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Williams, C. and Gardiner, C. (2015) Preference for a single or shared room in a UK inpatient hospice: patient, family and staff perspectives. *BMJ Supportive and Palliative Care*, 5 (2). 169 - 174. ISSN: 2045-435X

<https://doi.org/10.1136/bmjspcare-2013-000514>

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Preference for a single or shared room in a UK in-patient hospice: patient, family and staff perspectives

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Keywords: Hospice care, palliative care, patients' rooms, patient preference, staff attitude

Word count: 3455

ABSTRACT

Objective: This study investigated the preferences of patients, family and staff for single or shared rooms in a UK hospice.

Method: Semi-structured interviews were conducted with patients, informal carers and staff at a hospice, focussing on room type preference.

Results: 14 current and former hospice in-patients, 15 patients attending the hospice day centre, 23 carers of current and former in-patients and 10 hospice staff were interviewed. Patients most often stated a preference for a shared room, especially if they had experience of being in this room type at the hospice. The main reason for this preference was the company of others. Patients preferring single rooms cited the benefits of increased privacy, reduced noise and private facilities. Other patients said their room preference would depend on how ill they were. Carers valued the social contact and increased staff presence in shared rooms, but felt that single rooms were easier for visitors and more appropriate when patients reached the end of life. Staff found it easier to observe patients in a shared room, and to maintain privacy and confidentiality in a single room.

Conclusion: The study concludes that both single and shared rooms should be available in hospice. Innovative planning can enable the social benefits of shared rooms to be maintained without compromising patients' privacy and dignity.

INTRODUCTION

Increasingly, modern in-patient hospices in the UK are built with single bedrooms as standard,[1] as it is believed that patients prefer these rooms, that they offer improved privacy and dignity and help with infection control.[2] However, studies investigating whether patients would prefer a single or shared bedroom in a healthcare environment have produced conflicting results. For example, one UK study exploring room preferences in an oncology ward reported that the majority of patients prefer a shared room to a single,[1] while a study in a UK hospice showed that patients overwhelmingly favour single rooms over shared.[3] Many studies of room preference advocate a mixture of room types in order to accommodate patients' preferences as much as possible.[3-5] In the UK, where basic healthcare is free of charge, patient preference and need along with availability will determine room type allocation rather than the patient's ability to pay.

One of the main factors underlying patient preference for shared rooms is the company of others.[5, 6] This was seen as a particular advantage in a study exploring the preferences of patients in a hospital palliative care ward in Canada. Patients often reported that they valued the social support provided by other patients in the shared room.[4] Another factor influencing patient preferences for shared rooms is the advantage of seeing healthcare staff more often[6].

Patients preferring single rooms in healthcare environments often cite aspects such as privacy,[3, 7] peace and quiet,[3, 8] better sleep and preferring to be alone[5] as key factors behind their preference. Patients may also prefer a single room if they worry about disturbing or upsetting other patients, or fear embarrassment, for example because of difficult symptoms.[3]

A number of studies have identified disadvantages to sharing a room. These include being with patients who are unfriendly, have a lot of visitors, or who are very ill,[9-11] confused or agitated.[3] Within a palliative care setting, watching and hearing other patients dying can be acutely distressing for some patients,[4] particularly if they had formed a bond with a patient.[12] However, evidence suggests witnessing death may also lead to self-reflection:[7] some studies reported that palliative care patients who had seen another patient die were less likely to be depressed and more likely to have found the death comforting than distressing.[4, 13]

A patient's room preference may differ according to the type of room that the patient is occupying when asked. A hospice-based study[14] found that patients whose only experience of room type was being in a five-bedded room were more likely to state a preference for a shared room or say they had no preference. However, when patients who had experienced a single room were asked, they overwhelmingly favoured a single room. Differences in room

preference have also been found at different stages of a patient's illness. For example, advanced cancer patients had a clear preference for a shared room when they were well enough to interact with others, but stated that they would prefer a single room if they became very ill or close to death.[15]

Patients' carers and family may also have opinions on the different room types. One study showed that patients' next of kin were more likely to prefer a single room for their relative than the patient themselves, but were still more likely to state a preference for a shared room than a single.[1] Patients' families sometimes worried about the effect on the patient of seeing others who were very ill or dying, and may also become distressed themselves.[4] However, families also acknowledge the benefit of their relative being in a shared room, such as perceived greater observation from nursing staff.[4]

Other studies have investigated the views of healthcare staff on the different room types. In the acute hospital setting, health professionals agreed that provision of appropriate privacy options was key to achieving an optimum environment for end of life care. However, there was little agreement as to whether single or shared accommodation was the most appropriate, and advantages and disadvantages were described for both.[5]

The evidence suggests a lack of clear consensus regarding optimum room type at the end of life, and a lack of understanding regarding the mechanisms that influence room preference. In addition, there is a lack of research attempting to align the views of the various stakeholders who utilise the care environment. This study attempts to address this gap in the literature by exploring room preference from the perspective of a large range of stakeholders, within a hospice setting.

METHOD

This study took place in an independent hospice for adults in a city in the North of England. The hospice serves an ethnically and socio-demographically diverse population, and has 20 in-patient beds and 100 day patient places each week. Five of the in-patient beds were in single en-suite rooms, and the remainder were in single-sex shared rooms each accommodating a maximum of four patients. One shared room had an en-suite bathroom and the others had adjacent facilities. The hospice is situated in a suburban area and is not geographically linked to a hospital. Ethical approval for the study was obtained from the hospice's Clinical Governance group as an independent charity no outside ethical approval was needed.

Given the limited existing evidence base and the experiential nature of the enquiry, a qualitative study design was adopted.

Semi-structured interview schedules were developed following guidelines for qualitative interviewing[16] and on the basis of the aims of the study and the

existing literature. Demographic information was also collected for all participants. Data collection took place over 6 months in 2010. With the assistance of senior nursing staff, CW identified and approached patients, carers, and staff at the hospice. Patients were excluded if they were very unwell or close to death, had severe communication or psychological difficulties, or had cognitive impairment. Some patients declined to be interviewed, generally on the grounds of being too unwell or tired. Carers were excluded if they had suffered a recent bereavement (within 3 months). All staff members with a clinical role were eligible for inclusion. Convenience and snowball sampling methods were used, with consideration given to achieving the maximum variation of experience within each group. All interviews were conducted by CW. Data collection continued until data saturation had been reached.

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All patient and staff interviews were conducted face-to face at the hospice; some current and former informal carers were interviewed by telephone if they requested this. All staff and carer interviews were conducted in a private room; some patients were interviewed in a private room and others in shared spaces. Participants were asked a series of questions on room preference. Interview schedules for each group of participants are contained in Appendix 1. The researcher used prompts and further questioning to explore the topics discussed. This method allowed for a richer and more detailed explanation of the topic at hand. Participants were also offered an opportunity to raise any other issues or thoughts they had regarding room type.

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During each interview, the researcher made hand-written notes of the participants' responses, audio recording was not possible due to resource restrictions.. Interviews lasted between 10 and 45 minutes. Data were analysed using thematic content analysis. This technique aims to bring order and structure to data by identifying themes and assessing whether there is any relationship between them.[17] This method is appropriate for this study as it allows prior categories informed by the interview guide to be applied to the data, while still being flexible enough to allow new categories to emerge. To aid the validity and reliability of the study, a second researcher analysed six of the patient interviews, to ensure that the themes emerging were consistent with those identified by the primary researcher.

RESULTS

Semi-structured interviews were held with 29 patients, 10 informal carers, 13 bereaved informal carers, and 10 staff members from the hospice. Table 1 provides details of the sample. All participants were aged over 18.

Participants	N
Current in-patients (4 women and 4 men; age range 57-85)	8
Former in-patients (4 women and 2 men; age range 53-82)	6

Day care patients (who had never been in-patients) (10 women and 5 men; age range 48-89)	15
Informal carers of current patients (7 women and 3 men; age range 43-80)	10
Bereaved informal carers of former patients (9 women and 4 men; age range 44-84)	13
Health professionals (7 nurses; 2 health care assistants; 1 doctor)	10

Table 1: Details of the sample (n=62)

Participants	N	% male	Age range (years)
Current in-patients	8	50.0%	57-85
Former in-patients	6	33.3%	53-82
Day Care patients	15	33.3%	48-89
Informal carers of current patients	10	30.0%	43-80
Bereaved informal carers of former patients	13	30.8%	44-84
Health Professionals			
Nurses	7		
Health Care Assistants	2		
Doctor	1		

The following themes were identified from interview transcripts:

Shared rooms

Many patients reported a preference for a shared room, with all giving the company of others as the main reason for their preference. Several patients said they had enjoyed talking to other patients when in a shared room, with some saying they had made friends with another patient. Avoiding isolation was mentioned as an advantage of, or reason to choose, a shared room with patients saying that they would find being alone unnerving or boring.

Current in-patient (female aged 57): "I find it comforting to know someone else is there if I wake up at night."

Many carers expressed a preference for their partner or relative to be in a shared room. A sense of shared experiences, camaraderie and mutual respect amongst patients in a shared room was mentioned, with one carer feeling that her partner had been able to discuss things with other patients that he had not been able to raise with her. Carers themselves could also benefit from the social aspect of shared rooms. Many had chatted to other patients' families while visiting their partner or relative, and some had kept in touch with people they had met. Some found it particularly beneficial to share experiences with other visitors or to know that they were in a similar situation.

Husband (aged 84) of patient who died at the hospice: "We were able to talk things over with the other people, and find out how they were coping... there was a real rapport there."

The main advantage of shared rooms for clinical staff was the ability to better observe patients, with some saying that they could keep an eye on the other patients in a room when attending to a patient. Some thought that this increased observation may lead to fewer falls. Shared rooms were also believed to increase the visibility of staff to patients, with the consequence that patients were more understanding when staff were busy.

Patients stated that the main disadvantage of sharing a room was noise, with the main source of noise being other patients and healthcare staff.

Former in-patient (male aged 75): "One man often got out of bed in the night and this felt eerie because it was dark... I was also woken up by the noise."

Several carers also felt that noise was a disadvantage. Many mentioned potential disturbance from other patients, for example patients with behavioural issues, and some felt that their partner or relative had got less rest because of this.

Wife (aged 56) of patient who died at the hospice: "[The shared rooms] felt like a thoroughfare.... more like a hospital than a hospice."

Another disadvantage of shared rooms for carers was the lack of privacy. Some felt the bed curtains provided enough privacy, but others disagreed, saying that conversations could be easily overheard.

Husband (aged 44) of former in-patient: "[We] had to have some difficult conversations with staff and the curtain didn't give adequate privacy."

Privacy was mentioned as a disadvantage of shared rooms by several patients. However, some felt that the bed curtains provided sufficient privacy, and others said they did not have an issue with other patients overhearing their conversations with doctors.

Former in-patient (female aged 62): "The medical staff tended to speak more quietly when talking to me [in the shared room]."

Issues around privacy were seen as the main disadvantage of shared rooms for staff. Some mentioned the difficulty of having private conversations with patients, especially if the patient was bedbound and therefore unable to move to a more private space.

Nurse: "It is usually clear to other patients what is going on behind a curtain."

Some patients mentioned that others in the same room as them had died in the room. Some found the death upsetting, with one patient finding it

particularly hard as he had 'built up a relationship' with that person, and the other saying it made him think about his own death.

Former in-patient (male aged 63): "[In the shared room] the two very ill patients died... I found this eye-opening and upsetting. It made me realise that I might be in the same position one day."

Single rooms

Several day patients said that they would prefer a single room if they came into the in-patient unit at the hospice. All but one of these patients had never been a hospice in-patient, although some spoke of their experiences of shared and single rooms in hospital.

Reasons for preferring a single room were varied, with many patients believing that it would be quieter or more restful.

Current day patient (female aged 84): "I would sleep better in a single room... I wouldn't be disturbed by other people snoring, or by people who wanted to stay up later than I did."

Other patients stated that they would prefer a single room because they thought it would be more private, and privacy was given as the main advantage of single rooms. Some felt the increased privacy when seeing doctors was a particular benefit.

Some current and former carers said they would have preferred a single room for their partner or relative. The extra privacy offered was given as the main reason for preferring this room type. Being able to have private conversations was another advantage.

Husband (aged 44) of patient who died at the hospice: "She could say what she thought".

Single rooms were seen as particularly appropriate for certain types of patient, especially those who were very ill or close to death, or where extra privacy was needed. However, this could lead patients who were moved into a single room to worry about the reason for the move.

Daughter (aged 69) of patient who was moved from a shared to a single room: "She assumed it must mean that she was dying, and she was the sort of person who didn't like to think about death".

Several carers felt that single rooms were easier from a visitor's perspective – for example because they did not have to worry about getting upset in front of others. Some believed that it was easier to have a larger number of visitors in a single room, or that it had enabled them to stay overnight. Some former carers also reported that a single room had allowed them and their family to spend time alone with the patient as death approached.

Wife (aged 65) of patient who died at the hospice: "I was in an emotional state ... other members of the family also got upset and this was difficult in a shared room. We just wanted to be on our own with [the patient]".

More privacy when communicating with patients was seen as an advantage of single rooms by some staff. One staff member stated it was easier to have difficult conversations with patients, and another believed that patients communicated more honestly when not overheard. Some felt that single rooms enabled staff to carry out procedures and examinations with more privacy.

The main disadvantages given by patients of single rooms related to a lack of social company. Many had concerns about being isolated or cut off.

Current in-patient (female aged 57): "I don't like being on my own... I would get lonely."

Carers thought that the main disadvantages of single rooms were isolation and loneliness. Several had concerns about reduced contact and observation from nursing staff in single rooms, and some thought that it would be harder for patients in single rooms to alert nurses if they were in difficulty.

Wife (aged 81) of patient who died at the hospice: "[The room] was at the end of the corridor... he ended up feeling depressed."

Observation of patients in single rooms was also seen as problematic for staff. Some felt there was more risk of patients falling and not being noticed. One staff member believed it was harder for staff to passively observe patients in a single room, as they might do when attending to another patient in a shared room.

Medic: "Nurses can't just pop in and keep an eye on patients in single rooms – they have to go in. There's is no opportunity to passively observe other patients when attending to a different patient."

Several patients and carers said that their preference for room type would depend on their circumstances, with single rooms being more preferable to patients if they were very ill and shared rooms if they were well enough to interact with others. Some staff members said that new patients who were very unwell or dying were likely to be allocated a single room, and all staff said that patients approaching the end of life might be moved from a shared room into a single.

DISCUSSION

The hospice movement has been lauded for its recognition of the importance of environment for patients reaching the end of life, however it is acknowledged that environmental and design challenges still exist.[18]This study attempted to address one of these challenges by investigating the room

type preferences of patients, carers and staff in a UK hospice. Our findings suggest that people who had been in-patients at the hospice were much more likely to prefer a shared room. This is consistent with other research which has suggested prior experience of one room type may predispose to future preference for that room type.[14] However, although previous research has found that palliative care patients are adaptive to their environment,[4] there was little evidence that patients in the current study changed their mind on room preference after being in a particular room type.

In common with previous studies,[4-6] the company of others was the overriding reason for patients and carers preferring a shared room. However, the presence of others was also seen as a disadvantage. Carers in particular cited lack of privacy as problematic, and staff could find privacy issues detrimental to their work, for example finding it harder to have difficult conversations with patients. Patients and carers also reported finding it hard to witness other patients ill or dying. Whilst single rooms are often seen as the preferred option for people at the end of life (Rowlands, 2008) , these results highlight that significant individual variation exists with respect to room type preferences. In addition, the preferences of patients, carers, and staff may not always align, adding further complexity to decisions around design and room allocation.

The reported advantages of single rooms were wide-ranging and included greater privacy and less noise. There was some evidence to suggest that patients were more likely to choose a single room if they had never been an in-patient at the hospice. Patients with no experience of hospice may have pre-conceptions of what a shared hospice room might be like. Their expectations may be shaped by difficult experiences sharing rooms in hospital, where there are frequently many more patients to a room, increased noise, and increased demands on staff time.[19] This may explain our finding that suggested an inpatient stay at the hospice seemed to lead to patients preferring a shared room.

Isolation and loneliness were the main disadvantages given for single rooms, and patients and carers worried about being overlooked by staff, with staff also concerned that it would be harder to monitor patients. Social isolation and loneliness are associated with numerous detrimental health effects (Nicholson), therefore every effort should be made to ensure privacy does not come at the cost of companionship and appropriate monitoring.

Boredom was another fear associated with single rooms for some patients and carers, along with a belief that time may drag – this was sometimes because of the lack of temporal cues present in single rooms. Providing a window with a view may help to alleviate this, and views and outdoor spaces are recognised as having a positive impact on patients in hospital [18]. Efforts should be made to facilitate access to outdoor spaces where feasible, and to ensure windows are at an appropriate height for bedbound patients to be able to see out of. [20]

Several patients believed that their room preference would be dependent on the stage of their illness, with most saying that they would prefer a shared room when feeling well, but a single if they were more ill. This finding is

backed up by other research[15] and also reflects evidence which shows changes in preferred place of death the closer someone is to dying.[21] This suggests that allowing patients to choose the amount of social contact they have might be beneficial, in addition to regularly revisiting preferences to accommodate any changes over time.

This study has some limitations. Patients who were very ill or close to death were not included and so their views could not be obtained. Although several former carers spoke of their experiences of their partner or relative being very unwell or dying at the hospice, their views may not have matched those of the patients. Convenience sampling was used to select former carers to participate in this study, and it is possible that those who had expressed a willingness to assist in studies may have been more likely to have had a positive experience of hospice care. Some patients were interviewed in areas where they could be overheard by other patients, which may have inhibited frank discussion. All participants were sampled from a single hospice, therefore findings may reflect a narrow perspective and transferability may be limited.

Despite these limitations, the study provides a useful insight into the room type preference of patients and carers, and the reasons behind these preferences. It also provides an insight into how the different room types impact upon the work of staff. The evidence suggests significant individual variation in room preference, and suggests a need for an individualised approach to eliciting preferences. In addition, hospice design should consider innovative ways to facilitate the provision of choice with regards to room preference, whilst continuing to meet the diverse and sometimes conflicting needs of patients, their families, and hospice staff. For example, shared rooms could incorporate movable soundproofed partitions to allow privacy when required. Further longitudinal research could provide insight into whether the room preference and environmental needs of patients and their carers change over the course of their stay and as a patient's illness progresses.

ACKNOWLEDGEMENTS

With thanks to all the patients, carers and staff who took part in this study, and also to Catherine Musgrave for assisting with the data analysis and editing.

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