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PATIENTS' EXPERIENCES OF NURSES' HEARTFELT HOSPITALITY AS CARING: A QUALITATIVE APPROACH

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ABSTRACT

Aims and Objectives

The aim of this study was to answer the question “What is the lived experience of hospitality during a patient’s hospital stay for elective surgery?”

Background

Hospitality centres on a host offering comfort to others, as in a personal care context. Caring constitutes the essence of what it is to be human, having a profound effect on wellbeing and recovery from surgery. Caring is one of the most elusive and diversely contested concepts in nursing, however, care provided by nurses seldom transcends as deep human connections and social utility. This study explored the nature, meaning and experience of hospitality as care from the perspective of elective surgery patients. COREQ criteria were used.

Design A hermeneutic phenomenological methodology.

Methods

Data were gathered through semi-structured, face to face interviews with seven patients from both private and public hospitals, and from different cultural backgrounds.

Results

Three interpretative notions were: experiences of hospitality as feeling “really” cared for, being at ease and being healed. Hospitality exists in the receiver’s lived experience, evoking a special moment which leads to feelings of great comfort and feelings of being truly cared about. When hospitality is received patients feel a connection, they begin to trust and their healing begins.

Conclusion

The offering of often small, yet heartfelt acts of hospitality, indicated that nurses can evoke powerful lived experiences which benefit patients undergoing elective surgery.

Relevance to clinical practice

The importance of prioritizing emotional and social connections to the hospitality experience needs emphasis at all levels of the clinical structure. Hospitality as caring needs to form a part of all undergraduate and postgraduate nursing curricula, and ongoing professional development. The participant quotes presented in this article could form exemplars for the provision of hospitable nursing care practices, highlighting nurses getting to know and understand their patients, and being interested in their lives.

Keywords: Hospital Care, Caring, Nursing Education, Patients' Experiences, Phenomenology,

What does this paper add to the wider global community?

- This paper provides first time phenomenological data on how surgical patients experienced care given by nurses.
- The data provides a basis for global nursing education on the powerful role that nursing care delivered with hospitality, from the perspective of the patient as a guest, can provide in fostering emotional and social connections that promote healing.
- Fundamental to nursing care across cultural contexts is that nurses show a deep interest in the lives and experiences of their patients.

INTRODUCTION

Caring constitutes the essence of humanism in nursing, being central to the delivery of effective nursing care. Beyond what care is provided, how care is provided is evidenced as mattering to those who receive it and to the delivery of nursing services (Adamson & Dewar, 2015). The 'how' of providing care has been situated in relational ethics (Cronqvist, Theorell, Burns, & Lutsen, 2004; van Hooft, 2011), caring *about* those cared for (Cronqvist et al., 2004; Henderson et al., 2007), and in doing the small invisible services that are not easily measured in practice (MacLeod, 1994; Pearcey, 2010; Williams, Kinnear, & Victor, 2016). While it may still be contested ground, the notion of caring recurs in nursing theory and research as fundamental to nursing education (Adamson & Dewar, 2015) and practice (Leyva, Peralta, JTejero, & Santos, 2015). The notion of hospitality in relation to caring is appropriate because hospitality does not need to sit within a specific context, but should instead be envisaged as a "condition and an effect of social relations, spatial configurations and power structures" (Lynch, Molz, McIntosh, Lugosi, & Lashley, 2011, p. 14). Hospitality centres on a host offering comfort to others. Burgess (1982) describes such acts of hospitality as a "gift exchange" (p.49) in which the gift is generous kindness. This paper draws on the findings from a phenomenological study. It illustrates how the participants' experiences of feeling cared about as patients, were experiences of hospitality offered in a hospital context.

BACKGROUND

Viewed from a moral perspective, Noddings (2003) defined caring as "a burdened mental state....[in which one] "has a regard for or inclination toward" (p. 9) someone. This suggests human caring may arise from a natural affection, concern or predisposition towards someone, and/or a responsibility or duty to care. Seen from a justice perspective, members of social institutions stand to honour others' rights because of the special relationships that exist within institutions (van Hooft, 2011). Putting this definition in the context of healthcare institutions, nurses are obliged to care because people present with special health needs. Like the other healing disciplines, nursing's standing is therefore highlighted by its "professional commitment to caregiving" (Kleinman, 2012, p. 1550). For this reason, Kleinman (2012) suggested caring might be best understood from an anthropological perspective as the giving and receiving of a gift. The giver of caring attends to doing what needs to

be done for the other and, in reciprocity, can be transformed by the relationship and social good created.

In accord with Kleinman's (2012) perspective of caring as reciprocity in gift-giving, a meta-synthesis of nursing literature on caring concluded that patients' and nurses' wellbeing are enhanced by nurses' caring (Finfgeld-Connett, 2008). Critical attributes explained in the caring process are synthesised as expert practice, evidenced as nurses' nuanced ways of understanding and doing; interpersonal sensitivity, evidenced as a receptivity to and apprehension of patients' realities; and forming comfortable, trusting relationships. The outcome is a reciprocity of nurses' conferred and received wellbeing (Finfgeld-Connett, 2008). This theorised outcome is conceptually congruent, with Nodding's (2003) supposition that caring is transformative. Moreover, the caring attributes explained by Finfgeld-Connett's (2008) process of caring are in line with the way Nodding's ethic of care is enacted and experienced in caring moments (Wright-St Clair & Seedhouse, 2004). Even in pre-hospital, trauma situations, patients' have recounted stories of experiencing when caring goes beyond "just medical treatment and life support" (Elmqvist, Fridlund, & Ekebergh, 2008, p. 191). Such data point to an existential difference between being cared for by nurses and being cared about as a person.

A distinction between nurses' experiences of doing the 'hands-on' patient care and doing the care in a way that communicates they care about the person has been illustrated in a number of studies. Historically, Florence Nightingale's approach was in her professionalization of "sensitivity to the person's experience, tender attendance to the needs of the suffering person, and to nursing as a spiritual practice" (Smith, 2013, p. 2). Her notions are in accord with early monastic understandings of caring for the sick as providing hospitality (King, 1995). Such hospitality existed in the host attending to the guest's security as well as physical and psychological comforts (Hepple, Kipps, & Thomson, 1990). Hence, the first 'hospitals' evolved in the Middle Ages from the hospitality early monasteries provided to the sick. "The close connection between caring for the sick and the church gradually developed into institutions that were eventually to be controlled by municipalities becoming a public service for the community"¹. Hence, contemporary hospitals emerged from hospitable care for those in need.

Mayeroff (2005) identified the major characteristics of caring as patience, honesty, trust, humility, hope and courage with the capacity to influence people's lives towards goal-directed outcomes. A nurse theorist, Watson (1979), framed caring as an inherently instrumental and expressive activity. Instrumental activities are manifested in meeting patients' physical and treatment needs, while expressive activities are psychosocially orientated behaviours, such as offering emotional support and empathy, being sensitive to patients' needs, and respecting their beliefs, rights and privacy. As an extension of this research, Kitson (1987) identified the shared characteristics of professional caring as practicing commitment to a sufficient level of knowledge and skills, while upholding the individual integrity of the patient. Together, these professional caring characteristics manifest in the nurse-patient relationship.

Nurse anthropologist, Morse and colleagues (1991) highlighted the five fundamental

¹ This reference has been blinded for review.

philosophical beliefs of caring; caring as a human trait, caring as a moral imperative, caring as an affect, caring as interpersonal interaction and caring as a therapeutic intervention. There have however been a number of relatively recent critiques that delegitimise caring as an essential concept in nursing (Watson & Smith, 2002), the contention being that the context and philosophical perspective influence how caring is defined. A recent integrative review concluded that caring remains as a complex, inexact, and elusive concept in nursing, in need of further critical development (Leyva et al., 2015).

The philosophical, historical and conceptual links between hospitality and caring in healthcare are evident. Over two decades ago, Patten (1994) proposed that enacting hospitality ought to be “a greater part of today’s nursing management” (p. 80h). Yet, a gap in knowledge exists with relatively few studies having sought to understand what hospitableness in caring means in hospital-based nursing. Therefore, this study set out to explore people’s experiences of hospitality during a hospital stay. This paper reports participants’ experiences of encounters with nurses, rather than all experiences disclosed during the study.

METHODS

Aim

The aim of this study was to answer the question “What is the lived experience of hospitality during a patient’s hospital stay for elective surgery?” The findings from the study as a whole have been previously published². The term ‘patient’ is used to signify that people’s stories relate to their time in hospital.

Design

A hermeneutic phenomenological methodology (Heidegger, 1927/1962) was chosen for this study. The methodology is recognised as a suitable approach in healthcare research to learn more about the nature and meaning of the human lived experience (Smith, 1998). It calls on the researcher/s to ask ‘what it is to be’ human to uncover the ‘what is’ of a given situation (Smythe, Ironside, Sims, Swenson, & Spence, 2008). While hermeneutic phenomenology may not be used to answer practice-based questions directly, the methods aim for a deep understanding of the phenomenon of interest in a way that can inform practice. Yet hermeneutic phenomenology goes beyond evoking deep descriptions of people’s lived experiences; it calls on the researcher to interpret what the phenomenon itself means. The interpretation of meaning is the researcher’s, rather than the participants’ interpretations (Gadamer, 1993), as it can only be gained from hearing and understanding all participants’ lived experience stories. In this instance, the participants’ shared their experiences of being an elective surgery inpatient, as lived by them. The researcher’s interpretations went beyond understanding what each story was saying, to interpreting what hospitality means for these elective surgery patients. Evocative language is used to describe the findings as a way of revealing the essence of the phenomenon; or that which makes this “‘thing’ what it is and without which it could not be what it is” (van Manen, 2001, p. 10).

² This reference has been blinded for review.

Consistent with the methodology, it was assumed the researcher's (first author's) history and experiences would be in play throughout the research process rather than be bracketed out (Lavery, 2003). For this reason, the researcher engaged in a pre-suppositions interview conducted by the second author, prior to data gathering, as a way of understanding what she already 'knew' about the topic of interest. In this pre-suppositions interview, she was invited to reflect upon what her own experiences of hospital care were and how she came to know what she did. Her reflections included her history in hospitality management, and of setting up and running a cafe in an acute hospital. She recounted experiences in which the patients that came to her cafe seemed somehow different when 'welcomed' in to this setting. In addition, she reflected on her own experiences of being in hospital and how that was for her. These reflections led her to the notions that hospitality within a commercial setting, for example a hotel or restaurant seemed no different than within a hospital, both offered accommodation, food and drink, the difference being that within one space the "customer" is sick (patient). Yet the expectation is the same; to receive a welcome, a service/product with a human exchange, the key to this being hospitality is that all must be 'heartfelt' and 'genuine' or the customer will not experience hospitality, which transcends in the same way for a patient experiencing care or not from a nurse. The transcript was used as a prompt to ask open questions of the participants and of the research findings, as a way of going beyond her own experiences and of remaining open to what might be. For example, one female participant was put in a mixed ward, it was evident that she was uncomfortable with this, this is not something the author had experienced, thus it was of interest to gain understanding of this situation so she asked the question "What is it, that you found particularly difficult about being in a room with men?"

The methods used to stay open to new understandings as well as to the later interpretations of the study findings were philosophically aligned with what Gadamer (H-G Gadamer, 1975/2004) named 'a fusion of horizons'. A fusion of horizons is said to occur when what is seen from a particular vantage point expands to take in another's horizon of understanding, allowing the interpreter to see far beyond what is close at hand (Lavery, 2003). During the iterative data analysis process, the researcher moved inward and outward in her thinking allowing the horizons of the study participants and her own to ultimately fuse together to uncover a deeper understanding of the meaning of the phenomenon itself (Koch, 1999). This interpretive method of delving in and out of the text continued until a "place of sensible meaning" (Lavery, 2003, p. 30) was described by Gadamer as being within the hermeneutic circle.

Ethical considerations

Auckland University of Technology Ethics Committee granted approval [number 13/193] for this study undertaken by the first author, in partial completion of a Master of International Hospitality Management (MIHN). Participants were given written information about the project including an introduction to the researcher, her interest in the topic, and her aim to complete a MIHM. Participants gave written informed consent and had the right to withdraw from their interview or the study without giving a reason. Participants' self-selected pseudonyms were used for the interview transcripts and all research outputs to protect confidentiality.

Setting and participants

Given the phenomenon of interest was patients' lived experiences of being an elective surgery inpatient, the inclusion criteria were designed to recruit people who had sufficient time in, and be able to recount their experiences of being in a hospital. Potential participants were eligible if they had been admitted to a public or private hospital for elective surgery for a minimum of at least three days within the previous year, were adults aged 22 or over, and resided in the Auckland region. Anyone who was a current hospital patient was excluded.

Participants, who were unknown to the researcher, were recruited using purposive sampling and snowballing. Initially, flyers about the study were placed at various locations in West Auckland, New Zealand, including community centres, libraries, doctors' surgeries and community notice boards. People who were interested in receiving more information about the study could telephone, email or text the researcher. People's eligibility to participate was established during the first point of contact. Those who met the inclusion criteria were sent a participant information sheet, which explained the purpose of the study 'to understand what hospitality means for patients undergoing elective surgery as a hospital inpatient', and a consent form. An appointment for individual interview at a convenient, private location was made with each consenting participant. After the first few participants were recruited, subsequent participants were invited to pass on information about the study to others who might be eligible. Recruitment continued until data analysis indicated sufficiency for interpreting the phenomenon of interest.

Seven women aged 22 to 65 years volunteered and were enrolled in the study. None withdrew prior to project completion. One had been admitted to a private hospital, and six to a public hospital. No men who indicated an interest in the study met the inclusion criteria. Participants were New Zealand citizens, had experienced different surgical procedures and were from different cultural backgrounds, including New Zealand-born European and Indian.

Data collection

Data were gathered by the first author during 2014 using semi-structured individual interviews that lasted between 50-90 minutes. All participants were interviewed once only, in their own homes, with no one else present, at a time of day that was convenient to them. Congruent with hermeneutic phenomenology, the researcher used a conversational-style of interviewing to encourage participants' story-telling related to the topic of interest. The interview questions were designed to evoke stories about particular moments of being in hospital, and of particular events (Wright-St Clair, 2015), rather than ask direct questions about hospitality. It was assumed that things that were experienced as hospitable in nature would emerge in the stories. For example, after some general conversation the researcher invited the person to "tell me about being a patient in hospital." In the talk, the researcher invited accounts of particular moments and events, rather than seeking general experiences, as in "tell me about what happened when you first arrived" or "tell me about things that happened that influenced your personal sense of being attended to." Consistent with

hermeneutics, the participants were asked also about their interpretations of things, such as "can you tell me why you felt that." In closing each interview, the participant was asked if there was anything else to add. Interviews were audio-recorded and transcribed verbatim.

A reflective diary was kept.

Data analysis

Data gathering and data analysis occurred hand-in-hand, by the first author, until saturation was achieved. In this way, initial interpretations informed the researcher's interviewing methods and the questions used. Data analysis was iterative. Each transcript was read and re-read to enable dwelling in the data. Then for each, discrete stories describing particular moments and events of being a patient were drawn from the verbatim transcripts and collated. Each person's collated stories, rather than the verbatim transcript, was returned for verification that they described the experiences, and for agreement to include the stories as part of the research data. Once participants verified their collated stories, data analysis progressed iteratively, by re-reading and writing about what the storied text was saying. This method allowed moments experienced as hospitable, or otherwise, to be heard in the data. At times it was the evocative language that was revealing, such as *"It was interesting I could not help but notice, that all these intensive care nurses were very busy socialising with each other; looking at their cell phones and gossiping, I was a bit taken aback with them just standing around gossiping. I thought aren't you supposed to be watching the patient?"* Other times stories described things that became "the 'ah ha' moments" (Smythe et al., 2008, p. 1390) in the data analysis. For example in this story the 'ah ha' came at the end *"Before the surgery he told me he would come to see me afterwards. So he came, he explained to me but even at that time I was not ready to listen. I think he woke me up and asked me how I was feeling, I remember I was in pain and then I went off to sleep again. But I remember he came."*

Once each participant's stories had been verified, Koch's (1999) method of interpretation through immersion in the data was used. Reading and writing about one participant's stories, and thinking about what they meant, moved from single stories to reading across them all. This was a way of engaging in the hermeneutic circle of contemplating the parts and the whole of the text. The writing about each story was interpretive; going behind the text itself by asking about what the text was saying to uncover deeper understandings announced within and across the stories. Ultimately, the illustrative stories were clustered together as notions that formed around participants' similar and dissimilar meanings of experience. Finally, the researcher read across all the notions, along with the illustrative quotes, to interpret the meaning of hospitality in hospitals for these participants. This interpretive approach is referred to as a "hermeneutic of suspicion" (Koch, 1999, p. 27) aimed at uncovering that which was hidden at first. The authors adhered to the Consolidated Criteria for Reporting Qualitative (COREQ) checklist in reporting the study (See Supplementary File 1).

RESULTS

The three notions interpreted from across all of the research data are presented. Each one is defined briefly before one or more participant quotes are presented and interpreted. The quotes were selected because they illustrate some of the raw data informing the analysis. Additionally, they allow the reader to see how the text informed the interpretation.

Experiencing hospitality as feeling “really” cared about

At times during their stories, participants spoke of moments when they felt overwhelmed by a nurse’s care and attentiveness. These were occasions when something occurred beyond what the person, as ‘a patient’, reasonably expected within a hospital environment. Such experiences led to memorable stories that would be told and retold. In this way, Hemmington (2007) talks about hospitality going beyond excellent service to provide unforgettable experiences. Beth’s story speaks of her surprise in such a moment:

On Saturday morning I mentioned to the staff that I would quite like to go to the chapel service on the Sunday if it could be arranged; if you can’t arrange it then it’s no big deal. But they did! I must say they were really, really good about arranging it. Which I thought was really sweet of them. Each time there was a change of staff, the staff member would say ‘I will take you to the chapel tomorrow’. In fact, I nearly said to them you are taking this way more seriously than I am, ha ha. I was prepared to jump into a wheel chair, and put my foot up, but the nurse said absolutely, categorically not, you have to stay in bed. Well I was like, you are kidding me; you are taking me to church in a bed? This will be a first.....I was the only one in the chapel in a bed the others were sitting on chairs or on walkers. That was really lovely; I felt really special that it was such a nice thing for them to do. (Beth)

Christie recalls experiencing a sense of shock at the nurses’ attentiveness:

I was excited you know, but very nervous because of a previous experience I’d had and also because my operation had been postponed before. So I was very anxious as to what is going to happen, whether I was going to have the surgery or not....The nurse came to take me, she said I shouldn’t feel uncomfortable, she joked with me about my bag,¹. I was shocked how much she noticed the little things. She said she can look after my bag for me....Even my shoes; she looked at me and said “are you comfortable to wear those heels here? I can give you another pair.” I was shocked, I mean...even the simple things, the little things she took care of. I was shocked actually, how much they are noticing me and they are caring about me. (Christie)

Cody’s story shows how her expectations of the nurses were shaped by her first few days in hospital. Then she noticed something different:

It wasn't until the last couple of days I had a really nice nurse and she was so nice that she made me realise what a pain in the neck some of the other ones had been. She was just helpful and right into that nurturing, that whole well being, going the extra mile, realizing that I still had no use of my whole arm; you know she was just supportive about I was going through. She was lovely, she was really, really nice. She stood out....This nurse had a great bedside manner. (Cody)

Similar to Cody's initial experiences, Beth understood what hospitality in a hospital was when it was seemingly missing. Beth's story illustrates her interpretation of being washed at night as a convenience for the nurses rather than as attentive to her needs. Yet, it may not have been what Beth's nurses intended:

There was one really weird thing that happened to me in hospital. The nurses came and washed me at midnight; I thought it was the weirdest thing. I was awake anyway, they said 'oh we will give you your wash', I'm like ok. I noticed they did this to some of the other patients too. I just thought maybe they were really busy during the day and they were just trying to kill the down time at night when they have nothing to do. One would have thought that they would want people to be resting in their beds, but I was washed at midnight. It was really quite bizarre, a really strange thing. (Beth)

In Beth's recounting, this experience, as "quite bizarre, a really strange thing", reveals her interpretation of the night wash as lacking consideration for her, and the other patients' needs in the moment. Not knowing the nurses' purpose left the space open for Beth to interpret the action as less than caring hospitality.

Being at ease

Other stories recounted by the participants pointed to occasions when a nurse, or another practitioner, engaged in a way that lightened their troubles. It was a way of relating. Some nurses had a way of freeing up the participants' concerns, of comforting them, and bringing about a tranquil state.

Susan's story hints at the comfort she felt when nurses seemed to recognise individuality and to give a little extra of their time:

On the main ward I remember being pushed into position, I can't remember if there was someone there to meet me, but very soon a nurse would come in and introduce herself.... and that was nice! What really made a difference were the nurses who made a personal connection; "what are you reading? I have read that, what do you think of this?" Even those who were really, really busy; if they gave me a bit of time, that was very much appreciated that they would share a bit of themselves. (Susan)

Tina's story uncovers an occasion when a midwife connected with her on a very personal level, recognising that other factors, not her medical care, were making her anxious and she reacted in a way that was beyond expectation to put her at ease.

There was one really amazing mid wife , she rang Mum, she wanted Mum's phone number, she wanted to ring her, so that Mum could come in and help bathe the baby. She said we will wait for you, so you can help with baby's first bath, she knew we had issues with the in-laws, that whole family thing, and Mum was feeling left out. The midwife had been listening to our conversations so she had got personally involved, I was shocked at that. I thought she was interfering at first but actually she was really, really nice; she was going out of her way to get everyone involved, it was quite 'wow', that was amazing. She really went over and above what she had to do. (Tina)

The next story reveals a moment for Grace when her nurse noticed her need to be calm enough for a restful sleep:

One night I couldn't go to sleep. I had plenty of drugs in me so I don't know why? But then one of the nurses said "Oh sometimes you know if we put an extra blanket over your feet and really tuck you in then you can fall asleep." And I thought, oh that's nice "Yes please". And it worked. Having the extra blanket over my feet must have just tipped the balance. (Grace)

This story points to the notion that hospitality in hospital encompasses more than a series of service transactions involving nourishment and accommodation; it also incorporates social interactions. When these are offered together in a harmonious way, the guests can feel at ease or 'at home' in their surroundings (Cassie & Reuland, 1983). As Pizam (2007) suggests, the 'ity' factor, as in 'hospital-ity', is created when a philosophy of caring happens in an environment with 'the right feel'. Patients want to feel comfortable and relaxed while in hospital, and it is often the impact of the surrounding environment in which they find themselves, which has a significant impact on their emotional and physical states and their 'being at ease' (Bitner, 1992).

Being healed

The stories in this section illuminate moments when these participants experienced nurses' presence as a socially-connecting experience that was, in some way, restorative. They were moments in which 'the patient' felt whole, more like 'a person', or moved towards recovery.

When asked about what hospitality meant when in hospital care, Susan expressed it as experiencing a nurse's sincerity in relating:

I have never associated hospitality with hospitals however on reflection I think it makes a big difference. To be able to make connections with people in a sincere way, not just "How are you darling?" but in a sincere way so that they look at you when you speak and you feel acknowledged. You can just tell can't you? And when a person makes a personal connection with you it is just lovely, you feel more yourself again and everyone likes to be acknowledged. (Susan)

Susan's words point to the notion that true hospitality, true presence and sincerity, is not something that practitioners can be taught. It is something that exists within the person. She suggests that some nurses have it and some do not. Presence is a quality, a way of being a nurse that should be developed and encouraged within hospital settings. Susan discloses how she felt better in herself, healed when a personal connection was made with her; it made a big difference.

In this next story, Christie recounts a different way in which the nurses' relating helped move her towards recovery:

A day after my surgery they asked me to walk around the ward; they wouldn't let me go on my own. Actually, they were worried about me because of my history. My previous surgeon, he told them "Remember how she came in? She has to go out the same way." I felt quite comfortable there. So I felt it was like my house, they looked after me so well, I didn't think of coming home. (Christie)

In Christie's recounting this story, she points to her experience of the relationship; of being a guest and of receiving special treatment. In the moment she felt homeliness, warmth and being safe. Christie experienced being cared about as a mode of healing.

Hospitality exists in the relationship between a guest and a host (Lashley, 2000). The nurse is, paradoxically, both the host and a guest in the patient's life, entering as a stranger who seeks to better understand the person to aid his or her healing (Nouwen, 1976; Parse, 1992). Attending to a stranger and opening one's mind to the other is to understand the lived experiences of the other and is described by Bunkers (2003) as acting with "a spirit of hospitality and attending to others in true presence" (p. 307). Holism of care embraces a philosophy of hospitality as way of managing patients' healing and satisfaction together (Patten, 1994).

DISCUSSION

Three interpretative experiences of nursing care as hospitality were revealed in this study; being “really” cared about, being at ease, and being healed. Together they suggest the meaning of caring in nursing is as a healing for patients. These concepts are complex to translate into nursing delivery care systems, needing to draw on integrated professional skills and a highly educated level of critical thinking and responsiveness. The offering of hospitality as a professional competency and the central crucible of what was desired, yet unspoken, from nursing care, provided in nuanced ways of understanding the phenomenon. Fundamental was that, these patients needed to sense comfort in order for them to feel they were healing. Highly salient was the interpersonal sensitivity of their nurses, which manifested as receptivity to, and apprehension of, patients’ realities, forming comforting and easy relationships. The hospitality care delivered to these patients informed a reciprocity of conferred and received wellbeing (Fingeld-Connett, 2008). This theorised outcome is conceptually congruent, with Nodding’s (2003) supposition that caring is transformative for healing and wellbeing.

Patients arriving for surgery have a heightened anxiety, in part due to worrying about what will happen to them, making them feel vulnerable and commonly fearful of what is to come (Hepple et al., 1990; Severt et al., 2008; Sørli et al., 2006). The participants in this study spoke of their heightened anxiousness being replaced by feelings of reassurance and comfort delivered through respectful welcoming nursing interactions. Such moments, often fleeting, enabled them to feel more at ease with themselves and in their surroundings.

These participants felt involved in conversations about them and felt respected. Such moments of offering hospitality as care happened as an individualized humanism that created a deep personal connection and a basis for healing. Feelings of ease and comfort were a recurring theme within the patients’ stories, with comfort often in the form of a few spoken words of reassurance, as Susan described. In contrast, they were noticed as absent in Beth’s story about her night wash.

Central to feeling cared about was that somebody else was thinking about what another person may need. Most participants expressed comfort through interactions with specific nurses; when the nurses’ actions appeared to originate out of a genuine desire for the pleasure and welfare of the guest who is in need (Telfer, 2000). The findings further suggest that it was sometimes just the smallest of things nurses did, or the mood in which something was done,

which played the most significant part in the lived patient experience. The deep connection with specific nursing staff facilitated care and a sense of wellbeing amongst them. These patients sought to be treated as a person and not as an object of analysis, suggesting that it is being connected that makes the difference to the overall wellbeing of the patient (Renzenbrink, 2011).

Through the interpretation of these patients' stories, hospitality presented in many forms, although in not the same way for each one. The embedding of hospitality as an act of professional care was seen to enhance the lives of these patients, within a context of respect recognized at once as subtle moments of *warmth, sincerity, or feeling acknowledged*. Similarly, other researchers report the showing of compassion by the tone of a nurse's voice, through a nod of the head, a look into the eyes, or a comment (Stanley, 2002). They constitute a temporary shared moment which acknowledges the other through a hospitable interaction (Lugosi, 2008). In congruence with our findings, it is this emotional, socially connecting form of hospitality which we suggest forms the basis of healing and is most beneficial in healthcare (Bunkers, 2003; Gilje, 2004;).

Hospitality was highly salient when visibly seen in nursing care delivery as manifested in the lived experiences of these hospitalized patients. When a patient experiences hospitality, it leads to an overall feeling of being cared about (Bunkers, 2003; Gilje, 2004; (Peloquin, 1993); Renzenbrink, 2011). Many such special moments of hospitality were uncovered in these stories and evoked different emotions: feeling respected, feeling listened to, feeling special, feeling noticed, and feeling happy.

When patients felt they were cared about through relational hospitality, they remembered the encounters in a positive way. Nurses professionally offering hospitality within their scope of care delivery was pointed to as aiding their overall healing. This finding is similar to literature reporting how moments of respectful kindness in caring is compassionate care that serves humanity (Williams et al., 2016). Thus, when nursing hospitality was received, it was experienced as "a genuine concern about the [recipients'] well-being" (Cronqvist et al., 2004, p. 68). When complex nursing

care interventions were delivered with the central tenant of hospitality present in the form of comfort and emotional connections it evoked a special moment which lead to feelings of ease, healing and being truly cared about.

Limitations

The limitations of the study include that despite attempts to recruit males, the participants were all adult women. Men's experiences may have been different and therefore their voices are absent in this study. People who had had elective surgery only were included. Hospitality as experienced by people in pre-hospital emergency or acute surgery situations may differ. The small number of participants might be considered a limitation, however, rich data were gathered which allowed for an in-depth exploration of the phenomenon of interest. The interpretations of the data are the authors' and not the study's participants. Rather than a limitation as such, this approach is consistent with the hermeneutic phenomenology methodology used. While generalizability of the findings was not the aim, the study's results may be transferable to similar practice settings elsewhere.

CONCLUSION

This interpretive phenomenological study enabled a deep understanding of people's experiences of nursing hospitality as it existed for them as elective surgery patients. By using a hermeneutic phenomenological approach, we were able to uncover poignant moments of participants' sense of being human in the hospital context. The similarities of the offering of hospitality and nursing care are not found only within the functional and technical aspects of nursing, but in the deep emotional and social connections that happen in nursing moments between a guest and a stranger. It is these occasions, such as when a nurse takes a moment of his or her time to show a genuine interest in the personhood and life of the patient, that people's lived experiences are most remembered as meaningful.

RELEVANCE TO CLINICAL PRACTICE

An understanding of the overall consumer experience of care and the central importance of hospitality enables nurses to provide memorable and socially connected healing experiences for patients in their care. A hospitable welcome and ongoing interest in the patient's wellbeing sets the scene for a patient's hospital stay. Furthermore, the importance of the supportive dimension of hospitality provides patients with critical knowledge of knowing who will take care of them, who will listen to them, in turn validating their humanism.

The nursing implementation of hospitality through fostering deep emotional and social connections will mean that patients feel they are 'expected' and welcomed upon arrival in surgical units. When the emotional needs of a patient are put at the core of care delivery statements, patients' hospital experiences will be greatly enhanced toward positive health outcomes. When a nurse attends to the emotional and psychological aspects of the treated patient alongside the medical aspects, patients' wellbeing and healing improves. (Wu et al., 2009).

While the theorization and application of care has always been fundamental to nursing service delivery, highlighting hospitality as a means to raise the visibility, respect and dignity of care needs to be incorporated into nurses' education and their ongoing clinical practices. They might take form of written stories or video clips of nursing care practices that reveal hospitality in play, being both highly visible and salient in all hospital policy and document processes. These exemplars of care hospitality would highlight nurses' mindfully getting to know and understand their patients, and being interested in their lives. The exemplars also would feature providing a warm welcome, ongoing courtesy, maintaining patient dignity and treating the patient as a guest in keeping with the principles of hospitality (Bunkers, 2003; Stanley, 2002; Youngson, 2012).

Hospitality as an adjunct to the centrality of nursing as caring can be made integral to all aspects undergraduate and postgraduate education curricula. This foundation should be underscored by the valuing of social connections and knowledge of the importance of role this plays in patients' understandings of how they were cared about. Such educational attention to emotional connections would be further enhanced with knowledge- and value-based education on the attributes of human dignity and integrity, autonomy, altruism and social justice (Fahrenwald et al., 2005). Education of this nature may serve to enhance how front line nursing staff are with people in the care context; in a similar manner to that which a concierge provides for hotel visitors.

This study's findings emphasize the importance of all levels of hospital structure, mission statements, ward care delivery, and nursing care prioritize providing hospitality. The valuing and provision of hospitality, with a mandate that the patient is treated as a guest, would also need to be included in the orientation and ongoing education of allied health and administrative staff. Also clinically relevant is ensuring that, when nurses conduct professional service delivery, they use that time to talk or listen to their patients, as acknowledged by our participants.

While numerous well researched theories exist elaborating on the centrality care to the nursing profession it is important that the contemporary delivery of humanistic care draws on the principles of hospitality, that can intervene in a dignified manner to put patients at ease, and enable the deep emotional and interpersonal connections that are crucial to promoting recovery.

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