Evaluation of Mhotel

FINAL REPORT

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❖Research Matters

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Evaluation Summary

Mhotel is a new service being trialed by Melbourne Health. The service is designed for inpatients of The Royal Melbourne Hospital who do not require the high level of care provided in an acute, tertiary hospital. Rather than occupy a hospital bed, patients were accommodated at Rydges North Melbourne, a four star hotel located approximately 500m from The Royal Melbourne Hospital. During the trial, a registered nurse was on duty in the hotel 24 hours per day. Patients' rooms were located on one floor of the hotel. Hotel facilities, such as the dining room, were shared with other hotel guests.

This report presents only the findings from the qualitative evaluation. The qualitative evaluation provided an opportunity for patients, carers and hotel/hospital staff to reflect on a range of issues related to Mhotel. Using standard qualitative methods, respondents described what worked well, and what did not. They also made suggestions about how Mhotel could be improved. These findings can be used to complement quantitative data such as surgical waiting lists; surgical cancellations; hospital bypass; infection and readmissions rates.

Most respondents, both patients and carers, described the hotel staff and nurses as extremely friendly and helpful. They were generally very satisfied with the services provided in the hotel, including the level of health care. Several respondents said they would be "*very happy to do it again"* – sentiments that are rarely expressed after a hospital admission. One rural respondent liked it so much that he and his wife were planning to stay at Rydges as "*paying customers"*.

Many respondents *"hoped"* Mhotel would continue to be offered as an option. They described the hotel as much better than hospital. Some respondents described it as *"a holiday"*. They enjoyed having a room to themselves, quietness, privacy, nice bed, hot shower and free cable TV. However, all respondents would expect to be cared for in a hospital, not a hotel, if they were *"really sick"*.

Hospital staff identified many benefits of Mhotel. These benefits included saving the hospital money, increasing availability of hospital beds, and preventing cancellation of procedures. Nurses in the preadmission clinic made a distinction between 'preoperative/social' and 'postoperative' admissions to Mhotel. They described the hotel as more suitable for social than postoperative admissions.

According to the Mhotel brochure, doctors refer patients to Mhotel. In practice, nurses also referred patients to Mhotel. According to nurses in the preadmission clinic, referring patients to Mhotel had increased their workload. The referral process included completing a comprehensive check list before patients signed the 'Mhotel Patient Agreement'.

Respondents who were informed about the reason(s) for their transfer to the hotel were mostly positive about their experiences in the hotel. However, approximately one in five respondents was not sure why he or she had been transferred to Mhotel. Some respondents would have preferred more information, and consultation, before being transferred to Mhotel.

Most rural respondents were well informed about Mhotel. According to staff in preadmission clinic, rural patients often requested accommodation in Mhotel after hearing about it on the "*hospital grape-vine*". Mhotel not only reduced the financial expense but also the nuisance of finding accommodation and parking close to the Royal Melbourne Hospital. They appreciated free hotel accommodation the night before appointments or surgery and described being much better prepared because they were more relaxed. Many respondents considered Mhotel preferable to staying overnight with friends or relatives. However, rural patients with relatives/friends in Melbourne created *"a dilemma"* for some preadmission nurses. Some nurses suggested that their requests for accommodation in Mhotel raised ethical issues of equity and resource allocation.

The "*hospital grape-vine"* caused some respondents to misunderstand their entitlements in Mhotel. Respondents often remembered verbal information, even if the information was incorrect. For example, patients remembered being told that the *"hospital will pay for everything".* Although patients' entitlements were documented, few respondents indicated that they had read either the Mhotel brochure or the hotel's welcome letter. Those who were not clear about their entitlements were more likely to receive an unexpected bill at check out, most commonly for extra soft drinks. In some cases, patients had no means to pay the bill. This was not only embarrassing for some respondents, it also created difficulties for receptionist staff at the hotel.

Those respondents who were not given sufficient information were more likely to express concerns and anxieties about being cared for in a hotel. These concerns often abated when the hotel's reception staff told "hospital guests" that there was a nurse on duty in the hotel. Both social and postoperative respondents described feeling more secure in the hotel when they were told that a nurse was nearby and easily accessible if required. They described feeling secure knowing they could *"buzz a nurse"* anytime, though one respondent would have also liked to have an emergency signal. Respondents were informed that the buzzer only worked from their room. This encouraged many respondents to stay in their hotel room even though they would have preferred to *"wander around a bit".* Others did not feel well enough to leave their rooms, much less wander around.

With a registered nurse on duty day and night, patients with increased health needs were able to be accommodated in Mhotel. Accommodating patients with increased health needs had implications for hotel staff's workload (e.g. increased demand for room service). These patients also impacted on the hotel's ambience. When health care equipment remained in corridors, or hospital guests arrived at the dining room in pyjamas, hotel staff said that the hotel resembled a health care facility rather than a four star hotel. In addition, some doctors treated the hotel like another hospital ward when they assumed medication would be available at the hotel.

Nurses in the preadmission clinic expressed concerns about sending patients to Mhotel who required "*close monitoring*" such as postoperative patients and those receiving a blood transfusion. Their concerns about Mhotel were based on their understandings of the standard of nursing care at the hotel, and the nurse-to-patient ratio. They were unsure whether one nurse was able to manage eight patients competently and safely. They questioned what would happen if patients experienced postoperative complications. They were particularly concerned about the safety of postoperative patients who were transferred to the hotel without a personal carer.

Most respondents, including those who experienced complications in Mhotel, were very happy with the level of nursing care in Mhotel. Several respondents observed how quickly the hotel nurses responded, and how helpful they were. Many of those who experienced pain, including postoperative pain, described their pain as better managed in Mhotel than in hospital. In Mhotel, they were not required to fit in with "*hospital drug round schedules"*. Rather than ask a nurse for analgesia, or wait for a nurse to administer it, respondents were able to administer it themselves, at times when they needed it. One respondent required a short readmission to the hospital to arrange more appropriate analgesia.

Several respondents said that the hotel's location provided them with a sense of security. With Rydges being so close to the Royal Melbourne Hospital, respondents were confident that any emergency transfer back to the hospital would be quick and uncomplicated. However, an emergency transfer during the Mhotel trial was complicated because paramedics were unable to fit an ambulance stretcher into the hotel lift.

According to the data, routine transfers between hospital and hotel were often complicated by long delays. Some respondents waited in the transit lounge while pharmacy organised their medication. In other cases, Mhotel patients were sent to the transit lounge during times when the shuttle did not operate (e.g. between noon and 4pm). This suggests hospital nursing staff were not aware of the shuttle's operating times.

When the shuttle service was not available, some patients were given taxi vouchers, others were not. This suggests a lack of criteria for allocating taxi vouchers. Staff in the transit lounge also described poor communication between staff when taxi vouchers were allocated. In one example, three separate taxis transported three individuals to Mhotel within less than half an hour. With better communication among staff, all three patients may have been transported in a single taxi.

When the shuttle service was not available, some respondents chose to travel to, or from, Mhotel by private vehicle or foot. One respondent chose to walk from the hotel to the hospital canteen for meals. Hospital staff expressed concerns about the implications for the hospital if an accident occurred in transit. Although a patient may feel well enough to walk to and from Mhotel, they were inpatients of the hospital and under hospital care. Duty of care was also an issue when a respondent was told to walk *"down the road"* to the hotel. This respondent stood alone in the *"middle of the road"* at 11 o'clock at night trying to read the map that a doctor had given him.

Those who stayed in the hotel for longer than one (1) night were more likely to describe the hotel room as *"a bit lonely"*, particularly those without a carer. Those respondents with a carer were grateful that their mothers, wives and husbands could stay with them in the hotel. The presence of a carer also made many respondents feel more secure. Many carers would have welcomed a softer and more comfortable chair for both themselves and the patient. Some carers, particularly those who stayed for more than one night, described the hotel meals as "*too expensive*".

Reaction to the hotel's meals varied. Most respondents who used the dining room enjoyed the food, particularly the buffet breakfasts and lunches. Several respondents described the meals as *"wonderful"* when compared to 'hospital food'. They praised the hotel kitchen for accommodating their particular dietary needs. In contrast, other respondents found the hotel food unsuitable because it was either too spicy or too rich. Older respondents and those recovering from surgery were often unable to eat food on the room service menu. They would have preferred simple food such as soup, roast and vegetables.

Hotel staff said that they treated all guests the same, regardless of whether they were hospital guests or regular paying guests. Hotel staff expressed disappointment when some regular paying guests stared at, or made hurtful comments about, people who were visibly ill. Some respondents described feeling uncomfortable with *"tourists at the hotel"*.

Hotel staff tried to ensure that all guests had an enjoyable stay at the hotel. Their positive attitude towards patients, particularly those with chronic illnesses such as diabetes and renal failure, made a significant impact on several respondents. Respondents with chronic illnesses said that they were "*surprised"* that the hotel staff treated them exactly the same as a *'normal'* paying guest. After many previous hospital admissions, they had become accustomed to being treated as a "*patient"*. In several cases, the hotel staff's positive attitude towards them made them re-think the way they felt about their illness. Rather than feel like a dependent 'hospital patient', they described feeling more like a 'person'. Their admission to Mhotel had given them a more positive attitude about themselves and their ability to manage their illness more independently. For some respondents, Mhotel was not just a four star hotel – it was a 'health-promoting hotel'.

Method

The qualitative evaluation was designed to answer questions about the Mhotel trial that could not be accessed through numerical analysis. Key stakeholders were interviewed about a range of issues related to their stay to Mhotel. Key stakeholders included patients, personal carers (wives, daughters, husbands), hotel staff, MHotel nurses, preadmission clinic nurses and transit lounge staff.

Sample

1. Patients

Eighty (80) respondents were purposively selected for a follow-up phone interview based on:

- demographic variables (gender, age, ethnicity, and residential location,)
- length of time in hotel
- reason for admission to hotel

The sample contained 41 women and 39 men with ages ranging from 24 – 82 years (mean 58 years). Although 10% of respondents were from a culturally and linguistically diverse (CALD) group, only two required interpreters (Greek and Italian). Respondents were either from a regional/rural area (60%) or Melbourne (40%).

According to the Mhotel spreadsheet, the participants' length of stay in the hotel ranged from 1 - 16 days, with 64% staying in the hotel for only one night (Table 1).

Table 1: Length of stay in Mhotel

Length of Stay	Number of Respondents
1 day	51
2 days	16
3 days	4
4 days	5
5 days	1
6 days	2
16 days	1

Patients in the sample were admitted to the hotel for a range of reasons (Table 2). Some patients were admitted for more than one reason. It was noted that 23 of the 27 preoperative admissions were preoperative rural admissions (i.e. social admissions). Eight (8) preoperative rural patients were also accommodated in Mhotel postoperatively.

Table 2: Reason for admission

Reason for admission	Number of Respondents
Preoperative	27
Postoperative	29
Surgical review	6
Day Care	7
Tests	20
Medication	6
Hospital in the home	6
Community support	3

2. Carers

Two separate strategies were used to recruit carers.

1. **Snowball sampling strategy**[1]

At the end of the phone interview with patients, patients were asked whether they had a carer, and whether their carer stayed overnight in the hotel with them. This strategy recruited fifteen (15) carers. All but one of these carers stayed overnight in the hotel with the patient.

2. **Convenience sampling strategy**

On five (5) occasions, only the carer, not the patient, was available to be interviewed.

In total, twenty (20) carers were interviewed (Table 3). The carers included sixteen (16) women and four (4) men. Sixteen (16) carers were from rural areas, three (3) from Melbourne and one (1) from interstate.

[1] This widely used qualitative research technique involved the evaluator asking respondents to nominate other potential participants.

Table 3: Demographic details of carers

Relationship to patient	Urban/Rural	Patient's reason for admission	Number of nights in Mhotel
Daughter	Urban	Diabetes, hospital in the home	4
Mother	Urban	Preoperative	1
Wife	Urban	IV infusions	1
Father	Rural	Preoperative	1
Daughter	Rural	Postoperative	1
Wife	Rural	Pre-and Postoperative	2
Wife	Rural	Postoperative	1
Wife	Rural	Surgical review	1
Wife	Rural	Pre-and Postoperative	2
Husband	Rural	Postoperative	1
Wife	Rural	Preoperative	1
Wife	Rural	Medication	2
Wife	Rural	Medication	3
Mother	Rural	Preoperative	1
Husband	Rural	Tests	1
Wife*	Interstate	Postoperative	2
Mother*	Rural	Pre-and Postoperative	2
Daughter*	Rural	Preoperative, medication, community support	1
Husband*	Rural	Preoperative	1
Wife*	Rural	Hyperbaric at Alfred Hospital	28

* These 5 interviews were with the carers only, not the patients.

3. Hotel staff

Three (3) women representing Reception, Dining and House Keeping attended a focus group discussion about the impact of the Mhotel trial on them and their workload.

4. Mhotel Nursing staff

Six (6) female nurses working in Mhotel attended a focus group discussion about the Mhotel trial. They came from a variety of nursing backgrounds. Most were recruited from the Royal Melbourne Hospital's Nurse Bank. One Mhotel nurse had previously worked as a community nurse.

5. Hospital staff

Eleven (11) female nurses working in preadmission clinic or daycare surgery attended a focus group discussion about the Mhotel trial, though one (1) participant left the room during the discussion. In addition, three (3) women working in transit lounge, including two (2) registered nurses, discussed the issue of transferring patients between hospital and hotel.

Interviews

See Appendix 1 for a copy of all interview and focus group schedules. During each interview and focus group, extensive written notes were taken summarising the respondents' feedback. Although the data is not verbatim, it appears in the report in "*italics and quotation marks".*

Analysis of data

All data from phone interviews and focus groups were entered into a computer software package designed for qualitative research (NVivo). The interview data was coded thematically according to categories and sub-categories (Figure 1). The data was analysed according to themes and critical issues.

Figure 1: Main categories used in the analysis

1. **Understandings of why transferred to Mhotel**
2. **Concerns about being cared for in Mhotel**
3. **Transfer process between hospital and Mhotel**
4. **Level of health care in Mhotel**
5. **Experiences during stay in Mhotel**
    - **Positive**
    - **Negative**
6. **Comparison with previous hospital admissions**
7. **Suggestions about improving Mhotel**

Findings

Understandings of why transferred to the Mhotel

Patients, carers, and health care professionals gave many different reasons to explain why patients were transferred to Mhotel. Nursing staff in preadmission clinic often decided whether or not patients were referred to Mhotel. They described two distinct groups who were referred to Mhotel:

1. Preoperative admissions (mostly rural "*social admissions*")
2. Postoperative patients

Health care professionals (both doctors and nurses) referred patients to Mhotel. According to nurses in the preadmission clinic, admitting patients to Mhotel had increased their workload by increasing the paperwork and number of phone calls.

> *It has created more work for us. More paperwork, more phone calls. We are the one's booking it and deciding whether patients need it. We get patients' consent.* (nurse, preadmission clinic)

Nursing staff in preadmission clinic were responsible for informing patients about Mhotel and gaining patients' consent. Although all respondents signed the appropriate consent form, some respondents would have preferred to be consulted.

> *They put him and his wheelchair in a taxi and transferred him to the hotel. He was not given any notice. He had no choice*. (daughter of 66 year old Vietnamese man, rehabilitation)

Although all patients gave consent to be transferred to Mhotel, fourteen (14) respondents (18%) did not understand why they were accommodated in a hotel, not a hospital (Table 4).

Table 4: Patients' reasons for admission to hotel

Reason given	Number (N=80)
Rural morning appointment	16
Not sure	14
Free up beds	8
No bed available	11
Not serious condition	11
Under observation	5
Cheaper for hospital	4
No carer at home	4
No hospital in the home	2
Awaiting transport	2
Trial	2
To avoid infection	1

Unsure why transferred to Mhotel

Hospital staff

It was not only patients and carers who were unsure about services in Mhotel. Staff in the hospital were also unsure of the services offered in Mhotel. For example, staff were unsure whether carers could use the hotel while patients were having treatment in the hospital.

> *I was not sure whether a patient's husband could go back to the hotel while his wife was having her operation, or whether he had to wait at the hospital.* (nurse, day surgery)

Hotel staff would welcome hospital staff coming to the hotel for a visit to see how things worked in Mhotel.

Patients and Carers

Patients and carers made assumptions about their transfer to Mhotel. One carer described Mhotel as a new *"hospital policy".*

> *I gather it is a new hospital policy. You go to hospital and then get transferred to the hotel.* (carer of 43 year old rural woman, preoperative, 1 night)

A respondent who spent 16 nights in the hotel was not sure why she was in Mhotel. If she had been given a choice, she would have preferred to be treated, and cared for, in a hospital.

> *They didn't give me a reason. I assume it was because there were no hospital beds.* (56 year old urban woman receiving IV antibiotics and waiting for hospital in the home, 16 nights)

A rural respondent said he was unable to drive home after his anaesthetic. He assumed that he would stay in hospital after his operation.

> *No real explanation, but I assume there were not enough beds to keep me in hospital. I could not drive home, I was full of anaesthetic. I needed someone to keep an eye on me. I assumed that I would stay in hospital, like before.* (54 year old rural man with no carer, postoperative, 1 night)

Saving the hospital money

Hospital and hotel staff said that a bed in Mhotel cost Melbourne Health *"substantially less"* than a bed in the Royal Melbourne Hospital. They described Mhotel as *"saving the hospital money".* It also enabled patients to have procedures without having to wait for a hospital bed to become available.

> *It saves a hospital bed, so we are saving money for the hospital.* (nurse, preadmission clinic)

As indicated in Table 4, patients also recognised that Mhotel freed up hospital beds. In total, twenty three (23) respondents referred to either a shortage of beds in the public hospital system and/or saving the hospital money.

Not seriously ill

Patients also distinguished between those who needed acute care and those who did not. Eleven (11) patients stated that only those who were *"seriously ill"* needed a hospital bed. They described their own condition as "*not serious enough"* for a hospital bed. However, staff in pre-admission clinic were concerned that some postoperative patients may become "serious enough" for a hospital bed if they experienced postoperative complications. Staff in pre-admission clinic were particularly concerned about patients in Mhotel after certain procedures such as a laparoscopic cholecystectomy.

Hospital in the Hotel

Several patients were under the impression that part of the hotel had become a health care facility. One respondent was concerned when he discovered only nurses at the hotel – he had expected doctors too.

> *I was told that they were taking me to part of a hotel that's been taken over by the hospital.* (69 year old urban man with no carer, hospital in the home, 35 previous hospital admissions, 4 nights)

Some doctors also mistook the hotel as a hospital ward, assuming medication was available at the 'hotel ward'. Without being told otherwise, a woman with 26 previous admissions to hospital arrived at the hotel as for all other hospital admissions – without medication.

> *I did not realise that I had to bring my own tablets to the hotel until after I had arrived at the hotel. My doctor told me it was part of the hospital.* (40 year old urban woman with no carer, blood transfusion, 2 nights)

Social/rural admissions

According to nursing staff in preadmission clinic, the criteria for a social admission to Mhotel were people who lived more than 400km from Melbourne and did not have relatives/friends in Melbourne. The sixteen (16) rural respondents with morning surgery were grateful for overnight accommodation in Mhotel.

> *It was of great assistance to me. I didn't have to drive all the way early in the morning. So I was far less stressed than I would have been. I had a really good sleep and was a lot calmer for my operation in the morning.* (32 year old rural woman with a carer, pre- and postoperative, 2 nights)

Staff in preadmission clinic were concerned that rural patients who knew about Mhotel have begun to request accommodation there. On some occasions, hospital nurses did not consider these requests for accommodation in Mhotel to be appropriate.

> *Rural patients who are on an afternoon surgical list will say they want to stay at the hotel because they do not want to get up at 5am to drive to Melbourne. These situations really should be referred to a doctor.* (nurse, preadmission clinic)

Since the Mhotel trial began, staff in the preadmission clinic were less certain of the criteria for using Mhotel.

> *We have been told to limit the social admissions to the hotel because patients should be able to find their own accommodation preoperative.* (nurse, preadmission clinic)

Some respondents would have been able and willing to stay with relatives

> *I could have stayed with my son. If she had been admitted to hospital, I'd have done that. But we were very pleased we could both stay in the hotel.* (carer of 60 year old rural woman, tests, 1 night)

It was noted that it may not be reasonable to expect rural people to stay overnight with relatives or friends.

> *Pre- and postoperative rural patients should not be expected to sleep on a relative's floor.* (nurse, preadmission clinic)

More convenient

Several rural respondents acknowledged that Mhotel was much more convenient than staying with friends and relatives in Melbourne. It was also much cheaper than staying overnight in a private motel/hotel.

> *It was good that the hospital paid for it. It made traveling to the hospital much more convenient.* (26 year old rural man with a carer, preoperative, 1 night)

> *He had an early morning appointment and the train doesn't leave town until 7.15am. He would have been too late. We have little money at the moment, so they put us in the hotel for the night. It was very nice of them.* (wife of rural man, preoperative, 1 night)

Mhotel was also considered more convenient for carers.

> *I stayed at the hotel just because they said I could. I had been staying with relatives in Preston and the parking at the hospital was very difficult. It was a lot easier staying with my wife at the hotel.* (carer of 61 year old rural woman, postoperative, 1 night)

> *I'd spent two nights in the hospital sleeping in a chair. So you can understand why I liked being in the hotel – I was able to sleep.* (carer of 30 year old NESB rural man, postoperative, 1 night)

Concerns about being cared for in a hotel

Insufficient information

Twelve (12) respondents described some initial concern about being cared for in a hotel rather than in a hospital. These respondents had not been given sufficient explanation before their transfer to the hotel. Once they were given an explanation, their fears abated. In many cases, it was the hotel receptionist who provided the reassurance.

> *I didn't know what they meant when they said they would "give me accommodation". I was expecting to be cared for in a hospital. Once I got to the hotel and the receptionist explained everything, I thought it was lovely.* (41 year old rural woman with no carer, tests, 1 night)
>
> *I didn't really want to be alone there.* (78 year old urban woman with poor vision and no carer, postoperative surgical review, 1 night)
>
> *I worried at first about how I was going to get to the hospital by 7am. The receptionist explained that she would get me a taxi.* (41 year old rural man, preoperative, 1 night)
>
> *I was concerned because I thought I would have to stay over there on my own. When I arrived at the hotel, they said my husband could stay there with me. So I thought it would be OK.* (61 year old rural woman with a carer, postoperative, 1 night)

When patients arrived at the hotel, they were given a letter explaining their entitlements in the hotel. This letter also includes information about the public phone in the foyer, and complimentary parking in the car park. Despite this letter, many respondents were confused about what the hospital pays for, and what it does not.

> *There are some problems with patients using all the services and not having enough money to pay. They're over-ordering from the menu sometimes and then expecting not to have to pay for it. They say the hospital has told them: "Everything will be paid for by the hospital"* (Hotel staff)

Hotel staff are aware that hospital guests may be flustered upon arrival and not able to absorb everything. Hotel staff are worried that many patients do not understand the written material – they worried that literacy may be an issue for some patients. They would prefer the contents of the letter to be explained to hotel guests verbally.

Sicker Patients

Hotel staff have noticed that several "hospital guests" were much sicker since nurses have been employed in Mhotel. The "hospital guests" are often more visibly ill or impaired.

> *We feel a bit out of our depth, despite the first aid training.* (hotel staff)

Some patients spoke to hotel staff about their illnesses in *"great detail".* Some hotel staff found this upsetting.

> *"Sometimes the hospital guests describe their forthcoming operation in a great deal of detail. You can't ignore them, but feel you're probably not quite the right person for them to be talking to. They still tell you a lot, even with the nurses now here. One hospital guest was booked in for three weeks, but he left a week early. He told me that his cancer was incurable. That was upsetting. It is not like finishing an engineering project or something... If I had wanted to work in a hospital, I would. But I chose to work in a 4 star hotel.* (hotel staff)

With increasingly sick people in the hotel, housekeeping staff were anxious about what they might find when they walk into the rooms.

> *We don't know what to expect when we walk into the room. The patients could be on their deathbed or passed out. We just never know what to expect.* (hotel staff)

Sometimes hospital guests came to the restaurant/bar in their pyjamas and dressing gowns. This was not only against the hotel's dress code, it was also "*daunting*" for other guests in the hotel, especially those who were not aware of the presence of patients in the hotel.

> *It's quite daunting if there are corporate guests paying lots of money to stay in the hotel and there are people around the reception or dining area wearing dressing gowns and looking like patients.* (hotel staff)

Quality of health care

Hospital nurses working in the preadmission clinic and day surgery expressed concerns about patients' safety in the hotel, particularly postoperative patients and those without a carer.

> *Given the range of patients, Mhotel requires experienced nurses with broad skills. (*nurse, preadmission clinic)

Staff working in the preadmission clinic were responsible for gaining patients' consent prior to their transfer to Mhotel. They expressed concerns about the possible professional ramifications if they inadvertently misinformed patients about the level of health care in Mhotel.

> *On the consent form, it is clearly stated that there is "a senior experienced registered nurse available 24/7". With nurse bank nurses working in Mhotel, there is no guarantee that the nurses are experienced or competent. (*nurse, preadmission clinic)

Hospital nurses also expressed concern about the nurse to patient ratio in Mhotel. They said that it may "*not be legal*". They based their calculations on the legal ratio in an acute hospital. However, Mhotel is not an acute hospital.

One (1) respondent indicated that Mhotel needed more nursing staff. This respondent did not have a carer staying with him at the hotel. He was concerned that the nurses did not always answer the buzzers promptly.

> *The poor girls do their best, but they need a few more on staff. I buzzed and no-one came. What if it had been an emergency?* (69 year old urban man with no carer, hospital in the home, 4 nights)

No carer

Of those respondents who stayed in Mhotel for more than 2 days, 85% did not have a personal carer. These respondents often spent time alone in their room. Many described "*feeling lonely"* in the hotel. In addition, hotel staff observed that the patients who stayed in the rooms put additional pressure on room service because they often requested meals around the same time. Hotel staff suggested that patients, particularly those without a carer with them, may prefer to eat meals together in the dining room rather than ordering room service alone in their rooms.

Confined to room

Several respondents were told not to leave their rooms because their buzzer only works when they are in their rooms. Many stayed in their rooms, just in case they needed a nurse. Although respondents appreciated the security of having buzzers, they would have preferred the buzzer to work from all areas of the hotel. Several respondents said that they would have liked to move around the hotel, including the pool area.

> *There was a pool, but we did not see it. We just stayed in the room. The buzzer doesn't work from the pool. It only works from the room. So we stayed in the room all the time. But it would have been good to walk around a bit, or go down to the pool. It would have been good to be able walk around and take the buzzer.* (72 year old rural woman with a carer, postoperative, 1 night)

Easing concerns about care in Mhotel

Respondents identified four (4) main factors that helped to increase the level of security in the hotel.

- Accurate information about Mhotel
- Presence of a loved one (carer)
- Nurse working in Mhotel 24 hours per day
- Hotel's proximity to hospital

Accurate information

Respondents who were well informed about Mhotel were less likely to express concerns and anxieties about being cared for in a hotel. This included knowing the reasons for their transfer to Mhotel, and accurate information about the provision of services in the hotel, including health care. Information about small things, such as access to parking at the hotel, also made a difference to respondents.

> *It would have been good if staff at the hospital had told us we could park at the hotel.* (64 year old urban man with a carer, IV infusions, 1 night)

Personal Carer

Forty one (41) respondents welcomed the opportunity for a loved one to stay with them in the hotel. They said having a loved one with them in the hotel increased their level of security. Carers were also *"delighted"* to be able to stay in the hotel. One carer described her experience in the hotel with her daughter as a "holiday".

> *I think they had an emergency admission, so they cancelled my daughter's surgery. We could have gone home, but she was not feeling very well. They said she could stay at the hotel, and that I could stay too. It was great that we were able to spend a night together. Mother and daughter being alone together in a hotel. It was kind of like having a holiday together.* (Mother of 24 year old urban woman, preoperative, 1 night)

Presence of a nurse/buzzer

Many respondents described feeling safe and secure because they were able to *"buzz a nurse"*. The presence of a nurse in the hotel was an important factor in respondents feeling secure in the hotel, particularly those without a carer. Although most respondents did not require specific nursing care, they appreciated a nurse checking on them from time-to-time. They also appreciated having access to a buzzer.

> *The nurse came and checked my blood pressure. She left a buzzer in case I needed her. I felt quite safe.* (71 year old rural woman with a carer, tests, 1 night)

Respondents who required health care were pleased with the standard of nursing care in Mhotel. They also expressed surprise at how quickly the nurse responded to the buzzer.

> *The nurses were all just wonderful. I had a lot of pain with headaches, but there was a buzzer in my room and I could just call the nurse, who answered straight away. The nurses responded much more quickly than in hospitals* (48 year old rural woman with no carer, postoperative, 6 nights)

The nurses were also quick to recognise when a patient required an unexpected transfer back to hospital. In this sample, four (4) respondents required an unexpected transfer to hospital. These four respondents were particularly appreciative of the nurses' presence, and commented on the nurses' competency.

Proximity to hospital

Many respondents described feeling secure because the hotel was close to the hospital. Their feeling of security was based on the assumption that paramedics would be able to quickly transfer them back to the hospital in an emergency. However, during one unexpected transfer to the hospital, the respondent was alarmed that a stretcher could not fit into the lift.

> *When they came to take me back to the hospital, they couldn't get a stretcher into the lift. That was okay for me, I could manage to walk, but if you'd had a heart attack or something, they would not be able to transfer you on a stretcher. Maybe next time they renovate they should get a bigger lift.* (46 year old urban woman with no carer, pre- and postoperative, 2 nights)

Transfer process between hospital and hotel

Most transfers between hotel and hospital were routine, not emergency. Patients were transferred by:

- shuttle service (operating at 7am, 8am, 9am, noon, 4pm, 5pm, 6pm)
- taxi
- private vehicle
- foot.

Transit lounge staff (hospital), hotel staff and patients described difficulties with transferring patients between the hospital and hotel.

Transit lounge staff

Staff in the transit lounge said that their job was *"to get people from A to B"*. They identified the main problems with getting people from hospital to Mhotel as "*co-ordination and communication"*. Rather than have *"one point of call"*, the process of transfer required staff in the transit lounge to liaise with patients, Mhotel co-coordinator, hospital nurses, hotel nurses and/or hotel reception.

The difficulties with transfer were highlighted when staff in the preadmission clinic and day surgery sent patients to transit lounge when the paperwork was complete, irrespective of whether the shuttle bus was due.

> *Once the patient has recovered, it is just a matter of making sure that the paper work is done and sending them down to the transit lounge* (nurse, day surgery)

Staff in the preadmission clinic and day surgery said that it would be helpful for them to have a list of the shuttle times. Without awareness of shuttle times, staff were often sending patients to the transit lounge at inappropriate times. When patients were sent to the transit lounge during times when the shuttle was not operating (e.g. between 12pm – 4pm), patients were either asked to wait for the shuttle or given a taxi voucher.

To organize a taxi voucher, staff in the transit lounge phoned the Mhotel co-coordinator, hotel nurses or hotel reception. Some patients received a taxi voucher, others did not – staff in the transit lounge were not sure what criteria were used to make the decision about a taxi voucher. Those patients who did not receive a taxi voucher sometimes chose to travel to the hotel in a private vehicle. Staff in the transit lounge discussed the possible implications for the hospital if an accident occurred "*while patients are under our care*".

Staff in the transit lounge also expressed concern about the lack of communication and co-ordination between those staff who sent patients to the transit lounge. For example, three separate taxis were recently used to transport people to Mhotel "*within less than half an hour*". With better communication, a single taxi could have taken all three patients, and *"saved the hospital money"*. It may also have benefited the patients by giving them the opportunity to meet each other.

Another delay in the transit lounge was due to patients' waiting for medications. Rather than wait for pharmacy in a comfortable environment (e.g. recovery room bed/chair), they were often sent to the transit lounge to wait.

Finally staff in the transit lounge said that it was inappropriate for patients to be sent to Mhotel in pyjamas and dressing gowns. They were concerned that patients would be embarrassed arriving at the hotel's reception in pyjamas.

Hotel Staff

When transferring patients to Mhotel, staff from different parts of the hospital phoned the hotel's front desk. They recommend streamlining the bookings so that one person is responsible for transferring patients to the hotel. They recommended a "*pyramid of communication*", with one person in each organisation responsible for communication between and within each organisation.

The hotel staff also raised issues with the shuttle service. Although hotel staff were responsible for operating the shuttle service, hotel staff were not trained health care professionals. As such, they expressed occupational health and safety concerns about transporting some patients (e.g. people in wheelchairs). They also wanted staff at the hospital to recognise that transfers between hospital and hotel were in addition to their normal hotel duties. Delays in the transit lounge (e.g. pharmacy, medical histories) impacted on their other hotel duties.

> *Hospital staff do not seem to understand that we are busy. We may have a conference or something on. I once had to leave the restaurant in the middle of a dinner sitting to go and get a patient. I went to the transit lounge but they said "Wait, we need to get the history" so I had to wait twenty minutes. I am not a driver. I have other work to do.* (hotel staff)

Hotel staff also described feeling awkward about being expected to transport carers as well as patients. They explained that the car can only fit four people. They were concerned when young people (e.g. daughter of patient) were left to find their own way to the hotel.

Patients

One (1) patient described herself as *"lucky"* that there was such a long delay in transferring her to the hotel.

> *While awaiting transfer back to Mhotel, I had a minor stroke. I was not feeling very well so I lay down on a stretcher. That is when I had the stroke. I guess I was lucky it happened there in the hospital, not in the hotel.* (73 year old rural woman with no carer, blocked renal shunt, 1 night)

Thirty seven (37) respondents described a *"smooth"* transfer, without any complications. They described the shuttle service as courteous, though not always available. Nineteen (19) respondents described complications, particularly long delays and *"rude"* taxi drivers.

The term "shuttle service" caused some confusion because respondents expected the service to operate continuously throughout the day. When they found the shuttle was not operating, some respondents used alternative transport.

> *I had to be at the hospital by 6.45am and the shuttle service doesn't start until 7am. I didn't mind walking*. (26 year old rural man with a carer, preoperative, 1 night)

> *I was too early for the shuttle. So I asked reception for a taxi. The receptionist just picked up the phone and called one. It was there almost immediately. She gave me a coupon. The hotel staff were terrific like that.* (68 year old rural woman with a carer, preoperative, 1 night)

Although taxis were prompt, several respondents described "*difficult taxi drivers*" who objected to the short distance and small fare. There was also some initial confusion about who was responsible for the taxi fare.

> *There was a bit of a mix-up about the taxi voucher. My husband paid the taxi fare. It was only about $6 each time. But the nurse at the hotel said the hospital should have given us a voucher. We didn't really mind, everything else was free after all.* (69 year old rural woman with carer, postoperative, 1 night)

> *No one wanted to pay the cab fare. The hospital kept saying the rehab should pay the cab voucher, but the rehab said if I was in the care of the hospital they should pay for it.* (64 year old urban female with no carer, rehab, 5 nights)

One participant was asked to wait for the shuttle, but she was not told where to wait.

> *I didn't know where to wait. I should have been in the transit lounge but I waited outside.* (82 year old rural woman with no carer, preoperative tests, 1 night)

Rather than wait for the shuttle, some respondents were asked to walk to the hotel.

> *The doctor told me that I should walk to the hotel. But it was pouring with rain and I had all my bags. He kept insisting that I walk, but I objected. I simply couldn't walk in the rain, so they got me a taxi voucher in the end.* (40 year old urban woman with no carer, blood transfusion, 2 nights)

One rural patient was given a map to help him find his way to the hotel.

> *I had no idea where I was and I had to walk. It was eleven o'clock at night. They gave me directions and a map, but the map only showed the major roads, not all the little ones. I felt very vulnerable. In the end I went into a 7-11 and he told me where to go. It was quite frightening. It was in the middle of the night and dark. I had to go into the middle of the road where the trams come along to get enough light to try to read the map.* (51 year old rural man with no carer, tests, 1 night)

When patients were in transit, patients remained inpatients of the hospital. Hotel nurses were aware that they had a duty of care. This duty of care included social admissions who were just "*stretching their legs*" after a long drive.

> *I went for a walk after I checked in – it had been a long drive and I needed to stretch my legs. The nurse explained I could not just wander off like that. Once I'd checked into the hotel, I was in their care. So they needed to know where I was. It hadn't been explained to me. Once they had explained, I thought it was fair enough.* (41 year old rural man, preoperative, 1 night)

Health care

Two (2) respondents expressed reservations about the level of nursing care in the hotel. The first respondent assumed that phoning the hospital for advice indicated inexperience, not experience. It is worth noting that this respondent had 157 previous hospital admissions. This was his first admission to Mhotel.

> *There was one experienced nurse and the others seemed less experienced. One had to call the hospital a couple of times for advice.* (64 year old urban man, IV infusion, 1 night)

The second respondent blamed her readmission to hospital on the nurse's *"inexperience"*.

> *The nurse over-reacted when I got diarrhea. She was too inexperienced to be alone in the hotel. She ended up sending me back to the hospital in a panic. It was not necessary.* (40 year old rural woman, blood transfusion, 2 nights, readmitted to hospital)

Most of the other respondents were happy, if not *"delighted",* with the nursing care in the hotel.

> *In my situation it worked very well. I didn't really need any medical assistance, but I felt very confident about the nursing care. They were very conscientious and friendly.* (57 year old man, rural, preoperative, 1 night)

Apart from routine vital signs, most respondents said that they did not require nursing care.

> *The nurse came every three to four hours to take my blood pressure, temperature and to find out if I needed anything. I feel I was treated as well at the hotel as I would have been in hospital.* (66 year old rural man with a carer, tests, 4 nights)

With thirty eight (38) respondents staying in the hotel with a carer, many caring duties were shared between nurses and carers. This gave the hotel nurses time for a patient who required more attention.

> *There seemed to be about one nurse for eight people. So you received lots of attention if you needed it.* (26 year old urban man, postoperative)

> *At the hotel, the nurse isn't trying to do ten things all at once. At the hospital, nurses are too busy to even answer the buzzers.* (40 year old urban woman, tests)

Nurses in Mhotel described their interactions with patients as better in the hotel than in the hospital. In the hotel, they were able to communicate better with patients because they were not rushed. For example, they had time to talk to the patients about their medication and their illness. They also had time to talk with families. Nurses described it as *"a more holistic and collaborative approach"*.

Respondents described Mhotel nurses as *"respectful"* towards patients. They also appreciated nurses in Mhotel leaving them in *"peace and quiet"*.

> *The hotel nurses were different from hospital nurses. They did not have the "do as you're told" and "we know best" attitude of so many hospital nurses. They were easy and friendly. It is much better, much more respectful.* (49 year old rural man with no carer, preoperative, 1 night)

According to a woman with twenty six (26) previous admissions to hospital, the nurses' attitude in the hotel was extremely important in her pain management. Like other respondents who managed their own analgesia in the hotel, she described her pain as much better controlled in the hotel than in hospital.

> *I was responsible for taking painkillers when I had pain. I did not have to wait for the hospital drug round. So I didn't have to wait for pain relief, like you do in hospital. This meant I was not frustrated or angry. When you are in pain, there is nothing worse than having to wait an hour or so for a nurse to give you painkillers.* (40 year old urban woman with no carer, blood transfusion, 2 nights)

Apart from a respondent who required a short readmission to hospital because he was sent to the Mhotel without adequate analgesia, most respondents described their pain as being very well managed in the hotel.

Several respondents described recovering more quickly in Mhotel than in hospital.

> *It boosts the patient not to be in hospital. I feel my wife's progress was quicker in the hotel than it would have been in hospital.* (husband of 61 year old rural woman, postoperative, 1 night)

> *Being in the hotel gave my husband so much more confidence to be independent. Last time, he was in hospital for a week once after surgery. He only needed dressings but he became quite dependent on the nurses. He would have been better in the hotel then too.* (carer of 30 year old CALD rural man, surgical review, 1 night)

Experiences during hotel stay

When asked to describe the positive things about their hotel stay, respondents talked about:

- Friendly nurses and hotel staff
- Delicious meals
- Clean and comfortable room
- Foxtel
- Hot shower
- Privacy
- Large bed
- Relaxing
- Convenience
- Independence and freedom (e.g. to walk around, sleep when you want, relax)

Several respondents were so impressed with the initiative that they *"would not hesitate to recommend it to anyone or to stay there again*".

> *If I was asked to go there again, I would look forward to it.* (54 year old rural man with no carer, postoperative, 1 night)

Alternatively, when asked to describe the negative things about their hotel stay, respondents talked about:

- Room not ready
- Negative attitudes from some hotel staff
- Inappropriate meals for people who are feeling sick and lack of choice
- Expensive meals for carers
- No comfortable chairs (only straight backed chairs)
- Dirty carpets
- Heavy doors
- Being confined to the room with door shut
- Low toilet, difficult to get on and off
- Cold sauna

Some complaints about Mhotel were due to respondents being unrealistic about their entitlements regarding room and meals.

> *I wanted the room upgraded from two people (myself and my husband) to five (5) people. They made us pay $124 for the extra room. I had expected to only have to pay for the extra meals.* (62 year old rural woman with several carers, preoperative, 1 night)

Meals

Reactions to the hotel meals were mixed. Some respondents enjoyed the hotel's food much more than hospital food. They described enjoying delicious buffet meals in the dining room and nice room service meals. Others would have preferred the food to be simpler. One patient walked from the hotel to the hospital canteen because the canteen's food was *"familiar"*.

> *After surgery, you don't feel like eating fancy things. I walked up to the hospital canteen a couple of times and had sausages, eggs and bread. It was better than the hotel food because it was simpler and more familiar.* (49 year old rural man with no carer, postoperative, 1 night)

Many respondents described the kitchen as *"accommodating*" to different dietary requirements. One respondent was accustomed to specific 'diabetic meals' on hospital menus. She described not knowing which meals were *"for diabetics"*.

> *There was nothing on the menu specifically for diabetics. I had grilled fish, but the steamed vegetables were almost raw, and the fruit salad was rock hard.* (79 year old rural woman with a carer, preoperative, 1 night)

Respondent who stayed only one night in Mhotel described a wide range of choices on the menu. Those who stayed longer described becoming sick of the same food, particularly the room service meals.

> *There wasn't much choice on the room service menu. It would probably be quite alright if you were only there for a night or two, but after a few weeks it became very boring. There was nothing simple like a roast or quiche and salad. One night my husband was very hungry but just could not stomach the thought of having the same old things from patients' room service menu. I suggested he order something from the normal hotel menu, like a club sandwich. But they wouldn't make one up for him because it was not on the patients' menu.* (wife of 70 year old rural man, hyperbaric therapy at Alfred Hospital, 28 nights)

> *They should change the menu sometimes. It was the same menu the whole time I was there. There was not much on the menu that I liked. So this made it hard for me to order meals.* (69 year old urban man with no carer, hospital in the home, 4 nights)

Some respondents described the hotel food as "*la di da*" and "*too rich and spicy*". It was considered unsuitable for people in poor health.

> *If they're going to have patients in the hotel they should get a decent cook who offers more suitable food. The menu had all this la di da stuff on it. I could not eat it.* (79 year old rural woman, preoperative, 1 night)

> *The food is all much too rich and spicy. When you are sick, you don't want spicy rich stuff. I asked for an omelette with a little bit of cheese, but when I cut it open, all this cheese and oil poured out. It was revolting* (40 year old rural female, blood transfusion, 2 nights, readmitted to hospital)

According to two respondents, the meals in the hotel may be more suitable for carers than patients.

> *I couldn't eat very much. I thought I'd be able to eat the fish and I ordered it, but I found I couldn't as my throat was too sore. So one of my friends ate it and he said it was sensational - the best fish he had ever eaten.* (26 year old urban man with carer, postoperative, 1 night)

> *My wife and I were not keen on the meals. We are both plain eaters. At the hotel, there was a lot of sauces and gravy all over everything. One meal, I ordered poached chicken and it was just too spicy. My wife had brought a sandwich from the hospital, so I had that instead. My wife ate the chicken.* (76 year old rural man with carer, tests, 2 nights)

Many carers enjoyed the rich and spicy food, and said that the price was what they expected. Some respondents described carers' meals as *"expensive".*

> *The price was a bit of a shock. We don't get city prices in the country. It cost $54 just for the wife. The lamb was $24 and dessert was $16.* (72 year old rural man with carer, pre- and postoperative, 2 nights)

Carers who stayed longer than a few days in the hotel said they could not continue to afford the hotel meals.

> *It would have been too expensive over the four weeks to pay for breakfast, lunch and dinner. I brought my own weetbix and milk for breakfast, and made a sandwich for lunch. When he was at the Alfred, I went to the hospital café for a meal. It was much cheaper.* (wife of 70 year old rural man, 28 nights)

Some respondents raised concerns raised about the quality of meals on the weekends, particularly the freshness of lunch boxes.

> *The lunchboxes are not fresh. We ordered one and it contained a ham and cheese sandwich, muffin, drink and an apple. The sandwich and muffin were stale.* (wife of 70 year old rural man, 28 nights)

Several respondents commented on the crockery in the hotel. They enjoyed drinking their tea in a crockery cup, not plastic like in the hospital. Those who ordered cold drinks were surprised to receive a bill when they checked out.

> *It would have been good to have a jug of iced water, or orange juice, something cold to drink. After the operation I was very thirsty. I ordered an orange juice but I discovered on discharge that it was $3.50. Not that I'm really complaining, the hospital was paying for everything else, but I do think it would have been good to have a cold drink.* (41 year old rural woman without a carer, postoperative, 2 nights)

Some older respondents, with many previous admissions to hospital, were accustomed to the dining culture at the hospital. In hospital they were entitled to soup, main course and dessert. They expected the same entitlements in the hotel.

> *The only problem with the hotel was meals. I could choose two courses only. There were three on the menu but I could have only the soup and main course, or the main course and dessert. I wanted to have all three like in the hospital.* (66 year old Greek urban man with no carer, postoperative, 1 night, 18 previous hospital admissions)

Hotel staff also identified previous hospital habits as an issue for older hospital guests. When older people ordered three courses - soup, main course, and dessert, they were expected to pay extra. This was a particular problem with those patients who had not brought cash or a credit card with them.

Rooms

Most participants enjoyed the privacy and quietness of a single room. One respondent described the room as safer and less risk of infection "*because there are no bugs in the room*".

Several respondents described difficulties opening the door to their hotel room. They described it as *"really heavy"*, especially for someone who is feeling sick.

> *I had some trouble getting my bags up to my room. They were heavy for me to carry as I was feeling a bit weak after being operated on. I didn't ask anyone because I didn't want to make a nuisance of myself, but they felt really heavy. I'm only forty one (41) so I'm not old and weak or anything. The door to the room felt heavy too. It was kind of okay and I managed, but for people who are older, or don't have a carer it could be a struggle* (41 year old rural woman with no carer, tests, 2 nights)

Once in the room, most respondents were mostly happy. The rooms were described as comfortable, clean and "*very well appointed*". Some respondents made comments about access.

> *The pan in the toilet was very low. They need to raise it. Also there were no hand rails.* (69 year old urban man, hospital in the home, 4 nights)

A respondent said that it may be helpful if hotel and nursing staff knew in advance about patients' special needs. She suggested giving patients a questionnaire on admission.

> *I think they probably need to give the patients a special needs questionnaire, for example, "Do you need a special toilet seat? Do you need hand rails? As it is, I assume you would have to ask at reception and it would probably take some time to arrange. This would be a problem if you needed to go to the toilet quickly.* (46 year old urban woman, no carer, pre and postoperative, 2 nights, readmitted to hospital with diarrhea)

Although many respondents described the hotel as "*spotless",* some respondents questioned the cleanliness of the hotel's carpets and suggested that the bathroom was "*not quite up to standard*". This suggests that some rooms may be in a better condition than others. A few respondents said that the carpets need to be replaced or *"at least steam cleaned"*. One respondent who spent 16 days in a hotel room without a carer receiving antibiotic therapy had time to consider both carpets and cleanliness.

> *I noticed that the day-to-day cleaning was good. But the carpets and bedspreads needed to be cleaned more often. If they are going to have sick people in the hotel, it will need to be cleaner.* (56 year old urban woman with no carer, IV antibiotics, 16 nights)

One respondent described her experiences in the hotel room as like being on a "*second honeymoon*", though without her husband. Other respondents did not enjoy being alone in the room. Some respondents, particularly those without carers, described being "*lonely and bored*", despite access to Foxtel. They said it would be better if they could meet other patients and maybe go to the dining room together.

> *I would have liked the hotel to provide somewhere where patients could meet and talk to each other. Being confined to the room seemed unnecessary. I was very lonely in a room by myself.* (78 year old rural man without a carer, postoperative, 1 night)

One respondent without a carer would have liked to share her room with another patient.

> *I wouldn't have minded sharing with another patient. There were two beds in the room so I thought they might put someone in with me.* (46 year old urban woman, no carer, pre and postoperative)

To help pass the time, some respondents tried to make phone calls from their rooms. However, to activate the phone in patients' rooms, patients were required to provide either a credit card or $50 cash deposit. Some respondents were confused with this arrangement.

> *I couldn't really find out how I could make a call without making a fifty dollar deposit. There may have been some information about it somewhere but I had trouble working it out. I was not sure if I could use the phone in the hotel room or not. Fortunately, I had my mobile with me.* (51 year old rural man with no carer, day care, 1 night)

Pool area

*Although many older respondents described being "*confined*" to their hotel room, some younger respondents described moving freely around the hotel. The nurse simply asked them to tell her if they were leaving the room. Some younger preoperative patients enjoyed swimming in the hotel's pool.* However, hotel staff expressed concerns about the safety of patients swimming in the hotel's pool.

> *They gave me a buzzer. The nurse asked me to let her know if I was leaving the room. I went for a swim.* (26 year old rural man with a carer, preoperative, 1 night)

Comparisons with previous hospital stays

Several respondents described the hospital and Mhotel as *"chalk and cheese"*.

> *They're chalk and cheese really. Hospital is hospital, and the hotel is a hotel. Although the hotel was much more comfortable, and provided better food, I would expect to be in a hospital, not a hotel, if I was really sick.* (54 year old rural man with carer, postoperative, 1 night)

> *It was not very hospital-like at all. There were no regulations or hospital timetables. I felt much better just because I was staying at the hotel.* (69 year old rural woman with a carer, postoperative, 1 night)

Five (5) respondents would have preferred to be in hospital than in Mhotel, whether or not they were "*really sick"*. A 56 year old woman who spent 16 days in the hotel would have preferred to stay in hospital "*because there are other patients to talk to*". However, she was not given any choice. A 77 year old woman without a carer would have also preferred to have remained in hospital after surgery because "*there are experienced staff in hospital if anything should go wrong".*

On the other hand, forty four (44) respondents described the hotel as *"much better"* than previous hospital stays. They said that they would prefer to be in Mhotel unless they required acute care.

> *I would prefer Mhotel to the hospital unless I was very, very sick.* (60 year old rural woman with carer, tests, 1 night)

> *The hospital's best if you're actually bleeding, but the hotel is best if you're only at risk of bleeding.* (46 year old urban woman with no carer, pre and postoperative, 2 nights, unplanned readmission)

Several respondents described feeling better and more relaxed because they were in a hotel, not a hospital.

> *It is far more relaxing in the hotel and there is no noise. The big hotel beds are much more comfortable. Also there are no nurses coming to check on other patients all through the night and waking you up.* (56 year old urban woman with no carer, postoperative, 2 nights)

Many respondents also described Mhotel as a better environment for visitors because they were not "*chucked out at 8pm*". It was also better for young children.

> *I prefer to be in the hotel, and my kids like it. They can make a noise there. In the hospital, children are not allowed to make any noise.* (43 year old CALD woman with no carer, postoperative, 1 night)

Unlike a busy public hospital, many respondents enjoyed the hotel's "*privacy*". They also enjoyed the freedom of not being confined to a bed or a strict routine.

> *I could watch TV at 1am if I wanted and not disturb anyone else. Same with the shower – I could do it anytime.* (45 year old urban man with no carer, tests, medication, hospital in the home, 6 nights)

In the hotel, there were choices – patients could choose when, and where, they ate their meals.

> *In hospital, you have to fit in around hospital routines. Also you don't get much sleep because there is so much noise. And the meals are horrible. The hotel was 100% better. There's good food, it is quiet, there is a comfortable bed and a nurse on call. What more could you want?* (72 year old urban man without a carer, postoperative, 1 night)

Some respondents were impressed by the level of efficiency in the hotel.

> *The hotel staff were very efficient. Unlike hospital staff, they did not stuff around. I did not have to repeat my medical history to each member of staff. I just went straight in. The nurse took my blood pressure, and then she left me alone to relax.* (29 year old rural man with no carer, postoperative, 1 night)

> *The hotel staff were very helpful, welcoming and friendly. Nothing was too much trouble. Unlike hospital staff, they did not make me wait. They just did it immediately. This made a big difference.* (49 year old rural man, preoperative, 1 night)

> *I went to the dining room one night, but I just didn't feel up to it. I asked if we could have the meal sent up to the room and they said "no problems". They sent it up in five minutes. There was silver service and everything*. (60 year old rural woman with carer, tests, 1 night)

Finally, several respondents with chronic illnesses described returning to society.

> ***In the hotel, it is like you're not really sick. You are treated like everyone else. You are sort of back in society.*** (61 year old rural woman with carer, postoperative, 1 night)

Suggestions about improving Mhotel

Information to patients

Patients receive information about Mhotel from many sources, including each other. Evidence indicates that patients did not read either the brochure or the hotel's admission letter. It may be better if information was explained verbally, preferably by hospital staff before transfer to Mhotel. It may also be worthwhile if hospital staff came to the hotel for an informal visit, such as a Friday afternoon 'happy hour'.

Information to other hotel guests

If regular hotel guests were aware of Mhotel, they may not be surprised to see patients in the hotel dining room or foyer. This may reduce patients' discomfort in the hotel.

Transport between hospital and Mhotel

Utilisation of the shuttle service could be improved if hospital staff became aware of the shuttle service's timetable. Patients would be sent to the transit lounge only when the shuttle service was available. Increasing the utilisation of the shuttle service would reduce the need for taxis. It may also prevent patients traveling independently while an inpatient of the hospital.

Admission to Mhotel

A designated person could be employed to assume responsibility for 'meeting and greeting' patients upon arrival in Mhotel, transporting patients to-and-from Mhotel, escorting them to their rooms, enquiring about special needs and discussing how things work in the hotel (e.g. entitlements, menu, phone, shuttle service, parking).

Food and drink

A daily jug of iced water may prevent patients ordering extra soft drinks and receiving an unexpected bill. To cater for people who prefer simple home-cooked meals and meals specifically designed for people who were not feeling well, it may be worthwhile for chefs at both the hospital and hotel to meet and compare recipes. It may also be helpful to ask patients what type of foods they would like to eat while in Mhotel. To cater better for the longer stay patients, the room service menu could change more regularly.

Mingling with other patients

Feeling lonely in the hotel could be alleviated by having a designated area (e.g. a patient lounge) where patients can congregate, have a "yarn" and arrange to have a meal together. This may also relieve kitchen staff of the rush of room service orders at meal times.

First aid and hospitality

With patients in the hotel, hotel staff are required to have First Aid training. With nurses in the hotel, it may be useful if nurses undertook a short hospitality training course.

Conclusion

According to the data, the continuation of Mhotel has strong support from patients, carers, hotel staff and nurses working in the hotel. Although hospital staff expressed concerns about health care in the hotel, there was little evidence to suggest that these concerns were warranted. The main barrier to the provision of health care in Mhotel was neither the number of nurses nor their seniority. It was the size of the hotel's lift. In the event of a health care emergency in Mhotel, paramedics need to be able to transfer patients to hospital quickly and without unnecessary complications. This requires being able to fit an ambulance stretcher into the lift.

Meals and transfer were the two main issues identified in this evaluation. Respondents either loved the meals, or could barely eat them. Likewise, the shuttle service either worked well, or it did not work at all. Both these issues can be addressed through better communication with staff and patients.

Most patients and carers were very satisfied with their care in Mhotel. This included receiving professional service from the hotel staff. By treating "hospital guests" just like every other hotel guest helped many patients to feel "normal". Many patients welcomed a hospitality, rather than clinical, perspective.

This evaluation suggests that Mhotel has much to offer the health care system. It is a model of care that allows patients alternative care in a safe environment. In particular, it has the potential to implement a patient-centred model of health care, one in which people are treated as "guests", not "patients".

Appendices

Patient questionnaire

1. What is your understanding of the reasons why you were transferred to the hotel rather than stay in hospital?
2. Did you have any initial concerns about being cared for in a hotel?
   If yes: What were your concerns?
3. How was the transfer process between hospital and hotel?
4. Please describe your experiences during your hotel stay.
5. What was good about your hotel stay?
6. Why was it so good?
7. What did you feel about the health care in the hotel?

For those with previous hospital admissions only

8. How did it compare with previous hospital stays?
9. Did the health care services at the hotel meet your needs?
   If yes: why? **If no**: Why not?
10. What was not good about staying in the hotel?
11. Why was it not good?
12. Did you experience any symptoms (e.g. pain, nausea, dizziness)?

If yes: Who helped you to manage these symptoms?
How well were these symptoms managed?

13. Do you have any suggestions about how patient care in the hotel could be improved in the future?

Carers' questionnaire

1. What is your understanding of the reasons why (NAME) was transferred to a hotel rather than stay in hospital?
2. Did you have any initial concerns about (NAME) being cared for in a hotel?
   If yes: What were your concerns?
3. Why did you choose to stay overnight in the hotel?

OR

4. Why did you choose *not to* stay overnight in the hotel?
5. Please describe your feelings about (NAME's) hotel stay.
6. What did you like about (NAME) staying in the hotel?
7. Why was it so good?
8. What did you feel about the health care (NAME) received in the hotel?
9. What did you not like about (NAME) staying in the hotel?
10. Why was it not good?
11. Do you have any suggestions about how things could be done better in the future?

Hotel staff focus group

1. What is your understanding of the reasons why patients are being transferred to the hotel rather than stay in hospital?
2. What is it like having patients as guests in the hotel?
3. Did you have any initial concerns about patients staying in the hotel?

   If yes: What were your concerns?
4. What aspects do you think are working well?
5. What aspects do you think are not working well?
6. How has it impacted on your work? Has it increased your workload?
7. Do you feel adequately supported to deal with patients? Who supports you and How?
8. Compared to normal paying customers, how do patients treat you? Are they more grateful? More demanding?
9. What are the best things about having patients in the hotel?
10. What is not good about having patients in the hotel?
11. Please give an example of a positive experience.
12. Why was it good?
13. Please give an example of a negative experience.
14. Why was it not good?
15. What new skills are you learning?
16. Do you have any suggestions about how service to patients in the hotel could be improved in the future?
17. How would you score "patients as guests" out of 10?

0 1 2 3 4 5 6 7 8 9 10

Nightmare hotel guest Ideal hotel guest

18. Are there any other issues you would like to raise?

MHotel nurses focus group

1. What attracted you to practicing nursing in a hotel.
2. What is your understanding of the reasons why patients are being transferred to the hotel rather than stay in hospital?
3. Did you have any initial concerns about patients staying in the hotel, not hospital?

   If yes: What were your concerns?
4. Do you feel patients are safe in the hotel? Are there some patients that are more suited to the hotel than others?
5. What aspects do you think are working well?
6. What aspects do you think are not working well?
7. Describe the type of nursing care you provide in this environment? Do you feel the environment impacts on your quality of care?
8. Describe the coordination between hospital and hotel?
9. What are the best things about caring for patients in the hotel?
10. What is not good about caring for patients in the hotel?
11. Please give an example of a positive experience.
12. Why was it good?
13. Please give an example of a negative experience.
14. Why was it not good?
15. What new skills are you learning?
16. Do you consider the hotel a health care facility or a hotel?
17. Do you have any suggestions about how this 'healthcare facility in the hotel' could be improved in the future?
18. Can you give Mhotel a score out of 10?

0 1 2 3 4 5 6 7 8 9 10

Very poor Very good

Hospital Staff: Transit Lounge/Pre-Admission Clinic and day surgery staff

1. What are the major issues for you?
2. Do you have any concerns about transferring patient to the hotel/admitting people into the hotel?
3. What aspects do you think are working well?
5. What aspects do you think are not working well?
6. How has it impacted on your work? Has it increased your workload?
7. What new skills are you learning?
8. What are the best things about transferring patients to the hotel?
9. What is not good about transferring patients to the hotel?
10. Please give an example of a positive experience.
11. Please give an example of a negative experience.
12. Do you have any suggestions about how transferring patients to the hotel could be improved in the future?
13. Are there any other issues you would like to raise?