Hospitality & Society
Volume 11 Number 1
 https://doi.org/10.1386/hosp_00035_1
Received 3 July 2020; Accepted 20 December 2020

ANN-SOFIE JONSSON
Örebro University

ÅSA ÖSTRÖM
Örebro University

MARIA NYBERG
Kristianstad University

Performance of hospitality within restricting meal frames: An observational study of four hospital wards in Sweden

ABSTRACT

Hospitality is a social phenomenon expressing relationships between a host and a guest. This relationship can be seen in its most extreme form within a hospital setting, where the guest is a patient staying within an establishment where the core activity is not to provide the patient with food and drinks but to treat medical conditions. The aim of this study is therefore to explore how hospitality was performed by nursing staff and meal hosts in the dining room environments at four hospital wards and to explore the specific role of the room and its

KEYWORDS

hospitality
hospitals
mealtime
observations
dramaturgical theory
mise en place

artefacts in facilitating or hindering acts of hospitality. In total, twenty non-participating observations were conducted across four wards within two Swedish hospitals. The dramaturgical theory proposed by Goffman was used as theoretical lens. Field notes were analysed in accordance with qualitative content analyses and yielded two overarching themes: (1) Hospitality and hospitableness through acts of caring and (2) The dining room environment's potential to promote or hinder acts of hospitality. The findings suggest that the dining room environment facilitated timely service for the patients when the materiality within the room followed the principles of mise en place *and included the constant presence of a staff member. This is seen as an important finding in relation to what needs to be addressed when planning hospital dining room environments and to the patients' ability to consume a meal within a frame that acknowledges and assists the patients during their meals.*

INTRODUCTION

Hospitality and *hospital* share the same etymology (Hoad 1996). However, the similarities between the words do not prevail in the use of hospitality in the hospital setting, even if knowledge from the hospitality industry is argued to be of importance and also requested by other industries such as hospitals (Pizam 2007). Pizam (2007: 500) states that 'the difference between hospitals and hospitality is "ity" but that ity can make a significant difference in the recovery and stay of hospital patients'. The provision of this 'ity' factor refers to excellent customer service, and how this service can improve the chances of recovery. The importance of understanding this 'ity' factor is then, according to Pizam, not as much marketing driven as it is medically driven.

To be able to further the understanding of hospitality within hospitals, we sought to explore how hospitality was performed by nursing staff and meal hosts in the dining room environment at four hospital wards, as well as to investigate the specific role of the room and its artefacts in facilitating or hindering acts of hospitality.

THE CONCEPT OF HOSPITALITY

Hospitality often refers to situations relating to tourism, hotels and restaurant management rather than to a core concept for medical care and care of patients recovering from illness. Nevertheless, Hepple (1990), Patten (1994), Gilje (2004), Kelly et al. (2016), Kelly et al. (2018) and Justesen (2014) open up a discussion of understanding hospitality within the hospital context and how acts of hospitality arguably would enhance a patient's hospital stay. The meaning and content of hospitality differ in the literature (Brotherton 1999; Filimonau and Brown 2018; King 1995; Lashley 2000a), and it is thereby of value to outline how hospitality is understood in this article. Lashley argues that

> Hospitality is essentially a relationship based on host and guest. To be effective, hospitality requires the guest to feel that the host is being hospitable through feelings of generosity, a desire to please, and a genuine regard for the guest as an individual.
>
> (2000b: 15)

According to Selwyn,

> The basic function of hospitality is to establish a relationship or to promote an already established relationship. Acts of hospitality achieve this in the course of exchanges of goods and services, both material and symbolic, between those who give hospitality (hosts) and those who receive it (guests).
>
> (2000: 19)

Moreover, these acts of hospitality should be understood in relation to where these exchanges are taking place and whether they are voluntarily entered into (Brotherton 1999). In a hospital environment the guest is a patient, thus displaying the most extreme form of host–guest relationship (Severt et al. 2008), since the patient is arguably not there voluntarily, and the hosts (e.g. nurses) are not there primarily to provide food, drinks or accommodation. A power relationship that is not mutual in its hospitality provision is present, displaying a vulnerable situation for the patients (Lugosi 2014). Instead, the aim is more to provide person-centred care and to shift the power focus towards the patient (Ekman et al. 2011). Therefore, the use of hospitality in hospitals needs to be discussed based on previous knowledge of the concept and applying it in a setting where the notion of being hospitable may be of more importance than in a commercial restaurant or in the privacy of one's home (Severt et al. 2008). According to Patten, hospitality can be understood as *public*, *personal* and *therapeutic*, where therapeutic hospitality refers to 'enhancing both patient satisfaction and progressive healing' (Severt et al. 2008: 667), which 'ultimately may reflect professional caring practice' (Patten 1994: 80). The provision of food and drinks is central here, with meals being considered facilitators of social interactions through meeting over, about and through the food itself (Nyberg 2009).

The definition of hospitality used in this article merges the notion of hospitality as suggested by Lashley (2000a), where hospitality is discussed as a social phenomenon involving relationships between people, with hospitality as a therapeutic undertaking, as described by Patten (1994) and recently highlighted by Kelly et al. (2018). Hence, acts of hospitality are viewed as hospitable behaviour (Telfer 2000) involving a desire to please and accommodate wishes, with the ulterior motive of promoting a sense of well-being for the guests during their mealtimes. This study also acknowledges hospitality through and within space and place (Höykinpuro and Yrjölä 2020) and the materiality at hand during meal service (Lugosi 2014).

MEALTIMES WITHIN THE HOSPITAL SETTING

The food-service operations within the hospital arena have been identified as key actors for promoting a higher food intake for patients during their stay and thereby decreasing as well as preventing malnutrition-related conditions (Beck 2001). Moreover, the hospital arena is of interest, as staff members serving food to patients need to accommodate wishes from individuals who are not known by the staff in the same way as, for example, those in residential care settings (Heaven et al. 2013). Staff thus face challenges in serving meals to a diverse clientele with different cultural backgrounds, nutritional and personal needs and appetite levels.

Research that addresses mealtimes in hospitals from the patient perspective mainly acknowledges the importance of the food quality as well as the food service for the patients' overall meal satisfaction (Hartwell et al. 2016). However, several aspects have been identified as affecting a guest's meal experience (Edwards and Gustafsson 2008b; Gustafsson et al. 2006), including the immediate environment where the food is served (Edwards and Hartwell 2004; Markovski et al. 2017), the social interactions during the meal (Baptiste et al. 2014; Beck et al. 2019; Paquet 2008), the meal menu (Ottrey and Porter 2016; Ottrey and Porter 2017), the food-service system (Hartwell et al. 2007) and the availability of mealtime assistance (Howson et al. 2018). A meal experience is therefore considered a multisensory experience involving a guest's multiple senses (Spence et al. 2014). The sounds in the restaurant, and smells from the kitchen as well as the interior of the room all interact with the product (the food) on the plate (Gustafsson et al. 2006; Nyberg and Grindland 2008). But also, how the serving staff talk, their tone of voice and how tactile the servers are, can affect the guest's (patient's) experience of the meal (Beck et al. 2017; Gustafsson et al. 2006; Walter et al. 2010). From the perspective of the staff the mealtime entails competing activities (Marshall et al. 2019). At the same time as the meal is considered to be a mundane task to perform (Heaven et al. 2013), it might also include feelings of being disempowered to prioritize nutrition (Ross et al. 2011). Beck et al. (2016) found in their observational study of a neurological ward, that 'meals were at a high risk of being served as a mindless task without the recognition that mealtimes are sensed with the whole body of the patient and not only by the mouth' (Beck et al. 2016: 1614). The meals were seen rather as a task needing to be performed than as one of providing the patients a nice mealtime experience.

Research that includes the notion of hospitality in relation to meals entails exploring how the staff act during the mealtime in residential care (Odencrants et al. 2020) and how an enhanced dining environment in hospitals can create a more home-like environment and feelings of togetherness for the patients (Hartwell et al. 2013). Previous research has also shown how hospitality can be understood as being co-created by staff and patients as well as involving meal-related artefacts (Justesen et al. 2014; Justesen and Overgaard 2017). A recently conducted ethnographic exploration by Ottrey et al. (2018) of the dining room environment within the hospital setting found that in their mealtime practices health care staff, volunteers and visitors strove to provide patient centredness during mealtimes. However, that effort was challenged by the complexity of the healthcare system itself together with the food-service system. This study draws upon the findings from Ottrey et al. (2018) as well as Beck et al. (2016) and includes the notion of hospitality in the investigation of the room itself to further the understanding of how mealtimes are staged and performed for patients during their hospital stay.

THEORETICAL FRAMEWORK

According to Goffman (1990), everyday life interactions can be understood as *performances* enacted to project images of oneself to others viewed as the audience. The social interactions also involve cooperation, which Goffman refers to as *teams*. Moreover, these interactions and team performances are conducted within *frames* (cultural) that define the situation and give a general understanding of the situation encountered, both for the actors and the audience. The hospital context provides an interesting frame for studying meals

in relation to the dining room environments and the actors within, especially since the two hospitals included in the study provide differences in *scenery* (dining rooms or dayrooms, described below) and *artefacts*, as well actors within (meal host or nursing staff).

The hospital frame also provides a general idea of how to act and what to say, where both patients and staff can be argued to have conversations that follow a predictable, well-known and expected form, being part of the *scripts* used in the social interactions. The use of the dramaturgical theory (Goffman 1983, 1990, 1991) thereby presents opportunities to explore the interchangeableness of roles being enacted within the dining room environment, where the health care script (nursing staff) meets the service script (meal hosts) and how these rooms are used during meal service. However, an important criticism of the application of the dramaturgical theory is that neither the lived experience nor the meanings that the actors may attach to the behaviour is accounted for, nor is the risk of overly interpreting the theory as an explanation of the behaviour. That is, while the theory helps to unfold the understanding of the behaviour; it is not the behaviour itself (Sandstrom et al. 2014: 37). And it was through looking upon people as actors on a stage that one better could understand how people play their roles and construct social structure. Goffman's work has been used in several studies to understand the mealtime e.g. to explore older patients as well as nursing staffs roles during mealtime within an institutional setting (Sidenvall 1999), understanding the mealtime scripts embedded in nursing homes (Harnett and Jönson 2017) as well as revealing how elderly people living at home performed and practised meal-related activities (Nyberg et al. 2018). In this particular study, the use of the dramaturgical theory is used to understand the institutional frame and the scenery of the dining room environment and to try to unfold and understand the behaviours conducted within these restricting meal frames.

THE CONTEXT OF THE STUDY

The study was conducted at four wards within two Swedish public hospitals (herein referred to as hospital A and hospital B) that care for adult medical, orthopaedic and geriatric patients. The hospitals belong to the same regional county care and were chosen due to the implementation of a novel food-service model including a flexible meal menu and the use of meal hosts to facilitate the meal service.

The hospitals contract the same food-service organization, which prepares and cooks all the meals for the patients. The food-service system is cook-chill, and the meals are packed in ready-to-heat boxes that are stored in refrigerators at each ward. The menu consists of several different choices of dish, including warm meals, soups, cold salads and pies and different kinds of desserts. Meal hosts, employed by the contracted service organization (distinct from the food-service organization), prepare the patients' meals and are responsible for the kitchen area, as well as in some wards, for serving the patients their meals. Hence, the responsibility of the meal hosts differs between the different wards as well as between the hospitals and depends on the procurement with the service organization (which also provides other services, for example, cleaning). With regard to the meal service, the wards differ both in how the meals are ordered by the patients and in how and by whom they are served.

Hospital A

At hospital A, all meals are pre-ordered before meal service and prepared by a meal host in a kitchen area located at the ward and thereafter delivered to the patients by registered nurses or assistant nurses (herein referred to as nursing staff). The patients order their meals by choosing from the menu and placing their orders with the nursing staff. The nursing staff in turn give the meal host the orders. The meal host heats all the meals at once and places them in a larger trolley that is provided to the nursing staff to deliver the meals to the patients. All meals have a set time frame, including when the dishes are to be returned to the kitchen.

The dining room environments in hospital A are referred to as 'dayrooms' and are located in the middle of the ward corridors. The dayrooms are quite similar, each having two tables (that could be manually adjusted) with six assigned seats, together with a small kitchen area with a refrigerator, and a lounge area. These rooms are used as a place to dine as well as for other activities, such as socializing with visitors or watching TV, or as a meeting space for the staff.

Hospital B

At hospital B, the meals are also prepared by the meal hosts; however, the meals are not pre-ordered. Rather, the meal host takes the patients' orders in the dining room environments, referred to as dining rooms. The patients consult the menu and place their order with the meal host. Thereafter, the meal host heats the boxed meal in a microwave and serves the meal on a tray to the patient. The meal host also prepares the meal orders for those patients who either choose to or have to eat their meals in their own rooms. These patients have placed their orders to the nursing staff. The nursing staff come to the dining room to collect these trays and serve these to the patients in their rooms. The meal host is present in the dining room from commencement of breakfast to completion of the evening dinner, except for the evening coffee at approximately 7.30 p.m. The time frame for eating is flexible. A schedule posted at each dining room states that lunch, for example, is served between 11.30 a.m. and 1.00 p.m.; however, the actual timing is flexible, to be able to accommodate the patients' wishes.

The dining rooms have five or six tables with room for six chairs at each table. The tables are height adjustable, and the chairs have wheels on the front legs that facilitate moving them back and forth. The meal boxes are on display in refrigerators.

METHODOLOGY AND DATA MATERIAL

This study was based on an ethnographic methodology aiming to explore the day-to-day activities of meal provision within an institutional framing (Atkinson 2007; Hammersley and Atkinson 2019). The study positions itself in the interpretive perspective that upholds that social life is subjective and social reality can only be understood through the exploration of peoples' everyday actions and the ways that people make sense of and interpret the world (Adorjan and Kelly 2016). According to Geertz (1973), being out in the field involves providing 'thick descriptions', implying that the ethnographer not only describes what is observed but also accounts for the social context and the participants' interpretation of their actions and the meaning given to them.

Thick descriptions involve giving quite detailed descriptions of the phenomenon observed through its context so that others can get an understanding of the observed situation (Ponterotto 2006).

Ethnography thus provides the researcher with a methodological perspective that facilitates the researcher becoming immersed in the field and being part of and capturing the day-to-day activities performed (Atkinson 2007). By being present in the field, the researcher can explore first-hand experiences of what is said and done in specific moments, settings and contexts (Atkinson 2007). Most commonly, participant observation is used as a method to capture the everyday life activities of the study setting of interest (Atkinson 2007). However, this study used non-participant observations with interaction as a method (Bryman 2016; Gobo and Molle 2017). The interactions were short conversations initiated by the staff members, patients or relatives. This decision was taken, as the researcher could not serve the patients their food or prepare the food before serving. Nevertheless, to be part of the field does not mean that the researcher experiences and provides a 'true' objective picture of reality, but rather an interpretive picture, constructed and bound with the meaning and context that it is placed within (Sandstrom et al. 2014). This also means that the mere presence of the first author may have influenced the nursing staff and/or meal hosts to perform differently than usual and constructed an alternative performance during meal service known as the 'Hawthorne effect' (Gobo and Molle 2017). However, as Gobo and Molle (2017: 130) state, 'The unavoidable influence of the researcher should not be regarded as a fault of the methodology but rather as an intrinsic advantage of it'.

The observations were carried out on weekdays as well as weekends by the first author and included a total of twenty mealtime observations (lunch and dinner) in the dining room environments, with eleven during lunch and 9 during dinner, amounting to a total of 24 observation hours and 70 pages of transcribed text. The observations covered the activities before, during and after completion of the meals by the patients. Data saturation (Gobo and Molle 2017) was sought to be reached through observing several consecutive days at each study ward. When all observations had been conducted, the data displayed a coherent picture regarding the meal-service performance within the two hospitals as well as between the four study wards.

The observations were informed by the Five Aspect Meal Model, FAMM (Gustafsson et al. 2006). FAMM is a meal model that includes five aspects needing to be considered when planning a meal so that a meal experience will be as positive as possible for the guest (Edwards and Gustafsson 2008a; Gustafsson et al. 2006). The five aspects are *the room*, *the meeting*, *the product*, *the management control system* and the overall *atmosphere*, which is seen as the sum of all the other aspects. Even if it is argued that FAMM has a meal producers' perspective, the model is also developed with the guest perspective in mind (Gustafsson et al. 2006). It is argued that a guest not only experiences the product on the plate, but also considers the eating environment (the room) and the social interactions taking place during the mealtime (the meeting). The conducted observations focused on how the nursing staff and meal host used the room and the materiality within it, together with how social interactions were performed during the meal service.

After each observation, the first author transcribed the field notes and wrote down reflective comments.

The participants

All staff who worked either as nursing staff or as meal hosts were part of the observations as long as they were present in the dining room environments during the observed mealtimes. The patients who were present in the dining room environments were indirectly observed; however, the focus was not on what the patients did or said but on how the staff acted towards the patients.

Ethical considerations

At all the participating wards the nursing staff as well as the meal hosts were informed about the study objective and procedures either at their monthly staff meeting, at daily meetings or by personal communication with the first author. They were informed that observations were to be conducted and that they could contact the researcher team if they had any questions or did not want to be included in the observations. They were also informed that they could ask the researcher to leave at any time point during the observation.

Upon each observation, the nursing staff and meal host were approached and orally asked for permission to be observed during lunch or dinner in the dining room environment. Moreover, a poster was visible at these areas, with information about the purpose of the observations and noting that if anyone – patient, relative or staff – was not comfortable with the researcher being present, they could ask the researcher to stop the observation and leave. However, no staff member, patient, relative or visitor asked the first author to leave.

Written consent to observe in the dining room environments was given by the head of each participating clinic.

The study was approved by the regional ethical board of Uppsala,[1] Sweden (DNR 2018/145).

Data analyses

The analytical process within qualitative work is not a straightforward process following pre-defined steps (Bazeley 2013). Instead, it is better described as a constant back and forth approach towards the collected material. The analytical process started during fieldwork, with attention directed towards the social interaction between staff members and between staff members and patients during mealtime, in accordance with the dramaturgical theory outlined by Goffman (1990) and the notion of hospitality (Lashley 2017; Patten 1994; Telfer 2000).

During each observation the first author wrote field notes openly. All field notes were then anonymized during the transcriptions process and entered into the qualitative analysis programme MAXQDA 2020. In the initial stage, all the authors read the transcriptions of the observations, to become familiar with the data. An initial analysis of the data was performed by two of the authors (AJ and MN) to test an overall consensus between the authors. The data were thereafter analysed in accordance with the qualitative content analysis framework as suggested by Graneheim and Lundman (2004) by rereading each observational transcript as a whole, coding all observations using condensation and labelling the condensed units with a code. These codes were then merged into sub-categories and categories and discussed with the co-authors, and rendered into two overarching themes: (1) *Hospitality and hospitableness through acts of caring* and (2) *The dining room environment's potential to promote*

1. Since 1 January 2019, the regional ethical board has had a new organizational structure and is now called the Swedish Ethical Review Authority.

or hinder acts of hospitality (see Tables 1 and 2 for the coding process). The data were collected in Swedish but coded and analysed in English. All quotes were therefore translated from Swedish to English and discussed for accuracy before inclusion in the article.

FINDINGS

The four study wards were shown to have similarities as well as some differences with regard to how the meal service was performed during mealtime. At all wards, both nursing staff and the meal hosts performed hospitality in a *personal* as well as *flexible* manner and interacted with the patients with warmth and physical closeness. However, the ability to perform hospitality during mealtimes differed between the wards and could be hindered as well as facilitated by the *location* of the dining room environment and the *materiality* within. This implied that creating a meal performance was in a sense dependent on the physical scenery as well as the meal-service procedures in place. The findings show the importance of recognizing the potential of the room itself to promote (facilitate) or hinder hospitable behaviour towards the dining patients as well as how the meal-service procedure is implemented and performed.

In the following sections the two themes, (1) Hospitality and hospitableness through acts of caring and (2) The dining room environment's potential to promote or hinder acts of hospitality, will be presented in relation to the categories under each theme (see Tables 1 and 2).

HOSPITALITY AND HOSPITABLENESS THROUGH ACTS OF CARING

The social interactions observed during the fieldwork resulted in two categories representing the overall theme, namely, *Hospitality as personal* and *Hospitality as flexible*. These two categories enclose the complex task of performing a meal service within an institutional frame where the main purpose is to care for people in need, thus, providing food and drinks to someone who may have a low appetite, difficulties handling their own food or restrictions regarding their diet.

Theme	**Hospitality and hospitableness through acts of caring**				
Categories	**Hospitality as personal**			**Hospitality as flexible**	
Sub-categories	Knowing the patient	Acknowledging the patient	Emotional and physical closeness	Accommodating wishes	Unforeseen and disruptive events
Examples of codes	Uses first name	Listens to the patient	Squatting next to the table	Changing the dishes	Patient gets emotional
	Knows previous orders	The patient is asked what they want	Sits next to the patient	Provide meals outside the menu	Patient has difficulties eating
	Knows likes/dislikes	The patient is made active	Leans towards the patient	Makes sure that patients get what they want	Patients needing medical care
		Oversees the whole room	Puts a hand on the shoulder	Time frames to eat	Needs to leave the room to get something
			Laughs together		

Table: 1: An overview of the coding process for theme 1.

Theme	**The dining room environment's potential to promote or hinder acts of hospitality**				
Categories	**The location of the room**		**The 'materiality' of the room**		
Sub-categories	Meal-service procedure	Events outside meal service	The function of a 'meal host' in the dining room	The dining rooms mise en place[2]	The restrictions of the dining room
Examples of codes	Nursing staff collects meal trays in the dayroom Nursing staff collects the tray trolley at the kitchen area	Foot scooter passing by Cleaning wagon passing by The sounds of the alarms from the patients' rooms	Constant presence Timely assistance Ability to communicate the patients' meal preferences with nursing staff and vice versa	The nursing staff searches for something Needed to go out to get something	The size of the room Adjustable tables and easy to use chairs Flexible menu

Table 2: An overview of the coding process for theme 2.

2. *Mise en place* is a French expression meaning 'everything in its place' (Pizam 2010: 455).

Hospitality as personal

During the meal service taking place in the dining room environments at the wards, the meal hosts as well as the nursing staff acknowledged the patients through actively involving them in their food choices and also through acts of physical and emotional closeness.

> The meal host acknowledges the patient by their first name and takes a seat next to the patient. The meal host and the patient initiate a conversation around the meal. The meal host asks the patient what he/she wishes to eat and gives the patient some information about the dishes, what they are and also including the taste. The patient is asked what he/she would like to drink with the meal. The patient and the meal host seem to have a nice moment together, since they talk and laugh together. Before the meal host leaves the patient to prepare the meal, the patient is asked if he/she wishes anything else.
>
> (Observational note, hospital B, lunch)

The meal ordering for the patient was thus a nice moment, a moment of being acknowledged, involved and listened to as well as a moment that seemingly provided a nice meeting. This personal hospitality and familiar atmosphere were observed to be facilitated by nursing staff's as well as by the meal host's performance of knowing the patients. The observations captured, for example, interactions that showed that the meal host and nursing staff knew what the patient wanted to eat or remembered what the patient ate the day before. To be able to remember previous orders as well as being able to provide suggestions for the patients not only showed hospitality as personal but also showed hospitality through acts of caring.

Moreover, in hospital B these interactions between the meal host and/or nursing staff and the patients were observed to be facilitated by the menu. That is, the meal host and the nursing staff used the menu as an artefact in the interaction with the patients concerning the meal. In addition, it was also

noted that the menu sparked conversation between the patients, as well as between patients and their relatives. The menu thereby became a materiality within the room, and this will be further discussed in relation to the second theme.

Still, knowing the patients was also prevalent, when for example, nursing staff dissuaded patients from eating certain food items on the plates or suggested drinks that would be beneficial for their health condition. The food became symbols of care for the patients. These performances displayed a relationship with the patient, through knowing, as well as performances of involving the patients in the meal service and providing them choices. For example, the meal hosts and nursing staff were seen to describe food items in the menu or to ask the patients if they wanted dessert now or later, or in general to have an overview of the dining room.

Interactions, between the patient, the meal host and the nursing staff was observed to be warm, caring and inclusive of the patient. Moreover, the interaction showed a performance of knowledge by the meal host regarding the options provided by the menu as well as an ability to be in tune with the patients' wishes.

> A nursing staff member comes with a patient in a wheelchair and takes the patient to the kitchen area where the meal host is working. The meal host addresses the patient with his/her first name and says that it is time for some food now. The meal host asks the patient if he/she would like some soup and provides different choices. The patient does not seem too keen about soup. The meal host instead suggests pancakes, which the patient confirms to be good.
>
> (Observational note, hospital B, dinner)

Further, it became prevalent that both the meal hosts and the nursing staff were closely interacting with the patients during meal service, from squatting next to the table while taking the patients' meal orders to gently stroking the patients over their shoulders to calm them down or leaning close towards their good ear to ensure that they heard.

> The nursing staff talk with each other and at the same time one of the staff members strokes the patient gently and calmingly over the patient's shoulders and asks him/her if the meal was nice. The nursing staff leans over the patient's back so that the patient can hear.
>
> (Observational note, hospital B, lunch)

Hospitality as flexible

In a hospital setting, hospitality seemed to be performed in a flexible way, implying that routines could change instantly depending on unforeseen or disruptive events. During the observations, it became obvious how, for example, patients becoming too tired suddenly could need special assistance during mealtimes, and patients in need of medication had to interrupt their meals. During one observation, at hospital A, a patient said that he/she was cold, and moments later the nursing staff arrived with a blanket. This example showed how the nursing staff as well as the meal hosts most often acknowledged the

patients and provided them assistance or help that was not directly asked for and by doing so performed acts of hospitable behaviour.

Hospitality as flexible was also evident in the way meal hosts and nursing staff accommodated the patients' wishes, for example, manipulating the dish to make the portion smaller or to include only specific items in the dish – acts that circumvented the restricting institutional and room frame to provide the patients with what they wished for, or at least, as much as possible.

Hospitality as personal as well as flexible was thus performed for, as well as with, the patients, enclosing a person-centred approach. However, in a sense these performances were seen to be dependent on the dining room environment and the access to meal-related materiality, as presented in the next theme.

THE DINING ROOM ENVIRONMENT'S POTENTIAL TO PROMOTE OR HINDER ACTS OF HOSPITALITY

During the fieldwork, it became prevalent that the dining room environment could both hinder and facilitate hospitality through the location of the room and the 'materiality' within the room as well as the way tables and chairs could be arranged and rearranged to facilitate the mealtime for the patients.

The location of the room

In hospital A the mealtimes took place either in the dayrooms at the wards or in the patients' own rooms. These dayrooms were separated from the kitchen area where the food was heated and prepared on trays. *The meal-service procedure* encompassed the nursing staff retrieving the trolley with the trays outside the kitchen area and transporting it down the ward corridor. The nurses stopped at each door and entered with a tray. The trolley then stopped at the dayroom, so that the patients in the room could be served. Meanwhile, a cleaning cart might pass by as well and even stop to clean the floor right outside the dayroom or to drop something down the disposal outside the dayroom. Other staff members passed by, including staff on foot scooters. Hence, in hospital A the location of the room provided scenery for other *events outside the meal service*.

During the observations at hospital A, it was also noted that there was a constant presence of sounds from the alarms connected to the patients' rooms and monitors. In a way, this sound, often the only sound heard, became a reminder of the specific setting of the institutional frame, of where the meal was consumed.

> It becomes very silent in the room; the only sounds that are heard are the sounds from the monitors in the patients' rooms. After a while a nursing staff goes by and tells one of the patients that they will be there soon.
>
> (Observational note, hospital A, lunch)

The example above also highlights that the patients were most often left in the dayroom by the nursing staff after being served their tray. Fellow patients could be in the room, but not always, and the staff came in if they had a reason to or if they needed to provide feeding assistance. A silence was therefore most often sensed in the room.

In hospital B, the dining rooms were located down the hall of the ward corridor. *The meal-service procedure* started when patients entered the dining room or when the nursing staff entered the room and provided the meal host with a list of what the patients had ordered. In comparison to the wards at hospital A, the location of the dining rooms at hospital B generated an environment that was not characterized by the healthcare script or other performances such as cleaning. The sounds from the alarms were not noted within the dining rooms, but present outside in the ward corridor.

Moreover, the distance between the dayrooms and the kitchen area at the wards in hospital A required the nursing staff to walk from the dayrooms to the kitchen area or back to the trolley in the event that something was missing during the mealtime or requested by the patients, situations that were not observed at hospital B. The nursing staff thus had to work within a dining room environment that restricted them having access to what was seemingly needed during meal service. Assistance to the patients thereby became interrupted and arguably not given in a timely manner. Hence, the restriction of the dining room locations also intertwined with the access to materiality within the room.

The 'materiality' of the room

The 'materiality' of the room refers to the functions that the dining room environment encloses, that is the function of the furniture, the menu and the food items as well as the concept of *mise en place*, and also, in relation to hospital B, a meal host. The meal host here is referred to as a materiality through *function*, an infrastructure, of the meal service. This infrastructure was not available at all observed wards and is therefore referred to as materiality within the room.

In hospital B, the function of a meal host was observed to promote a sense of commensality for the patients during the mealtimes. The patients were not alone, even if they dined alone at their tables. The meal host was constantly present during meal service from early morning to completion of the dinner in the evening, which enabled timely assistance to the patients as well as consistency regarding the acts of hospitality. The patients thereby received meal service from the same person throughout the day, providing an observed continuance for the patients. On the other hand, patients at hospital A often had several nursing staff during meal service both serving them and answering their queries. This often resulted in the patients having to repeat themselves, and to some extent this seemed to result in a sense of inconsistency in the service provided as well as the risk of not being listened to.

> The patient wishes to have the chocolate pudding for dessert, or are there other options? The nursing staff says that there are other options. The patient would like that and says that he/she would like to have it after the meal.
> The patient wonders about his/her dessert to another nurse present. This nursing staff asks if the patient had ordered it yesterday, because one needs to do that, but says that he/she will go see if it is possible, anyway, although was not sure that it could be arranged.
>
> (Observational note, hospital A, lunch)

In the above example, the dessert exemplifies the concept of *mise en place* and the observed performances needing to be carried out in relation to it. *Mise*

en place is a French expression that refers to a way of working, and planning the work environment before meal service, as well as how the meal service is performed (Schlegel et al. 2019). It was observed how the nursing staff often needed to leave the dayroom in hospital A to get food items, as noted above, or items needed or requested by the patients, for example, lingonberry jam, drinks and extra salt, but also paper napkins, a bottle opener and toothpicks, items that could have been stored in the kitchen area within the dayroom to promote timely assistance for the patients.

In hospital B, all food items were placed in the main dining rooms or the accompanied kitchen area. The *mise en place* of the food items as the entire meals facilitated the meal host as well as the nursing staff being able to provide on demand what the patients wished for and being able to offer, for example, the option of a complementary dessert course, coffee or adjustment of the meals. Thus, the rooms' *mise en place* also facilitated flexible hospitality during the meal service for the patients.

Moreover, the availability of a menu as well as the size of the room could both hinder and facilitate hospitality during the meal service. In hospital B, the availability of the menu became intertwined with the procedure of the meal service. The meal host as well as the nursing staff had the time to interact with the patients and have a conversation around the meal. Issues concerning flavours, preferences, previous orders and suggestions were facilitated through both the procedure of the meals as well as the ability to use the menu and the availability of several meal options, hence, an artefact enclosing hospitality through materiality, and the possibility of involving the patients during meal service.

The size of the room was also observed to have implications for how hospitality was performed by the nursing staff and the meal hosts. During one observation at hospital A, the dining room was reorganized to enable nine patients to sit together and eat their lunch. The tables were brought together creating one long table. This arrangement seemed to facilitate and promote a positive atmosphere for the patients during the meal as well as ensuring that several nursing staff attended the meal service. However, rearranging of the tables also created a crowded feeling in the room. Several of the patients were sitting in wheelchairs, making the tables too narrow for nine patients. The patients along one side of the table could not be moved if the fellow patients were still sitting at the table. The chairs that needed to be taken away to provide room for the wheelchairs were placed in a group at the other side of the room. This placement of the chairs would later also hinder the nursing staff from wheeling the patients out of the room.

> The nursing staff need to create a route through the chairs that were placed on the other side of the tables to be able to get by.
>
> (Observational note, hospital A, lunch)

This exemplifies how the room and its materiality were used to create a positive meal experience for the patients. However, it also illuminates how the dayroom did not provide enough physical space for all patients, and how the hospitality performance had to be acted out not only within restricting institutional frames, but also in specific, restricting *room* frames.

It was also observed how the tables often acted as conveyors of hospitality, as the nursing staff and meal hosts could adjust the tables' height to accommodate the patients' ability to sit comfortably. The interactions that the

staff had with the tables and together with the patients created meaning and symbols of hospitable behaviour through acts of caring for the patient. The ability to adjust the height of the table was thus of significance.

The meal host was also observed to cooperate with the nursing staff during the meal service to provide the patients the correct food consistency. Moreover, the cooperation displayed how the meal host interacted with the nursing staff as a team (Goffman 1990). This team interaction displayed meaning in the relation that they created between each other in their joint performance to provide the patient a meal tailored to his/her needs. It was also observed that the meal host performed acts of hospitality towards the nursing staff.

> The nursing staff member goes to the next table and asks how the meal was and if they wish to have some dessert. One of the patients would like a chocolate ball. The meal host overhears this and immediately arrives at the table with it.
>
> (Observational note, hospital B, lunch)

This final example encloses both themes found in this study, where the meal host and nursing staff as a team performed acts of both personal and flexible hospitality in relation to, and with help from, the materiality within the room.

DISCUSSION

The aim of this study was to explore how hospitality was performed by nursing staff and meal hosts in the dining room environment at four hospital wards, as well as to explore the specific role of the room and its artefacts in facilitating or hindering acts of hospitality. The findings showed that hospitality was performed both personally and flexibly by the nursing staff and the meal hosts, and that the dining room environment, its location and materiality, could both promote and hinder acts of hospitality. To the best of our knowledge, this is the first ethnographic study to acknowledge the specific role of the hospital dining room environment in understanding how the staff, both meal hosts and nursing staff, perform hospitality within and with the help of the scenery provided by the room context and the materiality within. Moreover, the use of Goffman's (1990) dramaturgical theory as a theoretical lens has highlighted the everyday activities performed and enacted within these hospital wards, findings that show how these enactments address what needs to be considered when designing new as well as existing dining room environments.

Previous research has found that having meals in the communal dining room in hospitals can promote higher food intakes among patients and also can make it easier for staff to provide more assistance during mealtimes (Markovski et al. 2017; Walton et al. 2013; Wright 2006). This study complements these findings by adding knowledge regarding the importance of the *location* of the dining room environment and its *materiality*. Showing how these could both hinder and promote the hospitality performance among nursing staff and meal hosts as well as acting as welcoming spaces (Lynch 2017). In this study, the constant presence of a meal host enabled timely assistance to the patients, and the meal host became an additional team member to the nursing staff during mealtimes. The function of a meal host, here argued to be part of the meal-service infrastructure (as suggested by Shove et al. [2012]), was also seen to be part of the materiality of the dining rooms, ensuring that the meal

was planned and prepared before the meal service commenced (Schlegel et al. 2019). According to previous research, this is a function that could represent a person who 'possesses hospitality meal competencies' (Justesen 2014: 46), in line with providing person-centred care during mealtimes, previously identified as a challenge (Ottrey et al. 2018).

SERVING MEALS WITHIN RESTRICTING INSTITUTIONAL ROOM FRAMES

The findings from this study demonstrate the importance of *location* of the dining room environment, the *materiality* within the room and how the staff interacted with the patients to provide timely assistance during mealtimes as well as acts of hospitableness. Especially the concept of *mise en place* (Pizam 2010; Schlegel et al. 2019) seemed to be essential. During the observations at one of the hospitals, the nursing staff needed, on several occasions, to leave the room to get something that was requested by the patients. This illustrated that the room itself, at this hospital otherwise used as a dayroom, was not prepared for meal service, and thus exposed restrictions that the nursing staff needed to interact with and perform in relation to. The location as well as the size of the room arguably did not enclose hospitality towards the nursing staff's ability to use the room (Höykinpuro and Yrjölä 2020). Having all things needed would have facilitated the service (Walton et al. 2013), and this is also what is referred to as the management control system in FAMM (Gustafsson et al. 2006). Here the management control system is to be understood as the planning and managing of the meals in relation to items being in place and who should do this. The meals within the dayrooms were not managed in relation to *mise en place*, implying that the dayrooms were not set, prepared and ready for a meal service to be performed. As a result, these findings both confirm as well as complement the findings from Ottrey et al. (2018) as well as Beck et al. (2016), who discussed the tension of providing patient-centred mealtimes within a challenging hospital system and how the mealtime was compared to eating in a railway station. Our findings are thus in line with Beck et al. (2016) and Ottrey et al. (2018), highlighting the importance not only of the *room* being a place to dine in but also of creating time to provide the meals within these room framings to promote a working environment for the staff that facilitates positive mealtime experiences for the patients.

However, the patients had different opportunities to be active participants during the meal service and to interact with the nursing staff or the meal hosts. When the patients were served pre-ordered trays with food, the patients were observed to be in more of a receiving role and not as active during the mealtime. The patients were not having spontaneous interactions with the nursing staff, as was, on the other hand, observed when the meal host was constantly present in the room. The patients who were served their food on prepared trays did not seem to get the same opportunities to ask or to be asked if they wished for anything else, confirming previous findings that also been highlighted in residential care settings (Sydner and Fjellström 2005). Hence, the overall organization of the meal provision, and the lack of a constant presence of a person and the absence of the menu as an interaction medium, seemed to hinder the patients' involvement during the meal service. The menu as an important artefact (Goffman 1990) and a facilitator of social interactions has also been previously discussed (Beck et al. 2019). Moreover, the involvement and co-creation of hospitality events could further strengthen

the patients, and facilitate empowerment during mealtimes (Justesen 2014; Justesen and Overgaard 2017), thereby promoting a sense of well-being for the patients during their mealtimes through acts of hospitality that enclose the performances of truly listening and acknowledging the patients (Kelly et al. 2016; Lugosi 2008; Patten 1994).

THE ENACTMENTS OF CARING THROUGH PERFORMANCE OF HOSPITALITY

The ability to perform hospitality arguably encompasses more than delivering a tray of food to a patient. It also involves seemingly small gestures of adjusting a table, asking if the patient wishes to have coffee with the meal or putting a hand gently on the patient's shoulders and making sure that the patient has everything wished for. Moreover, to be welcomed into the dining room environment can provide a sense of being seen and acknowledged, which, within the person-centred care approach, is of utmost importance (Ekman et al. 2011; McCormack and McCance 2006). These gestures can embody hospitableness and thus be part of performing person-centred care. Even if the host provides/offers a service and the guest is the recipient, the interactions between host and guest can co-create the meaning of reciprocity and togetherness.

Previous studies have stated the effect that the staff serving the meal has on how the patients experience the meal service and how the patients experience themselves during these moments (Beck et al. 2019). This is also what Patten (1994) would label as *therapeutic hospitality* and also in a way the 'ity' factor proposed by Pizam (2007). The ability as well as the knowledge and the skills to identify the needs of a patient and to remember previous orders are here argued to be enactments of hospitableness, based on the relationship between the host and the guest (Lashley 2000a; Telfer 2000), as well as performance of person-centred care (Ekman et al. 2011). Importantly, this study shows how the notion of hospitality can be used to illustrate the importance of how and where a meal is served, what happens during the meal as well as how it ends (Walter et al. 2010). Serving a patient a meal could, with reference to Goffman (1990), be interpreted as central symbolic rituals showing reverence for the patient. As Bell (2011) put forward, through the use of Goffman, hospitality can be seen both as a relational doing and an interactionist doing, as well as an affective doing. For this study that might enhance the understanding of the performances of hospitality by the nursing staff and meal hosts in doing hospitality work within a frame where certain scripts are given. Hospitality, as a social lens, would within this scenery, create a partial understanding of relational behaviours between actors in an institutional environment.

CONCLUSION

The findings from this ethnographic exploration of four dining room environments within two Swedish hospital settings indicated that hospitality was performed both personally and flexibly and that both the location of the dining room environment and its materiality could promote as well as hinder acts of hospitality. The concept of *mise en place* is highlighted as important when planning the meal service (CIA 2014), to facilitate timely assistance for the patients and the performance of hospitality during mealtimes. The *dining room environment* and its artefacts were thus significant parts for understanding the meal provision within the hospital setting and for being able to perform

hospitable behaviour centring the patients' needs during meal service. Also, by focusing on how staff performed during meal service towards the patients, a more comprehensive picture is provided to strengthen the discussion of the complementary nature of the patient-centred care approach with the notion of hospitality (Patten 1994). The findings contribute to the discussion of hospitality within total institutions and how enactments of hospitableness and hospitality can be viewed as empowering or disempowering performances towards individuals within a constrained and controlling frame.

The findings of this study were based on observational data and have not included the staff's or the patients' own voices through interviews. The use of observational data was seen as a strength, to make visible the day-to-day social interactions that were enacted in the dining room environments, and how these social interactions in turn were performed within restricting room frames. Through observations, the room's prerequisites became visible. However, the study has some limitations that need to be acknowledged. The study was based upon what the first author observed and noted during the fieldwork, and thus framed/informed explicit or implicit by pre-understandings of mealtimes within the hospital context and what a mealtime is or could be for the patients. As social reality is constructed through interactions with others and artefacts given the meaning as it is prescribed, the observations must be understood in relation to the observer's pre-understandings and experiences of the world (Denzin and Lincoln 2017; Geertz 1973). In the words of Geertz, 'what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to' (Geertz 1973: 314). The first author had no affiliation or previous experience of the participating wards and hence provided an outside perspective on the observations. This outside perspective could, however, be seen as a limitation, since certain behaviours, routines or other aspects might have been observed if the author had had a nursing education or previous experience working in a hospital environment.

As this study has shown, meal performances were enacted differently according to setting as well as in relation to different modes of meal service. Using a dayroom as a dining room seemed to create a more stressful atmosphere than having a designated dining room. There were also more social interactions during meal service between staff members and patients when the menu could be used as a meal-ordering artefact. In a way, the dining room environment created a more welcoming atmosphere, an organizational welcome (Lynch 2017), for meals than was possible in the dayrooms. However, the performances of hospitality and acts of hospitableness are not argued to be conditioned by the room environment, as hospitableness is discussed as a personal trait (Telfer 2000) and a part of performing fundamental care (Patten 1994) as well as a performance influenced by institutional and serving scripts. Nevertheless, the room is argued to be a facilitator for hospitality within the constrained meal frames of hospital settings.

The importance of the room context has been acknowledged, implying that the room where the meal service is provided needs to be designed not only as a room for different day-to-day activities, but also as *a specific room* for meal service, promoting hospitality as well as the patients' healing process. More research is called for that continues to address hospital*ity* within the hospital frame to be able to give strong recommendations regarding dining rooms and their placements in hospitals, materiality within the rooms as well as modes

of conducting meal service among the staff at the hospital wards. Referring back to the introduction of this article – the difference between hospitals and hospitality is just 'ity', but this 'ity' can make the real difference when providing patients their meals in respect to recovery, enjoyment and satisfaction.

REFERENCES

Adorjan, M. and Kelly, B. (2016), 'Interpretive sociology', in G. Ritzer (ed.), *The Blackwell Encyclopedia of Sociology*, https://doi.org/10.1002/9781405165518.wbeos0698. Accessed 11 February 2021.

Atkinson, P. (2007), *Handbook of Ethnography*, 1st ed., London: Sage.

Baptiste, F., Egan, M. and Dubouloz-Wilner, C.-J. (2014), 'Geriatric rehabilitation patients' perceptions of unit dining locations', *Canadian Geriatrics Journal*, 17:2, pp. 38–44.

Bazeley, P. (2013), *Qualitative Data Analysis: Practical Strategies*, London: Sage.

Beck, A. M., Balknäs, U. N., Furst, P., Hasunen, K., Jones, J., Keller, U., Melchior, J.-C., Mikkelsen, B. E., Schauder, P., Sivonen, L., Zinck, O., Oien, H. and Ovesen, L. (2001), 'Food and nutritional care in hospitals: How to prevent undernutrition – Report and guidelines from the Council of Europe', *Clinical Nutrition*, 20:5, pp. 455–60.

Beck, M., Birkelund, R., Poulsen, I. and Martinsen, B. (2017), 'Supporting existential care with protected mealtimes: Patients' experiences of a mealtime intervention in a neurological ward', *Journal of Advanced Nursing*, 73:8, pp. 1947–57.

Beck, M., Birkelund, R., Poulsen, I. and Martinsen, B. (2019), 'Hospital meals are existential asylums to hospitalized people with a neurological disease: A phenomenological–hermeneutical explorative study of the meaningfulness of mealtimes', *Nursing Open*, 6:2, pp. 626–34.

Beck, M., Martinsen, B., Poulsen, I. and Birkelund, R. (2016), 'Mealtimes in a neurological ward: A phenomenological-hermeneutic study', *Journal of Clinical Nursing*, 25:11&12, pp. 1614–23.

Bell, D. (2011), 'Hospitality is society', *Hospitality & Society*, 1:2, pp. 137–52.

Brotherton, B. (1999), 'Towards a definitive view of the nature of hospitality and hospitality management', *International Journal of Contemporary Hospitality Management*, 11:4, pp. 165–73.

Bryman, A. (2016), *Social Research Methods*, 5th ed., Oxford: Oxford University Press.

CIA (2014), *Remarkable Service*, 3rd ed., Culinary Institute of America, Hoboken, NJ: Wiley.

Denzin, N. K. and Lincoln, Y. S. (2017), 'Introduction: The discipline and practice of qualitative research', in N. K. Denzin and Y. S. Lincoln (eds), *The SAGE Handbook of Qualitative Research*, 5th ed., Los Angeles, CA: Sage.

Edwards, J. S. A. and Gustafsson, I.-G. (2008a), 'The five aspects meal model', *Journal of Foodservice*, 19:1, pp. 4–12.

Edwards, J. S. A. and Gustafsson, I.-G. (2008b), 'The room and atmosphere as aspects of the meal: A review', *Journal of Foodservice*, 19:1, pp. 22–34.

Edwards, J. S. A. and Hartwell, H. J. (2004), 'A comparison of energy intake between eating positions in a NHS hospital – a pilot study', *Appetite*, 43:3, pp. 323–25.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I.-L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L.-E., Rosén, H., Rydmark, M. and Sunnerhagen, K. S.

(2011), 'Person-centered care – ready for prime time', *European Journal of Cardiovascular Nursing*, 10:4, pp. 248–51.
Filimonau, V. and Brown, L. (2018), "'Last hospitality" as an overlooked dimension in contemporary hospitality theory and practice', *International Journal of Hospitality Management*, 74, pp. 67–74.
Geertz, C. (1973), *The Interpretation of Cultures: Selected Essays*, New York: Basic Books, https://hdl.handle.net/2027/heb.01005. Accessed 11 February 2021.
Gilje, F. L. (2004), 'Hospitality: A call for dialogue', *Nursing Forum*, 39:4, pp. 36–39.
Gobo, G. and Molle, A. (2017), *Doing Ethnography*, 2nd ed., Thousand Oaks, CA: Sage.
Goffman, E. (1983), 'The presidential address: The interaction order', *American Sociological Review*, 48:1, pp. 1–17.
Goffman, E. (1990), *The Presentation of Self in Everyday Life*, London: Penguin.
Goffman, E. (1991), *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Harmondsworth: Penguin.
Graneheim, U. H. and Lundman, B. (2004), 'Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness', *Nurse Education Today*, 24:2, pp. 105–12.
Gustafsson, I.-G., Öström, Å., Johansson, J. and Mossberg, L. (2006), 'The Five Aspects Meal Model: A tool for developing meal services in restaurants', *Journal of Foodservice*, 17:2, pp. 84–93.
Hammersley, M. and Atkinson, P. (2019), *Ethnography: Principles in Practice*, 4th ed., London: Routledge.
Harnett, T. and Jönson, H. (2017), 'Shaping nursing home mealtimes', *Ageing & Society*, 37:4, pp. 823–44.
Hartwell, H. J., Edwards, J. S. and Beavis, J. (2007), 'Plate versus bulk trolley food service in a hospital: Comparison of patients' satisfaction', *Nutrition*, 23:3, pp. 211–18.
Hartwell, H. J., Shepherd, P. A. and Edwards, J. S. A. (2013), 'Effects of a hospital ward eating environment on patients' mealtime experience: A pilot study', *Nutrition & Dietetics*, 70:4, pp. 332–38.
Hartwell, H. J., Shepherd, P. A., Edwards, J. S. A. and Johns, N. (2016), 'What do patients value in the hospital meal experience?', *Appetite*, 96, pp. 293–98.
Heaven, B., Bamford, C., May, C. and Moynihan, P. (May 2013), 'Food work and feeding assistance on hospital wards', *Sociology of Health and Illness*, 35:4, pp. 628–42.
Hepple, J., Kipps, M. and Thomson, J. (1990), 'The concept of hospitality and an evaluation of its applicability to the experience of hospital patients', *International Journal of Hospitality Management*, 9:4, pp. 305–18.
Hoad, T. F. (1996), *The Concise Oxford Dictionary of English Etymology*, Oxford: Oxford University Press.
Howson, F. F. A., Robinson, S. M., Lin, S. X., Orlando, R., Cooper, C., Sayer, A. A. P. and Roberts, H. C. (2018), 'Can trained volunteers improve the mealtime care of older hospital patients? An implementation study in one English hospital', *BMJ Open*, 8:8, https://doi.org/10.1136/bmjopen-2018-022285. Accessed 11 February 2021.
Höykinpuro, R. and Yrjölä, M. (2020), 'Space-to-face (S2F) hospitality in spaces and places', *Hospitality & Society*, 10:1, pp. 23–41.
Justesen, L. (2014), 'Hospitable meals in hospitals: Co-creating a passion for food with patients', Doctoral dissertation, Aalborg: Aalborg University.

Justesen, L., Mikkelsen, B. E. and Gyimothy, S. (2014), 'Understanding hospital meal experiences by means of participant-driven-photo-elicitation', *Appetite*, 75, pp. 30–39.

Justesen, L. and Overgaard, S. S. (2017), 'The hospitable meal model', *Hospitality & Society*, 7:1, pp. 43–62.

Kelly, R., Losekoot, E. and Wright-St Clair, V. A. (2016), 'Hospitality in hospitals: The importance of caring about the patient', *Hospitality & Society*, 6:2, pp. 113–29.

Kelly, R., Wright-St Clair, V. and Holroyd, E. (2018), 'Patients' experiences of nurses' heartfelt hospitality as caring: A qualitative approach', *Journal of Clinical Nursing*, 29:11&12, pp. 1903–12.

King, C. A. (1995), 'What is hospitality?', *International Journal of Hospitality Management*, 14:3/4, pp. 219–34.

Lashley, C. (2000a), 'In search of hospitality: Towards a theoretical framework', *International Journal of Hospitality Management*, 19:1, pp. 3–15.

Lashley, C. (2000b), 'Towards a theoretical understanding', in C. Lashley and A. Morrison (eds), *In Search of Hospitality. Theoretical Perspectives and Debates*, Oxford: Butterworth-Heinemann, pp. 1–17.

Lashley, C. (2017), 'Introduction. Research on hospitality: The story so far/ways of knowing hospitality', in C. Lashley (ed.), *The Routledge Handbook of Hospitality Studies*, Abingdon, Oxon: Routledge.

Lugosi, P. (2008), 'Hospitality spaces, hospitable moments: Consumer encounters and affective experiences in commercial settings', *Journal of Foodservice*, 19:2, pp. 139–49.

Lugosi, P. (2014), 'Hospitality and organizations: Enchantment, entrenchment and reconfiguration', *Hospitality & Society*, 4:1, pp. 75–92.

Lynch, P. (2017), 'Mundane welcome: Hospitality as life politics', *Annals of Tourism Research*, 64, pp. 174–84.

Markovski, K., Nenov, A., Ottaway, A. and Skinner, E. (2017), 'Does eating environment have an impact on the protein and energy intake in the hospitalised elderly?', *Nutrition & Dietetics*, 74:3, pp. 224–28.

Marshall, A. P., Takefala, T., Williams, L. T., Spencer, A., Grealish, L. and Roberts, S. (2019), 'Health practitioner practices and their influence on nutritional intake of hospitalised patients', *International Journal of Nursing Sciences*, 6:2, pp. 162–68.

McCormack, B. and McCance, T. V. (2006), 'Development of a framework for person-centred nursing', *Journal of Advanced Nursing*, 56:5, pp. 472–79.

Nyberg, M. (2009), 'Mycket mat, men lite måltider: En studie av arbetsplatsen som måltidsarena', Doctoral dissertation, Lund: Lunds Universitet.

Nyberg, M. and Grindland, B. (2008), 'The influence of the room context in the meal experience: Examples from a hospital and a nursery', *Journal of Foodservice*, 19:1, pp. 35–43.

Nyberg, M., Olsson, V., Örtman, G., Pajalic, Z., Andersson, H. S., Biücher, A., Lindborg, A.-L., Wendin, K. and Westergren, A. (2018), 'The meal as a performance: Food and meal practices beyond health and nutrition', *Ageing & Society*, 38:1, pp. 83–107.

Odencrants, S., Blomberg, K. and Wallin, A.-M. (2020), '"The meal is an activity involving at least two people": Experiences of meals by older persons in need of elderly care', *Nursing Open*, 7:1, pp. 265–73.

Ottrey, E. and Porter, J. (2016), 'Hospital menu interventions: A systematic review of research', *International Journal of Health Care Quality Assurance*, 29:1, pp. 62–74.

Ottrey, E. and Porter, J. (2017), 'Exploring patients' experience of hospital meal-ordering systems', *Nursing Standard*, 31:50, p. 41.

Ottrey, E., Porter, J., Huggins, C. E. and Palermo, C. (2018), '"Meal realities" - An ethnographic exploration of hospital mealtime environment and practice', *Journal of Advanced Nursing*, 74:3, pp. 603–13.

Paquet, C., St-Arnaud-McKenzie, D., Ma, Z., Kergoat, M.-J., Ferland, G. and Dubé, L. (2008), 'More than just not being alone: The number, nature, and complementarity of meal-time social interactions influence food intake in hospitalized elderly patients', *The Gerontologist*, 48:5, pp. 603–11.

Patten, C. S. (1994), 'Understanding hospitality', *Nursing Management*, 25:3, pp. 80A-80H.

Pizam, A. (2007), 'The "ity" factor', *International Journal of Hospitality Management*, 26:3, pp. 499–501.

Pizam, A. (2010), *International Encyclopedia of Hospitality Management*, 2nd ed., London: Routledge.

Ponterotto, J. G. (2006), 'Brief note on the origins, evolution, and meaning of the qualitative research concept "thick description"', *Qualitative Report*, 11:3, p. 538.

Ross, L. J., Mudge, A. M., Young, A. M. and Banks, M. (2011), 'Everyone's problem but nobody's job: Staff perceptions and explanations for poor nutritional intake in older medical patients', *Nutrition & Dietetics*, 68:1, pp. 41–46.

Sandstrom, K. L., Lively, K. J., Martin, D. D. and Fine, G. A. (2014), *Symbols, Selves, and Social Reality: A Symbolic Interactionist Approach to Social Psychology and Sociology*, New York, NY: Oxford University Press.

Schlegel, C., Flower, K., Youssef, J., Käser, B. and Kneebone, R. (2019), 'Mise-en-place: Learning across disciplines', *International Journal of Gastronomy and Food Science*, 16, https://doi.org/10.1016/j.ijgfs.2019.100147. Accessed 11 February 2021.

Selwyn, T. (2000), 'An anthropology of hospitality', in C. Lashley and A. Morrison (eds), *In Search of Hospitality. Theoretical Perspectives and Debates*, Oxford: Butterworth-Heinemann, pp. 18–37.

Severt, D., Aiello, T., Elswick, S. and Cyr, C. (2008), 'Hospitality in hospitals?', *International Journal of Contemporary Hospitality Management*, 20:6, pp. 664–78.

Shove, E., Pantzar, M. and Watson, M. (2012), *The Dynamics of Social Practice: Everyday Life and How it Changes*, London: Sage.

Sidenvall, B. (1999), 'Meal procedures in institutions for elderly people: A theoretical interpretation', *Journal of Advanced Nursing*, 30:2, pp. 319–28.

Spence, C., Piqueras-Fiszman, B. and Blumenthal, H. (2014), *The Perfect Meal: The Multisensory Science of Food and Dining*, Chichester: John Wiley & Sons.

Sydner, Y. M. and Fjellström, C. (2005), 'Food provision and the meal situation in elderly care – outcomes in different social contexts', *Journal of Human Nutrition and Dietetics*, 18:1, pp. 45–52.

Telfer, E. (2000), 'The philosophy of hospitableness', in C. Lashley and A. Morrison (eds), *In Search of Hospitality: Theoretical Perspectives and Debates*, Oxford: Butterworth-Heinemann, pp. 38–55.

Walter, U., Edvardsson, B. and Öström, Å. (2010), 'Drivers of customers' service experiences: A study in the restaurant industry', *Managing Service Quality*, 20:3, pp. 236–58.

Walton, K., Williams, P., Tapsell, L., Hoyle, M., Shen, Z. W., Gladman, L. and Nurka, M. (2013), 'Observations of mealtimes in hospital aged care rehabilitation wards', *Appetite*, 67, pp. 16–21.

Wright, L., Hickson, M. and Frost, G. (2006), 'Eating together is important: Using a dining room in an acute elderly medical ward increases energy intake', *Journal of Human Nutrition and Dietetics*, 19:1, pp. 23–26.

SUGGESTED CITATION

Jonsson, Ann-Sofie, Nyberg, Maria and Öström, Åsa (2021), 'Performance of hospitality within restricting meal frames: An observational study of four hospital wards in Sweden', *Hospitality & Society*, 11:1, pp. 47–69, doi: https://doi.org/10.1386/hosp_00035_1

CONTRIBUTOR DETAILS

Ann-Sofie Jonsson is a Ph.D. student in Culinary Arts and Meal Science, campus Grythyttan, Örebro University. The research project aims to explore and understand the meal provision within the hospital setting through the lens of hospitality with an emphasis towards older patient's mealtime experiences.

Contact: Örebro University, School of Hospitality, Culinary Arts and Meal Science, Sörälgsvägen 1, SE-712 60 Grythyttan, Sweden.
E-mail: ann-sofie.jonsson@oru.se

https://orcid.org/0000-0001-5913-6146

Åsa Öström is Ph.D. and professor in Culinary Arts and Meal Science, Campus Grythyttan, Örebro University. Her field of research includes sensory research from an interdisciplinary perspective such as basic research in complex meal and multisensory settings. Current research focuses on developing methods in sensory science that assess food combinations and how sensory experiences can be communicated.

Contact: Örebro University, School of Hospitality, Culinary Arts and Meal Science, Sörälgsvägen 1, SE-712 60 Grythyttan, Sweden.
E-mail: asa.ostrom@oru.se

https://orcid.org/0000-0001-8848-5812

Maria Nyberg is Ph.D. and associate professor in sociology within the area of food and meal science at Kristianstad University, Sweden. Her research interest is related to the social, cultural and organizational aspects of food and meals. Through ethnographic methods, food behaviour and food choice have been investigated within hospital and elderly care as well as within schools and in workplaces.

Contact: Kristianstad University, Department of Food and Meal Science, Elmetorpsvägen 15, SE-291 88 Kristianstad, Sweden.
E-mail: maria.nyberg@hkr.se

https://orcid.org/0000-0001-7331-1684