narratives. Service users, patients and their families, spoke of experiencing a rollercoaster of emotions prior to arrival. Many spoke of feeling anxious, concerned, full of trepidation, unsure of what the experience will bring and, at times, scarred by their experiences elsewhere:

'When I got in here what I actually felt was a tremendous sense of relief as the atmosphere was so different from the hospital' (relative).

The stark contrast to the welcome received in other healthcare environments they had experienced was noted time and again by patients:

'It didn't take much to sort of, feel that I was in the right place here'

and their relatives:

'Straight away I just took a deep breath and thought phew, they are looking after him!'

The extent of difference experienced is aptly described by one bereaved relative:

'If you want to put it in simple terms, it [i.e. moving to a new environment] was like going to a holiday camp to go and die'.

The experience is not trivialised it is normalised, a state so welcomed by many in this position:

'When I knew he wasn't going to get better I thought I would go in a depression (...) this is the way I would like to go (...) even if these people are very, very ill, it isn't like that. It is just like ordinary life' (relative).

A hospitable arrival into hospice care had the capacity to inject humanity and raise the spirits of all concerned:

'They have treated him like a human, like an individual' (relative).

Such acted as a conduit for value co-creation on many occasions, returning a confidence to service users:

'feel as if these are my friends, and I can rely on them' (relative).

The simplest of human acts were profoundly significant and appreciated:

'I thought how did she know my name? Little things like that really make a big difference' (relative).

Staff and families co-operated over transport and access arrangements:

'I have a volunteer driver who picks me up and sees me into the building. He comes back and picks me up again' (outpatient).

4.3 Amenities

The importance of amenities to patients and their families dominated narratives. The availability of operand resources (Baron and Warnaby, 2011) and standards of finish fed into a level of comfort akin to that found within commercial hospitality experiences. In terms of the physical attributes of in-patient rooms, most service users were very positive about their surroundings, patients observing the décor:

'The rooms are beautifully furnished' (inpatient)

and family comforted in different ways:

'We can see that everything is set up here so she's safe' (relative).

Where comfortable chairs were in place they were particularly appreciated. Visitors do spend considerable time periods in them. In fact, what did matter to patients was having open hours contact with their family and friends:

'look, I'm staying, my bed is there! (...) I was able to just be by his side which was how it would be at home' (bereaved family),

and knowing that they were being looked after too:

'The whole team not only look after the patients but the family get looked after which takes a lot of stress off the family and just makes it a happier place for everyone' (relative).

Without exception, the food and beverage offering in every unit studied was described in terms such as 'excellent', 'delicious', 'so accommodating', 'never a trouble'. Comments were accompanied by smiles, a relaxed demeanour and provided valuable, uniting, common conversational reference points. Whilst the range of provision was frequently applauded:

'You get a choice of fruit, soup or pate as the first course, at least 2 choices for the main meal, or, if you don't fancy either of them, you can ask for an omelette and for the sweet you get a choice for that as well' (outpatient),

so too was the manner in which the service was delivered. Staff in each unit were consistently praised for their attention to detail, which included anything from cutting off crusts to preparing omelettes for people unable to face anything from the menu:

'the other day I had egg and chips which was great as I can't swallow that much and egg goes down well' (inpatient).

Food and beverage options offered to carers and families were appreciated too, many patients anxious about the consequences of their illness upon their loved ones:

'wonderful food, the staff really looked after me as well' (inpatient carer).

Interestingly where criticism appeared it was commonly voiced by carers and family members.

It was commonly linked to repetition of choices:

'It is exactly the same each week! Well – the soup is different but the sandwiches are the same each week' (outpatient)

and the speed at which trays were removed from patient bedsides. Whilst such matters were incidental to a patient, they did matter to their family and friends who were sensitive that service offerings should match the individual foibles of their loved one.

Alongside the standard service available, patients longed for simple services which they enjoyed in everyday life, a cigarette and a pint of beer for instance. Others craved chocolate, subsequently supplied by a nurse, and:

'fish and chips from the chippy!' (Patient),

which were more complicated to provide. Rules on bar service varied unit to unit. Services were regularly appreciated where available:

'The bar he liked, there is a bar that comes around that's what he liked' (Bereaved),

although not everyone was aware of these facilities, however, or indeed the 'rules' relating to access to them.

All units provided core hospitality facilities easily accessible to all service users, be it a patient or their family:

'loads of facilities to use like the microwave, the fridge the fans' (Relative);

'you can make a cup of tea (...) and read the books or papers or magazines' (Bereaved).

The access to these facilities was pivotal to enhancing wellbeing, the following quotation, repeated time and time again, indicative of conversations about what really mattered:

'being able to come and make yourself a drink, have food whenever you want'

(Relative)

4.4 Social

The composition of amenities was pivotal to unlocking *social* opportunities too which provided the most direct opportunity to assess the contribution of hospitality to this care setting. Concurring with earlier research (Rasmussen and Edvardsson (2007), a sense of home, fresh flowers, a peaceful courtyard to look out onto, a tea room to satisfy both inpatient and visitor needs were all welcomed for their warmth and inclusivity, indicative of person-centred care as they offer choice. They provide opportunities for patients, if they so wish, and are able, to mix with other patients. They engage cerebral activities and help to prevent feelings of isolation:

'You don't want it too quiet as it becomes insular then, which then defeats the object of coming which is the company and the friendship you can get from it' (outpatient).

Some service users spoke of friendships developing with people they met in these spaces prompting connections and mutual support:

'Helps too because a lot of people don't have good days and you learn that you're not the only one' (outpatient).

Shared spaces are not automatically hospitable landscapes for everyone however. Not everyone wants to be social, to co-operate and to connect. Illness does not strip a patient of their personality. Just as in times of health patients may be happy in their own company, so too, during times of illness these solo traits can continue. Consequently, not all service users had positive experiences of socialising with other patients, for reasons which may have nothing to do with medical circumstances:

'she always struggled in the company of others' (relative).

For others, problems arose because their illness caused communication difficulties, or, more often, they avoided social spaces because they found it difficult to watch other people decline:

'I made some really good friends who have sadly passed away, so I tend to shy away from going to a set group now, it is hard watching people decline as you get better and move on' (discharged outpatient).

4.5 Holistic

Holistic services were an integral part of the hospice landscape. The composition of these services varied unit to unit, often including: complementary therapies; feel-good treatments (e.g. massage and beauty treatments); relaxation services (e.g. Tai Chi); classes (e.g. art, seat Yoga); library; café; gift shop; and spiritual support. Holistic services had the capacity to return, even if only momentarily, a sense of normality and identity, stripped away by illness and treatment regimes. Whilst more often than not these services were utilised by patients, families were co-beneficiaries in value created, enjoying their transitional utility:

'She was always fussy about her hair and the little hair clips she used to wear, and she would say look at the state of my hair! We used to come and sit and brush it and put her little clips it and make sure she felt nice'. (Bereaved)

Holistic services introduced a sense of normality into a complex life stage, consistent with the ethos of person-centred care. However, accommodating the wishes of patients is not always easy. Some requests may be manageable:

'fish and chips from the chippy [i.e. a fast food style fish and chip shop]' (inpatient).

Others can be more problematic:

'I wanted to smoke (...) was doing it in the bathroom (...) they [staff] weren't happy' (inpatient).

Offering a hospitable home from home environment, at times, whilst consistent with person-centred care, can be the juxtaposition of ‘health care’ aggravating the circumstances that underpin the need for hospice care in the first place:

‘they gave him a drink [alcoholic] (...) it’s set him off [drinking] again’ (relative).

5. Conclusions

This study has sought to provide a more nuanced understanding of the contribution of hospitality to person-centred care for service users experiencing palliative care. We have adopted a service ecosystems lens which enables us to consider multiple actors involved in delivering care (service providers), receiving care (patients), and supporting care (family and friends). All have contributed to the study with the data collected providing a rare insight into a community facing intense complexity. Whilst the nature of the study, life-limiting illness, prevented a longitudinal study of patients and carers, our results emerge from an extended period of observation not usually achieved in hospitality research, which is testament to provider commitment to the pursuit of service excellence. Hospice care is responsive and make a difference to the lives of not only patients, but families too. Hospitality is pivotal to the delivery of person-centred care in this environment. It has a profound impact upon making people feel welcome and safe. People have trust in this care.

As with any empirical study though there are limitations which are important to consider, and which may well offer opportunities for future research. Our study is UK based and focuses upon one part of the healthcare sector, palliative care. It has considered a service largely delivered through the public sector, a service ecosystem configured accordingly. Future research would benefit from considering whether the same findings would emerge in a study

of curative treatment, a study of private healthcare, a study of other international locations less focused upon public provision.

Extending the data collection to include the family allows us to appreciate the pivotal role such play as hospitality resource integrators. All service users, whether they are patients or family members, shape value of care in everyday interactions with service providers. Researching dyads has empirically confirmed that value of care is person and situation dependent. Our findings show that different users value different components of the same service delivery. For instance, a hospitable setting for patients may be reflected in the hustle and bustle of shared wards. In contrast, family, believing that they are speaking for the patient, may value the calm and personal space of individual rooms. Testing this potential ambiguity within other health-care settings, care homes for instance and transitional health-states, diabetes for instance, would be a useful next step.

Currently each stair in Figure 2 is presented as of equal significance. Testing this model against the differing levels of responsibility patients and their families take for their care, or the care of their loved ones, at different stages of the palliative care journey, within different settings, including care homes for instance, would allow a more granular insight into person-centred service needs at this life stage. In so doing it would also unlock further opportunities for the hospitality research community to apply their skills and continue to make a profound uplifting difference to individual and community health and wellbeing at this most challenging of lifestages.

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