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Top Management's Perceptions Of Service Excellence And Hospitality: The Case Of Dr. P. Phillips Hospital

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TOP MANAGEMENT'S PERCEPTIONS OF SERVICE EXCELLENCE AND
HOSPITALITY:
THE CASE OF DR. P. PHILLIPS HOSPITAL

by

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B.S. University of Florida, 2005

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Science
in the Department of Hospitality Services
in the Rosen College of Hospitality Management
at the University of Central Florida
Orlando, FL

Summer Term
2008

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ABSTRACT

This study investigated service excellence and hospitality in a healthcare setting. It is unique from other hospitality research in that it considers hospitality and service excellence as separate concepts, applicable across industries. Part of the premise of this study explores how hospitality extends past service excellence to create a comfortable and welcoming environment to combat patient anxiety and stress. Furthermore, this is one of the first qualitative studies on the importance of service excellence and hospitality in the healthcare industry.

This case study measured top management's perceptions of service excellence and hospitality within one community-based hospital located in Orlando, Florida. The researcher conducted one-hour interviews with twelve leading managers to gain their opinions of service excellence and hospitality within their organization. Consistent with a thorough review of literature, three conclusions were revealed: 1) there is a strong, but mixed, top management commitment to service excellence and hospitality throughout organization; 2) the terms "service excellence" and "hospitality", when used, were discussed interchangeably as if the two theories were equivalent; and 3) External barriers to the patient experience that were identified included improvement of technology, increased consumerism, quality regulations, and workforce deficits. Internal barriers to the patient experience include communication and inconsistency.

The research provided implications to healthcare organizations that are looking to implement practices of hospitality and service management to improve service delivery. Additionally, the study of hospitality outside the industry offers ideas of improvement for hospitality management and organizational researchers. It can also be used as a foundation to formulate additional studies in the area of service excellence and hospitality within the healthcare field, as this research is limited to only top management's views.

This project is dedicated to Noah Elledge Severt, who throughout the journey of daunting

mountain peaks and abysmal valley lows, has unconditionally blessed rays of sunshine, love, and

mercy upon all of the prophets seeking closure for unresolved and unappreciated injustices.

ACKNOWLEDGMENTS

I would first and foremost like to acknowledge my family for always encouraging me to work harder and strive to be my very best. I am so fortunate to have such loving and supportive parents and brothers who have and will always see me through. Had I not had such a lousy service experience during such a trying time, none of this wonderful research would have ever happened. I have endless amounts of love for my parents who sat in my hospital room every single day and gave me the strength to continue.

I would also like to thank Shannon Elswick, Cheryl Cyr, and the administrative team for recognizing the need for the relationship between Orlando Regional Healthcare's Dr. P. Phillips Hospital and the UCF Rosen College of Hospitality Management. The organization has been so warm, welcoming, and supportive of our presence within the walls of the hospital and there is not a single day where I leave that facility without a smile on my face. You both should be very proud of what your organization stands for.

Recognition and thanks also are given to Dr. Paul Rompf and Dr. Deborah Breiter for serving on my thesis committee. I appreciate all of the unconditional personal and academic support I have received from working with both of you throughout my education. I am truly grateful for all of the encouragement I have received from this entire college.

Finally, I have to give the most appreciation for this research to Dr. Denver and Dr. Kimberly Severt. You both have accepted me as a daughter, student, and friend and the lessons I continue to learn from each of you everyday have truly changed my life. One small decision back at the end of March in 2007 ended up turning into a career that I absolutely love. Thank you for taking the time and the commitment to teach me. I admire you both so much and I am deeply honored to have been blessed with this experience.

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CHAPTER ONE: INTRODUCTION

External forces such as increased competition and increased consumer knowledge of services have forced several hospitals to reevaluate their service practices to ensure that patients receive comfortable and stress-free care (Chen & Huang, 2007; Stock, McFadden, & Gowen, 2007). Service excellence, concentrating on the consistency and flexibility of service delivery to exceed the expectations of the customer, might not be enough (Lashley, 1997). Hospital administrators need to be aware of the concept and importance of "hospitality" and how improving service strategies will improve patient care, satisfaction, and overall facility operations. Hospitality refers to the quality or disposition of receiving and treating guests and strangers in a warm, friendly, and generous way (Brotherton, 1999; Lashley, 2000). Unfortunately, without adequate efforts to integrate hospitality into healthcare, this term seems almost foreign within a modern healthcare system focused on politics, competitiveness, and financial figures. A hospital's reputation should be created and maintained through its focus on superior patient service practices.

Ironically, the terms "hospital" and "hospitality" are derived from the root word "hospice", referring to the idea of offering a place for rest and shelter to sick and weary travelers on a long journey (American Cancer Society, 2008). In modern times, hospice care focuses on treating and healing the person, not the disease (American Cancer Society, 2008). At first consideration, many people would not consider the healthcare field and the hospitality industry to be directly related, but the increasing focus on hospitality in healthcare gives recognition to the word's origin. Developments in patient services that have begun to appear in hospitals are integrating concepts of service excellence into its best practice strategies for quality patient care

in hopes of ultimately achieving comfortable and relaxing experiences for patients (Studer, 2003). According to Pizam (2007), "the difference between hospitals and hospitality is 'ity', but that 'ity' can make a significant difference in the recovery of hospital patients." The act of being hospitable, through increased attentive social interactions with patients, improved guest amenities, and a supportive organizational culture for hospital employees, is postulated to increase a patient's mental and physical well-being while advocating total quality patient care (Pizam, 2007).

Significance of the Study

Why Is Service Excellence Important to the Healthcare Industry?

The purpose of this study was to investigate the perceptions of departmental administrators and top management regarding their visions for service excellence and hospitality within their hospital. As defined by Studer (2003), service excellence is the standard achieved when employees feel valued, physicians feel their patients are getting great care, and patients feel the service and quality they receive are extraordinary. When the mission/vision and leaders and staff are internally aligned to service excellence goals, the bottom line can also be positively affected (Ford, Sivo, Fottler, Dickson, Bradley, & Johnson, 2006).

Consumers have access to more information and can now make more educated choices about their healthcare, thus resulting in increased competition among facilities. The threat of malpractice, accreditation requirements, government regulations, and budget constraints has begun to affect the way in which administration strategically manages operations in their

facilities (Harrington & Trusko, 2005). Because of this, it is important for service researchers to take notice of how service delivery can be improved upon given these circumstances. Berry and Bendapudi (2007) identified six areas of under-researched topics in service management in regards to healthcare services. The first area relates to healthcare service providers being in a unique situation that requires them to cater to consumers that are more sensitive, demanding, dependent, and emotional as compared to the typical customer. The current study addresses this call to scholarly researchers in service management by investigating the perceptions of service from top management on service excellence and hospitality in an effort to continually improve service excellence.

How Does Hospitality Extend Beyond Service in Hospitals?

Currently, healthcare in the United States is the largest service industry in the world (Sheehan-Smith, 2006). For the purpose of this study, service excellence has been defined as the consistency and flexibility of service delivery to exceed the expectations of the customer (Lashley, 1997). Additionally, hospitality is defined as the inclusion of a comfortable environment for patients in the form of a welcoming feeling (Lashley & Morrison, 2000). By adding hospitality services within the overall hospital environment, many advantages can be achieved. Many of the guests in a hospital only interact with a hospital a few times in their life (Elswick, 2008). Due to the high emotional value associated with hospital encounters, there are enhanced memories related to that experience. These memories become stories that are then shared in a positive or negative light with other potential patients. By integrating a strong hospitality component, the first visit can hopefully be one of welcome instead of one of fear and

unfortunate emotions, lessening the impact of negative emotions that most patients feel in association with a hospital experience (Randall & Senior, 1994).

Though the emotions cannot be removed or taken away, with a strong hospitality component instilled through various offerings made available from hospital door to home door, the hospital is much more likely to have satisfied patients. However, in a healthcare environment, the health outcome and the experience outcome can be positive or negative. Both can be enhanced by a positive process time in the hospital, hence offering hospitality may produce positive financial returns as well as better overall experiences for patients (Dagger, Sweeney, & Johnson, 2007; Johnson, 2004; Sollenberger, 2006; Studer, 2003).

Why DPH?

The setting for this research study took place at Dr. P. Phillips Hospital (DPH), a full-service medical facility that is a branch of Orlando Health catering to the immediate Central Florida area. DPH operates under the same mission statement as the one established for the Orlando Health corporation. This mission states that the organization will improve the health and quality of life of the individuals and communities that it serves. Moreover, Orlando Health has a specific service mission "to build customer loyalty through consistent delivery of excellent service." The vision statement of Orlando Health is "We are dedicated to improving the health and quality of life of the individuals and communities we serve. We always have been and always will be." (Orlando Health, 2008)

Nearly 50 million domestic and international leisure and business tourists visit Orlando every year (D.K. Shifflet & Associates, 2005). Because the surrounding community is

populatedby hospitality and service businesses, this setting was chosen as ideal for the case study. It is only consistent that the area features a healthcare facility that is synonymous with the city's overall focus on innovative and exceptional hospitality and service excellence. With so much traffic in and out of the city on a daily basis, trauma and crisis is bound to occur among both tourists and local residents. An ailing out of town visitor generally has two options for immediate treatment located within Southwest Orlando—Dr. P. Phillips Hospital located about a mile from Sea World, and Celebration Hospital, situated about one mile south of Walt Disney World.

Research Objectives

Given the exploratory nature of this study, which crosses boundaries outside of traditional hospitality research and into the healthcare industry, two research objectives were established:

1) Explore the perceptions of top management concerning service excellence and hospitality using a hospital setting.

2) Identify external and/or internal barriers to service excellence and hospitality from the management perspective.

Methodology and Data Analysis

In this exploratory research, a case study of DPH was conducted that utilized a singular unit and management views. Case studies investigate a program, event, or process of one or more

individuals. Researchers using case study approaches are bound by time; detailed information and data are collected through qualitative procedures over a sustained period of time (Creswell, 2003).

For the purpose of this research, the perceptions of the importance and awareness of service excellence and hospitality by top management within DPH were explored. Data was collected through observations, the review of documents, and face-to-face interviews with key informants of the DPH staff, with a particular focus on the top management team. This small internal population provided a narrow approach to the investigation, while also paving the way for future research among the organization's other departments, employees, and strategies, including those among middle management and front-line employees.

By first interviewing DPH's president, the following reports from the organization's other leading administrators provided a top-down stream of information that revealed whether service excellence and hospitality are in fact perceived similarly by all organizational leaders, or whether there was some dissonance occurring in the translation of information. This investigation of the top managers' perceptions of service and hospitality was instrumental in determining whether a cohesive understanding of DPH's service standards and goals exists among the top administrative team and if the established patient service programs are complimentary to the hospital's mission and vision.

A thorough literature review was first conducted to support the justification for the study. Data was organized and coded to reveal relevant themes and trends that were apparent from the interviews. The results were then analyzed to formulate overall conclusions to the study, implications of the research for management, limitations of the study, and suggestions for future research.

Summary

This study of Dr. P. Phillips Hospital in Orlando, Florida sought to examine the extent to which service excellence and hospitality have become an important focus within a hospital setting. This was accomplished through an investigation of top management's perceptions of service excellence and hospitality, using the review of documents, observations, and interviews for data collection. Chapter Two provides an in-depth analysis of the current literature in service excellence in both hospitality and healthcare, as well as an investigation of prominent service measurement measurements that exist to evaluate the quality of healthcare practices. Chapter Three describes the methodology that was used by the researcher to conduct this study. Chapter Four reports the findings and captures perceptions of top management in regards to the importance of service excellence in healthcare. Chapter Five completes the thesis, discussing the conclusions drawn from the themes that were revealed in the investigation. The chapter also provides recommendations for future research on service excellence and hospitality in healthcare, limitations to this research, and implications for applied managerial practice.

Definition of Terms

Case study: An exploration of a system over time through detailed, in-depth data collection involving multiple sources of information rich in context (Creswell, 2003).

Healthcare services: Services that are rendered within a healthcare setting that are delivered to patients in a time of great physical ailment (Studer, 2003).

Hospitality: The inclusion of a comfortable environment for patients in the form of a welcoming and warm feeling. It also includes acts that provide a commitment to meeting the needs of patients through a host and guest relationship (Brotherton, 1999; Lashley & Morrison, 2000)

Qualitative methodology: An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social problem using complex, holistic pictures, the analysis of words, detailed observations, and the completion of research in a natural setting (Creswell, 1998; Creswell, 2003; Rubin & Rubin, 2005; Trochim, 2006).

Reliability: Refers to the consistency in a set of measures consistency of data. Reliability is achieved when the steps of the research are verified through the close examination of data, process notes, and data reduction products (Golafshani, 2003; Marshall & Rossman, 2006; Trochim, 2006; Yin, 2003)

Rounding: A practice used by managers to describe routine walks through their organization in an effort to build relationships with staff through focus on employee and patient/guest satisfaction (Studer, 2003).

Service excellence: Refers to the consistency and flexibility of service delivery to exceed the expectations of the customer (Lashley, 1997).

Validity: The act of drawing meaningful and useful inferences from content. It is also established when the research is credible and measures what it is intending to measure (Appleton, 1995; Brink, 1987; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Trochim, 2006; Yin, 2003).

CHAPTER TWO: REVIEW OF RELATED LITERATURE

This review of literature is organized by first introducing the concept of service quality and the supporting theory that justifies the need for the current research. The literature review then gives an overview of service excellence, service excellence in hospitals, and then explores the literature surrounding hospitality in hospitals. Finally, this section explores increased consumerism in healthcare and how that affects organizational efforts towards service excellence and hospitality.

Service Quality

In order to create strategies for service excellence within an organization, leaders must first understand what their customers expect from the service experience they receive. Zeithaml, Parasuraman, and Berry's (1990) research of service quality and gap theory in service management identifies a five-gap model on potential causes of service quality shortfalls between the customer and the service provider. Gap 1 of the researchers' model espouses discrepancies between customer expectations and managements' perceptions of those expectations. Not knowing what customers expect from the service experience can contribute to diminished service quality, especially in the hospital setting where people are vulnerable and require supervised care.

Key factors that contribute to Gap 1 are lack of marketing research orientation (insufficient marketing research, inadequate use of research findings, and lack of interaction between management and customers), inadequate upward communication (the flow of

information from employees to upper levels and how top management seeks and facilitates that information) and having too many levels of management in the organization that separate frontline employees from top management (Parasuraman, Zeithaml, & Berry, 1985; Zeithaml, Berry, & Parasuraman, 1988; Zeithaml et al., 1990).

Interestingly, Zeithaml's (1990) research shared that Gap 1 is usually small across a multitude of industries. For hospitals, one of the primary ways to minimize Gap 1 is to focus on the communication and empowerment of employees that are providing the service to customers and therefore act as a link between the patients and the overall organization and top management team. Another way is to conduct the appropriate research and use the proper tools to ensure that the patients' voices are being heard concerning their experiences in the hospital service exchange. A combination of this awareness will help to bridge the gap between the hospital's top management and the patients it serves through identifying what kind and quality of services are required to meet and exceed the patients' expectations.

An Overview of Service Excellence

For an organization, service excellence refers to consistency and flexibility of service delivery to exceed the expectations of the customer as made possible through the empowerment of employees (Lashley, 1997). Berry (1999) identified seven characteristics valued by employees that work in organizations achieving service excellence: innovation, joy, respect, teamwork, social profit, integrity, and excellence. These characteristics of an empowered work culture should translate into the consistent and flexible delivery of service that Lashley (1997) mentioned.

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In general, service excellence can be viewed in many different ways. Typically, service excellence within an organization refers to excellent service that is provided both internally and externally as a competitive advantage between businesses (Dickson, Ford, & Upchurch, 2006). The type of service being provided and the clientele that is receiving the service generally influences how organizations define their service cultures and service excellence (Frey, Leighton, & Cecala, 2005; Skalen & Strandvik, 2005).

According to Frey et al. (2005), service excellence strategies should also encourage the creation of work cultures that are innovative, proactive, accountable, and emphasize mutual respect and communication between all levels of employees. Service excellence in any business is ultimately reliant on the individual employees that are providing the service to customers (Bates, Bates, & Johnston, 2003; Crotts, Dickson, & Ford, 2005; Dickson et al., 2006; Frey et al., 2005; Skalen & Strandvik, 2005).

Service Excellence in Hospitals

Because the healthcare industry has an increased awareness of service excellence, administrators have also started to understand and appreciate acts of hospitality as a vital role in hospital operations. Service excellence in the healthcare industry can be defined as the standard achieved when employees feel valued, physicians feel their patients are getting great care, and patients feel the service and quality they receive are extraordinary (Studer, 2003).

Healthcare is a huge industry that accounts for over 15 percent of the United States' gross national product, however service within healthcare is greatly suffering as staff shortages and costs of care have forced healthcare organizations to put less emphasis on service excellence

(Tisch, 2007). Because of this, many different strategies are being developed by healthcare

administrators in order to improve the awareness and implementation of consistent service

excellence in patient care.

Berry and Bendapudi (2007) recently put out a call to scholarly service researchers with

suggestions for studying the social, psychological, moral, and economic impacts of healthcare

service research. The researchers identified how healthcare service differs from other services,

and thus requires further inquiry in order to properly diagnose how service excellence can be

rightfully achieved in these situations. Six areas of impact were recognized as under-researched

topics in service management as it applies to healthcare services:

1) Customers have some combination of illness, pain, fear, and lack of control. Because of this,
health service providers are in a unique situation that requires them to cater to consumers that are
more sensitive, demanding, dependent, and emotional than the typical consumer. How can
healthcare be delivered to increase patients' sense of control over their care?

2) Customers may be reluctant co-producers because healthcare is a service they need, but don't
necessarily want. This changes the typical service provider-consumer exchange because the
customers' wants and needs conflict through the experience of heightened emotions and
anxieties. How can increased motivation be manipulated by clinicians to ease the minds of
reluctant co-producers?

3) Customers surrender privacy and are forced to relinquish personal and emotional information
during the service exchange. They discuss information with their physicians that they reveal with
few other people, and may form a personal ongoing relationship with their healthcare provider.
How can researchers identify the predictors of customer self-disclosure in one-on-one
interactions with their physicians?

4) Customers need "whole person" service. Specifically, healthcare consumers need
personalized service applicable to their own medical conditions, age, preferences, family history,
and financial situation. What can clinicians improve upon to be better prepared for the need to
respond to physical and psychological needs?

5) Service provided through healthcare puts customers at risk. Patients are at realistic risk for
medical error in the execution of care, hospital-acquired infections, communication errors in
diagnosis or treatment, and prescription errors. Approximately 70% of these errors are accidents
that involve human error, and because of this, it is important to understand how healthcare

service impacts the physical and psychological state of the patient (Stock et al., 2007). How do patients mentally process the healthcare-related service failure?

6) Clinicians are emotionally and physically stressed. They work long shifts with little downtime and stand on their feet for the majority of their workday. They experience a variety of stressful and emotional situations in their work, which requires a create deal of focus and concentration to ensure proper care to the patient. How can healthcare providers avoid emotional burnout in their jobs, and how can the quality of service communication be improved in the clinician-patient exchange of information?

The research questions brought forth from Berry and Bendapudi's (2007) inside look at the Mayo Clinic provide a foundation for creating further service research studies based in healthcare management. Through this comprehensive look at issues currently being realized within the healthcare sector, service researchers and healthcare administrators can begin to bridge the gaps between some of the common service delivery failures that are found throughout the healthcare industry.

The need to improve service excellence within an organization, particularly in the healthcare industry which faces such sensitive and unique requirements of service, often entails the evaluation of how the business firm is managed from the top of the executive team down to front-line workers (Ford et al., 2006). In order to become a completely patient-centered organization, management needs to empower and motivate employees to buy into the culture they are attempting to create (Johnson, 2004).

A supportive leadership team in an organization is a priority to guarantee that the goals and visions for accomplishing service excellence are being properly managed. A culture of service excellence first needs the devotion of administrators and leaders to guide the organization towards their service vision (Bolster, 2007; Johnson, 2004; Snipes & Runge, 2008; Whitney, 2007). Ultimately, the hospital CEO and board of administrators are responsible for

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implementing the strategy and direction for an organization (Sollenberger, 2006). Consistent with Gap 1, buy-in must be achieved by all individuals in leadership positions (Zeithaml, 1990). This must happen before employees can be expected to uphold organizational strategies.

An internal alignment study by Ford et al. (2006) investigated internal organizational factors with the service mission statement to strategy, systems and staffing within the healthcare setting. The authors found that managers and executives who properly align their service mission statements with its actions, words, and systems design can achieve organizational mission by shaping a positive service culture. In turn, this impacts employee satisfaction which will ultimately affect overall customer satisfaction (Ford et al., 2006). This is especially important in healthcare as service excellence has become a vital corporate strategy in achieving increased patronage, competitive advantage, and long-term profitability (Dagger et al., 2007).

Studer (2003) identified nine basic principles of service and operational excellence within healthcare that can potentially help leaders focus on actions that will have the greatest benefits to an organization's five pillars of excellence: People, Service, Quality, Finance, and Growth. Studer (2003) also identified nine principles of service excellence that, when properly established and implemented, have been found to lower staff turnover, raise employee, physician, and patient satisfaction, improve service quality, create greater capacity to service patients, and ensure a healthier bottom line for the organization. The nine principles are: 1) commit to excellence; 2) measure the important things; 3) build a culture around service; 4) create and develop leaders; 5) focus on employee satisfaction; 6) build individual accountability; 7) align behaviors with goals and values; 8) communicate at all levels; and 9) recognize and reward success. This proposed action plan of service excellence within healthcare is highly focused on creating a positive organizational culture that conversely empowers and encourages

self-motivation of employees at all levels to put passion into their work in order to cohesively achieve operational excellence.

Studer (2003) recommends a practice of "managing up" within healthcare organizations. Managing up allows leaders to focus more on the organization rather than personal agendas. This requires managers to set clear expectations for accomplishments—both personally and organization-wide—and provide employees with the proper tools and resources to become empowered to succeed at delivering quality service in everyday tasks. Studer (2003) suggests rounding to employees (management by walking around) to ensure that employee needs are being met. Through relationship-building and by giving employees a consistent outlet in which they can voice their concerns, leaders can uncover firsthand knowledge of efficient and non-efficient systems while building value and loyalty among staff. Fottler, Dickson, Ford, Bradley, and Johnson (2006) also suggested connecting with staff to investigate potential problems in service delivery through the use of focus group sessions. By considering and acting upon the results of staff focus groups and patient focus groups, healthcare administrators can get a greater grasp on what specific factors influence patient satisfaction.

However, before administration can expect a culture of service excellence to be created through strategic management, they need to understand who primarily embodies the organization. Top leadership teams should focus on providing service to the employees who deliver service to the organization's customers. Building a culture that encourages the empowerment and satisfaction of employees will have a greater chance of achieving levels of service excellence (Studer, 2003). Numerous studies have emphasized the importance of establishing and maintaining employee satisfaction within an organization as a precursor to ensuring customer satisfaction (Bolster, 2007; Dagger et al. 2007; Ford et al. 2006; Fottler et al.

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2006; Johnson, 2004; Patrick & Spence-Laschinger, 2006; Rathert & May, 2007; Sollenberger, 2006; Studer, 2003).

Healthcare employees who feel as though they work in an organization that provides them organizational support are generally more satisfied with their jobs, experience feelings of acceptance as they work in teams with other employees, view their work as significant, exciting, and challenging, and are more likely to take work-related risks without fear of reprobation from management (McConnell, 2007; Patrick & Spence-Laschinger, 2006; Valadares, 2004; Yoon, Choi, & Park, 2007). This has been directly linked to greater pride in work responsibilities, improved service delivery, and increased patient satisfaction (Rathert & May, 2007; Snipes & Runge, 2008). As a result, even though leaders may generate and implement strategies of service excellence, the key to sustaining a culture of service excellence is the commitment and dedication provided by the organization's employees (Studer, 2003). Thus, the hospitable attitude towards service must filter down first from administration into employees, who then carry that mindset with them as they deliver service to patients.

Providing high quality service to patients has many benefits to the organization. Among these benefits, service excellence can result in increased patronage, competitive advantage, and long-term profitability (Dagger et al., 2006). In order to provide high quality service to patients in an effort to become a culture of service excellence, it is important to understand what patients expect from a hospital experience. Dagger et al.'s (2006) research states that patients perceive the quality of healthcare services across a series of dimensions. The first dimension, *interpersonal quality*, describes the attitude, manner, and behaviors that caregivers provide within the service setting. It also relates to the communication and interactive component of service and the strength of the relationship developed as a result of the service exchange. The

second dimension, *technical quality,* describes the caregiver's expertise, competence, and knowledge displayed across service encounters. The third dimension, *environment quality,* describes the atmosphere (intangibles—smell, sounds, comfort) and physical aspects (room layout, facility layout, cleanliness) of the service exchange that may have an affect on the experience that the patient may receive. The final dimension, *administrative quality*, refers to the timeliness of service, the coordination of care with other departments, and the perceived support that patients receive from clinical and non-clinical programs and amenities throughout the hospital.

Rathert and May (2007) also recognize that a healthcare service culture that encourages support to create an awareness for complete patient-centered care results in better health outcomes for the patient. Establishing interpersonal communications and relationships between staff and patients has been shown to be a top influencer in achieving patient satisfaction (Ekwall, Gerdtz, & Manias, 2008). This is supported by Dagger et al. (2006), Ford et al. (2006), and Yoon et al. (2007), who all described the role of the interpersonal relationship created in the service experience to be of significant value to the patient.

Hospitality in Hospitals

Although service excellence must first be achieved within an organization, hospitality has been identified in numerous ways. It most relates to the entire experience that customers receive, and extends beyond the principle of service excellence (Severt, Aiello, Elswick, & Cyr, 2008). According to Lashley and Morrison (2000), hospitality provides a commitment to meeting guests' needs as the primary focus in commercial operations through a host and guest

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relationship. The host and guest relationship is further characterized by hospitableness and various service exchanges or service encounters that result in accompanying emotions (Lashley & Morrison, 2000). Hospitableness includes a welcoming attitude and service environment or servicescape. These two ideas, backed by genuine company actions, indicate service excellence as a priority.

Brotherton (1999) identified four distinct characteristics of modern hospitality from previous literature: 1) It is conferred by a host on a guest who is away from home; 2) It is interactive, involving the coming together of a provider and a receiver; 3) It is comprised of a blend of tangible and intangible factors; and 4) The host provides for the guest's security, psychological, and physiological comfort. Brotherton (1999) argues that researchers provide various definitions mostly being conceived as some combination of products, processes, and experiences. Similar to a hospitality business, a hospital stay or experience conforms to the aforementioned criteria of modern hospitality.

As discussed by King (1995), there are generally two types of hospitality: 1) private hospitality and 2) commercial hospitality. *Private hospitality* refers to warm and welcoming acts by individuals towards other individuals within a host setting, such as a home. It is not limited to simply personal interactions, but can also include cities, universities, and craft guilds. Emphasis is usually placed on the generous offering of food, drink, and entertainment. In contrast, *commercial hospitality* was historically derived from locations where travel flourished, requiring hosts to appropriately provide for the welfare of travelers. Primarily for-profit organizations, commercial hospitality corporations operate to provide meals, beverages, lodging, and/or entertainment to visitors who are willing to pay to receive such services. In this relationship, the

host strives to bring pleasure and enhance the comfort and well-being of the guest in an effort to foster guest satisfaction and develop repeat business (King, 1995).

Patten (1994) recognized the infiltration of hospitality within healthcare services as an ideal that should be embraced by caregivers. The study posited three types of hospitality that are applicable across various situations. *Public hospitality* refers to basic courtesy that is expected in hotels, airlines, and restaurants. As viewed in the healthcare sector, public hospitality can be translated into everyday interactions in the gift shop or cafeteria. *Personal hospitality* is composed of personal invitations and interactions that go beyond common exchanges, such as self-disclosure and sharing of interests through conversation. In the hospital setting, personal hospitality is evident in nursing units where there are contacts over a longer period of time, or in the emergency room where interactions are short but intense and emotional. Finally, *therapeutic hospitality* indicates a service to mankind with the idea of encompassing a moral/ethical element. Therapeutic hospitality is used to connect people in order to reduce the sense of separation and loneliness while advocating healing and care. This is especially important in a medical setting that can often lead to emotions of frustration, anxiety, fear, and loneliness. Patten (1994) suggested that nurses embrace a mission of managing therapeutic hospitality within their organizations to enhance both patient satisfaction and progressive healing.

The analysis of Patten's (1994) definitions of public, personal, and therapeutic hospitality acted as the foundation for Severt et. al's (2008) study on hospitality-centered programs (HCP) within the hospital setting. Hospitality-centered programs can be defined as services designed for the hospital environment that are used to create a comfortable and satisfying experience. These include rounding techniques, guest services amenities, spiritual care services, and implementation of patient education technology systems (Severt et al., 2008) The authors used

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Patten's (1994) study of public, personal, and therapeutic hospitality to analyze the relevance of each initiative in achieving service excellence in healthcare. In addition, Severt et al. (2008) noted that top management should be most committed to service design and delivery for the awareness of a philosophy of hospitality within the hospital organization to be a success. This included strategies of support that were evident through a combination of resources from the service environment, employees, and internal and external councils to assess and support organizational missions.

It is important, however, that the integration of hospitality in hospitals emphasize the harmony created between the human component represented by healthcare staff members and the traditional hospitality accommodations. Reynolds and Leeman (2007) described how hospitality-based services were typically outsourced operations within a healthcare organization until they started being replaced by facility-managed services. This upholds the ideal of managing the infiltration of hospitality services throughout the organization to support high-quality patient care in regards to satisfaction and healing.

The Reynolds and Leeman (2007) article classifies "hospitality-related support services" as foodservice, housekeeping, and maintenance without recognizing the definition of hospitality as the creation of a welcoming environment which would apply throughout the hospital. While the article does touch on the importance of facility-managed hospitality-related services within the healthcare realm as an efficient means to service delivery with a customer focus, it does not directly refer to hospitality services as patient-focused, noting that "hospitality-related services are unrelated to a healthcare organization's core business" (Reynolds & Leeman, 2007, p.186). This may be due to the context the authors used to describe hospitality-based services, but it

disregards the recognition of the role healthcare staff members play in the creation of a hospitable environment for patients.

King (1995) found that the integration of hospitality-type services within the hospital setting is used to sustain a competitive advantage and improve patient satisfaction and retention. Traditionally, healthcare organizations are not viewed as typical hospitality organizations even though it is a service-based industry offering arguably the most personal and important service product that consumers can purchase (Berry & Bendapudi, 2007).

Classified by King (1995) as a "non-hospitality organization", the literature suggests that healthcare organizations may use hospitality as a metaphor to describe that by treating patients as guests, they are creating a closer relationship between the caregiver and receiver. The difference between a patient and a guest is not reciprocal; a patient can be a guest, but a guest is not always a patient. Therefore, the metaphor of a patient being treated as a guest should account for the sensitivity that is found in the healthcare service exchange. In addition, this metaphor is used under the assumption that the healthcare employees agree to buy into how the hospitality metaphor is valued by the organization and what that metaphor means to their everyday delivery of service. It must be understood that the hospitality infiltration will be trained for, communicated, and practiced throughout the entire organization—not just simply enforced onto frontline staff by top management (King, 1995).

The Consumer Movement in Healthcare

It is evident that consumers are playing a greater role in the service they receive from their healthcare providers. Because of this increased movement of consumerism, which is largely

influenced by increased access to healthcare information via the internet, healthcare organizations are being held accountable for the quality of their operations and services. Positive regulatory assessments and achievements in service excellence that are accessible to the public can improve market image to consumers and improve the likelihood for loyalty (Cunningham, Weber, & Cook, 2007). The following metrics and awards are used in healthcare to evaluate and recognize service provided to patients. Though several awards recognizing service excellence exist, there are currently no awards available for hospitality in healthcare.

External Metrics Used in Healthcare Services

Currently, there are several independent organizations and improvement programs that exist to recognize the quality of patient care within the United States. Though these programs are comprised of different service strategies and initiatives for a wide range of organizations, they were built to ensure positive customer experiences. The assessment of healthcare services can be accomplished through two widely used initiatives—Six Sigma statistical analysis and The Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) patient satisfaction scores. For the business, participating in such programs can mean the development of long-term customer relationships, customer willingness to recommend the service to others, employee satisfaction, and good image (Harrington & Trusko, 2005; Hensley & Dobie, 2005). For the patient, service-centric facilities concentrate on decreasing medical errors and recovery time while increasing comfort, communication, and safety (Harrington & Trusko, 2005). The following quality service programs will be briefly discussed to give the reader an understanding of programs in place that deal with service excellence.

Six Sigma

An increasing number of healthcare facilities are using the Six Sigma quality improvement program to enhance productivity and the efficiency of everyday operations. It is a statistically-based quality improvement plan that utilizes a data-driven roadmap process known as DMAIC, which stands for *define, measure, analyze, improve, control* (Hensley & Dobie, 2005; Voelkel, 2005). Developed by Motorola in the mid-1980s, Six Sigma was expected to increase productivity and profits due to reduced costs. This was accomplished through setting a goal that encouraged all processes to statistically perform at an error rate of no greater than 3.4 errors per million opportunities. This idea was then applied to all processes within the company, not just those involving manufacturing. Six Sigma became increasingly popular after Motorola won the Malcolm Baldrige award in 1988, thus acting as benchmark for total quality improvement across an entire organization (Harrington & Trusko, 2005).

The process requires significant organizational change, which is integral to the success of the program. Because of this, full-time Six Sigma experts, known as Black Belts, are commonly employed within Six Sigma organizations to analyze organizational progress through advanced statistical techniques and technical leadership (Fraser & Olsen, 2002; Harrington & Trusko, 2005). Six Sigma organizations also spend a great deal of time integrating the strategy into the established service culture through various training, coaching, and certification programs. Commitment, focus, and patience are critical to successful implementation, but the rewards include reduced medical errors (e.g. patient falls, errors from high risk medications, medication ordering and administration errors, improved turnaround on pharmacy orders), improved patient case management (length of stay, improved exam scheduling, reduced

emergency room diversions), improved business operations (e.g. improved revenue cycle, employee recruitment, and employee retention) and patient satisfaction (Lazarus, 2004).

Six Sigma methodologies are implemented by healthcare organizations by utilizing the DMAIC process. The following presents a breakdown of the DMAIC process as it applies to the overall improvement of hospital operations:

- *Define* the scope or case of the project. What needs to be improved? Approximately how long will this take?
- *Measure* current processes through the collection of data to determine how the success of implemented strategies. Is the process valid and reliable?
- *Analyze* the data to uncover areas of poor performance. What is the root of the problem? What needs to be improved upon?
- *Improve* current practices by identifying a course of action. What specific actions need to be taken to make change occur?
- *Control* the improved processes by establishing a standardized system of change across all organizational departments. How should this system be controlled to ensure that Six Sigma goals are being accomplished?

It is through this process of DMAIC that Six Sigma initiatives are properly employed by healthcare organizations to ensure that operations are providing the highest quality service to its patients while maintaining cost effective solutions to hospital operations (Fraser & Olsen, 2002; Hensley & Dobie, 2005; Hospitals & Health Network, 2007; Pellicone & Martocci, 2006; Proudlove, Moxham, & Boaden, 2008; Voelkel, 2005).

The Hospital Consumer Assessment of Health Providers and Systems (HCAHPS)

Measuring the effectiveness of the implemented service programs that exist within the hospital often entails the collection of patient perception of the service they received. Patient satisfaction surveys are distributed to evaluate several components of patient care. The Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey is used as a

standardized method of data collection for measuring patient perceptions of hospital care. Because many hospitals collect information on patient care and there are currently no national standards for collecting and publicly reporting such information, the HCAHPS act as a core set of questions that are combined with a customized set of facility-specific measures (Cunningham et al., 2007).

According to the U.S. Department of Health and Human Services (2007), there are three broad goals that shape the HCAHPS survey. First, the survey is created to produce comparable data on the patient's perceptions of care that allow objective comparisons between hospitals on issues that are of a concern to consumers. Second, because survey results are reported publicly, this strategy has been designed to create incentives for hospitals to improve their quality of care. Finally, public reporting serves to enhance public accountability in healthcare by increasing the transparency of the quality of hospital care provided in return for public investment.

The HCAHPS survey consists of 27 items. Eighteen of these items cover critical aspects of the hospital experience, including communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of the facility, pain control, communication and education about medications, and discharge information. The remaining items are used to screen patients, adjusting for the mix of patients across hospitals while supporting congressionally-mandated reports. A comprehensive HCAHPS survey can increase staff's understanding of the importance of measuring patient perceptions of care, while improving service delivery and market image (Cunningham et al., 2007).

Recognition of Service Excellence in Hospitals

There are presently two main pathways to achieving recognition for the healthcare field. The Malcolm Baldrige Quality Program awards U.S. businesses, educational systems, and healthcare organizations for excellence service operations, while the Joint Commission accredits healthcare organizations that demonstrate service excellence. Although each program has its own standards that define service excellence, they all center on the principle that quality service is imperative in operation safe and effective healthcare practices.

Malcolm Baldrige

Created in 1987, The National Baldrige Quality Program (NBQP) exists as a public-private partnership to improve the performance of organizations within the United States. It is managed by the National Institute of Standards and Technology within the U.S. Department of Commerce as a means of increasing effectiveness within the workplace while maintaining a competitive advantage. The program exists across three separate categories: 1) manufacturing, 2) service, and 3) small business. In 1995, separate criteria were created specifically for healthcare and educational organizations (Meyer & Collier, 2001). NBQP involves tools for understanding an organization's strengths and opportunities for improvement, while creating a foundation for the granting of The Malcolm Baldrige National Quality Awards, which is presented every year by the President of the United States to recognize outstanding organizational performance excellence.

The Criteria for Performance Excellence as established by NBQP consists of about 100 questions grouped into an organizational profile and seven categories. The organizational profile represents the organization's influences on current operations and opportunities for improvement. Criteria are applicable to three separate industries: healthcare, education, and business. The 2007 Healthcare Criteria for Performance Excellence are defined as following key themes that are integral to the specific needs of healthcare organizations:

- The different types of organizational missions (e.g., HMOs, home health care agencies, hospitals, and/or teaching and research institutions)
- The patient as the key customer and multiple other customers and stakeholders (e.g. the community and payers)
- The complex leadership structure that includes both administrative/operational and healthcare providers
- The multiple roles that healthcare providers, including physicians, may play as a staff, supplier, and customer; and
- The importance of healthcare service delivery as the primary focus of the organization's process (Baldrige National Quality Program, 2007)

Each category is measured and scored on a point system that evaluates each area of organizational performance within the company. These measures are proposed to ensure the balance of organizational strategies within the workplace in an effort to achieve advanced levels of performance excellence through operational functioning and service delivery (Baldrige National Quality Program, 2007; Meyer & Collier, 2001).

The Joint Commission

Since 1951, The Joint Commission organization has operated under the mission "to continuously improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare organizations" (The Joint Commission, 2007). Standards are generated using the input

of healthcare administrators, physicians, and customers. In doing this, The Joint Commission keeps up-to-date with modern standards that focus on improving the quality and safety of healthcare services and care provided by medical facilities around the world—including Brazil, Poland, Russian, and South Africa. In order to receive the accreditation, on-site surveys measuring the care provided are distributed. Unannounced surveys are also utilized to ensure the reliability of the data output. Surveyors track the quality and efficiency of patient care through tracking patients' progress, treatments, and provided services. The Joint Commission evaluates a wide range of medical services including general, psychiatric, children's and rehabilitation hospitals, medical equipment services, hospice services, nursing homes, addiction services, group practices, office-based surgeries, and freestanding laboratories (The Joint Commission, 2007).

Summary

The literature supporting the current research investigated the relevance and importance of service excellence, and ultimately, hospitality, in an effort to improve the care of patients and the operational health of hospital. This has many facets, including the recognition that top management, frontline employees, and customers all play a role in the creation of service excellence.

The gap identified in the current literature relates to service excellence, hospitality, and an increased awareness of consumerism as unique to the healthcare industry. It responds to a recent call to scholarly researchers put out by Berry and Bendapudi (2007) to increase awareness of service in healthcare and hospitals. Specifically, the first area that Berry and Bendapudi

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(2007) addressed in the improvement of service in healthcare was the understanding that healthcare organizations have to understand their customers and their needs and expectations. Healthcare consumers are unique because they are more sensitive, demanding, dependent, and emotional. Because of this, it is important to look at service excellence and how those efforts can translate into acts of hospitality by administrators and employees inside the organization to address the increased knowledge and expectations of consumers.

Through the literature review (the importance of service excellence and hospitality in healthcare), the current trends in healthcare (increased consumerism and how that affects service delivery), and Berry and Bendapudi's (2007) call to scholarly service researchers, a significant delimitation that was identified was that an internal qualitative view of administration and employees hadn't been conducted. Thus, there was a need to interview administrators who execute policies regarding their beliefs surrounding service excellence and hospitality within the hospital setting.

CHAPTER THREE: RESEARCH METHODOLOGY

This study investigates the importance of service excellence and hospitality within the hospital setting as it is perceived by the top management team of a regional hospital located in Orlando, Florida. The population of interest in this research study was the top management team of an enterprise. A case study was developed utilizing qualitative methodology. Specifically, this study sought to address the following objectives which arose from the decision to investigate service excellence and hospitality and its surrounding literature:

1) Explore the perceptions of top management concerning service excellence and hospitality using a hospital setting.

2) Identify external and/or internal barriers to service excellence and hospitality.

Importance of Qualitative Methodology

Because the researcher was conducting an in-depth investigation of top management's perceptions of service excellence and hospitality within a healthcare organization, it was most useful to employ qualitative methodologies. This was done to ensure that the most detailed descriptions of the natural setting and situations were captured through the data collection process. Through the usage of observations, the review of documents, and interviews with top management, the researcher captured rich data relevant to each research objective in the current study. Specifically, this methodological technique was appropriate for the current study because of its exploratory nature in the investigation of service excellence that has been used at the researched facility (Creswell, 2003). Top management was used as the key informants in the

study to capture a comprehensive view of the organizational leadership team that oversees and manages the most salient operations of the entire organization. The qualitative research process was most appropriate for this particular study for reasons that are congruent with literature by Creswell(2003), Hesse-Biber and Leavy (2004), Miles and Huber (1994), Rubin and Rubin (2005), and Yin (2003).

The data collection techniques employed by the researcher for this study included observations, review of documental evidence, and interviews with the organization's top administrators. Qualitative methodologies usually focus on words, rather than numbers, in order to provide rich descriptions and explanations of contexts (Miles & Huberman, 1994). These words represent a field of inquiry that encompasses micro- and macroanalyses contrived of historical, comparative, structural, observational, and interactional knowledge (Hesse-Biber & Leavy, 2004). Qualitative data were collected in the form of observations, interviews, and documents through a series of activities conducted in close proximity to the research setting for a prolonged period of time (Miles & Huberman, 1994).

Although there are many ways to conduct qualitative research studies, researchers should take into account the nature of their studies when choosing a qualitative technique in which to follow through. For the purpose of this research, a case study was developed to investigate top management's perceptions of service excellence within healthcare. Case studies strategically research a program, event, or process of one or more individuals. Detailed information and data were collected through qualitative procedures over a sustained period of time (Creswell, 2003). It was also important to begin this research with a qualitative study in order to promote theory-building through in-depth detailed evidence (Xiao & Smith, 2006). This is due to the fact that the

researcher analyzed the collected data in an effort to describe the meaning of the findings from the observations, review of documents, and interviews.

Face-to-face interviewing was used to capture the perceptions of the top management participants that were used in the study. Interviews involved structured and open-ended questions that were few in number and intended to elicit specific views and opinions from participants (Creswell, 2003). Interviews gain the most credibility when conversational partners are experienced, have first-hand knowledge of the research problem, and reflect a wide variety of perspectives, therefore, the use of key informants provides a required foundation for the current study's research parameters (Miles & Huberman, 1994; Rubin & Rubin, 2005). The following open-ended questions were developed from the research objectives and were used in the current study. The exact form in which the interview notes were taken also can be referenced in Appendix A.

Interview Questions

- Why are service excellence and hospitality in the hospital setting so important?

- What is the vision for service at Dr. P. Phillips Hospital?

- Where does the organization currently stand regarding that vision for service?

- What are the barriers in improving service excellence?

- Why is service important to patients?

- What do you do to verify the patients' perceptions of service at DPH? How do you know they perceive DPH the way you intend for them it perceive it?

- How is service important to employees?

- What else would you like us to know about service excellence, hospitality, and healthcare from your point of view?

Data Collection

The data was collected through the use of observations, the investigation of documents, and structured interviews that were conducted over the course of six weeks throughout the summer of 2007. The setting for this case study was a full-service medical center located in Orlando, Florida. Because the facility is located so close to many reputable hospitality establishments—theme parks, restaurants, and hotels—and is located in a community that revolves around the success of the tourism industry, it was deemed appropriate to conduct the research within an organization that has awareness of the importance of hospitality. The researcher became acquainted with this facility through a relationship that was built between the University of Central Florida and the organization itself, Orlando Health's Dr. P. Phillips Hospital. It was through this relationship that the hospital's president decided that he would like further research performed by the University in the alignment of hospitality and healthcare management. Through two initial meetings with the researcher, the president outlined specific areas of service management that he wanted investigated within his organization. In addition, metrics to measure and recognize service excellence were described as means to improve operations within the organization.

Since Ford et al. (2006), Fottler et al. (2006) and Studer (2003) all identified the importance of top management's influence and commitment to service excellence as a precursor to employee satisfaction, and thus customer satisfaction, the need to identify top management's views of service excellence within the Dr. P. Phillips Hospital organization became very apparent. Without a commitment to service excellence from the top organizational management team, an awareness of service excellence from the hospital's front-line staff would never fully be embraced into the organizational culture. Using this underlying theme in addition to the suggestions made by the hospital president and the review of literature, the researcher formulated prospective interview questions to use in the data collection process. The questions were then reviewed and further revised by a professor in service management, a qualitative researcher, and the hospital's president for the sake of validity and reliability.

To begin the research process within the hospital, the researcher first had to gain agreement from the top management team of the facility, which included twelve of the organization's top managers from various operational departments within the business. An introduction meeting was conducted between the researcher and the top management team, in which the researcher explained the importance of the study and how it will ultimately help the organization in fulfilling its mission to achieve service excellence and create a culture of hospitality. After receiving approval and support from the administrators and managers, the researcher needed to gain security clearance in order to access the facility during the multiple visits made to the hospital required during the data collection process. The gatekeeper that validated the researcher's access to the hospital through the security clearance process was the Manager of Hospitality Relation. It was at this point that the researcher needed to gain approval from the University to conduct the study.

Approval to conduct research on human subjects was sought through the University of

Central Florida Institutional Review Board (IRB). As required by IRB, the researcher first had to

complete a training course, known as the Collaborative IRB Training Initiative (CITI) in the

protection of human research subjects so that the exact logistics of ethical and moral treatment of

potential research participants was guaranteed during data collection After CITI training was

complete, the researcher had to register with the UCF IRB office in order to submit her study for

review from the compliance office. This required the submission of all proposed methods,

consent letters, and potential interview questions. After revisions, the Institutional Review Board

of UCF approved the research. The official approval document can be found in Appendix B. The

letter of consent that was approved by the IRB office is contained in Appendix C.

Because the president specifically asked that the researcher interview twelve of the

organization's top managers, the researcher did not have to specifically determine who to

sample; in other words, a pre-determined representative sample was used in the data collection

process. The researcher was then provided with an organizational chart as found in Appendix D.

In order to schedule interviews with each of the administrators and managers, the researcher

received aid from the president's executive assistant. The interviews took place over a course of

approximately six weeks during the summer of 2007. Each of the interviews lasted roughly one

hour in length and was conducted on-site at Dr. P. Phillips Hospital.

Although more questions could be presented due to the open-ended process of the

research, the interview results included the eight primary questions answered by all participants.

This semi-structured format guided the research and the data is presented according to the format

of the eight questions.

Participants were first given the approved letter of consent so that they could read about the purpose of the study and what they could anticipate as a result of participation. After giving their consent, the researcher presented the respondent with a list of the interview questions so that he or she could follow along as each question was addressed.

In order to capture the most accurate and rich data possible, a variety of collection techniques was used so that the researcher knew that the recorded data was as reliable as possible. First, the researcher took her own notes while the participants answered each question. Second, an audio-recorder was utilized so that the researcher could personally transcribe and review the conversations at a later date. Finally, the researcher brought along a transcriber to every interview who manually recorded the conversations as they were happening. After each interview was complete, the researcher could then return to her notes, the audio-recorded transcriptions, and the transcriber's transcriptions to ensure that the information captured was accurate and reliable.

In addition to the interview portion of the data collection, the researcher reviewed documental evidence provided by the organization in regards to the mission and vision statements and strategies. This information was made available from DPH's Manager of Hospitality Relations and the Human Resources and Organizational Development Manager. The researcher also spent supervised time at the hospital after the interview period was complete through shadowing and attendance at Customer Service Excellence Council and Hospitality Advisory Board meetings. These observations of the environment of the hospital were done to take note of the staff practices that relate to metrics and formal recognition of service excellence.

Data Analysis

The researcher analyzed the study's data through a process of qualitative coding. Coding is used in qualitative research to provide a reduction of data into categories of themes that still retains the integrity of the information (Creswell, 1998; Richards, 2005) Known as axial coding, the categories that are revealed through the coding process contribute to central phenomena and thus, strategies are created to address the phenomena revealed from the data analysis (Creswell, 1998). Through consultation with a qualitative researcher, the researcher adopted a personal style of descriptive coding that was most conducive to the type, amount, and context of the data collected (Richards, 2005). After the interviews were documented accurately, the researcher organized the data by putting each person's responses into one overall document.

This document listed each of the eight interview questions and included each respondent's answers to each individual question. To account for anonymity, the respondents were numbered so that no bias was created in the researcher's interpretation. Then, the researcher performed a brief review of the interview questions and responses, searching for overall themes that may become apparent during the coding process. The data were independently analyzed by three separate individuals—once by the researcher, once by a qualitative researcher, and once by a university professor. The three individuals coded each question by performing an in-depth scan of the interview output while searching for key themes and phrases that appeared throughout each participant's responses.

Themes were categorized and those that were similar were grouped together. Then, to ensure validity and reliability, the three documents were compared against one another to determine whether similar themes were revealed from each person's coding method. In addition,

the researcher recoded the data to ensure consistency in the style of coding over time (Richards, 2005). Specifically, the researcher used a color coding scheme to identify key words and phrases throughout the interview responses. Next, the researcher grouped those phrases together to see if any answers were similar. Similar key words were consolidated for clarity. Then, the researcher met with other individuals who compared key words and themes identified by each while noting obvious discrepancies. Once any discrepancies were identified, they were discussed for clarification. The themes were then used to summarize the data and create relevant assumptions about the information. These assumptions were matched to each of the research objectives to provide evidence about the research topic. An example of this process is shown in Appendix E.

Validity and Reliability

As with all research studies, issues of validity and reliability needed to be addressed so that the researcher could establish confidence and consistency of the findings. The current study used qualitative methodology, and accounted for validity and reliability given the parameters required by social science research for quality research design (Yin, 2003). Validity is the act of drawing meaningful and useful inferences from content. It is also established when the research is credible and measures what it is intending to measure (Appleton, 1995; Brink, 1987; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Trochim, 2006; Yin, 2003). Reliability is the consistency in a set of measures consistency of data. It is achieved when the steps of the research are verified through the close examination of data, process notes, and data reduction products (Golafshani, 2003; Marshall & Rossman, 2006; Trochim, 2006; Yin, 2003). Table 1 illustrates the case study tactics used to establish validity and reliability within the current study.

Table 1: Case Study Tactics for Establishing Validity and Reliability

Tests	Case Study Tactic Used in the Current Study	Phase of Research in which Tactic Occurs
Construct Validity	Used multiple sources of evidence (observations, investigation of documents, interviews)	Data Collection
Internal Validity	Not used; only required in causal case studies	N/A
External Validity	Analytical generalization explored to generalize results to a broader theory.	Research Design
Reliability	Organized to be easily reanalyzed by other researchers Established through determining how consistent findings were when compared to coding schemes of other researchers in the current study.	Data Collection Data Analysis

SOURCE: Yin (2003)

Validity

As with all research studies, issues of validity and reliability need to be addressed so that

the researcher establishes confidence and consistency of the findings. Because qualitative

techniques use a naturalist approach in investigating philosophical phenomena, approaches in

ensuring validity and reliability will vary significantly from traditional quantitative techniques of

testing credibility. Instead, the credibility of qualitative research depends on the ability and effort

of the researcher (Golafshani, 2003). Due to the controversial nature of qualitative research, it is

important to justify why qualitative techniques are appropriate for particular studies. Specifically

in checking for validity and reliability, qualitative research studies are often criticized for not

adhering to traditional approaches to procedures of verification or having standardized measures

to ensure consistency of findings (Appleton, 1995; Armstrong, Gosling, Weinman, & Marteau.

1997; Brink, 1987; Burla, Knierim, Barth, Liewald, Duetz, & Abel, 2008; Creswell, 1998; Golfshani, 2003; Healy & Perry, 2000; Hinds, Scandrett-Hibden, & McAulay, 1990; Miles & Huberman, 1994; Moret, Reuzel; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Patton; 1999 Van der Wilt, & Grin, 2007).

Validity can be achieved through first establishing a sample of participants that are knowledgeable on the research topic and therefore can provide informed answers and insights towards the research problem (Appleton, 1995; Brink, 1987; Morse et al., 2002; Patton, 1999; Trochim, 2006; Twinn, 1997). Input of the top management team of DPH gave the researcher an enhanced understanding of the topic and ensured that the data being collected was as applicable to the study as possible (Appleton, 1995; Brink, 1987). The selection of key informants also provided efficient saturation of topics from a range of diverse backgrounds (Morse et al., 2002; Twinn, 1997).

Validity is also established when the research is credible and measures what it is intending to measure (Appleton, 1995; Brink, 1987; Morse et al., 2002; Trochim, 2006). According to Guba and Lincoln (1981), qualitative research achieves validity when the participants find the results plausible. The current research included accurate descriptions from observations, the review of documents, and individual perceptions gathered through interviews. Multiple sources of evidence from the data collection are used to ensure construct validity (Yin, 2003).

Furthermore, as identified by Appleton (1995), Sandelowski (1986), and Trochim (2006), participant responses should be immediately recognizable by participants as their own opinions. During the interviews, the researcher confirmed with participants that their statements were understood by verifying the meaning of their arguments and clarifying industry jargon that was

unclear. No follow up briefing was necessary with participants as agreement and saturation was reached.

The study investigated the perceptions of service excellence and hospitality by top management of a singular organization, and therefore relies on analytical generalization, which generalizes results to a broader theory (Yin, 2003). Therefore, this study may pose a threat to external validity, as it cannot be easily generalized to other similar organizations (Yin, 2003). A similar study may not yield comparable results, but is generally related around a central theory, thus creating analytical generalization. Internal validity was not verified as this was not a causal case study.

Reliability

In understanding reliability as it applies to qualitative research, consistency of data is achieved when the steps of the research are verified through the close examination of data, process notes, and data reduction products (Golafshani, 2003). According to Yin (2003), an efficient means of ensuring reliability in an exploratory case study is to concentrate on minimizing error and biases through documenting the procedure step-by-step so that the rationale behind the design decision can be defended and so that the same results would be achieved if the study was replicated using the same procedures (Marshall & Rossman, 2006). Unfortunately, replicability in qualitative research is hard to achieve because of the use of real-world experiences and changes (Marshall & Rossman, 2006). Therefore, in terms of reliability, the current study concentrated on keeping the collected data thoroughly organized so that it could be reanalyzed by other researchers. Reliability was then established through determining how

consistent the findings were when compared to the coding schemes of the other researchers who coded the same data in the current study (Appleton, 1995).

Summary

This chapter provided a description of the methodological techniques used for the current study. An investigation of purpose of qualitative methodology was provided to explain why this type of research is appropriate and beneficial to the goals of the research. The chapter also provided detailed explanations of the data collection and data analysis process that the researcher used in conducting this study.

CHAPTER FOUR: RESULTS

This chapter presents findings from an analysis of the data and investigates key trends that were revealed as a result of the data coding and organization. An introduction to the mission and vision statements of Dr. P. Phillips Hospital and an overview of their current service initiatives are first included to give the reader an understanding of the organization's current service initiatives. This information was gathered through the researcher's observations and review of relevant documents. Then, each interview question is reported using verbatim excerpts from the data collection to emphasize each argument. At the end of each presented question, relevant themes, as revealed through the data coding process, are stated to summarize the overall output.

Organizational Profile of DPH

Dr. P. Phillips Hospital operates under the same mission statement as the one established for the parent corporation, Orlando Health. This mission states that the organization will improve the health and quality of life of the individuals and communities that it serves. Moreover, Orlando Health has a specific service mission "to build customer loyalty through consistent delivery of excellent service." It is accomplished through a focus on three core values: people, quality, and community.

- *People:* This involves an organizational focus on teamwork to make Orlando Health the best place to work. DPH and Orlando Health maintain a "family" of team members dedicated to offering exceptional service and quality healthcare to Central Florida.

- *Quality:* DPH operates with the goal of providing cost-effective, yet superior, health services. This is defined as the utilization of cutting-edge healthcare technologies, well-staffed facilities, and high caliber physicians.

- *Community:* Leadership and teamwork are at the forefront of DPH's commitment to providing quality health services to the members of Central Florida's diverse communities. (Orlando Health, 2008)

The corporation also promotes a strict commitment to service excellence. It defines service excellence as "how we meet the needs of our patients and guests, as well internal partners through the creation of a healing environment" (Orlando Health, 2008). Orlando Health also has established Dimensions of Care that are reviewed during company orientation for new staff. The Dimensions of Care include Emotional Support, Respect, Physical Comfort, Access, Coordination of Care, Communication & Education, Involvement of Family & Friends, and Transition & Continuity. These eight principles were created as a result of company focus groups and patient surveys to identify the most critical points of care from the perception of the patients (Orlando Health, 2008).

DPH is a full-service medical facility that uses the latest technologies in association with the area's most qualified team of physicians and nurses. DPH also has an established service vision in conjunction with Orlando Health. The organization is "dedicated to improving the health and quality of life of the individuals and communities we serve. We always have been and always will be" (Orlando Health, 2008).

Current Service Initiatives at DPH

To better service the growing population of the Central Florida community, DPH is currently expanding its facilities and creating service-centric strategies to accommodate the

demands for quality healthcare in Southwest Orlando. This includes increasing its bed capacity

from 150 to approximately 290 beds. A five-story tower is being constructed to include:

- 48 intensive care beds
- 48 progressive care beds
- 8 operating rooms
- 5 interventional suites
- 48 pre-procedure/recovery beds
- Expanded imaging & non-invasive diagnostics
- New central energy plant
- Renovated kitchen and dining facilities (Orlando Health, 2008)

The hospital is also home to a few unique service programs that are distinctive features

of this particular location. Perry Pavilion is a recent addition of DPH that acts as a "home away

from home," providing convenient and reasonably priced full-service accommodations for

families of patients. In addition, DPH has recently developed a patient advocacy program that,

with the help of hospital volunteers acting as liaisons between patients and hospital staff,

promotes improved patient service, comfort, and satisfaction. Furthermore, to support this

innovative patient advocacy program, DPH is in the process of partnering with the University of

Central Rosen College of Hospitality Management to integrate the SKYLIGHT program, a

service strategy that utilizes interactive patient-support system technology to enhance the patient

experience, hospital staff satisfaction, and administrative productivity. The organization also

provides a guest services department available to patients and their families, and actively

distributes patient satisfaction surveys to measure the perceived quality of service and care that

patients receive.

These service programs, along with a supportive and knowledgeable hospital staff, are

posited to contribute to DPH's continued commitment to superior patient service and

satisfaction. Departmental managers meet every month to discuss patient satisfaction survey

scores and how their facility rates compared to the national average. Known as the Customer Service Excellence Council, these leaders discuss solutions to problem areas revealed through the survey scores and then develop and educate their staffs on how to improve service delivery.

The initial investigation as to whether service excellence is important to the hospital was primarily explored through the review of documentation and initial discussion with the president. Service excellence is perceived to be a priority as a result of the investigation of documents and facts, including the mission and vision statements, prioritization of the president, and observations in meetings. Cohesively, this data is prima facia evidence that service excellence holds relevance within the organization.

Participant Profiles

Selective demographic information was collected from the top management team and the results vary across the twelve respondents. A majority were white females, with two-thirds in the age range of 45-55, have earned a master's level education, and have worked with the corporation at least ten years (See Table 2). In addition, nearly one-third of respondents reported either a high school diploma or an associate's degree as their highest level of education. This implies that some administrators most likely gained knowledge of their industry and position through significant work experience and promotion. The job titles of the respondents included President, Chief Operating Officer, Chief Medical Officer, Patient Care Administrator for Surgical Services, Patient Care Administrator for Nurses, Administrative Coordinator for Operational Planning, Human Resources and Organizational Development Manager, Ancillary

Departmental Administrator, Manager of Hospitality Relations, Guest Services Supervisor,

Manager of Volunteer Services, and Environmental Services Manager.

Table 2: Demographic Information of Participants

	Percentage
Gender	
Male	42%
Female	58%
Age	
Below 44	17%
45-50	25%
51-55	41%
56 and over	17%
Race	
White	92%
Black	8%
Education	
Doctor of Medicine (M.D.)	8%
Master's degree	51%
Bachelor's degree	8%
Associates degree	25%
High School	8%
Tenure	
0-10 years	42%
11-20 years	25%
20 and over	33%

Interview Results

The following discussion explores and presents relevant themes that were derived from

the participants' combined responses and is further organized according to the eight interview

questions. Following each question is a synthesis of respondents' comments, supporting direct

quotes, summarizing comments, and a core of themes. Although a singular theme was revealed

for each interview question, multiple issues may be presented.

Interview Question #1: Why are service excellence and hospitality in the hospital setting so important?

Confirmed by the literature and according to top management, our modern society has become highly consumer-friendly. In addition, information on healthcare facility ratings is readily accessible and patients have discovered that they are able to take charge of their own care and make decisions as to where they receive their medical aid. The level of sophistication of healthcare consumers has increased, and because of this trend of consumer-driven medical care, patients quite often do have a choice unless they are faced with a serious emergency situation. Healthcare patients as a whole are becoming more educated and can make informed decisions as consumers. Service excellence has become a part of staying competitive in the healthcare market and word-of-mouth plays a big role. This is exemplified through some of the participants' responses:

> More and more, healthcare is becoming elective or selective in how we pick. Though I work in a hospital everyday, most people only touch a hospital three, four, or five times in their lifetime. You'll always remember that time in the hospital. And service episodes in healthcare can have such a dramatic impact on a person or a family—either positive or negative. It is a powerful emotional experience.

> Because patients sometimes do not have a choice, we have to be able to provide them with an atmosphere where service is key, so that mentally, when going through a critical time, they have to feel as though they are in control of their care. Service has to be a part of that. This mindset will help them to recover more quickly.

> Because service is not tangible, the perception has to be by the patient that what we are providing is safety and the opportunity to get better or cope with what is confronting them. Also, this is important because any hospital in town can have a CAT scanner, a surgeon, can deliver the tech component, and do the diagnostics. Where we make a difference is how we treat the patients and respond to their problems. We have a patient and family focus.

Summarizing, the patients' perception of service is one of the most vital components in developing a culture of service excellence within an organization. These perceptions ultimately guide the experience that the patient is likely to have. If the patient is generally pleased with their stay and the interactions and care they have received from the medical staff, it is postulated that this increases their likelihood to return to the facility in the future for their healthcare needs. If they do not like the treatment they are receiving, they have the option of transferring from one facility to another. The awareness of high quality service is an ideal that needs to be embraced throughout the entire organization. As a result, demonstrating sensitivity to patient concerns should be reflective of the organizational vision that has been created and instilled throughout the service culture.

Theme: Patients have a mixed choice—they are becoming more educated and proactive in the participation of their care. However, when faced with an emergency situation, patients do not always have a choice in where they will be taken to receive emergency medical care. It is important for the organization to remain competitive due to the influence of word of mouth, so service excellence is a huge influencer to that competitive advantage.

Interview Question #2: What is the vision for service at Dr. P. Phillips Hospital?

The administrative team of this organization generally wants to see DPH as a top-rated healthcare facility—whether that is just within Orlando, the general Central Florida region, or across the country. This requires the hospital to establish a reputation of delivering high quality services. Consistent delivery of customer satisfaction and patient comfort is at the forefront of the service vision, which seems to be one of the greatest factors that the organization can work on with its employees in order to reach their goals.

We can be measuring among hospitality people. We can be running with the hotel crowd. Maybe we won't be at the top initially because of the industry we are in, but we are in a new league. We are not comparing ourselves to other hospitals. I want us to be measured in terms of service that you would find in a hotel. Service is all about what the customer thinks it is.

If someone was to give a recommendation, and you need something done from a healthcare perspective, I want them to say: "Choose Dr. P. Phillips Hospital. They treat me well, they give me the care I need, they are quick about it, and they are sensitive to me. They don't assume that I exaggerate my symptoms." The outcome is not always good. This is not always a nice thing to have. You have to do everything else right if we cannot solve your problem. It is always hard to get past the bad news.

An additional concept is the idea of hospitality, which administration has begun to integrate into their ever-evolving goal to reach optimal service excellence. For this organization, the infiltration of hospitality has been recognized as a combination of superior service delivery and sensitivity to patient care. The leadership team, overall, would like to see their organization's focus on service being compared to that of a top-rated hotel or attraction. At the same time, employees need to ensure patient comfort by delivering the care that patients need in a timely manner while giving constant attention to any concerns that may arise.

Coming from the north, I visited Disney a couple times as a tourist. When you see that level of service and then you come to a hospital, I think the vision that I see is that there needs to be that hotel-like atmosphere where there is constant attention being given. We need to adopt that and give constant attention to the customer and the patient at all levels. It is more than designing a nice lobby with nice furniture. It is the floor, the entire hospital, all of the employees, the strategies and policies we implement—it all has to be part of the picture.

I would like us to be a trendsetter in terms of customer service. But we also must be the most caring company out there. If we are not caring, we are in the wrong business. By providing service throughout the continuum of care for a guest, we can alleviate a lot of anxieties.

Theme: Administration would like to see DPH as a top-rated facility, although there are discrepancies in whether that is on a community-scale or nationwide scale, and whether that is

throughout the healthcare industry or crossing over into the hospitality industry. Consistency of

communication among administrative leaders and service delivery from the front line is a top

priority for achieving that goal. The leaders used the terms "service excellence" and "hospitality"

often interchangeably, as if they did not realize there was a difference in their definition.

Interview Question #3: Where does the organization currently stand regarding that vision of service?

Dr. Phillip's Hospital's vision for service is constantly evolving. Satisfaction is currently

one of the most important aspects of their organizational service philosophy towards healthcare,

which includes sensitivity to issues, positivism, and consistency of delivery. However, there are

differences in opinions between how the organization is perceived by its administrators in terms

of service excellence. While some recognize their journey in achieving service excellence is just

beginning, others view the current initiatives in practice as indicators that the hospital is almost

on par with the organizational vision.

> I'm not sure we have started. We have the desire. We have an advisory board with desire. We must change our thinking. We are just beginning to regroup. I strongly feel we haven't started yet. This race is a race with no finish.

> We are well on our way. I think we are one of the top in the community right now. We need more polishing to make customer service better. There are so many people that visitors and patients interact with. One of the links in the chain can be bad; if a patient has a perfect experience and then something happens with the discharge, everything positive isn't erased. But it is diminished.

> We are on our way. There are so many factors and I think we could communicate better. Human error can be there, but there's still sometimes a lack of communication, something breaks down, and the patient's stay could have been better.

> It is front and center. We preach service all the time. We are here to serve when it matters most. When there is urgency from the health perspective, you come here not because we are closest, but because you specifically chose us. It is preached all the time and that is what we talk about.

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Although the administrative leaders seem to be in agreement about the importance and awareness of service within their organization, the perception of where the organization currently stands is somewhat mixed, with some saying they have already achieved the goal and others believing that they have not even begun. The administrative team seemed to understand this in bits and pieces, but no other leader shared the same vision for potential as the president. This creates a gap of understanding between the top of the organization and what may be interpreted by the frontline staff.

Theme: There are misinterpretations among the top management team concerning where the organization stands in achieving their goals centered on service excellence and hospitality. This was further identified when top management was asked about specific things the departments do to ensure service excellence. The managers could list service initiatives that the overall hospital partakes in to achieve service excellence, but did not identify specific initiatives by their respective departments.

Interview Question #4: What are some barriers, if any, in improving patient service excellence?

There seems to be an issue with staffing and hiring the passionate, service oriented types of people into the organization that will work under the hospital's service philosophy. Because there is a nationwide shortage of certain healthcare positions, the hospital is sometimes forced to fill those positions with sub par candidates.

> There are still some hard to fill positions. We don't want to hire a person because they have the qualifications but then we are unsure whether they have the service attitude that we are looking for. You can teach people the skills, but it is hard to turn those people around. The hardest areas to hire for are nursing, respiratory therapy, housekeeping, and food and nutrition. We have just as hard of a time

attracting people to those positions. We have to continue to work on finding, keeping, and retaining the best and the brightest.

I really do not think there are barriers for improving satisfaction. I think, overall as we hire, we need to be more selective. We need to put the right body in the right spot. We have to be more selective.

In addition, communication is another barrier. There are communication issues between administration and staff (service philosophy buy-in), communication issues between hospital and physicians (doctor buy-in to hospital philosophies) and communication issues between physicians and patients (nature of the job). A consequence of these inconsistencies is the gap that is created between patient perceptions and expectations. This is one of the main reasons that patients can end up dissatisfied with their experience. Inconsistencies show patients that their expectations about the service experience are likely to be hindered. As a result, patients that are increasingly anxious about inconsistencies with communication within the organization are not likely to be as satisfied.

Communication between clinical and non-clinical staff is a barrier. We need to recognize what we can and cannot do to help each other. It is a slow process. We are doing rounding now, in addition to the patient advocates' rounding, in order to ensure we are properly assisting each and every patient. Customer service ratings should improve as we include more patient advocates. Rounding to some floors and not rounding to others causes inconsistency.

Sometimes, it is getting everyone on the same page. We do a pretty good job with that, but all people have to have the same outlook on customer service to make it work.

Communicating what is happening with the patient is another barrier. It is the process of what is going on with you—or to find out nothing is going on with you. Then once we do know, it is about getting the doctor to stand there and give them undivided focused attention to explain what is going on in a way that the patient understands. If you are in a scenario like that, say to the doctor, "What is going on with me?" They take a lot for granted. In patient satisfaction, we see some deficiencies in the patient/doctor interaction. There are some variables that impair the patient experience and I think we can do a better job. The doctor and the hospital are often two different components.

We deal with such a diverse group of nationalities and cultural backgrounds. If someone is of a different culture, there is a different mindset. Out of the country, out of the state—sometimes the communication barriers can cause more anxiety for the patients. How can you overcome that except with education?

Patient expectations are a barrier. Patients don't quite understand the medical process and assume that everything is going to get better immediately. The greatest challenge we have is to temper the enthusiasm we have for patient satisfaction with the realities of medicine and sometimes that is not very pleasant.

Issues with capacity as they construct the renovations on the existing facility also have the potential to diminish patient satisfaction. The new tower will be completed at the end of 2008, however, for the time being there are instances when the emergency department is backed up and there are no empty beds on the floors in which to put patients. The organization, at this time, has no means of solving this issue pending the completion of the current renovations and additions.

As volume increases, the ability to drive satisfaction decreases. Volume is inversely related to satisfaction as long as it is a volume you are not geared up and built for. If you gear a system for optimality, then you will go broke. If you are sick and the system is clogged up, you think, "Why am I sick and not being taken care of? Why did some other person go straight back?" Folks cannot see what is going on—they only have a perception of why they are being skipped.

The acute care factors do struggle with score due to capacity and the difficulty of getting the patient served in a quick and intense way. People are not managed unless they are quite sick, so they are not admitted just to rest. This is not an option, so you have to be very sick in order to be admitted into the hospital.

Money is another barrier that limits satisfaction because patients without insurance are forced to pay excessive amounts of money to see the doctor in the hospital for nonsensical purposes. Because the hospital is forced to charge a lot of money in order to be sensitive to the organization's resource usage, this greatly dissatisfies many patients even though it is a nationwide issue that is regulated through insurance companies and the government.

Money is a barrier and it is not cheap to come to the hospital. From the ED perspective, we are interested in satisfying every patient that comes here—we

don't know until after you are treated where you have insurance. Not a week goes
by that we do not have to say, "You had a stomachache and it was $4300, and
that's something that could have been addressed by Walgreens." I am afraid that
this is one of those frequent scenarios and our assumption is that you are having a
real problem. That stomachache that you present to triage cannot be properly
diagnosed until we run some very expensive test. We do not take anything lightly.
Even if the outcome is good, the process and cost of it can be bad. It is a horrible
waste of resources. The insurance and the healthcare costs really limit what we
can do.

This is one of the reasons why there is such a need for positive service experiences within

healthcare; the costs of these services are a barrier to patient satisfaction that cannot be addressed

by administration. Although the hospital has no control over governmental regulations of

healthcare costs, by ensuring that they are delivering the highest quality service possible to the

patients, they can alleviate some of the frustrations that occur due to issues that are outside of the

organization's control.

Theme: The hospital faces both external and internal barriers in achieving service excellence,

and ultimately, hospitality. Hiring qualified individuals who will perform their job duties with

the level of service and commitment required by the organization is a constant struggle.

Communication errors and consistency of service to patients is also a concern for the

organization. The cost of healthcare is also an external barrier that can limit how administration

can create unique service experiences. Current volume of the facility and diversity of cultures in

patients are also other potential barriers.

Interview Question #5: Why is service important to hospital patients?

The main theme that was revealed from this section is sensitivity to the patients'

circumstances. People come to the hospital to be cared for in a time of extreme need, fear, and

confusion, and they look to the hospital to comfort those stressors.

No matter where you go, service is so important. We just expect it. People want to be treated with respect, dignity, and kindness to be in zone of comfort.

They are in an unfamiliar environment and they are anxious about their disease process. They want to feel comfortable and confident that they are going to be safe and that the plan is going to return them to as normal of a state as possible. Being in the hospital is unexpected and so we need to make it as comfortable and as safe as possible.

I think it is a basic human need to be respected and feel you are important. The hospitals who succeed in the future will be the ones that address those needs.

Meeting and exceeding guest expectations is a large part of being sensitive to patient anxieties. Patients and their families are extremely vulnerable when they are faced with a hospital stay, and it is up to the organization to provide the assurance they need through quality services and interactions.

I will start by saying that when patients come here, they are vulnerable. Somehow, and this had puzzled me for many years, you walk in and your rights change. People take away your clothes and your ability to get food and your freedom to do all the things you did before. They have to come to us for things. They need the service and they need to get well. Service crosses all lines. We are giving the patient the healthcare product they need to survive. We do a lot to empower our patients while they are here.

Due to high vulnerability, you are stripped. Someone is telling you what you can do, what you can eat, that you can't get out of bed and that you have to call to go to the bathroom. Your dignity is checked at the door with your clothes and wallet. It is up to us as the hospital to do almost everything for you while here.

Patient confidence in the care received at the hospital is a big part of improving the delivery of quality service. Because this hospital actively monitors customer satisfaction scores and gives patients several outlets in which to voice their concerns about the service they received (i.e. comment cards, surveys, daily rounds from staff and volunteers), the organization uses this accountability as a foundation to constantly improve upon.

Theme: Sensitivity to individual patient situations is a vital requirement to understanding the importance service awareness. Patients are vulnerable, in an unfamiliar environment, and have sought out comfort from the hospital specifically to care for them in their time of need. Therefore, high quality service is essential to ensuring a positive experience.

Interview Question #6: What is done to verify the patients' perceptions of service at DPH? How do you know they perceive DPH the way you intend for them to perceive it?

The majority of administrators mentioned rounding (management by walking around) as an effective way to talk to patients. Some personally do this, unannounced, to speak to the patients and directly address any issues they may have during their stay within the hospital. Others do this on a less frequent basis, but monitor their departmental managers to ensure that patients are presented the chance to speak with a supervising leader at least once during their stay. It should also be noted that, as suggested by Studer (2003), rounding to employees is equally as important as rounding to patients. Leaders should regularly round to their staffs to make certain that the employees are capable of handling any issues that may arise.

> The assistant managers, nurse managers, and charge nurses are rounding on every shift. We have a little communication board in the patient room that they can write notes on. We also have a discharge folder that we have lots of information in. We encourage patients to write notes and questions out so they will not forget.

> We work at this daily and we are not just waiting for scores to roll in. The managers do daily huddles and people are rounding on various floors. In some areas where there is lots of mobility and the services are very intense, they have a patient advocate that rounds and tries to identify patient problems.

> To ensure patient satisfaction, we do rounding and hope that everything has happened the way you think it will. I give them my card so I can address any deficiencies that may need to be addressed. Rounding is one of the best things we can do. We do not want to disappoint anyone. We also have RNs who call patients after they have already been discharged.

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We round. We ask about issues and we try to address those in real time. We don't want to let things linger. We look at all complaints and address the issues that are relevant to those complaints. The patients have complaints and issues, but the staff must feel as respected as the patients. It is the administrations' responsibility to not inundate the staff with issues that make them unable to do their jobs.

Another measure used to gain patient insight is to survey. Surveying within the hospital comes in the form of mail, telephone, and discharge surveys and voluntary comment cards placed in each patient room and outside every department. Real-time surveying will also be available via the new patient education system, Skylight, which will allow patients to access information about the hospital and their condition through the televisions in their rooms. Surveying allows the administrative team to track patient outcomes and care, while investigating whether the organization is effective in the care provided.

To verify patient perceptions, ask questions. Just ask simple questions and give patients the attention they deserve. "Has everyone helped you?" We use surveys—both telephone and the mailed out surveys. The hospital calls all patients within 24-48 hours asking if their stay was ok and whether or not they need further information on anything. It is the simple questions—"what can we do? Are you ok?"

Something that we are going to be implementing is the Skylight system, which will allow us to do service recovery while people are in the hospital. It will set incentives so that people will take the time to do the survey. It is another mechanism to identify wrong things.

Our surveys go out to about 35-40% of patients. We do a council and we analyze the numbers and the comments. Personally, and I cannot prove this, I feel that we do not survey enough. They assure me in market research that the number is a representative group.

We have comment cards. Volunteer services hands them out and the cards are readily available throughout the hospital. One of my duties is that I review the comment cards and make sure to give a response to administration. I review them so I can see what is going on in the hospital.

The hospital also has a Customer Service Excellence committee that meets once a month to review the patient satisfaction scores that were received from the surveys in previous months. The committee is comprised of hospital administrators, managers, and staff from departments all over the hospital. By closely investigating each survey question, the team then brainstorms to develop solutions to any area within the survey that may be receiving average to below average scores. Sub-committees are also utilized to work on specific strategy projects to increase the levels of satisfaction for future survey periods.

Theme: Many metrics are in place to measure service including rounding by clinical, non-clinical, and volunteers, phoning patients for follow-up feedback, Skylight technology, surveys, and comment cards. An internal team, entitled Customer Service Excellence Council, is present to evaluate service practices within the hospital. An external board, entitled the Hospitality Advisory Council, is also formed of industry professionals to provide input on organizational strategy.

Interview Question #7: How is service important to employees?

There exists an emphasis on teamwork within the organization. Everyone is encouraged to recognize their role within the hospital and how each department relies on one another to effectively operate and care for the patients. The goal is to get all employees across all areas focused on a common, service-oriented goal, and for those who do not comply with this standard, they are counseled, and sometimes let go. This is done in an effort to foster the most service-minded employees as possible.

> Satisfaction drives consumer choice. With that, satisfaction of the employee is also extremely important. I can't solve the labor crisis but I can be aware of the competition and try to make my employees love what they do. I want them to be happy and engaged. I nurture a family concept that this is a safe place to work. Bring yourself and work, and we will sponsor the whole life of the employee.

When employees feel you offering excellent service sincerely, you get a two-fold return. It is comforting to watch others be helped. That comforts employees and makes them want to comfort others as well.

It reinforces a sense of team when you are focused on the common goal. If I cannot take care of this, I take it to the next level. I can follow up. We all work together and this unifies the goal and we show that to each other as well. It makes you feel good to know that the organization treats visitors nicely and employees the same way. It is very important that we cater to interpersonal relationships. We have behavioral standards and employees must meet them. First and foremost, you must buy into our hospitality and supportive behaviors. Second, you must embrace teamwork and the philosophy of helping one another. You are held to an accountability standard and there will be zero tolerance. I have terminated people for a deficit in their performance that does not meet our goal and is not acceptable to our corporate culture.

In addition, some of the administrators mentioned having sensitivity to employees' personal lives through providing the same service to both staff and customers. By treating employees as if they are in a comfortable, supportive, family-type environment, it teaches them to be more sensitive to the environment around them and the patients that they touch each day.

Rounding to all employees is very important. For mine, I encourage them to pursue other interests and to recognize that there are other things they could do and achieve. This comforts them, knowing that we encourage a life outside of work.

The organization sees a personal life as very important and we hope that you take a lot of pride. When you come here, you should be proud of what you do. Embrace that message and understand that we will be sensitive to whatever is going on in your life outside if these walls.

By rounding to the employees that they directly supervise and oversee, leaders can ensure that their staff's concerns and personal needs are being addressed. It is important to show employees that they are supported and that their opinions are valued within the organization.

Theme: A focus on teamwork is important to service throughout the entire organization. It can also be noted that from a management standpoint that creating the same comforting environment for patients and employees is important to employee empowerment and satisfaction. Further,

they encourage teamwork, empowerment, and value on personal life and they check up on employees through rounding.

Interview Question #8: What else would you like us to know about service excellence, hospitality, and healthcare from your point of view?

Many administrators touched on the complexity of the healthcare system. That is a major factor that affects the satisfaction of patients because the nature of the industry in modern times can limit the power healthcare systems have to truly maximize patient satisfaction. Administrators are required to adhere to governmental regulations that are monitored not only by the federal government, but by everyday consumers as well. Satisfaction ratings are easily accessible through the internet, and because of this, administration is constantly trying to develop creative strategies in which to keep satisfaction high.

> The government requires us to measure satisfaction of patients and be in compliance with all of the regulations. There are many trends within our country that involve healthcare, but I think that patient satisfaction is just as an important factor that will affect healthcare as anything else. If I had to name five of the most important trends that have an impact on our healthcare systems, its technology, patient satisfaction, quality regulations, workforce, and aging.

> Healthcare is very complicated and complex. All of the regulations, insurance, and legislation—this makes for a litigious atmosphere. Someone is always threatening a lawsuit and this increases complexities. I try to make it as easy as possible for the caregivers to do their jobs, so that they have the most time and most energy to give to that patient. If you spend a few minutes talking to patients, it can influence their stay.

> As an industry, we have come a long way. The fact that the federal customer can look online and evaluate what we are doing is huge influencer. We are not viewed as healthcare, but as healthcare joined with service type of industries. We have to be very much aware of what we do. Not the amount of CT scans that we do. A lot of this is now being generated by the federal government. It cannot be something that is a fad and that is cyclical and that we constantly evaluate and change and

then move forward as necessary. There is always going to be a trend that we need to continue.

The important thing is for people that look at hospitals and satisfaction, they need to look at it from both sides. You have to have a happy staff. The threat of liability in hospitals is much more than in any other industry. With anything other than a perfect outcome, there are disagreements and issues of how patients are managed. Expectations with patients are problems of a lack of understanding from the patient view. It is not always a happy ending. People will die, and people will die unexpectedly. Those are the issues that make the industry hard to handle.

However, within the operations that can be directly controlled, satisfaction comes directly from a service model buy-in from the staff. As a result, it is up to the organization's administrative team to infiltrate that philosophy into the culture as much as possible. By employing people who love to serve and recognize the mission and vision of the organization, service can continue to constantly improve as a consistent emphasis on service excellence is placed.

Managing patient satisfaction here in this type of environment is difficult. Healthcare has more difficulties than any other industry. People continue to have more and more choice on where to go for healthcare. This has to be a major focus of what we do.

With so much information being available to patients and with a more educated patient, they want to know their questions are being heard and answered. If they are not satisfied with how we handle business, we will lose their business. We must be focused on how well our service is perceived.

Patients are looking and seeking specific facilities to plan for if they are going to be ill. They are looking for facilities of excellence. Initially, nurses generally feel threatened by offering hotel-like amenities. With increased service initiatives, it will be interesting to see what the nurses and nurse managers have to say because they have not been trained in hospitality. However, it just goes back to being treated with respect. Be kind and be respectful to everyone.

One of the most important themes that were mentioned several times was the involvement of employees in creating a high quality experience for the patient. The delivery of

service is the most important aspect of creating a service-centric organizational culture, and that can only come from the frontline caregivers. This requires commitment, teamwork, and consistency.

Theme: Government regulations related to public reporting of satisfaction scores changes the course of the hospital environment. Regulation, insurance, and legislation of the healthcare system create a complicated and complex environment. Consumers have access to high volumes of information related to the selection of healthcare choices. Employee buy-in is also key in strategic operations of the hospital system.

Summary

This chapter investigated the interview questions that were presented to the twelve Dr. Phillip's Hospital administrators. Through an analysis of the interview responses and the data coding process, themes were developed that were relevant to the overall investigation of service excellence and hospitality within the hospital. Each interview question cited specific quotes from the participant interview responses to support the themes that evolved from the answers to the questions.

Table 3 summarizes the relevant themes that were revealed as a result of the interviews with the Dr. Phillip's Hospital top administrators. In the final chapter, the results from the identified themes are reduced to three major conclusions. The conclusions will be presented from the overall study along with implications to hospital management and the hospitality industry, and limitations and suggestions for future research will explained.

Table 3: Themes Derived from each Interview Question

Interview Question	Theme
Why is service excellence in the hospital setting so important?	Patients have a mixed choice—they are becoming more educated and proactive in the participation of their care. It is important for the organization to remain competitive due to the influence of word of mouth, so service excellence is a huge influencer to that competitive advantage.
What is your vision for service at Dr. P. Phillips Hospital?	Administration would like to see DPH as a top-rated facility, although there are discrepancies in whether that is on a community-scale or nationwide scale. Consistency of service delivery is a top priority for achieving that goal. The terms "service excellence" and "hospitality" were often used interchangeably among leaders when defining their service visions for the organization.
Where does the organization currently stand regarding that vision?	It is evolving. However, there are misinterpretations among the top management team concerning where the organization stands in achieving their goals.
What are some barriers, if any, in improving patient satisfaction?	Hiring qualified individuals who will perform their job duties with the level of service and commitment required by the organization is a constant struggle. Communication errors and consistency of service to patients is also a concern for the organization. The cost of healthcare is also an external barrier that can limit how administration can create unique service experiences. Current volume of the facility and diversity of cultures in patients are also other potential barriers.
Why is service so important to hospital patients?	Sensitivity to individual patient situations is a vital requirement to understanding the importance service awareness.
What do you do to verify the patients' perceptions of service at DPH? How do you know they perceive DPH the way you intend for them to perceive it?	Many metrics are in place to measure service including rounding by clinical, non-clinical, and volunteers, phoning patients for follow-up feedback. Skylight technology, surveys, and comment cards. An internal team, entitled Customer Service Excellence Council, is present to evaluate service practices within the hospital. An external board, entitled the Hospitality Advisory Council, is also formed of industry professionals to provide input on organizational strategy.
How is service important to employees?	A focus on teamwork is important to service throughout the entire organization. It can also be noted that from a management standpoint that creating the same comforting environment for patients and employees is important to employee empowerment and satisfaction. Further, they encourage teamwork, empowerment, and value on personal life and they check up on employees through rounding.
What would you like us to know about satisfaction and healthcare from your point of view?	Government regulations related to public reporting of satisfaction scores changes the course of the hospital environment. Regulation, insurance, and legislation of the healthcare system create a complicated and complex environment. Consumers have access to high volumes of information related to the selection of healthcare choices. Employee buy-in is also key in strategic operations of the hospital system.

CHAPTER FIVE: CONCLUSIONS

This chapter discusses the conclusions generated from the themes that were revealed from the results section. The objectives of the study were to: 1) Explore the perceptions of top management concerning service excellence and hospitality using a hospital setting; 2) Identify barriers to service excellence and hospitality from the management perspective. From a review of the results, three conclusions surfaced and are presented in this chapter. Implications for the healthcare industry concerning management of service excellence and hospitality in a hospital environment are then presented, followed by implications for the hospitality industry. Suggestions for future research and limitations of this study are also provided to conclude the study.

Three major conclusions evolved from the results reported in the previous chapter. First, there is a strong, but mixed, top management commitment to service excellence and the practice of hospitality throughout the organization. Second, the term "hospitality" was not mentioned as often as the term "service excellence" in discussing various initiatives throughout the hospital and some administrators seemed to use the two terms interchangeably while others seem to differentiate the two terms. Thirdly, several potential barriers for providing service excellence exist and were classified into internal and external barriers.

Commitment to Service Excellence and Hospitality

The hospital administrators and managers believe that service excellence and hospitality are important from the patient perspective. The senior official has the most optimistic view of the

benefits of service excellence and hospitality within his organization. This appeared to create an alignment of attitudes towards service excellence and hospitality with the other administrators and managers. Though his view was optimistic, he also reported that the organization has not even begun to scratch the surface of what they can accomplish. The President thought more about this than most of the managers although the other managers in the organization appeared to have a healthy attitude about service excellence. Overall, top management is aware of the importance of creating an atmosphere of service excellence throughout the entire organization. They understand the current trends within the industry and how that will affect their business and their patients.

As part of its commitment to service excellence, the hospital employs a variety of metrics. Examples include rounding by clinical personnel, non-clinical staff, and volunteers, phoning patients for follow-up feedback, and randomly surveying patients after discharge. Additional systems include Skylight technology in each patient room allowing for the reporting of service problems, post-discharge customer satisfaction surveys mailed out to former patients, and comment cards located throughout the hospital. An internal team of managers, entitled Customer Service Excellence Council, is present to evaluate service practices within the hospital. An external board, entitled the Hospitality Advisory Council that is comprised of hospitality industry professionals, provides input on the service excellence and hospitality components of the organizational strategy.

Of specific note, several managers mentioned most of the practices that the overall hospital focuses on, but did not mention their individual departments and practices that they use to enhance service excellence and hospitality. This indicates that the company does a superior job at publicizing overall service initiatives, but may need to emphasize practices of individual

service and hospitality. Additional suggestions for this hospital include the development of departmental projects that are aligned to organizational initiatives for the improvement of service excellence and hospitality.

Service Excellence versus Hospitality

One emergent topic with mixed beliefs and some support in the literature is the distinction between service excellence and hospitality as different organizational outcomes of the patient experience. The concepts of service excellence and hospitality are distinct in this organization for some managers but not as distinct for most managers. The term "hospitality" was not a term that was commonly used among the administrators and managers interviewed for the study. Instead, the terms "service" and "service excellence" were predominantly used.

When asked to give their opinion on the importance of service excellence and hospitality within the healthcare environment, the majority of the administrators and managers used the words "service excellence" and "hospitality" interchangeably with no distinction between the two. Confusion appears to exist in distinguishing between the terms "service" or "service excellence" and "hospitality". Upon investigating the hierarchy of the interview respondents, only the hospital President and the Manager of Hospitality Relations perceive hospitality to be a practice that extends even further beyond service excellence. Ironically, the Manager of Hospitality Relations even stated that the word she hears most often to describe the experience at DPH was "hospitality", however, several of the managers did not mention the same belief.

To elaborate on this issue, Lashley (1997), a hospitality researcher, defined service excellence as consistency and flexibility of service delivery to exceed the expectations of the

customer. Specifically applied to healthcare, Studer (2003) defined service excellence as the standard achieved when employees feel valued, physicians feel their patients are getting great care, and patients feel the service and quality they receive are extraordinary. By contrast, Lashley and Morrison (2000), defined hospitality as a commitment to meeting guests' needs as the primary focus in commercial operations through a host and guest relationship. In the healthcare research, no distinctions between the two terms have been made to this point. For the purpose of the current research, hospitality was defined as a philosophy that goes beyond service excellence to create a comforting environment for anxious patients.

The literature affirms that a difference exists between the two terms though few studies have empirically investigated the issue. Before the practices of hospitality can be recognized and achieved within the organization, that difference should be understood. This may also help management and companies differentiate levels of service, as many are accused of only paying lip service to service programs. A more specific distinction of hospitality as a higher level of service may assist organizations to help define these terms to their employees, which in turn, could help to improve overall service delivery. The definition of hospitality should be clearly stated, understood, and embraced throughout the entire organization, rather than just referred to as a simple "fad" or "buzzword" to redefine service excellence.

Therefore, it is recommended that healthcare organizations use hospitality as a framework for describing the treatment of patients as guests. This creates a closer relationship between the caregiver and receiver. The difference between a patient and a guest is not reciprocal; a patient can be a guest, but is not always treated as such (King, 1995). Though a relatively new concept, several scholars have agree that service excellence and hospitality are different, but that demonstrating service excellence and hospitality are critical for companies that

wish to sustain a strong customer base. Some have said that the hospitality delivered with

service excellence would be a higher form of excellence and one that may help institutions offer

and define more standards in their service (Pizam, 2007; Severt et al., 2008).

If the two concepts are translated into specific tasks and roles to be performed by

employees, then it may allow for more standardization in the delivery of service. In the case of

the hospital analyzed, though the established Dimensions of Care are a well-publicized standard

at the hospital, few of the top administrators mentioned this during the interviews. By combining

the Dimensions of Care with service excellence and hospitality, additional consistency may be

achieved.

A hospitable attitude towards service must filter down first from administration into

employees, who can then use that attitude themselves in their service delivery to patients. By

defining the initiatives specifically across departments for patients, more clarity could be

achieved in terms of the goals of offering hospitality beyond that of a typical hospital. This is

supported by research by Severt et al. (2008), whom used Patten's (1994) framework of public,

private, and therapeutic hospitality to give definition and purpose to specific service initiatives

within a healthcare organization.

<u>Barriers to the Patient Experience</u>

Through the interviews, both external and internal forces that can be potential barriers to

service excellence and hospitality were identified. External barriers include challenges

surrounding technology, increased consumerism, quality regulations, an aging population, cost of

services, workforce deficits, volume and capacity issues. Internal barriers to the patient

experience include communication between clinical and non-clinical employees, and inconsistency in the service delivered based on various system constraints.

The most frequently mentioned external barriers that top management cannot immediately control in regards to their operations were increased consumerism, improvement of technology, quality regulations, cost of services, and workforce deficits. Consumers have access to the internet and because quality regulations require that customer reports are readily available to the public, anyone can go online and review a hospital's strengths and weaknesses in healthcare services through customer satisfaction scores. This enables consumers to be more informed about their healthcare decisions than ever before, while also making it more difficult for hospitals to meet the expectations of healthcare consumers. The likelihood that these scores can be linked to medical fiscal reimbursements provides increased pressure to enhance delivery and allows the public to make comparisons between institutions that may vary greatly.

Another barrier is that medical care is expensive and insurance plans, or the lack thereof, may influence the medical care that a patient receives. Though this should not affect the service experience, it creates a complication in the medical system based on serving many different types of patients with many different insurance plans. Additionally, healthcare jobs are stressful with nurses topping the list of jobs with the most burnout (Patten, 1994). This creates many workforce shortages and prevents a full staff. Finally, the organization being studied struggles with long emergency department waits for patients waiting admittance into the hospital. This was in large part because the emergency department needs have outgrown the hospital. The hospital is currently expanding to overcome this struggle.

The organization has more control over the internal barriers that can affect a patient's stay. Two of the most frequently noted internal barriers to the patient experience were

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communication and consistency of service. For healthcare organizations and their leaders, there is always going to be an ominous fear of liability that could potentially occur as a result of a service failure, miscommunication, or a medical error, or some combination of these. Communication errors can occur between employees and patients, employees with other employees, employees with management, and employees with other departments. The high demand for services creates waits beyond the control of the facility, definitely influencing the perception level of service excellence and hospitality. Regardless of whether the communication errors are direct to patient or indirect, these can impact the experience of the patient as related to hospitality and service excellence.

Consistency errors were identified to be most related to a lack of employee buy-in to organizational standards, rounding to some units and not others, lack of anticipation of patient needs, and reduced interpersonal interactions with patients. By putting emphasis on aspects that top management can control through proper training and follow-up of middle management and frontline staff, the impact of internal barriers related to communication errors can be minimized. For example, new standards of hospitality and service excellence divided across divisions and departments may create more conversations in the specific organization regarding the different roles of clinical and non-clinical staff and how they may work together to enhance hospitality and service excellence.

Additionally, the ongoing internal Service Excellence Council at this hospital could use those meetings to discuss and minimize the occurrence of such communication errors. This also creates a standardized practice of leadership and could lead to a high likelihood of standardizing the patient experience. This is also asserted by Studer (2003) as related to the management of service in hospitals. For the hospital, using the councils and work teams to study and discuss the

various barriers can help to acknowledge potential issues and devise strategies that can be employed to minimize the negative affects of the barriers.

Implications to the Hospitality Industry

Though this is a case study, the distinct philosophies of service excellence, combined with hospitality, creates an optimal experience that may provide additional managerial implications for the hospitality industry. By looking at the complicated healthcare industry and comparing back to hospitality businesses, it is possible that the idea of boards and councils (both internal and external) may broaden the conversation around the potentially jaded response of employees when referring to "good" or "excellent" service. Additionally, considering the division of the service excellence portion of the hospitality business from the hospitality offered and developing a more thorough understanding of how the two work together to create service excellence would be helpful for these businesses.

Furthermore, the opportunity of cross-industry comparison offers powerful opportunities for learning, or at a minimum, seeing things with a fresh perspective. For example, comparing an emergency department wait with a restaurant wait could offer new insights for improving waits for each business   Also, by choosing the top ten service mistakes at a restaurant and having a team to address these mistakes, this could minimize errors and standardize outcomes of service when these issues are compared back to the emergency room service design. Moreover, having a Service and/or Hospitality Board with members outside the hospitality industry may provide a fresh perspective while building community relationships. The comparison of these industries can provide implications to managers that have not otherwise been explored.

Suggestions for Future Research

After conducting this study, the researcher identified the need for future studies specific to the conclusions and limitations of this study. Additional qualitative studies need to be conducted combining the top management perceptions of more than one similar sized hospital regarding perceptions of service excellence and hospitality and the internal and external barriers faced by the different hospitals. This would support this case study or reveal differences identified here.

Research should also be conducted focusing on the awareness and views of service excellence and hospitality from middle managers and frontline clinical staff (including nurses and technicians) in this specific hospital and how it varies across departments and employees. This would provide more depth than a simple view of the reports of top management. Further comparisons of this information would be helpful to organizations for new development of standards that are more specific.

There should also be a study on the difference in perceptions between acts of service excellence and hospitality. This conversation should likely be developed further to identify the merits for researchers and companies in identifying differences between the concepts. For example, studying hospitality as a philosophy applicable to all settings may further help educate society towards true benefits of hospitality beyond the surface level belief of the importance of being nice.

Research should be developed to investigate the possibility of having an overall theory of hospitality that is generalizable across industries and similar business types. This may offer a

large contribution to the current hospitality body of knowledge. Currently, there is no standardized definition of hospitality and how it can be measured. For example, a study such as this could be especially applicable to specific lodging sectors regarding the difference between service excellence and hospitality for comparative purposes to this study.

Limitations of Research

This research study presented a number of limitations. Primarily, this research was a case study investigation of one organization. The research also only investigated the perceptions of service excellence and hospitality from the top management team. The study did not utilize any quantitative methodology that would produce empirical and definitive implications and trends that are easily generalizable to other healthcare facilities. It was limited to open-ended interview questions asked to twelve of the hospital's administrative managers to describe their opinions of service excellence and hospitality within their organization. No follow-up study was conducted to reaffirm these views. The study also was limited to a single facility within a corporation that includes seven other healthcare facilities. There was also a potential bias in the study as permission to conduct this research was granted by the top management team itself, who also acted as the participants in the study.

Summary

This chapter presented the study objectives, introduced the discussion points that were generated from the themes identified in Chapter 4, and provided implications to those discussion points for the healthcare and hospitality industry. Next, specific research suggestions related to this study's findings and objectives were provided. Finally limitations of the current case study were provided.

APPENDIX A: INTERVIEW QUESTIONS

Why is service excellence and hospitality in the hospital setting so important?

What is the vision for service at Dr. P. Phillips Hospital?

Where does the organization currently stand regarding that vision for service?

What are the barriers in improving service excellence?

Why is service important to patients?

What do you do to verify the patients' perceptions of service at DPH? How do you know they perceive DPH the way you intend for them it perceive it?

How is service important to employees?

What else would you like us to know about service excellence, hospitality, and healthcare from your point of view?

APPENDIX B: IRB APPROVAL LETTER

Notice of Expedited Initial Review and Approval

From **: UCF Institutional Review Board**
FWA00000351, Exp. 5/07/10, IRB00001138
To : **Denver E Severt**
Date : **July 06, 2007**
IRB Number: **SBE-07-05055**
Study Title: **A Culture of Hospitality and Service: Enhancing the Patient Experience: The Case of Dr. P. Phillips Hospital**

Dear Researcher:
Your research protocol noted above was approved by **expedited** review by the UCF IRB Vice-chair on 7/6/2007.
The expiration date is 7/5/2008. Your study was determined to be minimal risk for human subjects and expeditable per federal regulations, 45 CFR46.110. The category for which this study qualifies as expeditable research is as follows:

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

The IRB has approved a **consent procedure which requires participants to sign consent forms.** Use of the approved, stamped consent document(s) is required. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s). All data, which may include signed consent form documents, must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

To continue this research beyond the expiration date, a Continuing Review Form must be submitted 2 – 4 weeks prior to the expiration date. Advise the IRB if you receive a subpoena for the release of this information, or if a breach of confidentiality occurs. Also report any unanticipated problems or serious adverse events (within 5 working days). Do not make changes to the protocol methodology or consent form before obtaining IRB approval. Changes can be submitted for IRB review using the Addendum/Modification Request Form. An Addendum/Modification Request Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at http://iris.research.ucf.edu .

 Failure to provide a continuing review report could lead to study suspension, a loss of funding and/or publication possibilities, or reporting of noncompliance to sponsors or funding agencies. The IRB maintains the authority under 45 CFR 46.110(e) to observe or have a third party observe the consent process and the research.

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:
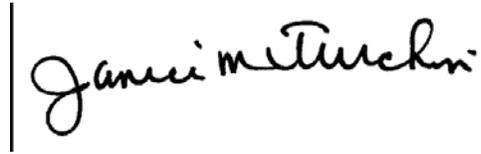
Signature applied by Janice Turchin on 07/06/2007 03:14:21 PM EDT
IRB Coordinator
University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

APPENDIX C: SAMPLE CONSENT DOCUMENTS

Letter to Hospital Administrators and Managers

Dear Dr. P. Phillips Hospital Administrators,

 My name is Taryn Aiello, and I am candidate for the degree of Master of Science in Hospitality and Tourism Management. I am currently conducting a case study research study in conjunction with Dr. Denver Severt at the Rosen College of Hospitality Management and the Dr. P. Phillips Hospital to examine current practices of service initiatives at this facility.

The purpose of this study is to investigate the overall quality of patient-focused services, including but not limited to, topics of patient care and comfort, employee commitments to service, and the analysis of a service-oriented culture and work environment. Specifically, we would like to investigate the integration of "hospitality" services as they apply to a healthcare setting. The act of being hospitable, through increased attentive social interactions with patients, improved guest amenities, and a supportive organizational culture for hospital employees, is postulated to increase a patient's mental and physical well-being while advocating total quality patient care and creating a competitive advantage for the facility.

We are requesting an interview which will take approximately one hour of your time on location at Dr. P. Phillips Hospital. You have been selected to participate in this study due to your expertise as a top healthcare services manager within this organization. Your participation in this study will result in no benefits to you besides those of learning about the research process.

Interviews will be audio taped only with your permission; otherwise, the researcher will take notes during the interview. This will be done to capture your valuable information pertaining to this topic. All audio tapes will be stored in a locked filing cabinet. The primary researcher and her supervising faculty member will be the only people with access to the files.

The interviews are strictly on a voluntary basis. All information is strictly confidential and no names will be reported. This will be done to protect the identity of the participants and their responses to ensure that the respondents' job security is not threatened. You can select not to answer any question you chose and the interview can be ended at any time. There are less than minimal risks associated with this study. In addition, this study has been approved by the Institutional Review Board (IRB) of the University of Central Florida.

Your valuable insight as a hospital administrator at the Dr. P. Phillips Hospital is important to the success of this study. If you have any questions regarding this study, please feel free to contact me at taiello@mail.ucf.edu.

Sincerely,

Taryn Aiello
Master of Science Candidate
University of Central Florida
9907 Universal Blvd. Box 160
Orlando, FL 32819
Phone: 386-316-5301
taiello@mail.ucf.edu

Dr. Denver Severt
Department of Hospitality Operations
University of Central Florida
9907 Universal Blvd Rm. 238
Orlando, FL 32819
Phone: 407-903-8036

Consent Form

Culture of Hospitality and Service: Enhancing the Patient Experience
The Case of Dr. P. Phillips Hospital

You are invited to participate in a research that will investigate the overall quality of patient-focused services, including but not limited to, topics of patient care and comfort, employee commitments to service, and the analysis of a service-oriented culture and work environment within Dr. P. Phillips Hospital. The purpose of this study is to investigate the integration of "hospitality" services as they apply to a healthcare setting to determine the benefit of creating a hospitable healing environment.

This study is being conducted by the University of Central Florida-Rosen College of Hospitality Management.

Procedures

If you agree to participate in this study, you should be familiar with the nature of this study so you know what to expect. This project involves data collection through the use of face-to-face interviews that will be conducted on-site at Dr. P. Phillips Hospital. The respondent will be asked to answer a series of questions related to personal experiences and opinions of the service culture as an employee and leading administrator at the hospital. The researchers will be taking notes during the interview process in addition to audio recording the session in order to properly capture in depth responses.

Dates

This study will commence on July 19, 2007 and end on August 15, 2007.

Compensation

Employees will not receive any additional compensation as a result of participating in this study.

Confidentiality

All information collected from this study will be kept completely private. In order to do this, the data collected from this study will be kept in a locked filing cabinet inside of the principal researcher's locked office for period of approximately three years. In addition, this signed consent form will also be stored separately from the data in a concealed location under lock and key for approximately three years after the study's cessation as required by the Institutional Review Board (IRB) of the University of Central Florida.

Voluntary Nature of Study

This study is completely voluntary. Your participation within this study will not affect your current or future position with the corporation. If you decide to participate in this study, please feel free to omit any questions you do not feel comfortable answering or withdraw from the study at any time.

Contacts and Questions

This research project is being conducted by Dr. Denver Severt and Taryn Aiello. If you have any further questions about this study, please feel free to ask them at this time, or contact the researchers at:
Office Phone: 407-903-8030
Cell Phone: 386-316-5301
Email: taiello@mail.ucf.edu or dsevert@mail.ucf.edu

Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board. Information regarding your rights as a research volunteer may be obtained from:

Joanne Muratori
IRB Coordinator
Institutional Review Board (IRB)
University of Central Florida (UCF)
12201 Research Parkway, Suite 501
Orlando, Florida   32826-3246
Telephone: (407) 823-2901

You will be given a copy of this information to keep for your records.

Statement of Consent:

I understand the procedures listed above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been provided with a copy of this form.

_____
Name of Participant (please print)

_____   _____
Signature of Participant   Date

_____   _____
Signature of Researcher   Date

APPENDIX D: DPH ORGANIZATIONAL CHART

Dr. P. Phillips Hospital

Medical Staff Ldrshp Chair	DPH President, Senior VP

Human Resources Organizational Dvpmt — Executive Assistant

CMO — **CFO** — **CNO** — **COO**

CNO → Admin Assistant

COO → Admin Assistant

CFO branch
- Financial Liaison
- Patient Business
- Matls Mgmt
- Revenue Integrity

Pt Care Administrator Clinical Svcs
- CDU
- PCU
- Medical Unit 5A/5B
- Patient & Family Counseling
- Spiritual Care
- Case Mgmt/ Social Work
- Homecare Coordinator
- Dialysis

Pt Care Administrator Surgical Svcs
- Perioperative Svcs PAT
- Surgery
- PACU
- Surgical Supplies
- SPD
- Cardiac Cath
- Surgical Unit 6A/6B
- Respiratory Therapy
- Endoscopy
- OP Services
- Pain Mgmt Svcs
- PICC/IV Therapy

Emergency Department
- Chest Pain Center
- Pharmacy
- Quality Spec Projects
- Administrative Supervisors
- Risk Mgmt
- Education Special Projects
- ICU

COO branch
- HIM
- Lean Six Sigma
- Facility Mgmt
  - Engineering
  - Protective Services
  - Meeting Services
  - Parking Deck
  - Bio Med
- Hospitality Services
  - Perry Pavilion
  - Guest Services
  - Volunteer Services
  - Gift Shop
  - Tele-communications
  - Valet Services
- Ancillary Administrator
  - Radiology & Nuc Med
  - Non-Invasive Cardiology/ Vascular
  - Lab
  - Food & Nutrition
  - Environmental Services
  - Neuro-diagnostics
  - Rehab
  - Wound Care Center (DHS)
  - Campisi Health Ctr
  - Imaging Marketing
- Physician Marketing
- Admin Coord. OP Planning
  - Dr. Hernandez practice
  - Intensivists
  - Dr. Rosenberg practice
  - Move Coordination
  - Dr. Campisi practice
- Facility Dvpmt
- EA Program
- TBD

Future position

1-30-08

APPENDIX E: EXAMPLE OF DATA CODING PROCESS

Research Objective

Interview Question Researcher 1

P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
A	A	A	D	G	D	A	A	A	B	C	D
B	G	G	E	I	G	C	E	E	E	F	G
G	F		G	J		F	G	G	G	H	
E			H			G	H				
						J					

Interview Question Researcher 2

P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
A	A	A	A	G	D	C	A	A	A	C	D
B	E	G	D	I	G	F	E	E	B	F	G
C	F		E	J		G	H	G	E	H	
E			H			J			G		

Compare Keywords

Identify Themes

Check Reliability

Make Conclusions
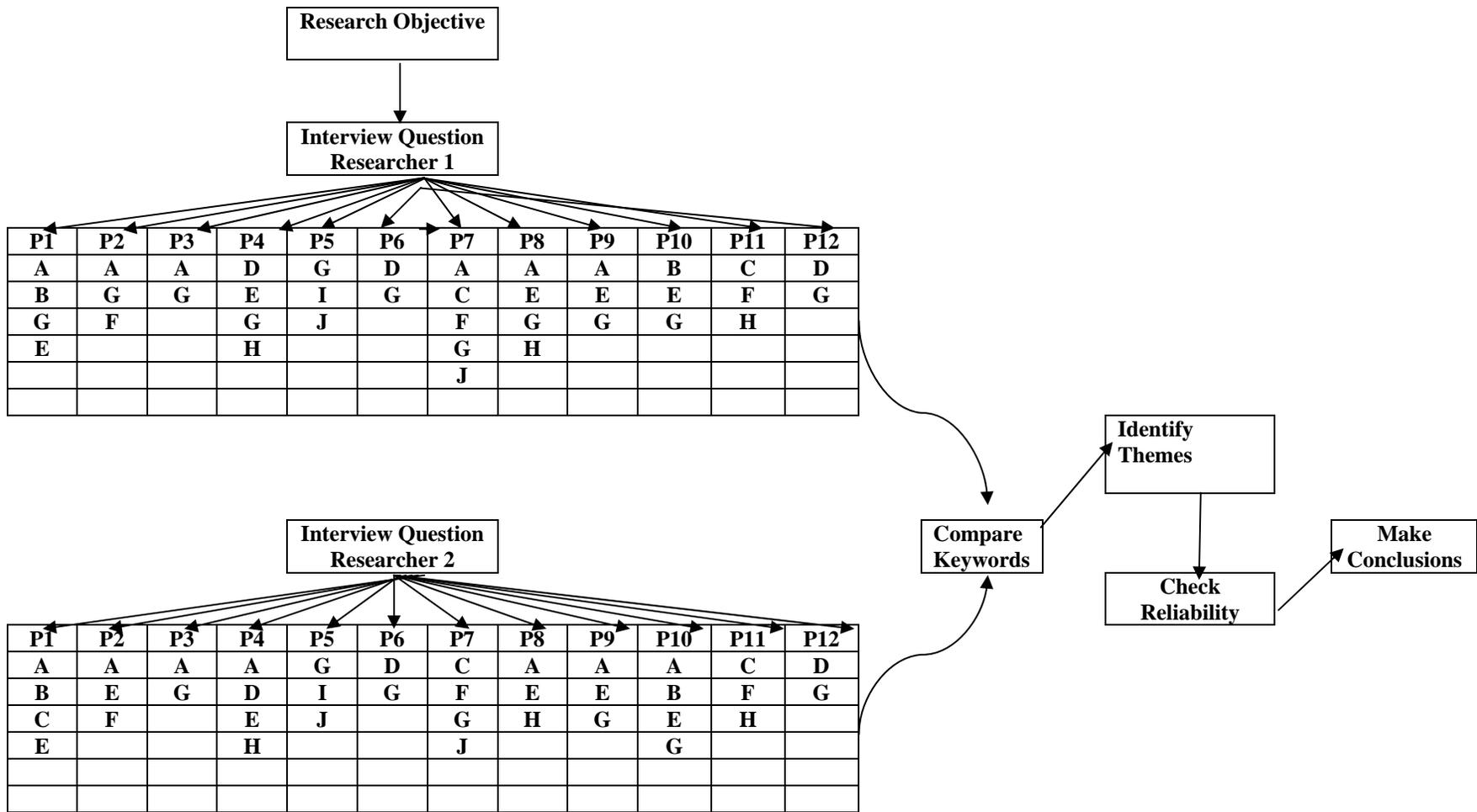
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