The Social Practice of Care Hotel Vacations

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Chapter Summary

Due to the increase in the number of elderly and people seeking medical care, the hotel market with a blend of care and leisure experiences is expected to grow in the future (Han, 2013; Karuppan & Karuppan, 2010; Laesser, 2011). The role of care hotels as an intersection between the care and the tourism sectors makes a vacation in a care hotel an interesting social practice to study. In this contribution a social practices approach (Spaargaren, 1997) is applied to investigate how demand and supply interact during a care hotel vacation. Semi-structured interviews are used to identify successful and less successful interactions or practices between senior guests and personnel in five Dutch care hotels. These interactions are related to materials (care and leisure facilities), competences (skills and empathy of the personnel) and meanings (motivations and aspirations of guests) in the care hotel practice (see Shove et al., 2012). The results show that a social practice approach combined with a qualitative research method may be more suited to analysing the complex encounters between guests and personnel during care hotel vacations than more traditional theories from service or experience quality studies. Simultaneously, this study makes clear that we need to develop alternative qualitative (and/or quantitative) research methods to study more privacy-related or intimate practices or rituals as in the case of care hotels

Learning Objectives

After reading this Chapter, the reader will be able to:

1. Understand that a social practice approach offers opportunities to comprehensively study the complex interactions between guests and service providers in the context of a care hotel vacation.
2. Understand that the success of interactions or consumption junctions in the practice of a care hotel vacation is strongly influenced by mutually interlinked elements as materials, competences and meanings.

3. Realise that in case of privacy-related or intimate practices it is not always possible to conduct face-to-face interviews and/or participation observation, although these research methods are very appropriate for analysing social practices

The Issue, Opportunity or Trend: Vacation in a Care Hotel

The role of care hotels

According to Goodrich (1994), care hotels are essentially tourist facilities seeking to attract tourists with a blend of health-care services and facilities and regular tourist amenities (Lee, 2010). Care hotels offer a combination of privacy, products, services and hospitality, linked to 24 hour personal care from physicians, nurses and other health-care professionals (Han, 2013). Due to the increase in the number of elderly and people seeking medical care, the hotel market with a blend of care and leisure experiences is expected to grow in the future (Hui & Wan, 2009; Hume & DeMicco, 2007; Karuppan & Karrupan, 2010; Laesser, 2011). 'Regular' hotels increasingly cater for guests who need a temporary replacement of care at home (respite care) and/or an adapted environment to go on vacation (Hofer, Honegger & Hubeli, 2012).

The role of care hotels as an intersection between the care and the tourism sectors makes a vacation in a care hotel an interesting social practice to study, because care hotels are confronted with the challenge of mixing professional care with a comfortable hotel environment including related services and leisure activities (Han, 2013). Nevertheless, the care hotel vacation has gained little attention from hospitality and tourism researchers, and thus has not been well studied as a facet of both the hotel industry and the care sector (Cook, 2010; Han, 2013). As these sectors have undergone a shift from supply-led to demand-led environments (Connell, 2013; Fottler, Ford, Roberts, & Ford, 2000; Setterfield, 2002), it is increasingly important for them to provide high quality service and positive guest experiences.

Research on Interpersonal Service Encounters

In recent decades service quality models have become very popular in hospitality, health-care and tourism research to examine how customers assess (health) service quality (Bakan, Buyukbese, & Ersahan, 2014; Duggirala, Rajendran, & Anantharaman, 2008). While in the 1980s and 1990s the focus was on studying consumers' expectations of services related to service performance or perceived service to judge their satisfaction, in recent years links with concepts as loyalty, emotions, values, intentions and experiences of customers have been more frequently included to evaluate services or service encounters (see Dagger, Sweeney, & Johnson, 2007; McColl-Kennedy, Vargo, Dagger, Sweeney, & van Kasteren, 2012; Vargo & Lusch, 2004). According to Lemke, Clark, & Wilson (2011) the contemporary consumer demands more than just competent services, and also seeks experiences which are engaging, robust, compelling and memorable. In articles on service-dominant logics scholars study in a more holistic manner how customer experience

quality is served through and co-created by product/service usage and peer-to-peer interaction, and not just product and service quality (Karpen, Bove, & Lukas, 2012).

Even though personal aspects nowadays play a more important role in service or experience quality research and supply side and service encounters are studied more frequently in a hedonic manner (cf. concepts as ‘servicescapes’, ‘experiencescapes’, ‘services as destinations’), much research still focuses on the development of attributes or scales by using quantitative assessment measures (see Brand, Cronin, & Routledge, 1997). These studies also adopt either a customer or provider lens, even though the interaction between the two is vital in the contemporary ‘co-creation’ of experiences (Morgan, Lugosi, & Ritchie, 2010; Prahalad & Ramaswamy, 2004). We argue here that a practice approach can be an interesting tool to study complex interrelationships between demand and supply in care hotels as an adapted holiday environment. In the next sections we will present a multiple case study on the practices in care hotels using this theoretical approach.

The Innovation: Care Hotels as an Adapted Environment for Senior Tourists

Case context

Care hotels with an adapted environment for senior tourists can be found in countries such as Norway, United Kingdom, Germany, Spain and The Netherlands. As already indicated by Goodrich (1994) and Han (2013), care hotels attract tourists with a mixture of care and/or medical services and facilities, linked to 24 hour personal care from physicians, nurses and other professionals, and regular tourist (health) amenities. Although care hotels focus both on (post-)care services and vacation experiences, they do not offer medical surgeries in general (Han, 2013).

These characteristics were also applicable to the five care hotels in the Netherlands we studied (Stoffelen, 2011). Because not all fourteen officially recognized care hotels in our country agreed to participate, our study can be conceived as a multiple case study with a convenience sample. Besides care and hospitality facilities, the five care hotels offered both short and long stays, and had vacation guests as an important target group. The care hotels involved were similar in terms of services (5 stars) and price range (150 - 200 Euro per night), although they had different locations (e.g., city centre, village) and sizes (number of rooms varies from 10 to 70). Our main intention was to generate a broader view of interactions between different stakeholders or actors in these care hotels, and not to compare the hotels based on their background characteristics or to generalize the results (cf. Gibbs, 2007).

Stakeholders Involved

To study the encounters between different stakeholders or actors, face-to-face interviews were held with senior guests and managers of the five care hotels. Unfortunately, in three of the five hotels it was not possible to interview hospitality and care personnel, because the management teams “did not want to disturb the services to the guests”. Therefore, we decided to interview only the managers as representatives of the supply side. Interviews with managers seemed an acceptable approach, because the five care hotels were small organizations in which the managers cooperated closely with the rest of the personnel, and were fully aware of what happens at the workplace.

Additionally, to obtain an as complete and diverse possible picture of the interactions in the five care hotels fourteen senior guests from the various care hotels participated in a face-to-face interview, outside of the care hotel. Eight out of the fourteen guests had physical or mental disabilities (e.g. need dialysis, physiotherapy, assistance because of wheelchair use) which, however, did not impair them in answering questions during the interview. The other six guests were accompanying the guest with disabilities. All interviewed guests visited the care hotel as an adapted environment to be on vacation and did not live near the care hotel.

Two topic lists were established for interviewing purposes: one for the managers of the care hotels and one for the guests of the care hotels (see Bryman, 2008; Ritchie & Lewis, 2003). Voice recordings were used to register the information from the interviews. The recordings of the interviews were completely transcribed afterwards and functioned as the main data for this study. By constructing a data matrix, it became possible to detect connections and interrelationships and to compare the answers of the guests and hotel managers (cf. Bryman, 2008; Miles & Huberman, 1994).

Care Hotel Vacations: A Social Practices Approach

Whereas service or experience quality studies tended to deal either with supply or demand, by using a Social Practices Approach (SPA) the concrete interaction points between senior guests and personnel in the care hotel practices could be studied from a more holistic perspective. The SPA approach was developed by Spaargaren in 1997 and adopted from the structuration theory of Giddens (1979, 1984). The application of a practice theory approach is part of a general wave of renewed interest in practice theory in consumption studies, which aims to bridge the actor-structure dualism (see Schatzki, Knorr-Cetina, & von Savigny, 2001; Shove, Pantzar, & Watson, 2012; Spaargaren, Lamers, & Weenink, 2016; Warde, 2014). However, in recent years practice theory has already been successfully applied by academics in studying (leisure) practices (Bargeman, Richards, & Govers, 2016; Lamers & Pashkevich, 2015; Van der Poel & Bakker, 2016; Verbeek, 2009), but to date not in the health-care tourism sector.

Practice theory centres on the social practices that people are engaged in during their everyday life (Rpke, 2009; Southerton, 2012; Warde, 2014). Social practices can be conceived as activities that are ordered across time and space, driven by routines, and shared by groups of people (Reckwitz, 2002; Spaargaren, 1997). Because the SPA does not focus on the content of the interactions between demand and supply, the theory of Shove et al. (2012) has been used to study care hotel practices more extensively. According to this theory social practices consist of three types of ‘elements’: meanings, materials and competences. (Symbolic) meanings refer to motivations, aspirations and ideas of the actors, for example the motives and aspirations of guests to perform leisure activities in the care hotel. The materials focus on tangible physical characteristics of the practice such as resources, tools and objects. Examples related to the care hotel practice were specially-adapted facilities, leisure facilities and amenities in the physical environment of the care hotel. Understanding, skills and know-how can be conceived as ‘competence’ elements, which we related to the human resource capabilities and services provided by the care hotels. The interview items focused on an operationalization of the three elements of Shove et al. (2012) and helped us to study the crossing points or ‘consumption junctions’ (Spaargaren, 1997) in the care hotel practices. The interaction between demand and supply could either operate well, or difficulties could arise. An unsuccessful interaction suggested a ‘poor fit’ or ‘misfit’, resulting potentially in a negative outcome, while a successful interaction could be interpreted as a ‘good fit’ involving a positive outcome.

Findings

Competences and Empathy of Personnel

The interviews with guests indicated that the most important consumption junctions in the care hotels studied were the moments at which the guests met and communicated with the hospitality and care personnel. The hospitality personnel included receptionists, waitresses, cooks, hostesses, volunteers, and housekeepers. The care personnel could be divided into carers and nurses. Important fits in the care practices are related to the competences and empathy of the personnel.

For instance, several respondents were pleased with the provision of 24 hour care and mentioned that they (and their family) felt very secure thanks to the idea of having a qualified caretaker nearby at all times (cf. Dagger et al., 2007; Han, 2013). In addition, the guests interviewed pointed out that they received adequate and helpful assistance if they undertook leisure activities outside the care hotel environment. The majority of the hotel managers were keen on trying to assist guests to access these (leisure) activities in such a way that a successful experience was provided. If necessary,

hostesses and volunteers are present to assist guests with a trip outside the care hotel environment, but also to have a conversation, play a game, shop for groceries, or have a short walk with them. Referring to this, the guests indicated they were very pleased that hospitality employees are able to answer both care-related and hospitality-related questions, regardless of their function.

The interviews with the guests also identified situations in which empathy or individual attention played a crucial role in the experience.

“What I liked so much, and also found very special, is that so many people entered our room to introduce themselves, and they were all, one by one, so nice and compassionate! It made me wonder, how did they get these employees?”–

Guest

According to one care hotel manager, these aspects make care hotels different from ‘regular hotels’. In addition, another manager highlighted that her care hotel focused on pampering its guests; they wanted to provide guests with a trouble free vacation and meet their wishes as well as possible.

“We just try to provide an amazing product in which the guest is centralized and regains control over his or her own life.” – Manager

Hence, to pamper their guests from time to time the care hotels treated eating and drinking as a special experience or event. In one hotel a guest was selected to decide the menu for that evening once a week. In the other hotels, for example, guests were invited to take a look in the kitchen and diner at the chef’s table.

Materials: Care and Leisure Facilities

Consumption junctions in the care hotels studied were positively facilitated by various material amenities. The interviewed guests were satisfied with the eating facilities provided in the care hotels, like a hotel bar and restaurant which provided high quality meals adapted to the wishes of the guests (including free room service). Many guests used words like ‘outstanding’, ‘fabulous’, and ‘delicious’.

The care facilities were also highly appreciated. The hotel managers indicated that specially-adapted care facilities have been provided (e.g. turning circles for wheelchairs, patient lifters, lockers at eye level, kidney dialysis equipment) in order to reduce the guests’ physical restrictions as much as possible. Most care hotels had chosen modern furniture, which was perceived by the interviewed guests as “a warm homelike atmosphere with a hint of luxury” and which “stimulated their healing process and vacation feeling” (cf. Fottler et al., 2000). Some care facilities, such as hinged arm supports, shower chairs and toilet seat risers, were only installed in the room if the guest needed them. The underlying thought with regard to this policy was that guests needed to feel that they were in a hotel environment, and unnecessary care facilities might disturb their vacation experience.

Moreover, to offer a comfortable hotel environment, the care hotels studied provided many leisure facilities, such as sports, wellness (e.g. sauna, sun bed, and whirlpool), health, beauty, media and entertainment facilities, and a small store near the front desk with souvenirs. The guests did not prefer lunch and dinner possibilities elsewhere, as they stayed in the care hotel on a full-board basis.

Meanings: Motivations and Aspirations of Guests

The guests interviewed exhibited a mixture of care- and leisure-related motives for staying in a care hotel, such as the possibility to escape from everyday life, the availability of care facilities and services as a relief for informal carers, and the search for rest and individual attention. The guests noted that they particularly enjoyed relatively calm individual leisure activities during their stay, such as reading a book, listening to music and watching television in the common rooms, and taking a short walk in the garden. Sports facilities were generally only used by guests who needed them for physiotherapy. Both the respondents of the demand and supply side noted that the wellness facilities were rarely used too. It seemed that the motives and aspirations of the current 'stereotypical' care hotel guest did not fit with the wellness facilities and services provided. In addition, one manager believed that using wellness facilities does not form an important part of the Dutch culture, as is the case in Germany for instance.

Implications & Lessons learned

According to Yeoh et al. (2013), care hotels have to mix care and medical services with a comfortable hotel environment including leisure facilities, to be attractive for a more diverse and growing group of elderly tourists who need an adapted holiday environment (see Han, 2013; Hui & Wan, 2009). We would argue that this mixture of care and leisure services, in combination with a focus on the practice of a care hotel vacation instead of a focus on either the guests or providers, requires a multidisciplinary and holistic research framework such as that offered by a practice approach. The theoretical framework used in this multiple case study, a combination of the SPA (Spaargaren, 1997) and the three elements derived from the theory of Shove et al. (2012), was found to be applicable in the care hotel context. The chosen theoretical framework, which was strongly linked to the interview topics, assisted us in understanding more comprehensively the specific consumption junctions that arose in the inter-sectorial context of the five Dutch care hotels.

Focusing on interactions between the interviewed personnel and guests, allowed us to focus on various successful and less successful consumption junctions. The findings indicated that the successfulness of these consumption junctions

was related to three types of elements which are strongly interlinked in the care hotel practice: materials (care and leisure facilities), competences (skills and empathy of the personnel) and meanings (motivations and aspirations of guests) (see Shove et al., 2012). The most successful consumption junctions in the five care hotels were related to the element 'competences'. 'Fits' arose because several guests were very pleased with the qualified care and adequate, friendly and helpful assistance of the care and hospitality personnel who provide them a very positive holiday experience. The element 'competences' was strongly interlinked with the element 'materials' (see Shove et al., 2012), because the well-evaluated care and assistance of employees in the five hotels studied were positively facilitated by various care and leisure facilities. In addition, successful consumption junctions were found related to the 'warm' and comfortable environment of the care hotels and the eating and care facilities which stimulated the guests' vacation feeling. The care hotels studied seemed to deal well with the different health conditions and dietary demands of guests. This flexibility had a good fit with the needs of different types of care hotel guests and the inter-sectorial character of care hotels (see Hofer et al., 2012). A less successful practice was identified for wellness and sport facilities, because these facilities were rarely used by the guests interviewed. Because the care hotel industry is relatively new, particularly in the Netherlands compared to countries such as Germany, Dutch people are not familiar with the various care, leisure and wellness facilities of care hotels. Due to these factors their motives and aspirations ('meanings') did not fit with the wellness facilities and services provided by the care hotels they visited.

It is clear that our multiple case study has some limitations. An important lesson learned or limitation is related to the fact that it was not possible to conduct face-to-face interviews with care personnel and to do participant observations, because of privacy issues of both guests and employees. As we stated before, particular participant observation is a very appropriate research method for analysing social practices. But what are the potential alternatives if we aim to study more privacy-related or intimate practices or rituals as in the case of care hotels (see Collins, 2004)? The development of new methods to collect such sensitive data would help to throw light on the nature of service encounters that are bounded by professional ethical concerns. Another limitation is that only Dutch care hotels have been studied, while a future study might include a wider variety of guests and personnel and more care hotels both in the Netherlands and abroad.

As Connell (2013) argues, more research in the emerging field of health-care tourism is needed in order to understand how this sector operates, particularly as it is likely to grow due to the aging of the baby boom generation (e.g., Hofer et al., 2012; Yeoh et al., 2013). Additionally, it is likely that the health-care industry and ancillary industries will grow even more in the future, and that care services will be increasingly integrated into hospitality environments. This will inevitably bring new challenges for the hospitality industry in adapting to the new consumption junctions that arise at the interface between health-care and hospitality. A practice perspective could be helpful to analyse the elements

which affect new interactions between guests and personnel and to disentangle the dynamics in existing consumption junctions.

Discussion Questions

1. Due to a further aging of the baby boom generation, which new consumption junctions would arise at the interface between health-care and hospitality both in the Netherlands and abroad, and how could the hospitality industry adapt to these new consumption junctions?
2. How could a social practice approach be helpful to analyse these new consumption junctions and to disentangle the dynamics in existing interactions between guests and personnel in the context of care hotels?
3. What are alternative qualitative (and/or quantitative) research methods to study more privacy-related or intimate practices or rituals as in the case of care hotels?

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